The Competition Commission (“CC”) published its detailed Provisional Decision on Remedies (“PDR”) on 21 January 2014. The CC has refined the list of remedies that it put forward in 2013, in particular narrowing considerably the number of divestments that private hospital operators could be required to make and distinguishing more clearly between different forms of clinician incentives.

Key elements of the package are as follows:

- Divestment of hospitals in areas where operators are found to face limited competition
- Requiring new PPUs to be assessed against a competition test akin to that under merger control (where merger control does not otherwise apply)
- Banning direct clinician incentives and imposing constraints on equity participation by clinicians in private hospitals and PPUs
- Greater transparency of fee information and qualitative information on consultant and hospital performance.

The introduction of a new process for vetting new PPU contracts in line with a ‘substantial lessening of competition’ test as under merger control rules will likely impose additional burdens on those hoping to enter into such arrangements unless sensible ‘safe harbours’ or exceptions are established. However, this revised remedy is arguably less onerous than the options previously considered and has the advantage of flexibility as each case in future would be considered on its merits.

Background

In August 2013, the CC published provisional findings that concluded the private healthcare market had several features, both structural and conduct-related, that gave rise to an adverse effect on competition or “AEC”. In a number of local markets, the CC considered that the private hospital operator did not face enough competition and this, combined with high barriers to entry, led to higher prices for patients.

The CC was also concerned about certain types of incentive schemes that they considered encouraged consultants to refer patients to particular hospitals, or to recommend certain tests or procedures. These take many forms, but direct incentive arrangements, including the provision of free secretarial support or other facilities for free or at a discounted rate and linked to the amount of revenue generated by the consultant, were considered the most problematic.

More generally, the CC considered that patients and referring GPs were not in a position to make effective and informed decisions on where to go for treatment and which consultants to be referred to, and there was not enough information available on consultants’ fees, as well as on consultant and hospital performance.

Revised remedies package

The PDR sets out a package of measures to deal with the above issues. The CC is careful to point out first that they have not made a final decision on the underlying AEC finding and if that were materially revised before the final decision, this would have an impact on the remedies required. Secondly, the package needs to be considered as a whole and the CC does not believe any of the proposed measures in isolation would be sufficient to deal with all the issues identified.

Divestments

Requiring the sale of a business or part of a business is the most interventionist measure the CC can impose and until relatively recently this remedy has been used extremely rarely. The CC required the disposal of three airports by BAA in 2010 and most recently it has required divestments following the Aggregates market investigation which concluded in January last year. In this case, the list of hospitals has narrowed considerably since the provisional findings were published from twenty-one to nine.

The CC will be required to sell only two hospitals in the Central London area and BMI seven hospitals in Greater London and elsewhere in the UK. Spire will no longer be required to sell any of its hospitals. As part of the consultation, the CC wants to know whether the safeguards they have proposed are sufficient, e.g. a commitment on the selling hospital not to encourage or induce key staff to move their practices/employment, and requiring the rollover of existing insurer terms for 18 months following sale as a backstop.

Divestment remedies are generally controversial and particularly at a time when demand for private healthcare is relatively flat, this could give rise to serious issues for private operators and their funders. It also clearly raises the stakes sufficiently to encourage companies involved in these inquiries to consider very carefully indeed whether there is scope to challenge the CC’s findings.

PPUs

Originally focussed on areas where private hospital operators faced limited competition, the new proposal would extend the scope of this second ‘market opening’ remedy throughout the UK. However, instead of an outright ban on participation in NHS Private Patient...
Units ("PPUs") in ‘problematic’ areas, each case would be considered on its merits in light of the circumstances at the time.

New PPU transactions would have to be notified to the Competition and Markets Authority ("CMA") and either evaluated as a merger if appropriate, or tested against the same test – whether partnering through the PPU gives rise to a substantial lessening of competition – potentially leading to prohibition. However, there would be no Phase 2 reference process.

The CC considers that this will enable greater flexibility to make an assessment as the market changes in future, and will also allow the CMA to take into account countervailing factors such as patient benefits that may arise and whether there are in fact any other bidders for the relevant contract. It particularly sought views on two safeguards to minimise the regulatory burden – whether there should be:

- a ‘safe harbour’: eg. a share of supply threshold below which no scrutiny would be required
- a ‘de minimis’ value threshold, possibly set by reference to the threshold under EU procurement law.

There is a further practical question as to the timing of such reviews and the amount of information required with the associated cost. The CC presently appears to anticipate that notification would be made in the course of the tender process so that in problematic cases, the tenderer could simply withdraw. It is not clear how realistic this is or the impact on incentives to participate in such tenders if the extent of information required is similar to that required in an ordinary merger control process. That too is going to become much more onerous from 1 April 2014 under the new CMA merger control regime.

Incentive schemes

The core remedy here would be a ban on ‘direct’ incentive schemes which explicitly or implicitly link the value of rewards to the consultant to the consultant’s conduct in referring patients for treatment or tests to the hospital concerned, subject to a de minimis level of £500 a year.

Indirect incentives, including equity participation, are considered less problematic, particularly as equity participation also helps promote or encourage market entry. Therefore, the CC’s proposed remedy would instead:

- limit the size of the equity stake that may be held to 3%
- require payment to be made up front at fair market value
- require that equity participation is not linked to any express or implied referral requirements or practising commitments (eg. to conduct a minimum percentage or volume of private practice work or tests, or practice for a minimum period at the facility).

As part of this remedy, private hospitals and consultants would have to be open about the types of arrangements that exist and the value of benefits received.

Information provision

The CC has also proposed a number of measures to improve the amount and quality of information provided to patients and GPs. This would cover hospital and consultant performance, as well as the provision of fee information by consultants in a standard format which in due course would also be published.

Measures to improve transparency are relatively common and broadly this is consistent with other initiatives in the wider healthcare market to improve the ability of patients and GPs to make informed choices about where they can seek treatment and what they can expect, whether that be from a public or private sector provider.

Particularly in relation to the provision of qualitative information, it is recognised that this is not straightforward and the right mechanism needs to be found with a suitable independent body to manage it. The CC suggests that this body be funded jointly by private hospital operators and insurers. The remedy would be introduced over time not just because of its complexity, but also to ensure consistency with wider developments in the sector.

There is always a delicate balance to be struck in terms of providing the right kind of information to genuinely help improve customer/consumer choice, and providing too much, or information of a kind that the customer still has difficulty in making the right comparisons. That issue is just as significant in the sensitive area of healthcare where the trade offs and judgements that patients in particular have to make are complex and the underlying information is not necessarily readily comparable.

Next steps

Once the CC’s final report is published and on the basis that there is no material change to the above, the inquiry moves into the remedies phase with a period of consultation on the detail of the remedies to be put in place. If the report is published after 1 April, a statutory six month timetable will apply, subject to the possibility of one extension for four months. The statutory deadline for the inquiry is 3 April.

The CC itself envisages that the orders to put most of the above measures into effect would be implemented within around six months of the date of the final report, by October 2014. A longer period of adjustment may be allowed to the extent any existing arrangements involving shared equity/joint ventures between hospitals and clinicians need to be unwound (April 2015).

---

1 The OFT and the CC will merge and become the CMA from 1 April 2014.
2 Equity participation which linked the value of shares allocated to the revenue generated by the consultant would be considered a direct incentive and prohibited.
While it may be rare for the final report and remedies package to change markedly after a PDR is published, there was a quite decided shift in the recent Aggregates investigation following this stage, so further changes may yet be made to the overall package.

Further, a number of issues of due process have been raised in the inquiry already and the private hospital operators are firmly of the view that the competition concerns identified by the CC are misplaced or unfounded or at least greatly exaggerated. It therefore remains possible that the final report, if it maintains the provisional findings and these proposed remedies, would be subject to challenge. Judicial review of decisions of the CC in both merger and market inquiries has become increasingly common in recent years.

For any further information please contact:

Jenny Block
Partner
Litigation & Compliance
T: +44 (0)20 7490 9685
M: +44 (0)7500 578321
E: jenny.block@pinsentmasons.com

Barry Francis
Partner
Projects
T: +44 (0)20 7418 7340
M: +44 (0)7973 312150
E: barry.francis@pinsentmasons.com

Angelique Bret
Partner
Litigation & Compliance
T: +44 (0)20 7418 8218
M: +44 (0)7733 307377
E: angelique.bret@pinsentmasons.com

This note does not constitute legal advice. Specific legal advice should be taken before acting on any of the topics covered.

Pinsent Masons LLP is a limited liability partnership registered in England & Wales (registered number: OC333653) authorised and regulated by the Solicitors Regulation Authority and the appropriate regulatory body in the other jurisdictions in which it operates. The word ‘partner’, used in relation to the LLP, refers to a member of the LLP or an employee or consultant of the LLP or any affiliated firm of equivalent standing. A list of the members of the LLP, and of those non-members who are designated as partners, is displayed at the LLP’s registered office: 30 Crown Place, London EC2A 4ES, United Kingdom. We use ‘Pinsent Masons’ to refer to Pinsent Masons LLP, its subsidiaries and any affiliates which it or its partners operate as separate businesses for regulatory or other reasons. Reference to ‘Pinsent Masons’ is to Pinsent Masons LLP and/or one or more of those subsidiaries or affiliates as the context requires.

© Pinsent Masons LLP 2015.

For a full list of our locations around the globe please visit our website www.pinsentmasons.com