Overview
The CC focused its analysis on private hospitals and private patient units ("PPUs") that provide inpatient care (as opposed to day-patient and outpatient care). The CC has confirmed previously that the scope of its investigation does not cover the role of the NHS as such in terms of its ability to enter into PPUs or invest in private hospitals, although some of the remedies proposed could clearly have an impact in this respect.

The CC provisionally concludes that the market for privately funded healthcare consists of a number of features which, in combination, result in adverse effects on competition in the market. These features are:

• High barriers to entry for full service hospitals and weak competitive constraints in many local markets including central London
• The existence of incentive schemes operated by private hospital operators to encourage consultants to refer patients to their hospitals
• Lack of sufficient publicly available information on consultants’ fees and performance
• Lack of sufficient publicly available information on private hospital performance.

As a result the CC has proposed the implementation of a wide-range of structural and behavioural remedies, including divestitures of approximately 20 hospitals, the identities of which are confidential but which are all operated by BMI, HCA and Spire; a prohibition on expansion in certain other local areas by partnering with NHS hospitals to operate PPUs; and a prohibition on the use by private hospitals of certain consultant incentive schemes. The findings and the proposed remedies will be subject to third party comments, the deadline for which is 20 September 2013, and will be the subject of hearings with interested parties before the CC publishes its final decision by 3 April 2014; the final remedies may therefore be more limited in scope.

High barriers to entry and weak competitive constraints
Provisional finding
The CC provisionally concludes that barriers to entry are high for full service hospitals. The greatest such barriers include the significant capital (and sunk) costs required to set up a hospital, economies of scale relative to the size of local markets such that many local markets are only large enough to support a small number of efficiently sized hospitals and the static demand for private health services with no foreseeable growth in the future. Other less significant barriers included lack of site availability and the need for consultant commitment to new facilities.

Additionally, the CC finds that there are low competitive constraints exerted by hospitals on each other at the local level. Many local markets are very highly concentrated, especially in central London where constraints exerted by hospitals in greater London and the NHS are also considered to be insufficient.

The CC provisionally concludes that these structural characteristics give the three largest hospital operators (HCA, BMI and Spire) market power in their negotiations with both self-pay patients and private medical insurers ("PMIs") in certain locations and, as a result, private hospital operators currently charge higher prices in local areas where they face fewer competitive constraints. Additionally, because hospital operators generally do not set prices at the hospital level but instead set them at the same level across the hospital operator’s portfolio of hospitals, prices charged are also higher at a national level.

The CC also states it has found that BMI, HCA and Spire have earned consistent and significant profits over the last five years and states that this finding supports its provisional conclusions in relation to HCA, BMI and Spire’s market power and the existence of high barriers to entry.

While the CC acknowledges that Bupa and AXA PPP may have some countervailing buyer power, it finds that this does not fully offset the market power of those hospital operators.
Provisional remedies
To remedy the concerns around concentration in local areas, the CC has proposed both structural and behavioural remedies.

Structural remedies
The CC proposes that divestitures be made in those local areas in which one private hospital operator owns two or more facilities and where the CC's economic analysis suggests that a decline in local concentration might be expected to lead to an improvement in competitive outcomes for consumers. On the basis of the CC's preliminary analysis this would result in approximately 20 divestitures in 11 local areas. For example, in central London HCA owns eight hospitals and other facilities (such as outpatient treatment and diagnostic centres). The CC's proposed remedy would require HCA to divest a hospital/s or other assets ("the divestiture package") to a suitable purchaser or purchasers sufficient to impose a competitive constraint on HCA's remaining hospitals in central London. For areas outside of London, the CC proposes that BMI and Spire be required to divest of a number of their hospitals.

The CC proposes that the size of the divestiture package will depend on: (i) the range of medical services offered by each of the hospitals; (ii) the location of the hospital of concern and distance from both other hospitals owned by the same operator and competing facilities; (iii) the catchment areas of the hospitals in areas of concern and the extent to which co-owned hospitals have overlapping catchment areas; (iv) the mix of patients treated at the hospitals, i.e. insured, self-pay, overseas and NHS; and (v) the size of the hospital in terms of admissions.

The CC seeks comments from interested third parties on the proposed remedies, including in relation to the adequacy of the proposed remedies, the availability of suitable purchasers or less intrusive remedies, the possibility of certain assets conferring market power on the acquirer and the period in which divestments should be required to be made.

Behavioural remedies
The CC also proposes implementing a behavioural remedy which would prevent BMI, HCA and Spire from using their market power in certain local areas. This would be through, either:

• A prohibition on BMI, HCA and Spire from raising their prices nationally in response to a PMI changing its network policy in a way that meant patient volumes to the hospital operator were likely to fall, e.g. through the PMI removing one of the operator’s hospitals from its network ("option 1")
• A requirement on BMA, HCA and Spire to offer and price their hospitals separately and individually to PMIs ("option 2"). The rationale for this option is that it is expected that the hospital operator would charge lower prices in competitive areas but would either raise them elsewhere (thus encouraging new entry) or be deterred from doing so by the threat of new entry or reputational risk and would accept lower margins overall.

In relation to option 1, the CC acknowledges that, as the remedy does not remove the operator's buyer power, there exists a risk that the parties would simply find a way to exercise their market power in other ways. In relation to option 2, the CC acknowledges that it would need to be confident that the negotiating costs entailed in separately pricing hospitals would not render the process unviable for either the operators or the PMIs.

Lastly, for those local areas which are served by just one hospital or by two hospitals owned by different operators (and in which therefore, divestments would not be a suitable remedy), the CC has proposed a further remedy of restricting expansion by an incumbent hospital operator through a partnership or other business agreement with a PPU. This is based on the CC's finding that outpatient and day-patient healthcare providers face high barriers to entry to the inpatient sector due to the scale economies involved in providing this care. As PPLs are generally co-located with NHS hospitals and thus have access to their infrastructure, partnership with a PPU could provide a means of market entry for hospital operators.

The CC asks for comments in relation to these behavioural remedies, including in relation to how many local areas a PPU partnership would be likely, the practicability for other hospital operators to form PPU partnerships in areas where they did not already operate a hospital, possible unintended consequences and the necessity, if any, of monitoring the remedies.

Consultant incentive schemes

Provisional finding
The CC investigated the competitive effects of incentives offered by private hospitals to consultants to encourage referrals or treatments at their facilities. The CC distinguishes between short term incentive schemes where the value of the scheme to the consultant is only dependent on the conduct of an individual consultant (e.g. fee per referral schemes) and longer-term incentive schemes where the value of the scheme depends on the conduct of a number of the scheme's participants (e.g. equity participation schemes).

The CC provisionally concludes that all types of incentive schemes can have an adverse effect on competition but that certain equity partnerships between hospital operators and consultants can also have pro-competitive effects by lowering barriers to entry.

Proposed remedy
The CC's proposed remedy is to prohibit hospital operators from offering to consultants any incentives, in cash or kind, which are intended to or have the effect of encouraging consultants to refer patients to or treat them at its hospitals save in limited circumstances.

In practice, this means that short-term incentives will be prohibited outright. For example, if private hospital operators provide consultants with resources such as consulting rooms it will generally now need to be shown that the consultant was charged a fair market price for such use. However, long term incentive schemes such as share/equity ownership schemes may still be acceptable if it can be demonstrated that "such ownership results in a reduction in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful". How this balancing exercise is to be undertaken is likely to be a crucial issue and it is hoped that the CC's final report will provide sufficient clarity and guidance in this respect.

The CC has specifically requested interested parties' views on the practicality, reasonableness, comprehensiveness and likely cost of the proposed remedy as well as any likely customer benefits arising from equity participation that would not otherwise be available. In addition it asks for comments on whether there are...
Insufficient publicly available information on consultants

**Provisional finding**
The CC notes that while there is currently readily available information on the qualifications and specialties of consultants throughout the UK, there is insufficient publicly available information on consultants’ performance and fees. The CC provisionally concludes that this lack of information prevents the proper functioning of competition between consultants. The CC refers to the NHS’ plans to collect and disseminate performance data for individual consultants in ten medical specialties in England in the summer of 2013 and notes that while this addresses the problem in relation to performance information for consultants in the UK, similar information needs to be provided for Scotland, Wales and Northern Ireland in order to address the competition effects in the UK as a whole.

**Proposed remedy**
The CC therefore proposes to make a recommendation to the health departments in Scotland, Wales and Northern Ireland that they collect and publish individual consultant performance indicators to include activity and clinical quality measures across the same or an equivalent range of medical specialties to that included in the NHS England scheme. Data would be standardized so as to permit a genuine comparison between consultants in the same specialty working in different parts of the UK.

In relation to fee information, the CC proposes to require all consultants practising in the sector to publish their initial consultation charges to patients in writing, in advance of any treatment. Further, the CC would require consultants to provide a list of proposed charges to patients in writing, in advance of any treatment.

The CC invites comments on the practicability of the remedy, including on their practicability and reasonableness as well as views on how the remedy should be specified and the extent of any monitoring that would be required.

**Insufficient publicly available information on private hospital performance**

**Provisional finding**
The CC finds there is also insufficient publicly available information in relation to the performance of private hospitals. It provisionally concludes that such a lack of information prevents competition between private hospitals. It refers to the much higher level of detail publicly available for NHS hospitals.

**Proposed remedy**
The CC proposes to require all private acute hospitals in the UK to collect data equivalent to that collected in respect of NHS hospitals and make appropriate arrangements for its publication. This would include ‘hospital episode statistics’ (HES) which comprises detailed information on procedures and patients, as well as ‘patient reported outcome measures’ (PROMS) which provide qualitative information on patient care in the context of four commonly performed procedures.

The CC again invites comments on the practicability of the remedy, including the capabilities of hospitals to collect such information and whether there is any other data that should be collected.

**Conclusion**
The provisional conclusions are tougher than expected; the scope of remedies the CC has put forward is comprehensive, only stopping short of price controls, but they do not rule this out altogether. BMI, HCA and Spire will no doubt make strenuous submissions to the CC arguing against the need for the proposed remedies. BMI has already commented in the press that the CC’s finding in relation to its excess profits fails to recognise “financial realities such as the necessary costs of keeping our hospitals equipped with the ever more expensive technology required to meet the needs of patients, commissioners and insurers.” However, other interested parties, including the insurers and smaller private hospital operators, are likely to be supportive of the CC’s provisional findings. Even if they stick to their provisional view, the CC clearly recognises that implementation of some of their remedy options may carry risks and have unintended consequences; for example, the CC recognises that in some circumstances consultant incentives, particularly in the context of a share participation scheme, can be pro-competitive in the sense that they can facilitate new entry.