

Competition Commission private healthcare market investigation

A response from the AAGBI to the Competition
Commission notice of provisional findings on the Private
Healthcare Market Investigation and possible remedies

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THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

The Association of Anaesthetists of Great Britain & Ireland (AAGBI) welcomes the opportunity to comment on the Competition Commission's (CC) notice of provisional findings on the Private Healthcare market Investigation¹ and possible remedies².

Comments on Provisional Findings

PMIs

The PMIs are critical to the supply of private healthcare. The AAGBI remains disappointed that this inquiry is concentrated on the providers and not on the PMIs. The CC's fundamental assumption seems to be that the PMIs, as purchasers of over 80% of private healthcare, would be expected to function as advocates for the consumer, driving down the cost and improving the quality of care.³ This assumption only holds true in practice if the surplus generated by the PMIs' collective buyer power⁴ is passed on to the consumer, whilst maintaining or improving choice of hospital and consultants. The evidence of PMIs' insurance policies consistently going up in price while the cost per case goes down suggests that savings are diverted into the PMIs' company profits, whilst consumer choice of hospitals and consultants is reduced, because hospitals and consultants decide not to enter the market, or decide to leave the market because it is not commercially viable.

Bupa, the cost leader⁴, admits that it does not consult consultants or their representatives when reducing their benefit maxima, and thus the fees that consultants can charge (paragraph 7.42 of the Provisional Findings)¹. This ought to prompt detailed further investigation by the CC. It would be unwise to assume that a buyer with market power sufficient to unilaterally reduce its suppliers' prices without prior notice, will actually pass these savings on to its customers.

The AAGBI has provided evidence that this extreme buyer power is a particular issue for anaesthetists, who are the lowest earners in the sector⁵. FIPO has also demonstrated the declining proportion of consultants working privately⁶. Those hospitals and consultants that remain in the market will be deterred from investing and innovating if there is insufficient commercial justification, thus reducing the quality of care and the quality of the service being purchased, particularly in comparison with the NHS.

The AAGBI requests that the CC looks again at the adverse effects on competition of the PMIs' buyer power and the weakness of competition between them. The CC's investigation has found that the PMI industry is dominated by only four companies, two of which have a combined market share of over

¹ http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/provisional_findings_.pdf

² http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130828_remedies_notice.pdf

³ For example, in paragraph 7.60 of the Provisional Findings, the CC states: "in the absence of the PMIs constraining consultants' fees, it is unclear how such fees would be constrained". In such a scenario, the AAGBI submits that fees would be constrained by the normal competitive process, as it is in other parts of the private healthcare sector such as cosmetic surgery.

⁴ The CC has found that other PMIs tend to use Bupa's benefit maxima as the industry benchmark, meaning that they do not set prices independently of each other (paragraph 7.35 of the Provisional Findings).

⁵ http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/140403_aagbi.pdf

⁶ http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130405_fipo.pdf

65%. This was the main reason the industry was referred to the OFT by the AAGBI and others. The AAGBI continues to believe that there is a strong case that there are adverse effects on competition arising from the PMI market.

Consultants and consultant groups

The AAGBI supports and welcomes the CC's provisional conclusion that individual consultants or consultant groups in local areas do not have market power and that consultant groups may provide benefits to patients¹.

The AAGBI notes that the CC concluded that “*BUPA and AXA PPP have buyer power in relation to consultants*”, but that they “*found no evidence to suggest that it is being exercised in such a way as to harm competition, for example, by leading to a shortage of consultants in private practice or to a reduction in innovation or quality of consultant services*”¹. The AAGBI consider that it is unreasonable to conclude that “no evidence” was available as both the AAGBI⁵ and FIPO⁶ did submit evidence “to suggest” that the supply of consultants to the private sector is reducing, particularly anaesthetic consultants. The CC has not yet sought the level of evidence required to justify the conclusion that the buyer power of the PMIs is not leading to consultant shortages. This does not mean that this evidence does not currently exist and it does not mean it will not exist in the near future. Until such evidence is available, it should be recognised that the buyer power of the PMIs accepted by the CC could be expected to result in consultant shortages, poorer quality and stifled innovation, and that the CC should ensure that this does not happen by abuse of their market power by taking appropriate remedial action. We suggest that the reasoning in section 7 (and therefore para 52 of the Summary) is altered accordingly¹.

In this respect, it would be extremely helpful if the CC's final conclusions repeat the endorsement in the Annotated Issues Statement of the right of consultants to charge a “top-up fee” if estimated in advance¹. This would provide a valuable control on PMI buyer power, whilst encouraging the provision of advance information and promoting consumer choice.

Whilst the AAGBI is disappointed that the CC is not yet persuaded by the detailed evidence submitted by ourselves⁵ and others about the unreasonable practices of the PMIs, we are pleased to note that the CC recognises that the PMIs need to ensure that they provide clear and accurate information about the reasons for recommending some consultants over others¹. As the AAGBI believes that these reasons are entirely commercial, we would welcome a specific remedy to this issue. In this respect, it is notable that the Association of British Insurers and the Financial Services Authority (now the Financial Conduct Authority, FCA) have failed meaningfully to address the requirement of the OFT to improve PMI information at the point of sale⁷. Stronger measures are therefore required to enforce both the recommendations of the CC and the OFT. The AAGBI strongly supports these recommendations, which it believes are essential towards improving customer experience and competition in the private healthcare market, perhaps more essential than the recommendations regarding information about hospital and consultant performance contained within this CC report. Without specific remedies, enforced by the CC, these recommendations will be pointless, as they will continue to be ignored by the PMIs.

The AAGBI fully supports the CC's conclusions regarding “clinician incentives”, but notes that there is no mention of the considerable impact of NHS work in this respect. The CC notes the increasing importance of NHS work on private hospital profitability¹. The AAGBI has previously noted that NHS contract work is almost exclusively in the gift of private hospital managers, and that the fees offered to surgeons to perform NHS operations are substantially more than those offered to anaesthetists⁵. This acts as a very effective form of incentive for surgeons to continue to bring insured private cases to the hospital – they would naturally fear that if they withdrew their insured work, they would lose the lucrative NHS work as well. This disparity, which is not justified by additional secretarial or indemnity costs, and would not exist were the patients to be treated in an NHS hospital, is a considerable financial inducement to surgeons that exceeds many other types of incentive mentioned in the CC provisional findings, both in value and incidence. The CC mentions a “fair market price”, and this concept is relevant in this context. A fair market price would be the same for all clinicians of similar

⁷ http://www.of.gov.uk/shared_of/market-studies/OFT1412.pdf Para 1.29

training and experience, who are paid the same in the NHS. This type of incentive would be covered by the definitions used in remedy².

Comments on Possible Remedies

Remedy 4—Clinician inducements

The AAGBI strongly supports the CC recommendations to disallow all forms of financial inducements to clinicians². This should include payment for NHS work at rates exceeding that paid to other clinicians of similar NHS standing. We would welcome specific exclusion of this type of incentive.

Remedy 5—a recommendation to the health departments of the nations

The CC has put much reliance on the consultant performance data to be published by NHS England^{2,8}. However, these data are only relevant to 10 specialities and, although the data may be adjusted for case-mix, complexity of intervention and co-morbidity, it will be very difficult for patients to interpret. In the worst-case scenario, it may be misinterpreted to the patient's potential detriment.

The AAGBI suggest that the CC, the PMIs and the private hospital operators work with the relevant speciality representatives to provide a realistic and readily interpretable dataset of consultant performance that is relevant to prospective private patients without substantial risk of misinterpretation, for all specialities and not just 10 of them.

With respect to anaesthesia, the AAGBI would be keen to assist in developing systems that assess the performance of anaesthetists. Clearly, some detailed work would be required to make sure that the remedy achieves its aims and does not give rise to misleading or distorted information.

We suggest that any performance dataset should be updated annually, or at least five yearly, in accordance with the local appraisal or GMC revalidation cycles, respectively.

Remedy 6—An information remedy

The AAGBI is pleased that the CC quoted its Voluntary Code of Practice⁹ as an example of good practice².

The suggestion of providing advance estimates of consultation fees and treatment costs to patients is practicable for the majority, but it should not be required to be "in writing"². It would be reasonable to do so, but it will also be reasonable for a patient to receive a quotation by telecom, look up the proposed fee on a website or publication, and confirm on admission that they had done so, thereby accepting the proposed charges. It may also be reasonable for those consultants who choose to do so to state that all professional fees will be in accordance with insurance company benefit maxima, or that this will only be applicable for patients insured by specified PMIs, with a guarantee that no top-up fees will be charged. No specific estimate would then be necessary.

For a minority of patients, it will not be practicable to provide an estimate in advance, for example, emergency patients, children and those with diminished mental capacity. In these circumstances, every reasonable effort should be made to inform a close relative of the proposed charges provided this does not compromise confidentiality.

Any advance estimates must contain caveats relating to changes to treatment, or the development of complications.

It is reasonable to expect that all consultants should apply these arrangements, regardless of the income they generate.

There should be agreement on the amount of notice that is considered reasonable in order to allow the patient to look into other options and compare prices. The cosmetic surgery industry is required to

⁸ <http://www.england.nhs.uk/wp-content/uploads/2012/12/everyonecounts-planning.pdf>

⁹ http://www.aagbi.org/sites/default/files/code_of_practice_08.pdf

provide a two-week “cooling off” period¹⁰, and this would seem a reasonable aim for the rest of private healthcare to aspire to. However, it has to be accepted that sometimes patients will want shorter notice admissions and this will be in their best interests.

Estimates should otherwise be inclusive of all charges, including hospital costs. Hospital costs seem to be excluded in the CC discussion on this issue¹, but there is no logical reason to do so.

Consultant Anaesthetists will have difficulty in providing advance estimates, as they usually do not see patients until the day of admission. This will be a particular problem for short notice and emergency admissions. Hospital management and consultant surgeons should be directed to have a duty to assist anaesthetists in providing estimates within an acceptable timescale. Consultant Anaesthetists should provide Consultant Surgeons with a list of their proposed fees, or a website link, or phone contact, so that all the professional fees and hospital charges can be provided to the patient at the surgical consultation. It should be accepted that, on occasion, an anaesthetic fee estimate will be provided on the day of admission, but every effort should be made to avoid this.

Consultants should encourage insured patients to compare fee estimates with the benefit maxima provided by their insurers. There should be no obligation on the consultant or hospital to do this for the patient and if they do so, a fee for this service might be chargeable.

Regarding oversight and enforcement, the AAGBI suggests that the private hospital providers should be required to provide data indicating the proportion of patients who are given fee estimates in advance within the agreed timescales. This would be considered part of the accreditation process required by the Care Quality Commission (CQC). Deviation outside agreed limits could prompt referral by the CQC to the FCA.

Remedy 7—An information remedy

With regard to HES and PROMS data², the AAGBI suggests that the CC and others work closely with PHIN, which has already made significant advances. The remedy is practicable and applicable to all private hospitals, but only if it is based on ICD10 coding and CCSD is abandoned.

The private hospitals should be required to fund PHIN in the long term, but it should be recognised that the cost of performance assessment, enforcement and reporting will ultimately be met by the consumer in the form of increased hospital charges.

PROMS data assumes that patients can discriminate reliably between good and bad clinicians. Unfortunately, this is not the case. Good communicators are not necessarily good clinicians and vice versa. High patient satisfaction does not necessarily indicate good outcome and low satisfaction may not indicate poor clinical performance. More emphasis should be placed on *Peer-Reported Outcome Measures* and more objective assessments of performance, as addressed in remedy 5. Similarly, HES statistics are not particularly meaningful to patients and are difficult to interpret. Performance assessment, as defined by the CC and others, should be reported to the CQC as part of the accreditation process.

¹⁰ The Royal College of Surgeons of England (2013), Professional Standards for Cosmetic Practice. <http://www.rcseng.ac.uk/publications/docs/professional-standards-for-cosmetic-practice/>