



Competition Commission Private Healthcare Market Investigation

Response to Statement of Issues

Presented by
Aviva Health
July 2012



1 Executive summary

- 1.1 Aviva Health welcomes the Competition Commission's (CC) investigation into the private healthcare (PH) market. There are a number of features of the current PH market that constrain competition, to the detriment of our customers and all patients of PH. As a consequence, PH costs have been increasing at a rate that is not sustainable. The vast majority of PH is accessed via patients with private medical insurance (PMI). Cost growth in PH directly impacts PMI premiums. Customers of PMI are price sensitive – as PMI prices rise, many leave the market or trade-down their cover. Without action to address the competition failures in the PH market, costs will continue to rise and inefficiency will be protected, to a point where PMI, and hence PH, is not accessible to many.
- 1.2 We agree with the theories of harm articulated by the CC in the issues statement. They cover the key areas where we see competition problems in the current market. We group the features of the market that restrict competition and harm customers into three sets of issues:
- a) There is a significant lack of published comparable information on the cost and quality of consultants and PH providers. The referral of a patient by a general practitioner (GP) – so critically important in influencing the treatment pathway – is typically made without reference to any comparable metrics on cost or quality. This is important because it means key decisions are being made without reference to information that in other markets facilitates choice and competition.
 - b) A patient's consultant is the key influence on the course of treatment, the cost and the place of treatment for the patient. As well as clinical motivations to provide high quality care, consultants also face financial incentives. For instance, income levels are directly impacted by the level and intensity of care received (as fees may be higher) and some consultants receive financial incentives to treat patients at particular PH facilities. GPs and consultants who are currently primarily involved in the treatment pathway, have no incentive to control cost, and the patient is in no position (due to information asymmetry) to challenge the course of treatment recommended by the consultant.
 - c) The largest five hospital groups are responsible for 70% of privately funded healthcare in the UK. Each owns facilities that Aviva Health needs to recognise if we are to offer PMI with national coverage. National coverage matters to many of our customers, such as large corporate customers with employees across the UK. The large chains recognise this need and use this market power in their negotiations with Aviva Health. We believe this leads to higher prices and pricing practices that discourage competition. By blunting competition, inefficiency and over-capacity has persisted in the sector and new entrants have been discouraged from entering the market because price signals are distorted and inefficient facilities are cross-subsidised by other facilities in a chain's network. We are forced to recognise higher priced facilities, even in local areas where alternative facilities offer more competitive pricing.

Lack of available information (theory of harm 6)

- 1.3 In its survey of GPs conducted for the Office of Fair Trading, GHK (2011) found that GPs view themselves as the single most important influence of a patient's choice of treatment location – over 90% of GPs surveyed indicated that patient always or usually follow their recommendation. Typically GPs do not discuss the costs of treatment pathways with PMI customers at the point of referral. Less than 30% of GPs surveyed indicated that they discussed consultant or treatment facility costs with PMI customers. Nor is it evident that GPs have access to – or use – sufficiently comparable information on the quality of consultants and treatment facilities in discussing options with patients and making a recommendation. Less than half of the GPs surveyed indicated that they routinely provide information to PMI customers on key performance measures – such as waiting times and medical and clinical outcomes. In our own survey of GPs (Aviva Health, 2011) less than 10% indicated that they discussed the quality of the consultant with their patient.
- 1.4 The most striking feature of the consultants' market is that there is no published data available to help patients judge the cost and quality of their consultant. As with many markets requiring professional expertise there are significant information asymmetries. In contrast to other markets, in health the professional rarely makes information relevant to the customer available at an early stage. For example, 50% of consultants surveyed by GHK did not routinely make fees known to patients before consultation. Even with cost information, PMI patients do not have sufficient information to assess the clinical necessity of the treatment recommended, or the relative value of their consultant – or recommended treatment pathway – compared to alternatives.
- 1.5 This is a significant issue in the market because consultants have a key role in determining what treatments are provided to their patients and the likely cost – consultant fees account for 30% of Aviva Health's claims spend in the PH market. Consultants also determine the level and intensity of treatment, which will impact cost.

Incentives along the treatment pathway (theory of harm 2 and 5)

- 1.6 When a patient uses their PMI to access PH, they will come into contact with three groups during their treatment: their GP, their consultant (and potentially anaesthetist); and the hospital provider. None of these agents has an incentive to manage the cost of treatment. Indeed there are financial incentives to increase the level of treatment being delivered as it may increase fee income. For example, both PH providers and consultants are generally paid on a fee-for-service basis, creating a direct link between number of treatments and fee income.
- 1.7 In the case of consultants (including anaesthetists), Aviva Health uses fee schedules, which represent the maximum we will pay for a particular procedure. Consultants are free to charge above these and in 2011 30% did. When this happens either the patient, or us, will need to pay the difference (the 'shortfall'). The lack of transparency of fees therefore matters both to the insurer and the patient. As the GHK (2011) survey showed, more than 50% of consultants do not provide patients with their fees before the first consultation.
- 1.8 The patient will often not know their risk of shortfall until after treatment has commenced. When we speak with our customers we provide specific advice for their situation so that they are fully aware if there is a risk of a shortfall. This causes anxiety for customers at a time when they have already started on their treatment pathway and switching costs are likely to be (or are perceived to be) high.

- 1.9 Even in the event that they are given fee information before the treatment there is no comparable information on quality. So they are unable to assess the value of the consultant compared with alternatives. We see substantial variation in the fees charged by consultants for the same procedures—and consequently the shortfalling of patients across the UK. Due to the lack of information on clinical outcomes we can find no evidence that these higher fees are linked to higher quality. Our analysis suggests that the number of cases of fee limits being exceeded between geographies bears no relationship to the cost of living in that area (see 3.5).
- 1.10 As well as concerns about the level of fees, Aviva Health also has concerns about the treatment pathways being recommended for patients. There are financial incentives to over-treat to raise fee income. Clinical factors make it hard to draw definitive evidence, but as an example we see a lot of variation in the treatment pathway for cataracts surgery. Of the 383 ophthalmologists that billed us for cataracts procedures in the 12 month period to 31 June 2011, 23% used general anaesthetics (GA) with every patient they saw. Half never used a GA. By using a GA, the procedure is more invasive, requires the use of an anaesthetist and will result in longer hospital stays. Yet clinical best practice suggests GA should not be used routinely in cataract surgery. The Royal College of Ophthalmologists' Cataract Surgery Guidelines 2010 outlines that GAs should only be used in 4% of cases, due to the inherent risks of GA use linked to patient age and co-morbidities.
- 1.11 As a result of these incentives in the treatment pathway, Aviva Health has looked at ways to influence the treatment pathway, promoting best clinical practice. We have done this to manage both the cost and quality of care – in the same way that commissioners of care do in other health systems – without compromising access to care. Where we have done this, we have seen benefits through improved outcomes for patients and reduced costs, whilst utilisation has increased. Our argument is not that customers should be prevented from accessing care, but that we should be encouraging them to use more of the right type of care.
- 1.12 Our market leading Back-Up proposition is the first fully case managed pathway that we are actively providing to our customers. The patient is referred to a physiotherapist directly by us. They do not need to go through the GP referral process, speeding up access to treatment. They are given a clinical case manager, who assesses their care from the outset, who provides for a fully managed and focused course of interventions (with no limit on how many sessions). We use a well governed network of treatment providers ensuring consistency and quality of treatment.
- 1.13 With the Back-Up proposition we have seen the average hands-on physiotherapy required for rehabilitation on spine and neck claims reduce to less than 5 sessions from over 9. In the early stages of roll out of a similar approach on other musculoskeletal conditions in our Back-Up Plus proposition, we have seen the average reduce from a similar benchmark to between 5 and 6 sessions. This has occurred while maintaining or improving customer satisfaction, indicating the quality of care and the outcomes are the same or better. The amount of treatment required to reach “recovery” is agreed between the treating physiotherapist, through physical assessment of the patient, and the clinical case manager. Notably we have also seen a reduction in the number of cases requiring more intensive treatment i.e. surgery or pain management injections. In doing this a number of key objectives are achieved. We have been able to improve access, the incidence of claims is 48% higher, 99% of customers rate service very good or excellent and an average Back-Up case costs 40% less than a non-managed case.

- 1.14 We are looking at similar examples in other treatment areas. However, such programmes are difficult to implement and receive significant resistance from consultants who argue such approaches limit clinical freedom. This is certainly not our objective – the goal is to implement evidence-based best practice treatment pathways, which can improve cost control, ensure consistency in treatment, whilst also allowing flexibility for justified clinical variation. In the case of Back-Up, patients are referred to physiotherapists and so by-pass consultants, which made it an easier treatment pathway for us to implement. It did not require a behaviour change may be on the part of consultants. In other treatment pathways, such as cataract surgery, resistance will be much stronger and behaviour change much harder to effect as consultants may lose revenue if they change their own clinical practice to conform with best practice.

Concentration of hospital market (theory of harm 1, 3, 5 and 7)

- 1.15 We negotiate and agree treatment rates for our customers with hospital providers and hospital groups. The concentration of the hospital market, and the way in which the large hospital groups leverage their facilities with market power, strengthens their bargaining position in these negotiations.
- 1.16 We have analysed the market shares of private healthcare providers (by Aviva Health's expenditures) in 54 counties (where Aviva Health spent a minimum of £250,000 in 2011 on treatments patients received), to assess the level of concentration. This analysis suggests that the market for private healthcare in those counties is highly concentrated. For example, in 2011, in 17 of the 54 counties where Aviva Health provides coverage, a single private healthcare provider or large hospital group had more than a 70% market share. Indeed, *Hospital Group A* alone had more than a 70% market share in 10 counties.

Table 1 Ownership of Aviva Health's 'must have' hospitals shows the ownership of these facilities by the large hospital groups, independents or smaller groups and the NHS

Hospital ownership classification	Number of essential facilities
Hospital Group A	24
Hospital Group C	12
Hospital Group D	6
Hospital Group E	8
Hospital Group B	2
Independent	6
NHS	7
Total	65

- 1.17 This level of concentration illustrates the market power that hospital operators have over patients in different areas. The five largest hospital groups in the UK account for 70% of all privately-funded healthcare. They own facilities that insurers must have in order to offer national coverage and we see them leverage that power in their negotiations with Aviva Health.

- 1.18 Ownership of ‘must haves’ gives the large hospital groups considerable leverage in price negotiations. They exercise this leverage in a number of ways:
- a) In our experience, treatment rates increase every year and there is little room for negotiation;
 - b) Prices are negotiated on a national basis, with a single price for access to a group’s facilities, with a requirement that Aviva Health recognises all of a group’s facilities. Single national pricing distorts competition in local markets. Where we have attempted to exclude certain hospitals from our hospital lists (e.g. because a local competitor offers a better price at appropriate quality), we are threatened with price rises on the remaining facilities that would leave us in a worse position. If we attempt to control costs in any way, the hospital groups renegotiate, or threaten to renegotiate, the terms of our agreement to stay in a revenue neutral position.
- 1.19 Table 2 shows average prices for a treatment episode, in aggregate, across a bundle of procedures, between 2007 to 2011. The prices of the large hospital groups are much higher, and have also been growing at a faster rate.

[X]

Table 2 Total average price increases across a bundle of treatments, 2007 to 2011

[X]

- 1.20 Aviva Health has developed initiatives to control the rising costs of healthcare providers, however, we have met strong resistance by the large hospital groups. For example, if we negotiate a lower rate on MRI scans because other providers offer lower rates, they threaten to renegotiate rates on other treatments to stay in a revenue neutral position. Clauses in our agreements with the large hospital groups allow them to renegotiate the terms of agreement if we take any action to try to control costs, and they lose revenue as a result.
- 1.21 The remainder of our submission expands on these points and others relevant to the investigation. We look forward to supporting the Competition Commission in their work.

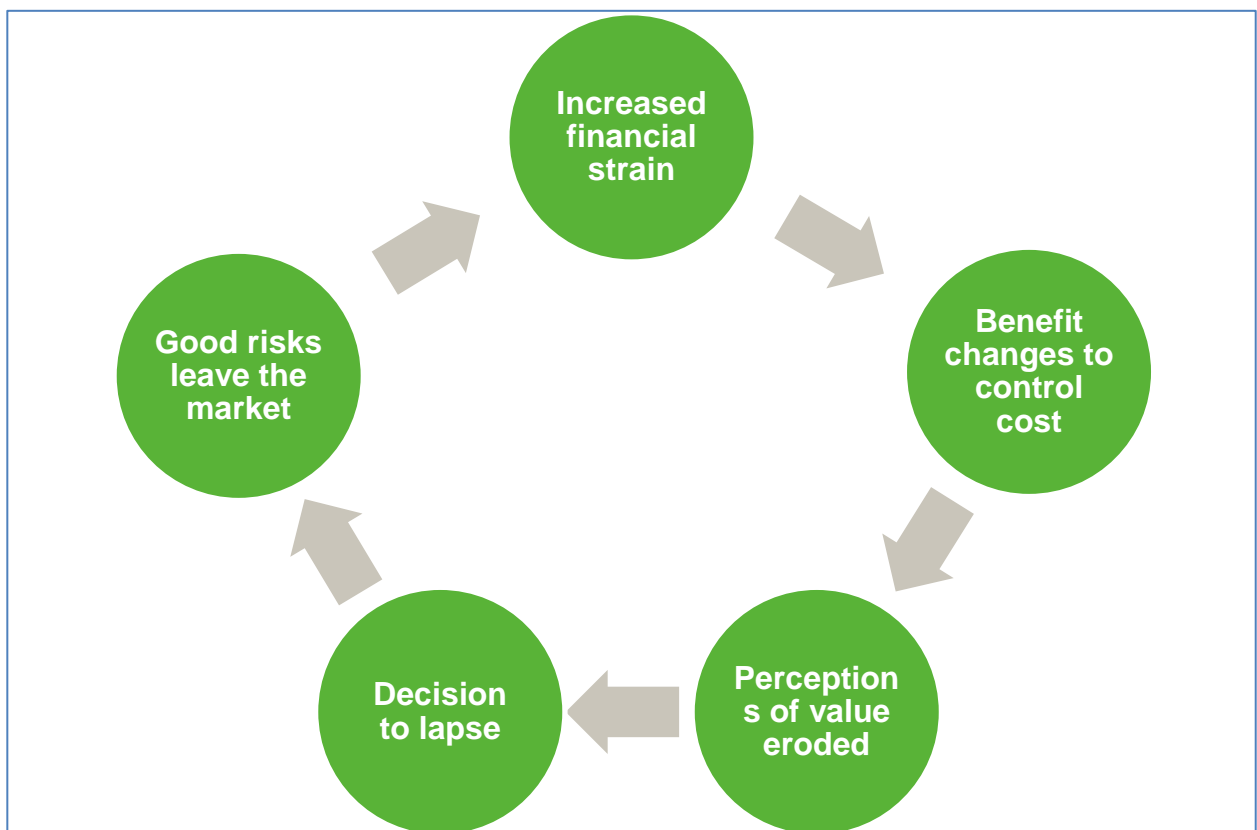
2 Introduction & background

- 2.1 Aviva Health is the UK's third largest Private Medical Insurer with 11% market share and 921,000 lives insured. We have been operating in the market for over 20 years. We offer both individual and corporate PMI policies, which bring different requirements when we contract with the PH market. We are part of the Aviva Group, which operates across a number of markets in the insurance sector.
- 2.2 Aviva Health welcomes the opportunity to work with the Competition Commission as it examines the market for the acquisition and supply of PH.
- 2.3 Our own experiences mirror many of those highlighted by the OFT and reported by other stakeholders during their initial submissions to this inquiry. We urge the CC to look at competition in the PH market and how it impacts all customers.
- 2.4 Due to contractual obligations we are unable to directly name the PH suppliers where we have analysed our commercial interaction with them in the market. For the purposes of this document we refer to them as "Hospital Group A" etc.
- 2.5 In our response to the Statement of Issues, we cover the following areas:
 - Aviva Health's response to the overall Statement of Issues document, including Market Definition;
 - The characteristics of the PH market that Aviva Health believes the "Theories of Harm" need to acknowledge and address;
 - Aviva Health's response to the Theories of Harm.

3 Aviva Health's view of the PH market

- 3.1 Aviva Health supports the CC's investigation into the PH market because we do not believe the market is sustainable in its current form. Costs are rising ahead of inflation, which we believe is linked to the fact that all stakeholders in the provision of private healthcare have strong incentives in the short term to increase revenue and profits, which in turn increase the cost of PH. Aviva Health takes a longer-term view, which is that continued cost growth is not sustainable. As PH costs rise, the cost of PMI increases. The market is very price sensitive and as prices rise, customers leave the PMI market or trade-down their insurance cover. This reduces the demand for insured PH and eventually the market will no longer be viable. Almost 80% of patients access PH in the UK through PMI funding.¹ This is shown diagrammatically in Figure 1.

Figure 1 Current Market Cycle

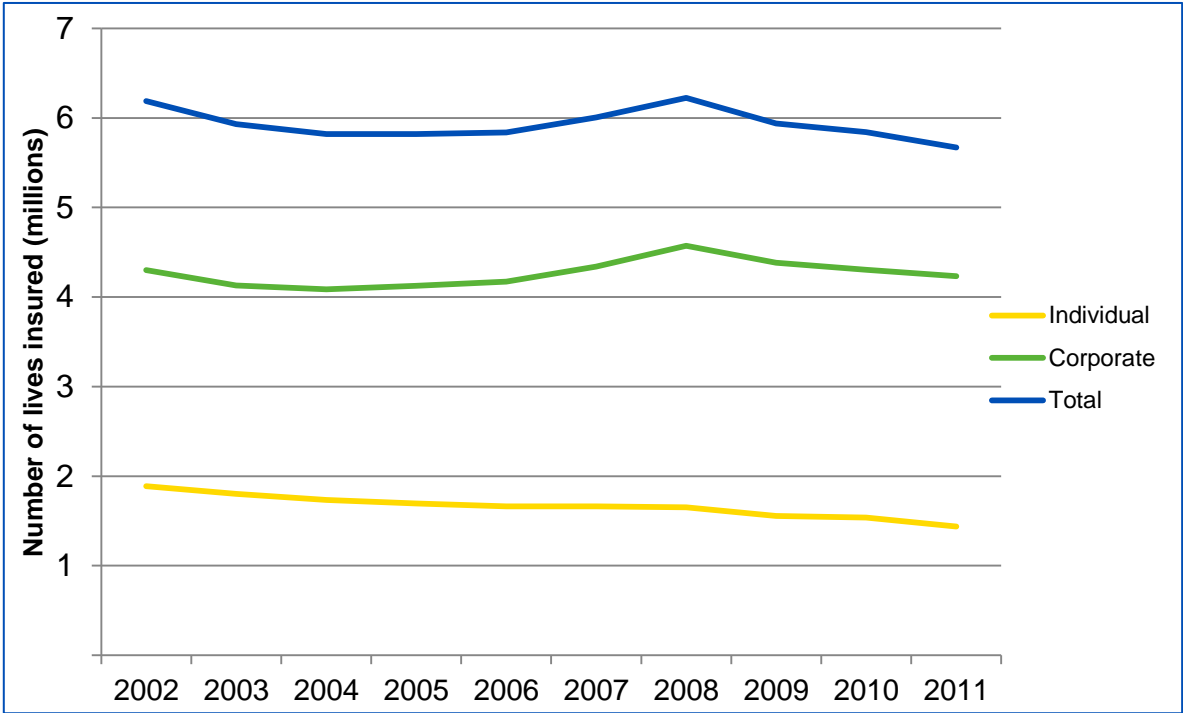


- 3.2 Aviva Health believes that addressing the failure of competition in the PH market will begin to put competitive constraints on cost growth. We believe the CC's intervention can shift the market to one that is responsive to the demands of customers, where choices are based on cost and quality information, and where behaviours are driven by what customers want – an effective PH market that can be accessed by cost effective insurance options.

¹ Laing & Buisson Healthcare Market Review 2011-12

3.3 ABI market data (see Figure 2) shows that the number of lives covered by PMI since 2007 has declined – most notably individual customers taking out PMI for themselves (or their families). The overall number of lives insured is the lowest it has been for the past 10 years.

Figure 2 ABI Market size data



[X]

3.4

[X]

3.5 The theories of harm identified by the CC cover the key areas that Aviva Health believes are driving the current trends in the PH market. With appropriate remedies, we believe the market can function in a way that puts the customer and patient at the fore in the market, where behaviours are driven by information and evidence. This will enable insurers to develop a range of products that help customers access PH, which in turn sustains the PH market.

3.6 The CC has highlighted the significant role that insurers play in the PMI and PH market, in particular the incentives that they face to influence a patient's choice of healthcare services. There are two key points that we urge the CC to recognise in this regard:

- Insurers have a strong interest in both the cost and the quality of PH. Aviva Health's reputation and the attractiveness of our PMI products to customers is entirely contingent on us being able to offer cost effective PMI that provides access to high quality services. If the quality of service provided to Aviva Health members fell, customers would not purchase our products. We mention it here explicitly to address a misconception expressed in a number of the Initial Submissions. Some of these suggested that insurers are concerned only with cost management and not the quality of care. PMI would not be attractive to customers if this were the case.
- Aviva Health does try to influence the supply of PH, currently in a very limited way. We try to put some constraint on the fees that consultants can charge by setting – and making available on line – fee schedules for procedures (although we do not set fee limits for initial or follow-up consultations). We also aim to have contracts with PH providers (although we note we have been unable to agree contracts for a number), and we encourage the use of evidence based medicine to inform clinical decision-making. We discuss all these in more detail in Section 4 and Section 5. We do not attempt to limit the clinical freedom of clinicians, as some of the Initial Submissions by the medical profession suggest. We do seek to ensure that costs are proportionate and that practice is based on good evidence. This is the commissioner role that is present in most developed health economies as a balance to the information asymmetries and incentives in the practice and delivery of care.

3.7 We encourage the CC to consider the patient journey as it examines competition and incentives in the market. This will help the CC to understand the incentives that individual actors face at key stages in the treatment pathway and will highlight the lack of control that patients have over their treatment. It will also highlight the significant absence of information on the cost and quality of provision to inform the delivery of care. Examining the patient journey will also illustrate the influences on PMI customers – as patients they have little incentive or ability to consider the cost and quality of PH, but as purchasers of PMI cost and quality have a big impact on the price of PMI. When purchasing PMI they are price sensitive, so the incentives and information they face as users of PH are an important component of the prices they face in the PMI market.

4 Characteristics of the private healthcare market

4.1 Approximately 80% of private healthcare in the UK is paid for by PMI. The remainder comes from patients paying for their own care (self-pay patients) and the NHS making use of private hospitals.² Within PMI, Aviva Health's customers fall into two broad categories:

- Corporate purchasers of PMI: This is where a company (the customer) chooses to purchase PMI on behalf of their employees (the members). The detail of corporate PMI schemes varies significantly from employer to employer. Corporate purchases are usually completed via an intermediary or broker. In Aviva Health's experience, corporate purchasers are well-informed, price sensitive and typically expect national coverage of PH facilities. They expect their insurer to manage the costs of PH and will work closely with the insurer to develop a bespoke PMI offering.
- Individual purchasers of PMI: These customers are purchasing PMI for themselves – and so are the customer and the member. They will often have held PMI for a number of years and so are familiar with the products offered. National coverage may be less important, and they will want access to their local PH facilities. They are price sensitive and in the face of rising PH costs, which impact their PMI premiums, will often trade-down their PMI products or leave the PMI market and exit PH altogether. They expect their insurer to manage the costs of PH but may resist attempts to manage costs at the point of claim.

4.2 Insurance is a crucial part of the PH market. The sustainability of the PH market is contingent on patients having access to PMI products that offer value for money and provide funding for patients. Without insurance many customers would leave the market. If they required PH, many would potentially face very high costs at the point of treatment. Insurance is a form of risk pooling where customers can protect against these very high costs.

[X]

4.3 We believe that the PMI market is highly competitive, and that our members are very sensitive to increases in premiums.

4.4 Figure 3 shows the behaviour of members at renewal since January 2011. Each month there has been a net downgrade of cover, amongst customers renewing. Customers are selecting cover options with lower premiums. 52% of former holders of PMI policies indicated cost as their reason for leaving the market, in a survey of 912 UK adults recently conducted by YouGov. 60% of adults (from a sample of 3,841) indicated that cost was the main reason for not purchasing PMI.³

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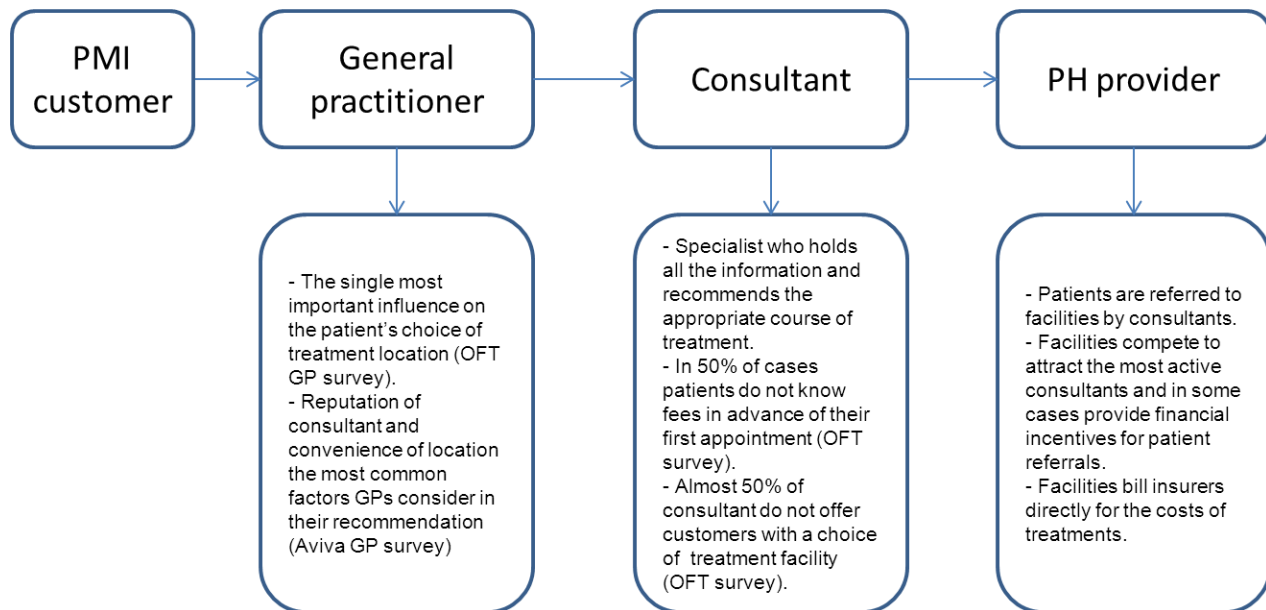
Figure 3: [X]

² Laing & Buisson Healthcare Market Review 2011-12

³ YouGov SixthSense: Private Sector Dynamics Presentation, November 2011

- 4.5 The margins in PMI mean that Aviva Health is not able to absorb the rising costs in private healthcare; we have to pass these costs on to our customers. The price sensitivity of our customers means that as these costs increase, the number of lives covered by PMI falls or the cover they have in place is reduced. On current trends, we are concerned for the long term sustainability of the market. There are greater incentives to increase treatment and levels of supply than to reduce costs. We believe this allows inefficiency in PH provision to persist and excess capacity is not taken out of the system. This pushes costs even higher. As PMI customers decline, those remaining are in effect paying higher premiums to cover the fixed costs of the infrastructure within the PH market.
- 4.6 Aviva Health sees big differences in how insurance operates across the markets we work in. The Aviva Group provides various types of insurance policies to customers such as household, buildings and motor insurance. In these sectors, the dynamics of the claims markets are very different to health. In household insurance, for example, there is a competitive supply market - when meeting a claim to replace furniture, the cost is driven by the price of furniture, which is determined in a competitive furniture market. Competition in the markets for goods being claimed for keeps these costs in check, which in turn impacts premiums.
- 4.7 Private health is different - competition in supply does not keep costs in check and is not focused on generating best value for patients or PMI customers. Aviva Health believes that there are competitive constraints in the supply market that prevent the market from functioning effectively, to help manage the cost of claims. For this reason, we welcome the Competition Commission's investigation into the private healthcare market and believe that the Theories of Harm articulated by the Competition Commission in the statement of issues characterise the features of the market that are restricting competition. The market is not functioning in the best interests of customers.
- 4.8 When a patient uses their PMI to access PH, they will come into contact with three main agents during their treatment: their GP; their consultant (and potentially anaesthetist); and the hospital provider. None of these agents has an incentive to manage the cost of treatment – indeed consultants and PH providers have a direct financial incentive to increase the supply of PH and generate additional fee income. Neither the patient nor the GP has access to information on the cost and quality of treatments to make informed decisions. The patient has a strong incentive to want information about the quality of treatment, but there is insufficient information currently published to allow them to assess this. They also have little incentive to consider cost as the link between their own claims costs and subsequent PMI costs will be weak.
- 4.9 An example of a typical treatment pathway for a PMI customer is shown at Figure 4 and we discuss the incentives at each stage in more detail below.

Figure 4: Typical treatment pathway for PMI customer using PH



- 4.10 The PMI customer will first visit the GP before being referred to a consultant. The GP therefore has a critical role in facilitating and promoting choice and competition between consultants and PH providers on the basis of cost and quality. However Aviva Health is concerned that in many cases GPs lack – or do not provide patients with – sufficient information on the cost and quality of consultants to make informed decisions at the point they refer the patient. As we discuss below, this is critical because once a patient has been referred to a particular consultant by the GP, it is very difficult (or perceived to be difficult) to alter their treatment pathway - in terms of the consultant and PH provider used. Beyond this point, switching costs (or perceived switching costs) are high and there is little information on which to base decisions.
- 4.11 GPs view themselves as the single most important influence on a patient's choice of treatment location – over 90% of GPs surveyed by GHK indicated that patient always or usually follows their recommendation. Typically GPs do not discuss the costs of treatment pathways with PMI customers at the point of referral. Less than 30% of GPs surveyed indicated that they discussed consultant or treatment facility costs with PMI customers, they expect PMI providers to control the costs of consultants and PH facilities. Nor it is evident that GPs have access to – or use – sufficiently comparable information on the quality of consultants and treatment facilities in discussing options with patients and making a recommendation. Less than half of the GPs surveyed indicated that they routinely provide information to PMI customers on key performance measures – such as waiting times and medical and clinical outcomes.⁴
- 4.12 Following the GP referral, the consultant is the key actor that influences the patient's choice of treatment pathway, venue and associated costs. Consultants are generally paid on a fee for service basis. In Aviva Health's case, patients hold the contract with consultants, but Aviva Health will meet consultant costs (up to fee limits, beyond which patients meet the costs). The more services that a consultant provides, the more they are able to bill the patient.

⁴ GHK, *Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants: Survey Analysis Report for the Office of Fair Trading*, August 2011

- 4.13 The most striking feature of the consultants market is that there is no published data available to help patients judge the cost and quality of their consultant. As with many markets requiring professional expertise there are significant information asymmetries. In private healthcare the professional rarely makes information relevant to the customer available at an early stage, which is in contrast to other markets. For example 50% of consultants surveyed by GHK did not routinely make fees known to patients before consultation. Even with cost information, PMI patients do not have sufficient information to assess the clinical necessity of the treatment recommended, or the relative value of their consultant – or recommended treatment pathway – compared to alternatives.
- 4.14 The consultant is also influential in selecting where a patient is treated. Just fewer than 50% of consultants surveyed said that they do not provide customers with a choice of treatment facility, with a further 23% of consultants indicating that a choice was rarely offered.⁵ The consultant decides what treatment is necessary for the patient – including diagnostic and other tests, the use of drugs and prosthetics, whether an anaesthetist is required (and in most cases selecting the anaesthetist) and the length of stay for the patient in hospital.
- 4.15 Aviva Health and others have already highlighted that the situation with anaesthetists is even more pronounced with the choice of the anaesthetist being made by the surgeon, the hospital or an anaesthetist group. The identification of the anaesthetist at a late stage in the clinical pathway also means that the customer cannot effectively choose another and Aviva Health has little opportunity to advise if the maximum allowable fee levels will be exceeded.
- 4.16 Excessive unit costs are not the only risk for the patient or PMI customer due to the financial incentives facing consultants. Overtreatment – examples of which may include the use of general anaesthetics when not clinically necessary, or early surgical intervention when less invasive techniques were not pursued first – can also be a consequence of the financial incentives facing consultants and hospitals (coupled with the information asymmetry facing customers). Aviva Health is aware that some PH providers have incentive schemes with consultants, which reward (either financially or via services in-kind) consultants for referring more activity to a facility. This further compounds incentives to increase costs but also has the potential to be a barrier to other providers entering the market. At the extreme, it has the potential to lead hospitals to compete for consultant business on the level of the incentives they are able to offer in return for referrals.
- 4.17 Aviva Health has little input into decisions about where patients are treated. This is typically determined by the consultant or GP making the referral. Aviva Health negotiates rates (tariffs) that we pay for access to the facilities by our customers. In these negotiations, the bargaining position of the large hospital chains is strengthened by the high level of concentration of the hospital market. The leverage of the large hospital groups comes from:
- Ownership of “must have” facilities ⁶, which give the hospital group market power in a certain area (theory of harm 1);
 - Setting national prices for treatments that apply to all their facilities by leveraging the market power of their ‘must have’ or solus facilities (theory of harm 3). In these circumstances, prices do not reflect the competitive characteristics of a local market, but are rather determined by the insurer’s desire to have access to ‘must have’ facilities and the uniform national price proposed by the PH provider.

⁵ GHK, *ibid*

⁶ We discuss our ‘must haves’ in Section 5.1. We have not conducted a formal study to define geographic markets, and look at the capacity and specialisms offered by private healthcare providers in each town, city or region of a city (relevant for London only).

- 4.18 These national negotiations mean that Aviva Health must recognise all facilities of the hospital operator at the national price, in order to offer a viable PMI product. The potential leverage that we have in these negotiations – to refuse recognition of the hospital group’s facilities if prices cannot be agreed – is not credible. The concentration of the market – and the ownership of facilities that have market power – strengthens the bargaining position of the hospital groups. With only 11% of the PMI market, we do not possess sufficient leverage to control the costs of a highly concentrated hospital market.
- 4.19 In our response to theory of harm 3, we provide evidence from our own experience of how the large national hospital groups leverage their market power to increase prices and mitigate our efforts to control costs.
- 4.20 We explore all these issues in more detail below. In summary, there are weak incentives in the current PH supply market to control costs – both consultants and PH providers have an incentive to increase their revenues and there is little practical constraint on this at the moment. The knock-on impact is that costs are passed back to the insurer, which in turn impacts PMI premiums. If these costs were synonymous with higher quality, we would be less concerned – Aviva Health has every incentive to encourage high quality PH provision as this will impact the reputation of our PMI products. But there is no evidence that the cost increases are justified by quality improvements. Aviva Health urges the CC to consider how competition can be improved in the market to provide a competitive constraint on costs, whilst protecting quality.
- 4.21 Aviva Health does use a number of techniques to attempt to control PH costs. Because of the lack of competition on PH supply, we try to take on a role in the market to balance cost and quality. For example:
- Aviva Health uses fee schedules with consultants to try and constrain consultant fees. We describe in more detail how these fees are set and reviewed in Section 5. We review these regularly. Since January 2011 Aviva Health has reviewed 128 codes. 63% have been increased; 11% decreased; 26% have remained the same and the remainder are new codes (see 5.8).
 - We contract with PH hospitals to agree tariffs. Rates are increased every year, and hospitals have made few improvements in efficiency, despite technological improvements reducing the complexity of many of our most common procedures. Since 2007, the average cost of an episode of treatment across our top 15 (by volume) inpatient procedures has increased by 17%.
 - We develop evidence-based treatment pathways that can improve outcomes and drive-up quality, relative to the traditional PH treatment route. Our most established example of this is ‘Back-Up’, which Aviva Health launched in 2006. Through this pathway, customers with musculoskeletal problems are able to access care quicker than the traditional PMI referral process (Aviva Health refers customers directly to physiotherapists without the need for a GP appointment or consultant intervention). This is an example of how the vertical linkages between insurers and providers can both control the costs of healthcare whilst improving outcomes for patients (see our response to theory of harm 7). We have seen benefits through improved outcomes for patients and reduced costs, whilst utilisation has increased. Our argument is not that customers should be prevented from restricting care, but that we should be encouraging them to use more of the right type of care.
- 4.22 These techniques are fairly blunt and have limited impact given that there are a number of features of the PH market that restrict competition.

- 4.23 With the exception of Back-up, Aviva Health has little input into decisions about where patients are treated. This is typically determined by the consultant or GP making the referral. We are also not typically involved in any clinical decisions, despite being billed for the treatment directly by the hospital. Despite our efforts to influence the costs charged by consultants and hospitals, we see a lot of variation in the bills that we receive from hospital groups and consultants for the same procedures, both between and within hospital groups.
- 4.24 Figure 5 shows the variation in treatment costs across six procedures (including hospital fees and consultant fees), from our top 22 inpatient procedures by total value. These procedures were included on the basis that the hospital groups had a minimum of 20 episodes in 2011. We see a lot of variation in the interquartile range of costs that we are billed for the same procedures. Hospital Group B is the most expensive, and for a number of procedures (H2002, M4510, W8500) they also have a much larger interquartile range in costs.

Figure 5: Variation in the costs of treatment across selected top procedures by total value (interquartile range, 2011 claims data)
[3<]

- 4.25 Because we are not involved – nor consulted about – any of the clinical decisions that drive up the cost, we are not able to negotiate when we receive bills for procedures. Along the treatment pathway, a number of decisions made by the consultant can drive up the costs.
- 4.26 One element of treatment that can drive up cost – and is included at the direction of the consultant – is the use of an MRI test. An MRI scan costs Aviva [3<] on average. Figure 6 shows the incidence of MRI use amongst the major hospital groups, NHS and independents, for the same procedures between 2007 and 2011. We have split out the London and non-London markets. For all four of these procedures the incidence of an MRI at Hospital Group B is higher – for certain procedures, significantly higher. There are of course clinical reasons why an MRI is required for some patients and not for others, for the same procedure. This decision is left entirely to the judgment of the consultant. We are not sure why – for these procedures – consultants working at Hospital Group B facilities would have cause to have such a higher incidence of MRI use on their patients. As we are not involved in the treatment pathway, we are not able to query these clinical decisions – which have a significant impact on the cost of the treatment – before the tests are conducted.

Figure 6: Propensity to use an MRI, selected procedures from top 22 inpatient procedures, 2007 – 2011
[3<]

- 4.27 In the following section, we link our view of the characteristics of the PH market in the UK to the theories of harm articulated by the CC

5 Responses to the theories of harm

5.1 Theory of Harm 1 - Market power of hospitals in certain local areas

- 5.1.1 Aviva Health agrees with the CC's theory of harm that certain hospital operators have market power over patients in their local areas. We must recognise these hospitals - part of the core offer of PMI and PH is that patients can access local facilities. Corporate customers in particular expect their PMI to offer national coverage. Individual customers expect to be able to access facilities in their home town or city.
- 5.1.2 Aviva Health has not undertaken a formal exercise to define hospital markets. Many factors will influence market definition (e.g. willingness to travel and complexity of case). There may also be a difference between how far customers are willing to travel when purchasing PMI and how far they are prepared to travel when making use of PH. We agree with the factors that may convey market power onto a hospital operator, which include:
- A limited number of rival facilities nearby;
 - A limited number of rival hospitals nearby that offer or specialise in a particular treatment; or
 - A limited number of rival hospitals nearby with significant spare capacity.
- 5.1.3 However we also note that the current treatment pathway – in particular how patients are referred by a GP to a consultant who in most cases chooses the hospital for them – can also convey market power onto a particular consultant and in turn their preferred PH provider. Competition, between two hospitals in a similar geographic location that offer the same services, may be constrained by entrenched referral patterns and the relationships between consultants and PH providers. This makes it crucial to understand how GPs are making referrals to consultants and how consultants choose the hospital. Aviva Health's view, supported by our own data and survey information collated by the OFT, is that these are made on the basis of past relationships and experiences rather than objective data on cost and quality. As insurers have little influence over where the patient is treated and by whom – it is beneficial for hospitals to compete with each other by establishing relationships with GPs, and by creating incentives for consultants to refer patients to their facility. We do not believe that this type of competition is in the best interests of customers.
- 5.1.4 There are a number of methods to assess the level of concentration within a particular market. This may include an analysis of the market shares of the largest firms in the market as well as a calculation of the Herfindahl-Hirschman Index (HHI). HHI is the sum of square of the market shares of all firms in the market and its maximum value is 10,000 for a complete monopoly. The Competition Commission's (CC) guidelines on market investigations state that it will have regard to the OFT's HHI thresholds; that is, they will consider any market with an HHI of over 1000 to be concentrated and any market with any HHI of over 2000 to be highly concentrated.
- 5.1.5 An analysis of the market shares of private healthcare providers (by Aviva Health's expenditures) in the 54 counties where Aviva Health spent a minimum of £250,000 on treatments in 2011 has been conducted. This analysis suggests that the market for private healthcare is highly concentrated. For example, in 2011, in 17 of the 54 counties where Aviva Health provides coverage, one private healthcare provider had more than a 70% market share. *Hospital Group A* alone had more than a 70% market share in 10 counties. Although the appropriate geographic market for the purposes of the CC's analysis has yet to be defined, this snapshot at the county level provides valuable insight into the current state of the market.

- 5.1.6 Our calculation of HHI for individual specialisms at the county level tells a similar story regarding market concentration. Looking at Aviva Health's seven largest specialisms (by expenditure) across the 54 counties represents one approach to defining a market by both its product and geographic dimensions. For every 366 out of the 378 county-specialism combinations we found an HHI of over 2000, the threshold that defines a highly concentrated market according to the CC's guidelines. In most cases the HHI is much higher than this threshold, with over 50% having an HHI of over 5,000 and 7 county-specialism combinations being complete monopolies with HHI's of 10,000 (see Appendix A).
- 5.1.7 The preceding analysis suggests that the private healthcare market is highly concentrated. High concentration suggests that some of the large providers may have the ability to exercise market power to the detriment of patients and insurers.
- 5.1.8 To be able to offer our customers access to local facilities – and our corporate customers national coverage – recognising a single provider in one county (even in the event they offered every specialism) will not be sufficient. At the time of purchase of PMI, customers want access to local facilities – near where they live and work. For the purposes of defining who we need to recognise on our hospital lists to have national coverage, we look at the capacity and specialisms offered by private healthcare providers in each town or city (or area of the city in the case of London) across the UK (hereafter referred to as 'areas'). A list of towns and cities used in this analysis is contained at Appendix B. We stress that we are not defining each of these towns or cities as a geographic market. However as we have not conducted a formal market definition exercise, we aim to have adequate coverage across all specialisms (with sufficient capacity) in each town and city in order to offer our customers national coverage.
- 5.1.9 Where a hospital in a particular city accounts for 80% or more of our expenditure in a given specialty (in that city), and we spent at least £250,000 at that hospital on that specialism (or those collective specialisms) in 2011, that hospital (or healthcare provider) is a 'must have' in order to offer national coverage.
- 5.1.10 In each town and city there is typically more than one hospital that meets our 'must have' criteria. This highlights how hospitals will often not compete across the full range of services offered. We need to recognise multiple facilities in the same area to offer national coverage across all specialisms.
- 5.1.11 As shown in Table 4, based on our 2011 expenditure data we had 65 'must have' facilities across the UK.

Table 4: Ownership of Aviva Health ‘must have’ facilities by the large hospital groups, independents and NHS

Hospital ownership classification	Number of “must have” facilities in 2011
Hospital Group A	24
Hospital Group C	12
Hospital Group D	6
Hospital Group E	8
Hospital Group B ⁷	2
Independent	6
NHS	7
Total	65

Source: Aviva Health expenditure data 2011

5.1.12 Each of the large five chains owns a number of facilities which we consider to be “must haves” on our hospital lists, in order to sell PMI products to customers living in those areas. Hospital Group A alone owns 24 “must have” hospital facilities.

5.1.13 One way that market power impacts customers is through the higher prices that the hospital charges. By setting national prices the large hospital chains mask price variation between their facilities that operate in competitive markets, and those that don’t. The national price may be higher than the ‘average price’ if all their facilities were exposed to competitive pressure (a discussion of the effects of national pricing is contained at Section 4).

5.2

To compare the prices of different hospitals, we look at the average cost of an episode of treatment. A treatment episode commences from the initial consultation and ends when the customer has been treatment free for 60 days. Analysing claim costs from an episode perspective allows us to bundle together all the hospital specific costs (i.e. excluding consultant fees) associated with separate consultations and interventions that relate to the same claim. Using claims data for our top 22 inpatient procedures (by volume) we identified 15 procedures that each PH provider group⁸ carried out a minimum of 50 procedures. Using the average episode cost for each procedure we created an average episode cost for each PH provider group, and a national average (excluding *Hospital Group B*⁹). We indexed each provider group against the national average episode cost for the bundle of 15 procedures. The list of procedures is contained at Appendix C. As Table 5 illustrates *Hospital Group A* and *Hospital Group C* are the most expensive non-London hospital groups, with all other PH provider groups falling under the national average. Given the absence of comparable information of the quality delivered by facilities owned by the different hospital chains, there is no evidence to suggest that these higher prices are representative of higher quality of care. *Hospital Group A* and *Hospital Group C* are the two largest hospital chains – and they own the largest number of facilities that Aviva Health considers to be ‘must haves’ in order to offer national coverage. Given this market power – and their ability to leverage it through setting national contracts and prices – the fact that prices are higher at these chains is not surprising.

Table 5: 2011 price index of major hospital groups, NHS and independents

⁷ Due to the number of Hospital Group B facilities in London only two individual facilities for this group are ‘must haves’ based on the approach undertaken

⁸ We bundle all NHS facilities into an NHS PH provider group, and we bundle all other facilities into an ‘independent’ PH provider group

⁹ Hospital Group B is excluded because its prices are so much higher than the other hospitals it distorts the index

[REDACTED]

- 5.2.1 Given the paucity of price and quality data by local geography, we can illustrate how hospital operators leverage market power to raise prices through examples of recent contract negotiations.
- 5.2.2 In March 2011, following a joint venture between *Hospital X* and one of the major hospital groups, that hospital group imposed new rates on Aviva Health to access services at *Hospital X*. This constituted a 30 – 40% increase on the rates that Aviva Health had previously been charged by *Hospital X*.
- 5.2.3 *Hospital X* [REDACTED] accounted for 95% of Aviva Health's expenditure on [REDACTED] in [REDACTED] during 2011. Aviva had had little choice but to accept these rates, in order to provide customers in [REDACTED] with local access to a [REDACTED] treatment facility.
- 5.2.4 In 2010, our contract with an NHS Trust (the Trust) was due for renewal. The Trust is represented as 2 hospitals on the Aviva Key and Extended Hospital Lists and another (a PPU) on the Aviva Trust Care list. In 2011 The Trust account for 78% of Aviva's spend on cardiology in [REDACTED] One of these hospitals is the only hospital in that area on the Aviva Trust Care list.
- 5.2.5 In November 2010 we contacted the Trust to commence negotiations for a contract renewal. We received a proposed fee schedule which represented a substantial increase in prices for all treatments from 2009/10 to 2010/11 (see Table 6).

Table 6: Trust proposed tariff increases for 2010/11

[REDACTED]

Source: Aviva Health data

- 5.2.6 By December we had not been able to conclude negotiations. The Trust threatened that 'out-of-contract' rates would apply (30% higher than the proposed rates) if negotiations were not concluded by 31 December.
- 5.2.7 Following further negotiation, the Trust offered slightly improved rate increase as their last and final offer (see Table 7).

Table 7The Trust's revised proposed rate increases for 2010/11

[REDACTED]

Source: Trust proposed rate increases, Aviva Health procurement data

- 5.2.8 Given the importance of the Trust in respect of cardiology in [REDACTED] the hospital in question was the only local hospital on the Aviva Health Trust Care list, we felt obliged to reach an agreement with the Trust. We knew our members would still use their facilities – regardless of whether they were on our hospital lists or not - and we would be forced to pay the out of contract rates. We reluctantly agreed to the rate increases proposed by the Trust for 2010/11.

- 5.2.9 These examples illustrate the leverage that hospital operators are able to use in our contract negotiations. With a limited ability to influence the treatment pathway, delisting a hospital operator because they propose significant price increases is not a credible threat. We know and hospital groups know our members will still be directed towards those facilities through the GP referral process, especially in cases where there are no local alternatives.
- 5.2.10 Despite some one-off examples of hospitals leveraging the market power of must have facilities to drive prices up, national pricing masks the transparency of the effects that these facilities have on the market. The concentration of the national hospital market, and the national contracting approaches adopted by the large chains, means that the 'must have' facilities are leveraged to secure higher prices for all of the groups facilities. Examples of how this behaviour constrains competition and drives prices up for our customers are explained at Section 5.3.

5.3 Theory of Harm 2 - Market power of individual consultants and/or consultant groups in certain local areas

- 5.3.1 Aviva Health agrees that consultants or consultant groups exercise market power over patients. However we believe this is a significant feature of the market as a whole and not necessarily peculiar to certain local areas.
- 5.3.2 The lack of choice and competition along the treatment pathway – exacerbated by the information asymmetry between consultants and GPs and patients – conveys market power on individual consultants. We agree that a shortage of consultants has the potential to exacerbate this issue. However based on our own experiences, we do not see a correlation between the number of consultants in a particular area that are supplying services to our patients, and a higher level of prices for those services. In fact, the opposite; which we discuss further below applies.
- 5.3.3 We have analysed the fees charged by consultants for specific procedures against our fee schedule limits for the procedure. Each consultant may treat a number of our customers each year. The total claim for the consultant – and the number of our customers that he/she saw – we record in aggregate. The top 15 specialities - by the number of consultants that exceeded our fee schedule limits during 2011 – are listed at Table 8.

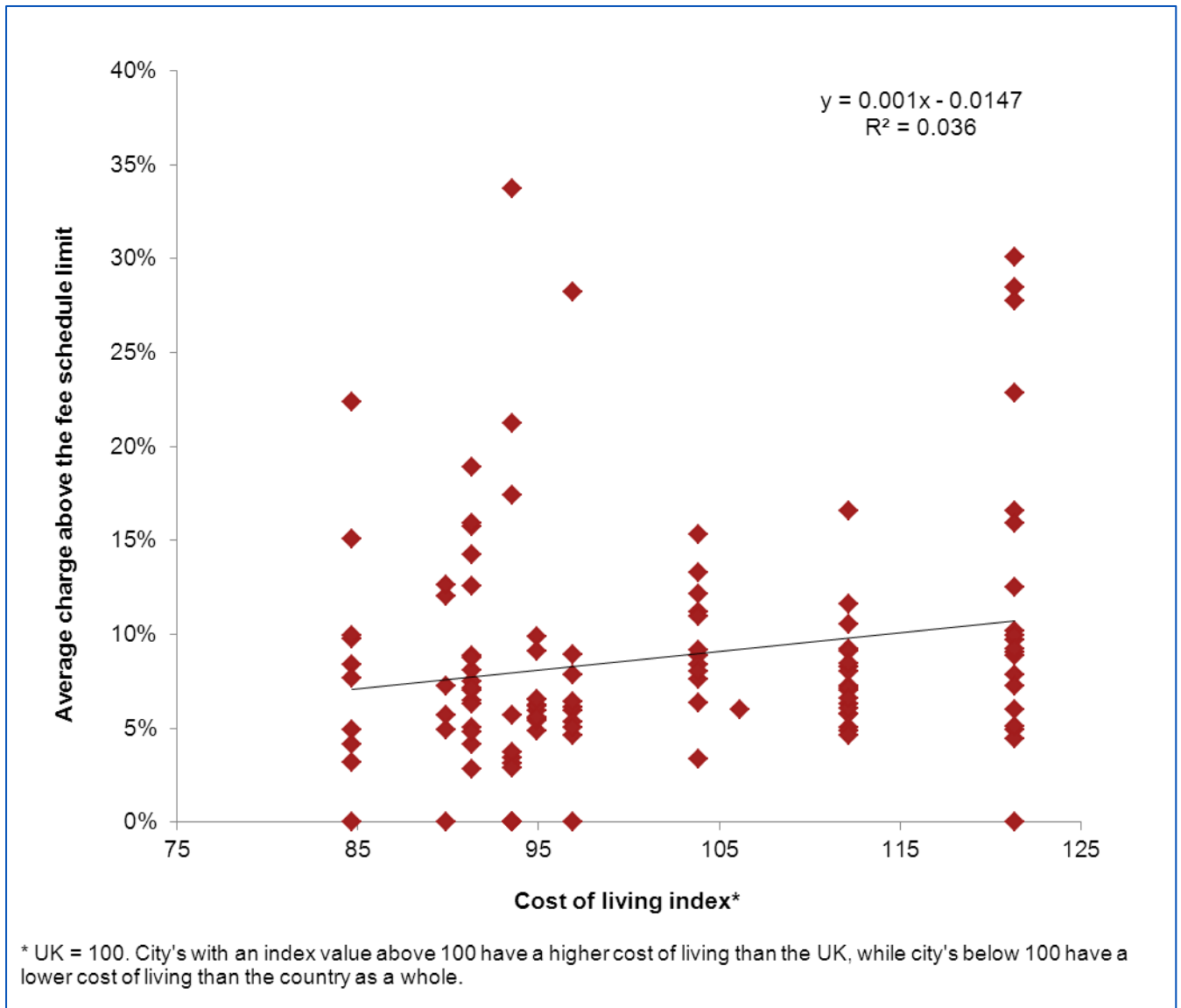
Table 8: Top 15 specialities by number of consultants overcharging in 2011

Consultant type	Number of consultants that make claims	Number that charge over fee schedules (in aggregate)	Proportion charging above fee schedule limit	Average amount above fee schedule (£)	Weighted proportion of amount above fee schedule
Anaesthesia	8,082	3,303	41%	271.3	14%
Orthopaedics and trauma	6,260	1,448	23%	651.4	7%
General surgery	4,472	1,268	28%	332.1	6%
General medicine	3,684	870	24%	260.8	11%
Obstetrics gynaecology	3,079	810	26%	380.3	10%
Ophthalmology	2,655	698	26%	318.7	13%
Urology	2,215	698	32%	274.7	8%
Otolaryngology	1,534	604	39%	177.3	5%
Cardiology	1,894	596	31%	384.5	20%
Dermatology	1,540	413	27%	217.8	7%
Plastic surgery	951	370	39%	538.2	16%
Radiology	1,181	332	28%	224.5	24%
Oncology	1,198	273	23%	418.9	11%
Oral and maxillofacial surgery	665	183	28%	278.3	6%
Neurology	1,663	182	11%	326.9	18%

5.3.4 We find a lot of variation in the prices charged by consultants and the rate of overcharging between regions. Due to the lack of data on clinical quality outcomes, we have not found any evidence that these price variations are driven by differences in quality.

5.3.5 We also find no evidence that higher prices are driven by the cost of living in the local areas. To examine this we analysed our data on consultants by city, using the address of the treatment unit that they practice from. To construct a cost of living index for each city, we used ONS household expenditure data, that is split by region (refer to Appendix D for a description of how we constructed the cost of living index). For each of the top 15 specialities for which consultants charge above the fee schedule, we calculated the weighted proportion of overcharge amount across all specialities. We weighted each consultant by the system price of the episodes they had treated in a year. Shown in Figure 7 we show a weak relationship between the cost of living of different cities and the proportion of overcharging across all the different consultants in 2011. The aggregated consultants from each city are represented by a dot on the chart.

Figure 7: Relationship between the amount consultants charge above fee schedule limits in a city and the cost of living index, all specialties 2011 claims data

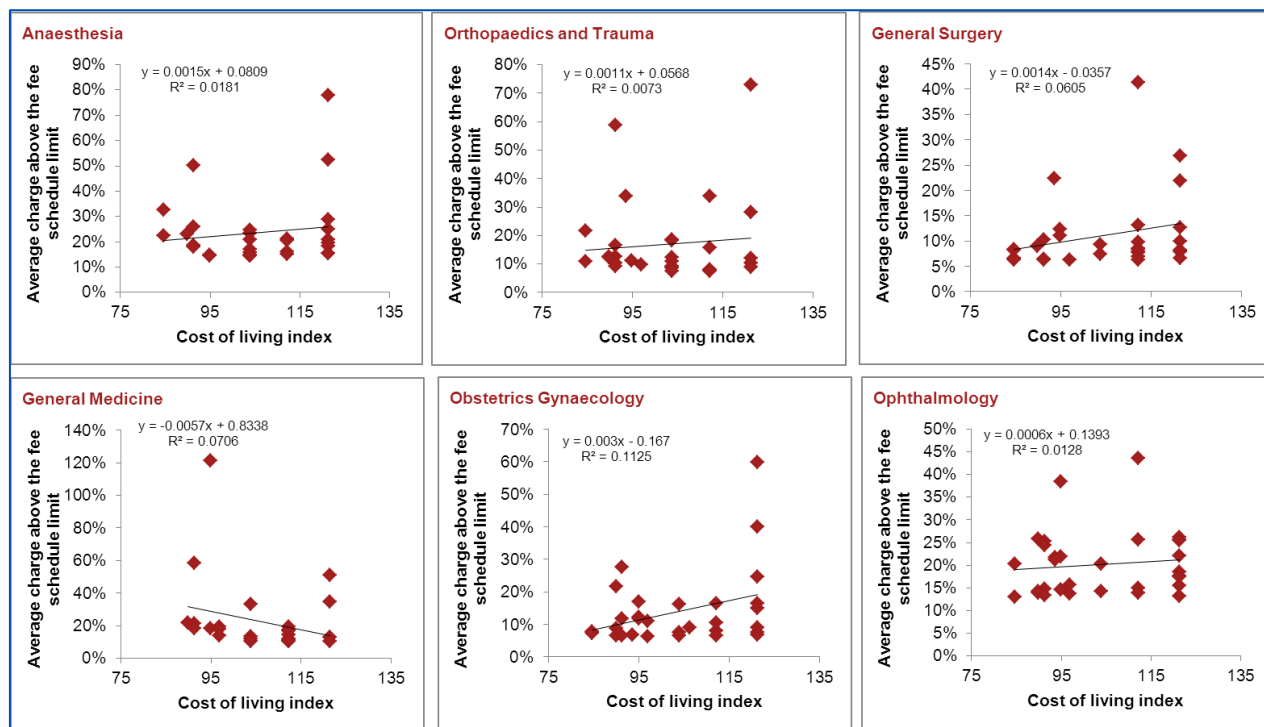


5.3.6 Table 9 shows the amount consultants charge above the fee schedule limit for individual specialties in 10 cities – the 10 cities where instances of exceeding limits is highest for the specialty. Despite London featuring frequently in the top 10 – which we anticipate given the higher costs of living and working in London – there does not seem to be any other pattern in respect of the instances of fee limits being exceeded in an area and the cost of living index.

Table 9: Top 10 cities for proportion of consultants charging in excess of fee limits for selected rates for selected specialities, 2011

[X]

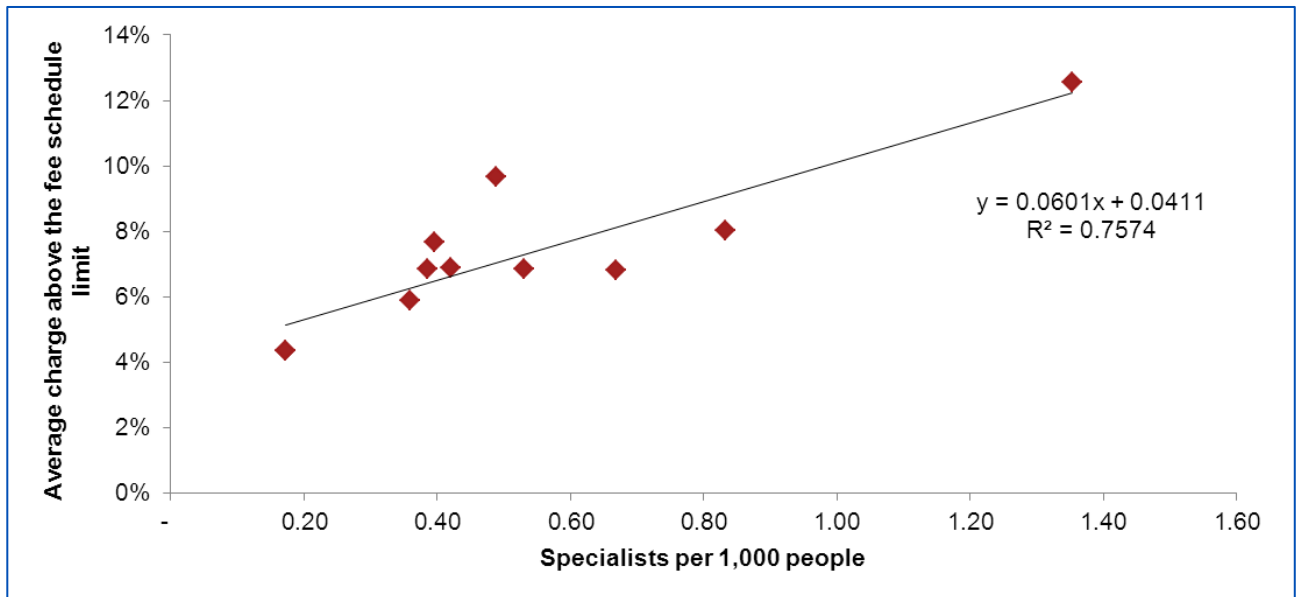
Figure 8: Relationship between the proportion of consultants charging in excess of fee schedules in a city, and the cost of living index for six specialities, 2011 claims data



Source: Aviva Health consultant data, ONS household expenditure data

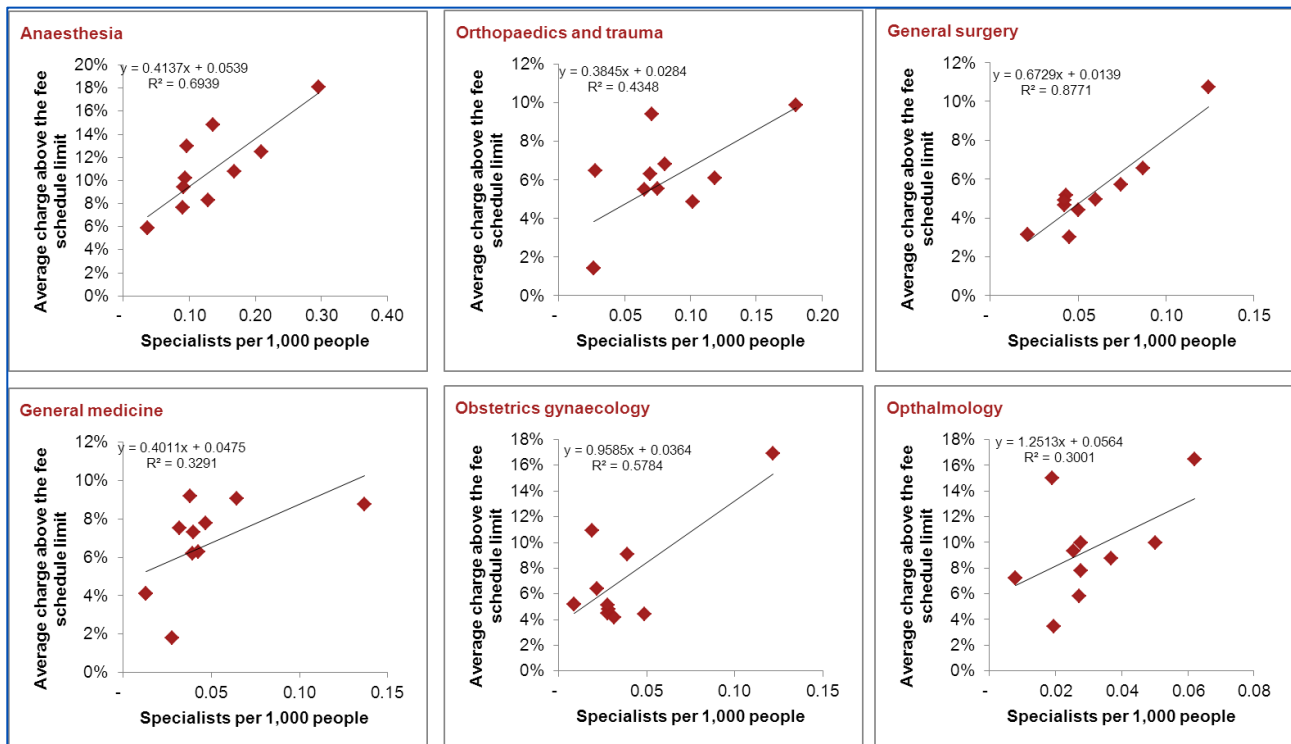
5.3.7 We also found no evidence that instances of consultants charging in excess of fee schedules are more frequent in areas where there are fewer consultants per 1,000 persons. In a normal competitive market, where there is a shortage of supply we would expect prices to rise, and our customers to be paying more fees to see consultants in those areas. We in fact see the opposite. Figure 9 illustrates the relationship between the number of consultants in a given city that made claims during 2011, and the proportion of consultants charging in excess of fee schedule limits in each region. As the number of consultants in a region increases, so too does the rate of charging in excess of fee schedule limits by those consultants. We see the same relationship when we look at each speciality individually (see Figure 10).

Figure 9: Relationship between the number of consultants in a city, and the proportion of consultants exceeding fee limits: All specialities, 2011 claims data



Source: Aviva Health data

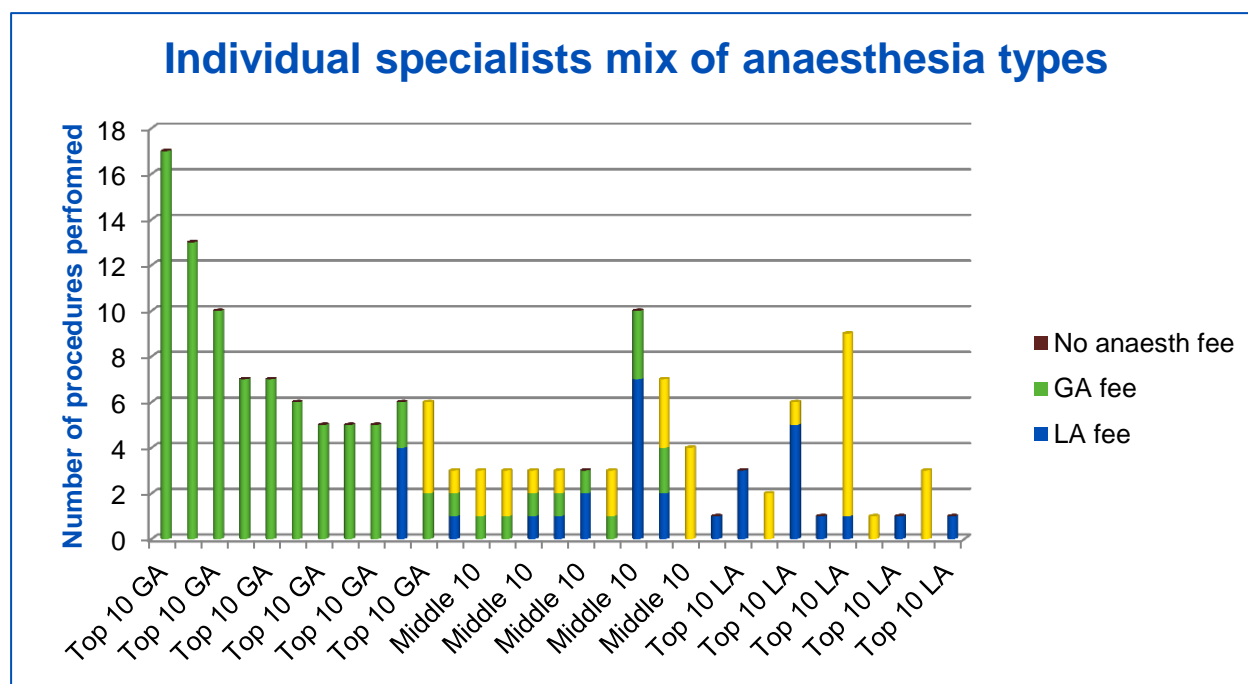
Figure 10: Relationship between the number of consultants in a city per 1,000 people, and the proportion of consultants exceeding fee limits: Selected specialities, 2011 claims data



Source: Aviva Health consultant expenditure data

- 5.3.8 These findings raise a number of interesting questions about the behaviour of consultants. Are consultant groups – and higher prices as a result - more likely to form in more highly concentrated regions? Do consultants discuss fees with each other, which impacts prices in a region? We know that consultants are encouraged to discuss fees with one another and not to adhere to insurer's fee maxima. The Federation of Independent Practitioner's Organisation (FIPO) has published a presentation on its website where it encourages consultants not to compete with each other on price and discount their fees if insurers try to manage costs (see Appendix E).
- 5.3.9 In addition to power over fees, consultants also have power over the treatment delivered to patients. They determine the procedures performed. We see wide variation in the type of treatment carried out by consultants on patients with similar conditions and we have no evidence to suggest that pathways always reflect best clinical practice.
- 5.3.10 Using cataracts as an example, we see a wide variation in the use of a general anaesthetic fee by different ophthalmologists (see Figure 11).

Figure 11: Rate of general anaesthetic use by a sample of ophthalmologists for cataract procedures Aviva Health claims spend data 01 July 2010 - 31 June 2011



Source: Aviva Health data

Note: GA = General anaesthetic, LA = Local anaesthetic

5.3.11 Across the 383 ophthalmologists billing us for cataract procedures performed from 1 July 2010 to 31 June 2011:

- 23% are associated with a 100% GA rate for cataracts.
- 25% are associated with an 80% or over GA rate.
- 39% are associated with a 40% or over GA rate.
- 57% are associated with 0% GA rate.

5.3.12 The Royal College of Ophthalmologists' Cataract Surgery Guidelines 2010 clearly outlines good practice with regard to all elements of cataract surgery in the UK.¹⁰ According to these guidelines:

- Local anaesthesia (LA) is administered in 96% of cataract surgery cases in the NHS (as of 1996-7).
- The vast majority of patients undergoing cataract surgery would be put at greater risk if general anaesthesia (GA) was administered due to their age and co-morbidities.
- The use of GA for cataract surgery is indicated only in exceptional circumstances.
- LA is administered by the ophthalmologist in the majority of cases.

¹⁰

http://www.rcophth.ac.uk/core/core_picker/download.asp?id=1255&filetitle=Local+Anaesthesia+in+Ophthalmic+Surgery+2012

- 5.3.13 Whilst there are a number of different cataracts procedures, 98% of our procedures are the same (extracapsular extraction with implant – unilateral). We do not understand what clinical factors could cause such variations; and such patterns in behaviour by particular individuals in the use of general anaesthetics amongst ophthalmologists. Excessive use of general anaesthetics increases the cost of treatment and generates additional income for consultants and providers. But it also brings risks to the patient and of course the patient is in no position to assess whether a general anaesthetic is clinically necessary. They put their faith in the judgement of the consultant. If we as the insurer were informed about the proposed anaesthesia we may be able to flag to the patient that there could be an alternative.
- 5.3.14 We encourage the CC to investigate these issues of consultant power further. The GP referral decision, where the choice of consultant is often made, is not based on good information about the cost and quality of consultants. Yet this is a critical point in the treatment pathway as beyond this point consultants face few incentives to control costs and patients are unlikely to switch to an alternative. As a result we see a lot of variation in the fees charged and the type of treatment administered, for similar conditions. This harms patients through the shortfalls they face and incidence of overtreatment – such as unnecessary use of a general anaesthetic – which can be dangerous. Our customers are also harmed, as we face higher costs associated with overtreatment and excessive consultant fees that we cover. This in turn impacts insurance premiums.

5.4 Theory of Harm 3 - Market power of hospitals during national negotiations with insurers

- 5.4.1 The hospital market in the UK is highly concentrated – the five largest hospital chains account for 70% of privately-funded healthcare revenues. This constrains competition. Prices are higher than they otherwise would be in a competitive market, and hospitals face few incentives to rationalise capacity or to improve quality.
- 5.4.2 The large hospital chains set national rates for access to their facilities for our customers, regardless of competitive or cost pressures in a particular market. Aviva Health is unable to build hospital lists based on our customers' requirements. Where we have tried to do this, some of the hospital chains have proposed prohibitively high prices for the facilities we propose to include on our lists. As Aviva Health's share of the PMI market is relatively small (11%), our ability to counter these behaviours is limited and if we were to not recognise one of the five hospital chains it would affect our ability to offer PMI with national coverage. This impacts our competitiveness in the PMI market.
- 5.4.3 As we outline in Section 2, the large hospital chains each own a number of facilities that we consider "must haves" for our lists, in order to sell PMI products to customers living or working in that area.

Table 10: The Five large hospital chains and their ownership of Aviva Health's "must have" facilities

Hospital classification	ownership	Number of must have facilities in 2011
Hospital Group A		24
Hospital Group C		12
Hospital Group D		6
Hospital Group E		8
Hospital Group B		2

- 5.4.4 All of the large chains set national prices for access to their facilities, under either a legal contract, or a heads of terms agreement. Our preference is to enter into legally binding contracts with the hospital groups – to limit our exposure to rate increases. If pre-agreed rates were not in place, we know our customers would still use the group’s facilities – by virtue of their market power in certain areas and our lack of control over the treatment pathway. To minimise cost we are forced to have pre-agreed rates.
- 5.4.5 The two key features of our negotiations with large hospital groups that we wish to communicate to the CC are:
- a) To offer national coverage we need to work with all major hospital groups;
 - b) The chains set prices for access for our customers to their facilities, and there is little room for us to negotiate.
- 5.4.6 If we attempt to control costs in any way (by creating lower cost networks or directing patients), hospitals will renegotiate – or threaten to renegotiate – their rates so that they stay in a revenue neutral position.
- 5.4.7 On average the large hospital groups increase rates annually. In our experience, Hospital groups do not pass on any efficiencies that they get from changes in clinical practice or improvements in technology that reduce the complexity – and resources used – in treatments. Rate increases invariably lead to higher costs of treatment for our customers.
- 5.4.8 Focusing exclusively on rate increases masks the increasing cost of treatment at the large hospital groups. In order to illustrate this we have compiled an index for each hospital based on the episode costs for our top 15 inpatient procedures by value (Table 11).

Table 11: Average episode cost across top 15 inpatient procedures at the major hospital groups, 2007 – 2011

[§<]

- 5.4.9 Hospital Group B had the sharpest growth in average episode costs between 2007 and 2011. The total average episode cost for the procedure bundle grew from [§<] an increase of 38%. Over the five year period the total average episode cost for the procedure bundle for the large chains grew between 8% and 38%. In contrast total costs for independents grew by 15%, and NHS PPU’s by 8%. Despite our best efforts to negotiate against annual rate increases, the leverage that the large chains have due to the concentration of the market and their ownership of our must have facilities, we have a limited ability to control escalating costs.
- 5.4.10 In the absence of being able to push back effectively on headline rate increases, we have made a number of other attempts to control costs. Typically these attempts are met with strong resistance by the large hospital groups – they threaten to raise rates on either other treatments, or facilities – so that the overall impact on revenues is neutral. This is best illustrated with a series of recent examples, provided below:

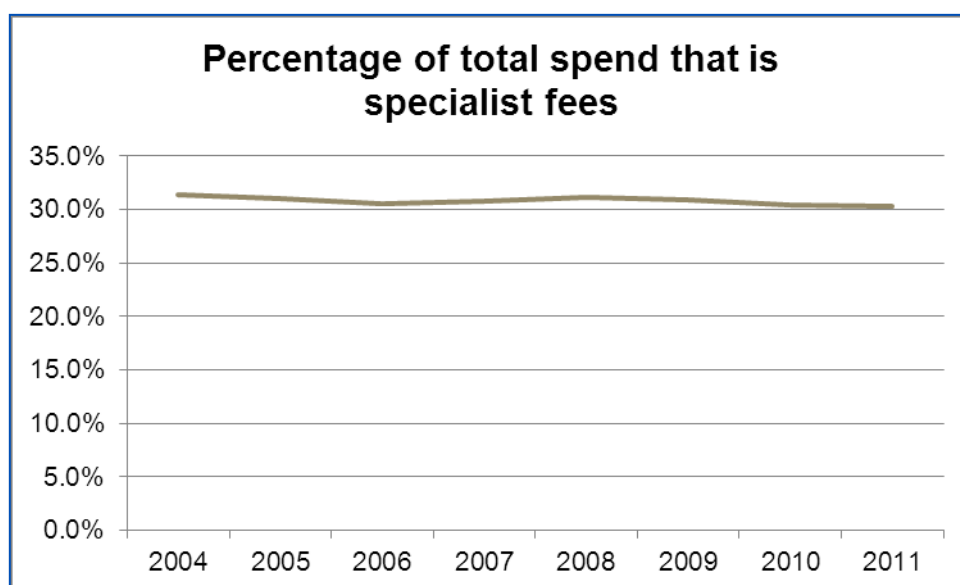
- 5.4.11 In May 2008 Aviva Health introduced a network of facilities to provide MRI scans to address the wide variance in MRI costs between providers. The rationalised network involved closer involvement with providers to enable better quality, service and value for the end customer. Average costs were reduced from [§<] However this was met with strong resistance by some of the large hospital groups. Hospital Group C wrote to Aviva Health objecting to the concept of tendering, and making it clear that they would not support the ‘cherry picking’ of their services to their financial detriment. Hospital Group C threatened that any erosion of value from the current agreement would call the whole agreement into question. Hospital Group C stated that they were happy to discuss reducing their MRI fees on a ‘cost neutral’ basis – such that prices on other treatments would increase. Hospital Group C eventually reduced their rates for MRI and were included in the network but proposed rate increases for other services to keep their position revenue neutral.
- 5.4.12 Hospital Group B reacted in a similar fashion. Hospital Group B’s MRI rates [§<] are substantially higher than our average rate charged by any other supplier. Hospital Group B did offer lower pricing in exchange for increased volumes (which were not achievable) and their position was that MRI revenue was material to their agreement with Aviva Health and so any changes which were not mutually agreed would mean that whole agreement would cease to be viable for Hospital Group B. Hospital Group B’s final position was that they were included in the MRI network at existing rates.
- 5.4.13 The CC notes that insurers may have leverage in negotiations with hospital operators through two mechanisms:
- a) The insurer could use the threat of not including a given hospital or only certain treatments in its network;
 - b) The insurer may be able to develop mechanisms to influence the patient’s choice of hospital or ‘steer’ patients away from one hospital operator or facility to another.
- 5.4.14 It is our experience that neither of these mechanisms is effective at increasing our leverage in negotiations, due to the concentration of the large hospital chains. We illustrate this point with some examples.
- 5.4.15 In January 2010, Hospital Group D proposed a 6% increase in its rates for the second successive year (having previously sought an increase of 9% in 2009). In a bid to control escalating claim costs, we proposed an arrangement to remove nine of Hospital Group D’s facilities from our hospital list – in areas where other hospitals offered more competitive pricing. In response Hospital Group D raised prices at its other facilities and proposed a 3 tier charging structure with some facilities having a 3.5% increase, some a 6.2% increase and some a 39% increase. The overall effect of these proposed price increases was that it cancelled out any benefit that we could get from delisting the hospitals and directing patient volumes towards the providers in those areas that offered more competitive pricing.
- 5.4.16 We have also tried to develop bespoke hospital lists for our corporate customers that have asked us to bring their premium costs down. Corporate Customer A is a major corporate customer of Aviva Health. During a number of contract renewal discussions in 2009, we discussed a number of options to better manage claims costs. Aviva Health came under pressure to lower costs in order to keep Customer A’s business and so attempted to secure further discount from Hospital Group C. Hospital Group C agreed to increase their discount to 10% against Corporate Customer A rates (previously they operated a 5% discount at one hospital only).

- 5.4.17 We presented a number of options to Corporate Customer A highlighting the financial benefits of applying a new claims model to include a 'tailored network of providers' (restricted list of hospital providers). Corporate Customer A then asked us to implement a restricted hospital list removing higher cost providers where competition exists.
- 5.4.18 In January 2010 we launched the new tailored network, 12 hospitals (amongst others) within Hospital Group C were removed from the Corporate Customer A hospital list and members no longer had access to these facilities. Hospital Group C became aware of the situation and made a complaint to Aviva Health regarding the restricted access citing how this is contrary to the spirit of the relationship between them and Aviva Health and asked Aviva Health to restore the excluded hospitals. Hospital Group C requested that Aviva Health speak with Corporate Customer A and restore access to their facilities.
- 5.4.19 Hospital Group C also threatened to withdraw the discount that they currently offer Aviva Health for Corporate Customer A's business if access is not restored. We communicated to Hospital Group C that their high charges were the reason why access to the facilities would not be restored. Hospital Group C retracted the discount that they offered to Corporate Customer A employees, whilst access was restricted, and they lobbied the customer directly to include all Hospital Group C hospitals in their lists. At instruction from Corporate Customer A, we included Hospital Group C's excluded hospitals on the customer list, which reduced the cost savings from the tailored list.
- 5.4.20 This also highlights the difficulty that we face in trying to steer patients towards less costly providers, to control the costs of premium. Hospital Group C threatened us with legal action – claiming that we had breached a clause in our contract [3<]
- 5.4.21 Due to the fact that the customer was choosing to remove the hospitals from its network – we were not in breach of our contract. However clauses such as this one and those in agreements with Hospital Groups B and D (see below) limit our ability to direct patients towards less costly providers, without jeopardising our existing agreement. This is another example of how the large chains renegotiate – or threaten to renegotiate – agreements to remain in a revenue neutral position. They refuse to compete on prices.
- 5.4.22 For example, Hospital Group D have the right to terminate our agreement if we undertake any action or introduce any schemes (such as those that may divert volumes away from Hospital Group D) and have a material adverse impact on the group, they have the right to terminate the agreement with Hospital Group D [3<] In our agreement with Hospital Group B, a material breach of the agreement is defined as [3<]
- 5.4.23 The conduct of the large hospital groups, and the leverage that they have via the concentration of the market, constrains our ability to encourage competition on price and quality. We believe the PH market is less efficient as a result of this, resulting in higher prices for consumers. The impact on quality is not clear. There is insufficient comparable data with which to compare the performance of different hospital facilities. We encourage the CC to investigate further the conduct of the large hospital chains – including national pricing and contracting – as we believe it is a feature of the market which restricts competition.

5.5 Theory of Harm 4 - Buyer power of insurers in respect of individual consultants

- 5.5.1 Theory of harm 4 proposes that insurers power as a purchaser effectively counters the potential impact of the consultants. Aviva Health does not believe that this is the case for us.
- 5.5.2 Private medical insurance provides reimbursement to individuals for the costs of eligible treatment delivered on a private basis. Costs arise from two main sources, the hospital or other facility where treatment takes place and the individual practitioner who provides the care.
- 5.5.3 Aviva Health's approach has been unrestrictive to customers and allows reimbursement to customers for costs incurred by any consultant meeting our definition within the policy terms and conditions. To reflect the demand to keep premiums affordable Aviva Health has operated a fee schedule approach that sets the maximum amount that may be reimbursed for any given procedure or combination of procedures. Our approach to this is set out in the policy terms and conditions and the actual fee schedule is available freely to anyone who requests it.
- 5.5.4 Aviva Health's insurance policies define a consultant as:
- A registered medical practitioner who:*
- *has at any time held and is not precluded from holding a substantive consultant appointment in an NHS hospital, or*
 - *holds a Certificate of Higher Consultant Training issued by the Higher Specialist Training Committee of the relevant Royal College or faculty, or*
 - *is included in the Specialist Register kept by the General Medical Council and who is recognised by us to provide the treatment you require for your condition.*
- 5.5.5 This definition is broad enough to include most, if not all, specialists who work in private practice in the UK allowing customers and their GP as much choice as possible.
- 5.5.6 Specialist fees account for a third of overall costs and this has remained consistent over time. (See Figure 12).

Figure 12: Specialist fees as a proportion of total spend



- 5.5.7 Fees paid to consultants are often considered in terms of the benefit maxima allowed for coded procedures. This narrow view encourages a consideration of each individual transaction rather than a patient's entire healthcare journey. A better way to understand both the costs involved and the value gained by the patient is to consider the total lifecycle of a patient's experience. As the market is constructed to manage a series of transactions this analysis is difficult to conduct and without measures of value gained (health outcome improvement) not sufficient to drive competition.
- 5.5.8 The result of the current market paradigm leaves few levers for insurers, managing the fee schedule is one of the few as recognised by the OFT in their review of the market¹¹
- 5.5.9 Our experience is that it is not clear how consultants decide to set their fees, in direct communication it is rare to find a methodology behind the fee levels and in discussion with our Chief Medical Officer we often receive compliments that our approach is clear and transparent. We also note that the BMA consultant handbook states: "In attempting to establish their own fees, consultants are advised to consult with colleagues in the same field and to seek information on the benefit maxima paid by the main insurance companies."¹² There is no reference to calculating a fee by looking at expenses, complexity of case or time involved
- 5.5.10 Our fee schedule does not set out what a specialist will be paid for a procedure or consultation, it sets out the maximum benefit that will be reimbursed to the customer. This information is freely available online¹³.
- 5.5.11 Our fee schedule uses the industry standard code, provided by the Clinical Coding and Schedule Development Group (CCSD). This group launched a new set of codes and descriptors in 2006 following an extensive project to review the existing codes. The review process involved over 130 consultants working in 22 specialty groups to develop improved codes and descriptions for surgical procedures performed within the private sector. Since launch a regular review process ensures that any amendments, that may include new procedure codes, narrative changes or code inactivations are released on a monthly basis. The CCSD group maintains the list of codes and narratives, this list is available to any party that wishes to make use of it, for individual practitioners there is no license fee payable. The CCSD group does not determine fee benefit levels, these are decided by each insurer.
- 5.5.12 Aviva Health sets benefit maxima using a transparent process and a "fair and reasonable" principle. We make extensive use of our Chief Medical and Chief Surgical officers who are contracted to provide expert advice to Aviva Health. In advising us of appropriate fee maxima they consider a range of factors: length of time in theatre; length of hospital stay; morbidity and mortality; complexity of the procedure in the specialism; and the general complexity and risk of that surgical speciality.

¹¹ Private Healthcare Market Study, Report on the market study and final decision to make a market investigation reference. April 2012. OFT1412, 5.100

¹² The Consultant Handbook. May 2009. Page 100

¹³ <http://www.aviva.co.uk/health-insurance/practitioner-zone/online-fee-schedule/>

- 5.5.13 The benefit maxima that Aviva Health sets equates to a rate for surgeons between [3<] per hour for their operating time. It is important to remember that the fee allowed for procedures also includes the postoperative supervision not simply the operation time. Consequently the higher rate tends to apply to the more complex procedures that will require more intensive post operative supervision. Examples of these more complex procedures would be paediatric cardiac surgery or laparoscopic oesophago-gastrectomy.
- 5.5.14 Codes are reviewed on a rolling basis and prioritised according to the degree of problem that they cause. We seek to actively review codes where our customers experience a shortfall regularly or where consultants are concerned that they do not correctly reflect their work.
- 5.5.15 Since January 2011 months we have reviewed 128 codes (6%) with the following decisions on the benefit maximum:

Number of codes adjusted upwards	75	63%
Number of codes adjusted down	14	11%
Number unchanged	32	26%

- 5.5.16 Within our policy wordings we set out for our customers what benefit is available for consultants' fees:
"We cover consultants' fees up to the limits in our fee schedule. If the fee is higher than the limit in our fee schedule, it is your responsibility to pay the consultant the difference".
- 5.5.17 To help our customers understand the effect that the fee benefit maximum will have in their particular circumstances our claims process seeks to identify the procedure being undertaken and the consultant responsible so that we can advise the customer of the potential likelihood and size of a shortfall. Equipped with this information our customer can discuss with their consultant the proposed charges and make a choice whether to accept these or not. We appreciate that this is not an ideal situation as it is inconvenient to change consultant. Where the customer does want to do this we provide assistance.
- 5.5.18 On occasion the procedure being performed is unusual or there are other circumstances that mean that the existing codes do not accurately describe what is required. In these situations we have an escalation process that ensures that the fee limit paid to the consultant is commensurate with the complexity of the procedure.
- 5.5.19 As set out in 5.4.4 Aviva Health uses a broad definition of specialist, this ensures that our customers have access to a wide range of specialists across the UK.
- 5.5.20 The registration process for specialists is straightforward, the individual or their secretary completes an application form and once we have checked that they meet the criteria we issue a provider number and set them up as an active provider on our claims system.
- 5.5.21 We believe that private practice remains an attractive market for consultants and typically see 90 new applications per month with a very low number of requests to relinquish their recognition.

- 5.5.22 Aviva Health recognises that the contractual arrangements traditionally in place mean that the consultant is entirely independent from the insurer. They are responsible for the quality and costs of the services that they supply and enter into a contract with their patient for these. The contract that Aviva Health has is with the patient as a customer and managing the interaction of the various parties can be complex.
- 5.5.23 Our experience is that despite working in a commercial market consultants prefer not to engage with insurers to develop ways of working that would provide a better experience for customers. The fees that they set are not framed in the context of the costs of running their business and we rarely have the opportunity to engage with them in how a better market for customers could be created.
- 5.5.24 In particular it appears to us that:
- Consultants overheads are low as consulting rooms, secretarial and administration services are often provided by hospitals at discounted rates
 - The costs of medical indemnity are opaque and vary by speciality and amount of private practice performed
 - There are a variety of incentives provided by hospitals in return for bringing patients to that hospital, again the nature of these is not clear and may range from preferential arrangements for theatre time to more direct financial arrangement.

5.6 Theory of Harm 5 - Barriers to entry including contracts and incentives

a) barriers to entry into privately-funded healthcare provision resulting from national bargaining between insurers and hospital operators

- 5.6.1 We agree that there are barriers to entry into the private healthcare market for hospital operators that are exacerbated by the concentration of the hospital market, and national contracting by the large five hospital groups. We do not think that these barriers in any way relate to our conduct in the market place. Aviva Health has significant incentives to recognise a new market entrant that can offer competitive pricing and quality. We do not have any clauses in agreements with suppliers that explicitly prohibit us from recognising new facilities – nor would we agree to such clauses. However we note that the behaviour of the large hospital chains – in setting national prices for access to all their facilities can create a barrier to entry.
- 5.6.2 We believe this can happen for two reasons:
- a) National prices and contracting distort local price signals and mask inefficiencies. This may be a barrier to new entrants as the hospital chain sets a price that is lower than the competitive price in that market (i.e. in a high cost area) and subsidised with profits made with the same price used for facilities in lower cost areas.
 - b) The conduct of the large hospital chains – to renegotiate or threaten to renegotiate treatment rates if volume falls to maintain their top line revenue – can act as a disincentive to recognise new entrants.
- 5.6.3 Because of the market power held by the large hospital chains, we are often not successful in attempts to control costs, such as diverting patients towards less costly providers, or creating restricted networks for specific treatments.
- 5.6.4 We would like to be able to create restricted hospital lists or networks if it met with the demands of our customers. This is one of the few levers available to insurers to control the costs of hospitals. Due to the level of concentration, and the national approach to contracting and price setting by the big chains, it is not effective in the current private healthcare market. In order to have national coverage, all of the large five chains would need to be included on the network

b) barriers to entry into privately-funded healthcare provision resulting from the relationships between hospital operators and consultants or GPs

- 5.6.5 We agree that relationships between hospital operators and GPs and consultants are a feature of the private healthcare market that restricts competition. We are concerned that both financial relationships and informal relationships can constrain choice and competition along the treatment pathway and create incentives to over treat. We note that we have only limited information to evidence these practices, but we encourage the CC to investigate these further.

- 5.6.6 We are aware of Nuffield Practice Privilege Plus - a partnership reward scheme from Nuffield Health that rewards consultants for growing the amount of business that they conduct in Nuffield Health treatment facilities. We are concerned that schemes such as this one, create an even stronger financial incentive for the consultant to over-treat the patient, and may further constrain the patient's choice of treatment unit. As the OFT survey of consultants identified, around 50% of consultants do not offer patients a choice of treatment facility. Incentive schemes such as the one offered by Nuffield Health, may be one of the key drivers of this behaviour.
- 5.6.7 There is substantial variation in the costs of the same procedure for Aviva Health patients across and within hospital groups. Aviva Health acknowledges that in many cases this variation may be driven by clinical necessity – however we are concerned that these relationships can strengthen the already-present financial incentives of consultants to over-treat patients. This overtreatment potentially pushes up the cost of PMI to customers,.
- 5.6.8 Aviva Health believes that financial relationships between hospitals and consultants create a significant barrier to new entrants coming into the PH market. The new entrant will need to be confident that they can secure patient flows. The consultant is the key influence on the patient's choice of treatment facility. Consultants typically do not offer their patients a choice of treatment facilities, and consultants treat between 71% - 100% of their patients in their preferred facility (according to the OFT survey). 50% of consultants surveyed by the OFT did not offer their patients a choice of treatment facility. If consultants are financially tied to the incumbent, new entrants may struggle to secure the referral flow.
- 5.6.9 A natural response from a new entrant in that situation will be to offer more valuable incentives to consultants in order to secure their business. Hospitals may compete on the level of financial inducement and competition for consultants will begin on the level of financial inducement each provider is willing to offer. Aviva Health is concerned that this competition is not in the best interests of customers. The potential for inducements to influence will increase, as these inducements are bid up. The patient does not have sufficient information – nor are they in a position – to assess the impact the consultant's financial inducement has on their recommended treatment pathway.
- 5.6.10 We are also concerned that formal, or informal relationships between GPs and consultants, or hospitals, is further constraining customer choice and competition. GPs view themselves as the single most important influence on a patient's choice of consultant and treatment facility and the reputation of the consultant is the most common factor driving their recommendation, followed by their previous experiences with a facility. The most common source of information that GPs use to inform their recommendation are marketing materials sent by facilities, followed by informal social contracts¹⁴.

¹⁴ GHK, *ibid*, 2011

- 5.6.11 We are concerned – given the evidence cited in the OFT Private Healthcare Market Study (OFT, 2011) - that PH providers might be rewarding GPs in exchange for referrals. An example cited in the OFT report was where a PH provider is the landlord to the GPs surgery and offers discounted rent to the GP to incentivise referrals. The GP is the most important influence on a patient's choice of consultant or PH facility. If the GP has incentives to refer the patient to a particular consultant or facility, this is a potential constraint on competition, and affects patient's choice. They may not be aware of the incentives that the GP faces, and believe that the recommendation is being made in their best interests. Such arrangements could be a barrier to entry into the private healthcare market. In the same way as entrenched referral patterns – based on historical behaviour or informal relationships – can be a barrier to entry.
- 5.6.12 We encourage the CC to investigate further the incentives provided to consultants and GPs, which we believe can constrain patient choice as to where they are treated, and also create incentives for overtreatment.

c) other barriers to entry into privately-funded healthcare provision

- 5.6.13 Aviva Health does not have any specific views on whether capital requirements and sunk costs, and planning delays and the strategic use of the planning regime by incumbent providers is a barrier to entry.

d) barriers to entry into the provision of consultant services in private practice

- 5.6.14 Consultants face barriers to entry into the market because of the high level of qualification (and therefore years spent studying) that are required before they can become a consultant. Once they are a registered consultant (in the NHS) Aviva Health does not think there are any barriers to entering private practice other than those put in place by consultants themselves. On average we register around 90 new consultants every month.
- 5.6.15 However in specific geographic locations there may be barriers to entry for consultants. We agree with the CC that consultant groups may have an incentive to prevent new market entrants from entering the market, and lowering the high prices. We encourage the CC to investigate this issue further, as it restricts competition between consultants and higher costs and lower quality could eventuate as a result.

5.7 Theory of Harm 6 - Limited information availability

- 5.7.1 Aviva Health agrees that there is limited comparable information on consultants and private healthcare providers that is available to patients, GPs and insurers. This lack of information constrains competition between consultants, and between private healthcare providers, on the basis of cost and quality. Information is particularly important in this market because of the information asymmetries that exist between patients and the providers of their healthcare (GPs, consultants and hospitals). Decisions along the pathway are not being influenced by good information on the cost and quality of care. Aviva Health believes that the financial incentives facing consultants and PH operators are significant influences on the pathway, which are not countered by good information.

5.7.2 We believe that there are two main areas where information asymmetries constrain competition and harm private healthcare customers:

- a) Information asymmetries between consultants and patients and GPs during the care pathway – patients cannot trade off between cost and quality, which constrains competition.
- b) National pricing by the large hospital chains, which masks regional variations in cost.

Taking these in turn:

Information asymmetries along the treatment pathway

5.7.3 As we described in Section 4, the GP referral is the key influence on the patient's choice of consultant – over 90% of GPs indicate that patients always or usually follow their recommendation, according to the GHK survey of GPs.¹⁵ We are concerned that GPs do not have information on the cost and quality of consultants and hospitals when recommending choices for patients. This is a big concern as the GP referral in large part determines who influences the remainder of the treatment pathway – and the cost to patients and insurers. Aviva Health's [2011] survey of GPs illustrates that a consultant's reputation is the most common reason for referrals (Table 12). The quality of the consultant and cost of treatment were rarely factors that were considered. Similarly, in response to GHK's survey, less than 50% of GPs indicated that they regularly discuss waiting times and medical and clinical outcomes with the patient.

Table 12: Which of the following do you consider when making private referrals? (select all that apply) – Aviva survey of 208 GPs

Factor	% selecting
Reputation of Consultant	77.40%
Reputation of Hospital	40.87%
Quality consultant	7.21%
Quality of hospital	4.33%
Clinical outcome	28.37%
Patient experience	56.37%
Convenience of location	63.46%
Speed of access	54.81%
Cost of treatment	11.54%
Other – please specify	6.25%

5.7.4 We are also concerned that our customers do not have sufficient information about the costs of treatment, and their risk of shortfall, at the time of referral. Just over one in 10 GPs indicated that they discussed the cost of treatment with a patient. Aviva Health's survey of GPs, presented to the OFT, showed alarming differences about their knowledge of the cost of PH provision (Table 13). And once a patient is referred to a consultant they will often not get any more information on expected fees until at least their first consultation. 50% of consultants surveyed by GHK did not routinely make fees known to patients before consultation. More than 10% of consultants surveyed indicated they did not provide fee estimates before sending patients a final bill.

¹⁵ GHK, *ibid*, 2011

Table 13: GP's estimate of the total cost of three procedures - Sample size=208

Procedure	Min	Max	Range	Interquartile range	Median	Aviva's average cost
Cataracts	£50	£7500	£7450	£2000	£2000	£2698
Colonoscopy	£200	£7000	£6800	£900	£1000	£1475
Hip Replacement	£1000	£20000	£19000	£5250	£6750	£10504

- 5.7.5 The lack of published information on the cost and quality of consultants constrains what advice we can provide to customers. We can warn customers about their risk of shortfall with a particular consultant (based on previous behaviour), but without comparable data on clinical quality we can't help our customer to make a decision based on value. By the time our customer contacts us it is often too late. Our customer will typically not contact us until they need pre-authorisation for treatment. By this point critical decisions about the treatment, and place of treatment, have already been made – usually by a patient's consultant.
- 5.7.6 Quality metrics for hospitals are mainly reported at the group level in the PH sector (not individual hospitals) and do not measure aspects of quality that are particularly meaningful. For instance, some PH groups report data on healthcare acquired infection rates, but these rates are so low in the vast majority of cases that variations between providers are largely meaningless. They do, however, provide a useful data-point for assuring that providers meet a minimum quality standard on infection rates.

National pricing by chains

- 5.7.7 We also believe that the information asymmetry between hospital groups and Aviva Health – exacerbated by their approach to national pricing – distorts competition. National prices – offered across all the facilities of the hospital chains - distorts local markets and masks the relative efficiencies and inefficiencies of different providers.
- 5.7.8 This harms patients because it confuses the signals normally seen in competitive markets that new entrants can use to inform which markets to enter and at what prices. This is an important constraint on incumbent providers, which does not exist in PH.
- 5.7.9 Provision of more data is essential, but not sufficient, for a better functioning market. For information to be valuable to a patient there needs to be a filter – someone that can translate information about clinical outcomes that is meaningful to the patient. Given the switching costs of changing consultants, the patient needs sufficient information about the relative cost and quality of different consultants, in order to make a decision based on value. The GP can help the patient in making this decision, however the incentives that a GP faces, and entrenched referral patterns, can get in the way. The GP may also not be able to communicate to the patient their risk of shortfall with a particular consultant. Increased availability on the clinical outcomes of consultants will not help the market to function better without cost information communicated alongside. If the GP is not able to do this, then there is a role for Aviva Health to communicate this to the patient – before they commence their treatment pathway – and help the customer to identify alternative consultants if they wish to avoid a shortfall.

- 5.7.10 Equally, the conduct of the large hospital groups needs to be addressed, before requirements for greater transparency over price can have any impact. A requirement for hospitals to publish price lists for all their facilities will deliver no benefits to choice and competition if hospitals can still enforce national pricing and leverage the market power of certain facilities. Improving the transparency of information should be viewed as part of a bundle of solutions to improving choice and competition in the private healthcare market.

5.8 Theory of Harm 7- Vertical effects

- 5.8.1 Aviva Health agrees with the CC's current belief that vertical linkages between insurers and providers do not lead to significant harm to competition.
- 5.8.2 We are aware of Bupa's ownership of the Cromwell Hospital in London and have no concerns. Aviva Health itself does not currently own any primary care facilities, but has a relationship with HCML to deliver the Back Up service.
- 5.8.3 We believe vertical integration between insurers and PH providers can in some instances deliver benefits to customers through improved efficiency and quality. It introduces a strong cost and quality incentive into the decision-making process – insurers have an interest in both as they seek to help manage costs and improve quality. Demand for our products, and our reputation, depends on both.
- 5.8.4 Our partnership with HCML – to deliver Back-Up – is an example of where management of the clinical care pathway has improved outcomes and reduced costs for our customers.
- [§<]
- 5.8.5 We urge the CC to consider the impact of vertical integration between providers. This is an increasing feature of the PH market. We have previously provided to the OFT a number of examples of vertical integration, which highlight our concerns.
- 5.8.6 The examples of vertical integration provided have the potential to further distort current referral mechanisms. They limit the choices available to the customer, foreclosing the consumer as well as limiting the supply of referrals and therefore activity and income to competitors.
- 5.8.7 Both purchases that we cited (and indeed the general trend towards vertical integration) have been explicit in their role to increase the number of patients being referred to the acute hospital or Hospital Group. For example, on purchasing Lifespan, Spire commented "This is a great acquisition that will result in an increase in the number of patients being referred to Spire hospitals for follow-up care."¹⁶
- 5.8.8 No examples of vertical acquisition, nor any other examples of provider led vertical integration that we have experienced, have resulted in a fall in prices or an improved offering or outcome that one might expect to follow from the increased efficiency gains or economies of scale that are typically cited as reasons for purchase.

¹⁶ <http://www.spirehealthcare.com/Corporate-News/Lifescan-Acquisition/>

- 5.8.9 Aviva Health's view on integration is that integration of care means a seamless journey. This does not mean the same provider delivering all of a care pathway. Rather it is much more dependent on information flows across providers in a pathway than on any one provider delivering the whole journey. "Back up" (as described in detail in 1 above) illustrates how integration can be achieved without compromising competition between providers.
- 5.8.10 We are particularly concerned of the impact of vertical integration on both our and other insurer's ability to innovate across the care pathway if the care pathway is dominated by a single provider whose aim is to maximise the number of referrals across a single group. When the referral mechanism is dominated by a hospital group there is no incentive for them to consider alternative pathways with another provider when there is no financial gain.
- 5.8.11 We have similar concerns about our ability to help corporate customers manage healthcare costs when the referral mechanism is foreclosed. This foreclosure also hampers our ability to analyse claims activity within a competitive market. We have enclosed (see Appendix F) an independently compiled report using one London based corporate client to illustrate this case (Claims Analysis, October 2010).
- 5.8.12 The OFT has already indicated that it has concerns about information asymmetry and the relationship between consultants and providers. Aviva Health is concerned that the type of vertical integration being pursued by providers expands this issue by reducing the choices available to patients. Instead referral flows along the patient pathway will be based on commercial ownership structures rather than quality and cost considerations.
- 5.8.13 We agree with the CC that the vertical linkages between an insurer and a healthcare provider are not a feature of the market which constrains competition and choice. As our experience with Back-Up highlights, management of the treatment pathway by a clinical case manager – who does not face the same financial incentives as a consultant or hospital – can control the costs of treatment and improve outcomes.
- 5.8.14 Of far greater concern are the vertical linkages between referral centres and private healthcare providers [3<]. These vertical linkages – in addition to other types of formal and informal relationships between GPs and consultants and hospitals – could distort the incentives of GPs, and constrain patient choice.

6 Summary

- 6.1 The theories of harm articulated by the CC cover the key areas where we believe features of the market are restricting competition and causing harm to customers. We have outlined our arguments and evidence from our own experience. However as we have only an 11% market share, we have limited access to information to conclusively evidence the problems we see in the market. We urge the CC to investigate these issues further.
- 6.2 We do not agree with theory of harm four - that our behaviour in any way suppresses consultants' fees to a level below those that would prevail in a competitive market. We see significant numbers of new consultants entering the market and registering with Aviva Health (around 90 every month). We also see that aggregate spend on consultants continues to grow. We urge the CC to consider whether the current treatment pathway is functioning in the best interests of customers of PH and customers of PMI.
- 6.3 We believe that in many instances consultants have market power over patients, conveyed upon them by entrenched referral patterns by GPs, and the information asymmetry that occurs along the treatment pathway. They are in the best position to recommend the course of treatment and also have financial incentives to increase fee income. Survey evidence shows that patients will often not know fees until it is too late, and are not in a position to assess the value of one course of treatment over another. Switching costs may be high.
- 6.4 Consultants are also the most significant influence over where a patient gets treated. Survey evidence collected by GHK shows that consultants often do not offer patients a choice of treatment facility, They may receive financial incentives for referring a patient to a particular hospital.
- 6.5 Our claims data shows wide variation in fees charged by consultants for the same procedure. There is no evidence that higher fees are linked to higher quality. We also find no evidence that higher fees are systematically being charged in areas with higher costs of living – suggesting that our fee schedules are adequate for many consultants. Interestingly fees tend to be higher where there is a greater supply of consultants in a particular area.
- 6.6 We do not believe that consultants compete on costs and quality to attract patients. There is a significant lack of comparable information on quality, and fee information is typically not made available to the patient before they have commenced along their treatment pathway. We try to control their costs through setting fee schedule limits for different procedures. Consultants do not have to stick to these limits – in fact they are publicly encouraged by FIPO (a medical organisation representing the majority of the medical professional organisations that have private practice committees), not to adhere to them.
- 6.7 We believe that there is an important role for an intermediary along the treatment pathway to help counter balance the information asymmetry and financial incentives to over treat that consultants and hospitals have. This could help to reduce treatment variation – some of which may be unnecessary. The success of Back-up, both in terms of reducing costs and improving patient outcomes, is an example of how a case managed pathway can deliver benefits for patients and our customers. Our argument is not that customers should be prevented from restricting care, but that we should be encouraging them to use more of the right type of care.

- 6.8 Our experience indicates that the hospital market is highly concentrated, and that the large hospital groups leverage the 'must have' facilities that they own in negotiations. Through national contracting, they secure higher prices – than would otherwise eventuate in a competitive environment – across all of their facilities. If any of their rates for particular treatments are exposed as being uncompetitive, they threaten to renegotiate contracts if we try to divert patients to less costly healthcare providers.
- 6.9 We urge the CC to investigate the impact that the concentration of the hospital market – and the conduct of the large hospital groups – has on competition.
- 6.10 There is a significant lack of comparable information on the cost and quality of consultants and hospitals. This needs to be addressed to facilitate competition and greater choice for patients. But we do not believe that provision of information, on its own, will address the features of the market that constrain competition. To reduce treatment variation, there is an important role for an intermediary (commissioner) to help the patient interpret the information and the advice given to them by consultants.
- 6.11 Equally, the conduct of the large hospital chains needs to be addressed, before requirements for greater transparency over price can have any impact. A requirement for hospitals to publish price lists for all their facilities will deliver no benefits to choice and competition, if hospitals can still enforce national pricing and leverage the market power of certain facilities. Improving the transparency of information should be viewed as part of a bundle of solutions to improving choice and competition in the private healthcare market
- 6.12 Aviva Health welcomes the opportunity to continue to work with the CC as the investigation progresses.

7 Appendices
Appendix A:
HHI scores for each county

Table 1: Market share and HHI by County
[✂]

8 Appendix B:

List of towns & cities that Aviva Health has used for the purposes of identifying 'must have' facilities

[<]

9 Appendix C:

Procedures used to construct average episode cost for PH provider group

Methodology to create the latest index;

- We reviewed the top 20 procedures by volume across our claims spend (note - they are not only I/P procedures).
- We then selected those procedures (15) where each major group had carried out the procedure on at least 50 occasions (with the exception of C7122 where Hospital Group B's volumes are slightly less).
- We then calculated the average cost per procedure by each provider by year (2007 – 2011).
- We then added the average unit cost for each of the 15 procedures together to provide us with a total 'basket' cost.
- This value was then divided into the national average cost for the basket to give us an index figure.

Procedures used

C7122	Phakoemulsification of lens with implant – unilateral
D1510	Myringotomy and insertion of tube through tympanic membrane (and bilateral)
E1432	FESS Endoscopic uncinectomy, anterior and posterior ethmoidectomy (and bilateral)
F0910	Surgical removal of impacted/buried tooth/teeth
H2002	DIAGNOSTIC COLONOSCOPY, INCLUDES FORCEPS BIOPSY OF COLON AND ILEUM
J1830	Laparoscopic cholecystectomy
K6510	ANGIOGRAM ADULT CATHETER BOTH SIDES HEART-INC CORONARY ARTERIOGRAPHY
M4510	DIAGNOSTIC ENDOSCOPIC EXAMINATION OF BLADDER/CYSTOSCOPY
Q1700	Therapeutic endoscopic operations on uterus (including endometrial ablation)
T2000	Primary repair of inguinal hernia
W3712	PRIMARY TOTAL HIP REPLACEMENT WITH OR WITHOUT CEMENT
W4210	Total prosthetic replacement of knee joint, with or without cement,
W7420	Autograft anterior cruciate ligament reconstruction (as sole procedure)
W8200	Arthroscopic meniscectomy (including debridement)
W8500	Multiple arthroscopic operation on knee (including meniscectomy, chondroplasty, drilling or microfracture)

10 Appendix D: Methodology for cost of living index

As part of our analysis (see section 5.2), we constructed a cost of living index in order to compare the average overcharge of consultants with the relative cost of living in different regions of the UK. In order to construct this index, we used weekly household expenditure data of various commodities and services from the *Living Costs and Food Survey* and the *Expenditure and Food Survey* carried out by the Office of National Statistics (ONS)¹⁷.

From the list of commodities and services set out in the ONS data, we identified those categories that we considered ‘essential’ items, i.e. items that are necessities rather than discretionary purchases. The index only includes essential items as expenditure on discretionary items may reflect regional preferences for entertainment and non-essential items, which are not important to this analysis. A full list of expenditure categories and those we identified as essential is set out in Table [A1.1] below.

Table A1.1: Household expenditure categories and ‘essential items’

Household expenditure categories	Essential item?
Food and non-alcoholic drinks	Yes
Alcoholic drinks, tobacco and narcotics	No
Clothing and footwear	Yes
Housing*, fuel and power	Yes
Household goods and services	No
Health	Yes
Transport	Yes
Communication	Yes
Recreation and culture	No
Education	Yes
Restaurants and hotels	No
Miscellaneous goods and services	No
Other expenditure	No
* Excluding mortgage interest payments, council tax, and rates in Northern Ireland	

Source: ONS

The average household expenditure on each essential item category was summed for each region. These values were then indexed, with the UK as a whole being 100. Regions with an index value greater than 100 represent areas that have a higher average cost of living than the UK average and those areas below 100 have a lower average cost of living than the UK average. The index values for each region in the UK are set out in Table [A1.2] below.

Table A1.2: Cost of living index for UK and its regions

¹⁷ We used the most recent data available, which covers the period 2007 to 2009.

Region	Cost of living index value
UNITED KINGDOM	100.0
England	101.1
North East	84.7
North West	91.3
Yorkshire and The Humber	85.5
East Midlands	94.9
West Midlands	96.9
East	102.7
Greater London	121.3
South East	112.2
South West	103.8
Wales	89.9
Scotland	93.6
Northern Ireland	106.2

Source: ONS data, PwC analysis

11 Appendix E:

FIPO presentation - Can consultants negotiate fees with insurers: an extension of game theory

Negotiating with Insurers Game Theory and the The Philosophy of Purchasers and Suppliers



Accepting or Declining Discounts with Insurers

- Consider the following scenario where 2 consultants each undertake 50 cases per annum
- The total market for insured cases is 100 cases

The Start

- | | |
|-------------------------|-------------------------|
| • Consultant A | • Consultant B |
| • Cases p.a. 50 | • Cases p.a. 50 |
| • Fee per case £1000 | • Fee per case £1000 |
| • Income £50,000 | • Income £50,000 |

Insurer offers more cases to Consultant A if they reduce fees by 10%; the total market is the same at 100 cases

- | | |
|-------------------------|-------------------------|
| • Consultant A | • Consultant B |
| • Cases p.a. 56 | • Cases p.a. 44 |
| • Fee per case £900 | • Fee per case £1000 |
| • Income £50,400 | • Income £44,000 |

This means that in Year 1

- Consultant A has to do 12% more work and must treat 6 more cases to maintain the same income
- If the insurer fails to actually send the 6 extra cases Consultant A will see his income drop
- In this deal consultant A bears all the risk

In the next year let us assume that

- The market has not grown (and there is no evidence to suggest that these fee reductions will be passed on in lower premiums and more subscribers)
- The insurer has in fact now managed to redirected 20 cases from consultant B to consultant A

The new situation with a total market the same at 100 cases is

- | | |
|-------------------------|-------------------------|
| • Consultant A | • Consultant B |
| • Cases p.a. 70 | • Cases p.a. 30 |
| • Fee per case £900 | • Fee per case £1000 |
| • Income £63,000 | • Income £30,000 |

Consultant B is now panicking so

- The insurer offers to include consultant B in the managed care scheme if he lowers his fees by 10%
- The insurer then stops redirecting patients and restores the equilibrium

The new situation in Year 3 with a total market the same at 100 cases is

- | | |
|-------------------------|-------------------------|
| • Consultant A | • Consultant B |
| • Cases p.a. 50 | • Cases p.a. 50 |
| • Fee per case £900 | • Fee per case £900 |
| • Income £45,000 | • Income £45,000 |

Thus the situation in Year 3 is

- Both consultants are back treating the same volume of cases
- Both consultants are earning 10% less than at the start

Now the insurer returns to Consultant A requesting a 10% fee cut for more work

- | | |
|-------------------------|-------------------------|
| • Consultant A | • Consultant B |
| • Cases p.a. 56 | • Cases p.a. 44 |
| • Fee per case £810 | • Fee per case £900 |
| • Income £45,360 | • Income £39,600 |

The process restarts and is always a downward pressure

- Consultant A has to undertake 12% more work and treat 6 more cases to maintain about the same lowered income as the previous year
- Total income is down for both consultants
- The redirection and ongoing downward spiral continues.....

The end result of the discounted and agreed fees

- The patient is excluded from the equation and the consultant/patient contract has been broken
- This is now being applied on a grand scale by certain major insurers
- It is a step wise reduction in income for ALL consultants
- No overall growth in insured referrals

This is the end result of discounted and agreed fees

Most importantly this means
**Restriction of Patient
Choice**

<http://www.fipo.org/docs/FIPO-Surveys.htm>

12 Appendix F: Independent claims analysis conducted by a broker

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Introduction

“Company A” have renewed their private medical Insurance with Aviva for the second year but I have seen, even prior to Aviva, claims costs rising to such a level that the scheme is now subject to higher than average single rates and a continually worsening risk profile.

“Company A” have a key strategy for 2010 and 2011 to reduce the claims spend on this medical arrangement to drive down premium costs for the future.

Spend can be reduced in a number of ways:

1. Reduce or amend the benefit offering
2. Review the spend at a more micro level and then focus on more directional care to drive down spend
3. A combination of 1 and 2

We have undertaken further evaluation of the claims spend since renewal with Aviva to establish a clearer picture of the risk profile of this scheme. Where relevant we have looked at “Company A”, “Subsidiary X” and “Subsidiary Y” independently.

In reviewing each of the “Company A”, groups in isolation the majority of claims spend fell within 3 main areas across all groups:

1. Musculoskeletal
2. Head and neck
3. Gastro-intestinal Spend

In addition two sections saw high spend in two further areas:

“Subsidiary X” - Oncology, and
 “Company A” - Gynaecological

To address the claims spend and review options to drive down cost focus needs to be given to these higher spend areas, where the biggest impact on risk can be achieved.

This report is aimed at providing further clarity on scheme usage.

Headline Data

Hospital Spend in London

Hospital Spend in London	
“Company A”,	23%
% of London hospital spend in Hospital X	56%
Aviva average spend in Hospital X of all London hospital spend	10%

We have identified the claims spend seen at the Hospital X as this, as an Hospital Group Hospital, is high cost and often sees high usage, especially where Occupational Health / Private GP referrals exist.

High usage in the Hospital X can have its benefits what we need to ascertain is whether the high usage is generating an abnormally high spend that could be avoided by directing care through other providers or through managed processes.

Inpatient Stays

Within the top three claimed conditions, there have been 10 inpatient / day patient stays in London Hospitals. On evaluating these, the home postcodes of the relevant claimants are all except 1 outside of London. Predominantly they are from Surrey, Kent, East Sussex and Hertfordshire.

Of these 10 stays, 6 are within the Hospital X and no claimant has a London postcode.

Patients often feel that due to an initial referral being to a London based hospital any inpatient treatment that may follow also has to be received in London. This may not be the case and a facility closer to home may be more cost effective and preferential to the patient.

Summary of Spend %

	Musculoskeletal-	Head and neck	Gastro-intestinal	Oncology	Gynaecological
Company A	35%	7%	14%	N/A	10%
Subsidiary X	52%	8%	10%	N/A	N/A
Subsidiary Y	41%	14%	11%	17%	N/A

Breakdown by Condition

Musculo-skeletal	Head and Neck	Gastro-intestinal	Oncology	Gynaecological
Spinal	Nose	Lower GI Tract	Colon Cancer	Vaginal Abnormalities
Other	Ear	General Symptom	Breast Cancer	Female Prolapse
Hip	Throat	Upper GI tract	Prostate Cancer	Uterine Disease
Ankle & Foot	Maxo-Facial	Hernia		Cervix
Knee	Dental	Other		Endometriosis
Shoulder	General	Biliary		Other
Osteoarthritis	Symptom	Rectal Bleeding		
Wrist & Hand				

Of the top three areas spend was as follows:

Musculoskeletal	-	£215,171
Head and Neck	-	£45,633
Gastro-intestinal	-	£72,676
Total	-	£333,480

(Spend at Hospital X - £50,369.58 – 15%)

Breakdown by Treatment Type (In, Out or Day Patient)

	Out Patient Spend	Inpatient Spend	Day Case Spend
Market Norms	29%	46%	25%
Spend in Total	49% - £165,465	31% - £106,329	20% - £66,286
Average Top 3 Conditions	57% - £191,137	31% - £105,165	12% - £41,777
Musculoskeletal	54% - £115,602	37% - £81,120	9% - £18,449
Head and Neck	57% - £26,264	31% - £14,111	11% - £5,259
Gastro-intestinal	58% - £40,060	17% - £11,529	25% - £17,453

Out patient spend is high within the three main conditions claimed for and are above the market norms. This can generally be a positive view in that treatment deferred to out patient from an inpatient or day patient basis often will carry a claims saving. What may not be so positive is if the outpatient spend is not a diversion from inpatient or day patient treatment but just an increased usage of out patient expense.

On evaluating further, the outpatient spend totals circa £287,185 of which the spend can be broken down as follows:

Total Spend	Outpatient Spend	Highest Spend per	Claimant / % of Claimants that
-------------	------------------	-------------------	--------------------------------

		per Claimant	Claimant	exceed £1,500 spend per annum
Company A	£224,224	£1023	£5,195	49 / 22%
Subsidiary X	£19,040	£550	£2,136	2 / 6%
Subsidiary Y	£26,440	£574	£2,327	4 / 8%

*within regions there was one high claim for £17,000 in out patient expense by one claimant. We have removed these figures from the above to avoid distortion.

Subsidiary X and Subsidiary Y saw all out patient expense fall between £0 and £2,400 per claimant. Company A saw 27 claimants (12%) claim in excess of £2,400 totalling circa £87,000

On further evaluation of these 27 claimants £57,000 was claimed amongst the top three conditions.

£38,000 - Musculoskeletal
£11,000 - Gastro-intestinal
£8,000 - Head and Neck

Data Analysis

On evaluating the data further we have evaluated each condition category in isolation:

Musculoskeletal

Musculoskeletal claims account for between 35% and 41% of each section usage. Market averages on musculoskeletal spend are between 30 – 35%. Company A have historically seen musculoskeletal spend at circa 37 – 39% but this spend is increasing.

On analysing musculoskeletal usage we can establish the following:

Of a claims spend on musculoskeletal usage we can establish the following:

Of a claims spend on musculoskeletal of £215,171 employees have claimed £117,705 and dependants £97,466.

Spend was seen in the following areas:

CT / MRI - £32,438
Pathology - £5,403
Physiotherapy / Therapies - £33,333
Radiology - £9,653
Specialist Consultations - £28,351
Inpatient charges -£105,993

	Outpatient Spend	Oupatient Spend	Day Case Spend
Musculoskeletal	£115,602	£61,120	£18,449
Musculoskeletal	£47,874	£7,807	£29,979
in London			
% of spend in	41%	42%	36.9%
London			

£26,297 of this spend was at the Hospital X (12%)

In breaking this Hospital X usage down further

- £14,849 related to MRI scans
- £1,020 to physiotherapy
- £2,114 to theatre fees
- £1,092 to X rays
- £2,981 to pain management

MRI Spend

Focusing on the MRI usage overall spend on MRI's was £26,477.85, which equated to an average cost of £778.75 per MRI. When evaluating the MRI usage in the Hospital X, spend was £14,849 or an average MRI cost of £989. Non London MRI scans averaged at a cost of £612.

Additionally of 124 claimants, 34 received MRI scans of which 15 were at the Hospital X. Of the 124 claimants, 19 were seen at the Hospital X.

Of 19 referrals to the Hospital X 15 received MRI scans – 79%. Of the remaining 105 claimants 19 MRI scans were received – 18%.

Not only is the average treatment cost at the Hospital X high the referral rate for MRI scans is also high. Had this usage been outside of the Hospital X and within average referral rates a claims saving of circa £13,000 could be achieved (4% saving).

Physiotherapy Spend

Physiotherapy spend has been for £27,086.13 and averages out at £26 per session. We have evaluated the hospital chain and physiotherapy centres and on average a cost per session is £40-£50.

Hospital Group D	- £39 per session
Hospital Group A	- £41 per session
Hospital Group C	- £46 per session
Hospital Group B	- £78 per session
Independents -	- £50 per session

The Hospital Group B (including Hospital X) is again reflecting high cost treatments but usage in this facility has been relatively low at £1,020.

Whilst spend in the Hospital Group B has been low the use of independents has been high at a total of £20,590. Of the independents used the following are the most heavily utilised:

Physiotherapy Clinic A

Physiotherapy Clinic B

Physiotherapy Clinic C

Physiotherapy Clinic D

Utilising a preferred provider option to negotiate a preferred session rate may be worth investigating.

Of independent usage £5,739 was in the City of London, £5,592 was in other areas of London (West) and £1,368 was in Ipswich.

Market Norms as far as physiotherapy spend is concerned is an average 2% of spend. "Company A" are experiencing spend at almost 6%.

Pain Management Spend

£14,039 in total has been spent on pain management.

21% of this was at the Hospital X with the remaining spend split between the Hospital U, Hospital T, Hospital S. On evaluation the Hospital X spend is one claimant driven.

Consultation Spend

With all medical conditions a large % of spend will be on consultations as all forms of treatment are commonly supported with a consultation. Of all musculoskeletal claimants of which there were 124, 56 of these had consultations with 48 having a follow up consultation.

With spend on consultations being £37,029 this equates to an average spend on consultations of £356 per consultation or £661 per claimant.

Head and Neck

£45,633 has been claimed in total for head and neck conditions and these appear to all be for a variety of conditions including:

- Tonsillitis
- Sinusitis
- Dizziness
- Hearing Difficulties

The majority of the spend is for inpatient treatment and these appear to be for minimal low cost inpatient treatment. The quantity as opposed to the value spend is driving the spend upwards.

The majority of children make claims within the categorisation.

There have been 17 claimants claiming an average of £2,684.29.

Gastro-Intestinal

£72,676 has been claimed by members for Gastro-intestinal conditions of which £22,737 relates to unassigned treatment centres. Of the remaining £49,939, £12,362 was received at the Hospital X which represents 17% / 24% of spend. The average cost per claim per hospital is £37.96 yet this increases to £196.84 when reviewing the Hospital X.

Gynaecological and Oncology

The spend seen in each of these areas, whilst relatively high would appear to be based on scheme usage by a few lone claimants.

The Gynaecological spend is for one high value hysterectomy operation in London and the Cancer claims are predominantly down to two large colon cancer claims. What is of interest is that this claimant whilst treated at the Hospital X the patient lives in Kent.

Whilst we could evaluate this spend further to reduce cancer claims further directional usage of the NHS will be the only impacting option and this may moralistically not sit comfortably with "Company A".

Summary

In general the spend on “Company A” across all three sections is relatively standard with no obvious trends from a medical condition perspective. Musculoskeletal, Head and Neck and Gastro-intestinal claims contribute to the highest element of spend and for this reason we have evaluated the spend in these areas further. However in general the spend in these areas does not appear to be hugely different from the market norm expectations.

To establish why the performance on “Company A” differs to that of “Subsidiary X” and Regions and the market average, we have had to look further at where claims spend sits by micro analysing the claims spend. From this we have deduced that whilst the quantity of out patient claimants is average the spend seen by claimant for “Company A” is out patient expenditure is above average.

On “Subsidiary y” and “Subsidiary X” out patient spend rarely exceeds £2,000 per claimant but on “Company A” this occurs frequently and the level of additional exposure accounts for almost 13% of the claims fund.

The exposure on out atient spend is further exacerbated through:

- High physiotherapy utilisation
- Increased usage at the Hospital X
- High levels of MRI spend within cases referred to the Hospital X
- Increased usage / treatment leading to increased consultations

