



**PRIVATE HEALTHCARE MARKET INVESTIGATION**

SUBMISSION OF AXA PPP

20 July 2012

**REDACTED VERSION**

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## ANNEXES

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1.

## EXECUTIVE SUMMARY

AXA PPP welcomes the opportunity to participate in this market investigation, which we feel comes at an important time for the private healthcare sector given the current economic climate and the pressures on the UK healthcare system.

### Overview

This submission is structured as follows:

- In Chapter A, we provide an overview of our business, the typical steps in an insured customer’s journey within the private healthcare system, and our approach to claims management.
- In Chapter B, we consider market definition issues, with a particular focus on the distinct features of the Central London market.
- Chapter C provides AXA PPP’s perspective on the healthcare provider landscape in the UK. We describe the market dynamics from a local and national perspective and provide a detailed description of our network and related strategies, including our “open referral” products which we believe increase patient choice and facilitate product development and lower premiums. We also discuss our contractual and pricing arrangements with the key PH providers.
- Chapter D focuses exclusively on the Central London market, and in particular on the market position and conduct of HCA including concerns about the level of fees charged by HCA, the provision of incentives to consultants, HCA’s vertical integration via the investment in primary care facilities. and other conduct which we believe could restrict competition.
- In Chapter E we outline our relationships with consultants, including our approach to fee schedules and contractual arrangements with consultants. Our primary objective in this respect is to maintain a position whereby fees will be met in full and customers do not

experience a shortfall. Only 3% of the consultants that we recognise are subject to caps on reimbursement or contractual restrictions on the amount that they can charge to customers. Chapter E also sets out our concerns with respect to anaesthetic groups which have an agreed fee schedule for their members and reduce patient choice.

- Chapter F outlines our significant concerns with the provision of incentives by PH providers to consultants (and, potentially, to GPs). In our view, such practices may adversely influence professional judgement and distort competition by PH providers to the detriment of patients.
- Chapter G briefly considers the difficulties that patients and insurers encounter in accessing reliable information in this sector.

## **Key Issues**

From AXA PPP's perspective, our key concerns are as follows:

### ***Central London / HCA***

While all of the main PH provider groups benefit from market power in respect of particular solus facilities, we also have particular concerns regarding HCA's market position in Central London.

In our view, Central London has the features of a distinct market given the reputational draw of certain facilities and consultants, the fact that new technology will tend to be introduced in London before other locations, the importance of London facilities to large corporate customers, and the fact that many customers living both within and outside London prefer to be treated within Central London.

HCA benefits from a substantial market position in this market via its ownership of six of the seven elite facilities, private patient units at UCH and Queens (in Romford) and the London Oncology Centre. HCA also owns or has interests in a number of primary care facilities, which we consider has material influence on referral patterns into secondary care. This market power has resulted in steadily increasing prices, and HCA's index of charges against the national average stands at.

### ***Incentives***

AXA PPP believes that there is a widespread culture of incentive payments made by PH providers to consultants, which influence professional judgement, distort competition and raise barriers to entry. We believe that such incentives comprise a range of practices, including providing consultants with free or discounted consulting rooms, equipment and / or administrative support, participation in joint ventures, ownership of facilities to facilitate or protect referral into hospitals; commission payments to doctors, profit shares and equity ownership arrangements.

We believe that incentives could encourage overtreatment, wastage of resources and commissioning of overpriced services, resulting in higher prices for insurers which are ultimately reflected in patient premiums. Such incentives also have the effect of raising barriers to entry for other providers and consultants. We note that many such practices have been subject to sanctions in the US, and would urge the CC to conduct a thorough investigation of such practices.

### ***Specialist practices***

Our third key area of concern relates to certain specialist practices, notably the formation of consultant groups. These are particularly prevalent in the field of anaesthetics.

From our perspective, these practices have a number of consequences. First, patient choice is, in any event, ostensibly reduced or removed, as the anaesthetist tends to be chosen by the surgeon

on behalf of the patient, without particular regard to cost. This selection then forms the basis of a contractual relationship between the anaesthetist and the patient, in circumstances in which the patient will have limited opportunity to understand the nature of that contract or to evaluate alternative suppliers. Second, groups of the type referred to above, which are unconstrained by competition, have a tendency to set high charges (which are fixed across the group) thus exposing the patient to a potential shortfall for which he or she will be personally liable.

In our view, such groups, which are also in use in other practice areas, distort competition to the detriment of patients.

## **Response to the CC's Issues Statement**

We have considered the CC's Issues Statement carefully, and our views on each of the potential theories of harm are summarised below.

We note that the CC's early thinking has identified seven theories of harm, which are set out in the Issues Statement published on 22 June 2012.

AXA PPP summarises its initial reaction to each of these theories of harm below, accompanied by cross references, where relevant, to those parts of this submission in which these issues are discussed in greater detail. We look forward to discussing these issues further with the CC as the investigation progresses.

### ***Theory of Harm 1: Market power of hospital operators in certain local areas***

AXA PPP agrees that many hospital operators, including each of the main private hospital groups, hold market power with respect to patients in particular geographic areas where available facilities may be limited. We also agree that hospitals in certain locations may have market power in respect of some treatments but not for others.

This may result in higher prices, as anticipated in paragraph 25 of the Issues Statement. As we discuss in section 9.2 our experience is that discounts are not usually available for "solus" hospitals. [REDACTED]

Paragraph 26 of the Issues Statement notes that the CC intends to consider whether insurers have significant countervailing buyer power in negotiations with hospital operators. As we describe in section 8.3, AXA PPP has developed a network in an effort to balance the market power of the hospital operators. We consider that the negotiating power of the national hospital groups (BMI, Spire, Ramsay and Nuffield) is, to some extent, counterbalanced by our national network, although as we discuss in sections 8 and 9, our efforts to introduce sub-networks which we feel would benefit patients have not always been successful due to PH provider resistance.

AXA PPP has particular concerns with respect to the Central London area, in which, in our view, HCA has local market power (and lacks a national network of hospitals for which it needs to secure recognition). We discuss Central London and HCA in Chapter D below.

### ***Theory of Harm 2: Market power of individual consultants / consultant groups in certain local areas***

AXA PPP agrees with the Issues Statement that there may be areas in which there are a limited number of consultants for specific treatments, and that the way in which referrals are made may result in entrenched referral patterns with incumbent consultants facing limited pressure. We believe that our "open referral" products, whereby AXA PPP provides members with assistance in selecting an appropriate specialist, may operate to increase patient choice and reduce market power of certain specialists.

As discussed in Chapter E, the particular features of the private healthcare market mean that consultants are in a trusted position and have a financial interest in the treatment (type and volume) that they prescribe and, in broad terms, are free to charge as they wish. We discuss our approach to consultant fees in section 15. We are also concerned, as discussed in Chapter F, that incentives between consultants and PH providers may both influence professional judgement and increase market power of consultants to the detriment of patients.

### *Consultant Groups*

We agree that consultant groups, in particular anaesthetic groups, have market power over their patients in certain areas. Our main concerns in this respect are that (a) the process by which anaesthetists are appointed (usually, by the surgeon) deprives patients of any choice in this respect; and (b) even if choice existed, the prevalence of anaesthetic groups with fixed prices limits any choice in relation to price. We discuss one particular example in section 16.2 below.

### ***Theory of harm 3: market power of hospitals during national negotiations with insurers***

AXA PPP agrees with the Issues Statement that in some bilateral negotiations, a hospital operator may have market power which is not offset by the buyer power of the insurer. We have little choice but to contract with each of the main hospital groups in order to ensure that we are able to provide our members with national coverage. This is particularly important for many of our large corporate customers. Our contracting relations with the main hospital groups are described in section 9 et seq. We also discuss our relationship with HCA in section 11 et seq.

We accept that insurers have some leverage in these negotiations, as suggested in paragraph 32. As noted above, and described in detail in section 8, we created a network in 1999 with a view, in part, to counterbalancing the negotiating power of the main hospital groups. However, it is important to note that AXA PPP's main network recognises 190 out of circa 200 private hospitals in the UK, and it is very difficult for legal and commercial reasons to "delist" a hospital once it has been recognised. We also note that our efforts to create sub-networks or alternative, more limited, policies for patients (in return for lower premiums) have been met with resistance by some hospitals, as described in section 8.4.

The Issues Statement also suggests that insurers may be able to develop mechanisms to influence the patient's choice of hospital or "steer" patients away from one hospital to another. AXA PPP assumes that the CC may have in mind the "open referral" policies which AXA PPP has introduced alongside its existing policy offering. These policies are described in detail in section 8.4.4 (see also sections 2.3 and 3.10 on referral and open referral generally). In our view, such policies have the advantage of enabling greater choice for patients and facilitating the development of new products which drive lower premiums for customers, and potentially open a new market segment.

We also note the CC's suggestion at paragraph 34 that it may need to consider a separate theory of harm, whereby the insurers have buyer power over hospital operators, such that insurers may exert too much pressure on the price paid to the hospital operator. In AXA PPP's view, this theory of harm is not sustainable. While we accept that PMI providers may be considered important counterparties for PH providers given their desire to access our members, our efforts to secure cost reductions in circumstances where such reductions are clearly achievable given improvements in technology are sometimes unsuccessful due to resistance from PH providers. Section 8.4 considers this issue further.

### ***Theory of Harm 4: buyer power of insurers in respect of individual consultants***

The Issues Statement notes (at paragraph 35) “We understand that it is common for insurers to stipulate in their policies that there is a maximum reimbursement rate that they will pay consultants for a given treatment. Consultants may charge more than this amount for their services, in which case the insured patient is obliged to pay the excess.”

Sections 14 - 15 of this submission describes in detail how we reimburse consultants. Our primary objective in this respect is to maintain a position whereby fees will be met in full and customers do not experience a shortfall. We are very aware that shortfalls are a significant source of customer dissatisfaction. We are also focused on managing claims so that premiums for our customers (both corporate and individual) are as low as possible.

[REDACTED] If we identify a particular consultant as consistently charging significantly in excess of his peers, we may take steps to “cap” that consultant to our minimum fee schedule. In the event that the consultant continues to charge in excess of those capped rates, the customer may experience a shortfall. We work hard to ensure that our customers are aware in advance that they may experience a shortfall and, where possible, the potential level of such shortfall. Around 3% of the 36,000 specialists that we recognise are “capped”.

The Issues Statement also notes (at paragraph 35) that some insurers stipulate that in order for certain consultants to be recognised to treat their policyholders, the consultant must agree not to charge more than the amount specified by the insurer. In 2008, AXA PPP introduced a new system for managing fees for newly qualified specialists, whereby recognition of the specialist is contingent on that specialist entering into a contract which includes an obligation on the specialist not to charge in excess of our published fee schedule, and not to seek to charge our customers separately. This enables us to give an unequivocal guarantee to our customers that they will not experience a shortfall if they see one these contracted specialists. Currently around 13% of the 36,000 specialists that we recognise are contracted specialists.

We are not aware of any evidence to suggest that our reimbursement practices are suppressing consultant fees to a level below those which would prevail in a competitive market. Nor are we aware of any difficulty in attracting suitably qualified consultants in sufficient numbers to treat our members to an appropriate standard and the number of consultants applying for recognition has not materially reduced since the introduction of this initiative.

### ***Theory of Harm 5: Barriers to Entry***

#### *Contractual terms*

The Issues Statement suggests (at paragraph 39) that national bargaining between insurers and hospital operators creates barriers to new local entrants, in particular as a result of contractual terms that prevent or disincentivise insurers from recognising new entrants.

As noted in relation to Theory of Harm 3, AXA PPP agrees that hospital operators have market power in national negotiations. We have little choice but to contract with all of the main PH providers in order to provide sufficient coverage for our members with full national network products, and frequently come under pressure to recognise all the hospitals within a certain PH provider’s group. [REDACTED]

As noted above, this is a complex issue as, given the interrelation between high fixed costs and capacity, our experience is that the introduction of a new entrant into a particular local area may in fact result in prices increasing, as described in section 6. This issue therefore requires careful consideration.

#### *Incentives*

AXA PPP agrees that incentives are commonly (and increasingly) used by PH providers to attract or retain consultants. Such incentives may be combined with other tactics whereby PH providers seek to prevent consultants from working at other facilities.

It is the case that potential new entrants will often seek advance commitment from us to include the new facility on our network before they commence work (as noted in the Issues Statement, paragraph 46). We are generally unable to provide such commitment until a full assessment of the constructed facility has been carried out.

The provision of incentives by PH providers to consultants (or GPs) is a serious cause for concern for AXA PPP, which we discuss in detail in sections 17 – 20 of this submission. In our view, such practices are likely to distort competition in a number of ways, including by raising barriers to entry.

#### ***Theory of Harm 6: Limited Information Availability***

AXA PPP agrees that there is limited comparable information on either price or quality available to patients or insurers. The challenges of compiling such information in a readily comparable way, however, should not be underestimated. The Care Quality Commission inspects hospitals and ensures that general quality standards are maintained. At a procedure or individual consultant level, there is no data currently collected which would allow an objective assessment of quality and for many services there is no consensus about what information could or should be collected. Small numbers and variations in other patient factors would make interpretation difficult or impossible at this level.

We note the indication at paragraph 53(b) that “if insurers were able to direct their insured patients to recognised consultants (e.g. through “managed care”), there appears to be a risk of patients being directed to cheaper rather than better consultants due to the information asymmetries between patients and insurers”.

AXA PPP does not accept that this risk exists. Our open referral policies are described in detail in section 3.10, in which we make clear that, as discussed at the CC’s site visit on 13 July 2012 (the “**Site Visit**”), these policies do not operate to steer patients to “the cheapest” consultant, but rather seek to provide patients with increased choice and minimise the risk of shortfalls.

#### ***Theory of Harm 7: Vertical effects***

Paragraph 55 of the Issues Statement notes that the only insurer that is vertically integrated is BUPA, through ownership of the Cromwell hospital in London. The Issues Statement notes that BUPA and possibly some of the other insurers may also own some primary care facilities.

AXA PPP does provide some occupational health services via its AXA ICAS subsidiary. However, it is not otherwise present in primary care. We agree with the CC’s initial view that vertical linkages between insurers and health care facilities is not likely to lead to significant harm for competition. However, we are concerned that vertical linkages between primary and secondary care facilities operated by PH providers may distort competition. In particular, we consider that HCA’s ownership / investment in two private GP practices in Central London (Rood Lane and Blossoms Inn) has increased the number of patient referrals to secondary HCA facilities. We would encourage the CC to investigate this form of vertical integration carefully.



## TERMINOLOGY

In this submission (and generally in our corporate documents) we make use of the following terminology:

- **Consultant** and **specialist** are interchangeable.
- **Facility**: includes full-service (i.e. acute) hospitals as well as consultant facilities and limited medical facilities ranging from outpatient clinics to standalone scanning units.
- **Members**: beneficiaries of our individual and corporate private healthcare insurance policies.
- **Network**: our established network of recognised private healthcare facilities (as set out in our published Directory of Hospitals).
- **PH provider**: private healthcare provider, but not including consultants.
- **PMI provider**: private medical insurance provider

## **A. AXA PPP OVERVIEW**

### **1 Our business**

AXA PPP is the second largest private medical insurance (“PMI”) provider in the UK. AXA PPP is therefore a significant funder of a range of private medical treatments and deals directly or indirectly with a wide range of hospitals, specialists, consultants and other healthcare practitioners.

The origins of AXA PPP can be traced back to the London Association for Hospital Services which was conceived in 1938 as a health insurance scheme. The scheme (which became known as Private Patients Plan) spread across the UK and by 1970 had 367,000 members. The 1970s and 1980s saw the introduction of new plans including family, private hospital and retirement plans and membership reached 1.79 million in 1990, and AXA PPP maintains a membership of around 1.8 million today. In 1997, we introduced our hospital network, described in detail in section 8 below. In 1998, PPP was acquired by Guardian Royal Exchange, and itself acquired Medical Industrial Services, the UK’s leading provider of occupational health services. The following year, Guardian Royal Exchange was acquired by Sun Life & Provincial Holdings, part of the AXA Group and in 2002, the company was renamed AXA PPP healthcare.

Since then, AXA PPP has launched several new products and services including a range of corporate products. In 2007, it acquired ICAS International Holdings, a provider of health and wellbeing services, leading to the creation of AXA ICAS. AXA PPP International was launched in 2009 in response to the growing international market.

In March 2012, AXA PPP acquired Health-on-Line with a view to accelerating promotion of our lower-cost modular products for UK-based individuals and SMEs. Our Health-on-Line proposition is discussed in section 8.4.5 below.

### **2 The customer journey**

We summarise below the key steps that an AXA-PPP member, whether covered by an individual or a corporate policy, is likely to encounter when seeking treatment under his or her insurance policy. This is summarised in the Customer Service – Delivering Excellence presentation given by AXA PPP at the Site Visit.

#### **2.1 Initiation of Journey**

The patient journey begins usually when the patient recognises or suspects that he or she has an illness. At the inception of this journey it may be far from obvious that a disease process is present. Many illnesses begin with vague or non specific symptoms, these may resolve spontaneously or the patient may wish to obtain support or advice about the nature and implications of symptoms. In many cases people do not consult a doctor when unwell unless they perceive the condition as a threat or troublesome. There is considerable variability in how people respond to illness that is commonly seen in general practice. Some people are regular attendees at general practice surgeries whilst others with the same type of symptoms would never see their GP.

#### **2.2 GP Consultation**

A patient seeing a GP is generally seeking professional guidance and advice although some patients, particularly well-informed private patients, may already have decided that

they want a referral to a specialist. At the other end of the spectrum, some patients defer decision making completely to their GP although this occurs much less so than it did in the past. There is, however, generally at least some giving up of patient autonomy.

The GP then makes an initial decision as to whether the patient needs any further investigation or treatment and whether this can be managed in the primary care setting or whether referral to a specialist is required. There is considerable variation in clinical practice and in referral rates by GPs into secondary care. The reasons for this are complex and include the resources available to an individual GP and the individual GPs judgement. [REDACTED]

Thus the pathway to referral to specialist is not a simple “patient falls ill, GP refers to secondary care”. Rather this is a much more complex interaction of many factors.

### **2.3 Decision to refer**

Once a GP has determined that a referral is appropriate, the next question is to whom. Traditionally the GP would consider what type of specialist is required, whether a particular sub speciality is needed and where such a specialist is located. In the vast majority of cases the specialist chosen is the one available at the most convenient hospital. Where there is choice, this might be influenced by a large number of factors such as having met one of the specialists, attending a presentation given by him or her, what other GPs say about a specialist or how long the waiting list is. In the public sector, GPs may tend to refer to a consultant with a shorter waiting time to get the patient seen more quickly. For a private referral the GP may choose the same specialist because the specialist is offering a better NHS service. Another factor may be that the GP or the patient has had a good or bad experience of a specialist. This can be for example the helpfulness of the correspondence from the specialist (or otherwise), or a patient complaint. However this “feedback” will be rather ad hoc and by exception. There is no meaningful systematic data that allows the choice based on quality of care provided by a specialist i.e. how good he or she is. Neither is there systematic data on the softer measures such as patient feedback.

Outside of the local area the GP is very unlikely to know what services are available and be able to widen the choice of specialist.

In the NHS few referrals still follow the pattern above. Over the past decade the majority of referrals have been made simply to the local specialist department. In these cases the GP writes a “general” referral letter rather than naming a particular specialist. The introduction of “choose and book” in the NHS also encouraged referral where specialist was not named, allowing the patient more choice. More recently in the NHS, referral centres have been set up. In these, the referring GP contacts the referral centre that employ GPs to examine the referral to consider if more can be done in primary care and if not which specialist to send the referral to.<sup>1</sup> This is likely to become far more common with the proposed NHS reforms as GP commissioning groups seek to better manage budgets and tackle some of the variations in referral rates referred to above.

When making a referral to the private sector the GP (usually NHS) ideally needs additional information, such as the specialist’s scope of practice, the ability of the specialist, and also, in the interests of obtaining value for money / avoiding a shortfall, information about the likely fees that the patient will incur – or at least where that can be found, whether a specialist is recognised by the insurer and whether the specialist works in a hospital

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<sup>1</sup> See for example, [http://www.kingsfund.org.uk/publications/referral\\_management.html](http://www.kingsfund.org.uk/publications/referral_management.html)

recognised by the insurer. Whilst much of this information can be found on, say, AXA PPP's website, it would take time and effort by the GP for which, as an NHS practitioner referring to the private sector, there is little incentive to expend.

## **2.4 Specialist Consultation**

When the GP refers to a specialist privately (on the basis that the patient is insured or will be a self-paying patient) the patient must complete a number of administrative type tasks. If the patient is insured, he or she should check that he or she is covered for the proposed consultation both in terms of whether the condition is one which is covered and whether the specialist is recognised by the insurer. Patients (both insured and self-pay) will need contact details of the specialist's secretary in order to arrange an appointment.

In most cases the process operates smoothly. However, if there is an issue with specialist fee levels, network arrangements or appointment times, under these circumstances the patient needs to go back to the GP and seek a referral to a different specialist.

Patients may well want to search for a specialist themselves rather than simply follow what a GP has advised. Patients can be successful in doing this as there is information available on the internet to help them via resources such as the Dr Foster website<sup>2</sup>, NHS Choices and hospitals' own websites. However, most patients choose not to, or in practice do not find this an easy thing to do. In general, these resources will not provide them with meaningful information to distinguish between specialists on quality terms. In addition, specialists tend not to publish their fees. Even where they do, it is difficult for patients to estimate what their total financial liabilities may be. At the start and indeed along the journey, it will not be clear what treatments or investigations are going to be needed and therefore the costs of these.

However, for the informed and motivated customer, having a non-named or "open referral", perhaps accompanied by a suggestion by the GP, gives a patient much more choice and more flexibility. We discuss open referral initiatives further in sections 3.10 and 8.4.4.

## **3 Claims management**

Private healthcare is a complex market with patients generally having pre-paid (via insurance), and hence not concerned by cost when they are claiming. Treatment is entirely at the behest of specialists who, of course, have a financial interest in providing treatment. Furthermore specialists have little incentive (certainly compared to NHS Practice) to limit the number and types of tests they carry out on patients and often no regard for the cost (unless they have a financial incentive to actually *increase* the numbers and/or types of tests being undertaken).

As a responsible insurer, AXA PPP is driven to provide accessible, quality and value for money propositions to its customers and to innovate, with the aim of growing its position and the market overall. It is by doing this that we deliver sustainable returns for our shareholders. Moreover, AXA PPP receives considerable feedback from customer – corporate and individual – about the cost of private treatment. The availability of NHS provision, rates of medical inflation and lapse rates also make us fully aware that private health care is discretionary.

In meeting such objectives, we are proactive in managing and reducing claims costs wherever possible. This is a key function for our business as we are responsible for the

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<sup>2</sup> <http://www.drfoosterhealth.co.uk/>

management of the premiums that our customers pay and thereby have a requirement to be fair to all our customers who pay premiums including those who do not make a claim.

Our ability to manage claims is also core to our proposition to corporate customers, as large corporate customers ultimately pay for their own claims either directly in the case of trusts and administration-only schemes, or through their future premiums which will be based on the claims experience of previous years.

We understand that our responsibility to manage claims causes various tensions for our members who, when they are making a claim, want the cost of their claim to be met in full. Managing claims is often also misaligned with PH providers' (and consultants') objectives who expect us to pay for any treatment or service that they provide for members.

Our mechanisms for managing claims are set out below, and described elsewhere in this submission as indicated.

### **3.1 Products**

At a policy level we employ various mechanisms to control claims costs. First, we ensure that our policies are very clear on what we will and, as importantly, will not cover. Part of our claims management responsibility is to ensure that we do not pay for things that are not eligible for cover. This is a source of tension with members (and providers) who will not want to hear that their proposed treatment is not covered. It is not easy to tell a member that his or her claim is not eligible, but it would not be treating our customers (defined as being those who pay premiums) fairly to pay for ineligible items. We have worked hard over the years to make our policy terms as clear as possible.

We also have various benefit limits including:

- Excesses where the member pays the first part of a claim.
- Benefit limitations, the most common of which is out patient benefit restrictions.
- Six week rule option policies where we will not pay for treatment if it is available on the NHS within 6 weeks.

These limits are chosen by the customer at the point of sale.

### **3.2 Provider Contracting and Management**

We manage costs with our providers through negotiation and contracting and in the vast majority of cases will pay the providers direct for the services they provide on behalf of our customers. We operate a network model where we have agreed prices with our network hospitals based on it being in our provider network.

Where possible and achievable we have package prices in place which promote certainty for both the PH provider and AXA PPP and enable us to monitor pricing. When bills are received from hospitals they are checked against the prices we have agreed and paid in accordance with these agreements.

These mechanisms are discussed in detail in section 9.3 below.

### **3.3 Specialist fees**

Ideally, we would like to pay all charges in full as this is what our customers would like from us. However, since specialists are generally free to charge what they wish to patients, it is not always a viable proposition for AXA PPP or its members. We do pay the majority of

specialists fees in full but there are a small number whose level of charges is greater than we are prepared to pay (see Chapter E for more details).

Following this process, we cap the amount we pay to a small proportion (generally about 3%) of specialists and do everything we can to ensure that members are aware that they are going to be treated by a specialist who charges more than we will pay and help members assess the likely shortfall they will incur. We will also offer to help members find an alternative specialist who is not subject to a cap. An individual member for example, may accept this offer where, having already paid a significant premium for PMI, he or she does not want to incur a top-up payment.

We also have some contractual arrangements in place, although many consultants refuse to enter into contracts or agreements with insurers.

Specialist fees and our relationships with specialists are addressed in detail in Chapter E below.

### **3.4 Pre-authorisation**

We ask all our members to pre-authorise their treatment with us before it happens (where possible) so that we can ensure that the treatment is eligible under the terms of their policy. For example, the majority of PMI policies do not cover cosmetic procedures or chronic conditions.

As mentioned above we have worked hard to make our policy terms as clear as possible. However, unfortunately, due to the technical nature of our market and the high degree of complexity of treatments available it is impossible to cover every situation. We will, where required, engage with the patient's medical practitioner (with the patient's consent) to ensure that we fully understand the treatment that is being proposed - particularly if the treatment is complex or the situation unusual - so that we are as fair as possible in making decisions on the eligibility of treatment.

Unfortunately we do experience instances where providers will not give us all the information we need in an effort to 'encourage' us to pay for something we would not otherwise have covered. As an example some fertility treatment (usually not covered by PMI) has been presented as gynaecological treatment and we therefore have to monitor these claims carefully. As noted above, we have a responsibility to our customers not to pay for ineligible claims or treatment.

### **3.5 Medical Teams**

We have a number of teams of medical experts who interact with our customers and providers on a case by case basis.

These medical experts become involved in claims at various points in the process. Some examples are:

- Authorisation of extended lengths of stay. Where a patient needs to stay in hospital for over 10 days we will have a discussion with the provider to determine why the stay is necessary and assess the condition of the patient;
- Authorisation of psychiatric treatment. We employ specialist mental health nurses who work with our psychiatric providers and authorise when in-patient treatment can be covered by AXA PPP; and
- Verification of high-cost, lengthy drug regimes.

### **3.6 Specialist Healthcare Solutions Team**

For patients with cancer and serious heart conditions we offer an extended service through our medical team. All members are given a dedicated nurse and have the opportunity to speak to this nurse throughout their treatment. The nurse will discuss all the patient's treatment options with them on an ongoing basis to ensure that the patient not only understands what is happening, but also understands all options for his or her treatment. The nurse will help the patient get the best package of care to suit the patient's individual requirements which might utilise treatment in both private and NHS facilities.

If a member chooses to be treated in an NHS facility as an NHS patient – bearing in mind that, for example, a lot of cancer care outside London is provided within the NHS and broadly patients receive no additional benefit from being a private patient<sup>3</sup> - AXA PPP is then able to use this cost-saving to provide other benefits for the member which would not routinely be offered as part of a PMI package. These additional benefits are tailored to patients and often include concierge type services such as child care, travel costs or hotel accommodation costs.

This service can be highly valued and a key part of what we do is ensuring that the patient is in control of choosing the path of his or her care, NHS or private, with AXA PPP support. It also has cost benefits for AXA PPP, but the choice always rests with the patient. This service is not always popular with PH providers because it can reduce their opportunity to gain revenue.

### **3.7 High cost Items**

When we are billed for high-cost items that are not included as part of a package price we verify the charge being levied to make sure it is in accordance with our hospital contract. A historic pricing mechanism that is common in the market allows providers to charge the list price for an item and apply a percentage mark up (to cover their internal purchasing costs). Some of the amounts charged as mark-ups are significant because of the high costs of various consumables.

### **3.8 Audit**

We regularly audit a number of our providers to review their charging practices, both in terms of fees and charging patterns but also looking at items such as the use of scanning and ordering of pathology tests. If a provider is an outlier and seems to be charging for more of a particular item (e.g. scans) than other providers we will review them more closely and if necessary carry out an in depth audit. In reality, this is time consuming and not feasible to carry out on an industry-wide scale, so in effect only significant outliers (of which there are some) are reviewed.

We are likely to have particular concerns if we are aware that a specialist also owns his or her own equipment, given the clear incentive that the specialist will then have to over-use a piece of equipment. A difficulty we face, however, is that often we (and by extension our members) are not aware if a specialist also owns his or her own equipment.

### **3.9 New Technologies and Treatments**

When requested to provide cover for new technologies (e.g. robotically assisted surgery) or new treatment regimes, AXA PPP uses its medical expertise (doctors and nurses) to

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<sup>3</sup> This is entirely the member's choice as he or she can receive treatment privately under the terms of the policy.

determine whether the treatment is a proven one. It does not necessarily follow that because a new treatment is available it will be funded by AXA PPP, and all requests for cover are considered and researched. The use of new technology is managed in the NHS however the threshold for the use of new technologies tends to be much lower in the private sector and our experience shows that specialists and hospitals will try to use very expensive technologies even where the evidence for patient benefit is minimal or absent.

### **3.10 Open referrals and “managed care”**

We note that a number of initial submissions made to the CC during May 2012 expressed concern in relation to “open referral” or “managed care” practices adopted by the PMI providers.

It appears that there is some confusion with respect to the terminology used in this area. There is no universally accepted definition of managed care. From AXA PPP’s perspective, in this submission, the term “managed care” means active intervention by PMI providers in the choice and type of treatment carried out on members depending on their condition, i.e. active management of the actual clinical pathway of the type sometimes undertaken in the US. The term “open referrals” refers to the situation whereby GPs do not make a referral to a named consultant, and in turn the PMI provider assists the patient in the selection of a suitable specialist or the referral is made to a hospital instead to “source” the specialist. The subsequent clinical pathway is then determined by the specialist without intervention by the PMI provider.

At the current time, AXA PPP relies on the treating specialist to determine the treatment that the patient requires and does not seek to manage the clinical pathway.<sup>4</sup> We will then fund this treatment – subject to eligibility and policy benefit limits - it is not our policy to interfere in medical practice. We therefore rely on specialists to determine the appropriateness of the treatment they are providing. By way of example, whilst we will not pay for unlicensed drugs (policy term), we do not influence the choice of licensed drugs that the specialist might choose from.

As discussed further in section 8.44 below, some of our policies include “open referral”. In our view, open referrals are beneficial to our members for a number of reasons:

- Open referrals allow PMI providers to provide patients with the names of consultants whose fees will be met in full, thereby offering the patient a choice of consultant;
- Open referrals offer PMI providers an ability to select PH providers, from current lists that patients can review, and choose those who are more cost- and time-efficient; and
- Open referrals are facilitating the development of new products in the PH market, thereby driving lower premiums. As a result, customers who might leave the market (for example, due to the recession) are retained and the PH market becomes accessible for customers to whom it was not previously.

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<sup>4</sup> For completeness, AXA PPP offers an optional pathway to its large corporate customers known as the Psychological Health Pathway. This involves an assessment of the patient by a psychologist at AXA Health Services who recommends a treatment pathway. The corporate customer has the choice to make the pathway optional or mandatory, and to date, the majority of participating schemes (of which there are very few) have selected optional. AXA PPP is also currently piloting a musculoskeletal treatment pathway which involves an assessment and recommendation by a physiotherapist at AXA Health Services. This pathway is available on an optional basis only.





## **B. MARKET DEFINITION**

### **4 Product market**

AXA PPP agrees with the Issues Statement that there are a number of issues that must be taken into account when considering the relevant product market in the context of private healthcare services, and that these include:

- A high degree of differentiation between treatments (both in terms of treatment types, and the way in which treatment may be provided from one facility to the next), which are also characterised by varying degrees of complexity;
- Limited ability of patients to switch between treatment types; and
- The ability for some suppliers to alter the services that they supply, depending on the type of services and the nature of the supplier. We agree that supply side substitution by consultants is likely to be more limited than supply substitution by hospitals. We also agree that the competitive influence of different facilities and consultants may be asymmetric.

We note the CC's suggestion that treatments may be aggregated into clusters of treatments for analytical purposes. While we accept that this may be a valid approach in some instances, we agree that any such proposal should be treated with caution given the distortions that may result when considering the scope of the geographic market.

We also note the CC's intention to consider the extent to which private patient units (PPUs) represent a competitive constraint on hospital operators or whether the NHS represents a material competitive constraint on privately funded healthcare services. AXA PPP considers that PPUs should form part of the CC's investigation and certain PPUs should be included in the relevant product market, based on their scale and activities and given the increasing number of PPUs being managed or operated by PH providers. The competitive constraint exercised by PPUs must be determined on a case-by-case basis. On the other hand, while the NHS undoubtedly constrains the provision of privately funded healthcare services, we do not believe that services provided by the NHS form part of the relevant product market .

### **5 Geographic market**

We similarly agree with the Issues Statement that both local and non-local factors are likely to be relevant for geographic market definition.

#### **5.1 National aspects**

As the Issues Statement notes, national aspects may arise given that negotiations between insurers and hospital operators take place at a national level. We note that the CC intends to consider whether and how the extent of a hospital operator's network and the degree of a hospital operator's local market power affect the scope of the relevant geographic market when negotiations between insurers and hospital operators are considered.

We provide further insight into the nature of these negotiations in section 7 et seq. of this submission below.

#### **5.2 Local aspects**

AXA PPP agrees that local features are also relevant to geographic market definition, primarily as a result of patient preferences to be treated at a facility which is conveniently located. The demand for PMI is different from many other types of product in several ways. First, for most products, for example, a car, consumers will only research and buy a car when they want or need to buy a car. In the case of PMI, the product is purchased when the customer is in good health, and does not know a) whether he or she will become ill and b) if he or she does become ill, with what condition. Accordingly, in choosing a PMI provider, the customer will wish to know that he or she will be able, under that plan, to obtain treatment, once the medical condition is known, at whatever is the most appropriate hospital. This will often, for a range of non-life threatening conditions, be the most conveniently located hospital to the patient's home. For serious conditions, however, patients may want access to hospitals with the strongest reputations for treating their condition.

In this respect, AXA PPP notes that it is difficult to identify robust rules of thumb by which to define local geographic markets (for example by reference to drive-time isochrones) due to a number of complicating factors. In particular:

- For many patients, a conveniently located facility may be closer to their place of work rather than their home address.
- Patient willingness or ability to travel may be materially influenced by the nature of the treatment for which they have been referred.
- Referral patterns may vary for various reasons. GP referrals tend to follow the NHS referral pathways and as such, GPs making private referrals to a private consultant often tend to refer to the same providers that are used in the NHS. This may not always be the provider which is geographically closest to the patient.
- Admitting rights and, where the consultant has a choice, his or her preference, depending on his or her relationship with the hospital and/or any incentives.
- Hospitals differ by location.

In AXA PPP's view, therefore, local competition must be assessed on a case-by-case basis. Furthermore, it must be recognised that even if some customers might, in a self-pay market, consider a wider area of substitution, PMI providers need to provide access to PH facilities in effectively every location where they have members.

### **5.3 Central London**

In AXA PPP's view, Central London has the features of a distinct relevant market for a number of reasons.

- Members who live in Central London buy products to enable them to be treated in Central London, and in particular in one of the large and prestigious London hospitals which tend to have a large proportion of consultants from the teaching hospitals and centres of excellence in London. For these customers, hospitals outside London do not provide an alternative as a) patients generally wish to be treated near to home and b) hospitals elsewhere generally do not have the same reputation.
- The position of the London hospitals results largely from the reputational draw of London and in particular the 'Harley Street' effect whereby many customers

assume that the ‘best’ doctors work in London, in and around Harley Street<sup>5</sup>. We are not aware of any objective measures that demonstrate that Harley Street consultants are medically superior to consultants elsewhere, but from our perspective many customers believe this is an undoubted feature of the market. Moreover, this reputational edge in general allows Harley Street consultants to charge a price premium, and this price premium itself appears to reinforce the initial beliefs.

- Central London hospitals also tend to have a high level of technology and, as a general rule, new technologies and new types of treatment are introduced to London first. This further reinforces the reputational draw of London.
- Many PMI customers acquire PMI through their employer. We believe that access to a range of prestigious London private hospitals is a “must have” for a broad range of customers. In particular, city and other banks, law firms, accountancy practices and other high status professional groups based in London all require access to these hospitals in their PMI policies. This stems from a variety of factors including their reputational pull, the fact that around 20% of customers actually live in central London and would only have very limited alternatives and thirdly, many patients from around London use these hospitals either because it is convenient due to their work location or due to the nature of the treatment required.

The particular features of the Central London market are discussed in further detail in section 11 et seq. below.

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<sup>5</sup> Teaching hospitals and large post graduate specialist centres in London also attract a high proportion of specialists.

## C. PRIVATE HEALTHCARE PROVIDERS

### 6 Overview of healthcare market dynamics

Healthcare markets can be subject to some, on the face of it, counter-intuitive outcomes. This is as a result of the specific dynamics that operate to influence the normal supply and demand trade off. Some of the key issues to be noted are:

- In most instances, patients have pre-paid through some form of private or social insurance. At the point of treatment their focus is, therefore, almost exclusively on quality, however perceived.
- Decisions made about cost and access to treatment vary depending on the circumstances. A person may well rationally accept a limit to cancer treatment (e.g. for very expensive cancer drugs) when they are well and seek to reverse this when they are directly impacted.
- Patients have very limited access to information about treatment options, and are wholly reliant on the treating specialist for professional and unbiased advice. In an itemised fee-for-service model, there may well be a bias toward more intervention.
- Lack of objective quality information will tend to leave patients believing that the most expensive suppliers are the best, in the absence of any other information.

With specific reference to hospitals, they are faced with circumstances that drive behaviour which will lead to a high intervention model. The key factors are:

- Hospitals are businesses with high fixed costs (we estimate 70-80%). This situation gives a clear incentive to increase activity.
- Hospitals represent about two thirds of the cost of treatment, and around 55% of an insurance premium. A 10% price discount from a hospital is, therefore, diluted to 5-6% when fully passed on to the customer by an insurer.
- It is widely believed that PMI is not price elastic (not a view shared by AXA PPP). Hospitals, therefore, believe that the 5-6% price discount would further be diluted in terms of increased demand.
- As the PMI market expands, additional customers do not initially claim as much as established customers. This is due to selection and underwriting effects. This further dilutes/delays any response in demand to a price change by a hospital.

It is no surprise, therefore, that hospitals have tended to focus more on other strategies than price reductions. Profit maximisation for a hospital will, because of these factors, focus on two key areas, increasing the flow/share of patients and maximising revenue per patient.

Whilst insurers have tried to use networks as a means of introducing price competition, this has only been an imperfect substitute for real price competition. We believe that it has only had a limited and geographically varied impact on competition.

The focus on patient flow and revenue per patient explains why hospitals are very keen to attract specialists and to incentivise these specialists to order more tests and treatments for their patients. Given the position on fixed costs, an extra £100 of treatments equates to

£70-£80 of profit. This combination of factors can lead to some otherwise unforeseen outcomes.

## 6.1 Entry into a solus area

A theoretical example of a solus hospital in a geographically distinct area (e.g. Norwich, or a similar location, as discussed at the Site Visit) illustrates this point.

- In the first instance, an established hospital (Hospital A) with a solus position will tend to focus on a low cost/high margin model. This means the hospital will use mobile scanning or similar equipment, or indeed use the local NHS facility. Hospital A will need to invest in equipment and facilities necessary to provide good patient treatment in an environment that private patients might expect. However, they will not feel the need to invest in luxurious patient facilities, or on incentives to specialists to bring new patients. Our experience is that solus hospitals tend not to view these as attractive investments. They appear to make stronger returns from a lower capital base.
- If over time the market were to expand, then sooner or later a second operator, Hospital B, would seek to enter the market. Their immediate focus will be to secure a strong share of patient flows. As these flows are controlled by specialists, it is the specialists who become the focus. Specialists are likely to suggest various reasons why they would direct patients from Hospital A to Hospital B.
  - (i) Reduce patient (and doctor) inconvenience by investing in a wider set of onsite facilities, e.g. MRI scanner, other testing facilities etc.
  - (ii) Improve public areas and the hotel facilities in general.
  - (iii) Provide better and preferably free facilities for consultations and practice management.

New entrants will, therefore, develop a more capital intensive facility. This will be positioned as higher quality, thus putting pressure on insurers to recognise it.

- Disappointed by its loss of share, Hospital A will quickly respond with an investment programme to match Hospital B.
- The local market will then quickly have moved, for example, from supporting a mobile MRI scanner once a week to having two permanent on site scanners. Hospital margins, given no material increase in overall patient numbers will, therefore, fall. At this point, providers will seek to increase prices and may be motivated to incentivise specialists.

In this process, the market is transformed into a high cost model. Whether this outcome is actually desirable for consumers is less clear.

## 6.2 Large local employers

Another refinement which some hospitals focus on is where the local hospital has a particularly strong position and there are a small number of large local employers. Examples of these in the provinces include Derby, North Kent and Sunderland. We also believe that this is the case for HCA in central London. The hospitals concerned will then approach the local employer(s) direct to sell their quality message, thus reducing the influence of the insurer in the overall process. This will have the affect of reducing the insurer's ability to manage price increases. Large employers are the segment of the

market where insurers can lose share at the highest rate due to their ability and willingness to switch insurer.

## 7 UK landscape for private healthcare facilities

### 7.1 National perspective

There are five main PH provider groups active in the UK, each of which owns a network of PH facilities located throughout the UK: General Healthcare Group (GHG), which operates a number of PH facilities through its subsidiary BMI Healthcare, Spire Healthcare (Spire), Nuffield Health (Nuffield), HCA International (HCA) and Ramsay Health Care UK (Ramsay). In brief:

- BMI is the largest national provider with a network of more than 70 hospitals and healthcare facilities.
- Spire Healthcare has 37 hospitals in the UK, and is the second largest private hospital group in the UK. It was formed when private equity firm Cinven acquired Bupa Hospitals in 2007.
- Ramsay is an Australian-owned group which owns 117 hospitals and facilities worldwide, including 40 in the UK.
- Nuffield is the largest healthcare charity in UK with a national network of over 200 hospitals, well-being centres, workplaces and local authority facilities.
- HCA, with 6 major private hospitals, has developed a significant market position in Central London, discussed further in section 12 below. HCA is owned by HCA International in the US.

These top five PH providers accounted for approximately 77 per cent of the PH market by revenue in 2010.

While the footprint of PH facilities in the UK has remained largely unchanged, the market for PH facilities has become more concentrated in recent years at a national, regional and local level. Some of the key market changes since 1999 are summarised below.

**Table 1**

1999	AXA PPP divested its share in the HCA Group of hospitals
1999	HCA acquired the St Martins Group of hospitals in Central London adding the Lister (Chelsea) and the London Bridge to its existing portfolio of 4 hospitals
2005	BUPA sold a proportion of its hospitals to LGV Capital and formed a new group, Classic
2006	BUPA sold its remaining hospitals to Cinven, establishing Spire
2006	Ramsay Healthcare acquired the former Capio Group of hospitals
2006	HCA acquired the private unit at University College London Hospitals (UCLH) , branded as Harley Street at UCH
2008	Spire acquired the Classic Group
2008	Nuffield sold 9 of its hospitals which were acquired by BMI who subsequently divested 2 to Spire and Ramsay

2010	BMI acquired Abbey Group (5 hospitals)
2010	BMI opened a new hospital in Central London (Weymouth Street) and acquired Fitzroy Square (formerly St Luke's Hospital for the clergy)
2010	New Victoria (Kingston) went into administration
2010	Circle opened a new hospital in Bath

In AXA PPP's view, each of the main PH providers benefits from national market power in the context of negotiations with AXA PPP and other PMI providers, described further in sections 9 - 12 below.

## 7.2 Local perspective

In AXA PPP's view, the main PH providers each have market power with respect to particular geographic areas. The issue is particularly acute in London, discussed further in section 12 below.

AXA PPP does not have a formula for determining whether or not a particular area is a solus market. When we originally established our network, described in section 8.3 below, we took the view that if a consultant had admitting rights at more than one facility, those facilities would likely be competing. However, the range of services offered by different facilities will also be relevant. For example, although a new clinic ( X has recently opened in X , in our view the X hospital in X continues to have solus status as the X does not offer the same range of services as the X hospital.

In general, we have agreed a national tariff with each of the main PH provider groups in relation to which various discounts apply depending on local conditions. [REDACTED] Similarly, where one PH provider acquires another provider, or acquires one or more facilities, our experience is that the acquiring provider seeks immediately to move the acquired facilities onto a higher tariff.

However, a further complexity is that, we believe the introduction of competition in a solus area does not necessarily result in a decrease in prices. Resulting over-capacity may in fact lead to increased costs as PH providers seek to recover their fixed costs by, for example, increasing the use and / or price of certain pieces of equipment or incentivising consultants. While we would therefore welcome increased competition between PH providers at both a national and local level, the simple fact of new entry into a particular area does not, of itself, guarantee such enhanced competition given other features of the market. These issues are discussed further below.

## 8 AXA PPP's network arrangements

### 8.1 Overview

This section describes the various efforts made by AXA PPP to counteract the market power of PH providers and secure lower costs for its members, together with the recent and ongoing difficulties that have been encountered vis-à-vis a number of PH providers. We have particular concerns with respect to the London market, which are addressed separately in sections 11 et seq. below.



As described in detail below, AXA PPP has a network of acute facilities to provide treatment to its members in the UK. We currently have 248 hospitals in the network which includes the majority of acute private hospitals in the UK<sup>6</sup> and a number of NHS PPUs.

The network was originally established in 1999 and has been relatively stable in terms of the facilities included since inception. The vast majority of our members (>90%) have a network policy, the terms of which require that any in-patient or day-case treatment is provided at a network hospital unless the medical condition requires treatment elsewhere. Network agreements are therefore attractive to PH providers on the basis that they provide the PH providers with access to AXA PPP healthcare members for acute in patient and day-case treatment.

Since the establishment of the acute hospital network, we have developed further sub networks relating to Scanning, Oral Surgery, Cataract and Direct (Open) Referrals and have most recently launched a new product with a streamlined hospital and consultant network, with around 130 hospitals included on a full refund basis.

The key objectives behind the creation of the network were to streamline the providers available to our members whilst fulfilling the need for national coverage and access to timely, quality treatment. This thereby increased the volumes of patients treated at network facilities and enabled us to benefit from reduced prices. The combined objectives of achieving national coverage and timely access to treatment in addition to achieving the lowest costs means that hospitals are not chosen on the basis of price alone.

## **8.2 Background to the network**

AXA PPP commenced the creation of its network in 1997 via an extensive tendering process. This involved assessing likely member requirements on a geographic catchment basis according to member population at a regional level. Approximately 160 areas were identified and the initial phases of tendering concentrated on those areas where two or more PH providers were present and competing. The later phases of the tendering were carried out in areas of 'solus' PH provision.

All hospitals in the UK were invited to tender, including NHS hospitals. Each hospital was asked to specify its key terms including prices, quality standards and services covered in its facilities. For NHS facilities, having a dedicated PPU is a general requirement for network inclusion (by dedicated private facilities we expect dedicated In Patient and Day-case beds and accommodation). Other facilities such as theatres, radiology, high dependency areas etc., are shared with the NHS<sup>7</sup>.

All hospitals which responded positively indicating that they wanted to be considered for network inclusion were visited and a detailed quality inspection was carried out together with an audit of their responses to the tender.

Hospitals were initially assessed on quality criteria and those meeting the quality criteria were then chosen for inclusion in the network based on an assessment of quality, price, the range of services provided and the local demand. The process was complex and took almost three years to complete, resulting in the publication of our Directory of Hospitals in September 1999.

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<sup>6</sup> 190 out of the circa 200 private hospitals in the UK are in our network.

<sup>7</sup> For completeness, we note that we have pricing agreements with all NHS facilities in the UK (some are negotiated and with others we accept their standard tariff), as Members will on occasion choose to receive their treatment in an NHS facility when their nearest / most convenient PH provider is unable to perform a particular treatment or due to the complexity of any treatment required.

Over 90% of our current members are on a network product. If a member receives treatment in a network hospital he or she is guaranteed to receive a full refund of hospital fees. The remaining members are covered to receive treatment at any facility in the UK. Therefore for treatment purposes we “recognise” all facilities in the UK and have agreed rates with most PH providers, but the term “recognition” in the context of our network refers to inclusion in our Acute Hospital Network as listed in our Directory of Hospitals.

For the avoidance of doubt, whilst regions were used for the purposes of designing the tender process, members are entitled to be fully indemnified for any treatment received in any hospital included in their policies, and are not therefore restricted to using their local PH providers. As described in section 5.3 above, this is a particularly significant point when considering London as a market where members living outside London may still elect to be treated at a London facility.

As noted above, there are some instances where medical necessity requires a member to be treated in a non-network facility (because for example the most convenient PH provider from within our network does not provide the treatment required or cannot provide the treatment in a timely enough fashion). We have a process in place that allows members to receive treatment outside our network in these circumstances which is reimbursed in the usual way (subject to receiving pre-authorisation from us).

### **8.3 Evolution of our network**

Our network has not altered substantially since its inception in terms of the acute medical facilities we recognise. The existing network serves our customers well and we perceive no pressing need to review the network on a national scale, although as demonstrated below it has never been our strategic position that the network is ‘set in stone’. In any event, beyond some consolidation and acquisitions among the PH providers (summarised in Table 1 above) there has been limited change in the available private provision in the UK (either in PH providers or NHS PPUs).

We have however carried out many enhancements, described below. In addition, following the original development of the network we carried out two major geographic reviews:

- In 2003 we re-tendered in the Leeds catchment area because Nuffield had significantly re-developed its site in the area (which had previously been unsuccessful in its application to be admitted to the network) and requested a review. Following the re-tender Nuffield was still not successful in becoming our preferred provider, which remained Spire’s hospital in Leeds (at that time owned by BUPA).
- In 2005 we re-tendered in Oxford because when the network was originally established we had been unable to reach a decision on a network provider because of the lack of suitable facilities in the area. Following a major new build by Nuffield we repeated the tender process to determine if one of the providers would be granted preferred status (in which event we would have removed other providers in the area from the network) and concluded that this was not in our commercial interests at the time.

AXA PPP is periodically asked to include additional hospitals in its network and we give full consideration to each request (including considering whether to exclude an existing facility in the event that the new facility is successful). In addition to assessing the commercial proposals that we receive, we will review factors such as (a) our existing provision and

whether an additional facility would give us additional capacity that we require or additional services not provided by an existing hospital; and (b) our existing arrangements with other suppliers, including the terms of any contract that we already have in place.

For completeness AXA PPP has listed the facilities we have added to our network over the last ten years. With the development of the Care Quality Commission which regulates the quality of private facilities – something which did not happen in 1997, pricing now tends to be the most compelling reason for deciding to include a new facility in our network.

**Table 2**

Date	Provider	Location
2003	Hospital of St John and St Elizabeth	London
2005	BMI The Manor	Oxford
	The Churchill	Oxford
2006	Spire Dunedin	Reading
	Spire Clare Park	Farnborough
2006	BMI The Woodlands	Middlesbrough
	Harley Street UCLH ( <i>HCA managed</i> )	London
2007	Spire Thames Valley	Slough
2008	BMI The Cavell	Enfield
	Holly House (Aspen)	North London
2010	Fitzroy Square and Weymouth Street (BMI)	London
	Nuffield Vale Clinic	Cardiff
2011	Highgate Clinic (Aspen)	North London
	Guys and St Thomas NHS Trust ( <i>HCA managed</i> )	Central London
	Pembury NHS Trust	Tunbridge Wells
2012	Circle Bath	Bath
	Circle Reading	Reading

#### 8.4 Development of sub-networks

The network negotiations with hospital have enabled AXA PPP to arrive at hospital fees which can be guaranteed to members as never open to shortfalling. AXA PPP has in the past decade tried to develop packaged care – negotiations with hospitals which can agree an all-in price for major tests or treatment (including accommodation, tests, treatment and surgical/anaesthetic fees). As you will see below, this has had mixed success but some progress has been made. Notwithstanding the broadly static nature of our acute hospital

network we have developed, to this end, additional networks that sit under or alongside our main hospital network, as follows.

#### **8.4.1 Scanning**

This was first established in 2000 and sits alongside our network of acute hospitals. This network broadens the access to scanning services for our members and was developed to take account of the fact that a number of stand alone out patient facilities (diagnostic centres) had developed their own scanning services and offered cost effective terms in competition to our existing acute network providers.

#### **8.4.2 Oral Surgery**

This requires our members to receive oral treatment at an approved "Oral Surgery Centre". This is a sub-network which includes some Acute Network facilities and many other standalone Out Patient facilities.

The network was developed in 2005 in response to our concern that we were paying excessive prices for oral surgery procedures (primarily the removal of wisdom teeth). We had previously tried to bring down the cost of these procedures by recognising "surgical dentists" and thus increase supply of providers. This tactic proved unsuccessful as the surgical dentists simply charged the same fees as the specialists. All PH providers in the UK who are able to carry out Out Patient Oral Surgery were given the opportunity to tender for providing this service on the basis that they would provide package prices fully inclusive of all fees relating to the treatment of our members including surgeons and, where required, anaesthetists. This was our first initiative to include surgeon's prices as part of an overall package price. Although many services provided by specialists such as radiologists and pathologists are already included in package prices agreed with hospitals, this was the first time we had sought to include surgeons' and anaesthetists' fees in a total package. We attempted to gain a further cost reduction by allowing surgical dentists (in addition to maxilla facial specialists) to perform procedures but this was unsuccessful as the surgical dentists responded by increasing their fees to the same level as the specialists.

This initiative has not only enabled us to reduce the costs of treatment by negotiating packages at the facilities we included, but also to guarantee to our members that there would be no shortfalls on their consultants' fees (which are a constant source of dissatisfaction in our market).

The Oral Surgery Network was successfully rolled out in 2006 and is now embedded in our Network products.

#### **8.4.3 Cataract Surgery Network**

Our attempt to establish a Cataract Network started in 2006 following the establishment of the Oral Surgery network with the same objectives and using the same principles. It has been our intention to broaden the principle of fully inclusive packages where possible as we believe they are an effective cost control mechanism that enables us to guarantee a full refund to our members but specialists (as outlined below) have been broadly resistant.

For cataract surgery, improvements in technology and treatment techniques had resulted in the majority of routine cataract procedures being performed in an Out Patient setting as

opposed to having to admit patients to hospital overnight.<sup>8</sup> As with our Oral Surgery Network, our objective was to reduce the price of a procedure that in a short space of time had moved from being classified as complex<sup>9</sup> to being relatively routine in practice and to improve the patient's experience avoiding unnecessary admissions to hospitals. We also tried to address the issue that each component of the treatment pathway for cataracts remained priced as if it was a complex procedure, with each interested party (the provider, the surgeon and the anaesthetist) seeking to retain their part of the previous profits. In the case of surgeons, they were continuing to charge as if the procedure required a long time in theatre and anaesthetists continued to charge the price for their historic service despite the fact that most anaesthetics for cataracts are local as opposed to a full general anaesthetic being administered.

We had the same intention as for Oral Surgery, to agree fully inclusive package prices, including the surgeons and, if required, the anaesthetists. All PH providers able to carry out cataract surgery on an Out Patient basis were invited to apply to join, including our Acute Network PH providers.

Setting up this initiative was much less successful than the implementation of the Oral Surgery Network and we have only been able to implement it in part. There are a number of reasons for this partial success, including:

- the reaction of, and resistance from, many surgeons and anaesthetists who refused to work with private facilities and be paid by them, as they wanted to continue to protect their own positions. Many specialists appeared to regard this proposal as the 'thin end of the wedge' and were concerned that it took them down an unattractive strategic route; and
- the reaction of some key PH providers, notably  $\times$ , who refused to reduce their prices for cataract surgery and to take part in securing composite prices with specialists and, in effect, opted out of the cataract network. At the end of 2007 we advised  $\times$  that it would, therefore, be excluded because its existing price (£ $\times$  per procedure at the time) was too high.  $\times$  claimed that this would mean that it would lose the £ $\times$  we spent with it on cataracts at the time.  $\times$  stated that it would therefore have to recover all of this £ $\times$  loss of revenue by increasing its prices with us elsewhere to compensate. In our view this was tantamount to an admission that the price it was charging was almost completely profit.

We believe that our inability to implement this network fully has resulted ultimately in detriment to our members as prices have not decreased as significantly as they could have and we have not been able to get traction behind other initiatives (our Pathways product and  $\times$ 's experience with trying to include specialists fees is discussed below).

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<sup>8</sup> Until the 1990s, traditional cataract extraction was performed using an open operation. The usual approach was known as extra capsular extraction which involved making an incision in the eye and removing the lens leaving behind the posterior capsule which naturally contains the lens. The procedure took approximately 40 minutes and was usually performed under general anaesthesia. Most cataracts are now removed by phacoemulsification. This is performed through a small incision and involves the use of ultrasound to liquefy the lens which is broken up sucked out. An artificial folding lens is then inserted into the natural lens capsule. The lens expands after insertion and the wound in the eye is closed sometimes using a stitch although the incision is small and may not need a suture at all. This takes about 15 minutes to perform in an outpatient setting.

<sup>9</sup> Insurers classify procedures by complexity for simplicity. There are five complexity bands in order of increasing complexity minor, intermediate, major, extra major and complex. Traditional extracapsular extraction was classified as extra major. Phacoemulsification is now described as being intermediate complexity.

It is our opinion that this “entitlement culture” demonstrated by many providers together with high fixed costs is a constraint on the reduction of prices in the market. AXA in particular uses a ‘basket of goods’ argument, by which it essentially claims that AXA PPP is buying a basket of goods from AXA that costs “£X” and therefore if we stop paying for one item in the basket the rest of the basket’s costs will have to increase to continue to achieve “£X”. This attitude adversely affects the prices our members are paying by inflating some items with little regard to the way the procedure is currently performed (e.g. most cataract cases do not require an anaesthetist to be present in theatre and yet anaesthetists continue to charge for their services in many instances).

#### **8.4.4 Direct Referral Product – Corporate Pathways**

In 2009 we developed our first direct (open) referral product (“Pathways”) in conjunction with BMI. BMI approached us, keen to innovate in the market by developing a lower cost proposition to offer to corporate customers, which would also guarantee no shortfalls to members by including the surgeons and anaesthetists fees for all procedures. BMI offered a 10% discount applicable to all corporate customers on a Pathways product treated at its facilities and to include the specialists’ fees in its charges. BMI also undertook to sign specialists up to the proposition and to invoice on their behalf also with a 10% discount relative to average prices.

The Pathways policy requires members to be treated in a BMI facility if they live within 20 miles of a BMI hospital nationally or 10 miles within London. A further objective for BMI relative to London was to draw treatment away from London to its well situated facilities around the M25.

The product was offered to our Large Corporate client base and was launched with effect from 1 January 2010. Members who need to receive treatment are required to obtain an ‘open’ (no specialist named) referral from their GP. Once AXA PPP has checked that the treatment is eligible under the terms of the policy the member is referred to a BMI call centre if he or she lives in a BMI hospital catchment area. BMI arranges treatment on behalf of the patient at a convenient hospital and is responsible for identifying the specialist, including, where required, the anaesthetist.

The product has had limited sales success (we currently have 20 corporate customers covering approximately 16,000 members on the Pathways product) due to a number of factors. In particular, the product at launch only included BMI hospitals and so cover was not broad enough nationally and many members still required treatment at an alternative facility. This meant that these members (who ultimately were not treated at BMI) did not benefit from the discounted hospital terms or the inclusion of the specialists fees, reducing the discounts in premiums available to members. AXA PPP was also unable to offer a full refund guarantee in terms of specialist costs at non BMI facilities because they were not compositely billed.

[REDACTED]

#### **8.4.5 Health-on-Line**

AXA PPP launched its new value proposition in 2011 through its newly acquired subsidiary Health-on-Line. This product is aimed at individuals and SME and includes a newly tendered for, more limited, network of acute hospital and specialists chosen by us based on their overall episode costs.

For the establishment of the network underpinning this proposition we divided the UK into 14 regions that broadly corresponded with the current NHS Strategic Health Authority areas and invited all hospitals to respond asking them to discount their prices relative to their existing contracts with AXA PPP on the basis that broadly we would be reducing our existing network of providers by 50%. The Health-on-Line hospital network today includes 130 hospitals and is broadly made up of  $\propto$ , some  $\propto$  facilities, a few  $\propto$  facilities and a number of others.

We had a mixed response from the providers [REDACTED]

Members on this product are entitled to use non Health-on-Line network hospitals and specialists subject to a 40% coinsurance.

## **8.5 Current Issues**

The issue of whether we can recognise a competing facility or a new entrant in an area where there is an incumbent is complex.

One important factor is our customers. Although it is technically possible to remove a hospital from a member's entitlement, in practice it is not possible to do so without causing potential patient detriment and practical difficulties. Ongoing and pre-authorized treatment would have to continue to take place even after a hospital has been removed and this has been a key consideration in some of the disputes we have faced with providers. It is, therefore, easy to add new provision but not to remove existing provision, so it is difficult for a fair competitive tendering process to take place.

## **9 [REDACTED] Contracts and pricing with PH providers**

### **9.1 Each of the main providers is an essential counterparty**

We believe our network has generally enabled us to agree lower prices with PH providers for the services they provide to our members. This enables us to provide as broad a range of cover as possible for members whilst managing costs. It also means that we have been able to agree prices on behalf of our members which allow for full indemnification.<sup>10</sup>

Ultimately, however, given the market position of the main four PH providers (BMI, Spire, Ramsay and Nuffield) outside Central London and the fact that all four own solus hospitals, it would be difficult for any insurer to have a national proposition without some of the hospitals owned by at each of the main PH providers being included (i.e. it would be difficult to have a viable, comprehensive, competitive proposition with one of the main four excluded). As a general point, the more hospitals a PH provider group owns in different locations, and, in particular, the more solus operations they have, the less we would be able to consider removing the group from our network altogether.

In AXA PPP's view, therefore, the negotiating power (outside of London) is to some extent balanced between our continued efforts to manage costs and the PH providers' objective to achieve recognition for as many of their non solus hospitals as possible.

Hospitals have significantly high proportional fixed costs which they seek to cover. Therefore new/more competition in a given area does not necessarily lead to lower prices especially if it leads to significant over capacity. Rather, prices may inflate as PH providers

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<sup>10</sup> In addition, there are financial advantages for the hospital in receiving payment for treatment from AXA PPP rather than from individual patients. These include faster payment (usually by electronic transfer of funds) which benefits cash flow and the freeing-up of resources required for debt collection.

pay more via incentives to attract consultants to their facilities and / or engage in over treatment of patients in an effort to maximise revenue. We have concerns (that we have shared with X ) with its consultant incentive model in this regard. Their model poses the question of whether consultants will have an incentive to increase treatment and/or testing given their financial interest in the facility.

[REDACTED] these propositions accept the fact that on occasion we will have to allow members who need treatment to use a non participating hospital and therefore they will not benefit from discounted premiums for treatment in these locations.

## **9.2 Contract terms**

We have agreements in place with all of the PH providers which have facilities in our network which generally speaking have similar terms. They include

- Termination terms;
- The services we are buying;
- Prices;
- Billing requirements;
- Audit rights;
- Dispute resolution;
- Complaints resolution; and
- Service standards.

We have agreed a national tariff with each of the main PH providers to which various discounts are applied depending generally on local competition. The pricing contracts attempt to cover all items that a hospital is entitled to charge for and specifies where relevant, what is included in each price. By way of example, a charge for accommodation will include all nursing charges. The contract thereby seeks to protect both parties from disputes and AXA PPP from being charged additional extra contractual items without these being pre-authorised.

Each of the national providers has solus facilities which we have to recognise because otherwise we would have no treatment coverage. This gives each of the providers negotiating 'power' in these locations. This is counterbalanced to some extent by the fact that each national provider wants to achieve recognition for as many of its facilities as possible, so wants as many hospitals in competitive locations to be included in our network products.

It may be the case that a new entrant in to the market will have difficulty in obtaining recognition with us for its facility, if we already have adequate provision in the area, due to the nature of our contract and pricing with an incumbent provider. As noted in section 8.3above, AXA PPP carefully considers every request for inclusion in its network on the basis of a range of factors, including existing contracts, and there is no formulaic process whereby a facility will be automatically recognised or refused.

## **9.3 Pricing arrangements**

The pricing agreements with providers cover all elements of services provided by them to our members but are not standard in format and there are major differences in the shape



of pricing structures between, in particular, the main groups. It has been our long-term objective to have as many package prices in place as possible that include the main elements of a patient's care relating to a hospital stay in order to pay a fair sum to PH providers and consultants. We have been broadly successful in agreeing packages with hospitals and with many providers we have procedure prices in place for the most common surgical procedures. Note that these procedure prices do not include the specialist's fees or any diagnostic services or follow up care. We discuss specialist fees in detail in section 14 et seq. below.

Per diem rates and rates for other consumables are then agreed for non-surgical procedures and for any items not included in the packages. Mark-ups are applied by PH providers to various consumables such as high cost drugs and prostheses (if not part of package price) which means the more ad hoc items a provider can bill for, the more opportunity it has to increase revenue. These mark-ups and the practice of adding mark-ups to various consumables is an historic one and some mark-ups that are applied are now significant because they are routinely a percentage of the manufacturer's list price for the item. This means that the provider is unlikely to be paying the list prices (because it will have negotiated contracts with manufacturers) but charges the list price plus a percentage mark-up. Package prices aim to improve efficiency of providers (for example, removing incentives for patients to stay in hospital when this is not necessary), ease administration and help avoid disputes with providers over what they can and cannot charge for.

The number of procedure prices in place with providers does differ. In London, in particular, we have not been successful in agreeing procedure prices [REDACTED] our experience is that some providers perceive the opportunity to charge additional items as an effective way of increasing their revenue. Prices with providers are negotiated annually and many contracts have a formula based on published indices detailing the maximum overall increase a provider will be given on its tariff. The actual price is still subject to a negotiation around specific items. Prices are not specifically related to volume so retrospective volume discounts or increases are not included in our contracts currently, [REDACTED]

Many of the providers display what we consider to be an "entitlement culture", possibly related to high fixed costs. For example, the 'basket of goods' negotiating stance (as we saw when developing the cataract network, described in section 8.4.3 above) has meant that driving down costs of some services has been difficult as providers simply seek to re-balance the overall charges. This does not tend to effectively counterbalance (by keeping the prices of procedures that are routinely rising lower than they would otherwise be) because there are relatively few instances of an existing procedure actually increasing in costs and these are in any case far outweighed by procedures reducing in cost.

To enable us to compare price between providers we calculate the overall episode costs. This also enables us to calculate national comparisons where the PH provider owns more than one facility. The analysis calculates how much an 'episode of care' costs at a given facility based on the claims we have received and compares this with others. An episode of care is determined by reference to the total inclusive cost of a particular treatment and by definition includes a number of assumptions. We then compare episodes of care to the average, adjusted for the case mix complexity.

The indexation and AXA PPP's spend with our main providers is shown below.

[REDACTED]

In a competitive market, we might expect a lesser spread between providers, especially where the highest prices also attract the greatest volumes and might be expected to compete to retain volume.

In addition to all our network agreements we have pricing agreements with all private and NHS facilities in the UK (some are negotiated and with others we accept their standard tariff). This is because members may choose to or require to receive their treatment in a non-network facility when their nearest/most convenient PH provider is unable to perform a particular treatment or due to the complexity of the treatment required.

[REDACTED]

## **10 Insurer buyer power vis-à-vis PH providers?**

We note that the Issues Statement suggests (at paragraph 34) that the CC may consider a separate theory of harm whereby the PMI providers have buyer power over PH providers, such that PMI providers may exert too much pressure on the price paid to the hospital operator. The potential outcome of such a theory of harm is that hospital operators may reduce investment in facilities and equipment, and that (if the market for private medical insurance is not competitive) lower prices paid to hospital operators may not be passed on fully to purchasers of insurance through lower premiums.

In AXA PPP's view, this potential theory of harm is not sustainable. While we accept that PMI providers may be considered important counterparties for PH providers given their desire to access our members, as can be seen above our efforts to secure cost reductions in circumstances where such reductions are clearly achievable given improvements in technology (for example in relation to cataract procedures) are frequently unsuccessful.

AXA PPP seeks to pass on cost reductions to its customers in the form of lower premiums. The introduction of our alternative network products, such as Health-on-Line (discussed at 8.4.5 above), is one example of an initiative whereby reduced costs are reflected in lower premiums.

## D. HCA AND THE LONDON MARKET

### 11 HCA background

AXA PPP has a long relationship with HCA. In the 1990s AXA PPP and HCA co-owned (AXA holding a 49% share) the then Columbia group of hospitals which comprised 4 flagship hospitals: Portland; Harley Street Clinic; Princess Grace; and the Wellington. By the end of the 1990s AXA PPP had been acquired by AXA and a strategic decision was made to divest the 49% shareholding and the group was then acquired fully by HCA. Shortly afterwards, HCA acquired the St Martins group, adding the Lister in Chelsea and the London Bridge hospital to its portfolio.

HCA has continued to significantly increase its footprint and therefore its influence in the Central London market. In 2006 it took over the management of the private unit at University College Hospital London, branded as "Harley Street at UCH". In 2010 HCA acquired 49% of the London Oncology Centre located on Harley Street and shortly afterwards gained total ownership. [REDACTED] (.) In 2011 the Wellington opened its purpose-built £22m Platinum Centre substantially increasing the Wellington's Hospital footprint, thereby further affecting the Hospital of St John and Elizabeth.<sup>11</sup>

In 2006 HCA launched an initiative to expand each of its hospitals' footprints by opening various satellite centres. The first of these was the Wellington Diagnostics and Outpatients Centre located in Golders Green. There are now HCA-owned outreach centres located at Canary Wharf (referring patients to the London Bridge Hospital), Broad Street (London Bridge Hospital), 30 Devonshire Street (Princess Grace Hospital), Chelsea Outpatient Centre (Lister Hospital), the Harley Street Clinic Diagnostic Centre at 13/14 Devonshire Street and the New Malden Diagnostic Centre (both of which refer to the Harley Street Clinic).

HCA's influence has also continued expanded into primary care. This exerts considerable influence over the referral patterns into secondary care. There is a private primary care practice at the HCA-owned Wellington Hospital and recently HCA acquired Rood Lane, a significant provider of primary and diagnostic services to City employers with 26 registered GPs<sup>12</sup>, and a shareholding in Blossoms Inn, the only significant competitor to Rood Lane, with 25 registered GPs.

We note that the Issues Statement identifies vertical integration as a possible theory of harm, with reference to BUPA's ownership of the Cromwell hospital in London. We agree that the vertical link at the Cromwell is unlikely to lead to significant harm on competition. However, we are concerned that the vertical integration of PH providers, notably HCA, with respect to primary and secondary facilities, may distort competition. We would therefore encourage the CC to consider this issue.

In addition HCA has recently increased its footprint outside London by the acquisition of the private facilities at the Christie Clinic, Harley Street at Queen's Hospital, Romford and two more outreach centres in Sevenoaks and Brentwood.

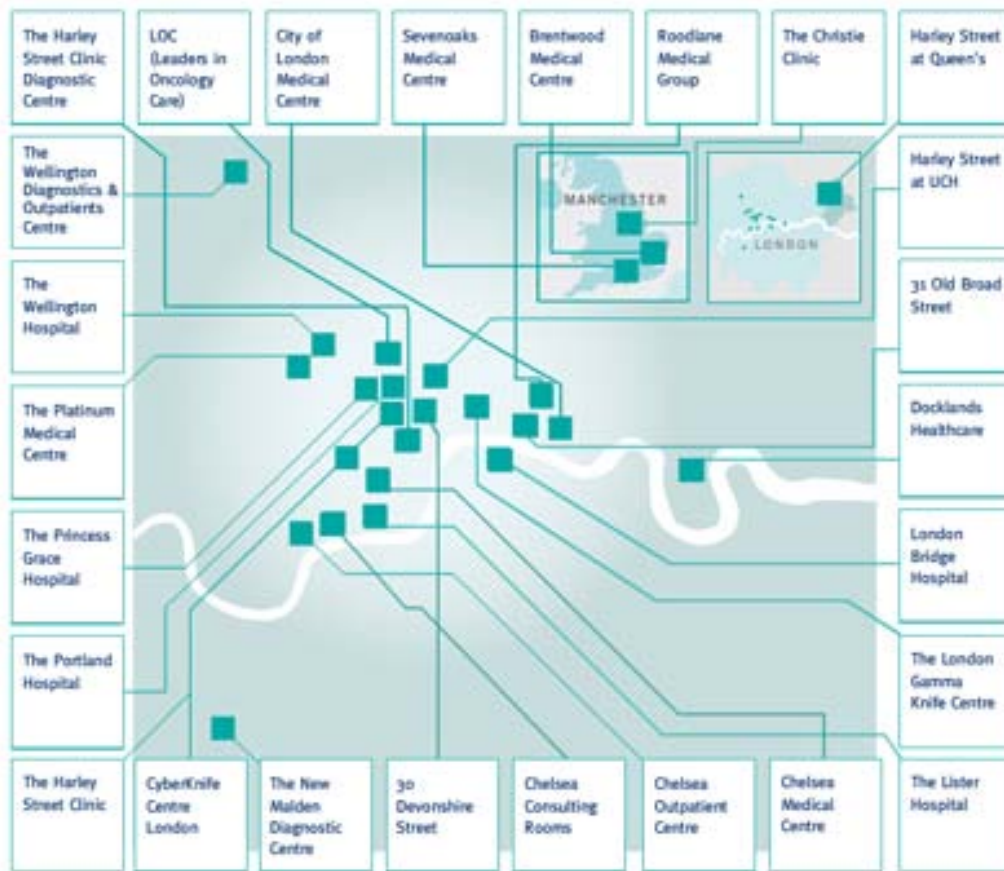
HCA has also recently purchased a stake in a company which undertakes purchasing for the NHS. Most recently, we understand that HCA has won the contract to manage the PPU at Guy's and St Thomas's NHS Trust.

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<sup>11</sup> [REDACTED]

<sup>12</sup> <http://www.roodlane.co.uk/private-gp-services-6.htm>

An overview of HCA's current footprint is provided below.



Source: [www.hcahospitals.co.uk](http://www.hcahospitals.co.uk)

## 12 HCA's market position

As noted above, AXA PPP considers that PH provider facilities in Central London demonstrate the features of a separate relevant market given the reputational draw of certain facilities and consultants, the fact that new technology will tend to be introduced in London before other locations, the importance of London facilities to large corporate customers, and the fact that many customers living both within and outside London prefer to be treated in Central London.

AXA PPP considers that there are 7 Central London hospitals that comprise an elite group (must have), distinct from other facilities. There are also some other large private providers and some PPUs competing to some extent.

**Table 5: Elite Private Facilities in London**

Hospital	Provider
London Bridge	HCA
The Wellington	HCA
The Lister	HCA
Harley Street Clinic	HCA

Hospital	Provider
The Portland	HCA
Princess Grace	HCA
London Clinic	n/a <sup>13</sup>

As noted in the table above, HCA owns 6 of these 7 hospitals. In an “ordinary market”, where customers shop around when they need to buy and know what they need to buy, this degree of control of a market would of itself give the company a very powerful market position. However, in market where customers (or their employers) are purchasing an “option demand”, that is, they are contracting in advance to be able to choose later where to be treated, it is clear that any PMI policy purporting to offer a full network that only included 1 of the 7 core London hospitals would not be seen as a credible policy. Accordingly, PMI providers supplying the London corporate markets have no choice but to include HCA hospitals in their network. [REDACTED]

HCA's marketing messages about its position in the London market present it as London's number one hospital group, stating that:

*“Our facilities are unsurpassed in the private sector.*

*No other private hospitals in the UK have more intensive care beds, achieve such consistently high patient survival rates or work with as many leading specialists and doctors from renowned NHS teaching hospitals.*

*We treat patients from London, from across the UK and from all over the world and promise privacy, respect, comfort, cleanliness and the highest standards of medical care.”<sup>14</sup>*

AXA PPP considers that the share of HCA hospitals in the provision of private healthcare in Central London is on any measure high, and in the provision of complex procedures is extremely high. Whilst for minor treatments, other non HCA facilities also play a role in provision, AXA PPP's data suggests that for complex procedures in Central London, HCA's share of treatments of AXA PPP patients, at around the 70% level, is consistent with this characterisation of the market. AXA PPP accepts that high market share, whilst sometimes an indicator of market power, is not proof a market failure, however, we consider that an evaluation of the business practices and conduct of HCA reveals modes of behaviour that are concerning in their own right, suggesting that the firm is not subject to effective competition in the marketplace.

### 13 [REDACTED]

<sup>13</sup> The London Clinic is an independently owned, non profit hospital

<sup>14</sup> [www.hcahospitals.co.uk/about-hca.asp](http://www.hcahospitals.co.uk/about-hca.asp)

## **E. CONSULTANTS**

### **14 Overview of the consultant relationship**

Consultants are critical to our business, and key to the members' claiming experience. Consultants have contact with our members at a critical time and, of course, decide what treatment to recommend, where the treatment is to be provided, and how much treatment to provide. In effect, as the primary contract is between the consultant and the member, the consultant has complete control over what he charges the member and thus a direct influence on costs. By the time the member seeks indemnification from AXA PPP, we generally have little or no control over the initial or primary cost of the treatment.

Consultants have to apply for recognition from AXA PPP. To be recognised they must be on the General Medical Council's Specialist Register and hold, or have held, a substantive consultant post in the NHS and have admitting rights to at least one private facility. The ongoing monitoring and adherence to quality standards for consultants is the responsibility of each PH provider's Medical Advisory Committee or Panel. AXA PPP currently recognises around 36,000 specialists and practitioners in the UK.

In the sections that follow, we discuss our approach to consultant fees and our concerns about certain consultant practices. Chapter F addresses incentives provided by PH providers to consultants.

### **15 Fees**

#### **15.1 Overview**

This section describes the approach of AXA PPP in three key areas:

- (i) The management of specialist fees for established consultants (the great majority of consultants that we recognise).
- (ii) The management of specialist fees for newly recognised (by AXA PPP) consultants.
- (iii) An overview of the income sources of consultants who operate in the private healthcare market.

Our submissions are made in the context of a Theory of Harm set out in the Issues Statement, indicating that excessive control of specialist fees may, over time, limit the supply of newly qualified consultants. Separately, we are aware that there have been a number of submissions indicating that published fee schedules have not been increased for an extended period of time. The implication is that income levels have been suppressed hence giving rise to concern that long term harm may result, with ultimately a reduction in private consultants available in the market.

#### **15.2 AXA PPP Strategy**

In considering its strategy for the management of specialist fees, AXA PPP has focused in particular on achieving the following three outcomes:

- (i) Achieving, as far as possible, a position where fees will be met in full and that, therefore, customers do not experience a shortfall. We are very aware that shortfalls are a significant source of customer dissatisfaction.

- (ii) Managing, as far as possible, the cost of claims so that premiums can be as low as possible. We are also aware that price increases, which have consistently exceeded inflation, are a major source of customer dissatisfaction.
- (iii) Where fees are not to be met in full, our obligation to our customers is to clarify as early as possible the amount that we will pay so that they can understand the level of any potential shortfall.

Evidently, there is a potential for conflict between these various aims. In trying to manage these objectives, AXA PPP is not aware of any problem in attracting suitably qualified consultants in sufficient numbers to treat its members to an appropriate standard, which is all that AXA PPP seeks to achieve.

### **15.3 The AXA PPP Fee Schedule**

It is our view that, in order to be clear with our customers, we need to publish a schedule, as part of the policy conditions which sets out the level of reimbursement guaranteed under our policies. Until 2011 we relied on a more general wording based on reasonable and customary fees charged in the market. Whilst having some advantages, we concluded that this approach was potentially out of line with developments in regulation.

[REDACTED] Our general approach for a very long period, which has not been altered by the introduction of the AXA PPP fee schedule, has been to pay approximately 95% of the bills submitted to us in full. We believe that this allows us to give a strong reimbursement message to our customers whilst allowing us to focus cost control efforts on extreme charges. [REDACTED]

Specialists may submit an unusually high bill compared with their normal practice, for a variety of reasons. This may be because the particular case was unusually complex, or simply that there has been some error in the coding system. In order to avoid unnecessary friction in relations with specialists, it is only when a specialist is consistently, and by a material margin, charging more than the published fee that we will challenge his or her practice. We also concentrate our reviews on consultants who bill large amounts in total in order to focus effort efficiently. Consultants who meet both these criteria are then challenged.

### **15.4 The Capping Process**

If a consultant is identified as a systematic high charger, he or she will be reviewed in a staged process.

In the first instance we will contact the specialist and point out that he is charging significantly in excess of the market and invite him to provide an explanation as to why this might be justified. Where one is supplied this is usually on the basis that the specialist has some personal expertise that should command a premium. In some instances the explanation will have some basis in fact, for example the circumstances of particular patients.

At the same time, we will review the fees charged in the local area, and in particular those for the same speciality. If these are generally higher than the UK average, or the local supply for the particular speciality is limited, then these factors will also be taken into account. In addition to maintaining a high overall level of reimbursement we are careful to ensure that there should be the minimum of instances where a full refund option is not available for our customers.

In the absence of a plausible explanation for high charging, and in the presence of alternative local supply, we will invite the specialist in question to reduce his fees to an acceptable level. In many instances, there will be a process of negotiation where a specific level of charging is agreed and particular charges for that specialist are applied.

If agreement cannot be reached then we will apply a fee cap to the specialist. This means that we will only pay up to the amount set out in the published fee schedule. Evidently, this will be a material drop in payment and is intended to act as a real incentive to the specialist concerned. At present, only 3% of specialists have a fee cap applied.

Having applied a fee cap, our main aim is to ensure that, where a customer is referred to a specialist who is capped, then they are informed as early as possible in the process so that the patient can be aware of any possible shortfall and provided with an alternative if he or she wishes. Our actions in this area include:

- Marking the specialist in our system so that the matter can be discussed with the customer at the pre-authorisation stage. This extends to marking specialists who often work with secondary specialists (e.g. anaesthetists) who may cause a shortfall to occur.
- Identifying specialists on our website whose fees we meet in full.
- We tell specialists they need to inform patients that there may be a shortfall.
- We encourage customers to get a fee quote as early as possible in the process so that they can understand the potential quantum of any shortfall. More recently we have sought to quote the average level of shortfall experienced in the past so that customers can understand their position before the first consultation.

It should be noted that the capping process does not in any way preclude specialists from setting their own fee levels and charging patients the balance of their fees where we do not pay in full. Clearly, being fee capped is not an outcome that specialists prefer, but even in these instances fee payment by us is in line with a large part of the market. Specialists clearly feel uncomfortable in justifying to patients why it is that their fees are significantly in excess of their peers, and prefer to stay within the limits of full reimbursement. Those who feel they can, and in practice do, justify their fees are not prevented from doing so.

## **15.5 Newly Recognised Specialists**

In 2008 a new system of managing fees was introduced for specialists newly recognised who, for the most part, will be those who have most recently qualified. The main reasons for this were as follows:

- We would prefer to give an unequivocal guarantee that customers will not experience a shortfall if they see a "Fee Assured" specialist. In the absence of a contract this gives rise to at least the theoretical risk that the specialist could unexpectedly submit a very large fee and we would be required to pay it under the insurance contract.
- Newly qualified specialists registering their qualification on our system gave us a process into which we would introduce the contract.

Our approach has been to make recognition of newly recognised specialists by us contingent on them entering into a contract the main feature of which is that they will agree



to charge our customers in line with our published fee schedule and not seek to charge customers separately.

We were conscious of the fact that the introduction of the contract might give rise to a suggestion that the flow of new specialists being recognised has reduced. We have monitored the position (see Annex 11) and there is no evidence to support this view.

We are approached from time to time by contracted specialists who are seeking to increase their fees. In a small number of cases we will agree a new fee rate if circumstances (i.e. the expertise of the specialist and local market conditions) justify this. A small number of specialists have chosen to give up their recognition where we have declined to increase their contracted rate.

For reference the distribution of specialists is currently as follows:

**Table 6**

Fee approved specialists	84%
Contracted specialists (Fee Assured)	13%
Capped specialists	3%

## **15.6 Specialist Income**

We are aware that a number of submissions from specialists have noted, with reasonable accuracy, that the fee schedules used by insurers have not been materially updated for an extended period. We assume this has led to the CC raising the issue of the impact on specialist supply. In considering this particular issue, the CC should, in our view, consider the following points:

- It should not be assumed that the fee schedule is a wholly efficient or unambiguous method for managing charges. Specialists can and do use a variety of strategies to present their bills in a way which will maximise their revenue, and have become more adept at doing so. Such billing practices are set out at section 15.7 below.
- It should not be assumed that the fee schedule covers all of the fees charged by specialists. At present, the fee schedule accounts for 40% of the amount paid by AXA PPP to specialists. Other charges, including daily rates for non-surgical (referred to as medical) cases, physicians fees and a whole range of other charges including, until the last 4-5 years, fees for patient consultations, are or have been outside the schedule. In practice these other charges are ones where insurers do not have strong controls and specialists have not been slow in taking advantage of this fact.
- [REDACTED]. This does not indicate that specialists have seen a notable reduction in their share of claims, until the last 2-3 years. We are not clear as to what is driving this recent trend.
- We do not believe that our overall strategy on fees differs significantly from that of any other insurers. That being the case, in practice many specialists charge in excess of our published fee schedule and have their fees met in full.

- It is also the case that, where they can justify their fees, specialists (who are not newly recognised) are at liberty to receive these from the patient. If many are reluctant to do this we would contend that this reflects on their market value.
- We are aware that hospitals compete vigorously for specialist business and that this competition extends to various direct or indirect inducements.
- Many specialists have become increasingly involved in the provision of outpatient services. For instance, they have set up outpatient clinics in which they perform consultations, conduct various tests and gain revenue from pathology services. These activities add to specialist revenue but are not categorised as specialist payments.
- We have not observed a significant change in the flow of specialists seeking recognition or the numbers treating our customers.
- In fact, the supply of specialists is governed by the NHS and its requirements. We believe that changes in NHS practice are far more likely to influence the supply of specialists than the actions of insurers. Indeed, the supply increased markedly in the period of growth in NHS expenditure. It is noteworthy that in this period of increased supply the prices charged by specialists did not fall as we might have expected.
- Insurers have a strong incentive to maintain the broadest possible range of fee assured specialists in order to be competitive in the market. Excessive shortfalling can quickly become an issue, especially in the large corporate market.
- It is in AXA PPP's commercial interest to maintain adequate supply of doctors to meet the needs of our policyholders and in early 2011, fees were increased for some breast reconstruction procedures and for some complex spinal surgery. In addition all anaesthetic fees were uplifted by 3% to reflect the growing market pressure in this area. A further review is planned for later in 2012.

In light of these factors we do not believe that Theory of Harm 4 is one which has any merit.

## 15.7 Billing practices

In order to submit claims to insurers, healthcare providers use a standard coding system.

These codes are in effect a common language which allows complex medical services to be translated into codes which insurers can use to assign benefits or check that bills are reasonable.

In the UK private sector the coding system is known as CCSD. These are issued by an organisation known as CCSD which is owned by a number of insurers. CCSD has a licence to issue codes based on the OPCS coding system which is owned by the Crown.

Because insurers have traditionally assessed bills from providers by reference to these codes and some e.g. BUPA or Aviva have fixed scales of reimbursement directly linked to coding, the code used directly drives the reimbursement available. It follows then that miscoding or creative use of the coding system can result in payments which were not intended.

This opportunity has led to some doctors and billing agencies developing some fairly sophisticated creative billing strategies aimed at obtaining higher reimbursement than was

intended, whilst apparently staying within insurance maxima. These strategies are not unique to the UK but are seen in all systems based on a coding system and fee for service.

Principal creative billing strategies are as follows.

### ***Unbundling***

Unbundling is the most common creative billing strategy. It involves making a full charge for a service and making additional charges for its component parts as if they were extra. A lay example would be charging for decorating a room and then claiming that wallpapering and painting were extra. Once couched in medical terms it can be very difficult to spot without a detailed technical knowledge and as insurers become wise to these billing strategies, new combinations develop. Unbundling of services for billing can be very creative – we have seen examples where different provider names are used to bill for different parts of the service or where the timing of interventions is deliberately manipulated to make it appear that two services have taken place.

Because of the technical nature of this type of misbilling it is hard to explain to customers why a bill apparently within their insurance allowance has not been paid in full.

### ***Upcoding***

Upcoding is the use of codes designed for more complicated services than those actually being undertaken. Because what is billed is the right type of operation for the patients condition it is almost impossible to spot unless billing is examined over time and compared to other units. A small number of doctors have been suspended by the GMC for this type of billing, but this problem remains widespread.

### ***Misrepresentation***

Misrepresentation occurs where a completely inappropriate code is used – for example a cosmetic operation is performed (not covered by insurance) and billed using a code designed for an operation that is covered. We consider this to be fraudulent.

### ***Multiple procedures***

This is where more than one operation is performed at the same time. Usually these secondary operations are very minor such as the removal of a skin lesion or “manipulation of a joint under anaesthetic” but the primary purpose of the intervention is to create a multiple procedure benefit. AXA pay 25% uplift to the insurance benefit of the main procedure where a second procedure is performed and 40% when a third procedure is performed. AXA PPP receives many bills calculated using the AXA formula.

To illustrate this with a practical example, say a procedure is performed with a £2,000 benefit. Two additional procedures are then performed each of which would pay only £90 if done in isolation, yielding a total of £2,180 if invoiced separately. Using the AXA formula, however, a bill is raised for £2,800.

### ***Anaesthetic examples***

Bills from anaesthetists are particularly prone to creative billing and AXA PPP healthcare has had many disputes over the years with anaesthetists seeking to raise benefits by claiming for additional services. The service of anaesthesia comprises preoperative assessment, the anaesthetic and immediate postoperative care. A number of anaesthetists have sought to claim additional fees for parts of this service specifically charging extra for:

- Preoperative assessment – sometimes performed on a separate date or by a separate person
- Preoperative tests of fitness for anaesthesia.
- Provision of pain relief after surgery using nerve blocks or epidural injections
- Charging for routine postoperative care for example in a high dependency unit

In our view all of these “additional” services should form part of the general anaesthetic service.

### ***Multiple specialists***

A recent phenomenon is the increasing tendency for multiple doctors to perform operations. This results from three principal drivers

- (a) Best practice guidance
- (b) The shortened training period for consultants meaning some are unhappy undertaking some procedures alone
- (c) By choice or where a doctor cannot treat a patient but does not wish to forego his fee.

The use of multiple specialists is not per se a problem, but it becomes problematic when both seek to make a full charge as if each had performed the entire service himself.

## **16 Anaesthetist Groups**

### **16.1 Overview**

The Association of Anaesthetists of Great Britain & Ireland (“**AAGBI**”) estimate that there are 45 anaesthetic group practices.

AXA PPP is aware of a number of these. [REDACTED]

Insurers and customers have particular difficulties with fees from anaesthetists generally for the following reasons:

- Anaesthetists are chosen by the surgeon on behalf of customers.
- This is done without consideration of cost.
- The anaesthetists then claim a direct contractual relationship with customers. They may charge over the insurance benefits and ask for shortfalls to be paid by the customer personally.
- Customers often only meet anaesthetists on the day of surgery or at least the night before when they are effectively committed to incurring some costs.
- Customers faced with personal bills in these circumstances feel that they have been unfairly treated.

Historically anaesthetic group practices have caused additional difficulties for the following reasons:

- The tendency to set high charges.

- The tendency of some groups (X are notable examples) to charge more than the fees quoted to customers often adding “extra” services to the bill. These extra services which include things such as preoperative assessment or postoperative management are at least in our opinion part and parcel of the service of anaesthesia and not extra. Even if they were considered to be extra, being predictable, they should be included in the price. The decision as to what is included and what is extra is ultimately a matter of opinion, and one on which customers are not able to make an informed decision.
- The difficulty for customers and surgeons in obtaining alternatives as all group members use a common fee scale.

The AAGBI argue that anaesthetic groups benefit patients<sup>15</sup>. They cite the provision of 24 hour on-call cover, critical care support and links with the local NHS ITU. This is in our view, a disingenuous argument. It is essential that all private hospitals have 24 hour on-call cover and links to a proper ITU and as far as we know all hospitals whether or not they have an anaesthetic group have such an arrangement in place. It may well be the case that having a group facilitates this from an administrative point of view. However, the provision of on-call cover is ultimately only the agreement of an on-call rota and ITU transfer arrangements are usually achieved by a service level agreement with an appropriate ITU. It is not necessary to fix prices or control the supply of services in order to provide out of hours and emergency cover.

There are some subspecialties within anaesthesia most notably paediatrics, cardiothoracic and some neurosurgery where specialised training and experience over and above normal anaesthetic training is required. However, most private anaesthesia is straightforward and within the competence of any qualified anaesthetist. The service is fairly homogenous - what customers require is an anaesthetic which is safe, where co-existing medical conditions are managed properly and where adequate postoperative pain relief is provided. Because of the sheer number of anaesthetists, these services ought to be open to competition and the way in which local groups dominate a local area is a barrier to this occurring.

## 16.2 Case study: X Anaesthetists

AXA PPP has assessed one particular anaesthetic group: X Anaesthetists. Our findings can be summarised as follows.

- X Anaesthetists, a partnership, was formed in 2007. Fees increased generally when the group was formed.
- The partnership currently controls 93-96% of anaesthesia in the X area.
- When the partnership was formed, average anaesthetic charges in a sample of procedures checked generally rose, in one case by 34%, and there was marked fee convergence. Our correspondence files show that patients have been asked to pay shortfalls, that they were unable to obtain alternative anaesthetists, and that the group has been unwilling to negotiate with us or meet to discuss our concerns.
- Fees in a sample checked (relating to six common procedure types) were consistently higher than the national average, and over 20% higher in the case of hysteroscopy and knee replacement procedures.

<sup>15</sup> OFT submissions by these organisations.

**Table 7: Comparison of fees at X and the national average**

Procedure	National Average (£)	X Fee (£)	% difference
Cataract	X	X	14%
Lap chole	X	X	7%
Hysteroscopy	X	X	21%
Hernia	X	X	17%
Knee	<sup>16</sup> X	X	23%
Arthroscopy	X	X	4%

- The group provide an on-line quotation service but in some cases, for example in 50% of a sample of fees for knee replacement, the actual fee charged to AXA PPP policyholders was higher than that produced by the on-line quote system. The additional charges in these cases related to preoperative assessment. This is not a service which would result in additional insurance benefit.

### 16.3 Patient detriment

The position of a customer faced with an anaesthetist providing subcontract services is fundamentally unfair. These services are requested by the surgeon on their behalf without consideration of cost and there is no opportunity for customers to make a choice. There is a compelling argument that anaesthetic fees should be subsumed into the hospital or preferably the surgical fees as this would match the decision to commission the service with responsibility for the financial consequences of that decision.

Some anaesthetic groups act in a way so as to control the supply of anaesthetic services in a local market controlling the supply of anaesthetic services and fixing prices.

The AAGBI argue the benefits of anaesthetic groups in terms of providing emergency and on-call cover. This may be the case but the provision of emergency cover does not justify or require a group to control the supply of elective services or fix prices. There is no link between the two.

<sup>16</sup> For all procedures (other than knee), the mean, mode and median averages were identical. For knee, this is the median average (range of £X to £X ).

## F. INCENTIVES

### 17 Overview

AXA believes that there is a widespread culture of incentive payments made by PH providers to consultants, which distort competition and raise barriers to entry, as identified in the Issues Statement.

Patients put considerable trust in their doctors. The expectation is that a doctor will act entirely in the patient's interest. The importance of this position of trust drives many of the ethics of the practice of medicine dating at least as far back as Hippocrates. The current GMC guidance on good practice for doctors makes several statements on this issue under the heading of conflicts of interest. These are:

*"You must act in your patients' best interest when making referrals and when providing or arranging treatment or care. You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe for, treat or refer patients. You must not offer such inducements to colleagues"*<sup>17</sup>

*"If you have financial or commercial interests in an organisation to which you refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the healthcare purchaser"*<sup>18</sup>

The payments already admitted to the OFT by private health providers, and referred to in initial submissions to the CC appear to us to contravene good medical practice. For example, we note that the BMA submitted that "Indirect incentives such as free or discounted consultation rooms and free or discounted administration staff, are widespread in the market."<sup>19</sup> HCA stated "PH providers compete vigorously to attract and retain consultants and their ability to offer financial and non-financial incentives is part of the competitive process".<sup>20</sup>

We interpret these statements as revealing not only that these inducements occur, but also that they are endemic and considered part of business practice for some providers. We believe it is a worrying situation where both hospitals and doctors are engaged in practices which undermine or even destroy trust in them. We believe the inducements which are given to doctors in the private healthcare market include the following:

- (i) Free or discounted rooms;
- (ii) Purchase of leases from doctors in excess of £100K;
- (iii) Use of free or discounted equipment which doctors bill for;
- (iv) Transfer of doctor's staff to hospital payroll;

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<sup>17</sup> Paragraph 74 of the GMC's Good Medical Practice, available at [http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)

<sup>18</sup> Paragraph 75 of the GMC's Good Medical Practice, available at [http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)

<sup>19</sup> [http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/120517\\_bma\\_initial\\_submission.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/120517_bma_initial_submission.pdf)

<sup>20</sup> [http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/120509\\_hca\\_initial\\_submission\\_non\\_confidential.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/120509_hca_initial_submission_non_confidential.pdf)

- (v) Joint ventures set up between Consultants and  $\text{X}$  funded by  $\text{X}$  loans to the doctors (e.g.  $\text{X}$ );
- (vi) Free administrative services such as web design and marketing;
- (vii) Introduction to and payment for billing agencies who publicise that they will increase specialist income by 30%;
- (viii) Purchase of facilities to facilitate or protect referral into hospitals (diagnostic facilities and primary care/occupational health);
- (ix) Payment to doctors for each blood test or scan they order;
- (x) "Profit shares" (for increased billing and exclusivity); and
- (xi) Equity shares.

We believe that the primary motivation of such payments is to influence behaviour of doctors. We believe that incentives are intended to, and could successfully, encourage overtreatment, wastage of resources and commissioning of overpriced services. They could, in addition, if they become public also undermine public confidence in the industry. Members of the public assume, not unreasonably, that doctors, who occupy a position of special trust in society, will act without compromise in the interests of patients.

In the US, many of the incentives outlined above are illegal and have led to hefty fines. In 2003 HCA in US agreed to pay the US government \$1.7 billion in settlement for health care fraud it previously had admitted. \$900 million of this payment was for illegal kickbacks to doctors. The US Assistant Attorney General said in US government press release on these fines said:

*"Health care providers and professionals hold a public trust, and when that trust is violated by fraud and abuse of program funds, and by payment of kickbacks to the physicians on whom patients and the programs rely for uncompromised medical judgement, health care for all Americans suffers"*<sup>21</sup>

In the US, Federal government prohibits or restricts the referral of government-funded healthcare by doctors to facilities in which they have a financial interest. The reason for doing this is to remove incentives that increase cost.

Incentives are contrary to the General Medical Council's duties of a doctor but these are not being enforced effectively. We believe that doctors' decisions about where to refer should be made on the basis of patients' needs and assessment of cost and quality and that incentives and referral into units where doctors have a financial interest should for this reason not be permitted, consistent with the regulatory approach in the US. Certain of the incentives listed in points (i) – (xi) above are similar to the conduct which was classified as fraud in the US. Whatever other issues may arise, AXA PPP has concerns that the impact of these incentives on the market may be to restrict or distort the competitive process and we would invite the CC to investigate both the conduct and the likely market effects.

We have raised with the GMC during informal meetings the extent of incentives in the market. They invited us to forward particular cases if we had evidence but appeared reluctant to take on a general regulatory role in relation to incentives.

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<sup>21</sup> US Department of Justice Press Release: Largest Health Care Fraud Case in US History Settled; HCA Investigation Nets Record Total of \$1.7 billion. 26 June 2003.



## 18 [REDACTED]

- [REDACTED]

## 19 Further case studies

AXA PPP views specialist incentives as a serious distortion of competition. Since making our submissions to the OFT, we have conducted a further analysis of suspected incentives relating to X as follows:

- An investigation has been conducted into the practice of a Dr X who has extensive financial interests in X facilities. We are able to demonstrate some of his financial interests and have evidence that some patients have been referred from other hospitals against their wishes to obtain treatment at a higher cost at X facilities.
- As the provision of free accommodation seems to be a key incentive provided by X, we performed further work to try to further clarify the situation. Approximately 80 properties have been identified which are owned by X. While complete data regarding the use of these properties is unavailable to AXA PPP, a number of clinics have been discovered which we believe could be the recipients of incentives from X.

### **Dr X**

Dr X is a consultant cardiologist at the X Hospital. Dr X has extensive financial interests in X hospitals. He has been unwilling to discuss these but we know of the following:

- Dr X is a partner in a Limited Liability Partnership together with X Hospitals in an organisation known as the X Diagnostic Centre which provides diagnostic tests. This LLP has a number of physician shareholders and appears to be funded in part by a loan from X. [REDACTED].
- Dr X also runs a company known as X Limited which we have been told was set up to provide diagnostic cardiology tests at the X Hospital. Despite our meeting Dr X and asking him to clarify we are unable to understand the financial arrangement as we pay him personally, not X, for tests. [REDACTED]
- Dr X's secretary uses the address X for correspondence. Investigators visited this address and noted it to be a semi-detached residential-type building. A land registry search showed that this property is owned by X Ltd.

At the time of writing we do not know the nature of the financial relationship between Dr X and X, however the provision of the property is suggestive of the X "fully managed practice" arrangement whereby we believe doctors agree to refer patients to X hospitals and use X diagnostic facilities in return for free or discounted services which may include accommodation.

We are concerned that Dr X pressurises patients to use the X diagnostic facilities even when he is seeing them in the X Hospital where the same tests are available at lower cost. We have also noted that Dr X is associated in some way with 26% of patients admitted to the X in 2010 and 16% in 2011 and is the hospital's biggest admitter. [REDACTED] Patient A had an outpatient appointment at the X. She wished to have

tests carried out at X and was told by Dr X that she could not but had to go to his unit at the X. The tests were available at the X.

- Patient B was similarly seen at the X and then sent to the X for tests. Patient B was not offered a choice or told that the tests were available at the X which was local to her.
- Patient C asked to have his tests performed at the X and was told by Dr X's office he could not although this is untrue. Patient C was not told of Dr X's financial interest in the X.

The cardiac tests that these patients had – stress tests, echocardiography and ECG – are widely available across the UK. They are not specialised nor do they require special equipment or a particular expertise over and above what is widely available for their interpretation.

These tests are available at X and we can see no reason for patients to have to travel to the X causing them to suffer inconvenience and unnecessary costs, and we are concerned that the motivation for this is financial. [REDACTED]

Following an investigation into Dr X's billing, an agreement was reached with Dr X in January 2012 in which he agreed to give patients a choice about where tests were to be performed. The case of patient C occurred in May 2012 and it appears that this part of the agreement has not been adhered to, at least not in the case of Patient C.

[REDACTED]

## **20 A full investigation is required**

AXA PPP would urge the CC to conduct a full investigation of incentive arrangements between PH providers, specialists and GPs. In our view, such arrangements have the clear potential to distort competition to the detriment of patients by distorting choice and raising barriers to entry.

## **G. INFORMATION ISSUES**

### **21 Measuring the Quality of Healthcare**

For the market in healthcare to work efficiently it is recognised that there needs to be choice and information to support this choice. This information should include information on both the cost of providers and the quality of services they offer.

We agree with the CC's comment in the Issues Statement that the limited information available to patients may compromise the patient's ability to choose the best hospital or consultant for their condition, which may result in a number of adverse effects.

Measuring the quality of healthcare is elusive. There is no systematic collection of quality data and for many interventions, it is not clear what quality indicators could meaningfully be collected. Furthermore where the differences in outcomes are small the sample size in many cases needed to demonstrate quality is far greater than any individual's practice. Outcome measures are also heavily influenced by an individual doctor's case mix and the propensity to treat – for example a doctor who has a low threshold for treating simple cases may well look better than a doctor whose cases are more complex and whose threshold for operating is higher. There is often judgement made by doctors around whether there is a need to treat, a variety of treatments that could be offered, diseases vary in severity, individuals vary in their response to treatment and individuals vary in factors that may influence the outcome such as age/sex/co-morbidities and the benefits of a treatment may be small. By way of illustration evaluating whether a pharmaceutical works is relatively simple conceptually. However proving this requires large randomised trials costing millions of pounds. To prove that one doctor was offering better quality of outcome for a given problem would require a similarly impractical study. In many interventions it is unclear whether or which patients benefit from them and the extent of this benefit. A situation where this isn't known puts into perspective the challenge of distinguishing between individual doctors on quality of care.

With a lack of objective quantifiable measures of quality, reliance is placed on training and regulation of doctors. Training is long, competitive and subject to examination. Once a specialist is on the specialist register of the General Medical Council (GMC) they are expected to keep up to date and participate in audit. The GMC is currently working on the introduction of revalidation for doctors which is proposed to start in 2013.

The Care Quality Commission also sets minimum quality standards for clinics and hospitals and most doctors participate in process of clinical audit.

In markets consumers are ideally able to trade off cost and quality. In healthcare, in the absence of quality measures the choice of doctor is not subject to this. In fact perversely higher cost may be perceived as representing quality itself although it is our belief that there is no correlation between price and the quality or ability of a specialist.

The other source of information in this market is reputation or word of mouth. In the submissions to the OFT many doctors appeared to argue two conflicting positions. The first is that one can't measure the quality of doctors. The second is that choice of doctors had to be left to clinicians as they knew who the good doctors were. We believe the first proposition but not the second. Word of mouth, in an environment where it is not usually possible to causally link inputs (the treating doctor and treatment offered) to the outcome for the patient, cannot distinguish between doctors. It may be comforting to believe that

doctors do know this information but it is misplaced. There are sufficient examples of the failure of this information (e.g. ✕ and the) to show it is not reliable.

While we are therefore supportive of efforts to increase the amount and quality of information available to patients, and to AXA PPP, we do not believe that there are any straightforward solutions in this respect. Nor do we consider that information asymmetries are the only or main issue to be addressed in this market investigation.