



redefining / standards

16th April 2013

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Dear Christiane,

HCA's reply dated 22 February 2013

I am writing in connection with HCA's reply to our response to HCA's submission.

We believe that the points we have made in our response dated 15 November 2012 are clear and well founded, and in the interest of brevity we will not restate them here. However we wish to comment as follows on the small number of new points in HCA's reply.

Complexity coding

- Paragraph 3.17 refers to the agreement of CCSD codes and the relative complexity of treatments between interested parties. We have always been happy to co-operate with the coding aspect of this activity as it benefits all parties in the market, including customers, by making administrative processes easier. However, defining the *complexity level* ascribed to a particular new procedure will feed through directly into contracts between insurers and hospitals, and as such will automatically affect price. We are aware that the relative complexity of treatments is discussed and agreed by the Hospital Liaison Group – which comprises HCA, BMI, Ramsay Health Care, Nuffield Health, HMT, Spire Healthcare and NHS PPU. ⚡ Although AXA PPP adopts many of the classifications in practice, we have repeatedly refused to be bound by such classifications as they are so central to defining prices, which we negotiate separately with individual providers.
- The CCSD website notes that the OFT investigated the initial project work titled 'Relative Values Review'. 'The 'Relative Values Review' was made up of two components:
 - (1) Updated procedure codes and narratives.
 - (2) Relative complexities for each procedure for surgeons and anaesthetists.

The OFT advice was that the second component of the project only, relating to relative values should not be progressed.' See: <http://www.ccsd.org.uk/FAQ1>

- We have been concerned that, whilst not identical to the proposed Relative Values project for consultants, the discussion of complexity levels as described by HCA will have

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similar effects on the prices charged between hospitals and insurers. Specifically, it will fix the relative amounts charged for various procedures. We have not been a party to such discussions, and have raised our concerns about this in the past at the CCSD. We would recommend that the CC investigates this further with a view to determining its impact on competition.

Experimental treatments

- It is difficult for us to comment on the examples of experimental procedures that HCA appears to list, given the scale of the redaction in paragraphs 2.5 to 2.10. It would be helpful if those examples could be shared with us in order that we might be given the opportunity to respond. We do expect new treatments to be supported with evidence to prove that they are safe and effective before we will pay for them. We do not limit this evidence to experience in this country or require them to be current standard practice. As we have outlined previously this requires expert interpretation where we have strong experience. As noted in the attached article published recently in the BMJ, the benefits of new technology are not always clear-cut.
- Further, if it is possible to share the examples concerning Cyberknife which are redacted in paragraphs 2.35-2.37, we are very willing to share our decision-making rationale for these instances. As noted above our consistent approach to such cases is based on acceptance of high quality clinical evidence of efficacy; and such evidence changes over time. We are very concerned at the accusation that our processes result in patient detriment and would invite HCA to provide an instance where this has happened, especially bearing in mind that HCA and the consultants concerned are at all times responsible for the clinical management of these cases.

Multi Disciplinary Teams

- In paragraphs 2.30 and 2.31 HCA describes the group's use of a Multi Disciplinary Team ('MDT') to assess 'in detail' whether admission to the Cyberknife centre would be in the patient's best interest, based on clinical data. It adds that the 'majority of the MDT will not comprise members of the JV'. We note that HCA has acknowledged that it should be paying some regard to such conflicts of interest in their financial arrangements with specialists. We would highlight that we have sought to build on HCA's process to assist our decision-making and now routinely request copies of MDT meeting minutes to understand the clinical decision-making process and the conclusions reached. ✂
- ✂ In such cases we will ask for additional information and evidence of efficacy. The point we make is that the interweaving of commercial and clinical interests means that we are not completely assured that only the clinical interests are at play. We believe that more stringent arrangements should be in place. In particular we look forward to seeing whether HCA will put in place new rules to conform with the recently published GMC Guidance in this area, particularly Paragraph 79 which states that, in addition to declaring a conflict of interest, consultants should be prepared to step aside from decision-making. See: http://www.gmc-uk.org/Financial_and_commercial_arrangements_and_conflicts_of_interest.pdf_51462148.pdf

Other matters

- In paragraph 3.11 HCA refers to our index of prices. We highlight that our methodology adjusts for acuity and indeed shows higher prices in London. ✂

- In paragraph 4.6 we note that the National Audit Office report quoted by HCA considered the impact of the NHS contract launched in 2003 on private provision and concluded that the number of consultants undertaking private practice work 'has remained relatively stable'; the decrease in the number of consultants they refer to was by some 600 (or 3.6%) over 12 years, from 16,349 in 2000 to 15,754 in 2012. This was perceived to be a success of the new NHS contract implemented in 2003. We believe that the estimated numbers of consultants quoted by the NAO are understated. Our own records show a 3% increase in the number of consultants we paid in respect of the same period from 16,349 to 17,000.
- In paragraph 8.2 HCA says that both BUPA and AXA PPP have recently been making significant downward adjustments to their reimbursement rates. We would point out that as regards AXA PPP, HCA is incorrect. 3% In fact we have not reduced our published fee scale at all since it was first published in 2008. As noted in our earlier response for many years until 2011, we relied on a more general wording based on reasonable and customary fees charged in the market. Our approach, which has not been altered by the introduction of the AXA PPP fee schedule, has been to 3%. In June 2008, AXA PPP published a schedule of fees and billing principles and required all newly recognised specialists to bill at that level; in 2011 AXA PPP published a fee scale for all specialists. For the vast majority of customers (95% of bills) there is no shortfall on consultant fees. 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.

We would be happy to discuss the points above with you if useful.

Yours sincerely

Fergus Craig
Commercial Director