

Response from the AAGBI to the Competition Commission Private Healthcare Market Investigation Statement of Issues (July 2012)

The Association of Anaesthetists of Great Britain & Ireland (AAGBI) is a voluntary professional organisation with more than 10,000 members that represents the substantial majority of consultant anaesthetists, intensivists and pain physicians clinically active in both the private and NHS healthcare sectors in the UK. Its members comprise the largest consultant specialty group active in the private healthcare market in the UK. The primary objects of the organisation are safety, education and research, and it actively promotes its four key principles with regard to independent practice:

- Putting patient safety first
- Preserving clinical teamwork
- Providing transparent fee estimates and benefit levels
- Promoting fully informed patient choice

The Competition Commission (CC) has published a statement of issues regarding the Private Healthcare Market Investigation and has invited parties to comment on the key characteristics and resulting topics identified for investigation. References to paragraph numbers in this submission are to paragraphs in that issues statement.

This submission contains some general comments from the AAGBI. However, the AAGBI is keen to engage with the CC as soon as possible in detail on the issues that potentially affect anaesthetists, particularly the CC's second and fifth theories of harm.

Key Characteristics

Para 12. Patients will usually seek the advice of their GP to recommend both the private hospital and a specific specialist. In the absence of any alternative source of more objective advice, the GP is well placed to make recommendations based on an assessment of quality, from experience of previous patient outcomes from that specialist, both in the NHS and the private sector. These recommendations have the considerable merit of usually being devoid of any commercial interest. The same cannot be said for the alternative approach being adopted by Private Medical Insurers (PMIs), which bypass the independent opinion of the GP, for purely commercial reasons. The PMIs claim that their referral recommendations are made on the basis of quality outcome measures, but this data has not been presented or independently validated, despite repeated requests to do so. It may be that insurers are using nationally available outcome statistics through organisations such as Dr Foster.

The AAGBI considers that this data is not necessarily appropriate or robust enough to inform referral in the private healthcare sector. In this respect, it should be noted that patient satisfaction is generally found to be inadequate as a measure of quality. The main motivation for referral by PMIs is that the specialist agrees to charge according to the published insurance benefit maxima and this may not be in the best interest of patients if quality is not assured. The AAGBI requests that the CC challenge the insurers to justify their referral methodology and to prove that this is superior to the currently mainly anecdotal, but well informed opinion of GPs.

Para 13. It should be noted that BUPA and AXAPPP together have more than 65% of the PMI market share, which allows these two companies to exert considerable buying power and control on the market, with the potential to cause distortion. There are common policies that enhance this distortion, eg, restrictive "recognition" agreements with new consultants.

Para 14. The private institutions are becoming increasingly dependent on NHS revenue, with over 25% of income from this source [2]. As NHS tariff payments are considerably less than the insured reimbursement from the PMIs, the NHS patients are likely to represent more than 25% of total numbers treated in many private hospitals. This proportion is likely to grow, because of changes to

NHS commissioning arising from the Health and Social Care Act 2012. Therefore, the NHS is likely to exert considerable downward influence on the cost of private healthcare. The AAGBI agrees that the CC should investigate this influence further.

Market Definitions

Para 17. It should be noted that treatments are provided by a professional team, including for example, surgeon, anaesthetist, radiologist, pathologist, nurses, pharmacists and physiotherapists. All have an essential role in ensuring an optimal outcome. In the case of surgery, the surgeon is usually the primary reason a patient chooses a particular team and institution, even though the surgical outcome is dependent on the function of the team as whole. The surgeon usually chooses the team members and not the patient. This is particularly relevant to the choice of anaesthetist, although the patient could request another, or move to another surgical team in another institution if the choice of anaesthetist is a deciding factor.

The AAGBI notes that the anaesthetist is a crucial determinant of patient safety in the private sector, providing advanced resuscitation skills, intensive care and safe inter-hospital transfer when life threatening complications occur. This is taken for granted in NHS institutions, but is often poorly organised and regulated in the private sector. Anaesthetic groups provide 24/7 emergency cover, unlike individual practitioners.

Para 18. The PMIs often restrict patients' ability to consult widely from different specialist teams in different institutions regardless of geographic location. To some extent, therefore, local markets are created by the PMIs' administrative convenience rather than by market forces. If a PMI restricts such choice, the degree of such restriction should be clearly identified at the point of sale and the patient should be free to entirely fund or top up treatment costs if these are not covered by their insurer.

Theories of Harm

Paras 27-29. The AAGBI would like to engage with the CC as soon as possible on its second theory of harm. We believe that a thorough understanding of the competitive environment in which anaesthetists work, and in particular the benefits of anaesthetist groups, will lead the CC to conclude that the concerns in paragraphs 27-29 do not represent an adverse effect on competition in relation to anaesthetists. In this submission, the AAGBI will make some general points, but the AAGBI hopes to have the chance to explain in detail the competitive environment to the CC during the market investigation.

Para 27. The AAGBI believes that there are very few (if any) geographical areas in the United Kingdom where the local market power of consultants is relevant, in terms of higher costs and/or reduced quality of care. The vast majority of the country allows the patient a choice of several specialist teams and several hospitals within a reasonable travel time and specialists can and do travel to hospitals and treat patients with a base (e.g.) one hour or more away.

The OFT's market study report discusses a 30 minute drive time for assessing local markets, which the AAGBI believes exaggerates the market power of 'solus' hospitals. The AAGBI believes that the CC should look afresh at the issue of local market definition. The use of a 30 minute drive time seems to have been derived primarily from the approach taken by the OFT as part of its first phase merger assessments. It may have been an appropriate approach in the context of those specific merging parties and given the OFT's short timescales in merger cases, but the AAGBI believes the CC should revisit this issue in detail. The AAGBI believes that the definition of local geographic markets may be quite complex. For example:

- (a) Patients may sometimes be referred to a hospital close to their place of work rather than their home. These two locations may of course be some distance apart. The CC will therefore need to be careful when using a patient's home address as a basis for analysis.

- (b) It is far from clear to the AAGBI that the appropriate measure of a catchment area in this unique sector is the geographical area within which 80% of patients are located (the standard catchment area used in OFT first phase merger assessments).
- (c) PMIs frequently require patients to travel further than 30 minutes in order to visit one of the PMI's preferred hospitals.
- (d) As stated by the CC in its issues statement, patients may well be willing to travel different distances for different types of treatments.
- (e) The private healthcare sector, in common with many other sectors, provides fewer choices to patients living in rural areas, but it is not immediately clear to the AAGBI how this can be remedied. Also, a patient who lives in a rural area may in fact work in an urban area where choice may be greater.
- (f) As stated by the CC in its issues statement, the situation will obviously be different in different parts of the country. Some of the initial submissions published on the CC's website argue that London has some special characteristics, but it may be that other areas of the country also have some special characteristics.

Para 28. The AAGBI accepts that "the process for choosing anaesthetists for a patient *appears* to differ from that for other consultants". However, the AAGBI believes this to be a misunderstanding and an oversimplification of the clinical provider selection process. Consultant anaesthetists are chosen by the surgeon or physician in exactly the same way as he/she chooses to request the assistance of other specialists to treat the patient as part of the team, e.g. radiologist, cardiologist, pathologist, all of whom will make a charge for their services to the patient. This is in effect exactly the same as the GP who selects the surgeon on the basis of reputation and clinical ability – i.e. one clinician recommending to the patient the services of another. In addition, contrary to the assertion that anaesthetists are the only professional groups which set joint fees, the AAGBI can provide the CC with many examples of joint pricing by groups of surgeons, both in formal partnership arrangements and at the insistence of PMIs, as part of their restrictive "recognition" requirements.

Surgeons exert market power by engaging the services of other professionals on behalf of the patient, such as anaesthetists. However, the fees charged by surgeons and remunerated by insurance companies are two to three times that of anaesthetists for a similar duration of treatment. This is despite the fact that surgeons and anaesthetists are rewarded equally in other professional areas such as the NHS, the armed forces and legal services. The AAGBI suggests that paragraph 28 is extended to a fourth sub-paragraph (d) to address this issue.

Para 29. The use of the word *fees* in sub-paragraph (a) is confusing; *benefits towards payment of consultants' fees* would be more accurate.

Para 35. The AAGBI considers that it is important to recognise that most established consultants have a contract with the patient and not the PMI. As a result, the PMI reimburses the consultant on behalf of the patient. PMIs often encourage patients to believe that consultants are obliged to charge within the PMI's benefit maxima as this has commercial advantage. New consultants are being coerced to contract with the major PMIs in restrictive "recognition" agreements that discourage new entrants into the market, but the majority of consultants are not subject to any agreement with PMIs and have not entered into any negotiation with them.

The AAGBI considers that it is not for the PMI to decide whether or not a consultant should be permitted to practise medicine in a particular specialty – this is the remit of the GMC. The use of the word "recognition" by PMIs should therefore be limited, as it unreasonably suggests to patients that the PMI is acting as the regulator, when the meaning is actually that a financial contract exists between the PMI and the consultant. Consultants who do not wish to contract with the PMI are unfairly pressurised to do so, as to be not "recognised" implies that the quality of their practice is suspect. It is therefore suggested that the PMIs should use the following terms:

Recognised Consultants qualified to practise as determined by the GMC.

Benefit assured Consultants who have entered into an agreement with a PMI not to charge more than their published benefits.

Not benefit assured Consultants who have not entered into an agreement with a PMI not to charge more than their published benefits.

Para 36. Again, the use of the word *benefit* rather than *fees* would be helpful for the sake of clarity. The use of the word *overcharging* is unfortunate. If the CC means charging more than the benefits, this should not be called *overcharging*, particularly in an environment where PMIs are decreasing benefits. If defined in this way, a consultant could charge exactly the same fee for a procedure for twenty years, only to find that they are eventually '*overcharging*' because of reductions in PMI benefits. The AAGBI recommends the use of the following terms:

Benefit The amount that PMIs pay towards expenses such as consultants' fees.

Fee The amount actually charged by the consultant.

Insurance benefit shortfall The difference between the benefit and the fee when such exists.

Top-up fee The sum paid by the patient to the consultant to make good an insurance benefit shortfall.

The AAGBI believes that anaesthetic benefit maxima and resulting fees may well be too low in many cases (see also the comments above regarding paragraph 28). Ordinarily, low prices may be seen by the competition authorities as a desirable state of affairs. However, in the unique circumstances of the private healthcare sector, the AAGBI believes the CC will find that it leads to distortions of competition that do not benefit patients. The AAGBI agrees with the CC's fourth theory of harm as summarised in paragraph 37 of the issues statement, and the AAGBI would welcome the opportunity to explore this aspect in greater detail as the CC's market investigation progresses.

Para 44. The AAGBI asks the CC to investigate the incentive provided to surgeons by private hospitals in offering them substantially larger fees than other consultant groups for treating the NHS patients that the hospital has attracted in return for the surgeon's loyalty to that hospital in terms of continuing to bring insured patients to the hospital for treatment.

Paras 46-48. Consultants may wish to build a new private facility at their own expense, invest in or otherwise assist and encourage the development of local competition. Hospitals and hospital groups frequently state that practicing privileges will be withdrawn if a consultant assists the development of local competition and this is therefore a potential adverse effect on competition that should be investigated.

Para 51. The AAGBI would welcome the opportunity to engage with the CC on theory of harm 5(d), which is related to the second theory of harm (discussed above). Anaesthetic groups provide many significant advantages, both to ensuring patient safety 24/7 and promoting high standards of care. Indeed, it can be argued that the only solution to providing effective emergency cover for inpatients is by some form of group working. Another benefit of anaesthetic groups is the ability to cover colleague's lists, offering patients more choice with their preferred anaesthetist.

Patients have the choice of different anaesthetists if , and indeed have the ability to cover each other's clinical lists providing patients with a choice of which anaesthetist they would wish to go.

Confidentiality

This submission contains no commercially sensitive material within the meaning in Part 9 of the Enterprise Act 2002. The CC may publish it in full if it wishes to do so.

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2. Laing & Buisson, *Laing's Healthcare Market Review 2011/2012* – published January 2012 (NHS outsourcing of primary care services – current demands/future trends) <http://www.laingbuisson.co.uk/MarketReports/AboutourReports.aspx> (accessed 20/7/12)

The NHS Information Centre (but not current)

www.ic.nhs.uk/services/independent-sector-information-programme (accessed 20/7/12)