



Competition Commission Private Healthcare Market Investigation

Response to the Annotated Issues
Statement – Redacted Version

Aviva Health

March 2013



1. Introduction

- Aviva Health welcomes the Competition Commission's ("CC") continued investigation into the private healthcare ("PH") market. We will continue to engage with the CC to support this investigation. We are broadly supportive of the CC's findings which are set out in the Annotated Issues Statement ("AIS"). In this response we will provide our view on the CC's current thinking on each of the theories of harm laid out in the AIS. We also wish to highlight a few areas where we submit new information and evidence.
- We wish to submit new evidence with respect to theories of harm 1, 3 and 6. Specifically, we wish to elaborate on our experience in the London market, provide additional examples of where hospital operators have exercised market power in negotiating with Aviva and put forward our suggestions of information that is required to mitigate the effect of information asymmetries.

2. Responses to the theories of harm

2.1 Theory of Harm 1

Local Market Power of Hospitals

- Broadly we are in agreement with the findings of the CC so far in connection with the market power of hospital operators in certain local areas. The CC's findings that there are a number of hospitals of potential concern accord with our experience.
- Aviva Health believes that a thorough analysis of the level of competition between hospitals in a given geographic area needs to be done at the specialism or even sub-specialism level. We strongly believe that aggregating specialities together will overstate the level of competition in a given geographic area by incorrectly identifying hospitals that act as a competitive constraint on hospitals of concern, or failing to identify all hospitals of concern.
- The CC appears to rely on supply side substitution as part of its rationale for aggregating clusters of treatments together. In other words, if private hospitals are able to switch between providing different specialities in a short time period without undertaking significant additional investment, it is likely that the competitive constraints acting upon these specialities are similar. Therefore these specialities can be aggregated together for the purpose of conducting a competitive analysis. However, the CC needs to explore the extent to which supply side substitution is actually possible between specialities; in particular, the CC must consider the time and investments required for hospital operators to substitute between specialities given that it may require bringing in specialised staff and equipment. In the absence of compelling evidence of supply side substitution, the CC should conduct its analysis at the specialism and sub-specialism level.

London Market

- Aviva Health is particularly concerned about the market power of HCA hospitals in London. HCA accounts for over 70% of Aviva Health's spend in central London and owns 6 out of 9 private London hospitals. We are charged significantly higher prices for treatments at HCA compared with other private London facilities (see Appendix A). We have little alternative but to pay these higher prices. Our 9 largest corporate clients in London have all either selected a product allowing access to our Extended List or chosen to include HCA on their tailored network. HCA's market power has a negative financial impact on insured customers as we are forced to pass along HCA's higher prices and annual, above-inflation price increases to our customers, in the form of higher premiums.

- HCA has cited numerous investments that it has made to justify the premium prices it charges to insurers such as Aviva Health. However, HCA has put forward no evidence that investments it has made in its hospitals have resulted in better outcomes for patients. Indeed, there is no evidence that investments made by HCA are driven by customer demand as one would expect to see in a competitive market. [↗]
- As a vertically integrated hospital operator, HCA may also be using its control of key inputs such as diagnostic centres, GPs and primary care facilities to channel customers to HCA hospitals in a way that forecloses competitors and maintains its market power. Vertical integration has the potential to create pro-competitive efficiencies that may benefit customers. However, when vertically integrated firms have market power, there is the potential for anti-competitive foreclosure to occur which would limit customer choice and act as a barrier to entry. We do not believe that vertical integration in this specific context is driven by a desire to deliver benefits to customers. Rather we believe that it is motivated by a desire on the part of HCA to strengthen their market power. The CC's preliminary analysis suggests that HCA may have market power in London and therefore the CC should investigate the extent to which it has the power to foreclose competitors and potential competitors.

2.2 Theory of Harm 2

Market power of consultants along the pathway

- Aviva Health agrees with the CC's position that some anaesthetist groups appear likely to have market power and we welcome the findings of case studies that the CC is conducting in this area. We would also encourage the CC to investigate the impact of groups of consultants in other specialisms.
- We are concerned by the CC's statement in its annotated issue statement that *'In relation to the conduct of consultants acting individually, we have not received evidence of any harm to competition.'* In our response to the issues statement we put forward our view that consultants exercising market power over patients was a feature of the market as a whole, and not just specific to certain areas or the behaviour of consultant groups.¹ The GP referral is critical for a patient's choice of consultant – around 80% of Aviva patients are referred to a named consultant – but GPs lack comparable information on the cost and quality of alternative consultants, and fees are rarely discussed with patients.² Following this initial referral, patients are very unlikely to switch consultants, even when their consultant advises them that they charge fees above the fee limit set by the patient's insurer.
- We urge the CC to further consider the link between the lack of comparable information on the cost and quality of consultants available to patients and GPs, and the nature of competition between consultants to secure patient referrals from GPs.

2.3 Theory of Harm 3

Market power of hospital operators in their negotiations with insurers

- Aviva Health agrees with the CC that large hospital groups have market power in some negotiations with insurers.
- This has been further demonstrated in two examples of recent negotiations with hospital groups:
 - **Contract negotiations with [↗]**
 - **Contract negotiations with [↗]**

¹ See paragraph 5.3.1 of Aviva's Response to Statement of Issues.

² Only 10% of GPs discussed fees with patients when making a referral to a named consultant (see GHK, 2013, *Private Healthcare Market Investigation: Surveys of GPs and Consultants*)

- Paragraph 89 of the AIS discusses countervailing buyer power of PMIs. We anticipate that Aviva Health's experience in negotiating with hospital groups will be different from the experiences of the 2 larger PMI providers. As was demonstrated through the examples from our response to the issues statement, the threat of 'delisting' a hospital is less credible from a PMI provider of our size³. We are also unable to secure the same volume discounts as larger insurers and we believe that any assessment of the way hospital groups can negotiate with insurers must consider volume discounts. Our experience of negotiations with hospital groups is that they are not attempting to win business from us by demonstrating innovation, improved efficiency or improved services but rather they know we have little choice but to contract with them. As a result our main focus in contract negotiations is to minimise the level of annual price increases.

2.4 Theory of Harm 4

- Aviva Health agrees with the CC's position that insurer action to influence the choice of consultant or to limit the fees charged may be the only constraint on the fees charged to insured patients. Similarly, we agree that buyer power exerted by insurers is likely to lead to lower prices for customers and that insurers do not have incentives to reduce prices to such an extent that there would be an inadequate supply of consultants.
- We agree with the CC's position that insurer action to either influence choice of consultant or limit fees charged can be an important constraint on fees charged to insured customers.
- We would like to draw the CC's attention to the following points in relation to fees charged by consultants:
 - **A significant proportion of invoices we receive contain charges at rates over and above the fee schedule:** In 2010 over 17% of consultants invoiced us for an amount or amounts exceeding fee schedule limits.
 - **Over a third of consultant income derives from services not constrained by fee schedules in any event:** In 2011 over 35% of fees paid to consultants were for things other than the actual surgical procedure (such as consultations, sample collections, day patient stays) which means that over one third of the income that consultants earn from our fees is not subject to fee schedule limits. As we discussed with you at our hearing, fees for these services are not constrained and consultants have considerable latitude over the volume of these services they deliver. We therefore urge the CC to consider total incomes earned by consultants rather than fee schedule limits.
 - **Fees paid to specialists have remained a consistent proportion of the total spend over time³.**

2.5 Theory of Harm 5

Barriers to Entry

- Aviva Health agrees that there may be barriers to entry into the private healthcare market which reduce competition, particularly resulting from the following instances:
 - where hospital groups negotiate with insurers on a national basis and leverage the power of their must have facilities to secure recognition – and therefore patient volumes – for all of their facilities; and
 - where there are relationships between hospital operators and consultants or GPs that restrict patient choice and competition.

³ See example in paragraphs 5.2.4 to 5.2.8 of Aviva's Response to Statement of Issues.

- As stated in reference to theory of harm 1 above, the vertical relationships between HCA and various diagnostic centres, GPs and primary care facilities in London have the potential to act as a barrier to entry by foreclosing the market to new entrants.

2.6 Theory of Harm 6

Information

- Aviva Health agrees that there is a clear asymmetry between the patient and the provider as regards the appropriateness, quality and price of various treatment options that may be available to the patient. We agree that this asymmetry restricts the patient's (as well as the GP and PMIs) ability to make an informed choice about the most appropriate hospital/consultant for their condition and distorts competition.
- The nature of health care is such that the information is often complex. This was discussed in relation to both hospitals and consultants during the OFT market study at two roundtable events including a wide range of stakeholders.⁴ Despite this we believe that it is possible to provide more information that patients are able to use as part of their informed choice:
 - Outcome and process measures relating to treatments conducted should be made directly available to patients and to other relevant bodies (for example PMIs) which can then be interpreted and conveyed to patients.
 - Hospitals and consultants should make their charges for a private patient first consultation more widely available so that patients know this – and can compare fees – prior to consultation, including any incentive payments that would arise.
 - Consultants should be obliged to provide a fee estimate at or soon after first consultation in order to show an indicative price for treatment.
- Aviva Health has previously submitted a more detailed discussion of the types of data that should be available and how they would be used in our response to the Market Questionnaire.⁵ These types of data will need to be presented to patients in way or ways that they can meaningfully understand and are also required by PMIs to manage relationships with hospitals and consultants to secure customer benefit. Our negotiations with hospital groups currently focus around annual price increases with little mention of service improvement, improved innovation or efficiency. The absence of information relating to costs hinders negotiation and highlights a lack of focus on improving service or efficiency.

Overtreatment

- The findings of the CC are that the PH market is characterised by information asymmetries. These may affect competition at several points in a patient's healthcare journey but in particular at the point of referral from the GP to a consultant. The choice of consultant is typically made with reference to the GP's recommendation although the GP has incomplete information on which to make that recommendation. Once the choice of consultant has been made other aspects of the healthcare journey are effectively decided and further choice, such as hospital, are foreclosed.
- The incentives to over investigate and over treat are well described in many healthcare systems including the NHS and it is interesting to note that when additional information is provided to patients their choices are different. Shared decision-making is not only seen as an ethical imperative but also reduces unwanted variation in clinical practice leading to better outcomes⁶. Evidence also shows that when presented with information 20% of patients choose a less invasive surgical option than those not given the information.⁷

⁴ OFT Private Healthcare Market Study consultation paper December 2011, Annex B

⁵ Aviva Health Market Questionnaire q 54.

⁶ Making shared decision making a reality: No decision about me, without me, Coulter & Collins 2011, published by The Kings Fund.

⁷ Shared Decision Making to Improve Care and Reduce Costs. Lee & Emanuel. N Engl J Med. 2013 Jan 3;368(1):6

Aviva Health's own experience suggests that overtreatment may also be taking place in the private healthcare market.⁸

- Whilst there is a theoretical risk that PMIs will seek to encourage under treatment we do not believe that this is a serious threat. The nature of the PMI product and market is that it seeks to provide customers with a sufficiently attractive benefit that is differentiated from the services available from the NHS. In order for PMIs to demonstrate the value of the product we need to, as a minimum, show customers that they are attaining a good clinical outcome. Under treatment will not achieve this and will be recognised by customers who will then no longer purchase our product.

2.7 Theory of Harm 7

- We share the CC's concern that ownership by a hospital group of primary care and/or outpatient diagnostic centres might lead to foreclosed referral pathways or to unnecessary testing or treatment. This will restrict choice and distort incentives and potentially create barriers to entry. Although, there can be benefits to vertical integration in terms of delivering a seamless treatment pathway, these benefits are more dependent on patient information flows across providers rather than through formal integration of providers at different levels. On the basis that vertical integration is not necessary to deliver benefits, we are concerned about the negative impact it has on our customers through reduced choice and competition, and we worry about the market power it confers upon providers.
- As stated above, Aviva Health believes this is a particular issue in London where HCA have acquired, or entered into arrangements with Primary Care providers including GPs who are engaged directly by corporates in London.

3. Close

Aviva Health welcomes the opportunity to continue to work with the CC throughout this investigation.

⁸ See the example of variation in use of general anaesthetic for cataract surgery at paragraphs 5.3.10 to 5.3.13 of Aviva's Response to the Statement of Issues

