COMPETITION COMMISSION
PRIVATE HEALTHCARE MARKET INVESTIGATION

Response To Annotated Issues Statement Published 28 February 2013

PRUHEALTH INSURANCE

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We have reviewed the Annotated Issues Statement (and appendices) and offer some comments by referencing to:

33. With regard to medical specialty:

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(a) We have identified 16 specialties that are offered by the vast majority of general private hospitals and PPUs in the competitor set defined in paragraph 32(c).[12] We have considered these specialties together.

(b) Oncology is offered by a lower proportion of general private hospitals and PPUs in the competitor set defined in paragraph 32(c), but it represents a significant share of patient admissions and revenue. We have therefore, where possible, considered it separately (see Annex 1 to Appendix B on local competition).

We may look at other specialties and would welcome evidence on which we should consider.

Two specialties that get hidden in the analysis are Pathologists and Radiologists. They maybe employed or 'retained' by the hospital and paid on a fee per test basis for reporting services to deliver this 'investigation' service. Their professional fees are not transparent to the market and their role in delivering clinically appropriate and cost-effective healthcare is often hidden from the customer. For hospitalised treatments, the Hospital invoices for all pathology and radiology charges and the customer and or the payer often has little means to verify that the principal treating consultant did in fact order the necessary investigations.

81. We would welcome further evidence on the behaviour of these, and any other price-setting, consultant groups.

Attached is a 'limited' analysis from one book of our business, i.e. excluding ex Standard Life data that compares the anaesthetic tariff of solo to group practices to some common occurring procedures:

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Average cost comparison

Procedure code	Procedure	Events Solo	Group	Average Anaesthetist charge Solo	Group	Solo/Group
W8500	Multiple arthroscopic operation on knee (including meniscectomy, chondroplasty, drilling or microfracture)	363	93	Deleted		95%
Q3800	Laparoscopy and therapeutic procedures including laser,diathermy and destruction e.g.endometriosis,adhesiolysis,tubal surgery	151	13			98%
W8200	Arthroscopic meniscectomy (including debridement)	119	31			92%
W7420	Autograft anterior cruciate ligament reconstruction	85	18			100%
C7122	Phakoemulsification of lens with implant - unilateral	139	11			106%
Q1800	Hysteroscopy including biopsy, dilation, curettage and polypectomy	193	28			93%
F0910	Surgical removal of impacted/buried tooth/teeth	146	22			103%
J1830	Laparoscopic cholecystectomy	71	18			100%
A5770	Facet joint injection (under x-ray control with sedation/G.A.) - 6 joints	114	12			140%
W3712	Primary total hip replacement with or without cement	68	18			103%
Weighted average		1449	264			95%

Solo practice is 5% cheaper than group practice on a weighted average. The costs for most of the high volume procedures is very similar, except for A5770 where solo is actually more expensive on average.

Group anaesthetic practices may deliver improved social value in their continued availability for example surgical complications and hence justifying their higher charges. The issue of group practices should include whether they serve as a barrier to entry for solo consultants and this should not be restricted to anaesthetists as applies to all consultant groups.

144. We would be concerned if in addition we identified financial or other incentives designed to capitalize or exploit the asymmetry, for example by private hospital providers offering incentives to consultants to perform additional tests or procedures at their facilities.

One is never sure if these type of statements are driven by fact or urban legend. Whilst I may advocate that we should not be legislating or regulating doctors financial interests in treatment facilities, a level of responsibility to protect the consumer, needs to lie with the consultant body to control/manage the consultant outliers who may engage in perverse incentives. The key issue that has been identified in managing perverse incentives is information asymmetry. In other

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private healthcare markets consultants have used diagnostic coding (such as ICD10) to justify/defend their utilisation of investigations or frequency of procedures driven by patient factors.

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