

## PRIVATE HEALTHCARE MARKET INVESTIGATION

### Summary of hearing with Aviva held on 24 October 2013

#### Divestment remedies

##### *Central London*

1. Aviva was of the view that there needed to be three separate hospital operators in central London to make a competitive market. It considered that enabling three providers to operate in central London would overall be more important in ensuring genuine competition, than the individual sites to be divested.
2. Aviva expressed some concerns about HCA's control over patient pathways as a result of its vertical integration strategies, in particular as a result of its share of consulting rooms, outpatient and diagnostic centres in central London. It was concerned that even if some HCA hospitals were to be divested to alternative providers, it might still have a significant influence over patient pathways.
3. Aviva considered that there needed to be a balance between the synergies generated by common ownership of multiple hospitals and providing customers with an appropriate level of choice. Aviva did not think it could offer its customers that choice in central London currently. If there were three competitors in central London, Aviva would be able to deliver a 'tiered proposition', in particular to its corporate customers, whereby it could demonstrate a differential in service between suppliers and would be able to price this accordingly.
4. Aviva believed there would be buyers interested in acquiring any hospitals divested in central London, including existing hospital operators in the UK as well as potentially overseas-based buyers. Aviva would be concerned if the acquisition of a particular hospital would provide a buyer with a dominant position in a particular area. Aviva would prefer any sites sold to be acquired by different buyers.

##### *Outside central London*

5. Aviva was supportive of the Competition Commission's (CC's) proposed remedy of divestments outside of central London. It considered that divestment of facilities to new operators would create more competition and hopefully generate lower prices.
6. Aviva agreed that divestments in solus markets would not be an effective remedy as it would merely substitute one owner for another and therefore would not make a difference to competition in the local market. Aviva hoped that over time, in light of the other remedies proposed by the CC, it would be able to make solus markets work.
7. Aviva believed there would be buyers interested in acquiring hospitals in some areas outside of central London, but thought it might be more difficult to find purchasers in some areas, based on demand, capacity and whether certain hospitals were specialists in an area. Aviva was not in favour of hospitals being sold as a package to a single buyer, particularly if that buyer was one of the existing hospital groups. It considered that having more hospital operators in those areas would be a better outcome.

## **Tying and bundling**

8. Aviva supported both tying and bundling remedies proposed by the CC. In particular, it was in favour of proposing a local and geographic-based approach to pricing negotiation with hospital operators. It saw this as having an advantage to the market and to Aviva's customers. It considered that in order to future-proof this remedy it should be applied consistently across all hospital groups, not just towards particular local markets.
9. Aviva was of the view that this remedy should be tied to another behavioural remedy concerning the provision of information on service, so that private medical insurers (PMIs) were not only able to negotiate on price.
10. Aviva considered that remedy 2(a) (which proposed to restrict the ability of BMI, HCA and Spire to change their national prices if a PMI changed its network policy) would need to be monitored and enforced structurally through a contract between the PMI and the hospital operator.
11. In terms of remedy 2(b) (which proposed that BMI, HCA and Spire price their hospitals separately), Aviva noted that this remedy presented a challenge to Aviva as most of its customers were corporate customers and therefore it needed to achieve some form of UK coverage. For a consumer offering, it might be able to benefit from local pricing and lower pricing in some areas. However, Aviva needed to have a proposition for corporate customers who had employees located across the UK.
12. Aviva believed that the CC's proposed remedies in relation to tying and bundling were a positive step, because they would move power away from the major hospital groups and the market would benefit from this. However, scale was still going to be important to PMIs in their negotiations with hospital groups.

## **Restriction on expansion of hospital operators into private patient units**

13. Aviva was supportive of the CC's proposed remedy that hospital operators in solus and duopoly areas should be restricted from operating a private patient unit (PPU) in those regions. If the CC did not have this remedy, it considered that there was a risk that a more dominant local provider would be created. However, Aviva noted that in some areas PPUs might be effective competitors against private hospitals, but in other areas they might not be.

## **Consultant incentives**

14. Aviva was opposed to any incentive schemes that influenced the patient pathway. In its view, payment of direct financial rewards by hospital operators to consultants for volumes of patients or value of business referred to a facility should not be allowed. It considered there was a level of incentive, such as a Christmas present or gift, which did not need to be prevented, but should be recorded.
15. Aviva did not think it was necessary to impose a complete ban on consultants taking equity shares or financial interests in hospitals. It considered that equity schemes could have benefits, because they provided the consultant with an interest in making sure that the hospital was operating effectively, growing the hospital business, attracting customers and competing effectively. Where consultants wanted to develop and grow a service to patients, they would be prepared to invest in the facility and buy the equity at a fair market value. However, Aviva considered it would

be difficult to demonstrate that a consultant had the right incentive in directing patients to a facility where their share was gifted to them by the hospital operator.

16. Aviva considered it important that consultants disclosed to their patients why they had recommended that they were treated at one hospital over another, as well as any information about their financial interests in a particular facility.
17. In terms of consultants holding equity stakes in particular pieces of equipment, Aviva considered that there needed to be some controls put in place around authorizing treatment. There was evidence in the USA that doctors who owned scanners completed more scans. Specific legislation and rules had been put in place in the USA to counter some of these issues.
18. The mechanisms for enforcing any ban on the direct payment of incentives to consultants were already in place through the good practice guidance administered by the General Medical Council, however, there was currently limited policing of these issues. Aviva suggested that hospital or facility operators should be required to disclose where they had made direct payments to consultants practising at their facilities and there would need to be sanctions in place for a failure to disclose. Financial penalties could be imposed on hospital operators that were found to be offering incentives that influenced consultants' treatment choices.

## **Information remedies**

### ***Consultant quality***

19. Aviva supported the CC's recommendation around making information available on consultant quality across the UK. However, it considered that the information on consultant quality currently published by NHS England was not extensive enough. There was quite limited information available on individual consultants, in particular in a form which could be understood and made use of by a layperson.
20. In Aviva's experience, patients were not typically interested in information on infection rates, death, or those types of rare occurrences, as safety was assumed. A patient would want to know primarily what difference a treatment was going to make on their life, whether they would be in more or less pain following treatment, how long it would take them to recover with a particular surgeon and when they would be able to resume their normal level of activity, in order to compare different surgeons. The information collected by NHS England at the moment was only a small step along this pathway.
21. Aviva was fully supportive of there being an independent body to collect, oversee and develop consultant quality information for the private healthcare industry. Aviva considered that the CC needed to expand the nature of the Private Healthcare Information Network (PHIN) which was currently owned by the major hospital groups. Aviva would like to see cross-industry ownership or influence on the PHIN board, with representation by PMIs and consultant bodies. Aviva thought this would deliver a far richer and long-term solution for providing information about consultant quality.
22. Aviva considered that there needed to be some form of remedy around enforcing the publishing of data on consultant quality, to ensure the industry was actually getting data out of hospitals and consultants. The data collected across the industry also needed to be consistent.

## ***Consultant fees***

23. Aviva was supportive of any remedies which required consultants to inform patients in advance of the fees for treatment, but it had some reservations about requiring the publication of consultant fee information due to concerns it might lead to upward pressure on fees. Aviva said that patients currently used pricing information as a proxy for quality, in the absence of other suitable information. It was concerned that if consultants had access to information on what other consultants were charging, and their nearest competitor was charging a higher fee, a consultant might wish to increase their prices to counter any perception that they were of a lower quality.
24. In Aviva's experience, patients often picked consultants who were more expensive in the belief that they were of a better quality. It considered that the consultant quality remedy was important and needed to be tied directly with any remedies around consultant fees.
25. Aviva suggested that the CC should require consultants to be open and transparent about their standard costs for procedures at the outset of treatment. It suggested that moving to an episode-cost-type situation and transparency of those costs would be a step forward for the industry.

## ***Private hospital information***

26. Aviva was in support of there being more information made available and better collection methods on quality and outcome data for hospitals. It considered that cross-industry participation was required to determine what information should be collected. More information needed to be collected about the patient condition as well as the treatments being used for those conditions.
27. Aviva noted that PHIN was currently creating data which concerned primarily when things went wrong in the hospital setting, but considered that PHIN was missing the collection of clinical-outcome based data which addressed whether the treatments undertaken were making life better for patients. It likened this to Patient Reported Outcomes Measures (PROMs) data which was collected for the NHS.
28. Aviva said that the private healthcare industry was currently using a consistent set of coding called Clinical Coding and Schedule Development (CCSD) coding. This was an improvement from the industry position eight to ten years ago where providers each used their own codes. Aviva was becoming increasingly of the view that the private healthcare industry needed to move away from CCSD coding and considered adopting OPCS coding which was used by the NHS. This would enable comparisons between NHS and private hospital performance, particularly if PPU's were expected to take a greater role in the future in providing private healthcare.
29. Having access to patients' NHS numbers would allow the industry to track a patient if they moved between the NHS and private healthcare systems. At the moment without access to the NHS number, there was no way of tracking what an individual patient's experience was. However, there were a range of confidentiality issues surrounding the private healthcare industry gaining access to NHS numbers.
30. Aviva considered that patients generally desired the following indicators in terms of private hospital quality: information on whether they would be safe at a particular facility; information on the clinical experience (ie PROMs-style data) and information on actual hospital experiences of patients. Aviva did only routinely collect this type of information for specific services and conducted questionnaires or surveys for a limited number of its corporate customers along with receiving any complaints from

its members about their hospital experiences. Aviva suggested the reason why it had not traditionally collected this information was because PMIs had not exerted a significant amount of control over the patient pathway, in terms of where patients were treated or what consultant they saw.

31. Aviva believed that there was a role for an independent body to have responsibility for collecting data for the private healthcare industry and considered that PHIN was making some headway in this space. However, it reiterated that PHIN required more cross-industry representation in order to be fully effective.

### **Accounting of hospital operators' costs**

32. Aviva proposed an alternative remedy to the CC, which involved requiring some form of open-book accounting by hospital operators to justify the costs of procedures. Aviva suggested that this remedy would address concerns in solus hospital areas, as PMIs could determine whether prices in these markets were reasonable. In Aviva's experience, hospital operators were very closed in sharing any detail about how their prices were set and how their costs were reflected in negotiations. It suggested that hospital operators move to an open-book accounting process, rather than simply informing PMIs that the cost of a procedure would increase by a certain percentage without any details.
33. Aviva said that hospital operators typically applied a mark-up on their costs of procurement from third parties (eg for items such as prosthetics and tests), but PMIs currently had no sight of those procurement costs. Being able to understand hospital operators' costs would mean that hospital operators would need to become more competitive and consider their expenses in approaching price increases with PMIs. Aviva suggested that this remedy could be enforced contractually between hospital operators and PMIs.