

## PRIVATE HEALTHCARE MARKET INVESTIGATION

### Summary of hearing with PHIN held on 6 November 2013

#### Background

1. PHIN (the Private Healthcare Information Network) was an independent, not-for-profit company limited by guarantee, without shareholding. PHIN's main objective was to collect data from its member organizations and publish it as comparative information to help patients make a more informed choice of hospital provider, as well as hoping to improve the quality of service offered by the hospitals and consultants.
2. PHIN currently received and displayed data from around 194 independent hospitals and clinics across 11 member organizations, with a further seven organizations in the process of becoming members. The current membership covered all of the major private hospital groups.
3. Although the NHS had not chosen to publish the data for its PPU's, PHIN did collect the data and was keen to discuss the possibility of publication with the NHS in the near future.

#### Overview of the PHIN project

4. PHIN's main source of data was an organization called Healthcode. Healthcode collected and translated private patient records for the private hospital system into something similar to 'Hospital Episode Statistics' (HES) which were collected by NHS England. Healthcode was responsible for ensuring that the data it collected reached PHIN's specified standards and mapped it to the OPCS coding used by the NHS.
5. Northgate, PHIN's principal information supplier, processed data collected by Healthcode and HES data for NHS patients into one database, and produced for each given hospital what it called 'Independent Hospital Episode Statistics' (IHES). PHIN supplemented this with third-party data including patient reported outcome measures (PROMs) data from the Health and Social Care Information Centre (HSCIC), National Joint Registry information and infections data from Public Health England. PHIN then took responsibility for publishing this data on its website and producing analytics. Northgate was also producing a system for PHIN that would enable providers to check their data online, subject to agreeing to the principle of volume transparency; otherwise the system would need to be redeveloped.
6. PHIN's service covered around 1 million patient episodes (approximately 650,000 privately-funded and 350,000 NHS-funded) a year from around 200 independent hospitals.
7. PHIN's website was launched in April 2013, and its main function was to allow patients to search by hospital, procedure or area. It had comparative data on, for example, the activity level, the volume of procedures being undertaken and length of stay.
8. PHIN held and produced a range of additional data which was not currently available to hospital operators. PHIN had built the IHES system in order to allow hospital operators to check their own data. PHIN was currently working through some issues that its provider group had identified regarding volume transparency. In NHS HES

data, providers could access explicit patient volumes by procedure and by hospital, however, in the private healthcare sector, this sort of information had always been considered commercially sensitive, confidential information. PHIN's Members were currently debating whether volume information could or should be published for private patient volumes, setting aside commercial concerns. HSCIC had recently given PHIN permission to identify consultants within the HES data, and once it provided this data to PHIN, it would enable it to publish the whole practice for a consultant. Such quality data would be beneficial to both the doctors, who could use it for revalidation purposes (in particular with the GMC) and the patients.

9. PHIN were keen to expand their data set and work was already underway to publish information on activity levels, length of stay, day-case rates and PROMs for hips and knees. It also thought it important to collect a broader more basic range of data, for example patients' NHS numbers, readmissions, transfers and mortality rates. Unfortunately, PHIN was dependent on other parties to collect or agree to release the data. It was important to note that public bodies were not funded or mandated to do any work as regard private patients.
10. The issue of integrating price and quality remained a matter to be kept under review. Self-pay pricing was currently done through individual providers on their websites, whereas quality information was being produced centrally. There was a good argument for bringing those two together in some forum so that patients could review price and quality together and locate value propositions in one place.
11. PHIN had little sight of outpatient data in private healthcare, a situation complicated by the fact that there were a lot of private clinics where consultants saw patients outside of the hospital. In many cases the patient pathway could be complex with patients being treated in more than one hospital.
12. It was important to get private providers or private patients to do routine diagnostic coding so that case-mix adjustments (for example, which take into account the complexity of a consultant's practice) could help to create a proper comparator of performance between consultants.
13. PHIN was aware that some stages of a patients' treatment could be missed and not reported, due to a lack of distinct coding at particular stages of treatment. This was particularly apparent in cancer patients. PHIN was currently working with the National Cancer Registration Service (NCRS) to ensure that PHIN was recording stages of procedures correctly. It also hoped to receive some private patient staging information from NCRS to include in its data for quality measures. This work was at an early stage.
14. PHIN told us about a recent NHS consultation document which outlined the move from collecting HES data to care episode statistics. This new dataset would look at the whole patient journey, including any multiple interactions. It would be imperative for the private healthcare world to play its part in providing matching data, ensuring that the whole patient journey was recorded.

### **Improvements to data collection and presentation**

15. PHIN believed it was important that data was published in the public domain. Not only was it good for patients, but it also helped encourage consultants and hospitals to perform better. However, PHIN was of the opinion that more could be done to present data in a way which was meaningful to patients.

16. PHIN felt that the outcome data currently collected was very limited and should be expanded to include patient-reported outcome data and data outlining patients' experience in hospital.
17. Ideally, PHIN would welcome the chance to collect outcome measures for all procedures; however, concentrating on high-volume procedures was more practical because of data validity issues. Collecting data for low-volume procedures was more difficult. The principal issue was achieving comparability and making sure the correct method of obtaining results was adopted.
18. There were various tools available that PHIN could implement relatively quickly to start collecting generic, high-level outcome measures scores for nearly all procedures. However, a common standard and approach to how data was collected and how things were measured needed to be adopted, rather than competing to own the tool of measurement. This was something that the hospital providers were in agreement with.
19. PHIN was in favour of moving towards the NHS's method of collecting and cataloging data, which was using the OPCS coding system. It believed that this was becoming a more pressing matter, driven by the foreseeable need to be able to contribute to patient-centered information from a range of care settings, in NHS formats. To move forward PHIN would require in-system changes both from providers and from insurers in order to cope with a different system of coding. It would not be a small undertaking and would need to be carefully planned to ensure it was carried out correctly.
20. Hospitals which carried out a mix of NHS and private work currently had dual coding systems.

### **Consultants and quality information**

21. One of PHIN's aims for 2014 involved working towards publishing aggregated data on private and public work by individual consultants. This information would be available not only to the consultants but to the general public. However, further investigation was required into the quality of the data in terms of consultant pooling and attribution. PHIN expected that future NHS data would start recording the surgeon, consultant and anaesthetist separately, which would help provide more accurate data.
22. From a patient's point of view, quality rested more on the consultant than on the hospital quality of outcome. However, to look at outcome measures, it was important to consider the case mix adjustment in order to do a fair comparison between the hospital and the consultants.
23. Although insurers had a duty for safety and quality, they took a somewhat narrow view in determining recognition or non-recognition. This had led to tension between consultants and insurers. In particular, PMIs seemed to make decisions on recognition based on the use of proprietary and incomplete information, not available for checking or challenge by the subjects of that information. PHIN considered that if such decisions were based on transparent, open and shared information such as that which PHIN could produce, open to challenge by consultants, then that might increase confidence in directed referral and recognition processes.
24. PHIN hoped to expand its information base so that it had sufficient scope, breadth and credibility to enable it to become a resource for the private healthcare sector and

act as cement which could bring the sector together, rather than in any way deepening the divisions.

## **Consultant fees**

25. PHIN was not currently working on the publication of consultant fees, although it did believe that there should be a resource in private healthcare where a patient could see specific relevant information on all the charges and quality measures that applied for a hospital and/or consultant, or any other factors that were relevant. This information did not necessarily need to be published on PHIN's website, but it was happy to play a role in developing the idea.
26. PHIN supported the idea of publishing outpatient consultation charges and considered it should not be difficult for consultants to provide information about what a patient should expect to be charged for a consultation. However, beyond that consultation, it would be more complicated to provide information about fees, since a consultant might refer a patient to two or three different environments for diagnostic testing of different sorts and any surgery may be performed in various environments where charges may vary. Up front publication of indicative fees is achievable, but complicated to produce reliably.
27. PHIN conducted a pricing exercise with the hospitals earlier in the year. This had included a representative consultant price, which involved a whole package of care price and representative consultant fee for that hospital. All of those pricings were on the respective hospitals websites and caveated by stating that 'it may be that if you go to a particular consultant that consultant charges more'.
28. PHIN felt consultants should be able to forewarn patients of extra charges for procedures or treatments at the outset. However, it believed that there would be reluctance from consultants to identify sufficient normal or standard pathways that would allow a patient to get a decent grasp on costs in a comparable form, because it would be too complex and quite individual to a lot of consultants.
29. The publication of consultant fees could lead to an increase in prices. People would use price as a proxy for quality and with 80 per cent of the private patient being insured, so not paying the price, the public would look at self-pay prices and use that as a proxy for quality.
30. Consultants should find it relatively easy to provide a tight range of charges for less complex procedures, for example, cataract operations; however, the more complicated a procedure became, for example heart surgery, the more difficult it would be to provide a range of charges.

## **Governance**

31. PHIN was aware of concerns about its financing background and the impact it had on the independence of PHIN. The hospital providers had invested simply because they recognized the work had to be done. However, PHIN was keen to broaden its membership and was holding initial conversations with a number of insurers who were interested in what PHIN was doing.
32. PHIN's long-term objectives could only be achieved if the insurers signed up. Among the hospital operators which were PHIN's existing members, the general feeling was in favour of creating a platform that was demonstrable and credible before broadening the membership and potentially complicating things.

33. PHIN hoped to be in a position to formally invite insurers to become members during the early part of next year. If everybody came on board PHIN could become a sector-wide central information provider, providing a good cross-sector service. PHIN cautioned that it was important for insurers to recognize and at least initiate membership conversations with PHIN within the timeframe of the CC's investigation: it would be potentially harmful if insurers were still at arm's length when the investigation closed, potentially seeing information availability as an issue only for hospitals and consultants rather than one in which their participation was essential.
34. PHIN believed that Bupa's database, which it used to refer patients to consultants, should be transparent and available for its patients to see, or better yet that Bupa should rely on PHIN's common and open information resource (acknowledging that this had not been available to date). Bupa's model of sector leadership had always been a pioneering model, leading by example and extending competitive advantage, rather than a collaborative or paternal model of leadership that might move the whole sector. Going forward PHIN felt that a different mode was required. One which would bring everybody together, ensuring the flow and exchange of information. It had more value if it was the same type of information, and had a common language that could be used everywhere.
35. As part of its governance PHIN had approached both the HSCIC and the Care Quality Commission with a request for them to contribute a non-executive director; however, both companies had been unable to do so, because any individual they would make available would be conflicted. PHIN was currently considering alternative options such as an advisory panel or organizational directorships.
36. PHIN would be happy to be tied in to any CC remedies, because it was keen to be a productive player in the development in the market. One of the easiest remedies would be to require the hospital providers to provide more information.
37. Before PHIN was constituted and still in its preparatory stage, it expressed a view that to help meet the costs of running PHIN, the ultimate aim should be to have joint funding between insurers and patients, which should be paid for by the insurer and the provider. Self-pay patients should be funded for by the provider. To run PHIN it roughly cost £1.50 for every private patient and 50p for every NHS patient.
38. To expand and take on extra tasks, including joining insurers, adding services for doctors, diagnostic coding and collecting PROMs-style data, PHIN would require additional funding in the short term. There was significant scope for improving the information and the service through these extensions. However, PHIN was conscious of adding unnecessary additive costs, which would end up on the patient's bill. In the longer term there were only so many patients and so many measures that could be applied, so eventually funding requirements would stabilize or reduce.
39. Although PHIN did not believe it would be practical to allow consultants to become members, engaging with consultants could be carried out through their employer organizations and the providers. It was essential that consultants felt that they had an adequate voice and were represented, this could come through representation on PHIN's board. One possibility was to involve the consultant representative bodies.
40. PHIN believed that the NHS commissioners, such as the Clinical Commissioning Groups (CCGs) would be interested in the collaboration of information, since they were trying to service and assess the needs of the local population and then commission for it. The private sector and what it did was very relevant to that. CCGs had already expressed an interest in NHS-funded patients. The Department of Health was also interested in gaining a better understanding of the overall sector.