

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with PruHealth held on 30 September 2013

Lack of information

1. PruHealth believed that the lack of information for both patients and private medical insurers (PMIs) was an inherent failing of the market. There was no information for patients and consumer groups to help them make an informed choice when choosing a consultant for a particular course of treatment. This had been largely driven historically through blind trust in consultants, working on the presumption that UK consultants were well-trained. There was a stringent regulation and revalidation process which gave the customer comfort.
2. Unfortunately private healthcare providers tended to publish only high-level quality information that was difficult for the consumer to interpret. The data of value to a patient, for example statistics on a particular consultant, was not currently available.
3. As an insurer, PruHealth required a level of data which enabled it to make comparisons between providers in order to judge their cost-effectiveness. There was a need for a proper coding structure which would help identify when a hospital provider was overcharging, over-treating or over-servicing. Again this sort of data was not available. If the proper data was provided then PruHealth could set up condition-specific networks that would enable it to direct patients to the most cost-effective, highly-valued consultant or hospital.
4. PruHealth identified running patient surveys, collecting hospital data and customer feedback as ways of collecting the type of data it required. Some of this information was already being collected by the Private Healthcare Information Network (PHIN) project, but more data on patient outcomes or customer feedback could be collected. Collected data should be centralized.

GPs

5. GPs had little input on what happened in the private sector. There was no exchange of feedback between the GP and the private sector. A patient's past medical history, previous operations etc were not always forwarded when a patient was referred. However, PruHealth believed that it would be a great benefit to have access to electronic patient records.

Treatment pricing

6. There were two elements to establishing a reference price for a particular treatment. First, consultant tariffs should be set as a benchmark. Second, economic principles should be drawn up from which prices could be calculated, in particular pertaining to high-cost technologies and high-cost drugs, where there was an open, transparent process in the way a price was calculated, excluding the mark-up. The PMI would then decide the mark-up which should be applied for a particular geographical region. The difficult part was deciding if the mark-up should be different.
7. Transparency on pricing was currently lacking in the market. South Africa was an example of where transparency had been achieved. The hospitals, consultants and insurers had panel meetings once a year to discuss new technologies and average

pricing. These were then reviewed every third year to assess how efficiencies had changed. If utilization had decreased, prices were reviewed in order to pay off costs.

8. Although the National Institute for Health and Care Excellence (NICE) offered guidance for the healthcare market, PruHealth had been told that going forward NICE was going to do very little about cost-effectiveness. This would leave a gap in the market that needed to be filled.

Divestitures

9. PruHealth was not wholly convinced that divestiture was a necessary remedy and suggested that any divestiture should only be approached as a two-phase option. First, the provider should be corrected and required to cease any bad behaviours. If things did not improve then divestiture should be imposed and preferably to a new entrant.

Central London

10. PruHealth did not necessarily believe that the sale of one or more of HCA's hospitals would exert downward pressure on prices and in all likelihood a new entrant would charge the same as HCA. PruHealth also noted that if a London hospital was operating at full capacity, and did not have any spare beds, it would not have the incentive to lower its prices.
11. One problem which needed to be addressed was the 'embedded behaviours' of some hospital staff and consultants who practised medicine in hospitals in both private and NHS practices and drove up the final cost of treatments. PruHealth suggested that these behaviours could be addressed by limiting incentives paid to consultants.

Outside of London

12. There were two main differences in the market outside of London when compared with the market in central London. First there was a national tariff which PruHealth paid to hospital operators, and embedded in that was the inefficiencies over costing. PruHealth was not aware of any evidence to suggest that there was any upward pressure on prices as a result of the dominance of hospital operators in certain important geographical areas and any such impact on the prices would be diluted.
13. It was PruHealth's view that international hospital groups could be interested in entering the UK market, should the Competition Commission (CC) pursue divestitures outside of central London.

Private Patient Units

14. PruHealth raised some concerns about HCA owned and operated private patient units (PPUs). In particular, PruHealth queried the economics behind HCA purchasing a PPU from the state which had a different cost base and imposing its standard tariff. For example, HCA's tariff was based on the cost of delivering a service and among other things included its purchase price of property, upkeep and maintenance, staff costs and pension within that cost. Purchasing a PPU could not be compared as like-for-like. First because PPUs did not offer the full range of services, and they had a different cost structure, offering insurers a 10 per cent discount of tariff. Costs were

traditionally one-third lower prior to being privatized. There was also a certain amount of over-utilization of services, for example pathology and radiology.

15. Imperial College Trust and the Royal Marsden were examples of PPU's that had set their private tariffs in a transparent manner.
16. PruHealth did not believe that PPU's could be wholly effective competitors to private healthcare providers within central London, although they could be with regards to certain complex treatments for conditions and specific procedures, for example cancer, but were unlikely to be effective competitors outside of central London.
17. PruHealth currently recognized all hospitals that provided acute services that were covered by its insurance policies, but there might be some hospitals or clinics that were not recognized because they provided services that could not be claimed on PMI. Although PruHealth currently did not use delisting as a negotiating tool with hospital operators, if hospital data were to become more readily available and it then became apparent that a hospital was low quality, it could delist it. Any hospital delisting should be based on cost-ineffectiveness, poor quality or over-utilization.

Behavioural remedies

18. When asked about the remedy proposed by the CC—which related to preventing major hospital operators raising prices nationally in the case of a PMI operator removing one or more of their hospitals from its networks, or add a competitor's hospital to its network—PruHealth was of the view that an adjudicator or other enforcement mechanism would not be necessary.
19. With regard to efficiency analysis and case mix comparison, in order to determine which hospitals were operating inefficiently, PruHealth told us that a number of the larger hospitals had agreed to supply it with data relating to diagnostic coding. Having access to this data would supplement the majority of the CC's proposed remedies, and might even replace some of them.

Hospital pricing

20. PruHealth believed that the CC's proposed remedy requiring each hospital to offer independent pricing was impractical and would be onerous on the parties. However, pricing discounts should be based on efficiency analysis. If information was more readily available PruHealth would be in a position to compare, challenge and defend tariffs with particular hospital groups as a whole, as opposed to a hospital-by-hospital basis.

Clinician incentives

21. PruHealth did not raise concerns about clinicians having equity shares in a hospital, if their interest was clearly recorded, fair and open. PruHealth believed it was for the insurer to prove whether a clinician was over-servicing and/or over-utilizing because of a vested interest in a particular hospital. With the correct coding that was achievable.
22. PruHealth believed that a strong regulatory body, such as the General Medical Council (GMC), should be responsible for regulating whether consultants might be over-servicing because of their interest in a hospital. PruHealth suggested that there would need to be additional legal panels within the GMC to monitor and judge what

was considered to be acceptable. Data analysis would need to be undertaken elsewhere and made available to the GMC.

23. PruHealth considered that consultants' holding equity shares in equipment could be a problem, as they might provide consultants with the incentives to increase prices and/or over-utilize the equipment. However, if the data was available insurers could monitor where the equipment was being used by consultants appropriately.
24. PruHealth pointed out that there were areas where a certain level of understanding and training was required in order to use certain pieces of equipment. With a greater number of technical experts being located in London, utilization might be much higher in London than for the same piece of equipment in, say, Bournemouth. However, it did not necessarily mean that in London consultants were overusing the equipment and in Bournemouth were not.
25. Whether a consultant was over-utilizing equipment would need to be evaluated in each individual case. Some individuals might be enthusiastic to use a particular piece of new kit, for example a CyberKnife as opposed to alternative clinical means, so it would be quite hard to identify over-serving from overenthusiasm. However, with the correct information base it would be possible for a regulator to come to correct decisions. PruHealth felt that before an individual case reached the regulators' attention it should be considered by the appropriate professional body, for example the Orthopaedic Society or Oncology Society. The GMC already set out the code of practice of what was acceptable. Any breach of this code, if exposed, would be reported to the GMC.
26. This remedy should apply not only to hospitals but to diagnostic clinics, laboratories etc. Wherever there was a case to be made for potential over-utilization of servicing, PruHealth believed there should be rules and processes in place.

Consultant fees information

27. PruHealth had concerns that the publication of fee information might result in upward pressure on prices, rather than the opposite. This had happened in the South African healthcare market when fees were initially published. It believed that once a tariff was set, everybody would view that as a minimum charge and aspire to earn that.
28. PruHealth told us that some consultants were charging as much as £1,500 per hour. Consumers needed protection from such charges and unless price caps were set, it believed there needed to be some degree of regulation. PruHealth did not believe in allowing its customers to pay top-up fees and would rather derecognize a consultant.

Private hospital information

29. PruHealth believed it was worth PMIs exploring the idea of contributing to the funding of either PHIN or a similar regulatory body that was given enforcement powers in the market, since much of the benefits were going to accrue to the PMIs and their customers.
30. To ensure that PHIN worked for the future, it was important to develop a robust set of data that gave patients the ability to look at something and interpret it for their benefit, and not the benefit of PMIs or hospitals. PMIs would see the benefit of participating in the development of the information data.

Coding

31. Steps were being taken to update the current coding system known as CCSD. These codes were just procedural-based and provided no knowledge about consultations, how long the consultation had taken and whether the consultation was complex. New pathology codes were expected in January with others to follow. PruHealth considered that the current CCSD codes should not be owned only by the insuring industry, but have stakeholders such as hospital operators and consultants included.