PRUHEALTH

COMPETITION COMMISSION
PRIVATE HEALTHCARE MARKET INVESTIGATION

Response to Notice of Possible Remedies under rule 11
Published 28th August 2013

PRUHEALTH INSURANCE

September 2013

20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

Possible remedies on which views are sought

Price control (14)

General commentary
Alternative solutions to price control

PruHealth does support the view that price controls may well result in unintended consequences. The main areas of uncontrolled costs are in hospital charge-master items that mainly focus on level of mark-ups for drugs and appliances/prosthesis, and the pricing of pathology and radiology tests. These fees/mark-ups are often over inflated and do not reflect the cost of providing the service. Often the rationale used for these charge-master price settings is that other areas of the tariff are inadequately priced. However PruHealth firmly believes that a price must be reflective of the cost incurred in delivering a service together with a reasonable profit margin, and that there should be limited cross subsidy of one service type by another. There are an increasing number of hospital invoices where the costs of pathology and radiology account for more than 50% of the total hospital invoice and is indicative of overcharging in this area to subsidise the charges from other areas. The complexity in the UK private healthcare market is that hospitals invoice for the investigations and payers having no line of sight or confidence that the investigation was indeed ordered or even if appropriate, and compounded in that the treating consultant often has no record in their medical notes of recording the investigation request or frequency of the investigation.

We propose that a consideration is made on how equipment charges are reimbursed. This would define the reference price (not tariff) for pathology and radiology investigations. The reference price needs to be based on the purchase cost of the equipment/reagent, leasing/depreciation costs over 7 years, insurance costs, maintenance costs and a defined utilisation rate.

Structural remedies
General considerations regarding divestiture remedy options (26)

In reviewing the proposed structural remedies, it is very difficult for PruHealth to comment on either the appropriateness or potential impact without sight of the proposed divestiture.

At our hearing we advised that we did not believe that competition outside of London caused us any adverse effect. It is however of concern that any proposed divestment would adversely affect us to the extent that it unnecessarily disrupts the existing structure of supply in particular geographic areas (currently unknown) which we believe currently works effectively and to the advantage of PruHealth and our customers.

Paragraph 10(a) of the 'Notice of possible remedies under Rule 11….' requires any remedy option to be effective in achieving its legitimate aim – but in this instance it is difficult for PruHealth to assess without understanding the geography of the proposed divestitures.

We therefore respectfully request that the detail of the proposed divestments is also shared with us, as the change in structure may well work to the advantage of the dominant PMI (Bupa & AXA PPP), but not to others, putting others (including PruHealth) at a further disadvantage, as a result of the undue influence that the larger insurers have on the function and structure of the market.

20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

- **Issues for comment 1, central London (Page 6)**

(a) ***Would divestiture remedy address the adverse effect on competition (AEC) in central London effectively and comprehensively?***
PruHealth remains ambivalent as to whether HCA's divestment of one of more of its' private hospitals would benefit the market. Many of the HCA identified hospitals operate in an area of a duopoly with another independent hospital within easy drive time, example Princess Grace and London Clinic. The exception is the London Bridge Hospital which would maintain solus market power irrespective of the owner and this would further be affected by the 'ownership' of the Guys NHS PPU. Our key concern is the 'administration owner' of London based PPU's. Since HCA assumed responsibility for the UCLH PPU, treatment costs have escalated and largely driven by pathology costs as these costs are now charged against the HCA charge-master. The alternative remedy is to change the reimbursement model along the lines described in the paragraph on Price Control above.

(b) ***Are there suitable purchasers available with the appropriate expertise, commitment and financial resources to operate and develop the divestiture business as an effective competitor without creating further competition concerns? Would the remedy be effective only of the entire package were divested to a single owner or would ownership of the divested business by two or more purchasers address the AEC effectively?***
Entry costs to the market are significant so a successful sale is likely to be to an existing provider, otherwise sale to a new entrant would be high risk due to the funding, and market expertise required to successfully run an operation. In the event of a divestment, we believe it would be highly likely that the new individual single owner would simply pick up the existing HCA tariff and associated billing practices, so divestment alone would not address the fundamental issues of utilisation and pricing, as the behaviour are embedded and intrinsic to the operating model of the facility. A group purchase of all of the HCA divestiture identified hospitals would be presumed to balance the competition but remain concerned that the status quo of costs charged would merely be replicated by the new purchaser.

(c) ***Would a divestiture remedy on its won be sufficient to address the AEC or would additional measures be required to ensure a comprehensive solution?***
Divestment per se is not the solution – it's the embedded behaviours of hospital staff, and consultants whose practice varies between hospitals and between private and NHS practices, which drives the final cost of treatments. If the perverse incentives to admit patients are removed, and consultant performance (for which efficiency) is incentivised then there should be a paradigm shift in charging practices. By way of example if the London Clinic and Princess Grace

20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

had to adhere to the same ground-rules of not offering perverse consultant incentives then the consultant choice as to which hospital facility they would prefer to hold admitting privileges would be driven by hospital quality and treatment facilities offered.

This opens the debate on alternative reimbursement models, and reimbursement by Diagnostic Related Grouping (DRG), is one of them. The DRG enables efficiency analysis between those hospitals owned by a single party and reflects the differences in costs of treatments when case-mix adjusted (to allow for like for like comparisons). This would clearly identify which of the individual HCA hospitals is cost-inefficient/treatment ineffective and driven by over-utilisation/over-servicing for a Diagnostic Related Group of procedures when compared to its peer hospitals. This assists insurers to claw back monies paid to inefficient hospitals and rewarding those hospitals that are cost efficient/effective but this would have no benefit to the self-pay customer who would have no means of identifying the cost-ineffective/treatment ineffective hospital. The solution for the self-pay customer is a degree of price control on pathology and radiology as previously stated.

(d) ***Are there other assets or businesses, besides hospitals and their out-patient facilities, which would be necessary or appropriate to include within a divestiture package?***

For any divestment programme to be effective it should extend across the whole of the estate, including consulting rooms, pathology laboratories, radiology services. However as stated above it is believed that a simplistic divestment programme would be insufficient to influence the charging profiles and practices of admitting consultants, or the staff employed within the units themselves. The concern of joint ventures between NHS and private hospital groups to administer their PPU's has been discussed previously and the impact that the significant increase in treatment costs has on the consumer. In the main the private hospital tariff is used for the NHS PPU despite significant reduced cost exposure to buildings and infrastructure, sharing the facilities of the NHS for critical care units/ theatre facilities and investigation facilities and different staff and pension costs.

(e) ***Would divestiture of an HCA hospital or hospitals and /or other assets confer market power on the acquirer?***

As above it is unlikely that the divestment programme would significantly change the profile of charges incurred, nor indeed significantly reduce the baseline tariff. What is called for is a radical overhaul of the charges/tariff so that prices reflect the costs incurred in providing services. It is reasonable that there is a differential in prices within the central London market, when compared to the rest of the country, but the pricing differentials must be transparent and reflective of the cost of providing services.

With divestiture of the HCA group of hospitals there is a risk to HCA that the acquirer could achieve significant market power as HCA historically have destroyed value relationship with insurers and a reaction could be to try and exclude all of their remaining hospitals from any insurer hospital network

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

(provided their remains enough of hospital distribution footprint in the London geographical area). The divestiture of the London Bridge Hospital (or more importantly whoever has ownership of this hospital – albeit HCA) would maintain market dominance in the London market unless Guys NHS PPU becomes more competitive or there is a new entrant into this geographical area.

(f) ***How long should HCA be given to effect the sale of the divestiture package?***
6 months is an unrealistic timescale for a divestment programme – a period of 12 – 18 months being more realistic.

(g) ***What are the relevant costs and benefits that we should take into account in considering the proportionality of the divestiture options?***
No comment

(h) ***Are there other remedies that would be as effective in remedying the AEC that would be less costly or intrusive?***
As described previously fundamental change in reimbursement model, and the restriction on HCA of acquiring or managing any new facilities, including NHS management contracts in the central London area. We propose that any current management of London PPU facilities is removed.

- **Issues for comment 1, outside central London – (Page 7)**

(a) ***Would divestiture remedy address the AEC effectively and comprehensively?***
Very difficult for us to comment on this as we do not have line of sight of the proposed changes. We have some concerns that enforced divestment of facilities could result in the reduction of patient choice, and costs increase in remaining facilities.
As stated above PruHealth did not express concerns about the structure and functioning of the market outside of London. It seems that the change in structure is at the behest ad design of the two largest insurers, and we do not believe this to be equitable or in the markets best interest, as the unplanned consequences may be in the short – medium term to reduce the range of available facilities.

(b) ***Are there suitable purchasers available with the appropriate expertise, commitment and financial resources to operate and develop the divestiture business as an effective competitor without creating further competition concerns?***
We have no line of sight of availability funding for new entrants, it is likely that purchasers will come from existing providers in the market, and that the issue with true competition will continue

(c) – (h) inclusive as per London market commentary

20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

- **Behavioural Remedies**
  Issues for comment 2a, preventing tying or bundling (Page 9). The aim of the remedy is to prevent Spire, BMI and HCA from using their market power in certain local areas

(a) ***Would this remedy be effective? Would hospital operators be able to deter PMI's from removing hospitals from their network or recognising a local rival in ways other than by raising or threatening to raise process in response?***
The remedy proposal to prevent a hospital provider from raising its prices nationally if a PMI changed its network policy, or reduced patient volumes to the affected group of hospitals by insurers directing away from cost/treatment-ineffective hospital facilities, is a welcome measure. The private healthcare market has remained flat for over a decade and few hospital operators have accepted any responsibility for growing or sustaining the insured market. This is a price sensitive market and the rising cost of healthcare has directly impacted on premium and therefore the number of insured lives. Hospital groups have to take ownership for cost-inefficient and inappropriate treatment practices' by their consultants and the levels of hospital charges for mark-ups, pathology and radiology. The hospital providers have historically focused on balancing their profit return to that of previous years. Insured lives have reduced or at best remained static and hospital occupancy levels continue to decline, aggravated by low theatre efficiency. The continued response by hospital groups is to increase prices and penalise the insurer for any decrease in admission volumes or costs of treatment.
The response by Hospitals to prevent insurers from delisting a local hospital should be to improve the range of services offered, deliver better quality and more cost-effective healthcare than its rival. Within the hospital group those identified individual hospitals that are shown to have significantly higher costs (due to over-servicing and not by recognised patient or surgical complexity/complications) and poor treatment outcomes (as reported on standardised quality measures) would serve as justification to delist and the insurer should not face punitive national increases for their other listed hospitals.

(b) ***How quickly would this remedy come into effect? Would it be necessary to wait until existing contracts with PMI's had come to an end to implement it or could this process be accelerated, and if so, how?***
PruHealth would expect any changes to come into effect at the end of an existing contract, unless it was determined that any of the clauses within the existing contracts were 'illegal' due arising from unfair terms coming to light in the new environment. If any quality issues are identified an insurer should have the right to immediately delist the affected hospital without any punitive increases in national tariffs.

(c) ***Is the remedy reasonable? Might a hospital operator have appropriate grounds for seeking a price increase from a PMI in the event that it***

20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

reduced the amount of business it did with the operator?

If there is justification as to why the insurer has delisted the hospital group or its individual hospitals in specific geographical areas then price increases are not warranted. With improved bill audit, management of consultant outliers and case management of complex cases the incomes paid to hospitals should be reduced. The continual argument by hospital providers that as their income has decreased they need to raise prices is false economy. The market is changing with ever increasing day-case surgeries and home-based care replacing in-patient admissions impacting on hospitals pricing models/ revenue streams and as such they need to drive innovation to improve their inefficiencies to drive profitability and not be reliant on just increasing their tariffs with insurers or self-pay customers to balance the books. There is always a risk that a hospital operator would attempt to recover lost income through its pricing agreements. However in the ARM scenario, if rewards were offered for improved performance then hospitals could be incentivised to improve the overall efficiency of their units, and share in a performance risk model of reimbursement, as happens elsewhere in the world.

(d) ***Would it be necessary to provide for continuous monitoring of the remedy and/or to establish a mechanism for adjudication in the event of disputes?***

We would expect that any remedy would be supported by individual contract terms with hospitals/suppliers, including for example clauses which allow – or do not unreasonable prohibit the changing of any hospital network membership.

In the event of an alternative reimbursement model being in place, a style of which exists in NHS agreements with the private sector, then performance standards are defined in the supporting contracts, and the terms enforceable in commercial law.

It is not believed that any ‘additional’ legislation is required, as unfair contract terms, are addressed under existing legislation – other than perhaps to define what constitutes an unfair or anti-competitive contract term in the healthcare sector.

(e) ***What other measures would be necessary to prevent circumvention of the objectives of this remedy?***

Efficiency analysis and case-mix comparison is reliant on diagnostic coding. The private healthcare market has been relatively protected from patient severity as by far the majority of surgical case admissions are relatively healthy or controlled on medication. However to truly compare apples with apples diagnostic coding is necessary to enable the hospital group to defend their cost position or patient outcomes data on quality. We are aware that a number of hospital groups are in the process of providing ICD-10 coding information for all customer admissions/treatments.

20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

- **Behavioural Remedies**
  Issues for comment 2 b, preventing tying or bundling (Page 9-10). This remedy would require BMI, Spire and HCA to offer and price their hospitals separately and individually to PMI's

(a) ***Would this remedy be practical? Would the scale and complexity of negotiating process on an individual hospital basis be sustainable?***
One could individually price hospitals, use a national tariff (as is our current practice), use a national tariff with a percentage discount off the national tariff for individual hospitals within the hospital group (which perform poorly or wish to drive customer volumes in competitive areas) or to use the alternative method of reimbursement such as the DRG model as discussed previously.
The proposed remedy of BMI, Spire & HCA pricing their hospitals separately to PMI's would result in a series of individual tariffs all of which would have to be loaded and maintained on claims adjudication systems. The number of tariffs to be negotiated maintained and updated for PruHealth would increase from 3, to c 125, for these three groups alone. The introduction of multiple tariff negotiations would require an increase in resources (i.e. staffing both at insurer and provider) – and impact most at the smaller insurers, with restricted resources and limited budgets.
The options are the maintenance of national tariffs with a percentage discount off the 'rack rate' for poorly performing or competitively positioned hospitals, with ultimately a ARM (alternative reimbursement model) that uses performance monitoring against a set of agreed parameters, with adjustments made off line, on a six monthly or annual basis to address/avoid embedding of clinical and cost inefficiencies.

(b) ***How quickly would this remedy come into effect?***
No further detailed response has been given, as PruHealth believes that this remedy is onerous, in addition to the above, significant system development work would be required to modify the claims system

(c) ***If practical, would it be effective? To what extent could reputational risk be relied upon to deter price increases in Single hospital areas?***
Hospital providers are acutely aware that in the main Corporate and SME clients wish to have a policy that covers all hospitals that are in the area to be served by their employees and whilst employers remain price sensitive to the premium they are agnostic about the provider costs and will continue to churn their business as premiums rise in response to rising provider costs. Hospital providers are only concerned by reputation risk in so far as quality of treatments are concerned not the price charged.

(d) ***If prices were raised in Single hospital areas how confident could we be that this would lead to new entry and over what time period?***
In the ideal competitive world high prices would be a stimulus for a new entrant but there remain significant barriers to entry for building and managing a new hospital. This is aggravated by a market which is stagnant and is

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

significantly under-utilised. This dynamic could well change if there was significant growth in the PMI market.

(e) ***Is it likely that this remedy would have unintended consequences? For instance, would it be likely to lead to hospital operators to close hospitals and if they did would this result in consumer detriment?***
Those hospital providers who maintain the operational status of not exploring or growing new and existing markets, redefining their operating model and relying on tariff increases significantly higher than inflation to balance their books should be forced to close down their hospital. If they are in close proximity to rival hospital providers there will be no consumer detriment provided the remaining providers have the ability to cover 80% of admitting procedures. For solus hospitals there is a strong business case for an innovative, price conscious and quality driven hospital provider to purchase the failing hospital. The risk to PMI's is that low tariff hospitals would simply increase utilisation and treatment inappropriateness and with limited diagnostic coding the PMI is hard pressed to question.

(f) ***Would hospital operators be able to frustrate the aims of remedy by entering into arrangements with consultants that would prevent or deter them from practicing at an entrant's hospital? Could hospital operators deter or delay PMI's recognition of an entrant?***
Hospital operators could engage with consultants in exclusive contract dealings which recognise their admitting privileges are a condition that they work exclusively for the one hospital group. Consultants would then have a choice as to whether or not they wish to conform to such a restrictive contract. Provided such contracts are not linked to perverse incentives there should be limited consumer detriment. The issue of consultant perverse incentives is discussed later in this response document. Suffice to say that if consultants are only rewarded with the opportunity to **purchase** equity (and therefore form part of a controlled dividend pool) and derive no additional income from cash-payments/bonuses reflective of their patient volumes or costs generated or any subsidised administration services or consulting rooms the decision by the consultant whether to operate from Hospital A or B is driven by the hospital quality, standard of technology/facility and local reputation. PruHealth holds a view that all providers (including consultants) are initially recognised on quality standards and/or qualifications. Continued recognition is then based on quality outcomes, treatment appropriateness, cost-effectiveness and customer complaints.

- **Single and duopoly hospital areas**
  Issues for remedy 3, restrictions on expansion (Page 11). This remedy may mitigate the AEC in Single or Duopoly areas by preventing an incumbent hospital operator from expanding through a partnership or other business agreement with a PPU

20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

(a) ***Would this remedy be effective? In how many and which Single or Duopoly areas is it likely that PPU's will be launched?***
It is agreed that in the areas of a Single or Duopoly that owners should be prevented from acquiring or partnering with NHS facilities as discussed under comment 1. This view is as a response to our exposure to significant cost increases when an incumbent with Duopoly market power has partnered with a NHS PPU. It appears that an increasing number of PPU's are seeking to outsource their PPU's to private hospital providers. This is largely driven by the need to fund or cross subsidise NHS budgets. PruHealth however must stress that the provision of private healthcare in a PPU setting is not like for like with the healthcare service being provided in a standalone private healthcare facility. As discussed previously the fixed cost base is significantly lower and the service facilities (except the normal accommodation) are shared with the general population of the NHS.

(b) ***How practical would it be for other hospital operators to form PPU partnerships in areas where they did not already operate a hospital?***
We do not believe this to be a barrier to entry. Most of the hospital groups operate nationally and centrally coordinate their activities.

(c) ***Would the remedy give rise to unintended consequences or distortions? Would NHS Trusts suffer because they would be unable to partner with an incumbent hospital operator which could offer a financially more attractive arrangement than an entrant?***
The main reason for the attractive financial arrangement is the market power of the incumbent hospital operator and this has had an adverse effect on competition. If a private healthcare provider enters into a relationship with a PPU, the related tariff for services must reflect the cost incurred in providing the available healthcare services. The related business case should stand on its own merit, and services to extend the range of services not otherwise available in the independent healthcare sector, not simply duplicate those services already widely available and quadruple the costs.

(d) ***Would customer detriment arise if the incumbent was prevented from partnering in a PPU but no entrant appeared?***
If an existing PPU is closed due to an incumbent not being replaced, the impact upon the private market will be entirely dependent upon the range of services provided, and the distance to the next nearest NHS or private providers.
As a compromise permissions could be sought for an incumbent to partner with a PPU provided that the costs of the service for all customers is justified and not just replicating the incumbent's tariff and charge-master from its private facilities.

(e) ***What provisions would need to be made for oversight and enforcement of this remedy and which body should be responsible? Would it, for example, fall within Monitor's remit?***
Oversight and enforcement of these requirements are dependent upon the contractual agreements in place, and the support of payors such as insurers. The success or otherwise however of such units' rests largely with the consultant user groups, who determine the most appropriate environment/setting in which to undertake treatments. A key aspect of the PMI proposition is customer choice, and not all insurers mandate or direct to a sole provider. There can be no guarantees as far as business volumes are concerned, but the customers have a very specific expectation as far as the standard of hospital services are

20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

concerned (quality of room, catering requirements, car parking, reception, TV, telephony, internet access, standard of housekeeping etc).The PPU's and independent sector facilities should both be subject to the same regulatory standards for clinical performance.

- **Existence of Incentive schemes by private hospital operators to encourage patient's referrals**
  Issues for remedy 4, preventing hospital operators from offering to consultants any incentives (Page 12). This remedy would prohibit private hospital operators from offering consultants any cash or non-cash incentives to encourage them to undertake work at their facilities. agreement with a PPU

(a) ***Is this remedy practicable? What framework of rules could be used to determine reasonably and practically whether the benefits of an incentive scheme in terms of lowering barriers to entry, outweighed the distortions created? Who would exercise monitoring?***

At PruHealth we share the view that equity shareholding per se is not the root cause of over-serving in a fee for model reimbursement model. Individuals have the personal choice to invest in equity and if not the consultant then another family member/spouse may well invest on their behalf. Equity shareholding is generally only an issue when the size of the equity shareholding is sufficient to influence adverse behaviours. Equity shareholding does drive a culture of pride in the institution in which they work and endeavours to enforce behaviours that protect the institutions market reputation. One consultants' over-servicing behaviour, with less than 10% shareholding would have minimal effect on the company's dividend return to its shareholders. Equity shareholding can be easily defined for a public listed company as the share price is reported and a transparent dividend return. There is a degree of complexity with private/charitable institutions and dividend schemes based on phantom shares could be formulated but transparency is essential.

True perverse incentives include:
- cash rewards based on the degree of admissions, costs generated
- cash incentives to join a particular facility/hospital
- cash or other incentives to prescribe or utilise specific drugs, appliances or prosthesis
- subsidised / free consulting rooms
- subsidised / free administration services
- share/equity options and dividend payouts that are not related to share value

These perverse incentives should not be limited to consultants but include all health professionals including General Practitioners.
The GMC should be made responsible through a probity scheme for the monitoring of financial incentives to consultants, and consultants held accountable for accepting perverse incentives influencing their treatment choices, and admitting practices. Responsibility starts with introduction and enforcement of rule of professional conduct, subject to independent audit, and external scrutiny.
The role of the HMRC is fundamental in ensuring that any declared private income from private practice activities is justified against an expense statement. No private consultant should be generating private income without incurring or explaining their administration and rental expenses. If these are significantly

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

subsidised (and identified by the HMRC), this is then viewed as benefit in kind and taxed accordingly.

(b) ***Is the remedy reasonable?* Should certain kinds of arrangements still be permitted and if so which?**
The remedy is entirely reasonable and practical. There is no reason however that consultants should not be allowed to invest in healthcare facilities (using their own money), on a commercial basis, provided this is restricted to less than 10% equity shareholding. Indeed there is a strong argument that this should be encouraged, as no clinician wants to be associated with poorly performing or a poor quality facility. A key motivator is to be 'the best', and being associated with a high calibre, clinically effective high performing facility is the best aide to self promotion.

(c) ***Is the remedy comprehensive? Should it apply to other healthcare service providers such as laboratories or diagnostic imaging? Should PMI's be permitted to operate incentive schemes which reward consultants who recommend cheaper treatments or less expensive hospitals?***
The remedy should be comprehensive – and apply to laboratories, pharmaceutical companies, suppliers of all types of medical consumables, imaging service providers etc, without limit.
As to the point of incentivising/ rewarding consultants for cost-effectiveness, this is no different to the reimbursement/reward levels that should apply to hospital providers. Based on an 80% basket of commonly performed procedures by each surgical discipline one is able to define the total average cost per event and adjust for geographical differences and complicating and recognised patient or surgical factors. One is able to compare those consultants who are cost-effective and offer appropriate treatments and investigations and these consultants should earn a higher remuneration level than the cost-ineffective or inappropriate utiliser of investigations. Measuring and rewarding on quality is complex and with current data is not possible. Consultants need to be educated in the cost of treatments and investigation costs (as most have limited knowledge of these costs but utilise and prescribe them frequently). No consultant should be choosing price over quality but with limited information and a market that sets prices that are not reflective of quality one cannot make the assumption that cheaper treatments or less expensive hospitals will have an adverse patient outcome.

(d) ***Are there regulatory regimes in other jurisdictions that the CC could learn from in the context of remedy specification and implementation? Would, for example, the Stark Law in the USA, be a useful model as regards restrictions on the commercial relationships between healthcare facilities and clinicians?***
We hold the view that the Stark Law was a piece of legislation to tackle the outlier consultant offenders which has resulted in consumer detriment in more remote/solus hospital areas. The starting position has to be improving diagnostic and procedure coding so that those cases of over-servicing or inappropriate utilisation of treatments/investigations can be readily identified by firstly the hospital responsible for the admitting privileges of the consultant and secondly by the PMI. Alternative kick-back legislation is more appropriate as is a gift register of declaring all gifts/benefits in kind over a certain financial value.

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

(e) ***What would the cost be of implementing this remedy, in terms of unwinding existing equity arrangements?***
We are not supportive of preventing consultants or their immediate family from having equity arrangements

(f) ***Particularly in the context of market entry and expansion, are any relevant customer benefits likely to arise from equity participation by consultants in hospitals that would otherwise be available?***
As discussed in (b) above – it could be argued that a consultant with an investment in a facility are more motivated to perform well and demonstrate to patients (and their peers) that they are 'the best'. As discussed in (d) above the issue of 'encouraging' consultants to more remote areas without some degree of financial incentive could well impact on customers in that remote region.

- **Lack of sufficient publicly available performance information on consultants Issues for remedy 5, Consultant Quality (Page 13). This remedy would make recommendation to all health departments that they collect and publish on their patient facing website individual consultant performance indicators**

(a) ***Is the proposed remedy practicable in all of the nations?***
PruHealth supports the remedy proposed which should be implemented in all nations. Although it would be relatively rare for a consultant to have a material practice in more than one nation, there should be a unified approach to reporting.

(b) ***Is the proposed list of ten specialties for which performance data will be available on an individual clinician basis appropriate?***
Please refer to Appendix 1 which is a PruHealth internal document explaining the recently published consultant data. Some of these seem more appropriate than others, for example mortality rates are published for some very low mortality rate procedures, which render the results almost useless, as nobody can be classified as an outlier. For some specialties they go into more detail and seem to have chosen more target indicators. Whether these are appropriate from a clinical perspective requires someone with clinical knowledge and therefore not appropriate for consumers of healthcare. They report on volumes of procedures, which is a good proxy for experience, as typically volumes and quality is positively correlated. Additional quality measures should include: unplanned readmission rates, infection rates, bed sores, rates of deep venous thrombosis and pulmonary embolism and "never events" (e.g. operating on the wrong limb, leaving behind a medical instrument, swabs, failings identified from not conforming to the WHO theatre checklist). The age of the consultant might be useful to publish, as consultants at the extremes of age may well have technical competence issues.

We would recommend looking at the Inpatient Quality Indicators (IQI's) published by the Agency for Healthcare Research and Quality (AHRQ) in the United States. http://www.qualityindicators.ahrq.gov/modules/iqi_resources.aspx and http://www.qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

In addition, Patient Surveys could also be conducted in a standardised format across all hospitals and published. This can include Functional Scores (like PROMS) or Patient Experience Surveys (also conducted by AHRQ).

(c) ***Are the indicators that are currently published for consultants appropriate?***
The format of display is not ideal neither for a lay-person nor someone who would like to analyse the data. The current display method is very technical and not appropriate for a laymen's audience. On the other hand, a data analyst might well understand the graphs, but is unable to obtain data in a format to analyse. Ideally data should be published in standardised Excel files or text files to allow a comparison of consultants. This is currently near impossible (requires a laborious data capture exercise form the individual websites, and values often have to be estimated from a graph). We would propose this should be published on a centralised website in a standardised format.

(d) ***Does the remedy risk giving rise to unintended consequences?***
The adjustment to take account of patients with significant higher co-morbidities or complex surgical factors can be very onerous and will never be perfect As mortality rates are generally low a small incidence of deaths when compared against a low private operating volume will significantly skew the outcome measures. Possible solutions are:
- report on other KPI's where death rates are very low (e.g. readmission rates, infection rates, etc)
- choose procedures that do have high mortality rates, where proper risk adjustment is possible.
- Diagnostic ICD-10 coding so that the patients co-morbidity conditions can be readily identified and therefore risk adjusted.
- Discharge forms should also be considered (including relevant discharge information, e.g. in what state was the patient discharged and to where).

We hold a view that by far the majority of complications that ensue post-discharge are referred back into the NHS for further care and these complication rates are not generally reported. Patient Experience surveys have less of a need for risk adjustment and are a good starting point.

(e) ***With what frequency should performance indicators be updated?***
These should be updated at least every 6 months.

20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

PRUHEALTH

- **Consultant fees. Issues for remedy 6, An Information Remedy (Page 15. This remedy would require all consultants to publish their initial consultation fees on theirs and the practicing hospitals website and for the consultant to provide a proposed list of proposed charges to patients in writing, in advance of treatment.**

(a) ***Is the remedy practicable? Do consultants' outpatient fees vary significantly between different patients such as to render an average fee or range of fees unhelpful?***
We hold the belief that in an immature competitive environment the impact of publishing prices is that it results in significant price increases. As consultants become aware of their colleagues prices the initial reaction is to match these prices as the belief remains 'I am as good/valuable as them' with no justification based on level of training and expertise, outcomes, efficiencies, consumer reputation, quality outcomes, professional and practice costs, etc. In an immature market the starting point needs to be educating on how to calculate one's professional worth that is defendable. One solution could be the creation of a reference price which is based on average costs, time and pricing. The key challenge with average reference prices is that they become the minimum price and not a reflection of average price charged.
Consultants may well vary their fees dependent on the reimbursement rates by the insurer, but to protect the self-pay consumer it is expected that both consultants and hospitals publish rates that these consumers can expect to pay for their healthcare services. An economist may well take the view that differential pricing discrimination serves the greater customer good but this is generally a discounted rate off the rack rate, and it is this rate that should be published.
The published rates should not only be limited to initial consultation but also follow-up consultation rates and procedure fees.

(b) ***Is it possible for consultant to estimate fees before undertaking a procedure?***
For a procedure the frequency of unexpected complications is low and by far the majority of patients in the private healthcare market have limited co-morbidities (and this is largely as a result of inadequate ITU facilities or 24hr medical staffing in many of the private hospitals). As part of the fee disclosure form a statement should be included stating that the fee quoted excludes any further costs that may arise out of recognised surgical or unexpected patient complications.

(c) ***Is it reasonable to require all consultants to disclose their outpatient consultation fees? Should only those earning over a certain level do so?***
All consultants should disclose their fees to the consumer and this must not be restricted to consultation services only. Practically it may not be feasible for the consultant with limited private practice to publish their rates on theirs or a hospital facilities website, but this should not obviate their responsibility to discuss fees with the patient at the time of the initial consultation.

20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

(d) ***How should the remedy be specified?***
As with any other professional services fees must be disclosed at the first personal contact. Unlike other professional services, private patients as consumers are affected by health conditions which may well impact on their right to make an informed choice. Consumer choice is further restricted by the disease in that their only concern is to get well and they at the time have little regard for the cost of the treatment (the reality of the costs often only becomes apparent post treatment). Therefore some additional degree of consumer protection is needed compared to customers securing the services of other professional persons.

Consultants should have a clear understanding of the potential shortfall from their quoted rate to that the insurer is prepared to pay or publishes as reasonable and customary. It is this £ differential that needs to be clearly explained to the consumer. Some consumers may question or ask for clarity on the reason for the price differential but as stated many consumers of private healthcare are debilitated by illness and this affects their ability to make informed choice on consultation charges.

Anaesthetic, pathology and radiology consultants do have a unique issue in that they have limited opportunity to discuss their fees and we would propose that for all elective cases the principal practitioner (for example the surgical consultant) clearly informs the customer on the tariffs and any potential short-fall from these attending practitioners, or at the very least provides a contact number/email address for the customer to approach these consultants directly prior to the booked elective procedure/investigation.

(e) ***What provisions would need to be made for the oversight and enforcement of this remedy and which body(s) should be responsible?***
The issue of additional protection for consumers by inappropriate high charging consultants must be addressed. By way of example, an orthopaedic consultant quotes a fee of £1500 to a customer for an arthroscopy. They explain that the insurer may only pay £600 and they justify as to why their rate is so high – no increase for the last ten years, technically the best, has the best outcomes, etc. The consumer is debilitated by disease and therefore agrees to the shortfall of £900. The consumer would have no idea that should this orthopaedic consultant charge all arthroscopies this fee and they only do this type of surgery and work 6 hours a day doing 6 arthroscopies a day, no weekends/bank holidays, for 45 weeks a year they would be generating an income less practice and professional costs well in excess of £1,200,000 per annum. To place into context the total hospital fee which includes accommodation, theatre and staff fees, drugs and dressings is less than the fee charged by the consultant. What is the customers' recourse?

Professional associations have no private practice peer review function or any censuring power. The General Medical Council has adopted a limited responsibility to address private tariff matters or to offer consumer protection to inappropriate high charging consultants. The view of the professional bodies and the GMC would be that the consultant discussed the fees with the consumer and they agreed to the shortfall. There is no reference point for consultant tariffs and more importantly limited consultant understanding on what basis fees should be calculated. It is our contention that they are not reflective of the cost of delivering the service, the level of technical ability, the level of complexity, the level of

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

comparative professional value and the level of sociological value.

Consultants practicing in a competitive environment have every right to set their levels of fees however in other private healthcare markets there is a cap, beyond which the consultant will have to defend their charges to a body of their peers or a professional regulator such as the GMC. These caps could be x% above a published reference price or a % of the total hospital cost. Most consultant procedure charges account for significantly less than 40% of the hospital invoice and levels above 40% should be actively challenged.

This responsibility should rest with a newly launched probity/private practice arm of the GMC, promoting best commercial practice, monitoring consultant incentives and protecting patients from financial harm.

- **Lack of sufficient publicly available information on private hospital performance. Issues for remedy 7, An Information Remedy (Page 16). This remedy would require all private acute hospitals in the UK collect HES equivalent and PROMs data for private patients and publish**

(a) ***Is the remedy practicable? Are all private hospitals in the UK capable of collecting HES data?***
PruHealth agrees that this remedy is practical and is long overdue. The requirement to collect and report HES data should be implemented within 6 – 12 months of the publishing of the final report and recommendations

(b) ***Is the remedy practicable? Are all private hospitals in the UK capable of collecting PROMs data?***
Yes

(c) ***Besides the HES and PROMs equivalent data, what other data should be collected by private hospitals? Would it be appropriate for the CC to specify the coding, for example ICD-10?***
Customer surveys and hospital discharge information as to admission diagnosis and to where discharged. Please refer to the comments under remedy 5 for consultant data.
As discussed throughout this response there is more than enough justification as to why the use of diagnostic codes, such as ICD-10 forms the basis for interpretation of quality indicators, efficiency analysis and case-mix comparisons between treatment providers. The use of diagnostic coding can also be used to identify of over-utilisation/ inappropriate therapies in a fee for service reimbursement model with or without equity shareholding in treatment facilities and therefore providing an indication of perverse incentive behaviour. As such we strongly recommend that the use of ICD-10 diagnostic coding is mandated for use on any provider invoice.

20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

(d) ***What measures could or should the CC adopt in order to ensure than PHIN is sustainable?***
Mandatory membership/subscription of PHIN or equivalent, for all private healthcare providers, along with cost based membership fee to support sector. Mandate reporting of key stats on a regular/common calendar bass across all of membership with fines for failure to meet submission deadlines.

(e) ***What costs should the CC take into account for this remedy?***
No comment

- **Insufficiency of competitive constraints. Issues for remedy 8, A price control (Page 16). This remedy would set the maximum prices that could be charged at hospitals which we consider to have market power.**

The CC decided that it would not be an appropriate remedy but invited views
We agree that price control would be complex to design and update, however we believe that certain principals need to be considered when setting price for all providers (not just those with market power). The reason why this is necessary is to maintain transparency of pricing to enable consumers and payors of healthcare to challenge the prices that are proposed or levied by providers of healthcare. For all of the reasons stated in this response submission the purchase of a healthcare product is different from any other consumer good and an additional degree of consumer protection is necessary. To this there also needs to be a professional body or regulation authority that can protect consumers from exorbitant charging costs. The key charging items that we have identified that have the greatest impact are:
- mark-up charges for drugs, prosthesis and appliances. These range from 10% to **70**%! The mark-up should be reflective of the handling, storage, administration costs and not a means to balance the profit account. By way of example many joint prosthesis are delivered by the medical technology company which are already sterilised and in a sterile operating pack. These may be delivered either on the day of the planned surgery or stored at the facility. These are high cost items and for the consumer to face a 70% mark-up on the manufacture price significantly impacts on medical inflation, premium increases and the costs for self-pay customers.
- pathology investigation costs
- radiology costs

For the latter two, the health sector is one of the few sectors where improved technologies have significantly driven up price. The efficiency gains from technological advancement have never been passed onto the consumer and in a stagnant market with low utilisation efficiencies (driven by all facilities installing the latest technologies and insufficient patient volumes to maximise efficiency),

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

the pricing response is for all providers to increase the treatment costs for the use of the technology. Even when efficiencies do improve (due to increased volumes) these initial high costs remain as the benchmark and increase year on year at rates greater than inflation.

The pricing principals should:

Reflect the investment made and include a commercial return on the investment or capital made

Acknowledge the payback period – between 3-7 years.

Include set up, running, insurance and maintenance costs

Assume ‘reasonable’ utilisation rate starting at lower % levels in year one rising to 80% over a 5 year period

20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

APPENDIX 1

Consultant Quality data published

Background

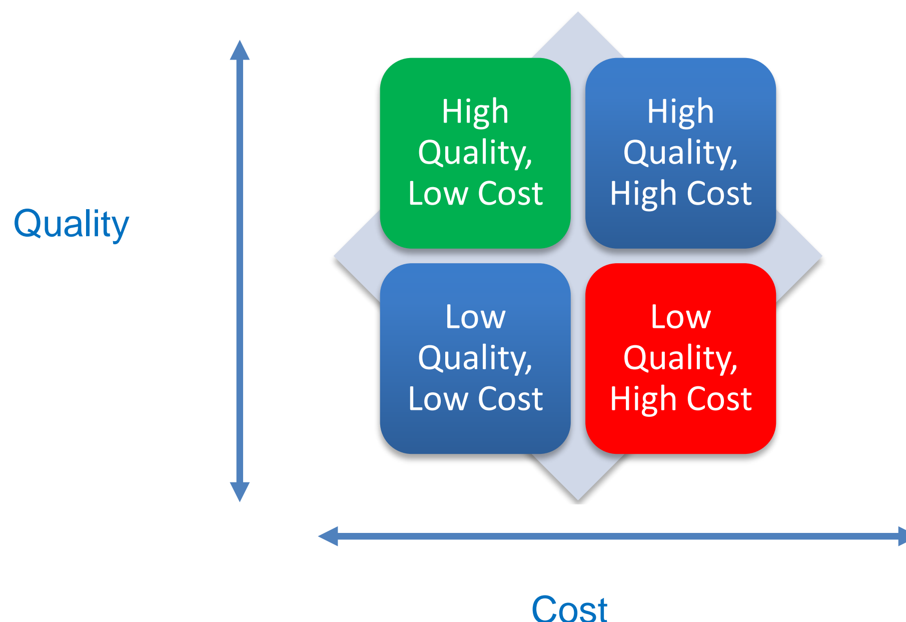
The NHS recently published consultant level quality outcome measures as part of a drive to improve transparency and hence drive up the quality of care.

Prof Sir Bruce Keogh, National Medical Director of NHS England, said: "This is a major breakthrough in NHS transparency. We know from our experience with heart surgery that putting this information into the public domain can help drive up standards. That means more patients surviving operations and there is no greater prize than that." The reporting of the data was led by Prof Ben Bridgewater from the Healthcare Quality Improvement Partnership (HQIP). Prof Bridgewater is a practising heart surgeon who leads the successful cardiac consultant-level reporting which paved the way for this work.

Note that data is published for consultants who practice in the NHS and does not generally include any private practice data. It is foreseen that most consultants who practice in the private sector also practice in the NHS, although there may be some exceptions. Further note that most reports highlight very few consultants (if any) as being outside the expected norm. This is partly because mortality rates are so low for the procedures under analysis, leading to very wide confidence intervals.

Strategic Aim

The aim for clinical risk management is to incorporate this information into the provider profiling, so as to assess consultants not only on cost, but also on quality.



20 GraceChurch Street, London, EC3V 0BG
Tel: +44 20 7000 Web: pruhealth.co.uk

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

Data available

Main Website:
http://www.nhs.uk/choiceintheNHS/Yourchoices/consultant-choice/Pages/consultant-data.aspx

Adult Cardiac Surgeries

- Number of procedures for isolated CABG, isolated AVR, isolated MV, isolated AVR+CABG, isolated MV+CABG
- Cardiac Surgery Risk-Adjusted Mortality Rates over 3 years

Source: http://www.scts.org/modules/surgeons/default.aspx

Vascular Surgery

- AAA repair - the proportion of patients who died in hospital after surgery for those patients who had an elective repair of an infra-renal abdominal aortic aneurysm.
- Carotid endarterectomy - the proportion of patients who had a stroke or died within 30 days of the operation.

Source: http://www.vsqip.org.uk/surgeon-level-public-reporting/ (also saved as pdf)

Orthopaedic Surgery

- Number of procedures performed for: Knee revision, Knee primary, Hip revision, Hip primary (compared to national average)
- Knees 90 day mortality rate – risk adjusted over 10 year period
- Hips 90 day mortality rate – risk adjusted over 10 year period

Source: http://njrsurgeonhospitalprofile.org.uk/

Urological Surgery

- Nephrectomy – number of procedures performed, split by radical, simple, partial and nephroureterectomy
- Outcomes reported: mortality rates, complication rates, LOS, transfusion rate
- All rates are risk adjusted

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

Source: http://www.baus.org.uk/patients/surgical_outcomes

Thyroid and Endocrine Surgery

- Number of thyroid operations
- Number of first time thyroid operations
- In-hospital mortality
- Length of stay
- Rate of re-exploration for bleeding
- Related readmission rate
- Late Hypocalcaemia
- Degree of completeness of data relating to these outcomes

Mortality*: In the National Endocrine Surgery Registry out of a total of 10,416 first-time thyroid surgery operations that had a recorded patient status at discharge, there were only 9 reported deaths which represents a post-operative in-hospital mortality rate of 0.09% (95% Confidence Interval: 0.04 - 0.17%).*

LOS*: Shows the distribution of lengths of (overnight) stay for First-time Thyroidectomy cases (compared to benchmark of all surgeons).*
Relevance: Shorter lengths of stay may be desirable for patients, and in terms of efficient use of hospital resources. They may also represent a surrogate measure of overall complications, which often result in longer hospital stays.

Re-exploration for bleeding*: Shows the proportion of First-time Thyroidectomy cases requiring re-exploration of the neck to arrest haemorrhage.*
Relevance: Bleeding in the neck can be potentially life-threatening, and its incidence directly under the influence of the operating team.
Avg = 0.9%

Readmission rate*: Shows the rate of re-admission to hospital for reasons related to surgery for First-time Thyroidectomy cases.*
Relevance: May act as a surrogate measure of overall complication rate. Avg = 2.1%

Late Hypocalcaemia*: Shows the proportion of First-time Total Thyroidectomy cases (excluding those having simultaneous level 6 lymph node dissection) who require oral calcium and/or Vitamin D supplements to maintain normal blood calcium levels at 6 months following surgery.*
Relevance: Acts as an indicator of long-term hypoparathyroidism (damage to parathyroid glands), which can lead to other health problems, in addition to the inconvenience to the patient of taking daily tablets.
Avg = 8.9%

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.

PRUHEALTH

Source: http://baets.e-dendrite.com/

Cardiovascular Interventional

1. Total number of PCI procedures

2. Total Number split by presenting clinical syndrome

3. Risk adjusted Major Adverse Cardiovascular and Cerebrovascular (MACCE) event rate.

Risk adjustment data not complete. Upper 95% confidence interval is also provided

Source:
http://www.bcis.org.uk/pages/page_box_contents.asp?pageid=775&navcatid=157

Bariatric Surgery

- Number of bariatric surgeries
- Number of bariatric surgeries by procedure:
- In Hospital mortality rate
- Post operative LOS

Both rates are risk adjusted. Errors on website, unable to view results

Source: http://nbsr.e-dendrite.com/nbsr

Data to be published autumn 2013

- Colorectal surgery (surgery on the bowel)
- Upper gastrointestinal surgery (surgery on the stomach and intestine)
- Head and neck cancer surgery

PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.