

COMPETITION COMMISSION ("CC")
PRIVATE HEALTHCARE MARKET INVESTIGATION
NOTICE OF POSSIBLE REMEDIES
SIMPLYHEALTH GROUP LTD ("SIMPLYHEALTH")

RESPONSE DOCUMENT

Introduction

Simplyhealth welcomes the opportunity to make representations on the Notice of Possible Remedies ("Notice"), released on 28 August 2013.

Simplyhealth encloses its comments on the proposed remedies, its views on the potential implications for the healthcare market and the consequences it believes these proposed remedies may have for smaller insurers such as Simplyhealth.

With reference to the CC's observation that remedies hearings may be appropriate in relation to the Notice, Simplyhealth would be pleased to be invited to participate.

Simplyhealth requests that this response is treated confidentially, but is willing to provide a non-confidential version that the CC may publish on its CC website.

Remedy 1—Divestiture of one or more hospitals and/or other assets in areas where competitive constraints are insufficient – Central London

Generally

Simplyhealth believes that the impact of a divestiture strategy, particularly outside of London, could impact smaller insurers disproportionately and detrimentally, resulting in less customer choice and a greater concentration of the PMI market in fewer providers.

- a) Would a divestiture remedy address the AEC in central London effectively and comprehensively? Are the criteria that we have set out for specifying a divestiture package appropriate? If not, what criteria should we use to specify the divestiture package and what assets should be included in it?

Simplyhealth submits that, in respect of central London, divestiture would have very few consequences for the existing competitive constraints; HCA would simply be replaced by a different provider, with the consequence that there would be no material changes.

As recognised by the CC, entry costs to join the private healthcare market are significant and any 'new' (UK or international) provider not currently operating in central London, entering the central London market, with a view to buying one or more of HCA's facilities, is likely to do so as an investment driven decision. Such a decision is likely to be based on the current profits that can be achieved, with the company in question seeking to amortise the investment it has made and make a profit. In Simplyhealth's view it is entirely likely that any new providers will look to adopt the current tariffs or, to justify their purchase, seek to actually increase fee rates fairly swiftly, if not immediately, with the consequence that the hospital rates in

central London may actually increase, resulting in patients and PMI providers paying more for medical procedures in central London.

It is also the view of Simplyhealth that HCA might actually look to circumvent any divestiture obligations imposed in the context of this market investigation, by increasingly contracting with NHS PPUs, with an aim of sustaining income. This would be detrimental as treatment costs for using these units are likely to escalate as a result.

Simplyhealth notes that the potential obligation on HCA to divest some of its hospitals may hamper its ability to continue to provide some of the specialist care services it is able to offer currently through a network of closely interlinked care units. Furthermore depending on the divestiture method chosen by the CC, HCA might actually decide to remove itself from the UK market entirely, resulting in detriment as described 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 if 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?

Simplyhealth recognises that some providers may satisfy criteria in relation to expertise, commitment and financial resources, but is inclined to respond to this in the negative and refers the CC to its response to sub-question a), above.

- c) Would a divestiture remedy on its own be sufficient to address the AEC or would additional measures be required to ensure a comprehensive solution? Would, for example, the remedy be liable to circumvention through arrangements with consultants that would result in them conducting their private practice wholly or predominantly at HCA's remaining hospitals? Are there other ways in which HCA could circumvent a divestiture measure?

Simplyhealth refers to its response to sub-question a), above.

- d) Are there other assets or businesses, besides hospitals and their out-patient facilities, which it would be necessary or appropriate to include within a divestiture package? These could be physical assets, such as consulting rooms, or, for example, they could be joint ventures with others or NHS contracts to operate PPUs. Would divestiture of any such assets or businesses present particular problems?

As there is interdependency within the HCA network, Simplyhealth is of the view that it may be necessary to combine the divestiture of specific hospitals with that of specific other associated HCA facilities. This would make the exercise complex and convoluted.

- e) Would divestiture of an HCA hospital or hospitals and/or other assets confer market power on the acquirer? In what circumstances might this risk arise? Are there hospitals or other assets whose divestiture would be particularly likely to give rise to this risk?

Simplyhealth believes that divestiture alone would not provide an adequate solution and that a combination of remedies would be required to address the current issues.

- f) How long should HCA be given to effect the sale of the divestiture package? Our guidelines state that in relatively straightforward divestiture cases a maximum period of six months is appropriate. Is that sufficient in this case?

Simplyhealth believes that divestiture of HCA hospitals in itself would not be a wholly effective remedy and therefore feels that it is inappropriate to comment on the implementation period.

- g) What are the relevant costs and benefits that we should take into account in considering the proportionality of the divestiture options?

Simplyhealth has no comment to make.

- h) Are there other remedies that would be as effective in remedying the AEC that would be less costly or intrusive?

Simplyhealth is of the view that remedy 2(b), which relates to unbundling, may, in London, as defined by the CC, alone be an effective measure to resolve the AEC. This measure would be less costly and intrusive than divestiture and provide greater cost control. It would benefit both PMI providers and self pay patients alike.

Remedy 1—Divestiture of one or more hospitals and/or other assets in areas where competitive constraints are insufficient – Outside of Central London

Generally

Simplyhealth has found it difficult to evaluate the potential impact of this remedy effectively in the absence of information relating to geographical locations of the potential divestitures. As a result the below responses have been generalised.

Simplyhealth is supportive of divestiture of some hospitals outside of London, but is of the view that it should lead directly to more accessible healthcare and no reduction in patient choice. The proposed remedies should be a catalyst for the wider healthcare market to change, to reflect best practice in care delivery settings and to facilitate innovation in care delivery for the benefit of patients and customers.

- a) Would a divestiture remedy address the AEC effectively and comprehensively? Are the criteria that we have set out for specifying a divestiture package appropriate? If not, what criteria should we use to specify the divestiture package and what assets should be included in it?

As there has been no disclosure of the specific locations where such a remedy might apply, Simplyhealth believes this could be a positive step, but only if a genuine change in the status quo can be achieved as a result. To be effective, the remedy would also need to be underpinned by much greater transparency on clinical costs and clinical outcomes.

In addition, Simplyhealth has a preference for giving the hospital providers themselves a degree of choice as to exactly which hospitals are chosen to be divested in a specific geographical area.

- b) Are there suitable purchasers available with the appropriate expertise, commitment and financial resources to operate and develop the divested hospitals as effective competitors without creating further competition concerns?

Simplyhealth thinks that there are unlikely to be suitable purchasers available outside of central London that are genuine new entrants to the market. Although

there may be parties that might be interested in acquiring the hospitals identified for divestiture, these will more likely be incumbent providers. Accordingly, Simplyhealth feels that there will be a risk of "horse trading" between present incumbents. This will not fundamentally change the sustainability of the private healthcare market, as it does not address the underlying problems, in relation to which Simplyhealth believes that a different delivery/care model is required. A failure to address this would result in the issues with regards to competition continuing.

- c) Would a divestiture remedy on its own be sufficient to address the AEC or would additional measures be required to ensure a comprehensive solution. Would, for example, the remedy be liable to circumvention through arrangements with consultants that would result in them conducting their private practice wholly or predominantly at the divesting hospital operator's remaining hospitals? Are there other ways in which BMI or Spire could circumvent a divestiture measure?

Simplyhealth does not think that divestiture on its own will be sufficient to address the AEC. In particular, Simplyhealth feels that remedy 4, relating to incentives for consultants, would also need to be applied for remedy 1 to be genuinely effective.

Simplyhealth is also of the view that a divestiture remedy should be combined with a direction as to the future clinical use of the facility. Hospital providers have an estate of hospital premises that encourage treatment practices that are becoming outdated, due to advances in clinical practice, and hospital occupancy levels continue to decline. The changes in clinical practice are reflected in changing requirements, with day case surgery and home based care replacing the traditional hospital stay. The suggested use should reflect current medical practice and benefit the needs of the local patient groups. This could increase the range of facilities and reflect the changes and innovation in clinical practice that are now needed within the healthcare market e.g. the increasing range of treatments that can be safely performed in primary care settings.

Potential hospital purchasers/owners should, in particular, demonstrate new and innovative service delivery and not merely adopt the current hospital fees and tariffs systems.

- d) Are there other assets or businesses, besides hospitals and their outpatient facilities, which it would be necessary or appropriate to include in a divestiture package? These could be physical assets, such as consulting rooms, or, for example, they could be joint ventures with others or NHS contracts to operate PUs. Would divestiture of any such assets or businesses present particular problems?

Simplyhealth does not think that there are any other assets or businesses that may be included (but refers to its comments in relation to remedy 3).

- e) Are there particular assets whose divestiture would confer market power on the acquirer? To avoid creating further competition concerns would it be necessary to exclude certain assets from the sale?

As the identity/details of the (up to) 20 hospitals is not available, Simplyhealth is unable to comment on whether any specific assets may confer market power on a potential acquirer. Simplyhealth does, however, have concerns as to how this might impact patient choice and costs in retained hospitals if volume remains a significant factor in cost control.

- f) How long should BMI and Spire be given to effect the sale of the divestiture package? Our guidelines state that in relatively straightforward divestiture

cases a maximum period of six months is appropriate. Is that sufficient in this case?

As discussed under sub-question c) above, Simplyhealth proposes a more complex solution, which will combine divestiture with a direction as to the future clinical use of the facility in question. In view of this complexity, an implementation period of more than 6 months would be appropriate, if the intention is to create a different healthcare delivery model. If Simplyhealth were merely supportive of divestiture of certain hospitals, it is submitted that a time-period of up to 6 months would be reasonable.

- g) What are the relevant costs and benefits that we should take into account in considering the proportionality of the divestiture options?

Without knowing the specific details of the hospitals identified, Simplyhealth is not in a position to fully answer this question.

- h) Are there other remedies that would be as effective in remedying the AEC that would be less costly or intrusive?

As suggested under sub-question c) above, Simplyhealth is of the view that a divestiture remedy should be combined with a direction as to the future clinical use of the facility. The suggested use should reflect current medical practice and benefit needs of the local patient groups.

Remedy 2a—preventing BMI, HCA or Spire from raising prices in response to changes in patient volumes

- a) Would this remedy be effective? Would hospital operators be able to deter PMIs from removing hospitals from their network or recognizing a local rival in ways other than by raising or threatening to raise prices in response?

While Simplyhealth is supportive of the remedy, it submits that the effect would be limited; in the experience of Simplyhealth, market tariffs that are related to volume targets to be met over a contractual period of time. As a consequence, in the experience of Simplyhealth, price increases do not normally happen as the result of a specific hospital being delisted, but as a consequence of patient volumes not being met. The direct consequence of a hospital being delisted could of course be that volume targets are not met. The price of health insurance premiums is sensitive to market changes and overall the number of insured lives across the market remains almost static, but is impacted by rises in hospital charges.

For the remedy to be more effective, in the view of Simplyhealth, the exercise of choice by a PMI to delist a hospital or to send patients elsewhere for perfectly valid reasons, in relation not only to price but also to the quality of clinical care and poor treatment outcomes, should not be penalised by a hospital increasing prices. In Simplyhealth's view, this remedy would be even more effective the more information there will be available on clinical outcomes (please see comments in relation to remedy 7).

Simplyhealth is not in a position to speculate on the ways that hospitals may devise to deter PMIs from removing hospitals from their networks, other than applying increases related to reduced volumes at a future date.

- b) How quickly would this remedy come into effect? Would it be necessary to wait until existing contracts with PMIs had come to an end to implement it or could this process be accelerated, and if so how?

It has become evident through the CC investigation that lengths of contract vary, mainly within a 3-year and 1-year contract period. For the remedy to be efficiently implemented, it is Simplyhealth's view that implementation should take place at the end of the existing contract, in line with the current contract term.

- 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 reduced the amount of business it did with the operator? What economic rationale would there be for a cross-operator (rather than single hospital) volume discount, for example?

Simplyhealth feels that the remedy is reasonable. It is current practice within the market for a hospital operator to seek a price increase from a PMI, in the event that the volume of business with the operator reduces. Simplyhealth recognises the feature of cross-operator (total volume of business with a hospital operator) volume discounts but opposes any penalties, either during or subsequent to the contractual term, should patient volumes decrease as a result of legitimate delisting of hospitals e.g. CQC intervention or material failures to meet contractual service level agreements.

- 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? If it would, which would be the most appropriate body to undertake these functions and how should it be funded? What would be the expected costs of monitoring?

Simplyhealth believes continuous monitoring would be necessary, but is unable to provide further assistance to the CC as regards the identification of an appropriate body to carry out this task.

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

Simplyhealth considers that there should be a mechanism in contracts that would allow for delisting of hospitals due to failure to meet key performance indicators. It is stressed that it should not be possible for hospital operators to increase prices for PMIs because volume targets are not being met, when it is the hospitals themselves that are the cause of this loss of volume, owing to a failure to meet key performance indicators.

Remedy 2b- requiring BMI , Spire and HCA to offer and price their hospitals separately.

- a) Would this remedy be practicable? Would the scale and complexity of negotiating prices on an individual hospital basis be sustainable?

Simplyhealth believes that this would be not a practicable option for any other than the two largest PMIs in the market. The scale and complexity involved with hospitals being priced separately ensure that this remedy is not economically sustainable. The immediate consequence, for most PMI providers, would be that significantly higher investments would have to be made into the work force and systems, in order to cope with the increased workload. Simplyhealth believes that the effect on competition would, accordingly, be detrimental, as some providers might have to

leave the market altogether, with the consequence that consumer choice would be reduced.

- b) How quickly would this remedy come into effect? Would it be necessary to wait until existing contracts with PMIs had come to an end to implement it or could this process be accelerated, and if so how?

It is the view of Simplyhealth that this proposed remedy is not practicable and should not be introduced.

- c) If practicable, would it be effective? To what extent could reputational risk be relied upon to deter price increases in Single hospital areas?

As set out above, Simplyhealth does not think that this is a practicable remedy. In addition, Simplyhealth also thinks that the remedy would not be effective. The relatively small market share of most smaller insurers, resultant patient volumes and relative hospital market power means that reputational risk cannot be relied upon to deter price increases in single hospital areas.

- 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? Would this depend on the size and attractiveness of the local market concerned, for example the number of PMI subscribers or corporate scheme members in the hospitals' catchment areas?

Simplyhealth thinks that raising the prices in single-hospital areas will not lead to new players entering the market. PMI providers are often able to negotiate different pricing schedules, depending on the relative market share they represent in the specific hospital location.

- e) Is it likely that this remedy would have unintended consequences? For instance, would it be likely to lead hospital operators to close hospitals and if they did would this result in consumer detriment?

Simplyhealth feels strongly that this remedy may have the unintended consequence that large PMIs can choose to place all their business with a single hospital in a geographic location. This, in turn, may have three consequences:

- Firstly, the removal of volumes from a hospital by a larger insurer may result in it becoming economically non-viable, with the further consequence of closure and therefore reduced choice for insured and self-pay patients.
- [redacted]
- Thirdly, the relative patient volumes of the largest PMIs, which follows from these negotiations could in some instances increase volumes at a single hospital, to the exclusion of other PMIs. As a result, there will be detrimental effect on consumer choice and price.

Furthermore, the hospital losing volume may decide to remedy the resulting loss of income by seeking to increase prices for the remaining insurers and patients. This is the case because some insurers and self-pay patients may regard a hospital as a "must-have" facility. Hospital providers are well aware that corporate clients actively seek to have hospital coverage for all their employees in the locality of their work or home and recognise when they become a "must have" facility .

In addition to price increases, clinical quality may also be adversely affected. Consultants may shift their clinical practice to the hospital location giving them the biggest patient volumes. Again, this can impact patient choice for those self-pay

patients or those choosing smaller PMI providers.

- f) Would hospital operators be able to frustrate the aims of the remedy by entering into arrangements with consultants that would prevent or deter them from practising at an entrant's hospital? Could hospital operators deter or delay PMI s' recognition of an entrant?

As set out above, Simplyhealth does not think that this proposed remedy is practicable, that it should not be introduced and that it will result in consultant shift, without the need for entering into arrangements with consultants.

It is not the experience of Simplyhealth that hospital operators have sought to deter or delay the recognition of an entrant.

Remedy 3—restrictions on expansion

- a) Would the remedy be effective? In how many and which Single or Duopoly areas is it likely that PPU will be launched?

Simplyhealth is generally supportive of implementing this remedy and believes that it would also be an effective measure. In the absence of additional details regarding the areas on question, Simplyhealth does not feel able to provide further comments.

- b) How practicable would it be for other hospital operators to form PPU partnerships in areas where they did not already operate a hospital?

Simplyhealth recognises that that it would be practicable for other hospital operators to form PPU partnerships, but is of the view that it would not be desirable. Simplyhealth would like to suggest the NHS is itself is capable of running these facilities, without the need for such partnerships to be formed.

- 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?

It is Simplyhealth's view that, when a private healthcare provider operates facilities in partnership with a PPU, the fees and charges for services should reflect the cost incurred in providing the healthcare services. Distortion is a possibility where, in partnership agreements, services are merely duplicating those already available at an enhanced cost to all users.

- d) Would customer detriment arise if the incumbent was prevented from partnering in a PPU but no entrant appeared?

Simplyhealth refers to its responses under sub-questions b) and c) above. Simplyhealth is of the view that partnering with incumbent may lead to price increases without improving quality.

- 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?

Simplyhealth believes that this is not a clear-cut issue, as even in respect of the NHS, responsibilities of regulators has not been ultimately defined. On balance, however, Simplyhealth is of the view that the most appropriate body would be Monitor, in its capacity as the sector regulator.

Remedy 4— incentives to consultants

- a) Is the 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? What degree of oversight would be required to monitor compliance and who should fund it and exercise monitoring? How could the 'fair market price' test be monitored and enforced and who would be responsible for doing so?

Simplyhealth is of the opinion that incentives can be offered in many guises. This complicates the methods of identification and potential enforcement. Incentives may include cash payments, below market rate or free support services and office space and equity stakes that can be characterised as hospital stakes in consultant groups and consultant equity holding in hospitals.

Simplyhealth is supportive of the principle underlying this remedy, which would prevent the offer of cash and non-cash incentives to consultants. Simplyhealth questions, however, why the restriction is limited to consultants, and has concerns that there could be a shift of approach by hospitals with similar incentives being offered to other market players if this remedy were implemented, in particular to GPs.

Simplyhealth has not found any specific monitoring mechanism to assess the potentially pro-competitive effects of such a measure.

- b) Is the remedy reasonable? Should certain kinds of arrangement still be permitted and if so which? Should, for example, those with a value of less than a certain amount, be deemed 'de minimis'? If so, what should this figure be?

Simplyhealth is of the view that the remedy would be reasonable and practical. It is cautiously suggested to make a distinction between established market players and new market players. The latter may benefit from the assumption that incentive schemes can facilitate market entry and therefore be pro-competitive for a limited amount of time. The full effect of incentive schemes such as large equity stakes in hospitals by consultants have not been fully appreciated in the UK, as it has only been adopted in a very limited number of instances i.e. the potential impact to patients in the event of the impending dissolution of such entities have not been tested.

Permitting certain kinds of arrangements (e.g. de minimis), may have different meanings in different local market structures. It would therefore be difficult to measure precisely when the remedy would be pro-competitive and when it would be anti-competitive; Simplyhealth is of the opinion that it would be more appropriate to prohibit all incentives to consultants, irrespective of size, within the limits mentioned in the response to sub-question a).

- c) Is the remedy comprehensive? Should it apply to other healthcare service providers such as laboratories or firms supplying diagnostic services such as imaging, for example? Should PMIs be permitted to operate incentive schemes which reward consultants who recommend cheaper treatments or less expensive hospitals?

Simplyhealth believes that the measure should be comprehensive but, with reference to the response to sub-question a), that it should be extended, for instance to GPs as well as other facilities such as laboratories. The remedy should apply to everybody,

including PMIs, provided that the scheme operated is a genuine incentive scheme (as opposed to remuneration for a service).

- 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 and their introduction?

Simplyhealth accepts that the Stark Law in the USA would be a useful model, subject to a suitability review and allowing for adaptation to the UK healthcare market.

- e) What would be the cost of implementing this remedy, particularly in terms of unwinding existing equity sharing arrangements? Would it be necessary or desirable to 'grandfather' existing arrangements?

Simplyhealth submits that it is not best placed to estimate the cost of implementing this remedy, as the extent of equity sharing arrangements, as well as its associated costs, are not readily available.

In respect of existing arrangements, Simplyhealth will encourage the unwinding of existing arrangements, rather than grandfathering existing schemes/rights.

- 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 not otherwise be available?

In the UK, equity stakes in hospitals are a largely unproven model; as yet the UK has only one significant example of a provider using this model. Simplyhealth believes this model should be measured on an ongoing basis, in order to establish whether there is a direct link between market entry, expansion, patient benefit and those incentive schemes.

Whilst accepting there is too little information available and it is too early to assess the success or otherwise of this operating model Simplyhealth appreciates that it may have beneficial outcomes for patients in the longer term. In regions where coverage of private hospitals is poor, consultants might be more attracted to opening new facilities if they can have an equity stake, thereby increasing patient choice. Equity participation may have the effect of tying consultants to particular hospitals for the longer term, which may in itself have anti-competitive effects to new entrants. Simplyhealth appreciates that in using such an equity model, consultants are directly associated with a particular hospital and may be motivated to ensure that, as a whole, the hospital performs well and achieves high standards of clinical care and outcomes. Consultants may then be incentivised to prove this particular operating model, not only with potential patients but also with their peers.

Where PMI providers themselves set up arrangements with consultants or networks of consultants, the particular arrangement should be declared. This must be entirely transparent through every stage, including pre-sale. Simplyhealth accepts that incentives could be used, but these should be expressly declared and transparent to all parties. Patient clinical interests and needs, along with quality of the treatment delivered should be overriding criteria. Simplyhealth currently uses this operating model for directional care.

Conceptually, Simplyhealth believes it is inappropriate for hospitals to incentivise consultants, laboratories and GPs to ensure treatment in specific facilities. As effective and robust monitoring could require substantial cost, Simplyhealth proposes the alternative method of voluntary declaration of incentives, coupled with publication of a 'list of incentives', along with allowance for effective 'whistleblowing'

procedures. With reference to its response to sub-question 6 e), Simplyhealth suggests that the General Medical Council may be an appropriate body in this regard.

Remedy 5—a recommendation to the health departments of the nations

- a) Is the proposed remedy practicable in all of the nations? Where a consultant practises partly in one nation and partly in another should performance data published in one nation be confined to that relating to performance in that nation?

Simplyhealth is very supportive of this remedy and welcomes the publication of consultant performance data in Scotland, Wales and Northern Ireland, which will be comparable with the data that is already being published by NHS England. Simplyhealth would welcome 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?

Simplyhealth believes that the proposed list represents an appropriate starting position and would also welcome the continued development of performance indicators and qualitative measures for an increasing number of specialties to be included to enable informed decisions to be made.

- c) Are the indicators that are currently published for consultants in each of the ten specialties, the way they are presented and the manner of their distribution appropriate? Are they (or some combination thereof) appropriate for other areas of specialty? If not, which indicators would it be appropriate to adopt for each specialty and how should they be presented and distributed?

Simplyhealth believes that indicators, when they are being set and published, need to reflect the intended audience and should be easily understood by the patient themselves. The indicators, the manner in which they are presented and the mode of their distribution all need to be audience-appropriate. A standardised format that is easily located in one place is the preferred option.

- d) Does the remedy risk giving rise to unintended consequences? Even with standardized mortality rates, might consultant incentives to treat more seriously ill patients be affected?

As set out above in the response to sub-question c), Simplyhealth feels strongly that audience understanding is important. With a view to avoiding patient misunderstanding or misinterpretation, Simplyhealth would recommend that the Royal Colleges and NHS England work together in an ongoing dialogue, in order to support the correct interpretation of data and to develop new indicators, as clinical changes occur to broaden the information available to patients and the public at large.

- e) With what frequency should performance indicators be updated?

Simplyhealth believes this should be frequently to ensure records are kept up to date. With the changes in clinical practice, this could be as frequent as every 6 months.

Remedy 6—An information remedy

- a) Is the remedy practicable? Do consultants' outpatient fees vary significantly between different patients such as to render an average fee or a range of fees unhelpful?

As a general comment, Simplyhealth is very supportive of the CC's proposal for consultant fees to be published. In its previous submissions, Simplyhealth has drawn attention to the paucity of information currently available in the market, which is recognised as having negative consequences for (privately insured and self-pay) patients.

It is appreciated, that requiring all consultants to publish all fees may not be practicable, as individual consultants are likely to be using fees that differ for particular hospitals, or in respect of each PMI provider. Ensuring that this is given accurately to the patient would be a challenge. There is also a need to protect the interests of the self-pay patient.

Simplyhealth believe that it should be possible and practicable to expect consultants to produce and publish a scale of fees that a patient would expect to pay. This will allow for an indicative range, but will still enable patients to make an informed decision. Simplyhealth acknowledges that the risk attached to this solution will be that consultants could price their services towards the upper end of the range.

As a practical measure, Simplyhealth suggests that a scale of fees be published that does not just reflect the costs of an initial consultation. Most patients actually have follow-up consultations, as well as some form of treatment or procedure performed. The consultant's scale of fees for these subsequent steps should also be made available, which the patient may then choose to accept or not.

Simplyhealth advocates that, where anaesthetist services are going to be required, the fee being provided should include the associated anaesthetist fees as well as the likely cost of investigations, such as pathology and radiology.

As part of the fee disclosure statement Simplyhealth would like to see a statement indicating whether the fee quoted excludes any further costs to further aid transparency and enable patients to make informed choices.

By publishing indicative self-pay rates Simplyhealth believes this will also give the insured patient a greater understanding of the fees involved.

- b) Is it possible for consultants to estimate fees before undertaking a procedure since unforeseen complications may arise? Would there need to be a means of adjusting fees in response to complications? Are there particular medical specialties where consultants would face particular problems in providing such an estimate in advance? How else might patients be informed of the likely costs of their treatment?

Simplyhealth believes that with most insured patients, the unexpected complication risk is relatively low and that, it should be possible for an experienced consultant to estimate this clinical risk before treatment in identifying what type of complications may arise. Private hospitals do not generally have ITU facilities and tend to treat patients with a lower incidence of co-morbidities and complications and in Simplyhealth's view there is not a requirement for fee estimates to accurately allow for complications, should they arise.

Simplyhealth therefore feels it is possible to evaluate complication risks with privately insured patients and that it would suffice to provide indicative costs (range)

associated with complication risks identified.

It is recommended that hospitals and consultants collaborate to produce a more accurate indicative price range to include likely investigative procedures that may be performed shortly after consultation, although it is acknowledged that it may be challenging to provide an exact price.

Simplyhealth notes that anaesthetists, may not be personally identified until shortly before surgery/treatment. It is also observed that this has been a source of complaint to PMIs and to the CC in the context of this investigation and feel strongly that likely anaesthetist fees should be provided at the earliest opportunity before treatment.

- c) Is it reasonable to require all consultants practising in the private sector to disclose their outpatient consultation fees? Should only those earning above a certain level do so?

Simplyhealth feels that it is reasonable for all consultants to disclose their outpatient consultation fees to the patient and in doing so, provide greater clarity for patients. The risk that consultants adjust their individual prices based on those charged by their colleagues, which could in itself result in a breach of competition law.

Simplyhealth believe that all consultants should be included in this obligation and not just those that earn above a certain fee level. Certainly publication on the hospital website is a sensible step but this should not then take away the consultant's responsibility for discussing the rates again face to face with the patient and setting out why these rates apply.

- d) How should the remedy be specified? How far in advance of treatment should a consultant be required to provide a patient with an estimate of the proposed fees for treatment? Is it practical, in all cases, to inform patients of costs in advance of treatment? Should any other information or advice be included with the estimate? For example, should the consultant notify the patient of his or her PMI fee maximum for the procedure concerned, or advise the patient to check this him or herself?

Simplyhealth would like to see disclosure of fees at the earliest opportunity. Whilst appreciating that not all treatments by consultants can be carried out in a timely fashion, which makes drafting rules about exactly when the fee disclosure should be provided a challenge.

Simplyhealth has commented on the position with regards to anaesthetist services above. We believe that the consultant should leave a fair amount of time between providing the fee disclosure and carrying out the treatment, although it is noted that certain investigations or minor procedures may be carried out immediately, with little real patient choice.

- e) What provisions would need to be made for the oversight and enforcement of this remedy and which body(s) should be responsible?

Simplyhealth suggests that the General Medical Council (GMC), which currently provides oversight on standards in the provision of medical services, would be the most appropriate body to oversee this remedy. It is Simplyhealth's view that this may require new areas of responsibility within the GMC but that this is the most appropriate body for this oversight role.

Remedy 7—An information remedy

- a) Is the remedy practicable? Are all private hospitals in the UK capable of collecting the equivalent of HES data? If they are not currently capable of doing so, what would be a reasonable timescale for the implementation of this remedy?

Simplyhealth is very supportive of this remedy, having clearly advocated that there is a paucity of available information which is a source of concern. This remedy, accordingly, is to be welcomed. Simplyhealth believes that private hospitals should be capable of delivering the information required within a 6-12 month timescale, depending on the relative system capabilities and requirements of the hospitals in question.

- b) Similarly, are all private hospitals in the UK capable of collecting PROMs data for the same procedures that it is collected for NHS England? If they are not currently capable of doing so, what would be a reasonable timescale for the implementation of this remedy?

Simplyhealth submits that a number of private hospitals already collect PROMS data in respect of NHS patients and procedures that are being carried out at their facilities. It should, therefore, not be too challenging to gather such information in respect of privately insured patients. Simplyhealth believes that private hospitals should be capable of delivering the information required within a 6-12 month timescale depending on the relative system capabilities and requirements of the hospitals in question.

- c) Besides HES and PROMs equivalent data, what other data should be collected by private hospitals and to whom should it be made available? Would it be appropriate for the CC to specify the coding, for example ICD10, to be used in data collection and classification?

Simplyhealth draws the attention of the CC to the fact that a number of insurers currently request that hospitals provide them with ICD10-coding, alongside CCSD data. The reason behind this is that the addition of ICD10 codes ensure that more detailed data is provided. Simplyhealth proposes that ICD10-based data be required to be provided alongside CCSD data, as this will lead to a better understanding and more transparency in the market.

- d) What measures could or should the CC adopt in order to ensure that PHIN or its equivalent retains sufficient funding to continue its activities after the completion of the CC investigation?

As a general observation, Simplyhealth welcomes the efforts and proposals by PHIN, but points out its concern that the bulk of planned implementation dates of its solutions appear to lie beyond the time-limits of the market investigation. Simplyhealth believe that there is a risk that, if too much reliance is placed on the activities of bodies such as PHIN in advance of such activities being implemented, there is a risk that the CC's expectations may not be met. The consequence could then be that only limited information and data will be provided.

With regards the funding of PHIN (or an equivalent body), Simplyhealth suggests that membership be made compulsory for all private healthcare providers, with the fee level being set in such a way that the body in question will be adequately funded.

- e) What cost and other factors should the CC take into account in considering the reasonableness and proportionality of this remedy or the timing of its implementation?

Simplyhealth does not feel it is appropriate to provide its views on this issue.

Remedy 8—A price control

Whilst appreciating that the CC is not intending to consider this remedy further, Simplyhealth would like to identify and make representations regarding one of the main areas where price controls may be an appropriate remedy. Hospital charge-master items for appliances, drugs, prosthesis and pricing of pathology and radiology tests are fees charged and incur mark-ups that may range from 10% to more than 50% in respect of certain products. Most notably, mark-ups may range 10%-50% for prostheses and pharmaceuticals, or even well in excess of that amount in relation to certain low-cost medicines and consumables.

It is difficult to understand how these fees and mark-ups are justified as they do not reflect the cost of providing these items and services or any reasonably related administration. This common practice has resulted in mark-ups forming an ever increasing proportion of the total cost of treatment. Such pricing is invoiced routinely and applies not only to Simplyhealth, but also to other insurers and self-pay patients. Simplyhealth is of the opinion that a reasonable and appropriate mark up cap should be set for each of these. An appropriate mark up should be reflective of the actual cost incurred, plus a reasonable profit margin. Where equipment is utilised this could be calculated based on realistic incremental utilisation rates, reasonable payback periods and a fair return on investment.

Simplyhealth is unable to conclude whether mark-ups are the consequence of specific market power at the local level or the result of lack of transparency of the market in relation to pricing, but feels that is most likely a reflection of the former and not the latter.

Simplyhealth proposes that a price control measure be put in place for mark-ups, with a maximum cap being placed at around [redacted] above the actual cost price. This would then enable transparency of charges rather than tariff rates.