

Competition Commission Private Healthcare Market Investigation

Response from the Association of Anaesthetists of
Great Britain and Ireland (AAGBI) to the Provisional
Decision on Remedies

February 2014



THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

The AAGBI welcomes the opportunity to comment upon the Competition Commission's (CC) private healthcare market investigation provisional decision on remedies. We have already commented¹ on the notice of possible remedies published with the CC Provisional Findings and trust that the CC has taken note of our views.

As a general point, the AAGBI remains disappointed that the CC's investigation has not focused on the adverse effects on competition caused by the conduct of the private medical insurers (PMIs). The AAGBI believes that the overall assumption of PMI beneficence is unfounded. The AAGBI considers that the inexorable increase in PMI premiums strongly suggests that any savings generated by the CC's laudable remedies will not be passed on to the consumer as the CC assumes, but will instead be diverted into corporate profits, surpluses, salaries, bonuses and capital investments. Commenting on the likely effects of the CC inquiry, the Chief Executive of Bupa, Mr Stuart Fletcher, recently said "*consumers were unlikely to benefit from the regulator's intervention through lower premiums*" and "*I don't think we're going to see a reduction in premiums*"².

It is the AAGBI view that by excluding measures to control PMI power, the CC remedies are insufficiently robust to ensure consumer benefit.

Nevertheless, this submission does not repeat the AAGBI's arguments regarding the PMIs. Instead, we will concentrate on the two remedies of most relevance to anaesthetists, in relation to which we have some important points to make:

▪ **Remedy 4 – the prohibition of clinician inducements:**

As the CC is aware, the AAGBI supports this remedy. However, the CC's provisional decision does not explicitly deal with the way in which NHS work is used as an inducement for surgeons to bring additional private work to private hospitals (PHs). This is a much more significant inducement in financial terms than any other, both individually and together (more than £50m per annum, and growing). This inducement falls squarely within the logic of the CC's remedy and should be recognised explicitly in the CC's final decision.

▪ **Remedies 5-7 – the provision of information about consultant performance:**

As the CC is aware, the AAGBI supports this remedy¹. However, there are some important issues that will need to be addressed if the remedy is to be successful. In particular, those consultants who can demonstrate the highest quality of care should be able to charge higher fees than those who cannot. It is illogical to allow the PMIs to continue to restrict the ability of consultants to set their fees. Consultants must be allowed to charge a "top-up fee", if estimated in advance, and patients should be allowed to pay this if they wish to. Without this, the remedy will not achieve its purpose.

These issues are explained in more detail below.

¹ http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/aagbi_response_to_provisional_findings_and_possible_remedies.pdf

² Financial Times, January 26 2014. *Bupa examines single-condition policies to reverse patient exodus*. [Online] Available at: <http://www.ft.com/cms/s/0/96b2a872-85e5-11e3-b30d-00144feab7de.html#axzz2raveveR5>. [Accessed 2 February 2014].

Remedy 4. Clinician Incentives.

As the CC is aware, the AAGBI supports this remedy^{1,3}. However, further work needs to be done if the remedy is to be effective.

In recent years, increasing volumes of NHS work have been undertaken in PHs. The NHS proportion of total PH funding has grown from <5% in 2002 to a projected 29% in 2013⁴. It is estimated that in 2014, this proportion will be at least 35%, as Laing and Buisson report that NHS spending continues to grow at a rate of 5-10% per annum in real terms⁵. As NHS contracts are heavily discounted compared to privately insured work, being dependent on the national tariff⁶, volumes are substantially greater than these income proportions suggest. In some PHs, NHS work represents as much as 70% of the patient volume⁷. This proportion is likely to continue to increase in accordance with UK Government policies.

Private hospitals tender for NHS contracts from NHS Trusts and Commissioning Groups. A PH may therefore contract to perform a specific number of procedures (for example, 20 hip replacements) for an agreed price, usually based on a percentage of the national tariff. The PH manager allocates this NHS work to surgeons. As one might expect, those surgeons who are loyal to the PH and who bring in the most private work tend to be rewarded by the hospital manager with additional NHS referrals. The surgeon who diverts his/her private work to a rival hospital, either in full or part, will lose some or all of his/her valuable NHS work and so will be less inclined to move.

Additional NHS activity in PHs is also procured by the AQP (Any Qualified Provider) "Choose and Book" arrangements whereby patients can choose a surgeon and hospital in the private sector, funded by the NHS. Referrals are made to specific surgeons, but the total cost is negotiated by the hospital in the same way as that described above and the hospital manager decides on the fees to be paid. Usually, the fees for NHS work are the same, regardless of the referral pathway. The surgeon is less dependent in these circumstances, but will still require considerable co-operation from hospital management in the provision of operating time, equipment and beds. In practice therefore, a surgeon who is seen as disloyal will find it much more difficult to treat AQP patients than one who is not.

More importantly, the basis of fee allocation to the various specialists involved in NHS patient care acts to further incentivise surgeons. In the NHS, consultants from all medical specialties are paid according to identical pay scales. However, for the same NHS work undertaken at PHs, the PH manager decides how to divide the fee income received by the PH from the NHS amongst the clinicians who carry out the operations and any other work associated with surgery, such as radiology and pathology. The hospital manager generally chooses to divide the fee disproportionately in favour of the surgeons, as they have the ability to divert private work to that hospital.

Surgeons are often paid up to three times the hourly rate paid to other consultants with similar training, experience and responsibility, and it is this additional payment that acts as a significant inducement⁸.

To give a practical example, a surgeon is commonly paid just over £500 for an NHS total hip replacement, whereas a consultant anaesthetist is paid £260. All else being equal, if a consultant anaesthetist is willing to undertake the work for £260, we would expect a consultant surgeon to be paid the same⁹. In this example, the removal of the inducement would not only remove its distortive effects on the private healthcare market, but would also save at least £240 of public money at a time when NHS budgets are under pressure.

³ http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130704_aagb1.pdf

⁴ LaingBuisson Healthcare Market Review 2013-2014. Fig 1.1.2. p 32. Sources of funding for independent acute medical/surgical hospitals and clinics, UK 2012. Twenty sixth edition. Laing & Buisson Ltd, London.

⁵ LaingBuisson Private Acute Medical Care UK Market Report 2013. Executive Summary & Report Highlights iii. Laing & Buisson Ltd, London

⁶ <http://www.monitor.gov.uk/nt>

⁷ LaingBuisson Private Acute Medical Care UK Market Report 2013. 3.3.5 Ramsay Health Care, p65. Laing & Buisson Ltd, London

⁸ AAGBI can supply the CC with various fee schedules for NHS work at various PHs on request.

⁹ The surgeon would also receive significant additional fees for outpatient consultations with the patient, which do not involve other consultants.

In summary, this issue therefore acts as a direct inducement to surgeons to bring additional private work to the hospital in two main ways:

1. The promise (implicit or explicit) of additional NHS work as a reward for bringing in private work to the hospital.
2. The use of disproportionate fee schedules for that NHS work, which overpay surgeons compared to the fees of other consultants, i.e. those who do not have the power to divert private work to that hospital, and compared to the earning ratios that would have been in effect in the NHS, without an objective justification.

Each of these two issues represents tens of thousands of pounds per year for individual surgeons (occasionally hundreds of thousands), and are therefore fundamental to their practice and their annual income in such a way that other inducements specified by the CC, such as the provision of equity, free consultation rooms and secretarial support, become insignificant for many consultant surgeons.

The total cost of this inducement can be roughly calculated. In 2012, private consultants were paid £1.64bn in fees¹⁰. 27.5% of the hospital income was from the NHS, so it is not unreasonable to estimate that 27.5% of the specialist fees were also from this source, i.e. approximately £450m. The bulk of this funding was for elective surgery¹¹. The majority of this was paid to surgeons and anaesthetists; we estimate 80%, or around £360m. Surgeons earn fees for outpatient work and surgery under local anaesthesia or sedation, reducing the total fees earned for procedures involving an anaesthetist by perhaps 30%, i.e. to approximately £250m. There were 345,200 NHS admissions to the private sector in 2011/12¹², so the average total fees per procedure would have been around £725, which seems approximately correct⁸. Fees are usually split approximately 60/40 in favour of the surgeon, i.e. £150m to the surgeons and £100m to the anaesthetists⁸. The value of the inducement was therefore approximately £50m in 2012. As the amount of NHS work performed in the private sector increased to 400,000 admissions in 2013¹³, and is expected to increase further in the future, the value of this inducement is also increasing alarmingly. In 2014, it could therefore be more than £70m, or an average of £14,000 per annum per surgeon¹⁴.

This is public money that is being channelled into PHs and is being used as an inducement. If all consultants treating NHS patients in PHs were paid similar hourly rates, the PHs would be able to bid lower for the NHS work being tendered and the exchequer could therefore save tens of millions of pounds, which could be returned to the public purse and used to treat more NHS patients.

This situation adversely affects all consultants who are not surgeons, but who are essential to the totality of care. More importantly from the CC's point of view, it also adversely affects competition in the private healthcare market because it greatly distorts the referral decision-making process. Surgeons are incentivised to treat patients at PHs on a basis other than pure medical need. We see this issue as falling squarely within the intended ambit of, for example:

- Paragraph 8.133 of the provisional findings, which states: "*The competitive harm that arises from consultant incentives on choice of hospitals is that they might incline consultants to refer patients to or treat patients at a hospital that they would not have chosen on grounds of either quality or of price and that hospital operators may therefore choose to compete over rewards to consultants rather than on the basis of the quality or price of their facilities.*"
- Paragraph 2.382 of the provisional decision on remedies, which states: "*We thought that any scheme operated by a PH operator, whether contractual or not, which provided an inducement to, or created an obligation on, a clinician to treat or refer patients for tests at its hospital or hospitals should be prohibited outright.*"

¹⁰ LaingBuisson Healthcare Market Review 2013-2014. Fig 1.1.1. p 30. Private acute medical care market value by component, UK 2012. Twenty sixth edition. Laing & Buisson Ltd, London 2014..

¹¹ LaingBuisson Healthcare Market Review 2013-2014. Para 1.15. p 30. Twenty sixth edition. Laing & Buisson Ltd, London 2014.

¹² <http://www.theguardian.com/society/2012/nov/01/nhs-use-private-sector-increasing>

¹³ LaingBuisson Healthcare Market Review 2013-2014. Fig 1.1.3.,p34. Twenty sixth edition. Laing & Buisson Ltd, London 2014.

¹⁴ There are 7537 consultant surgeons in England. <http://www.rcseng.ac.uk/media/media-background-briefings-and-statistics/surgery-and-the-nhs-in-numbers>. We estimate that like consultant anaesthetists, about 70% work privately, ie about 5000.

Although these inducements are arguably already covered by the CC's provisional remedy, we believe they ought to be included explicitly in the CC's final remedy because far less financially significant inducements have been specified. If this inducement is not made specific, the AAGBI believes that the ban on other inducements will have no significant impact, as by comparison, they are of minimal financial value. The proposed remedy will then be ineffective in ensuring that surgeons choose private facilities for their patients unfettered by their own commercial considerations. As such, the remedy would be disproportionate, as it would not justify the administrative cost of regulation.

We suggest that in this respect, a fee would act as an inappropriate inducement where the surgeon's hourly pro rata payment after deduction of directly incurred expenses is more than 10% higher than the rates offered to consultants from other medical specialities also involved in the treatment of these patients.

As a final point, we recognise that publicly funded healthcare is outside the CC's statutory remit. However, it is clearly within the CC's remit to remedy conduct that has distortive effects on the private healthcare market, wherever that conduct occurs.

Remedies 5-7. Information on consultant and hospital performance.

As the CC is aware, the AAGBI is supportive of the remedies that improve the availability of information on consultant and hospital performance^{1,3}. However, there are some important issues that still need to be addressed.

PMI benefits

We believe that comparative information on PMI benefits ought to be included alongside all the other information that will be collected centrally (to the extent this is possible given the CC's AEC findings). Consumer interests will be best served by having all the necessary information in one place. Consumers should be able easily to compare the consultant and hospital performance indicators, fees and hospital charges for a proposed procedure code with the PMI benefits (reimbursement of fees) they have paid for, so they can shop around for the best deal. This will not only promote competition between consultants and PHs, but also between PMIs, going some way towards addressing the notable failure of the PMIs to action the OFT recommendation that they should work with the FCA and the ABI to improve the transparency of PMI benefits at the point of sale¹⁵.

For the same reason, the AAGBI considers that the hospital charges should also be made available centrally.

PHIN

The AAGBI notes that the CC recommends that PHIN act as the central information resource, which, although funded by the industry, will be independent of PMIs and PHs. The AAGBI supports this suggestion and believes it is absolutely essential that this independence be preserved. We welcome the suggested arrangements to ensure this.

Representation

We note that the AAGBI is specifically mentioned as an example of a professional organisation that could act for consultants and we confirm that as the representative of the largest consultant speciality active in the UK's private healthcare sector, we would be pleased to do so, alongside organisations such as FIPO¹⁶ and the Association of Surgeons of Great Britain and Ireland (ASGBI)¹⁷. The involvement of the Royal Colleges might best be served by involving The Academy of Medical Royal Colleges (AoMRC)¹⁸, as traditionally, although active in quality improvement initiatives, the Royal Colleges have limited interest in the private sector, as indicated by their lack of involvement in this investigation.

The CC has invited submissions on how member organisations should be represented within the information organisation. Firstly, we do not consider that the PMIs, as funders of private healthcare, not regulators or providers, should have any executive authority or membership. Consultants and

¹⁵ http://www.of.gov.uk/shared_of/market-studies/OFT1412.pdf. Para.1.29

¹⁶ <http://www.fipo.org.uk/>

¹⁷ <http://www.asgbi.org.uk/>

¹⁸ <http://www.aomrc.org.uk/>

PHs, as the providers of private healthcare supplying the relevant information, should be represented at executive level and in the membership base in equal proportion in terms of voting power.

Data protection

The AAGBI notes that raw data are to be shared across multiple organisations. We have concerns that this will be misused for commercial gain, particularly by the PMIs. We are concerned that consultant anonymity and confidentiality will not be preserved, particularly by use of the GMC number, as it is very simple to look up the name of a consultant using their GMC number on the GMC website¹⁹. If such data are to be shared with external organisations such as the PMIs, the CC should seek further advice on the information governance implications. Pseudo-anonymous consultant identifiers should probably be generated by the PH and should not be shared with any external organisations without consent. We have no objection to the sharing of anonymised, analysed, combined data, but sharing of raw data and/or consultant identifiers will probably require signed consent, if this is allowed at all according to data protection regulations. Such consent should be freely given and not dependent on commercial factors, e.g. PMI “recognition” or PH regulations. However, most consultants will probably agree to be identified, as they will wish to be able to promote the quality of care they provide, thus justifying the fees they propose to charge. However, if their fees are to continue to be constrained by the PMI recognition requirements, they may see little point in co-operating with this initiative and may refuse consent (see below).

Complexity and delay

The AAGBI considers that the cost of the central information organisation has been considerably underestimated, as has the complexity of the process of data collection, analysis and presentation in a convenient and understandable format. There are thousands of procedure codes to be matched in ICD10 and CCSD, with thousands of consultants providing individualised data on performance and fees, all of which will need to be regularly updated. Nevertheless, the AAGBI supports the CC's ambition to achieve this.

The AAGBI is concerned that the central collection of fee information will be delayed until 2016, pending the development of a robust system for performance analysis. This seems to be at the request of the PMIs, who fear a “race to the top”. We believe that again, the commercial considerations of the PMIs seem to be considered above the interests of the consumer. It is the AAGBI's view that the consumer would be best served by a centralised source of all relevant information as soon as possible, so they can compare the cost and quality of care with the benefits provided by their PMI, if they are insured. The competition principles underlying the CC suggestion for more available information on quality and cost at a central facility must prevent the “race to the top”. If there is good evidence that fee escalation would occur in the above circumstances, then the whole concept is flawed and the huge costs of implementation have to be re-considered against the diminished advantages gained. It is the AAGBI view that this is an “all or nothing” situation and central data collection of all relevant information, including fees and PMI benefits, should proceed simultaneously.

Promoting competition

The AAGBI agrees with the CC that the above remedies should encourage the consumer to shop around on the basis of quality and cost, so promoting competition between consultants, PHs and PMIs. This should drive down the cost and increase the quality of private healthcare and health insurance. However, this will only work if consultant and hospital fees are allowed to vary according to free market principles and customers are free to choose on the basis of quality and cost. This does not happen currently and it will not happen in the future unless PMI constraints on customer choice are removed²⁰. If this continues, the cost of providing the central information service will not justify the assumed benefit and the remedy will not therefore be proportionate.

Therefore, PMI-controlled fee restrictions within recognition agreements should be prohibited by the CC, so that a truly free market prevails and maximum value pertains from the above remedy. In

¹⁹ http://webcache.gmc-uk.org/gmclrm_p_enu/start.swe?SWECmd=GotoView&SWEView=GMC+WEB+Doctor+Search&SWEApplet=GMC+WEB+Health+Provider+Search+Applet

²⁰ LaingBuisson Private Acute Medical Care UK Market Report 2013. Executive Summary & Report Highlights iv. Laing & Buisson Ltd, London. “—the market must be supported by unfettered competitive levers which are endogenous to the market, rather than the market being subject to exogenous regulatory controls—”

particular, those consultants who can demonstrate the highest quality of care should be able to charge higher fees than those who cannot. Patients should be able to choose these consultants and if necessary, pay a top up fee to do so, unrestricted by their PMI. The CC's final conclusions and remedies should repeat the endorsement in the Annotated Issues Statement of the right of consultants to charge a "top-up fee" if estimated in advance²¹, without the fear of PMI de-recognition. The AAGBI believes this is crucial to the success and value of this remedy. Without this, the remedy will be disproportionate.

Fee estimates

The AAGBI notes that the CC recognises the difficulty in providing fee estimates for anaesthesia in advance of surgery, particularly at short notice. We agree with the suggestions made to resolve this problem but are concerned that the surgeon or hospital may provide a quote for anaesthesia, which might then be considered binding, without consulting with the anaesthetist. The AAGBI suggests that after failure of every reasonable effort to consult with the anaesthetist or his/her representative, an anaesthetic benefit calculated from survey data that would represent the local median or mode value should be quoted, but with the proviso that this is not binding and the patient should confirm the anaesthetic fee at pre-operative assessment with the anaesthetist. However, we would expect this to be a very rare occurrence.

Passing on the costs

The AAGBI is extremely concerned that the substantial costs of implementing these remedies will be passed on to the consultants and PMI subscribers in the form of reduced PMI benefit maxima and increased hospital costs. The CC should enforce robust mechanisms to ensure that this does not happen. We note that the CC suggests that all funding should be provided by the PMIs and PHs. The AAGBI agrees with this approach as, ultimately, cost savings will result from this investment, which should be passed on to customers via reduced costs of treatment and lower PMI premiums. However, we are concerned that without more robust monitoring, savings will instead be diverted into profits, surpluses, capital investments and executive salaries. We suggest that the private health market should continue to be closely monitored by the FCA and CMA.

Other Remedy Proposals

The AAGBI is disappointed that the CC did not discuss our suggestion of a new remedy to enforce the OFT recommendation that they should work with the FCA and the ABI to improve the transparency of PMI benefits at the point of sale¹⁵.

The AAGBI strongly supports the PruHealth suggestion for a remedy that implements a sensible basis for the setting of consultant fees, based on average costs, time, risk and complexity rather than on arbitrary PMI benefits. Similar systems work very well in other nations and have not resulted in fee inflation or stifling of competition. Each consultant would be able to decide the baseline unit cost and so would insurers. We would anticipate considerable variation in this baseline unit, stimulated by competition, far more variation than in the current UK system, which is, in effect, constrained by the PMI benefit maxima and the Bupa 5x5 table in particular. We agree that a new system would be complex to establish, but disagree that this would be difficult to maintain or be disproportionate to the benefits realised. We strongly suggest that the CC re-examines this excellent proposal.

²¹ http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/provisional_findings_.pdf