

ULSTER INDEPENDENT CLINIC

SUBMISSION TO THE COMPETITION COMMISSION IN RESPONSE TO ITS PROVISIONAL DECISION ON REMEDIES RELATING TO THE PRIVATE HEALTHCARE MARKET INVESTIGATION

1. INTRODUCTION

- 1.1 The Ulster Independent Clinic (**UIC**) has reviewed the provisional decision on remedies published by the Competition Commission (**CC**) on 16 January 2014 (**Decision**).
- 1.2 UIC in principle agrees with the prohibition on clinician incentive schemes and the increased provision of information on hospital and consultant performance and fees to patients. However, it believes that the implementation of these remedies in the Decision (Modified Remedies 4 - 6), as currently drafted, raise a number of practical issues. We set out below a summary of the main issues we have been able to identify in the time period provided for responses but would be happy to discuss any of the issues raised in further detail with the CC.
- 1.3 Please note that we have adopted the CC's abbreviations as set out in the Glossary, where appropriate.

2. REMEDY 4: PROHIBITION AND RESTRICTIONS ON CLINICIAN INCENTIVE SCHEMES

- 2.1 UIC welcomes the proposed ban on clinician incentive schemes in principle. However, we believe that the *de minimis* limit of £500 set in paragraph 2.379 is too low. For example, if a hospital provides free coffee to employees and consultants working at the hospital, the annual market value of the coffee provided to a clinician alone could exceed £500. We do not believe that the provision of, for example, free coffee and newspapers is intended to be caught by the proposed prohibition and we therefore suggest raising the *de minimis* limit or to base the valuation on the cost of providing the service.
- 2.2 In addition, if the cumulative value of the services provided to a clinician falls below the *de minimis* limit, then it seems clear that they will not influence or incentivise clinicians and therefore it is difficult to understand why services of this nature should be disclosed on the hospital's website.
- 2.3 We note that paragraph 2.378 of the Decision refers to the provision of parking spaces as services of higher value. How do you envisage dealing with a situation where a private hospital has one car park which is available for free

use by patients, staff, visitors and consultants and where no spaces are specifically allocated to any one individual or group of people?

3. REMEDY 5: PUBLICATION OF INFORMATION ON HOSPITAL AND CONSULTANT PERFORMANCE

Publication of Information

- 3.1 We note that paragraph 2.465 of the Decision provides for certain information to be made available by private hospital operators to the information organisation. This includes, inter alia, the volumes of procedures undertaken and the average lengths of stay.
- 3.2 The UIC considers that this type of information, given its nature, is commercially sensitive and, while it is happy to provide this data to an independent information organisation, it believes that it should only be used by the organisation as a reference to calculate, for example, the percentage of readmission rates for a certain type of procedure but should not to be published in itself.

Coding

- 3.3 Paragraph 2.467 of the Decision states that “[w]e were told that the private hospitals currently use OPCS coding for their NHS patients and CCSD coding for private patients...by April 2019, we will require the insurers to adapt their IT and billing systems to use OPCS coding, allowing the private hospitals to submit invoices with a single procedure code”.
- 3.4 UIC does not use OPCS coding any more having moved from OPCS coding to CCSD coding a number of years ago, UIC is concerned at the administrative burden and cost such a change will incur.
- 3.5 UIC also notes the reference in footnote 229 to ICD 10 coding. While it would be important to have a universal diagnostic coding system, we believe that further consultation, with clinical input, on the best coding for this purpose would be required.

Membership of PHIN

- 3.6 We note the proposal in paragraph 2.472 that the Chair should nominate new board members. Good governance would suggest that a nomination committee be formed for this purpose.

Data protection

- 3.7 UIC has concerns about the data protection implications of disclosing patient identifiable data to the information organisation as suggested in paragraph 2.465 of the Decision. The obligation to disclose sensitive personal data, including NHS numbers, to facilitate publication of performance measures lacks sufficient clarity to justify the release of this personal information. There is a real possibility that individual patients could be identified. Patient consent will need to be sought and informed consent cannot be obtained where there is uncertainty as to how sensitive personal data will be used. A data sharing agreement setting out how data will be collected, used and disposed of would be necessary.
- 3.8 UIC also has concerns in relation to the data protection implications of the proposed provision of GMC numbers of the consultant responsible for each patient episode. The ability to obtain consent to provide this information and ensure fair processing, in the face of uncertainty as to how this information will be used to assess individual performance.

4. REMEDY 6: PROVISION OF CONSULTANT FEE INFORMATION

Initial Letter and Standard Terms of Business

- 4.1 UIC notes paragraph 2.527 of the Decision which states that “[t]he first letter should be sent at the same time as the outpatient consultation is confirmed with the patient.”
- 4.2 UIC is unclear what a private hospital is required to do in circumstances where a short notice appointment has been made, e.g. where a patient phones in the morning for an appointment that afternoon or the next day. One of the reasons why patients choose private healthcare is the speed with which they can get an appointment. In UIC’s experience, many appointments are made with less than 48 hours notice. The consultants are often not on site at the time the appointment is made and therefore not able to send out the letter prior to the appointment. Indeed, consultants may see patients at external consulting rooms which are not linked to the hospital.
- 4.3 Another practical difficulty with this remedy is the fact that a consultant will not always have the benefit of the GP letter when the appointment is made. In UIC’s experience, the appointment is made directly by the patient in the majority of cases, with the patient bringing the referral letter with them to the appointment. In these circumstances, it is unclear what information a consultant can give a patient at the time the appointment is made.

- 4.4 In addition, where the consultation takes place at external consulting rooms independent of the hospital it may not be clear, at the time the appointment is made, in which hospital the treatment, if required, will be provided. Equally, if a consultation takes place at a private hospital, the treatment will not necessarily happen at the same hospital. It would not therefore be possible to provide accurate fees on hospital charges until it is clear which hospital will be used for the treatment.

Follow-up Letter

- 4.5 We also note paragraph 2.524 of the Decision which states that “[a]t the time of recommending or confirming further treatment, whether surgical, medical or other, the consultant should provide patients with written confirmation of: (a) their diagnosis; and (b) a fee quote for the specific treatment (pathway) recommended for the patient...”
- 4.6 It is important to point out that, at the time a consultant recommends or confirms a further treatment, a diagnosis may not yet have been made. In fact, it is this further treatment which may assist the consultant in making the diagnosis. If this is the case, the consultant cannot provide patients with a written confirmation of the diagnosis.

Enforcing Compliance

- 4.7 Paragraph 2.527 of the Decision requires private hospital groups “to ask every patient undergoing treatment at their facilities to confirm (by signing) that they received the above information in advance. Where consultants do not provide sufficient information to patients, it would be the hospitals’ responsibility to enforce compliance”. We presume that this requirement applies to all private hospital operators and not just private hospital groups.
- 4.8 In view of the fact that consultations can take place in private consulting rooms independent of the hospital or indeed in other hospitals, we agree with the suggestion by Nuffield in paragraph 2.508 of the Decision that professional bodies be responsible for the oversight and enforcement of this remedy.

Implementation

- 4.9 The implementation of this remedy represents a major change in the current practice of private hospitals and consultants. The UIC believes that an implementation time-scale of 6 months from the order being made is entirely unrealistic but that a time period of approximately 18 – 24 months may be achievable.