

HCA's response to the CMA's Notice relating to Article 22 of the Private Healthcare Market Investigation Order 2014

10 November 2016

1. Introduction

- 1.1 HCA submits this response to the CMA's notice dated 10 October 2016 stating its intention to vary the Private Healthcare Market Investigation Order 2014 and to bring Article 22 of the Order into force (the "Notice"), as set out in the draft Variation Order annexed to the Notice.
- 1.2 The Notice invites comments in relation to the following:
 - timing for the implementation of Article 22;
 - variations to Article 22 proposed by the CMA in its draft Variation Order; and
 - whether there has been a material change in circumstances relevant to Article 22.
- 1.3 We further note that the CMA has a general duty to keep the Order under review and from time to time consider whether by reason of any change of circumstances the Order needs to be varied as the current form of the Order is no longer appropriate (section 162 of the Enterprise Act 2002).
- 1.4 HCA supports the CMA's objective of improving transparency of consultant fees for the benefit of patients, and welcomes this opportunity to comment on the implementation of Article 22 of the Order.
- 1.5 HCA appreciates that the CMA is eager to put Article 22 into effect as soon as practicable. However, it is of primary importance that appropriate planning and preparatory steps take place first so that the remedy has the desired effect on day one and delivers the expected benefits to private healthcare users. In that regard, while the CMA's timescales for the submission of information to PHIN (under Article 22.1) appear to be broadly reasonable, it is submitted that the time frame for implementing some of the measures in Article 22.2 are not realistic and pose a risk to the successful implementation of the remedy.
- 1.6 HCA does not comment in this submission on the provisions of Article 2.1 of the draft Variation Order, which set out the proposed timetable for the submission of information of fee (and other related) information by consultants directly to PHIN for publication on its website. With respect to the other substantive provisions of Article 22 and of the Variation Order, while HCA supports their underlying intention, as presently drafted, a number of provisions are at risk of being completely unworkable and, more importantly, worsening patient welfare. In particular, HCA has concerns that specific provisions in Article 22 could have the unintended effect of deterring patients from undergoing important treatment.
- 1.7 HCA sets out below the further steps the CMA can take in order to improve the effectiveness and practicability of the remedy while also minimising the impact on the quality of patient healthcare.
- 1.8 As the CMA is aware, quality of care is multidimensional and encompasses, among other things, the quality of "customer service". This is particularly important in healthcare, as many patients will exhibit feelings of anxiety or stress prior to and during their treatment, therefore

minimising the administrative burden on them, managing the flow of information to them, and making their patient journey as seamless as possible must be given importance by the CMA (alongside the goal of transparency) when implementing Article 22.

1.9 Prior to finalising the Variation Order, HCA invites the CMA to meet with HCA's staff and doctors practising at its facilities in order to hear their views on the practical issues and more fundamental obstacles which may arise in implementing Article 22. HCA would be more than happy to organise such a meeting to facilitate a constructive discussion focused on shaping a more effective remedy.

1.10 This submission is comprised of the following parts:

- Section 2: Summary of the key points
- Section 3: Provision of fee information to patients
- Section 4: The terms and conditions of Practising Privileges
- Section 5: Compliance monitoring by hospital operators

2. Summary of key points

2.1 **A statement of services which have not been included in the estimate, such as those arising from unforeseeable complications (Article 22.4(c)):** If applied as currently drafted, HCA has concerns that this provision is not only unworkable (as it requires doctors to foresee the "unforeseeable"), but that it may have serious consequences for patient welfare. The CMA should be very wary of requiring doctors to present to their patients a long list of theoretical eventualities which may conceivably arise on the day of treatment as, among other things, it may have the effect of deterring patients from undergoing important treatment or diagnostic checks. At the very least, the CMA ought to consult with clinician and patient groups to discuss this provision further prior to its implementation.

2.2 **An estimate of the cumulative consultant cost of the treatment pathway (Article 22.4(b)):** The application of this provision raises practical difficulties for doctors, particularly where the treatment pathway is likely to be uncertain in complexity and length. Given the possibility that such a provision will place a resource strain on doctors, HCA suggests that the CMA allow doctors to include the estimated cost of treatment for the "typical patient" in their fee communication. HCA also recommends that the CMA limit the scope of this provision to self-pay patients only, as it is unlikely to be of meaningful value to insured patients. On a general note, HCA is concerned about the level of "information bombardment" which patients have raised during consumer research sessions of their experience while at hospital. The Variation Order is an opportunity to streamline the information requirements to what is strictly beneficial for different patient groups.

2.3 **Two working day rule (Article 22.6):** The CMA has included a two working day rule in respect of fee communications under Article 22.4 (prior to further tests or treatment). However, the design of the rule is flawed and risks adversely affecting patients' healthcare. In particular, it does not provide an opportunity for doctors to deliver "non-emergency" (but still potentially important) care to patients the next day, and HCA has included a suggestion below for dealing with this gap in the Order.

- 2.4 **Compliance monitoring forms (Article 22.7 as amended by the Variation Order):** Whilst HCA appreciates the underlying intention behind this provision, HCA assumes that the CMA did not intend for patients to sign a form prior to every appointment or "procedure" that they are about to undergo as this could result in multiple forms being signed within a given hospital stay. HCA also has concerns about whether patients are likely to understand all of the questions which are required to be put to them or be able to recall precisely what information was or was not provided by a given doctor. HCA suggests that the CMA put in place alternative measures which would be more practical to implement and involve a single point of confirmation for a given hospital admission. Alternatively, the CMA could instead require that hospital operators devise and implement their own compliance monitoring process, rather than adopt a one-size fits all approach involving more patient forms.
- 2.5 **Timing for implementation:** Imposing an implementation date (in respect of Articles 22.2 and 22.7) of 2 months from the date of the Variation Order is not realistic and risks jeopardising the successful implementation of the remedy. When introducing sweeping changes to consultant Practising Privileges and working practices, there will need to be an appropriate period of consultation and training with doctors and their staff (primarily medical secretaries), and time for procedures and checks to be put in place so that this practice is uniformly adopted across HCA's hospital network which will involve training and development of business office colleagues. For that reason, HCA submits that a period of 12 months from the date of the Variation Order is the minimum deadline that should be incorporated into the Variation Order.
- 2.6 **Condition of Practising Privileges:** To the extent that HCA is not already complying with this aspect of the Order, it is simply not possible to implement changes across the entire population of doctors' Practising Privileges documentation within a two month time frame. A period of 12 months from the date of the Variation Order is more realistic given the number of doctors involved and taking into account the time required to consult with doctors and address their queries.

3. **Provision of fee information to patients (Articles 22.2 – 22.6)**

- 3.1 Article 22.2 requires hospital operators to provide consultants with an appropriate template communication (approved by the CMA), for the purpose of providing upfront fee information to patients. In particular:
- (i) the information specified in Article 22.3 prior to outpatient consultations; and
 - (ii) the information specified in Article 22.4 prior to further tests or treatment.
- 3.2 HCA is of course willing to provide fee template communications to consultants. However, there are some important issues for the CMA to consider prior to confirming the wording of the template communication.

The provision of fee information prior to outpatient consultations (Article 22.2(a) and 22.3)

- 3.3 HCA remains supportive of the requirement that consultants send a communication to patients prior to the patient's consultation session setting out the consultant's outpatient fees and other information specified in Article 22.3.
- 3.4 Nonetheless, there will need to be an appropriate period of consultation with doctors across the range of specialties before finalising the form of template communication. A period of

time will also be required to ensure procedures are put in place so that this practice is uniformly adopted across HCA's hospital network. To accommodate that process, HCA suggests that the timing for implementation in the Variation Order be specified as "no later than 12 months from the date of the Variation Order".

- 3.5 With respect to the specific provisions to be included in the communication, it would be helpful if the CMA could clarify in its revised Explanatory Memorandum the meaning of "financial interests" in Article 22.3(b), and if this extends beyond the form of financial interests which must be disclosed under Article 19.1 of the Order.

The provision of fee information prior to further tests and treatment (Article 22.2(b) and 22.4)

- 3.6 While HCA understands the underlying objective behind the provision of the information in Article 22.4 to patients, as noted in previous submissions, there are some serious practical issues with this part of the remedy which must be addressed and clarified now in order to ensure the remedy is workable and benefits patients.

(a) The reason for the relevant further test or treatment

- 3.7 This seems like an entirely reasonable and important piece of information for patients to receive (in writing or orally) and HCA supports its inclusion in Article 22.4.

(b) An estimate of the cumulative consultant cost of the treatment pathway recommended

Insured patients

- 3.1 As the CMA recognised, in the case of insured patients, the critical issues for the patient are (i) whether they are pre-authorized by their insurer for the consultant's cost of the proposed treatment, and (ii) whether there is likely to be a "top-up" fee payable.¹ Any other information relating to the **total cost** of the treatment journey risks unnecessarily confusing an insured patient and offers little or no value. The considerations that arise in the case of self-pay patients are of course different (as noted below).
- 3.2 First, insurers generally require that every step in the policyholder's pathway is checked and pre-authorized. This is the requirement that insured patients must be careful to comply with to avoid a shortfall or unexpected cost. The consultant's role is therefore to aid the patient in providing information their insurer requires (usually only the supporting clinical reasoning as per Article 24(a)). Insurers have their own, well-established means for assessing if the consultant is, first, recognised and, secondly, if the cost of treatment is covered under the policy and will advise the patient accordingly.
- 3.3 Secondly, in the CMA's original Final Report, the supporting evidence for more disclosure of consultant fees to insured patients appears at paragraph 9.16 of the Final Report, where the CMA noted that: "Whether the **PMI** would cover their fees" was the third most important factor to patients when choosing a consultant. Moreover, at paragraph 7.113 of the Final Report, the CMA notes that one of the main criticisms of "**insurers' conduct**" was "providing misleading information to patients on the status of consultants and/or their level of charges". Therefore, the issue of whether a patient is fully covered for care under their PMI policy is a matter of direct dialogue between the insurer and patient.

¹ Private Healthcare Market Investigation, Final Report (April 2014), 11.628 - 9.

- 3.4 For the above reason, Article 22.4(b) should be removed for "insured patients" and replaced with a more relevant (and beneficial) provision akin to Article 22.3(d), for example: "a statement that insured patients should check with their insurer the terms of their policy, with particular reference to the level and type of cover they have".
- 3.5 HCA is concerned about the "information bombardment" which patients take issue with while at hospital. The Variation Order is an opportunity to streamline the information requirements to what is strictly beneficial for different patient groups.

Self-pay patients

- 3.6 For **self-pay** patients, who, by definition, fund their own treatment, the information concerning the cumulative consultant costs will be of value and should of course be provided. There will still be practical difficulties with assessing the cost of a treatment pathway. For example, if the pathway involves a post-operative stay, a patient may take longer to recovery from surgery or develop complications which mean the treatment pathway is materially different from that expected.
- 3.7 To alleviate the burden on clinicians on this issue, HCA recommends that the CMA permit consultants to disclose the standard cost of consultant treatment for the "typical patient". This would also ensure that consultants competing to attract patients have a common understanding of this part of the Order and that self-pay patients can, if necessary, make a like-for-like comparison between consultants.
- 3.8 In the CMA's revised Explanatory Memorandum accompanying the Order (or in the Order itself), it would be helpful if the CMA clarified what consultants should do in the event that a materially different treatment pathway is required. Treatment is an iterative process and, in some cases, may change course considerably within a short period of time.

(c) [part 1] a statement of any services which have not been included in the estimate, such as those resulting from unforeseeable complications.

- 3.9 As noted by HCA during the original remedy consultation, it is this aspect of Article 22 which requires very careful reconsideration by the CMA, as it risks causing confusion amongst practitioners and patients, and potentially poses a serious risk to patient welfare.
- 3.10 First, a requirement that the communication detail "any" services which have not been included in the estimate, such as those resulting from "unforeseeable complications" is, on a plain reading, impossible to achieve. If a complication is **unforeseeable** it cannot, by definition, be foreseen by the consultant and the associated services cannot be disclosed at the outset.
- 3.11 Secondly, while it is of course necessary to be forthright and transparent with patients, the CMA should be extremely wary of unnecessarily compounding any patient anxiety with a long list of theoretical or speculative eventualities that may conceivably arise on the day of treatment. The risk here is serious. A patient may decide against important treatment based on an improper assessment of the probability of such a complication arising at a time when the patient is vulnerable.
- 3.12 Thirdly, it is not clear what the CMA means by a "statement of **any** services which have not been included in the estimate" and of what value this is to the patient. Also, on a plain

reading of the Order, this means literally "any" service not expected to be provided to the patient.

3.13 Fourthly, under Article 22.5, we note that in the case of "same-day treatment" it may be necessary to provide this information orally. To be presented orally to a patient, it should be a salient and easy to understand message. On the current drafting, it would not be.

3.14 It is possible the CMA intended to refer to a "short statement of services which may be necessary following *reasonably foreseeable* complications". However, even this wording is not without practical difficulties. A large variety of complications may be reasonably foreseeable (albeit unlikely), depending on the procedure and the patient. Ultimately, an element of discretion will need to be afforded to the consultant to decide which services (in the event of complications) should be communicated to the patient.

3.15 In sum, there are clear difficulties with this aspect of the Order which it is submitted should be addressed now. When doing so, it is again worthwhile recalling the underlying purpose of the provision. In the case of insured patients it is so the patient can confirm their cover status in authorisation discussions with the insurer, and, in the case of self-pay patients, it is so the patient can prepare themselves for the potential expense. As part of that, HCA urges the CMA to carry out a short remedy consultation process with insured and self-pay patient focus groups in relation to this (and other aspects of the Order) to help shape this part of the remedy.

3.16 In HCA's view, there are two possible options available to the CMA:

- (a) Remove this provision altogether as it is the part of this remedy which has the highest risk of causing more harm than good (or, at the very least, consult with patient groups about its potential impact on patient decision making prior to deciding on its inclusion).
- (b) Replace it with: "an insured patient should consult his insurer to determine what cover will be provided in the case of unforeseeable complications", and, in the case of self-pay patients, a general note of caution that "the estimate does not include costs arising from unforeseeable complications."

(c) [part 2] Where alternative treatments are available but the appropriate treatment can only be decided during surgery, the estimate should set out the relevant options and associated fees

3.17 As noted above, the part of the provision requiring the consultant's "associated fees" is of no or little value to insured patients whose chief concern is that they are fully covered under their policy.

3.18 We further note that the above measure may be unnecessary where the "alternative treatment" (which is decided upon during surgery) is the **same** cost as the primary treatment. To minimise the burden and information load here, the wording, "if the cost of treatment is different" before the words "the estimate".

3.19 As noted in our introductory remarks above, we invite the CMA to discuss with consultants the practicalities of this aspect of the Order. An open and constructive discussion with doctors will help the CMA to implement a workable remedy of benefit to patients.

Timing for implementation of Article 22.2(b) and 22.4

- 3.20 This part of the remedy requires particularly careful planning and consultation with doctors across HCA's hospital network. The fee communication under Article 22.2(b) gives rise to a number of potentially complex scenarios which will need to be discussed and resolved by consultants and hospital operators working together. Furthermore, the appropriate compliance monitoring process must be put in place alongside too, which itself raises challenges (see Section 5 below). For that reason, a deadline of at least 12 months from the date of the Variation Order is more realistic and achievable.

Timing for providing fee information

Same day "tests" (Article 22.5)

- 3.21 In the event of a test being carried out on the same day as a consultation, Article 22.5 allows for the information in Article 22.4 to be provided "orally" (rather than in writing). HCA understands that the provisions contained in Articles 22.4(b) and (c) relate specifically to the provision of "treatments", rather than the commissioning of **diagnostic tests**, therefore, in the case of tests, Articles 22.4(b) and (c) are not relevant and do **not** apply. HCA would welcome the CMA's confirmation of its interpretation of the Order.
- 3.22 In any event, a clearer distinction should be made in Article 22.5 between same day "tests" vs. same day "treatment" in the Order.

Outpatient fee communication (Article 22.6)

- 3.23 HCA agrees that the point at which confirmation of the outpatient appointment is provided is a suitable stage for providing the information in Article 22.3.
- 3.24 Under Article 22.6, consultants must provide the above information at "the same time as the outpatient consultation appointment is confirmed." In many cases, an appointment may be "booked" over the telephone or email with the consultant's secretary and be confirmed in writing shortly after. To avoid confusion over the precise moment of "confirmation", HCA recommends adding "in writing" after the word "confirmed".

Communication prior to further tests or treatment (Article 22.6)

- 3.25 The CMA has included a two working day rule in respect of Article 22.4 communications. However, the design of the two working day rule is flawed and risks adversely affecting patients' healthcare.
- 3.26 The CMA provides for the two working day rule to be breached in the case of "emergency treatment". However, it is also possible that the consultant wishes to act **promptly** (e.g. by delivering care the next day), but this does not strictly amount to an "emergency". For example, it may be of clinical importance that a patient with possible cancer is screened promptly, but at that stage it could not be properly classified as an "emergency". Under the Order, the consultant cannot do this as there is a requirement to provide at least two working days gap between an outpatient session and treatment. HCA believes that the CMA did not intend for its two working day rule to interfere with clinical decision making. Therefore, HCA suggests that the CMA insert the words "or for other clinical reasons" after "emergency" to accommodate a shorter gap between consultation and treatment.

- 3.27 As for the two working day rule itself, HCA can understand the reason why such information should, ideally, be provided two days **prior** to the treatment itself. Given that the patient may wish to make a decision on whether to proceed with the treatment, a reasonable window of time should be provided.
- 3.28 On the other hand, the requirement that the fee communication be sent no later than two working days **after** the final outpatient session is overly burdensome. First, if the treatment day is scheduled for considerably later than the outpatient session, it creates a strain on the doctor to prepare what could be a complex communication in an unnecessarily short period of time. Secondly, the doctor may be awaiting the results of tests or scans or on further deliberations with this colleagues before deciding on treatment and, as a result, require longer than two working days to prepare the fee communication. Thirdly, if the CMA believes at least two working days **prior to treatment** is sufficient for a patient to absorb this information and make a decision, this should be the uniform standard for all patients. Accordingly, the second part of the two working day rule should be omitted from the Order (i.e. by deleting the words "following the final (pre-treatment) outpatient consultation or").

4. Condition of practising at a hospital facility (Article 22.2)

- 4.1 Article 22.2 requires operators of private healthcare facilities to make the compliance with the provisions set out in Article 22.2 – 22.6 a "condition of permitting a consultant to provide private healthcare services at that facility".
- 4.2 HCA supports a measure requiring consultants to comply with Article 22 of the Order as an express condition of each consultant's Practising Privileges. [3<]
- 4.3 Practising Privileges are generally granted to consultants annually and renewed on a rolling basis, with the result that doctors may each have a different renewal date. HCA has found that the distribution of renewal dates across the year means that the process of updating and implementing changes to Practising Privileges is more manageable and cost-efficient given the large number of doctors involved. It also provides a reasonable window of time for doctors to be consulted and put forward any queries in relation to the proposed changes.
- 4.4 Now that it is clear that Article 22 will come into force, if the CMA's view is that a general compliance term is not sufficient, HCA can go through the lengthy and expensive process of introducing further compliance wording (expressly noting the substantive provisions of Article 22) into each doctor's Policy document. However, it is highly unlikely that HCA would be able to compress this into a 2 month process as it would affect thousands of doctors.
- 4.5 HCA therefore requests the CMA to amend Article 22.2 so that the words "by 12 months from the date of the Variation Order" are substituted for "from the date this article 22 is brought into force". In the interim, HCA would be prepared to publish on its website a notice to consultants informing them that it expects consultants to comply with all aspects of the Order and will take appropriate action where it is aware of consultants not doing so.

5. Compliance monitoring by private hospital operators (Article 22.7)

Form of monitoring

5.1 Under Article 22.7, hospital operators are required to ask every privately-funded patient (admitted for inpatient, day-case or outpatient "procedures") to sign a form confirming that the relevant consultant provided the information required by Article 22.4.

5.2 In the draft Variation Order, the CMA proposes to make a further, clarificatory amendment to this provision so that Article 22.7 and a new Article 22.8 read as follows:

22.7 "Subject to Article [22.8] (sic), the operator of a private healthcare facility shall ask every privately-funded patient undergoing any inpatient, day-case or outpatient **procedure**, including diagnostic tests and scans at that facility, to sign a form confirming that the relevant consultant provided the information required by Article 22.4, and shall take appropriate action if there is evidence that a consultant has failed to do so. Alternatively, private hospital operators shall take equivalent measures, as approved by the information organisation and its members to monitor and enforce compliance with article 22."

'22.8 "The duties in Article 22.7 owed by the operator of a private healthcare facility do not apply in the case of a private patient who attends a consultation at premises which are not part of the relevant facility and who does not thereafter have treatment at the relevant facility pursuant to attending the consultation."

5.3 As HCA supports the CMA's information remedy, it would have been prepared to take steps independently to monitor compliance with the Order absent Article 22.7. However, the CMA's proposed variations, and indeed the original text of the Order, raise a number of practical obstacles.

5.4 First, a hospital visit may comprise a single procedure, or it may entail a combination of procedures, tests, consultations and overnight stays. Clearly, the CMA did not intend for patients to sign a form prior to **every** appointment or "procedure" that the patient is about to undergo confirming that they have received the specific fee information for that procedure. In complex cases (or even where a sequence of tests will be commissioned), this could result in multiple forms being signed during a single stay. Therefore, from a practical perspective, HCA assumes that the CMA intended for there to be a **single** confirmation for a given hospital visit.

5.5 Secondly, and as noted above, a hospital visit is often a stressful time for patients and patients may not be best placed to recall whether specific information was or was not provided to them in a communication (and may have failed to bring the communication with them) and may even object to answering the question. As a result, it is likely that unnecessary investigative action will be repeatedly brought against consultants who have correctly complied with the Order. Such investigations may eventually be resolved once copies of correspondence were produced, but the volume of investigations and waste of resource in resolving each of these is likely to be very burdensome on the doctor and hospital.

5.6 Thirdly, patients are unlikely to be able to confirm that they have been provided the "information required by Article 22.4" as this would require a high degree of familiarity with the Order, and it is simply not practicable (or desirable) to ask a patient four specific questions going through each limb of Article 22.4.

- 5.7 Fourthly, there are already concerns among patients regarding the volume of questions and paperwork that they must complete during hospital visits [3<].
- 5.8 Given these practical difficulties, HCA sets out alternative recommendations for the CMA below:
- (i) The CMA could instead require that hospital operators devise and implement their own compliance monitoring process, rather than adopt a one-size fits all approach involving more patient forms. For example, hospital operators may adopt an internal audit system, whereby each year a number of randomly chosen consultants are asked to produce documents confirming their compliance with the Order. The anonymised results of this audit process can be used to inform all consultants about best practices for complying with the Order.
 - (ii) Rather than specifically enquire, prior or after "every procedure" whether each provision of Article 22.4 has been satisfied, the CMA should aim to test the **overall effectiveness** of the remedy, for example, hospitals could instead ask patients: "Do you feel you were provided with sufficient, upfront fee information by your consultant and (if applicable) insurer concerning the cost of your care?" Such a question would only draw an informative answer at the **point of discharge**, as the patient's treatment journey will have been completed, and it could be accommodated into existing patient feedback forms completed at discharge by inpatients and day-case patients.

Investigation

- 5.9 Article 22.7 requires hospital operators to "...take appropriate action if there is evidence that a consultant has failed to [comply with Article 22.4]." As noted above, the volume of investigations is likely to become impracticable to manage and extremely difficult to resource. HCA would suggest that the wording is amended to "shall take appropriate action where there is evidence that a consultant has **persistently** failed to do so".

Timing for implementation

- 5.10 The implementation of this step should broadly align with the deadline for implementing Article 22.4, i.e. 12 months from the date of the Variation Order. It is not realistic to expect hospital operators such as HCA to change their business office processes, and engage staff and doctors (and their medical secretaries) within a 2 month timeframe.