

**SPIRE HEALTHCARE**

**COMPETITION AND MARKETS AUTHORITY  
PRIVATE HEALTHCARE MARKET INVESTIGATION**

**RESPONSE TO THE NOTICE OF INTENTION TO VARY THE  
PRIVATE HEALTHCARE MARKET INVESTIGATION ORDER  
2014 AND BRING ARTICLE 22 OF THE ORDER INTO FORCE**

**10 NOVEMBER 2016**

## 1. INTRODUCTION & EXECUTIVE SUMMARY

1.1 This document provides the response (the *Response*) of Spire Healthcare (*Spire*) to the Notice of Intention to vary the Private Healthcare Market Investigation Order 2014 (the *Order*) and bring Article 22 of the Order into force (the *Notice*) issued on 10 October 2016 by the Competition and Markets Authority (*CMA*).

1.2 As Spire has consistently stated, it unequivocally supports the CMA's efforts to increase the information available to patients regarding the cost of private healthcare, to support informed patient decision-making and patient choice. Spire is therefore committed to full compliance with Article 22 of the Order.

1.3 In order to ensure that the Order is appropriately implemented, systems and processes need to be put in place to support individual consultants in an effort to make the process as seamless and as efficient as possible for patients. The fulfilment of the obligations imposed on consultants is intrinsically linked to the hospitals' administrative systems. Therefore, to properly fulfil the aims of the Order, the process has to be managed in an integrated way, with the appropriate infrastructure supporting the provision of information to patients by consultants.

1.4 However, the two month timeframe proposed by the CMA for the implementation of certain provisions of Article 22 of the Order by consultants and operators of private healthcare facilities will not allow sufficient time for proper implementation of this remedy now that the judicial review has been determined. There are several key reasons why the proposed timeframe is not appropriate:

- (a) Providing patients with information from individual consultants without the full suite of quality/performance and standard fee information being available on PHIN's website will be largely meaningless, as it will not allow comparison, and risks undermining patient confidence from the start.
- (b) The timeframe is unreasonable and unrealistic given the challenges raised by the implementation of all the necessary steps to achieve compliance with the various elements of the information remedy. None of these steps can realistically be implemented in the timeframe proposed by the CMA.
- (c) Shortening the timeframe also imposes a disproportionate burden on consultants and operators of private healthcare facilities, since there were good reasons to expect a longer timeframe for implementation, namely the uncertainty around the outcome of the judicial proceedings brought by FIPO and the fact that the CMA had previously signalled that a longer implementation period would be given.
- (d) Failing to give sufficient time for implementation could fundamentally undermine the effectiveness of the remedy to improve the level and consistency of information patients receive and to allow patients to effectively compare providers and "shop around". It would also be in patients' best interests to develop the most efficient and cost effective way of complying with the Order.

1.5 In this context, the CMA should align the implementation period with PHIN’s publication timetable, or, at least, allow consultants and operators of private healthcare facilities twelve months to take all necessary steps for implementation of the information remedy.

1.6 With respect to the amendment to Article 22.7 of the Order, the CMA has failed to articulate – much less evidence – any change of circumstances which could allow the Order to be varied under the Enterprise Act 2002 (*EA*). Therefore, the legal requirements for variation are not met. Furthermore, there are practical reasons why the change is inappropriate, especially in the proposed implementation timeframe.

## **2. DUTY OF CONSULTANTS TO PROVIDE FEE INFORMATION TO PHIN AND PUBLICATION OBLIGATIONS OF PHIN (ARTICLES 22.1 AND 24.6 OF THE ORDER)**

2.1 The CMA is proposing to (i) vary Article 22.1 of the Order to make the operative dates 30 June 2017 (for the provision of outpatient consultation fee and standard terms and conditions information to PHIN) and 30 June 2018 (for the provision of standard procedure fee information to PHIN) and (ii) vary Article 24.6 of the Order to update the dates for PHIN to comply with its publishing obligations as follows: 30 September 2017 (outpatient consultation fees and standard terms and conditions information); and 30 September 2018 (standard procedure fees information).

2.2 Spire has no comments in relation to the proposed timeline for the implementation of these obligations as it considers PHIN to be better placed to comment on whether the suggested timeframes are reasonable.

2.3 However, Spire notes that this timeline for implementation is far from being aligned with the proposed timeframes for the provision of quality/performance and standard fee information to patients by individual consultants and operators of private healthcare facilities. Article 22.4 of the Order requires consultants to include a statement informing private patients of PHIN’s website and indicating that this will provide useful information on the quality of performance of hospitals and consultants. This indicates that the various elements of the information remedy are intrinsically linked. And rightly so, as to allow patients to “shop around”, patients will need the two pieces of information. The failure to align the two timelines for implementation runs the following risks:

- (a) First, the information provided by the individual consultant will be largely meaningless without the pool of information about other consultants against which the patient can effectively compare the terms offered by the individual consultant. The CMA is thus proposing a scenario in which the remedy does not in fact work.
- (b) Second, the CMA’s proposal risks undermining patient confidence in the scheme from the start. It would be extremely confusing for patients to receive a statement about the wealth of information available in PHIN’s website only to discover that such information in fact is not going to be available until much later, i.e., 30 September 2018 for the full suite of information.

2.4 To address these problems, the implementation timetables should be fully aligned and patients should only receive information from consultants after PHIN is in a position to publish the full suite of information (i.e., 30 September 2018) or, at least, after PHIN starts publishing the first tranche of information (i.e., 30 September 2017).

**3. DUTIES OF OPERATORS OF PRIVATE HEALTHCARE FACILITIES (ARTICLE 22.2 OF THE ORDER) AND OF CONSULTANTS TO GIVE PRIVATELY-FUNDED PATIENTS RELEVANT INFORMATION (ARTICLES 22.3 AND 22.4 OF THE ORDER)**

3.1 The CMA is proposing to bring Article 22 of the Order into force on a date two months after the day on which the instrument varying the Order is made. This largely covers (i) the duties of operators of private healthcare facilities (Article 22.2 of the Order) and (ii) of consultants to give privately-funded patients relevant information (Articles 22.3 and 22.4 of the Order).

3.2 Spire considers that the proposed timeframe for entry into force of those provisions of the Order is manifestly unreasonable and unrealistic, imposes a disproportionate burden on consultants and operators of private healthcare facilities and risks undermining the effectiveness of the information remedy.

***The proposed timeframe is unreasonable and unrealistic***

3.3 Implementing the relevant provisions of Article 22 of the Order will involve several key steps. The remedy covers several distinct stages of the patient “journey”, each with its own set of practical requirements for implementation. As explained below, none of these steps can realistically be implemented in the timeframe proposed by the CMA.

Template letters for approval by the CMA

3.4 The template will identify precisely the information that consultants need to gather/include in the letters and define the most appropriate format to provide that information to patients. As set out in paragraph 3.16 below, there are material issues to be resolved around the detail which needs to be included in the template which will need to be dealt with through the template letter approval process. Until the template letters are approved, the exact information that needs to be gathered and provided will not be clear and therefore consultants will not have a precise idea of the actual scope of their obligations in this respect.

3.5 Agreeing the required information and deciding on a format which is appropriate and intelligible for all procedures, scenarios and patients is a material challenge. This process alone will probably take longer than two months complete.

System to ensure that patients receive the right information at the right time

3.6 [X]

3.7 [X]

3.8 [X]

3.9 [~~3~~] Compliance with the 2 working day requirement for the provision of this information will also be particularly challenging for several reasons, including:

- (a) Some letters will have to include multiple estimates to comply with Article 22.4(c) of the Order which requires estimates for alternative treatments where the appropriate treatment can only be decided during surgery;
- (b) The consultant is unlikely to know the identity of specialists (e.g., anaesthetists) who would treat the patient within the 2 working day period, and therefore will be unable to give either the contact details or a price estimate for that specialist (as required under Article 22.4 (b) of the Order); and
- (c) If it is appropriate to include a self pay package price agreed with the hospital, issuing the letter will require consultation with the hospital, to ensure the estimate is appropriate for the procedure and consistent with the communication which the hospital sends to patients about the self pay package to avoid conflicting or confusing information being sent to the patient.

3.10 The implementation of this letter will be a material change in the way in which consultants communicate with patients and consistency in communications must be safeguarded. It will take time to establish the most efficient and accurate way to approach this and it will involve a material change in Spire's and consultants' systems.

3.11 [~~3~~]

3.12 [~~3~~]

3.13 [~~3~~]

3.14 [~~3~~]

3.15 The CMA itself has recognised the complexities of the process of collating, processing and presenting all this information in paras. 17 and 18 of the Notice.

Process for obtaining confirmation from patients that they received the necessary information (for the purposes of Articles 22.2 and 22.7 of the Order)

3.16 This process must be organised in a way which is most efficient for hospitals, consultants and, most importantly, the patient to ensure it fits in with the existing patient administration processes where possible, or that new processes are introduced efficiently.

3.17 The process must also involve steps in case a patient indicates they have not been provided the required information and does not wish to go ahead with the further treatment/tests until he or she has received the information. In that scenario there should be a system in place to provide the patient with the necessary information without delaying the procedure and disrupting the hospital's procedure list. In this context, it will be necessary to balance the impact on patient experience, the efficiency of the hospital, and patient safety.

3.18 Planning and implementing this process will require additional time to ensure minimal disruption for the patient.

3.19 The proposed implementation date gives no time for operators of private healthcare facilities to explore alternative equivalent measures, as approved by PHIN and its members, to monitor and enforce compliance with Article 22, as envisaged by Article 22.7 of the Order. Therefore, the CMA will effectively render ineffective that provision of the Order and remove the right of operators of private healthcare facilities to devise alternative and potentially less intrusive measures.

3.20 Finally, it is important to bear in mind that, in parallel with the process outlined above, consultants will also be required to validate their data ahead of publication by PHIN, as part of PHIN's data quality verification process. This process will require consultants to (i) become familiar with the database; (ii) verify the accuracy of a very substantial volume of information; (iii) cross-check the information against their records to ensure that the information accurately reflects their practice; and (iv) resolve errors and deal with queries in close cooperation with hospitals.

3.21 In summary, to expect operators of private healthcare facilities and consultants to be able to take all these steps within a two month period is manifestly unreasonable and entirely unrealistic. The CMA failed to take into account the effort necessary to ensure compliance with the obligations set out in Article 22 of the Order.

***The proposed timeframe imposes a disproportionate burden***

3.22 The CMA mentions on several occasions throughout the Notice that consultants and operators of private healthcare facilities have known since October 2014 that these requirements would come into force at some point in time. There are three main reasons why this fact cannot justify the proposed timeframe:

- (a) First, there were good reasons to wait for the outcome of the judicial challenge. The outcome of the proceedings could have a very material impact on what consultants and operators of private healthcare facilities would have to do to implement this section of the Order (if at all). The uncertainty around the terms of the obligations was too great to commit resources past a planning stage.
- (b) Second, it is not appropriate for the CMA to just shorten the timetable because of the delay imposed by the exercise by FIPO of its fundamental right to seek judicial review. The judicial challenge should not result in a more compressed timeframe for implementation of the obligations set out in Article 22 of the Order but rather should merely "suspend" the timeline with the CMA re-starting the process as if it were in the moment when the challenge was brought.
- (c) Third, it would be reasonable for the CMA to give consultants and operators of private healthcare facilities a sufficient amount of time to take the necessary steps to comply with those obligations. It is worth noting that the CMA had envisaged that "*private hospital operators would be able to introduce these requirements on consultants practising at their facilities*

*within six months of the order being made*". Therefore, it was legitimate for Spire to expect that it would have significantly more time than two months after the CMA made the necessary variation to the Order to prepare for those obligations entering into force.

3.23 Finally, the CMA alludes to the fact that existing guidance on financial and commercial arrangements and conflicts of interest from the General Medical Council in its Good Medical Practice would impose similar requirements to Article 22 of the Order and therefore consultants would only need a short period to adapt their current arrangements to comply with the specific requirements of Articles 22.3 and 22.4 of the Order. However, this guidance is quite generic, does not cover all the items in Articles 22.3 and 22.4 of the Order and does not require the implementation of a system to provide information to all patients in writing and in a standard format nor for hospital providers to obtain written patient confirmation of their receipt of such information.

***The proposed timeframe risks undermining the effectiveness of the remedy***

3.24 It is in the interests of patients for consultants and operators of private healthcare facilities to have adequate time to prepare and implement the Order requirements properly. There are three main risks to consider:

- (a) First, there is a high risk that rushing the implementation may result in the Order being inadequately applied, to the detriment of patients, because it would increase the likelihood of the patients receiving insufficient, poorly presented, inadequate or confusing information. Such an outcome would entirely undermine the effectiveness of the information remedy.
- (b) Second, adequate time should be given for proper engagement between consultants and operators of private healthcare facilities and with the CMA and PHIN (to ensure an appropriate level of consistency in the information presented) and also for planning and testing the implementation.
- (c) Third, in addition to ensuring that all the information is gathered and available, the focus should also be in ensuring that that information is provided in a patient friendly format so that patients can make the best use of that information to "shop around".

3.25 The CMA's approach does not take into account, or make any adequate effort, to mitigate these risks. This is not a practical or reasonable approach to achieve effective implementation. For example, the CMA has recognised the importance of clear and effective customer communications in other markets with low levels of customer switching, such as the energy market. In its Final Report on the Energy Market Investigation the CMA concluded that the information being provided to customers was too complex (and potentially excessive) inhibiting customers from making value-for-money assessments of available options. To address this issue the CMA shaped a detailed remedy involving measures to provide customers with different or additional information, including a recommendation to develop and test proposals (including through randomised controlled trials, where appropriate) concerning, *inter alia*, changes to the information in domestic bills and how this was presented.

3.26 A similar approach should be taken in the present case to ensure a significant level of engagement with the market by patients. Without a carrying out carefully thought through trials of different formats of template letters and taking into account patient feedback to adjust the templates, the effectiveness of the information remedy risks being seriously undermined, or, at least, the remedy will not be as effective as it could possibly be. Such trialling will be impossible in the timeframe proposed by the CMA in the Notice and would require a longer implementation period.

3.27 Finally, it will be in the patients' best interests for consultants and operators of private healthcare facilities to be allowed sufficient time to develop the most efficient and cost effective solutions.

#### **4. VARIATION OF THE ORDER (ARTICLE 22.7 OF THE ORDER)**

4.1 The CMA is also proposing to amend the wording of Article 22.7 of the Order in order to align it with the drafting of para. 11.600 of the Final Report.

4.2 Notwithstanding the fact that the proposed new wording may correspond more closely to the Final Report, the proposed amendment corresponds to a variation of the Order. Under section 162 (2) (c) EA, an enforcement order can only be varied by reason of any change of circumstances. The CMA has not alluded to any facts which could amount to a change in circumstances for these purposes and has adduced no evidence to justify the variation. In fact, there has been no material change which could justify the need to amend the Order. Therefore, the statutory requirements allowing the CMA to vary the Order are not met and, as such, the existing drafting of Article 22.7 of the Order must remain unchanged.

4.3 Furthermore, even if it were procedurally possible, the proposed variation should not be accepted on grounds of substance and practicality. The amendment amounts to a material change to the Order, since it effectively extends the scope of the obligation beyond admitted patients to also cover patients undergoing outpatient procedures. The current wording of Article 22.7 of the Order is clear: operators of private healthcare facilities are only required to obtain written confirmation (of receipt of the required information from consultants) from admitted patients, which would only cover patients for day case and inpatient procedures. There are good practical reasons for the decision to refer only to admitted patients. Extending this obligation to outpatient procedures would impose a very considerable new burden on operators of private healthcare facilities, particularly with respect to tests or treatment given on the same day of the consultation.

4.4 In any case, should the CMA persist in its intention to vary the Order, Spire strongly opposes the CMA's proposed timeframe for entry into force of this amended provision, since it does not provide sufficient time to implement the effect of the proposed change of scope.

#### **5. SPIRE'S PROPOSAL OF AN APPROPRIATE TIMEFRAME FOR IMPLEMENTATION**

5.1 In order for the remedy to be effective, parties required to comply with the Order will need a realistic and achievable timetable to put in place the infrastructure and procedures needed to support various facets of the remedy. As stated above, a



period of two months is manifestly insufficient and unreasonable given the amount of work involved in implementing the information remedy.

5.2 As indicated above (paras. 2.3 and 2.4), the timeframe for implementation should be brought in line with the timetable for publication in PHIN's website, i.e., the obligation to provide patients with outpatient consultation information should enter into force on 30 September 2017 and the obligation to provide patients with information on tests and treatments should enter into force on 30 September 2018. This alignment will ensure that patients receive information which is meaningful and allows them to make informed choices, thus fully achieving the objective of the information remedy to promote competition.

5.3 If that alignment is not possible, Spire considers that consultants and operators of private healthcare facilities will need a period of, at least, twelve months to take all steps to put in place the systems and processes necessary to ensure compliance with the obligations set out in Article 22 of the Notice. This timetable would ensure that the information remedy is implemented in an effective way with minimum patient disruption.

5.4 The proposed extended timetable should, at the very least, cover the implementation of Articles 22.4 and 22.7 of the Order in relation to the provision of information prior to further tests or treatment and obtaining written confirmation thereof, given the specific practical difficulties raised by those cases.

## **6. FINAL REMARKS**

6.1 Spire is committed to support the provision of information to patients to encourage switching and, to do so, it needs sufficient time to ensure that the implementation of this remedy is done properly, in the best interests of the patients.

6.2 The timeframes proposed by the CMA largely ignore the volume and complexity of the work required to achieve proper implementation of Article 22 of the Order and the time necessary to carry out that work. A two month implementation period is manifestly insufficient and would likely result in a poor outcome for patients. Spire urges the CMA to give consultants and operators of private healthcare facilities sufficient time to carefully plan and implement the appropriate steps to comply with the information obligations set out in Article 22 of the Order and guarantee the full effectiveness of the information remedy for the benefit of patients and competition. Spire believes that the implementation timeframe should be aligned with PHIN's publication timetable, or that the CMA should, at least, allow consultants and operators of private healthcare facilities twelve months to take all necessary steps for implementation.