

Response to the proposed amendments to the Order

This is PHIN's response to the CMA's *Notice of intention to vary articles 21 and 22 of the Private Healthcare Market Investigation Order 2014 and to bring article 22 of the Order into force*, published 28 February 2017.

We have just a few comments, set out below.

1. Article 21.2(b)

We appreciate the CMA's amendment to this Article in an effort to improve clarity and remove ambiguity. However, we think that the wording could be further improved.

The point of this change is to help private healthcare facilities to respond to the Order by placing them under a very clear duty, and thereby giving them an incontestable legal basis, to supply data to PHIN that includes personal data.

Please note if and when redrafting that this Article should not itself make reference to either the Data Protection Act 1998 nor Article 21.3, as to do so would be self-referential: it is Article 21.2 that provides the legal duty and basis of disclosure that ensures that Article 21.3 is fulfilled.

Specifically, whilst the phrase '*or equivalent patient identification number*' is presumably intended to allow for variation across the four home nations in terms of the principal administrative number, we believe that there is potential to interpret the phrase as meaning that an alternative number may be substituted at the private healthcare facility's discretion. Further, in the absence of absolute clarity, we believe that it may be argued that the CHI Number used in Scotland is not 'equivalent' to the NHS Number because the format inherently contains some clues as to the patient's identity, where the NHS Number does not. We think this ambiguity is avoidable, and propose the amendment as below:

Original (2014):

b) the National Health Service or equivalent patient identification number or alternative information from which an NHS number may be derived or a pseudonymised equivalent, or, in the case of patients from outside the UK, a suitable equivalent identifier, as determined by the information organisation;

As amended in the draft notification of intent to vary the Order (Feb 2017):

b) the National Health Service or equivalent patient identification number or, in the case of patients from outside the UK, a suitable equivalent identifier, as determined by the information organisation;

Further amendment proposed by PHIN:

b) the National Health Service Number (NHS Number) for patients in England and Wales, Community Health Index Number (CHI Number) for patients in Scotland, Health & Care Number (H&C Number) for patients in Northern Ireland, or such equivalents as may be in use by the relevant authorities from time to time or, in the case of patients from outside the UK, a suitable equivalent identifier as determined by the information organisation;

A related issue is that whilst these particular requirements are specified at 21.2 (a) through (d), the Order as laid lacks clarity in authorising PHIN to specify the further information deemed necessary to produce the performance measures; rather than being clearly set out, this appears only as a duty on private healthcare facilities at 21.1 to supply information “*which is sufficiently detailed and complete to enable the information organisation to publish the following types of performance measures*”.

As such, Article 21.2 would ideally contain a further stipulation giving PHIN discretion to specify additional data fields as necessary, as is in practice required. For example:

e) such further information as may be determined by the information organisation to be necessary to enable the publication of the performance measures specified at article 21.1

In our view this remains a clarification, not creating any new duties, as it simply reflects the necessary practices established to date in the implementation of the Order.

2. No mechanism for audit is specified

Recent discussions of the draft amended Order with stakeholders have resurfaced concerns that there is no clear approach in the Order to assuring the accuracy of the fees published; i.e. nothing to prevent initial lowballing if any parties take an unscrupulous approach, or simply fail to understand the actual costs that patients will experience along the pathway.

Of course, most consultants and hospitals will strive to provide a fair picture, but it is the small minority that may not do so that are the area of concern. Patients will enjoy standard consumer protections from unfair trading and misleading advertising, and will have rights to complain if they believe that they have been misled, but those are relatively weak and indirect mechanisms.

We have discussed two potential ways to address this issue:

1. External audit of published prices against charges raised; presumably organised by the CMA using a competent third party auditor on a sample basis;
2. Continuous collection of data on fees actually paid, and submission to the information organisation, to permit ongoing assessment of accuracy.

The first route is clearly simpler, however the second would potentially be more accurate and add more value.

Hospital representatives have recognised the problems around proving accuracy of standard fees and, have been willing to discuss submitting charging data along with clinical records. However, unless there is a clear imperative in the Order it is frankly unlikely that we would be able to take this further. The collection of data on fees paid would be a substantial undertaking by all parties, but would have probative value if done correctly.

We suspect that it is too late to address this issue but remain willing to discuss it further.

3. The outpatient loophole: inconsistency between Articles 21 and 22

There is a problematic inconsistency between the treatment of Outpatients in Articles 21 and 22, due to article 21.5 which provides that

The duty in article 21.1 does not require a private hospital operator to supply the information organisation with information concerning any outpatient activity.

By contrast, Article 22 clearly does require the submission of fee information to PHIN for outpatients

22.1 (a) ...outpatient consultation fees, which may be expressed as either a fixed fee or an hourly rate;

22.7 "...every privately-funded patient undergoing any inpatient, day-case or outpatient procedure, including diagnostic tests and scans at that facility..."

This creates significant practical impediments to implementation and the creation of meaningful information for patients.

1. Consultants with outpatient-only practice are unknown to PHIN.

Due to Article 21.5, PHIN is currently only aware of the existence of consultants where they appear in episode records submitted by private hospital operators in accordance with Article 21.1 – i.e. where they are responsible for private treatment other than ‘outpatients’.

PHIN is therefore unaware of consultants whose practice is wholly based in outpatients. This may be as many as 40% of all consultants in private practice, notably dermatologists but also gynaecologists, allergy specialists and other physicians, who nonetheless appear to be subject to Article 22.

We currently have no reliable basis for identifying these consultants as practising privately, as distinct from those listed by the GMC as being licenced to practice and on the specialist register but who may have no private practice.

Currently we can envisage two routes to identifying these consultants, both of which have potential flaws:

- a. Consultants come forward and identify themselves; this is the solution most consistent with the Order, but we will need to develop a process to receive such communications, and it will be difficult to establish who has not contacted us (and is therefore in breach of the Order) to inform enforcement by the CMA or other parties.
- b. Hospitals identify all consultants with practice privileges to PHIN, and we extrapolate those who have admitted episodes and those who do not; but this is not required in the Order (so would be voluntary, and probably inconsistent) and would not work for consultants who have no relationship to hospitals (e.g. many who practice from consulting rooms on Harley Street).

In practice we would probably use a combination of both methods, but it will be an imperfect process.

2. All consultants subject to the Order must refer patients to PHIN's website for information on performance, but for many no information will be available

This relates to the requirements at Articles 22.3(e) and 22.4(d). As noted above, for perhaps 40% of consultants, and their entire specialties, PHIN's website will have no relevant information other than fees information, based on the Order as currently constructed.

3. For consultants with outpatient-only practice, we will be required to publish fee information in the absence of any performance measures or even activity-based information such as counts of outpatient consultations.

The availability of fee information alone was, we understand, considered to be undesirable during the Investigation. However, there is no practical alternative while Article 21.5 stands.

In our view, the ideal route to resolving these issues is to close the Article 21.5 'outpatient activity' loophole, which in itself is highly problematic.

'Outpatient' is not a well-defined term, and this Article has provided a significant loophole for where organisations or selected services are or can be excluded from the scope of the CMA's remedies.

We are concerned to find that a number of private healthcare facilities designate as 'outpatients' services which are directly comparable to those delivered as daycases or even inpatients elsewhere; we have produced guidance for members and potential members on when we think 'outpatient' activity should be included. In some circumstances Article 21.5 could actually create an economic incentive to reclassify service lines as outpatients in order to avoid having to comply with the remedies and the associated costs, for example of clinical coding.

A striking example of where this is a concern is in ophthalmology. Most of the specialist and high-street providers deem their clinical environments to be 'outpatient', and some will conduct Cataract

procedures. These are also conducted by the majority of private hospitals and are among the most common and measurable of the procedures about which we will publish data, but where they occur in an 'outpatient' setting the CMA will currently be unable to enforce the supply of information. Risks, known complications, prices, experience and even the surgeons are comparable in either 'outpatient' or 'day case' settings (as far as we know).

Similarly, endoscopy services may be deemed as outpatients and excluded, even though mortalities are a rare but known occurrence.

We see no justification for the exclusion of significant activity from the scope of the remedies based on a malleable definition. The problem will also exacerbate over time, as more care shifts from inpatient to daycase, and from daycase to an outpatient setting. Even if all care were delivered as outpatients we believe that the need for information on quality and price for patients would persist.

We do not believe that the original intent of Article 21.5 was to arbitrarily exclude whole areas of activity, but to acknowledge the difficulties that PHIN reported at the time with collecting information from providers' outpatient systems. We advised that we had neither required nor received information on consultations and diagnostics at the time, but were alarmed that the wording of the Order created a broader and more definite exclusion.

In short, PHIN believes that Article 21.5 as formulated has resulted in an unintended loophole that will see much private healthcare treatment as envisaged at Article 21.1 excluded from scope, and will create inconsistencies with Article 22.

Given the above, we recommend the removal of Article 21.5 or, alternatively, rewording it to improve consistency and integrity in the Order overall.

We feel that this requires further discussion, and have stopped short of suggesting any alternative wording.

Matt James

Chief Executive

13 March 2017