

## Land valuations

### Introduction

1. As set out in Appendix 6.13, the balance sheet value of the land and buildings owned by each of the relevant firms<sup>1</sup> does not necessarily reflect the value to the business (deprival value) of those properties, nor were they valued on a consistent basis across the relevant firms, with some using historic cost and others revaluing the assets on change of control or for the purposes of raising finance.<sup>2</sup>
2. In this appendix, we set out the various sources of information on land values that we have taken into account in assessing an appropriate value of land for the profitability analysis, including:
  - (a) the DTZ report, commissioned by the CC;
  - (b) the Colliers report, provided to the CC by BMI;
  - (c) the Knight Frank and Ashkirk reports, provided to the CC by Spire; and
  - (d) the Altus Edwin Hill report, provided to the CC by HCA.
3. In addition, we discuss other submissions from the relevant firms in relation to the draft DTZ report and the CC's profitability working paper published on 1 March 2013.

### The challenge of valuing land

4. The value of land in the UK is determined to a great extent by the type of planning permission that has been, or is likely to be, granted on that land. Agricultural land tends to be worth between £18,000 and £22,000 per hectare, while land with planning permission for residential development varies in price from around £775,000 per

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<sup>1</sup> The relevant firms are: Bupa Cromwell Hospital (BCH), General Healthcare Group (BMI), Healthcare Corporation of America (HCA), Nuffield Health, Ramsay Health Care UK, Spire Healthcare and The London Clinic.

<sup>2</sup> See Appendix 6.13 for discussion of the basis on which the relevant firms' financial information has been prepared and the valuation principles that we are applying in our profitability analysis.

hectare in Stoke to just under £5 million per hectare in outer London areas and significantly more in central London.<sup>3</sup> The price of land in central London depends largely on the size of the building that can be placed on it, rather than the size of the plot of land itself, as well as on the 'use' of the building, ie whether the building is residential, commercial, retail etc.

5. The planning permission use class relating to a hospital is 'C2 Residential institutions', which also includes uses such as residential care homes, nursing homes, boarding schools, residential colleges and training centres.<sup>4</sup> As DTZ explains in its report, land is rarely offered for sale with C2 planning permission in place. As a result, PHPs may need to consider the acquisition of sites with alternative use classes in place, which could be converted to C2 use. In many cases, we understand that offers made by PHPs to acquire land are contingent on receiving the appropriate planning permission.<sup>5</sup>
  
6. In addition to the existing use class of land, the price of a site suitable for a private hospital will depend on the level of competition for the site among PHPs. This, in turn, will often depend on the location of the site and the significance of location in terms of local competitive dynamics. A site close to the local NHS hospital at which consultants practise will attract a premium compared with a similar site in a less desirable location, as it gives the purchaser a significant competitive advantage in terms of attracting consultants to practise in the facility, and hence in attracting patients.<sup>6</sup>

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<sup>3</sup> Source: Valuation Office Agency, *Property Market Report, 2011*: [www.voa.gov.uk/dvs/\\_downloads/pmr\\_2011.pdf](http://www.voa.gov.uk/dvs/_downloads/pmr_2011.pdf).

<sup>4</sup> [www.planningportal.gov.uk/permission/commonprojects/changeofuse/](http://www.planningportal.gov.uk/permission/commonprojects/changeofuse/).

<sup>5</sup> Circle told the CC that this was how it had acquired its plots of land in Bath, Edinburgh, Reading and elsewhere in the country.

<sup>6</sup> For example, see our case study on Edinburgh in Appendix 6.14, which highlights Spire's concerns that consultants would move their practice to a competitor's hospital if one were available close to the Edinburgh Royal Infirmary.

7. There have not been many new hospitals built in the UK over the last five to ten years, which means that there are a limited number of transactions to serve as reference points when valuing hospital land. On the other hand, care homes also require C2 planning permission and there have been a larger number of transactions for this use which may serve as a suitable benchmark.

## **Our process**

8. In our profitability methodology consultation document<sup>7</sup>, published on 7 November 2012, we set out our intention to commission a report from DTZ to estimate the MEA value of land. In that document, we also highlighted both recent transactions and alternative uses as potential benchmarks for the value of land.
9. We asked DTZ to provide a draft report in the first instance, setting out its methodology in detail and providing initial estimates of the cost of acquiring the plots of land based on this methodology. Our instructions to DTZ were to estimate the cost of acquiring the relevant firms' hospital sites on the assumption that these sites were vacant and had achieved, or would be able to achieve, planning permission for hospital use.<sup>8</sup> This draft report was sent to the relevant firms on 31 January 2013 for comment. Having received and evaluated their comments on the DTZ report, we agreed with DTZ a number of revisions to the initial approach. DTZ's final report (dated 4 June 2013) is based on this revised approach and is shown in Appendix 6.15.
10. Based on the relevant firms' comments and the CC's own views, DTZ's report was adjusted in the following principle respects:

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<sup>7</sup> [http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/121107\\_profitability\\_methodology.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/121107_profitability_methodology.pdf)

<sup>8</sup> We provided DTZ with details of the size and location of the sites and asked it to make the assumption of both a willing buyer and seller of land.

- (a) greater weight was placed on the estimated cost of the current hospital sites within an area, and relatively less weight on potential alternative sites in the same area;
- (b) where sites were valued with reference to potential alternative site prices, DTZ ensured that the price per acre<sup>9</sup> applied reflected any premium that would need to be paid for a plot that would be able to gain planning permission in a reasonable timeframe; and
- (c) to provide an estimate of the costs of obtaining planning permission for the CC to include in our analysis.

### **DTZ valuation methodology<sup>10</sup>**

11. DTZ revised its report to reflect the adjustments set out above. DTZ explained its approach as:

The methodology adopted for our appraisal reflected elements of the RICS Appraisal and Valuation Standards 8<sup>th</sup> Edition and in particular VS 6 Valuation Standards and GN 6 Guidance Note, which is for the 'Depreciated replacement cost method of valuation for financial reporting.'

In appraising the sites, the fundamental principle of the above method is that a hypothetical buyer for a modern equivalent asset would purchase the least expensive site that would be suitable and appropriate for its proposed operations.

The manner in which the price for the site would be calculated would be based on alternative uses, with residential and employment land the two main use types which influence land prices.<sup>11</sup>

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<sup>9</sup> An acre is equivalent to 0.4047 hectares. The large majority of reports that we received on land values used acres rather than hectares as the unit of measurement. In the interests of simplicity, we have not adjusted this information to quote figures in hectares.

<sup>10</sup> This section sets out the methodology applied by DTZ in its final report to the CC.

12. In most cases, DTZ valued the sites according to the prevailing land use in their current locations, with alternative site values taken into account where there were equally suitable and less costly sites in close proximity to the existing sites. DTZ assessed the suitability of a location with reference to proximity to the local NHS hospital, proximity to affluent residential areas where both potential patients and consultants generally live, and quality of transport links.
13. Where sites contained substantial quantities of land that was not in use as buildings, car parking, access roads or services, DTZ made adjustments to the site size in reaching a value. This was done on the basis that a PHP would not pay for land that it did not require for its hospital operations. Full details of DTZ's approach are set out in its report (see Appendix 6.15).
14. Table 1 shows the total land values estimated by DTZ for the non-London relevant firms. For the relevant firms operating in central London, DTZ estimated the cost of acquiring a replacement building rather than a plot of land. As discussed in Appendix 6.13, we have not used these alternative building costs in our profitability analysis and hence do not discuss them in detail here.

TABLE 1 DTZ estimated land prices, by firm

<i>Company</i>	<i>No of sites*</i>	<i>Total cost £m</i>	<i>Average cost per site £m</i>
BMI	[X]	[X]	[X]
Nuffield	[X]	[X]	[X]
Spire	[X]	[X]	[X]
Ramsay	[X]	[X]	[X]

Source: DTZ Report, 4 June 2013.

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\*DTZ only provided values of owned hospital sites. All the operators leased at least some of their sites, with Ramsay leasing the large majority of its hospitals. Total costs here do not include stamp duty, land tax, fees or the costs of obtaining planning permission.

15. DTZ also provided an estimate of the cost of achieving planning permission for a new hospital:
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<sup>11</sup> DTZ Report, Appendix 6.15, paragraphs 2.6–2.8.

Planning cost can vary significantly. For smaller hospitals on brownfield sites, costs are likely to be below £50,000. For hospitals on sites which are allocated for employment uses, we would expect planning costs to be higher, in the £100,000 to £150,000 range. Notwithstanding this, given the use of a hospital will be an employment creating use, planning should not be contentious on such sites.

Planning costs are likely to be most expensive for either larger city centre hospitals or hospitals which are situated on sites where any development may not accord with current planning policy. Planning costs and time are likely to range from £250,000 upwards, with DTZ aware that some hospitals may have expended in excess of £750,000 in planning fees.<sup>12</sup>

## **Views of the relevant firms**

### ***Overall valuation methodology***

#### ***BMI***

16. BMI submitted two reports prepared by Colliers in response to the DTZ draft report. The first of these provided a critique of DTZ's approach and proposed an alternative methodology, while the second comprised a valuation of BMI's land and buildings, undertaken in September 2012, employing a different approach both from that adopted by DTZ as well as that recommended by Colliers in its critique of DTZ's draft report. In this subsection, we describe these two alternative methodologies in turn.<sup>13</sup>
  
17. Colliers put it to us that the depreciated replacement cost approach was not the correct method of ascertaining the value of land and noted that it was considered to be the 'method of last resort' by RICS. Instead, Colliers suggested that private

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<sup>12</sup> DTZ Report, paragraphs 2.16 and 2.17.

<sup>13</sup> In addition, BMI made a number of submissions to the CC questioning the independence of DTZ's report and the extent to which the approach adopted in that report was anticipated by the profitability methodology consultation.

hospitals should be valued on a profits basis, with reference to comparable sales transactions of both private hospitals and care homes:

The 'Profits Method' is made by assessing the Fair Maintainable Operating Profit ('FMOP') of the business in the hands of a reasonably competent operator. The FMOP is then capitalised at an appropriate rate of return ('Year Purchase' multiplier) to reflect the risks and rewards of the property and its trading potential.<sup>14</sup>

18. In addition, Colliers provided a small number of comparable transactions in the private hospital (five transactions) and care home (six transactions) sectors, although it did not provide (or seek to provide) a valuation on this basis.
  
19. The (separate) Colliers valuation report which was submitted by BMI as additional evidence provided a market value for 35 of BMI's hospitals on the basis of their trading potential, although the valuation was undertaken from the point of view of a property investor rather than a hospital operator. Colliers set out its approach to valuation as follows:

In reaching our opinions of value we have had regard to recent and current trading of the lessee as set out in the management accounts provided ... and our benchmarking tool to arrive at our assessment of current unit profitability (EBITDARM). We have assessed portfolio EBITDARM at £[REDACTED].

We have deducted from the unit EBITDARM a figure that represents an allocation of head office costs ... We have also deducted for Maintenance CapEx to arrive at unit EBITDAR. We have assessed portfolio EBITDAR at £[REDACTED].

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<sup>14</sup> Colliers critique of the DTZ Report, p3.

To assess current Market Value we have decided to consider the current market rent based on delivering a rent cover of 1.5 and have, on a unit by unit basis, applied a yield to the resultant rental to reflect both market transactions, the covenant strength of the tenant and the location and quality of the real estate and rental income stream. [REDACTED]<sup>15</sup>

20. The market valuation estimated on this basis comprised both the hospital buildings and land. Colliers did not, as part of this report, apportion the value between these two elements.

### *Spire*

21. Spire submitted two reports on land values to the CC: one prepared by Ashkirk, which provided a critique of the DTZ approach, and another prepared by Knight Frank, which also provided a critique of the DTZ approach and provided two alternative valuations of Spire's plots of land (one of these valuations is based on the DTZ approach using different assumptions and data, and the second is based on RICS valuation guidance).
22. Ashkirk suggested that the recent sale and leaseback transactions undertaken by Spire suggested a higher value of the plots of land, which could be estimated by applying a residual value approach to the acquisition price. This approach is similar to that suggested by Colliers in its report for BMI. Adopting this approach, Ashkirk estimated a land value of £[REDACTED] million for the Spire Bushey hospital (3.5 acres) and £[REDACTED] million for the Spire Bristol hospital (5.2 acres, of which 2.2 acres developable land). Table 2 sets out in full the Ashkirk valuations for five of Spire's sites on this basis.

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<sup>15</sup> The Theatre Portfolio valuation, 35 private acute hospitals leased to and operated by BMI Healthcare, Colliers, September 2012, paragraphs 9.2 to 9.6.



TABLE 2 Ashkirk land valuations

Spire hospital	£ million		
	Hospital price	Hospital development costs	Gross site price
Bristol	[REDACTED]	[REDACTED]	[REDACTED]
Bushey	[REDACTED]	[REDACTED]	[REDACTED]
Edinburgh (Murrayfield)	[REDACTED]	[REDACTED]	[REDACTED]
Leeds	[REDACTED]	[REDACTED]	[REDACTED]
Southampton	[REDACTED]	[REDACTED]	[REDACTED]

Source: Ashkirk Report, April 2013.

Note: Hospital development costs include construction, fit-out, financing and sales costs, as well as fees, contingencies and an allowance for developer's profit.

23. Knight Frank provided two valuations of Spire's properties. The first was conducted based on RICS Valuation Guidance and uses information on recent private hospital land transactions in order to estimate a benchmark price per acre, whilst the second was conducted based on a valuation approach similar to that adopted by DTZ and considers alternative use values for the sites.

*Knight Frank: approach 1*

24. On the basis of the transactions set out in Table 3, Knight Frank estimated that the average price of hospital land in the UK was approximately £[REDACTED] per acre. Knight Frank used a band of ±15 per cent around this mid-point as the range of prices that would apply to Spire's hospitals, ie a price range of £[REDACTED] to £[REDACTED] per acre.<sup>16</sup> It then reviewed Spire's portfolio in order to assess the quantity of land required by the hospitals, increasing the size of sites where necessary to account for off-site services provided by the hospital and reducing the size of others where there was excess land, for example woodland, included within the boundary of the site. Finally, Knight Frank graded the quality of Spire's sites using a grading scheme based on the value ranges seen in the comparable transaction data (A, B, or C) to account for the site size, site location and site defects/benefits. (Knight Frank identified the order of preference for site location for a private hospital as follows: (i) proximity to NHS

<sup>16</sup> This range approximately mimics the range of transaction values used by Knight Frank.

facilities; (ii) proximity to the local customer base, and (iii) prominent position and transport connections.<sup>17</sup> The best sites (A grade) were valued at £[redacted] per acre and the least desirable (C grade) at £[redacted] per acre (based on the adjusted site sizes). Finally, Knight Frank applied a regional adjustment to the land values, which ranged from a reduction of 15 per cent to an increase of 20 per cent.<sup>18</sup> These adjustments were based on the Land Registry House Price Index<sup>19</sup> and are set out in Table 4.

TABLE 3 Knight Frank list of comparable transactions

[redacted]

Source: Knight Frank Report, 8 April 2013.

TABLE 4 Regional price adjustments

Region	HPI Jan 2013	KF adjustment (%)
South East	293.46	20.00
South West	284.74	17.50
East Anglia	281.07	15.00
Wales	222.47	-5.00
North West	193.60	-10.00
Yorkshire	196.59	-10.00
North	177.35	-15.00
West Midlands	221.33	-5.00
East Midlands	219.37	-5.00
<b>Average HPI</b>	<b>232.22</b>	

Source: Knight Frank Report, 8 April 2013.

25. The total value of Spire's hospital portfolio was £[redacted] million on this basis.<sup>20</sup>

*Knight Frank: approach 2*

26. Knight Frank's second methodology was to adopt an approach similar to that adopted by DTZ. Knight Frank assessed the value of land required to replicate the current Spire estate based on an alternative use for either residential or care-home purposes. Knight Frank provided evidence of the depression in commercial property development during the recent economic recession and, on this basis, explained that

<sup>17</sup> Knight Frank report, paragraphs 3.14 & 3.18.

<sup>18</sup> In effect, this meant that the range of prices applied to sites was £[redacted] to £[redacted].

<sup>19</sup> Knight Frank identified this as being relevant to competing bidders for the sites on the basis that most hospital-appropriate sites also have good residential development potential.

<sup>20</sup> For the 34 sites valued by DTZ, Knight Frank estimated their value to be £[redacted] million.

it did not consider employment land as a likely alternative use for any of Spire's sites. Residential land prices were based on data provided in various Knight Frank publications and the VOA property market report, with Knight Frank using £[redacted] per acre for 'low'-value sites, £[redacted] per acre for 'medium'-value sites and £[redacted] per acre for 'high'-value sites. Care-home land prices were based on some recent transactions (see Table 5). Knight Frank used a price of £[redacted] per acre for 'low'-value sites and £[redacted] per acre for 'high'-value sites.

TABLE 5 Knight Frank list of care home transactions

[redacted]

Source: Knight Frank Report, 8 April 2013.

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Note: Knight Frank indicated that the above transactions were on sites that had C2 planning permission and were 'generally between 0.75 and 1.5 acres'.

27. Knight Frank made the same adjustments to the size of the sites that it did in its first valuation approach. It also reviewed the sites and determined whether their most valuable alternative use was residential or care home and whether in light of their location, the site was high, medium or low value. Finally, Knight Frank applied a regional adjustment to the land values as in its first valuation approach.
  
28. On this basis, the total value of Spire's hospital portfolio was £[redacted] million.<sup>21</sup> Knight Frank also provided these values for each year back to 2007, with adjustments based on changes in the house price index. (Knight Frank included charts evidencing a degree of correlation between development land and residential house price changes). We set out in Table 6 the changes in total values over the period. This shows a decline of approximately 5 per cent between 2007 and 2011.

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<sup>21</sup> For the 34 sites valued by DTZ, Knight Frank estimated their value to be £[redacted] million.

TABLE 6 Index of land values, Knight Frank

	2006	2007	2008	2009	2010	2011	2012
Aggregate land prices	100	104	91	96	95	94	94

Source: Knight Frank report and CC analysis.

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*Note:* We have rebased the land values provided by Knight Frank to 100 as of 2006. Knight Frank provided figures for January each year. We used these as indicative of the year end value of land for the preceding year, i.e. January 2007 figures were taken to be representative of 2006.

## HCA

29. HCA submitted two valuation reports to the CC, the first prepared by Altus Edwin Hill on a depreciated replacement cost basis, and the second prepared by KPMG on an alternative use basis, which estimated a total value for HCA's hospital buildings and land. HCA told us that it considered that due to the methodology employed, the AEH valuations significantly underestimate the capital employed in its facilities, and therefore are not appropriate to use in the profitability analysis. HCA considered the KPMG report to be the relevant basis on which to value its properties as this took into account their opportunity cost of owning the buildings. The KPMG report is discussed in Appendix 6.13 as it primarily addresses buildings values, which it does not separate from land values due to the nature of the residual land calculation employed which values the collective site based on what could either be developed or reconfigured from the existing building(s)
30. Altus Edwin Hill's report calculates the value of land used by HCA's buildings with reference to the price of land for office use, which it considers to be the most appropriate comparable for a hospital. AEH describes its approach as:
- In each case, a hypothetical site which would be designated for office development is likely to form the basis of the appropriate land value.
- These values have been arrived at using residual valuations using the

Gross Internal Area of the hypothetical modern replacement hospital building adopted for the DRC of the building element.<sup>22</sup>

31. In effect, this approach estimates the price of an office building of a similar size to the hospital building and deducts the costs of construction, including developer's profits, to arrive at the land value as a residual. The land values calculated by AEH are set out in Table 7.

TABLE 7 Land values of HCA's hospitals

<i>Building</i>	<i>Land value £'000</i>
Devonshire Hospital	[REDACTED]
Lister Hospital	[REDACTED]
London Bridge Hospital	[REDACTED]
Portland Hospital	[REDACTED]
Princess Grace Hospital	[REDACTED]
Wellington Hospital	[REDACTED]
Total	[REDACTED]

Source: Altus Edwin Hill report, January 2013.

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## Our views on valuation methodology

### *Valuation methodology*

32. The profit-based approaches to land valuation put forward by Colliers (on behalf of BMI) and Ashkirk (on behalf of Spire) are not suitable for the purposes of profitability analysis since they risk capitalizing any excess profits that the businesses are able to generate in the value of land. This is demonstrated clearly in the valuation that Ashkirk highlights for Spire's Bushey hospital, which equates to just over £[REDACTED] million per acre, despite residential land in a similar area (Enfield) selling for around £1.7 million per acre. Similarly, this approach values the Bristol site at around £[REDACTED] million per developable acre, as compared with a residential land price of around £0.85 million per acre in Bristol.<sup>23</sup> It is clear that these prices depend substantially on the profits generated by the hospital. As a result, they may introduce circularity into the

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<sup>22</sup> Altus Edwin Hill Report, January 2013.

<sup>23</sup> Residential land prices are sourced from the VOA Property Market Report, 2011.

profitability analysis by inflating the value of capital employed above its replacement cost. We have not, therefore, applied this approach in conducting our analysis.

33. The approaches to valuation put forward by Knight Frank are, in principle, suitable for the purposes of profitability analysis in that they valued the land without reference to the profitability of the hospitals sited on the land. We did, however, have some concerns regarding Knight Frank's execution of its methodologies. In the first instance, we found the approach adopted in both valuations to be generic (or high level), with a small number of data points being used to estimate the values of 37 sites across the country, as opposed to being based on the specific conditions in each local property market. We consider that this approach risks introducing inaccuracies and/or biases into the analysis, which may be substantial when aggregated across a large number of sites. Second, we did not agree with the adjustments made by Knight Frank to increase the area of some of Spire's sites to reflect the size of site that a PHP would choose in an ideal situation. We consider that larger and hence more costly sites are likely to result in operational efficiencies for a PHP.<sup>24</sup> If this were not the case, then there would be no rationale for buying a larger site. However, in our profitability analysis, we have not made any adjustments to the operational performance of the hospitals to reflect the benefits associated with such sites. Therefore, we do not consider it appropriate to include the cost of larger sites in the value of capital employed.
34. Our principal concern with the first of Knight Frank's valuation methodologies is that the comparable transactions that form the basis of the valuation may not be representative of the market as a whole. These transactions are taken from relatively high-value areas of the UK, including Bath, Edinburgh, Reading, Cardiff and Kent, whereas Spire's hospitals are located throughout Great Britain, including in a number

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<sup>24</sup> These may take the form of increased revenues or lower costs.

of lower-value areas, such as Wrexham, Sunderland and Blackpool.<sup>25</sup> By applying an average price per acre from these transactions to other areas of the UK, this methodology may overstate the average replacement cost of Spire's sites.<sup>26</sup> In addition, we note that these transactions may not be fully representative of the areas from which they are drawn. For example, the Shawfair transaction quoted is Spire's original purchase of the site in 2008, at which point it paid around £[redacted] per acre for land. However, in 2012, Spire acquired additional land in the same location and paid around £[redacted] per acre.<sup>27</sup> Similarly, information provided to us by Circle indicates that the price paid per acre at Bath was approximately £690,000 rather than £[redacted] per acre, as suggested by Knight Frank.

35. We had some similar concerns regarding how representative the care-home transactions used in the Knight Frank's second valuation approach were of the market as a whole. Of the ten transactions, five are located in relatively high-value areas of the country, including Sunningdale (near Windsor), Macclesfield and Lymm (Cheshire), Heswall (Wirral) and Cheltenham.<sup>28</sup> DTZ's report included details of a number of care-home transactions which were drawn from a broader geographical cross-section of the UK. (See DTZ Report, Appendix 6.15). These had substantially lower average values than those used by Knight Frank. Hence, we consider that the range of values used by Knight Frank is likely to overstate the alternative use value of Spire's sites.

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<sup>25</sup> High value areas have been identified with reference to the VOA Property Market Report, 2011.

<sup>26</sup> Information provided to the CC by Circle highlights a number of additional transactions in other areas of the country. Many of these took place in 2007/08 (which was the peak of the market), and have values both higher and lower than the range used by Knight Frank. For example, Circle signed land purchase agreements at £[redacted] per acre for land in Plymouth and £[redacted] per acre in Southampton, as well as £[redacted] per acre in Tunbridge Wells. Hence, the approach of applying an average value from a limited number of transactions to estimate the value of all of Spire's sites in the UK does not appear to us likely to produce an accurate estimate.

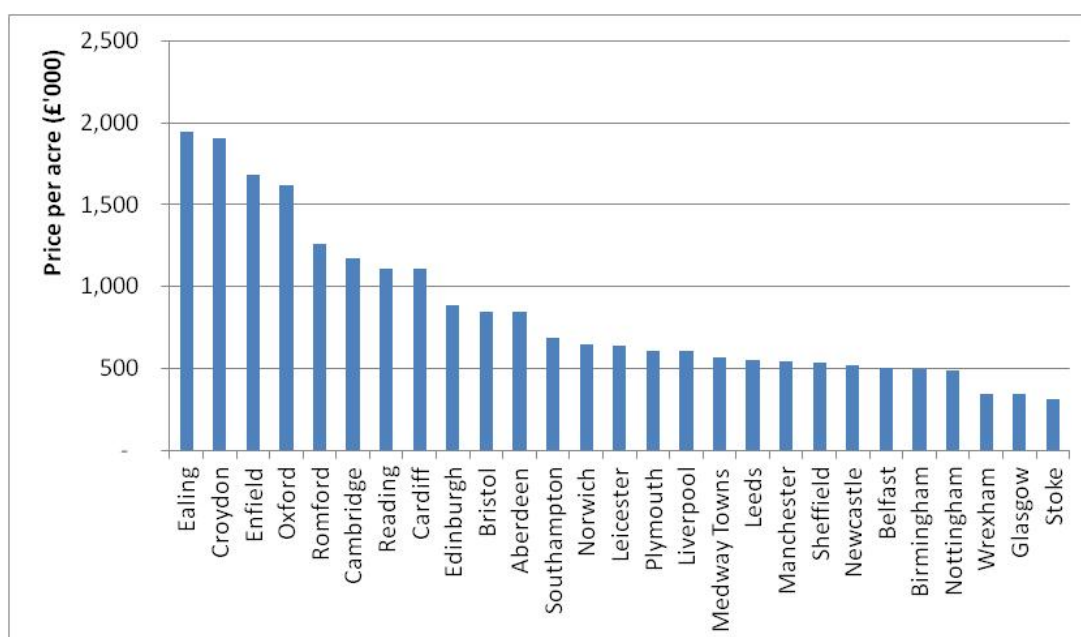
<sup>27</sup> We understand that competition among the private hospital operators may put upward pressure on land prices. This appears to be a particular issue where the location of the site confers a particular competitive advantage to the owner of that site, as was the case in Edinburgh. We note that this dynamic may, in certain cases, result in some element of the profitability of the market being capitalized in the asset values of the businesses.

<sup>28</sup> Spire argued that Cheshire and Wirral were not particularly high value areas of the UK. However, data on the specific wards of Heswall and Lymm indicate that these towns are significantly wealthier with higher property prices than the surrounding areas. See: <http://lymm.com/about/housing-statistics>  
<http://www.doriconline.org.uk/Resource.aspx?ResourceID=183&refP=PowerSearch.aspx?txtQuery=Lymm&rbSearchFor=Resources&rbSearchType=Wildcard>  
[www.wirral.gov.uk/downloads/787](http://www.wirral.gov.uk/downloads/787)

36. Our review of the residential values used by Knight Frank (based on VOA data, see FIGURE 1) indicates that a reasonable range of values has been applied on the basis of the information supplied by the VOA. It was unclear, however, whether the VOA estimates, which focused on larger towns and cities around the UK, were necessarily representative of other areas of the UK which were not covered by the estimates.

FIGURE 1

**Residential development land prices, VOA data, 2011**



Source: VOA Property Market Report, January 2011.

37. Our view is that DTZ's methodology is consistent with the value to the owner principles that we are using for our profitability analysis. We consider that its report provides the most comprehensive valuation of land outside central London, considering the dynamics of the local property market in each area and identifying the prices that would have to be paid at the current time for the various types of land that could be converted to private hospital use. The report identifies the key factors that the private hospital operators take into account in choosing where to locate and estimates the cost of a replacement plot of land within an appropriate catchment area.



38. However, we recognize that some recent transactions have taken place at higher values in certain areas<sup>29</sup> and that some of the alternative sites used by DTZ to estimate the value of the relevant firms' actual sites may not be fully equivalent. In particular, we considered that agricultural land with a reasonable probability of gaining planning permission for development was likely to sell at a discount to land that had already achieved planning permission, in light of the delays and uncertainty involved in the planning process in the UK. Our base case analysis seeks to allow for these uncertainties by using a cost of obtaining planning of £250,000 per site, ie a figure towards the upper end of the range provided by DTZ. In addition, despite our concerns regarding the approaches adopted by Knight Frank we have used these valuations as the basis for a sensitivity in our profitability analysis. (See Appendix 6.13.)
39. In addition, we have used the land price index included in Knight Frank's report in our analysis, applying it to the land values of all the non-London hospital operators. This assumes that these land price trends would affect all the relevant firms similarly over the 2007 to 2011/12 period. We believe that this assumption is reasonable.
40. We consider that the AEH report provides an appropriate land value for central London hospitals (both HCA's and TLC's). Given the competitive market that exists for office space in central London, we do not believe that the use of the residual value methodology risks distorting the price of land. It appears highly unlikely that the price of office space is influenced by the profitability of any single industry and certainly not by that of the private hospital industry. We address the alternative use value of HCA's land and buildings in Appendix 6.13.

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<sup>29</sup> Although, we have already noted that other transaction values are lower than those used by Knight Frank.

## **Application of valuation approach**

### ***Relevant firms' view***

41. In addition to the views on the valuation methodology set out above, the relevant firms raised a number of more detailed points on DTZ's approach. In particular:
- (a) Ramsay and Nuffield questioned the net-down assumption made by DTZ, whereby gross land prices were reduced by 15 per cent to reflect the price that would be paid for a plot given limits on the proportion of any site that could be developed.
  - (b) The Knight Frank and Ashkirk reports submitted by Spire questioned DTZ's approach to reducing the size of sites where DTZ considered that there was excess land that a new entrant would not acquire. They argued that the adjustments made by DTZ did not take into account sites that were constrained by either size or planning, where a new entrant would wish to acquire a larger plot.
  - (c) BMI put forward the view that DTZ should not have made adjustments to land prices based on affordable housing and section 106 requirements as these did not apply to private hospital operators.
  - (d) BMI argued that as DTZ's report did not constitute a 'valuation' under the RICS 'Red Book' standards but only an estimate of land prices or costs, it could not be relied upon.

### ***Our views***

42. As set out above, the relevant firms raised two points in relation to the area valued by DTZ. The first related to DTZ's assumptions regarding the size of sites required by the relevant firms where it considered that hospitals had excess land.<sup>30</sup> The second

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<sup>30</sup> DTZ based its assessment of the existence of excess land on an inspection of satellite photos of the sites, as well as information on the built area of the hospitals.

was in relation to the 'net-down' assumption, which reduced land receipts by 15 per cent for sites larger than 1 acre.

43. We consider both these adjustments to be appropriate in the context of the land valuation methodology adopted. DTZ has estimated how much a new entrant would pay for a plot of land that could accommodate the relevant firms' existing hospital operations in each local area. Where sites have large areas of park- or woodland, which are not being used to provide hospital services, it is logical that a new entrant would not pay for this space. We recognize that, in some cases, a larger site would be desirable in order to expand operations, operate more efficiently or be able to provide customers with greater parking facilities. However, these benefits could be expected to have an impact on the profits of the business, as well as the capital employed. Hence, a consistent treatment would require such a profit effect to be taken into account alongside the increase in capital employed. We have considered only the existing performance of the businesses and hence their existing asset bases.
44. The 'net-down' assumption reflects an adjustment to the gross price per plot to the net price per developable acre of land. It makes the assumption that a developer would only pay for usable land.<sup>31</sup> Although this assumption is likely to represent a simplification of reality, with the appropriate figure varying by site, none of the relevant firms has submitted an alternative figure that they consider to be more appropriate.
45. When estimating what an entrant would have to pay for a plot of land with reference to alternative uses, we consider it consistent to take into account the actual price the alternative use would pay. Where DTZ has valued a plot on the basis of residential

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<sup>31</sup> This adjustment is to price and not to the actual size of the plots, although we recognize that this was not clear in the DTZ draft report.

alternative use, the affordable housing and section 106 adjustments reduce the gross price a residential developer would pay to the net price. Logically, it is this net price that a PHP would have to match or exceed in order to secure the plot of land.

46. Finally, we note BMI's concern regarding DTZ's report not constituting a valuation under RICS standards. We understand that this is necessarily the case since DTZ did not inspect the sites, nor did it follow a RICS-recognized valuation methodology, although it had reference to VS 6 Valuation Standards and GN 6 Guidance Note, which is for the 'Depreciated replacement cost method of valuation for financial reporting'. In assessing which approach to 'valuing' land is appropriate for the purposes of profitability analysis, we have had reference to the value to the owner principles, articulated in Appendix 6.13. We consider that the approach employed by DTZ adheres most closely to these principles and hence is appropriate, although we have taken into account the uncertainty over land values by applying a sensitivity to our results. We do not have reason to believe that by conducting the analysis on a 'desktop' basis (as opposed to inspecting the sites), DTZ is likely to have systematically erred in its estimates.

## Anaesthetist groups

### Introduction

1. This appendix describes our analysis and results of the impact of anaesthetist groups on prices and of any entry barriers created by anaesthetist groups to individual anaesthetists. It also summarizes the relevant findings from our survey of consultants.<sup>1</sup>
2. Several insurers told us that some anaesthetists had formed groups that collectively set prices and shared revenue. They added that in some cases these groups accounted for a very large proportion of anaesthetic treatments in one or more hospitals. This, according to several insurers, resulted in higher prices set by anaesthetist groups compared with independent anaesthetists and, in turn, to higher average prices set by anaesthetists. On the other hand, anaesthetist groups and the Association of Anaesthetists of Great Britain & Ireland (AAGBI) argued that group formation helped in delivering higher quality of service.<sup>2</sup>
3. Table 1 shows a relatively higher rate of anaesthetist groups being formed between 1981 and 1990 and another spike between 2001 and 2010. This is based on a sample of 45 anaesthetist groups who provided full responses to our questionnaire.<sup>3</sup> Around five out of the 26 anaesthetist groups established between 1960 and 2000 either changed from loose associations to formal legal structures or moved to collective price setting between 2001 and 2010.

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<sup>1</sup> Findings from our survey of consultants are similar to those previously presented in the AIS, Appendix C, found at [www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/ais\\_app\\_c\\_toh\\_2.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/ais_app_c_toh_2.pdf)

<sup>2</sup> See Annex A for a summary of the view/evidence provided by various parties on the impact of anaesthetist groups.

<sup>3</sup> The questionnaire was sent to over 100 anaesthetist groups.

TABLE 1 Establishment of anaesthetist groups over time

<i>Time period</i>	<i>Number of anaesthetist groups established</i>
1960–1970	1
1971–1980	7
1981–1990	13
1991–2000	5
2001–2010	19
Total	45

Source: CC analysis.

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4. Our analysis includes 11 local areas, and anaesthetist groups active in these areas, that insurers mentioned specifically, as these were likely to be among the most problematic ones (see paragraph 6).<sup>4</sup>
  
  5. This appendix is structured as follows. First, it describes the analysis conducted on the impact of anaesthetist groups on prices. Second, it presents our findings on whether anaesthetist groups create barriers to entry for individual anaesthetists. Finally, it summarizes the relevant findings from our survey of consultants.

### **Price analysis of anaesthetist groups**

6. We did not have enough information on the anaesthetist groups' presence across UK hospitals to test systematically their possible impact on average fees charged by anaesthetists.<sup>5</sup> Therefore, our analysis covered only a number of local geographic areas, and anaesthetist groups active in these areas, that insurers mentioned specifically (ie 11 in total), as these were likely to be among the most problematic ones. This section describes the data used, outlines the methodology applied and summarizes the results of our analysis.

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<sup>4</sup> The changes to the analysis undertaken by the CC as a result of comments received in response to the [AIS](#), are noted in the methodology section below.

<sup>5</sup> AAGBI does not maintain records of their members' membership of anaesthetists groups and was unable to provide a comprehensive list of anaesthetist groups and was not able to provide any information of their membership. The PMIs confirmed that they do not in many cases know whether an anaesthetist is part of an anaesthetist groups when being invoiced. Similarly, the hospital operators had varying information on whether anaesthetist groups were operating in their hospitals and which anaesthetists were members of such groups.

## **Data**

7. There are two key elements of information for this analysis: data on the treatments and data on the presence and importance of groups of anaesthetists. The data set containing this information was put together by merging two different databases.
8. The first database included anaesthetist data for insured patients at the treatment level for the period 2006 to 2012.<sup>6</sup> The source was the invoice-level data provided by all insurers in response to our data questionnaire.<sup>7</sup> It contained information on each treatment—ie type of treatment,<sup>8</sup> the invoiced price, the hospital in which the treatment was administered and the GMC number of the anaesthetist who administered the treatment.<sup>9</sup> We removed some outliers for each treatment by excluding all observations for which the fees charged by consultant anaesthetists fall in the top or bottom 1 per cent.
9. The second database contained information on membership of anaesthetist groups. We received full responses to our questionnaires from 45 anaesthetist groups,<sup>10</sup> informing us of the dates the groups were formed, the rationale behind forming their groups, names of their members and the private hospitals in which they served private patients. We used this information to identify the anaesthetists in the first database that were in these groups. The groups also told us about their main centralized activities, requirements for group membership, any arrangements with hospitals and insurers and how they set their fees. We note that the database did not cover all the anaesthetist groups in the UK.

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<sup>6</sup> Data for 2012 covered only part of the year. The period covered in 2012 varies among insurers. Therefore, all the analysis conducted for 2012 covered part of the year.

<sup>7</sup> The composition of the clean insurer database, after removing outliers, was: 49.4 per cent Bupa, 29.5 per cent AXA PPP, 10 per cent Aviva, 7.3 per cent PruHealth, 3.3 per cent WPA and 0.6 per cent Simplyhealth.

<sup>8</sup> The database contained codes which refer to each treatment. In most cases these refer to standardized treatments (eg knee replacement), though there may be some variation within the same treatment (eg different types of anaesthetic treatments for knee replacement). This may be one of the factors (alongside regional differences, the type of hospital, presence and importance of groups etc) that explain some of the price variation within the same treatment and which we cannot account for.

<sup>9</sup> The GMC number allowed us to know if the anaesthetist belongs to a group through matching it with our second database.

<sup>10</sup> The questionnaire was sent to over 100 parties identified from information provided by AAGBI, the main hospital operators, the PMIs and from the internet as potentially anaesthetist groups.

## **Methodology**

10. A key aspect of the analysis was to find for each local area, and anaesthetist group, an appropriate control group that allowed us to compare the fees for treatments administered by consultants who belong to anaesthetist group(s) with the fees of the control group. The more similar the circumstances that affect the fee level of the treatment offered by the two groups, the more likely that any difference in prices can be attributed to the presence of the anaesthetist group. As our control groups will not, in general, capture all other factors, there is some uncertainty associated with our results from our analysis.
  
11. We controlled for the mix effect of different treatments performed in the different local areas by looking at six<sup>11</sup> of the ten most common treatments in the UK under general anaesthesia.<sup>12</sup> We adjusted our selection of treatments based on AAGBI's response to the annotated issues statement. AAGBI told us that two<sup>13</sup> out of the six treatments presented in the annotated issues statement were most commonly used by anaesthetists as secondary procedures performed in addition to the primary procedure under general anaesthesia, which increasingly attract no additional fees. When these codes are used alone, they are used primarily for chronic pain work which is only rarely part of anaesthetic group practice. Therefore, we have replaced these two treatments after consultation with AAGBI.
  
12. Where data was available, we have conducted the analysis for each of the six treatments. First, we conducted price analysis at the national level to give an overview on the UK anaesthetist market. Then, as mentioned above, we focused our

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<sup>11</sup> Multiple arthroscopic operation on knee (including meniscectomy, chondroplasty, drilling or microfracture) (w8500); arthroscopic meniscectomy (including debridement) (w8200); phakoemulsification of lens with implant—unilateral (c7122); hysteroscopy including biopsy, dilatation, curettage and polypectomy with/without mirena coil insertion (Q1800); diagnostic endoscopic examination of bladder (including any biopsy) (m4510); surgical removal of impacted/buried tooth/teeth (f0910).

<sup>12</sup> These account for around 18 and 19 per cent of observations with non-missing CCSD codes by volume and by value respectively.

<sup>13</sup> Local anaesthetic blockade of major nerve trunk (including occipital block, spheno-palatine block, diagnostic block of trigeminal branch, intercostal nerve block & supra-scapular nerve block) (A7350); and epidural injection (lumbar/caudal) (A5210).



price analysis on local geographic areas, where insurers complained specifically about the presence of anaesthetist groups. Based on the 11 areas identified by insurers, we conducted regional analysis and individual case studies. The different pieces of analysis undertaken are outlined below:<sup>14</sup>

(a) *National analysis.*<sup>15</sup> We compared the average fees in the UK, between 2006 and 2012,<sup>16</sup> charged by anaesthetists who according to the data collected belonged to any of the 45 groups we identified with anaesthetists who did not belong to a group. The latter include independent anaesthetists and anaesthetists who may belong to groups but which we could not identify.

(b) *Regional analysis.*<sup>17</sup> Ten out of the 11 groups we examined are located in one of two regions in the UK. Accordingly, we conducted the following analysis for each of the two regions separately:<sup>18</sup>

- (i) We compared average fees in the region, for each year between 2006 and 2012, charged by anaesthetists who we knew belonged to any of the 45 groups we identified with anaesthetists who we did not identify as belonging to a group. The latter includes independent anaesthetists and anaesthetists who may belong to groups but which we could not identify.
- (ii) We compared the average fees charged by each group examined that operates in the region with the regional average (where we exclude from the regional average treatments provided by anaesthetists who are identified in our dataset as members of any of the 45 groups) between 2006 and 2012.<sup>19</sup>

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<sup>14</sup> The national and regional analyses were concluded following the AIS. In the AIS we examined three individual case studies using the methodology described in paragraph 12(c).

<sup>15</sup> A minimum of 20 observations per treatment were required to calculate the average fees per treatment. Where we had fewer than 20 observations for some treatments, we note this in the results section.

<sup>16</sup> This comparison is not conducted on an annual basis; for each treatment we compare two average prices calculated for anaesthetist services provided between 2006 and 2011.

<sup>17</sup> A minimum of 20 observations per treatment were required to calculate the average fees per treatment. Where we had fewer than 20 observations for some treatments, we note this in the results section.

<sup>18</sup> Three groups are located in Region 1, seven groups are located in Region 2 and one group is located in Region 3. We have conducted the regional analysis for Regions 1 and 2.

<sup>19</sup> Similar to the national analysis, this comparison is not conducted on an annual basis.

(c) *Individual case studies.*<sup>20</sup> Depending on the information available and the facts in each case study, we carried out the following pieces of analysis for each of the 11 local areas to the extent we had the relevant data:

- (i) We compared annual price levels of anaesthetist groups with a regional average (where we exclude from the regional average treatments provided by anaesthetists who are identified in our data set as members of any of the 45 groups). This is different from the regional analysis above ((b)(ii)) as it compares price levels for each year between 2006 and 2012. The regional analysis did not look at price levels over time but rather looked at a single average price for anaesthetist services provided between 2006 and 2012.
- (ii) We compared the price change of anaesthetist groups pre- and post-formation of the groups or changing of their legal status (where these were within the period covered by our data) with the price change of a regional average over the same period. The percentage change in price pre- and post-event is compared with regional average, which excludes the treatments provided by anaesthetists who belong to the group under study.
- (iii) We compared the average prices of anaesthetist groups with independent anaesthetists (ie not belonging to the group) in the same hospitals in a given geographic area.
- (iv) We compared prices in hospitals where the anaesthetist groups' presence is significant with those in nearby hospitals where groups are not present or are not present to the same extent. We considered that the best comparator would be nearby hospitals (as the price of the treatment may reflect some local factors, eg local supply of anaesthetists) and a hospital that belongs to the same corporate group (as prices of anaesthetic treatments may be influenced by the corporate group).

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<sup>20</sup>The eligibility criterion to compare average fees per treatment is having at least 20 observations for four out of the seven years. We conducted case studies for the local areas where we were able to compare average fees for at least three out of the six treatments selected. We note in the results section the local areas, where we did not have enough observations for at least three treatments in order to conduct an individual case study.

13. We observed that even for each specific treatment there is substantial price variation in anaesthetist fees across the UK. Therefore, any difference between the average fees set by members of group(s) and non-members of groups in the national and regional analyses, could be explained by factors other than the presence of a group. We have taken this into consideration while interpreting the results of these analyses.
14. The individual case studies provide more detailed analyses that aim at better controlling for geographical variations. The pre- and post-event analysis is the most useful. The difference between the groups prices pre- and post-event and those of non-groups, particularly in the same region, represents a good comparator as the only (observable) feature is the group formation or change in group legal structure. However, this could only be applied to three case studies where the group was formed during the period examined (2006-2012). The second best comparator is independents working in the same hospitals, which was applied to four case studies. In theory, comparing average fees between group members and independents in the same hospital is a good comparator as the only (observable) feature that differentiates them is that they are not part of a group. However, one possible disadvantage of this approach is that independents may choose to follow the prices set by the groups. The third best comparator is comparisons with nearby hospitals, which was applied in three case studies. We had difficulty conducting this analysis because of lack of data and information about the presence and/or size of anaesthetist groups in nearby hospitals.

## **Results**

15. The detailed results are summarized below. As noted in paragraph 13, as there is substantial price variation in anaesthetist fees even for each specific treatment across the UK, this is taken into consideration while interpreting the results from the national and regional analysis.

### *National*

16. The analysis shows that average fees charged by anaesthetists identified to be members of any of the 45 groups across the UK appear to be higher than those charged by non-members (independents or members who are not identified in our database) for the six treatments examined between 2006 to 2012. The weighted average price difference between members and non-members is around 7 per cent.<sup>21</sup>

### *Regional*

17. The first type of analysis (see paragraph 12(b)(i)) shows that average annual fees charged by group members in Region 1 appear to be higher than those charged by non-members (independents or members who are not identified in our database) for the six treatments examined between 2006 and 2012. For Region 2, average annual fees charged by members appear to be higher for five treatments. For the sixth treatment, fees charged by members were higher for the initial part of the period and reached levels below non-members between 2010 and 2012.
18. Tables 1 and 2 show the second piece of regional analysis (see paragraph 12(b)(ii)). They summarize the price differences between the ten groups that are located in Regions 1 and 2 and the relevant regional average.<sup>22</sup> For seven groups, average fees charged by each group are higher than the relevant regional average (excluding treatments provided by anaesthetists identified to be members of groups in the region) for most of the treatments examined. In addition, we looked at the difference between the weighted average price charged by the group for the six treatments and the relevant regional weighted average price.<sup>23</sup> For six groups, the weighted average

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<sup>21</sup> The weights are the national volume of anaesthetic services provided for each treatment.

<sup>22</sup> The 11<sup>th</sup> group is located in a third region that is not included in the regional analysis.

<sup>23</sup> The percentage price difference between average fees charged by the group and the relevant regional average is calculated separately for each treatment. A weighted average price difference for all treatments is calculated, where the weights for each treatment are the number of observations provided by the members of the group.

price difference is at least 9 per cent. For three groups, the weighted average price differences range between 2 and 4 per cent. For one group it is –9 per cent.

TABLE 2 **Region 1: Group members versus regional average fee comparison**

	<i>No of treatments where group prices are higher than regional average</i>	<i>No of treatments where group prices are lower than regional average</i>	<i>Weighted average price difference %</i>	<i>Individual case study below</i>
Group 1	6		18	A
Group 2	6		9	N/A*
Group 3	3	3	-9	D

Source: CC analysis.

\*Denotes groups where we did not have enough observations to conduct individual case studies.

TABLE 3 **Region 2: Group members versus regional average fee comparison**

	<i>No of treatments where group prices are higher than regional average</i>	<i>No of treatments where group prices are lower than regional average</i>	<i>No of treatments where group prices are close to regional average*</i>	<i>Weighted average price difference %</i>	<i>Individual case study below</i>
Group 4†	5	1		13	C
Group 5	6			10	E
Group 6	2	2	2	2	B
Group 7	5	1		12	F
Group 8	4	2		4	N/A‡
Group 9§	6			12	N/A‡
Group 10¶	2	2	2	4	N/A‡

Source: CC analysis.

\*Includes a price difference of less than or equal to 2 per cent.

†There is low number of observations (ie less than 20) for two treatments (greater than regional average).

‡Denotes groups where we did not have enough observations to conduct individual case studies

§There is low number of observations (ie less than 20) for one treatment.

¶There is low number of observations (ie less than 20) for two treatments (one greater than and one lower than regional average).

## Case studies<sup>24</sup>

19. We did not have enough observations to conduct the individual analysis for five out of the 11 anaesthetist groups. Results from the six individual case studies analyzed are summarized below:

(a) Results on three case studies (namely A, B and C below) were to some extent mixed. Some of the results on three case studies suggest that the anaesthetist

<sup>24</sup> The number of treatments we were able to examine for each case study may vary across the different pieces of analysis undertaken. For example, for some case studies we had enough observations to look at more treatments under the pre- and post-event analysis, which compares two time periods, compared with the other three pieces of analysis carried out, which compare annual fees. Another example is having enough observations for some treatments to compare the average fees charged by the group to regional averages but not having enough observations on fees charged by independents to compare fees.

groups may have an impact on prices. It is worth noting that the most significant result for the three groups is the pre- and post-event analysis.

(b) Results on three case studies (namely D, E and F below) do not suggest that the presence of the group leads to higher prices. However, for these case studies we were unable to carry out what we regard as the strongest piece of analysis—the pre- and post-event price analysis—as the groups were formed before our period of study (2006 to 2012).

### *Case study A*<sup>25</sup>

20. The anaesthetist group in this area has a high share of all anaesthetic treatments—over 80 per cent by volume.

21. The findings for case study A are:

(a) Average fees for the anaesthetist group for each of the six treatments are higher than the regional average fees for the period 2006 to 2012.

(b) There is more variation in fees for each of the six treatments before the group was formed than after it was formed.

(c) The increase in average fees of the anaesthetist group when the group was formed was higher than the increase in regional average fees for five treatments and lower for one.

(d) The level of fees for the anaesthetist group and independent anaesthetists in the same hospitals for two treatments are broadly the same. It is difficult to make comparisons for three treatments due to the low number of observations for the non-groups.<sup>26</sup> We are unable to compare fees for one treatment because there are no observations for the non-groups.

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<sup>25</sup> This is the same local area and anaesthetist group presented in the [AIS](#) under the name 'case study A'.

<sup>26</sup> There are few observations for anaesthetists not in groups for all treatments where we have made comparisons.

(e) There are higher average fees in one hospital, where the anaesthetist group operates, compared with another hospital in nearby areas, belonging to the same hospital group and where another group operates and accounts for less than 40 per cent of anaesthetist treatments, for three treatments for all years. We were unable to make comparisons for the other three treatments due to the low number of observations.

### *Case study B*<sup>27</sup>

22. The anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—around 60 per cent by volume.
23. The findings for case study B are:
- (a) Average fees for the anaesthetist group are higher than the regional average fees for two treatments for which we have sufficient data.
  - (b) The increase in average fees of the anaesthetist group when the group changed from a loose association to a formal partnership was higher than the increase in regional average fees for four treatments and lower for one.

### *Case study C*<sup>28</sup>

24. The anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—above 50 per cent by volume.
25. The findings for case study C are:
- (a) Average fees for the anaesthetist group are higher than the regional average fees for two treatments. For the third treatment, fees were higher between 2010 and 2012.

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<sup>27</sup> This is a different local area and anaesthetist group from the ones presented in the [AIS](#) under the name 'case study B'. After changing the set of treatments, we did not have enough observations to present a separate case study on the local area/ anaesthetist group previously presented in the [AIS](#) as 'case study B'.

<sup>28</sup> This is the same local area and anaesthetist group presented in the [AIS](#) under the name 'case study C'.

- (b) The increase in average fees of the anaesthetist group when the group was formed was higher than the increase in regional average fees for four treatments, for which we have data.
- (c) There were higher fees for the anaesthetist group than independent anaesthetists at the same hospital for two treatments and broadly the same fees for the other treatment.

#### *Case study D*

- 26. The anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—above 80 per cent by volume.
- 27. The findings for case study D are:
  - (a) Average fees for the anaesthetist group are broadly lower than the regional average fees for four treatments, for which we have data.
  - (b) Average fees for the anaesthetist group for two treatments in one hospital are similar to those in another hospital in a nearby area (that belongs to the same hospital group where another group of anaesthetists operates but accounts for only 50 per cent of anaesthetist services).<sup>29</sup>

#### *Case study E*

- 28. The anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—above 70 per cent by volume.
- 29. The findings for case study E are:
  - (a) Average fees for the anaesthetist group are higher than the regional average fees for four treatments. For the other two treatments, fees were higher only in the

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<sup>29</sup> For one treatment we only have data to conduct the comparison between 2006 and 2009.



initial part of the period before dropping to levels close to or below national and regional averages.

- (b) The level of fees for the anaesthetist group was higher than independent anaesthetists in the same hospitals for two treatments. However, the gap was decreasing over time to reach similar levels. For the third treatment, independents appear to charge higher fees for part of the period.
- (c) Average fees for the anaesthetist group for two treatments in one hospital were higher for part of the period only than those in another hospital in a nearby area (that belongs to the same hospital group where another group operates and is of similar size). This result demonstrates that prices can differ in these comparisons for reasons other than the size of the anaesthetist groups.

#### *Case study F*

- 30. The anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—over 70 per cent by volume.
- 31. The findings for case study F are:
  - (a) Average fees for the anaesthetist group are higher than the regional average fees for three treatments for the whole period, higher for one treatment towards the end of the period and lower for one treatment for the whole period.
  - (b) The level of fees for the anaesthetist group was close to independent anaesthetists in the same hospitals for one treatment. For the second treatment, it was lower till 2009, then exceeded fees charged by independents for the rest of the period.

## Barriers to entry

32. We examine whether anaesthetist groups create barriers to entry for individual anaesthetists. We focus our analysis on the 11 anaesthetist groups operating in the local areas examined in the previous section.
33. We used two sources of information to conduct our analysis. First, the responses of the 11 anaesthetist groups to our questionnaires provide information on the groups' arrangements with hospital operators.<sup>30</sup> Second, the same data set constructed for the price analysis above is used to calculate the proportion of anaesthetist services provided by anaesthetists who are members of a group relative to individual anaesthetists.<sup>31</sup>
34. The evidence shows low barriers to entry for individual anaesthetists to practise independently from the group. In response to our questionnaire, all anaesthetist groups mentioned that they did not have any exclusive arrangements at any of the hospitals at which they operated. They added that, like individual anaesthetists, each group member had to apply individually for practising rights at the hospitals at which the group operated. Our analysis shows that individual anaesthetists broadly account for between 50 and 10 per cent of anaesthetist services at the main hospitals, where the 11 groups operate.
35. We note that the documents we reviewed show that individual anaesthetists can join anaesthetist groups if they wish. In response to our questionnaire, all groups mentioned that the main eligibility requirement for group membership was being appointed to an NHS consultant post locally. Six out of 11 groups mentioned that group membership was open to all anaesthetists who would like to join,<sup>32</sup> while the

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<sup>30</sup> For more information on the questionnaires, see paragraph 9 above.

<sup>31</sup> See paragraphs 7 to 9 on the sources of data used to construct our data set.

<sup>32</sup> For most of these groups this is through sending invitations to all newly-appointed NHS consultants.

other five had a selective process. Three of these groups<sup>33</sup> mentioned that voting of existing partners determined whether a new member was admitted in the group. The other two groups<sup>34</sup> mentioned that membership was by invitation by the group. By reviewing the information on group membership between 2006 and 2012 provided in response to our questionnaire, we found that new members have actually joined all the anaesthetist groups during this period, except for one group, which was only formed in 2007.<sup>35</sup>

### **Consultants survey**

36. Our survey of consultants found that:

- (a) 39 per cent of anaesthetists were in groups. 22 per cent of other consultants were in groups.<sup>36</sup> 60 per cent of anaesthetists in a group said that they used the guidelines set by the group to set their fees. The proportion for other consultants was 51 per cent.<sup>37</sup>
- (b) In terms of all anaesthetists (ie those in and not in groups), 24 per cent said that they used the guidelines set by the group to set their fees (14 per cent at the level specified by the group and 10 per cent with reference to the guidelines specified by the group). The proportions for other consultants are: 10 per cent (split 4 per cent and 6 per cent).<sup>38</sup>
- (c) 10 per cent of those in consultant groups and aware of consultants not in a group said that those in groups (anaesthetists and other consultants) charged higher prices than those not in groups. Allocating 'don't knows' increases this proportion to 16 per cent.<sup>39</sup>

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<sup>33</sup>Group 2 (not in a case study), Group 6 (case study B) and Group 8 (not in a case study).

<sup>34</sup>Group 4 (case study C) and Group 10 (not in a case study).

<sup>35</sup>Group 6 (case study B), where we found a price effect.

<sup>36</sup>Source: E2/4, [GP and Consultants survey](#).

<sup>37</sup>Source: E3, [GP and Consultants survey](#).

<sup>38</sup>Source: E3, [GP and Consultants survey](#).

<sup>39</sup>Source: E6, [GP and Consultants survey](#).

(d) For those not in consultant groups and aware of consultant groups and of other consultants not in a group, the proportions are 16 and 37 per cent.<sup>40,41</sup>

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<sup>40</sup> Source: E6, [GP and Consultants survey](#).

<sup>41</sup> In response to the [AIS \(AAGBI response to AIS\)](#), AAGBI mentioned that the statistics provided under paragraphs 36 (c) and (d) did not support the argument that AGs had market power, but actually showed the opposite. This actually means that 84–90 per cent of consultants thought there was no significant difference, or that group fees were lower, or that they did not know. AAGBI disagreed on allocating all the ‘don’t knows’ to support the argument that anaesthetic groups charged higher fees.

## Summary on views put forward by various parties

### The PMI's viewpoint

1. The three main insurers (Bupa, AXA PPP and Aviva) provided some extensive responses and some analysis to illustrate their concern about the effect of groups of anaesthetists.
2. AXA PPP provided analysis for two anaesthetist groups:
  - (a) For the first group, it compared the average fees of anaesthetists in the local area between 2007 (when the group started to set fees collectively) and 2008 for the six most common procedures. AXA PPP claimed that the analysis showed that for one type of procedure, fees increased by 34 per cent. It also claimed that for the procedures examined, fees were 4 to 24 per cent higher than the national average. AXA PPP told us that it responded to such anaesthetist groups by adopting some of a number of strategies, in different cases. These included declining to pay excessive charges, warning its patients about the risk of shortfalls, negotiating with groups and in some cases delisting some consultants.
  - (b) For the second anaesthetist group, AXA PPP mentioned that the group charged 50 to 80 per cent more than its colleagues in a nearby area. It is worth noting that this analysis does not control for the different mix of treatments that can be performed by anaesthetists in the two geographic areas. AXA PPP added that 14 per cent of the group's patients had additional charges for full preoperative assessment against a national rate of approximately 3 per cent.<sup>42</sup>
3. Bupa provided us with data on the frequency of shortfall (ie when patients have to cover part of the anaesthetists' fees), their magnitude and the proportion of treatments carried out by anaesthetist groups at the group's main hospital. They

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<sup>42</sup> [AXA PPP response to AIS](#).

provided data on eight groups and argued that these had systematically charged above the Benefit Maxima<sup>43</sup> and they were sufficiently large that patients had no alternatives. Bupa mentioned that, in many cases, the alleged benefits of consultant groups do not appear to flow through to patients—a number of the largest anaesthetist groups charge the highest fees, for example. Bupa added that there is no objective evidence that it is necessary and proportionate to form a group with a uniform price structure (or profit sharing arrangement) to achieve these benefits.<sup>44</sup> In response to the annotated issues statement, Bupa raised the following points:

- (a) Bupa was concerned about focusing analysis just on price as consultant market power could be exercised through volumes or restrictions of choice.
- (b) Individual consultant fees were already above competitive levels. The situation was exacerbated (ie taken closer to the monopoly price) by consultant groups which could restrict rivalry further in local markets.
- (c) Bupa noted the CC Consultant Survey findings that 39 per cent of anaesthetists were in groups and that 60 per cent of anaesthetists in a group said that they used the guidelines prepared by the group to set fees. However, Bupa cautioned that these results might understate the harm to competition and restriction of choice from groups. As a way of example, Bupa referred to the AAGBI statement that 64 per cent of anaesthetist groups ‘share profits equally between members of the group’, meaning that there was little reason to differentiate service for group members. These types of arrangement might lead to common prices across the group even if there was no explicit guidance to set uniform prices. The presence of groups also blunted the effectiveness of any new entry to stimulate

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<sup>43</sup> This is the maximum reimbursement rate provided by Bupa.

<sup>44</sup> [Bupa response to IS](#), paragraph 6.48.

competition. Bupa added that non-group members might simply follow a group's pricing, given the lack of price competition.<sup>45</sup>

4. Aviva also argued that anaesthetist groups that were unwilling to use Aviva's fees had caused financial concerns and concerned customers.
5. PruHealth stated that it was aware of a large number of anaesthetic groups that set charges collectively and that several groups refused to discuss fees with it. In response to the annotated issues statement, PruHealth added the following:
  - (a) It compared the anaesthetic tariff of solo to group practices for ten commonly occurring procedures.<sup>46</sup> Solo practice was 5 per cent cheaper than group practice on a weighted average. The costs for most of the high-volume procedures were very similar, except for one treatment, where solo was actually more expensive on average.
  - (b) Group anaesthetic practices may deliver improved social value in their continued availability and hence justify their higher charges. The issue of group practices should include whether they served as a barrier to entry for solo consultants and this should not be restricted to anaesthetists as applied to all consultant groups.
6. WPA mentioned anaesthetist groups in four local areas and said that some of the fees set collectively were above their normal reimbursement rates.

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<sup>45</sup> See [www.aagbi.org/sites/default/files/AAGBI%20FINAL%20response%20to%20OFT.pdf](http://www.aagbi.org/sites/default/files/AAGBI%20FINAL%20response%20to%20OFT.pdf) (accessed June 2012). The AAGBI noted, for example, that 'The way that a newly appointed consultant will enter private practice will depend upon local circumstances. If there is a local AG, they will most likely seek to become a member of the AG, and indeed may be invited to join the AG as an automatic consequence of their taking up a consultant post'; *ibid*.

<sup>46</sup> PruHealth noted that this analysis was limited to one book of business (ie excluding ex Standard Life data). [PruHealth response to AIS](#).

## **The anaesthetist groups' viewpoint**

7. Anaesthetist groups explained the main rationale behind group formation. The main arguments put forward by the anaesthetist groups, which we included in our case studies, can be summarized as follows:
  - (a) *Higher quality of services.* Groups allowed for providing emergency cover to patients 24 hours a day, seven days a week. Other benefits included enhanced routine follow-up and better pre-assessment services by anaesthetists. Involvement in discussing and creating clinical policies, pathways and guidelines as a group ensured high standards of care.
  - (b) *Communication and patient information.* The group's administration team provided a single, reliable point of contact for patients, surgeons, hospitals and insurers. This provided higher transparency and ability to address financial and non-financial queries from patients, hospitals or insurers.
  - (c) *Finances.* Having a single billing system led to higher efficiency financial dealings, including estimates, invoicing, banking and accountancy. In addition, it allowed the group to provide estimates efficiently to all patients pre-operatively.
  
8. It is worth mentioning the following points regarding fees:
  - (a) Some groups stated that not all members adhered to the level of fees set by the group as they had to follow the insurers' fee schedules. This was specially the case for new consultants who signed the new consultant contracts with Bupa and AXA PPP.
  - (b) One anaesthetic group argued that anaesthetist charges were not an important factor when patients selected to have surgery in the independent sector as they relied upon the surgeon to select an anaesthetist. The Group argued that anaesthetist groups allowed the patient to have greater knowledge of their likely costs.



(c) Some groups mentioned that they aimed at providing a single fair price for anaesthetist services to all patients regardless of their insurers. The guidelines used to set the prices varied among groups. For example, some groups followed the WPA schedule, which was the highest among insurers, others followed the Bupa fee schedule plus 10 per cent increase, and others constructed an average of the various reimbursement levels set by insurers.

## AAGBI

9. AAGBI is a voluntary professional and specialist organization with over 10,000 members that represents the substantial majority of consultant anaesthetists, intensivists and pain physicians clinically active in both the private and NHS health-care sectors in the UK. The primary objects of the organization are safety, education and research.<sup>47</sup>
  
10. AAGBI's central argument in response to the annotated issues statement can be summarized as follows:
  - (a) any price effect arising from setting of prices by groups was small;
  - (b) fees charged by consultant anaesthetists were in any case low, so there was no cause for concern if groups were achieving slightly higher rates;<sup>48</sup> and
  - (c) patients benefited from consultant anaesthetists being members of groups, so this justified, or might justify, higher fees.<sup>49</sup>

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<sup>47</sup> [AAGBI response to AIS](#).

<sup>48</sup> AAGBI mentioned in its response to the AIS that: patients may complain about shortfalls and top-up payments to anaesthetists. However, we assert that this derives primarily from the PMIs' contracts with their customers, which anaesthetists obviously have no control over, and from a historical and no longer justified inequity between the benefits allowed for surgeons and anaesthetists. Given that these two groups have similar training, experience, expertise, responsibility, and time input, and enjoy identical pay in the NHS and from services to other government bodies such as the Courts and armed forces, it is illogical that the benefit levels differ by up to 300 per cent, particularly given the additional, substantial sources of income that surgeons enjoy, eg outpatient activity.

<sup>49</sup> In response to the [AIS](#), AAGBI mentioned that anaesthetist groups—as a result of their structure, shared expertise and ability to provide continuous, flexible cover—could provide a more consistent, reliable and therefore safer service to patients, surgeons and hospitals than could most individual anaesthetists. AAGBI provided a summary of the benefits of anaesthetist groups. AAGBI has also provided the results of a survey that it commissioned Enventure Research to conduct with Anaesthetic Groups. The purpose of the survey was providing useful information to inform AAGBI's submission to the CC on the benefits of these groups.

11. AAGBI added that, based on WPA data, consultant anaesthetic fees were only 12 per cent of all consultant fees and 2.6 per cent of the total cost. Therefore, AAGBI concluded that the issue of anaesthetic fee shortfalls was insignificant.
12. AAGBI argued that, notwithstanding the limitations to the analysis provided in the annotated issues statement, in only one of the three case studies was there evidence that the anaesthetic group concerned charged more than the regional average for the majority of procedures. As the three groups concerned were targeted because they were representative of the nine groups that the PMIs were most concerned about, there was likely to be even less evidence that the remaining 91 groups surveyed charged fees that were significantly greater than the regional average.

### **The hospitals' viewpoint**

13. Hospital views on anaesthetist groups were mixed, with little argument to support a negative impact on fees.
14. BMI mentioned that agreements between consultants might restrict competition and make it more difficult to manage a hospital or to implement efficiency measures. It could also impact the consultants' collective ability to obtain better fee settlements in cases where these were negotiated with the hospital and not insurer.
15. HCA stated that it had limited experience of working with consultant or anaesthetist groups that set their fees collectively, therefore any impact on HCA's business was likely to be immaterial.

16. Ramsay mentioned that there were advantages and disadvantages to consultants operating in groups.<sup>50</sup> Advantages included dealing with a single organization to get an anaesthetist, developing expertise in subspecialties and allowing the hospital to offer a whole specialty solution to patients. However, the groups typically set higher fees than levels reimbursed by PMIs, which resulted in a shortfall for patients. In addition, where there was a consultant group in place it could be difficult for new consultants to establish their practice if they did not wish to be (or could not be) part of the group.
17. Ramsay added that one key area where these groups did have an impact on its business was in relation to NHS patients. The NHS tariff was a fully inclusive price which included the cost of both the surgeon and anaesthetist and so Ramsay had to negotiate directly with these groups in relation to NHS fees.
18. [REDACTED] noted that different anaesthetist groups had a different impact on the business. [REDACTED] was the only hospital operator that provided a detailed list on its view on the impact of around 21 anaesthetist groups on its business. [REDACTED] identified groups which had no impact on its business, others which had a negative impact, and a third category where [REDACTED] believed that the higher fees charged by the group were outweighed by the benefits provided.
19. Two of the groups mentioned by [REDACTED] are part of our case studies:
- (a) *Case study 1.* Our view is that evidence suggests an impact of the anaesthetist group on prices. [REDACTED] mentioned that the anaesthetist group set its own fees for private work, which were higher than market rates, so there was a shortfall for patients. The group was not Bupa fee assured and Bupa had recently placed restrictions on using non-fee-assured anaesthetists for corporate clients. [REDACTED]

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<sup>50</sup> Ramsay reiterated the advantages and disadvantages of consultant groups in response to the AIS. ([Ramsay response to AIS.](#))

Therefore, unless the group members became Bupa fee assured, the hospital would not have sufficient anaesthetic cover.

(b) *Case study 2.* Our view is that evidence does not suggest an impact of the anaesthetist group on prices. [REDACTED] mentioned that a large majority of anaesthetists in the area were part of the group. It added that the group negotiated fees and had no impact on the hospital as far as [REDACTED] was aware.

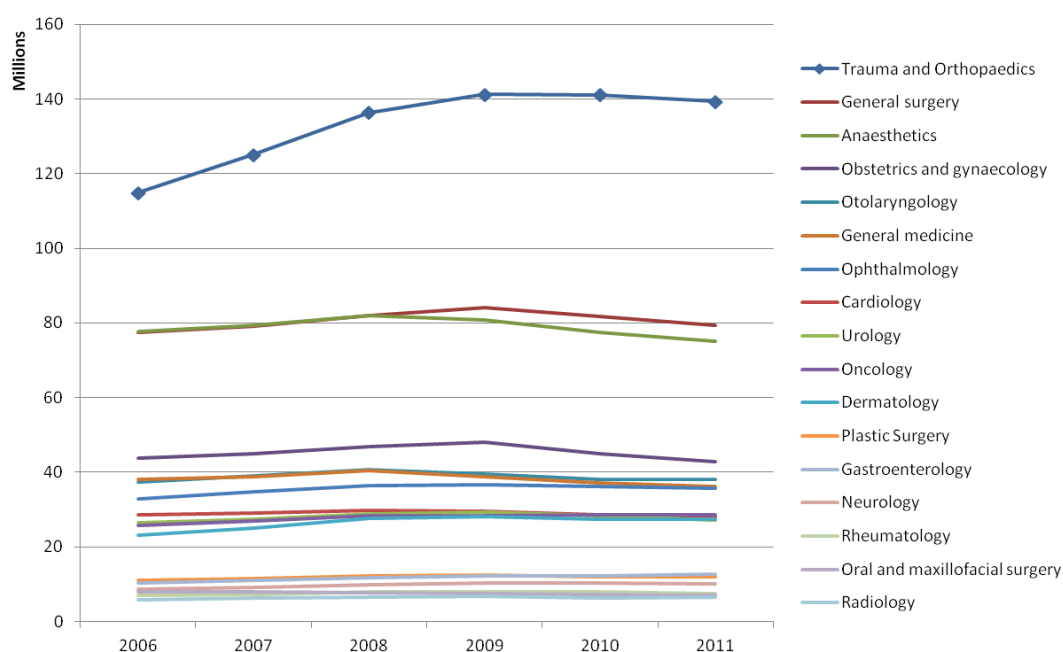
20. Nuffield believed that anaesthetist groups had the potential to have a material impact on the business, although it was not currently evident in any major way across the Nuffield Health Group.

## Consultant remuneration

- In carrying out an initial assessment of consultant charges, we tried to determine the size of the market for private consultant services by specialty. We looked at the relative market size by revenue by specialty and considered the change in revenues for each specialty between 2006 and 2011. Consultant revenue was calculated as the total fees billed by consultants to PMIs<sup>1</sup> in each specialty (Figure 1).

FIGURE 1

### Total annual fees billed by consultants per specialty



Source: CC analysis.

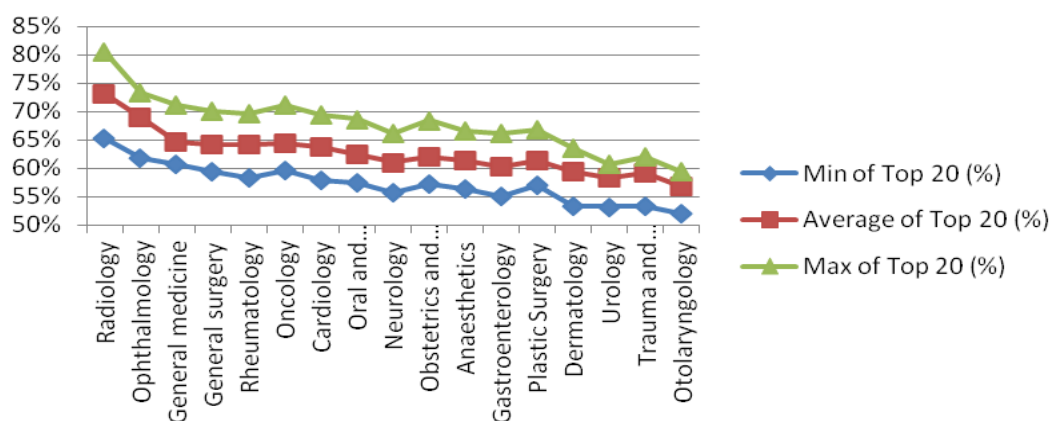
- In many specialties, our initial analysis showed a real-term decline in revenues in particular since 2008/09 depending on specialty. Trauma and orthopedics was the largest specialty by revenue by a significant margin and it was the only specialty to have seen a significant increase in revenues between 2006 and 2011. However, this appeared to have leveled off since 2009.

<sup>1</sup> Data was only available for Bupa, AXA PPP and Aviva.

- As noted on several occasions, private consultant services are extremely fragmented. There is, in addition, significant variation in the level of fee income by consultant specialty and by individual consultant. In order to arrive at some form of concentration proxy we used the percentage of fees paid to the top 20 per cent of the highest billing consultants by specialty out of the total percentage fees paid by PMIs<sup>2</sup> by specialty between 2006 and 2011—see Figure 2.

FIGURE 2

**Share of fees paid to the top 20 per cent of the highest billing consultants, 2006 to 2011**



Source: CC analysis.

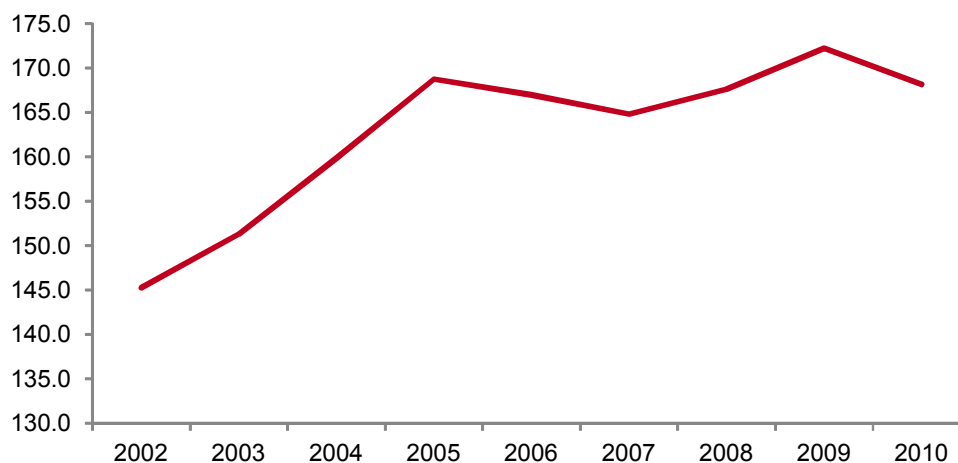
- Our preliminary analysis showed that the average percentage of fees paid to the top 20 per cent of consultants by specialty ranged between 55 to 65 per cent except for Radiology and Ophthalmology where the range is 73 per cent and 69 per cent respectively. This percentage may be explained by higher volumes and/or higher fees charged by such consultants.
- Our preliminary analysis is broadly in line with analysis carried out by Laing & Buisson. According to Laing & Buisson's analysis consultants' aggregate private fee income, in real terms, grew rapidly in the ten years to 2005 before it leveled off in the

<sup>2</sup> Data was only available for Bupa, AXA PPP and Aviva.

second half of the 2000s, growing by around 20 per cent between 2002 and 2009 (after which it fell)—see Figure 3.

FIGURE 3

**Real index for specialist private practice fee income, 1995 = 100**



Source: Laing and Buisson, Private Acute Medical Care 2012.

6. At the same time, ie between 2002 and 2009, the number of consultants increased, by about 35 per cent, and continued to rise while consultant fee income, in aggregate, fell post 2009—see Figure 4. Overall, whilst more was being spent on consultants' fees there were more consultants, potentially at least, to share it. The total number of consultants in England grew from around 27,000 in 2002 to 40,000 in 2012. We do not have as complete a data series for the other nations but in Scotland, consultant numbers rose to just over 4,400 in late 2011, a rise of just over 1 per cent compared with the previous year.<sup>3</sup> In Wales there were around 2,000 consultants<sup>4</sup> in 2011, representing an increase of more than 50 per cent over 2001.<sup>5</sup>

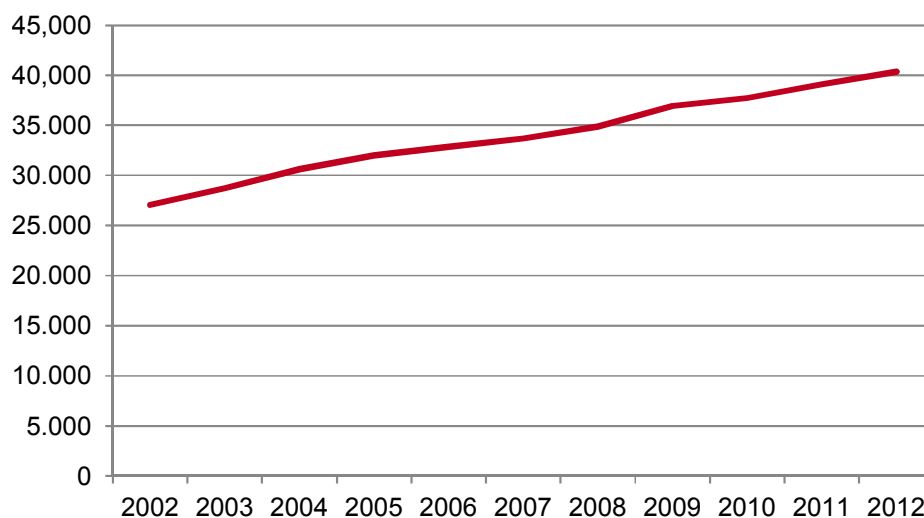
<sup>3</sup> [www.isdscotland.org/Health-Topics/Workforce/Publications/2011-06-28/2011-06-28-Workforce-Summary.pdf?81724184752](http://www.isdscotland.org/Health-Topics/Workforce/Publications/2011-06-28/2011-06-28-Workforce-Summary.pdf?81724184752).

<sup>4</sup> [www.wales.nhs.uk/sitesplus/documents/863/WORKFORCE%20FINAL.pdf](http://www.wales.nhs.uk/sitesplus/documents/863/WORKFORCE%20FINAL.pdf).

<sup>5</sup> [www.cfwi.org.uk/publications/leaders-report-shape-of-the-medical-workforce/at\\_download/attachment1](http://www.cfwi.org.uk/publications/leaders-report-shape-of-the-medical-workforce/at_download/attachment1).

FIGURE 4

**Consultant numbers, England, 2002 to 2012**



Source: [www.hscic.gov.uk/catalogue/PUB09367/nhs-staff-earn-sept-2012-tab.xlsx](http://www.hscic.gov.uk/catalogue/PUB09367/nhs-staff-earn-sept-2012-tab.xlsx).

7. We also looked to see whether the overall increase in consultant numbers concealed differences in growth rates between the main clinical specialities (see Table 1). We saw no evidence of significant differences between trends within particular specialities.

TABLE 1 **Medical and dental consultants within each speciality group 2002 to 2012**

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Accident & emergency	533	561	618	689	725	749	819	938	1,053	1,145	1,279
Anaesthetics	3,874	4,121	4,355	4,502	4,698	4,791	4,991	5,369	5,618	5,824	6,026
Clinical oncology	315	347	392	438	482	506	533	543	524	544	588
Dental group	604	655	670	671	692	700	762	840	673	690	717
General medicine group	5,931	6,284	6,726	7,072	7,277	7,517	7,906	8,275	8,384	8,862	9,204
Obstetrics & gynaecology	1,308	1,353	1,413	1,458	1,506	1,506	1,570	1,670	1,789	1,855	1,957
Paediatric group	1,695	1,807	1,902	2,033	2,154	2,198	2,211	2,416	2,543	2,646	2,724
Pathology group	2,219	2,287	2,411	2,398	2,416	2,460	2,513	2,611	2,597	2,660	2,676
PHM & CHS group	779	857	926	927	885	897	914	943	935	851	827
Psychiatry group	2,979	3,229	3,555	3,759	3,805	3,957	4,021	4,236	4,320	4,394	4,435
Radiology group	1,745	1,860	1,928	2,058	2,105	2,133	2,269	2,400	2,442	2,528	2,620
Surgical group	5,088	5,389	5,754	5,988	6,129	6,260	6,401	6,709	6,977	7,217	7,467
All specialities	27,070	28,750	30,650	31,993	32,874	33,674	34,910	36,950	37,752	39,088	40,394

Source: Health and Social Care Information Centre, Medical and Dental Workforce Census.



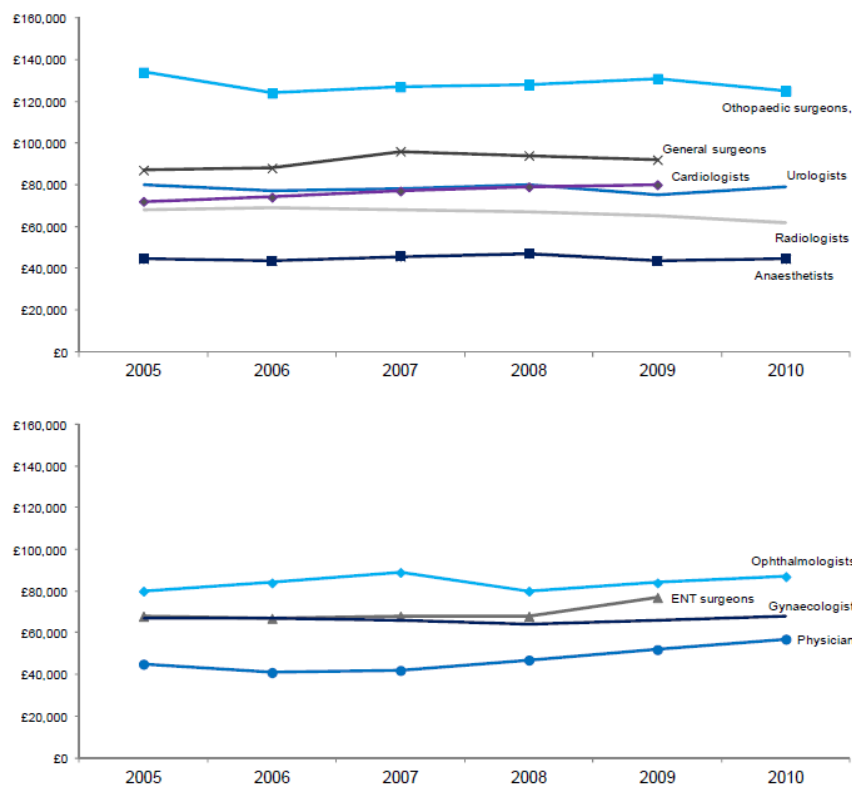
8. We also looked at a number of other data sources. Benchmarking data is collected by firms providing financial advice to clients in the medical sector, including consultants. However, these may not necessarily be representative of consultants as a whole since the firms concerned operate on a national basis and tend to deal with higher-earning consultants and partnerships rather than lower-earning, sole practitioners, for example, who may use a local firm. That said, this benchmarking data suggests, for example, that in 2011 orthopaedic surgeons were earning, on top of their NHS remuneration, gross income of around £180,000 a year from private practice. Anaesthetists, by contrast, earned around £62,000 a year gross on top of their NHS remuneration.<sup>6</sup>
9. The profitability (ie fees minus costs) of consultants in different specialisms within private practice appears to follow the same pattern as gross revenue with orthopaedic surgeons being, on average, the most profitable sector and anaesthetists the least. This pattern, as is shown in Figure 5 below, appears to be very stable over time: there is no evidence of a sustained reduction in the profitability of private medical practice within any of the specialisms though ophthalmologists average profits appear to drop between 2007 and 2008 and then remain relatively flat.

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<sup>6</sup> [www.independent-practitioner-today.co.uk/profits\\_focus\\_article.php?r=1616&a=Public](http://www.independent-practitioner-today.co.uk/profits_focus_article.php?r=1616&a=Public).

FIGURE 5

**Average private consultant profits by specialism  
(after accounting for practice expenses)**



Source: Independent Practitioner Today, Stanbridge Associates Limited.

Note: Average pre-tax profit by specialism for consultants working in private practices is calculated after accounting for practice expenses such as staff costs, consulting room hire, professional indemnity, office costs, others. Earnings were not available for all specialisms in 2010.

10. Although based on data around ten years old, a study of consultant earnings in the Journal of the Royal Society of Medicine in 2008<sup>7</sup> of the NHS and private earnings of consultants provides a potential comparator with today's earnings. The top earning categories are shown in Table 2, below.

<sup>7</sup> Morris et al, JRSM 2008;101:372-380.

TABLE 2 Analysis of consultants' NHS and private incomes in England in 2003/04

Speciality	Total earnings	£	
		NHS	Private
Plastic surgery	222,731	73,486	149,245
Trauma and orthopaedic surgery	183,933	74,339	109,594
Otolaryngology	162,486	77,361	85,125
Neurosurgery	161,259	80,342	80,917
Ophthalmology	144,370	77,081	67,289
Cardiology	146,503	78,555	67,947
Dermatology	129,587	69,555	60,032
Medical oncology	126,393	72,606	53,787
Clinical oncology	126,143	73,860	52,283
Urology	135,459	80,797	54,662
General surgery	135,912	81,676	54,235

Source: [http://jrs.sagepub.com/content/suppl/2013/04/01/101.7.372.DC1/080004\\_appendix.pdf](http://jrs.sagepub.com/content/suppl/2013/04/01/101.7.372.DC1/080004_appendix.pdf).

11. In 2012, consultants in England earned from the NHS, on average, and including extra payments on top of their basic pay, £109,600 a year.<sup>8</sup> The Stanbridge Associates benchmark data in Figure 9 can provide a useful comparison to the Journal of Royal Society of Medicine data analysis. Table 3 indicates that orthopaedic surgeons, for example, were earning around £110,000 a year in private work in 2003/04 compared with approximately £120,000 after costs in 2010 according to the Stanbridge benchmark data in Figure 5. Similarly for ophthalmologists the data suggests that they were earning in private practice on average £67,000 in 2003/04 compared with approximately £80,000 after costs in 2010.
12. We also looked at evidence submitted by third parties. FIPO had conducted a survey of its members' earnings. This showed that consultants' earnings had fallen in real terms between 2009 and 2011, remaining stable in nominal terms. FIPO pointed out, though, that it was too early for any changes in consultant earnings that might result from Bupa's new fee arrangements to have become evident.<sup>9</sup>

<sup>8</sup> <http://www.hscic.gov.uk/>

<sup>9</sup> FIPO response to AIS.

13. The BMA's survey of consultant income<sup>10</sup> indicated a mean income from private practice of around £72,000 and a median of £36,000 though this varied with both speciality and location. According to the BMA survey, the mean gross income from private practice for ophthalmologists was £145,000. The next highest earning specialities were surgery and obstetrics with mean gross incomes of £112,000 and £103,000 respectively. Specialists in emergency medicine had the lowest mean gross income, of £14,000. Consultants in London reported the highest level of mean gross income (£111,000) and those in Wales the lowest (£27,000).
14. The BMA survey, in common with the benchmarking data, suggests that consultants' earnings from private work have been fairly flat or declining. 40 per cent of respondents said that their private practice income had stayed the same as the previous year; 45 per cent said that it had fallen and just 15 per cent that it had risen.
15. However, FIPO acknowledged that the net effect of a smaller proportion of consultants engaging in private practice together with an increase in their total number had almost balanced each other out: the number of consultants in private practice had declined only marginally, from 16,349 in 2000 to 15,745 in 2012.<sup>11</sup>
16. That said, these factors might signal that the pool of NHS consultants available to the private sector might shrink in the future. However, drivers in the other direction include the fact that basic pay in the NHS has been frozen for the past two years and, as indicated by responses to the our survey of consultants, even with a longer

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<sup>10</sup> BMA Survey of consultant income, May 2011.

<sup>11</sup> [FIPO response to AIS](#). FIPO explained to us that the number of consultants had already decreased both as a percentage and in numerical terms. This, coupled with the economics of private practice (evidencing that costs are increasing and income is declining) and the fact that consultants are expected to prioritize NHS work over private practice work, corroborates concerns that patients' choice of consultants will be reduced (see [FIPO response to AIS, p11](#)).

working week, 47 per cent of consultants who responded said that they had time available and would like to undertake more private work.<sup>12</sup>

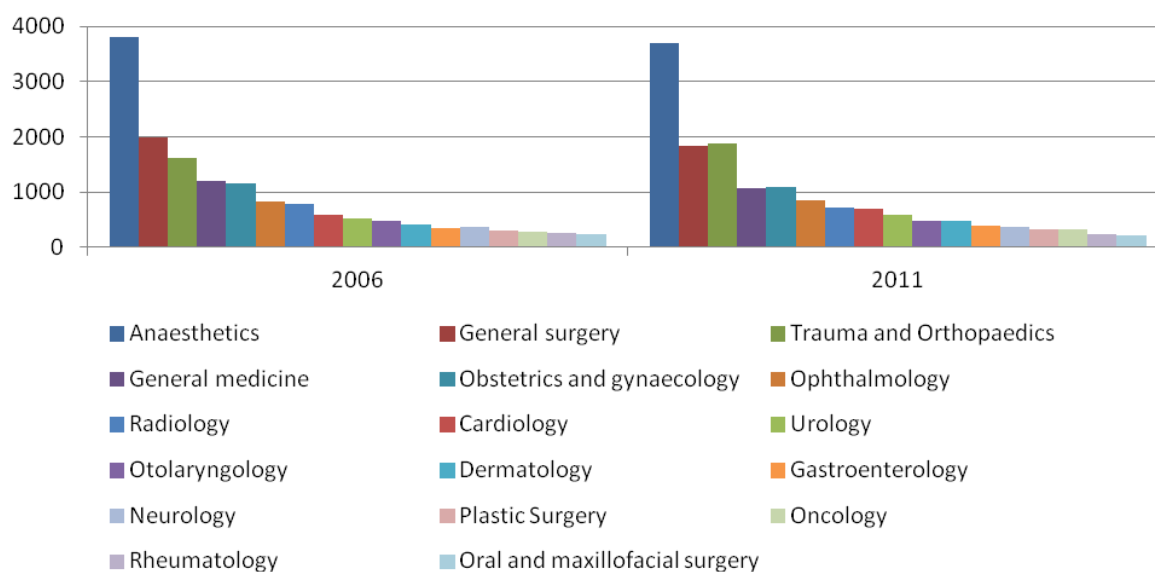
### **Availability of consultants in private practice**

17. A number of parties have submitted that the number of consultants in private practice has decreased recently. Some have quoted a recent NAO report<sup>13</sup> which found that 39 per cent of NHS consultants undertook private work in 2012 compared with 67 per cent in 2000.

18. Figure 6 below analyses the average number of consultants billing the three largest PMIs in 2006 and in 2011. Our analysis shows no material change in numbers by specialty.

FIGURE 6

### **Number of consultants per specialty**



Source: CC analysis.

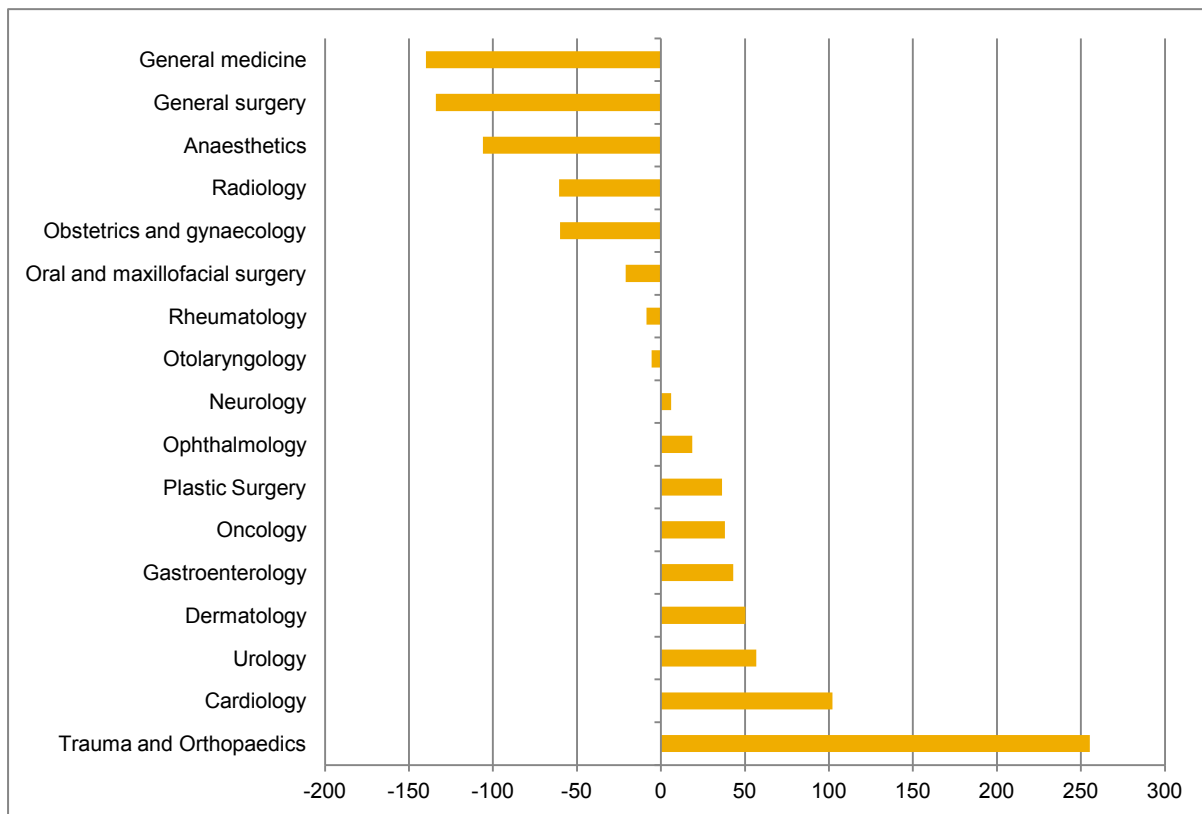
<sup>12</sup> Laing & Buisson Private Acute Medical Care 2012 p125.

<sup>13</sup> [www.nao.org.uk/wp-content/uploads/2013/03/Hospital-consultants-full-report.pdf](http://www.nao.org.uk/wp-content/uploads/2013/03/Hospital-consultants-full-report.pdf) p21.

19. We also looked at the number of consultants between 2006 and 2011 by specialty billing the PMIs.<sup>14</sup> (Figure 7)

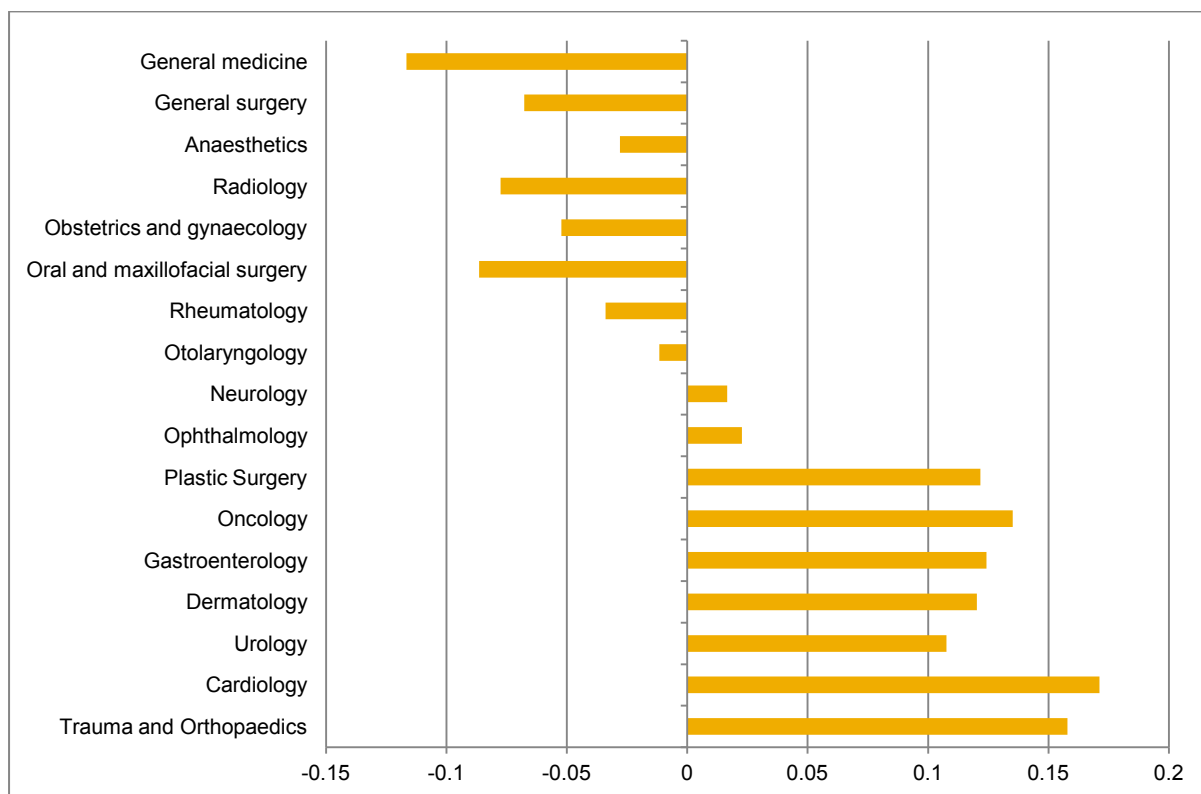
FIGURE 7

**Change in the number of consultants per specialty, 2006 to 2011**



<sup>14</sup> Again, data is only available for Bupa, AXA PPP and Aviva.

## Percentage change in the number of consultants per specialty, 2006 to 2011



Source: CC analysis.

20. Trauma and orthopaedics had the largest increase in the number of consultants between 2006 and 2011 which broadly matches the increase in revenue shown in Figure 7. On average 250 more trauma and orthopaedic consultants were billing PMIs in 2011 compared with 2006. General medicine had the largest decrease in the number of consultants billing PMIs between 2006 and 2011 (140 fewer such consultants).
21. The vast majority of consultants who undertake private practice also work within the NHS: very few doctors who work in the private sector do so exclusively.<sup>15</sup> There are a number of reasons why the percentage of consultants in the NHS also in private practice may have declined in recent years. Higher NHS starting salaries, more

<sup>15</sup> Only 2 per cent of the consultants who responded to our [GP and consultant survey](#), all of whom undertook private work, said that they worked exclusively in the private sector.

progressive pay structures and longer working week introduced in 2006 with the aim of limiting private practice work by NHS consultants might be expected to lessen consultants' incentives to seek private work. Furthermore, the rising costs of professional indemnity insurance may also have been a factor depressing the numbers of consultants undertaking private practice as a proportion of the total number of NHS consultants. A BASS survey, for example, indicated that indemnity charges for spinal surgeons was the most commonly given reason for leaving or deciding not to enter private practice.<sup>16</sup> As described at paragraph 2.8 there has also been a decline in demand for private work, at least outside London and the South-East, and the increased number of consultants competing for work.<sup>17</sup>

22. Most of the PMIs commented that they had not seen a decrease in the number of new consultants seeking recognition.
  
23. These factors might signal that the pool of NHS consultants available to the private sector might shrink in the future. However, drivers in the other direction include the fact that basic pay in the NHS has been frozen for the past two years and, as indicated by responses to the our survey of consultants, even with a longer working week, 47 per cent of consultants who responded said that they had time available and would like to undertake more private work.<sup>18</sup>

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<sup>16</sup> BASS response to AIS.

<sup>17</sup> <http://careers.bmj.com/careers/advice/view-article.html?id=20007822>.

<sup>18</sup> Laing & Buisson Private Acute Medical Care 2012 p125.



## Summary of consultant and trade body/professional association submissions by theme

### ToH 4: buyer power of insurers in respect of individual consultants

This table presents a summary of the submissions we received from over 300 consultants regarding consultant interaction with PMIs, with specific examples of the concerns that they raise. We also note some examples of where a similar point has also been made by a particular consultant trade body or professional association.

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
<b>Fees</b>		
1. Benefit maxima	Benefit maxima are not allowing consultants to recoup the expense they incur when performing a treatment or procedure.	Bupa
	Consultants are required not to charge above the maxima set by Bupa—rates have not changed even to take account of inflation. <sup>1</sup>  In April 2012 Bupa slashed fees by nearly 50 per cent for many surgical procedures. Bupa has now unilaterally restricted the maxima paid for an outpatient consultation.  Bupa virtually halved the cost of tariffs they would pay for procedures. This was a unilateral move on the part of Bupa with no consultation with specialists.  Benefit maxima were intended to be used by patients to identify levels of reimbursement, but are now used by PMIs as a basis to limit consultant reimbursement with compliance maintained through threat of de-recognition. <sup>2</sup>	AXA PPP
2. Fee schedules	Insurers are requiring new consultants to sign up to fee schedules or else they won't be recognized—they must be 'fee-assured'. <sup>3</sup>	Bupa
	Insurers are changing their fee-schedules and patients are being directed away from certain consultants on the basis that the consultant now 'over-charges' despite their fee level not having changed in a number of years.	AXA PPP

<sup>1</sup> See BMA response to IS.

<sup>2</sup> See BMA initial submission, p2.

<sup>3</sup> See FIPO initial submission, p6 .

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
3. Setting fee levels	Surgical fees have not increased since 1992.	Bupa
	Remuneration from the private healthcare companies have changed little if at all in that time, whilst the cost of doing business—secretarial support, malpractice insurance, room rental etc has rocketed. <sup>4</sup>	AXA PPP
	Insurers work as a cartel in setting consultants' fees.	PruHealth
	PruHealth are asking some consultants to reduce their fees because they charge more than PruHealth's average.  If insurers are suppressing consultant fees to a level below those which would prevail in a competitive market, this could lead to a reduction in the quality of service provided by consultants to patients and affect the incentives to innovate. In addition, there may be distortions to competition between consultants when caps on the reimbursement of fees are applied to some consultants (eg newer or junior consultants) and not to others (eg more experienced ones). In the longer term, this may result in a shortage of consultants willing to practise and in a reduction in the potential output of the sector. <sup>5</sup>	
4. Reimbursement <sup>6</sup>	Reimbursement levels of fees are all within a very narrow band.	Bupa
	Reimbursement from insurers to consultants has decreased steadily over the last 14 years while premiums paid to these companies have risen steadily over this time frame. <sup>7</sup>	AXA PPP
	Reimbursement arrangements are stifling the market and preventing development—innovation is not rewarded unless it has got a Bupa code.	Bupa
5. Top-up fees <sup>8</sup> /shortfall	Transparency with regard to top-up fees should be encouraged.	Bupa
	Some companies such as AXA PPP and Aviva insist that the consultants charge their rates and do not charge patients for the shortfall.	AXA PPP Aviva
	A new consultant was advised that he would be de-recognized if he asked Bupa members to pay a top up fee for their care at any stage.	Bupa
6. Coding <sup>9</sup>	Insurers are introducing new codes by changing descriptors at will.	PruHealth

<sup>4</sup> See Independent Doctors Federation (IDF) initial submission, p2.

<sup>5</sup> See IDF response to IS, p2; The London Consultants Association (LCA) response to IS, p2.

<sup>6</sup> See FIPO response to IS.

<sup>7</sup> See FIPO initial submission, p6.

<sup>8</sup> See British Osteopathic Association initial submission, p1; FIPO initial submission, p5.

<sup>9</sup> See FIPO response to IS.

*Submission classification*

*Examples of complaints*

*Insurer(s)*

Bupa has recently published new procedural codes that reduce significantly the level of complexity and therefore the remuneration paid for many procedures. This is an action taken by a major healthcare provider to drive down surgeons' fees under the pretext that somehow these surgical procedures have suddenly become less complex while requiring a lower level of competency to perform.

Bupa

PMIs have managed to manipulate CCSD to introduce unacceptable coding combinations [and they] use the coding principles to control the healthcare market.

Bupa and Aviva

The process of 'bundling' a clinical procedure such as cataract surgery with a follow up consultation into a single CCSD code to reduce reimbursement is as unacceptable as the process of 'unbundling' procedures into multiple elements to fraudulently increase remuneration.

***Interference in clinical pathway***

1. Managed care<sup>10</sup>

Insurers are diverting clinical referrals away from those consultants who charge their own fee schedules, and to cheaper consultants, stating that this is based on quality when it is absolutely only based purely on cost, and many of the cheaper consultants are actually less experienced, with poorer reputations.

Bupa

'Managed care' cannot be in the patient's best interests since the restrictions to healthcare are being invoked by non-practising doctors and managers working for PMIs, ultimately with an interest in profitability rather than clinical excellence.

Patients are encouraged by insurers to contact them directly for a reference rather than to see a consultant recommended by their GP—the referring person in such a case is somebody, possibly without medical training and no detailed knowledge of the medical problem.

2. Open referral<sup>11</sup>

Insurer-led referrals will severely limit patient choice of consultants.

Bupa

GPs should be able to choose to direct referrals based on their assessment of what is in their patient's best interest and insurers should not compromise their clinical judgement by insisting they make an 'open' referral.<sup>12</sup>

AXA PPP

So called 'open' referral is a method of assuring referral to a 'closed book' of specialists and hospitals/clinics selected by the PMI and not a referring doctor. This closed list often excludes access to doctors who are world leading authorities in their fields working in some of the best

<sup>10</sup> See BMA initial submission, p3; LCA response to IS, p1.

<sup>11</sup> See IDF response to IS; FIPO response to IS; LCA initial submission.

<sup>12</sup> See IDF initial submission, pp1-2.

Submission classification	Examples of complaints	Insurer(s)
	hospitals in the UK.	
	Bupa's new 'Premier Consultant Partnership' requires that you refer to Bupa-recognized consultants, and use only Bupa-recognized facilities and anaesthetists, unless you can make a clear clinical case not to.	Bupa
	The concept and use of the term 'approved providers' from insurance companies suggests a certain element of quality assurance to the patient. It is of great interest that when a patient of mine asked for a list of approved providers for a specialist knee surgeon from a major insurer he was given a list of 3 surgeons; my patient visited these 3 surgeons websites and found that their main interest was hip surgery. Interestingly this same patient then Google searched knee surgeons in his local area and found a different list.	
	Currently Bupa uses terms such as 'premier' consultants'. This simply relates to those consultants who operate within a fee agreed structure and have no relationship to quality of service or clinical outcomes.	Bupa
3. Quality of care	This is being destroyed as a result of insurers making inappropriate referrals to consultants within their network.	Bupa
	Insurance companies are ignoring GPs' recommendation for particular specialists—this is clinically dangerous.	
4. Hospital choice	Patients are being 'forced' into hospitals where the consultant does not regularly work, on the basis of an agreement between the patient's insurer and a hospital network.	Bupa
5. Intervention in clinical decisions on treatment	Insurers are introducing 'support teams' to complement consultant care manned by non-medical staff but giving advice on clinical matters.	Bupa
	Bupa has set itself up as an authority to interfere in clinical decisions. It has done this by declining to cover procedures during the preauthorization process while at the same time contradicting the recommendations of certified clinicians.	Bupa
	Non-medical personnel are directing medical investigation & treatment: patients are being given permission to follow treatments according to protocols drawn up by non-specialists in the relevant field. <sup>13</sup>	
	Bupa now insist on filling in a form to approve an arthroscopy. This is then seen by a non-medical Bupa employee and the procedure is either approved or not. <sup>14</sup>	Bupa

<sup>13</sup> See British Association of Spinal Surgeons (BASS) initial submission, p1.

<sup>14</sup> See British Orthopaedic Association (BOA) initial submission, p2.

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
6. Referral to the NHS	<p>PMI patients are being directed to the NHS for expensive treatment.</p> <p>A letter was received by a patient in May 2012 from Bupa offering cash payments to the subscriber if they opted for NHS treatment and not for Bupa reimbursed private care.</p> <p>Question the morality of Medical Insurers policies that provide incentives to not use private healthcare facilities but to rather use NHS facilities by providing kick back returns to policyholders or by imposing 6 week treatment restrictions.</p> <p>Insurance companies have cherry picked provision of cover for procedures in order to minimise their exposure to ongoing care and to pass the costs of any complications of treatment on to the NHS.</p>	Bupa
<b><i>Insurer approval and incentives</i></b>		
1. Recognition	<p>Insurers are requiring new consultants to sign up to fee schedules or else they won't be recognized.<sup>15</sup></p> <p>Recognition is purely based on cost—insurers are creating lists of 'recognized' medical practitioners irrespective of qualifications or recognized standards which are used to direct policyholders to limited numbers of medical practitioners for which levels of policy cover will be agreed.</p> <p>AXA PPP has an established record of derecognizing Consultants who question their practices.</p>	Bupa AXA PPP AXA PPP
2. Delisting	<p>Insurers are dropping established consultants from approved lists if they do not sign up to a fee-capping contract with the insurer.</p> <p>Insurers are dropping consultants from approved lists even if they adhere to benefit maxima (but are not contractually obliged to).</p> <p>No appeal process and no recourse to any independent body.</p> <p>Delisting gives patients the impression that the consultant is not fit and proper even if that is not the case.<sup>16</sup></p>	Bupa AXA PPP
3. Incentives to join	<p>A consultant was asked to become a Bupa member and receive 10 per cent per annum as a lump sum of their earnings, but they are not aware of ever having received this.</p>	Bupa
<b><i>Change management</i></b>		
1. Notice to consultants	<p>Insurers do not communicate changes (to fees, benefit maxima etc.) to consultants in advance of implementation.</p>	Bupa

<sup>15</sup> See BASS initial submission p1, LCA initial submission, p2.

<sup>16</sup> See IDF initial submission, p2; IDF response to IS, p2.

Submission classification	Examples of complaints	Insurer(s)
2. Responding to questions	<p>Insurers are unresponsive to queries from consultants.</p> <p>Bupa have made irrational and unilateral decisions regarding treatment; for example withdrawing funding for ultrasound guided foam sclerotherapy for varicose veins. This was based on a misinterpretation of the literature by the company. A consultant wrote directly to the medical director on many occasions and was blanked. They consider the failure to respond to enquiries from a fellow physician to be unacceptable.</p> <p>A consultant had written to Bupa several times recently about these issues, first about their telephone operators suggesting other consultants when the patient has been referred to that consultant and second about reducing payment for procedures. The consultant received no reply.</p> <p>Bupa wrote to a consultant in order for them to sign up to an agreement to provide outpatient diagnostics services. This would reduce fees due to the consultant by something like 40 per cent so they asked by email and in writing for clarification. None was forthcoming.</p> <p>The consultant appreciated that fees need to be transparent and structured otherwise liberties will be taken. They have attempted on numerous occasions to engage Bupa and resolve this. They have not replied to their last 3 letters and 2 phone calls. What more can the consultant do?</p>	<p>Bupa</p> <p>Bupa</p> <p>Bupa</p> <p>Bupa</p> <p>Bupa</p>
3. Information asymmetry <sup>17</sup>	<p>Bupa advertises that all fees are covered, freezes and then reduces reimbursements, and then blames consultants for overcharging.</p> <p>There is a rapidly growing number of patients who are bewildered by the lack of information they receive concerning their private medical insurance. Information almost invariably only comes to light once they are actively seeking medical care, the very worst time for them to be made aware of potentially significant deficiencies in their policy.</p> <p>Patients need to know <i>exactly</i> what they are being offered when buying medical cover.<sup>18</sup></p>	<p>Bupa</p>
4. Transparency	<p>Policyholders do not realize that they are under-insured until it is too late.</p>	<p>Bupa</p>
<b>Specialty specific submissions</b>		
1. Orthopaedics <sup>19</sup>	<p>Bupa have recently reduced the cover offered for certain knee procedures by 60 per cent.</p> <p>Bupa have written to all consultants having re-graded many orthopaedic procedures to a lower fee.</p> <p>Bupa has bundled a number of procedures codes (which set out the complexity of a procedure) into</p>	<p>Bupa</p> <p>Bupa</p> <p>Bupa</p>

<sup>17</sup> See FIPO response to IS; LCA initial submission, p3.

<sup>18</sup> See BOA initial submission, p2.

<sup>19</sup> See BOA initial submission.

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
	one, eg. Arthroscopic codes in order that the fee provided to the surgeon be reduced.	
	Bupa have just announced their new pricing schedule of remuneration to consultants in various specialities with effect from 23rd April 2012. For a lower limb surgeon they have made changes for 25 procedures, 6 have gone up and 19 have gone down, in one case by 40 per cent.	Bupa
2. Osteopathy <sup>20</sup>	A consultant was told by Bupa that new osteopath network fees of £40 for a new patient and £30 for an old patient were part of a standardised contract price for the whole of the UK. The consultant then learnt that the Bupa clinic in Canary Wharf is charging £84 for a new patient and £59 for an old patient.	Bupa
3. Ophthalmology	Cataract surgery has seen a 20 year freeze in insurers' benefit maxima followed by a 60 per cent reduction.  Insurers introduced a clearly discriminatory contract that meant that new NHS consultants, appointed after 2010 were required to sign a contract that paid them much less for cataract surgery than a surgeon appointed before this time (£360 for the new consultant and 750-850 for the others) and are now moving to 'conquer' the profession by reducing fees further to just £250 per cataract to all consultants.	Bupa
4. Pain Medicine	Bupa excluded Pain Medicine Consultants from their list of consultants able to give spinal injections (or required them to give injections under the supervision of sometimes less qualified consultants), some of which these consultants are the only ones trained to do.  A consultant was informed by Bupa that procedures will now require the authorisation of another consultant in another speciality.	Bupa AXA PPP Bupa
5. Radiology	On many occasions, patients requiring complex radiological interventions have been refused care in an institution with far better equipment and trained staff because the institution is not a member of the network.  Radiologists at BMI hospitals have had their fees slashed without any consultation and no right of appeal.	
6. Physiotherapy	There is an increasing trend for insurers to limit the treatments they will pay for by categorising certain treatments such as physiotherapy as 'rehabilitation' which is not covered by most policies. Even postoperative physiotherapy after spinal surgery is under threat.	
7. Oncology	The agreed maxima for the supervision of chemotherapy and other supportive therapies have hardly changed over a number of years. They do not reflect the increasing complexity of care and changes	

<sup>20</sup> See BOA initial submission.

*Submission classification*

*Examples of complaints*

*Insurer(s)*

in toxicity caused.

There are a number of expensive biological therapies, often administered along-side conventional cytotoxic therapies that are licensed to be administered continually until the patient's cancer shows signs of progression (ie no longer benefiting from therapy). Several companies sell policies that do not make it clear to patients that funding of such therapies will be limited to an arbitrary time such as 12 months. This has no basis in clinical evidence and leads to patients with confidence in an existing private provider having to switch to the NHS (if the treatment is available there) or stop a beneficial treatment.

Insurers are 'bribing' customers with full insurance policies to switch their treatment to the NHS when faced with expensive and extended oncological therapies (eg radiotherapy).

8. Anaesthesiology

88 per cent of procedure codes have had no change in reimbursement level in the last 11 years.

9. Psychotherapy

Co-payment is standard in many insurance companies, and consultants wondered why Bupa and AXA PPP have forbid this practice in addition to imposing a fee structure.

Bupa and  
AXA PPP



## Information availability

### Choosing a private medical insurance policy

#### **Overview**

1. PMI is a product which is usually purchased with little or no knowledge of what medical condition or treatment it will be needed to cover. There is also likely to be quite a long interval between the purchase decision and usage of the policy. Consumers may, therefore, not fully appreciate at the point of choosing what features or benefits of the schemes they are considering are likely to be most important at the point of actually claiming.
2. We have tried to assess here whether information available to consumers from PMIs at the time of purchase is adequate to enable them to understand the coverage and benefits of the product or whether, at the time of claim, misapprehensions may be revealed. We set out below submissions that have been made to us and information that we have collected, including on consumer satisfaction with and complaints regarding PMI products.

#### **What we were told**

3. In its Market Study, the OFT said that as a result of concerns expressed by consumers over payments sought by some medical practitioners when these were not wholly reimbursed by PMIs (ie 'shortfalls') it had raised the issue with the then regulator, the Financial Services Authority (FSA).<sup>1</sup> It reported that the FSA had told it that it intended to work with the Association of British Insurers (ABI) and individual

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<sup>1</sup> OFT Market Study, paragraph 9.4.

PMIs to ensure that insurers made clear the possibility of shortfalling to consumers though noted that this was already a requirement under FSA rules.<sup>2</sup>

4. We contacted the Financial Conduct Authority (FCA), the successor body to the FSA, which told us that while it would keep the matter under review, it did not currently feel that any changes to the rules for PMIs were necessary or appropriate.
5. Like the OFT, we also received submissions from individual consumers. Approximately 60 members of the public wrote to us expressing a variety of concerns.

### *Members of the public*

6. A very common concern expressed by members of the public who contacted us was that their PMI had reduced its fee maxima for certain procedures such that the patient's consultant of choice could only be used if the patient made up the shortfall and that it had done so without informing them of, what they characterized as, a reduction in coverage or benefits.<sup>3</sup> Bupa was more likely to be mentioned in this context than other PMIs.<sup>4</sup> We provide below, by way of example, extracts from some of the letters expressing these concerns.

7. One member of the public told us that:

In July 2012 Bupa reduced the fee they paid consultants for cataract surgery from £741 to £289. Bupa did not write to advise us of any such changes ... As a result of Bupa's actions we were required to pay over

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<sup>2</sup> The FSA rules it referred to were the Insurance Conduct of Business sourcebook (ICOBs).

<sup>3</sup> In some cases where it was alleged that the PMI had altered the terms of the policy unilaterally it was evident that the correspondent was part of a corporate scheme, not an individual member. We have assumed that, in fact, these changes would have been agreed between the PMI and the employer, who may have perhaps failed to communicate this to employees.

<sup>4</sup> In June 2010 Bupa introduced its new consultant contract which required consultants wishing to be recognized by Bupa to charge within its fee maxima. Although this made it less likely that a consumer would be faced with a shortfall, it may also have led to certain consultants no longer being available to Bupa subscribers because they did not consent to Bupa's terms. (See [Bupa response to IS](#), p104.)

£900 to the consultant. This would not have been the case had those operations taken place prior to July 2012.<sup>5</sup>

8. A second member of the public made exactly the same complaint regarding a cataract operation ie that they returned to the same surgeon for a second cataract operation but between the first and the second the Bupa maximum had been reduced and, consequently, they were faced with either seeing what they described as 'a less experienced ... surgeon' or making up the shortfall, in this case of just under £600.<sup>6</sup>
9. Another, an individual Bupa subscriber, said, in this context, 'I feel that I should have the right to be informed when my insurer makes changes to my policy terms or benefits which may affect me ... Policyholders only become aware of what benefits/restrictions exist when they come to make a claim'.<sup>7</sup> An AXA PPP personal subscriber said that 'AXA does not make fee-capping absolutely clear in its literature and omits to mention it when phoning to check that you are renewing'.<sup>8</sup>
10. Shortfall concerns did not arise solely over surgeons. Two member of the public told us that their PMI had shortfallen them over anaesthetists fees. One said she underwent urgent surgery and that whereas Bupa paid her surgeon's fees in full she had to make up the shortfall to the anaesthetist's fee and that, upon querying this, was told that Bupa could not provide a recognized anaesthetist at this particular hospital. The correspondent attributed this situation to the position of the local Anaesthetist Group.<sup>9</sup> Another told us that Bupa's fee maximum for anaesthetists in the procedure concerned was £325 whereas the estimate for services provided by

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<sup>5</sup> Member of the public 11.

<sup>6</sup> Member of the public 36.

<sup>7</sup> [REDACTED]

<sup>8</sup> Member of the public 18.

<sup>9</sup> Member of the public 2.

the York Anaesthetists Group was £385 and that Bupa was unable to provide an anaesthetist in that area who worked within its fee maximum.<sup>10</sup>

11. It was very rare for consumers to complain that their PMI had directed them to an inappropriate consultant (say a hip specialist for an elbow condition) though some consultant bodies had criticized PMIs on this score.<sup>11</sup> However, a few told us that they thought that consultants put forward as alternatives by their PMI were less appropriate or less experienced than their consultant of choice. One member of the public told us that the consultant that he had previously seen regarding an ear complaint had ceased to be recognized by Bupa which had suggested that the patient see another consultant who, he said, whilst having some experience of ears specialized in head and neck conditions.<sup>12</sup>
  
12. We also received a few expressions of concern that some PMI policies prevented consumers from using their hospital of choice, though it appeared that in these cases the consumer was part of a corporate scheme which gave members access to a restricted list of hospitals. We assumed that in these cases the employer would have been aware of and had agreed to this arrangement but that this had not been communicated to the member, who in some cases had retired from the firm.
  
13. Finally, several consumers, with different PMIs, said that, despite their dissatisfaction with the way their claims had been handled, they were unable to switch insurers since doing so would mean losing coverage for pre-existing conditions. Typical was one who told us that 'it is very difficult for Bupa members of long standing ... who

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<sup>10</sup> [Member of the public 38.](#)

<sup>11</sup> See for example, [British Association of Spinal Surgeons initial submission.](#)

<sup>12</sup> [Member of the public 32.](#)

have no restrictions on policies to be able to get medical cover from alternative providers without health restrictions, effectively limiting choice'.<sup>13</sup>

14. These submissions indicated to us that there were, potentially at least, some information asymmetries between PMIs and their customers regarding the scope and coverage of the products they provided which were manifesting themselves at the point of claim and giving rise to dissatisfaction. However, submissions from some other parties suggested that, in general, consumers were satisfied with private medical insurance products and not concerned over any lack of transparency as regards the risk of shortfalls. We now turn to these.

#### *Other submissions*

15. Which? told us that it had conducted a survey of over 3,000 of its members in October 2012.<sup>14</sup> 78 per cent of respondents said that they were very or fairly satisfied with their PMI, though 17 per cent expressed dissatisfaction over the value for money their policy represented.<sup>15</sup> Two-thirds of respondents had made a claim under their policy in the last three years, and those who had claimed were more satisfied with their policies than those who had not. This suggested that the PMI's handling of their claims matched their expectations and that shortfalls, for example, were not a particular source of concern for them. Which? provided us with a table showing customer satisfaction by provider.

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<sup>13</sup> Member of the public 31.

<sup>14</sup> [www.which.co.uk/money/insurance/guides/choosing-private-medical-insurance/pmi-customer-satisfaction-survey-/](http://www.which.co.uk/money/insurance/guides/choosing-private-medical-insurance/pmi-customer-satisfaction-survey-/).

<sup>15</sup> The ABI's Q4 2012 survey indicated that 58 per cent of consumers who did not have PMI considered it too expensive.

TABLE 1 PMI customer satisfaction survey

Policy	Customer score %	Customer satisfaction				
		Clarity of written communication	Choice of consultants	Ease of contact	Ease of purchase	Medical treatment
CS Healthcare	81	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Exeter Family Friendly	74	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Simplyhealth Group	68	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
WPA	67	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
CIGNA	57	★★★★★	★★★★★	★★★★★	N/A	★★★★★
BUPA	55	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
PruHealth	53	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
AXA PPP	53	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Aviva	51	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Saga	48	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★

Source: Which?

Note: In a survey in October 2012, Which? received responses from 3,512 Which? members with private medical insurance. The customer score is based on the overall satisfaction of respondents with their policies and their likelihood to recommend them to friends.

16. The ABI told us that PMIs were required by regulation to set out in clear terms the nature of the cover that was in their policies during the sales process and that any insurer that failed to comply with these requirements would face regulatory action. It said that the number of complaints to the Financial Ombudsman Service (FOS) regarding PMIs was low and that so was the rate of complaints upheld.<sup>16</sup>
17. The Private Patients Forum (PPF)<sup>17</sup> however, did have some concerns regarding consumer information provided by PMIs. It told us that consumers might not be clear at the time of purchasing a private medical insurance policy that, for example, the PMI could choose which consultant or hospital the consumer could use or that the policy excluded claims where diagnosis and treatment took place on the same day.<sup>18</sup>
18. Some professional bodies also raised concerns regarding the information provided to consumers by PMIs. The British Association of Dermatologists told us that the multiplicity of policies and the difficulty in assessing the cost of cover made it difficult

<sup>16</sup> ABI response to AIS.

<sup>17</sup> [www.privatepatientsforum.org](http://www.privatepatientsforum.org).

<sup>18</sup> PPF initial submission.

for patients to choose a competitively priced insurer. It said that there was much less asymmetry in choosing a consultant.<sup>19</sup>

19. The AAGBI, in response to our annotated issues statement, said that the potential concerns raised by our Theory of Harm 6 applied to PMIs as well as hospitals and consultants and was disappointed that we had not made this point, particularly as it said that the OFT had referred this matter to the FSA for resolution with the ABI.<sup>20</sup>

### ***Survey evidence and complaints***

#### *Our survey evidence*

20. Though not a major focus of our consumer survey, we did ask some questions that were relevant to the experience of customers claiming under PMI policies.<sup>21</sup> We asked whether those making a claim had had it met in its entirety by the PMI. 64 per cent of respondents said that they had. The majority of respondents who said that their PMI had not met the costs of their treatment fully said that this was the result of a policy excess.<sup>22</sup>
21. 5 per cent of patients said that they chose a consultant who was not fully covered by their insurance, resulting in them having to pay for some or all of their treatment. Nearly all of these respondents said that they had been made aware of monetary restrictions in their policy regarding consultants' fees but it was not clear from their responses whether this was at the time of purchase or at the beginning of the claims process.

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<sup>19</sup> [British Association of Dermatologists response to IS.](#)

<sup>20</sup> [AAGBI response to AIS.](#)

<sup>21</sup> [www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/survey\\_patients\\_report.pptx](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/survey_patients_report.pptx).

<sup>22</sup> A policy excess is the amount that a policyholder agrees, at the time of taking out the insurance policy, to pay towards the cost of a claim.

## Complaints

22. We looked at the number of complaints received by the FOS concerning private medical insurance providers as a potential indicator of information asymmetry.<sup>23</sup>
23. The FOS received 513 new cases relating to PMI in the year ending March 2012, compared with 506 the previous year.<sup>24</sup> However, between March 2012 and March 2013 complaints regarding PMI increased by 85 per cent to 949.<sup>25</sup> The FOS was reported to attribute the increase in complaints to public awareness of PPI mis-selling.<sup>26</sup>
24. As the largest number of these disputes related to Bupa<sup>27</sup> [REDACTED], we next looked at Bupa's complaints data in more detail. We examined the number of complaints in the relevant categories that Bupa had notified to the FSA since 2010. We show these below.

TABLE 2 Bupa's complaints data

	31/12/10	30/06/11	31/12/11	30/06/12
Advising, selling and arranging	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Terms and disputed sums/charges	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
General admin/customer service	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Source: Bupa.

25. The majority of the concerns that were put to us by individual consumers (ie consultant choice and shortfalls) would fall into the second and third categories listed in the table above and both show a steady increase. In the case of disputed sums, which we believe would include, but not be limited to, shortfalls, these have grown by [REDACTED] per cent since the second half of 2010.

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<sup>23</sup> These are complaints which the PMI has failed to satisfy.

<sup>24</sup> [www.financial-ombudsman.org.uk/publications/ar12/about.html](http://www.financial-ombudsman.org.uk/publications/ar12/about.html).

<sup>25</sup> See [www.financial-ombudsman.org.uk/publications/ar13/ar13.pdf](http://www.financial-ombudsman.org.uk/publications/ar13/ar13.pdf), p46. Complaints regarding critical illness insurance grew by less (68 per cent) but were more numerous (1,370).

<sup>26</sup> [www.healthinsurancedaily.com/health-insurance/product-area/pmi/article420777.ece](http://www.healthinsurancedaily.com/health-insurance/product-area/pmi/article420777.ece).

<sup>27</sup> Of the new cases received by the FOS in the second half of 2012, 211 involved Bupa compared with 58 involving AXA PPP and 52 Aviva Health.



26. Bupa told us that in May 2011 the FSA published new rules on how firms should handle complaints, for example moving from a two-stage handling process to a one-stage process and that this could partly explain the rise in the number of complaints.

27. We therefore looked at complaints notified to the FSA by Bupa and the other major PMIs since 2010.<sup>28</sup>

TABLE 3 **Complaints notified to the FSA, 2010 to 2012**

<i>PMI</i>	<i>Complaints opened H1 2010</i>	<i>Complaints opened H2 2010</i>	<i>Total 2010</i>	<i>Complaints opened H1 2011</i>	<i>Complaints opened H2 2011</i>	<i>Total 2011</i>	<i>Complaints opened H1 2012</i>	<i>Complaints opened H2 2012</i>	<i>Total 2012</i>
Bupa Insurance Services Limited	4,211	3,879	8,090	4,806	5,337	10,143	6,039	6,126	12,165
AXA PPP Healthcare Limited	1,744	1,612	3,356	1,685	1,764	3,449	1,288	1,441	2,729
Aviva Health UK Limited	1,010	881	1,891	868	915	1,783	1,472	2,072	3,544
Prudential Health Services Limited	724	650	1,374	800	846	1,646	852	1,026	1,878

Source: FCA website.

28. Although it is the case that the number of complaints that Bupa notified to the FSA was (20 per cent) higher in 2011 than in 2010, when the rules changed, this does not seem to explain why it would then have risen again (by 20 per cent) in 2012. Further, the number of complaints notified by other PMIs does not appear to increase at the time that the FSA rules changed. AXA PPP's level of complaints, which were about one-quarter of Bupa's in 2012, remained fairly constant throughout. The number of complaints reported by Aviva does show a sharp increase but in 2012, quite a long time after the change in the FSA rules was introduced.<sup>29</sup>

<sup>28</sup> These data refer to all complaints and may therefore include some complaints relating to medical insurance other than PMI.

<sup>29</sup> Aviva has attributed recent increases in the number of disputes being taken by Aviva customers to the FOS to the growth of its PMI business as well as high profile media coverage of PPI driving wider complaint activity across protection products. See Shock rise in complaints to FOS about medical insurance, Health Insurance, 11 April 2013. [www.hi-mag.com/health-insurance/product-area/pmi/article420777.ece](http://www.hi-mag.com/health-insurance/product-area/pmi/article420777.ece).

29. Bupa told us that at the same time that the changes in complaints-handling took place, an increase in complaints arose from: the size of premium increases it had been obliged to set because of rising healthcare costs, particularly in London; the publicity surrounding the hospital negotiation dispute between it and BMI in 2011/12; and consultants encouraging patients to complain about Bupa changing its benefit maxima (which Bupa had done for some procedures in 2012), including over the shortfalls which resulted. Bupa also told us that it had applied eligibility terms more tightly during the year to March 2013.

***Preliminary conclusions—choosing a PMI***

30. The overall impression we have formed is that PMI policy terms have been sufficiently transparent to consumers at the point of purchase that they have not reported, through surveys, dissatisfaction or disappointment at the point of claim.
31. While around 60 individuals contacted us to express concerns based on their own experience, we place greater weight on our own survey data and, for example that provided by Which?, which showed relatively high satisfaction levels among those making claims, as we think survey data is more likely to be representative of consumers' experience with PMIs.
32. We note, however, that the number of complaints notified to the regulator by Bupa and the number of new PMI cases received by the FOS has been rising quite sharply. We think it is likely that the change in the complaints-handling procedure introduced by the FSA in 2010 contributed to this and that the timing of its impact may have varied between PMIs since they had until July 2012 to implement it. It also seems likely that Bupa's policy premium increases, changes to its fee maxima, its application of treatment eligibility terms more tightly and the publicity surrounding its dispute with BMI may have contributed to this. Nonetheless, there would appear to

be scope for the PMIs to address the issue of information availability when choosing a PMI more effectively than they are currently doing.

## Glossary

<b>AAGBI</b>	Association of Anaesthetists of GB and Ireland.
<b>ABI</b>	Association of British Insurers.
<b>Act</b>	The Enterprise Act 2002.
<b>Acute condition</b>	A medical condition of typically short duration which has severe symptoms (as opposed to <b>chronic conditions</b> which are persistent and recurring).
<b>Admission</b>	A patient will be admitted to hospital where their treatment requires admission to a hospital bed. This is a clinical decision and a patient admitted may be admitted either as a <b>day case</b> patient or an <b>inpatient</b> .
<b>AEC</b>	Adverse effect on competition as set out in section 134 of the <b>Act</b> .
<b>AIS</b>	The annotated issues statement published on 28 February 2013.
<b>Anaesthetist group</b>	A group or partnership of individual consultant anaesthetists, however structured, set up for the purposes of providing consultant anaesthetist services jointly rather than individually.
<b>Aviva</b>	Aviva Health UK Limited, a principal subsidiary of the Aviva plc, provider of insurance, savings and investment products.
<b>AXA PPP</b>	AXA PPP healthcare, a subsidiary of The AXA Group and provider of <b>PMI</b> .
<b>BMA</b>	British Medical Association, the trade union representing registered medical practitioners including consultants.
<b>BMI</b>	BMI Healthcare, part of <b>GHG</b> , a private hospital group in the UK
<b>Bupa</b>	A provider of <b>PMI</b> and a <b>hospital operator</b> .
<b>Bupa Benefit Maxima</b>	<b>Bupa's</b> scale of the maximum charges for procedures that it will normally reimburse consultants under a <b>PMI</b> policy.
<b>CAPM</b>	Capital asset pricing model.
<b>Cash plan</b>	Plans which provide for cash reimbursement of some or all of the costs of optical, dental, alternative therapies, and chiropody etc. and cash benefits for admission to hospital and maternity benefit etc.
<b>Catchment area</b>	Geographical area from which a hospital draws most of its patients.
<b>CC</b>	Competition Commission.
<b>CCSD</b>	The Clinical Coding & Schedule Development. A group consisting of representatives from five <b>PMIs</b> : <b>Aviva</b> , <b>AXA-PPP</b> , <b>Bupa</b> , <b>PruHealth</b> and <b>Simplyhealth</b> , which establishes and maintains a

common standard of procedure codes and narratives within the independent healthcare sector.

<b>Chronic conditions</b>	Long-term illnesses that cannot currently be cured.
<b>Central London</b>	The area inside the North and South Circular Roads.
<b>Circle</b>	Circle Holdings PLC, a <b>private hospital operator</b> .
<b>Consultant</b>	A registered medical practitioner who holds or has held or is qualified to hold an appointment as a consultant in the NHS in a speciality other than general practice or whose name is on the register of specialists kept by the <b>General Medical Council</b> . A consultant may work exclusively for the <b>NHS</b> or in private practice or a combination of the two. Except where the context otherwise provides, consultant refers to a consultant in private practice whether or not they also work in the <b>NHS</b> .
<b>Cosmetic surgery</b>	Plastic and reconstructive surgery that modifies or improves the appearance of a physical feature, irregularity or defect.
<b>Continuing medical exclusions (CME terms) underwriting</b>	When switching cover from one insurer to another on CME terms, medical conditions excluded from cover by the previous insurer as detailed on the membership certificate, will continue to be excluded by the new insurer, but conditions suffered while covered by the previous insurer will continue to be covered by the new insurer subject to the terms of cover provided by the new insurer. Advice should be sought before cancelling cover with your present insurer and switching to a new one.
<b>Corporate PMI</b>	<b>PMI</b> provided by an employer to its employees and in some cases dependants of the employee.
<b>Corporate policyholder</b>	A person who is covered by <b>PMI</b> through a <b>corporate PMI</b> .
<b>Cost of capital</b>	The return that investors in a project expect to receive over the period of that investment. It is an opportunity cost and can be seen as the yield on capital employed in the next best alternative use.
<b>CQC</b>	Care Quality Commission, a non-departmental public body established to regulate and inspect health and social care services in England.
<b>Daypatient</b>	A patient admitted electively during the course of a day with the intention of receiving care without requiring the use of a hospital bed overnight. If the patient's treatment then results in an unexpected overnight stay they will be admitted as an <b>inpatient</b> .
<b>Department for Health &amp; Social Services</b>	Welsh Government Directorate, Department for Health and Social Services
<b>DHSSPS</b>	Department of Health, Social Services and Public Safety (Northern Ireland)

<b>DoH</b>	Department of Health in England.
<b>Drive time</b>	Time taken to drive from the patient's home to a hospital.
<b>Elective surgery</b>	Surgery that is scheduled in advance because it does not involve a medical emergency.
<b>ERP</b>	The 'equity risk premium'. This is typically used in calculation or estimation of a cost of capital.
<b>FOS</b>	Financial Ombudsman Service.
<b>FSA/FCA</b>	Financial Services Authority. On 1 April 2013 the FSA was abolished and the majority of its functions were transferred to the Prudential Regulation Authority (PRA) and the Financial Conduct Authority (FCA).
<b>Full medical underwriting</b>	Requires the proposer to provide details of his/her previous medical history and to give the insurer permission to seek further information from the proposer's GP. Pre-existing conditions that occurred prior to the commencement of cover will normally be excluded from cover.
<b>GHG</b>	General Healthcare Group, a <b>private hospital operator</b> . GHG is the parent company of <b>BMI</b> , which manages its hospitals.
<b>GMC</b>	General Medical Council, the independent regulator for doctors in the UK.
<b>GP</b>	General Practitioner, a doctor who works in a local surgery or health centre, providing medical advice and treatment to patients registered on their list.
<b>GP referral</b>	A referral from a GP for specialist treatment.
<b>Greater London</b>	The area outside <b>central London</b> but within the London Government Region defined by ONS.
<b>Guided referral products</b>	A PMI policy under which the policyholder is required to obtain an <b>open referral</b> in order to claim under the policy.
<b>Guidelines</b>	The <b>CC's</b> guidelines on the conduct of market investigations (CC3)
<b>HA</b>	Health Authority.
<b>HAP</b>	Hospital Agreement Plan.
<b>HCA</b>	HCA UK Holdings Ltd, a <b>private hospital operator</b> .
<b>Health and Social Care Directorates</b>	Scottish Government Health and Social Care Directorates
<b>Healthcare provider</b>	A person that provides preventive, curative, promotional, or rehabilitative health care services including a hospital, clinic, <b>GP</b> , <b>consultant</b> or other medical professional.

<b>Healthcode</b>	A provider of online practice management software and services to the private healthcare market.
<b>Hospital Group</b>	A <b>private hospital operator</b> that operates more than one hospital.
<b>ICU</b>	Intensive care unit.
<b>Independent hospital</b>	A private hospital not belonging to a hospital.
<b>Individual PMI</b>	<b>PMI</b> purchased by an individual for themselves and/or their dependents. An individual policyholder is a person who has <b>individual PMI</b> .
<b>Inpatient</b>	A patient admitted to hospital with the expectation that they will remain in hospital for at least one night.
<b>Insured patient</b>	A patient who will use <b>PMI</b> to pay [in whole or in part/the majority] for their medical care.
<b>Insurer Network</b>	A list of private hospitals which are on a <b>PMI's</b> approved list. Some <b>PMIs</b> create narrower networks for different types of policies.
<b>IS</b>	The statement of issues published on 22 June 2012.
<b>LOC</b>	London Oncology Centre.
<b>LOCI</b>	Logit Competition Index, a concentration measure which formed the basis of the <b>CC's</b> use of weighted market share.
<b>London</b>	The combined area of <b>central London</b> and <b>Greater London</b>
<b>Main hospital groups</b>	<b>BMI, HCA, Nuffield, Ramsay and Spire.</b>
<b>MDT</b>	Multi-disciplinary team.
<b>Medical history disregarded</b>	For groups of 20/25 or more directors and employees and for an additional cost, any pre-existing medical conditions suffered by members of the scheme will be covered, provided they fall within the terms and conditions of the scheme.
<b>Monitor</b>	The independent regulator of NHS foundation trusts, directly accountable to Parliament. Monitor was established in January 2004 to authorize and regulate NHS foundations trusts.
<b>Moratorium</b>	The proposer is not required to declare his/her medical history on application, but any pre-existing condition suffered in (usually) the previous five years will eventually be covered if no symptoms, treatment, medication, tests or advice is received for that condition for a further period of (usually) two years.
<b>NHSs</b>	National Health Services in England, Scotland and Wales and the Health and Social Care Services in Northern Ireland.
<b>NHS Trust</b>	A public benefit healthcare organization created by Act of

Parliament to treat **NHS** patients.

<b>NHS Cash Benefit for Treatment</b>	Money back payment from a PMI for electing to have treatment by the NHS instead of exercising the right to private treatment.
<b>NICE</b>	The National Institute for Health and Care Excellence. NICE's guidance supports healthcare professionals and others to make sure that the care they provide is of the best possible quality and offers the best value for money.
<b>NRV</b>	Net realizable value. The amount that can be obtained by selling an asset net of selling expenses.
<b>Nuffield</b>	Nuffield Health, a private hospital operator.
<b>OFT</b>	Office of Fair Trading.
<b>Open referral</b>	A process whereby a GP or other clinician makes a patient referral within a particular area of medical practice but without specifying a named individual consultant and/or hospital.
<b>Other consultant groups</b>	A group or partnership of individual consultants (excluding <b>anaesthetist groups</b> ), however structured, set up for the purpose of providing consultant services jointly rather than individually.
<b>Outpatient</b>	A patient treated in a hospital, consulting room or clinic, who is not admitted.
<b>PCA</b>	Price concentration analysis.
<b>PHIN</b>	Private Healthcare Information Network, a body whose membership is made up of <b>private hospital operators</b> .
<b>PMI</b>	Private medical insurer/insurance. An insurance product under which an insurer agrees to cover the costs, in whole or in part, of acute medical care.
<b>PPU</b>	A private patient unit is a facility within the <b>NHS</b> providing medical care to private patients. Such units may be separate units dedicated to private patients or be facilities within the main NHS site which are made available to private patients either on a dedicated or non-dedicated basis.
<b>Pre-existing conditions</b>	Any conditions (disease, illness or injury) for which an applicant for <b>PMI</b> has received medication, advice or treatment or has experienced symptoms, whether diagnosed or not, before insurance cover commenced.
<b>Primary care</b>	The first contact of a patient with a healthcare provider, usually a GP, dentist or optician, in a given episode of illness.
<b>Privately-funded healthcare services</b>	Services provided to patients via <b>private hospitals</b> and other facilities, including <b>PPUs</b> through the services of consultants, medical and clinical professionals who work within such facilities.
<b>Private hospital</b>	A hospital that charges fees for its services including a PPU. Except where the context provides otherwise, hospital refers to a



	<b>private hospital.</b>
<b>Private hospital operator</b>	A person that operates a <b>private hospital</b> .
<b>Private Healthcare Provider (PHP)</b>	A <b>healthcare provider</b> that charges fees for their services.
<b>Private patient</b>	A patient who pays for medical services either as a <b>self pay patient</b> or as an <b>insured patient</b> .
<b>PruHealth</b>	Prudential Health Services Limited and Prudential Health Insurance Limited, providers of <b>PMI</b> .
<b>Ramsay</b>	Ramsay Health Care UK Operations Limited, a <b>private hospital operator</b> .
<b>Related conditions</b>	A medical condition (symptom, illness, disease pre-existing conditions or injury) arising from or associates with a pre-existing condition.
<b>ROCE</b>	Return on capital employed, a measure of profitability = profit for a period divided by net assets relevant to the same period expressed as a percentage.
<b>Secondary care</b>	A service provided by medical specialists in a particular field of medicine. Secondary care is usually delivered in hospitals or clinics and patients have usually been referred by their <b>primary care</b> provider (usually their GP).
<b>Self-pay patient</b>	A patient who pays for their medical care themselves.
<b>Shortfall</b>	The difference between the fee that an <b>insured patient</b> is charged for medical care and the amount which their <b>PMI</b> will reimburse, which the <b>insured patient</b> is not aware of or does not agree to in advance of treatment.
<b>Simplyhealth</b>	Simplyhealth, a <b>PMI</b> provider.
<b>SME</b>	Small or medium sized enterprise.
<b>Specialties</b>	The <b>GMC</b> divides areas of medical care into 65 specialties.
<b>Spire</b>	Spire Healthcare Limited, a <b>private hospital operator</b> .
<b>ToH</b>	Theory of harm
<b>Top up fee</b>	A payment made by an <b>insured patient</b> to a <b>consultant</b> whose charges are not covered in full by their <b>PMI</b> , which the <b>insured patient</b> has agreed to in advance of treatment.
<b>TLC</b>	The London Clinic, a <b>private hospital operator</b> .
<b>Tertiary Care</b>	More specialised medical services provided by more specialised centres. Patients may be referred to <b>tertiary care</b> either by either their <b>GP</b> or by a <b>consultant</b> .

<b>UK</b>	United Kingdom.
<b>WACC</b>	Weighted average cost of capital.
<b>WPA</b>	Western Provident Association Limited, a <b>PMI</b> provider.