

PRIVATE HEALTHCARE MARKET INVESTIGATION

Information availability

Introduction

1. In our description of the private healthcare industry we referred to the consumer ‘pathway’ to both private health cover and private healthcare. At various points on this pathway the consumer has to make choices: which private medical insurance product to buy, which consultant to see, which treatment recommendation to follow and at which hospital or clinic to be treated. If the consumer lacks the necessary information on which to base these choices, or if information asymmetries exist, it is possible that distortions may arise.
2. As the OFT pointed out in its Market Study,
accessible, standardized and comparable information is vital for ensuring that consumers can exercise informed choice so that markets work well. Information asymmetries, where suppliers have better information about the quality and price of a product than consumers, can dampen competition between suppliers and result in poor outcomes for consumers in terms of price, quality, innovation and productivity.¹
3. In our annotated issues statement we posited (Theory of Harm 6) that the private healthcare market was characterized by both lack of information and information asymmetries. In addition, we said that we would be concerned if we identified financial or other incentives designed to capitalize or exploit any asymmetry, for example by private hospital providers offering incentives to consultants to perform

¹ www.of.gov.uk/shared_of/market-studies/OFT1396_Private_healthcare.pdf.

additional tests or procedures at their facilities. (We discuss elsewhere schemes adopted by private hospitals to encourage consultants to use their facilities.²)

4. We now set out our current thinking on Theory of Harm 6 on the basis of the responses that we have received to our annotated issues statement and of further research and analysis that we have undertaken.
5. We consider consumer information availability in the following contexts:
 - (a) choosing a private medical insurance policy;
 - (b) choosing a treatment option;
 - (c) choosing a consultant; and
 - (d) choosing a private hospital.

Choosing a private medical insurance policy

Overview

6. Private medical insurance 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.
7. We have tried to assess here whether information available to consumers from private medical insurers (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

² www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130603_hospital_competition.pdf.

made to us and information that we have collected, including on consumer satisfaction with and complaints regarding private medical insurance products.

What we were told

8. 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 are not wholly reimbursed by PMIs (ie 'shortfalls') it had raised the issue with the then regulator, the Financial Services Authority (FSA).³ It reported that the FSA had told it that it intended to work with the Association of British Insurers (ABI) and individual PMIs to ensure that insurers made clear the possibility of shortfalling to consumers though noted that this was already a requirement under FSA rules.⁴
9. 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.
10. 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

11. 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

³ OFT Market Study, paragraph 9.4.

⁴ The FSA rules it referred to were the Insurance Conduct of Business sourcebook (ICOBs).

reduction in coverage or benefits.⁵ Bupa was more likely to be mentioned in this context than other PMIs.⁶ We provide below, by way of example, extracts from some of the letters expressing these concerns.

12. 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 £900 to the consultant. This would not have been the case had those operations taken place prior to July 2012.⁷

13. 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 £600.⁸

14. 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.' An AXA PPP personal subscriber

⁵ 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.

⁶ 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 the issues statement](#), p104.)

⁷ Member of the public 11.

⁸ Member of the public 36.

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.'⁹

15. Shortfall concerns did not arise solely over surgeons. Two member of the public told us that their PMI had shortfalled 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.¹⁰ Another told us that Bupa's fee maximum for anaesthetists in the procedure concerned was £325 whereas the estimate for services provided by the York Anaesthetists Group was £385 and that Bupa was unable to provide an anaesthetist in that area who worked within its fee maximum.¹¹

16. 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.¹² 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 authorized 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.¹³

⁹ Member of the public 18

¹⁰ Member of the public 2.

¹¹ Member of the public 38.

¹² See for example, [British Association of Spinal Surgeons initial submission](#).

¹³ Member of the public 32.

17. We also received a few expressions of concern that some private medical insurance 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.
18. 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 have no restrictions on policies to be able to get medical cover from alternative providers without health restrictions, effectively limiting choice.’¹⁴
19. 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

20. Which? told us that it had conducted a survey of over 3,000 of its members in October 2012.¹⁵ 78 per cent of respondents said that they were very or fairly satisfied

¹⁴ Member of the public 31.

¹⁵ www.which.co.uk/money/insurance/guides/choosing-private-medical-insurance/pmi-customer-satisfaction-survey/.

with their PMI, though 17 per cent expressed dissatisfaction over the value for money their policy represented. 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.

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.

21. 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.¹⁶

22. The Private Patients Forum (PPF),¹⁷ 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

¹⁶ ABI response to annotated issues statement, March 2013.

¹⁷ www.privatepatientsforum.org.

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.¹⁸

23. 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 for patients to choose a competitively priced insurer. It said that there was much less asymmetry in choosing a consultant.¹⁹
24. The Association of Anaesthetists of Great Britain and Ireland (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.²⁰

Survey evidence and complaints

Our survey evidence

25. Though not a major focus of our consumer survey, we did ask some questions that were relevant to the experience of customers claiming under private medical insurance policies.²¹ 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.²²

¹⁸ PPF initial submission.

¹⁹ British Association of Dermatologists response to the issues statement.

²⁰ AAGBI response to the annotated issues statement.

²¹ www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/survey_patients_report.pptx.

²² 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.

26. 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.

Complaints

27. We looked at the number of complaints received by the FOS concerning private medical insurance providers as a potential indicator of information asymmetry.²³
28. The FOS received 513 new cases relating to private medical insurance in the year ending March 2012 compared with 506 the previous year.²⁴ However, between March 2012 and March 2013 complaints regarding private medical insurance increased by 85 per cent to 949.²⁵ The FOS was reported to attribute the increase in complaints to public awareness of PPI mis-selling.²⁶
29. As the largest number of these disputes related to Bupa²⁷ [✂], 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.

²³ These are complaints which the PMI has failed to satisfy.

²⁴ www.financial-ombudsman.org.uk/publications/ar12/about.html.

²⁵ See 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).

²⁶ www.healthinsurancedaily.com/health-insurance/product-area/pmi/article420777.ece.

²⁷ 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.

TABLE 2 **Bupa's complaints data**

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

Source: Bupa.

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30. 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 [X] per cent since the second half of 2010.
31. 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 this could be one explanation for the rise in the number of complaints.
32. We therefore looked at complaints notified to the FSA by Bupa and the other major PMIs since 2010.²⁸

²⁸ These data refer to all complaints and may therefore include some complaints relating to medical insurance other than private medical insurance.

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

<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.

33. 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 a 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.²⁹

Preliminary conclusions—choosing a PMI

34. The overall impression we have formed is that private medical insurance 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.

²⁹Aviva 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.

35. 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 amongst those making claims, as we think survey data is more likely to be representative of consumers' experience with PMIs.
36. 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 but it is not clear why. The timing of this increase coincides with Bupa's adoption of the new consultant contract in 2010 though it was not until Q1 2012 that open referral became the default option for corporate clients. Other possible explanations include the media coverage surrounding the PPI scandal and its effect on people's propensity to make complaints about insurance products but it is not clear why Bupa in particular would be affected by this.

Choosing a treatment option

Overview

37. Patients are very unlikely to be as medically well informed as their consultants and will thus have to rely on them for expert and impartial advice. If that consultant is participating in a scheme which offers him or her incentives to, for example, admit patients to a particular hospital or to refer them for certain tests, even if patients are aware of this they may be uncertain whether the consultant has taken account of this in making a recommendation. In these circumstances there will be asymmetry of information between the patient (the principal) and the consultant (his or her agent) which may give rise to distortions.
38. In this section we examine what information is available to patients to enable them to evaluate consultant recommendations regarding treatment options and if this is

sufficient to address concerns regarding information asymmetry in this particular context.

Variations in patient treatment

39. Bupa told us that variation in treatments could signal market malfunction. It said that while variations in treatment could be clinically justified or explained by patient preference, it had observed wide variations in the way consultants and hospitals treated specific conditions in UK private healthcare, some of which amounted to ‘unwarranted variation.’ It said that such variation could harm patients, placing them at risk of unnecessary complications or death, and also affecting the cost of healthcare.³⁰
40. Bupa submitted a number of case studies which it said illustrated unwarranted treatment, one of which dealt with shoulder repair. It said that it had observed high levels of variation in two types of shoulder surgery to repair the rotator cuff muscle: arthroscopic acromioclavicular decompression and extensive open repair of rotator cuff muscles. Bupa told us that its members were [redacted] per cent more likely to receive the first treatment and [redacted] per cent more likely to receive the second treatment than comparable patients using the NHS. Bupa cited published articles advocating that initial treatment for rotator cuff damage should, in general, be non-surgical and quoted the American Academy of Orthopaedic Surgeons to the effect that patients with rotator cuff-related symptoms, in the absence of full thickness tear, be initially treated non-operatively, using exercise and/or non-steroidal anti-inflammatory drugs.³¹

³⁰ [Bupa response to the issues statement](#). See in particular Annex E: unwarranted variation—a symptom of a market not working well.

³¹ [Bupa response to the issues statement](#). See in particular Annex E: unwarranted variation—a symptom of a market not working well.

41. There is a fairly substantial body of academic research on treatment variation which is variously interpreted as clinical inconsistency or, more positively, as evidence of doctors taking account of patient preferences.³² However, in order to express preferences and participate in ‘shared decision making’ (SDM)³³ patients need reliable information about their condition and the treatment or support options available. We now look at what information on treatment options is available to consumers in the UK.

Information available on treatment options

42. We review here information sources on treatment options which, while they are mainly provided by the NHS for NHS patients, are, of course, available to private patients.

National Institute for Health and Clinical Excellence clinical guidelines

43. The National Institute for Health and Clinical Excellence (NICE) produces clinical guidelines with recommendations on the appropriate treatment and care of people with specific diseases and conditions. They are based on available evidence and developed in association with the Royal Medical, Nursing and Midwifery Colleges. In general, healthcare workers in the NHS are expected to follow NICE’s clinical guidelines.
44. NICE had produced 168 clinical guidelines and more than 60 guidelines were in development. Topics are referred to NICE by the Department of Health. Topics are selected on the basis of a number of factors, including the burden of disease, the

³² Mulley, Trimble and Elwyn, *Patients’ preferences matter*, The King’s Fund, 2012.

³³ Coulter and Collins, *Making shared decision making a reality*, The King’s Fund, 2011.

impact on resources and whether there is inappropriate variation in practice across the country.³⁴

45. Most guidelines aim to support clinicians but NICE also produces versions of its clinical guidance written for the public to help patients make informed decisions. These versions summarize the recommendations that NICE makes using suitable language for people without specialist medical knowledge: for example, the NICE guidance describes the various options for patients with prostate cancer together with questions the patient should consider himself or ask his doctor.³⁵

NHS Choices

46. NHS Choices is funded by the Department of Health and describes itself as ‘the UK’s biggest health website’³⁶ receiving, in the first quarter of 2013, an average of over 25 million visits a month.³⁷ NHS Choices includes detailed information about common diseases and conditions and treatments on its publicly available website and contains links to other relevant NHS sites such as Choose and Book.
47. The website also provides consumers with access to its advice to clinicians, through ‘maps of medicine.’ We show below the ‘map’ for shoulder pain where the clinician considers this may arise from rotator cuff damage.

³⁴ A list of published clinical guidelines can be found at <http://guidance.nice.org.uk/CG/Published>.

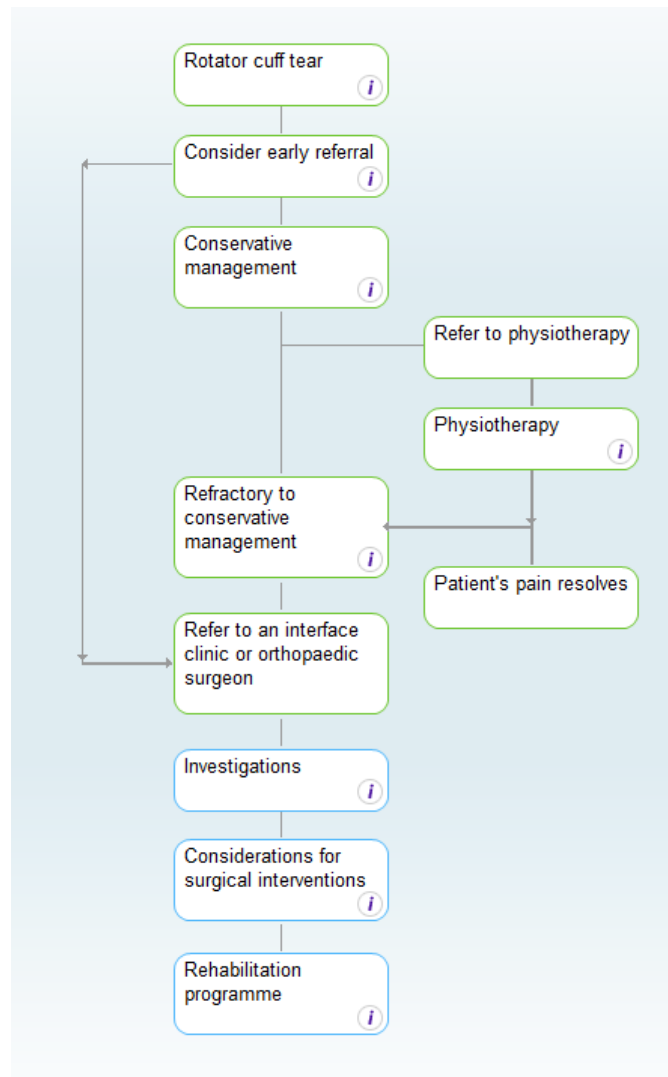
³⁵ www.nice.org.uk/nicemedia/live/11924/39526/39526.pdf.

³⁶ www.nhs.uk/aboutNHSChoices/Pages/NHSChoicesintroduction.aspx.

³⁷ www.nhs.uk/aboutNHSChoices/professionals/developments/Pages/Preformancestatistics.aspx.

FIGURE 1

Map of medicine for shoulder pain



Source: NHS Choices.

48. As can be seen, the 'map' indicates conservative management (physiotherapy) initially though provides for early referral if this is considered appropriate by the clinician.

Patient decision aids

49. Patient decision aids are similar to clinical guidelines, in that they are based on research evidence, but they are designed not just to inform patients, but to help them think about what the different options might mean for them and to reach an informed

preference. They are also designed to emphasize the principle that there should be 'no decision about me, without me.'³⁸

50. Patient decision aids take a variety of forms, spanning everything from simple one-page sheets outlining the choices, through more detailed leaflets or computer programmes, to DVDs or interactive websites that include filmed interviews with patients and professionals, enabling the viewer to delve into as much or as little detail as they want.³⁹
51. Decision aids for 36 conditions were developed by the Right Care Programme, a workstream of the Department of Health's Quality, Innovation, Productivity and Prevention (QIPP) programme. These decision aids are available on the Right Care website⁴⁰ and mimic the exchanges between clinician and patient that would take place through a process of SDM.⁴¹ The guides take a patient through various stages of the decision process, enabling them, for example, to access additional information at various stages if they wish to do so.
52. The Health Foundation, an independent charity, is sponsoring the Making Good Decisions In Collaboration (MAGIC) project which is exploring how SDM can be embedded into mainstream clinical practice.⁴²

Preliminary conclusions—choosing a treatment option

53. It was put to us that there is a substantial amount of unwarranted variation or over-treatment within the private healthcare sector and that this arises, partly at least, because of a lack of patient information regarding treatment options.

³⁸ www.kingsfund.org.uk/publications/making-shared-decision-making-reality.

³⁹ www.kingsfund.org.uk/publications/making-shared-decision-making-reality.

⁴⁰ <http://sdm.rightcare.nhs.uk/pda>.

⁴¹ www.kingsfund.org.uk/publications/making-shared-decision-making-reality.

⁴² www.bmj.com/content/341/bmj.c5146.

54. We think that it would be extremely difficult to quantify the extent of over-treatment in private medicine since, for example, it is difficult to find an appropriate benchmark. Certain procedures might rarely be performed under general anaesthetic within the NHS on cost grounds, for example, even if patients would prefer this. It might therefore be unreasonable to characterise the use, in private medicine, of general anaesthesia as 'over-treatment.' One reason consumers take out private health insurance is to avail themselves of options not generally available on the NHS.
55. Even if it could be shown that unwarranted over-treatment was commonplace, on the basis of this, albeit limited, review we think that lack of consumer information or information asymmetry regarding treatment options would be unlikely to be its cause. We think that there is a great deal of information available to consumers about the treatment options available to them for many common conditions. Further, we think that this is likely to increase over time since the NHS is aiming to save money and making patients aware of (cheaper) treatment options is aligned with this goal.

Choosing a consultant

56. We start by distinguishing between two types of information concerning consultants:
- (a) professional information (relating to the consultant's professional qualifications, areas of clinical expertise, consultation fees and the hospitals at which he or she practises); and
 - (b) financial information (whether the consultant has a commercial interest in a hospital or other service provider, for example).

Professional information

What the parties told us

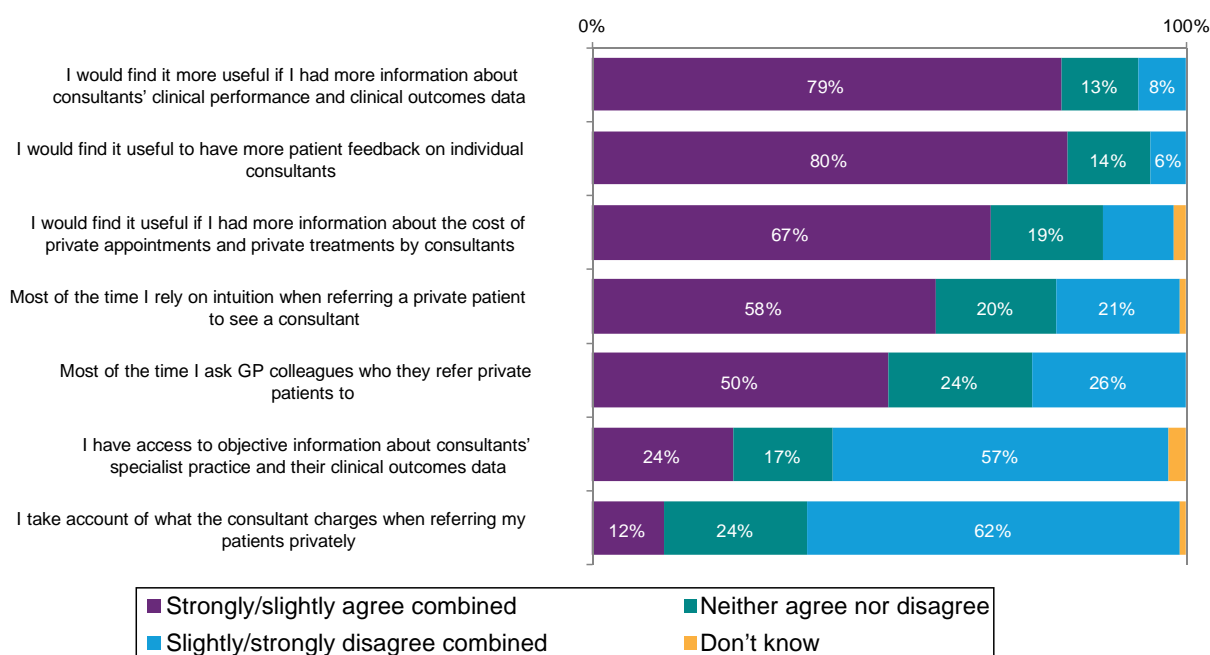
57. Bupa said that it had significant concerns that consultants (and hospitals) in private practice had failed to produce data that allowed patients, GPs and insurers to

evaluate and compare the quality of the treatments they performed and the care they offered, as well as the cost. It said that this gap in information put patients at risk and also created the perverse outcome that patients sometimes incorrectly assumed that price was a sign of quality. It told us that greater transparency of information was fundamental to empowering patients (and the commissioners of care on their behalf).⁴³

58. Bupa provided us with the results of a survey that it had conducted among GPs. This indicated that GPs would like more information about consultant performance and clinical outcomes, with half of those responding saying that they either relied on intuition when making a referral or asked a colleague for a recommendation.⁴⁴

FIGURE 2

Bupa GP survey findings



Source: Bupa (KantarHealth Survey, December 2011/January 2012).

Note: Base: 397 GPs.

⁴³ Bupa response to the issues statement, paragraphs 1.110 & 1.111.

⁴⁴ Bupa response to the issues statement, Section 4.

59. Aviva too said that there was clear asymmetry between the patient and the provider as regards the appropriateness, quality and price of various treatment options that may be available to the patient. It said that this asymmetry restricted the patient's (as well as the GP and the PMI's) ability to make an informed choice about the most appropriate hospital/consultant. It said that while it recognized that healthcare information was often complex it was possible to provide information that patients could use and would find useful. It cited, for example, outcome and process measures relating to treatment conducted.⁴⁵
60. Aviva noted the importance of the GP in the early referral process and that the majority of patients followed the GP's recommendation. However, it said that it was concerned that GPs were not well informed about the quality of consultants. A survey of GPs which it had conducted indicated that that more GPs recommended a consultant on the basis of his or her reputation (77 per cent) than on the basis of their quality (7 per cent).⁴⁶
61. Private hospital operators did not, generally, comment in detail on Theory of Harm 6. Ramsay, however, said that it thought that information asymmetries were not as extreme as depicted by the CC and that current initiatives, for example the Private Healthcare Information Network (PHIN) project,⁴⁷ would, in any case, solve the issue. It said that the surveys undertaken by the OFT indicated that patients and GPs were not as concerned by a lack of information as the CC had suggested.
62. It quoted the OFT's patient survey which had explored patient attitudes to, for example, the number of procedures that a clinician had carried out or mortality rates among a consultant's patients: 'most [patients] did not feel equipped to assess such

⁴⁵ [Aviva response to the annotated issues statement](#), section 2.6.

⁴⁶ [Aviva response to the issues statement](#), 5.7.3.

⁴⁷ www.phin.org.uk/About.aspx.

information and did not think it was necessary for the GP to provide this level of detail.⁴⁸

Our surveys

63. Our survey of patients⁴⁹ indicated that clinical expertise and reputation were the two most common reasons that respondents gave for choosing a consultant, specified by 38 per cent and 36 per cent of respondents respectively. Whether the PMI would cover their fees came reasonably close behind (29 per cent), though after the GP's recommendation (32 per cent) and the length of time the patient would have to wait for an appointment (32 per cent).
64. Roughly 60 per cent of patients did not know which consultant to see before they visited their GP. Just under one-third of respondents had sought information about a consultant's reputation or expertise and about half of these would have liked to have had more information but did not identify any specific information gaps.

Financial information

65. We now turn to arrangements between consultants and hospitals which may encourage consultants to use that hospital's facilities. We described in our working paper on hospital competition⁵⁰ the nature and extent of these schemes and noted that private hospital operators had been reshaping them, coincident with the regulatory intervention by the OFT and the coming into force of the Bribery Act 2010.
66. We also set out the requirements of the General Medical Council (GMC) which restrict clinicians' ability to seek or accept certain payments or gifts or other

⁴⁸ Ramsay response to the annotated issues statement, p29.

⁴⁹ www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/survey_patients_report.pptx.

⁵⁰ www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130603_hospital_competition.pdf.

inducements and which require that, if a conflict of interest does arise, then the consultant declares this to the patient.⁵¹

What parties told us

67. The PMIs condemned incentive schemes for consultants, with AXA going so far as to tell us that the practice represented an additional Theory of Harm. It described this as the distortive effects of consultant incentives to refer patients and/or commissioning excessive treatment. It said that while medical specialists endeavoured as part of their professional ethical obligations to act in the best interests of patients, consultants were far from immune to responding rationally (if often subconsciously) to financial incentives that, in this case distorted competition by raising entry barriers and leading to cost inflation.⁵²
68. Hospitals, in their submissions on this issue, tended to argue that in some parts of the country, London in particular, the practice had become widespread since it was necessary to offer incentives to attract key consultants and that competition for consultants was intense.⁵³ However, some said that they would welcome clarification from the CC on the merits and de-merits of various types of scheme.

Our research

69. Our working paper on hospital competition for clinical referrals⁵⁴ revealed that the practice of offering consultants incentives to treat patients or refer them for tests at particular hospitals had been widespread, though since 2011 schemes had become more sophisticated and more liable to stress the clinicians' obligations to comply with GMC guidelines regarding the best interests of their patients.

⁵¹ www.gmc-uk.org/guidance/good_medical_practice.asp.

⁵² AXA PPP response to the annotated issues statement, paragraph 1.3.

⁵³ See, for example, [General Healthcare Group's response to the issues statement](#), paragraph 2.3 b.

⁵⁴ www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130603_hospital_competition.pdf.

70. Our survey of clinicians, however, did not indicate that consultants were aware of the practice. Over 80 per cent of consultants said that hospitals either did not offer incentives to encourage them to use their facilities or equipment or that they did not know whether they did. 11 per cent said that hospitals did offer incentives. Only 3 per cent of consultants said they personally had been offered any type of incentive or benefit (such as reduced room fees, secretarial support etc) in the past five years. One possible explanation for this, apparent, under-claiming is that the practices referred to may be considered by clinicians to reflect badly on the profession. Another could be that, in the case of consultants who had accepted an incentive or benefit was bound by a non-disclosure agreement.
71. The GMC rules not only prevent clinicians from accepting inducements: they also require that where a conflict of interest does arise it must be declared.⁵⁵ We did not undertake a systematic review of consultant or practice websites to determine the extent to which consultants who are involved in, for example, joint ventures with hospital groups or who own an equity stake in a hospital or clinic, disclose this. However, the impression that we formed during this investigation, from reviewing consultants' and practices websites was that, generally, they did not do so on their websites⁵⁶ though they may, of course, disclose this at their consulting rooms by means of a notice, for example, or tell patients in the course of their consultation.

Preliminary conclusion—choosing a consultant

Professional information

72. There is some evidence that patients may particularly value 'soft' information, such as the reported experiences of other patients, to help them choose a consultant

⁵⁵ www.gmc-uk.org/guidance/good_medical_practice.asp.

⁵⁶ An exception was the New Malden clinic on whose website this notice is posted. <http://newmaldendiagnosics.co.uk/uploads/Doctor%20ownership%20statement.pdf>.

though this might, of course, simply reflect the lack of quantitative performance data currently available.⁵⁷

73. Performance/outcome data for individual consultants is not generally available in the UK.⁵⁸ Only the Society for Cardiothoracic Surgery in Great Britain and Northern Ireland publishes such data.⁵⁹ Other than this, little information is currently available to patients or GPs on individual consultants as regards clinical outcomes or the extent of their experience with particular procedures, say the number they have undertaken.⁶⁰
74. Plans to disclose through NHS Choices data on individual NHS consultant's performance in key specialities were announced in 2012 for implementation in England in the summer of 2013. At the time of writing it is not clear when and in what form this information is to be published or to what extent consultants are likely to participate in the scheme.⁶¹
75. Other information about consultants, such as where they practise, their specialities, qualifications and professional memberships is, however, more easily obtainable from portals such as Dr Foster,⁶² PMI websites,⁶³ hospital websites⁶⁴ or consultants' own websites.

Financial information

76. Very little information is currently disclosed publicly, for example on consultants' or clinics' websites, that would indicate to patients or GPs that a financial arrangement

⁵⁷ www.nuffieldtrust.org.uk/sites/files/nuffield/130322_rating_providers_for_quality_full_report-final.pdf.

⁵⁸ Where are we with transparency over performance of doctors and institutions?/by Aniket Tavare BMJ 2012 345 (published 3 July 2012).

⁵⁹ www.scts.org/patients/.

⁶⁰ Can patients really make an informed choice: an evaluation of the availability of online information about consultant surgeons in the United Kingdom/by Sarkhell Saadi Radha et al, BMJ Open Access Medical Research, 20 March 2012.

⁶¹ www.bbc.co.uk/news/health-22889141.

⁶² www.drfoosterhealth.co.uk/consultant-guide/.

⁶³ For example, <http://finder.bupa.co.uk/>.

⁶⁴ For example, www.hcahospitals.co.uk/our-specialists/.

exists between a hospital provider and consultants.⁶⁵ It is not clear whether any information asymmetry would be extinguished even were the existence and the nature of such relationships to be disclosed since consumers and GPs would not know whether or not the arrangement would be likely to influence the consultant.

Choosing a hospital

77. As we have pointed out elsewhere⁶⁶ in some parts of the country patients have little or no choice of which private hospital to attend given the typical distance they are willing to travel to attend a hospital. We now look at what information is available to those who are able to choose.

What parties told us

78. There was general agreement between the PMIs that more information on private hospital quality and performance would be desirable.

79. Bupa agreed with the CC that it saw no reason why performance and outcome data on private hospitals should not be comparable with that available for NHS hospitals.⁶⁷ Aviva set out additional information that it would like to see published and explained the use that it would make of it. The information it would wish to see available included safety data (for example, the percentage of admissions with MRSA) access information (whether the patient was given a choice of dates) and information on the patient experience.

80. The submissions of hospital groups on performance data were not extensive. Ramsay, however, said that it believed that the PHIN project would, in the very near

⁶⁵ As noted in our paper on hospital competition, in some cases clinicians are subject to non-disclosure obligations under the scheme agreements.

⁶⁶ www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/local_competition_assessment_of_hospitals_of_potential_concern.pdf.

⁶⁷ Bupa response to the issues statement, paragraph 1.117.

future, deliver information on private hospitals equivalent to if not more comprehensive than that available on NHS hospitals.⁶⁸

81. PHIN, which was formerly known as the Hellenic project, is a collaboration involving the main hospital groups⁶⁹ which intends to publish standardized and directly comparable information which will allow consumers and doctors to search for local hospitals by procedure and to compare how they perform based on treatment data of more than 1 million patients a year. The site launched at the end of April 2013 with fairly limited information, for example the frequency of performing particular procedures and whether it is licensed to treat children as well as adults. It planned to extend the information that it published to Patient Reported Outcome Measures (PROMS) for hip and knee surgery in the summer and mortality rates for cardiac procedures along with infection rates in the autumn.

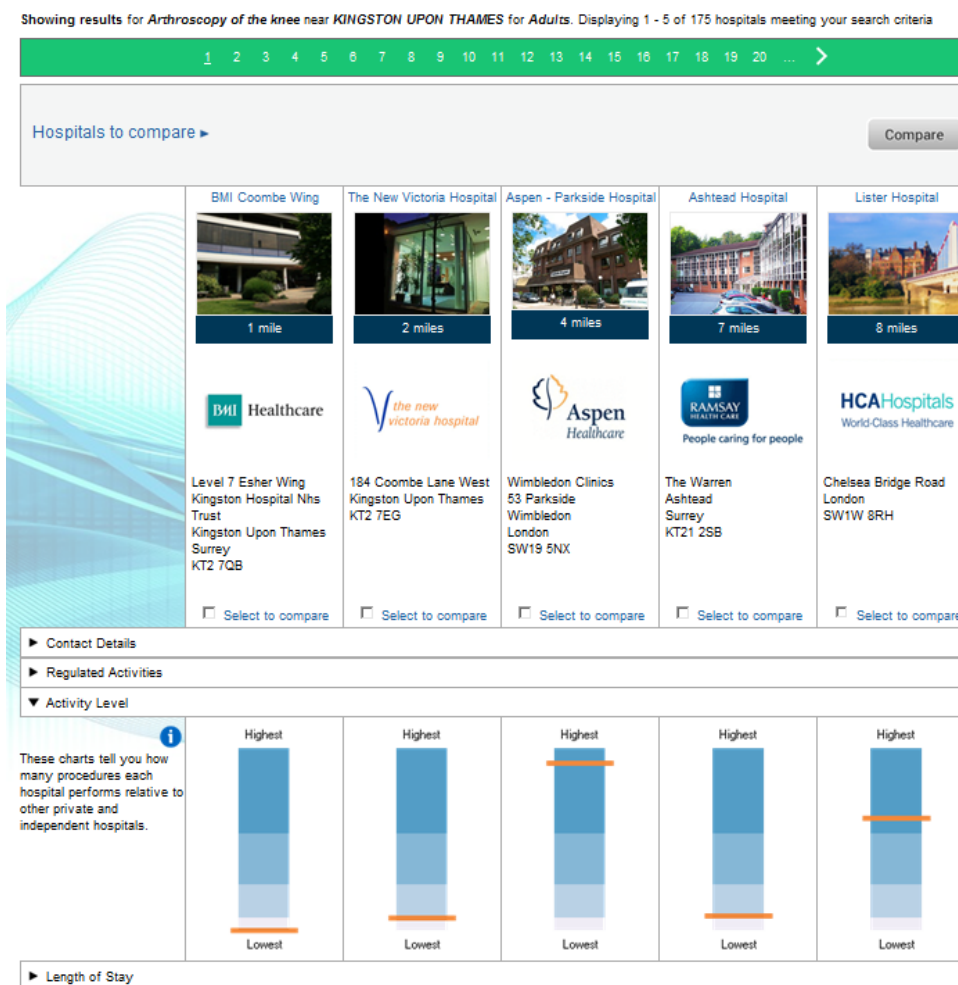
82. We show below the first page results of a sample search, for hospitals offering knee arthroscopy centred on Kingston, Surrey. This shows how frequently the procedure is carried out at the identified hospitals which are rank ordered by distance from the postcode used in the search. It can also display the number of nights a patient could expect to be in hospital for this procedure though only the BMI PPU involves an overnight stay.

⁶⁸ [Ramsay response to the annotated issues statement](#), paragraph 10.9.

⁶⁹ Including BMI, HCA, Spire, Ramsay, Aspen and Circle.

FIGURE 3

PHIN sample search results



Source: PHIN.

83. Ramsay also noted that the hospitals participating in PHIN had engaged in a process by which each operator would publish indicative tariffs for a set of self-pay procedures in a format that was consistent and comparable.⁷⁰ This was launched in early June 2013 and a link to the relevant Ramsay self-pay web page is provided here: www.ramsayhealth.co.uk/prices.aspx.

⁷⁰ Ramsay response to the annotated issues statement, paragraph 10.14.

Preliminary conclusion—choosing a hospital

84. As we have noted elsewhere,⁷¹ in some parts of the UK patients have little or no choice of private hospital provider. Even where they have had a choice, however, there has been little consistent and readily comparable data on performance on anything like the range of indicators and metrics available for NHS hospitals.
85. The Hellenic/PHIN project has experienced some setbacks but it now appears that this may provide a source of private hospital information at least comparable to that currently available for the NHS. However, the extent to which any information asymmetries may be extinguished by publishing performance data is a separate issue that has been the subject of some debate.
86. Research carried out by Which? indicates that consumers tend to use subjective and informal information, such as word of mouth, to choose a hospital.⁷² Work by the Kings Fund found that while patients placed a high value on the quality of care they rarely used objective measures of hospital performance to make their choice.⁷³
87. Reviewing US experience, one study concluded that sophisticated quality measures and reporting systems have not led to the ‘consumer choice’ market envisaged though public disclosure may motivate quality managers and providers to make changes to improve the delivery of healthcare.⁷⁴
88. A UK study by the Kings Fund similarly concluded that, even were consumers or GPs, who were somewhat sceptical as to the reliability of performance data, not to

⁷¹ www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/local_competition_assessment_of_hospitals_of_potential_concern.pdf.

⁷² www.staticwhich.co.uk/documents/pdf/liberating-the-nhs-greater-choice-and-control-which-response-242304.pdf.
www.staticwhich.co.uk/documents/pdf/liberating-the-nhs-an-information-revolution-which-response-242303.pdf.

⁷³ Quoted in www.nuffieldtrust.org.uk/sites/files/nuffield/130322_rating_providers_for_quality_full_report-final.pdf, p68.

⁷⁴ <http://qualitysafety.bmj.com/content/10/2/96.full.pdf+html>.

use hospital quality information, hospital managers might use it to identify areas where their performance might be improved.⁷⁵

89. For consumers to make use of hospital performance information they would have to understand it, which may involve presenting it in a simple, summary form. A very recently published study by Nuffield Trust, produced at the request of the Secretary of State for Health, has explored how this might be achieved and whether, in particular, a ratings scheme might be developed similar to that applied by Ofsted to schools.⁷⁶ The report concludes that there is a clear gap in the provision of clearly presented, comprehensive and trusted information on the quality of care providers which might properly inform the public and users about the quality of care and recommends that the concept is pursued further, including a consideration of the costs and benefits entailed.

⁷⁵ www.kingsfund.org.uk/sites/files/kf/Patient-choice-final-report-Kings-Fund-Anna%20Dixon-Ruth-Robertson-John-Appleby-Peter-Purge-Nancy-Devlin-Helen-Magee-June-2010.pdf.

⁷⁶ www.nuffieldtrust.org.uk/sites/files/nuffield/130322_rating_providers_for_quality_full_report-final.pdf.