



Private healthcare market investigation

Response to Issues Statement

Bupa Health & Wellbeing

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1. EXECUTIVE SUMMARY

- 1.1 Bupa welcomes the Statement of Issues published by the Competition Commission (CC) on 22 June 2012 (the “Issues Statement”). Bupa sees the CC investigation as a unique opportunity to improve competition, choice and consumer welfare in the market for private healthcare (PH) provision.
- 1.2 We summarise below our comments and evidence on:
- i. some of the characteristics of the market set out by the CC in the Issues Statement;
 - ii. the market definition approach to apply in private healthcare;
 - iii. each of the CC’s Theories of Harm;
 - iv. what we believe needs to be done to improve the functioning of the market.
- 1.3 We also signpost where in our submission additional information and evidence on each issue can be found. First, as context for our views, we provide a short introduction to Bupa and its role in the market.

BUPA IS COMMITTED TO HEALTHCARE IN THE UK

- 1.4 The Bupa Group is an international healthcare company active in private medical insurance (PMI), healthcare provision and care homes. Our purpose is to help people live longer, healthier, happier lives. We are focussed on health and care, which we see as a critical differentiator from other multi-line insurers.
- 1.5 As an organisation without any shareholders, Bupa reinvests all surpluses in providing more accessible and affordable healthcare and in providing access to advice and care that is right for each person. We take a long-term view, which we believe is needed in an industry like healthcare.
- 1.6 Our roots are in the UK. We have been providing PMI in the UK since 1947. Bupa Health and Wellbeing UK (BHW) represents the interests of over 2.5 million people with PMI; talks to over 3.5 million people annually in its call centres; and serves over 125,000 thousand people annually through a network of wellness centres across the UK. We work actively to commission high quality, affordable care on our members’ behalf from over 19,000 consultants and over 400 private hospital and clinic operators each year. The Bupa Group also owns the Cromwell hospital in London and funds some treatments in the UK to expatriate customers through our international PMI business Bupa International.

BUPA’S COMMENTS ON THE MARKET CHARACTERISTICS

A critical time for action in UK private healthcare

- 1.7 Bupa is committed to the long-term sustainability of the UK PH market. Our members need high quality and affordable care today and in the future. However, the PMI market is fragile. It is facing an affordability crunch following a decade of rapidly escalating healthcare costs. Fewer and fewer people can access the levels of cover they need, and they increasingly limit the level

of cover they buy through including excesses and exclusions. The proportion of people in the UK covered by PMI is at its lowest levels since the mid-1990s. The number of individuals buying PMI for themselves declined from 2.5 million lives covered in 1995 to 1.6 million in 2010. The growth in companies buying PMI on their employees' behalf was modest during the early 2000s with significant declines during the recession. Further, the sector faces a challenging future. Affordability will continue to be put under pressure by the ageing population, rising chronic disease costs, continued economic uncertainty, and a weakening risk pool. Insurers pay approximately 80% of every pound of PMI premiums in claims to hospitals and consultants. So rising healthcare costs pass through directly and substantially to consumers.

- 1.8 Bupa is concerned that market failures and a lack of effective competition between healthcare providers are driving unnecessary costs into the system. These factors are also restricting the ability of the sector to innovate and reconfigure, as it must do, to meet the future challenges. It is for that reason we believe the Competition Commission must urgently address failures in PH provision by consultants and hospitals.
- 1.9 Section 3 of our submission sets out more detail on the market context, the challenges facing insurers in meeting customers' needs, and the important impact this has on the PH market.

The PMI market is highly competitive

- 1.10 The CC indicates that competition in the PMI market is not under investigation (Issues Statement, para 3). It is important to note, however, that the PMI market is highly competitive with over 15 firms providing PMI to personal and corporate customers in the UK. The PMI market has also seen players enter and expand successfully in the past 10 years.
- 1.11 Insurers compete directly on the value for money of the PMI they offer, but also against the threat that customers will switch out of PMI entirely (to rely on the NHS) when they are not seeing value for the premiums they pay. The threat of switching by customers maintains strong competitive tension¹ and there is continual focus on attracting new customers to sustain the quality of the risk pool.
- 1.12 Insurers like BHW have responded to market challenges, customer needs, and cost inflation from suppliers (hospitals and consultants) through innovation in:
 - i. the types of products and services offered to customers (e.g. the Bupa By You product launched in 2011 gives consumers more flexibility and choice in PMI cover, and the Open Referral service in 2011 for corporates improves the quality of choice of consultants available to patients and guarantees no shortfalls).
 - ii. the channels through which they reach customers.
 - iii. the internal structure of operations (e.g. BHW has undertaken significant back-office efficiencies and rationalisation in the past decade).
 - iv. the ways in which insurers seek to improve value for money from consultants and hospitals (e.g. Bupa has launched new treatment network propositions during the past 5 years).

¹ For example, over 90% of the large corporates Bupa serves (accounting for just under 1 million of our members) use brokers to buy on their behalf, with over 80% shopping around the market for best value for money at each annual policy renewal.

The heterogeneity of PH services and operators results in many pockets of market power

- 1.13 The services provided by PH operators are highly varied and not all hospitals offer the same range of treatments (Issues Statement, para 9). This means competition between operators should be assessed at a disaggregated level (the specialism level at a minimum). It is inappropriate, for example, to assume two hospitals place competitive constraint on each other simply because they are located near each other – they may each focus on entirely separate specialisms and each have market power (given the barriers to entry and expansion discussed in relation to Theory of Harm 5 at para 1.104 below).
- 1.14 As the treatments needed by patients are highly varied, they affect the choices available to insurers. An insurer must be able to offer members access to the full range of services/treatments covered by their policies. This means that the insurer may have to work with a hospital in an area because it is the only operator that offers a particular specialism (or offers that specialism on sufficient scale to serve the insurer's customer base), even where other hospitals in the area offer better value for money more generally. Market power in one specialism can be leveraged across the other services the hospital offers.

Unwarranted variation within treatments is a symptom of market malfunction

- 1.15 As well as taking account of the variation between treatments/specialisms discussed above, the CC should consider also the degree of variation within how often a specific treatment or diagnostic test is delivered to patients.
- 1.16 Bupa observes significant variation in the way consultants treat certain conditions e.g. some consultants have significantly higher rates of diagnostic testing and surgical intervention than peers. Our analysis suggests, for example, that a Bupa patient in England is 300% more likely to receive knee arthroscopy surgery than a similar patient in the NHS².
- 1.17 While some variation will be justified by care being tailored to the needs of the patient, Bupa has significant concerns that some of the observed variation is 'unwarranted'. Unwarranted variation puts patients at risk clinically and, through performance of inappropriate surgery or tests (which can themselves encourage inappropriate surgery), adds unnecessary cost to the PH system. It is a signal that the market is not working well.
- 1.18 Action is needed to address underlying market features that allow, and often encourage, unwarranted treatment variation to occur.

Insurers play a critical role within PH in meeting the needs of customers as both payors and patients

- 1.19 For around 80% of users of PH the patient journey starts a stage earlier than falling ill and visiting the GP. The first stage is buying PMI. The majority of people would not be able to access PH if they did not benefit from the cost savings of risk sharing and collective purchasing offered by PMI. The needs of customers at this first stage, therefore, matter a great deal because if these needs are unsatisfied the customer may never access PH.

² Annex E of our submission provides more detail on this and other case studies of treatment variation.

- 1.20 PMI customers, both individuals and employers³, consistently tell us that value for money is a critical issue⁴. PMI must both be affordable and offer high quality, accessible care. 'Gold plated' care that is unaffordable is of little general use and cheap policies that significantly limit cover or access are similarly unattractive. If customers do not see value for money they switch insurer or out of PH entirely. Therefore, **the insurers' incentives align strongly with achieving customers' objectives**, as this is the only way to retain existing customers and to attract new ones⁵.
- 1.21 The challenge for the insurer is that the incentives of various actors along the patient journey are often misaligned with delivering value for money care. This includes the fact that:
- i. Survey evidence shows the majority of GPs do not take account of cost in making their referrals to consultants (which limits any competition between consultants on price)⁶.
 - ii. Both consultants and hospitals have profit incentives which can put upward pressure on both the price and volume of treatments (this is supported by the fee-for-service reimbursement model and the majority of patients being insensitive to the price at point of use and in vulnerable bargaining positions).
 - iii. The lack of accessible and comparable data on the quality of care delivered by different providers means that there is little competition between consultants and between hospitals along the quality dimension to ensure value is delivered consistently.
- 1.22 Therefore, the insurer must work hard to make the best care available to keep the customer satisfied when he or she is a patient, while keeping control of costs to keep the customer satisfied when he or she is renewing PMI. If the insurer does not have the tools available to deliver both elements then the system unwinds. For example, the insurer must be able to select the providers it wishes to work with (which creates some incentives for providers to deliver value and so be recognised) and to derecognise the ones that do not provide value or put patients at risk.
- 1.23 Bupa strongly disagrees with the CC's comment in the Issues Statement (para 53) that: "if insurers were able to direct their insured patients to recognized consultants (e.g. through 'managed care'), there appears to be a risk of patients being directed to cheaper rather than better consultants due to information asymmetries between patients and insurers":
- i. We cannot compromise on the quality of providers patients are given access to. If customers perceive us to be making available only inferior consultants they will leave the PMI scheme.

³ Over 70% of lives covered are through employers buying insurance on their employees' behalf.

⁴ Personal customers, for example, tell us the value for money is the number one reason when choosing their PMI provider. Price is given as the number one reason why personal customers do not buy PMI in the first place, and it has become the number one reason given by customers lapsing their cover.

⁵ Insurers must meet consumers' high expectations on managing both quality and cost from providers. Customer research conducted by The Value Engineers in 2010 shows: 87% of consumers expect their insurer to monitor consultants to ensure they offer high standards of care and follow best clinical practices; 83% expect their insurer to work with consultants to keep costs down; 83% expect their insurer to work with hospitals to keep costs down; and, 89% expect their insurer to monitor hospitals to ensure they offer high standards of care and follow best clinical practices.

⁶ A GP survey conducted in 2011 by KantarHealth found that only around 10% of GPs 'strongly' or 'slightly' agree that they take account of what the consultant charges when referring patients privately.

- ii. There is little evidence that the existing patient journey, where a GP makes a named referral to a consultant, guarantees high quality outcomes. In fact, we have observed many issues caused by entrenched referral patterns.
- iii. Consultants have failed to produce accessible, comparable information on their quality with which the 'better' consultants can be identified or with which any price premium can be justified. We do not consider it reasonable for the high-charging consultants to simply assert, without any evidence, that consultants who charge more reasonable amounts are 'worse'. There is no evidence that the most expensive consultants are necessarily the best.
- iv. Bupa takes an end-to-end view of treatment costs rather than looking at each episode of the treatment journey in isolation. High quality care often results in lower costs over the end-to-end journey. For example, we are willing to pay a higher amount for better outpatient care where this cures the problem before expensive inpatient surgery is required. Therefore, Bupa seeks to work with consultants who deliver end-to-end value compared to peers. These consultants practice evidence-based, best practice techniques.

1.24 There is a regulatory gap in PH. Many of the checks and balances within the NHS are not present in PH e.g. private hospitals and consultants do not publish their treatment activity data which would allow review and scrutiny. This regulatory gap can put patients at risk. It means that there is an important role for insurers – the commissioners of care. Insurers need to be provided with the tools and authority to identify and address poor behaviours from consultants and hospitals.

The patient and the payor are often not the same entity

1.25 The majority of PMI is purchased by companies on behalf of their employees. However, in our experience, companies want the same as individuals – access to high quality, affordable care (i.e. value for money). The implications of the fact that it is not always the patient who pays for the insurance (raised by the CC in para 10 of the Issues Statement) are:

- i. **More people access PH than would otherwise have occurred:** The structural decline of the personal PMI market has been sustained since the 1990s. So without employers buying on their employees' behalf, significantly fewer people in the UK would now be able to access PH (and there would be a greater burden on the NHS). However, the number of employers buying PMI for their staff has also been in decline since the mid-2000s.
- ii. **There is a keen focus on quality and price:** Similar to individual consumers, the focus for employers is on value for money in its broadest sense from PMI. The quality of healthcare employees get through the policy cannot be compromised as this directly affects the employer's staff engagement, productivity and reputation⁷. At the same time, the employer demands keen prices and product flexibility. The significant majority of companies use intermediaries and tenders to get best value for money. The trend of employers buying on employees' behalf has put greater emphasis on value for money

⁷ Customer research on large companies, for example, shows the top 5 reasons they buy PMI are: Been seen as a caring employer; Improving the health and welfare of staff; Improving employee engagement; Getting employees back to work quickly; Being seen as an employer of choice. Employee Benefits Healthcare Research 2012.

and brought about innovation from insurers (for example, BHW's launch of Open Referral in 2011 was in response to the needs of a particular corporate customer).

- iii. **There are sometimes communication challenges to overcome.** Inevitably there will be some challenges when the company purchases on its employees behalf in the company explaining to staff, the ultimate patients, the cover available. Bupa has dedicated teams working with companies to help them manage staff engagement about policy cover.
- iv. **There is a strong focus on nationwide coverage.** Many large corporates want their employees across the UK to be able to access healthcare where it is convenient to those employees. The insurer needs to have this nationwide coverage if it wishes to serve the customer segment effectively.

The role of the NHS

- 1.26 Bupa sees PH in the UK as an important complement to the NHS in delivering healthcare to consumers. Indeed, this is a reason why remedying failures in PH is so important at a time when the NHS is facing significant funding challenges.
- 1.27 As the universal free alternative, the NHS impacts PMI and PH demand. Insurers have to continuously demonstrate the value from private healthcare (something which is difficult to do in the absence of data on PH provider treatment outcomes and performance). However, Bupa does not see NHS provision to patients as a direct substitute for PH, or that it provides an effective competitive constraint on PH providers serving insured patients. Even those parts of the NHS focussed on PH, NHS Private Patient Units (PPUs), offer little real constraint on PH operators (as discussed further below). The focus of the CC's market investigation should therefore remain PH only (issues of competitive neutrality between PPUs and private hospitals, for example, will not solve the problems at the heart of the PH market).
- 1.28 Bupa recognises that NHS commitments and salaries do impact the volume of consultants available to PH and where those consultants can be located geographically (see Theory of Harm 5 below). NHS training and development also enhances the skills of all consultants offering PH.
- 1.29 Bupa wants the CC to assess the impact on private hospital profits that has come from serving NHS patients⁸. The OFT Market Investigation Reference (MIR) Decision notes that in 2004 private hospitals earned 10% of their income from treating NHS patients. In 2010, this had grown to 25%. Yet insured patients do not appear to have shared any gains in the form of improved prices.

⁸ The OFT MIR Decision (para 6.55) explains "*PH providers have stated that PMI funded patients are significantly more profitable compared to NHS patients...*" and that OFT analysis showed "*...revenue earned from treating NHS patients often did not appear to cover all costs associated with treating NHS patients*".

MARKET DEFINITION IN PRIVATE HEALTHCARE

1.30 Bupa looks forward to engaging with the CC on an appropriate approach to market definition. As the CC's analysis may build on that done by the OFT in its market study we provide comments on the OFT analysis first. We also set out additional points the CC should consider.

The OFT's approach to market definition provides a starting point only

1.31 The OFT work on market definition in PH identified many of the challenges in applying standard market definition techniques to this market (because of the unique features of the market and the lack of appropriate data)⁹. It also highlighted the empirical evidence that techniques applied to define hospital markets in the past had flaws (often defining markets too broadly, particularly in urban areas).

1.32 Bupa understands the OFT's decision to use a 30-minute drive-time isochrone around a provider as a pragmatic starting point for the competitive assessment. We do not believe there is evidence this drive-time should be increased.

1.33 However, Bupa is concerned that:

- i. The OFT's **assumption on product aggregation is too strong**. Aggregation can hide pockets of market power in certain treatments/specialisms (a point recognised by the CC in paragraph 18(b) of the Issues Statement)¹⁰. From an insurer's perspective we must give customers access to the full range of services covered under their policies. Therefore, where the geographic market for a particular treatment is very narrow, we have limited choices of hospitals to recognise (giving the provider of this treatment market power) even if patients would travel further for other treatments. Bupa considers that the CC should apply more disaggregated product bundles than applied by the OFT.
- ii. The OFT **overstates the effectiveness of supply-side substitution**. To justify broadening markets, supply-side substitution needs to occur quickly (usually within a year) and effectively (on a scale to be a real constraint) in response to a small but significant non-transitory increase in prices/reduction in quality. The strength of supply-side constraint is limited by the barriers to entry and expansion in this market – see the discussion on Theory of Harm 5 at para 1.104 below. Therefore, before broadening product markets, the CC needs to assess whether supply-side substitution is sufficiently rapid and inexpensive to be a credible constraint.
- iii. The OFT's conclusion on a '**national dimension' to competition (because hospital groups set standard national prices with insurers) is inappropriate**. This so called 'national dimension' exists because hospital groups provide no other alternative¹¹. There is in fact very little head-to-head competition between hospital groups at this national level. The main hospital groups are located in different geographic areas with relatively few local markets of significant overlap. There is also only marginal opportunity for an insurer to play one main group off against another, as each group owns 'must have'

⁹ See the literature review conducted by Oxera on the OFT's behalf, "Techniques for defining markets for private healthcare in the UK", November 2011.

¹⁰ Ibid. Oxera notes that the aggregation of treatments into bundles, for example 'acute general hospital care', can lead to incorrect broad geographic market definitions

¹¹ Bupa would prefer prices to reflect dynamics of competition, demand, supply and cost at a local level rather than a single national price list

hospitals and so knows that the insurer will have to do business with it in the end. [X]¹². Bupa therefore considers that the starting point for the relevant market should remain local markets and that this should only be expanded if there is genuine evidence of hospitals competing over a wider region (and that a national market is inappropriate).

- iv. **The inclusion of NHS PPUs in the product market carries risks because they are, in general, not effective competitive constraints on private operators.** The OFT included PPUs in the product market but also recognised that the extent of their influence varied on a case-by-case basis. In Bupa's experience, PPUs do not provide a competitive constraint on the conduct of private hospital operators and continue to face barriers to expansion in PH (so we do not expect the constraint from PPUs to increase materially in the near term¹³). Some of these barriers are similar to those faced by other small hospitals (detailed in the discussion on Theory of Harm 5 below), but several are specific to PPUs including the fact that PPUs: (i) consistently and significantly perform below other private hospitals in patient satisfaction surveys conducted by Bupa and that addressing some of these shortcomings will require significant investment; (ii) face organisational pressures that limit PH work (such as the duty to serve NHS patients first); (iii) face political pressures, in particular of expanding private provision at a time when NHS beds are being reduced; and (iv) tend to be small¹⁴, which means they are seldom effective alternatives for insurers looking to switch away from a larger hospital in a market. Even the strongest PPUs in London offer competitive constraint in certain specialisms only, and not across the board¹⁵.
- v. **Markets will be defined too broadly because of existing market power.** Bupa believes there are many local markets in the UK in which hospitals/consultants already have significant market power (either individually or collectively¹⁶) meaning that any further increases in price (or decreases in quality) may lead to patients travelling further or switching out of PMI (to the NHS). This switching is not evidence the market should be widened (it is the cellophane fallacy in action). So before data on patients switching away from a particular provider is seen as evidence that the provider faces effective competition or that the market should be widened, the CC must consider whether there is evidence of existing market power.
- vi. The fact that **markets have strong local dimensions** (particularly for insurers) is given insufficient weight in the OFT's approach. There is evidence patients want to be treated near their home or in some cases their place of work. There may also be limits on the

¹² [X]

¹³ Given the barriers to entry and expansion, we do not expect that the role of PPUs will change materially or rapidly following the lifting of the private patient income (PPI) cap to 49%. This cap was not binding for the significant majority of PPUs even before it was lifted.

¹⁴ For example, as an indication of relative size, Laing and Buisson 2011 explains that the largest PPU within the M25 ranks only 17th in the list of hospitals in the M25 by number of beds.

¹⁵ London's second largest PH provider, The London Clinic, states: *"In The Clinic's opinion, PPUs are not close competitors to HCA, The Clinic or the other private hospitals because they do not offer comparable service ... [they] are unable to accommodate Consultants working for other NHS Trusts or private hospitals. The service they offer also falls below that expected at private hospitals ... The weakness of competition from PPUs is most marked in relation to tertiary care of PMI funded patients (eg specialist oncology treatment) which is dominated by HCA with The Clinic and the other private hospitals taking a smaller share."* Initial Submission available at: http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/120516_london_clinic_initial_submission.pdf

¹⁶ For example, take a consultant group that controls a local area with all group members charging a uniform price leaving patients bearing a shortfall. Some patients may have to travel a distance to another area to avoid this shortfall. This does not necessarily mean that this other area is an effective constraint on the group and the group has no market power. The group may simply have pushed up price so far that patients are forced to travel.

patients' ability to travel to hospitals in more distant locations. This matters because when buying PMI customers want policies that give them access to hospitals convenient to them. So insurers need to have access to hospitals near the customers they serve and want to serve. This gives strong bargaining positions to providers in locations where insurers have few alternatives located nearby.

vii. **Patient travel patterns may not reflect real choices and competitive constraint.** The patient journey (Section 4) demonstrates that in many cases private patients have limited ability to make choices between providers during the treatment journey. Consultants do not compete with each other on price, as the referring GP seldom knows what a consultant will charge, or on quality as there are no comparable data available. Similarly, hospitals do not compete for insured patients on price or quality, but for the consultants who bring the patients to the hospital. The patient is relatively passive (often given little, if any, choice) so observed patient travel patterns must be used with care in market definition¹⁷.

viii. **A 'Chain of substitution' argument will apply only in exceptional circumstances.** The 'chain of substitution' argument relies on a well-functioning competition mechanism. However, the competition mechanism functions poorly in PH. As a result, there can be very little competitive tension between hospitals located in the same isochrone, and so it becomes unlikely that competition will flow across isochrones. A 'chain of substitution' is made even less likely by the heterogeneity of patients (isochrones assume homogenous patients) and heterogeneity of hospitals. For example, even though there are several hospitals in Central London this does not necessarily justify a London-wide market; there could in fact be smaller markets within London.

1.34 In summary, Bupa considers that markets in private healthcare are narrow from both a product and geographic perspective.

THEORY OF HARM 1: MARKET POWER OF HOSPITAL OPERATORS IN CERTAIN LOCAL AREAS

1.35 There are a large number of hospitals in the UK with market power at a local level. This market power comes from high levels of concentration at the local level and the presence of barriers to entry and expansion. The discussion on Theory of Harm 3 (at para 1.57 below) explains how the main hospital groups leverage the market power in their 'must have' hospitals across their whole hospital portfolios.

Identifying hospitals with market power

1.36 From an insurer's perspective, a hospital may have market power in a local area **if any** of the following factors exist:

- i. **There are no, or a very limited number, of rival hospitals located nearby.** The insurer 'must have' the hospital in this location if it is to be able to serve customers in this area (this is what patients/customers expect). It can also happen that rivals nearby are owned by the same group and so do not offer genuine competitive constraint on each other e.g.

¹⁷ Patient travel patterns could be distorted by consultant incentive schemes, for example.

HCA owns 6 main facilities clustered in Central London and BMI controls a number of the hospitals across Scotland.

- ii. **The rival hospitals nearby do not offer particular key specialisms** which the insurer must be able to offer to patients in that area.
- iii. **The rival hospitals nearby have limited capacity** that could not serve the insurer's local demand. For example, we consider the [X] to be a 'must have' hospital because, even though there is a PPU within a few minutes drive, this PPU is too small and accounts for only 3% of Bupa's spend in the area.
- iv. **The consultants at the hospital are unwilling or unable to direct their patients elsewhere** even if the insurer wishes not to work with the particular hospital in question. According to Bupa's claims data [X] of consultants work at one private hospital only. Many hospitals also tie in consultants with financial and non-financial incentives (which raise consultant switching costs). This creates a significant barrier to an insurer switching hospital because the insurer will need to convince all of these consultants to change referral patterns (e.g. to acquire or use practice privileges elsewhere).
- v. **Rival facilities may not offer consistency of customer service**, which limits the ability of the insurer to rely on them. This is particularly a challenge for PPUs, as noted above.
- vi. **Customers may be unwilling or unable to switch.** Customers (and patients) may be unwilling to switch to an alternative provider e.g. certain hospitals are 'must have' to particular corporate clients¹⁸.

1.37 It should also be recognised that even where an insurer establishes alternative options there are substantial switching costs in redirecting patients away from a particular facility:

- i. A comprehensive communications and engagement strategy is needed to explain why the move is necessary and to respond to customer and consultant concerns. This aims also to mitigate the negative reputational impact created by the hospital and rival insurers writing to Bupa members in the affected local markets encouraging them to move insurer.
- ii. The insurer will need to continue using the hospital in question for certain patients (e.g. those in mid-treatment) and will have to pay higher 'out of contract' rates for these treatments. These 'out of contract' rates can be between [X] and [X] more expensive.
- iii. If the hospital is part of a group, the insurer may now face significantly higher prices at the other hospitals in the group it must continue to use (see discussion on Theory of Harm 3 below).

1.38 The insurer may have very limited buyer power against a hospital given the costs of next best options, in particular where the hospital is part of a group.

¹⁸ For example, the [X] is essential for the insurer if it wants to serve North Sea oil and gas clients. If the insurer failed to offer this hospital, it would lose the business of these companies across the UK. Another example is that several large corporate customers insist on Bupa offering access to the [X] because of its convenient location to the [X].

There are a large number of ‘must have’ hospitals in the UK

- 1.39 Bupa presents analysis on the main hospitals it uses in the UK in Section 5.
- 1.40 **Over 60 of the hospitals that Bupa uses have significant market positions with market shares of over 80% in their local area and Herfindahl-Hirschman Index (HHI) values of over 6,000 making these areas very highly concentrated. The list of hospitals with significant market positions (“must have” hospitals) doubles when concentration in key specialisms is considered.** This is before analysing whether patients and consultants could be convinced to switch (which may not be the case), which would lengthen the list of hospitals with strong local positions.
- 1.41 **Each of the main hospital groups owns ‘must have’ hospitals** with [redacted] owning the most in number.
- 1.42 Bupa has significant concerns about concentration in certain regions. **Concentration levels in Central London are high** (with a HHI of over 3,000) because of HCA’s increasing control of the area¹⁹. **BMI and Spire are the only main hospital groups in Scotland** (resulting in an estimated HHI for the region of over 4,400). Wales faces high concentration of over 2,000 HHI and Northern Ireland is very highly concentrated with a HHI in excess of 5,000. This regional concentration illustrates that often there remains little choice for insurers even if patient could be persuaded to travel significant distances for treatment.
- 1.43 As an example of the challenge faced by an insurer, during the Bupa/BMI negotiation in 2011 Bupa analysed the BMI portfolio of 63 hospitals in detail. [redacted].

The effect of ‘must have’ hospitals

- 1.44 Hospitals that do not face competition in local markets have less incentive to invest in quality, achieve efficiency and innovate. They also have pricing power over both insurers and self-pay patients²⁰. However, as the main groups all set a single price for their portfolio and do not publish quality data at a hospital-by-hospital level, the effects of an individual ‘must have’ hospital can be more difficult to identify (its market power may in fact be felt in other local markets).

THEORY OF HARM 2: MARKET POWER OF INDIVIDUAL CONSULTANTS AND/OR CONSULTANT GROUPS IN CERTAIN LOCAL AREAS

Individual consultants have strong market positions

- 1.45 Consultants are in strong positions in the patient journey as they are **the specifiers of the type, volume and the venue of care**. There are a number of factors that combine to give consultants market power, some of the most important being:

¹⁹ [redacted]

²⁰ Empirical evidence from the US shows that more concentrated hospital markets have higher prices and often lower quality. See for examples, (i) Vogt and Town (2006) “How has hospital consolidation affected the price and quality of hospital care?”, Robert Wood Johnson Foundation, Research Synthesis Report No. 9, February 2006, and (ii) “Improving Health Care: A Dose of Competition”, A Report by the Federal Trade Commission and the Department of Justice, 2004.

- i. **GP referral behaviours not accounting for cost:** Consultant fees are not under competitive pressure because the majority of GPs, who refer a patient on to a consultant in most cases, do not have either the incentive or information to take cost into account in their referral. The OFT's survey evidence, for example, suggested that 75% of GPs 'rarely' or 'never' know the cost of the consultant's first appointment²¹. GPs are even less likely to know the end-to-end treatment costs, i.e. beyond the first appointment, of that consultant (which should at least be part of the considerations regarding the choice of consultant).
 - ii. **The lack of published information on consultant performance and quality:** There is no published comparable information on consultant performance or quality, making it difficult for the GP or patients to make value for money decisions. The absence of this data means that effective competition between consultants on quality cannot take place. Its absence also means that patients, with little alternative information available, sometimes incorrectly interpret price as a signal of quality.
 - iii. **The patient has very little bargaining power relative to the consultant:** Significant information asymmetries exist making it difficult for the patient to challenge either the fees or the course of treatment the consultant recommends. The patient may also be in a vulnerable position from a health, emotion and time perspective; and will have significantly more at risk than the consultant. Evidence suggests patients, even those who self-pay, seldom negotiate fees. Evidence also suggests a significant number of consultants do not explain likely costs to the patient at their first meeting and do not give the patient choice on the type or venue of treatment when there are in fact options.
 - iv. **Switching costs limit patient choices:** The consultant's bargaining power significantly increases as the patient moves through the treatment journey, as the switching costs facing the patient rise. If the consultant failed to explain the end-to-end costs of care at a point when the patient could have switched, then at later points the patient has little option but to accept the consultant's bills.
 - v. **Local markets are often concentrated and protected by entry barriers:** the consultants in these local markets understand their interdependence (and are likely to interact daily in the NHS) and so face less incentive to compete with each other. In many cases, they may also form consultant groups which further limit choice and competition.
 - vi. **Hospitals place little discipline on consultants:** Consultants are self employed. Hospitals compete actively for consultants and often give them both financial and non-financial incentives (e.g. subsidised offices). However, this also means that hospitals seldom place any discipline on the conduct of consultants or monitor their behaviour.
- 1.46 Bupa also notes that **anaesthetists have particularly strong market positions**, given there is seldom opportunity for the patient to negotiate or switch at the point of meeting his or her anaesthetist. The **economic markets anaesthetists serve are very narrow**, a patient may only be able to switch to other anaesthetists within the same hospital in response to learning of a likely shortfall (switching to anaesthetist further afield would mean delaying the operation, moving hospital and possibly changing consultant).

²¹ The OFT GP Survey, p34.

- 1.47 Insurers provide some constraint on consultant market power through setting reimbursement limits (called benefit maxima in Bupa's case). However, these limits cover only a portion of consultant charges²², some consultants do not follow them, and they do not constrain unwarranted variation.
- 1.48 Bupa also provides our members with additional information on consultants cost and performance at the point of claim pre-authorisation. Bupa has received very positive feedback from patients for this advice and support (see, for example, our Open Referral service explained in more detail in Section 6). However, though the insurer can share a wider set of data with the patient than could be gathered by the GP or the patient alone, this information is constrained by the absence of comparable data in the industry on consultant treatment outcomes.
- 1.49 Therefore, insurers provide some counterweight to consultant market power, but this is not always sufficient. Self-pay patients have little protection. We discuss insurer actions further under the section on Theory of Harm 4 below.

Consultant groups

- 1.50 Bupa is concerned about the growing trend of the consultants forming groups. This is not limited to anaesthetics. We have seen consultant groups being formed in many specialisms, including ophthalmology and rheumatology.
- 1.51 Consultant groups have negative impacts on both choice and competition at the local level. The most direct impact for patients is that groups tend to set uniform fee rates across all members. This means that if a group becomes too large within a particular local market (i.e. encompassing the majority of relevant, available consultants), patients may have little choice other than to pay the group fee rate²³.
- 1.52 We present evidence in Section 6 that certain anaesthetist groups (AGs) have become so large within the local markets they serve, that they can, and do, abuse their dominant positions²⁴.
- 1.53 In addition to the direct negative impact on choice, the groups have further indirect negative effects for patients:
- i. Group members have little incentive to compete with each other on quality offered to patients. For example, The Association of Anaesthetists of Great Britain and Ireland (AAGBI) states that 64% of Anaesthetist Groups (AGs) "share profits equally between members of the group" meaning a group member has little reason to differentiate service relative to a fellow group member as he or she will simply share the benefits²⁵.
 - ii. The threat of new entry to the market is blunted by the presence of groups. The AAGBI notes, 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

²² For example, under 50% of Bupa's spend with consultants in 2011 was on treatments constrained by benefit maxima.

²³ Claims evidence shows that many anaesthetist groups span more than one hospital in the local area, meaning that the patient may not be able to find non-group anaesthetists even in hospitals further away. An example is the Bath Anaesthesia Group LLP, which covers services at the Royal United Hospital Bath (NHS), BMI Bath Clinic and Circle Bath. These comprise all of the private hospitals in Bath.

²⁴ [X<]

²⁵ See <http://www.aagbi.org/sites/default/files/AAGBI%20FINAL%20response%20to%20OFT.pdf> (accessed June 2012).

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 post²⁶. It is unsurprising new consultants will join the group because the group members will in many cases be their superiors in the local NHS hospital where they are also employed.

- iii. Consultants outside the group often simply ‘follow’ the group rates in a local area, leading to higher fees for all patients.

1.54 Bupa is not aware of any evidence or quantification of the alleged benefits of consultant groups. It is unclear whether forming groups with uniform price structures is necessary to achieving any of the alleged benefits. Further, in many cases these alleged benefits (e.g. cost savings due to shared use of resources) do not appear to flow through to patients – a number of the largest anaesthetist groups charge the highest fees, for example.

Consultant trade associations

1.55 Bupa considers it necessary for the CC to assess the conduct of certain consultant trade associations. These bodies vociferously encourage consultants to act collectively, sometimes with anticompetitive effect. For example, the Federation of Independent Practitioner Organisations (FIPO) has provided information to its members discouraging them from participating in initiatives that lead to lower prices and incomes for consultants²⁷ even though lower prices would be in the best interests of patients.

1.56 It should be noted also that certain of these consultant trade bodies receive significant funding from some of the main hospital groups – for example, HCA has previously been a substantial contributor to FIPO. FIPO has itself provided significant funding to the Private Patient Forum.

THEORY OF HARM 3: MARKET POWER OF HOSPITAL OPERATORS DURING NATIONAL NEGOTIATIONS WITH INSURERS

1.57 The five main hospital groups – BMI, Spire, HCA, Nuffield and Ramsay – together account for [3<] with hospitals in the UK. Bupa invests significant resources in the negotiations with these groups because any additional benefits that Bupa can achieve flow directly through to better value for money PMI for our members²⁸.

1.58 The challenge is that these groups each have market power, [3<] being the strongest. Each owns ‘must have’ facilities. They negotiate on a “one in, all in” basis, setting a standard price for all hospitals in their portfolios. They have significant scale, which some continue to grow through acquisition and through PPU-partnering. The barriers to entry and expansion (discussed in the section on Theory of Harm 5 below) also restrict the ability of smaller rivals to place any effective constraint on the main groups.

1.59 Insurers do not have countervailing buyer power against these main hospital groups.

²⁶ Ibid.

²⁷ This material is available through the FIPO website at (<http://www.fipo.org/docs/FIPO-Surveys.htm>) and we include it also in Annex F. The FIPO website also links the user through to US research which encourages doctors to cooperate rather than compete (<http://jbjs.org/pdfaccess.ashx?ResourceID=58369&PDFSource=19>).

²⁸ Bupa’s claims spend with these five groups accounts for nearly [3<] of each pound of premium income earned.

The market power of 'must have' hospitals is leveraged across the group's portfolio

- 1.60 The market power of 'must have' hospitals is a concern in its own right (as noted in the discussion on Theory of Harm 1 above). However, a group can also use its 'must have' hospitals to leverage bargaining power across the group's whole portfolio. The hospital group knows that it would be extremely costly (if even possible) for the insurer to switch away from the 'must have' facilities. Therefore, the group can force the insurer to recognise all its facilities on the threat that either it would withhold the 'must have' hospitals or it would significantly increase the prices at these facilities. This threat raises the switching costs for the insurer in those local markets in which there is alternative provision to the group's facilities.
- 1.61 The "one in, all in" strategy can be put into effect through contractual clauses, pricing structures, or the threats to withhold access. As examples:
- i. Certain groups have contractual clauses that oblige the insurer to recognise all their hospitals, even those recently acquired, at the standard group price²⁹. [§].
 - ii. Bupa launched an Ophthalmology network in 2007 through competitive tender. [§].
 - iii. [§].

The scale of the hospital group increases its bargaining position

- 1.62 It is more difficult for an insurer to go 'out of contract' with a large hospital group because a greater number of patients and consultants will be affected. The logistical challenge facing the insurer, therefore, increases every time a group acquires a new facility³⁰. For example, Bupa's negotiation with BMI revealed that because of BMI's scale, Bupa would need to convince [§] who worked only at BMI hospitals to switch.
- 1.63 HCA's scale in Central London is a particular issue. [§].
- [§]
- 1.64 Comparing the costs of treatment of a basket of 100 surgical procedures, [§].
- 1.65 Within Central London, [§] for the basket of 100 surgical procedures, demonstrating how much more expensive Central London is than the rest of the UK (which explains Bupa's serious concerns about HCA's satellite facility strategy that seeks to direct patients from outside of London into its expensive London facilities).
- 1.66 There is no evidence that any economies of scale benefits that the large hospital groups enjoy pass through to patients. For example, some of the largest hospital groups charge the largest mark-ups on drugs and prosthesis. This is discussed in Section 5 of our submission.

²⁹ These clauses also allow the more expensive hospital groups to bid higher prices than smaller rivals when hospital facilities go up for sale, as the group knows it will immediately be able to apply its higher price if its bid is successful.

³⁰ The OFT MIR Decision (para 6.72) notes that internal strategy documents from one of the larger PH providers show that increasing the number of hospitals owned by the provider was part of improving its bargaining position against insurers.

There is no justification for price differentials in terms of quality

- 1.67 Bupa conducts a quarterly patient satisfaction survey of Bupa members treated in hospitals. There is no differential in the [§<] scores relative to other operators that explains their significantly higher prices.
- 1.68 As there is no comparable data on the treatment outcomes of hospitals it is not possible to demonstrate that the main groups offer superior quality.

Indirect costs of the hospital group market power

- 1.69 Consumers bear indirect costs from the market power of the main hospital groups. Of greatest concern to Bupa is that the large groups are able to protect their inefficient hospitals from market forces. These hospitals benefit from the quiet life with the consumer having to pay for the higher cost base. It also means that more efficient independent hospitals and business models are prevented from growing. This again leads to higher costs for consumers to bear today and in the future.
- 1.70 Certain hospital groups have also been in a position to insist on contractual clauses with insurers that restrict the insurer's ability to direct patients away from that hospital or to launch new products without that group being included. [§<] has clauses of this kind in its contract with Bupa. This harms consumers because insurers are not able to launch innovative products and because they restrict the ability of efficient independent hospitals to enter or grow in the market.

Insurers do not have countervailing buyer power

- 1.71 Bupa's buyer power is not countervailing against the strength of the main hospital groups. Bupa's outside option to move away from a main group is extremely costly (see para 1.36 above for example). This cost increases with:
- i. **the scale of the hospital group** which affects the number of facilities for which redirection plans will need to be made, the number of patients who will be negatively affected, and the number of consultants who will need to be persuaded to move practices.
 - ii. The **group's control of 'must have' hospitals** which Bupa would need to continue to use during an 'out of contract' period, but for which Bupa would be required to pay significantly higher prices.
- 1.72 The reputational costs of a dispute fall asymmetrically on the insurer compared to the hospital group. The customers who leave the insurer during a period of dispute are unlikely to return to the insurer. Therefore, even a short dispute can have a material and permanent negative impact on the insurer.
- 1.73 Bupa has taken steps to improve its bargaining position with hospitals; including the launch of insurer networks; investments in the ability to guide patients; and, the delisting of hospitals during negotiations. However, **these have not been sufficient to counterbalance the strength of the groups.**

The threat to delist hospitals has been used in hospital negotiations, but is a damaging last resort for insurers, and is only credible over a limited timeframe

- 1.74 Bupa took the exceptional step of delisting hospitals during an ‘out of contract’ period in its recent negotiation with BMI. This caused significant upheaval to patients and it damaged the reputation of both Bupa and the industry as a whole. It was, however, the last possible step available to Bupa to encourage BMI to bring BMI’s earlier [redacted] price increase proposals to more acceptable levels. It was also a decision that depended critically on the circumstances of that particular negotiation.
- 1.75 Bupa is satisfied it has secured a better deal for its members than originally proposed by BMI. However, this should not be interpreted as evidence that Bupa now has countervailing buyer power. The CC should bear in mind:
- i. BMI started the negotiation with treatment prices significantly out of line with other comparable hospital groups (despite BMI’s claimed economies of scale). Bupa estimated that BMI was [redacted] more expensive [redacted] without showing higher levels of quality.
 - ii. There was substantial reputational and commercial damage caused for Bupa during and as a result of this dispute. The OFT MIR Decision (para 6.67), for example, notes that other insurers had won corporate business away from Bupa because of the dispute.
 - iii. [redacted]
 - iv. BMI’s decision to agree terms without a lengthy ‘out of contract’ period was, in part, because BMI was facing acute debt refinancing challenges. Bupa cannot rely on these factors always being present to encourage BMI (or other operators) to offer better value for money.
- 1.76 The case study highlights the malfunctioning of the PH market (and is discussed further in Section 5 of the submission).

Insurer networks can deliver substantial benefits, but their effectiveness is being undermined by the market power of the main hospital groups

- 1.77 The launch of facility and treatment networks by insurers can have significant benefits for consumers:
- i. **Networks allow insurers to manage costs** through encouraging hospitals to offer discounts to get into the network in order to access more volume. The customer benefits because the cost savings of these discounts are passed through in the form of lower premiums. The insurer is also able offer price certainty to the patient once the hospital is in contract.
 - ii. **Networks allow insurers to offer customers a greater choice of flexible, low cost PMI products.** For example, some customers may choose to buy a cheaper PMI product that gives access to a narrow network of hospitals, where other customers may pay more for the choice of a wider selection of hospitals. By increasing the choice and affordability of PMI products, networks grow the volume of people able to access PMI.
 - iii. **Networks can raise the quality offered by facilities** where network inclusion depends on meeting specified standards.

- iv. **Networks reward efficient hospitals** with additional patient volumes. Efficient hospitals can offer better value for money and so are more likely, in theory, to be included into the network. This encourages inefficient hospitals to improve.
- 1.78 The benefits of networks have previously been acknowledged by both the OFT and the CC. The use of networks is also standard business practice in many sectors.
- 1.79 However, networks are costly to design and launch. The insurer needs to be confident the network will have sufficient coverage to make any PMI product linked to that network attractive to a sufficient number of customers. To achieve coverage the network is likely to need to include certain 'must have' hospitals. The groups that own these 'must have' hospitals can undermine the effectiveness of networks by using 'one in, all in' to force the inclusion of their other hospitals into the network even where the insurer may not require them. This diminished the attractiveness, even accessibility, of the network to other independent hospitals. Hospital groups can use the tactic to build barriers to entry and expansion for rivals and to keep their own inefficient capacity in the market. To be clear, the anticompetitive outcome is the effect of the hospital group market power rather than because of the insurer networks.
- 1.80 Bupa's experiences in launching its Ophthalmology network in 2007 and its Low Cost Network in 2011 provide examples of how hospital groups can undermine the effectiveness of insurer networks.

Investments have been made to improve the ability to guide patients, although challenges remain

- 1.81 Bupa has invested in developing the ability to guide patients during the patient journey to providers offering high quality, affordable care e.g. our Open Referral service launched in 2011. This improves the incentives of hospitals and doctors to compete. While this service is receiving very positive feedback from customers, it is facing significant resistance from some providers. This service is still in its infancy and is not yet on a scale to provide effective discipline on hospitals. Key challenges to overcome are: the lack of comparable information on hospital quality; entrenched hospital market power in certain local areas because there are simply no alternative providers to which the patient can go; and, entrenched referral patterns (e.g. because of consultants being tied into particular hospitals through financial and non-financial incentives).

THEORY OF HARM 4: BUYER POWER OF INSURERS IN RESPECT OF INDIVIDUAL CONSULTANTS

- 1.82 The CC explains that it wants to assess whether insurers' reimbursement limits are below those that would prevail in a competitive market, which could lead to a reduction in supply and quality.

1.83 Before summarising our evidence on this point (which is set out in more detail in Section 6) it is important to note the following:

- i. It is well understood in economics that, in almost all cases, buyer power is in the interests of consumer welfare³¹. Consumers benefit directly from lower prices, superior quality and often through enhanced innovation. The gains flowing to consumers increase with the degree of competition in the buyer's market, with even a monopoly buyer passing through a significant proportion of gains to consumers³². It is unsurprising that suppliers complain about buyer power and request for competition authorities to intervene. However, competition authorities should only do so if there is overwhelming evidence that consumers are made worse off by the buyer power. These cases will be extremely rare, as noted by the OFT³³.
- ii. Consultants are in a position of significant market power themselves relative to the patient (see discussion on Theory of Harm 3). Therefore, any alleged distortion from an insurer's use of buyer power should be weighed against the significant market distortion that would result if the insurer was restricted from commissioning care on its customers' behalf.
- iii. Bupa has a long term view and understands that effective provision of PH requires a diverse range of value for money consultants (and hospitals). It is not in our members' interests for us to suppress PH supply or push consultants offering high quality, affordable care from the market, as our members will have to bear the consequences.
- iv. Bupa has to demonstrate value for money from PH continuously to keep customers in the market and to attract new ones. We cannot compromise on quality.

The use of benefit maxima to manage costs

1.84 Bupa employs a publicly available schedule of benefit maxima which sets out the maximum we will pay a consultant for a particular treatment depending on complexity. However:

- i. These maxima only impact a portion of the fees we pay to consultants. Under 50% of Bupa's spend with consultants in 2011 was on treatments on which benefit maxima apply.
- ii. A number of consultants still choose to charge above the maxima where they do apply.
- iii. Benefit maxima relate only to the unit price of an episode of treatment, and do not relate to the volume of episodes a consultant delivers to patients.

³¹ The UK submission, prepared jointly by the OFT and CC, to the OECD roundtable on Monopsony and Buyer Power in 2008 notes that "Buyer power can be seen as presumptively benign and harmful only in rare cases" (p232), and that "Buyer power mostly serves to reduce prices or otherwise increase competitive tension in the marketplace. It is no surprise, therefore, that businesses will lobby for its removal. Just as when assessing exclusionary abuses, it is essential for competition authorities to ensure they intervene only when necessary to protect the process of competition, in the interests of consumers, rather than protecting competitors and suppliers" (p242). Available at <http://www.oecd.org/dataoecd/38/63/44445750.pdf>

³² The PMI market is competitive meaning that almost all gains from buyer power flow through to consumers.

³³ The OFT indicates: "Although, in principle, charging excessively low purchase prices could constitute an abuse of a dominant position, the OFT considers that it is only likely to do so in exceptional circumstances. In the absence of barriers to exit by suppliers from the relevant market, a purchaser which paid excessively low prices would be unable to obtain supply beyond the short term even if it was a monopsonist. Hence the OFT considers that excessively low purchase prices will normally be self-correcting and would not, absent price discrimination, usually justify action under Chapter II of the CA98 (although the OFT will of course consider each case on its own merits)." OFT decision in BetterCare Group Ltd/North & West Belfast Health & Social Services Trust, December 2003, para 56.

- 1.85 Therefore, the majority of consultants retain significant commercial freedom³⁴, particularly in the volume and type of treatment they prescribe.
- 1.86 Benefit maxima are necessary because of the lack of competition between consultants, the weak negotiating position in which patients find themselves, and the practice of consultants not informing patients about fees in advance³⁵. Maxima also allow insurers to give clarity to both the patient and the consultant up front about what will be reimbursed. This is particularly important given that the insurer – the funder – is typically excluded from any conversations on price by the consultant. In a world without maxima we would expect consultant fees to rise across the market, with a negative effect on patients in terms of the affordability of PH and PMI.
- 1.87 The competition authorities have previously found that benefit maxima are a reasonable tool to control consultant costs:
- i. In 1994, the Merger and Monopolies Commission (MMC) confirmed benefit maxima were not against the public interest. The MMC report (para 1.11 and 11.125) states³⁶:

“...we find that the setting of the BUPA benefit maxima is a legitimate step by BUPA in carrying out its functions as an insurer. Insurers must be able to inform policy-holders of the benefits they will receive if they claim for events that are covered by their policies. BUPA and the other insurers are the principal counterweight to the consultants, given the weak position of patients. The BUPA benefit maxima have had a restraining effect on consultants’ charges.”

“...given the weak bargaining position of patients and the comparatively strong position of many consultants each within his own area...we expect that consultants would be able to resist any attempts by insurers – and even an insurer of the size of BUPA – to reduce their charges below a competitive market level...we are satisfied that it [the setting of benefit maxima] provides a safeguard against overcharging by consultants but does not, and is not likely to, unreasonably depress their charges.”
 - ii. The OFT reassessed the MMC’s findings in 1999 and concluded³⁷:

“...the BUPA Benefit Maxima remain valid and that the removal of BUPA’s Benefit Maxima, with no comparable replacement, would lead to significant increases in consultants’ fees.”
- 1.88 Bupa accepts that benefit maxima are not a perfect instrument. We want to link reimbursement to the quality of care the consultant provides. However, there is an absence of the comparable information on consultant quality, and so rarely are there grounds to justify paying one

³⁴ Bupa changed its consultant recognition criteria in 2010, with one aspect of the change relating to the consultant committing to charge within the maxima. Over 2,750 new consultants have been recognised on this contract since June 2010 and a further 830 already-recognised consultants have asked to move to this new contract. Only for these consultants would the benefit maxima be contractually binding.

³⁵ Maxima provide an important control on the fees for episodes of treatments when the patient is further down the treatment journey (i.e. mid treatment), as at this point the patient has little alternative choice and no real negotiating power.

³⁶ Monopolies and Mergers Commission, “Private Medical Services – a report on agreements and practices relating to charges for the supply of private medical services by NHS consultants”, 1994, p1.11.

³⁷ OFT news release, November 2009, available at http://www.of.gov.uk/shared_of/market-studies/40_99.pdf (accessed June 2012).

consultant more than another³⁸. As long as consultants fail to collect and publish this data, we do not see an alternative reimbursement mechanism being possible.

No evidence that insurers have too much buyer power

- 1.89 The concern that insurers have too much buyer power is without merit.
- 1.90 First, there is no evidence insurers indiscriminately delist consultants. Insurers must offer patients as many consultants offering high quality, affordable care as possible. However, it is an insurer's responsibility to delist consultants in circumstances when the consultant places the patient at risk. Delisting, therefore, is a necessary action a responsible insurer must sometimes take to benefit patients. Even in these circumstances Bupa would give the consultant an opportunity to explain his or her actions prior to being delisted. Bupa also has an appeal process available to consultants if they believe they have been delisted unjustly.
- 1.91 It is noteworthy, for example, that a FIPO consultant survey in 2010 showed how rarely consultants are delisted³⁹. Of the 765 respondents, 95% had never been delisted by an insurer, and 81% had never even been threatened to be delisted by an insurer. Bupa had proposed to delist under 3% of respondents, and actually had delisted only 3 individuals (less than 0.3% of the sample).
- 1.92 Second, the number of consultants available for private practice has remained strong despite the shrinking number of people using PH (it must be emphasised that the number of lives covered by PMI is now at similar levels to those in the mid-1990s). Indeed, Bupa has recognised over 2,750 new consultants since June 2010. There is no evidence of a shortage of supply being created. Further, as a significant number of consultants are willing to come into the market and commit to charge the benefit maxima (and a large number of existing consultants already do), this suggests the maxima are not depressed below competitive levels.
- 1.93 Third, consultant earnings have remained robust despite the growing number of consultants serving the market, the declining number of PMI subscribers in the market, and the effects of the recession. Research by Independent Practitioner Today, for example, shows that each of the consultant specialisms they monitor saw stable profits (after practice expenses like medical indemnity insurance) from private practice over the period 2005 to 2010. Few other small businesses in the UK can claim similar success through this recession.
- 1.94 Bupa is also not aware of any evidence showing that UK consultants' private earnings are significantly out of line with peers in other advanced economies⁴⁰.
- 1.95 Fourth, there has been significant medical technology improvement over the period. In many cases these advances have reduced the length and complexity of surgical episodes, which should have put downward pressure on fees.
- 1.96 Finally, consultants may want fees to rise, but with the industry spend on consultants totalling over £1 billion, it is clear that consultant fee inflation would quickly translate into significant

³⁸ We do engage with, and sometimes pay more to, consultants who believe they have robust evidence that they should be paid a higher amount (e.g. because a particular treatment was more complex than normal due to patient complications).

³⁹ FIPO Consultant Survey into Current Private Medical Insurance Trends, Detailed Review of Results, May 2010, available at <http://www.fipo.org/docs/axa-ppp/survey-detail-may-2010.htm>.

⁴⁰ International benchmarking of private practice incomes is clearly challenging due to differences in healthcare systems, but what analysis there is appears to indicate UK consultants' private earnings compare very favourably with peers overseas.

additional premiums increases for insured patients. This would be unsustainable for the market. When Bupa has made upward adjustments to benefit maxima previously, consultants have quickly adjusted their pricing behaviour to capture the gains⁴¹.

The launch of Open Referral to improve choice and competition

- 1.97 Bupa introduced Open Referral in 2011 at the request of a corporate customer. The customer wanted more cost-effective healthcare for its employees and fewer shortfalls, while not compromising on the quality of consultants or level of benefits offered to its employees. This would allow the client to offer PMI to more of its employees. Open Referral helps meet these needs and has received very positive patient feedback, as well as achieving significant savings for clients.
- 1.98 In the Open Referral process, rather than a Bupa member being referred to a single named consultant by the GP, the referring GP specifies the clinical need (the clinical speciality, sub-speciality and whether an appointment is urgent) and Bupa then gives the member a choice of two or more consultants offering appropriate care at convenient locations. Bupa uses its claims database, augmented with additional quality data, to match a patient's requirements with relevant consultants in the local area. The patient will be offered a selection of two or three consultants located convenient to them who practice within the norms of their specialty (after taking into account case-mix). The patient will be guaranteed not to face a shortfall. The patient is not obliged to choose only from the options we recommend and can see other consultants (provided they are Bupa recognised) for continuity of care reasons or if his or her GP considers there to be an objective clinical reason (which would need to be explained to Bupa). In the vast majority of cases patients have been highly satisfied with the options recommended – survey evidence shows that 93% of patients 'strongly' (79%) and 'slightly' (14%) agree that the "choices given were suitable for me" with only 1% disagreeing. At June 2012, we had had only [X] GP escalations about the recommendations we have made from the many tens of thousands of referrals to date.
- 1.99 The Open Referral service is a step towards addressing the significant information asymmetries that face GPs about the cost or quality of private consultants. The lack of comparable data on cost or quality available to GPs means that 'named' referrals can seldom be made on complete information. The GP is highly unlikely to know the typical end-to-end treatment practices and costs for every consultant in the local area. Nor can GPs be expected to have this wide-ranging knowledge given the changing number of consultants in the market, the large number of specialisms and sub-specialisms, and the small percentage of private patients a GP will see within his or her daily NHS rota. This, however, does mean that patients may sometimes be referred to one consultant by the GP where a consultant offering better, more affordable care was available.
- 1.100 Bupa can use its large database of previous patient experience together with its clinical expertise to provide a richer amount of information to patients on which to choose the consultant. The Open Referral service is enhanced daily as our database gets richer. In the very rare cases, amongst the tens of thousands of successful referrals, where a patient/clinician feels we offered an inappropriate choice we can quickly update our records to avoid the

⁴¹ For example, in January 2001 Bupa increased a number of benefit maxima for anaesthetic procedures by 20% overall. While there was a short term reduction in the number of anaesthetists shortfalling above the benefit maxima, the rate of incidence rapidly returned to pre-adjustment levels. This left patients paying more across the board for treatment, and still facing shortfalls.

situation arising again. We actively encourage patients and consultants to engage with us to enhance the data in the system⁴².

1.101 Therefore, Open Referral is giving patients choices based on more information. However, to be clear, Open Referral could be significantly improved further if all consultants in the UK provided:

- i. objective data on their activity in private practice (linked to NHS activity as well, where possible);
- ii. objective and comparable data on their treatment outcomes; and
- iii. common coding of impairments (i.e. the conditions of patients before treatment).

1.102 Therefore, consultants should still be obliged to fill the information gap created by their failure to publish information on quality.

1.103 Open Referral is in its early stages and currently offered to corporate customers only. However it is delivering excellent results and consistently high patient satisfaction. It is meeting a clear customer need. Around 8 out of 10 of our corporate clients are choosing this option at renewal, meaning that, as of mid July 2012, over 500,000 of our corporate members are now eligible to use the service.

THEORY OF HARM 5: BARRIERS TO ENTRY AT DIFFERENT LEVELS

Barriers exist at the hospital level

1.104 Bupa considers there are significant barriers to entry for hospital operators in PH provision⁴³. Some structural barriers are natural features of local markets – for example, certain localities do not have sufficient PH demand to support more than the existing hospital. Of greater concern, however, are the non-structural barriers that are erected strategically by incumbent hospital operators. These restrict efficient entry even when entry could have been possible, and they also restrict the expansion of smaller rivals.

1.105 The CC should pay particular attention to the following barriers:

- i. **A lack of comparable information on hospital quality.** Private hospitals produce very little data that allows direct comparison between hospitals in terms of quality. Private hospitals trail the NHS in publication of data significantly. This makes it difficult for a new efficient entrant to differentiate itself objectively in the eyes of patients, GPs, consultants or insurers. It is not rewarded for offering better service by capturing increased patient volumes. The main hospital groups make much of the Hellenic Project as a solution, although there is no evidence this project is delivering results (and in fact it has significant shortcomings).

⁴² It must be emphasised that in those extremely rare cases where the patient feels we have sent them to the wrong consultant, there is no patient safety risk. The patient would simply alert us of the error and we would send them to someone more appropriate.

⁴³ We discuss the issues of entry barriers into the hospital level in Section 6 of our submission.

- ii. **“One in, all in” negotiation strategies by the main hospital groups (who each own ‘must have’ hospitals).** Such strategies disadvantage rivals and potential entrants in these local markets, as they now have to share patient volumes with the group’s facility even where the rival offers better value for money. “One in, all in” outcomes can also be put into effect by the hospital group through the pricing schedule it offers the insurer. For example, prices on the whole hospital portfolio may increase rapidly if the insurer does not meet existing volume benchmarks with the hospital. This makes it costly for the insurer to direct any volume away from the hospital group, which creates a barrier for rivals.
- iii. **Strategies that entrench consultant and GP patient referral patterns.** There is evidence of incumbent hospitals using schemes to make it costly for a consultant or GP to refer patients to other facilities. For example, consultant incentive schemes that offer the consultant a profit share on the incremental income of each patient he or she sends to the hospital create a cost of switching for the consultant. These strategies limit patient choice directly and create a barrier to entry for rivals. Bupa considers both direct financial incentives and indirect benefits to a concern, as both can have the effect of tying a consultant/GP to a particular facility. Bupa is also concerned about the trend of hospital groups acquiring or aligning with GP practices e.g. in London HCA has acquired Rood Lane, General Medical Clinics, and taken a financial interest in Blossoms Healthcare.
- iv. **Contractual clauses and threats** that restrict the ability of insurers to make available volume to new entrants. Bupa has worked hard to remove clauses in contracts that limited its ability to work with independent hospitals that offer better value for money. However, concerns remain. For example [redacted] contract with Bupa includes provisions that restrict Bupa’s ability to offer products that do not include [redacted], which effectively puts other hospitals at a disadvantage.

1.106 These entry barriers lessen competition and choice. Concentrated local markets remain concentrated. Supply-side substitution into new specialisms is limited even for operators already present in the market. Inefficient hospitals are sheltered from market forces, allowing high costs to remain in the market, while more efficient entrants and care models are prevented from expanding. And insurers are left with weaker bargaining power against incumbent operators.

1.107 Bupa notes that some hospitals told the OFT that difficulties in getting absolute assurance of recognition by an insurer in advance of building the hospital may deter new entry⁴⁴. Bupa understands the concern, but does not believe it is reasonable to expect insurers to ‘guarantee’ recognition, in advance, to a hospital that is still being built. The hospital needs to demonstrate it meets minimum quality and commercial standards operationally before it can be recognised, otherwise our members are put at risk. The insurer would be placed in a very difficult situation legally if, once built, a hospital that had been guaranteed recognition was found to be substandard. So insurers cannot be expected to provide an ‘absolute assurance’. However, new entrants can take comfort from Bupa having a strong incentive to recognise a new hospital that offers value for money. We work with new entrants to understand the local market, providing insight and data where appropriate. This is, for example, evidenced by our support for, and recognition of, the Circle hospital in Bath.

⁴⁴ OFT MIR Decision (para 8.19): “...smaller PH provider groups state that they are unwilling to risk the costs of setting up a new PH facility without an absolute assurance of PMI provider network recognition”.

Barriers exist at the consultant level

1.108 There appear to be some barriers for consultants to enter private practice generally and to enter certain local markets. Over 85% of consultants work in the NHS and have NHS time commitments which limit the amount of time available for private practice. Consultants may struggle to enter particular local markets if there are no relevant vacancies in NHS facilities in that area. Consultants also face barriers to entry into local markets given the lack of competition between consultants on either price or quality dimensions. This can make changing GPs' existing referral patterns challenging and can slow the development of a practice.

THEORY OF HARM 6: LIMITED INFORMATION AVAILABILITY

1.109 Bupa has significant concerns that consultants and hospitals in private practice have failed to produce data that allows patients, GPs and insurers to evaluate and compare the quality of the treatments they perform and the care they offer, as well as the cost.

1.110 This gap in information weakens competition and choice, protects incumbent providers, and puts patients at risk. It also creates the perverse result that patients sometimes incorrectly assume price is a signal of quality. So incumbent providers profit from this gap, which explains why so little progress has been made during the past decade to address it. The private sector continues to lag the NHS, and private sectors in other countries, in this area.

1.111 Greater transparency of information is fundamental to empowering patients (and the commissioners of care on their behalf). It is also fundamental to the industry being able to self-diagnose and address poor treatment practices⁴⁵. Finally, improved information on quality would allow the sector to better articulate to customers its strengths (critical to explaining value for money and stemming declines in the PMI market).

1.112 An illustration of the potential gains for patients from this comparative data is that one of the few specialisms – Cardiothoracic Surgery – that has focused on robust collection of data on consultants' clinical outcomes identifies this data as a key reason for a 50% reduction in risk-adjusted mortality in the treatments provided⁴⁶. The routine collection and study of quality information improves practice and patient outcomes.

1.113 We explain in Section 4 where the key information asymmetries exist in the patient journey (for example, the fact that 79% of GPs tell us that they would find it helpful to have more information on consultants' clinical performance and clinical outcomes⁴⁷). Section 4 also discusses the differing abilities and incentives of players on the journey to use the information. There are clearly limits, for example, on the amount of time GPs can dedicate to gathering data on private providers in the local area and in informing private patients of options during short NHS appointments.

⁴⁵ We have discussed above our concerns about unwarranted treatment variation. This issue exists in part because of the lack of information through which to monitor and challenge treatment practices.

⁴⁶ See The Society for Cardiothoracic Surgery in Great Britain & Ireland (2011), "Maintaining patients' trust: modern medical professionalism", available at http://www.scts.org/_userfiles/resources/634420268996790965_SCTS_Professionalism_FINAL.pdf (accessed May 2012).

⁴⁷ KantarHealth Survey commissioned by Bupa, December 2011/January 2012. Base: 397 GPs

Failure to deliver information to patients is a key concern

1.114 Bupa is also concerned that some providers do not give sufficient information and choice even where it does exist. Failure to provide information on fees and conflicts of interest is a fundamental concern. There is evidence also that consultants do not give full information to patients on the choices of venue in which care can be provided⁴⁸ or on the different options the patient may have for treatment.

Information asymmetries have negatively impacted insurers

1.115 As an insurer, Bupa sees the challenges of engaging constructively with consultants and hospitals on fees and treatment practices in the absence of information on quality. Bupa would happily pay more to providers who could objectively demonstrate they offer superior care and outcomes. At the moment, however, it is challenging to identify and monitor better quality from providers. In fact, we consider it unreasonable to expect an insurer to have to prove why it is not paying a consultant more. In the majority of markets it is the duty of the supplier to justify its fee to the buyer by demonstrating why its quality is superior (why the reverse should be expected in PH is unclear).

1.116 The information gap limits Bupa's buyer power. It also imposes costs on Bupa and its members in trying to bridge the gap (where possible) to improve decision making.

The Hellenic Project is unsatisfactory in its current form

1.117 Bupa echoes the OFT's concerns in its MIR Decision (para 5.34) on the Hellenic project – the data delivered needs to be comparable with the NHS, participation needs to be mandated for all providers not just the main five hospital groups who have controlled the design thus far, and it needs a committed deadline as it has taken too long to bear any fruit. We emphasise the importance that the data should be presented at a facility level, not at a hospital group level, so that any underperformance by a specific hospital cannot be hidden within aggregate numbers.

THEORY OF HARM 7: VERTICAL INTEGRATION

1.118 The CC notes that it is keeping an open mind about whether any vertical theory of harm exists in the market. The CC specifically names Bupa's ownership of the Cromwell hospital as an example of a vertical relationship, although it notes that it does not believe at this stage that these linkages would cause significant harm to competition.

1.119 We see no evidence that our ownership of the Cromwell is negatively affecting consumers or distorting competition. In addition, we do not have vertical integration at an operational level in terms of patient flows or funding between the Cromwell and BHW.

1.120 However, we strongly believe that vertical linkages between the funding and provision of healthcare can deliver substantial benefits to patients by better aligning the incentives of both sides to deliver high quality and affordable care. Linking the insurer and the hospital better aligns the incentives of the hospital to deliver high quality and affordable care (as the hospital

⁴⁸ 48% of respondents to the OFT Consultant Survey said they never give patients a choice on the hospital in which treatment takes place. Cancer patients, for example, have told Bupa about the benefits (both financial and emotional) of receiving chemotherapy at home rather than in hospital. Yet the treatment option appears to be seldom offered by consultants.

shares in the benefits of the insurer's success in attracting and retaining customers), instead of the hospital simply seeking to maximise treatments and profits as can be the case when it is independent. Similarly, when the insurer employs salaried consultants, these consultants have a stronger incentive to manage costs and quality than those working on a fee for service basis, cutting out any unnecessary overtreatment and waste.

- 1.121 We have seen substantial efficiency gains in Spain through the integration of our Sanitas subsidiary's insurance business with three hospitals and 17 smaller medical/diagnostic centres. As a result of this model, Sanitas has observed enhanced patient satisfaction scores, improved quality performance (e.g. the Sanitas hospitals have [redacted] lower mortality rates than other benchmark hospitals), and cost-effective treatment practices (e.g. [redacted]). The insurance business has seen significantly lower policy lapse rates in this customer group using the Sanitas provision than in the wider PMI population. Therefore, customers have enjoyed the benefits of the model through high quality care at more cost effective prices. In the US there is also evidence of this integrated insurer-provision model delivering benefits e.g. Kaiser Permanente and Geisinger Health.
- 1.122 Of significant concern to Bupa, however, are the vertical linkages between hospitals and consultants/GPs. We have discussed above consultant (and GP) incentive schemes which have the effect of tying a consultant (GP) to a hospital. These vertical linkages can entrench referral pathways, build entry barriers, and can lead to unnecessary over-treatment and over-diagnosis. There is evidence also that hospitals are actively integrating down the referral chain through acquisition of private GP practices. HCA, for example, purchased the Rood Lane private GP practices in London in 2011, a stake in Blossoms Healthcare in 2012 and General Medical Clinics in 2012.

THE CHANGE WE BELIEVE IS NECESSARY IN THE MARKET

- 1.123 The CC's investigation comes at a critical time for the private healthcare sector. The CC has the powers to address some of the deep-rooted issues that are currently causing the sector to perform poorly for consumers. Patients, GPs and insurers are not able to solve these issues on their own. This is an opportunity to put the sector on a more sustainable footing by injecting competition where possible and improving the quality of choices available to patients and GPs.
- 1.124 Bupa appreciates that the CC will only consider the design of remedies towards the second half of its Market Investigation. However, below we briefly set out some actions we believe would enhance the welfare of consumers significantly.

Necessary actions that will directly address existing market failures

- 1.125 'Must have' hospitals enjoy significant local market power over the patients they serve and confer to their owners significant bargaining power in negotiations with insurers. Obligations should be placed on 'must have' hospitals in relation to their terms of supply and pricing to counteract this market position and the negative effects of "one in, all in" negotiation.
- 1.126 [redacted]
- 1.127 Clear guidelines on what types of consultant/GP incentive schemes are anticompetitive and which are acceptable must be set out. In addition, individual hospitals and consultants should be obliged to declare publicly and transparently each year the incentive schemes that are in place.

- 1.128 The CC should make it clear that clauses in hospital contracts that restrict the ability of insurers to offer choice to customers are not acceptable.
- 1.129 The responsibilities on consultant groups (particularly anaesthetist groups) which are dominant within their local markets must be set out. It is too costly for patients and insurers to take Competition Act cases against groups individually.
- 1.130 The CC could acknowledge the important role insurers like Bupa have in commissioning care on patient's behalf.

Information transparency

- 1.131 Improving the information available to patients, GPs and insurers about consultant and hospital performance and quality will lay foundations for better decision making, choice and competition.
- 1.132 Producing this information, in a standardised way, must be mandatory for all private providers to allow comparisons. It must also be at a sufficiently granular level, ideally consultant-by-consultant, to make meaningful decisions (and to prevent poor performance being hidden behind aggregated, grouped numbers). Ideally it must link in with data in the NHS to allow comparison between the NHS and PH, and to monitor patients moving between the NHS and PH.
- 1.133 Bupa believes data should be provided in its most granular, raw form, rather than in metrics manufactured by the providers. Insurers and third parties (e.g. Dr Foster) could then compete and innovate in how this raw data is analysed and presented to patients. This will also manage the risk that a specific metric becomes out-dated and irrelevant (e.g. because of medical technology change).
- 1.134 Bupa believes significant steps can be made by using datasets and coding structures already in place. Therefore, Bupa believes there are workable solutions, which we would be happy to discuss with the CC.
- 1.135 Critically, however, **information transparency is part of a solution, but is not sufficient on its own**. It will not solve some fundamental issues of entrenched market power. Its impact will be gradual (taking years) where the market needs more urgent, targeted change. The issues of local market power of hospitals, the impact of 'one in, all in' negotiation tactics by the hospital groups, consultant incentive schemes, and consultant groups need to be tackled directly. If these features are allowed to persist, improved information transparency will have relatively little value to patients.

2. INTRODUCTION

- 2.1 Bupa believes that there is currently wide scope for improvement in the supply of PH that would benefit consumers and enable more people to afford access to private healthcare. Competition in PH provision is being undermined by market failures (such as local market power and information asymmetry) and the exclusionary conduct of certain hospital and consultant groups. These concerns are noted by the OFT in its Market Investigation Reference (MIR) Decision. The OFT recognised also that many of the features that distort competition are interlinked and act in combination. Insurers and patients do not have the buyer power necessary to address the deep-rooted, interlinked failures in PH provision. Far-reaching intervention is required from the Competition Commission (CC).

Bupa is committed to the long-term sustainability of the PH market in the UK

- 2.2 Our organisation was founded in April 1947, when 17 provident associations joined together to create Bupa with the Articles of Association to “prevent, relieve and cure sickness and ill health of all kind”. Today, the Bupa Group is an international healthcare company active in PMI, healthcare provision and care homes, and the focus of our purpose is **to help people live longer, healthier, happier lives**.
- 2.3 We are focussed exclusively on health and care, which we see as a critical differentiator from other multi-line insurers. As **an organisation without shareholders**, we reinvest all surpluses in providing more accessible and affordable healthcare and in providing access to advice and care that is right for each person.
- 2.4 **Bupa takes a long-term view**, which we believe is needed in an industry like healthcare.
- 2.5 We have been active in UK healthcare for over 60 years. Today, our subsidiary Bupa Health and Wellbeing UK (BHW) represents the interests of over 2.5 million people with PMI in the UK; talks to over 3.5 million people annually in its call centres; and serves over 125,000 thousand people annually through a network of wellness centres across the UK. Bupa also owns the Cromwell hospital in London and funds some treatments in the UK to expatriate customers through our international PMI business, Bupa International.
- 2.6 We operate strong corporate governance processes to ensure appropriate standards are maintained throughout the organisation. We are regulated by a number of bodies including the Financial Services Authority (FSA), the Financial Ombudsman Service and the Care Quality Commission (CQC).
- 2.7 As a commissioner of care, we have a responsibility to make available high quality care at affordable prices. BHW works actively to commission high quality, affordable care for our members from over 19,000 consultants and over 400 separate hospital operators each year. The doctors in BHW, who are regulated by the General Medical Council (GMC) and the CQC, work closely with our managers and in-house analytics teams to help us understand what care is being received by our members and to take action where we believe that care can be improved.

Structure of submission

2.8 We set out our evidence in the following sections:

- i. The Executive Summary links our evidence to each of the Theories of Harm set out in the CC's Issue Statement.
- ii. After this introduction (Section 2), Section 3 explains the challenging market context in which insurers must commission care on behalf of their customers.
- iii. Section 4 explains the patient treatment journey in PH. The incentives and dynamics along this journey are crucial to understanding how competition functions in PH.
- iv. Section 5 explains how Bupa manages its relationships with hospitals. We explain why the large hospital groups have significant market power against which patients and insurers do not have countervailing power.
- v. Section 6 explains how Bupa works with consultants. It presents evidence on why consultants are in a strong market position, and how some consultants take advantage of this position to the detriment of patients.

3. UNDERSTANDING THE MARKET

- 3.1 The UK PH market plays a crucial role alongside the NHS in delivering quality healthcare to UK consumers. A thriving PH market is in the interests of everyone in the UK. Consumers gain choice and flexibility in how they access care, businesses gain productivity from healthier workforces, and the resource-constrained NHS benefits from a partner in delivering care to the UK population.
- 3.2 In its current form, however, the PH market is unsustainable.
- 3.3 **Fundamental needs of consumers and corporates – affordability and value for money – are not being met.** As we highlight below, continued healthcare cost inflation means that the number of consumers and businesses priced out of PH is growing. This harms those priced out of the market, but also those remaining in the market who have to bear a greater share of cost.
- 3.4 Yet the PH provider market is not demonstrating sufficient agility or competitiveness to respond to these concerns. In fact many consultant trade bodies and hospital groups actively resist initiatives seeking to give improved value for money PH because of a perceived threat to their own short-term economic interests.
- 3.5 This section sets out the market context in which the negative effects of the market failures must be assessed. It explains that:
- i. **There is continued upward pressure on healthcare spend:** Rapidly rising healthcare costs in the UK is a reality that the PH and PMI markets must be ready, and able, to address.
 - ii. **The PMI market in the UK is fragile:** PMI plays a critical role as a gateway through which the vast majority of customers access PH. However, the PMI sector faces a number of structural and affordability challenges which has resulted in a PMI market in decline.
 - iii. **Value for money (quality and cost in combination) is a critical factor affecting the take up of PMI:** The debate on the future of PH must focus on both quality and cost dimensions, as both needs must be met to retain existing PMI customers and to attract new ones. However, GPs, consultants and hospitals in the patient pathway do not tend to consider cost, with potentially harmful long term consequences. We include evidence that customers are being priced out of the PMI market, and that existing customers are reaching the upper limit of what they are willing to pay for PMI.
 - iv. **There is a vicious cycle facing the PMI and PH markets:** As the PMI markets shrinks, existing customers are left with higher premiums to cover, leading to further shrinkage. This cycle will accelerate if action is not taken to manage costs and improve quality. External intervention is required to neutralise this cycle; **it will not self correct.**
 - v. **The PMI market is highly competitive:** PMI providers compete intensely on value for money to customers. The majority of customers are sophisticated purchasers, price sensitive buyers. Health insurers trade on thin margins, with nearly 80% of every pound of premium income passing through to hospitals and consultants. So

insurers have little choice other than to pass through healthcare cost inflation to customers.

- vi. **A response is needed to the challenges:** Competitive forces must be allowed to push inefficient provision capacity and anticompetitive practices from the market. A simple consolidation of existing models and practices (e.g. the concentration of power in the hands of certain hospital groups through mergers) in this shrinking market will only increase the speed of decline.

There is continued upward pressure on healthcare spend

- 3.6 The dynamics and performance of the PH market need to be assessed against the tide of increasing healthcare funding pressures. Almost 80 pence of every pound of PMI premium is accounted for by healthcare costs; making it the primary driver of PMI premium inflation⁴⁹.
- 3.7 Both demand- and supply-side factors have driven, and are expected to continue to drive, healthcare costs upwards. Figure 1 illustrates some of the main macro level drivers:
 - i. On the demand-side, the need for healthcare is rising as populations live longer, face higher rates of obesity and the mounting burden of chronic diseases like diabetes and cancer. Consumer expectations of healthcare services also continue to increase.
 - ii. On the supply-side, new healthcare technologies and innovative drugs have improved patient experience and outcomes, but have not necessarily removed cost from the system. Many innovations increase the overall cost of the system by augmenting or complementing existing treatments (and so enlarging the options for care) rather than replacing existing treatments. The supply side of markets is also challenged by the conduct of parties with misaligned incentives⁵⁰.

Figure 1: [✂]

- 3.8 As an example of the upward pressure on healthcare costs, recent research by Bupa suggests that the costs of cancer diagnosis and treatment in the UK will increase by over 60% in real terms by 2021⁵¹. Both the NHS and private sector, supported by the voluntary sector, will need to find new resources, and better utilise existing resources, to meet this future cost.
- 3.9 To be sustainable, healthcare systems need to respond to these healthcare cost drivers. They must be:
 - i. positioned to accommodate the effects of those drivers that are unavoidable (e.g. population aging and new technologies);
 - ii. ready to minimise the effects of those drivers that can be influenced (e.g. helping people find a healthy lifestyle); and

⁴⁹ Laing and Buisson (2010-11) notes that across private medical insurers in the UK the loss ratio (claims costs relative to premium income) was 79% in 2009. The industry loss ratio has been around this level through the past decade.

⁵⁰ For example, hospitals and consultants benefit from a fee-for-service model which can incentivise more treatments rather than better treatments. Similarly, hospitals may discourage a movement of care into 'as effective', lower cost setting if this leaves hospital beds empty.

⁵¹ Cancer Diagnosis and Treatment: a 2021 projection, research by Bupa conducted 2011 (available at http://www.bupa.com/media/355766/cancer_diagnosis_and_treatment_-_a_2021_projection_-_final.pdf).

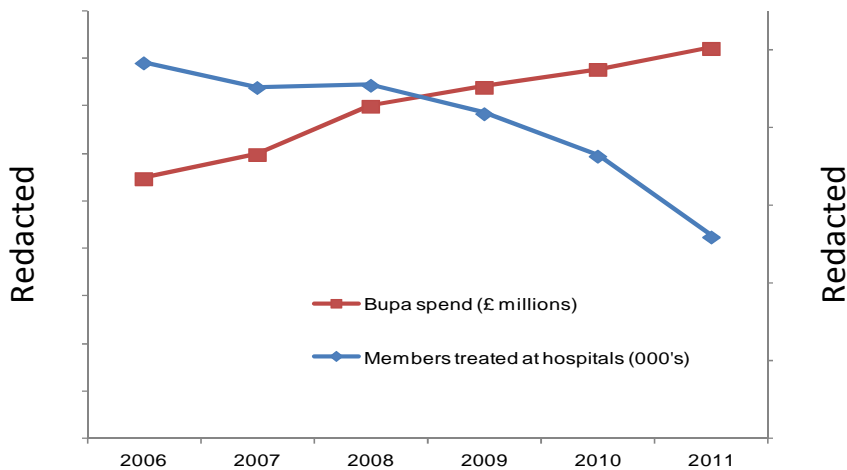
- iii. able to remedy those drivers that can be addressed directly (e.g. eliminating wasteful spend, vested interests and practices that unnecessary inflate cost).

3.10 The healthcare system in the UK faces these pressures, demonstrated by spend on public and private healthcare accounting for 9.8% of gross domestic product in 2009 with this spend growing in real terms⁵². On the public side, the Government has responded by requiring substantial efficiency savings from the NHS. On the PH side, however, the market is showing little agility or restraint. Total spend on PH has increased rapidly through the past decade as shown in Figure 2 while at the same time the PMI market has been relatively static (and is now in sharp decline). Hospital revenues account for approximately 70% of overall PH costs and these have grown most significantly in real terms⁵³.

Figure 2: [Redacted]

3.11 Figure 3 shows that BHW's spend with hospitals has increased even as the number of Bupa members treated by hospitals has reduced (due to the declining PMI market).

Figure 3: Bupa spend at hospitals, 2006-2011



Source: BHW claims data

3.12 Given the constraints on funding in the NHS, there exists an important opportunity for PH to grow its role in delivering high quality healthcare to consumers in the UK. However, as will be discussed below, this can only happen if PH is affordable for a greater number of people.

The private medical insurance market in the UK is fragile

3.13 Currently around 80% of people access PH through having PMI cover. PMI gives consumers the necessary cost savings from the diversification of risk across a pool of people (risk sharing) and the purchasing power of the insurer (relative to an individual). Without these cost savings PH would be beyond the means of most consumers; particularly as the treatment of certain conditions like cancer can run to tens of thousands of pounds, with the total costs of care

⁵² Between 2000 and 2009, health spending per capita in the United Kingdom increased in real terms by 4.8% per year on average, almost one percentage point faster than the OECD average (4.0% per year). OECD Health Data 2011 available at <http://www.oecd.org/dataoecd/46/4/38980557.pdf> (accessed May 2012).

⁵³ [Redacted]

uncertain when treatment begins. Therefore, **a healthy PMI market is critical to PH** (and vice versa).

- 3.14 However, the PMI market in the UK is fragile. As shown in Figure 4 the number of lives covered by PMI has remained largely static through the 2000s and has fallen significantly during the recession⁵⁴. **In terms of lives covered the market is now the same size as in the mid-1990s, with the proportion of the UK population with PMI is at its lowest levels in nearly 20 years.** These headline numbers tell only part of the story. There has also been **substantial down-trading of cover** in the market in recent years making the extent of decline even greater⁵⁵. As will be discussed below, the decline is driven to a significant extent by rising PMI premiums, which are in turn driven by rising healthcare costs.

Figure 4: [X]

- 3.15 The PMI market serves personal customers (individuals covering themselves and their families), small businesses (SMEs) and large corporates.
- 3.16 The number of personal customers buying PMI has fallen significantly over the past 15 years – declining from 2.5 million lives covered in 1995 to 1.6 million in 2010⁵⁶. This structural decline is set to continue. The business-to-business (B2B) segment showed some moderate growth over the period 1995 to 2010 – from 4.4 million lives covered in 1995 to 5.2 million in 2010 (having reached a peak pre-recession of 5.8 million lives covered) – although continued economic uncertainty is causing significant decline in this segment. Currently the B2B segment accounts for approximately 70% of the PMI market by sales income and over 75% by lives covered. Figure 5 shows the breakdown of Bupa’s members to illustrate the relative size of the segments.

Figure 5: [X]

Value for money is a critical factor affecting the take up of PMI

- 3.17 **Value for money** – cost and quality in combination – is important to each of the three customer segments (personal, company, and corporate) in deciding to buy or renew PMI. Gold-plated care that is unaffordable is of little use, and cheap policies that constrain to a significant extent the access to quality provision are similarly unattractive. In all cases, customers (personal and B2B) can turn to the NHS as a free alternative. So insurers cannot be complacent in delivering value for money to keep existing customers and to attract new ones.
- 3.18 Table 1 shows that personal customers buy PMI for the **peace of mind from rapid, flexible access to treatment**. Our customer research shows that customers are unwilling to trade off the quality and speed of healthcare they receive for lower premiums.

⁵⁴ [X]

⁵⁵ Note “lives covered” tells only part of the story on the dynamics of the PMI market, as the total amount of cover per life is also relevant. In recent years there has been significant **down-trading** of cover i.e. people maintain the policy but accept higher excess levels, more exclusions etc.

⁵⁶ Laing and Buisson Market Review, 2010-11. In terms of number of subscribers (where a subscription may cover more than one life e.g. a family), the B2C market has fallen from 1.4 million in 1995 to 1 million in 2010.

Table 1: Top reasons to purchase PMI for Personal customers

Reason to purchase PMI	% of sample providing this reason in the top 3 reasons
Avoid waiting lists if need treatment	70%
Faster access to specialists for diagnosis	63%
Peace of mind	51%
Can see specialists at times that suit me	49%
Better quality of medical treatment and advice	41%
Comfortable rooms in hospital	38%
Able to choose a hospital location that suits me	38%
Access to the best consultants	36%
Good quality aftercare	32%
Reduce the amount of time worrying	31%
Clean hospitals	30%
To avoid having to pay unexpected healthcare bills	29%
Able to choose my consultant	28%

Source: Nunwood Analytics, "Optimising BUPA's menu based proposition and pricing strategy, July 2010"

3.19 Table 2 and

3.20 Table 3 show that maintaining a **happy, engaged and productive workforce** is why B2B customers offer PMI to their employees. Both SMEs and Corporates offer PMI to show employees that they care and as part of the company competing to attract and retain talented staff. **There can be no compromise on the quality of healthcare employees receive.**

Table 2: Main reasons to purchase PMI for Corporate customers

Reason to purchase PMI	% of sample providing this as the main reason
Being seen as a caring employer/providing a duty of care	24%
Improving health and welfare of staff	19%
Improving employee engagement	10%
Getting employees back to work quickly	8%
Being seen as an employer of choice	6%
Preventing future health issues for staff	6%
Achieving good staff retention	5%

Source: Employee Benefits Healthcare Research 2012

Table 3: Reasons to purchase PMI for SME customers

Reason to purchase PMI	% of sample providing this reason in the top 3 reasons
The benefit gives the employees peace of mind	65%
Shows employees the company cares	59%
To prevent future health issues for employees	54%
To support employees to difficult times at work or home	49%
Maximises employee retention/Loyalty	47%
Minimises employee time off/maximises productivity	46%

Source: BHW SME Segmentation, The Value Engineers, July 2011

3.21 Part of the value that customers see in PMI policies is that insurers – through their role as “commissioners of care” in PH – play a critical role in ensuring they get high quality care at affordable prices. Research shows the high expectations people put on their PMI provider to manage the costs and quality of hospitals and consultants⁵⁷:

- i. **83%** of consumers expect their insurer to work with hospitals to keep costs down (against only 4% who do not have this expectation, the remainder being neutral).
- ii. **83%** expect their insurer to work with consultants to keep costs down (against only 4% who do not have this expectation).
- iii. **89%** expect their insurer to monitor hospitals to ensure they offer high standards of care and follow best clinical practices (against only 4% who disagree).
- iv. **87%** expect their insurer to monitor consultants to ensure they offer high standards of care and follow best clinical practices (against only 5% who disagree).

3.22 The challenge for insurers is that if they cannot deliver on these expectations, the consumer switches away from the insurer or from PMI in general. However, as discussed in Section 4 (the patient journey), price consciousness is more acute at the point of buying/renewing PMI than during the treatment journey.

3.23 Price and changes of disposable income (often acting in combination) are important factors determining whether a personal customer takes up or lapses PMI cover⁵⁸. Figure 6 illustrates that price/cost is the primary barrier to market entry for personal customers.

Figure 6: [✂]

3.24 Even for individuals who have decided to take up PMI, ‘Value for money’ is a key driver of choice of PMI provider, as shown in Figure 7 (although as shown in the chart it is about “value”

⁵⁷ The Value Engineers, December 2010. [✂]

⁵⁸ Other factors impacting choice of PMI may include, for example, proximity to a particular well-respected NHS facility or the customer lapsing/losing cover when he loses his job.

rather simply having the “cheapest price” which ranks towards the bottom). **Delivering value for money a primary basis on which PMI providers compete.**

Figure 7: [redacted]

- 3.25 Price and cost are also important for B2B customers. For example, a recent survey of B2B customers by Employee Benefits found that: *“Since 2006, cost has remained the most important factor influencing employers’ decisions to buy, or to continue to offer, healthcare benefits. Cost and obtaining the best possible value for money has always been a key consideration for employers, never more so than during a period of such economic change”*⁵⁹.
- 3.26 In the survey, **88%** of respondents cited cost as the most important factor influencing their decision to buy or continue to offer healthcare benefits. Respondents had also taken action to find better value for money. The survey found that since the recession 40% had reviewed their healthcare providers to obtain a better deal and 39% have re-brokered their insurance benefits.
- 3.27 The majority of B2B purchases are made through brokers and intermediaries meaning there are sophisticated purchasers who know where to find value for money in the market. For example, at end December 2011, on Bupa’s Corporate book [redacted] of registrations (lives covered) and [redacted] of organisations were intermediated and in the Bupa SME book [redacted] of registrations and [redacted] of organisations were intermediated.
- 3.28 Research shows that B2B customers take action to find best value for money. Figure 8 shows that on receiving renewal quotes from their PMI provider, **approximately [redacted] of B2B customers test the market for comparison quotes** (with a further [redacted] simply asking for a premium reduction directly). B2B customers do switch when direct negotiation (with the threat of switching) with the insurer for better value for money does not lead to a satisfactory outcome for the customer. Figure 9 illustrates that finding better value for money (the same cover at a lower price, for example) is the most important driver behind actual switching for B2B customers⁶⁰.

Figure 8: [redacted]

Figure 9: [redacted]

- 3.29 Price and affordability are also key factors causing existing Personal members to lapse their policies. Figure 10 illustrates the main lapse reasons given by personal customers to Bupa in 2011⁶¹. Price is a primary reason for personal customers alongside ‘Non Payment’ which also incorporates affordability issues. Figure 11 shows also that price (encompassing the reasons ‘too expensive’ and ‘financial circumstances’) is playing an increasingly important role in Bupa B2C members choosing to lapse cover with Bupa.

⁵⁹Employee Benefits healthcare research 2012, (available at http://www.employeebenefits.co.uk/download/6580/EBS_060612.pdf, accessed June 2012).

⁶⁰ B2B research suggests 70% of B2B customer have previously switched PMI provider. [redacted]

⁶¹ When a customer decides to lapse his policy, Bupa endeavours to collect the lapse reason from the customer (although this is not always possible).

Figure 10: [✂]

Figure 11: [✂]

3.30 The trend is similar for B2B customers, as shown in Figure 12 and Figure 13, where price has been the primary lapse reason for SME and corporate customers.

Figure 12: [✂]

Figure 13: [✂]

3.31 This observed price sensitivity is echoed in customer research. Figure 14 illustrates the results of conjoint analysis to estimate price elasticity of demand (PED)⁶². At current premium levels, all age groups are in the price elastic range. The chart illustrates that young people are more price sensitive, where older people who use PH more often (and so see the value of PMI more frequently) are slightly less price sensitive. This means that as premiums rise, so the demographic of individuals using PMI will age (younger people leaving PMI more quickly than older age groups), which will have a disproportionate impact on increasing average claims costs.

Figure 14: [✂]

3.32 The challenge for insurers is that there may be limited additional room to increase prices (even if healthcare costs rise) before customers exit, particularly given the financial squeeze of the continued economic uncertainty. Figure 15 shows the findings of customer research commissioned by Bupa in December 2010 to examine new product propositions. It suggests that at that time actual and potential customers surveyed were already towards the upper bound of what they are willing to pay for PMI. The figure also shows that people who claim under PMI are more likely to pay more than people who do not.

Figure 15: [✂]

There is a vicious cycle facing the PMI and PH markets

3.33 As PMI becomes increasingly unaffordable for UK consumers and businesses, so the PMI market shrinks. This reduces the number of users of PH (as without PMI, most consumers will be unable to access PH). **This risks a vicious cycle.** Falling PH/PMI user numbers lead to higher per user costs (as fixed costs are spread over a smaller group) and higher premiums. This leads to further falls in user numbers. Over time the quality of the risk pool also deteriorates (increasing the ratio of claimers to non-claimers)⁶³.

3.34 Bupa is concerned that this vicious cycle has already begun in the UK and that this cycle will accelerate as more people reach the maximum they are willing and able to pay for PMI. The continued economic uncertainty of the recession is accelerating the decline, although the cycle was in motion even before the recession.

3.35 PMI premiums have been pushed upwards by a number of factors. Healthcare cost inflation is the primary driver (accounting for the vast majority of every pound of premium). The same treatments cost more each year (e.g. above-RPI increases in outpatient consultation fees for

⁶² PED values below -1 (e.g. -4) indicate price elasticity – a 1% increase in price will lead to a greater than 1% fall in demand.

⁶³ The pool of customers across which the insurer can diversify risk (i) shrinks in number and (ii) weakens in quality (healthy individuals, the 'good risk', tend to be first to exit PMI, as they observe the least direct value from their policies).

consultants). There is a shift towards higher cost treatments (e.g. new treatments with higher complexity or more expensive technological equipment). And, there is an increasing volume of treatments delivered per customer.

- 3.36 There are certain specialisms and regions that are disproportionately driving up healthcare costs. Oncology claims costs accelerate each year at rates that significantly outstrip general inflation. Bupa also has particular concerns about London. A significant disparity already exists between hospital claims costs per member in Central and Outer London ([£] and [£], respectively, in 2011) and the rest of the UK ([£] in 2011). This disparity widens each year. Indeed, Central and Outer London hospital claims costs per member have risen at a compound average growth rate of just [£] per annum between 2006 and 2011, significantly ahead of RPI over this period.
- 3.37 Figure 16 shows the significant structural decline in the personal (B2C) market as premiums have increased by more than 150% in nominal terms since 1995. This understates the full decline because it omits down-trading over this period (i.e. people continuing to buy a policy but limiting the cover of that policy through excesses and exclusions for example). While there will be various factors driving this decline, premium increases are the significant factor. This trend of decline in B2C is expected to continue. Figure 17 shows that the corporate market had its strongest growth in number of lives covered in the period between 1995 and 2000. This growth was more moderate through the mid-2000s supported by the strong UK economy. However, these gains have been stripped away rapidly by the economic uncertainty of the recession leaving the B2B market size at much the same levels as in 2000, yet facing significantly higher premiums.

Figure 16: [£]

Figure 17: [£]

The PMI market is highly competitive

- 3.38 The PMI market is highly competitive. The primary basis of competition in PMI is on value for money, followed by factors such as PMI provider's product flexibility, innovation, medical expertise and reputation. There are over 15 companies offering PMI to individuals or companies, and there are relatively low entry barriers (with evidence of successful entry and expansion over the past decade e.g. PruHealth). The vast majority of customers are sophisticated purchasers willing and able to switch to find value in the market (as illustrated at para 3.28).
- 3.39 Health insurers trade on slender margins relative to the significant capital employed. Four-fifths of premium income simply pass through the insurer to be paid to consultants and hospitals. There is little remaining to account for the administrative costs of running large consumer-facing insurance businesses (e.g. with call centres and medical staff to serve customers) and the financial capital tied up to meet regulatory solvency requirements. Unlike other types of insurance (e.g. life insurance), investment income for PMI insurers is also relatively low given the liabilities faced by a health insurer are short-term in nature (and so must be matched by investments in short-term assets which offer lower returns).
- 3.40 This means that insurers cannot themselves absorb inflation in input costs (e.g. from rising hospital, consultant, and drug costs) and have to pass these through to consumers.

Responding to the challenges

- 3.41 Healthcare costs have risen rapidly and are expected to rise further. PMI is becoming increasingly unaffordable for customers – both individuals and companies. The PMI market is now at the same size (in terms of lives covered) as it was 15 years ago. Yet PH providers have not shown agility in responding to these challenges through innovation in business model and ways to deliver care.
- 3.42 To address the vicious cycle in PMI, competitive forces must be allowed to push inefficient PH provision capacity and anticompetitive practices from the market. The *status quo* is unsustainable. Further, a simple consolidation of existing models and practices (e.g. the concentration of power in the hands of certain hospital groups through mergers) in this shrinking market will only increase the speed of decline. The concentration of power in the hands of certain providers (e.g. through expansion of hospital groups or through the formation of consultant groups) gives further opportunity for the extraction of short-term profits by the providers, with no evidence of customers benefitting from any claimed economies of scale.

4. THE TYPICAL TREATMENT JOURNEY FOR A PATIENT IN PRIVATE HEALTHCARE

- 4.1 Through the decades of our operation in the UK and internationally, Bupa has supported millions of patients through their individual journey of private healthcare treatment. We know each patient faces his or her own journey, one that is a very personal experience. It can be a traumatic time for both the individual and his or her family; a period of difficult decisions. It is a period when the patient wants support, information, advice and reassurance.
- 4.2 Bupa believes that the dynamics of competition in PH depend fundamentally on the patient journey. There are several areas in which the patient journey in PH could be improved to deliver better quality and cost effective care. The focus of this section is to illustrate where and why the issues arise in these areas.
- 4.3 We focus below on a “typical” journey for an insured patient from acquiring PMI to falling ill and receiving an intervention (e.g. surgery or physiotherapy)⁶⁴. The journey of a self-pay patient will differ at points from that of an insured patient. The treatment journey for a disease such as cancer is likely to have more complexity given the longer term of treatment and the increased likelihood of a variety of treatment courses being required (e.g. surgery followed by chemotherapy). We use the typical journey to illustrate the issues in the function of the market, but we strongly believe the CC should look also at the patient experience in the treatment of complex diseases like cancer, as these treatments are a significant and growing part of the PH market in the UK.
- 4.4 A summary of the key implications of the patient journey would be as follows:
- i. **The patient wants high quality care, but needs PMI and PH to remain affordable.** Yet the main actors on the treatment journey – the GP, the consultant, and the hospital – do not have strong incentives to control costs on the patient’s behalf.
 - ii. **The insurer acts as a commissioner of care on the patients’ behalf.** The insurer has the incentive to offer value-for-money and high quality PMI products, as this is how insurers attract and retain customers. However, the insurer’s ability to manage costs and quality is constrained by the limited influence it has over the course of the patient’s journey and the strong positions of consultants and hospitals.
 - iii. The typical patient has low levels of health literacy and when ill a patient is in an even more vulnerable position in making effective decisions and trade-offs. Therefore, the patient wants support and information. The patient tends to “trust” his or her care to the hands of the GP, consultant or hospital, even where the care provider’s incentives may not align (and may conflict) with his or her own. The patient is unlikely to challenge the care provider on whether a particular treatment or referral is appropriate or necessary.
The patient has little buyer power on his or her own.

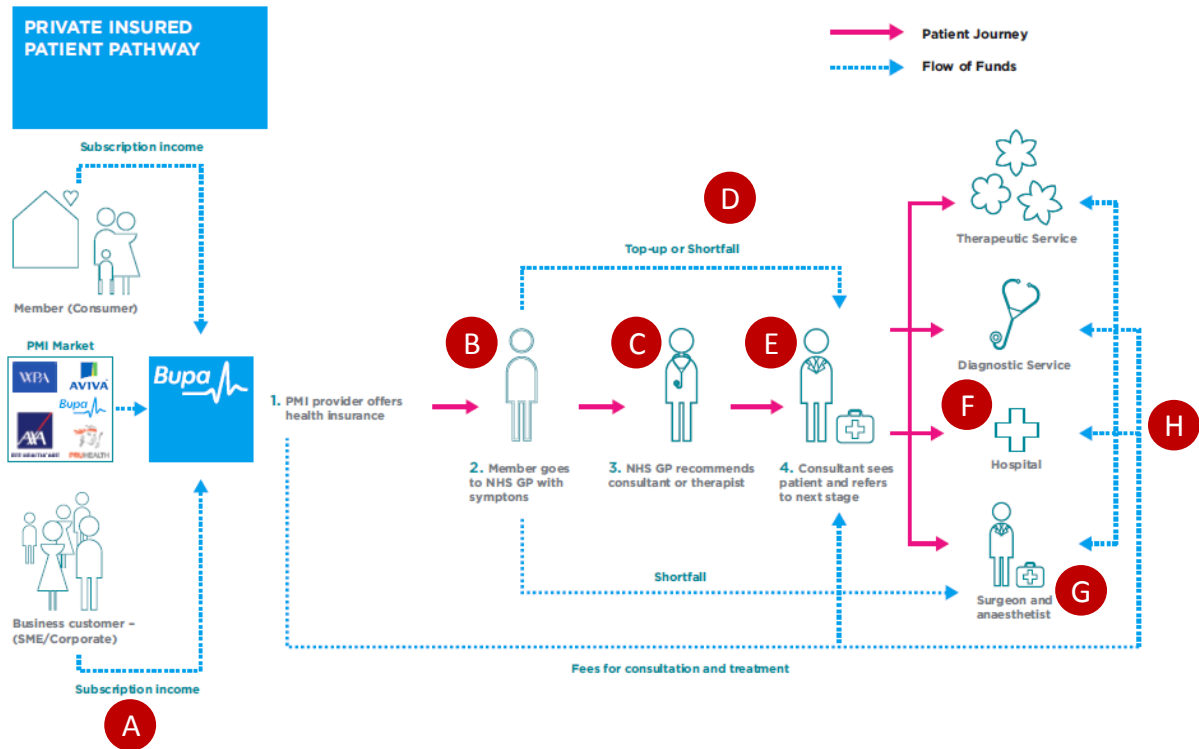
⁶⁴ Bupa agrees with the OFT’s representation of the treatment journey (set out in Chapter 3 of its MIR Decision) and this section augments the OFT’s analysis. Bupa has also submitted as part of its Off the Shelf request (submission dated 25 April 2012) an extensive piece of customer research commissioned by Bupa on patient journeys: The Futures Company, “Mapping Health Experiences”, April 2012.

- iv. The GP plays a gate-keeper function to access PH. However, at this key decision-making point the absence of accessible, comparable information on consultant and hospital performance, cost and quality makes it difficult for GPs to offer patients fully-informed choice.
- v. The lack of transparency on consultant cost and quality means that **consultants do not compete for patients effectively**. An individual consultant has little incentive to reduce fees or enhance quality unilaterally, as this is unlikely to gain him additional referrals through differentiation against peers. Without competitive tension between consultants, patients face the risk of clinically inferior/unnecessary care and high prices.
- vi. **The consultant plays the key role in choosing the type, venue and volume of treatment**. However, many consultants do not discuss treatment costs with the patient until it is too late for the patient to switch (or threaten to switch) effectively. This also sometimes results in surprise and unwelcome shortfall payments for the patient.
- vii. The key role consultants have in specifying patient treatment pathways means that **hospitals tend to compete for consultants rather than directly for patients** at a local level. To do this, hospitals offer financial and non-financial incentives to attract and retain consultants. These incentives do not necessarily benefit the patient – many add cost to the system and they do not necessarily improve quality.
- viii. Neither the insured patient nor the consultant take account of the fees charged by that hospital, as in most cases the insurer will reimburse the hospital directly and fully. So **hospitals do not compete effectively on price at the local level** – indeed, the majority of hospital groups charge uniform national prices non-reflective of dynamics of competition at the local level. There is also little direct competition between hospitals on quality.
- ix. When an anaesthetist is required, the patient tends to have little opportunity to negotiate or shop for a competitive fee, as he or she meets the anaesthetist shortly before the surgery. The patient also faces significant switching costs at this point in the journey. Therefore, anaesthetists have appreciable market power (which can be further increased if they are part of an anaesthetist group).

A “TYPICAL” INSURED PATIENT JOURNEY

4.5 A typical journey for an insured patient is summarised in Figure 18, with each step in the journey described in the paragraphs that follow.

Figure 18: Illustrative journey for Bupa-insured patient



A: Pre-treatment stage - the purchase of PMI to access PH

- 4.6 At the point of purchase of PMI the customer – whether an individual or an employer – reveals his or her need for affordable and value-for-money healthcare (as discussed in Section 3). Critically, if the customer cannot be persuaded of the value of PMI and PH at this stage, he or she may not be able to access PH⁶⁵. The customer is more cost conscious at this point (where he or she is a **payor**) than at later points in the journey when actually undergoing treatment (where he or she is a **patient**).
- 4.7 The customer will consider various factors at this stage to find cover that matches his or her needs. For example, location of treatment is an important factor considered at this stage⁶⁶. This means that the customer wants a PMI policy that gives him or her the option of access to local

⁶⁵ Only a small proportion of non-insured customers self-pay. Laing and Buisson 2011-2012 notes that the proportion of PH patients that self-pay has fallen from approximately 18% in 2004 to approximately 14% in 2010.

⁶⁶ The Oxera Market Definition report describes that consumers prefer to minimise the distance travelled for treatment, all else being equal. Customer research conducted by The Value Engineers in 2010 explains: “Customers are very clear on the importance of being treated in a location close to home ... They are concerned both about their ability to reach the hospitals if they are unwell, and also the distance family and friends might have to travel to visit them ... Letting customers know that they will be seen close to home is a powerful emotional reassurance”.

hospitals. The implication of this is that insurers have to contract with hospitals close to the customers they serve and want to serve⁶⁷.

- 4.8 The majority of customers actively choose to trade-off certain features of the policy cover at this stage including: the list of hospitals they can attend; the policy excesses they will have to pay if they claim; and, the treatments that will be excluded from the policy cover. Our customer research shows, for example, that some customers are willing to purchase a cheaper policy that gives him or her access to a narrower list of hospitals (and so he or she will have to travel further) in exchange for a lower premium⁶⁸. Patients are, however, unwilling to compromise on speed of access to care or access to certain drugs not available on the NHS in exchange for lower premiums.
- 4.9 Customers value having choice and the ability to tailor cover to their needs – a ‘one-size-fits-all’ policy is not appropriate. However, with this choice and flexibility can come the challenge of communicating the policy terms and conditions to customers⁶⁹.
- 4.10 As discussed in Section 3, **the insurer must meet the customer’s needs as both a patient and a payor**. So the insurer’s role in the patient journey is to manage both the cost and quality of care providers to customers. It does this through commissioning high quality, affordable care on the customer’s behalf (Section 5 and Section 6 explain how Bupa manages our relationships with hospitals and consultants). However, the insurer’s ability to do so is limited by the fact it is excluded from many of the key decision points on cost or quality during the patient journey.

B: The treatment journey begins – the customer becomes ill and seeks treatment

- 4.11 As the treatment journey begins, it is valuable to consider the position of the insured patient and his or her incentives. The patient does value choice and wants to be involved in decisions that affect him or her. However, the patient can be emotional and fearful at the point of requiring treatment. Therefore, the patient seeks support, advice, and reassurance in the decisions and trade-offs made. Further, he or she is likely to focus on resolving the health concern and will place little emphasis on how his or her decisions and journey impacts on the wider PH system⁷⁰.
- 4.12 The patient is unlikely to have medical knowledge, and so faces an information asymmetry in terms of understanding the type of treatment he or she is offered. The patient will also only be able to assess the value of the treatment after it is received. The patient is therefore relatively passive and must ‘trust’ the decisions of the medical professionals (e.g. the consultant and the GP) not being in a position to question them or to negotiate⁷¹. The lack of medical knowledge

⁶⁷ This means that in some areas insurers have no option but to contract with a particular hospital if there is no other suitable alternative facility.

⁶⁸ The Value Engineers, “Project Crossroads, Developing Customer Centric and Value based propositions for personal customers”, October 2010.

⁶⁹ Bupa works hard to communicate information clearly and effectively to policyholders as is our responsibility under Financial Services Authority regulations on treating customers fairly. It is noteworthy that in the year to 31 March 2012, across the whole PMI market in the UK (covering just over 7 million lives), there were only 513 customer complaints to the Financial Ombudsman Service (FOS) about PMI which is under 0.0019% of all complaints about financial services products received by FOS.

⁷⁰ Patients may act in their own short-term interests but not in the interests of fellow policyholders in general. When faced with a need for an intervention, the patient may want to have ‘all the bells and whistles’ of treatment and diagnostics if he knows he may enjoy a potential health gain and he will not bear the full additional costs of this treatment – the costs will be spread across all fellow policyholders in the form of higher premiums.

⁷¹ The Oxera report for the OFT on Market Definition in Private Healthcare (2011, p4) notes that: “...many consumers of PH services are relatively passive, in the sense that they are unwilling or unable to shop around for the best deals – at least when it comes to choosing how and where to be treated”. The passive nature of patients is also demonstrated by the finding in the OFT

also impacts the patient's ability to interpret medical metrics and data. For example, the patient may incorrectly interpret higher prices as a signal of superior quality.

- 4.13 The outcome is that the patient is likely to have little buyer power. The patient is in a vulnerable position with a lot at risk and, as discussed below, he or she may not have, or be given, choice in the type or location of care given.

C: The visit to the GP – the 'gatekeeper' of care

- 4.14 Typically, the patient accesses PH services through his or her GP and as such the GP plays a key 'gate-keeper' role in the journey.

- 4.15 The GP plays an influential role in choosing the consultant for the patient⁷². The GP usually refers the patient to a "named" consultant when making a private referral, although "open referrals" are also made in a minority of cases⁷³. The influence of the GP is illustrated by the findings in the OFT GP Survey (p24) that 92% of GPs believed that patients 'usually' (80%) or 'always' (12%) followed their recommendations. The reliance the patient places on the GP's recommendation is increased because there is so little information about consultants' cost or quality available to patients⁷⁴.

4.16 The GP, however, often makes his or her referral decision on incomplete information:

- i. The GP does not have access to objective, comparable information on the quality of consultants. As shown in Figure 19 under a quarter of GPs considers that they have access to objective information on consultants. And what little information that is available often makes comparison difficult (see Figure 20).
- ii. The GP is unlikely to have complete knowledge of the costs of the consultants in the local area (nor of the likely cost of care for the full treatment journey)⁷⁵. The OFT GP Survey (p34) found that 75% of GPs surveyed 'rarely' or 'never' knew the consultant's fee for the first consultation. Only 2% of GPs indicated that they 'always' knew the relevant consultant's first consultation fees.
- iii. The GP does not have a strong incentive to assess costs, as he or she bears no financial consequences for the decision. Indeed, a GP survey conducted for Bupa in 2011 (results shown in Figure 19) found only around 12% of GPs strongly or slightly agreed that they

Consultant Survey (p68) that 92% of consultants reported that self-pay patients 'rarely' or 'never' attempted to negotiate the level of fees which is surprising given that one would expect self-pay patients to be more price sensitive.

⁷² The OFT Survey indicated approximately 70% of GPs (74% for self-pay patients), when asked, thought that they were the most important influence on a patient's choice of facility and/or consultant (p26). The OFT MIR Decision explains also "[t]he importance of the GP's role is confirmed by the OFT patient interviews which showed the large degree of trust and reliance that patients tended to place on their GP's opinion, with many patients seeking to delegate their choice of consultant to their GP" (para 5.9).

⁷³ In making an "open referral", a GP may specify the PH facility/specialist unit (by addressing the referral letter to 'Dear Colleague' for instance) or, in regard to some PMI funded patients, filling out a referral form that specifies neither the consultant nor PH facility.

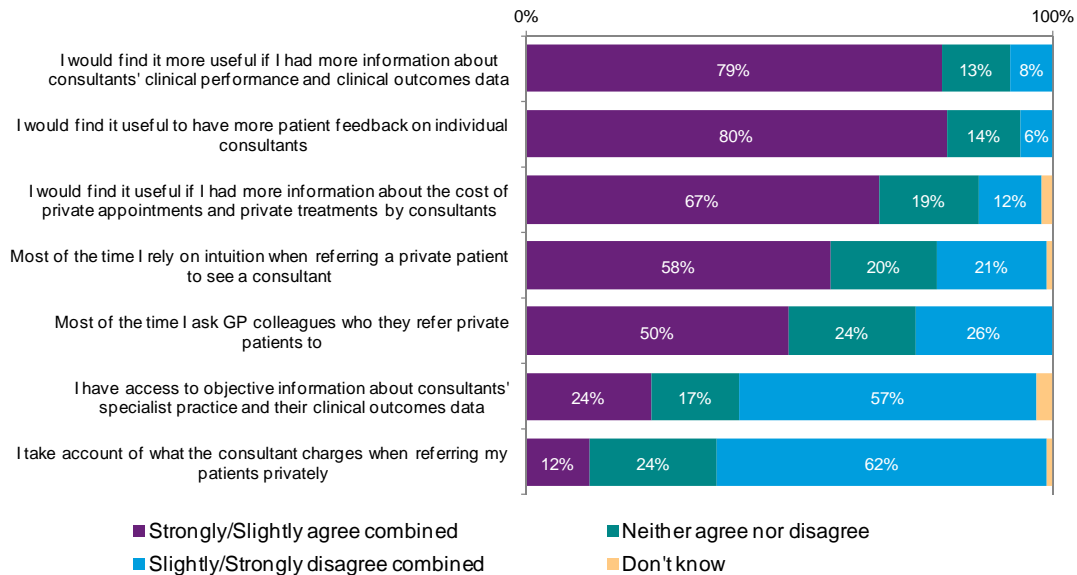
⁷⁴ Bupa provides some assistance to patients about consultants (e.g. name, specialism and location) through its website <http://consultant-guide.bupa.co.uk/>.

⁷⁵ GPs do not have the incentive to invest in building this knowledge, as they enjoy little of the financial benefit and see private patients relatively infrequently in their rota of NHS patients.

take account of what a consultant charges when referring patients privately compared to over 60% who did not⁷⁶.

4.17 Figure 19 and Figure 20 show that the majority of GPs share the concerns about having unsatisfactory levels of information. These concerns are echoed in the OFT GP Survey which found that significant numbers of GPs felt their information needs were unmet.

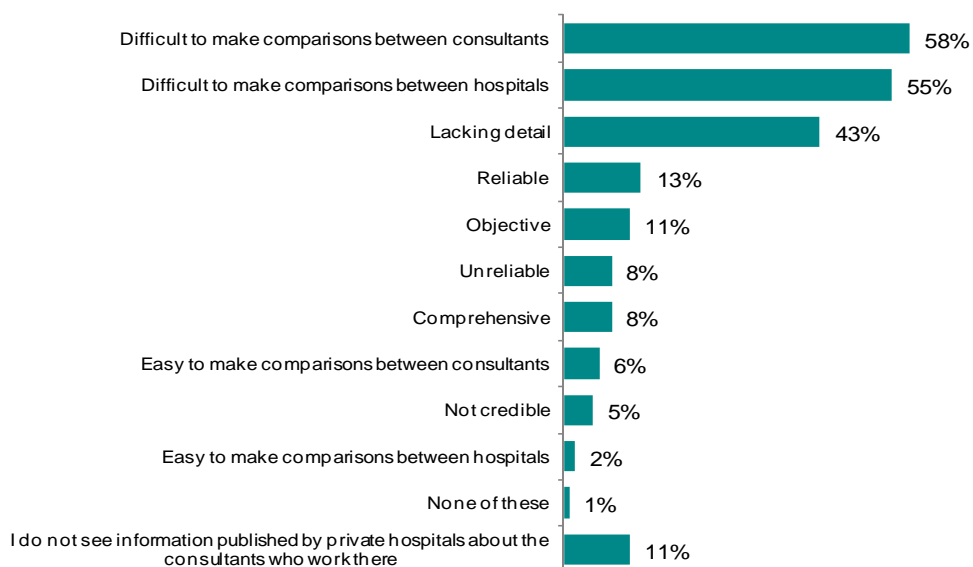
Figure 19: GP survey, referral process



Source: KantarHealth Survey, December 2011/January 2012
Base: 397 GPs

⁷⁶ The OFT GP Survey found a similar result. It noted that for GPs the most significant difference between PMI and self-pay patients was in respect of the importance of the cost of treatment as a factor influencing their recommendation. Just 13% of GPs identified it as an influencing factor with regard to PMI patients; and, just 2% of GPs as the single most important factor. For self-pay patients, however, 36% of GPs identified the cost of treatment as an influencing factor, and 15% of GPs nominated it as the single most important factor when making a recommendation.

Figure 20: GP survey, responses to the question: “Think about information published by private hospitals about the consultants who work there, which of the following, if any, describe the information?”



Source: KantarHealth Survey, December 2011/January 2012
Base: 397 GPs

- 4.18 The GP, therefore, has to make the referral based predominantly on his or her own experiences and anecdotal information⁷⁷. This may be satisfactory in certain cases, although in general it means that key decisions are often made without sufficient information on costs and quality. This undermines competition among consultants⁷⁸. A consultant will not necessarily be rewarded for superior care or lower fees by GPs directing more patients to him or her. This also then **blunts incentives to compete on price**. And inferior consultants may remain in the market unchallenged on their performance (as underperformance is difficult to identify) which puts patients at risk of receiving poor or unsatisfactory care.
- 4.19 Given this information gap, which consultants have failed to fill, Bupa has recently launched the “Open Referral” product to corporate clients. Under the terms of this product the patient must ask for an open referral from the GP. The patient then consults with Bupa in selecting a consultant. Bupa can use its database on consultant performance and cost (across time and across a wider range of patients) and its clinical expertise to offer the patient a selection of choices of relevant consultant in the local area who will not shortfall the patient. This initiative does not solve the information gap problem (and is not available to all patients), but aims to improve the quality of choice that Bupa members have at this stage in the journey (this initiative is discussed in more detail in Section 6).

⁷⁷ GPs are described as having: “...a sort of ‘mental’ filing cabinet of informal information or soft intelligence about local consultants.” The King’s Fund: An Anatomy of GP Referrals (2007), p20.

⁷⁸ The OFT MIR Decision (para 5.68 and 5.69) emphasises: “Although this ‘soft’ intelligence may provide information to aid choices locally and is to be valued, it will not assist patients who, if provided with relevant information, may want to be treated by consultants other than those with whom the GP is familiar. These factors may be especially the case where a GP (such as a locum) has little connection with the local area and is therefore not privy to the types of soft, local information typically utilised. Over-reliance on soft intelligence or informal views can also raise the risk of entrenched referral patterns or biases which dampen demand-side competition in PH”.

D: Contacting the insurer: Pre-authorisation of the consultant

- 4.20 After the GP consultation the patient may call his or her insurer to preauthorise the treatment and care provider (i.e. to check whether it is covered under his or her policy). Whilst Bupa encourages customers to pre-authorise their treatment, it is not mandatory under the terms of the majority of our policies. In practise we find that the majority of our members do pre-authorise their treatment with us after visiting their GP⁷⁹.
- 4.21 The pre-authorisation contact is a key opportunity to discuss the member's treatment and support them with further advice⁸⁰. For example, we can tell them whether the consultant they have been referred to has agreed to charge within the Bupa reimbursement limits (a "Fee assured consultant") or whether the patient could face the prospect of a shortfall⁸¹. Patients value getting this price clarity upfront having seldom gained this information during the GP visit.
- 4.22 In Bupa's experience, [X] of patients who call to pre-authorise already have a named consultant provided by their GP. [X] choose to go to another consultant when we explain to them that their chosen consultant may charge above Bupa's benefit reimbursement limits. However, many are reluctant to change from the GP's decision, even if the GP did not make that decision on full information.
- 4.23 Clearly, self-pay patients do not benefit from further advice and support at this stage, and incur the search costs of having to establish consultants' fees themselves.

E: In the hands of the consultant – the specifier of care

- 4.24 The consultant plays the **key role in choosing the type, venue, and volume of treatment**.
- 4.25 While the vast majority of consultants aim to deliver high quality care to patients, there are some significant concerns about their incentives and conduct.
- 4.26 First, the consultant does not have any reason to pay attention to the overall costs of treatment. There is evidence that the majority of consultants do not discuss the costs of care with the patient in advance of treatment⁸². This reduces the patient's ability to make informed choice.
- 4.27 Second, **the consultant's own interests may conflict with the patient's interests**. Consultants in private practice do have a profit motive as they are running a business. The fee-for-service reimbursement model in private healthcare means there is a risk that consultants may **over-treat** (undertake more consultations and tests than needed) or **over-diagnose** (undertake a higher specification treatment than needed or perform unnecessary tests) to

⁷⁹ In 2010, for example, Bupa members pre-authorised [X] of outpatient and [X] of inpatient / day-case procedures.

⁸⁰ In the future we would like to provide members with more robust information on their treatment options, including details on the quality of different providers or merits of different procedures. Whilst respecting the clinical expertise of consultants, given our reach across various PH providers we are in a strong position to be able to collate data and share our experiences. We would hope that such a service would provide patients with a wider information base thereby enhancing their ability to better understand the options that may be available to them along their pathway. However at the moment such provider-led guidance is in its infancy.

⁸¹ Fee assured consultants are explained in further detail in Section 7. We explain to consumers (at <http://consultant-guide.bupa.co.uk/>) that: "Fee Assured' consultants charge within Bupa monetary limits, and many have entered into a voluntary arrangement with Bupa"; and, "Recognised' consultants have not entered into a voluntary arrangement with Bupa regarding fees, so may not charge within Bupa monetary limits. This means that members may need to pay something towards the cost of their treatment if it is higher than the amount Bupa agrees to pay".

⁸² The OFT Consultant Survey (p128) notes that only 43% of consultants provided a fee estimate to the patient at the first consultation. Some 13% did not provide an estimate before the final invoice was served. The OFT also cites the FIPO survey of its members which found that just over 30% of consultants did not give fee estimates.

maximise revenue. Evidence of this treatment variation is discussed in Annex E. The consultant may also face more direct conflicts of interest. For example, incentive schemes from a hospital that rewards the consultant for taking patients to that hospital (e.g. through a revenue share agreement) or for using a particular piece of expensive medical equipment may bias referral decisions. While, under GMC guidelines, the consultant is supposed to declare conflicts of interest to the patient, in Bupa's experience, this is seldom done in practice⁸³.

- 4.28 Third, **the consultant may not give the patient a choice** on the venue for any inpatient treatment if this is needed⁸⁴. The OFT Consultant Survey (p58) showed that only a small minority of consultants offered their patients a choice between their main PH facility and another PH facility – just under half (48%) of consultants said they never offered a choice, a further 23% said they offered a choice in under a quarter of cases, and only 9% offered a choice in more than half of the cases (p53). The Most consultants with admission privileges at two or more PH facilities reported that they would treat between 71 and 100% of their patients in their main PH facility over an average month.
- 4.29 Fourth, given the lack of effective competition between consultants on price or quality, consultants individually have significant market power in setting fees. This power grows as the patient moves through the treatment journey (i) because of switching costs for the patient, and (ii) because other consultants may be unwilling to take over the liability for a patient switching mid-treatment. Without sufficient pressure on consultant fees, insurers have responded by setting reimbursement limits (benefit maxima)⁸⁵. A number of consultants still choose to price above these limits asking the patient for a top-up fee up front or presenting them with a shortfall after the treatment. Of further concern, a large number of consultants are now forming consultant groups which can further limit patient choice and increase the group members' collective market power.
- 4.30 Finally, Bupa has concerns that consultants have not sought to fill the information gap on comparable outcomes and performance data. Without this data competition cannot develop in the market as patients and insurers do not have the ability to identify whether a consultant's higher fee is actually justified. More concerning, without this data, poor clinical practice cannot be identified and addressed, which places patients at risk. An illustration of the potential gains from this comparative data (and by converse the loss to patients if the gap remains) is that one of the few specialisms that has focused on robust collection of data on consultants' clinical outcomes identified this as the reason for a 50% reduction in risk-adjusted mortality in the UK⁸⁶.

⁸³ On being told of a consultant's conflict of interest during a consultation the patient may also not be in a position to assess the materiality of the conflict and how it will affect his or her care.

⁸⁴ In some local geographies there may be very limited choice of hospital for the specialism required (e.g. in solus markets).

⁸⁵ Bupa's reimbursement limits are explained in more detail in Section 6. It should be noted that Bupa's reimbursement limits do not apply to outpatient consultations and cannot constrain a consultant's ability to over-treat or over-diagnose.

⁸⁶ "[W]e believe that the marked, sustained, incremental improvement in the quality of care the surgical teams have achieved is directly associated with the process of recording, reporting and publishing outcomes at the level of the individual clinician", The Society for Cardiothoracic Surgery in Great Britain & Ireland (2011), "Maintaining patients' trust: modern medical professionalism", available at http://www.scts.org/_userfiles/resources/634420268996790965_SCTS_Professionalism_FINAL.pdf (accessed May 2012).

Pre-authorisation of hospital choice

- 4.31 The patient may contact the insurer at this stage to check whether the venue at which the consultant will take the patient for treatment is covered. If the hospital is not on the insurer's network the patient may need to go to an alternative hospital⁸⁷.

F: The venue of treatment

- 4.32 Should surgery be required, the consultant will take the patient to a hospital or clinic at which he or she has practicing privileges. The hospital provides the medical equipment, drugs and nursing staff to complement the consultant's service. The consultant and hospital will typically bill separately.
- 4.33 The patient usually prefers to be treated close to home (and sometimes close to work). Therefore, from the patient's perspective, what matters is the competition and choice between hospitals in his or her local area. This leads to narrow geographic markets. And it also means that insurers have to contract with hospitals near the patients they serve and want to serve.
- 4.34 However, as discussed above, the consultant may not give the patient much real choice on the venue for this treatment, particularly where an incentive scheme arrangement exists. In many areas of the UK there is also very little choice of venue due to hospitals being in monopoly positions geographically for specific specialisms (e.g. there may be only one hospital in the local area with a cardiology unit).
- 4.35 The private hospital will typically have a contract with the insurer agreeing the hospital's price list for treatments⁸⁸. The insured patient does not have visibility of these prices and is protected from any shortfall on the hospital treatment. However, it does mean that both the consultant and the insured patient are insensitive to prices that the hospital sets⁸⁹. This lack of price sensitivity for the vast majority of patients in the PH market means that hospitals have little incentive to compete directly on price or efficiency at the local level (in fact, the main hospital groups charge uniform national prices lists that do not reflect dynamics of competition at a local level).
- 4.36 The lack of price sensitivity can also be challenging for a new hospital entering a local area, as it may not be able to attract patients even if it offers substantially better prices. Consultants may not steer patients towards the entrant if they are tied into arrangements with the incumbent facility. And the insurer may not be able to direct patients to the more efficient entrant if the insurer is obliged to still offer access to the incumbent facility (because, for example, of 'one in, all in' negotiation by the hospital group, which is discussed in Section 5).
- 4.37 There is also little direct competition between hospitals on quality. Many private hospitals do publish metrics on quality; but these are not in a standardised or comparable format. This gives the patient, consultant and insurer little ability to compare facilities and make value-for-money

⁸⁷ If there is a clinical need that cannot be fulfilled at a patient's 'in network' hospitals, Bupa will allow treatment at an 'out of network' hospital.

⁸⁸ The price list tells only part of the story in that a hospital may be able to vary its practices (e.g. keeping a patient in hospital longer) to maximise revenue. As is discussed in Section 5 the patient and insurer actually need to understand the full hospital treatment costs (rather than simply the unit prices) to make effective choices.

⁸⁹ A self-pay patient will have some price sensitivity and may shop around for an alternative hospital on price (provided the consultant has practicing privileges elsewhere). The OFT MIR Decision (para 5.37), however, notes that self-pay patients still faced significant search costs, challenges in comparing prices presented in different formats, and self-pay patients did not feel in a position to negotiate a price with a PH facility in an informed way because of a lack of information about PH costs.

decisions⁹⁰. The data provided by hospitals to Bupa, for example, varies significantly in how it is compiled, what it covers, and how it is presented.

- 4.38 Therefore, there is little price or quality rivalry between facilities, even when located near each other. When combined with significant entry barriers, this ‘quiet life’ means that hospitals can run at low levels of efficiency (e.g. with excess capacity) and higher prices, which is unsatisfactory for the patient and payor who has to bear the extra cost.

G: The anaesthetist benefits from market power in the patient journey

- 4.39 Where an anaesthetist is needed for a surgery there is typically little or no opportunity for the patient to choose, switch or negotiate with the anaesthetist. The consultant surgeon (and in some cases the hospital) tends to assign the anaesthetist. In most cases, the patient will only meet the anaesthetist shortly before surgery commences, a difficult time for him or her to ascertain how much will be charged or what the level of quality of service will be. There are also significant switching costs for the patient at this stage. If he or she chooses to switch anaesthetist it may cause the operation to be postponed (and perhaps moved to another hospital).
- 4.40 The circumstances of anaesthetists’ position in the journey means that there is little competition between anaesthetists – a point acknowledged by The Association of Anaesthetists of Great Britain and Ireland (AAGBI): “*There is very little direct competition between anaesthetists. Neither surgeons nor patients “shop around” seeking competitive quotes from anaesthetists*”⁹¹.
- 4.41 Indeed, the geographic market for an anaesthetist can be defined as ‘within a specific hospital’ (only anaesthetists within the hospital offer the patient any practical choice, anaesthetist at other local hospitals do not) and could be time limited as well (only those anaesthetists available/on duty at the time of the patient’s procedure are practical alternatives).
- 4.42 The market power of anaesthetists has been further enhanced by the formation of anaesthetist groups which charge a uniform price across members. The OFT noted that 44% of anaesthetists are now in groups. When a group become particularly large within a hospital or local area, it can significantly reduce choice for the patient. As explained in Section 6, Bupa observes certain anaesthetist groups having significantly higher frequencies and magnitudes of shortfall than non-group anaesthetists.

⁹⁰ The OFT MIR Decisions notes that “The OFT considers that the current absence of access to, standardised, comparable information on the quality and self-pay prices of PH facilities, weakens the ability of patients, GPs and PMI providers to drive efficiencies and stimulate competitive between rival PH facilities and this may give rise to a dampening of competition between PH providers” (para 5.45). The OFT notes also that the provision of quality data by PH facilities compares unfavourably to the NHS.

⁹¹ “Response from the Association of Anaesthetists of Great Britain and Ireland to requests for information from the OFT in relation to its study of the private healthcare market”, p12 (available at <http://www.aagbi.org/sites/default/files/AAGBI%20FINAL%20response%20to%20OFT.pdf> and accessed June 2012). The AAGBI go on to argue that “*consultant anaesthetists are far from free to charge whatever they choose – the market is contestable. If surgeons believe that the anaesthetists with whom they work are charging excessive fees, and in particular if their patients are protesting, they will complain to the anaesthetists and will very likely engage the services of alternative, better value anaesthetists*”. However this argument is not compelling in a number of respects. There are entry barriers facing anaesthetists (e.g. the need for practicing privileges, the inability to differentiate oneself because of lack of data on quality, etc). In many areas, particularly those controlled by anaesthetist groups, there will be few alternative value for money anaesthetists available. And, critically, it again relies on patient raising shortfall concerns with the consultant and the consultant then acting on these complaints which there is little evidence takes place.

H: Billing and settlement

- 4.43 Once treatment has been provided the consultant will invoice the patient's insurer. However, as noted above, some consultants may charge fees above the insurer's reimbursement limits. In this situation the consultant will bill the patient directly for the balance. For Bupa members, approximately [§<] of surgical treatments face a shortfall, although this varies both between and within specialisms and is highest for anaesthetist treatments (where [§<] of treatments result in a shortfall).
- 4.44 In many cases the shortfall and its magnitude come as an unwelcome shock to the patient. Given the patient's expectations on his or her insurer to manage cost, patients often blame the insurer for these shortfalls.
- 4.45 The insurer will typically settle the hospital bill direct with the hospital. The patient may see a copy of the invoice, and this is usually the first time the insured patient will see either the hospital prices or the total cost of his or her care. If the insurer and hospital are 'out of contract', the patient will be sent the bill directly.

Conclusions on the patient journey

- 4.46 At various points in the existing patient journey for private patients there are **failures in terms of the information available to actors and the incentives of these actors**. The issues of information and incentives must be assessed in combination.
- 4.47 An outcome of the failures is that there is little effective competition between hospitals and between consultants on either a price or quality basis. **Individual providers do not have strong incentives to cut price or increase quality unilaterally**, as this action is unlikely to increase referral volumes. Without individual providers having this incentive, the system as a whole underperforms. Inefficient PH providers are sheltered from market forces, and there is limited incentive to make the way care is delivered more efficient. Further, the individual PH providers are incentivised to focus on their own short-term profits rather than on the long-term sustainability of the market as a whole.
- 4.48 There is little prospect of the failures in the journey correcting on their own. Individual PH providers have little incentive to fill the information gap if other providers do not participate. Patients have limited ability to effect change through their individual choices. Insurers also have limited ability to steer patients through the journey to providers offering high quality, affordable care (which aligns with the needs of the customer as payor and patient), as key decisions are taken by GPs, consultants and hospitals without involving the insurer.
- 4.49 Improving the information available to patients, GPs and insurers is fundamental to enhancing competition and informed decision making. However, this is only part of the solution. Market failures caused by local market concentration, consultant incentive schemes and consultant/anaesthetist groups would need to be addressed separately, as these would not be overcome by additional information transparency.

5. MANAGING OUR RELATIONSHIP WITH HOSPITALS

- 5.1 Bupa works with over 400 hospital and clinic operators each year in the UK to deliver care to our members. We pay [§<] of our annual claims spend to hospital providers. So the rapid rise of hospital costs over the past decade has impacted our members' premiums directly and substantially⁹².
- 5.2 Bupa has a strong focus on, and significant resources committed to, attempting to achieve better value for money from hospitals. However, we face critical challenges given the structure of hospital markets and the conduct of some of the main hospital groups. These challenges prevent Bupa, or other insurers and patients, from exercising effective buyer power.
- 5.3 The dynamics of the patient journey mean there is very little effective competition between hospitals on price⁹³, as both consultants and insured patients are insensitive to price, and on quality, as little directly comparable information on hospital quality is available. However, certain features of the market accentuate hospital market power. This chapter discusses and provides evidence for the following:
- i. There are highly concentrated local PH markets, particularly when considering key treatment specialisms. In many locations hospitals have local monopolies or face very limited rivalry.
 - ii. There are high barriers to entry and expansion from natural market features such as insufficient PH demand at a local level. These structural features are reinforced by strategies used by the main hospital groups to entrench their positions in markets (such as 'one in, all in' negotiation strategies and consultant incentive schemes) and to protect their existing revenue levels (e.g. anticompetitive contractual clauses with insurers). So many concentrated markets remain concentrated.
 - iii. Concentration and barriers to entry create market power which harms consumers directly. For example, we set out three case studies that show [§<]. Harm to consumers can also arise from lower levels of quality, innovation and efficiency.
 - iv. Insurers and patients do not have countervailing buyer power. For example, we explain why insurers' use of networks has been undermined by market power of the main hospital groups. This means that external intervention is needed from the CC to remedy the market.

HIGHLY CONCENTRATED LOCAL MARKETS

- 5.4 Bupa considers that there are a large number of local markets in the UK in which incumbent providers face little or no rivalry. This leaves little choice for either self-pay patients or the insurers commissioning care on their members' behalf.

⁹² Bupa's claims spend with hospitals increased from [§<], with costs increasing rapidly even as the number of Bupa members treated in hospitals has declined.

⁹³ Private hospitals have strong profit motives, supported by a fee-for-service model, some have highly leveraged business models, and with several of the main hospital groups owned by private equity investors.

- 5.5 Hospitals in these concentrated markets have less incentive to invest in quality, to achieve efficiency or to innovate. They have pricing power over both self-pay patients and insurers⁹⁴. The incumbents also have the ability to foreclose smaller rivals using strategies to build barriers to entry and expansion (e.g. consultant incentive schemes discussed in 5.68 below).
- 5.6 This market power at a local level is a significant concern in itself. However, limited choice for an insurer at the local level can have broader negative impacts on the market. If there is no effective competition to a hospital at the local level, it becomes 'must have' for an insurer if the insurer wants to serve existing and potential customers in that area. Where a 'must have' hospital belongs to a hospital group, the group can leverage the market power of this hospital across its whole portfolio of facilities during negotiations with the insurer. For example, the hospital group may tie its portfolio of facilities together, meaning that if the insurer wants the 'must have' hospitals owned by the group, it may be obliged to take all of the group's facilities (even those the insurer would not otherwise require). This "one in, all in" tactic by the group is discussed further at 5.57 below.
- 5.7 In assessing market concentration below we consider both the market shares of hospitals and estimated Herfindahl-Hirschman Index (HHI) ratios. The OFT and CC Merger Assessment Guidelines explain that a market in which the HHI exceeds 1,000 can be categorised as 'concentrated' and one in which it exceeds 2,000 can be categorised as 'highly concentrated'⁹⁵. We also refer to 'very highly concentrated' markets where the HHI is around 5,000⁹⁶. Our estimates of hospital market share and HHI are based on Bupa's annual claims spend with hospitals. We consider this to be a broadly representative indicator, although clearly the CC will be better placed to compile market share and HHI metrics directly from hospitals (as this hospital-level information is not in the public domain).
- 5.8 We explain below:
- i. Hospital markets in PH are narrow both from a product and geographic perspective. Markets have strong local dimensions, and there is no national dimension to the market.
 - ii. Hospital rivalry at the local level can be limited by several factors including specialisms offered, capacity, and relationships with consultants. Where there is insufficient choice at the local level, the hospital becomes 'must have' for insurers.
 - iii. There are over 60 hospitals in the UK that are in 'very highly concentrated' local markets, with market shares of over 80% and HHIs well above 6,000. The number of 'must have' hospitals increases significantly when looking at the specialism level. Each of the main hospital groups owns 'must have' hospitals.
 - iv. Even extending the geographic market beyond the local level, there are regions of the UK that are highly concentrated in general (and very highly concentrated in particular specialisms). For example, the estimated HHI in Scotland is over 4,400, in Wales it is over 2,000 and in Northern Ireland it is over 5,000. **Bupa has significant concerns**

⁹⁴ Empirical evidence from the US shows that more concentrated hospital markets have higher prices and often lower quality. See for examples, (i) Vogt and Town (2006) "How has hospital consolidation affected the price and quality of hospital care?", Robert Wood Johnson Foundation, Research Synthesis Report No. 9, February 2006, and (ii) "Improving Health Care: A Dose of Competition", A Report by the Federal Trade Commission and the Department of Justice, 2004.

⁹⁵ The OFT and CC Joint Publication, Merger Assessment Guidelines, 2010. Available at: www.of.gov.uk/shared_of/mergers/642749/OFT1254.pdf.

⁹⁶ We follow the CC's description in the Movies on Pay TV market investigation, where it is stated that: "...the HHI ... is around 5,000, suggesting that, by general standards, it is a very highly concentrated market".

about Central London⁹⁷, [3<]. The level of concentration in Central London is rising rapidly because of HCA's market growth strategies – examples include:

- In June 2010 HCA took a majority share holding in Leaders in Oncology;
- HCA has entered joint ventures with University College London Hospitals (in 2007) and Queens (2011) to develop their PPU's;
- HCA has built a network of satellite facilities in Outer London (e.g. New Malden and Seven Oaks) to channel patients into its Central London facilities; and,
- HCA is acquiring private GP practices in Central London (e.g. Rood Lane and General Medical Clinics).

Hospital markets are narrow

5.9 The OFT work on market definition in PH identified many of the challenges in applying standard market definition techniques in PH (because of the unique features of the market and the lack of appropriate data)⁹⁸. This work also highlighted the empirical evidence that techniques applied to define hospital markets in the past had flaws (often defining markets too broadly, particularly in urban areas).

5.10 The OFT MIR Decision looked at hospital market as follows:

- i. **The product market.** The OFT noted there is very limited, often no, demand side substitution between treatments. It considered that in some treatments, although not all, supply-side substitution could take place, meaning *“the competitive constraint provided by one PH facility on another is likely to relate to a group of treatments rather than a single type of treatment”* (para 4.11). The product market would include NHS PPU's (with recognition that the competitive constraint of PPU's varies on a case-by-case basis), but would exclude the NHS in line with the approach taken in merger cases. Therefore, the OFT focussed on privately-funded provision of *“a wide range of treatments by a PH facility”* (para 4.12).
- ii. **The geographic market.** Markets have a local dimension as patients want to be treated close to home. The OFT, therefore, applied a 30-minute drive time isochrone around a hospital. The OFT considered there may also be a national dimension, as competition appeared to take place at the national level between the PH providers in their contractual negotiations with PMI providers (with hospital prices set at a national level). The OFT recognised, however, that the competitive constraints between hospitals are predominantly local, and local conditions affect national negotiations between PH providers and PMIs⁹⁹. This means also that *“national market shares may overstate the competitive constraint imposed by the large PH providers on one another”* (para 4.57).

⁹⁷ “Central London” is defined as the area within the North and South Circular Roads. “Greater London” is the area within the M25. “Outer London” is the area outside the North and South Circular but within the M25.

⁹⁸ See the literature review conducted by Oxera on the OFT's behalf, “Techniques for defining markets for private healthcare in the UK”, November 2011.

⁹⁹ OFT MIR Decision (4.45): *“The OFT considers that, while there is a national dimension to competition, competitive constraints on PH provision are likely to be predominately local. This is because while there may be national negotiations, the OFT considers that competitive constraints on PH providers arise predominately from patients' need to access local hospitals.*

- 5.11 The OFT's approach provides a starting point. However, Bupa has concerns over certain aspects.

Existing market power creates a risk of defining markets too broadly

- 5.12 In Bupa's view, many incumbent PH facilities do not face effective competitive constraints and, as a result, have already been able to raise prices/degrade quality. There are significant barriers to entry and expansion in this market that limit the effectiveness of constraints from other private hospitals (e.g. credible entry could take a significant amount of time). There are also significant barriers to choice for patients (e.g. if their consultant is tied to a particular hospital¹⁰⁰) which limit the ability of the patient to switch and impose any discipline on the hospital.
- 5.13 In the presence of this market power there is a significant risk that markets will be defined too broad (the "Cellophane Fallacy"). The provider may already be exercising its market power, so any further increases in price (or reduction in quality) may lead to switching, but this switching is not evidence of effective competition. So before data on patients switching away from a particular provider is seen as evidence the provider faces effective competition or that the market should be widened, the CC must consider whether there is evidence of existing market power.

The product market should remain narrow

- 5.14 The services provided by PH operators are highly varied and not all hospitals offer the same range of treatments. This means competition between operators should be assessed at a disaggregated level. It is inappropriate, for example, to assume that two hospitals place competitive constraint on each other simply because they are located near each other – they may each focus on entirely separate treatments or specialisms and each may have market power.
- 5.15 The highly varied services also affect the choices available to insurers. An insurer must be able to offer members access to the full range of services covered by their policies. This means that the insurer may have to work with a hospital in an area because it is the only operator that offers a particular treatment or specialism (or offers that treatment or specialism on sufficient scale to serve the insurer's customer base), even where other hospitals in the area offer better value for money more generally. **Market power in one treatment or specialism can be leveraged across the other services the hospital offers in negotiations with insurers.**
- 5.16 Bupa is, therefore, concerned about the level of aggregation of products used by the OFT which could lead to incorrectly broad hospital markets:
- i. The OFT's **assumption on product aggregation is too strong**. Aggregation can hide pockets of market power in certain treatments/specialisms (a point recognised by the CC in paragraph 18b of its Issues Statement)¹⁰¹. From an insurer's perspective it is essential

In order to provide to these patients, PMI providers therefore appear to need to access local hospitals. Local competitive constraints may collectively influence national price setting during the negotiations between the PH and PMI providers".

¹⁰⁰ The OFT Consultant Survey (p 52) found that 48% of respondents never gave the patient a choice on location of treatment (often because the consultant did not have practicing privileges elsewhere), with a further 23% offering a choice of facility in under a quarter of cases. Only 8% of consultants gave a choice in more than half of their cases.

¹⁰¹ Oxera (2011) notes that the aggregation of treatments into bundles, for example 'acute general hospital care', can lead to incorrect broad geographic market definitions.

to be able to give customers access to the full range of services covered under their policies. Therefore, where the geographic market for a particular treatment is very narrow, we have limited choices of hospitals to recognise (giving the provider of this treatment market power) even if patients could travel further for other treatments. Bupa considers that the CC should apply more disaggregated product bundles than applied by the OFT.

- ii. The OFT **overstates the likelihood and effectiveness of supply-side substitution**¹⁰². To justify broadening markets, supply-side substitution needs to occur quickly (usually within a year) and effectively (on a scale to be a real constraint) in response to a small but significant non-transitory increase in prices/reduction in quality. The strength (even possibility) of supply-side constraint is limited by the barriers to entry and expansion in this market – see 5.42 below. Therefore, before broadening product markets, the CC needs to assess whether supply-side substitution is sufficiently rapid, inexpensive and will take place of sufficient scale to be a credible constraint. We do not believe that it would be easy and rapid to supply-side substitute between Oncology and Cardiology, for example, as specialist equipment and staff would be required.

5.17 In the analysis at para 5.30 below, Bupa looks at market concentration by major specialisms e.g. Cardiology, Oncology and General Medicine. Each specialisms would itself encompass a large number of treatments, and in many cases it will be appropriate to go to a more granular level¹⁰³. However, looking at the specialism level it is clear that there exist pockets of very high concentration which are masked within the aggregated data.

5.18 Bupa agrees strongly that **the relevant market does not include the NHS**. The NHS offers good healthcare. However, the majority of users of private healthcare want, and pay to access, certain features that they cannot get in NHS (see Section 3 on why customers buy PMI)¹⁰⁴. Even those parts of the NHS focussed on private healthcare, NHS PPUs, are not effective substitutes for most customers.

5.19 The inclusion of NHS PPUs in the product market carries risks because **PPUs are, in general, not effective competitive constraints on private operators**. We explain in Annex A that, in Bupa's experience, PPUs do not provide a competitive constraint on the conduct of private hospital operators and continue to face barriers to expansion in PH (so we do not expect the constraint from PPUs to increase materially in the near term¹⁰⁵). Some of these barriers are similar to those faced by other small hospitals, but several are specific to PPUs including the fact that:

- i. PPUs consistently and significantly perform below other private hospitals in patient satisfaction surveys conducted by Bupa and addressing some of these shortcomings will require significant investment;

¹⁰² The CC notes the importance of demand substitution relative to supply substitution in its Guidelines for Market Investigations (June 2012): "The willingness of customers to switch to other products is the driving force of competition. The boundaries of a product market therefore principally depend on the degree of demand substitutability between products" (para 13).

¹⁰³ That is, Bupa is not suggesting supply-side substitution could take place across all treatments within a specialism.

¹⁰⁴ The OFT MIR Decision notes that some PH provider said that the fact that insurers offered cash benefits to patients to use NHS facilities (and therefore accept longer waiting times etc.) instead of PH facilities was evidence that insurers saw the NHS as substitutable to the PH. However, the fact we must pay customers to use the NHS instead indicates that private patients do not see the two services as direct substitutes.

¹⁰⁵ Given the barriers to entry and expansion, we do not expect that the role of PPUs will change materially or rapidly following the lifting of the private patient income (PPI) cap to 49%. This cap was not binding for the significant majority of PPUs even before it was lifted.

- ii. PPU face organisational pressures that limit PH work (such as the duty to serve NHS patients first);
- iii. PPU face political pressures, in particular in relation to expanding private provision at a time when NHS beds are being reduced; and
- iv. PPU tend to be small¹⁰⁶, which means they are seldom effective alternatives for insurers looking to switch away from a larger hospital in a market.

5.20 Even the strongest PPU in London offer competitive constraint in certain specialisms only, and not across the board. This point is notably made by the second largest private hospital operator in London, The London Clinic: “...PPUs are not close competitors to HCA, The Clinic or the other private hospitals”¹⁰⁷.

5.21 In Bupa’s view, PPU should be included in the product market **only if** a thorough competitive assessment is then undertaken in each market that will rule out those PPU that are not effective competitors. If the CC plans to do fascia counts in local markets as a screening technique then it is inappropriate to include PPU.

The geographic market should be narrow

5.22 Bupa understands the OFT’s decision to use a 30-minute drive-time isochrone around a provider as a pragmatic starting point for the competitive assessment. We do not believe there is evidence this drive-time should be broadened.

5.23 From an insurer’s perspective, local dynamics are critical. PMI customers are clear on the importance of having the option to be treated in a location close to home (or close to work in some cases)¹⁰⁸. This matters because, when buying PMI, customers want policies that give them access to hospitals convenient to them. So insurers need to have access to hospitals near the members they serve and want to serve. This gives strong bargaining positions to hospital operators in locations where insurers have few alternatives located nearby.

5.24 Insurers do need to offer corporates nationwide coverage in PMI products. Many large corporates expect their employees to be covered wherever they are located in the UK. This increases the importance of having access to local markets across the country and also means that insurers cannot simply exit certain regions.

5.25 A ‘Chain of substitution’ argument should not be applied to extend the boundaries of geographic markets (i.e. when isochrones overlap). The competition mechanism functions poorly in PH. As a result, there can be very little competitive tension between hospitals located

¹⁰⁶ For example, as an indication of relative size, Laing and Buisson 2011 explains that the largest PPU within the M25 ranks only 17th in the list of hospitals in the M25 by number of beds.

¹⁰⁷ The London Clinic Initial Submission available at: http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/120516_london_clinic_initial_submission.pdf

¹⁰⁸ The importance of access to local hospitals is for example documented in customer research conducted by The Value Engineers in October 2010. Based on interviews with customers, the firm reported: “Customers are very clear on the importance of being treated in a location close to home ... They are concerned both about their ability to reach the hospitals if they are unwell, and also the distance family and friends might have to travel to visit them ... Letting customers know that they will be seen close to home is a powerful emotional reassurance”, although it should be noted that “though location is crucial to customers and the ideal is that they are treated close to home if the condition is serious enough and there is an expert available who can treat them they will go to great lengths to ensure treatment”. The OFT patient interviews also found that, in general, patients’ primary concern when considering a choice of PH facility was to be treated locally (OFT patient interviews, p 47).

in the same isochrone, and so it becomes unlikely that competition will flow across isochrones. A ‘chain of substitution’ is made even less likely by the heterogeneity of patients and heterogeneity of hospitals. For example, even though there are several hospitals in Central London this does not necessarily justify a London-wide market; the CC must consider whether there are in fact smaller submarkets within London.

There is no national dimension

- 5.26 The OFT considered there to be a ‘national dimension’ to markets because hospital groups set standard national prices with insurers. Bupa would prefer prices to reflect dynamics of competition, demand, supply and cost at a local level rather than a single national price list. The so called ‘national dimension’ exists because hospital groups provide no other alternative¹⁰⁹.
- 5.27 As explained at para 5.38, there is very little head-to-head competition between the main hospital groups across the UK. The main hospital groups are not all located in the same geographic regions¹¹⁰. For example, of the main five groups [redacted] giving insurers very limited choice. [redacted]. National competition is further blunted by each group owning ‘must have’ hospitals because there is limited ability for an insurer to switch away from a group, which means each group individually has little incentive to offer insurers value for money.
- 5.28 **Bupa does not believe a national market for hospital competition should be defined.** The starting point should remain local markets only expanding this if there is genuine evidence of hospitals competing over a wider region. To be clear, Bupa considers the national market shares of the main hospital groups to be a misleading representation of each group’s strength.

Identifying hospitals that are ‘must have’

- 5.29 From an insurer’s perspective, a hospital may have market power in a local area if any of the following factors exist:
- i. **There are no, or a very limited number, of rival hospitals located nearby.** The insurer ‘must have’ the hospital in this location if it is to be able to serve customers in this area. It can also happen that rivals nearby are owned by the same group and so do not offer genuine competitive constraint on each other e.g. HCA owns 6 main facilities clustered in Central London.
 - ii. **The rival hospitals nearby do not offer particular key specialisms** which the insurer must be able to offer to patients in that area. For example, in [redacted] there are two private hospitals – the [redacted] – located very near each other, but with no other hospitals within 30-minutes drive time. However, Bupa must work with both because [redacted] controls 100% of the Bupa activity in local market for Cardiology and Oncology (and around 90% in Ophthalmology), while [redacted] controls over 95% in Obstetrics & Gynaecology and around 90% in General Medicine.
 - iii. **The rival hospitals nearby have limited capacity** that could not serve the insurer’s local demand. For example, we consider the [redacted] to be a ‘must have’ hospital because,

¹⁰⁹ It would be inappropriate to consider a national market, and therefore dilute each of the main hospital group’s market shares, precisely because hospital groups are in such a strong position that they can insist on a national price list.

¹¹⁰ The OFT acknowledges this in its concentration analysis. The national market was found to be concentrated, with an HHI by revenues of over 1,300, although “the national HHI will mask areas of high local or regional concentration as not all of the main PH provider groups are present in all areas” (para 6.12).

even though there is a PPU within a few minutes' drive, this PPU is small and accounts for only around 3% of Bupa's spend in the area.

- iv. **The consultants at the hospital are unwilling or unable to direct their patients elsewhere.** According to Bupa's claims data around [X] of consultants work at one hospital only. Many hospitals also tie in consultants with financial and non-financial incentives (which raise consultant switching costs). This creates a significant barrier to an insurer switching hospital because the insurer will need to convince all of these consultants to change referral patterns (e.g. to acquire or use practice privileges elsewhere).
- v. **Rival facilities may not offer consistency of customer service,** which limits the ability of the insurer to rely on them. This is particularly a challenge in relation to PPUs.
- vi. **Patients may be unwilling or unable to switch.** For example, several large corporate customers insist on Bupa offering access to the [X] because of its convenient location to the City of London.

There are a large number of 'must have' hospitals in the UK

5.30 To illustrate the number of 'must have' hospitals in the UK, Bupa assessed its In-patient/Day-case episode volume with hospitals in 2011. The following methodology was applied:

- i. A 30-minute drive-time isochrone was calculated around each of the [X] main hospital facilities Bupa works with¹¹¹ – these hospitals together account for around [X] of Bupa's annual hospital spend. PPUs are included in the analysis, although as discussed above Bupa considers that many may not be effective competitive constraints.
- ii. If no other rival facilities are within this 30-minute drive-time isochrones, the focal hospital (the facility at the centre of the isochrone) is identified as 'must have' purely on a geographic basis.
- iii. If other facilities are present within the isochrone, Bupa's episode volume across all the facilities present in the isochrone was calculated in aggregate and in certain major specialisms¹¹²:
 - If the focal hospital controlled over 80% of Bupa's episode volume in aggregate in the local area it is added to the 'must have' list. This would indicate the focal hospital is much larger than any rival facilities near it (or has much stronger control of consultants in the area) and that Bupa would struggle to find sufficient capacity elsewhere to switch away from it.
 - If the focal hospital had less than 80% of the aggregate episode volume, but more than 80% in one of the key specialisms it was added to the 'must have' list.

¹¹¹ Smaller facilities that offer only outpatient treatments like pathology or scanning services were excluded.

¹¹² The following major specialisms were covered in the analysis: Orthopaedics, General Surgery, Oncology, Gastroenterology, Obstetrics and Gynaecology, Urology, Ophthalmology, General Medicine, Ear Nose & Throat Surgery, Anaesthetics, Cardiology, Plastic Surgery, Haematology, Oral and Maxillofacial Surgery, Neurosurgery, and Cardiothoracic Surgery.

5.31 The results of our analysis are shown in Table 4. These facilities have significant market positions, facing either no or very limited rivalry in the local market. **The HHIs within these local markets would be well above 6,000 in aggregate or in key specialisms.**

Table 4: Must have hospitals based on 2011 activity

	BMI	Spire	HCA	Nuffield	Ramsay	Other	Total
'Must have' by geography	[X]	[X]	[X]	[X]	[X]	[X]	42
'Must have' by over 80% in aggregate	[X]	[X]	[X]	[X]	[X]	[X]	21
'Must have' by over 80% in specialisms	[X]	[X]	[X]	[X]	[X]	[X]	73
Total	[X]	[X]	[X]	[X]	[X]	[X]	136

5.32 **HCA has a very strong position in Central London**¹¹³. [X].

5.33 For example:

i. [X]

ii. [X]

5.34 Therefore, given the common ownership of these facilities there is little alternative choice for an insurer in these specialisms in Central London. [X].

Table 5: [X]

Specialism	[X]	
	2007	2011
Oncology	[X]	[X]
Orthopaedics	[X]	[X]
Cardiology	[X]	[X]
General Surgery	[X]	[X]
General Medicine	[X]	[X]
Obstetrics & Gynaecology	[X]	[X]
Urology	[X]	[X]
Neurosurgery	[X]	[X]
Radiology	[X]	[X]
Haematology	[X]	[X]
Gastroenterology	[X]	[X]
Cardiothoracic surgery	[X]	[X]

¹¹³ HCA also controls The Christie in Manchester.

5.35 **Each of the main hospital groups owns ‘must have’ hospitals** with [X] owning the most in number. However, a simple count of must have hospitals is inappropriate, as some carry significantly more importance than others. For example, the [X] is essential for an insurer if it wants to serve major oil and gas clients. If the insurer failed to offer this hospital, it would lose the business of these companies across the whole UK. Similarly, the [X] is essential for an insurer to offer to corporate customers in the City of London.

5.36 There are also non-group hospitals that are ‘must have’. [X].

5.37 This analysis illustrates the high level of concentration in local markets. Further points to note are:

- i. The list of ‘must have’ hospitals may be underestimated by the 80% threshold, which is chosen only as an indicator, being too high. It could be that a hospital which has, say, only 50% of local episode volume (or spend) is sufficiently large compared to smaller capacity-constrained local rivals that it remains ‘must have’ to the insurer as rivals could not absorb that volume of redirected patients.
- ii. The analysis does not consider whether patients and consultants could be convinced to switch to the rival facility. Accounting for these issues would likely expand the list of ‘must have’ hospitals. For example, if a significant proportion of the consultants in a local area are tied to a particular hospital through consultant incentives, that hospital may remain ‘must have’ even if another facility is present.
- iii. The insurer may apply a materiality threshold that would shorten the ‘must have’ list marginally. It may be the case that a hospital has ‘must have’ characteristics but few PMI customers would be negatively affected if the insurer chose not to work with it. For example, Bupa delisted the BMI Gisburne Park in 2012 (although the facility remained within the Ophthalmology and MRI networks because of its location), which does not have other private hospitals within 30-minutes drive time, as it is very small accounting for under [X] of Bupa spend with BMI each year ([X]).

There is significant concentration even at a broader regional level

5.38 An insurer’s choices are very limited in certain areas of the UK even if customers/patients were able or willing to travel significantly further. We illustrate this by looking at 19 broad regions of the UK shown in Figure 21¹¹⁴.

5.39 An analysis of Bupa hospitals claims spend in 2011 shows:

- i. Many of these broad regions are highly concentrated, and very highly concentrated in particular specialisms.
- ii. The main five hospital groups do not compete ‘head to head’ in each regions. There are several parts of the UK where only 2 or 3 of the groups are present e.g. [X] (and why it is inappropriate to consider national market shares).

¹¹⁴ Bupa segments the UK into these 19 regions in its day-to-day operational and commercial planning. To be clear, Bupa does not consider these to be relevant markets from a competition law perspective.

Figure 21: [redacted]

5.40 Table 6 shows that there is high concentration even at the broad regional levels. The HHIs of the main five groups are shown, as well as the HHI of the operators (main groups and independents) that together account for over 85% of Bupa spend in the region. [redacted]. Some of the groups also have minimal or no presence in certain regions (with under 10% share shown in light grey).

Table 6: HHI by region for the main five hospital groups and hospital operators accounting for over 85% of spend in 2011

	Market share by Bupa spend					HHI of main 5 groups	HHI of hospitals accounting for over 85% of spend
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
East Anglia	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2,339
Northern Ireland	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	5,449
London*	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2,582
Mersey	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3,444
North East Thames	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1,986
North West Thames	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3,394
North Western	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2,173
Northern	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2,958
Oxford	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2,451
Scotland	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	4,446
South East Thames	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2,420
South West Thames	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1,396
South Western	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2,300
Trent	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2,867
Wales	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2,250
Wessex	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1,844
West Midlands	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2,809
Yorkshire	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3,310

Source: Bupa claims data 2011

Note: Channel Islands are not shown because no hospital operators are located there.

* "London" does not align with Central London (the area within the North and South Circular) discussed above. London here covers the majority of the area within the M25 so is broader than Central London.

5.41 Concentration is even higher within specialisms. Table 7 shows the estimated HHIs by region for 16 major specialisms. The HHIs are calculated using the market shares of the largest operators in each region that together account for over 85% of the market in each specialism. In each of the 18 regions insurers have extremely limited choice for particular specialisms.

Table 7: [redacted]

HIGH BARRIERS TO ENTRY AND EXPANSION

- 5.42 There are significant barriers to entry in PH provision by hospitals. Some structural barriers are natural features of local markets – for example, certain localities do not have sufficient PH demand to support more than the existing hospital. However, there are also non-structural barriers that are erected strategically by incumbent hospital operators. These restrict efficient entry even when entry could have been possible and they can also restrict the expansion of smaller rivals. Examples discussed below include the ‘one in, all in’ negotiation strategies by the main hospital groups, the use of schemes to tie in consultant and GP referrals, and contractual clauses that restrict the ability of insurers to make available volume to new entrants.
- 5.43 These entry barriers lessen competition and harm consumers through increased costs and reduced choice. Concentrated markets remain concentrated. Inefficient hospitals are sheltered from market forces, allowing high costs to remain in the market¹¹⁵. More efficient entrants are prevented from growing and, therefore, may not compete as actively today and in the future. Insurers are also left with weaker bargaining power against incumbent operators who know the insurers have, and will continue to have, limited options.
- 5.44 We discuss in this section the main structural barriers Bupa observes in the market, and focus particularly on the non-structural barriers. However, we note that:
- i. It is particularly challenging for a full-service line hospital (i.e. offering a range of specialisms) to enter given the costs involved of entering on a broader scale. This type of hospital entry, however, is necessary for an insurer to be able to switch away from an incumbent full-service line hospital. When assessing the effects of entry on competition in a local market, the CC must consider the specialisms on which entry took place to see whether the entry genuinely increased rivalry in the market.
 - ii. Some hospitals say that difficulties in getting commitment of recognition by an insurer in advance may deter new entry¹¹⁶. Bupa understands the concern, but does not believe it is reasonable to expect insurers to ‘guarantee’ recognition, in advance, to a hospital that is still being built. The hospital needs to demonstrate it meets minimum quality and commercial standards operationally before it can be recognised, otherwise our members are put at risk. However, new entrants can take comfort from Bupa having strong incentives to recognise a new hospital that offers value for money. We work with new entrants to understand the local market, providing insight and data where appropriate. This is, for example, evidenced by our support for, and recognition of, the Circle hospital in Bath.

There are significant structural barriers to entry

- 5.45 The structural barriers to entry into PH provision are material. Building a hospital takes substantial cost and time, accompanied by uncertainty. Bupa considers the major structural barriers to entry for a hospital operator to be: (i) securing sufficient demand; (ii) information asymmetries; (iii) the costs of acquiring a suitable site, constructing a facility and securing regulatory permissions; and (iv) the need to attract consultants to practice at the facility.

¹¹⁵ Entry of new models of care is critical for the long-term sustainability of the PH, as these models are more cost effective than the historic hospital infrastructure. Lowering entry barriers would provide competitive discipline on existing operators to reconfigure (e.g. to strip out redundant capacity) and to innovate.

¹¹⁶ OFT MIR Decision (para 8.19): “...smaller PH provider groups state that they are unwilling to risk the costs of setting up a new PH facility without an absolute assurance of PMI provider network recognition”.

A sufficient volume of local demand

- 5.46 The new entrant would need to be confident it could secure a sufficient proportion of local demand to reach a viable scale. Further, it would need confidence that this demand would be sustained (or would grow). In many areas of the UK demand is under pressure given the issues of affordability of PH and PMI. In practice, many areas where there is demand for PH already have established facilities serving the patient numbers available.
- 5.47 The new entrant would also assess whether the existing hospital had excess capacity, which could be used to absorb quickly any increases in demand. Bupa understands that currently there are many hospitals in the UK running with excess capacity. This excess capacity would act as a deterrent for an entrant.

Information asymmetries

- 5.48 The lack of accessible, comparable data on quality offered by PH hospitals across the UK makes entry difficult. A new entrant may not necessarily win share away from an incumbent even if it is offering better value for money care. Faced with a lack of information patients, GPs and consultants cannot make informed decisions to move away from an underperforming incumbent (i.e. existing referral patterns will remain entrenched).

The costs of acquiring a site, constructing a facility and securing regulatory requirements

- 5.49 The costs to build a new hospital building can be substantial¹¹⁷. These costs include capital expenditure, obtaining land and planning permission, and meeting regulatory requirements.
- 5.50 First, a new entrant has to identify a location that is conveniently located for both consultants¹¹⁸ and patients (e.g. with good access to transport facilities). Then it must get planning permission. Bupa understands that planning permission can be expensive, uncertain, and is time-consuming to obtain. In many cases the most appropriate site for a hospital is not necessarily the one where planning permission is readily available. There is no specific zoning (land allocation) in town and country planning for hospitals and no strategic structure plan for their development. Hence, each planning applications requires specialist consideration. This process allows opportunity for organised objection to the granting of planning permission by existing hospital providers.
- 5.51 Central London is a key example of a market that hospital providers are keen to enter but where it has proved to be exceptionally difficult due to the limited availability of suitable locations and the difficulties in obtaining planning permission. Of the main hospital groups only BMI has managed to open a small facility in Central London (Nuffield, Spire and Ramsay have not managed to open new facilities).
- 5.52 Second, developing a new hospital requires substantial capital investment. The OFT found that *“these costs are not insignificant ... a new PH facility can range from £3m to upwards of*

¹¹⁷ Entry into a local area may also be possible through acquisition of an existing facility. However, in the recent past it has been rare for individual hospitals to become available on the market. Where these individual hospitals do become available, they have typically been acquired by the incumbent main hospital groups.

¹¹⁸ Consultants may need to attend hospital several times a week in order to treat patients. The majority of consultants also carry out work at NHS hospitals, and much of their private practice work takes place before or after attending their NHS hospital. Therefore, hospitals located near to home or work locations of consultants are more convenient and more attractive to consultants. Attracting consultants is crucial in determining the success of a private hospital facility (see below).

£25m¹¹⁹. Bupa estimates a typical 50 bed private acute hospital with its own infrastructure (including operating theatres, pathology laboratory, pharmacy and medical stores) would cost [£<] to build, and that land costs, specialist equipment and other costs would add [£<]. A typical construction would take 18 to 36 months from start on-site to first patient admission depending on the site.

- 5.53 Third, the entrant would need to meet regulatory requirements. The Care Quality Commission (CQC) regulates all health and adult social care services in England, including those provided by the NHS and private companies. All hospitals (including newly built) have to ensure that essential common quality standards, set by the CQC, are met. However, it is not possible to apply for and be granted the relevant authorisation prospectively. Hence, a hospital developer builds a hospital with the risk that it may not be given legally required recognition to treat patients, or that obtaining the relevant permissions will cause delay in beginning operations.
- 5.54 The OFT also noted that the new “satellite” hospital model – where a provider sets up smaller diagnostic satellite facilities in area A that channel patients to its larger full-service facility in area B – may lower the capital costs for successful entry and so improve competition. Bupa accepts it may lower entry barriers, but cautions that the model is not always in the interests of consumers. The model can be used by dominant hospitals to extend their positions into new markets. We have, for example, seen HCA employ the satellite strategy in London. HCA has set up small facilities in areas outside of London that direct patients needing further treatment into their Central London hospitals. [£<] (and London is more expensive on average than areas outside London). Therefore, this strategy means a higher volume of patients are now being directed to the [£<] hospitals. Patients do not understand this dynamic when they visit the small diagnostic centre (and in any event the insured patients are not price sensitive). Furthermore, once in the HCA process, switching costs emerge for the patient, reducing the likelihood that they can or will switch to a better priced provider.

Attracting consultants

- 5.55 It is critical for a new hospital to attract a sufficient range of consultants¹²⁰. However, consultants usually have an established relationship with existing hospitals, and tend to base their practice predominantly at one facility (rather than splitting work across a number of facilities). Therefore, a hospital can be restricted from entry or expansion if there are too few available consultants in a local area (and, as discussed at 5.68 below, it is a particular concern where consultants in the local area are tied into working for the incumbent)¹²¹.

Incumbent hospitals can create non-structural barriers to entry

- 5.56 Bupa also believes that some of the main PH groups are behaving in a way which has the effect of creating non-structural barriers to entry and expansion. These behaviours are described below.

¹¹⁹ OFT MIR Decision, para 8.7.

¹²⁰ The OFT has previously acknowledged that the need to secure such relationships constitutes a barrier to entry. Spire/Classic merger decision, 2008, paragraph 79.

¹²¹ Consultants do face entry barriers themselves into local markets which can also mean that the hospital entrant struggles to get sufficient new consultants into an area. For example, the local NHS Trust may not have available vacancies for consultants which can restrict entry as the majority of private consultants are employed in the NHS at the same time.

The exclusionary effect of “one in, all in” negotiation by the main hospital groups

5.57 ‘One in, all in’ is a tactic used by the main hospital groups when negotiating prices with insurers. Under this negotiating strategy, a hospital group only allows the insurer to contract with either all of its hospitals or none at all. The group also sets a single uniform national price across all of its hospitals.

5.58 This practice has significant anticompetitive effects:

- i. Tying its hospitals together allows the group to leverage the market power of its ‘must have’ hospitals into other markets. The insurer has to recognise certain hospitals in the group’s portfolio (even if it does not require them) if it is to gain access to the ‘must have’ hospitals.
- ii. This can foreclose independents in the local markets where there is a choice of facilities, as these rivals now have to share patient volumes with the group’s hospital. This affects the independent hospital’s ability to move down its cost curve through economies of scale and also discourages independents from competing actively (as they know they will not be able to push an inefficient group hospital from the market).
- iii. As the practice distorts what competition could take place between hospitals at a local level, it makes entry decisions for independents less clear.

5.59 “One in, all in” can be achieved by the hospital group in various ways¹²². It can be (i) a negotiating stance by the hospital group (to only offer its portfolio of hospitals as a single bloc); (ii) put into effect through specific contractual clauses, or (iii) put into effect by volume discount schedules that make it very costly for the insurer to take volume to alternative providers.

Negotiation stance

5.60 Hospital groups typically negotiate with insurers on a ‘whole group’ basis with a single national price. In Bupa’s experience the main groups have been highly unwilling to have only a portion of their portfolio recognised or included in a particular network. [redacted] This meant the network launched with gaps in its coverage. Bupa was able to manage the situation, given it was for only one treatment, for a period of a year (although incurred significant additional costs) and so did not replace the independent facilities that had successfully won recognition into the network. However, Bupa ultimately had to resolve the situation with [redacted] and include all its facilities in the next generation of the network (which was then done on an ‘any qualifying provider’ basis).

Volume-discount schedule to effect “one in, all in”

5.61 [redacted]

5.62 [redacted]

¹²² The OFT MIR Decision (para 8.31) notes the “the interplay of ‘one in, all in’ clauses with ‘alleged pricing threats’ and ‘other contractual provisions relating to entry’... can mean that it may not be cost effective to recognise new facilities on a network.”

Table 8: [redacted]

5.63 [redacted]

5.64 [redacted]¹²³:

i. [redacted]

ii. [redacted]

iii. [redacted]

Table 9: [redacted]

Contractual clauses to effect “one in, all in”

5.65 “One in, all in” can also be achieved through certain contractual clauses. [redacted] .

5.66 [redacted]

Contractual clauses to restrict entry

5.67 Bupa has observed hospital operators with market power insist on clauses in contracts that seek to restrict the insurer’s ability to work with rival hospitals (e.g. entrants)¹²⁵. For example, [redacted] has clauses in its contract with Bupa which make it challenging for Bupa to launch network products with rivals that do not include [redacted] (these clauses are covered at 5.122 below). By restricting Bupa’s ability to launch these new products, and so attract new patient volumes to the market, there is less room available for entrants.

Strategies to control referral volumes

5.68 Certain private hospitals use strategies to lock in patient referral volumes with the effect of raising barriers to entry and expansion for other operators¹²⁶. The OFT MIR Decision (para 8.72) notes this concern: “*where consultant exclusivity or loyalty is encouraged or required by PH providers with local market power using direct or indirect financial incentives this may create further barriers to entry in the PH market as this reinforces the consultant drag effect, drawing consultants away from new entrants or other PH providers*”.

5.69 Clearly contractual clauses that oblige consultants (or consultant groups) to work exclusively for one hospital raise barriers if there are insufficient alternative consultants in that locality.

5.70 We give examples of consultant incentive schemes in Section 6 which have the effect of increasing the switching costs for consultants and biasing referral patterns in favour of one

¹²³ [redacted]

¹²⁴ [redacted] these restrictive clauses/terms; however, similar clauses may exist in other insurers’ contracts.

¹²⁵ The OFT MIR Decision (para 8.80) found that larger hospital operators impose conditions “*as part of the recognition of their facilities on PMI networks which may restrict the ability of PMI providers to recognise new entrants attempting to offer competing PH services on their networks. For example, some PH providers impose conditions on PMI providers that they be consulted on the recognition of a new entrant on a PMI providers’ network, or that impose price rises on a PMI provider should a new entrant be recognised*”.

¹²⁶ The incumbent may not need to tie in all volumes to barricade entry. It only needs to secure sufficient patient volumes to mean that the entrant cannot reach a viable scale.

hospital over another. These incentives can be both financial payments and non-financial benefits¹²⁷. Financial incentives (e.g. revenue-sharing agreements) clearly make it costly for the consultant to direct work to a new entrant that cannot match that scheme. However, non-financial benefits can be equally effective in restricting the consultant's ability to move work to a new facility. For example, if the consultant uses the hospital's IT and billing system to run his or her practice, there will be challenges for the consultant in moving all or part of his or her practice to another hospital.

- 5.71 Bupa has concerns about the trend mentioned in the OFT MIR Decision of private hospitals offering incentives to GPs.
- 5.72 Bupa is aware also that the main hospital groups actively target GPs through GP liaison teams and marketing encouraging GPs to make open referrals to their hospitals (yet at the same time oppose insurers offering open referral schemes).
- 5.73 Finally, Bupa has significant concerns about hospitals vertically integrating down into the private GP market, thereby capturing patients at the point of diagnosis. For example, HCA purchased the Rood Lane private GP practice in 2011 and General Medical Clinics in 2012. These acquisitions can entrench referral pathways in local areas, making it more difficult for rival hospitals to receive referrals.

MARKET POWER HARMS CONSUMERS

- 5.74 The significant market power of certain large hospital groups has material impacts on the treatment costs charged to patients and insurers.
- 5.75 Throughout the section Bupa refers to the “**hospital treatment costs**” as the total amount the insurer or patient has to pay a hospital for a treatment¹²⁸. We use the term “hospital treatment costs” rather than hospital “prices” to avoid confusion with the unit price rate cards hospitals have for services in their contracts with insurers. The unit prices in these rate cards tell only part of the story about how expensive a hospital is relative to peers. Treatment costs can be inflated through increases in the unit prices and/or through increases in the volume and type of treatments provided¹²⁹. As hospitals have some influence over the volume and type of care delivered when the patient is in the hospital (with the insurer/patient having little control or choice), this aspect must be taken into account in treatment cost comparison¹³⁰.
- 5.76 We set out three case studies that show that \gg . There is also little evidence that the higher hospital treatment costs charged are associated with superior quality (as discussed in 5.105).
- 5.77 The three case studies cover:

¹²⁷ Non-financial schemes often have a financial effect through allowing the consultant to avoid making payments for particular services, such as secretarial or billing support, that they would otherwise have to pay.

¹²⁸ This is separate to the amount the patient or insurer pays the treating consultant or anaesthetist (except in the rare circumstances where the hospital and consultant use a combined package price). And it does not refer to the costs the hospital itself incurs in delivering the treatment (which only the hospital can observe).

¹²⁹ For example, the hospital's rate card with the insurer may state a £200 per day unit price for accommodation; although, the ‘treatment cost’ paid by the insurer will include £800 for accommodation if the treatment requires 4 days in hospital. In this example, a hospital may be more expensive than another either if it charges a higher unit price (say £220 per day for accommodation), keeps the patient for longer than 4 days, or applies some combination of the two. The effects and evidence of variation in treatment practices is discussed in Annex E. Treatment costs can be inflated both by **over-treatment** (e.g. the patient being kept in hospital longer than necessary) and **over-diagnosis** (e.g. the patient being given an unnecessarily high specification of diagnostic test).

¹³⁰ The ways in which radiology and pathology services are organised and utilised by the hospital can escalate end-to-end treatment costs.

- i. An analysis of the relative treatment costs of the main hospital groups for a basket of 100 surgical procedures. [§<]. It shows also the very material disparity between the treatment costs in Central London hospitals compared to hospitals in the rest of the UK.
- ii. A detailed analysis undertaken by Bupa in 2009/10 during the negotiation between Bupa and [§<]. As will be explained, the lack of transparency and comparability in the way hospitals code procedures and invoice makes detailed price comparison a challenging task; typically requiring Bupa to hand check and compare procedures and invoices individually. Bupa undertook this in-depth analysis during its 2009/10 negotiation, and the case study illustrates that [§<].
- iii. A comparison of the mark-ups hospitals charge on drugs and prostheses. The larger hospital groups tend to enjoy the largest mark-ups and internalise, rather than pass on, any economies of scale in procuring these drugs and prostheses. [§<].

5.78 These case studies indicate that the direct financial harm of hospital market power to patients is substantial¹³¹. Bupa accepts there are caveats to the analysis, discussed below. However, many of the challenges in undertaking comparison stem from actions taken by hospitals.

5.79 Further, the harm illustrated in the case studies tells only part of the story because:

- i. The case studies analyse only 'relative' treatment costs between hospitals, meaning they do not account for hospital treatment costs being too high in general. The majority of hospitals are likely to have a degree of pricing power given the high levels of local concentration (at the specialism level in particular), entry barriers and consultant/insured patient insensitivity to price¹³². So the baseline for the relative treatment cost comparison is unlikely to be a 'competitive' level, meaning the relative analysis identifies only part of the welfare loss to consumers. This also means that welfare losses should be assessed against the counterfactual of how the market would perform absent the impaired competition. Currently costs are inflated against this counterfactual because less efficient hospitals are able to remain in the market while more efficient hospitals are prevented from being able to grow to replace them. In addition, innovative care delivery methods (such as care delivered at home rather than at hospital) and PMI products are kept from the market.
- ii. The case studies show only welfare losses from market power at a point in time, whereas losses accumulating over time will be greater.

¹³¹ The OFT MIR Decision (para 6.55) makes an observation which suggests prices for insured patients significantly exceed the marginal costs incurred by private hospitals in treating an insured patient. The OFT explains that "*PH providers have stated that PMI funded patients are significantly more profitable compared to NHS patients...*", which suggests average prices to insured patients significantly exceed prices to NHS patients. The OFT goes on to explain that hospitals are still able to cover direct treatment costs on NHS patients, stating there was "*... financial data, supplied by some of the PH providers and analysed by the OFT, which shows revenue earned from treating NHS patients often did not appear to cover all costs associated with treating NHS patients ... [and continuing in footnote 217] In these cases, while a profit was made relative to treatment and building costs, only a contribution was made towards administrative and overhead costs*".

¹³² Insurers also face the challenge that the first-round effect of the main hospital groups raising their prices leads to second-round effects of smaller hospitals raising their own prices. These smaller hospitals have little to gain from pricing keenly if the insurers are unable to shift volume away from the large groups (e.g. because of 'one in, all in' negotiation by the larger groups). This leads to higher prices across the market, with limited incentive for individual hospitals to cut prices unilaterally as they may see only limited incremental volumes.

- iii. The case studies relate to the hospital treatment costs that Bupa faces from hospitals. Self-pay patients and smaller insurers with lower volumes will likely face higher costs¹³³.

5.80 We understand that the CC may undertake a broader price comparison across hospitals during the course of its investigation. In doing so, however, it should be aware of the complexities of cost comparison and the need to undertake this analysis carefully to improve the robustness of results. Therefore, we set out below some of the challenges in hospital treatment cost comparison before discussing the case studies.

Issues to consider in hospital treatment cost comparison

5.81 There are several challenges to overcome in undertaking hospital treatment cost comparison:

- i. the heterogeneity of hospitals and the services they provide;
- ii. the lack of standardisation in the way hospitals code treatments and invoice insurers; and
- iii. the pricing strategies of the main hospital groups.

5.82 We discuss each in turn and what Bupa does to manage the challenge when possible. Bupa uses its claims database to undertake its comparison analysis, as this allows calculation of actual treatment costs paid to each hospital.

Heterogeneity of hospitals and services they provide

5.83 The large number of different hospitals across the UK makes comparison challenging. Bupa manages over 400 different hospital provider contracts. Each hospital (or hospital group) will have its own price lists and treatment patterns. Each hospital also offers its own portfolio of services. So, at a practical level, undertaking pair-wise comparison across this large population is a significant challenge (made more difficult by the lack of standardisation discussed below). Bupa focuses its analysis on comparisons between the main five hospital groups (which together account for [redacted] of Bupa's hospital spend) and a handful of smaller hospital operators (such as The London Clinic, the Aspen Group etc).

5.84 Bupa tends to conduct price comparison at a more aggregated level (e.g. at the level of Central London) to mitigate the challenge of having insufficient comparators at a local level. Bupa compares 'peers' in terms of geographic spread e.g. Central London hospitals against other Central London hospitals or one national group against another national group.

5.85 The large number of different types of treatment also makes comparison challenging. An individual hospital may offer thousands of different types of treatment. Even within a single specialism there may be hundreds of different types of treatment. This makes detailed price comparison a burdensome and time consuming process; particularly, as discussed below, given the different approaches hospitals use in coding treatments.

The lack of standardisation in the way hospitals code and invoice

5.86 A key challenge in cost comparison is the lack of a common coding structure across PH for the treatment undertaken and the condition of the patient pre-treatment.

¹³³ [redacted]

5.87 The majority of hospitals charge for surgical procedures using the CCSD coding structure¹³⁴. However, surgical procedures account for [X] of total Bupa spend with hospitals. [X].

Table 10: [X]

5.88 Alongside non-standard coding is the non-standard definition of services. For example, some hospitals invoice for pre-operative tests and post-operative physiotherapy separately while others bundle these into the price of the surgery. If little explanatory information is included on the invoice, matching and comparing the treatment costs with the costs of treatments at another hospital is challenging.

5.89 A patient's treatment may also involve multiple episodes or events over a period of days or years. Hospitals do not currently conjoin, or reference the related episodes or events, in their invoices. This makes capturing the full hospital treatment costs challenging. This means Bupa can typically only assess the hospital treatment cost from the time a patient entered the hospital for surgery to the time the patient was discharged. This allows a more meaningful comparison than looking only at unit prices between hospitals, although certain parts of a hospital's treatment cost (e.g. pre-operative diagnostic checks) may not be captured in the analysis.

The pricing strategies of the main hospital groups

5.90 Hospitals have discretion on how they set prices across their portfolio of products.

5.91 In Bupa's experience hospitals do not focus on fine tuning per treatment prices (as may be done in the retail sector for example) but on maximising revenues across the whole portfolio (i.e. the hospital is concerned that its total revenues goes up in each negotiation, and is less concerned about how prices go up on individual treatments). This leads to cross-subsidisation. A hospital might accept a lower margin in one segment of its portfolio if this is compensated for by higher margins in another segment. This means that focusing the costing comparison on too small a segment of the portfolio may lead to distorted results, as one hospital may price high on that segment and lower elsewhere where another may price low on that segment and higher elsewhere.

5.92 Table 11 shows Bupa claims spend across the main hospital groups (with PUs and Other shown for illustration) with this spend split into six broad categories. There are significant differences in where each provider earns its revenue across its portfolio. [X] earns comparably more of its revenues from drugs, for example, whereas [X] earns more of its revenue from the top 100 surgical procedures.

¹³⁴ CCSD is an independent body in the private sector that defines coding for all surgical procedures and certain diagnostic procedures.

Table 11: Percentage breakdown by category for Bupa spend with different hospitals in 2010

	BMI	HCA	Spire	Nuffield	Ramsay	NHS PPU's	Other
Actual spend (m)	[<]	[<]	[<]	[<]	[<]	[<]	[<]
Spend on Bupa's top 100 surgical procedures	[<]	[<]	[<]	[<]	[<]	[<]	[<]
Other surgical treatments	[<]	[<]	[<]	[<]	[<]	[<]	[<]
Drugs	[<]	[<]	[<]	[<]	[<]	[<]	[<]
Outpatient pathology and radiology	[<]	[<]	[<]	[<]	[<]	[<]	[<]
Outpatient scans (MRI, CT, PET)	[<]	[<]	[<]	[<]	[<]	[<]	[<]
Other treatment	[<]	[<]	[<]	[<]	[<]	[<]	[<]

Source: BHW claims data

5.93 Therefore, the larger the basket of procedures used in the comparison the more robust the results will be¹³⁵.

Case study: Cost comparison on basket of surgical interventions

5.94 When entering negotiations with a hospital, Bupa calculates an "affordability index" for a basket of surgical procedures¹³⁶. [<].

5.95 The strength of the index is that it allows comparison over a significant percentage of Bupa's spend with hospitals; [<] of the overall spend from Bupa is accounted for by top 100 surgical procedures. It is practical to do because of the higher level of standardisation across surgical codes. It can also be monitored over time to understand trends.

5.96 The affordability indices for Bupa's top 100 surgical procedures by volume in 2011 are shown below. Table 12 illustrates how much more expensive Central London is than the rest of the UK. [<] is [<] more expensive than the national average (and the national average is itself increased by the inclusion of Central London hospitals which accounts for approximately [<] of overall Bupa hospital spend in the UK)¹³⁷. The comparison of costs between hospitals in Central London is illustrated more extensively in the next case study.

¹³⁵ The OFT attempted to compare the prices across hospitals of just seven indicator treatments during the market study. However, this very small sample of procedures was not representative of broader pricing trends.

¹³⁶ [<]

¹³⁷ This is why Bupa has concerns about strategies by HCA to direct volume from outside of London into its Central London facilities.

Table 12: Affordability index of top 100 surgical procedures for main hospital groups, 2011

Overall	[X]	[X]	[X]	[X]	[X]	[X]
Index	[X]	[X]	[X]	[X]	[X]	[X]
Episodes of 100 procedures	[X]	[X]	[X]	[X]	[X]	[X]
Total Surgical Episodes	[X]	[X]	[X]	[X]	[X]	[X]
<i>Proportion of Episodes</i>	[X]	[X]	[X]	[X]	[X]	[X]
Bupa spend on 100 procedures (£m)	[X]	[X]	[X]	[X]	[X]	[X]
Total Bupa Spend (£m)	[X]	[X]	[X]	[X]	[X]	[X]
Proportion of Spend	[X]	[X]	[X]	[X]	[X]	[X]

Source: Bupa

Notes: *PPUs have been grouped for illustration, although in reality each PPU negotiates its price list and contracts on a standalone basis.

5.97 Table 13 shows a comparison of hospital peers located outside of Central London. [X] .

Table 13: Affordability index of top 100 surgical procedures, 2011 (excluding Central London)

Overall	[X]	[X]	[X]	[X]	[X]
Index	[X]	[X]	[X]	[X]	[X]
Episodes of top 100 procedures	[X]	[X]	[X]	[X]	[X]
Total Surgical Episodes	[X]	[X]	[X]	[X]	[X]
Proportion of Episodes	[X]	[X]	[X]	[X]	[X]
Bupa spend on 100 procedures (£m)	[X]	[X]	[X]	[X]	[X]
Total Bupa spend (£m)	[X]	[X]	[X]	[X]	[X]
Proportion of Spend	[X]	[X]	[X]	[X]	[X]

Source: Bupa

Notes: PPU's have been grouped for illustration, although in reality each PPU negotiates and contracts on a standalone basis.

Case Study: [X]

5.98 [X]

5.99 [X]

5.100 [X] :

i. [X]

ii. [X]

iii. [X]

Table 14: [redacted]

Case Study: Comparison of Drug mark ups

5.101 [redacted]

5.102 [redacted]

There is an absence of countervailing benefits from scale and scope of hospital groups

5.103 Economies of scale and scope are often claimed by hospital groups as justifications for their size. However, as shown above, Bupa is concerned that it sees no benefits flowing through to patients.

5.104 Evidence is also limited that size or high treatment costs differentials are linked to differences in quality. There is an absence of comparable data on clinical quality between the hospitals groups, which means that there is no tangible evidence of more expensive hospitals offering incrementally better care¹³⁹.

5.105 In terms of patient experience, Bupa undertakes a regular patient satisfaction survey across the hospitals that serve Bupa patients¹⁴⁰. [redacted]. This suggests that higher treatment costs do not necessarily mean better patient experience.

Figure 22: [redacted]

INSURERS DO NOT HAVE COUNTERVALING BUYER POWER

5.106 The hospital groups – in particular [redacted] – have significant bargaining power in negotiations with insurers as insurers do not have credible alternatives to the main groups.

5.107 The main groups are also not credible substitutes to each other; as noted at above, each controls ‘must have’ hospitals; each has relative strength in different regions (so do not face each other head-to-head across all parts of the UK); and, like other providers each faces barriers to entry and expansion. So the incentives for a hospital group to cut prices to an insurer unilaterally are weak.

5.108 Over the past decade, this power has become so strong that even larger insurers – Bupa and Axa – are unable to resist the groups’ price demands and “one in, all in” negotiation tactics. As in all negotiations, without credible alternatives there is little effective buyer power¹⁴¹.

¹³⁸ [redacted]

¹³⁹ As part of the OFT market study, Bupa submitted to the OFT analysis of how private hospital groups treating NHS patients performed in the NHS Patient Reported Outcomes Measures statistics (see <http://www.ic.nhs.uk/proms>). These PROMs cover performance for hospitals treating NHS patients in four procedures: hip replacements, knee replacements, hernia, and varicose veins. While the data for private hospitals was limited in places, the analysis suggested there was no discernible, consistent difference between the performance in terms of patient reported outcomes of the main private hospital groups and the NHS or other independent hospitals in treating NHS patients.

¹⁴⁰ Bupa commissions the Picker Institute to conduct an independent quarterly survey of Bupa members for all hospitals that serve more than 200 Bupa patients (currently 193 private hospitals and PPU units). The survey shows how each of Bupa’s major hospital providers perform from a ‘patient satisfaction’ perspective on a scale of 0 to 10. Scores are collected on the categories of “Overall” experience, Admissions, Facilities, Cleanliness, Respect, Involvement, Nursing, Discharge and Consultant.

¹⁴¹ Larger insurers may be better placed than smaller insurers and individual patients to negotiate with hospital chains, but this does not mean there is effective buyer power. The OFT’s guidance on Assessment of Market Power (2004, p24), for example,

5.109 The key challenges that insurers face are:

- i. [redacted]
- ii. [redacted]
- iii. [redacted]
- iv. [redacted]
- v. [redacted]
- vi. [redacted]

5.110 Bupa has taken what steps it can to improve its bargaining position to improve the deal we get for our members:

- i. Bupa has used insurer networks as tools to drive better value for money for consumers and to offer more choice. However, the effectiveness of networks in the UK has been significantly undermined by the strength of the main hospital groups.
- ii. Bupa has also launched the Open Referral product which improves Bupa's ability to guide patients to consultants who offer high quality and affordable care.
- iii. Bupa took the step of delisting facilities for a period of a couple of weeks during a negotiation with BMI in late 2011/early 2012.

5.111 We discuss each of these steps below. However, **we do not consider that these steps are sufficient to give Bupa effective countervailing buyer power** (in particular against [redacted]).

Insurers use networks to inject competition where otherwise there would be little

5.112 Insurers have relatively little ability to 'steer' patients to a particular hospital during the treatment journey, so hospitals have little incentive to compete on price once the patient journey has begun. Insurer networks¹⁴⁵ are tools used to create some competitive tension between hospitals before the patient journey begins.

5.113 Insurer networks can take many forms¹⁴⁶, with two broad categories being:

notes that "Size is not sufficient for buyer power. Buyer power requires the buyer to have choice". Insurers do not have sufficient credible choice in certain regions of the UK (particularly London).

¹⁴² [redacted]

¹⁴³ [redacted]

¹⁴⁴ The process of switching from a hospital group takes significant time and planning. It will need to be begun months in advance; and will be public weeks in advance (as we need to contact customers and consultants). This gives plenty of time for consultant and hospitals to resist the change. They do this by communicating direct with patients. It also gives time to the other hospital chains to increase their own prices.

¹⁴⁵ The concept of insurer network is different from the terminology of "hospital network". Many large hospital groups advertise that they have a national network of hospitals. However, from the patient's perspective this is of little consequence, as the patient typically requires access only to his or her nearby hospital.

¹⁴⁶ Networks can be national or regional in scope, can cover hospital treatment generally or only particular categories of treatment, and may restrict either the professionals providing the treatment or the hospitals where the treatment is provided. They can work on the basis of quantitative criteria (i.e. a restriction on the total number of hospitals in a network) or qualitative

- i. **Facility networks** which set out a specified (restricted) list of PH facilities at which a policyholder is entitled to be treated. PH facilities included in the list will have agreed suitable commercial and quality terms with the insurer for all treatments at their facilities covered by the policy. This gives both the patient and the insurer additional price certainty in advance of hospital treatment. The customer will know which hospitals he or she will gain access to at the point of buying the policy.
- ii. **Treatment networks** focus on a single treatment type/service line (e.g. cataracts or breast cancer) with the providers being included in the list only if they have met specified cost and/or quality and safety levels. Treatment networks are typically applied to service lines/treatments that are highly standardised across providers.

5.114 The insurer will need to design the network to provide suitable coverage for the customers that are targeted by the PMI product. If it is a PMI product that will be sold nationally, the insurer will need to include a sufficient spread of facilities to give customers across the country convenient access.

5.115 Planning and launching a network takes significant time and resources on the part of the insurer. This spans several stages: customer research and proposition design; stakeholder engagement; tendering the network; follow up bilateral negotiation with hospitals to ensure sufficient network coverage; and, finally, marketing the products to customers. Therefore, the insurer incurs significant costs and must be confident that the product will be attractive to customers (e.g. offering suitable geographic coverage).

Networks can deliver significant benefits to consumers

5.116 **Networks can enhance PMI choice.** The size of network that a PMI product gives access to is a way of offering different PMI product choices to customers. Some customers may choose products with a narrow network, others may choose products with a larger network, and some may want access to all hospitals the insurer works with (comprehensive access). By creating PMI product options more customers will be able to find a product that suits them¹⁴⁷. For example, a key reason why Bupa launched its Low Cost Network in 2011 was to attract new customers to the PMI market through providing a selection of low cost policy options.

5.117 **Networks can enhance PMI affordability.** Networks were originally introduced in the 1990s as a means of mitigating the spiralling costs of private healthcare. Networks encourage providers to compete more vigorously on price to get into the restricted network of suppliers (which will likely receive greater volumes). These cost savings can be passed through to end customers in the form of lower premiums¹⁴⁸. Further, providing customers with the choice of lower cost products increases the number of customers able and willing to access PMI. This allows the insurer to diversify risk across a wider risk pool, which leads to lower premiums for all customers than would otherwise be the case.

criteria (i.e. a network that any hospital that meets the specified price / quality criteria can join). It is through such features that networks also allow insurers to innovate within the product set and increase choice amongst PMI products.

¹⁴⁷ Our customer research indicates that customers accept and understand the offering of different networks as a means of controlling their treatment costs and offering PMI product choice.

¹⁴⁸ For example, [38]. Laing and Buisson suggest that initial cost savings of around 17% resulted from the launch of Bupa's Breast cancer network.

5.118 **Networks can enhance quality.** Bupa's treatment networks are specifically designed to increase the standards of care provided for particular categories of treatment by requiring hospitals/therapists to meet certain requirements¹⁴⁹.

5.119 **Networks reward efficient hospitals.** The most efficient hospitals should, in theory, be best placed to be included on networks (although as discussed below sometimes hospital group market power prevents this). This means that hospital efficiency is rewarded by networks in a way that may not otherwise happen in the patient journey – where a consultant's referral patterns may already be tied to an inefficient incumbent, for example. **Efficient hospitals (and new entrants) have a strong reason to want insurers to use network products.** Further, networks grow the size of the PMI market, and so PH market, through offering lower cost PMI product options that are affordable to a broader range of customers. The increased volume of PH users gives hospitals an opportunity to move down their cost curves, leading to better prices in the market overall. Indeed, in a world without networks (where consumers would have no option but to buy products with full facility access), many providers would be forced from the market due to the consumer demand contraction.

5.120 The beneficial effects of networks have previously been recognised by both the OFT and CC:

- i. The OFT noted in 1999 that “[insurer] hospital networks have been successful in encouraging hospitals to compete on price and quality and the evidence suggests that consumers are benefiting from these improvement efficiencies through wider choice of low cost PMI”¹⁵⁰ and that “The development of hospital networks has been a reasonable response to relatively static demand for PMI coupled with rising costs and overcapacity in the PMS market”.
- ii. The CC stated in 2000 that “there is no doubt that network products offered by PMI providers have widened the choice of lower-cost PMI available”¹⁵¹.

5.121 Networks have also been used successfully in other countries and other industries (e.g. motor insurers use a panel of approved repairers as a way of keeping down repair costs. Repairers compete to get onto the panel by offering better value for money to the insurer).

The effectiveness of networks is being undermined by the market power of the main hospital groups

5.122 The market power of the main hospital groups in the UK is undermining the effectiveness of networks in realising value for money for customers. Certain groups have both the scale and the control of ‘must have’ hospitals to be able to:

- i. Use ‘one in, all in’ negotiation to force all their hospitals onto an insurer’s network, potentially at the expense of other more efficient independent hospitals. This creates a barrier to entry for independent rivals (see at 5.57 above). The threat of ‘one in, all in’ negotiation has dissuaded Bupa from using narrower networks as much as it would have liked to in the past decade.

¹⁴⁹ Examples of parameters covered by these standards are length of appointment waiting times and presence of multi-disciplinary teams.

¹⁵⁰ OFT, “PMI and PMS markets are competitive says offt but better information for policyholders is needed”, November 1999 (available at http://www.offt.gov.uk/shared_offt/market-studies/40_99.pdf).

¹⁵¹ Bupa/Community Hospitals Group, 7 December 2000, para 4.109.

- ii. Use their market power to prevent insurers launching network products that may negatively affect them. [§].
- iii. Use their strength to veto or penalise the inclusion of new hospitals into existing networks. The OFT MIR Decision (para 8.40) notes: “Some contracts between PH providers and PMI providers provided to the OFT impose a price clause which is triggered in circumstances where a competing PH facility has been recognised. In some cases, there is a formula for calculating a price increase and in others recognition of a rival PH facility will result in a price renegotiation between the PMI provider and the owner of the incumbent PH facility.”

5.123 Examples of how hospital groups can undermine the effectiveness of insurer networks are illustrated by Bupa’s experiences in:

- i. **Launching the Ophthalmology network in 2007:** A competitive tender was used to select a list of 110 facilities across the UK to comprise the network. However, when the network launched in April 2007, [§] hospitals did not form part of the published network. [§] units were selected as an outcome of the competitive tender, but [§] took the position that it had a national contract with Bupa and therefore was only willing to offer all units (just over [§]) and it was unwilling to accept the outcome of the tender. [§] Bupa agreed to pay hospital charges in full for members attending the [§] selected [§] hospitals, but where possible re-directed ophthalmic cases within network to other locations. The costs of the Bupa’s [§] redirection programme for ophthalmology services were [§], which underestimates the total costs to Bupa in terms of patient dissatisfaction and reputational damage. It took until [§] to resolve the situation, when [§] and Bupa came to an agreement for the [§] facilities to be included as part of the network. [§].
- ii. **Launching the Low Cost Network in 2011:** Bupa launched a new “menu-based” product proposition to personal customers in July 2011. This proposition aims to give more choice to customers, in particular by giving them a new low cost PMI product – Bupa By You. Forming a new, narrower hospital network as an option for customers – called the “Essential Access network” or “Low Cost Network” – was a critical input to the product proposition¹⁵².

Planning and launching a network takes significant time and resources on the part of the insurer. It spans several stages: customer research and proposition design; stakeholder engagement; tendering process for the network; follow up bilateral negotiation with hospitals to ensure sufficient network coverage; and, finally, marketing the products to customers. Bupa began this process in late 2010, finally launching the new product, Bupa By You (Menu), in July 2011.

Bupa invited all the hospitals that it worked with outside of Central London to tender for recognition onto the network. [§].

¹⁵² In Bupa’s initial tender to hospitals for inclusion in the Low Cost Network we described our aim as follows: “This low cost network will support our drive to grow the health insurance market by attracting new customers and giving better value options. We anticipate that the new network will be regional, outside of central London, with the potential for expansion and will sit alongside our existing networks. Each region will be approximately half the size of current networks. The new network will offer new customers in particular, more product choices and access to high quality affordable hospital care. Hospitals will be selected to join the new network based on an offer of a discount from their current rates to enable us to build this new network.”

Figure 23: [redacted]

5.124 **Each of these anticompetitive effects should, however, be addressed at their core, rather than by constraining insurers' use of networks.** The anticompetitive effects are not the fault of networks *per se* (networks tend to provide strong pro-competitive effects, as discussed above). Constraining insurers' use of networks would only strengthen the existing market power of large hospital groups.

Bupa's use of networks today and in the future

5.125 Bupa currently operates three facility networks and seven treatment networks. Through one or more of our networks we recognise the vast majority of private hospitals in the UK.

5.126 Inclusion on a facility network is agreed in bilateral negotiations between Bupa and the hospital (hospital group) during contract negotiations (which for some hospitals are annual and for some are every 3 years). Bupa's three facility networks are:

- i. **The Network of Participating Hospitals:** Bupa's core network includes [redacted] facilities (at June 2012) that provide inpatient and day patient care (there are further facilities that provide only outpatient care and this raises the number of facilities currently on our Network of Participating Hospitals to [redacted]). Customers that purchase a 'full' or 'unrestricted' Bupa policy obtain access to this network which includes the vast majority of private facilities in the UK. All facilities that Bupa has a commercial agreement with are automatically included in this network.
- ii. **The Partnership Network:** This includes [redacted] facilities (at June 2012), a subset of the facilities in Participating network. Customers that purchase a product that is restricted to this network receive a small discount on their premiums. [redacted] of the lives covered by Bupa own a product that gives access to the Partnership Network (this number has grown over time as customers have down-traded their policy cover).

The Partnership network was established in 1996 to develop a lower cost PMI product for customers through offering access to a restricted list of hospitals (at that time [redacted] hospitals). At launch, Bupa was able to secure discounts on treatment costs from providers that were recognised onto the Partnership network. Bupa passed this discount through to customers, who purchased the lower cost, restricted access PMI product. [redacted] Bupa has continued to offer a marginally cheaper product to customers than for products accessing the Network of Participating hospitals to preserve choice for customers [redacted].

- iii. **The Low Cost Network:** Bupa launched this network in 2011 to offer more PMI product choice to consumers. It includes [redacted] facilities, but is not national in coverage (in particular it does not cover Central London).

5.127 In the past decade, Bupa has focussed on developing specialist treatment networks, which focus on a specific service line (e.g. cataract operations). Bupa has seven treatment networks (as at June 2012) [redacted]:

- i. **Out-patient Physiotherapy Network:** includes over [redacted] recognised physiotherapists;
- ii. **Out-patient MRI Network:** this includes [redacted] facilities;
- iii. **Cataract/Ophthalmology Network:** this includes [redacted] ophthalmic units;

- iv. **Mental Health Therapy Network:** this includes just under [X] therapists;
- v. **Bowel Cancer Approved Units:** this includes over [X] approved units;
- vi. **Breast Cancer Approved Units:** this includes [X] approved units; and
- vii. **Gynaecological Cancer Approved Units:** this includes [X] approved units.

5.128 The Cancer Approved Units (the last three in the list above) exist for the sole purpose of demonstrating a high level accreditation for the quality of these particular services i.e. inclusion of a hospital relates to its capability to offer an evidence-based, integrated cancer service, not to prices.

5.129 Admission to the specialist networks is decided by a tender process. In this process hospitals and/or facilities are selected for inclusion on the network on the basis of price and/or quality offerings¹⁵³. Bupa extends the invitation to tender to providers that it has an existing relationship with (i.e. the vast majority of those in the UK) and to any other provider that has registered an interest in responding to the tender. The criteria that are used to evaluate the tenders varies depending on the particular type of treatment network. Once the tender process is completed the network is fixed for a number of years (typically 3 years).

5.130 In 2011, Bupa spent approximately [X] for treatments within the four treatment networks (excluding the cancer approved units) - just [X] of our overall claims spend. Therefore, despite taking significant efforts and investment to launch, treatment networks can only impact a relatively small proportion of spend. Specialist networks are formed around procedures for which there is a greater level of standardisation of the treatment pathway between different providers and where there are a large number of providers. These standardised services tend to have more scope for creating competitive tension between providers. The influence of specialist networks will always be limited to the small proportion of procedures that are largely standardised.

5.131 [X]. At the present time networks remain the most effective means of managing costs and therefore need to be supported.

The threat to delist hospitals has been used in hospital negotiations, but is a damaging last resort for insurers, and is only credible over a limited timeframe

5.132 During a negotiation, an insurer may indicate that it is considering delisting one or more of a hospital operator's facilities if appropriate terms cannot be reached. The effect of this would be that it would no longer reimburse treatments at that facility - potentially leading to a reduction in volumes for the hospital in question. However, in most cases this will simply not be a credible threat due to the lack of suitable alternative provision in close proximity.

5.133 Even where delisting is theoretical possible, there can be constraints on an insurer actually switching patients away from the delisted hospital. Delisting a facility is extremely damaging to the insurer's customers in the affected local area and also to the insurer's reputation more widely. It may also be unacceptable for corporate customers to have gaps in the insurer's nationwide coverage. So delisting may mean the insurer can no longer serve existing, or attract

¹⁵³ The exception to this is the network of Cancer Approved Units for which there is a highly specialised tender criteria due to the nature of the treatment.

new, customers in that area. The costs to the insurer also escalate if the facility belongs to a hospital group, as the effect may be that the group then increases its prices at those facilities that the insurer must continue to use.

5.134 The credibility of a proposal to delist does have a time dimension – delisting a facility for a short period (i.e. a couple of weeks) may be more plausible, where delisting the same facility on sustained basis is not. However, an insurer has to assess in each case whether the high short-term costs that it will bear in this ‘out of contract’ situation (e.g. setting up redirection programmes and paying higher walk-in rates) may be offset by longer-term savings that may be achieved by continuing the negotiation with the hospital. The insurer must be confident the hospital will return to the negotiating table quickly. Otherwise, the direct costs of being ‘out of contract’ will soon outweigh any, as yet to be agreed and realised, longer-term benefits of reaching a better deal.

5.135 In practice, and for these reasons, it is extremely rare that a hospital will be delisted even for a short time during pricing negotiations. Hospitals know this. However, Bupa took the exceptional step of delisting hospitals for a short time during an ‘out of contract’ period in its 2011/12 negotiation with BMI. This caused significant upheaval to patients and it damaged the reputation of both Bupa and the industry as a whole.

5.136 The reason that Bupa was prepared to take this step in this case relates to the background and particular circumstances of this negotiation. At the start of the negotiation, Bupa had assessed BMI’s relative cost and quality and found [redacted] :

i. [redacted]

ii. [redacted]

iii. [redacted]

iv. [redacted]

5.137 The analysis also showed that [redacted] consultants worked only at BMI hospitals, significantly increasing the cost and challenge of going ‘out of contract’ with BMI as a group.

5.138 [redacted]. This created significant uncertainty for our members and damaging media attention for Bupa. Figure 24, for example, shows the significant number of patient complaints (letters, emails and calls) Bupa received relating to the dispute; as well as receiving patient petitions. We also observed a significant spike in complaints about BMI specifically during this period (relative to other hospitals).

Figure 24: [redacted]

5.139 [redacted]

5.140 Bupa considers that it was necessary for it to take this stand given the need to achieve better value for money for our members, and in so doing maintain the affordability of PMI. However, it

¹⁵⁴ See for examples: Financial Times, “Vultures circle GHG as restructuring looms”, 15 January 2012, available at <http://www.ft.com/cms/s/0/4d2617e4-3e10-11e1-ac9b-00144feabdc0.html#axzz21fhlvAZI>; Financial Times, “Hospital group GHG teeters on the brink”, 15 January 2012, available at <http://www.ft.com/cms/s/0/8f6efbd6-3df0-11e1-91f3-00144feabdc0.html#axzz21fhlvAZI>

was extremely costly for Bupa in terms of customer relationship and reputation (examples of negative media coverage are shown in Figure 25). We lost customers, both personal and corporate, as a result¹⁵⁵. Other insurers actively targeted our customers in the affected areas. It was also damaging for reputation of the PH industry as a whole, although we consider that the reputational costs fall disproportionately on the insurer compared to the hospital group.

Figure 25: Examples of media coverage during BMI/Bupa Negotiation



5.141 The CC should therefore bear in mind:

- i. It is extremely unusual for an insurer to delist hospitals, even for a short period, as a result of or during price negotiations;
- ii. [X]
- iii. BMI's decision to agree terms without a lengthy out of contract period was, in part, because of the particular financial difficulties that it was facing. This factor will not always be present.
- iv. This case study therefore should not be interpreted as evidence that Bupa generally has countervailing buyer power. In fact, the case study highlights the malfunctioning of the PH market.

Once the treatment journey has begun, insurers have limited ability to steer patients to particular facilities

5.142 For the majority of patients, insurers do not have an ability to steer patients to particular providers that offer value for money. Bupa has invested in setting up the Open Referral service to guide patients to particular consultant; however, this is still on too small a scale to

¹⁵⁵ The OFT MIR Decision (para 6.67) notes: "With regards to the reputational costs, the OFT considers that the removal of a PH facility from a PMI provider's network does appear to have some reputational costs for the PMI provider. As a result of the recent delisting of a number of GHG's PH facilities by Bupa, the OFT received complaints from individual consumers regarding their dissatisfaction at the removal of GHG's PH facilities. The OFT also received information from a few of the PMI providers who highlighted that as a result of the dispute with GHG, Bupa lost a number of corporate clients to other PMI providers".

significantly constrain hospital providers. Further, this service cannot address issues of consultant lock in (where hospitals tie consultants to their facilities) or issues of highly concentrated local markets where there is only a very limited number of hospitals to which patients can be guided.

VERTICAL INTEGRATION BY INSURERS TO IMPROVE EFFICIENCY

- 5.143 As noted at para 5.68 above, Bupa has significant concerns about the strategies employed by hospital groups to integrate down the referral pathway to tie in consultants and GPs. This type of integration can entrench strong market positions and can also lead to inappropriate referral patterns (e.g. giving the incentive for over-treatment and over-diagnosis).
- 5.144 Bupa does, however, believe that integration between the insurer (funder) and provision can have beneficial effects for consumers. Bupa has observed these efficiencies through its own experience in Spain, and there is evidence that this model delivers positive outcomes for patients and payors in other health systems e.g. in the US with Kaiser Permanente and Geisinger Health.
- 5.145 The Bupa Group subsidiary, Sanitas, is a leading healthcare provider in Spain. The health insurance business, Sanitas Seguros, provides cover to just under two million people. Sanitas is also active in the provision of healthcare to its PMI members through three hospitals (2 in Madrid and 1 in Barcelona) and 17 diagnostic/treatment centres – called Millennium Centres. The model of linking insurance with provision has driven significant efficiencies because it has better aligned the incentives for the insurer and hospital:
- i. The hospitals focus on delivering high quality care to patients in a cost effective way, rather than seeking to maximise their own individual profits. This reduces the incentives to over-treat or over-diagnose. For example, compared to a benchmark of other hospitals in Spain, [redacted]. The Sanitas hospitals also receive higher than average patient satisfaction scores, with the Sanitas La Moraleja Hospital in Madrid ranked in the top 20 best private hospitals in Spain.
 - ii. The Milenium Centres aim to treat as many cases in an outpatient setting as possible, referring cases into the main hospitals for inpatient treatments only when there is a clinical need. This delivers effective care quickly to patients, while reducing costs for the system overall.
 - iii. The insurance business has benefitted from being able to offer customers high quality care at more cost effective levels. This has resulted in lower policy lapse rates amongst customers who use the Sanitas facilities than those who do not. The PMI business has been able to offer more differentiated products to customers.

6. MANAGING OUR RELATIONSHIP WITH CONSULTANTS

- 6.2 Consultants play the key role in the patient journey. They determine the type, venue and volume of treatment, and so have significant influence over the cost and quality of treatment in private healthcare. They also control the direct contact with the patient and are entrusted with his or her care. Our working relationship with consultants is, therefore, extremely important to us.
- 6.3 Consultant claims also have a material direct impact on our members' premiums (accounting for approximately [x] of Bupa's total annual claims spend). In 2011, Bupa paid [x] million in claims to over [x] consultants in the UK. The levels of spend have been relatively constant ([x] million in 2006, for example) despite the shrinking number of lives covered by PMI (and so fewer member receiving treatment) and the recession.
- 6.4 We must give our members access to a broad choice of consultants who offer high quality, affordable care. So we have a strong incentive to recognise consultants who deliver high quality, affordable care. Bupa has recognised over 2,750 new consultants in the last two years alone (since June 2010). At the same time, we have a duty to our members to manage the supplier relationship to get members a good deal and, where necessary, to challenge unacceptable conduct by individual consultants. We must have the option to de-recognise any consultant who places patient safety at risk or engages in practices that unreasonably inflate medical costs.
- 6.5 This section builds on the issues raised on the role of consultants in the patient journey (Section 4) and includes:
- i. An overview of the consultant marketplace to set the context.
 - ii. An explanation of the issues that undermine the effectiveness of competition between consultants.
 - iii. The growing challenges to the functioning of the market presented by consultant incentive schemes, consultant groups, treatment variation, and the conduct of the consultant trade bodies.
 - iv. How Bupa manages its relationships with consultants to provide high quality and affordable healthcare.
 - v. A response to specific points that have been raised by some consultants about Bupa's initiatives.
- 6.6 In summary:
- i. Consultants are in a strong position because of narrow product and geographic markets, the presence of entry barriers (e.g. entrenched GP referral patterns), and the significant information advantage they have over a patient. Certain practices by consultants, and hospitals, restrict competition further e.g. consultants forming groups.

- ii. The lack of comparable information available to patients, GPs, and insurers about the clinical and cost performance of consultants undermines competition and creates entry barriers. It reduces informed decision making. It also reduces the incentive for one consultant to compete with another, as better, more affordable service are unlikely to be rewarded with more volume. And it makes it difficult to identify and challenge unwarranted variations in a consultant's treatment practices.
- iii. The patient has little effective bargaining power with the consultant, especially once the treatment journey is in progress.
- iv. Consultants are reimbursed on a fee-for-service basis, which in the absence of effective competition and oversight can encourage consultants to offer a greater volume of care rather than greater quality of care.
- v. There are lucrative returns for consultants who develop a business treating private patients. [§<] . For over 85% of consultants, private earnings would be in addition to a NHS salary of over £120,000 on average.
- vi. There is little downward pressure on consultant fees because of the absence of effective competition. Insurers use reimbursement limits (benefit maxima) as a tool to moderate consultant fees and give customers some price certainty in advance of the consultant delivering treatment. The competition authorities (the MMC in 1994¹⁵⁶ and the OFT in 1999¹⁵⁷) have previously acknowledged these maxima as a legitimate and necessary tool. These limits have provided some constraint on consultant fees, although only around 50% of Bupa's claims spend is on procedures to which benefit maxima apply¹⁵⁸.
- vii. A number of consultants fail to agree costs with patients or the insurer in advance of treatment, resulting in unexpected shortfalls. Managing unexpected shortfalling remains a high priority for Bupa, as this is a main source of member complaint.
- viii. Some consultants and consultant trade bodies argue that Bupa benefit maxima should have been increased over the past decade. However, these complaints fail to acknowledge the changes that have been made to Bupa benefit maxima over the years; the improvements in technology that reduce the time and complexity of many treatments; the strong supply of consultants serving a shrinking pool of private patients; the above-inflation increases in other consultant treatments (such as outpatient consultations); and, that average profits for most consultant specialisms are significant and have been robust despite the recession and shrinking PMI market. Further, the consequence of raising limits would simply be higher prices for consumers leading to a more rapid decline in the overall market.
- ix. Bupa is concerned about consultant costs because our customers expect PMI to remain affordable. We will not compromise on quality or patient safety. However, there is no evidence that more expensive consultants are better consultants.

¹⁵⁶ Competition Commission, Private Medical Services: A report on agreements and practices relating to charges for the supply of private medical services by NHS consultants (Cm 2452), 1994.

¹⁵⁷ A press release for this study can be accessed at: http://www.oft.gov.uk/shared_of/market-studies/40_99.pdf (Date accessed: 5th July 2012).

¹⁵⁸ Bupa's benefit maxima do not cover outpatient consultations, for example.

- x. Bupa observes significant variation in the way different consultants treat specific conditions. While some of this variation is expected, as care is tailored to the needs of a specific patient, some of it appears to be unwarranted. This unwarranted variation is, at least in part, driven by structural problems in the market (such as a lack of comparable information) and can place the patient at clinical risk and can raise overall healthcare costs.

OVERVIEW OF THE CONSULTANT MARKETPLACE

- 6.7 The OFT's Population Report estimates that there were around 46,000 medical consultants active in the UK in 2010¹⁵⁹. This number had increased by just under 4 per cent per year between 2001 and 2010. The significant majority of these consultants work in the NHS¹⁶⁰. The average earnings for NHS consultants in 2009 were £120,900¹⁶¹.
- 6.8 Commitments to the NHS mean that not all consultants undertake private work (as a minimum number of hours must be worked within the NHS each week). The OFT Consultant Survey (p113), however, notes that 81% of consultants typically have some spare capacity in an average month (above their NHS commitments) that could be filled with private work and 59% of those with spare capacity said they 'actively' sought to fill this spare capacity with private work. This suggests there are just over 23,000 consultants in the UK seeking to serve private patients¹⁶².
- 6.9 Private work can be very lucrative for consultants. Laing and Buisson 2010-11 (p116) notes, for example, that:
- “Based on an estimated 20,000 privately practising specialists in medical/surgical specialties in the UK, the aggregate private fee income of £1,558 million estimated for specialists in 2008 ... works out at about £78,000 gross per privately practising specialist. Average net income is estimated to be around £55,000 after expenses of between a quarter and a third of gross income. Figures compiled from annual tax returns by medical accountants Stanbridge Associates are in a similar range. They estimated that on average consultants in England grossed £68,000-£70,000 from private practice in 2003/2004, though in London the average was higher at £80,000-£90,000.”*
- 6.10 Figure 26 shows average consultant pre-tax profits (earnings after accounting for practice expenses) by specialism from private practice. It is noteworthy that these pre-tax profits have remained robust despite the recession and some increases in consultant practice expenses (e.g. indemnity insurance).

¹⁵⁹ Population Overview Report for the Office of Fair Trading, GFK, available at http://www.offt.gov.uk/shared_offt/market-studies/Population-Overview-Report-1.pdf

¹⁶⁰ The OFT Consultant Survey (p44) found only 4% of 401 respondents worked solely in the private sector, 96% undertook a mixture of NHS and private work.

¹⁶¹ National Audit Office: Management of NHS hospital productivity, 17 December 2010, p19.

¹⁶² The National Audit Office estimated that 55% of 32,000 NHS consultants (approximately 17,600) in England practicing in 2005-06 undertook private work. The NAO also explains that the average NHS pay for consultants in 2005-06 was £109,974 (basic salary and awards) and that this was above the average for OECD countries, and the highest amongst salaried (as opposed to self-employed) specialists across the OECD. National Audit Office, "Pay Modernisation: A new contract for NHS consultants in England", April 2007 (available at http://www.nao.org.uk/publications/0607/pay_modernisation_a_new_contr.aspx).

Figure 26: [X]

6.11 Bupa observes these trends in its own claims data. The total amount of Bupa spend with consultants has remained relatively flat between 2006 and 2011 – [X] – despite the significant contraction in number of lives covered by Bupa (and members seeking treatment) in this period.

6.12 Table 15 summarises the patterns of claims Bupa paid to consultants active in the top 20 specialisms (by spend) which together account for over 94% of Bupa’s consultant spend in 2011. Two points are notable:

- i. Column F shows that 80% of the spend is typically accounted for by under 50% of the consultants within the specialism. [X]. So there are ‘high volume’ consultants that are very focussed on private work, with a large proportion of consultants who do relatively small volumes of private work.
- ii. Column E shows the ‘high volume’ consultants can earn significant revenues; particularly bearing in mind that Bupa’s members will be only around 40% of the private patients the consultant will see.

Table 15: Analysis of Bupa consultant spend by specialism, 2011

Speciality	All consultants who bill Bupa			Consultants who account for 80% of spend		Proportion of consultants accounting for 80%
	Total Paid	Number of Consultants	Average paid	Number of Consultants	Average paid	
	A	B	C=A/B	D	E=(0.8xA)/D	
Orthopaedics and trauma surgery	[X]	[X]	[X]	[X]	[X]	[X]
General surgery	[X]	[X]	[X]	[X]	[X]	[X]
Anaesthetics	[X]	[X]	[X]	[X]	[X]	[X]
Obstetrics and gynaecology	[X]	[X]	[X]	[X]	[X]	[X]
Ophthalmology	[X]	[X]	[X]	[X]	[X]	[X]
Ear, nose and throat surgery	[X]	[X]	[X]	[X]	[X]	[X]
Cardiology	[X]	[X]	[X]	[X]	[X]	[X]
Dermatology	[X]	[X]	[X]	[X]	[X]	[X]
Urology	[X]	[X]	[X]	[X]	[X]	[X]
General medicine	[X]	[X]	[X]	[X]	[X]	[X]
Gastroenterology	[X]	[X]	[X]	[X]	[X]	[X]
Oncology (clinical / radiotherapy)	[X]	[X]	[X]	[X]	[X]	[X]
Oncology (medical)	[X]	[X]	[X]	[X]	[X]	[X]
Plastic surgery	[X]	[X]	[X]	[X]	[X]	[X]
Neurosurgery	[X]	[X]	[X]	[X]	[X]	[X]
Rheumatology	[X]	[X]	[X]	[X]	[X]	[X]
Neurology	[X]	[X]	[X]	[X]	[X]	[X]
Paediatrics	[X]	[X]	[X]	[X]	[X]	[X]
Psychiatry	[X]	[X]	[X]	[X]	[X]	[X]
Oral and maxillofacial surgery	[X]	[X]	[X]	[X]	[X]	[X]
	[X]	[X]	[X]	[X]	[X]	[X]
Total all specialisms	[X]	[X]	[X]	[X]	[X]	[X]

Source: BHW claims data.

6.13 Consultant claims spend varies by region. For example, Central London accounts for [X] of Bupa’s annual consultant claims spend with claims paid to ‘high volume’ consultants in this

area of [£<] on average in 2011. Edinburgh accounts for [£<] of Bupa's annual claims spend to consultants with an average claims to 'high volume' consultants of [£<] on average.

Shortfalls are a key concern for members

- 6.14 An issue that negatively affects consumers in the market is consultant 'shortfalls'. As will be discussed below, consultant fees do not face sufficient competitive pressure. Insurers therefore apply maximum reimbursement limits to counterbalance the consultant's market power. These limits affect around 50% of Bupa claims spend with consultants. Where the consultant charges more than the reimbursement limit, the patient must pay the difference between the consultant's fee and the limit out of his or her own pocket¹⁶³. We refer to this balance as a "shortfall"¹⁶⁴. The consultant will pursue the patient directly for the shortfall and this is a large source of customer complaint to Bupa.
- 6.15 The majority of consultants in the UK continue to see reimbursement limits only as a guide in setting their prices. Bupa's reimbursement limits are called benefit maxima. We observe significant variation in levels of fees and shortfalling around these maxima. Table 16 and Figure 27 show an example of the significant dispersion we saw for a procedure in 2011. The benefit maximum for this anaesthetic treatment was £325. As the chart shows very few consultants charged below this level, with a large proportion of anaesthetists charging well above the maxima. The median shortfall for the patient was [£<], with 10% of patients receiving shortfalls of over £[£<].

Table 16: Anaesthetic charge on a primary total hip replacement, 2011

Procedure		SCC		Volume of claims	Total Charged	Benefit Limit
W3712	Primary total hip replacement with or without cement	43	MAJOR	[£<]	[£<]	£325

Figure 27: [£<]

- 6.16 In Bupa's experience approximately [£<] of surgical treatments and around [£<] of anaesthetic treatments face a shortfall. The magnitude of the shortfalls can be substantial (particularly where the patient has to have repeated episodes with the consultant during the course of treatment). Table 17 presents average shortfalls observed in 2011 for some specialisms. There tends to be a broad range on shortfall levels within individual treatments.

¹⁶³ A small proportion of customers have 'full refund' policies in which Bupa would cover all shortfalls in addition to paying the provider the benefit maxima.

¹⁶⁴ The OFT saw a dichotomy between a "top up" fee – where the consultant negotiates and agrees with the patient in advance an above benefit maxima charge – and "shortfalls" where the patient only learns of the additional out of pocket expenses after treatment. Both, however, lead to higher fees for patients. Even if the 'top up' fee is known in advance this does not necessarily mean it is acceptable. The patient may have limited alternative choices but to accept the higher fee (e.g. if all consultants in an area charge the same price because they are in a consultant group).

Table 17: Average surgical shortfall amount by specialty, 2011

Surgical speciality	Average shortfall amount on those treatments with a shortfall
Cardiothoracic surgery	[<]
Orthopaedics	[<]
Obstetrics and gynaecology	[<]
Cardiology	[<]
General surgery	[<]
Urology	[<]
Radiology	[<]
Anaesthetics	[<]
Ear, nose and throat surgery	[<]
Dermatology	[<]
Rheumatology	[<]
All specialisms	[<]

Source: BHW claims data.

6.17 Unexpected shortfalls cause significant frustration to consumers (and great concern to those patients facing financial difficulties because of their conditions). Shortfalls and the price of PMI are the two most common types of complaint we receive from our members. We typically receive more than 1,000 complaints per month on these two issues alone. In many cases this leads to significant reputational damage to both the insurer’s brand and to the attractiveness of PMI in general.

FACTORS THAT UNDERMINE THE EFFECTIVENESS OF COMPETITION BETWEEN CONSULTANTS

6.18 Various factors mean that competition between consultants (including anaesthetists) seldom operates effectively. Some of these factors are structural in nature where others relate to the conduct of consultants, hospitals and consultant trade bodies. This section sets out key factors and should be read in conjunction with the discussion of the role of GPs and consultants in the patient journey (Section 4).

Local markets with entry barriers

6.19 Patients want to be treated locally, which limits the distance over which competition between consultants takes place. This can mean the patient’s choice can be confined to a narrow set of possible consultants.

6.20 While consultants are, in theory, mobile and able to move between local markets, evidence suggests that the majority of consultants base their private practice at a single private facility (even if they have practicing privileges at more than one facility)¹⁶⁵. Bupa’s claims data shows that approximately [<] of consultants work in one hospital only. Where consultants do work at more than one facility, these are typically hospitals in close proximity to each other.

¹⁶⁵ The OFT MIR Decision (para 3.19) notes “[...] most consultants with admission privileges at two or more PH facilities reported that they would treat between 71 and 100 per cent of their patients in their main PH facility over an average month”.

- 6.21 A major barrier, discussed below, is the challenge a new consultant faces in overcoming entrenched GP referral pathways in a local market. This stems from a lack of comparable information available to patients or GPs on consultant quality and cost.
- 6.22 A further barrier into a local market can be access to a NHS post in that locality. The significant majority of consultants are employed in the NHS, with consultants seeking to locate their private practice close to their NHS facility (e.g. for time efficiency reasons)¹⁶⁶. This, however, means that if a NHS hospital in a local area does not have vacancies for a particular specialist there may be little ability for a new consultant in that specialism to move into a local area to do private work.
- 6.23 In the case of anaesthetists the geographic market may be as narrow as the hospital in which the patient is planning to have surgery¹⁶⁷. The patient may only become aware of which anaesthetist will treat him or her just before surgery, at which point there are significant switching costs to moving to an anaesthetist at another location.

Constraints at the point of choosing a consultant

- 6.24 Competition should take place at the point the GP assists the patient in choosing an appropriate consultant. However, at this key stage there are significant failures, which undermine consultant competition.
- 6.25 First, there is an absence of accessible, comparable information on consultant performance from the perspective of quality of health outcomes they achieve for patients and how they interact with their patients. This issue was an issue emphasised in the OFT MIR Decision¹⁶⁸. This is consistent with a GP survey commissioned by Bupa in 2011 which found that only one fifth of GPs consider they have access to objective information on consultants¹⁶⁹. And of the information that is available on consultants, 58% of GPs found it difficult to make comparisons.
- 6.26 Second, there is a lack of upfront clarity and comparability on the costs of consultants. It is difficult for the patient or GP to assess anything further than the first consultation appointment fee at the time of choosing a consultant. 75% of GPs responding to the OFT GP Survey said they 'rarely' or 'never' knew the first consultation fee, with only 2% saying they 'always' knew the first consultation fee. As shown in Table 18 nearly half of GPs do not rank cost in the top three important things to consider when making a referral. The same survey found only 10% of GPs 'strongly' or 'slightly' agree that they take account of what the consultant charges when referring patients privately¹⁷⁰.

¹⁶⁶ This is supported by the OFT Consultant Survey (p 48), which shows that 85% of consultants who responded travel between zero and 30 minutes between their NHS and main PH facility.

¹⁶⁷ In addition the market could be limited by a time dimension. As the patient will often meet their anaesthetist only shortly before surgery, his or her choice will be limited to those anaesthetists available at the hospital at that time (otherwise he or she will have to incur the costs of delaying surgery).

¹⁶⁸ *"In general, the OFT considers that this shortage of accessible, standardised and comparable information weakens the ability of patients and GPs to drive efficiencies and stimulate enhanced competition between rival PH facilities and between consultants, and may give rise to a dampening of competition in the market overall."* OFT MIR Decision, April 2011, para 1.11.

¹⁶⁹ KantarHealth Survey, December 2011/January 2012 (Base: 397 GPs).

¹⁷⁰ The OFT GP Survey noted that for GPs the most significant difference between PMI and self-pay patients was in respect of the importance of the cost of treatment as a factor influencing their choice of recommendation. Just 13% of GPs identified it as an influencing factor with regard to PMI patients and just 2% of GPs as the single most important factor. For self-pay patients, however, 36% of GPs identified the cost of treatment as an influencing factor, and 15% of GPs nominated it as the single most important factor when making a recommendation.

Table 18: What considerations are important when you [GP] refer a privately insured patient to a consultant?

	General reputation and stature	Clinical outcomes data	Cost	Long standing relationship
Ranked 1st	61%	12%	10%	15%
Ranked 2nd	26%	28%	19%	22%
Ranked 3rd	10%	29%	26%	20%
Not ranked	4%	32%	46%	43%

Source: KantarHealth Survey, December 2011/January 2012 (Base: 397 GPs).

6.27 Because GPs do not have full, comparable information on the costs and quality of consultants (nor could they currently be expected to have as comprehensive information is not publicly available), a consultant has little incentive to cut his or her own price or to improve quality. These actions will not increase referral volumes.

6.28 GPs, therefore, have to make referral decisions based predominantly on their own experiences and anecdotal information¹⁷¹. The GP's decision may also be affected by the very limited time they have with the patient during an NHS appointment and the fact that the GP does not bear any of the cost or benefit for the patient of finding a private consultant who offers value for money care.

Little patient buyer power

6.29 The lack of information available to GPs to make informed referral decisions is compounded by the difficulties and costs patients face in researching and understanding their options independently. As a result, patients tend to trust the GP's decision. The influence of the GP is illustrated by the findings in the OFT GP Survey (p24) that 92% of GPs believed that patients 'usually' (80%) or 'always' (12%) followed their recommendations.

6.30 When in the consultant's office the patient has little bargaining power. He or she is unlikely to understand and be able to judge the value of the service the consultant promises to deliver. Further, a majority of consultants do not discuss fees with the patient at their first meeting meaning that the patient does not have sufficient information to make a decision to switch. The patient also has a significant amount at risk personally, especially if suffering from a serious condition, putting him or her in a vulnerable position.

6.31 In any event, a perverse result of the absence of information on consultant quality is that the patient may interpret the consultant's fee as a signal of quality – assuming incorrectly that a better consultant will cost more. However, there is no evidence that this is necessarily the case.

Switching costs

6.32 Patients cannot easily or without cost switch consultant mid treatment. The further down the journey the patient has progressed in the hands of one consultant, the greater the costs of beginning the journey again with another consultant¹⁷². This means that even if there was a

¹⁷¹ GPs are described as having: 'a sort of 'mental' filing cabinet of informal information or soft intelligence about local consultants.' (page 20, The King's Fund: An Anatomy of GP Referrals, 2007).

¹⁷² In some cases, it may not be possible to easily find another consultant willing to accept the indemnity insurance risk of taking on a patient that has previously been treated by another consultant.

degree of competition to acquire patients at the first appointment (which currently we do not believe there is) the consultant is able to impose higher fees or additional treatment costs later in the journey.

- 6.33 Switching costs are a particular challenge for (i) conditions that require extended treatment journeys with multiple episodes with the consultant (e.g. cancer) and (ii) anaesthetists as switching anaesthetists just before an operation could delay the entire operation (possibly resulting in additional consultant and hospital costs for the patient).

Factors act in combination

- 6.34 The above issues combine, and reinforce each other, to result in ineffective competition between consultants on either quality or cost terms. This lack of effective competition has been recognised previously – the CC noted in 2000 that “*consultants’ fees are not subject to effective competitive pressures*”¹⁷³.
- 6.35 However, there are limits on what the market itself can do to address these failures. For example, comparable data on consultant quality has failed to emerge (even though it could materially improve patient outcomes and experience¹⁷⁴) because of an inability to reach market consensus. High quality consultants have little incentive to collect and present data if low quality consultants do not participate and so there is no comparison possible.

GROWING CHALLENGES TO EFFECTIVE COMPETITION BETWEEN CONSULTANTS

- 6.36 There are several additional factors that Bupa considers have a negative impact on how the market for consultants works for consumers.

Consultant incentive schemes create conflicts of interest

- 6.37 Bupa is concerned about the effect that consultant incentive schemes by PH providers may have on the market. Some examples of such schemes and their effects are discussed below.
- 6.38 The lack of transparency of consultant incentive schemes makes it difficult to get a complete picture of their prevalence and impact in the market. We do not believe that the majority of consultants declare conflicts of interest to patients or to insurers, despite there being professional guidance to do so¹⁷⁵. This lack of transparency is itself a significant concern. However, even if consultants did disclose conflicts to the patient, it is unlikely the patient would know how to act as a result of this information.

¹⁷³ Competition Commission, “British United Provident Association Limited and Community Hospitals Group Plc: A report on the proposed merger; and British United Provident Association Limited, Salomon International LLC and Community Hospitals Group Plc; and Salomon International LLC and Community Hospitals Group Plc: A report on the existing mergers”, 2000, para 4.40(d). http://www.competition-commission.org.uk/rep_pub/reports/2000/fulltext/449c4.pdf Last accessed 5 May 2011.

¹⁷⁴ As illustrated by The Society for Cardiothoracic Surgery in Great Britain & Ireland (2011) which cut mortality rates by 50% through collecting quality information, noting “*we believe that the marked, sustained, incremental improvement in the quality of care the surgical teams have achieved is directly associated with the process of recording, reporting and publishing outcomes at the level of the individual clinician*”. See “Maintaining patients’ trust: modern medical professionalism”, available at http://www.scts.org/_userfiles/resources/634420268996790965_SCTS_Professionalism_FINAL.pdf (accessed May 2012).

¹⁷⁵ The GMC Good Medical Practice Guide explains: “*If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest.*” Further, the GMC Advice on Conflicts of Interest states that: “*In all cases you must make sure that your patients and anyone funding their treatment is made aware of your financial interest*”. Available at http://www.gmc-uk.org/guidance/good_medical_practice/probity_conflicts_of_interest.asp.

- 6.39 However, the use of consultant incentives appears to be extensive. Indeed, the OFT found evidence of consultant incentives across the market, with indirect incentives being widespread¹⁷⁶. It is notable also that a number of Initial Submissions to the CC raise concerns about consultant incentive schemes.
- 6.40 Some forms of incentive scheme may be needed for a new hospital operator to attract consultants. However, where these schemes, either financial or non-financial, have the effect of tying in or biasing a consultant to a particular facility they can lead to: reduced choice for patients on location of treatment; barriers to entry and expansion for rival facilities; constraints on the insurers ability to move away from a hospital; and, the risk of over-treatment and over-diagnosis where incentives are linked to revenue-sharing¹⁷⁷. These schemes also add extra costs to the PH system (and do not in most cases lead to patient benefit), which ultimately the patient must bear.
- 6.41 Bupa has observed evidence of direct financial incentives. An example contract from [redacted] to a consultant is included in Annex C, which explains that the consultant will gain a profit share of “20% of direct contribution, subject to incremental volume, unit revenue and margin” from committing to “transfer existing private practice to [named hospital] subject to clinical need”. We have also seen the rise of consultants holding equity in the hospital (as in the case of Circle), which gives them a significant incentive to increase the hospital’s profitability. These types of direct financial inducement reward over-treatment (which adds cost to the system and puts the patient at risk) and limit the incentive of the consultant to offer real choice to the patient. This is a serious concern for the system¹⁷⁸.
- 6.42 However, indirect incentives are of equal concern as they can effectively lock in a consultant. For example, if a hospital operator undertakes the consultant’s billing and IT on his or her behalf, then the consultant faces high switching costs to move hospital.
- 6.43 Bupa also notes the trend identified by the OFT of the use of GP incentives by some PH providers seeking to link GPs to particular facilities. Bupa is seriously concerned that such incentive schemes could undermine the effectiveness of choice and competition right at the start of the patient journey. Further, certain hospital groups are now focussing on a strategy of acquiring GP practices. This trend is a serious concern. It will bias referral patterns and threaten GP independence.
- 6.44 In general, Bupa would like to see much greater transparency across the whole market on which individuals and organisations are involved in which types of incentive schemes. Further,

¹⁷⁶ Other industry participants also note the prevalence of schemes: “Surgeons are often offered benefits, incentives or inducements by private hospitals in order to attract their customer, and these often significantly decrease their actual or effective practice expenses. Some 60% of surgeons use consulting rooms in private hospitals, and a substantial proportion of these are offered to the surgeon at zero or subsidised cost. We are not aware of any instances in which an anaesthetist has been so incentivised.” The Association of Anaesthetists of Great Britain & Ireland, “Response from the Association of Anaesthetists of Great Britain and Ireland to requests for information from the OFT in relation to its study of the private healthcare market”, 2012, p.13.

¹⁷⁷ Consultant incentive schemes also make it extremely difficult for an insurer to persuade consultants to move away from the hospital should the hospital and insurer be in a commercial negotiation or dispute. Therefore, incentives that raise consultant switching costs are a tool for hospitals to enhance leverage against insurers.

¹⁷⁸ As an illustration of the seriousness of the issue about inducements creating conflicts of interest for the doctor, the US government recently enacted the Physician Payment Sunshine Act (PPSA) which requires healthcare organisations to disclose: (i) payments and transfers of value to physicians, and (ii) ownership and investment interests of physicians and their immediate family. The PPSA applies to pharmaceuticals, medical device, biological and medical supply manufacturers as well as group purchasing organisations operating in the US. Failure to publish this information will lead to a fine which can range from US\$ 1,000 to US\$ 100,000. Although the PPSA does not cover payments from hospitals to physicians, it highlights the importance of disclosing conflicts of interest.

there should be clear guidance on which types of incentive schemes are appropriate and which are not, and sanctions against those who are applying inappropriate schemes.

Consultant Groups restricting choice and competition at a local level

- 6.45 Bupa is concerned about the growing trend of the consultants forming groups. This issue is not only prevalent in anaesthetics, but other specialisms as well. Consultant groups have negative impacts on both choice and competition at the local level.
- 6.46 Consultant groups take a variety of legal structures from legal partnerships to informal groups sharing services like billing and secretarial support. The most direct impact for patients is that a group tends to set uniform fee rates across the group members. This means that if a group becomes too large within a particular local market (encompassing the majority of relevant consultants), patients and their insurer may have little choice other than to pay the group fee rate. Certain groups have become so large within their local market that they can, and do, abuse their dominant positions without any benefits flowing back to patients.
- 6.47 In addition to the direct negative impact on choice, the groups may have further indirect negative effects for patients:
- i. Group members have little incentive to compete with each other on quality offered to patients, if a group member will not benefit directly from offering better quality than a fellow member. For example, The Association of Anaesthetists of Great Britain and Ireland (AAGBI) states that 64% of Anaesthetist Groups (AGs) “share profits equally between members of the group” meaning there is little reason to differentiate service for group members¹⁷⁹.
 - ii. The threat of new entry to the market will be blunted by the presence of groups. The AAGBI notes, 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”¹⁸⁰.
 - iii. Consultants outside the group often simply ‘follow’ the group rates in a local area, leading to higher fees for all patients.
 - iv. There is a trend of the groups linking themselves to particular hospitals. Hospitals have to pay to acquire the relationship with the group (and so benefit from the patients the group will bring with it). The costs to the hospital for acquiring this relationship will ultimately be passed through to patients in the form of higher fees.
 - v. The group may span more than one hospital in the local area, meaning that the patient may not be able to find non-group consultants even in hospitals further away. [3<].
- 6.48 Arguments are made by proponents of the groups that they bring about benefits. For example, the cost efficiencies for consultants in sharing resources and marketing jointly. However, in many cases these alleged benefits do not appear to flow through to patients – a number of the largest anaesthetist groups charge the highest fees, for example (see 6.58 below). It is also

¹⁷⁹ See <http://www.aagbi.org/sites/default/files/AAGBI%20FINAL%20response%20to%20OFT.pdf> (accessed June 2012).

¹⁸⁰ Ibid.

unclear whether it is necessary and proportionate to form a group with a uniform price structure (or profit sharing arrangement) to achieve these benefits.

- 6.49 To illustrate Bupa's concerns we look particularly at anaesthetist groups below. However, Bupa has concerns about groups in other specialisms as well¹⁸¹.

Anaesthetist groups

- 6.50 Anaesthetist Groups (AGs) have rapidly become a prevalent feature of the PH in the UK. Survey evidence from the AAGBI shows that around 44% of anaesthetists active in the PH market are involved in an AG and that the number of AGs has more than doubled in the last 5 years.
- 6.51 Bupa is now aware of over 40 AGs serving Bupa patients (and the number may actually be higher because some group members still invoice in their own individual name rather than in a group name). The AAGBI notes that 45 AGs responded to its survey and that this may underestimate the full number in the market marginally.
- 6.52 Bupa has concerns that some of these AGs can, and do, abuse their dominant positions. This is not to say that all AGs do this, but there are a significant number.

The role of the AG increases the power of the anaesthetist

- 6.53 As discussed in Section 4, the position the anaesthetist occupies in the treatment journey means that the patient has relatively little choice and high switching costs. This gives the anaesthetist pricing power. There is also little competition on quality. Bupa is not aware of any comparable information on anaesthetist performance being published. This pricing powers is increased by the formation of AGs.
- 6.54 The relevant market for anaesthetist services is likely to be very narrow. Realistically, a patient is likely to be able to switch only to other anaesthetists within the same hospital in response to learning of a shortfall. It is unlikely that the patient would switch the entire surgery to another location, potentially much further away, given the delays this would cause and the possibility of needing to change the consultant undertaking the surgery (as the consultant may not treat elsewhere). Therefore, whereas the OFT considered a relevant geographic market for a consultant to be local, Bupa considers that for anaesthetists this could be narrowed to just the hospital in which the treatment is taking place.
- 6.55 Many AGs now also publish their fees on the internet. This could be helpful in that it gives patients more transparency on costs (if they knew to look), but at the same time it allows more coordination between anaesthetists (both with other groups and with non-group members). Bupa has observed non-group members in local areas simply following the pricing of the group.

¹⁸¹ For example, in Ophthalmology the Consultant Eye Surgeons Partnership (CESP) now has 28 regional groups across the UK with over 200 consultants. In many areas CESP includes all consultant ophthalmologists who offer private service and this leaves members with no opportunity to use a surgeon who sets their fees independently. [3<]

The negative effects of anaesthetist groups

- 6.56 The negative impact on patients of AGs is illustrated by the complaint letters from patients in Annex D. In the two example letters, patients complain to Bupa that the AGs in their local area are so large that they can find no alternative choice and are forced to accept the shortfall.
- 6.57 Figure 28 shows the average shortfall over Bupa's benefit maxima for anaesthetic services. What is notable is that in the South West of the UK the magnitude of shortfalls has grown rapidly (more so than even in Central London). This is an area in which a number of large AGs operate. Patients in these areas have very little alternative but to accept paying a shortfall.

Figure 28: [✂]

- 6.58 Figure 29 shows the rate and magnitude of shortfall Bupa observed for eight of the larger AGs in 2011. The figures show:
- i. The percentage of Bupa activity the AG undertakes in the main hospital it operates within. It is evident that each group controls a dominant share of activity in its main hospital. We give examples also the amount of activity each AG controls in the surrounding hospitals beneath the figure.
 - ii. The rate of shortfall by frequency, which refers to procedures that result in the patient being expected to pay a shortfall (e.g. if 2 out of 4 episodes have a shortfall, then the shortfall rate for that procedure is 50%).
 - iii. The rate of shortfall by magnitude, which looks at the size of the shortfall relative to the benefit maxima (i.e. if the claim excluding the shortfall for a procedure is £200 and the additional shortfall charged is £50, then the relative shortfall magnitude is 25%).

Figure 29: [✂]

- 6.59 Important patterns of the data are:
- i. There is variation in the frequency of shortfalls, but seven of the AGs had shortfall rates substantially higher than the national average. [✂].
 - ii. The magnitude of the shortfall varies across the groups, but five AGs stand out in having materially larger shortfalls than the national average, emphasising their market dominance.
- 6.60 Each of these groups also controls activity at surrounding hospitals, meaning patient choice is further limited. Analysing the Bupa claims data for 2011, and using a 30 minute drive time as a proxy for a geographic market around a hospital, Bupa observes for example:
- i. [✂]
 - ii. [✂]
 - iii. [✂]
- 6.61 In summary, certain AGs use their dominant positions to raise costs for patients. Therefore, patients are not sharing in any of the cost-synergies that may exist when anaesthetists form these groups. Bupa is not aware of any objective analysis demonstrating that AGs improve either the quality of service offered to patients or the safety of patients, or that AGs are

necessary to achieve these benefits. Bupa considers it a priority that the CC investigates and sets clear guidelines on when these groups are in the interests of patients and when they are not.

Treatment variation is a symptom of market malfunction

- 6.62 Bupa observes significant variation in the treatment practices of consultants in PH in the UK. While some of this variation will be explained by tailoring care to a specific patient's needs, Bupa is concerned that a degree of this variation is unwarranted.
- 6.63 Consultants have complete freedom in the type and volume of treatment they specify (and do not bear the costs). The patient has little ability to challenge the consultant's recommendations. The insurer faces similar challenges because of the lack of comparable data on consultant performance and cost. Further, the effect of benefit maxima on controlling costs is limited where some consultants circumvent the maxima by specifying unnecessary treatments (e.g. diagnostic tests, which are outside of benefit maxima).
- 6.64 In Annex E we present a detailed discussion of treatment variation along with several case studies from Bupa's experience of where we have seen this occur. Our analysis showed that, even when adjusting for age and gender, Bupa members were receiving up to three times the number of knee arthroscopies as in the NHS. This was also the case for certain shoulder surgeries. Similarly, we observe consultants using surgical techniques that are no longer in line with evidence-based care.
- 6.65 Features of the market facilitating this unwarranted variation include:
- i. The fee-for-service reimbursement model where consultants are reimbursed based on the volume of treatments they perform rather than the quality. This can lead to over-treatment or over-diagnosis.
 - ii. Consultant incentive schemes that reward the consultant on the basis of referral volumes or the use of particular drugs and equipment.
 - iii. The lack of competition and choice between consultants which allows unwarranted variation to persist unchallenged by market forces (e.g. if choice and competition worked more effectively, wasteful practices be disciplined by patients switching away).
 - iv. The complete lack of granular, objective, comparable data on consultant performance, which makes unwarranted variation difficult to detect and correct. Further, consultants seldom give insurers the full reasons why they have undertaken a particular treatment (and not another) making challenging the conduct even more difficult.
 - v. Conflicts of interests that protect the use of certain treatments at the expense of more appropriate care.
- 6.66 Bupa launched medical review processes for certain treatments where rates of intervention appear out of line. For example, the knee arthroscopy medical review (explained in more detail in Annex E) was launched in April 2011 and has had a positive effect on consultant practices. However, there is substantial cost to Bupa, and resistance from consultants, in establishing these types of review processes. It would not be practical to roll out these types of medical reviews to the hundreds of treatments exhibiting variation.

6.67 Unwarranted variation is a symptom that the market is not working well for consumers. It harms patients both by placing them at risk clinically and also by affecting the costs of their care. While we are not asking the CC to make clinical judgments, we do consider it critical that the CC investigates and addresses the market factors (e.g. the lack of information) that facilitate this over-treatment and over-diagnosis (see Annex E for further information).

Consultant trade bodies can weaken competition

6.68 The consultant trade bodies – such as FIPO and the Private Practice Committee of the BMA – vocally call on consultants to resist change to the market. While these bodies should rightly represent the interests of their members, Bupa has concerns that their communications encourage consultants to coordinate behaviours to the detriment of competition, quality and consumers. These bodies sometimes misrepresent their actions as ‘protecting patients’ when they are in reality protecting the interests of consultants only¹⁸². Annex F provides an example. It illustrates materials provided by FIPO to consultants to illustrate the interdependence between consultants and how competing on price is not in the consultants’ best interests.

HOW BUPA MANAGES ITS RELATIONSHIPS WITH CONSULTANTS

6.69 As a commissioner of care Bupa has taken a number of steps to improve the quality and affordability of care that our members receive from consultants. These measures seek to counterbalance the strong market position of consultants (particularly relative to the patient), and to reward those consultants who do offer high quality care at affordable prices. Our members benefit from our measures directly in financial terms, in clinical terms, and in emotional terms (the feeling of support and fewer surprises during a difficult period).

6.70 Our initiatives aim to empower the patient at each point in his or her treatment journey – at the point of choosing consultant, at the point of receiving the appropriate treatment, and at the point of making payment. The section concludes by responding to arguments from some consultants and consultant trade bodies about how insurers, and Bupa in particular, work with consultants. There is no evidence that Bupa’s actions are adversely distorting the market, quite the contrary. For the reasons set out below Bupa considers the steps that it has taken to be reasonable responses to market circumstances and to the benefit of our members and the market.

Consultant recognition

6.71 Bupa must make available a wide choice of high quality consultants to our members. Therefore, we have a strong incentive to recognise all consultants who offer our members value for money. At the same time, we have a clear responsibility not to work with consultants who place our members at risk. This active management of the consultants we recognise is an essential part of Bupa giving comfort that the consultant our members will see meets appropriate standards.

¹⁸² The trade body may face conflicts of interest in its representation. For example, the HCA annual report from Companies House shows that it made a donation of £110,000 to FIPO in 2010. This accounted for over 60% of FIPO’s income during the year, according to FIPO’s annual report. It should be noted also that FIPO is a significant contributor to the Private Patient Forum.

- 6.72 We have a structured recognition process for consultants¹⁸³, and we monitor the performance of our recognised consultants on an ongoing basis. If, for example, the consultant does not have, or loses, his or her GMC licence we will not recognise them. Bupa may also derecognise a consultant if we identify treatment practices which harm patient safety or pricing and billing approaches that are systematically out of line with peers (and evidence-based care). Bupa will always engage with the consultant before making a decision over derecognition. The consultant will be given an opportunity to explain why he or she is systematically out of line. However, if no objective, evidence-based justification can be provided, the consultant will need to either address his or her conduct directly or Bupa will no longer make him or her available to our members. Historically this has happened in only a very small number of cases each year.
- 6.73 This active management of consultant recognition is an essential part of Bupa giving members comfort that the consultant they will see meets appropriate standards. This aligns with what consumers expect of insurers. Customer research conducted by The Value Engineers in 2010 shows:
- i. **87%** agree that they expect the consultants available with their insurer to deliver high quality care at affordable prices. Only 4% disagreed (with the remainder being neutral).
 - ii. **87%** expect their insurer to monitor consultants to ensure they offer high standards of care and follow best clinical practices (only 5% did not have this expectation).
 - iii. **83%** expect their insurer to work with consultants to keep costs down (against only 4% who did not have this expectation)
 - iv. **77%** trust their insurer to take appropriate actions where it seems that a consultant might not be providing the best quality treatment (against only 16% who would not).
 - v. **80%** feel reassured that the consultant they are seeing is recommended and approved by their insurer (against only 3% who disagree).
 - vi. **84%** expect their insurer to ensure that consultants do not charge members more than the standard cost for a treatment in order to keep PMI premiums affordable (against only 5% who did not have this expectation).

Benefit maxima and an important tool to manage costs

- 6.74 Bupa's main tool for managing consultant fees is benefit maxima. Benefit maxima are the maximum amount Bupa will reimburse a consultant on behalf of a member undergoing a specific treatment¹⁸⁴.
- 6.75 Benefit maxima apply only to inpatient surgical and certain day case treatments (covered by CCSD codes). They do not apply to outpatient consultations, and most diagnostics tests etc. Only around 49% of Bupa spend with consultants in 2011 was on procedures to which benefit maxima apply.

¹⁸³ The current consultant recognition criteria are available on Bupa's website at <http://www.bupa.co.uk/healthcare-providers/provider-application/consultant-recognition>. The consultant will remain recognised until retirement or death, unless we are required to derecognise them for misconduct or negligence.

¹⁸⁴ [S<]

- 6.76 Bupa's benefit maxima are set out for each surgical treatment in the publicly available Schedule of Procedures¹⁸⁵. Each treatment is reimbursed according to a matrix of 25 categories linked to complexity.
- 6.77 Benefit maxima are necessary because of the lack of competition between consultants, the weak negotiating position in which patients find themselves¹⁸⁶, and the practice of some consultants not informing patients about fees in advance. Maxima also allow insurers to give clarity to both the patient and the consultant up front about what will be reimbursed (this is essential from a liability perspective for the insurer). This is particularly important given that the insurer – the funder – is typically excluded from any conversations on price by the consultant. If benefit maxima did not exist, we would expect consultant fees to rise across the market, with a negative effect on patients in terms of the affordability of PH and PMI (and the size of the PMI market).
- 6.78 The competition authorities have previously found that benefit maxima are a reasonable tool to control consultant costs:
- i. In 1994, the Merger and Monopolies Commission (MMC) confirmed benefit maxima were not against the public interest. The MMC report (para 1.11 and 11.125) states¹⁸⁷:

“...we find that the setting of the BUPA benefit maxima is a legitimate step by BUPA in carrying out its functions as an insurer. Insurers must be able to inform policy-holders of the benefits they will receive if they claim for events that are covered by their policies. BUPA and the other insurers are the principal counterweight to the consultants, given the weak position of patients. The BUPA benefit maxima have had a restraining effect on consultants' charges.”

“...given the weak bargaining position of patients and the comparatively strong position of many consultants each within his own area...we expect that consultants would be able to resist any attempts by insurers – and even an insurer of the size of BUPA – to reduce their charges below a competitive market level...we are satisfied that it [the setting of benefit maxima] provides a safeguard against overcharging by consultants but does not, and is not likely to, unreasonably depress their charges.”
 - ii. The OFT reassessed the MMC's findings in 1999 and concluded¹⁸⁸:

“...the BUPA Benefit Maxima remain valid and that the removal of BUPA's Benefit Maxima, with no comparable replacement, would lead to significant increases in consultants' fees.”
- 6.79 Maxima have had a constraining effect on the surgical procedure charges to the direct benefit of consumers. Figure 30 shows that the reimbursements by Bupa over the period 2006 to 2011 for outpatient consultations, which are not currently subject to benefit maxima (and account for nearly 50% of consultant earnings), grew at a significantly faster rate than consultant surgery

¹⁸⁵ This is available at <http://www.bupa.co.uk/jahia/webdav/site/bupacouk/shared/Documents/PDFs/healthcare-professionals/Schedule%20of%20procedures%20web.pdf>

¹⁸⁶ Maxima provide an important control on the fees for treatments that occur mid way through the patient journey by which point the patient has little alternative choice (and so no real negotiating power).

¹⁸⁷ Monopolies and Mergers Commission, “Private Medical Services – a report on agreements and practices relating to charges for the supply of private medical services by NHS consultants”, 1994, p.1.11 and p.11.125.

¹⁸⁸ OFT news release, November 2009, available at http://www.of.gov.uk/shared_of/market-studies/40_99.pdf (accessed June 2012).

costs which are constrained by maxima. It is notable that consultation fee inflation has exceeded other benchmarks such as hospital claims spend inflation and RPI.

Figure 30: [X]

- 6.80 It is important to note that benefit maxima relate only to the price of treatments, and do not relate to the volume of treatments the consultant prescribes. Bupa currently has only limited ability to manage the risks of over-treatment and over-diagnosis inflating the overall consultant costs (treatment variation is discussed in more detail in Annex E). So maxima are an important tool to manage costs, but are by no means sufficient on their own.
- 6.81 Some consultants do shortfall patients. Therefore, Bupa has taken additional steps, discussed next, to give greater certainty to patients. This active management of consultant fees is what customers expect; for example, as noted at 6.73, 84% agreed with the statement “I expect [my insurer] to ensure that consultants do not charge members more than the standard cost for a treatment in order to keep my Private Medical Insurance premium affordable”.

Contractual arrangements with consultants

- 6.82 Bupa has employed two contractual schemes with consultants during the past decade to enhance the price certainty for our members:
- i. **The Consultant Partnership Scheme (CPS):** Through the 2000s Bupa ran a voluntary CPS where the consultant consented to charge within Bupa’s benefit maxima for all treatments (other than outpatient consultations), and in return Bupa would pay the consultant a small retrospective annual bonus on the consultant’s charges on Bupa members for that year. The bonus was originally [X] of the consultant’s Bupa member fees (excluding consultation fees), and this was increased to [X] in the later years of the CPS. The consultant also benefitted from being offered as a ‘fee assured’ consultant to patients during pre-authorisation calls with Bupa. As participation in the scheme was voluntary uptake varied by geography and by specialism. For example, relatively few anaesthetists joined the scheme. The CPS has been closed to new members since late summer 2010, although there are still just over [X] consultants in the UK who are Consultant Partners (at June 2012).
 - ii. **The New Consultant Contract:** Since June 2010 Bupa has operated a new consultant recognition process¹⁸⁹. The consultant signs a contract with Bupa under which consultants agree to charge within Bupa’s benefit maxima and to provide more information about their treatment practices on Bupa members. The New Consultant Contract also agrees fixed outpatient consultation charges to give greater certainty to members about the costs they could face. There has been strong uptake for the New Consultant Contract since it was launched in June 2010. Over 2,750 new consultants have been recognised on this contract since then and a further 830 already-recognised consultants have asked to move to this new contract.

¹⁸⁹ For the period between December 2009 and June 2010 Bupa’s consultant recognition process was closed to allow time for internal reorganisation to the New Consultant Contract. Bupa accepts this caused frustration to new consultants applying for recognition during this 6 month period (just over 600 in total), but Bupa quickly processed these applications once the process was reopened.

Giving more choice at claim pre-authorisation

- 6.83 The majority of patients contact Bupa prior to seeing a consultant to pre-authorise their treatment (although pre-authorisation is not mandatory on most of our policies). At this point we can advise the patient whether the consultant is 'fee assured' (e.g. a Consultant Partner) or if the patient could face a risk of a shortfall. Pre-authorisation therefore acts to give patients more information and options at the point of choosing the consultant.
- 6.84 In Bupa's experience, around [30] of patients who call to pre-authorise already have a named consultant provided by their GP. Approximately [30] of these will choose to go to a 'fee-assured' consultant when we explain to them that their named consultant may shortfall. By helping patients avoid these shortfalls, Bupa benefits the patients directly.

Open Referral to improve the quality of choice and competition

- 6.85 Bupa introduced Open Referral as a service option in 2011 at the request of a corporate customer. The customer wanted more cost-effective healthcare for its employees and fewer shortfalls, while not compromising on the quality of consultants or the level of cover offered to its employees. By controlling claims spend the customer wanted to expand the number of people being covered by PMI in the organisation. The Open Referral service helps meet these needs, has received very positive patient feedback, and significant savings for the client.
- 6.86 In the Open Referral process, rather than a Bupa member being referred to a single named consultant by the GP, the referring GP specifies the clinical need (the clinical speciality, sub-speciality and whether an appointment is urgent) and Bupa then gives the member a choice of two or more consultants offering appropriate care at convenient locations. Bupa uses its claims database, augmented with additional quality data, to match a patient's requirements with relevant consultants in the local area. The patient will be offered a selection of two or three consultants located convenient to them who practice within the norms of their specialty (after taking into account case-mix). The patient will be guaranteed not to face a shortfall. The patient is not obliged to choose only from the options we recommend and can see other consultants (provided they are Bupa recognised) for continuity of care reasons or if his or her GP considers there to be an objective clinical reason (which would need to be explained to Bupa). In the vast majority of cases patients have been highly satisfied with the options recommended – survey evidence shows that 93% of patients 'strongly' (79%) and 'slightly' (14%) agree that the "choices given were suitable for me" with only 1% disagreeing. At June 2012, we had had only [30] GP escalations about the recommendations we have made from the many tens of thousands of referrals to date.
- 6.87 The Open Referral service is a step towards addressing the significant information gap that faces GPs about the cost or quality of private consultants. The lack of comparable data on cost or quality available to GPs means that 'named' referrals can seldom be made on complete information. We have explained above that the significant majority of GPs do not believe they have access to comparable information on consultant quality. The GP is highly unlikely to know the typical end-to-end treatment practices and costs for each consultant in the local area¹⁹⁰. Nor can GPs be expected to have this wide-ranging knowledge given the changing number of consultants in the market, the large number of specialisms and sub-specialisms, and the small percentage of private patients a GP will see within his or her daily NHS rota. This, however,

¹⁹⁰ For example, as noted above, 75% of GPs say they 'rarely' or 'never' know the cost of the consultant's first appointment.

does mean that patients may sometimes be referred to one consultant where a consultant offering better, more affordable care was available¹⁹¹.

- 6.88 Bupa can use its large database of previous patient experience, together with its clinical expertise, to improve the amount of information available to patients on which to choose the consultant. This enhances competition between consultants to offer patients value for money.
- 6.89 The Open Referral service is in its early stages and currently offered to corporate customers only. However it is delivering excellent results and consistently high patient satisfaction. Bupa has assisted over [3<] patients through Open Referral since launching in 2011. And it is meeting a clear customer need. Around 8 out of 10 of our corporate clients are choosing this option at renewal, meaning that, as of mid July 2012, over 500,000 of our members covered through corporate policies are now eligible to use the service.
- 6.90 The Open Referral service improves daily as our database gets richer. In the very rare cases, amongst the many tens of thousands of successful referrals, where a patient feels we offered an inappropriate choice we can quickly adjust the database to avoid the situation arising again. We actively encourage patients and consultants to engage with us to enhance the data in the system.
- 6.91 Therefore, Open Referral is giving patients choices based on more information. However, to be clear, Open Referral could be significantly improved further if all consultants in the UK provided objective, comparable data on their performance. Therefore, consultants should still be obliged to fill the information gap created by their failure to publish information on quality or their activity in private practice.

Medical reviews to manage unwarranted variation

- 6.92 To address concerns about unwarranted treatments, Bupa has initiated medical reviews for knee arthroscopy, wisdom teeth extraction and shoulder surgery. These reviews ask the consultant to explain in a short form why the surgical intervention has been chosen. If the intervention is justified on medical grounds, Bupa will fund it. An interesting outcome of these medical reviews, however, is that since their introduction the number of consultants recommending surgery has declined suggesting that some surgical interventions were not strictly necessary.
- 6.93 [3<]. However, the costs to Bupa of launching and administering these reviews are substantial. The risks of unwarranted variation would be dealt with more effectively by counteracting the drivers that facilitate these practices.

RESPONDING TO ARGUMENTS BY SOME CONSULTANTS ABOUT BUPA'S INITIATIVES

- 6.94 Certain consultants and consultant trade bodies have challenged the use of reimbursement limits and 'managed care' by insurers. These complaints fail to recognise the important gains these actions deliver to consumers of PH and PMI.

¹⁹¹ For example, see Annex E where case study 4 looks at GP referrals for patients with cardiac arrhythmia.

Insurers do not have “too much” buyer power

6.95 The evidence from the PH market demonstrates that insurers, and Bupa in particular, are not abusing their buyer power.

6.96 Before presenting the evidence it is important to note:

- i. It is well understood in economics that, in almost all cases, buyer power is in the interests of consumer welfare¹⁹². Consumers benefit directly from lower prices, superior quality and often through enhanced innovation. The gains flowing to consumers increase with the degree of competition in the buyer’s market, with even a monopoly buyer passing through a significant proportion of gains to consumers. It is unsurprising that suppliers complain about buyer power and clamour for competition authorities to intervene. However, competition authorities should be cautious to do so, unless there is overwhelming evidence that consumers are made worse off by the buyer power. These cases will be extremely rare, as noted by the OFT¹⁹³:

“Although, in principle, charging excessively low purchase prices could constitute an abuse of a dominant position, the OFT considers that it is only likely to do so in exceptional circumstances. In the absence of barriers to exit by suppliers from the relevant market, a purchaser which paid excessively low prices would be unable to obtain supply beyond the short term even if it was a monopsonist. Hence the OFT considers that excessively low purchase prices will normally be self-correcting and would not, absent price discrimination, usually justify action under Chapter II of the CA98 (although the OFT will of course consider each case on its own merits).”

- ii. Consultants are in a position of significant market power themselves relative to the patient. Therefore, any alleged distortion from an insurer’s use of buyer power should be weighed against the significant market distortion that would result if the insurer was prevented from commissioning care on its customers’ behalf effectively.
- iii. The PMI market is competitive meaning that the vast majority of any gains from buyer power will flow through to consumers.
- iv. Bupa is committed to the UK PMI market for the long term. It is not in our members’ interests for us to suppress PH supply or to push consultants offering high quality, affordable care from the market, as our members will have to bear the consequences in the future.

6.97 There is no evidence that insurers indiscriminately delist consultants. Insurers must offer patients as many consultants offering high quality, affordable care as possible. It is an insurer’s responsibility also to delist consultants in circumstances when the consultant places the patient at risk. Delisting, therefore, can be a necessary action a responsible insurer must sometimes take to benefit patients. Even in these circumstances Bupa would give the consultant an

¹⁹² The UK submission, prepared jointly by the OFT and CC, to the OECD roundtable on Monopsony and Buyer Power in 2008 notes that “Buyer power can be seen as presumptively benign and harmful only in rare cases” (p232), and that “Buyer power mostly serves to reduce prices or otherwise increase competitive tension in the marketplace. It is no surprise, therefore, that businesses will lobby for its removal. Just as when assessing exclusionary abuses, it is essential for competition authorities to ensure they intervene only when necessary to protect the process of competition, in the interests of consumers, rather than protecting competitors and suppliers” (p242). Available at <http://www.oecd.org/dataoecd/38/63/44445750.pdf>

¹⁹³ OFT decision in BetterCare Group Ltd/North & West Belfast Health & Social Services Trust, December 2003, para 56.

opportunity to explain his or her actions prior to being delisted. Bupa also has an appeal process available to consultants if they believe they have been derecognised unjustly.

- 6.98 It is noteworthy that a FIPO consultant survey in 2010 showed how rarely consultants are delisted¹⁹⁴. Of the 765 respondents, 95% had never been delisted by an insurer, and 81% had never even been threatened to be delisted by an insurer. Bupa had proposed to delist under 3% of respondents, and actually had delisted only 3 individuals (less than 0.3% of the sample). These figures are particularly striking because the survey does not record why the consultant was delisted, and we would contend that in all cases there would be very sound reasons to delist (e.g. medical malpractice).
- 6.99 In addition, the number of consultants available for private practice has increased despite the shrinking number of people using PH (it must be noted that the number of lives covered by PMI in the UK today are at similar levels to in the mid-1990s). Indeed, Bupa has recognised over 2,750 new consultants in the past two years alone (since June 2010).
- 6.100 Finally, consultant earnings have been robust. Figure 26 earlier in this section showed that consultants have enjoyed stable profits (after practice expenses) from private practice over the period 2005 to 2010. This is despite the significant effect the recession has had on PH, with decreasing numbers of PMI subscriber and patient numbers, and the growing number of consultants active in the market.
- 6.101 Bupa is not aware of any evidence showing that UK consultants' private earnings are significantly out of line with peers in other advanced economies. International benchmarking of private practice incomes is clearly challenging due to differences in healthcare systems, but what analysis there is appears to indicate UK consultants' private earnings compare very favourably with peers overseas:

- i. Laing and Buisson notes a 2004 survey sponsored by Norwich Union and the Financial Times published in Healthcare Market News (February 2004) which "found senior hospital doctors in Britain receive fees of between 22% and 59% more for each operation than the average in the US, Australia, Canada and Germany"¹⁹⁵. This survey echoed the results of a survey in 1992 by Laing and Buisson which found that "UK private specialists' fees were the highest in the developed world at that time".
- ii. A 2011 article¹⁹⁶ in Health Affairs compared physicians' fees paid by public and private payors for hip replacements in Australia, Canada, France, Germany, UK, and the US. The authors found that UK orthopaedic surgeon hip replacement charges and total pre-tax earnings net of expenses were materially higher than other countries, other than the US. There are again limitations on the robustness of findings in this article, and it is only for one treatment, but UK earnings do not appear unreasonable.

Consultants cannot expect complete discretion in the fees they set and bill

- 6.102 Some consultants argue that insurers should not be involved in fee discussions between the consultant and the patient. Indeed, certain consultant trade bodies have actively encouraged

¹⁹⁴ FIPO Consultant Survey into Current Private Medical Insurance Trends, Detailed Review of Results, May 2010, available at <http://www.fipo.org/docs/axa-ppp/survey-detail-may-2010.htm>.

¹⁹⁵ Laing and Buisson 2010-11, p118.

¹⁹⁶ See <http://content.healthaffairs.org/content/30/9/1647.full?ijkey=HqIXCdVJkQzLI&keytype=ref&siteid=healthaff> (accessed 12th June 2012).

consultants to deal direct with patients, thereby excluding insurers¹⁹⁷. However, as both a commissioner and funder of care, insurers have both a right and duty to be involved to support our members.

- 6.103 Customer research shows that the majority of consumers expect insurers to be involved on their behalf in agreeing consultant prices (see 6.73). For example, the majority of respondents disagreed with the statement “I believe that consultants should be free to set their own charges for private medical insurance treatments”.
- 6.104 Some consultants complain also that insurers restrict their commercial freedom by setting reimbursement limits. However, in the absence of limits, insurers would be left with an unlimited liability to reimburse the consultant, despite (as is usually the case) the consultant not discussing and agreeing fees with either the patient or the insurer in advance of treatment. Further, this unrestricted commercial freedom would likely lead to increased prices to patients and payors, which would cause them to leave the market¹⁹⁸.
- 6.105 Bupa recognises that setting a common fee level for all consultants undertaking a procedure is not perfect. We would want to reimburse a consultant who provides better quality (in terms of medical outcome) a higher amount than for a consultant who provides inferior quality. However, the lack of comparable data on consultant quality prevents this solution. There are currently no objective grounds on which to move away from the common fee level.

The level of benefit maxima have, in general, not been increased because the dynamics of the market do not justify that action

- 6.106 Bupa reviews its benefit maxima from time to time, making modifications in light of new treatments, technologies, or changed complexity¹⁹⁹. However, the majority of Bupa’s benefit maxima levels have remained stable during the past decade. Bupa disagrees that maxima should have automatically increased each year.
- 6.107 First, as discussed above there is little evidence that maxima are currently too low. There have been substantial numbers of consultants coming into the market in the past two years willing to provide service at these rates – over 2,750 have signed Bupa’s new contract, and over 830 already-recognised consultants have expressed interest in moving on to the new contract. Consultant profits have also been robust through the past five years, despite the challenging economic circumstance and declining market.

¹⁹⁷ In March 2009, for example, the British Medical Association Private Practice Committee (PPC) published guidelines encouraging doctors to deal direct with their patients regarding fee levels (called ‘Good Billing Practice: A guide for private practitioners’). The guidelines introduction explains: “The PPC believes that the involvement of third parties [including PMI insurers] in both setting and controlling fee arrangements undermines the key principle of the independence of consultant practice.” It adds: “If a consultant hands over the billing arrangement to any third party they risk losing control of their practice, which has happened to some radiologists and pathologists.” The guidelines suggested that patients should be invoiced directly and included a draft letter to patients outlining their responsibility regarding fees before treatment.

¹⁹⁸ This point was recognised by the OFT in 1999 when it concluded: “...the BUPA Benefit Maxima remain valid and that the removal of BUPA’s Benefit Maxima, with no comparable replacement, would lead to significant increases in consultants’ fees.” See footnote 37.

¹⁹⁹ For example, in 2012 Bupa has reviewed the complexity ratings for certain procedures. This involves an external specialist assessing whether the level of complexity for a procedure has changes relative to other similar procedures. Where a code’s complexity rating changes its reimbursement level will change. The Schedule of Procedures has over 2,000 codes. In the complexity review conducted so far in 2012, 49 procedures have had the complexity rating increased, 25 procedures have been either removed or added to Schedule of Procedures, and 184 procedures have had their complexity rating reduced. The weighted average rise in fees for those codes for which complexity increased was 19%, with the weighted average decrease in fees for those codes that have reduced in complexity being 32%.

6.108 Second, there have been significant medical technology improvement over the period, which in many cases, has reduced the length and complexity of surgical episodes. Therefore, this should have put downward pressure on fees.

6.109 Third, when Bupa has made upward adjustments to benefit maxima, consultants have quickly adjusted their pricing behaviour to capture the gains. For example, in January 2001 Bupa increased a number of benefit maxima for anaesthetic procedures by 20% overall. While there was a short term reduction in the number of anaesthetists charging more than the benefit maxima, this rate of incidence returned to pre-adjustment levels within a short period. This left patients paying more across the board for treatment, and still facing shortfalls.

6.110 Fourth, some consultants may want fees to rise, but it is ultimately the patient who will bear the cost. With the industry spend on consultants totalling over £1 billion, it is clear that consultant fee inflation would quickly translate into significant additional premiums increases for insured patients. This would be unsustainable for the market, which is already in decline.

Anaesthetist fees are not too low

6.111 Bupa reimburses anaesthetists at lower rates than other consultant specialisms. However, there is little evidence to suggest Bupa should materially increase maxima levels to reduce anaesthetist shortfalls.

6.112 It is noteworthy that over [3<] anaesthetists have signed up to charge within Bupa's benefit maxima since June 2010. Further, despite the declining PMI market and the recession, anaesthetist profits from private practice have remained robust, as shown in Figure 31.

Figure 31: [3<]

6.113 Evidence suggests that anaesthetists in the UK do not earn salaries significantly out of line with international peers. A study by Stubbs²⁰⁰ estimated hourly anaesthetist rates across various specialties in the UK. It found that the average UK anaesthetist is reimbursed at £60 per hour when working in NHS contracted hours, £130 per hour when doing NHS work in non-contracted hours, and £170 per hour in private practice. An article in *Anaesthesia* (journal of the AAGBI) compared these findings internationally and found that "anaesthetists may well be equally valued, or at least similarly paid overall, in the UK and US, with Australia valuing its anaesthetists perhaps a little more highly"²⁰¹.

"Managed care" does not threaten the relationship between patient and GP

6.114 Bupa is becoming more involved in helping patients choose a consultant, but the GP still plays the role of diagnosing the patient and identifying the kind of consultant the patient should see. We assist by providing the patient with the fullest set of information we can to help make a sound decision (information that neither the patient nor GP could easily access). In those situations where the GP has a strong preference that the patient sees a specific consultant, he or she can discuss this with Bupa.

²⁰⁰ <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2044.2009.06238.x/full> (accessed June 2012).

²⁰¹ <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2044.2010.06326.x/pdf> (accessed June 2012).

6.115 Therefore, our involvement helps the patient make better decisions by augmenting the information available to the patient. The patient still has choice – we believe an improved set of options – and can still receive guidance from the GP.

6.116 Some consultants (particularly those incumbent consultants with entrenched GP referral patterns) argue that Bupa's interest is only to send patients to 'cheap consultants'. We disagree wholeheartedly. Our responsibility is to provide members with high quality care, and it would be an unsustainable strategy to compromise on quality. Members would leave Bupa, switching either to competitors or out of PMI entirely. Further, often the higher the quality of consultant, the lower the overall treatment cost for the patient (there are fewer unnecessary episodes, readmissions, etc.) meaning interests align as we focus on total treatment costs rather than first appointment fees. Finally, if a consultant is demonstrably the best option available for the patient from a clinical perspective, we will fund the patient going to that consultant. However, the responsibility should be on consultants to demonstrate this through quality data.

ANNEX A: THE INFLUENCE OF PRIVATE PATIENT UNITS ON THE PRIVATE HEALTHCARE MARKET

- A.1 Bupa works with a large number of PPU and Foundation Trust (FTs) NHS facilities. Bupa recognises over 70 PPUs and reimbursed claims of around [3<] million to PPUs in 2011²⁰². Bupa seeks to work with PPUs to deliver our members high quality and good value care. PPUs are recognised by Bupa on the same criteria as used for other private hospital providers.
- A.2 We want PPUs to succeed so that additional competition can be introduced to many concentrated local markets. However, in our experience, PPUs continue to face barriers to expansion in PH. Some of these barriers are similar to those faced by other small hospitals (such as attracting appropriate consultants, overcoming entrenched patient referral patterns, and weathering the impact of one-in, all-in negotiation by the main groups). However several are specific to PPUs which are limited by:
- i. negative patient perceptions;
 - ii. preference of consultants not to treat at PPUs;
 - iii. small size and therefore limited capacity, meaning they have significant investment requirements;
 - iv. weaker capabilities in commercial strategy and contract handling and organisational pressures (such as the duty to serve NHS patients first, the political pressures of expanding private provision, and the pressures from private hospital complaints about competitive neutrality and state aid); and
 - v. the fact that they act as individual operators and do not therefore constitute a competitive constraints at a national level.
- A.3 As also further explained below, there is little evidence that the change in the PPI cap will materially change the influence of PPUs.
- A.4 Private providers partnering with PPUs may inject some needed investment into PPU facilities. However, Bupa is concerned that certain of the main hospital groups are using PPU partnering and joint ventures as a strategy to expand scale and to increase bargaining leverage against insurers.
- A.5 Therefore, **in general PPUs do not provide a competitive constraint on the conduct of the main hospital groups (at either the local or national level)**. Only in a small subset of local markets do we believe PPUs are currently, or could become, effective competitors to other PH providers and this is typically only in certain specialisms²⁰³.

²⁰² Certain PPUs are themselves solus, facing little competition and we must use them to serve private patients, meaning that the total volume of spend at PPUs overstates the competitive strength of PPUs.

²⁰³ The OFT concluded that “*PPUs do form part of the relevant product market, although their competitive constraint on other PH providers varies case by case*” (MIR Decision, para 4.35). Bupa, however, cautions about PPUs being included by default in the relevant market as in significant majority of cases they are not effective competitors (and would not be included in the

- A.6 Even the strongest PUs in London offer competitive constraint in certain key specialisms only, and not across the board²⁰⁴. London's second largest PH provider, The London Clinic, makes this point:

"In The Clinic's opinion, PUs are not close competitors to HCA, The Clinic or the other private hospitals because they do not offer comparable service. PUs by definition operate as part of an NHS hospital and thus are unable to accommodate Consultants working for other NHS Trusts or private hospitals. The service they offer also falls below that expected at private hospitals both in terms of the "customer experience" but also access to dedicated facilities on a timely basis. The weakness of competition from PUs is most marked in relation to tertiary care of PMI funded patients (e.g. specialist oncology treatment) which is dominated by HCA with The Clinic and the other private hospitals taking a smaller share."²⁰⁵

- A.7 Bupa wants the CC to take action to support the development of the PUs as competitive alternatives. This will mean addressing existing barriers to entry and expansion. However, growth of PUs will not solve, and should not be relied on to solve, the competition problems at the heart of the PH market.

PPUs have significantly lower patient satisfaction scores than other PH providers

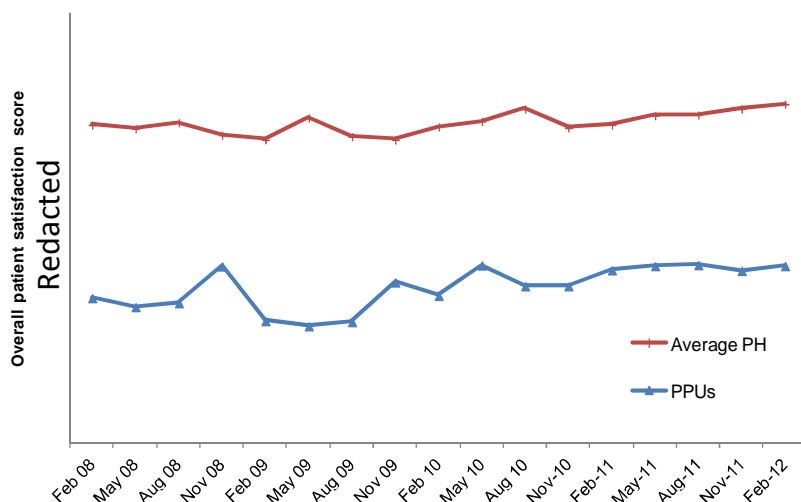
- A.8 An independent company undertakes a quarterly survey of Bupa members who have recently undergone treatment to understand their satisfaction with the experience at the treating hospital. The PUs in the sample consistently underperform relative to other private hospitals (as shown in Figure 32).

relevant market by a hypothetical monopolist test). Including PUs by default in the product market risks fascia counts in local markets overstating the amount of competition.

²⁰⁴ Laing and Buisson explains that eight out of the top 10 NHS trusts with the highest private patient revenue are based in Central London.

²⁰⁵ http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/120516_london_clinic_initial_submission.pdf

Figure 32: Patient survey of overall satisfaction scores 2008-2012 for PPU and Private Hospitals



Source: Bupa, Picker Survey²⁰⁶

A.9 As shown in Figure 33, [redacted]. It would require significant investment on the part of PPU to bring these on a par with other private hospitals.

Figure 33: [redacted]

A.10 A further patient concern is that PPU share facilities (e.g. operating theatres) with urgent and non-urgent NHS operations. As the hospital's first duty is to its NHS patients, the private patient faces the risk and concern that his or her treatment would be postponed in favour of a NHS treatment²⁰⁷.

A majority of consultants prefer not to treat at PPU

A.11 Consultants also reveal a preference not to work at PPU. The OFT Consultant survey found that while approximately 46% of consultants surveyed preferred to work from a privately owned PH facility rather than a PPU, only 17% preferred to be based primarily in an NHS facility treating private patients²⁰⁸. Consultants also explained in the survey that they preferred "to carry out their private work at a private facility, rather than at a PPU within an NHS hospital, in order to make a clear distinction between their NHS and private practice".

PPUs tend to have limited capacity

A.12 While there are exceptions, PPU tend to be small in terms of capacity and portfolio of specialisms compared with other private hospitals. This means that, even within a local market,

²⁰⁶ The Pickers Institute conducts independent quarterly patient satisfaction surveys for Bupa across all hospitals with more than 200 Bupa patients (currently 193 private hospitals and PPU units). Simple average score calculated for PPU and for other private hospitals. The Christie NHS Foundation Trust's PPU, controlled by Hospital Corporation of America since June 2010, is categorised as a PPU in the analysis.

²⁰⁷ The OFT MIR Decision notes that: "PPUs point out that the first duty of care of the NHS facility to which the PPU is attached is to NHS patients, and that PPU beds may be given to NHS patients if needed. Further, some PPU report that their NHS Trust often devotes very few resources (managerial and financial) to the PPU" (para 4.27).

²⁰⁸ OFT Consultant Survey, p51-52.

an insurer may be unable to switch away from another private hospital entirely to the PPU (to switch the insurer needs confidence the PPU could serve all its patients in that local area).

A.13 Table 19 shows that a large number of PPUs are within the M25, while in many areas of the UK there are very few PPUs (each relatively small in terms of number of beds). Even within the M25 it is not possible for Bupa to adequately substitute or “buy around” private hospital groups solely based on contracting with PPUs. For example, as an indication of relative size, Laing and Buisson explains that the largest PPU within the M25 ranks only 17th in the list of hospitals in the M25 by number of beds.

Table 19: Geographic distribution of PPUs

Geographic region	Number of PPUs	Number of beds	Proportion of total beds (%)
London	[X]	[X]	[X]
Southern Home Counties	[X]	[X]	[X]
South West	[X]	[X]	[X]
Northern Home Counties	[X]	[X]	[X]
North West	[X]	[X]	[X]
West Midlands	[X]	[X]	[X]
East of England	[X]	[X]	[X]
Yorkshire & the Humber	[X]	[X]	[X]
Wales	[X]	[X]	[X]
East Midlands	[X]	[X]	[X]
Isle of Man	[X]	[X]	[X]
North	[X]	[X]	[X]
UK	[X]	[X]	[X]

Source: Laing and Buisson Healthcare Market Review 2010-2011

A.14 As noted in the patient satisfaction survey results, existing PPU capacity already needs investment to be brought up to par with other private hospitals. Expanding PPU capacity will require further investment during a time when the NHS budget is significantly constrained. As discussed below, there is little evidence that the change in the private patient income cap will materially change the investment in PPU capacity.

PPUs tend to have weaker capabilities in commercial strategy and contract handling

A.15 Most PPUs are a very small part of NHS trust operations. Laing and Buisson notes that in 2009/2010 English trusts accounted for 96% of all private patient NHS activity across the UK and earned only 0.7% of their core revenues from private patients. Trusts in Wales earned only 0.2%, and trusts in Scotland and Northern Ireland earned only 0.1%²⁰⁹.

²⁰⁹ Laing and Buisson, NHS Private Patient Revenues Stall, April 2011 (available at http://www.laingbuisson.co.uk/Portals/1/PressReleases/NHSFinInf_11_PR.pdf, accessed June 2012). Further not all of this private income arises from treating private patients. The term private patient income does not refer only to income from private patients. It applies to any trust income that comes from private charges including ventures with private companies, sale or

A.16 Compared with private hospitals, PPU's tend to receive:

- i. Less management time and focus, given that managers have a significantly larger NHS operation to run;
- ii. Lower commercial focus and capabilities in handling contracts and claims from private patients, since the PPU's may not have the critical mass to justify maintaining such capabilities;
- iii. A greater likelihood for PPU's to drop out of contracts, e.g. currently [X] PPU's (which together account for just [X] of Bupa's spend with PPU's) are 'out of contract' though we continue to work with them.

PPU's are not a competitive constraint at a national level

A.17 PPU's act as individual operators and do not collectively represent a coordinated and unified market player to which insurers can credibly turn to avoid dealing with one of the large national groups. There is no collective brand or strategy and, in Bupa's experience, mixed commercial and management capabilities. As shown above there are many regions of the UK where there is extremely limited PPU provision.

There is little evidence the change in the PPI cap will materially change the influence of PPU's

A.18 The recent increase in the level of the PPI cap for Foundation Trusts to 49% may make it attractive for some FT's to extend their private provision²¹⁰. However, there is little evidence that this effect will be material or rapid.

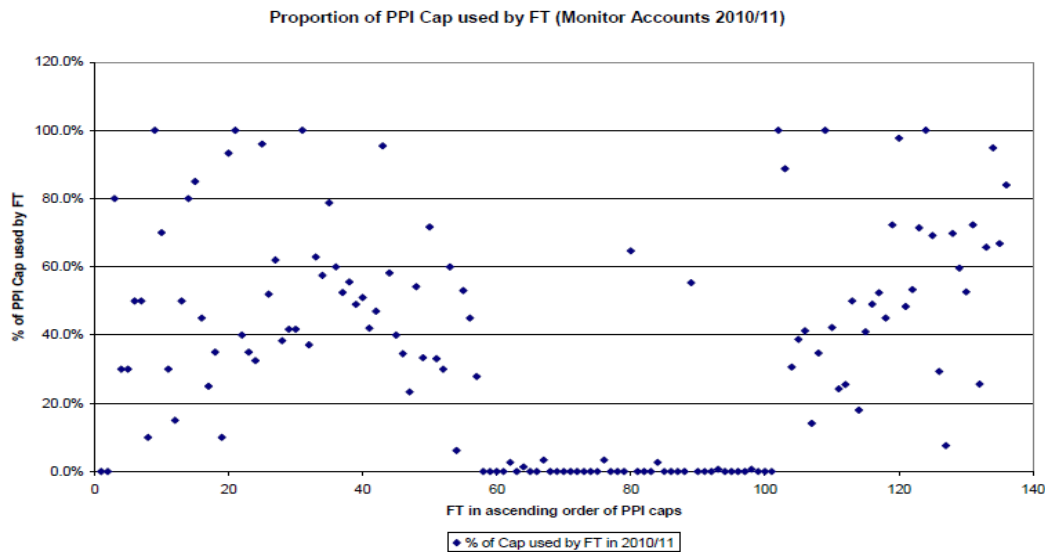
A.19 The cap was not a binding constraint on the vast majority of FT's even before it was lifted. The Department of Health's Impact Assessment of the Health and Social Care Bill 2011 notes: *"Data from Monitor's 2010/11 accounts indicates that during that year most FT's operated at a level significantly below their PPI cap [footnote omitted] – see the chart below [Figure 34]. The chart also demonstrates that there is not a strong relationship between the level of the cap and the FT's usage of their entitlement to earn non-NHS income ... Whilst it is not possible to predict how FT's will behave with the lifting of the caps, the evidence indicates that many FT's will not automatically make use of any ability to earn private income offered to them"*²¹¹.

license of intellectual property, rental agreements with private healthcare providers, even providing them with laundry or sterile supplies.

²¹⁰ See for example, "Expansion of Private care in NHS hospitals", The Times (Main), 27 December 2011, pages 1, 6, 7

²¹¹ Department of Health, Impact Assessment of the Health and Social Care Bill 2011, page 64, accompanying chart from page 65 (available at <http://www.parliament.uk/documents/impact-assessments/IA11-038.pdf> accessed June 2012).

Figure 34: Usage of the PPI cap by FTs



Source: Department of Health’s Impact Assessment of the Health and Social Care Bill 2011

Note: Not all private patient income is actually from treating private patients. It can come from other sources controlled by the hospital.

A.20 FTs also now have additional responsibilities that will impact the uptake of private patients:

- i. The main legal duty for FTs is to put NHS patient first.
- ii. Every FT is required to explain in its annual report the impact its non-NHS income has had on its NHS services.
- iii. Any increase (of 5% or more) in the proportion of an FT’s private income in a financial year needs to be approved by a majority vote of the FT’s governors.

A.21 Therefore, FTs will need to overcome public pressure against expanding private provision at a time when NHS services are being squeezed. Further, any expansion may be challenged by private operators on state aid and competitive neutrality grounds.

PPU partnerships cause concern in some cases

A.22 The lifting of the PPI cap has opened up the option for private companies to partner with PPUs, either as a joint venture or as a hosting model (where the private company operates the PPU, and pays the PPU a hosting fee). A number of hospital groups have already partnered with PPUs, making significant financial investments in infrastructure, brand and equipment.

A.23 These partnerships could improve outcomes for private patients by making a new alternative PH facility available in the local market. However, private hospital groups may also use the strategy to extend their scale and market power into new markets, or to consolidate their power in existing markets. [3<].

ANNEX B: “ONE IN, ALL IN” NEGOTIATION EXAMPLE CALCULATIONS

B.1 [X]

Table 20: [X]

B.2 [X]

Table 21: [X]

ANNEX C: EXAMPLE OF A CONSULTANT INCENTIVE SCHEME

C.1 [X]

ANNEX D: CORRESPONDENCE FROM PATIENTS ABOUT ANAESTHETIST GROUPS

D.1 The below series of letters provide examples of the types of customer complaint Bupa receives about anaesthetist groups. The patient's details have been redacted.

D.2 [✕]

D.3 [✕]

D.4 [✕]

D.5 [✕]

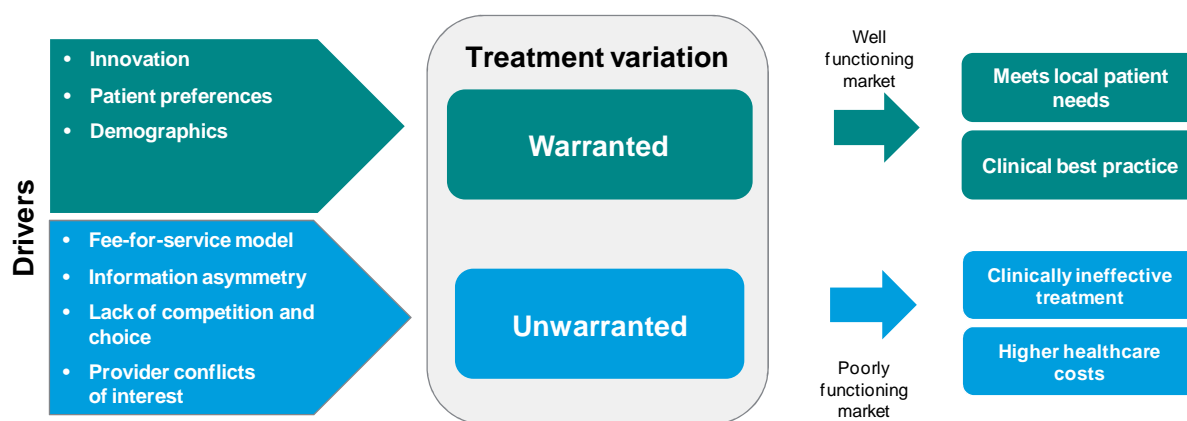
D.6 The letter below is from a Bupa customer complaining about excessive fees from an anaesthetist group in Gloucestershire.

ANNEX E: UNWARRANTED VARIATION – A SYMPTOM OF A MARKET NOT WORKING WELL

Introduction and overview

- E.1 Bupa observes significant, wide variations in the way consultants and hospitals treat specific conditions in UK private healthcare.
- E.2 When a patient presents with a medical condition, the consultant usually specifies the type, volume and venue of treatment. Hospital staff may also play a role in determining how and where the treatment is delivered. A degree of variation in the way the condition may be due to differences in patients. The clinical needs of individual patients will vary and clinicians tailor care to respond this. In conditions where there are several treatment options, and where evidence shows that one treatment is not necessarily better than the other, it is rational for different patients to make different treatment choices according to their personal preferences. For example, one patient may choose to have a surgical intervention where another with the same condition may choose to have non-invasive physiotherapy.
- E.3 However, some variation cannot be explained by clinical needs, patient preference or the capacity of the health system within which he or she is being treated. This type of variation in healthcare – **unwarranted variation** – may be driven by conflicts of interest facing the clinician, the fee-for-service reimbursement model, information asymmetries, a lack of effective competition between clinicians, and a lack of credible oversight and sanction (as illustrated in Figure 35). Unwarranted variation can harm patients; placing them at risk of unnecessary complications or death, and also affecting the costs of care. For example, if a consultant recommends surgery rather than a less invasive treatment option (without giving the patient the full facts to make an informed choice), the patient is likely to face both the higher risks of undergoing surgery and the increased costs of treatment.

Figure 35: Drivers and outcomes of treatment variation



- E.4 The presence and prevalence of unwarranted variation is a significant concern for Bupa as a commissioner of care with a duty to our members to ensure they receive the highest quality and appropriate care, as well as managing the overall costs. Bupa considers that unwarranted treatment variation adds significantly to the overall costs of PH in the UK, making the market less affordable for all consumers. It also places patients at serious clinical risk.

E.5 There are some safeguards against unwarranted variation in guidelines for clinicians prepared by regulatory bodies. For example, NICE, the GMC and the Royal Colleges have published guidelines on best practice methods for treatments²¹². Further, there are guidelines available to consultants about declaring conflicts of interest²¹³. However, Bupa has concerns that guidelines are often not followed. For example, we observe many clinicians still using treatment practices that appear out of line with guidelines (see case study 2 for example).

E.6 There are clear and effective actions that the CC can take to improve the situation for patients in this area and without the need to make judgements on the clinical advice given by consultants:

- i. The current lack of transparency on consultant/hospital practices and on treatment activity and outcomes means that patients, GPs and insurers cannot identify and address unwarranted variation systematically. If detailed information existed on consultant and hospital treatment patterns and outcomes, providers operating outside of the norms of best clinical practice could be quickly identified and challenged (either directly or through the forces of choice and competition directing patients away from them).
- ii. Certain mechanisms and practices in the market incentivise unwarranted variation. The CC could address these mechanisms directly. The CC should consider restricting the use of consultant and GP incentive schemes which can lead to over-treatment and over-diagnosis. The CC could also ensure all conflicts of interest are declared publicly by consultants and hospitals, as current safeguards are insufficient and not routinely followed.
- iii. The CC can acknowledge the important role patients' representatives such as GPs and insurers play in identifying and addressing treatment variation on their behalf. Currently a number of medical trade bodies and hospital groups misinform patients about why insurers are seeking to address this behaviour.

E.7 This remainder of this annex sets out:

- i. The different forms of treatment variation;
- ii. The factors that increase unwarranted variation;
- iii. Possible responses to unwarranted variation; and
- iv. Case studies that illustrate the materiality of treatment variation in the UK. These are summarised in Table 22.

²¹² For example, NICE publishes guidance on best practice treatments and expected quality standards for a wide range of treatments (e.g. lung cancer, stroke, glaucoma). These recommendations are based on clinical evidence and practitioner experience. NICE also publishes optimal patient pathways for the managing condition. (NICE clinical guidance, <http://www.nice.org.uk/guidance/>, last accessed 16th April 2012.

²¹³ For example, The GMC Good Medical Practice guide notes "If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest". The GMC Advice on Conflicts of Interest notes "In all cases you must make sure that your patients and anyone funding their treatment is made aware of your financial interest" http://www.gmc-uk.org/guidance/ethical_guidance/conflicts_of_interest.asp para 8.

Table 22: Summary of case studies

Title	Key findings
Case study 1: Knee arthroscopy	Knee arthroscopy interventions are significantly higher – between 180% and 300% depending on patient age group – for Bupa members than would be expected against rates observed in the NHS. Bupa has sought to address this variation by implementing a pre-authorisation medical review stage where the consultant fills in a short form, which simply includes the reasons for surgery and the procedure to be carried out. An assessment is made about whether the surgery is in line with best clinical practice before funding is agreed.
Case study 2: Hysterectomy	Bupa observes a number of consultants in private practice performing abdominal hysterectomies only in their case mix, when clinical studies and best practice guidelines set out that less invasive and less costly vaginal hysterectomies should be performed in most cases. The use of only abdominal hysterectomies by these consultants suggests the treatment is being dictated by the preferences of the consultant rather than the needs of the patient.
Case Study 3: Shoulder surgery	Bupa has identified high levels of potential overtreatment in two types of shoulder surgery. For arthroscopic subacromial decompression a Bupa member would be [\times] more likely to undergo surgery than a patient in the NHS. For an extensive open repair of rotator cuff muscle the differential would be [\times] more likely and significantly higher in older age groups.
Case Study 4: Cardiology	Analysis of Bupa member experience shows that the treatment pathway a patient receives depends critically on the skill-set of the consultant to which the patient is first referred by his or her GP. This case study shows that patients requiring ablation therapy to cure heart arrhythmia have significantly more costly and lengthy treatments if sent to a general cardiologist by the GP rather than a specialist cardiologist called an electro-physiologist. This highlights concerns about entrenched GP referral pathways.

The types of treatment variation

E.8 The issue of treatment or clinical variation is a recognised and researched concept in health systems across the world. In essence, treatment variation research looks at the reasons behind differences in healthcare activity (such as the number of operations performed) and healthcare outcomes (such as the re-admission rates) to determine whether the variation in clinical care is warranted or unwarranted.

E.9 The Dartmouth Atlas project²¹⁴ explains three distinct categories of care:

- i. **Effective care** covers evidence-based services and processes where benefits far exceed any risks, and so 100% of patients should receive similar care. Any variation from these established practices reflects failure to deliver needed care. For example, diabetic patients should routinely have haemoglobin A1C monitoring, meaning that if this is not part of their treatment process they are not receiving effective care.
- ii. **Preference-sensitive care** covers clinical decisions with more than one treatment options, each with different levels of risk and benefit. Individual patients' attitudes toward

²¹⁴ The Dartmouth Treatment Atlas is available at <http://www.dartmouthatlas.org/>.

these risks will vary according to their own beliefs and values. So any final decision should be made on the basis of a fully-informed understanding of the risks and benefits. For example, one patient may choose surgery, whereas another may choose a non-invasive option, when the medical evidence is that one treatment option is not necessarily better than the other overall. Another dimension of preference-sensitive care is the choice or clinical discretion exercised by the clinician. For example, a doctor may suggest a particular type of surgery because he or she only skilled in one type of procedure, rather being able to offer a range of procedures.

- iii. **Supply-sensitive care** covers services where the supply of a resource such as hospital beds, GPs, diagnostic equipment, or indeed skills and experience of specialists has an influence on utilisation rates. Differences in utilisation are driven not as much by medical need or evidence but by differences in local capacity and a payment system (fee-for-service) that encourages existing capacity to be fully deployed and utilised.

E.10 As discussed above, some variation will always be warranted, as care is tailored to the specific needs and preferences of the patient or as new innovative treatments filter into the market. Variation is, however, unwarranted if it cannot be explained by clinical reasons or patient's preferences.

E.11 Unwarranted variation may take several forms:

- i. **Under- or over-treatment** where the volume of treatment offered to the patient is suboptimal. For example, a consultant may recommend a patient has a series of follow up consultations after a surgery that is not strictly necessary (although the patient does not know this).
- ii. **Under- or over-diagnosis** where the type of treatment offered to the patient is inappropriate. For example, a patient may be given a full range of blood tests, X-rays and scans, even when these are not needed²¹⁵.
- iii. Clinical practices that are **not evidence-based**. For example, where a consultant uses a particular technique, even if it is not considered most appropriate, because this is the technique he prefers or has invested in the equipment for.

E.12 Many US studies have discovered strong evidence indicating the presence of unwarranted variation. Research in the NHS also shows that variation is widespread across different types of treatment and that this variation persists through time²¹⁶. A survey of 237 medical insurers in 48 countries found that 50% ranked "*overuse of care — practitioners recommend too many services*" as one of the top 3 factors driving increasing medical costs²¹⁷.

²¹⁵ [X]

²¹⁶ See for example the NHS Atlas of Variation, NHS Right Care, 2011. This also describes the theoretical basis for patient harm for over-treatment. A King's Fund study of GP referral patterns also identified significant variation. For example, some GP practices are more than ten times more likely than others to refer a patient to a specialist operating in certain specialities. The evidence suggests that a number of referrals made in general practice may not be clinically necessary. The King's Fund, "Improving the quality of care in general practice", 2011.

²¹⁷ The Towers Watson Global Medical Trends Survey conducted in January 2012, available at <http://www.towerswatson.com/assets/pdf/7394/TowersWatson-GlobalMedTrendsSvyRpt-NA-2012-23911.pdf>.

Factors driving unwarranted variation in the UK

E.13 There are various factors which facilitate unwarranted variation. Some are structural in nature (being part of the fabric of the market), whereas others are behavioural in nature (driven by the conduct of players in the market). Many of these factors are present in the UK PH market and are discussed in more detail below.

Fee-for-service reimbursement model

E.14 There is an extensive academic literature linking provider over-diagnosis and over-treatment with the fee-for-service reimbursement model²¹⁸. Under this reimbursement model, the consultant and hospital are paid for the volume of individual treatment episodes they carry out rather than the quality or outcome of the overall treatment. This risks providers seeking to maximise the quantity of treatments (to over-treat and over-diagnose) rather than the quality of treatments. The fee-for-service model can therefore contribute to higher overall healthcare costs²¹⁹. Patients are also placed at clinical risk, as more care is not necessarily better care²²⁰.

Information asymmetry

E.15 In an environment with a lack of comparable, granular data on inputs (i.e. activity) and outputs (i.e. outcomes) unwarranted variation may be more prevalent, and able to persist, because it is more difficult to identify. For example, gaining insight into what individual doctors actually did during the treatment process – for example, whether a specific drug was prescribed or how many injections were used – allows an assessment of whether or not effective, evidence-based care was delivered. Without this insight, only the consultant will know whether he or she delivered effective care (as the patient is unlikely to be in a position to challenge practices).

E.16 Where this data is comparable across consultants, benchmarking can be undertaken to inform whether a particular consultant is systematically out of line.

E.17 Information asymmetry also blunts effective competition from new providers that bring superior innovative care to the market, as these providers cannot differentiate themselves from the entrenched approaches.

Lack of effective competition and choice

E.18 In markets where there is little effective competition (e.g. because providers occupy monopoly positions), unwarranted treatment variation may persist unchallenged. For example, without rivalry from other providers, treatment practices of a certain pattern become embedded and routine. Further, even in markets where there are sufficient competitors, unwarranted variation could persist if patients are not being provided with effective choice by their GPs or consultants.

²¹⁸ For example, an article in the BMA's Health Policy Review acknowledges that *"a healthcare system which rests on the fee-for-service system could easily lead to the over-supply and/or over-utilisation of healthcare services. This phenomenon, known as supplier-induced demand, is well documented"*. Jonita Jabbal, "What motivates doctors? Theories of financial motivation", BMA Health Policy Review, Winter 2006.

²¹⁹ Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Capitation, salary, fee-for-service and mixed systems of payment: effects on the behaviour of primary care physicians. Cochrane Database of Systematic Reviews 2000, Issue 3. Art. No.: CD002215. DOI: 10.1002/14651858.CD002215

²²⁰ "Studies done through the Dartmouth Atlas have shown that an increased volume of care improves neither survival nor quality of care". *What Kind of Physician Will You Be?*, February 2012, p12 (available at <http://avoidablecare.org/wp-content/uploads/2012/04/dartmouth-res-report-what-kind-of-doc-will-you-be.pdf>).

E.19 Unwarranted variation can cause harm to the patient and reduces value for money for the patient and is wasteful from the patient's perspective. In a market where providers compete actively for patients on the basis of value for money, and patients themselves have greater choice over treatments, competitive pressures would eliminate unnecessary unwarranted variation over time. It would, for example, encourage providers to quickly move to innovative treatment methods that demonstrably deliver better value for money to patients, rather than persisting with out-dated techniques.

Conflicts of interest for the provider

E.20 Where the provider has a financial interest in how, where or how much care is delivered, he or she may choose to recommend a treatment option that may not always be in the best interest of the patient. For example, if a hospital invests in a particularly expensive piece of medical equipment, a risk exists that it will seek to maximise the use of the equipment (over-diagnose and over-treat) to earn a suitable return on its investment.

E.21 The use of consultant incentive schemes by hospitals (e.g. profit-sharing schemes) is likely to bias the destination and volume of care delivered. Consultants may also be influenced by clinical supply companies (such as pharmaceutical and prosthesis companies), to offer certain products to patients rather than more cost effective treatments.

E.22 The provider's decisions may be conflicted by the personal fear of litigation. This can lead to unwarranted variation as the provider practices 'defensive medicine' to protect against litigation rather than deliver best care to the patient²²¹.

CASE STUDIES

E.23 Bupa observes significant variation in the treatment practices of consultants and hospitals. By way of example, Figure 36 illustrates the significant variability of testing by different cardiology consultants in 2011 (we have redacted the consultant names for confidentiality reasons).

Figure 36: [redacted]

Case study 1: Knee arthroscopy

E.24 Knee damage can be assessed using various techniques of which knee arthroscopy is an option. Knee arthroscopy is a type of keyhole surgery, used to look inside and to treat the knee joint.

E.25 We analysed the rates of knee arthroscopy treatment seen amongst Bupa members against the rates observed in the NHS in England. We used the highest intervention rate area within the NHS as the baseline (as there is some variation across PCTs in the NHS in the rate of knee arthroscopy intervention). Despite this elevated baseline, there is evidence of substantially higher incidences of knee arthroscopy among Bupa members across the UK compared with NHS patients, and in particular amongst the higher age groups. The pattern is highly

²²¹ Studdert *et al* (2005) for example found in a survey of 824 physicians in the Pennsylvania, USA, 93% reported practicing defensive medicine. Defensive medicine may supplement care (e.g. additional testing or treatment), replace care (e.g. referral to another physician or health facility), or reduce care (e.g. refusal to treat particular patients). Studdert *et al* (2005), "Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment", *The Journal of the American Medical Association*, 2005;293(21):2609-2617.

pronounced in England where the average Bupa member was **300%** more likely to have a knee arthroscopy than a patient of similar age and gender in the NHS.

- E.26 Bupa has sought to address these higher rates of intervention by adopting a targeted process for medical review. This ensures that a treatment is in line with published evidence-based guidelines before Bupa agrees funding for the treatment. Consultants have to submit a short form including details of the reasons for surgery and what procedure will be carried out. Bupa then checks this against published evidence-based guidelines. If the treatment is warranted, then it is allowed to proceed. If the guidelines do not support the treatment, Bupa refers the case to an independent expert for clinical review. Based on this decision, Bupa decides whether or not to fund the procedure (which would mean the consultant would need to use more conservative treatment options first).
- E.27 Bupa faced significant resistance from consultants and consultant bodies in launching this quality initiative²²². Yet, since commencing the medical review process in April 2011, Bupa has observed a significant reduction in the number of applications for funding of knee arthroscopy suggesting that previously a proportion may have been unwarranted – as illustrated in Figure 37. Bupa believes that clinical practice has changed due to consultants being more measured in recommending surgery to patients than before the funding review process was in place. The significant reduction is not due to Bupa denying funding to patients. [3<]. The reduction in knee arthroscopies because of the medical review has led to cost savings.

Figure 37: [3<]

Case study 2: Hysterectomy

- E.28 Bupa observes a significant number of consultants in the UK practicing a surgical technique that is not best practice and that places significant additional costs on the system.
- E.29 A hysterectomy is a surgical procedure to remove a woman's womb (uterus). The published medical evidence on hysterectomy recommends vaginal hysterectomies should be undertaken in preference to abdominal hysterectomies. Where a vaginal hysterectomy is not possible, a laparoscopic (minimally invasive) version should be undertaken instead:
- i. *“because of equal or significantly better outcomes on all parameters, vaginal hysterectomy should be performed in preference to abdominal hysterectomy, where possible. Where vaginal hysterectomy is not possible, a laparoscopic approach may avoid the need for an abdominal hysterectomy.”*²²³
 - ii. *“vaginal hysterectomy is the approach of choice whenever feasible, based on its well-documented advantages and lower complication rates. [...] Laparoscopic hysterectomy is an alternative to abdominal hysterectomy for those patients in whom a vaginal hysterectomy is not indicated or feasible.”*²²⁴

²²² For example, the British Orthopaedic Association wrote to its 4,000 members in June 2011 stating that it would “strongly advise against” surgeons using the Bupa form. FIPO went to the media alleging the process would add unnecessary bureaucracy and delay treatment.

²²³ Nieboer TE et al. Surgical approach to hysterectomy for benign gynaecological disease (Review). The Cochrane Collaboration. Published in *The Cochrane Library* 2010, Issue 12.

²²⁴ The American College of Obstetricians and Gynecologists Committee on Gynecologic Practice. Choosing the Route of Hysterectomy for Benign Disease. Number 444. November 2009.

E.30 The advantages for the patient of a vaginal or laparoscopic hysterectomy to an abdominal hysterectomy are set out in Table 23. There are also additional cost implications of using the more invasive abdominal hysterectomy.

Table 23: Comparison of hysterectomy techniques

Comparison	Benefits
Vaginal Hysterectomy Compared With Abdominal Hysterectomy	Shorter duration of hospital stay Faster return to normal activity Fewer febrile episodes or unspecified infections
Vaginal Hysterectomy Compared With Laparoscopic Hysterectomy	Shorter operating time
Laparoscopic Hysterectomy Compared With Abdominal Hysterectomy	Faster return to normal activity Shorter duration of hospital stay Smaller drop in haemoglobin Lower intraoperative blood loss Fewer wound or abdominal wall infections Longer operating time Higher rate of lower urinary tract inquiries

Source: Nieboer *et al.* Surgical approach to hysterectomy for benign gynaecological disease (review). The Cochrane Collaboration. Published in the Cochrane Library 2010, issue 12.

E.31 A large proportion of hysterectomies for Bupa members continue to be abdominal hysterectomies – e.g. [36] of hysterectomies between 1st October 2010 and 30th September 2011. However, a number of surgeons only perform abdominal hysterectomies in their case mix, which suggests that this variation in treatment may reside with the skills, capabilities and preferences of the surgeon, and therefore is more likely to be unwarranted.

Case study 3: Shoulder repair

E.32 Bupa observes high levels of variation in two types of shoulder surgery to repair the rotator cuff muscle²²⁵:

- i. **Arthroscopic subacromial decompression:** a keyhole surgical procedure to reduce pressure on the muscle by removing part of the bone.
- ii. **Extensive open repair of rotator cuff muscles:** a surgical procedure to reduce pressure on the muscle by removing part of the bone through an open procedure rather than keyhole surgery.

E.33 Our analysis shows that for arthroscopic subacromial decompression a Bupa member is approximately [36] more likely to undergo surgery than a patient of similar age in the NHS. A Bupa member is [36] more likely to receive extensive open repair surgery than a NHS patient, with members over 65 years old having significantly higher rates of intervention. Bupa accepts that the NHS may not provide a perfect benchmark; however, the magnitude of the difference raises significant concerns about whether all interventions are required.

²²⁵ The rotator cuff is a group of tendons that hold the shoulder joint in place. The rotator cuff lets a person lift his arm and reach over his head. Wear and tear of the rotator cuff tendons is a normal part of ageing. However many people will develop pain in their shoulder at some time as the tendons degenerate and tears in the rotator cuff tendons develop. There may also be inflammation of the shoulder tendons or bursa (another part of the shoulder that helps it move).

- E.34 The levels of surgical intervention are also concerning given published medical evidence is clear in that initial treatment for rotator cuff damage should, in general, be a nonsurgical, conservative treatment such as physical rest, physiotherapy or injections²²⁶. For example, the American Academy of Orthopaedic Surgeons notes that: “we suggest that patients who have rotator cuff-related symptoms in the absence of a full thickness tear be initially treated non-operatively using exercise and/or non-steroidal anti-inflammatory drugs.”²²⁷
- E.35 Bupa is concerned that this high rate of surgery amongst Bupa members is a sign that non-surgical options have not been explored thoroughly. To address these concerns, Bupa introduced in May 2012 a medical review process (similar to that for knee arthroscopy) prior to any shoulder surgery. Any surgery that does not meet published evidence-based guidelines will require a second opinion or will be independently reviewed by one of our expert clinical advisers.

Case study 4: Cardiology

- E.36 The patient’s experience can depend critically on who the GP refers the patient to. This raises concerns about entrenched GP referral patterns and incomplete information at the point of making a referral.
- E.37 [X] of cases, Bupa members with arrhythmias (irregular heart beat patterns²²⁸) are referred by GPs to cardiology generalists rather than direct to specialist Electrophysiologist Cardiologists (EP). EPs are preferable because they are able to offer patients specialised treatment (catheter ablation) more rapidly when standard treatments (cardioversion) fail to resolve the condition. General Cardiologists will often refer the patient onward to an EP for catheter ablation.
- E.38 [X]

Figure 38: [X]

²²⁶ See as examples: (1) Beaudreuil J et al. *Clinical practice guidelines for the surgical management of rotator cuff tears in adults*. Service de rhumatologie, hôpital Lariboisière, AP-HP, université Paris 7, 2, rue Ambroise-Paré, 75010 Paris, France, 2010 Apr;96(2):175-9. (2) Holmgren T et al. *Effect of specific exercise strategy on need for surgery in patients with subacromial impingement syndrome: randomised controlled study*. BMJ 2012;344:e787 (Published 20 February 2012); (3) Strauss EJ et al. *The arthroscopic management of partial-thickness rotator cuff tears: a systematic review of the literature*. Division of Sports Medicine, Rush University Medical Center, Chicago, Illinois, USA. 2011 Apr;27(4):568-80; and (4) Gebremariam L et al. *Effectiveness of surgical and postsurgical interventions for the subacromial impingement syndrome: a systematic review*. 2011 Nov;92(11):1900-13. Department of General Practice, Erasmus MC - University Medical Center Rotterdam, the Netherlands.

²²⁷ American Academy of Orthopaedic Surgeons (AAOS). *Optimizing the management of rotator cuff problems*. Guideline and evidence report. Adopted by the AAOS Board of Directors. December 4, 2010.

²²⁸ Arrhythmia is an irregular rhythmic disturbance of the heart. Atrial fibrillation (the most common arrhythmia amongst Bupa patients) reduces the heart’s efficiency and performance, and can result in low blood pressure heart failure. Ablation therapy is a treatment to help cure arrhythmia (and it is highly effective in doing so). It involves an electrophysiologist cardiologist (EP), a specialist cardiologist, using a catheter to accurately locate areas of electrical disturbance, and then destroy the abnormal areas by heat, cold or laser. Many general cardiologists do not have the skills required to offer ablation therapy and would refer a patient on to an EP for the treatment.

Table 24: Bupa's findings of the differences in the diagnostic path taken from different GP referrals for Ablatable Arrhythmias

	Number of members in the sample	Average cost of pathway	Average number of days between initial consultation and ablation	Average number of consultations	Average number of diagnostics
Saw an EP specialist first	[<]	[<]	[<]	[<]	[<]
Did not go straight to an EP specialist	[<]	[<]	[<]	[<]	[<]
Difference in magnitude (%)		[<]	[<]	[<]	[<]

Source: Bupa Health Dialog.

ANNEX F: FIPO MATERIALS DISCOURAGING COMPETITION BETWEEN CONSULTANTS

F.1 FIPO has published the below slides on its website (<http://www.fipo.org/docs/FIPO-Surveys.htm>) to explain, through a game theory example, why it is not in the interests of consultants to decrease their prices to win business²²⁹.

**Negotiating with Insurers
Game Theory
and the
The Philosophy of Purchasers
and Suppliers**

**Accepting or Declining Discounts
with Insurers**

- Consider the following scenario where 2 consultants each undertake 50 cases per annum
- The total market for insured cases is 100 cases

The Start

• Consultant A	• Consultant B
• Cases p.a. 50	• Cases p.a. 50
• Fee per case £1000	• Fee per case £1000
• Income £50,000	• Income £50,000

Insurer offers more cases to Consultant A if they reduce fees by 10%; the total market is the same at 100 cases

• Consultant A	• Consultant B
• Cases p.a. 56	• Cases p.a. 44
• Fee per case £900	• Fee per case £1000
• Income £50,400	• Income £44,000

This means that in Year 1

- Consultant A has to do 12% more work and must treat 6 more cases to maintain the same income
- If the insurer fails to actually send the 6 extra cases Consultant A will see his income drop
- In this deal consultant A bears all the risk

In the next year let us assume that

- The market has not grown (and there is no evidence to suggest that these fee reductions will be passed on in lower premiums and more subscribers)
- The insurer has in fact now managed to redirected 20 cases from consultant B to consultant A

²²⁹ Above the link to the slides FIPO includes a link to an academic article written in the US: "Topics in medical economics: Lessons of the prisoner's dilemma", The Journal of Bone and Joint Surgery, April 2000. This article concludes: "Most orthopaedic surgeons are currently working harder than ever, and making less for it. How did we get there? Weren't all of our actions logical? Of course they were, but we did not realize that we were mired in a prisoner's dilemma and that logic is not the answer. So let's try a new way: cooperation. If we cooperate with each other, we may not trounce our rivals, but we won't get trounced ourselves. This strategy is not only nice, it is wise".

The new situation with a total market the same at 100 cases is

- Consultant A
- Cases p.a. 70
- Fee per case £900
- **Income £63,000**
- Consultant B
- Cases p.a. 30
- Fee per case £1000
- **Income £30,000**

Consultant B is now panicking so

- The insurer offers to include consultant B in the managed care scheme if he lowers his fees by 10%
- The insurer then stops redirecting patients and restores the equilibrium

The new situation in Year 3 with a total market the same at 100 cases is

- Consultant A
- Cases p.a. 50
- Fee per case £900
- **Income £45,000**
- Consultant B
- Cases p.a. 50
- Fee per case £900
- **Income £45,000**

Thus the situation in Year 3 is

- Both consultants are back treating the same volume of cases
- Both consultants are earning 10% less than at the start

Now the insurer returns to Consultant A requesting a 10% fee cut for more work

- Consultant A
- Cases p.a. 56
- Fee per case £810
- **Income £45,360**
- Consultant B
- Cases p.a. 44
- Fee per case £900
- **Income £39,600**

The process restarts and is always a downward pressure

- Consultant A has to undertake 12% more work and treat 6 more cases to maintain about the same lowered income as the previous year
- Total income is down for both consultants
- The redirection and ongoing downward spiral continues.....

The end result of the discounted and agreed fees

- The patient is excluded from the equation and the consultant/patient contract has been broken
- This is now being applied on a grand scale by certain major insurers
- It is a step wise reduction in income for ALL consultants
- No overall growth in insured referrals

This is the end result of discounted and agreed fees

Most importantly this means
Restriction of Patient
Choice