



Provider Enquiries:
01823 625171

Christiane Kent
Inquiry Manager
Competition Commission
Victoria House
Southampton Row
LONDON
WC1B 4AD

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Dear Ms Kent

Private Healthcare Market Investigation

As previously stated, we agree with the Competition Commission that some elements of the Private Healthcare Market have characteristics which work to the detriment of the consumer.

We believe that the issues are clear and also that the options for material improvement are reasonably simple and certainly achievable.

Patients

The special nature of healthcare is such that patients are hugely vulnerable – this is not a routine purchase of a sandwich or a vacuum cleaner where the usual market principles of willing purchaser and vendor apply. Providers should therefore carry a special duty of care to be transparent in all aspects of their service provision. Patients should be able to access good quality private healthcare, safe in the knowledge that basic principles of consumer protection exist.

Patients should, in advance of treatment, be able to obtain clear information on treatment quality outcomes and the cost of treatment to enable them to make an informed choice as to where, when and by whom they are treated.

The cost of private healthcare is substantial. It is imperative that this cost is consistently documented and controlled at levels which are both fair and appropriate to all parties.

Otherwise there are opportunities for dominant parties amongst both providers and insurers to distort the market to the long term detriment of consumers and suppress competition.

For patients, having the freedom of choice of consultant is hugely important and we observe the developments in the [open] restricted referral arena with concern.



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Consultants

What a consultant charges a patient for treatment is for the consultant and patient to agree before treatment starts. The consultant should be obliged to provide clear written terms to the patient before the initial consultation as to their level of fees for consultations and the most frequent treatments or operations they undertake. They should also declare if they have any form of financial interest in the facility.

Furthermore, the cost of any ancillary tests which might be undertaken at the time of that consultation should also be clearly communicated within such "terms of engagement" – a list of the most frequent test prices would enable patients to have an understanding of the costs which might be involved.

In the event that the patient subsequently requires further treatment, then they will already have an indication of the fee levels they can expect. For any other treatment, the surgeon and anaesthetist should provide a clear written quotation detailing their fees; highlighting the fact that the patient will be responsible for any shortfall in fees should their insurance company not meet their fees in full.

Consultants should therefore be obliged to publish their fees and have one level of fees for patients – this should *not* be dependent upon whether the patient has insurance or is self-funding, or whether the patient is insured by company A or company B. The potential for a situation where one patient is charged £400 for treatment through one insurer with a second patient being charged £800 for identical treatment is wrong and will adversely distort the market.

The Royal College of Veterinary Surgeons already stipulates this as a requirement for their four legged customers!

Consultant groups

We are aware that a number of consultant anaesthetist groups exist which set fees on a collective basis. In some cases of the fees set by such groups are well above the insurers' normal reimbursement rates.

Our own fee schedule reflects the charging rates on a customary and reasonable basis across all disciplines and takes account of fees levied by groups and individuals. What a consultant charges a patient is for the consultant and patient to agree clearly and up-front before treatment starts. We as an insurer have an interest in keeping what we reimburse on behalf of our customers balanced so as to keep our premiums affordable.

Consultant groups should be obliged to provide clear information on the cost of consultant and treatment. Each provider should publish a tariff of its charges and this should be readily available to everyone to view and compare. The group should be obliged to ensure that their patients have been properly forewarned of treatment costs, drawing specific attention to cases where the high probability of a shortfall is known. There is clearly a risk of localised micro-monopolies taking advantage of the local market to the detriment of consumers.



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Hospitals

As has already been established, the largest five hospital groups control 77% of hospital income. In addition many of these and other hospitals enjoy solus status. Also, the power and geographical spread of the large hospital groups means that they hold significant power in their negotiations with insurers, which must reach pricing terms in order to continue to offer viable insurance products to their customers in that geographical area.

Evidence indicates that the vast majority of customers prefer to receive treatment locally, within approximately 30 minutes of their home. If an established private hospital operates locally to the customer's home, then as long as a specialist exists for that condition and is recognised by the insurance company, then invariably that is the hospital where the patient will go for treatment - patients follow clinicians.

However, it is apparent that for certain specialities patients will be obliged to go further afield for their care. Similarly, if a patient has a particular condition where they consider that a specialist surgeon has specific skills or reputation, then the patient may travel further afield including central London.

There is little evidence of competition amongst hospital providers to attract private medically insured patients - the competition is to attract consultants – whose patients will then follow. If consultants have consulting facilities in a given hospital then the usual experience is that they will also have admitting rights there and this is where their patients will be treated. This, above all else, is the deciding factor as to which hospital is used by the vast majority of private patients.

The self-funding market is worth approximately 15% of hospital income. For self-pay individuals the market has much more competition with (in many cases), significantly lower prices and the inclusion of guaranteed packages. Such prices are not readily available to the market as a whole and are generally kept “under the counter” and only given out following assurance that the enquirer does not carry insurance.

There is a lack of transparency on pricing and quality in the private medical provision. Here the patient is not making a choice based on these factors. This has allowed the build-up of two tier pricing, which is common amongst private hospital operators whereby they have a lower more competitive rate of service provision for self-pay customers and a higher set of prices for insured patients. The adverse impact on premiums of the insured consumer is self-evident.

Hospital operators should be obliged to provide clear information on the cost of tests and treatment. Each provider should publish a tariff of its charges and this should be readily available to everyone to view and compare. The provider should be able to discount off this tariff by a set maximum (say of 20%), to reflect quantum or other special arrangements. That the cost of some treatments can vary by over 200% at the same hospital for the same items of service is counter to normal principles of market competition.

This would enable patients and other purchasers of healthcare to obtain clear pricing information to help them with their purchasing decisions.



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Insurers

The key issue is the monopoly position of the largest insurers and the way in which they appear to wish to control the market to the detriment of consumers.

It may be that the patient has seen the consultant before or through research of their condition wish to see a particular specialist. In many cases they will have received a recommendation from their GP or another consultant. To interfere with this process and potentially remove huge numbers of highly qualified specialists from the list of approved consultants is a huge restriction.

In addition, it will also in many cases mean a restriction in choice of hospital too – given that most patients will end up being treated in the hospital to which the restricted specialists have admitting rights.

A scenario will exist whereby restricted specialists could in time be forced to use only certain hospitals following insurer determined treatment plans and protocols.

It is imperative that the fees that are reimbursed are sustainable in the long term. If they are not then this will lead to the artificial reshaping of the pool of available consultants with some not being able to secure enough work to maintain a viable private practice. For those consultants agreeing to sign up to open referral it is highly likely that this will be done under duress, it is also highly likely that they will wish to charge higher fees to other insured patients.

If squeezing fees to potentially sub economic levels by a large insurer results in consultants maintaining much higher fees to patient of smaller insurers then there would be material detriment to smaller insurers. If the pool of insurance providers shrinks there would be restricted choice for the public.

This will lead to a restriction in patient choice and further enhancement of a monopoly position of the large insurers and hospital groups.

This is further exacerbated by the fact that many privately insured individuals will find it difficult to move insurers due to pre-existing medical conditions and the underwriting terms which would be applied.

We have a duty to all our stakeholders in ensuring that the level of fees which we reimburse on behalf of our customers are customary and reasonable, and properly reflects the appropriate skill and time required of the consultant to undertake a treatment.

Lack of clinical information

We consider that clinical outcomes should be something which is made publically available to help patients make an informed choice. The challenge is ensuring that the outcome data is clinically representative and objective, not just subjective.

Clinicians with greatest experience will often attract patients with the most complex conditions and least favourable prognosis – their outcomes may, on cursory analysis, appear lower than those of more junior people to treat people who are less sick.



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An additional indicator of performance might be the number of any given procedures a consultant has performed. Hospitals should be obliged to provide industry standardised questionnaires to patients. In this way data can be collected and published on a like-for-like basis across the hospital operators. This would include patients' opinions on quality measures across a range of areas, together with re-admission rates, mortality rates, returns to theatre, infection rates etc.

Consultants' performance should also be recorded and publicised on a like-for-like basis for each speciality. Consultants should publish data based on the number of treatments for a specific procedure they have undertaken, together with any subsequent failure rates etc. If this were put alongside a mini CV and the publication of their fees, this would be hugely helpful for consumer choice.

If you have any questions please do come back to my colleague Rosalind Johnson or me.

Your sincerely

Brian Goodman
Head of Provider Services
Email: brian.goodman@wpa.org.uk



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