

**BRITISH MEDICAL ASSOCIATION RESPONSE TO THE COMPETITION COMMISSION PRIVATE  
HEALTHCARE MARKET INVESTIGATION STATEMENT OF ISSUES**

**20 July 2012**

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**1. About the BMA**

1.1. The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine all over the UK. With a membership of over 145,000 worldwide, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

**2. Introduction and summary**

2.1. The BMA welcomes the opportunity to comment on the Competition Commission (CC) private healthcare market investigation statement of issues. As we explained in our submission on the scope of the market investigation, we have significant concerns that Private Medical Insurers (PMIs) have undue influence on consumer choice and consultants' participation in the market. The factors of the market that contribute to this include:

- PMI consultant recognition criteria
- PMI benefit maxima and fee schedules
- Consultant reimbursement levels
- Managed care arrangements
- Incentives paid to consultants and GPs

2.2. The statement of issues identifies a number of these factors as contributing to the theories of harm which may have an adverse effect on competition. Our response to the statement of issues focuses on the theories of harm that are of direct concern to our members. We provide general views on the relevant areas and suggest additional areas of focus. Our response can be summarised as follows:

**Theory of harm 2: market power of individual consultants and/or consultant groups in certain local areas**

- The practice of consultants submitting separate bills to patients is important to ensure transparency about fees and to maintain the doctor patient relationship. We are concerned that some insurers are using their recognition criteria to prohibit doctors from providing bills to patients.
- The geography of the UK prevents consultants in a local area developing market power over their patients. Patients should be free to use the value of their insurance policy with the consultant of their choice to increase competition in local areas.
- GP referral practices do not significantly increase the market power of individual consultants in a local area. The internet provides an unlimited resource for patients to research their conditions, appropriate treatments and consultants in their area. Armed with this knowledge, patients are much more likely to challenge referrals and request consultants they wish to see.

- There are numerous advantages of Anaesthetist Groups (AGs) to the market, including economies of scale, provision of on call rotas for emergency cases, liaison with local NHS facilities, enhanced risk-sharing, reduced costs and increased innovation.

#### **Theory of harm 4: buyer power of insurers in respect of individual consultants**

- We support the theory that PMIs have buyer power over consultants to set prices profitably below competitive levels. Reimbursement levels for some procedures in the BUPA Benefit Maxima have not increased for over 18 years and BUPA have recently reduced some reimbursement levels by over 50%. Consultants' costs including indemnity cover have risen considerably over this same time period.
- Competition in the market is reduced by restrictions on new consultants to only charge fees at levels outlined in insurer benefit maxima and specific fee schedules.
- The publication of PMI Benefit Maxima and Fee Schedules in order to explicitly limit consultant fees restricts competition in the market. We request that the CC consider the legitimacy and the purpose of these documents.

#### **Theory of harm 5: barriers to entry at different levels**

- We are concerned that there is no external appeals mechanism when consultants' practising privileges to undertake treatments of patients in a private hospital are refused or withdrawn. We feel this is a deficiency of the current process and would suggest that an independent arbitration service be set up. There are very few such instances in modern life where an appeal process does not exist.
- PMI recognition is required in order to treat patients who fund private healthcare through private medical insurance. We are concerned by the lack of any independent arbitration mechanism between PMIs and individual consultants when dealing with disputes about recognition.

#### **Theory of harm 6: limited information availability**

- There has been a significant increase in the level of information available to patients about consultant services. Patients can use this information to research the services and fees of different consultants to make reliable, informed decisions about which consultant to seek services from.
- The provision of quality information in the private healthcare market is complex. An assessment of the type of information that patients find useful when making decisions about their private healthcare is vital before a decision can be made about whether any lack of information has an effect on competition in the market.
- Decisions about the choice of facility and treatment pathways should be made in partnership with patients, guided by their GP and always based on clinical need. They should not be imposed through PMI managed care initiatives based on cost.
- The number of different policies currently in the private healthcare market can make it very difficult for subscribers to know what treatments are covered by their policies. We believe that there needs to be increased transparency at the point of sale about the scope and restrictions associated with policies.

### **Theory of harm 7: vertical effects**

- We support the proposal to review whether vertical integration has any adverse effects on competition in the market. In particular, the effect of PMI run primary care services on the market needs further investigation.

2.3. We have provided a detailed commentary on the issue of assessing quality in the market in our response to theory of harm 6. We would welcome the opportunity to meet with you at your earliest convenience to discuss this in greater detail.

### **3. Theory of harm 2: market power of individual consultants and/or consultant groups in certain local areas**

3.1. This theory of harm hypothesises that individual consultants and consultant groups may have market power in certain local areas. Before commenting on this, it is important to note that as a group, consultants do not hold sufficient market power over their patients to drive up fees excessively as has been demonstrated over the last 18 years (see discussion under theory of harm 4).

3.2. Individual consultants should set fees at a level that is fair remuneration for their services, based on the individual's circumstances such as experience, effort, skills and resources and professional time applied. Due to ethical and professional moral obligations, there should not be a significant difference between what a consultant charges a self pay patient and an insured patient for a similar procedure. This is becoming increasingly difficult, however, due to the restrictions placed on some consultants to only charge fees set by insurers (see discussion under theory of harm 4).

#### Consultant billing arrangements

3.3. The statement that consultants usually provide a separate bill to patients specifying their charges is true for all patients, regardless of whether they fund treatment through private medical insurance or through a self pay arrangement or whether a shortfall in insurance cover has occurred between the consultants fee and the insurers reimbursement level. This is a practice that we actively encourage for a number of reasons:

- The contract for payment is between the doctor and the patient, and it is the patient who remains responsible for ensuring that the consultant's fees are met.
- It provides fee transparency for both insured and self pay patients. This is important so that insured patients can see how the value of their policy is being used.
- It ensures that patients are involved in all aspects of their care. This maintains the doctor patient relationship which is invaluable to patients and the treatment process.

3.4. We are concerned that some PMIs have stopped consultants issuing separate bills to patients as a condition of recognition. Doctors face de-recognition if they choose to involve the patient in the invoice process in any way. This means that patients are not part of the process of how the value of their policy is being managed which can lead to a lack of information about the cost of their care and the consultant treating them.

3.5. The importance of transparent billing arrangements and the restrictions placed on consultants in this area should be an additional area of focus of the market investigation.

#### Limited number of consultants in a particular local area

3.6. We do not agree that a limited number of consultants in a local area pose a significant threat to competition in the market. While there may be a limited number of consultants in some local areas, this does not predicate that they will have market power over patients. The geography of the UK prevents this from developing. If fees become excessive there is an incentive for patients to look further afield. There is nowhere in the UK that is so isolated that travel to a different

consultant would be prohibitive. That many people already travel to London and abroad for treatment is testament to that.

- 3.7. Any market power of consultants in a local area can be easily mitigated by allowing patients who fund private medical treatment through private medical insurance to use the benefit of their policy with any consultant that they feel is the most appropriate for them. This would ensure that patients have the widest possible choice available to them and increase competition in the market.

#### GP referral practices

- 3.8. We do not agree that GP referral practices significantly contribute to a consultant's market power in a local area. Decisions about the choice of consultant should be made in partnership with patients, guided by their GP and always based on clinical need and patient safety.
- 3.9. The knowledge a GP has of consultants in their area and the importance a patient places on that knowledge should not be underestimated. GPs are often in the best position to assess the quality of the service provided to their patients. This is done through feedback and assessment of the success of the procedure from other patients in their care. GPs are themselves a business and would not continue to refer their patients to a consultant who did not provide a good service.
- 3.10. New consultants are able to challenge entrenched referral practices by marketing themselves to GPs through direct advertising. They have the opportunity to demonstrate the benefit of referring to their service, and the added value and enhancements offered over and above competitors. The use of social media and the web, along with marketing companies that specialise in private healthcare marketing is making this easier.
- 3.11. The influence web based marketing has on patients' decisions about their own care is also increasing. The internet provides an unlimited resource for patients to research their conditions, appropriate treatments and consultants in their area. Armed with this knowledge, patients are much more likely to challenge referrals and request consultants who they wish to see.

#### Anaesthetists

- 3.12. As stated in our initial submission, we do not agree that Anaesthetist Groups (AGs) or other consultant groups should be included in the market investigation. Following the OFT investigation into AGs in 2004, formal AGs emerged as a legitimate way to improve anaesthetist coverage in local areas while ensuring individuals were operating in the realms of competition law.
- 3.13. There are numerous advantages of Anaesthetist Groups AGs to the market, including economies of scale, provision of on call rotas for emergency cases, liaison with local NHS facilities, enhanced risk-sharing, reduced costs and increased innovation.

## **4. Theory of harm 4: buyer power of insurers in respect of individual consultants**

- 4.1. We support the theory that PMIs have buyer power over consultants to set prices profitably below competitive levels and can provide evidence to support this theory.
- 4.2. The BUPA Benefit Maxima is normally regarded as the industry standard fee schedule.<sup>1</sup> It has also been adopted by the NHS for a number of procedures undertaken in non-contracted hours. That some reimbursement levels have not increased in over 30 years, and that the Benefit Maxima as a whole has not increased significantly for over 18 years shows the level of insurers buyer power over consultants. The recent reduction of reimbursement levels, of over 50% for some procedures, is of significant concern to consultants and should be monitored closely by the CC when considering this theory of harm.

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<sup>1</sup> OFT Private Healthcare Market Study, *Report on the market study and final decision to make a market investigation reference*, April 2012, p.30 Footnote 57

4.3. The majority of consultants who undertake private practice do so in addition to their NHS work. Continued efforts to force fees down are making private practice increasingly unprofitable and unattractive for consultants. This is particularly acute for new starters and those in specialties who have high indemnity costs. As you have noted, this has the potential to limit the number of doctors in certain specialties which will reduce competition, stifle innovation and destabilise the private healthcare market.

#### PMI Schedules of fees

4.4. The CC has noted the distinction between the different conditions of recognition and the disadvantage this places on new entrants to the market. This is of considerable importance when considering the reduction in reimbursement levels outlined above. The restrictions for new consultants to only charge fees at the level specified in their schedules of fees has an adverse effect on competition in the market.

4.5. While we recognise the need for insurers to inform patients of the amount at which they will be reimbursed for certain procedures, the requirement in the new BUPA Terms of Recognition that consultants must agree to charge at the reimbursement levels outlined in the benefit maxima means that this document is no longer entirely published with policy holders in mind. The AXA PPP schedule of published fees has never existed for the purpose of informing policy holders about reimbursement levels. These documents both exist to inform doctors what they will be paid for their services. These are not guidelines, but are fees which must be adhered to as a condition of recognition with the insurer.

4.6. As we stated in our initial submission, we believe the publication of these documents contravenes the findings of the 1994 Monopolies and Mergers Commission report: *A report on agreements and practices relating to charges for the supply of private medical services by NHS consultants*.<sup>2</sup> We request that the CC considers the legitimacy and the purpose of benefit maxima and schedule of published fees, the constraining effect these documents have on consultants and the effect that this has on consumer choice.

## 5. Theory of harm 5: barriers to entry at different levels

5.1. This theory of harm sets out a number of scenarios that may be barriers to entry. On the whole we agree with the barriers identified, however, we would welcome clarification on how charges of incumbents would act as a barrier to entry for new consultants as outlined in 5(d) *Barriers to entry into the provision of consultant services in private practice*.

5.2. We also note the statement that GP incentives 'may be in breach of the BMA's guidelines on GP conduct'.<sup>3</sup> For clarification, we believe that these incentives may be in breach of the General Medical Council's guidance on Good Medical Practice.<sup>4</sup>

5.3. There are two further barriers to entry in addition to those outlined in the statement of issues:

#### Provider practising privileges

5.4. Admitting rights to a private hospital are generally approved by the hospital manager through the hospital's Medical Advisory Committee (MAC). The criteria and conditions under which consultants may be granted authorisation to undertake the treatment of patients in a private

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<sup>2</sup> Monopolies and Mergers Commission, *A report on agreements and practices relating to charges for the supply of private medical services by NHS consultants*  
[http://webarchive.nationalarchives.gov.uk/+/http://www.competition-commission.org.uk/rep\\_pub/reports/1994/348privmedical.htm](http://webarchive.nationalarchives.gov.uk/+/http://www.competition-commission.org.uk/rep_pub/reports/1994/348privmedical.htm)

<sup>3</sup> Competition Commission Private Healthcare Market Investigation, Statement of issues, 22 June 2012, P. 11 Footnote 19

<sup>4</sup> See General Medical Council's guidance on Good Medical Practice, Probity: Financial and commercial dealings / Conflicts of interest: [http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)

hospital are outlined in the hospital's practising privileges policy. Therefore a licence to use the facilities of a private hospital is known as practising privileges, and consultants are independent contractors of the hospital.

5.5. Although the criteria for granting practising privileges varies between hospitals, eligibility normally requires that a consultant:

- Is on the GMC's specialist register
- Can provide evidence to demonstrate relevant clinical experience of a nature appropriate to practice in an independent hospital/clinic, normally with evidence of direct patient responsibility.
  - Evidence of all procedures to be performed under practising privileges, demonstrating adequate numbers performed in each procedure over the previous two years.
  - Hold, or have held in the last five years, a substantive consultant post within the NHS or a Defence Medical Services hospital. If a consultant has not held a substantive consultant post, then they must be able to demonstrate experience of independent practice over a sustained period applicable to working in the independent sector.
  - Doctors on the GMC specialist register, who hold a locum consultant post, may be granted practising privileges limited to the duration of their locum appointment.

5.6. Hospitals are required to review their practising privileges every two years. In order to maintain practising privileges there is a requirement for consultants to have attained satisfactory appraisal process and the collection of 'whole practice' clinical data.

5.7. On the whole this system works well, however, there is no external appeal mechanism when practising privileges are refused or withdrawn. This can act as a significant barrier to entry depending on the provision of private hospitals in a local area. The lack of an independent appeal mechanism is a deficiency of the current arrangement which could be addressed by setting up an independent arbitration service to consider disputes.

PMI recognition of consultants

5.8. The market share of the two major insurers, BUPA (41%) and AXA PPP (25%)<sup>5</sup>, makes recognition by these insurers essential for any consultant setting up in private practice and continued recognition necessary to maintain a successful practice. Recognition criteria can often be very restrictive (see above). There is no mechanism to deal with disputes when recognition is refused or withdrawn which can end a consultant's private practice career.

5.9. When considering the role of recognition in the market, it is important to note that regulation of medical professionals in the UK is the responsibility of the GMC. PMIs do not have a role in professional regulation or the standards of consultants. Doctors' overriding standards are to the General Medical Council.

5.10. For this reason, disputes between consultants and insurers about recognition are likely to centre on fees or restrictive recognition criteria, rather than their suitability to treat PMI patients. We believe that there should be joint guidance, agreed by the profession and the PMIs about what are appropriate terms of recognition and the reasons why recognition can be withdrawn. This should be supported by an independent arbitration process when disputes occur.

## **6. Theory of harm 6: limited information availability**

6.1. This theory of harm posits that information asymmetries and limited information available to patients about hospitals and consultants may distort competition. We provide detailed comments on price and quality information below, however, it should be noted that there has never been as much information about consultants available to patients as there is now.

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<sup>5</sup> Laing & Buisson 2012, *Laing's Healthcare Market Review 2011-2012*, p.206

- 6.2. Consultants are becoming much more experienced at marketing their services to both GPs and patients. This can be through either direct advertising, or through websites explaining the services they provide and associated fees. Doctors can clearly define their service and demonstrate the benefit of using their service and the added value and enhancements offered over and above competitors. They can also provide information about their clinical skills and experience.
- 6.3. It is important to note all advertising must follow the guidelines set out by the General Medical Council.<sup>6</sup> This states that any information provided about medical services:
- Must comply with the law and guidance issued by the Advertising Standards Authority
  - Must be factual and verifiable
  - Must not make unjustifiable claims about the quality of service
  - Must not offer guarantees of cures or exploit patients' vulnerability or lack of medical knowledge
  - Must not put pressure on people to use the service, for example, by arousing ill founded fear for their future health or by visiting or telephoning prospective patients
- 6.4. In addition, many hospital websites have a function to search for consultants by location, specialty and subspecialty. This is an invaluable tool to assist GPs and patients in identifying the consultant and hospital at which to seek treatment, based on clinical need and patient choice.
- 6.5. As such, patients have increased access to reliable information about consultant services than they had in the past. They can use this information to research the services and fees of different consultants to make reliable, informed decisions about which consultant to seek services from.

#### Price information

- 6.6. We agree that limited information available on price may limit a self-pay patient's ability to make an informed choice about their consultant, or to shop around to find a consultant that best meets their requirements. However, we do not agree that this is an issue that is widespread in the market.
- 6.7. The BMA has been encouraging members to be open, transparent and upfront about fees for over 20 years. We always advise members to inform patients of the likely fee that will be charged for their private medical procedure in advance of their treatment. Where patients hold private medical insurance, we recommend that consultants should advise patients to check the reimbursement levels that will be available for their procedure. This allows patients the opportunity to seek the services of another consultant if they are not happy with the proposed fees. The availability of price information should not be different for insured and self-pay patients.
- 6.8. We would be happy to discuss further methods to increase the provision of consultant fee visibility in the market.

#### Quality information

- 6.9. We note that your definition of 'quality' includes all attributes of the product/service which may provide value to the consumer, including but not limited to: clinical outcomes, speed and convenience of treatment, comfort of accommodation, standard of customer service etc.<sup>7</sup>
- 6.10 While quality may include the totality of a patient's experience, it is important to distinguish between soft indicators of quality, for example standards of customer service and hard indicators of quality, such as clinical outcomes. The methods used to assess the different indicators will vary and the information is easier to gather in some areas than in others.

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<sup>6</sup> See General Medical Council's guidance on Good Medical Practice, Conflicts of interest: [http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)

<sup>7</sup> Commission Private Healthcare Market Investigation, Statement of issues, 22 June 2012, P.6 Footnote 15

- 6.11 Most episodes of care are uneventful and it becomes quickly apparent if someone in the independent sector is not providing good care. Hospital MACs have a duty to follow-up on any serious untoward incidents that happen in their hospital. This protects their reputation as a provider and ensures that any consultant practising from their facility is providing the highest standard of care.
- 6.12 Hospitals already collect a range of data which can be used to assess the quality of the hospital and the consultants practising there. These can include patient satisfaction, MRSA infection rates, C-Difficile infection rates, wound infections, returns to theatre, unplanned readmissions and adverse incident reporting.
- 6.13 As we stated in our initial submission, individual consultant clinical outcome data is more difficult to collect. Assessment of the clinical outcomes or success of a procedure is dependent on the recognised period of time needed to experience the full benefit of a given procedure and the durability of a procedure. To produce meaningful data would require a significant investment in the development of quality measures and the follow-up of patients over a sustained period of time. These longitudinal studies are difficult to undertake and are very expensive. We suggest that you take expert academic advice on the sort of data required to assess quality and how easy this data would be to obtain.
- 6.14 The provision of quality information in the private healthcare market is complex. An assessment of the type of information that patients find useful when making decisions about their private healthcare is vital before a decision can be made about whether limited information availability has an effect on competition in the market.

#### PMI managed care initiatives

- 6.15 We share your concerns that PMI 'managed care' arrangements direct patients to consultants based on price, in particular to those consultants who have agreed to only charge fees at PMI reimbursement levels.
- 6.16 Open referral policies remove decisions about treatment pathways from patients and GPs to case managers and case teams. This compromises patient choice in the short term and quality of care for patients in the medium to long term as decisions about treatment are based on what is deemed to be cost effective and not what is clinically appropriate.
- 6.17 These care initiatives undermine the clinical decisions of doctors which erode the doctor patient relationship and have the potential to cause prolonged treatment pathways by attempting to apply a universal model rather than an individual holistic approach. These open referral policies often prove to be administratively burdensome for patients.
- 6.18 There are also a number of ethical issues associated with managed care arrangements, not least the pressure on GPs to direct referrals based on PMIs restrictions and requirements, rather than to the consultant felt to be the most appropriate for the treatment required.

#### Information available to patients about insurance policies at the point of sale

- 6.19 The final OFT report proposed that the FSA, the Association of British Insurers (ABI) and individual PMI providers should work together to ensure that the possibility of an insurance benefit shortfall is made clear to consumers at the point of sale. While we support this initiative, we believe that there also needs to be increased transparency at the point of sale about the scope and restrictions associated with policies.
- 6.20 The range of policies available in the private healthcare market and the way they are sold can make it very difficult for subscribers to know what treatments are covered by their policies. Equally, restrictions related to pre-existing conditions and transferring from one insurer to another once a claim has been made are also not clear.



## **7 Theory of harm 7: vertical effects**

7.13 We support the proposal to review whether vertical integration has any adverse effects on competition in the market. Many of the theories of harm outlined in the statement of issues may become more entrenched if vertical integration was more widespread in the market.

7.14 That a number of insurers may own some primary care services is an important factor of the market and the effect of this should be given greater consideration. Primary care services, in particular GP services, are the most common route to secondary care. These services are offered by insurers on a self-pay basis, not as a benefit of medical insurance.

7.15 You have already noted that BUPA is the only insurer that is vertically integrated through its ownership of the BUPA Cromwell Hospital. Providing primary care services means that BUPA can influence every aspect of a patient's treatment.

7.16 We are concerned that anyone who visits a BUPA GP may only be directed to further BUPA services, for example physiotherapy services owned by BUPA, or the services of a BUPA recognised consultant at the BUPA Cromwell. This has the potential to limit patient choice and we would welcome greater consideration of how this may have an adverse effect on competition.