

14 Queen Anne's Gate
London SW1H 9AA

tel 020 7222 0975

fax 020 7222 4424

email info@fipo.org

web www.fipo.org

FIPO

federation of independent
practitioner organisations



PRIVATE HEALTHCARE MARKET INVESTIGATION

Third FIPO Submission

November 2012

(Proving Theory of Harm 4: buyer power of insurers in respect of individual consultants)

This is the Federation of Independent Practitioner Organisations (FIPO)'s third submission to the Competition Commission ("CC"). It has been drafted in light of the replies to the CC's Issues Statement published on the CC's website (the "replies", and each a "reply"). FIPO has carefully considered all replies. The focus of this submission is on the arguments put forward by the major insurers.¹ References in this document to "Aviva"; "Axa" or "BUPA" and paragraph numbers are references to specific paragraphs in the replies to the CC Issues Statement submitted by each organisation.

FIPO is concerned that some of the replies do not accurately reflect the way in which the market for private healthcare operates. In particular, FIPO believes that there are important issues to be assessed when considering Theory of Harm 4: buyer power of insurers in respect of individual consultants. As already pointed out in its own reply to the Issues Statement, FIPO considers that in this marketplace (namely, the provision of private healthcare services by consultants) the main insurers control entry and exit and conditions of supply. There is increasing evidence of the effects on consultants' ability to enter the private healthcare sector and to provide services to patients, to the ultimate detriment of the patients themselves. An increasing number of patients are directly impacted by the actions of their insurers.

FIPO receives funding from a number of sources, including, as the CC will know from the BUPA

reply, HCA. FIPO uses its resources to further its mandate, including by representing FIPO's views to the CC (without interference from any third party). Although at times there will be differences, as a representative body of providers of healthcare services, FIPO is able to identify with many of the challenges faced by PHPs. For the reasons outlined in this and in the previous two FIPO submissions, consultants generally experience a sense of foreboding in relation to the increasing influence and extent to which the main insurance companies already have control over the private healthcare sector, in particular over clinical issues and patient care. Consultants feel particularly uneasy about the way in which insurance companies such as BUPA obviously see themselves going forward.²

FIPO's role is to provide an all-round resource to the member organisations and to seek their views on issues of importance to them. Contrary to statements in some replies, FIPO has never encouraged consultants not to compete with each other on prices and discounts. Indeed, it is FIPO's contention that this marketplace can only function properly if consultants are allowed to compete with each other for treating patients, on the basis of price and quality (although "quality" in a healthcare setting is a difficult issue to quantify, patients choose consultants based on their own clinical history, their own research and the recommendations of their GPs and others). FIPO is increasingly worried precisely *because* competition on price and on quality is impaired by the insistence on the part of insurers that all consultants operate in the same way (and charge the same amount)³ for what can be quite different procedures, by consultants with different levels of experience, in different settings (with quite different practice cost frameworks), different geographies, with different patient risk profiles, on patients who require tailored care.⁴

¹ FIPO notes that only the replies of the major insurers, namely Aviva, AXA/PPP and Bupa, are available on the CC website

² For a summary of "the world according to BUPA" see below, para 4

³ Ironically, BUPA states that consultants "*do not compete on price because GPs do not know what a consultant would charge*" (BUPA: footnote 66): consultants are not allowed to compete, and to charge prices that reflect any difference in quality, because BUPA effectively in most cases "sets" the price.

⁴ The obsessive way in which BUPA sees variations of treatment as "unwarranted" is of concern: see BUPA: 1.15-1.18; footnote 45; 6.6(x), 6.12 (and table 15, unfortunately redacted so that consultants continue to be in the dark as to how BUPA analyses consultant spent by specialism), 6.62-6.67 and Annex E

INTRODUCTION

- 1.1 A world of private healthcare in which a few insurers with excessive market power control entry and exit⁵ and conditions of supply (as well as the clinical decisions and pathways), as BUPA delineates in its reply, does not operate in the best interest of patients or insurance policyholders.
- 1.2 FIPO considers that Theory of Harm 4: buyer power of insurers in respect of individual consultants can be proven, and its harmful effects substantiated. FIPO is however concerned that the CC may not be pursuing this line of enquiry as strongly as, in FIPO's opinion, it should. [§<]⁶ FIPO intends that this submission should form the basis and the framework for a further submission of economic and other data that FIPO hopes to collect.
- 1.3 This submission divides into four further parts.
 - 1.3.1 **Section 2** considers the arguments submitted by BUPA in its reply to the Issues Statement relating to buyer power;
 - 1.3.2 **Section 3** analyses buyer power using the approach taken in the the UK submission to the OECD roundtable on Monopsony and Buyer Power, prepared by the OFT/CC (the "UK submission to the OECD")⁷, and discusses the detrimental consumer effects resulting from such buyer power with emphasis on "demand withholding" as the main theory of harm; and
 - 1.3.3 **Section 4** draws conclusions based on the arguments developed in sections 2 and 3 in relation to BUPA's control over the market for private healthcare.

2. BUPA'S ARGUMENTS ON INSURER BUYER POWER – A REBUTTAL

- 2.1 BUPA's arguments concerning its buyer power can be summarised as follows:
- 2.2 First, BUPA states that economic theory suggests that, in almost all instances, buyer power

⁵ FIPO does not recognise as truthful statements such as that there is "no evidence that insurers indiscriminately delist consultants" (BUPA: 6.97). It is particularly strange to read that BUPA claims to engage with consultants and to provide an appeal mechanism against its delisting decisions. FIPO believes that this is not the case.

⁶ [§<]

is in the interests of consumer welfare, as consumers benefit directly from lower prices, higher quality and often through enhanced innovation.⁸ BUPA supports this argument with references taken from the UK submission to the OECD.

- 2.3 On the contrary, the UK submission to the OECD, the case history and the current competition law guidelines⁹ consistently show that buyer power needs to be considered as a possible source of adverse effects to consumers and therefore capable of leading to an adverse effect on competition (AEC). Indeed buyer power was of sufficient concern for the EU Commission when it decided that the so called vertical agreements block exemption regulation (VBER) needed to be amended in 2010,¹⁰ to incorporate in the overall assessment consideration of the market share of the buyer (under the previous version of the VBER, only the supplier's market share was relevant to the assessment). In the Q&A accompanying the revised text, the Commission stated: "*Just like suppliers, buyers can use their market power to put in place vertical restraints to the ultimate detriment of consumers. The introduction of a buyer's market share threshold is particularly beneficial to small and medium sized enterprises, because they are the most likely (as competitors of the powerful buyer or as a supplier unable to countervail the market power of the buyer) to be harmed by buyer-led vertical restraints.*"¹¹ In addition, BUPA has taken several quotations from the UK submission to the OECD out of their proper context: the submission clearly explains that "*there are circumstances in which consumers may be harmed as a result of the exercise of buyer power*".¹² These circumstances are explained further below in section 3.
- 2.4 Second, BUPA argues that the PMI market is competitive, "*meaning that almost all gains from buyer power flow through to consumers*", and further contends that, in economic theory, even a monopoly buyer *passes through* a significant proportion of gains to consumers. This argument is somewhat misconstrued. BUPA appears to be saying that *if* it

⁷ Submission available at <http://www.oecd.org/dataoecd/38/63/44445750.pdf> (pages 229 - 243)

⁸ BUPA, 1.83 (i).

⁹ We refer the CC to para 1.5 of the report : "*The Welfare Consequences of the Exercise of Buyer Power*" available at : http://www.oft.gov.uk/shared_oft/reports/comp_policy/oft239.pdf, and para 6.4 of "*Assessment of market power: Understanding competition law*" available at: http://www.oft.gov.uk/shared_oft/business_leaflets/ca98_guidelines/oft415.pdf.

¹⁰ Regulation (EU) No 330/2010 concerns the application of Article 101(3) of the Treaty on the Functioning of the European Union to categories of vertical agreements and concerted practices. It repeals the old Regulation (EC) No 2790/1999.

¹¹ Commission press release: 20 April 2010: 'Antitrust: Commission adopts revised competition rules for vertical agreements: frequently asked questions' (question 5: 'Why did the Commission introduce a buyer's market share threshold?').

¹² OFT/CC Submission, p231

had market power (which it denies), the CC should in any event presume that part of the gains would be passed on to the consumers. This is the opposite of the approach outlined by the European Commission guidelines¹³ which place the onus on the dominant undertaking itself to justify its conduct by demonstrating that it is objectively necessary or that it produces efficiencies that are sufficient to guarantee no net harm to consumers.¹⁴ In fact, all indicators point to the downstream insurance market not being competitive and to BUPA holding a dominant position. In this context it is much more likely that buyer power will lead to adverse effects for consumers.

2.5 Third, BUPA considers that competition authorities should only intervene if there is *overwhelming evidence* that consumers are made worse off through the exercise of buyer power. In fact, to our knowledge, nowhere in UK practice or cases, is there any reference to the need for “overwhelming” evidence that consumers are made worse off by buyer power, as implied by BUPA. Instead, it is clear that the UK authorities have in some cases found it necessary to intervene to stop adverse effects from buyer power from arising, as discussed at paragraph 3.15 below. This point is important in the context of the fact that, as FIPO has already pointed out to the CC, the most harmful effects of the most pernicious policies put in place by the insurers (and especially by BUPA) are only just being felt (but effects are already felt). It can be predicted that these effects will multiply if the other insurers follow BUPA’s example.¹⁵

2.6 Fourth, BUPA claims that *"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 restricted from commissioning care on its customers’ behalf"*. FIPO would encourage the CC to probe these assertions further especially considering that the primary gatekeeper of patients’ secondary care is the GP.

¹³ The CC is referred to the European Commission's "Guidance on the Commission's enforcement priorities in applying Article [102] of the [Treaty on the functioning of the European Union] to abusive exclusionary conduct by dominant undertakings (2009/C 45/02) OJEU

¹⁴ Ibid at para 28

¹⁵ As FIPO believes they will do: FIPO Reply to the CC’s issues statement para A.25 and A.26

3. THE BUYER POWER OF INSURERS OVER CONSULTANTS

3.1 As the UK submission to the OECD explains, *'there are circumstances in which buyer power can lead to adverse effects for consumers...Usually (albeit not in all cases), downstream market power is a prerequisite for adverse effects to arise from buyer power, and in these circumstances, authorities could assess downstream market power as a screen for buyer power or be clear about the negative downstream effect of the conduct'*.¹⁶

(i) The powerful buyer enjoys market power in its downstream market

3.2 FIPO has already submitted evidence about the way in which unfettered control of entry and exit and conditions of supply gives the main insurers power over the consultants.¹⁷ Under a traditional analysis of buyer power, the CC and the OFT would typically collect evidence related to the outside options¹⁸ of each party to assess the credibility of a buyer's (in our case, the insurer's) threats, which would allow the buyer to leverage better prices and/or terms and conditions from the suppliers (in our case, the consultants).¹⁹

3.3 The outside options of both the insurers and the consultants are considered below. As the analysis shows, whereas, for the time being, insurers have not experienced difficulty finding consultants to treat their members to what one of them calls "appropriate standards",²⁰ the consultants who wish to operate in the private healthcare sector need to secure the basis of patients who are holders of insurance policies. The CC will know that, for consultants, a private practice based on self-pay patients alone is not viable, in the light of the relatively low percentage²¹ of self-funded patients as against insurer-funded ones. The CC will also be aware that the majority (two thirds) of insurer-funded patients are insured with BUPA and AXA/PPP.

3.4 The main insurers (as buyers) can (and do) use the very real threat of delisting to leverage

¹⁶ UK submission to the OECD, pp 229-230

¹⁷ FIPO Reply, para. A.9 (iii); A.16; B53; B75-79

¹⁸ These outside options relate to the next best alternative to purchasing the input from the seller, when looking at the buyer, and the next best alternative to selling to the buyer, when looking at the seller.

¹⁹ The importance of assessing the strength of the 'outside options' is reflected in the CC's proposed guidelines for market investigations (see CC, Guidelines for Market investigations, June 2012, p.163)

²⁰ See point 3.5 below

better prices and terms and conditions of supply from the consultants with detrimental effects for patients and policyholders.²²

Availability of alternatives for the insurers

3.5 In the FIPO reply to the Issues Statement (points B.49 and B.50), FIPO explained that the insurers have a number of alternatives to purchasing services from any one individual consultant. The main insurers have confirmed this in their replies: they have not yet experienced difficulty with consultant recognition. In particular AXA/PPP states: “AXA is not aware of any problems in attracting suitably qualified consultants in sufficient numbers to treat its members to an appropriate standard, which is all that AXA seeks to achieve”.²³

3.6 FIPO is concerned that we may be heading towards a world where misinformed policyholders will only have access to what insurers deem to be “appropriate standards”, provided by consultants who are locked into an insurer's fee scale.²⁴ FIPO has already encountered numerous instances of disgruntled policyholders who, at the behest of their insurer, have been directed away from their consultant of choice or their existing consultant, often mid-way through their annual contract with the insurer, without being informed of the changes, without understanding why, for example, a cataract operation in one eye is covered by the BUPA policy one day and the very same operation a few months later on the second eye is not covered anymore. Patients who are informed about the possible existence of a shortfall between the consultant's fee and the insurer's reimbursement rate and are willing to cover the shortfall are nonetheless denied their choice.

3.7 [redacted]²⁵ [redacted]²⁶

²¹ We refer the CC to the OFT Report at paragraph 3.9 available at: http://www.of.gov.uk/shared_of/market-studies/OFT1396_Private_healthcare.pdf

²² FIPO is collecting evidence of the insurers' damage directly caused to patients by tactics such as re-directions and interferences with clinical care.

²³ AXA/PPP 15.2.

²⁴ BUPA states that there is no risk of consultants being selected because they are cheap: BUPA: 1.23. The practice of insurers capping new consultants will ensure that all consultants willing to enter private practice will be “cheap” and the rates of reimbursement unilaterally determined by BUPA. There are currently “over 2,750 new consultants” contractually bound to charge only what BUPA determined (BUPA: footnote 34)

²⁵ [redacted]

²⁶ [redacted]

Availability of alternatives for the consultants

- 3.8 Consultant services are typically provided by individual consultants, operating in a fragmented marketplace. The majority of consultants feel that they have no choice but to accept the terms dictated by insurers, which, for reimbursement rates, happen to be based on the BUPA maxima.²⁷ Since 2010, newly appointed consultants have no option but to accept the low fixed BUPA and AXA PPP benefit rates.
- 3.9 When considering benefit rates, FIPO refers to both reimbursements for procedures covered by the maxima, and reimbursements for procedures not covered by the maxima. This is important because Aviva and BUPA both insist that listed procedural (operation) reimbursement rates are only a fraction of what each of them pays their policyholders for medical care. Both AXA and BUPA quote that less than 50% of their payments are for procedures covered by the maxima, whilst the rest is for consultations and other services not covered by these. The insurers appear to quote these figures in order to conclude that the use of benefit maxima can only have a limited effect on "consultant market power".²⁸ FIPO is surprised at these figures as it believes that more than 50% of the payments made by the insurers should relate to procedures covered by the maxima. In any event, it is important that the CC understands that consultants are not free to charge their patients for their services, even when these services are not covered by the maxima. [X]²⁹ When services rendered are not covered by the maxima, there is no way for the consultant of knowing why, for example, his or her consultation fees are being reduced by an insurer (and why he or she is delisted, or threatened with delisting, if unwilling to comply).
- 3.10 For the consultants in private practice, intending to continue to operate in private practice, truly there are no alternatives: they must be recognized by the main insurers. Consultants who have entered the private healthcare sector after 2010, of course, have no choice at all (as BUPA indicated, if the main insurers have their way, soon all consultants in private

²⁷ Once again, and for the avoidance of doubt, FIPO does not dispute that the insurers have a right to devise insurance packages with their members as they think fit. FIPO passionately advocates a world where the professionalism of consultants is recognized and where patients can select their consultant of choice, if necessary by paying a shortfall.

²⁸ BUPA 1.47 and footnote 22. Incidentally, if consultants were in a position of market power *via-à-vis* patients and were able to abuse it, one would see many more consultants charge in excess of the BUPA maxima. Instead, as the AXA/PPP reply makes clear (15.4) only those consultants who believe that their services are such that they command a premium, will charge in excess of an insurer's maxima. AXA/PPP states that currently about 3% of payments made are outside the maxima.

practice will be capped in the amount they can charge).³⁰ Consultants who have entered the sector prior to 2010, and are unwilling to charge for their services the amounts imposed by the main insurers, often find themselves either delisted or threatened with delisting or simply have their patients diverted to another consultant. [X]

- 3.11 Insurers do not adhere to objective standards when delisting or threatening to delist. The semblance of adherence to a set of standards is expressed by BUPA when it states: *"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"*³¹. BUPA indicates that this is an ideal rather than a reality when it also states *"we want to link reimbursement to the quality of care the consultant provides"*.
- 3.12 In fact, this can only be an ideal. As the OFT found: *PMI providers indicated to the OFT that they did not possess sufficiently detailed information on the quality of care offered by consultants recognised by them and were in most instances unable to advise patients beyond information relating to the consultant's specialty and location.*³² FIPO strongly believes that patients should be able to choose their preferred consultant (if necessary, by opting to pay a shortfall). Their personal clinical history and often previous care under their consultant, their own research and the recommendation of others, including, crucially, their trusted GPs are all very relevant factors that determine the choice.
- 3.13 FIPO is aware of a number of consultants who have been faced with the choice between accepting insurers' imposed benefit maxima as fees for services rendered to their patients, or being delisted, for reasons that the consultant was unwilling to charge within the fee maxima, with no mention of the decision being premised upon any clinical concerns whatsoever. This has an obvious effect of the availability of care in the private healthcare sector: unfortunately for consultants, when patients are told by their insurer that their consultant is no longer "authorised", they often draw negative inferences about the quality of care provided by that particular individual, when in fact the decision was one based on costs alone.

²⁹ [X]

³⁰ BUPA: 1.88

³¹ BUPA 1.90

(ii) The resulting detrimental consumer effects

3.14 The UK submission to the OECD further explains that, when a powerful buyer enjoys market power, harmful effects can arise in several different circumstances, as follows:

- (i) Powerful buyers can seek to reduce the purchase price, reducing the amount they purchase at the prevailing market price (known as “demand withholding”), ultimately resulting in reduced supply and higher prices to final consumers;
- (ii) Powerful buyers can operate in their negotiations with suppliers in such a way as to reduce competition because of “waterbed effects”³³ and diminishing incentives for investment and innovation; and
- (iii) The bargaining power of powerful buyers can facilitate downstream collusion and hence lead to higher prices or lower quality to final consumers.

3.15 The UK submission to the OECD also sets out cases when it was determined that there were detrimental consumer effects resulting from buyer power.

3.16 An example of the first category of adverse effects (“demand withholding”) is seen in the “Clifford Kent/Deans Food” merger.³⁴ In this case, the CC concluded that increased buyer power as a result of the merger would eventually lead to higher prices for consumers. The merged entity would have been the buyer of approximately 70 per cent of all shell eggs giving the entity monopsony power. Lower prices to producers of eggs could benefit consumers if they were passed on to them. However, the CC considered that the quantity of eggs produced would likely fall; ultimately increasing prices to retailers and final consumers, particularly since the merger also enhanced downstream market power.

3.17 In the Groceries inquiry,³⁵ the CC examined the impact of buyer power on consumers in a variety of ways, including demand withholding in the UK fruit supply chain and a waterbed

³² OFT Private Healthcare Market Study, OFT 1396, page 69, para. 5.63.

³³ “Waterbed effects” describe instances where a powerful buyer reduces prices to a supplier who will then increase its selling price to other, less powerful, buyers.

³⁴ Competition Commission 2007, *Final report on Clifford Kent Holdings Ltd and Deans Food Group Ltd*. Available at www.competition-commission.org.uk.

³⁵ Competition Commission 30 June 2008, *Market Investigation into the Supply of Groceries in the UK*. Available at www.competition-commission.org.uk.

effect on small retailers. Whilst overall the CC did not consider that buyer power was detrimental to consumers in that particular case, the CC did find that some practices lead to excessive risk being transferred to suppliers. These would be *“likely to lessen suppliers’ incentives to invest in new capacity, products and production process... these practices will ultimately have a detrimental effect on consumers”*³⁶.

(iii) Demand withholding

3.18 FIPO considers it likely that the insurers in the private healthcare sector will have market power leading to adverse effects because of their ability to engage in “demand withholding”. The two additional theories of harm mentioned at para. 3.14 above arise in a context where bilateral negotiations are the norm, and would appear to be less likely candidates. FIPO is therefore focusing on demand withholding as the most likely theory of harm.

3.19 The economic framework for analysing the possible adverse effects of demand withholding is a traditional “textbook” view of buyer power. Typically a single buyer, a “monopsonist” (or a dominant buyer) purchases an input from competitive sellers.³⁷ Just as in a typical ‘market framework’ a supplier with market power (e.g. a monopolist) will have an incentive to reduce supply in order to increase prices, a monopsonist may withhold demand at the previously prevailing market price, thereby reducing input prices. This withholding of demand results in less input being purchased at the prevailing market price and hence reduced production, which will ultimately lead to less supply and higher prices for consumers.

3.20 Three necessary conditions need to be satisfied for this framework to be established, namely:

- the supply of consultants’ services is “upward sloping” (the lower the price, the fewer the consultants willing to enter private practice, and/or the lower the number of hours that an NHS consultant would consider spending in the private sector) (the “first condition”);

³⁶ Groceries Investigation, Final Report, paragraph 36. The practices of the insurers in the private healthcare sector directly lead to patient detriment, as indicated above.

³⁷ For a detailed exposition of this monopsony power, see Blair, R.D. and Harrison, J.L., Monopsony– Antitrust Law and Economics, Princeton University Press, 1993 or Dobson, Waterson and Chu, The Welfare consequence of the exercise of buyer power, 1998, pp11-16

- there is a single market price for suppliers' goods and services (the "second condition"); and
- the buyers have market power downstream (the "third condition").

First condition

- 3.21 First, for demand withholding to be established in our case, the supply of consultants' services needs to be "upward sloping", so that the lower the price, the smaller the quantities that are available to purchase.
- 3.22 FIPO expect that the supply of consultants for private practice will be upward sloping. Consultants choosing whether to practice privately are likely to have an NHS post. Insurers wrongly seem to infer from this that consultants who have an NHS post should wish to work in private practice at whatever terms and conditions the insurers are willing to offer, not only in terms of fees but also in terms of job satisfaction and ability to cure their patients.³⁸ In fact, the opposite is true.
- 3.23 Consultants who have spent that amount of time and effort to become consultants in the first place have an interest in what they do, which happens to be curing patients. It really does not make sense for a consultant to decide to work in the private healthcare sector when: (i) the environment in which they have to operate is a shopping centre; (ii) the conditions in which they operate do not include their ability to select their service care teams and other suitable specialist colleagues to deal with patients' needs;³⁹ (iii) they cannot provide appropriate tailored care⁴⁰ and (iv) the fees are unilaterally determined by insurers and decreasing over time, whilst costs, including the costs of liability insurance, tax and running costs are continuously increasing. The steeper the supply curve is, the greater the welfare loss resulting from buyer power.⁴¹
- 3.24 A reduction in fee rates and job satisfaction can be expected to lead to a more significant

³⁸ BUPA: 6.6(v)

³⁹ See FIPO reply, points B.5 and subsequent paragraphs.

⁴⁰ It is worth noting here that BUPA, in several instances has identified "variations in treatment" as the single requirement for delisting consultants.

⁴¹ Dobson, Waterson and Chu, The Welfare consequence of the exercise of buyer power, 1998, paragraph 4.5

withdrawal of supply for a consultant who already derives an income from a NHS post, than for a professional faced with the loss of his or her primary source of income. FIPO is reviewing preliminary data and it seems that entry in some specialties (such as those where the liability insurance costs are higher, such as spinal surgery and obstetrics) is already severely curtailed.

Second condition

- 3.25 Second, for the conditions of demand withholding to hold true, there would need to be a single “market price” for the suppliers’ goods or services (or services of a certain type). In such a situation there would be limited scope for individually negotiated prices.
- 3.26 If BUPA has its way, a single market price, with limited scope for obtaining individual prices, will soon be a universal feature of the provision of private healthcare services. Even now, in all cases where consultants cannot charge their patients directly for their fees, there exists a single market price, with limited scope for individual prices, tailored to location, type and difficulty of procedure and other circumstances such as the age and the profile of the patient.⁴² To a large degree, the prices set by the larger insurers already function like a single “market price”: other (perhaps smaller) insurers commercially will have no choice but to follow suit.⁴³ BUPA clearly sets out its “benefit maxima” for what it will pay a consultant for a number of procedures, insisting that the consultant cannot charge his or her patients a shortfall. This clearly acts as the ‘market’ price for these procedures, for all consultants within a specialty. Not only that. The main insurers’ attempt to use their market power to slash the fees for services outside the maxima. Variations of treatment, the very essence of medicine tailored to the needs of the patients, are deemed to be unwarranted unless robust data⁴⁴ can be provided as to why a consultant has acted in the way he or she did.
- 3.27 It appears therefore that the second condition of this framework is met in these circumstances.

⁴² It is interesting that the NHS for example recognises a London tariff, higher than the tariffs in the rest of the UK.

⁴³ See note 13 above

⁴⁴ BUPA “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”. BUPA 1.88, footnote 38; 1.115

Third condition

- 3.28 Third, the buyer must have market power downstream, so that there would be scope for restricting supply in the final market and ultimately harming consumers.⁴⁵
- 3.29 The market power of the larger insurers, and BUPA in particular, in their final market (the supply of PMI to consumers) should at least be presumed given their large market share⁴⁶ and its persistence over time. They therefore are in a position to restrict the supply of health services in the private healthcare sector.

4. CONCLUSIONS: THE WORLD ACCORDING TO BUPA

- 4.1 It follows that the conditions above hold and the consequences are that monopsonist (oligopsonist) buyers withhold demand from an increasing number of consultants in order to reduce input prices and affect other conditions of supply. This has started to result in a reduced supply of consultants in some specialties and a clear detriment to patients.
- 4.2 FIPO has already explained that the insurers have obviously identified the consultants as the “weakest link” in this marketplace.⁴⁷ Faced with rising costs of healthcare provision the insurers are targeting consultants. Evidence based on Laing and Buisson’s data show that insurer expenditure on consultants as a proportion of total expenditures in private healthcare has continued to erode significantly, to about [redacted] in 2010 (both BUPA and AXA/PPP appear to be deliberately vague in their assertions that the payments to consultants are in the region of 1/3 of all expenditures made by insurers and have remained constant).⁴⁸ In addition, since the beginning of this year (2012) BUPA has changed reimbursement rates for many common procedures. [redacted].⁴⁹ None of the insurers has disputed in their reply that the reimbursement rates have not increased significantly over the past 15-20 years and certainly have not kept in line with inflation.
- 4.3 Therefore, extrapolating from the available evidence and considering that other insurers will have no choice but to follow BUPA (other insurers will not be willing or able to pay more for

⁴⁵ UK Submission, p234

⁴⁶ In this regard, see the OFT Report, paragraph 3.32, footnote 57, paragraph 5.79 and footnote 179.

⁴⁷ FIPO: A.2 (iv)

⁴⁸ AXA Reply paragraph 6

⁴⁹ [redacted]

the same procedure performed on their policyholders, as compared to BUPA's) it appears to FIPO that the amounts spent by the insurers on consultants as a percentage of total spent, which has already been declining progressively over the years, will now decline fairly quickly by 20% overall for all procedures covered by the maxima and quite possibly the same for consultations and other services not covered (where the reimbursement rates paid are less transparent). However, this is an underestimate as the actual rate percentage cutbacks would depend on the rates that these procedures are performed and since the cutbacks affect the common operative procedures the rates are likely to be nearer the 30% range.

4.4 As an aside, FIPO would like to ask the CC to consider the following. FIPO does not have accurate information about the number of consultants currently in practice but notes that AXA PPP states that it "currently recognises around 36,000 specialists and practitioners in the UK".⁵⁰ FIPO also note that BUPA claims to recognise over 10,000 "fee assured" consultants. Of these, BUPA tells us that 3,580 are committed to charge within the BUPA maxima.⁵¹ This must mean that BUPA policyholders have access at best to less than one third of consultants operating in private practice (10,000 out of at least 36,000). Given BUPA's campaign to direct patients toward fixed fee consultants, at worst BUPA's patients can find their choice restricted to 3,580 consultants in total, most of them new consultants registered since 2010.

4.5 In BUPA's world, (and in some of the worlds inhabited by other insurers, to a lesser extent) BUPA controls all aspects of the provision of private healthcare. BUPA has become the regulator, without any of the cumbersome duties (of transparency, objectivity, fairness) that regulators have to follow: "*there is an important role for the insurers – the commissioner of care. Insurers need to be provided with the tools and authority to identify and address poor behaviours from consultants and hospitals*".⁵² Given that "*hospitals place little discipline on consultants or monitor their behaviour*",⁵³ BUPA will. (FIPO is willing to furnish full evidence that this is unfounded and completely rejects the implications of this statement. Strong clinical governance exists within the independent sector hospitals for

⁵⁰ AXA PPP Submission para 14

⁵¹ See BUPA, footnote 34: 2,750 new consultants registered since June 2010 who have no choice in the matter and 830 recognised consultants who have apparently "asked to move" to the new contract. FIPO refers to consultants committed to charging within BUPA's maxima as "fixed fee consultants".

⁵² BUPA: 1.24

⁵³ BUPA: s. 6

consultants, through CQC regulations, local structures and GMC guidelines which will become increasingly detailed with the onset of Revalidation early in 2013 and enhanced consultant appraisals). According to BUPA, all groupings of consultants should be banned.⁵⁴ BUPA sets the premium for the insurance products it offers; designs and changes the insurance policies at whim; employs salaried doctors⁵⁵ (who may or not have precise specialist knowledge) who are obliged to provide information at the most granular level to satisfy its perceived needs;⁵⁶ gives “provider-led guidance”⁵⁷ and takes away from “busy GPs” the task of clinical diagnosis and path to recovery; decides on the best clinical path for its policyholders; establishes its own clinical guidelines and decides on the price it pays the hospitals and for what. The impression is that, according to BUPA, nobody but BUPA can be trusted. BUPA takes a worryingly paternalistic approach towards the policyholders themselves in its reply when it claims that “the incentives of various actors along the patient journey are often misaligned with delivering value for money care”⁵⁸ and “the majority of patients being insensitive to the price at point of use and in vulnerable bargaining positions”.⁵⁹

- 4.6 This argument is just one of several used by BUPA to strengthen its own (self-proclaimed) position as “commissioner of care” in this market. BUPA's aspirations are towards a commissioning approach, where it can purchase services on a contractual basis from consultants, becoming in the process the ultimate arbiter in the patient-consultant relationship, the clinical decision-maker over the treatments offered, with no limits on the way in which it decides on matters, which could become in extreme cases matters of life or death.

EAL/KAC
Watson Farley & Williams LLP
November 2012

REF DOC NO: 41803331

⁵⁴ BUPA, 1.50-1.54; 6.45-6.49

⁵⁵ BUPA: 1.120

⁵⁶ BUPA: 1.132

⁵⁷ And laments that “at the moment, such provider-led guidance is in its infancy”, (BUPA: footnote 80)

⁵⁸ BUPA: 1.19-1.24, especially at 1.22

⁵⁹ BUPA: 4.4(iii); 1.121 (ii)

FEDERATION OF INDEPENDENT PRACTITIONER ORGANISATIONS

ANNEX I TO THE THIRD SUBMISSION: [✂]