Member of the public 1

29 August 2012

Dear Sir/Madam,

Theory of harm 1: Market power of hospital operators in certain local areas

I required laser surgery following cataract surgery and I wished the surgeon who carried out the original surgery to perform this as my condition was complex. My insurer, BUPA, refused cover unless I went to the [✂] hospital which they stipulated, I quote "all our laser eye treatment is carried out at the [✂] hospital". My chosen surgeon did not practise at that hospital.

Thus [✂], by virtue of an exclusive contract with BUPA, has a monopoly of laser treatment for BUPA patients. This is a factor additional to those in para. 23.

The surgery was carried out in a NHS private patient facility. I was responsible for its costs; BUPA refused even to pay the same sum as they would have paid [✂].

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

Re para. 28(c): As surgery is carried out by teams, I invariably accept a surgeon's recommendation for anaesthetist on the basis that they work effectively together. I have never been offered a choice of anaesthetist.

Anaesthetists' groupings appear to be a reaction to perceived low fee payments by PMI, and I am not aware of competing groupings in my area. Hence a particular anaesthetist's working relationship with a particular surgeon may give his/her grouping greater market power than anaesthetists who do not belong to the grouping.

Theory of harm 4: Buyer power of insurers in respect of individual consultants

I am shortly to have an operation which, as I understand it, is similar to one performed 10 months ago. Without warning, BUPA have reduced the payment to the orthopaedic consultant and anaesthetist to about one half of its previous value. I understand the reduction was made unilaterally and without negotiations. The consultant does not charge fees in accordance with those set by BUPA, so I paid the shortfall for the first operation and will now pay a larger one. The consultant says his fees are "in line with cover provided by WPA", however I could not realistically change PMI from BUPA to WPA as a new insurer will exclude existing conditions. Any benefits of competition are thus denied me.

Theory of harm 6: limited information availability

In common with many friends and colleagues, I rely on GP advice for choice of consultant. In a few cases where I know of others treated by the same consultant, I might receive a layman's assessment. This usually focuses on the consultant's personal presentation rather than quantitative information on clinical outcome.

Other Observations

Within the current regulatory framework, for those who make their own PMI arrangements there is a complete lock-in with no opportunity for competition between PMIs. In this situation PMI can, and do, escalate costs with impunity whilst simultaneously squeezing fees they pay. The table below shows the costs of my PMI for my wife and I over the years since I retired early from an employer who provided PMI through a company scheme.

Year	Annual Cost	% increase
2006	£722	(last year in company scheme)
2007	£1404	194%
2008	£1584	13%
2009	£1788	13%
2010	£1968	10%
2011	£2220	13%
2012	£2508	13%

I had little choice but to arrange cover with the PMI my employer used or face new underwriting and exclusions of conditions which occurred during my employment. My cost initially nearly doubled for a policy with a lower level of cover. Since that time, costs have risen by about 13% each year. The annual cost is now approaching, for example, the cost of my recent arthroscopic foot surgery for which hospital, surgeon and anaesthetist fees were £2700. At this level of premium vs benefit payment the underlying principle of insurance, namely the spread of risk across a population, starts to beak down and it may be cost effective to take my own risk. I put this forward as an example that the market is in danger of becoming defective.

Finally, I would observe that both this investigation and the original OFT work have minimal direct input from consumers/patients – a small number of interviews by the OFT and a handful of submissions such as this. I noticed a submission to you from the Private Patients Forum, the contents of which I fully endorse, but the number of consumers they speak for is unclear. Whilst your investigation appears to welcome direct input from the public, the public profile of the this investigation is small, there is no guidance on how to make a submission, and much of the language of the documents setting out the scope of the investigation is arcane.