Consultant 2

23 March 2013

Dear Sir/Madam

I would like to comment from a personal perspective on the Annotated issues statement 28 February 2013 - pages 16-18: Theory of harm 4: Buyer power of insurers in respect of individual consultants. I am a consultant ophthalmologist with a full time NHS contract and [✂] years relatively modest private practice.

101. Most of the submissions we have received from consultants are particularly critical of Bupa. Other insurers have not come in for similar criticism of their schedules of fee maxima.

The reason for this is very straightforward - everyone involved in private healthcare recognises that BUPA, by virtue of their dominant market share, wield enormous power. With respect to schedules of fee maxima, other insurers follow where BUPA "leads". Other insurers are also far less aggressive in their dealings with consultants and more honest and open in dealings with patients.

104. Bupa told us that considering the fee schedules in isolation was potentially mislead-ing as it ignored the efficiency gains that had been achieved over time. Due to tech-nological and other improvements, BUPA argued that consultants were now able to conduct many of the procedures much more rapidly than when the fee schedules were set.

This is untrue. Technological advancements in medicine and surgery have in the main focused on improving quality rather than reducing time. Cataract surgery, which has seen a 20 year freeze in insurers' benefit maxima followed by a 60% reduction, is not significantly quicker than 20 years ago. However, in that time there have been big changes from in-patient to day-case treatment, from general anaesthesia to local anaesthesia without an anaesthetist present and from multiple to single follow-up appointments, all of which have resulted in cost savings to insurers.

106. Although there is a clear disparity in size between an individual consultant and an insurer, in this context the consultant is the supplier of a service and the insurer is the buyer. Where a supplier reduces its price in the face of a strong buyer, this is usually likely to lead to lower prices for consumers. We also note that it would probably be against an insurer’s interest to reduce prices to such an extent that it had an inadequate supply of consultants.

Surely the patient (or their employer paying the insurance premium) is the buyer? Premiums have risen far faster than inflation at around 10% per year suggesting that consumers are not getting good value.

107. We have not seen evidence that indicates that Bupa’s fee schedules are leading to a lower quality of service, to lower incentives to innovate, or dissuading consultants from entering private practice, or remaining active in it, in such a way as to result in a long-term detriment.

Insurers clearly stifle innovation by declining to reimburse patients for novel procedures, intraocular lenses etc. Anecdotally, many new consultants now avoid private practice altogether and many established consultants restrict the scope of their private practice.

109. This enables Bupa to offer customers the assurance that fees will be fully covered, with ‘no surprises’.

On the contrary, BUPA's sudden large reduction in some benefit maxima has resulted in surprising and confusing shortfalls for many customers.

110. We find the argument that Bupa recognition is critical to many consultants persuas-ive. Bupa in particular, and Bupa and Axa-PPP together, represent a very large pro-portion of the private market for consultants. As such, they have a significant effect on the operation of the market as a whole.

BUPA suggests that consultant "recognition" is on the basis of quality whereas in reality their sole criteria appears to be price. In a market where reputation is important, loss of recognition can have far reaching consequences.

111. Whilst we appreciate that unexpected costs are unwelcome to patients, it is not evi-dent to us that patients are disadvantaged by top-up fees if they know about them in advance and if this would allow them to choose the consultant they prefer. Allowing such fees might provide greater patient choice.

BUPA advertises that all fees are covered, freezes and then reduces reimbursements, and then blames consultants for overcharging! Transparency with regard to top-up fees should be encouraged.

112. We are concerned that these practices can be expected to lead to a reduced choice of consultants available to patients insured by these insurers. Whilst purchasers of private medical insurance might be expected to switch supplier in response to changes to the service they receive when claiming on their insurance, we are concerned that customer response may be muted, especially since the market share of Bupa in the insurance market is around 40 per cent and the combined market share of Bupa and Axa-PPP in the insurance market is around 65 per cent.

Many patients are unable to switch insurers due to chronic health problems which would not be covered by a new insurer or would attract much higher premiums.

114. We note that the complaints we have received may not be generally representative of the views of consultants or of the PMIs’ conduct.

Many consultants are discouraged from complaining by open threats from insurers.

115. Several of these complaints raise matters of importance. However, the focus of our investigation is on competition in the market for privately-funded healthcare and we have not seen persuasive evidence that these complaints indicate a competition problem in that market.

I feel one patient's experience encapsulates BUPA's anti-competitive, threatening and misleading practices and their effect on quality of care. Having had a cataract operation by me for one eye, and been informed by me of the changes in BUPA benefit maxima, he enquired with BUPA regarding his options for a second cataract operation. He was informed that he should travel three hours, to one of three surgeons recognised by BUPA in one of the largest cities in the country, who he would meet for the first time in the operating theatre!