

PRIVATE HEALTHCARE MARKET INVESTIGATION
FIPO's reply to Annotated Issues Statement

April 2013

1. EXECUTIVE SUMMARY

- 1.1 We welcome this opportunity to comment on the Annotated Issues Statement (AIS).
- 1.2 The ability to charge top up fees to properly informed patients who value choice, would help to address some fundamental distortions in the market for private healthcare in the UK. We therefore welcome wholeheartedly the statements of the CC to this effect.
- 1.3 If properly informed patients could opt to meet a shortfall, there would be an incentive for patients to use the information made available to them (either as a result of this inquiry, or in other ways, including by GP recommendations, personal recommendations and by Internet chat rooms and webpages), to "shop around". Patients who value choice would be able to opt for a top up payment whilst those who do not can accept a "no shortfall" option. The choices available to patients would not just be limited to the choice of consultants, but also the choice of treatment, allowing a patient to opt for a new, more costly, treatment, by paying the shortfall.¹ The existence of a shortfall, if properly explained and accepted, would not be dissimilar to the existence of an excess: patients understand that under the terms of certain policies they have to bear the excess costs.
- 1.4 Consultants able to charge a shortfall would not be coerced into accepting fees unilaterally set by the insurers. Consultants who currently have no reason to provide cost information to their patients² would do so as a matter of course. The possibility of top-up fees would provide an incentive for investment by consultants in their private practice careers. The promise of private practice (patients to be allowed to see the consultant of choice in the facility of choice at a time of choice) would be fulfilled.
- 1.5 The existence of the BUPA Maxima and the fee schedules of other insurers will continue to provide an effective constraint on the fees charged by consultants. As recognised by the competition authorities at least since the 1994 MMC report on *Private Medical Services*, "*The BUPA benefit maxima have a restraining effect on consultants' charges*".³ This is borne out by the data provided at para.4.2 below: at times where the present aggressive strategies of the PMIs were absolutely unheard of, most consultants nevertheless charged within the limits of the BUPA Maxima.

¹ See below, para. 4.9

² Obviously there is no need to inform a patient of the costs of treatment if the consultants are not allowed to charge the patient.

³ See below, para. 6.17-6.18

- 1.6 For the ability to charge top-up fees to become a reality, however, the present practices of BUPA and AXA-PPP (and, anecdotally, AVIVA) which do not allow new consultants to practise unless they agree to charge in accordance with a fee schedule imposed by the insurers need to cease. The practice of the insurers to threaten to de-register those established consultants who do not abide by the fee schedules must also stop. Any statements to the effect that patients who are properly informed and wish to do so, must be allowed to pay top-up fees needs to be properly framed in a strong remedy, including a substantial prohibition; the possibility to impose a fine and the designation of an enforcing authority, as more particularly stated in paras. 2.4 to 2.6 below.
- 1.7 FIPO would be concerned if the CC position on top-up fees were to result in nothing more than a well-intentioned statement. Consultants are only too aware that in the past insurers have often used the requirement to inform patients of the possibility of shortfalls (a necessary pre-condition for patients to be able to make their choices) simply as an excuse to divert patients from their choice of consultants at pre-authorisation stage (on this see para 2.5 below).
- 1.8 As FIPO stated in its Reply to the Statement of Issues: *“We also consider that without proper consideration of the dynamics in the PMI market (and without the ability of policyholders to take their policy benefits and use them with the provider of their choice)⁴ the private health care market can be affected by the actions of actors outside it (...). Indeed, although FIPO applauds the OFT’s initiative to cooperate with the FSA to ensure that patients are informed about the possibility of shortfalls (and said so in its initial submission to the CC at paragraph 4.5), there is no timetable, no details of what the OFT and the FSA are discussing in practice and no obvious mechanism by which interested parties can bring to the attention of the FSA that patients are simply denied the possibility to exercise choice and pay a shortfall and that insurers have often used the requirement to inform patients about the possibility of shortfalls as an excuse to divert patients away from their choice of consultants”.*⁵
- 1.9 This reply divides into six further parts, each focusing on specific areas on which FIPO believes that it can provide a useful contribution. In each Section, the focus is the analysis of specific statements in the AIS:
- In **Section 2** we consider the arguments on top up fees.
 - In **Section 3** we consider the arguments about so-called “recognition” and “de-listing” by the main insurers (BUPA and AXA-PPP, as recognised by the CC but now, it appears, AVIVA as well).
 - In **Section 4** we consider patients’ detriment.
 - In **Section 5**, we consider the economic arguments for a consultant to decide to engage or remain in private practice.

⁴ Or, indeed to switch their policy providers, following the regulatory model in other jurisdictions, such as Australia

- In **Section 6**, we consider the effects of the interaction between the PMIs and the privately-funded healthcare sector

2. TOP UP FEES

2.1 We unreservedly welcome the CC position on top-up fees. In particular, we agree with the following statements:

2.1.1 *“whilst we appreciate that unexpected costs are unwelcome to patients, it is not evident 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 may provide greater patient choice”* (AIS, para. 111); and

2.1.2 *“our current thinking is that the buyer power of BUPA and AXA-PPP together, restrict patient choice in the market for consultants through the prevention of ‘top-up fees’”* (AIS para. 116).

2.2 We consider that the ability to charge top-up fees to informed patients who value the ability to choose consultants would in itself address a number of distortions in this marketplace. The existence of the BUPA Maxima provides a constraint on the fees charged by consultants to insured patients in any event (see below, para. 4.2 and 6.16-6.21). The ability for consultants to charge patients would provide a stronger link with the cost of treatment: as the CC’s survey of patients in private hospitals (the “CC Survey”) shows, self-pay patients are more likely to shop around (virtually all self-pay patients who replied to the CC Survey had obtained a quote before undergoing treatment). Interestingly, 29% of insured patients also obtained a quote for their treatment (see CC survey, slide 60)). Patients who value the choice of consultant would be able to choose and the CC survey showed that 40% of patients already knew or had a good idea of the consultant they wished to see at the time of seeing the GP. As many patients will NOT know in advance of the GP consultation the precise nature of their illness and therefore the type of consultant they may need, we believe that this figure of 40% shows clearly that patients do have an idea of their consultant of choice, which is consistent with the way in which patients today are much more likely to go to the doctor armed with Internet pages and knowledge of their illness and of the consultants they would want to see. If top-up fees were a reality, availability of cost information by consultants to patients would also increase (consultants obliged to charge the fees dictated by the insurers do not have any reason to provide cost information of course). Those patients who genuinely want to, would continue to be able to be directed by the insurers. The insurers could then design different policies, depending on the amount of choice given to the patients, charging a

⁵ FIPO’s Response to the Issues Statement, para. A.51

higher premium for the ability to choose.⁶ This will result in much more clarity at the point of purchase of a policy. Currently, most policies have limitations and excesses and network policies further limit the cover to certain hospitals, but the rhetoric surrounding these policies and the publicity by the PMIs (especially BUPA) is often quite misleading suggesting as it does that the patients would be able to have more control over their choice and healthcare provision when in fact, in FIPO's view, all choice is taken away from them. BUPA has even started to quote (misleadingly in our view) from the OFT referral documents, implying that the GPs do not have information on which to base their referral whilst BUPA does.⁷ [CONFIDENTIAL ✕]

- 2.3 The ability to charge top-up fees is incompatible with the limits currently placed by AXA-PPP, BUPA and, anecdotally, AVIVA too (see below) on newly established consultants. Currently, in order to be able to provide services, the new consultants need to agree to fixed fees (see below para. 3.4). The ability to charge top-up fees is also incompatible with the insurers threatening to de-register established consultants which do not agree to charge fixed fees (this is also mentioned below at para. 3.4).
- 2.4 The situation regarding top up fees has always been recognised by FIPO as one of the most important features of this market place that needs changing. For it to change, though, it is important that the CC translate statements such as the AIS statements quoted above into properly enforceable remedies. Unfortunately, the reality of the relative positions of consultants and insurers is such that consultants will be unable to take individual isolated action against insurers who chose to continue to impose fixed fees.
- 2.5 As seen above (paras 1.7 and 1.8), one aspect that the CC should recognise is that in the past insurers have used the requirement to inform patients about the possibility of shortfalls as an excuse to divert patients from their choice of consultant at the preauthorisation stage. For this reason, FIPO believes that all PMIs should have a universal method of informing patients at preauthorisation about their financial arrangements, to allow freedom of choice. Such a statement might simply say: *"You are entitled to see Dr AAA but you should enquire before seeing this consultant about his/her initial consultation fee levels. We would normally allow £ XX for a consultation. Of course, neither you nor the consultant may know at this stage what treatment or operation you will require in which case you may come back to us for further information on what benefits you will be allowed under the terms of your policy. You should understand that some conditions are not covered by your policy. Please note that your policy has certain exclusions (specify) or excesses (specify) to pay. If your consultant's charges exceed your benefits you will be responsible for the "top-up fees".* If the subscriber's policy is part of a limited network scheme which only allows access to certain hospitals, then this should also be made clear to the subscriber at pre-authorisation.

⁶ Thereby ending the present confusion between the expectations of the policyholders (often encouraged by the PMIs) that they will have a choice of treatment, hospital and consultants and the reality.

⁷ See Bupa's Open Referral Q&A and Open Referral Step-by-Step guide to claiming, at Appendix 5

- 2.6 FIPO urges the CC to consider a three pronged approach, without which statements in favour of top-up fees risk to be ineffective:
- 2.6.1 In terms of substance, a strong and unambiguous prohibition on the insurers to impose conditions of non-top-up-fees on (established or new) consultants, when the patients know about the shortfall and wish to meet it;
- 2.6.2 In terms of remedy, a system of penalties against insurers who breach the above prohibition, including by subordinating PMI registration of new consultants to a requirement to charge within their unilaterally imposed schedules, and by threatening established consultants with de-registration unless they comply; and
- 2.6.3 In terms of enforcement, the designation of an authority or an ombudsman to consider the issues, to give consultants a forum to appeal a decision to exclude them from the market and to impose the penalty, if necessary. In the case of established consultants, it is understood that the insurers in some cases need to de-register a consultant because of legitimate concerns (see below. para. 3.8). The authority or the ombudsman should be able to provide a proper forum for consultants to have a saying before they lose the ability to operate in the private healthcare sector (see generally point 3 below). A system of arbitration would we believe be acceptable to the profession. We note that such systems apply to other professions and are reasonably cheap to administer.

3. "RECOGNITION" AND "DELISTING" BY PMIs

- 3.1 We consider that the use of the term "recognition" to indicate the process by which an insurer agrees to reimburse policyholders only if they see certain consultants who are "approved" by the insurer is misleading. Insurers do not "recognise" consultants. Consultants are recognised by the several professional bodies deputised to appoint them (Royal Colleges for higher specialist degrees, Deanery for certification of higher specialist training, NHS Trusts for consultant appointments with a legally approved appointments committee and the GMC for formal registration and revalidation). The use of the term "recognition" gives rise to confusion. When a patient is told that his or her consultant of choice is not "recognised", often the patient assumes that the consultant has been found in some way lacking in his or her medical skills. A much better term to use to indicate the process of an insurer agreeing that a consultant can treat policyholder would be "PMI registration".
- 3.2 When considering PMI registration and delisting, we have considered in particular the following statements in the AIS
- 3.2.1 *"we find the argument that BUPA "recognition" is critical to many consultants persuasive. BUPA in particular, and BUPA and AXA-PPP together, represent a very*

large proportion of the private market for consultants. As such, they have a significant effect on the operation of the market as a whole” (AIS para. 110)

3.2.2 *“we are concerned that these practices [“recognition” of new consultants by BUPA and AXA-PPP only if they agree not to charge patients so-called “shortfalls”] can be expected to lead to a reduced choice of consultants available to patients insured by these insurers [BUPA and AXA-PPP]” (AIS, para. 112);*

3.2.3 *“providing misleading information on the status of consultants” (AIS, para.113(a));*

3.2.4 *“arbitrary ‘de-listing’ of consultants and a lack of transparency in insurers’ handling of such matters” (AIS, para 113(b))*

3.2.5 *“... 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” (AIS paragraph 115); and*

3.2.6 *“we have not received persuasive evidence that many of the consultants’ specific complaints have significant effects on competition in the market for privately-funded healthcare” (AIS, para. 116).*

3.3 We agree that registration by BUPA (and AXA-PPP) is critical for consultants who wish to enter the market for private healthcare (AIS, para 110). The MMC in its 1994 report⁸ had no difficulty in identifying the issue of registration as a constraint on entry: *“Since the costs of about two-thirds of all private medical services are met by insurers these limitations on specialists are important constraints on entry to the market” (para. 11.53).*

3.4 We also agree that the practice of recognition of consultants only if the consultants in question agree not to charge patients a shortfall can be expected to lead to a shortage of consultants (AIS para. 112). To clarify: the consultants who wish to enter the profession need to abide by the fees determined by BUPA and AXA-PPP for all procedures and for all consultations; current anecdotal evidence (to be confirmed) is that AVIVA is adopting the same strategy which would mean three different schedules. A number of existing consultants are also being targeted for not wishing to accept the cut backs unilaterally imposed by the PMIs. FIPO believes that these restrictions on top-up fees will have an even stronger negative impact on the incentives of consultants at the top of their field, to remain in private practice.

3.5 Given that BUPA and AXA-PPP and AVIVA together account for about 78% of premiums paid (see below, para. 5.22), we do not agree that the shortage of consultants will only affect the patients “insured by those insurers”: it will affect all patients, including self-pay patients. For the avoidance of doubt, and as explained above, we also do not consider

⁸ Monopolies and Mergers Commission Report on agreements and practices relating to charges for the supply of private medical services by NHS consultants - Cm 2452 February 1994, see below, paras.6.16 to 6.21

that the insurers' registration practices affect only the newly appointed consultants. Established consultants who are forced to accept a "fixed fee" deal (because a threat of deregistration is often followed by acceptance of the insurers' terms by the existing consultant)⁹ are equally affected and the fact that they are, adds to the argument that these practices can be expected to lead to a shortage of consultants in the longer term, as recognised by the CC, AIS para. 112.

3.6 We consider therefore that the insurers control market entry into the private healthcare market. The control of market entry is a recognised competition issue. In paragraph B.92 of the FIPO reply to the Issues Statement, FIPO already pointed out that BUPA and AXA-PPP (and if confirmed AVIVA) do not have the authority to impose restrictions on a profession. [CONFIDENTIAL ✂].¹⁰

3.7 ✂.]

3.8 For established consultants, the road to accepting "fixed fee" status goes via the threat of deregistration (or "delisting" to use the term in the AIS). [CONFIDENTIAL ✂].¹¹ As noted above (at para. 2.5.3), it is accepted that in some cases an insurer may have a legitimate reason to deregister an established consultant (e.g., if a consultant refers patients "for unnecessary or more elaborate diagnostic tests or forms of treatment for reasons other than the patient's best interest" (AIS, para. 143). However, for the insurer to be able to deregister without any checks and for the consultants to be expelled from the market without any recourse to an appeal mechanism is just unheard of. We therefore feel strongly that the CC is wrong in law and in fact when it states that it has "not seen persuasive evidence" that practices such as "providing misleading information on the status of consultants" and "arbitrary de-listing of consultants" indicate a competition problem (AIS, paras 113, 114 and 115).

4. THE RESULTING DETRIMENTAL CONSUMER EFFECTS

4.1 Consumer detriment takes at least three forms in the context of the market for private healthcare. The most obvious form (and the one which is mostly referred to in the AIS) is the fact that patients are not getting the treatment that they require. As the Stafford report¹² has made painfully clear, when considerations other than the best interest of the patients ("patients first") are at the heart of the provision of healthcare, the consequences can be dire. This is considered in detail below (para. 4.5 - 4.10).

4.2 Patients also need choice. The CC survey makes it very clear that the choice of consultants

⁹ See below, para. 3.8

¹⁰ ✂

¹¹ ✂

¹² Available at: <http://www.midstaffspublicinquiry.com/report>

is important to patients. When patients are denied choice, then one of the fundamental reasons for wishing to have an insurance policy is undermined and the entire market suffers. The CC survey found that choice of a consultant was crucial to the respondents but only 5% of them in fact chose a consultant whose fees were not fully covered by the insurance (slide 61). This needs interpreting. If we discard the possibility that all respondents willingly and freely happened to choose to see fixed fee consultants, which would seem odd, were the respondents in fact coerced to choose a fixed fee consultant? Alternatively this merely suggests that the vast majority of consultants have traditionally charged at, or close to, the PMI reimbursement rates, which is confirmed by the fact that the shortfall rate (i.e. the need for top up fees) has been very low in the past. [CONFIDENTIAL ¹³✂.]

4.3 The policyholders' position must also be properly assessed. Policyholders whose policy terms are varied in breach of contract and without their knowledge also suffer consumer detriment. See below (para. 6.15).

4.4 In analysing consumer detriment, we now refer in particular to the following statements in the AIS:

4.4.1 *"we have not seen evidence which 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 remain active in it,¹⁴] in such a way to result in a long term detriment"* (AIS, para. 107);

4.4.2 *"recommending inappropriate consultants for certain procedures"* (AIS, para 113(c));

4.4.3 *"using staff that lack appropriate medical qualifications to provide advice on medical matters"* (AIS, para 113(d));

4.4.4 *"There is a clear asymmetry between the patient and the provider as regards the appropriateness, quality and price of various treatment options that may be available to the patient. While some price information will be available, though not readily, to the patient, information about the appropriateness of various treatments may be harder to find and information of the medical skills and experience of individual clinicians will be very difficult to come by. Further, the patient, if insured, will have little incentive to seek out price information as the insurer will be paying for the treatment¹⁵. [Given these asymmetries, combined with the industry's fee for service model, there is an inherent incentive for the provider to take advantage of that asymmetry and refer patients for unnecessary or more elaborate diagnostic tests or forms of treatment for reasons other than the patient's best interest. This derives from the nature of private healthcare systems*

¹³ ✂

¹⁴ These aspects will be considered in Section 5

*and is a recognized issue in other countries*¹⁶. (It may also be considered that publicly-funded capitation models such as the NHS in the UK face incentives to ‘under-treat’.)” (AIS, para.143)

- 4.4.5 “We note that a number of PMIs are taking steps to limit the effects of this asymmetry, either generally or for specific conditions such as back pain, generally by modifying referral mechanisms. We note that this may in turn give rise to another consumer detriment: patients not being referred for particular tests or treatment for reasons other than their best interest. (AIS, para.145)

Patients first?

- 4.5 In Appendix 3, FIPO provides a selection of press articles with details of those instances of consumer detriment by denial or delay of treatment which have made it to the national press. It takes a lot for the British public to be so incensed that even newspapers such as the Times run prominent stories about the plight of BUPA’s policyholders.
- 4.6 [CONFIDENTIAL ✂]
- 4.7 On the CC website, letters from members of the public bring to the CC’s attention instances of detriment (the CC is referred to the submissions of Member of the public 2, 6, 11, 12, 23 and 25).
- 4.8 BUPA policy “Bupa by You”¹⁷, among other things directs the policyholders to a physiotherapist in case of a musculo-skeletal disorder such as hip, knee or back pain or indeed any form of muscular or other problem with the bones (see Appendix 7 for the relevant excerpt). Whilst it is possible of course that some people experiencing back pain may experience an improvement by seeing a physiotherapist, the choice to see a physiotherapist should be made with the help of a qualified doctor, not by a BUPA clerk or nurse. BUPA by You and similar policies introduce the possibility that the modification of the referral mechanism may not be dictated by the patients’ best interest (AIS, para. 145).
- 4.9 We do not understand therefore how the CC can state that they have not seen evidence of lower quality of service so as to result in a long term detriment (AIS, para. 107). Regarding evidence of lower incentives to innovate, given the above, it would also seem logical that an orthopaedic surgeon may be less inclined to innovate if he or she sees patients consistently directed to a BUPA physiotherapist. When considering innovation, it would be also important to think about the role of the PMIs in *discouraging* innovation. New treatments are often excluded from the treatment covered by the policy. Again, we understand that a new treatment may have a higher cost but surely the patient should be granted the choice to have the new treatment (paying a shortfall). The impossibility to pay a shortfall is also a

¹⁵ A clear remedy to ensure that top up fees can be charged should deal with this.

¹⁶ On this, see above, para. 3.7

¹⁷ Full policy wording available at <http://www.Bupa.co.uk/individuals/health-insurance/about-our-health-insurance>

barrier to innovation.

- 4.10 Granted, it is not the “*BUPA fee schedules*” (AIS, para. 107) which lead to lower quality etc. It is the managed care practices, the introduction of insurance led clinical care guidelines, the prohibition of top up fees, the recommendation of inappropriate consultants (AIS 113(c)) and the use of staff that lack appropriate medical qualifications to provide advice on medical matters (AIS para. 113(d)). These issues cannot be ignored. If patients in the private healthcare sector are faced with the same incentives to under treat that exist in capitation systems such as the NHS (AIS para. 143), why insure? If patients are not being given the treatment they require, possibly the insurer could even find itself responsible for serious health issues in patients, or even death. Indeed, WPA has published an opinion by a leading QC¹⁸ highlighting that insurers may well have vicarious liability in such cases.

5. CONSULTANTS’ CHOICES – THE ECONOMICS OF PRIVATE PRACTICE

- 5.1 In this section, we explain how consultants’ earnings on the NHS have increased, *provided that the consultant prioritises NHS work over private practice work*; how the number of consultants in private practice has declined as a percentage of total consultants between 2000 and 2012 (and it has declined in numerical terms, even taking into account the fact that the headcount of consultants has considerably increased in the period)(see paras 5.4 to 5.7 below); how the economics of private practice are such that the costs are rising and the income from private practice is already declining (or it is roughly stable in nominal terms over the period from 2009 to 2011)(see paras 5.8 to 5.10 below). All these factors corroborate the CC’s concern that the PMIs’ practices can be “*expected to lead to a reduced choice of consultants available to patients ...*” (AIS, para. 112. See also below, point 6).
- 5.2 This information then has to be framed in the wider context. The section above on patients’ detriment translates directly in job *dissatisfaction*: a consultant who cannot follow his or her patient through the clinical pathway, who has to justify every action to a financial company, who cannot charge for his or her services is unlikely to find private practice rewarding.
- 5.3 We consider that a strong remedy imposed by the CC to ensure that consultants who wish to do so can charge top up fees (provided this is properly explained to the patients) will go a long way to address the risk that consultant supply to the private healthcare sector will reduce to unsustainable levels, and that private policyholders leave the PMI market altogether. FIPO reiterates that the profession does not dispute that PMIs are at liberty to provide their policyholders with whatever benefits are available under the policy terms (provided that the policyholders are properly informed about these terms and about the changes to these terms, see below (para. 6.15)). PMIs cannot be allowed to control price

¹⁸ Available at : http://www.wpa.org.uk/literature/counsels_opinion.pdf

and conditions of entry of consultants to the private healthcare sector. Policy holders must be able to use whatever benefits are available under their policy as they wish.

Consultants' choices in the wider context of the medical profession – The NAO Report

- 5.4 On 6 February 2013, the National Audit Office published a report entitled *Managing NHS hospital consultants "The NAO Report"*¹⁹. The NAO Report focuses on *"the extent to which the expected benefits of the 2003 consultants' contracts have been realised and whether consultants are managed effectively in the NHS"*. Amongst other things, it provides details of the important work undertaken by the General Medical Council (the "GMC") in ensuring that doctors are "revalidated", every five years.²⁰ The proper structures to ensure that doctors remain fit to practice are in place and do not involve or require the disruptive actions by financial companies such as insurers. The NAO Report also gives details of the consultants' earnings on the NHS: as FIPO mentioned in its Third Submission, it is reasonable to assume that supply of consultants 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 (FIPO's Third Submission, para. 3.20). If so, the consultants will be more likely to engage in private practice if they feel that their patients are receiving the full benefit of their expertise, their continued investments and professional development and if the working conditions and the package available make it feasible and indeed rewarding in terms of job satisfaction and in financial terms for them to engage in private practice.
- 5.5 For the purposes of the present Reply, two main findings recorded in the NAO Report appear to be especially relevant.
- 5.6 The first is the explicit recognition that the 2003 NHS contract was *"designed to provide: [...] increased consultant commitments to the NHS, for example, by preventing an increase in private practice work"*.²¹ The statistics are that by 2012, 97% of consultants were on the 2003 contract. The remaining 3%, who chose to remain on the old contract did so to *"maintain a greater degree of control over their working life and their private practice commitments"*²²
- 5.7 The second is that the aim (of preventing increases in private practice work) was more than achieved. Only 39% of consultants undertake private practice work in 2012, compared to 67% in 2000. As the headcount number of consultants has increased, the actual number of consultants in private practice has declined, but only marginally (from 16,349 consultants undertaking private practice work in 2000 to 15,754 in 2012).²³

¹⁹ Available at : <http://www.nao.org.uk/wp-content/uploads/2013/03/Hospital-consultants-full-report.pdf>

²⁰ NAO Report, Summary, point 3, point 1.12

²¹ Ditto, 1.6, third bullet, emphasis added

²² Ditto, 1.7, emphasis added

²³ Ditto, 1.12

Consultants already “prioritise NHS work over private practice work”.²⁴

Job satisfaction

- 5.8 At a recent meeting of the FIPO Board, during which the CC investigation and its implications for consultants were discussed, one of the older participants wistfully interjected: “*private practice*”, he said, “*used to be agreeable and professional...*”. There was a murmur of assent. The doctors present at that meeting had entered private practice because they valued their professional relationship with the patients, the ability to follow the patients’ progress through his or her clinical pathway and the ability to have a say about availability of certain treatments or equipment at a private hospital, something denied them in the NHS (although now there is a swing back to more consultant decision-making in the NHS,- paradoxically as the private sector moves in the opposite direction with obvious consequences for the incentives of consultants to remain or to enter private practice and for policyholders to continue to be insured). Doctors in private practice now find themselves often stripped of their professionalism, the very core of being a doctor.
- 5.9 FIPO has mentioned this before. In FIPO’s Third Submission, for example, we said succinctly: “*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*” (at 3.23).
- 5.10 It is difficult to quantify an intangible issue such as “job satisfaction” but job satisfaction is an important part of a professional’s commitment to the profession.

The AIS

- 5.11 The following statements in the AIS are particularly relevant to this aspect:
- 5.11.1 “*we have not carried out profitability analyses for consultants since we consider that this would be impractical*” (AIS, para. 41)
- 5.11.2 “*In the statement of issues, we stated that if insurers are suppressing consultant fees to a level below those which would prevail in a competitive market, this could lead to a reduction in the quality of service provided by consultants to patients and affect the incentives to innovate. We also considered that insurer conduct may distort competition between consultants when caps on the reimbursement of fees are applied to some consultants (eg newer or junior consultants) and not to others (eg. more experienced ones). We said that in the longer term, this may result in a shortage of consultants willing to practise and in a reduction in the potential output of the sector*” (AIS para. 98).
- 5.11.3 “*BUPA told us that considering the fee schedules in isolation was potentially*

²⁴ Ditto, 1.13

misleading as it ignored the efficiency gains that had been achieved over time. Due to technological 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” (AIS para 104)

5.11.4 *“It is difficult for us to ascertain what the net effect of these changes has been on consultants’ incomes over time and whether consultants’ incomes today are more or less correct (sic) than at some point in the past” (AIS, para. 105)*

5.11.5 *“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 consumers²⁵]. 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” (AIS para. 106)*

5.11.6 *“we have not seen evidence which indicates that BUPA’s fee schedules are leading to [a lower quality of service, to lower incentives to innovate, or]²⁶ dissuading consultants from entering private practice, or remain active in it, in such a way to result in a long term detriment” (AIS, para. 107)*

5.11.7 *“We are concerned that these practices can be expected to lead to a reduced choice of consultants available to patients insured by these insurers” (AIS, para. 112)*

The economics of running a practice

5.12 FIPO is surprised that the CC simply states that they consider it “impractical” to analyse “the profitability” of consultants. FIPO considers that it should have been possible for the CC to add a section on costs and income to the consultants’ survey, for example. [CONFIDENTIAL ✕.]

5.13 FIPO is also concerned about the use of the term “profitability” in relation to the work of consultants. It is not possible to compare the profitability of private hospital groups, or the profitability of the PMIs,²⁷ with an individual consultant’s income and costs as the former are businesses which can be scaled up or down to take into account margins and returns. An individual consultant is not a business: he or she can only work a set number of hours (cannot scale the business up beyond a certain point) and will take into account wider opportunity costs than businesses. The cost of working an extra hour in private practice, v. spending more time with the family, for example, is likely to be a relevant consideration for a consultant. It is obviously not a relevant consideration for a business.

²⁵ This aspect is considered in Section 6

²⁶ This aspect is considered in Section 4

²⁷ On this, see below, Section 6

5.14 Income and costs therefore make up the economic outlook for consultants when they choose to enter or stay in private practice. We consider that the CC cannot decide, on the one hand, that it will carry out no analysis of costs and income for consultants, because this is judged “impractical”, but be willing to state, on the other hand that “*we have seen no evidence that BUPA’s fee schedules are dissuading consultants from entering private practice, or remain active in it, in such a way to result in a long term detriment*”, (AIS, para 107).²⁸ The CC has evidence from individual consultants pointing out that they are leaving the market, or considering doing so.²⁹ If the CC does not carry out any analysis of costs and income, more evidence may never be found. As a matter of good administration, the CC cannot derive from its own decision not to investigate an issue, a conclusion that the issue does not arise. There is also a fundamental fairness issue as regards the willingness of the CC to carry out a full profitability analysis for hospital groups and no analysis of costs and income of consultants (and only a limited analysis of the profitability of PMIs).

Consultants’ incomes

5.15 [CONFIDENTIAL ✂.] When considering income, it is important to distinguish between new consultants and established consultants. New consultants cannot bill patients directly and must only charge what the insurers decide is the amount for procedures and consultation. At para 108 AIS, the CC states that BUPA and AXA-PPP both impose these requirements. In its reply to the Issues Statement, FIPO has already pointed out (at para. A.52) that if BUPA and AXA-PPP are allowed to impose fixed pricing, then the other insurers will follow suit. Indeed, WPA mentions this point expressly in its submission to the CC.³⁰ Now, according to anecdotal evidence received by FIPO, AVIVA is imposing similar requirements for new consultants at this stage and is certainly cutting patient benefits on a number of common procedures.³¹

5.16 There are two important consequences. First, any new consultant is forced to follow several different fee schedules, depending on the patient’s insurer, which involves an extra administrative burden and costs. Secondly, a universal fixed fee totally ignores the reality of practising on the ground. [CONFIDENTIAL ✂] there are geographical variations in the costs of practising and such costs are] higher in London than outside [CONFIDENTIAL , ✂] To insist that all consultants entering private practice be paid the exact same, ignores economic reality.

5.17 When established consultants are also prevented from charging their own patients and

²⁸ On this point, see also below

²⁹ The CC is referred to the submissions of Consultant 90 and Consultant 147. FIPO does not represent doctors who are not in private practice. Nevertheless, we have received some evidence of an instance where a new paediatric neurologist recently established with a growing practice has exited the market as the economics were not viable. We would be happy to provide the CC with the background documents.

³⁰ “*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*”(WPA Submission to the CC dated 5 February 2013)

need to comply with the insurers' demands, similar results apply. The effect on the income of established consultants may be less immediately evident as the insurers work their way through their ranks, but it is only a matter of time before the market is totally distorted. In fact, if all new consultants are prevented from charging in accordance to expertise, location and patients' needs, even in the absence of insurers' action against established consultants it *will be* only a matter of time before the market is totally distorted.

5.18 The CC says (AIS para. 98), *"We also considered that insurer conduct may distort competition between consultants when caps on the reimbursement of fees are applied to some consultants (eg newer or junior consultants) and not to others (eg more experienced ones). We said that in the longer term, this may result in a shortage of consultants willing to practise and in a reduction in the potential output of the sector"*.

5.19 Although we appreciate that the AIS is an interim document and the CC has not yet arrived at a conclusion, we are surprised that the CC can use the conditional in para 98 AIS above. Competition is distorted and not just because new consultants are treated more harshly than established consultants (or, one may add, because some established consultants' services are reimbursed at a lower rate than a colleague's).

5.20 When prices are unilaterally imposed and slashed over time and entry for a party is dependent on acceptance of such terms, competition is distorted. When the prices so imposed take no account of consultants' expertise and seniority, geographic variations, or of necessary variations in treatment, competition is distorted (in fact variations in treatment, the very essence of medicine practised with "patients first" in mind is stamped out as undesirable). Not only this will result in consultants not being willing to practice. It will result in patients not being willing to pay for an insurance. It may be that eventually, as the CC says, the insurers understand 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"* (AIS para. 106) (and one may add, policyholders). In the meantime, patients suffer detriment.

5.21 [CONFIDENTIAL ✂³²].

5.22 [CONFIDENTIAL ✂.^{33 34 35}]

5.23 The final point to make relates to BUPA's assertions that consultants are now able to conduct many of the procedures much more rapidly than 20 years ago and so the slashing of reimbursement rates is somewhat justified (AIS, para. 104). BUPA have used this

³¹ Available at: <http://www.aviva.co.uk/health-insurance/practitioner-zone/recent-fee-changes/>

³² ✂

³³ ✂

³⁴ ✂

³⁵ ✂

argument in cataract surgery, for example, where the reimbursements have been slashed dramatically and have said that as the consultant can do three of these procedures in an hour (an exaggeration) the effective hourly rate at the previous benefit rate would be over £2,000. If it were really true that consultants could just perform three operations per hour, even at the new benefit rate (£ 350 for new consultants (until 2012) but only £289 for established consultants) the hourly rate would still be above £1,000 for the new consultants. Ignoring the weird anomaly of new and less experienced consultants getting more than their senior colleagues, there is a further consideration. If we take another common procedure, the repair of an inguinal hernia, it takes about one hour for one procedure to be performed. If BUPA considers that the hourly rate of a consultant who can now, according to them, perform three cataract surgeries per hour should be £867 - £1,050, then the benefit rate of a consultant performing the repair of an inguinal hernia should also be increased, by BUPA's own logic. Instead of which, for reasons that have nothing to do with the speed at which a consultant can repair an inguinal hernia, the reimbursement has been cut to £249. FIPO can apply this argument to many other procedures. Thus the BUPA argument of charging by time or the speed of any procedure does not stand up to simple analysis.

- 5.24 Another flaw in a fixed fee schedule is over consultation fees. It must be clear that when an otherwise healthy and young patient is diagnosed with a minor skin cyst, for example, the amount of time spent in discussing the options and treating the patient will obviously be considerably less than the time spent with another patient diagnosed with a cancer (which will not only take much more consultation time, but also will involve the consultant in reviewing with colleagues the X-rays, pathology and options for care in a multi-disciplinary team – meeting). These extra and uncharged for activities are not mentioned by BUPA who nevertheless have made other unwarranted demands, including about “quality” and multi-disciplinary teams (sometimes in specialties such as cardiology, where multi-disciplinary teams are not routine pre-treatment policy in the NHS or indeed most departments of cardiology in the private healthcare sector).
- 5.25 Again, it is not unreasonable for BUPA to wish to reimburse the same amount to its policyholders who suffer from the same affliction (or indeed, different afflictions). It is not unreasonable for BUPA to inform a patient that he or she can have the problem treated by a consultant chosen by BUPA at no extra cost, or by a consultant who charges a top-up fee. It is possible that the consultants charging a top up fee will be recognised authorities in their field, whereas the consultants who do not, will be less recognised. The patients who know this can make an informed decision. Patients who are provided misleading information about the status of a consultant (AIS para. 113 (a)), or are recommended inappropriate consultants (AIS para. 113 (c)), cannot make such a decision.
- 5.26 It is clear that the main motive for BUPA in cutting reimbursements is to save money and whist BUPA do state this, as seen above (para 2.2) they confuse the issue with various claims of improved choice for patients (in fact the reverse) and better care and at the same time claiming that some procedures are getting higher benefits. [CONFIDENTIAL ✕]

5.27 Another flaw in the argument relates to the easy, almost offhand assumption that consultants can just somehow ‘cram more patients in’ and maintain their levels of income. This is possibly a misconception born out of the confusion between a business and individual consultants. Whilst it is possible for a business to increase production when the marginal costs decrease, an individual is limited as to the amount of extra work that he or she can physically undertake. Irrespective of this general point, moreover, the specifics of the practice of medicine make this statement irrelevant in the context of the present inquiry. The statement presupposes that medicine is a commodity. Whilst it is possible that financial companies working on the basis of statistical algorithms may see the practice of medicine in terms of volumes, doctors see it in terms of putting patients first. Each operation is different and each patient needs to be assessed individually. Indeed, as stated by the doctor quoted in the Daily Mail article at Appendix 3: *“One of the key reasons for going private is so your consultant can take time to see you...But you may find those charging less piling patients high and selling them cheap...If they are seeing ten patients instead of five there is obviously going to be less time to spend with each individual to discuss aspects of their care”*.

Consultants’ Costs

5.28 Consultants’ costs include the costs of medical malpractice indemnity and the general administrative costs of running a private practice.

5.29 On the FIPO’s website, the CC will see a report “On the Market for Medical Malpractice Indemnity”.³⁶ This report was published in November 2011 and provides some interesting statistics. One such statistic is that claims inflation was approximately 10% p.a., and therefore subscriptions and premiums cannot but continue to rise for the foreseeable future.

5.30 [CONFIDENTIAL ✂].

5.31 [CONFIDENTIAL ✂].

5.32 [CONFIDENTIAL ✂].³⁷

5.33 [CONFIDENTIAL ✂]

5.34 [CONFIDENTIAL ✂]

6. THE INTERACTION BETWEEN PMIs AND THE PRIVATE HEALTHCARE SECTOR

The AIS

6.1 We refer, in particular, to the following statements:

- 6.1.1 *“As set out in the statement of issues,² the Office of Fair Trading (OFT) did not refer for investigation the private medical insurance market. Nevertheless, a key issue for this investigation is the way in which the privately-funded healthcare sector is affected by the conduct of, and interaction with, the private medical insurers (PMIs). We are also considering the impact on privately-funded healthcare providers of the different legislative frameworks and policies of the NHSs in each of the nations”.* (AIS, para 3)
- 6.1.2 *“Patients may take into account possible consequential changes to their insurance costs, for example due to the loss of no-claims bonuses. There are also some financial issues which have a bearing on insured patients’ decisions. Whilst they can expect most of their costs to be covered, they may have excesses or other limits on their policies and they may wish to pay a top-up fee to use a particular consultant”* (AIS para 19)
- 6.1.3 *“...We have done some limited financial analyses of the PMIs but profitability analysis is of less relevance as their revenues are obtained outside of the market for privately-funded healthcare”* (AIS, para. 41)
- 6.1.4 *“We note that Bupa and Axa-PPP, the two largest PMIs, have embarked on a number of initiatives to seek to control the costs they pay for consultant (and hospital) services. In the absence of insurer action, either to influence the choice of consultants or to limit the fees charged, it is not clear that there would be effective constraints on the fees charged for insured”* (AIS para. 100)
- 6.1.5 *“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]³⁸”* (AIS para. 106)
- 6.1.6 *“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”* (AIS, para. 112)

The PMIs are key to this investigation

- 6.2 The fundamental issue that we will consider in this section is that a proper investigation of the private healthcare sector in the UK cannot be conducted without a review of the way

³⁶ Available at: <http://www.fipo.org/docs/FIPO-BROCHURE-NOV11.pdf>

³⁷ ✂.

in which the private medical insurance market operates and interacts with the private healthcare sector (AIS, para. 3, reproduced in para. 6.1.1 above).

- 6.3 We welcome the recognition of this issue by the CC and are in fact relieved that this issue, which is fundamental in our view, is now firmly on the table. FIPO has highlighted it throughout and, in the context of the present investigation, from its very first submission (FIPO Initial Submission May 2012 at para. 4).
- 6.4 The fact that, in the conduct of a market inquiry, the CC is able to consider issues not referred to by the OFT (CC Guidelines for Market Investigations - June 2012 at para. 37 and 56) is a strength of the present system of competition law enforcement (incidentally, one which we hope will be retained when the OFT and the CC merge into the CMA). We note in passing that in the context of another inquiry, namely the private motor insurance inquiry, focusing on the practices of the insurers as the main focus, the CC has identified the situation in Northern Ireland as being of particular concern, notwithstanding that the OFT omitted it from its reference. The ability to see a market in the whole, irrespective of the way in which the OFT chose to categorise it, is therefore very important.
- 6.5 A side effect of the above is that the CC may find itself having to widen the investigation to actors and players which were not initially considered, with an impact on resources and timing. We are aware that resources may be an issue at this time of transition to the CMA. Nevertheless, issues of fairness and compliance with administrative law require that, having identified an issue, the CC should then properly investigate it.

The dynamics of the medical insurance market need to be understood and investigated even though strictly they are outside of the market for privately funded healthcare

- 6.6 We are concerned because the CC does not seem, so far, to have undertaken a systematic analysis of the PMIs' role. Without PMIs, the market for private healthcare would be unlikely to survive. The appeal of PMI insurance, with its promise that patients should be able to be treated quickly at a time convenient to them, and by a consultant of choice is disappearing and the private healthcare market is suffering the consequences. In this section, we make five points.
- 6.7 First, on the issue of top up fees, we consider that the CC should investigate why consultants' top up fees are such an issue for the major PMIs when, as the CC acknowledges (AIS para. 19) "*excesses or other limits on [...] policies*" are quite commonplace. The CC survey (slide 59) indicated that 26% of respondents were covered by a policy which included some excess provisions. Provided that the possibility of a top up fee is known and accepted by the policyholder, it is not that different from the policyholder knowing and accepting that a certain amount of the medical bill will be not

³⁸ This aspect is considered in Section 6

covered because of the excess limit on the policy. [CONFIDENTIAL ✂³⁹, ✂]

- 6.8 Second, the behaviour of the PMIs vis-à-vis the policyholders and the possible responses open to the policyholders are very relevant to the dynamics in the private healthcare market and should be investigated more. Para 112 of the AIS make this clear: in theory purchasers of PMI may be expected to switch but in fact the customer response is muted. This would merit an analysis. As FIPO has pointed out in its prior submission (FIPO Reply to the Issues Statement – July 2012 at Para A.2 (III) and A.17), there is a difference between personal and corporate policies. For example, 83% of respondents to the CC’s own Private Hospital Patients’ Survey had private medical insurance although 2% of them had to self-pay despite having private medical insurance. This is quite an interesting observation in terms of consumer detriment. 51% were covered by a corporate policy and 30% by a private policy. FIPO has pointed out in previous submissions that it is not the same to be covered by a corporate policy or by a private policy. Unfortunately no attempt was made in the published results of the CC Survey to distinguish between the corporate and the private policyholders, which would have been very interesting. FIPO considers that the people covered by a private policy are likely to share with the self-pay patients the characteristic of being “older”. This is also corroborated by [CONFIDENTIAL ✂] Older patients are more likely to find it difficult to switch provider in view of their medical history and therefore are likely to remain with their provider.
- 6.9 One finding from the CC Survey is that BUPA policies were “*more likely than average to be held as private policies*” (44% of BUPA policies were private as opposed to 37% on average for the other insurers (see slide 55)). The fact that 44% of BUPA’s policies are private has a number of possible consequences. If it is true that private policyholders are older, they may be making more claims on the insurance but at the same time they are more likely to be captive policyholders, locked into their policies. It appears to FIPO that it would be important to consider this aspect in more detail. Older policyholders are likely to be more vulnerable and less willing or able to switch. It would be very important to understand whether the older, vulnerable private policyholders are subsidising the lower costs of corporate policies.
- 6.10 Third, the issue of profitability of the PMIs deserves more consideration. We believe that the CC should consider whether it is fair and proportionate and rational for it to undertake a full review of profitability of hospital groups, no analysis of costs and income for consultants on the basis that this is “impractical” and only limited profitability analysis of the PMIs, on the basis that the PMIs’ revenues are obtained outside of the market for privately-funded healthcare (AIS para 41). In fact, we understand that BUPA is only active as a PMI.
- 6.11 It seems to us that it is not possible in the context of the dynamics of the private healthcare sector as it currently operates, for the CC to say that the profitability of the

³⁹ ✂

PMIs is “of less relevance” than the profitability of hospital groups (or, presumably, the costs and income of consultants) because it is obtained outside (in a sense, upstream, prior to fruition) from private healthcare.

- 6.12 For example: the CC makes statements such as that the buyer power of PMIs over consultants can effectively be disregarded because “where a supplier reduces its price in the face of a strong buyer, this is usually likely to lead to lower prices for consumers” (AIS para. 106). FIPO made a full submission to the CC, to explain why PMIs’ buyer power by demand withholding is an issue in this market place and very much hopes that the CC will be able to go beyond general statements which in this context do not seem to apply.
- 6.13 In this marketplace, the strong buyer is the PMI. The reduction in prices from the suppliers (the consultants) results in a lower cost for the PMI. If, in the hypothesis, in parallel to extracting lower prices from suppliers, the PMIs are increasing the insurance premiums to the patients, any reduction in price by the suppliers simply results in an increase in profit for the PMIs (the PMIs are pocketing the difference). Policyholders pay a higher premium for their policy but, when they require treatment, suffer the detriment identified above.
- 6.14 No-one is disputing that the costs of private healthcare have increased overall, but arguably the costs due to consultants’ fees as a percentage of overall costs have decreased [CONFIDENTIAL ✂]. The premiums paid by the policyholders have increased. In order to understand the current dynamics of the private healthcare sector in the UK, a proper analysis of the profitability of the PMIs would seem important.
- 6.15 Fourth, BUPA considers that it can change the terms of the policy at will. It cannot, because it is a condition in its own standard contract that the terms of the policy can be changed once a year on the anniversary of entering into the contract,⁴⁰ and therefore BUPA is often acting in breach of contract. [CONFIDENTIAL ✂] even the British Insurer Brokers Association (BIBA) is under the impression that “Insurers can freely change hospital directories without updating their membership. This only presents an issue at time of claim when policyholders assumptions are challenged”.⁴¹ Occasionally a patient will be sufficiently incensed to make a complaint to the Ombudsman,⁴² but the majority of patients will just accept this (if even BIBA accept it, what can be expected of individual policyholders?). It would be helpful if the CC could stamp out this misconception.
- 6.16 Last but certainly not least, we are concerned about the statement in AIS, para. 100 that “in the absence of insurer action, either to influence the choice of consultant or to limit the fees charged, it is not clear that there would be effective constraints on the fees charged

⁴⁰ In Appendix V of FIPO’s Reply to the Issues Statement, FIPO provided to the CC a copy of “Your Bupa Personal Membership Guide”. On page 10, Bupa expressly states that they can change the terms and conditions of the policy (including the amount and type of cover provided) **at the renewal date**. And on page 11: **if we make any changes to the terms and conditions of your membership, we will write to you at least 28 days in advance** (emphasis added).

⁴¹ BIBA’s response to CC investigation, available on CC website, para. 2(i)

⁴² CONFIDENTIAL ✂

for insured patients”.

- 6.17 This is an often repeated argument which is at least as old as the 1994 MMC report on *Private medical services: A report on agreements and practices relating to charges for the supply of private medical services by NHS consultants*.⁴³ The MMC found this in 1994, but in 1994 no-one had considered managed care and the MMC felt that the maxima as they were then applied could be allowed to stand, despite some misgivings.
- 6.18 In 1994, the MMC found that *“the setting of the BUPA benefit maxima is a legitimate step by BUPA in carrying out its functions as an insurer. Insurers must be able to inform policyholders of the benefits they will receive if they claim for events that are covered by their policies. BUPA and the other insurers are the principal counterweight to the consultants, given the weak position of patients. The BUPA benefit maxima have had a restraining effect on consultants’ charges”*.⁴⁴
- 6.19 The MMC’s findings are still relevant today. In 1994, no-one dreamt that BUPA and AXA-PPP would engage in a policy of prohibition of top up fees, delisting of consultants and managed care. In 1994, it was possible for the MMC to state that the maxima were needed so that policyholders could be informed of the benefits they would receive. In 2013, policyholders can count themselves lucky in some cases (i.e. BUPA by You) if they can see a consultant at all, never mind a consultant of choice.
- 6.20 As the MMC report makes clear, the existence of the maxima is sufficient to restrain consultants’ charges. There is no need to interfere with clinical guidance, stop patients’ choice or block the payment of top up fees. As seen above (para. 4.2), most consultants will charge within the BUPA Maxima in any event.
- 6.21 The MMC Report makes quaint reading at times. Para. 11.125, for example. *“... we expect that consultants would be able to resist any attempts by insurers-and even an insurer of the size of BUPA-to reduce their charges below a competitive market level. While, therefore, the setting of benefit maxima does have a restrictive effect, we are satisfied that it provides a safeguard against overcharging by consultants but does not, and is not likely to, unreasonably depress their charges.”* Events have shown that this assumption by the MMC was entirely wrong.

EAL
Watson, Farley & Williams LLP
April 2013

⁴³ http://webarchive.nationalarchives.gov.uk/+http://www.competition-commission.org.uk/rep_pub/reports/1994/348privmedical.htm

⁴⁴ Para. 1.11

