

British Medical Association summary of views on the Competition Commission market investigation into the market for privately-funded healthcare services.

May 2012

Introduction

We have had significant concerns about the way the private healthcare market operates for a number of years. Private Medical Insurers (PMI) have undue influence on consumer choice and consultants' participation in the market owing to their managed care initiatives, recognition criteria, benefit maxima and fee schedules. We fully support the Office of Fair Trading (OFT) decision to refer the private healthcare market to the Competition Commission (CC) for a market investigation.

The OFT has confirmed that the terms of reference for the market investigation include the role of PMIs and their relation to private healthcare providers, consultants and GPs.¹ We urge the CC to fully consider the evidence about the actions of PMIs that is submitted over the course of the market investigation. It is essential that the scope of the market investigation includes:

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

We have set out below the reasons why we believe these areas should be included in the scope of the CC market investigation.

Private Medical Insurers' consultant recognition criteria

We support the recommendation in the OFT report that the CC may want to consider the extent to which insurer recognition may be a barrier to new consultants entering the market. It is clear that the market share of the two major insurers, BUPA (41%) and AXA PPP (25%)², makes recognition by these insurers essential for any consultant setting up in private practice and continued recognition necessary to maintain a successful practice. Recognition criteria have recently been changed by some insurers to include a number of restrictions on a consultant's freedom to practice in the market, such as the requirement to charge services at specific levels, as outlined in more detail below.

Private Medical Insurers' fee schedules

Insurance companies publish benefit maxima and some have recently begun publishing schedules of fees. Benefit maxima were originally intended to inform customers of the level of reimbursement insurers will pay under their policies for services and procedures provided by consultants. For new consultants, however, the BUPA benefit maxima and the AXA PPP schedule of published fees outline the maximum fees they can charge for certain services and procedures. Agreeing to charge at the fees outlined in these documents are conditions of recognition. Consultants face derecognition from the insurer if they charge above these published fees.

In 1994, the Monopolies and Mergers Commission ruled that the BMA was unable to continue to publish guidelines for consultants on fees for private practice.³ Insurance companies were allowed to continue to

¹ OFT Private Healthcare Market Study, *Report on the market study and final decision to make a market investigation reference*, April 2012, P. 154, 10.50 (<http://www.offt.gov.uk/OFTwork/markets-work/private-healthcare/>)

² Laing & Buisson 2012, *Laing's Healthcare Market Review 2011-2012*, p.206

³ Monopolies and Mergers Commission, *Private medical services: A report on agreements and practices relating to charges for the supply of private medical services by NHS consultants*

publish their benefit maxima schedules as it was considered to be information for policy holders. The requirement to adhere to the reimbursement as set out in these documents means that they are no longer wholly guidelines for patients. Their main purpose is to inform doctors what they will be paid for their services. We believe the publication of the benefit maxima and schedule of published fees contravene the findings of the 1994 Monopolies and Mergers Commission report. We request that the CC consider the legitimacy and the purpose of these documents in the context of that report.

Consultant reimbursement

We support detailed examination of whether PMI fee schedules represent an appropriate level of reimbursement for the services that anaesthetists provide.⁴ This should be undertaken as part of a wider investigation into PMI policies that constrain consultant fees and the levels of reimbursements offered to consultants in all specialties.

We do not agree with the assessment that the lack of quality data about consultant practice is an area that restricts PMIs from developing less distortive measures to control consultant costs. As a group, consultants do not have the necessary negotiating or market strength to push fees up excessively. Consultants should be free to set their own fees for private medical procedures based on their individual circumstances such as experience, effort, skill and resources applied.

Assessment of the success of a procedure is dependent on the recognised period of time needed to experience the full benefit of a given procedure and the durability of a procedure. To produce meaningful data would require a significant investment in the development of quality measures and the follow-up of patients over a sustained period of time. These longitudinal studies are difficult to undertake and are very expensive. We suggest that you take advice from expert academic advice on the sort of data required to assess quality and how easy this data would be to obtain.

In the absence of quality data, it has been suggested that volume data of procedures undertaken may assist patients with making decisions about their care. The volume of procedures undertaken by individual consultants in the independent sector is often relatively low, either because the demand for a certain procedure does not exist in the independent sector, or because of a low uptake of private practice in certain geographical areas. Consultants may undertake a large volume of such work in the NHS and it is an individual's total experience that is important. While other soft data, such as patient experience, can be more easily collected, it is important that this information is not the only factor used to determine consultant 'quality'.

Managed care

The impact of managed care initiatives on patient care and the conflicts of interest that exist as part of a PMI's desire to manage costs should be considered as part of the market investigation. Managed care initiatives disrupt traditional, clinically proven referral processes and treatment pathways. Decisions are often based on what is deemed to be cost effective, or is allowed under the patient's insurance policy rather than what is clinically appropriate. This compromises patient choice in the short term and quality of care for patients in the medium to long term. There are also a number of ethical and clinical care issues associated with managed care arrangements, not least the pressure on GPs to direct referrals based on PMIs' restrictions and requirements, rather than to the consultant felt to be the most appropriate for the treatment required.

Consultant practising privileges

The inclusion of contractual restrictions or disincentives that limit a consultant's ability to practise at a range of private healthcare providers should be included in the market investigation. It is not good practice to require consultants to only practise in one hospital. There is no external appeal mechanism when the terms

⁴ OFT Private Healthcare Market Study, *Report on the market study and final decision to make a market investigation reference*, April 2012, P. 113, 7.10 (<http://www.of.gov.uk/OFTwork/markets-work/private-healthcare/>)

of practising privileges are restrictive or when practising privileges are refused or withdrawn. This is a deficiency of the current arrangement which could be addressed by setting up an independent arbitration service to consider disputes.

Consultant incentives

The CC should consider the extent to which consultant incentives could serve to raise barriers to new private healthcare providers entering the market. It should be noted, however, that indirect incentives such as free or discounted consultation rooms and free or discounted administrative staff, are widespread in the market.⁵ Therefore they are unlikely to act as a barrier to entry to new private healthcare provider entrants. Consideration should instead be given to whether the prohibition of these indirect incentives would have an adverse effect on the costs to patients.

GP incentives

The inclusion of GP incentives in the market investigation is welcomed. Referrals should be based on clinical decisions, not financial incentives. GP incentives raise a number of ethical issues and would be against the GMC's guidance on Good Medical Practice.

Anaesthetist Groups

We do not agree that Anaesthetist Groups (AGs) or other consultant groups should be included in the market investigation. In 2003 the OFT investigated whether anaesthetists in a number of local areas had formed themselves into groups and agreed within those groups the prices that each anaesthetist will charge for their private professional services. The OFT found that the AGs operated as a single undertaking for the purposes of competition law. Any agreement between the members of each group (within their respective groups) as to the levels of fees to be charged for their private professional services, did not amount to an agreement between undertakings.⁶ As a result, formal AGs began to emerge as legitimate way to improve anaesthetist coverage in local areas while ensuring individuals were operating in the realms of competition law.

The benefits of AGs for patient care also need to be fully considered. AGs provide added value to patients that may not be immediately evident to patients and insurers. The Association of Anaesthetists of Great Britain and Ireland submission to the OFT information request stated the considerable advantages of AGs to patient care include: 24/7 on call service to the private hospital; expert critical care support; and close liaison with NHS Intensive Care Units should private patients need to be transferred.⁷ It is essential that these benefits and the potential adverse effects of limiting these groups are considered in more detail before a decision is made about whether AGs should form part of the CC market investigation.

⁵ OFT Private Healthcare Market Study, *Report on the market study and final decision to make a market investigation reference*, April 2012, P. 132, 8.64 (<http://www.of.gov.uk/OFTwork/markets-work/private-healthcare/>)

⁶ <http://www.of.gov.uk/OFTwork/competition-act-and-cartels/ca98/decisions/anaesthetists-groups>

⁷ <http://www.aagbi.org/sites/default/files/OFT%20Letter%202022.11.11%5B1%5D.pdf>