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10th July 2012

Dear Ms Hawes

Private Healthcare Market Investigation

Thank you for your letter dated 22nd June 2012. The London Consultants' Association ("LCA") is aware of the Competition Commission ("CC") investigation in to the private healthcare market and welcomes it.

As the CC will know, the LCA comprises consultants predominantly but not exclusively in London who work in private hospitals. Information about the LCA is available at: http://www.london-consultants.org/. You will see from the website that we held an event on the 15th March on the implications of the CC investigation.

The LCA intends that its views should be made known to the CC through FIPO, the Federation of Independent Practitioner Organisations. The LCA is an active member of FIPO, as are a number of other specialist organisations, representing consultants in private practice. FIPO has some resources and is in a better position to provide evidence to the CC and to field questions to other membership organisations as appropriate. We are aware that FIPO has made an initial submission to the CC and agree with the arguments in it. We also know that FIPO intends to reply to the CC's Issues Statement and we are in touch with FIPO about this.

As the CC would have by now realised, a feature of this market place that requires investigation is, LCA believes, the unusual tripartite structure that sees self employed specialists working alone or in small groups, having to make their voices heard often in contraposition with the voices of large well resourced groups such as the large insurers. In this context, we have noticed with some weary amusement the insistence in some quarters that the tendency of consultants to group together may "reinforce their market power".

On the contrary, the relative weakness of consultants is well exemplified by the number of short letters that self-employed consultants have been able to send to the CC. At the last count, 52 consultants had taken time out from their practice to write to the CC but, of course, their resources and time are very limited by comparison to, for example, BUPA or even small independent hospitals. For this reason, we would urge the CC to refer questions to the larger organisations that group consultants in private practice, such as FIPO.

With the proviso that the arguments will hopefully be developed by FIPO, my colleagues and I, on the Board of the LCA, would like briefly to answer your questions as follows.

(a) The definition of the relevant market or markets - starting from the terms of the reference, the overall marketplace under investigation is, of course, the supply or acquisition of privately funded healthcare services in the UK. This is not a straightforward sector and a good starting point for a market definition is consideration of the actors involved, namely the consultants, the policyholders, the insurers, the hospitals, the patients and the patients' employers (we are pleased that, for the first time, the CC in its Issues Statement mentions the existence of group corporate insurance as an important feature). It may be that each of these actors need to be considered first separately and then in their interactions with the other stakeholders, in order to build a picture of the marketplace. In conducting this exercise, several interdependent submarkets may emerge.

(b) How easy is it to enter the relevant market(s) - it follows that the LCA believes that each stakeholder should first be considered in isolation. How easy is it to:-

a. become a consultant provider of healthcare services? The FIPO original submission makes the point that consultants have spent years qualifying, are stringently regulated by the General Medical Council and, by and large, need to have gained a NHS consultant post before they can start providing healthcare services in the private sector. This means that a consultant starting in this marketplace will have had to earn entry into a profession. This is not easy, but entry is available to all people with the relevant qualifications obtained by following a recognised path and on objective criteria.

b. become a consultant recognised by the insurers? A new consultant will have to achieve recognition by the insurers before he or she can start providing services to that particular insurer's patients. Unfortunately, the only way that new consultants can obtain insurance recognition by Bupa and by AXA PPP is by entering into contracts which limit the amounts that they can charge for their services. This makes a mockery of the view that consultants have any degree of market power. We believe that this requirement is an important barrier to entry as in some fields new consultants are simply opting not to enter the market place.

c. become a consultant in private practice generally? Like in all other sectors, an important requirement is that one should be able to have an income which covers the costs of provision and allows for a margin. When this does not happen, entry is impacted.

d. remain a consultant in private practice and continue to be recognised by the insurers. Unlike the entry requirements into the profession, which are objectively justified and applied, the major insurers AXA PPP and Bupa de-recognise consultants whimsically. The criteria are not transparent, applied randomly and with no possibility of appeal. The consequences of de-listing are so dire that the threat of de-listing is often sufficient to make individual consultants accept whatever terms the insurers decide to enforce. This also makes a mockery of any pretend "market power" of consultants.

e. become a policyholder? A good question and one that we hope the CC will be able to answer. Entry could be difficult if, for example, evidence suggested that it could be relatively easy to become a policyholder at a young age especially when being in active employment as part of a benefit package, but that entry became

progressively difficult with the passage of time. And whilst asking this question, it would be interesting to ask the mirror question, namely

f. how easy is it *to exit* one of the insurance schemes and maybe join another scheme? Customer lock-in appears to be an important feature in this market that really needs to take centre-stage. The CC may wish to consider the Australian market where, the LCA believes, the regulatory regime introduces an element of "policy portability": policyholders can move to another insurer without any loss of cover for pre existing conditions (providing the level of cover is not increased). Where the level of cover is increased a waiting period (usually of 12 months) is imposed on pre existing conditions.

g. become an insurer? This is not, of course, a question for us but one relevant consideration is that it may be possible to enter the market but not so easy to achieve market expansion. Bupa's and AXA PPP's market share has remained practically constant over the past 20 years or more. Bupa and AXA PPP together insure 65% of PMI funded patients (OFT Decision, para. 8.13). That does not appear to leave a big margin for manoeuvre to the other players.

h. become a hospital provider? Again, this is a question for the CC, but the capital requirements are very high and hospitals also need insurers' recognition in order to operate in the private healthcare sector. It seems to us that hospital groups are in a better position than single self-employed consultants to secure recognition and remain recognised.

i. finally, how easy it is to be a patient? Much is made of the fact that patients rely on medical specialists for their treatment and that there is "asymmetry of information" between a doctor and a patient. This happens in all professions. There is asymmetry of information between a lawyer and his clients, an accountant and her clients and so on. This is why someone is willing to pay a professional to sort out certain issues. What happens in most marketplaces is that the person needing a professional's help will be paying for the service. In the context of private healthcare, this could easily happen if consultants were charging their patients and the patients were claiming from their insurers whatever reimbursement rates they may be contractually entitled to. The insistence of the insurers that there should be no shortfall and that consultants should not be allowed to charge for their services creates a separation between payment and consumption, which is perhaps unique to this marketplace. This is something that is a particularly British phenomenon. The LCA understands that in Australia (where Bupa are a major player) and the USA patients expect to have to make co-payments.

(c) The structure of the market(s) for privately funded healthcare - it follows that this is a complex marketplace characterised by three main providers (consultants, hospitals and insurers) and two main purchasers (policyholders and their employers). As far as the consultants are concerned, the balance of power between the providers is skewed in favour of the insurers who control entry and control payments and other conditions of supply. As far as the purchasers are concerned, it would be interesting to know how many are locked into their policies.

(d) The conduct of, and the extent of competition between, current providers (including hospitals/clinics and consultants) of privately funded healthcare - we are not clear about the competitive dynamics in this marketplace. It seems fairly clear to us that the insurers are not competing to secure the services of

consultants. As far as the big insurers are concerned, consultants are fungible and expendable. More generally, competition between consultants happens within their specialty. As in all professions, there is a commoditised end of the market, at which competition on price is prevalent, and a high level provision of service in those fields which require higher ability and knowledge and where competition is based on quality more than price;

(e) The existence of consultant groups - single self employed consultants group together to share costs and provide a forum for discussion. Lawyers group together, accountants group together, architects do, etc. There is nothing sinister about it and, in fact, the OFT has cleared groups of anaesthetists of accusations of anticompetitive behaviour in the past. Self employed consultants cannot, of course, engage in collective action. The creation of groups cannot change that.

(f) The role or conduct of private medical insurers. Please refer to (b) above. Insurers control entry, dictate the terms of entry and exit, decree that patients cannot shop around or meet any shortfall and unfortunately (and worryingly) sometimes dictate the pattern of treatment;

(g) The role of the National Health Services throughout the UK. This is a big subject in itself. Perhaps the CC may wish to ask specific questions about it. Again, the LCA would urge the CC to direct the questions to FIPO.

(h) The role or conduct of general practitioners - the general practitioners are invaluable in the patient's journey. They know their patients and they know the consultants. To read the disparaging comments in the OFT decision devaluing the role and expertise of GPs is hard and difficult to accept, especially when it seems that the OFT endorses the alternative of a faceless insurer directing treatment.

(i) Any regional or local issues or differences across the UK - the LCA consultants work predominantly in London but there are clearly regional differences across the UK which will give rise to different patterns of practice. May we leave FIPO to expand on this question?

(j) The extent and quality of information available to patients - see above point b(i) for our view that asymmetry of information happens between a professional and his or her clients. The General Medical Council regulates consultants, which is an important safeguard. In any event, patients have very little use for information if they are denied access to consultants due to the insurers' practice of de-recognition. Having said all that, we are aware of initiatives currently being carried out with the active involvement of FIPO to ensure better quality of information is made available, to the greatest extent possible. We do hope that patients will acquire a corresponding right to use available information.

(k) Any other issues you consider relevant - only to reiterate that we would wish that the CC refers questions to FIPO in the first instance.

Yours sincerely

Duncan Dymond
Chairman of the London Consultants' Association