

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with Bupa held on 20 March 2013

Introduction

1. This hearing was focused on the operations of Bupa Health Funding, Bupa's private medical insurance (PMI) business, and not specifically the Bupa Cromwell hospital or Bupa International operations. Bupa's main role was to provide private healthcare for its 2.3 million customers. It did not have shareholders. It aimed to be a trusted health-care partner, giving customers information and guiding them through choice and advice. However, Bupa faced intense competition from its PMI rivals and a free NHS alternative that placed an acute focus on the value Bupa offered. This was enhanced by high levels of intermediation in the market and a difficult economic climate.
2. Bupa's supply chain was reliant on private hospitals and private consultants, each of whom had significant and increasing market power. Too often these critical suppliers simply expected care to be funded and for the prices and volume of care to rise without providing any evidence of superior quality or information to Bupa or its customers. Despite Bupa's best efforts, it struggled to control the rising costs of medical services due to structural problems in the sector.
3. Bupa believed that there were some areas in which the extent of the competition problems set out by the Competition Commission (CC) in the annotated issues statement and the resulting consumer harm might be underestimated. Three interlinked areas were: hospital market power, consultant market power and lack of information for consumers and commissioners of care.
4. First, with regards to hospital market power, Bupa was concerned about the excessive profits that the CC had found within the main hospital groups. Both barriers to entry and prices were too high. Bupa believed that private hospitals were run with little attention to efficiency, and there was a complete imbalance between hospitals on the one side and patients and insurers on the other. There were a large number of hospitals with local market power, typically in key specialisms, and many were part of hospital groups with significant scale. Patients and insurers had weak outside options when dealing with these hospitals. Bupa felt that central London was a particular concern given the dominant position of HCA.
5. Second, Bupa was very concerned about the negative impact that consultant groups had on choice and competition. Further, it believed that consultant groups were an extension of a greater fundamental competition issue, namely that individual consultants had market power. Bupa told us that there was little evidence of consultants competing on either price or quality, which left patients in a vulnerable position because there was insufficient information available to patients at the point of choosing a consultant.
6. Third, Bupa told us that radical change was needed on the amount, comparability and relevance of information published in the sector.
7. Finally, Bupa emphasized its significant concerns about the CC's thinking in the annotated issues statement that insurers' initiatives to address top-up fees would negatively impact patient choice. Bupa disagreed with this thinking. Top-up fees were often unfair to patients, but they had little choice but to pay them. There was very seldom sufficient information to assess whether the top-up fee was justified and top-ups were often presented only when the patient had little ability to switch. Bupa saw

insurers' initiatives as fundamental to preserving choice for customers who wanted affordable PMI and the peace of mind of financial surety.

The market

8. Bupa submitted a trading update to the CC showing that the market remained extremely challenging in the UK.
9. Bupa volumes had declined significantly since 2006, and Bupa was aiming to stem that decline and start to grow. It was focusing on a series of activities to manage claims and claims costs. It had introduced a programme in late 2012 to reduce overhead costs, in a bid to reduce its fixed-cost base. However, a main concern was the constraints on the supply side (hospital and consultant costs) which had driven above-inflation increases over time and made affordability a key issue for customers.
10. In 2007, Bupa sold its UK hospitals to Spire. Bupa believed there could be benefits gained from integrating provision assets with the funding assets, as in Bupa's Spanish business and Kaiser Permanente.
11. The recession had had an impact on Bupa's business, but affordability was the main issue (as could be seen in the personal market where declines predated the recession). It had seen a significant decline in numbers last year. It believed the market would continue to decline.
12. The current PMI market was highly competitive. Profitability in the market was low and declining. Bupa was keen to innovate its products, and encourage market growth, because it believed that that would be beneficial to all players in the market, not least the economy at large.

Corporate customers

13. Corporate covered both SMEs and large corporates. A high proportion of Bupa's corporate market was now channelled through intermediaries. With a reduction in the number of clients, there was a significant competition element for business in the corporate market and that competition had placed downward pressure on insurance premium prices. Growth had diminished, even though Bupa had innovated in this area of its business, bringing out a new lower-cost range of products targeting corporate organizations, in the last year. Businesses remained very uncertain about the economic climate and the escalating costs of private healthcare, so Bupa had continued to see challenges in growing this market.
14. Since the recession, health insurance was competing with other benefits such as pensions. Bupa's intermediaries were reporting that organizations were questioning whether they would be able to afford the provision of health insurance benefits for the long term.
15. Bupa had also noted that employers were shifting more risk on to employees, whereby employers offered a core health insurance benefit but any extension of this benefit came down to the individual employee.
16. In Bupa's experience corporate clients were price sensitive, and convenience for them and their employees was critical.

Personal customers

17. Bupa had lost approximately [X] per cent of its personal customers over the last four to five years and had found that customers were increasing excesses and reducing cover, for example limiting the number of family members on a policy.
18. [X] This was reflective of different dynamics. The corporate market was highly intermediated. A number of dynamics, including corporate professional procurement functions, put pressure on the margins. However, overall the market was very competitive within PMI and the overall margin was low at the current time.

Competition

19. Bupa had introduced its open referral policy as a way to try and improve the efficiency and effectiveness of the provider side of the market and to offer customers a wider choice of PMI products. Although market share was important to Bupa, it was interested in growing the health insurance sector overall and competed actively with its competitors.
20. Bupa considered the NHS as a competitor at the point of purchase of PMI (although at the point where patients came to use their PMI when they need to be treated, then the NHS was not an effective competitor). As a private medical insurer, Bupa had to continually demonstrate the value of choosing it over using the NHS, and of people paying to get access to private healthcare. However, people's experience of the NHS was complex and ranged from personal experience to what was read in the newspapers. Bupa did not believe that the money going in or coming out of the NHS had that big an impact on the market, and that ups and downs in the private healthcare market had more to do with the economic climate.
21. A second factor of the influence that the NHS was having on PMIs was the weakening bargaining power of private medical insurers over hospitals. With private hospitals taking up more NHS work, the proportion of private hospital spend that private medical insurers accounted for was diminishing and had diminished significantly in the recent past.

Pricing

22. Bupa believed that the discounts it received might be better than other insurers, but it was questionable whether the discounts sufficiently reflected the significantly higher volumes that Bupa brought to providers. However, Bupa competed with its competitors on a whole variety of factors. The market was tough with intense price competition. Bupa had also seen some of its competitors raise their commission rates to intermediaries. This could influence the advice given by intermediaries to customers and contributed to customer churn.
23. Some of Bupa's competitors were composite insurers and had broader relationships on the corporate side of the business. They had a range of products and services to offer their clients. Such companies competed in a different way to Bupa.
24. Bupa told us that some of its competitors had tended to have quite a different approach in terms of no-claims discounts and the pricing approach to new risk. Its competitors priced low to attract new business, but prices rose significantly after claims were incurred.

25. The escalation of cost and claims costs in London, where Bupa had a significant share, had caused more problems for it than any of the other insurers. Some customers were seeing increases of [X] per cent in their premiums due to the claim effects in London.

New products

26. Bupa had introduced new products in the last two years, such as Bupa Business Health Solutions, Open Referral and Bupa By You. As well as these products, it had introduced a range of services which added value to the current product range. There were further plans to expand the product range in the next few years.
27. Bupa offered its customers a variety of choices and products and services and believed that it had a responsibility to be transparent and clear when customers were buying its product. They needed to know how it would perform once they came to use it.

Local hospital market power

28. Bupa believed that there would always be certain parts of the country that might be served by just one hospital, simply because there might be a lack of demand. However, this situation had disproportionate effects that ultimately were not in Bupa's customers' interests.
29. In its issues statement response, Bupa had identified over 130 'must have' hospitals that were owned by the large hospital chains. Such hospitals could be remotely located or part of a group of hospitals with a good national footprint. The combination of large-scale hospital groups having large numbers of must-have hospitals and undertaking national pricing created a situation where there had been significant growth in hospital spend. This had been happening for over the past ten to 15 years. Must-have hospitals had significant price power, with the market power of a group being greater than that of the individual hospital.
30. In many local markets, once a hospital was established, it was unlikely that the market could support another hospital, and entry might simply raise costs.
31. Bupa explained that it was easier to negotiate with an individual hospital than with a hospital group. If there was one solus hospital owned by an independent, and it sought to leverage that significantly, an insurer would have a choice of paying what it asked and it might be manageable because of that market, but the insurer might also be able to mitigate higher prices due to factors that arose when dealing with one market at a time such as negotiating with its consultants, or offering short-term alternative provisions for certain services. The costs and challenges for the insurer, however, increased very materially when dealing with a hospital group if the insurer had to deal with a large number of local markets simultaneously.
32. Market power could be hidden across a portfolio of a hospital group and this could make it difficult to identify. It could be hidden at two levels. First, at the level of the overall contract negotiations, so that margin was being extracted from other hospitals where it would not otherwise be warranted; and secondly, at a local level. If a hospital in one local area tripled or quadrupled its prices, the members in that area would quickly reach their benefit limits, and would notice the pricing, whereas, for instance, where £50 was extracted from 65 different hospitals, the effects would not be as visible to the public.

33. Bupa worked with the vast majority of private patient units (PPUs) which represented about [x] per cent of its spend. Certain characteristics, including scale and range of services, however, meant that Bupa found that PPUs were not a good and adequate alternative to private hospitals, and did not pose a significant competitive constraint on the existing private hospital groups. In addition, the level of satisfaction of customers using NHS PPUs was generally lower than those using private hospitals. For these reasons, Bupa did not see PPUs as a good and adequate alternative. However, Bupa would welcome PPUs becoming more focused in delivering private services, since it would give itself and its customers more choice.
34. Bupa told us that a number of NHS hospitals were putting their PPUs out to tender and those tenders were being won by organizations like HCA. In Bupa's view this made the situation in the market more difficult.
35. Bupa believed that entry into the London market was difficult for hospital groups. There was much less excess capacity in London, and it was a wealthy market, with central London representing [x] per cent of Bupa's total hospital spend.
36. In Bupa's view, outer London hospitals did not provide effective competitive constraints on central London hospitals because corporate clients were keen to minimize the disruption to their employees making central London convenience of location very important. Although people had different sensitivities over price, patients (when they were ill), GPs (when referring patients) and consultants (when treating patients) were not concentrating on the price.
37. HCA had such a significant presence in London and its pricing contributed to increasing costs in central London significantly. When comparing HCA with the large national chains, such as BMI, the hospital price differential between them remained very material. Whilst there was some cost of living effect in London, Bupa felt that the observed difference was disproportionate to the effect that one might expect to see.
38. Over the years, Bupa had talked to all the national chains, saying it would welcome and recognize new hospitals to the London area which offered more innovative care. Unfortunately, none of the hospital providers had been able to enter the market. Bupa noted that the only operator to enter the market over recent years was Circle. It had recognized its hospital in Bath and then later Circle's other facilities on the basis of good commercial terms and quality.

Hospital groups

39. Bupa had a fairly systematic approach to recognizing new hospitals. It encouraged new entrants where to do so would inject competition into the market. Bupa spoke to new entrants, providing them with information to help them put together their business case and help them gain a sense of both the clinical and service requirements that Bupa required before it recognized a hospital. It was not able to guarantee recognition prior to a hospital actually being built, for technical reasons such as the need to secure regulatory approvals.
40. Bupa told us that when negotiating with a hospital operator opening a new facility, it had more strength than where it was seeking to de-recognize a hospital that already had established consultant referral patterns and member usage. However, once agreement and patterns were in place, Bupa moved into a weaker position.
41. On behalf of its customers, Bupa was always keen to drive competition and secure the best arrangements with a hospital group.

42. Bupa believed it was important for a hospital group to understand what the economics of the market were, including the number of insurance subscribers. Bupa had concerns about areas where there was limited demand, and there was one private hospital that was not fully utilized and another one opened up. Hospitals had high fixed costs, and in such circumstances what tended to happen was that the prices rose overall and customers ended up paying for it.
43. Bupa was interested in the nature of the ownership of a hospital because it believed that consultants were the key customers for a hospital. There were a variety of different models that hospitals used and incentive arrangements with consultants that could influence where they referred a patient.
44. Recognition could have an impact on Bupa's existing commercial arrangements with a hospital group. The opening of a new hospital could take away volumes that would lead to an increase in Bupa's marginal costs due to terms imposed by hospital groups. Therefore, in addition to quality and regulatory issues, the decision to recognize a new hospital also took into account commercial terms.
45. Bupa currently operated on a national pricing basis. This was a simple, efficient and straightforward approach. However, this approach also had a lot of knock-on negative effects. Therefore, Bupa was looking to adopt local pricing policies, which it believed would help the market to function better and more effectively. For instance, if excessive prices were being charged by a solus hospital then Bupa could bring it to the attention of the competition authorities; it would also give a greater incentive for another operator to enter the market and to compete in that area. In areas where the market was more competitive, Bupa would be able to negotiate more competitive prices. This approach would also allow Bupa to give its customers more choices about the range of hospitals available to them. However, Bupa told us that the existing model worked well for hospital groups, and the hospital groups had been resisting a move toward local pricing.

Negotiations

46. When opening negotiations with a hospital group, Bupa considered a number of factors. Along with the price, quality of service and customer satisfaction were also important. Bupa tried to standardize its contract across the hospital providers. This allowed it to ensure that it was treating the providers fairly and looked at areas where there would be differences in a way that was robust and that stood up to scrutiny.
47. Bupa undertook extensive quality assurance programmes on all its facilities. This consisted of an assessment of over 300 items of quality including hard clinical outcomes and customer satisfaction, such as the way a provider handled complaints. There was a minimum level that a hospital provider needed to reach in order to get Bupa recognition. Bupa also monitored and ran quality assurance programmes which included monitoring and engagement with the Care Quality Commission on its inspections, and management and identification of root cause of complaints. It ran an extensive customer satisfaction survey, which looked at a wide range of variables.
48. Bupa had two other considerations when negotiating with large hospital groups:
(a) the aggregate and overall revenue increases that resulted from features such as over-treatment or over-testing, and putting controls in place to try to address those;
and (b) clauses or restrictions that would remove competition, and trying to remove these from contracts.
49. Bupa had concerns about the 'one in all in' aspect of contracts with hospital groups as it believed it prevented effective local competition. Negotiations with BMI in 2011

had led to Bupa delisting 12 of BMI's hospitals. It was important to Bupa to have successful negotiations for the sake of its customers and its reputation. Bupa told us that the threat of delisting was not such a credible threat or powerful tool as to enhance its position in negotiations and moving towards local pricing, because it carried a significant risk of reputational damage to Bupa as it had learned from the BMI situation.

50. In general, hospital groups had the ability, when in a dispute, to raise prices at the must-have hospitals which gave them the cash and the returns to sustain a dispute. Bupa did not have a similar ability to raise additional cash from its members.
51. Bupa would be interested in offering alternatives of networks to policyholders. An example was Bupa's low-cost network, which offered customers a smaller number of hospitals to choose from, depending on the area in which they lived. Unfortunately, agreement for the network could not be reached with some providers. Open referrals was one means of guiding volume and rewarding hospitals that were most cost-effective within a network framework. Bupa sought to gain influence over care pathways to ensure that people were not over-treated, and Bupa used service line tenders to manage value on behalf of its members. Service line tenders also helped Bupa systematize and standardize quality. However, Bupa had met resistance from hospital providers when some hospitals were not recognized on a network because they did not offer the best value for money.
52. Bupa was keen to offer customers in different parts of the country a wide range of choices where they could trade off access to hospital, either for whole services or for specialist services, in terms of the price that they paid. In order for Bupa to be able to do that, it needed active participation by the main provider groups and a local competitive tension that did not currently exist.
53. During negotiations, Bupa said the large hospital providers' main ambition was to increase their revenue envelope. The hospital providers' prices increased every year. Many saw the Bupa volume as a right and something they sought to protect. In negotiations, Bupa was always considering its best alternative to a negotiated agreement, which quantified the likely costs Bupa faced if it fell out of agreement with a provider and the alternative provision that was available to its members. Where Bupa was not in a position to walk away from a significant part of a hospital's volume, the hospital could increase the price and hold Bupa to ransom.
54. Bupa told us that it did have some negotiating power, and it pointed to the example of open referral as support for this point. However, while this offered some minor restraint on hospitals, the negotiating power remained unbalanced when the providers retained the ability simply to extract price in other areas.
55. One hospital group increased its revenue beyond the headline unit price by introducing new services, usually without consultation with Bupa, and often with services of a dubious clinical outcome value. This led to the hospital group optimizing revenue rather than driving any efficiencies forward.
56. Bupa told us that one of the things that it attempted to do in bargaining was to look at the alternative providers before negotiating with a particular hospital group. However, the alternative options available, in Bupa's view, were usually very limited.
57. Ultimately, Bupa would like to reach a position which opened up further volume in the market—not just revenue increase but volume increase of customers coming into the market. If Bupa could find a network solution at a price point that improved afford-

ability of PMI and delivered value for money to its members, Bupa would want to offer such a network.

58. Bupa's aim during negotiations with hospital providers was to deliver high-quality care and offer better value for money for its customers. In terms of achieving that, Bupa sought to consolidate volume in exchange for lower prices and superior quality. Customers would have the option of trading price and travel time, and hence would be offered a narrow network, which would include coverage at a more restricted group of hospitals. Customers who valued convenience and locality would be offered a wider network. Networks would vary depending on customer needs. Hospitals would be used selectively depending on customer needs.

Hospital costs

59. Bupa believed that the NHS was in a position to give and withdraw business from private hospital groups at any time. This gave the NHS the ability to negotiate better rates. PMI providers who were locked in to needing private provision because of established patient pathways and repeat business, continuity of care etc, paid higher prices. NHS work was welcomed by many of the private hospital groups because it was predictable. BMI, for example, had progressively opened up more and more of its capacity to the NHS.
60. In so far as was possible, Bupa carried out analysis of individual hospital prices, so that it could look at episode costs, utilization of ancillary services, post-operative discharge etc. However, this was not always easy. Outpatient prices were not currently consistently coded and Bupa was unable to do the same analysis. Prices for similar procedures between hospitals varied considerably. This reflected a real focus on hospitals of moving charges around across different service lines to maintain revenue, but it did not necessarily bear a strong correlation with the underlying costs.
61. In Bupa's view, outpatient charges had been escalating and were particularly difficult to restrain. Bupa offered products to both corporate and personal customers where the customer could select a limit on outpatient benefit. Having an outpatient benefit limit made policies more affordable, but it was really a sub-optimal way of managing outpatient costs, because at some point the patient was likely to run out of benefit and have to pay further outpatient costs themselves or return to the NHS. This was a device that had been in the sector for a long time to constrain the cost of premiums. The problem for the customer was getting worse. With the inflation of outpatient costs, customers' limits were being reached quicker. This was one reason why Bupa wanted to have greater ability to manage outpatient charges from both hospitals and consultants. Bupa was aware that it was difficult for a customer to know when purchasing a policy what actual condition they were going to get and what treatment was likely to cost prior to going to an initial consultation.
62. The private sector currently lagged behind the NHS in the proportion of care that was being delivered in lower cost settings. This included day-case and outpatient treatment. Moving care into a lower cost setting was not necessarily in the private hospital providers' interests. One of the big trends that Bupa had been trying to promote was to have care delivered at home. Such care, eg chemotherapy, was a significant advantage to the patient in terms of experience and being more cost-effective, but faced resistance by some private hospital groups. Consultants and the issue of consultant incentives—for example, free secretarial service, billing arrangements—also impacted on offering healthcare at a patient's home. These arrangements tended to create barriers.

Consultants

63. In Bupa's view, individual consultants had market power and there was little evidence of any competition between consultants on either price or quality. With insufficient information at the point of choosing a consultant, the patient was left in a vulnerable position. Benefit maxima had helped constrain surgical fees, but this covered under half of the consultant's private earnings. Bupa had seen significant outpatient consultation fee inflation in the segment of fees currently unconstrained by maxima. In addition, some consultants over-treated and diagnosed, not always consciously, while accruing commercial benefits and risking harm to patients. There were both price and volume dimensions through which consultants exercised power.
64. Bupa believed that consultant fees were generous and lucrative. After reviewing comparable procedure prices in the USA, Australia and Canada, Bupa had found that the rates in the UK were, on average, higher.
65. Bupa told us that it was important for it to maintain a good supply of consultants for its patients and it was careful to monitor the supply of consultants in all specialities all over the country. Bupa had seen no signs of consultant exit from the market and signed up around 100 new consultants a month.
66. Over the past 18 months Bupa had been working through certain procedure prices that it paid and the relative ranking of each procedure versus other similar procedures on things like the level of skill required, the time it took, the level of risk associated and the level of experience that a doctor required to carry out the procedure. The levels of hourly rate were currently normally between £300 and £700.
67. Bupa did not stop its patients from seeing a consultant if they charged a top-up fee. Top-ups were not an ideal situation by any means and customers did not like it. Indeed, Bupa received significant numbers of complaints about consultants charging top-up fees. There was no evidence that the actions Bupa was taking to try to control top-up fees, which were for the benefit of the consumer, were limiting choice in any material way. Bupa tried to guide patients, via its open referrals system, towards consultants who charged within its benefit maxima, but that was for many patients quite difficult, because they felt compelled to follow their GP's recommendation. In addition, when patients called up to pre-authorize with Bupa and they were going to see a consultant who charged top-up fees, Bupa pointed that out. However, Bupa would not require a patient to see an alternative consultant.
68. For top-up fees to work, Bupa believed that patients needed to have full financial information explained to them and agreed in advance. The patient then must have the information and the ability to judge the value for money of that consultant versus a potential alternative. Such information must be available to them at a point when they could realistically switch consultants. Unfortunately, patients rarely found out about top-up fees until after they had seen the consultant or sometimes after they had had their procedure. It was not then realistic for them to switch to another consultant.
69. Under Bupa's new consultant contract, which was introduced in June 2010, consultants whose rates were not within Bupa's benefit maxima would not be recognized. The number of consultants who had declined Bupa recognition on the basis of those fees was extremely low, which meant that patient choice had not been affected.

Open referral

70. Bupa's open referral scheme was only available to its corporate clients. Eight out of ten of Bupa's new and current corporate clients had chosen the open referral scheme. Bupa believed that the scheme, which was not mandatory, offered better management of the costs of employees' care, without compromising on benefits, eg outpatient benefit limits or excesses. Secondly, the scheme offered a better employee experience, and finally, Bupa believed that over time the scheme would encourage consultants to use better care practices.
71. The main role for Bupa when applying its open referral scheme was to offer a selection of consultants for a customer to choose from. Bupa believed that within the GP referral process, the information that GPs were working from was very poor. GPs had limited quality or cost information and indeed little interest in cost. Bupa, on the other hand looked at consultant care practices. Bupa felt that it had more information and could therefore better guide this part of the referral process. Bupa did not stop a customer from choosing their own consultant on the basis of a shortfall. However, a Bupa-contracted consultant would be in breach of their contract if they did go outside of the maxima set by Bupa.
72. All of Bupa's consultants were quality assured. Bupa also used the General Medical Council to gain information on the speciality and sub-specialty of each consultant. Further information was gathered on the procedures that each consultant undertook on Bupa's members, the nature of the complaints that it received about them, issues on outcomes and features of a consultant's clinical practice.
73. Bupa believed that its open referral system could often speed up the patient receiving treatment, since customers were referred to an appropriate specialist more quickly and were able to change consultant very easily if their first choice was busy. The satisfaction from members who used Open Referral was high.
74. Bupa had a consultant profiling system which it used to score each consultant. This was used to decide which consultant would go through into the open referral structure. Although Bupa published the general criteria on which it ranked each consultant, the consultants could not see where they were ranked or the factors included in the profiling.
75. The purpose and objective of the open referral system was about giving patients more choice, managing costs and managing some variations in treatment patterns. It was also about ensuring greater peace of mind for the employees of the companies who were buying these schemes, because it could guarantee no shortfalls for them. Bupa believed that it was a way to get patients to consultants who it considered to be driving better care practices.
76. Bupa felt it faced a communication challenge. People found it difficult to believe that better quality healthcare was also often, almost usually, cheaper healthcare and that customers' often incorrect perception was that higher prices meant better treatment.
77. Research showed that there was an over-treatment issue and a lack of competition between the players. Bupa had a mapping technology which enabled it to look at a larger statistical sample and spot, for example, treatment variations.
78. Finally, Bupa explained that it was interested in giving the best value care possible to its members. This involved a combination of the consultants they saw, how the consultants practised and what they charged, and the facilities in which the member was treated. Bupa believed that the open referral system should get the consultants

interested in where and how they practised and how the decisions they were making contributed to the end-to-end costs of care. Bupa's aim was to create an alignment among the different players to focus on the quality of the care that was being delivered, how much of it there was, where it was, and did it conform to best practice.

Consultant groups

79. Bupa was concerned about the negative impact that consultant groups had on choice and competition. In Bupa's experience, the formation of consultant groups, eg anaesthetists, had led to increased charges with the propensity and frequency of shortfalls being greater. Groups of consultants tended to work together both privately and within the NHS, which made it difficult for consultants entering the market to stand alone. Inevitably, they joined the group which resulted in a restriction of choice. In fact, in some parts of the country there was no anaesthetist who charged within Bupa's benefit limits within more than 50 miles.
80. Bupa's preference would be for hospitals to take on the responsibility of arranging the anaesthetist and arranging the settlement of the fees. That would mean that it was no longer a problem for the individual member, as part of Bupa's negotiations with the hospital, individual hospital or a group, would include anaesthetists and their fees.
81. Bupa told us about occasions where it had experienced some consultant groups behaving in ways that, in its view, contravened competition law both in terms of price fixing between groups and in terms of dominant groups abusing their positions over patients.
82. Other consultant groups were approaching hospitals and offering to work alongside them, offering to bring their work to the hospital for a cut of fee that the hospital received.
83. There was no central list of consultant groups, and individuals often charged under their own name, although they were charging at the group rate.
84. Anaesthetist groups were a concern, but they were just an extension of individual consultants facing no competition and having market power themselves, which resulted in outpatient fees rising well above inflation. It also resulted in over-treatment which could not be addressed because there was no information getting published about the performance or activity. Bupa felt that market power could be felt through dimensions other than price.

Consultant incentives

85. Bupa was concerned about the consultant incentives. They added cost into the system, distorted the market and brought no patient benefit.
86. With regard to hospital groups acquiring private GP practices, Bupa saw this as operating against the customer's interest. The reason for doing it was to own more of the value chain, but it also served as the mechanism for generating more referrals into the owners' hospitals. Bupa felt that it was going to make an existing situation, where it saw high costs, over diagnosis and over intervention, worse.

Information

87. Bupa believed that radical change was needed on the amount, comparability and relevance of information published in the sector. The information gap was holding the

whole system back, preventing effective decision making by consumers, GPs and insurers, and hiding unwarranted treatment variation.

88. With regards to top-up fees, Bupa believed that although they were often unfair to patients, they had little choice but to pay them. There was seldom sufficient information to assess whether the top-up fee was justified and top-ups were often presented only when the patient had little ability to switch. There was the risk that consultants took advantage of patients' trust and vulnerability, particularly when the value of the service was difficult to assess in advance. Bupa would be concerned about any reduction of insurers' ability to provide customers with financial certainty around the costs of their treatment. To do so could lead to customers facing unexpected charges for their care.
89. GPs on the whole tended to be focused on the NHS. Bupa referred to the CC's survey analysis which showed that on average GPs referred just five patients a month to the private sector. It was difficult to see how any information solution would help with regards to GPs. Collating quality information was a real specialist skill which required special qualifications. The NHS already collected information through a system called HES and private sector entities, such as Dr Foster, used that data and packaged it and made it available to customers in a more accessible and understandable way.
90. One of the challenges in the private sector was that there was no common data being collected across the hospitals or across the consultants. If that data pool was available, then private sector entities could innovate the way that they delivered that data to GPs or through an NHS Choices equivalent website, but the fundamental requirement was standardized input.
91. Finally, Bupa told us that its 'consultant finder' database was publicly available on the Internet and it believed there was no reason why other insurers could not do the same.