

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with Western Provident Association held on 6 February 2013

Background

1. Western Provident Association (WPA), a not-for-profit organization, had a history of indemnifying its customers' healthcare costs going back over 100 years. It believed that the provision of private healthcare services in the UK should complement that of the NHS, not be in competition with or an alternative to the NHS. In its view, the private healthcare sector was about individuals exercising choices in their healthcare needs, whilst at the same time saving the NHS money.
2. The unique nature of the industry, whereby the patient was economically separated from the medical provider, had given rise in many cases to price abuse. WPA was clear in its view that the referral process, by which private patients accessed private healthcare facilities, had given rise to the exploitation of the monopoly position which many providers had to the detriment of insured customers. The consultant was, in most cases, the real customer of the hospitals.
3. Patients should enjoy the same consumer protection principles that the rest of society enjoyed. The key to this, WPA believed, was transparency of the cost and quality of treatment in order to allow consumers to make properly informed choices.

Business

4. WPA's business was broken down into three broadly equal parts: private clients, SMEs (small corporate) and large corporate clients. The private client and SME business was fully-insured business whereas the large corporate business was primarily administration-only business.
5. During the last few years WPA had secured a stable customer base, with a steady increase in its small corporate customers and larger growth in its large corporate customers. WPA had also been able to maintain a profit (or surplus) of around 1 to 2 per cent. It also had an investment income which had broadly followed the fortunes of the economy in terms of investment returns.
6. With regard to the personal market, approximately 87 per cent of customers renewed their policy last year. WPA believed that this figure was probably 5 per cent above the market average. WPA had a sales force of about 85 or 90 self-employed franchisee operations around the UK selling its products, and they were successful in topping up the balance.
7. 85 per cent of WPA's large corporate clients were brought in through brokers and it believed that recent increases in its share of the corporate market were due to WPA's general reputation for good customer service within the industry and ability to manage claims costs effectively.
8. However, medical inflation for its fully-insured customers, which covered the hospital costs, increased incidence of claim, new treatments and drugs were constantly rising and this impacted on policy costs which had risen by around 6 to 10 per cent, depending on the age profile of the customer in an area. WPA experienced continual

pressure with price rises from hospital providers, and in particular those in central London.

Patient pathway

9. WPA did not operate an open referral system, instead keeping to the traditional approach of freedom to choose. It published a list of customary and reasonable fees that it reimbursed to consultants on behalf of customers and this was used as a way of mediating the prices charged by consultants.
10. Although WPA had total control over what it would reimburse consultants, consultants were free to charge more but WPA insisted that they tell their patients up front. If a consultant's fee was higher than WPA was willing to pay, it would contact the consultant, as part of its pre-authorization process, to see whether they would be willing to reduce their fee. If not, WPA would feed this back to the patient. The customer could then make an informed choice.
11. Broadly, as long as a consultant had a licence to practise at a consultant level within the NHS, WPA was happy to recognize them.
12. WPA's relationship with hospitals was much more complex than the one it had with consultants. This was because to a higher degree the hospitals rather than WPA determined the pricing structure.

Switching

13. WPA told us that private customers with identified existing medical conditions on their policy may find it difficult to switch insurer. Another insurer may well be unwilling to include pre-existing conditions in a new policy. WPA saw it as its duty to try and keep its policies affordable. One way of doing this had been the introduction of shared responsibility, by which the patient elected to choose to pay a percentage of any treatment costs up to an agreed limit with the balance being fully funded by WPA. This type of policy would be attractive to somebody who was not expecting to make a claim. WPA found that this approach worked extremely well in making premiums affordable. WPA was aware of one, possibly two, companies that offered a similar type of policy.
14. Although WPA could not be sure, it felt that half to three-quarters of private customers it lost in the last year had exited the market completely. With regard to the small corporate market, approximately 60 per cent of the customers it lost would be switching to WPA's competitors, some gave up their policies and some reduced the number of people covered under the corporate scheme.
15. Another angle to the switching market was the large number of companies which had moved in and out of the private health insurance market over the years. There was no continuity for customers, particularly for private customers. WPA believed that security came from the many companies which were permanent fixtures to the market. The challenge for WPA was to keep premiums affordable in order to provide that security for customers.
16. An existing customer would always have a choice of products, so to switch policy was always an option for a customer. However, if they had got a pre-existing problem which was likely to recur, a private individual would find it difficult to move. There were some products available with moratorium periods in the market, although WPA had only a limited offering. Its approach was to price across each risk pool and whilst

it was a fact of life that claims costs for an individual aged 80 to 85 would be ten times higher than for someone 18 to 25, premiums needed to reflect that it did not differentiate between those had made claims and those that did not. WPA did not do no-claims discounts as this would severely distort the market by making it impossible to set effectively the correct premium level based on a fully-insured pot. Customers would find that their premiums would increase significantly if they made a claim. If they were then to exit the market they might find it more difficult to find cover as they would have a pre-existing condition.

Competitive position

17. WPA also had very good systems in place to deal with claims and was able to identify duplicate invoices and erroneous billing. This could account for 5 per cent of the bill.
18. WPA was also good at managing more complex cases successfully. It worked with customers to try and ensure that their treatment and stay in hospital was appropriate and fair. WPA worked very effectively on claims management.

Profitability

19. WPA earned a modest underwriting profit over the last ten years, with its main aim being to break even or make a 1 or 2 per cent surplus on the insurance side each year.
20. WPA had some concerns over the affordability of the private healthcare market in the medium term and there were some areas where it felt costs were rising at a level which was not sustainable.
21. The individual market was an area of greatest concern, because WPA was competing with a product that was free at the point of delivery with the NHS. However, if the NHS had funding or treatment availability problems, then as long as the private healthcare systems remained affordable there would always be a market.
22. WPA had seen medical inflation and premium increases over the last ten years. This was probably year on year about 6 to 10 per cent in the private market, and more so with the very elderly customers who, in many cases, had seen 12 or 15 per cent price rises and may be on high premiums of up to £4,000–£5,000. Although this was little more than the inclusive cost of an operation and overnight stay in hospital, this rise clearly would, at some point, become unsustainable. WPA spent a lot of time looking at innovative ways to try to help avoid putting up its premiums by 10 or 15 per cent.
23. WPA believed there were advantages to scale and there was a potential risk that the two larger insurers could be in a position where they could dictate terms with consultants and hospitals. This could also lead to the consultants and hospitals pushing up their prices for the smaller insurers.
24. WPA's customer base had remained solid over the last year or two and on the larger corporate side it had seen growth, because people liked WPA's ethos and culture of how it looked after customers and how it operated with the providers of healthcare. In WPA's view customers would exit the sector in droves if it adopted the approach whereby it chose the patient's consultant and hospital and what treatment they should have. The purpose of private medical insurance was to facilitate choice to enable patients to follow the clinical advice of people who knew them and who were medically qualified.

Market power

25. It was important for WPA to agree terms with the larger hospital providers so that it provided a large geographical base for its customers, providing access to as many hospitals as possible across the country.
26. There were some private patient units (PPUs) in the provinces which were generally smaller than the private hospitals, and WPA was very supportive of them.

Referral process

27. In eight times out of ten a patient was referred by their GP to a named consultant. Where that consultant had their consulting rooms was a big predeterminant of which hospital they were seen at. In many cases the hospitals were not invariably providing highly competitive prices. No prices were published, or if they were they bore no relationship in reality to what anybody paid, except maybe an overseas visitor. WPA's solution would be to require hospitals to publish their tariffs.
28. WPA queried the different prices paid by insured and self-pay customers. Some uninsured patients were often charged 50 to 60 per cent less simply for paying by cash or credit card. This was not a competitive practice and showed a market that was taking advantage of its monopolistic position.

Negotiations

29. Since the majority of hospital groups had centralized billing systems, WPA generally paid a national rate for their services. It often paid some hospitals a London surcharge for hospitals based inside the M25, but it was done on a national basis.
30. WPA had a system that provided it with an accurate picture of treatment costs. However, between the hospitals the cost charged for the same item of service often varied significantly. WPA believed that the hospitals were spending a lot of time looking at controlling their costs internally, but that was very different from putting the same degree of control on the prices which they looked to charge the insurers.
31. WPA had identified certain areas, eg pathology, where prices had increased dramatically over recent years. There were also significant price differences for tests carried out as an inpatient or an outpatient. Treatment prices also varied quite a lot from hospital to hospital. However, WPA was not in a position to pick and choose which procedures were carried out at individual hospitals. It was also not able to negotiate contracts with individual hospitals within a larger hospital networks.
32. A PPU working in partnership with a private partner would charge private sector prices.
33. WPA did offer its customers the option of not having access to premium hospitals, agreement of which would reduce the price of the policy.

Recognition of hospitals

34. WPA was content to recognize hospitals that met the appropriate Care Quality Commission (regulator) standard. Once approved, WPA started negotiations on pricing. WPA worked hard to contain costs which enabled it to pass on competitive premiums to its customers. This also meant that it could compete with the larger corporates.

35. WPA tried to ensure that the customer was made aware of any shortfall as early in the process as possible.

Consultants

36. WPA believed that the market for consultant fees was competitive and enjoyed good relations with the consultant bodies. As long as fees were clear and available to the patient up front then an informed choice could be made. After taking advice from clinical medical advisers and medical colleagues, WPA might not pay the full fee, and again it was up to the patient if they wished to see a particular consultant and pay the shortfall.
37. WPA had concerns about anaesthetist groups. The formation of such groups had driven up prices. If a group at a particular locality were to charge, say, 30 or 50 per cent more across the whole of its group, there would be no alternative choice for the customer. WPA believed that if anaesthetists were obliged to publish their tariffs, it would make the market more open and transparent.
38. With regard to the NHS, WPA said that NHS prices were not based on a like-for-like basis as was historically done in the private sector. NHS treatment costs were based on Healthcare Resource Group (HRG) codes.
39. WPA did not necessarily follow the examples of the market unless there was an industry-wide change that would benefit the industry as a whole.
40. WPA regularly reviewed its customary and reasonable fee levels for reimbursing consultants on the approximately 2,000 listed procedures. If a consultant were to make a representation to WPA regarding the fee for a particular procedure, it would investigate the charge and, if appropriate, adjust it accordingly. It also compared its fee maxima with those of its competitors.
41. WPA was aware that some consultants were, due to low increases in fees from some insurers, finding it difficult to continue working in private practice as their insurance and administration costs had increased over the years.

Vertical integration

42. WPA had some concerns over hospital groups in central London having GP and outreach centres, and the influence they would have over the patient experience and referral patterns.
43. WPA was aware of incentives being given to consultants by various hospitals, eg preferential theatre slots. Such incentives were wrong and consultants should be dealt with in a straightforward manner. WPA saw no problem with consultants owning a share of, for example, an MRI centre, as long as such an interest was dealt with in an open and transparent way.
44. Although the chance had arisen, WPA was against forming Preferred Provider agreements with hospital groups, which might lead to reduced rates at the expense of excluding other hospitals or restricting customer choice.

Referrals

45. WPA believed that GPs invariably worked with the local consultants and over time built up a picture of those who provided a good service. Such reputations would be

used as part of the referral process. WPA was not aware of any inappropriate influence on the way GPs went about decisions on referrals.