

Bupa Health Funding

Response to Working Paper

Information Availability

1) Overview

- 1.1 Bupa Health Funding (“BHF”) welcomes the Working Paper assessing “*Information Availability*” (“the Working Paper”) published by the Competition Commission (“CC”) on 14 June 2013.
- 1.2 This response sets out BHF’s comments on the Working Paper, although these comments are necessarily brief given the very limited period of time the CC has given to respond to the Working Paper.
- 1.3 The Working Paper assesses information availability at four stages of the customer pathway; we assess each in turn. Some overarching comments on the Working Paper and suggestions as to where BHF believes the CC could usefully focus are set out below:
 - i. **Commissioners of care.** The Working Paper focuses on information available to patients. However, it is equally important to consider whether robust information is being made available to commissioners of care (insurers). Private Medical Insurance (“PMI”) customers place high expectations on their insurers to achieve value for money from hospitals/consultants and to monitor the care provided by hospitals/consultants¹. However, currently the provision of data by private hospitals to insurers is inconsistent and patchy, and by private consultants is almost entirely absent. The measures discussed in the Working Paper are insufficient in that respect. For example, the PHIN website portal is currently of limited use to insurers in commissioning.
 - ii. **Standardisation of activity/impairment coding.** Critical to improving commissioning of care in the private healthcare sector, and so increasing competition between private healthcare providers, will be a greater **standardisation** in the way hospitals and consultants record activity data (i.e. the treatments actually delivered) as well as patient impairment information (i.e. the illness the patient presents with). Currently, [redacted]², [redacted]. Therefore, a beneficial outcome from the CC investigation would be to ensure that private healthcare providers are obliged to adhere to mandatory participation in common coding (for both treatment activity and patient impairment information) and coding standards of conduct. Provision of information in this standardised way would significantly improve benchmarking, analysis of treatment variation, and ultimately competition between providers. The CC could look at how the NHS uses the Hospital Episode Statistics (“HES”) dataset as an example of how competition between providers and quality overall can be improved through benchmarking/commissioning on the basis of standardised data.
 - iii. **Ability.** The Working Paper focuses on whether or not information is available to patients, rather than whether patients (or GPs) have any incentive or ability to use the available information. Patients must be able to act on the information available. For example, at the

¹ For example, customer research shows 89% of customers expect their insurer to monitor hospitals to ensure they offer high standards of care and follow best clinical practices (against only 4% who do not have this expectation); and, 87% expect their insurer to monitor consultants to ensure they offer high standards of care and follow best clinical practices (against only 5% who disagree).

²[redacted]

point at which the patient needs to use information on treatment options, they are often ill and vulnerable. Patients tend, therefore, to rely heavily on the advice of the consultant and are not in a position to challenge the consultant's advice i.e. they do not act on the information even if it is available. There must be a responsibility on the consultant to explain the full range of options to the patient and to support the patient in making a shared decision (and that advice must be impartial). This does not take place consistently in BHF's experience. For example, since launching the Treatment Options Service³ BHF has heard many cases of consultants who frequently present surgery as the only option without making the patient aware that less invasive treatment options are available.

- iv. **Patient safety.** The lack of published, comparable data on private hospitals and consultants not only weakens choice, but creates a significant patient safety risk. It prevents the regulators (like the Care Quality Commission ("CQC") and General Medical Council) from monitoring provider activity and identifying outliers as they are able to do in the NHS. The CQC, for example, does not have the same visibility of private hospitals as it has over NHS hospitals. Further publication of data would be required on this basis alone.
- v. **Unintended consequences.** Increasing information in the sector must be done with care. For example, publishing price data without any comparable information on quality could drive inappropriate decisions. Patients may incorrectly assume price is a signal of quality, with the result that prices are driven upwards. It may also facilitate coordination on price by providers given the highly concentrated local markets.

2) Choosing a private medical insurance policy

- 2.1 BHF welcomes the CC's conclusions that "*private medical insurance policy terms have been sufficiently transparent to customers at point of purchase that they [patients] have not reported, through surveys, dissatisfaction or disappointment at the point of claim*" (para 34).
- 2.2 BHF also welcomes the recognition by the Financial Conduct Authority ("FCA") that "*it did not currently feel that any changes to the rules for PMIs [about making clear the possibility the customers may face shortfalls] were necessary or appropriate*" (para 9).

Comments from the public

- 2.3 The CC cites survey evidence, a *Which?* survey of 3,000 customers for example, showing customers have high satisfaction levels with their PMI providers. We include in Annex A further survey evidence that reinforces that customers recognise the value for money of their PMI.
- 2.4 The high satisfaction levels are further evidenced by the extremely low numbers of complaints about PMI made to the Financial Ombudsman Service ("FOS"). There were only 949 complaints about PMI to FOS between March 2012 and March 2013, despite the industry serving over 5 million people (and many customers making multiple separate claims each year).
- 2.5 The CC notes concerns from some members of the public that BHF had reduced benefit maxima for some procedures without informing them. As the CC is aware, BHF adjusted a small number of its benefit maxima in 2012 following an evidence-based review of how the relative

³ This service, available to all of our members free or charge, gives the member access to a team of experienced nurses who can spend time discussing the various treatment options available to the patient.

complexity of procedures had changed over time⁴. We note that our standard policy terms allow us to vary the Schedule of Procedures from time to time. [§<].

2.6 We welcome the acknowledgement that it was “very rare” for consumers to complain that their insurer had directed them to an inappropriate consultant.

Comments about BHF FSA/FOS complaints

2.7 The CC notes that “the number of complaints notified to the Regulator by Bupa and the number of new PMI cases received by the FOS has been rising quite sharply but it is not clear why” (para. 36). We explain below why complaints have risen.

FSA-reportable complaints

2.8 As important context the following must be noted:

- i. The FSA defines a complaint as: “Any expression of dissatisfaction, whether oral or written, and whether justified or not, from or on behalf of an eligible complainant about the firm’s provision of, or failure to provide, a financial service”⁵.
- ii. A customer complaint becomes reportable to the FSA if it has not been resolved by the end of the next business day following receipt of the complaint.
- iii. The fact that a complaint becomes reportable to the FSA does not necessarily mean that the insurer was at fault in the matter, but merely that the insurer was unable to resolve the matter to the satisfaction of the customer before the FSA deadline (end of next business day).
- iv. [§<].

2.9 The Working Paper sets out complaints reported to the FSA by the four largest PMIs; the annual totals are summarised in Table 1 below. This shows that Bupa Insurance Services (“BISL”)⁶ complaints increased by around 50% between 2010 and 2012. Aviva and Prudential also experienced significant rises.

Table 1: Complaints notified to FSA, 2010 to 2012

	BISL	AXA	Aviva	Prudential	Top 4 PMI
2010	8,090	3,356	1,891	1,374	14,711
2011	10,143	3,449	1,783	1,646	17,021
2012	12,165	2,729	3,544	1,878	20,316
% change 2010 to 2012	150.4%	81.3%	187.4%	136.7%	138.1%

Source: Table 3 of Working Paper

2.10 A number of reasons underpin the increase in BISL reportable complaints over the period. The CC is, however, incorrect to imply a link between rising reportable complaints and the new consultant contract⁷. As noted to the CC previously, there is no logical reason why the new consultant contract would lead to increased customer complaints given that it would have improved the customer experience by reducing the number of shortfalls faced by customers.

⁴ [§<]

⁵ see http://www.tcfinfo.co.uk/site/107/What_is_a_complaint.aspx

⁶ BISL is the regulated entity that includes both Bupa Health Funding and Bupa International.

⁷ Indeed, the new consultant contract was launched in June 2010, and FSA reportable complaints were at their lowest in the half-year directly following this launch.

2.11 Figure 1 shows that 2010 was a year of relatively low reportable complaints.

Figure 1: [REDACTED]

2.12 [REDACTED].

2.13 In May 2011 the FSA published CP10/11⁸ which set out the new rules relating to the complaints handling process. In particular, CP10/11:

- i. Abolished the two-stage complaints-handling process. This means that customers have a right to go to FOS based on the first response from the insurer. Firms were given until 1 July 2012 to make this change;
- ii. Required firms to identify a senior individual responsible for complaints handling; and
- iii. Set out guidance on how firms can meet existing requirements relating to root cause analysis and taking account of ombudsman decisions and other guidance.

2.14 [REDACTED].

2.15 [REDACTED].

2.16 [REDACTED].

2.17 [REDACTED].

2.18 At the same time as these complaints-handling changes, BHF has had seen an increase in registered complaints from:

- i. Many customers have continued to complain about the size of premium increases that is driven directly by rising healthcare costs⁹. [REDACTED].
- ii. The very public dispute between BHF and BMI hospitals in late 2011 and early 2012.
- iii. The complexity review of benefit maxima in certain specialisms. Consultants angered by these changes sought to apply pressure to BHF through encouraging patients to complain¹⁰, through a media push that created uncertainty amongst the BHF membership, and through shortfaling patients.

2.19 Therefore, a number of events – internal and external – impacted the number of complaints BHF reports to the FSA. **The observed trend cannot be attributed to any one factor**; and we do not believe it can be fully attributed to the new consultant contract. [REDACTED].

FOS Complaints

2.20 The CC notes that there was an 85% increase in the number of FOS complaints related to PMI received in the year to March 2013 (compared to previous year to March 2012). At an industry

⁸ http://www.fsa.gov.uk/pubs/cp/cp11_10.pdf

⁹ For example, as the CC notes in its Central London Working Paper, hospital revenues in London have been rising at 8% per annum since 2009 which is significant when you consider the falls in PMI customer numbers over the same period.

¹⁰ See for example a patient leaflet prepared by FIPO explaining that patients should register complaints with Bupa and FOS at <http://www.sportsortho.co.uk/data/documents/FIPO%20-%20Patient%20Leaflet%20-%20May%202012%20.pdf>

level, the increase in FOS complaints about PMI is likely to be due to (i) increased propensity to complaint because of PPI, and (ii) the move to the one-stage complaint-handling process ([§<], and for all insurers by 1 July 2012 at the latest).

- 2.21 BISL (BHF and BI) had 319 FOS complaints in 2012. [§<] of these complaints related to BHF ([§<] in H1 2012 and [§<] in H2 2012). Given the 946 complaints relating to PMI in the year to March 2013, BHF's share of FOS complaints remains **significantly below** the number of complaints that would be predicted by our percentage share of the PMI market. Most importantly, over [§<] of BHF's decisions in relation to these [§<] complaints were upheld by FOS in 2012, which is in line with peers and well above the General Insurance industry average.
- 2.22 While the level of complaints made to FOS regarding BHF will have been affected by the factors noted in above, [§<].

3) Choosing a treatment

- 3.1 BHF is concerned that the CC appears to dismiss concerns about unwarranted variation in the private sector. The CC, for example, explains that measuring overtreatment is difficult because finding an appropriate benchmark is difficult. It then concludes: *“Even if it could be shown that unwarranted over-treatment was commonplace, on the basis of this, albeit limited, review we think that lack of consumer information or information asymmetry regarding treatment options would be unlikely to be its cause. We think that there is a great deal of information available to consumers about the treatment options available to them for many common conditions”* (paragraph 55).
- 3.2 First, there is significant unwarranted variation among private providers (which can be seen without needing to consider any external benchmark). Commissioners of care must be given sufficient data to compare the practices of private consultants and hospitals with their peers within the private sector to identify those hospitals or consultants whose performance is not typical. Therefore, the fact that it is challenging to find an external benchmark should not override the importance of getting more comparable data from hospitals/consultants.
- 3.3 Second, the CC overestimates patients' ability to use shared-decision making information to influence the options being set out by their consultant, since the patient is to a large degree reliant on the consultant and in a vulnerable position. If the consultant presents surgery as the only option (simply because that is what the consultant gets paid most for under a fee-for-service arrangement), then the majority of patients are unlikely to be able to second-guess this prescription even if they have access to information on other options.

4) Choosing a consultant

- 4.1 BHF agrees that patients, GPs and insurers do not have access to sufficient professional information (including clinical quality) and financial information (including membership of incentive schemes) of consultants. This clear deficiency must be remedied. Without this information there can be no effective competition between consultants or informed value for money decision-making by patients. This lack of information also hampers an insurer's ability to manage and select consultants on its members' behalf.
- 4.2 Consultants also do not provide patients sufficient information about the costs of their care in advance, which often creates the unwelcome surprises of shortfalls. Consultant must get full financial consent from patients in advance of treatment; they must be able to present evidence of doing so.

4.3 Moreover, BHF agrees with the CC that there should be greater public disclosure of consultant incentive schemes.

5) Choosing a hospital

5.1 The CC notes that PHIN/Hellenic “*may provide a source of private hospital information at least comparable to that currently available for the NHS*” (paragraph 85). We caution the CC on this conclusion¹¹. PHIN is not sufficient to improve quality for patients and to make the market work better¹², in particular because:

- i. Promises of progress on PHIN/Hellenic have been heard many times before. The only substantial progress of this initiative has taken place during the OFT/CC investigation. However, there is no evidence of long-term commitment to the project from the parties involved. This means that there is a significant risk that as soon as the CC spotlight is off the industry the pace of progress will slow. Participation must be made **mandatory** across all private hospitals (it currently covers only 160 hospitals) and a clear commitment to a pathway to delivering more data must be put in place;
- ii. PHIN would need to keep pace with progress on the publication of outcomes data in the NHS if it were to continue to offer information to patients in private healthcare ‘at least’ as good as available in the NHS. The NHS has recently committed to publishing consultant-level quality/outcomes data¹³; we are not aware of any plans from PHIN to match this progress;
- iii. From a commissioner of care’s perspective, PHIN is not sufficient and not comparable to what is available to NHS commissioners. The PHIN underlying dataset must be made available to commissioners of care for efficient benchmarking to be undertaken and BHF believes that it should be mandatory for private providers to contribute patient level data (across all their private and NHS patients) to the national datasets: HES, Secondary Uses Service (“SUS”), and the national registries. They must also participate fully in Dr Foster, as their NHS counterparts do; and
- iv. PHIN must extend its coverage to the full range of treatments offered and a far broader suite of Patient Reported Outcomes Measures¹⁴.

5.2 The CC must therefore drive further data publication by hospitals, in particular because the lack of information available from private hospitals creates a regulatory/patient safety risk. NHS hospitals provide far greater data to the CQC than is currently provided by private hospitals. In the case of private healthcare provision, this limits the CQC’s ability to identify patient safety problems in private hospitals. At the very minimum, private hospitals should be providing the same levels of data to the CQC as is available for NHS facilities.

5.3 As noted earlier, private hospitals must also start coding treatment activity and patient impairment information on a standardised basis. In 2006, the introduction of CCSD codes for procedures was an initial step to achieving this; however, there has since been significant resistance to rolling out standardised coding to other hospital services (e.g. diagnostics and

¹¹ The Working Paper recognises that even if PHIN was able to offer a range of information equivalent to that available for the NHS, the question of whether any information asymmetries would be mitigated by the availability of such data “*has been the subject of some debate*” (paragraph 85).

¹² We noted, for example, the concerns of Nuffield (a member of PHIN) in its Annotated Issues Statement response that: “*The project Hellenic initiative is insufficient for patients and GPs to make an informed choice about treatment*” (paragraph 1.36).

¹³ See NHS plans: <http://www.england.nhs.uk/wp-content/uploads/2012/12/everyonecounts-planning.pdf>. See, for example, <http://www.bbc.co.uk/news/uk-england-manchester-22878990>

¹⁴ Currently, PHIN will only report the four PROMs collected in the NHS for treatments on NHS patients. However, many private providers do not participate in these PROMs. [3<]

drugs/prosthesis). For example, there must be a measured transition to ICD-10 impairment coding across the industry.

- 5.4 Finally, insurers must be given the ability to audit the clinical data provided by private hospitals and contractual clauses that prevent insurers from publishing the quality data of a particular hospital should be removed.