

14 Queen Anne's Gate
London SW1H 9AA

tel 020 7222 0975
fax 020 7222 4424
email info@fipo.org
web www.fipo.org



PRIVATE HEALTHCARE MARKET INVESTIGATION

FIPO's reply to the Provisional Findings Report and Notice on Remedies

September 2013

1. EXECUTIVE SUMMARY

- 1.1. FIPO welcomes the Competition Commission (CC) remedies in the Provisional Findings Report (PFR). If these remedies are properly implemented, for the first time in many years the private healthcare sector in the UK would have a chance to operate in a competitive way, giving patients a chance to identify the best option for their treatment and to select the consultant they prefer based on sufficient information on consultants' performance (Remedy 5), consultants' fees (Remedy 6) and hospitals' performance (Remedy 7). FIPO also supports in general the removal of "incentives" for consultants but wishes to see clarification of some of the details in Remedy 4.
- 1.2. FIPO welcomes wholeheartedly this chance to make the private healthcare sector in the UK truly competitive. FIPO would like to work alongside all parties to see how the Remedies can be made to work: in other words how they will achieve the objective of remedying their underlying AEC (Adverse Effect on Competition). In this Reply we have responded to the CC's questions regarding Remedies 4, 6 and 7, highlighting the extent to which we consider they will require additional measures in order to work effectively.
- 1.3. Implicit in Remedy 6 in particular are two assumptions, namely that patients can choose consultants and that consultants can set their fees. Therefore, Remedy 6 requires: first, the 'any willing provider' principle. This principle applies under most insurance policies. In the case of medical insurance, the policyholder must have a right to take the benefits available under the policy to any consultant or indeed alternative care practitioner whom he has identified as willing and able to treat him.

This would allow for choice: the patient who is properly informed about fees and performance of consultants (and hospital operator) can make a decision either to attend a fee assured provider suggested by their PMI or decide to opt for a top up and attend the provider of their choosing.

- 1.4. Secondly, it is implicit in Remedy 6 that consultants must be able to set their fees; fixed fees, set by an insurer, would prevent Remedy 6 from working.
- 1.5. Furthermore the evidence available, if properly considered and assessed, proves that the actions of the PMIs are leading in many cases to patient detriment and a reduction in the quality of care and (potentially) innovation. The phenomenon of patient detriment is one which so far the CC has failed to address in detail but this lies at the heart of this investigation and cannot be avoided (see Appendix 1). The CC may also have failed to explore whether there is any need for the PMIs to act in the way that Bupa and AXA have been acting (see Appendix 4). We hope that the CC can see this and incorporate the appropriate evidence in the final report. In any event, if the CC can see how an obligation to publish fees, so as to ensure that there is competition amongst consultants on fees (Remedy 6), can only work if consultants are allowed to set their own fees and patients are allowed to use the services of consultants of choice, FIPO would be satisfied.
- 1.6. FIPO is largely in favour of Remedy 4 on consultant incentives. However more clarity is needed as to the scope of application of the proposed ban. In particular this concerns further guidance on the degree of connection to an underlying incentive to refer, which is not easy to assess in all cases, especially where benefits arise. We also highlight the guidelines mentioned in the Aspen submission, which we discuss below under Remedy 4 part (d). These deal with equity partnerships and would seem sensible guidelines to FIPO.
- 1.7. On Remedy 7 (on outcomes) FIPO constitutes the professional interface with PHIN. FIPO supports the production of improved and valid outcome data, but strongly believes that these will only work if they encompass the NHS and private practice together. Remedy 7 will only work if there is standardisation of diagnostic codes and also of the reimbursement codes used by the PMIs and hospitals. There are caveats in the presentation and analysis of this clinical data, but FIPO rejects the current posture of certain (not all) insurers who claim to be the arbiters of clinical quality, not just because these are unfounded, but also because this is beyond their remit as a financial services company; more importantly, such intrusions are increasingly affecting patient care.

- 1.8. Last, but not least, FIPO welcomes the recognition by the CC that consultants' groups have an important function in this marketplace. The fact that such groups are not in any way seen as anti-competitive is helpful but neither these groups or any individual consultant has any power when faced by the overwhelming force of a major insurer, who via threats and actual deregistration, can prevent any consultant from effectively continuing in practice. FIPO believes that this effect has, so far, been underestimated by the CC.
- 1.9. FIPO considers that the CC must mean well overall but unfortunately it has not yet assessed the implications of what it proposes. This PFR appears to FIPO to:
- be one sided in focusing on the consultants and ignoring the anticompetitive actions of the PMIs;
 - ignore potential effects and future consumers;
 - devise remedies, such as Remedy 6, which cannot have an impact unless the assumptions behind them are made explicit (so that the implementation of Remedy 6 without the attendant necessary requirements would appear to be such that no reasonable authority could mandate it); and
 - identify AECs and forget to discuss appropriate Remedies (see the Missing Remedies, section 6).
- 1.10. FIPO urges the CC to review its findings to make them compliant with requirements of legality, natural justice, proportionality and reasonableness; and to ensure that the CC is operating within its powers.

2. INTRODUCTION

- 2.1. FIPO has considered the PFR (published in Summary on 28 August 2013 and followed by the full report on 2 September 2013).
- 2.2. FIPO is focussed on obtaining the best outcome for patients and consultants alike. Provided that the Remedies are implemented properly, in such a way as to ensure they remedy the AECs they are intended to address, FIPO would be satisfied. In considering in particular what is needed to implement properly Remedy 6, the CC may want to reconsider the evidence available in accordance with the Appendices.
- 2.3. The following features were provisionally identified as giving rise to AECs in the market for privately funded healthcare:
- a) high barriers to entry for full service hospitals;

- b) weak competitive constraints in many local markets, including central London;
- c) the existence of incentive schemes operated by private hospital operators to encourage patient referrals for treatment at their facilities;
- d) lack of sufficient publicly available performance information and information on fees of consultants; and
- e) lack of sufficient publicly available information on private hospital performance.

2.4. The Remedies identified are:

- a) Remedy 1- divestiture of one or more hospitals and/or other assets in areas where competitive constraints are insufficient;
- b) Remedy 2- preventing tying or bundling by hospital operators;
- c) Remedy 3- restrictions on expansion of incumbent hospital operators through a partnership or business agreement with a PPU;
- d) Remedy 4- preventing hospital operators from offering to consultants any incentives, in cash or kind, which are intended to or have the effect of encouraging consultants to refer patients to or treat them at its hospitals, except where such ownership results in a reduction in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful;
- e) Remedy 5- a recommendation to the health departments of the nations;
- f) Remedy 6- requirement for all consultants practising in the private healthcare sector to publish their initial consultation fees on their websites and each private hospital, where they have practising rights, would be required to publish these fees on their websites;
- g) Remedy 7 - requirement that all private acute hospitals in the UK collect HES equivalent and PROMs data for private patients and appropriate arrangements are made for its publication to consumers; and
- h) Remedy 8- a price control would set the maximum prices that can be charged at hospitals which the CC considers have market power.

2.5. FIPO will only comment on Remedies 4, 6, and 7. The proper implementation of Remedy 6 is the crucial issue for FIPO.

2.6. In the Appendices we cover the following areas:

- a) Appendix 1 discusses the evidence: potential effects and future consumers; and market definitions;
- b) Appendix 2 is a timeline plotting the evidence that the CC has considered;
- c) Appendix 3 examines the Competition Law elements of the arrangement between the PMIs and the consultants;
- d) Appendix 4 establishes that the PMIs' actions are not justified. Nor should the PMIs be assumed to be the good shepherds of the private healthcare sector; and
- e) Appendix 5 contains case studies.

2.7. In Appendix 5, therefore, FIPO provides case studies which highlight the issues. The rationale behind this is that a real case can sometimes shine a light on a situation better than statistics and remind everybody that healthcare is literally a matter of life or death. With this in mind, and with reference to Bupa's actions directing policyholders, who suffer from back pain, to Apos Therapy and physiotherapists rather than GPs and consultants, we invite the CC to read the following note. It is the farewell note by the author Iain Banks, who died prematurely on 9 June 2013:

*"I am officially Very Poorly [sic]. After a couple of surgical procedures, I am gradually recovering from jaundice caused by a blocked bile duct, but that - it turns out - is the least of my problems. I first thought something might be wrong when I developed a sore back in late January, but put this down to the fact I'd started writing at the beginning of the month and so was crouched over a keyboard all day. When it hadn't gone away by mid-February, I went to my GP, who spotted that I had jaundice. Blood tests, an ultrasound scan and then a CT scan revealed the full extent of the grisly truth by the start of March. I have cancer. It started in my gall bladder, has infected both lobes of my liver and probably also my pancreas and some lymph nodes, plus one tumour is massed around a group of major blood vessels in the same volume, effectively ruling out any chance of surgery to remove the tumours either in the short or long term. The bottom line, now, I'm afraid, is that as a late stage gall bladder cancer patient, I'm expected to live for 'several months' and it's extremely unlikely I'll live beyond a year. So it looks like my latest novel, *The Quarry*, will be my last. As a result, I've withdrawn from all planned public engagements and I've asked my partner Adele if she will do me the honour of becoming my widow (sorry - but we find ghoulish humour helps). By the time this goes out we'll be married and on a short honeymoon. We intend to spend however much quality time I have left seeing friends*

and relations and visiting places that have meant a lot to us. [...] Lastly, I'd like to add that from my GP onwards, the professionalism of the medics involved - and the speed with which the resources of the NHS in Scotland have been deployed - has been exemplary, and the standard of care deeply impressive. We're all just sorry the outcome hasn't been more cheerful."

THE REMEDIES

3. REMEDY 4 – INCENTIVES

"Remedy 4 - Preventing *hospital operators* from offering to consultants any incentives, in cash or kind which are intended to or have the effect of encouraging consultants to refer patients to or treat them at its hospitals except where such ownership results in a reduction in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful."

Issues for comment

a) Is the remedy practicable? What framework of rules could be used to determine reasonably and practically whether the benefits of an incentive scheme in terms of lowering barriers to entry, outweighed the distortions created? What degree of oversight would be required to monitor compliance and who should fund it and exercise monitoring? How could the 'fair market price' test be monitored and enforced and who would be responsible for doing so?

3.1. FIPO is in principle against all incentive schemes which lead to foreclosure¹. FIPO's view is that, in a properly functioning competitive market, hospitals should compete to attract the services of consultants based on their facilities (e.g. state-of-the-art equipment, competent staff), and there ought to be a total ban on private hospital operators, as defined, to offer incentive schemes, except for bright line cases such as help for an initial period for newly appointed consultants, for example, as more particularly detailed below under the response to (b). Confronted with Chapter 8 and the *Notice on provisional Remedies*, however, FIPO is unable to opine as to whether the remedy is practicable, which, in itself, is an indication that the remedy may in fact not be practicable (unless a lot more clarity is provided).

3.2. *What is the remedy?* Before we can be asked whether a remedy is practicable, we need to understand exactly what the remedy is.

¹ Summary of CC hearing with FIPO on 17 April 2013: http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130628_fipo.pdf

- 3.3. FIPO would like to make the following points:
- 3.4. First, we understand that the CC intends to prevent *private hospital operators* from offering to consultants any incentives which are linked to referrals, save where barriers to entry are reduced. This conclusion is based on the wording describing Remedy 4, reproduced at paragraph 3 above.
- 3.5. Secondly, because the focus of the remedy is on *hospital operators*, FIPO understands that Remedy 4 only applies to “*the 215 general private hospital and PPU’s which provide in-patient care*”, as defined in footnote 23 of Chapter 5 of the PFR. According to this footnote, these “include”: “(a) all private general hospitals with inpatient care owned by BMI, HCA, Nuffield, Ramsay and Spire; (b) 19 of the largest other private general hospitals with inpatient care (including Aspen and Circle); (c) all general PPU’s with inpatient care managed by BMI, HCA, Ramsay and East Kent Medical Services; and (d) the 40 largest general PPU’s with inpatient care by revenue”. FIPO assumes that this includes the major stand-alone hospitals, [✂] but it would be good to clarify.
- 3.6. Therefore, FIPO concludes that small facilities owned or jointly owned by consultants who also practise there are *outside the scope of this remedy*. This is a fundamental point for clarification, also in light of paragraph 60 of the Notice of Possible Remedies, further discussed in the remainder of this section.
- 3.7. Thirdly, FIPO assumes that if this remedy is likely to apply, the hospital in question would be aware of it. In other words, FIPO assumes that there is no way that this remedy would apply to a facility currently unaware that this may be the case. This is a very important point, as many consultants practise in their own facilities, mostly carrying out day patient and outpatient treatments although, as the CC notes (e.g., paragraph 5.54(a)), the boundaries of these markets may be blurred.
- 3.8. Fourthly, on a first reading of Remedy 4, it is not clear to us whether “*offering to consultants any incentives, in cash or kind*” is allowed as long as barriers to entry are reduced, or whether this qualification only applies to *equity based ownership incentives*. Paragraph 60 and footnote 19 to the Notice of Possible Remedies seem to indicate that the former is the case.
- 3.9. FIPO’s reading of the position as expressed by the CC in the PFR is therefore as follows:
- “direct incentives”, or incentive schemes in cash (e.g., from paragraph 8.123: rewards for referrals) or in kind (e.g., from paragraph 8.123: subsidised consulting rooms and support when this is “explicitly or implicitly” linked to

the income generated)², by private hospitals as defined, will be banned, as they give rise to an AEC, if they encourage referrals and do not have a corresponding positive effect on competition by lowering barriers to entry;

- “indirect incentives” or equity ownerships by consultants in private hospitals as defined (but not in other healthcare facilities) give rise to an AEC and will therefore be banned, except where such ownership results in a reduction in barriers to entry likely to be at least as beneficial to competition as any distortion is harmful; and
- equity ownership of a single piece of equipment whereby consultants are part-owner of the equipment and share in the profits of using it would be banned, as the *“incentive properties are closer to those of a referral fee than those of a more dilute share in the profit from a wide range of health activities, such as a whole general hospital. It is less clear that any benefits that may arise from such schemes, such as encouraging investment in new equipment, outweigh their adverse effect”* (PFR, paragraph 8.131).

3.10. *On direct incentives in kind*, it is not clear to us in the specifics what types of incentives (if any) will be permitted. In other words, save for bright line cases such as a specific contractual obligation to refer (and perhaps contractual targets of number of referrals to be met?) linked to making available a room at a subsidised cost, for example, how closely linked to an intention to refer would an incentive need to be in order to be prohibited?

3.11. It would help FIPO to understand the thinking behind this Remedy 4 if the CC expressed a view about the incentive schemes in place between private hospital operators and GPs and/or consultants, mentioned in the PFR. At present FIPO is bewildered by paragraphs 8.5 to 8.115 where the schemes are enumerated but there is no way to know whether the changes made by the hospital operators actually are sufficient to deal with the issues. It is clear that the hospital operators thought that by, for example, removing explicit obligations to refer, they would be assuaging concerns. Are they right? Which incentives are anticompetitive? By way of illustration, the schemes are widespread (as noted by the CC at paragraph 8.116 of the PFR) and also extremely varied. Some are contractual, others are not. Some contracts have been amended to remove an explicit obligation or an expectation to refer patients to that facility, where others have been terminated, and as the CC notes (paragraph 8.119) schemes have become less common as of 2011, coincident

² BMA notes at paragraph 8.113 that since “indirect incentives” such as free or discounted consulting rooms are widespread they are unlikely to act as a barrier to entry.

with the OFT's market study. Some incentives are cash payments; others include offering facilities such as rooms or administration to consultants at varying degrees of discount. FIPO believes, for example, that there are very important issues to be considered when a hospital insists on clauses in their contract with consultants (as part of granting the consultants practising privileges in that hospital) that the consultants are obliged to keep any patient seen at the hospital for the duration of any follow up and treatments. [✂]

- 3.12. As regards *indirect incentives*, equity schemes in some cases are offered to the consultant in return for a proportion of a consultant's business allocated to a particular hospital. At paragraph 60 of the *Notice of Possible Remedies* the CC considers *short and long term* incentive schemes. At paragraph 59 of the *Notice*, an example of a short term incentive scheme is given as *fee per referral schemes*, relating directly to *individual consultants' conduct*. An example of a long term incentive scheme is given as equity participation, where the value of the incentive derived would depend on the conduct of all participant consultants *in the generality*. The CC then goes on to say (at paragraph 60 of the *Notice*) that it would be very difficult to draw a distinction between the two types: a small number of consultant shareholders in a specialist clinic *could mimic the effects of a fee per referral scheme*.
- 3.13. Given that the remedy is applicable to equity participations in hospitals and PPU's as defined (see above paragraph 3.6), is it a reason to ban equity partnerships in *hospital operators* that consultant shareholdings in a specialist clinic could mimic the effect of a fee per referral – type scheme? How is this relevant? Even if the effects could in theory be mimicked, a shareholding in a small clinic is likely to have positive effects that outweigh any potential for such a scheme to be akin to a fee per referral incentive, including providing competition to hospitals in particular as regards day patient and outpatient treatments (PFR, paragraph 8.134.). See also below, paragraph 3.24.
- 3.14. As regards *equity ownership of a single piece of equipment* we consider that, unfortunately, the cost of some items of equipment is now such that, without equity partnerships between hospitals and consultants, the equipment may simply not be acquired, with obvious negative consequences on dynamic efficiency, in particular innovation. We assume that the hospital groups will be able to provide data about the costs of certain items of equipment (e.g. MRIs, or cyber knives) and that the CC will realise that there are obvious advantages on allowing equity ownership schemes for the most expensive items of equipment at least. The time and effort invested to set up a new unit go beyond just the finance required, and an equity partnership may

provide protection for both sides (hospitals and consultants) to make the necessary investment.

- 3.15. Finally, FIPO infers from the above that the rationale for this remedy is that the incentives may lead to consultants directing patients to a certain hospital or a certain treatment or diagnostic testing for reasons that may not be in the patients' best interest [✂]. We strongly agree with the CC in paragraph 8.129 PFR that the current ethical and regulatory constraints are sufficient to offset any potential incentive to advise on any grounds other than in the patients' best interests as regards advice from consultants (and GP) to patients on treatment. Doctors have a fiduciary duty vis-à-vis their patients (and are required to declare any shareholding and similar schemes under Good Medical Practice GMC guidance) and can be also sued in negligence if they do not act in the patients' best interest.³
- 3.16. We would further stress that the very same regulatory and ethical constraints also prevent consultants from directing patients to a particular diagnostic test or piece of shared equipment. This is contrary to the views of the CC, expressed in paragraph 8.130 PFR. Allegations that consultants may ignore regulatory requirements and act in an unethical manner are very serious indeed. The GMC should be informed of such cases and act appropriately. The CC should be wary of making unfounded accusations of this kind, which taint an entire profession whose ethical standards are recognised and which has a very high rating in the eyes of the general public (according to several polls, see for example a poll⁴ concerning "Trust in Professions" carried out in February 2013). We would like to express our indignation on behalf of all consultants and GPs. It is disheartening that the CC seemingly accepts this argument without quoting any evidence whatsoever.

What framework of rules could be used to determine reasonably and practically whether the benefits of an incentive scheme in terms of lowering barriers to entry outweighed the distortions created?

- 3.17. Provided that the CC demonstrates that there is an AEC that relates to some specified incentives, and specifies the incentives caught, then the obvious way to ensure that the remedies do not catch schemes which lower barriers to entry is to ensure that some specific rules are laid out for those incentives intended to attract consultants to new hospitals and facilities being developed. It would appear to be exceedingly clear that the capital costs of building and fitting and operating a new hospital or facility

³ Hopefully the PMIs will also be subject to a duty of care as they direct patients away from clinicians, a point which is referred to in the WPA Opinion available at: http://www.wpa.org.uk/literature/counsels_opinion.pdf but of course they are not under any regulatory obligation.

⁴ The [poll](#) by Ipsos MORI revealed that 89% of the 1,018 adults surveyed trust doctors to tell the truth.

would not be undertaken lightly. If a new hospital is being developed, the owners would wish to develop it in an area where they have identified potential demand, after comprehensive business cases have been painstakingly drawn up. The CC should not be too prescriptive about the conditions that the schemes should meet in such cases. It is unlikely that anyone would develop a new hospital unless they firmly believe that there is a case for entry. The question then is whether the distortions identified really outweigh this case for entry. An additional fundamental question to be addressed would be the status and regulation of such incentives after the initial set up phase. Overall, we believe that hospitals which provide the best facilities (nursing, technology, safety) should be those which attract consultants. [✂]⁵.

What degree of oversight would be required to monitor compliance and who should fund it and exercise monitoring?

- 3.18. We do not see the need to create a separate monitoring function for a remedy on incentive schemes. It seems to us that, if a scheme has an adverse effect on competition, then the competition rules should be sufficient to deal with the anti-competitive agreement or practice. It is also likely that the hospital developers would be big companies as indeed would be those likely to complain: the PMIs and the existing hospitals. All of these actors have the resources to engage in public or private enforcement of the competition rules.
- 3.19. To the extent that the issue identified is that specific consultants and GPs are in fact advising on diagnostic tests on the basis of financial rewards, rather than the best interest of the patient, the regulatory medical bodies should be informed and the evidence provided. This would be a serious misconduct.

How could the 'fair market price' test be monitored and enforced and who would be responsible for doing so?

- 3.20. We do not understand what this means. Is this an error? Or, is this a reference to the principle that consultants should be allowed to invest in a shareholding when the price per equity unit is based on a fair market value? (See extracts from Aspen in answer to (d) below). If the latter, FIPO would support this but do not see a need to create a separate enforcement function. If, this notwithstanding, a monitoring function is considered necessary perhaps the CMA (or Monitor?) could hear any complaints.

⁵ [✂].

b) Is the remedy reasonable? Should certain kinds of arrangement still be permitted and if so which? Should, for example, those with a value of less than a certain amount, be deemed ‘de minimis’? If so, what should this figure be?

3.21. Until we understand more about the remedy, we cannot be sure whether it is reasonable. The comments above are an indication that, as far as FIPO can determine, more clarity needs to be given about the remedies in question. As FIPO has told the CC, FIPO is, in principle, opposed to incentives and there should be no need for incentives in a properly competitive market which rewarded consultants in accordance with their skills and expertise, which we hope will emerge as a result of this investigation.

3.22. FIPO considers that direct incentives in kind (such as subsidised consulting room and supporting secretarial or other staff) should be acceptable for young consultants who are just setting up, for an initial period (for example, up to one year). The support in this case would not be linked in any way to the income generated, so we assume that support for young consultants would be acceptable under the terms of Remedy 4, but the CC should state this clearly and also suggest an initial period during which the scheme would be acceptable.

3.23. We note that the CC distinguishes between “promotional activities” (e.g. seminars and market communications) and incentive schemes (paragraph 8.119). We assume that the purpose of the distinction is to highlight that promotional activities should be acceptable in all cases, but this should be clarified. In the same paragraph, educational and CPD activities are also mentioned. These are not listed as part of the promotional activities but FIPO assumes that they are equally safe from scrutiny, as the profession is reliant on these educational activities for their CPD requirements and, as academic activities are the lifeblood of a hospital, cannot be curtailed. Again, this is an important point and should be clarified.

3.24. Whether certain schemes should be *de minimis* depends on the adverse effect of the scheme. If the value of what is on offer is very small, even a theoretical (and, frankly, insulting) concern that consultants could take it into account when making their clinical decisions would be totally unfounded.

(c) Is the remedy comprehensive? Should it apply to other healthcare service providers such as laboratories or firms supplying diagnostic services such as imaging, for example? Should PMIs be permitted to operate incentive schemes which reward consultants who recommend cheaper treatments or less expensive hospitals?

- 3.25. FIPO is concerned about the first two questions, on behalf of those specialist clinics with a small number of consultants setting up as shareholders or partners. What is it that the CC is proposing as regards laboratories or firms supplying diagnostic services? Would the CC suggest that equity shareholding by doctors in laboratories or firms supplying diagnostic services and similar should also be banned? The CC needs to be cautious about the implications. Next, the CC would wish to ban law firms on the grounds that a partner in a law firm stands to benefit from recommending starting an action against an unreasonable decision by a public body (and accountancy firm partnerships on similar grounds). Surely people are allowed to invest in an activity and bring their skills to that activity with an expectation of reward. An ability for consultants to practice together in outpatients and day patients facilities has been recognised as important to provide some competition to the private hospitals in the PFR itself. [✂].
- 3.26. Allowing the PMIs to reward recommending cheaper treatments and low cost hospitals would seem utterly perverse. In the USA these tactics are known as “Gainsharing” and are condemned; in these situations, as an example, the insurer might reward a consultant who discharges a patient too early. A position statement on “gainsharing” from the American Association of Orthopaedic Surgeons (AAOS) elucidates a clear ethical policy: *“The AAOS believes that the orthopaedic surgeon’s first duty is always to the patient. AAOS therefore is opposed to any gainsharing or similar arrangement that will ultimately lead to a reduction in the quality of patient care. No agreement should ever compromise patient care, nor create a real (or apparent conflict of interest between the patient and the physician. A gainsharing agreement should never provide incentives for physicians to limit care or provide unnecessary care. A hospital’s attempt to control costs and maintain clinical programs should not interfere with the surgeon’s goal of providing the highest quality care and serving the patient’s best interest.”*⁶ In the US, “gainsharing” arrangements can invoke civil liability of \$2000 per patient to whom such an arrangement has been applied and they may even be a criminal offence carrying a custodial sentence⁷. As a minimum, such activity in the UK would expose the consultants and the GPs (but not the PMIs of course, as these operate totally outside any ethical or regulatory medical constraints) to the full rigour of the regulatory regime that applies to them, and the ethical disapproval of anyone that comes across such a scheme. We trust that the CC will outlaw any notions of gainsharing.

⁶ American Association of Orthopaedic Surgeons, Position Statement on Gainsharing, September 2006.

⁷ Special Advisory Bulletin on Gainsharing Arrangements by the Office of Inspector General, US Department of Health and Human Services: <https://oig.hhs.gov/fraud/docs/alertsandbulletins/gainsh.htm>

- 3.27. More generally, we note the statement in paragraph 8.122 that: *“any arrangement by which the economic benefit to the adviser varies according to the advice given and which reinforces the incentives inherent in the fee-for-service model and exploits the information asymmetry between patient and clinician therefore has the potential to distort competition”*.
- 3.28. We also note that the PMIs are operating *incentive schemes* whereby the economic benefit to them (who are now self-styled advisers on matters of medical care and treatment) *varies according to the advice given* and reinforces the incentives inherent in the PMIs’ initiatives intended to *break the medical chain from patient to GP to consultant*. We refer the CC to Consultant 185 on the CC’s website who explains:
- “I have also now seen BUPA patients that have been directed towards me on account of my reduced costs. A patient with a complex problem sought a second opinion via BUPA, she was referred by them to an orthopaedic surgeon who had a different unrelated sub specialist interest and saw him without being told of this. He suggested a more appropriate experienced surgeon but BUPA refused and redirected her to me on account of my fees being lower than his. I doubt this patient was made aware of the fact that she was therefore being referred to a new consultant rather than an established consultant of 10+ yrs experience. It seems obvious to me that if patients were aware that they have recently become underinsured without their knowledge they would be keen to move insurer - if they were able to transfer to another without losing cover for current conditions that is.”*
- 3.29. This exploits *the information asymmetry between the policyholder and the insurer* (also in light of the way in which the insurer simply changes the terms at will without informing the policyholders – see Missing Remedy 2). Therefore this *has the potential to distort competition*, and in fact does distort competition. To paraphrase the CC’s reasoning in paragraph 8.125, *it is our view that patient choices are being affected by these schemes in a way that would not occur in a well-functioning market. By affecting the outcome of competition between hospital operators and consultants these incentives can distort the market.*
- 3.30. It is quite clear that PMIs are getting a benefit from directing patients away from experienced established consultants. Indeed, in the way that this market has been allowed to develop, the PMIs have an incentive to underpay for care, as when a policyholder needs care, this translates in a cost for the PMI (see also Appendix 3). Bupa and AXA are directing patients without any *clinical insight* whatsoever, *in the absence of any regulatory or ethical requirements*, and leading to a lowering of clinical expertise amongst the consultants which are selected, often the consultants qualified after 2010.

3.31. It appears to FIPO therefore that the CC is treating similar situations in a very dissimilar way, applying totally different principles to the same situations, exempting the PMIs from all censure, ignoring relevant considerations, taking into account irrelevant considerations and generally tilting the playing field so much in favour of the PMIs that the whole exercise risks being tainted not only by illegality but even by Wednesbury unreasonableness.

(d) Are there regulatory regimes in other jurisdictions that the CC could learn from in the context of remedy specification and implementation? Would, for example, the Stark Law in the USA, be a useful model as regards restrictions on the commercial relationships between healthcare facilities and clinicians and their introduction?

3.32. We express no opinion on the Stark Law, other than it seems very convoluted and complex to apply and, we understand, only applies to Medicare and Medicaid. In reading paragraph 8.90 of the PFR, we see the five points that Aspen is apparently following in accordance with their submission and which they consider are in line with requirements in the USA. These are:

3.33. First, that *“consultants invest their own cash for a minority equity interest alongside Aspen and the price per equity unit is based on fair market value. No consultant was ever ‘awarded’ equity or received equity at less than market value in consideration of a commitment to make referrals.”*

3.34. Secondly, that *“Financial returns to consultants are derived from the profits of the JV and the return to each consultant is based on and proportionate to the level of the consultant’s equity investment and not on the number of patients that the consultant treats at or refers to the facility”*.

3.35. Thirdly, *“the JV agreement requires the consultant to exercise clinical judgement when deciding on treatments or venues for patients and always to act in the patient’s best interests”*.

3.36. Fourthly, *“the arrangement is transparent to patients, the JV agreement requiring the consultant to inform their patient of their stake-holding”*.

3.37. Fifthly, *“JV member consultants have the ability to sell their equity stake at any time”*.

3.38. These principles seem entirely sensible to FIPO and again it would have been helpful if, after enunciating them in paragraph 8.90, the CC could have expressed a view as to whether there would be any concerns with this approach.

(e) What would be the cost be of implementing this remedy, particularly in terms of unwinding existing equity sharing arrangements? Would it be necessary or desirable to 'grandfather' existing arrangements?

3.39. There needs to be a very clear case of documented AEC for unwinding existing partnerships. As a minimum, grandfathering existing arrangements would appear rather a necessity than a 'desirable' outcome.

(f) Particularly in the context of market entry and expansion, are any relevant customer benefits likely to arise from equity participation by consultants in hospitals that would not otherwise be available?

3.40. Yes: equity or other forms of profit sharing are undoubtedly beneficial (see paragraph 8.123 of the PFR). The case for banning certain incentives and not others would need to be strong, and to be demonstrated by reference to a proven AEC.

4. REMEDY 6

Requirement for all consultants practising in the private healthcare sector to publish their initial consultation fees on their websites and each private hospital where they have practising rights would be required to publish these fees on their websites.

Further, requirement for consultants to provide a list of proposed charges to patients in writing, in advance of any treatment.

Issues for comment

a) Is the remedy practicable? Do consultants' outpatient fees vary significantly between different patients such as to render an average fee or a range of fees unhelpful?

- 4.1. FIPO welcomes the CC's conclusions on remedy 6. In the context of the PFR overall, if transparency of fees (remedy 6) were coupled with greater information about hospital treatments (remedy 7) and information about consultants' performance, some of which is already available and more will become available (Remedy 5), private healthcare could realistically operate as a competitive market.
- 4.2. When considering whether any remedy is 'practicable' (and comprehensive and reasonable, in accordance with the CC market guidelines (CC3 Revised para 330)), it is relevant to examine what any remedy is designed to address: the AEC in question. As regards Remedy 6, the CC states (in paragraph 75 of the summary, see also paragraph 9.66 of the PFR) that *"We identified the lack of sufficient publicly available performance and fee information on consultants as a conduct feature in the provision of privately funded healthcare by consultants. This feature gives rise to an AEC due to the distortion of competition between consultants by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated. This reduces competition between consultants on the basis of quality and price."*
- 4.3. Perceived lack of performance information is addressed in Remedy 5 and the discussion therein. As regards lack of sufficient publicly available information on fees, for the remedy to be practicable there needs to be two basic obvious requirements: that the patients should be allowed to choose the consultants that treat them; and that the consultants should be able to set fees for their treatment.

- 4.4. Failure to provide for this would appear to make the identification of Remedy 6 unreasonable⁸. With respect, FIPO considers that no reasonable authority can devise a remedy to do with publication of fees so that patients can choose, in a situation where both consultants cannot set fees and patients cannot decide to pay such fees.⁹ It follows that Remedy 6 will only work if the following three requirements are met:
- 4.5. First, this remedy must be applicable to all patients, not just those patients who are not constrained by the policies of their medical insurer; otherwise it will be ineffective in addressing the AEC. It needs to be clarified therefore that all insured patients have a right to bring whatever benefits are available to them under the terms of their policies to *any willing provider*, any consultant or indeed alternative practitioner (if alternative care pathways need to be considered, as seems to be the case from reading the PFR (see below paragraph 5.7)). There are some statements in the PFR suggesting that Bupa patients can always see their consultant of choice and are able to pay a top up¹⁰. This is not true. There is ample evidence of loss of consumer choice which is now accelerating as the Bupa “open referral” has reached a point where in some cases patients are denied the opportunity to see a non-fee assured consultant of their choice even if prepared to pay any fee shortfall. In any event, if it were true, Bupa will have no objections to the principle being made explicit. Furthermore, indirect discrimination of patients wishing to exercise choice must also be outlawed. [✂].
- 4.6. Secondly, it needs to be clarified that the PMIs cannot deregister established consultants based on the fees these consultants charge for treatment (and they cannot imply, having done so, that the doctor is somehow “derecognised” or “delisted”, see also below, Missing Remedies, (section 6)). Without freedom to charge fees other than those that the PMIs decree, there can be no competition on fees by the consultants (the AEC that Remedy 6 is addressing) and therefore no need for consultants to publish any fees (the CC is referred to its own evidence here: those 58% of respondents to the CC's survey who set their fees at the same level as Bupa's fees do not need to publish any fees¹¹).
- 4.7. Thirdly, it is clearly implicit in Remedy 6 that newly established consultants must be able to enter the market without having to sign up to an inflexible fee cap. It is true

⁸ If the CC is concerned that this would lead to an increase in fees without constraint, please consider Appendix 4.

⁹ As we have said all along, this does not preclude the PMIs from designing their policies and deciding what their policyholders are entitled to; preferably by informing them in detail at the point of sale of their policies (see Missing Remedy 2).

¹⁰ See PFR paragraphs 7.51 and 7.73 and footnote 67 to paragraph 7.54.

¹¹ The CC omitted to ask the question about fees in its own survey

that these clauses should be illegal and null and void in vertical agreements (outside the block exemption) (see Appendix 3 for further discussion), but young consultants lack the resources to litigate the PMIs' demands and in any event if the PMIs can simply de-register a consultant at will (even outside the terms of any formal contracts), then there is little merit in litigating unreasonable conditions of entry.

4.8. From this it follows that Remedy 6, to be workable, has 4 components, namely:

- *Remedy 6(1)* – the “any willing provider” principle, which allows policyholders to decide on the way in which they use the benefits that they are entitled to under their policies, paying a shortfall, if necessary, on the higher fees which consultants have been allowed to set themselves;
- *Remedy 6(2)* – a clear obligation on PMIs not to deregister consultants on the basis that consultants charge in excess of the fees that the PMIs are willing to reimburse their policyholders;
- *Remedy 6(3)* – a clear statement that a fee cap cannot be imposed as a condition for recognition (as a condition for entry into the private healthcare market) on new consultants; and
- *Remedy 6(4)* – publication of fees by consultants.

4.9. The reason why Remedies 6(1), (2) and (3) must be implicit in what the CC proposes, namely Remedy 6(4), is because otherwise there would be no use for Remedy 6 at all, unless the CC is devising a remedy for self-pay patients, which would not make sense. Unless Remedy 6 is properly understood, one can easily see a situation where the consultants' websites all say the same: *we charge whatever [✂] has decided*, which would be absurd (simply codifying price fixing by the PMIs).

4.10. For the avoidance of doubt, a clear statement that properly informed patients are allowed to decide to top up for medical care (and, necessarily, for consultants to be allowed to set higher fees which patients can top up to), an obligation not to deregister consultants on the basis of fees and an obligation not to impose fee caps as a condition of entry, are all implicit in the need to ensure competition amongst consultants on fees which is the back drop to an obligation to publish fees in Remedy 6.

4.11. FIPO also strongly believes that the CC has erred in concluding that there is no evidence that the actions of the PMIs (in directing policyholders away from their consultants (and GPs) of choice, dictating fees, deregistering established consultants at will and imposing unreasonably low fee caps as a condition of entry) does lead to

detriment for consumers, innovation and quality. We would urge the CC to reconsider the evidence and to ask the right questions with reference to the market definition identified (see [redacted] in particular: Paragraph 7.71 Deconstructed [redacted]; [redacted] and [redacted], all of which point to the CC having failed to consider relevant considerations). But practically speaking, it does not matter that the CC has failed to consider the evidence fully, if the implementation of Remedy 6 can lead to proper competition amongst consultants on fees.

- 4.12. With this necessary proviso, FIPO believes that the remedy is practicable. In order for the remedy to work it cannot simply constitute a “central register” of fees (not least because the costs of providing treatment vary greatly by geography - see Appendix 1). A central register would appear to work a bit like a guideline and it is necessary for the CC to provide clarity about how any implemented remedy on fees will differ from the ban imposed by the 1994 decision of the Monopolies and Mergers Commission, which ruled that the British Medical Association was unable to continue publishing guidelines for consultants on fees in private practice.
- 4.13. Based upon the conclusion to the MMC Report (pages 156-184), it appears that the MMC decided to prevent the BMA from publishing its fee guidelines because these guidelines were providing the basis for consultants’ fees and were being directly used as a tariff (paragraph 11.161 MMC Report) and therefore represented an attempt on behalf of consultants to organize the market (paragraph 11.160 MMC Report). From paragraph 11.26 of the MMC Report it appears this conclusion was based on the fact that the BMA guidelines were acting as a consistent focal point for the setting of fees: at paragraph 11.26. The MMC concludes that *“a complex monopoly situation exists by virtue of section 7(1)(c) and (2) of the Act in relation to the supply of private medical services, the group concerned consisting of the BMA and those consultants who for the private medical services which they supplied set 50 per cent or more of their charges at or within 2 per cent of the levels indicated in the BMA Guidelines or the benefit maxima of the Table of Benefits related to the BUPA Schedule of Procedures. They are persons who so conduct their respective affairs as to prevent, restrict or distort competition in the supply of private medical services in the UK. The consultants in the group supplied over one-quarter (and, we estimate, nearly three-quarters) of private medical services by value in the UK in 1992.”* The MMC then further concludes at paragraph 11.27 that the *“monopoly situation exists in favour of those consultants within the group who follow the BMA Guidelines because it assists them to command higher fees than they would enjoy if they did not set their charges in the way we have described”* and the *“monopoly situation exists in favour of the BMA because the publication of its Guidelines benefits its members and so strengthens its position as the principal body representing consultants”*.

- 4.14. We consider it inappropriate therefore that there should be a “national list of consultation fees” and our view is that that all consultants should, at an individual level, make **fee ranges** known to their patients.
- 4.15. In answer to the second question, outpatient fees vary significantly between different patients: the age, co-morbidity (fitness) and the nature of the clinical problem of the patient may make a significant difference. This is one reason why the exercise by PMIs of their buyer power against consultants is so detrimental: the insistence of the PMIs that all patients should be charged the same amount for consultations and procedures which the PMIs happen to bundle under the same codes¹² has no bearing on the reality of practising medicine (see 4.24 below).
- 4.16. Therefore this remedy would be practicable if the four remedies are put forward together and consultants publish an indicative range of fees.

b) Is it possible for consultants to estimate fees before undertaking a procedure since unforeseen complications may arise? Would there need to be a means of adjusting fees in response to complications? Are there particular medical specialties where consultants would face particular problems in providing such an estimate in advance? How else might patients be informed of the likely costs of their treatment?

- 4.17. It is possible to give fee estimates. FIPO’s evidence from its own survey is that around [X] of respondents do give estimates of fees for consultation and procedures (and [X] also give estimates relating to anaesthetists)¹³. FIPO have always advocated fee estimates and examples are on the FIPO website¹⁴. According to the available evidence, therefore, the consultants who can operate in a relatively well functioning marketplace do publish fees. The others (on fixed fees) have no need to.
- 4.18. The nature of an “unforeseen” complication is of course that it cannot be estimated before it happens (it is *unforeseen*). Consultants are obliged to inform their patients about the risks of anticipated complications connected with any procedure. Consultants could be encouraged to inform their patients at that time about any extra costs that may be incurred. A complication might be either related to the surgery/treatment directly (such as a haemorrhage) which in fact may be partially “foreseen” or it might be totally unrelated and “unforeseen” (such as a heart attack after a simple operation). In the latter case different specialists would be required and costs could not have been predicted in advance. The CC should also clarify what

¹² [X]

¹³ [X]

¹⁴ <http://www.fipo.org/resources/index.htm>

it means by “*adjusting fees in response to complications*”. If by that the CC intends some formula or other complicated means to adjust fees, then FIPO is not aware of any possible way to adjust fees in this way.

c) Is it reasonable to require all consultants practising in the private sector to disclose their outpatient consultation fees? Should only those earning above a certain level do so?

4.19. FIPO has never made a distinction between consultants based on earnings. This type of classification would be unworkable as fees vary widely by geography, specialty and as noted above (4.12) according to the patients’ conditions. If it is intended that “high earners” should publish fees as, crudely, the CC assumes that they charge “high fees”, FIPO would ask who would define this “high fee level” and how would this be interpreted against the variable factors mentioned? It would be easier and much more important to require all consultants to give fee estimates prior to an elective procedure (and to inform patients about consultation fees), which should engender an expectation for patients that they will be told about the costs at the outset, and then in this way the patients can also be better equipped to compare the benefits offered by the different PMIs assuming that standardisation can happen properly (see reply to Remedy7).

4.20. Requiring only those consultants earning above a certain threshold to publish fees would seem to go against the very rationale for this remedy, as far as FIPO can tell.

d) How should the remedy be specified? How far in advance of treatment should a consultant be required to provide a patient with an estimate of the proposed fees for treatment? Is it practical, in all cases, to inform patients of costs in advance of treatment? Should any other information or advice be included with the estimate? For example, should the consultant notify the patient of his or her PMI fee maximum for the procedure concerned, or advise the patient to check this him or herself?

4.21. Patients in the private healthcare sector should have choice; otherwise one of the main reasons to have a private healthcare sector is negated. This includes deciding *when* he or she would like to have the treatment performed, where possible.

4.22. Whilst we understand the rationale for giving patients a period between informing them of the costs of a procedure and performing the procedure itself, in reality one of the benefits of private healthcare is that a procedure can be performed quickly, particularly for overseas patients. For some patients time really is crucial so to impose a requirement of a minimum period between giving the cost information and performing the operation (if that is the idea behind this question) would not be appropriate. The consultant should tell the patient about the cost and give the

patient a choice of time of performance, so that the patient can then decide whether he or she would like to “shop around” or have the operation performed more quickly.

- 4.23. It is not practical in all cases to inform the patient of the cost in advance of treatment, for example in emergency situations or where there is an unforeseen complication (as noted above if a patient has a chest pain he or she may be given a painkiller or in unfortunate, unforeseen cases go on to have a heart attack, or indeed all kinds of major interventions).
- 4.24. The suggestion that consultants should also inform the patients when their policies do not cover the full cost of treatment would appear to be a good one in theory but currently impossible in practice (see next paragraph below). If the PMIs were to provide the consultants in each specialty with information about the amount of the benefits that they are willing to pay, by the use of common standardised codes (see below, in answer to Remedy 7), this could be easily achieved. The PMIs could provide their standardised schedule (which would correspond with the consultants’ coded procedure list) to the consultants once a year, for example, and the fact that the benefits remain the same and are changed at a certain date could be reflected in the terms of the policies, also ending the practice of Bupa changing the codes during the term of the contract, without the policyholders’ knowledge (see below, Missing Remedy 2). FIPO thinks that, at a stroke, this remedy would increase transparency of the benefits available under the policies and help the patients understand what their benefit entitlement truly is.
- 4.25. Unfortunately, as matters stand, consultants could not be responsible for telling the patient the amount of benefits that the patient is entitled to, with any degree of certainty. The consultant can say what the operation is but they simply cannot find out the benefits that patients will receive in all cases because:
- all PMIs have different benefits;
 - PMIs use different codes (for the moment) making comparisons very difficult at the best of times;¹⁵
 - some PMIs [redacted] change their benefits at will without even informing their policyholders;¹⁶
 - some conditions are reimbursed by one insurer, but not another; and

¹⁵ [redacted].

¹⁶ [redacted].

- patients naturally have excesses and exclusions, so the best a consultant could do in any event would be to inform the patient that for that particular procedure Bupa reimburses £££, but that the patient should check his or her policy for any excesses or exclusions.

e) What provisions would need to be made for the oversight and enforcement of this remedy and which body(s) should be responsible?

4.26. There is a need for oversight of Remedy 6 as a whole (Remedy 6(1), 6(2), 6(3) and 6(4)). It would be important that:

- 6(1): policyholders denied the exercise of the “any willing provider” principle should be able to complain;
- 6(2): deregistration on the basis of the price charged for treatment is prohibited and consultants who believe that deregistration by PMIs is due to the amount of fees they charge should have a forum for an independent review. If the deregistration is due to issues related to the practice of medicine, the appropriate body for review is the General Medical Council;
- 6(3): new consultants obliged to sign up to a fee cap clause should have quick means of redress; and
- 6(4): patients and PMIs who consider that a consultant has not given information about the cost of treatment at the appropriate time should be able to have an independent assessment of whether this is the case.

4.27. The remedies above are really enshrined by what remedy 6 envisages, and would not work in isolation. The body to address these issues should be an adjudicatory body, as this is a dispute resolution issue.

4.28. [✂]

4.29. FIPO has in the past attempted to champion an arbitration solution to the issues surrounding deregistration. Other professions can rely on a neutral, inexpensive and acceptable arbitration service. Such a proposal has, unfortunately, been rejected by the insurers.

5. **REMEDY 7 - Lack of sufficient publicly available information on private hospital performance. Requirement that all private acute hospitals in the UK collect HES equivalent and PROMs data for private patients and appropriate arrangements are made for its publication to consumers.**

Issues for comment

- (a) Is the remedy practicable? Are all private hospitals in the UK capable of collecting the equivalent of HES data? If they are not currently capable of doing so, what would be a reasonable timescale for the implementation of this remedy?**

- 5.1. FIPO is very active within PHIN on standardisation of data on hospital performance (which of course involves the collection of data about treatment administered by consultants). In fact, FIPO constitutes the main interface between PHIN and the consultants. Hospitals produce routine Key Performance Indicators (KPIs) on (for example) re-admission, returns to theatre, mortality and infection rates. These are increasingly being applied at consultant level. FIPO has agreed with PHIN that the 10 NHS national outcome measures (NJR, NICOR, certain cancer data outcomes) should be applied to the independent sector. FIPO is actively working to coordinate this data production with PHIN. However, PHIN must answer for the practicalities and time frame of this work.
- 5.2. The remedy is in this case clear: the requirement that all private acute hospitals in the UK collect HES and PROMs data and that these data be published in some form. As for remedy 4, we assume that the addressees are the private hospital operators as defined, and note that the CC refers to the 194 hospitals already part of the PHIN organisation, and the seven more providers about to join in paragraph 9.53 of the PFR. It would be helpful if we could have clarification about the addressees of this remedy.
- 5.3. FIPO believes that private hospitals that treat NHS patients already provide the full standardised information to the NHS which includes codes for procedures, diagnoses, co-morbidities and PROMS, which shows they are capable and willing to do so. We would therefore expect this remedy to be practicable.

- (b) Similarly, are all private hospitals in the UK capable of collecting PROMs data for the same procedures that it is collected for NHS England? If they are not currently capable of doing so, what would be a reasonable timescale for the implementation of this remedy?**

- 5.4. Please see the response to (a) above

(c) Besides HES and PROMs equivalent data, what other data should be collected by private hospitals and to whom should it be made available? Would it be appropriate for the CC to specify the coding, for example ICD10, to be used in data collection and classification?

- 5.5. The CC should ask a more general question about whether the remedy is “comprehensive enough”.
- 5.6. This question (c) relates only to whether data other than HES and PROMS should be collected and FIPO believes that they should. Routine collection of diagnosis, co-morbidity, complications and procedure codes (using the ICD10 and OPCS already) should be standard and should be available for private patients too, available on hospital websites.
- 5.7. If the CC had asked the general question whether this remedy is comprehensive enough, two other considerations would have become clearer. First, whether the remedy (or any remedy) should address publication of *accurate* information on *treatment*. The CC should not just have considered that information on treatment is available: it should have considered whether what is available is *accurate*, and based on *medical knowledge*, in order to prevent patients’ detriment. Second whether the remedy should address providers other than the hospitals.
- 5.8. On the first point, namely whether adequate information on treatments is available, the CC states in paragraph 9.67 of the PFR: “*Whilst we acknowledged that information asymmetry between consultant and patient was inevitable, we consider that, in order for competition between consultants and between consultants and alternative healthcare pathways to function properly, patients should have access to information on the comparative benefits of different treatment options*” and then concludes that patients do.
- 5.9. FIPO agrees that there is now ample information available to patients, but the information still must be interpreted on an individual basis. This must be done in consultation with a consultant aware of the specific clinical risks and nuances relating to the patient in question. It is difficult to understand the CC’s reasoning in concluding that a layperson, in this case a patient, can be expected to make a value judgment on the different treatments available to him or her, based on outcome data with all its caveats and bias. In addition, what is perhaps more striking is that the CC appears to have misunderstood a fundamental point, namely that Bupa is not

qualified to give advice on healthcare pathways, and certainly not on an individual basis. This is simply not the province of a company with vested financial interests.

- 5.10. Could the CC please turn to paragraph 9.43 of the PFR? It says: *“Bupa’s website has a directory of over 600 healthcare topics, which provide information ranging from general lifestyle advice, to detailed descriptions of illnesses and treatment options. In addition, Bupa operates a ‘Treatment Options Service’, which is a call centre staffed by qualified nurses, who discuss the various treatment options that may be available to Bupa policyholders following their diagnosis. Similarly, AXA PPP’s website provides factsheets on a broad range of medical conditions, the information for which is supplied by NHS Choices. AXA PPP policyholders also have access to its panel of medical experts, to whom they are able to submit questions via the website”*
- 5.11. [✂] AXA at least has not yet started to publish information directing patients away from acknowledged medical best practice, but publishes NHS Choices information. Who is Bupa to operate a *Treatment Options Service*? Why are nurses secreted away in a Bupa call centre allowed to direct Bupa members over the phone to a “service” fitting a shoe device into the shoes of patients who suffer from back pain, keeping them away from a qualified medical examination *in person* by a doctor? (We refer here to the facilitation of AposTherapy, and BUPA referrals in the first instance to a physiotherapist instead of a consultant for musculoskeletal disorders). There MUST BE a remedy imposing limits on Bupa’s endless stream of non-medically checked information and “services”, in the interest of the very health of Bupa’s members. (In this regard FIPO refers the CC to Consultant 4 in the replies to the PFR on the CC’s website of 5 September 2013, an important case study which illustrates the detriment that can ensue when a patient’s clinical pathway is interfered with by insurers, and to case study 3).
- 5.12. The second point is whether information about operators other than the hospitals should be collected. The two other groups to be considered are of course the consultants and the PMIs. As usual, whilst the consultants appear to be under scrutiny, the PMIs are not.
- 5.13. On the question of whether data on performance of the *consultants themselves* is available, we note at paragraph 9.66 of the PFR that the CC *“could not be sure when or whether the remaining consultant performance data which it is envisaged will be disclosed in England will appear nor whether plans to disclose the same or analogous information in Scotland, Wales and Northern Ireland will emerge. We therefore provisionally conclude that a lack of sufficient publicly available performance and fee information on consultants prevents the proper functioning of competition between consultants and is a feature of the private healthcare market giving rise to an AEC”*.

We infer from this that the current NHS initiatives in England will provide adequate information about consultants' performance and that indeed this is a good model (provided there are adequate controls such as information on a consultant's case mix) for the other nations so that the CC intends to make a recommendation to the relevant departments in the other nations, in Remedy 5. FIPO is supportive of Remedy 5, as seen above and we are working towards whole practice outcome data, i.e. NHS and private work combined.

- 5.14. The second group is of course the PMIs. Standardisation of information under Remedy 7 must include the PMIs. In a well-functioning competitive market, if policyholders were able to switch policy (not feasible for the individual) and standardised information about policies would be published and be easily comparable, both as regards the *costs of treatment* and *the benefits payable* by the different insurance providers, a growing body of data would be available and patients could use the information to shop around and choose not only the best (in their own view) consultant, treatment and hospital, but also *the best insurance policy*. This would take good care of the PMIs' incentives to *under-treat* which the CC recognises but which does not get anywhere near the same attention as the opposite alleged incentives on consultants (to over treat) which have an entire complicated remedy of their own, Remedy 4.
- 5.15. The CC says, in paragraph 9.22 that "*In either circumstance (incentives to under-treat for the PMIs or over-treat for the consultants) the patient may wish to test the advice that they have been given and will therefore need to seek information. We examine below whether information is available to patients that would enable them to do so*".¹⁷ The CC then (as seen above) proceeds to consider remedies to deal with information on consultants, treatments and hospitals.
- 5.16. This ignores information on the benefits payable. FIPO is of the opinion that once information about hospital treatment is available, and information collected on the basis of HES using OPCS and ICD10 is standard throughout the private sector it will then be possible to publish prices of the various treatments in a truly comparative manner. *These codes need to be used as the standard with regards to the rates of benefits available to the insured patients as well.*
- 5.17. FIPO has explained the issues surrounding the insistence by the PMIs that only their proprietary codes (CCSD) be used in the reimbursements and then again each PMI

¹⁷ We are leaving aside here consideration of the inability to switch for private policyholders and the fact that policyholders may be stopped from seeing any consultant depending on the PMIs' will, which are referred to above.

interprets the codes as they think fit (we refer the CC to FIPO's Reply to the Issues Statement paragraphs A.40 – 45).

5.18. FIPO agrees wholeheartedly with the statement in the PHIN press release available at: <http://www.phin.org.uk/CCPreliminaryPHINResponse.pdf>. The PMIs' use of their own coding systems, such as CCSD, risks derailing the efficiency of the whole standardisation process. These codes are different from the standard NHS coding systems, namely OPCS and ICD10. OPCS gives greater clarity to operations/procedures and would allow proper comparisons; therefore NHS coding should be the standard.

(d) What measures could or should the CC adopt in order to ensure that PHIN or its equivalent retains sufficient funding to continue its activities after the completion of the CC investigation?

5.19. Private hospitals have funded the PHIN initiative to date. They could continue to fund it going forward as regards information on hospital performance. The PMIs must fund an equivalent exercise as regards benefit information, and make it available to patients too, so that every patient also has access to the information that the PMIs possess. We would like to point out that the only information that the PMIs possess relates to volume (not quality) and is restricted to a snapshot: their share of the market. So, for example, Bupa will have information on the number of a particular operation that a surgeon has performed on Bupa's patients. This information about the procedures an individual consultant may do is used by Bupa on its website as some sort of surrogate to support its "open referral" strategy. This is meaningless for two reasons. First there is an assumption that greater volume will equate with quality and whilst this may seem to be intuitive it may not always be true (we refer here to a recent report in the British Journal of Surgery from Imperial College of over 100,000 bowel resections for cancer which showed no relationship between volume and immediate outcomes). Secondly, the surgeon may have performed only a few on Bupa patients, but performed many on the NHS, or on patients insured by other PMIs, or on self-paying patients. It is clear that a consultant's scope of practice is (and should continue to be) strictly controlled by hospital governance.

(e) What cost and other factors should the CC take into account in considering the reasonableness and proportionality of this remedy or the timing of its implementation?

5.20. The costs already incurred by the hospitals should provide guidance as to the costs going forward. The PMIs should be required to undertake a similar process, bearing the costs, which we assume will be similar.

6 THE “MISSING REMEDIES”: INFORMATION ASYMMETRIES BETWEEN PMIs AND POLICYHOLDERS

- 6.1 The CC recognises (at paragraph 4.11) that *“the arrangements between the PMI and the policyholders, the PMI and the hospital operator, and sometimes (?) the PMI and the consultant(s) are of greater significance in assessing competition than the contractual arrangements between the patient/consumer and the provider/supplier”*. This is very true. Whilst at least the issues between the PMIs and the hospitals and the PMIs and the consultants are discussed in the PFR, the issues surrounding information asymmetries between PMIs and policyholders receive scant attention.
- 6.2 The CC is under an obligation to consider appropriate remedies when identifying an AEC [✂].

MISSING REMEDY 1 – INFORMATION ABOUT THE REASONS WHY A CONSULTANT IS NOT AVAILABLE TO A POLICYHOLDER

- 6.3 [✂]
- 6.4 In paragraph 53 of the Summary of Provisional Findings, the CC states: *“... PMIs, and in particular Bupa as they increase their role in directing patients to consultants, need to ensure that their policyholders are provided with clear and accurate information about consultants and the reasons for recommending some consultant or for advising against the use of particular consultants ...”* (CC Summary paragraph 53).
- 6.5 There is absolutely no reason why a PMI should direct patients away from the clinical pathway recommended by the patients’ doctors; this allows for multiple errors (see above response to Remedy 7 part (c), with details of Consultant 4) and this represents the tip of the iceberg. PMIs’ websites may contain information about consultants that they register, listed under their main specialty. If for some reason the consultant is not registered or listed the PMIs must be under an obligation to inform the policyholders that their preferred consultant is not available to them for whatever reason, it being clear that the PMIs cannot deregister a consultant on grounds of fees only, because of Remedy 6(2) and 6(3).

MISSING REMEDY 2 – INFORMATION ABOUT THE TERMS OF THE INSURANCE POLICIES AND CHANGES TO THEM

- 6.6 The CC states at paragraph 7.80 of the PFR: *“... It is clearly important that policyholders understand the terms of their policies at purchase and renewal. This includes being made aware and fully informed about changes to reimbursement*

notes and the recognition of consultants which will have a direct impact on the nature of and value of benefits available under their policies ...”

- 6.7 The CC goes on to say (paragraph 1.10 PFR): *“The CC understands that the ABI has confirmed to the FSA, on behalf of its members, that PMI providers will either cover the total costs so that no shortfall arises or will make clear the possibility of a shortfall payment as a result of the limits to which apply to the amount payable under their policies at point of sale and claim ...”*
- 6.8 FIPO believes that a remedy should be imposed as this is clearly an AEC. We believe that as PMI benefits vary between companies and between subscribers in any single company (due to exclusions and excesses), the role of the PMI is simply to have an agreed national statement applicable to all PMIs which would inform the patient at pre-authorisation of the benefits available to them for the anticipated procedure(s) and a standard warning that they should request an estimate of fees from their consultant. In this way, the PMI is acting as it should in providing agreed benefits to patients according to the terms of their contract. The pre-authorisation process should not be used as a method of patient diversion, clinical controls or as a means of financially penalising patients and denying them their full benefits if they fail to comply with some predetermined pathway decided by a PMI. An example of a standard universal national PMI statement at pre-authorisation could be: *“Your consultant Mr XXX is recognised by our insurance company and so is hospital YYY. The procedure proposed by your consultant is covered by your policy and your hospital bill will be fully covered for the anticipated length of stay. The benefits you are entitled to under your policy for your consultant’s fees are £AAA. You should obtain an estimate of fees from your consultant if possible. Please note that you have an excess on your policy and so you are responsible for the first £100 of your treatment, or I am afraid that you have an exclusion on your policy for this procedure and so we cannot cover these costs.”* FIPO believes that a standardised pre-authorisation process would create a clear and unambiguous way forward for subscribers when they become sick and this should be applied universally.
- 6.9 In that way the aspirations of the ABI would be met and a truly competitive market could exist. It would also return PMIs to their proper function as financial services organisations whose purpose is to facilitate their clients’ care and not to become embroiled in clinical governance or choice issues on behalf of their clients.
- 6.10 For the avoidance of doubt, the ABI has no powers of enforcement and so any statement by the ABI cannot be seriously considered as a “remedy”. The CC must provide for a remedy in these circumstances.

EAL/KAC
Watson Farley & Williams LLP
September 2013

APPENDIX 1



APPENDIX 2



APPENDIX 3



APPENDIX 4



APPENDIX 5

