

BRITISH MEDICAL ASSOCIATION RESPONSE TO THE COMPETITION COMMISSION PRIVATE HEALTHCARE MARKET INVESTIGATION PROVISIONAL FINDINGS AND REMEDIES

September 2013

1. About the BMA

1.1. The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine all over the UK. With a membership of over 152,000 worldwide, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

2. Introduction

2.1. We wish to record our concern at the timetable adopted by the Competition Commission (CC) for review of its provisional findings and remedies. The full Provisional findings report was published nearly a week after the Notice of provisional findings and Notice of possible remedies and that the CC's timetable for submitting a response is only 17 working days from publication of the Notices and 15 working days from the publication of the Provisional findings report. We are concerned that this suggests that the CC considers that there is limited scope to influence both the provisional findings and the proposed remedies. We hope that this is not the case and that this is reflected in the final findings and remedies.

2.2. We have set out our comments in three main areas: an executive summary, detailed comments on the provisional findings report and our response to the specific questions on the provisional remedies that apply to consultants.

3. Executive summary

3.1. Our response to the provisional findings and remedies is as follows.

- The BMA is disappointed that the CC has not proposed a remedy to prohibit Private Medical Insurers (PMIs) from preventing consultants from charging top-up fees. The CC should revisit the statement at ¶¶108-112 of the Annotated Issues Statement that preventing consultants from charging top-up fees may lead to a reduced choice of consultant for Bupa and AXA PPP customers and that those customers will have little opportunity to respond to this because of the market share of Bupa and AXA PPP. This issue is addressed in more detail below.
- While we welcome the finding at ¶153 of the summary of provisional findings that PMIs, and Bupa in particular, should provide patients with further information about why they are directing patients to one consultant rather than another, this recommendation does not go far enough and should constitute a formal remedy. The confusion that is created by PMIs redirecting patients to consultants based on their fee levels is damaging to individual consultants and limits patient choice. It also distorts traditional referral processes taking clinical decisions away from GPs to PMI case managers and case teams.

- We are concerned that the Office of Fair Trading's (OFT) recommendation at ¶9.4 of its Final Report (OFT1412, April 2012) that PMI information to subscribers at the point of sale should be improved and that PMIs and the Association of British Insurers (ABI) should work with the FSA (Financial Services Authority, now the Financial Conduct Authority) to ensure that this is addressed has not been taken forward. We believe that PMIs' failure to do this should result in the OFT's recommendation constituting a formal remedy in the final CC report.
- We support the CC's assessment that the presence of anaesthetic groups did not lead to higher prices for patients and that you did not find any competitive harm in other specialists forming professional groups (see summary of provisional findings at ¶¶48-49). This is in line with our submissions to the CC's market investigation.
- We support greater transparency and information availability to patients about consultant fees (see Notice of possible remedies at ¶¶71-74). This is addressed in more detail below.
- It is essential that the proposed remedies relating to private hospital providers set out in the Notice of possible remedies, particularly the divestment proposals, do not inadvertently negatively impact on consultants' ability to practise in their local area.

4. Detailed comments on the provisional findings report

- 4.1. We have some more detailed comments to make on particular aspects of the provisional findings report.

Consultants

- 4.2. The BMA is disappointed that the CC has not recommended that PMI influence over consultants' fees should be addressed, despite recognising at ¶152 of the Summary in the Provisional findings report that Bupa and AXA PPP have buyer power in relation to consultants.
- 4.3. As we have stated in previous submissions, preventing consultants from charging top-up fees leads to a reduced choice of consultants available to patients insured by Bupa and AXA PPP. If this were allowed to continue other PMIs would introduce similar policies which would further reduce the choice of consultant available to patients.
- 4.4. We agree with the statement at ¶17.70 of the Annotated Issues Statement that "If extensively and rigidly applied, fee-capping consultants could lead to distortions in competition and to reduced consumer choice. Fee-capping ... has the potential to increase the disincentives on consultants from setting fees to reflect their costs, experience, expertise and the local market conditions."
- 4.5. The consequence of prohibiting top-up fees is, as stated at ¶17.69 that "Bupa's Benefit Maxima, as the industry standard in particular clearly operates in practice for many consultants as both a maximum and a minimum fee schedule." This means that Bupa is able to engage in price fixing for all consultants in private practice. Were this done collusively, this would be a breach of the Chapter I prohibition under the Competition Act 1998. That this is done by the largest PMI with a dominant position through its over 40% market share, which is also vertically integrated through its ownership of the Bupa Cromwell hospital, makes no difference to the economic effect.
- 4.6. As stated at ¶¶108-112 of the Annotated Issues Statement these practices can be expected to lead to a reduced choice of consultants available to patients insured by these insurers and that purchasers' of private medical insurance response to this may be muted, especially since the market share of Bupa is over 40% and the combined market share of Bupa and AXA PPP is around 65%. While the CC states at ¶17.60 that "in the absence of the PMIs constraining consultants' fees, it is unclear how such fees would be constrained", we believe that the constraint on consultant fees would be by the market – by what consumers are willing to pay in order to have their consultant of choice.

- 4.7. If preventing consultants from charging top-up fees were to continue, the remedy on consultant fees (see Notice of possible remedies at ¶¶71-74) will be unnecessary as consultants will increasingly be required to agree their outpatient fees with PMIs and charge at PMI prescribed fee levels.
- 4.8. We believe that there has also not been adequate consideration given to the effect that preventing top-up fees has on quality of service. A PMI subscriber may wish to pay a top-up fee in order to secure the services of a consultant with particular expertise. That would provide an incentive on consultants to develop expertise and to compete on quality. This adversely affects not only consultants but also consumers because it limits their ability to select the consultant of their choice having regard to their quality and expertise.
- 4.9. While AXA PPP have provided assurances that it will monitor the proportion of consultants that they recognise who are required to charge at the levels published in their Schedule of Fees to ensure patients have adequate choice of consultant, Bupa – the dominant PMI with a market share of over 40% (¶3.96 Provisional findings report) – has given no such commitment. While it is true that the majority of those recognised on those terms are new to private practice this does not take in to account experience as a consultant. They are equally restrictive to all those recognised from July 2008 (AXA PPP) and June 2010 (Bupa) regardless of experience. We are not aware of anyone being offered less restrictive terms relating to their fees since these new criteria were introduced. We do not agree that PMIs should be responsible for deciding when consultants should be able to increase their fees (¶7.48 of the Provisional finding report). We are also concerned by Bupa’s intention to consult with consultants recognised before 2010 on how they work with them in the future.
- 4.10. We request that the CC reconsiders the consequences of PMIs preventing consultants from charging top-up fees and particularly the conclusion at ¶111 of the Annotated Issues Statement that “it is not evident to us that patients are disadvantaged by top-up fees if they know about them in advance and if this would allow them to choose the consultant they prefer. Allowing such fees might provide greater patient choice.”

Clinician incentives

- 4.11. We agree that incentive schemes operated by private hospital providers which encourage patient referrals for treatment at their facilities should be prohibited. We do have concerns that limiting all incentives may raise barriers to entry for consultants, especially those entering the market. We provide detailed comments on this in our response to the questions about the proposed remedy.

Information availability and asymmetry

- 4.12. We support greater transparency and information availability to patients about consultant fees. We highlight some initial practical considerations below but given the impact this remedy would have on our members, the BMA would expect to be consulted further and involved in the development of any process for publishing fees to ensure it is workable for doctors.
- 4.13. The BMA is supportive of initiatives to provide patients increased information about consultant treatment outcomes so long as that information is robust, rigorous, and risk adjusted. The publication of outcome data for consultants across the UK should be relevant to their private practice. As such we do not support the remedy as proposed and suggest that outcome data should be collected from private hospital Key Performance Indicators.
- 4.14. We have responded to the specific questions on the provisional remedies that apply to consultants below.

5. Response to specific questions on the proposed remedies

The existence of incentive schemes operated by private hospital operators to encourage patient referrals for treatment at their facilities

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.

(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?

- 5.1. The remedy is practicable. It would be necessary to develop a framework and guidance that establishes clear criteria for assessing whether the benefits of an incentive scheme outweigh any distortions it may create. The private hospital provider could then commission an independent assessment of the benefits of any scheme. We would suggest that incentive schemes that lower barriers to entry, both for consultant and hospital providers may have some benefits to local healthcare markets. It is essential that the terms of any arrangement are not restrictive for consultants. There should be transparency within the hospital and local area about these arrangements so that patients and other consultants are aware of their existence, being mindful that any transparency does not in itself present a barrier to competition. This would also satisfy GMC Good Medical Practice requirements that consultants inform their patients if they have any financial arrangements that may be interpreted as a conflict of interest.
- 5.2. The degree of oversight necessary to ensure that this remedy is met should be light touch and constitute no more than a commitment, as part of annual CQC registration, that the hospital provider is not entering into inappropriate arrangements with consultants and that any scheme has been independently assessed. Medical Advisory Committees could also have a role in ensuring that the remedy is being met. As we have stated in previous submissions, we believe that a sector wide arbitration mechanism should be set up to address disputes between consultants and private hospitals and consultants and PMIs when they occur. This could have a role in monitoring and enforcing the fair market price test.

(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?

- 5.3. While we agree with prohibiting financial incentives to consultants, we do have concerns that there will be an unintended consequence that may create a barrier to entry for new consultants entering the market. Some hospitals provide free or reduced cost consulting rooms and secretarial support to consultants while they are establishing their practice. If this were prohibited some consultants may find the initial costs of entering the market prohibitive which in turn would create a barrier to entry and reduce competition. It is essential that any schemes that may lower barriers to entry should not be unduly restricted. In order to ensure these schemes do not create an Adverse Effect on Competition, hospitals should offer these schemes equitably to new consultants and for a time limited period.
- 5.4. For the avoidance of doubt, we are not advocating incentive schemes that encourage consultants to refer to one private hospital over another or limit competition in the provider market in a local area. We are advocating schemes that assist consultants to enter the market which result in increased competition amongst consultants.

(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?

5.5. We do not have any evidence of the extent that incentives or equity partnership arrangements exist with other healthcare service providers and we are not aware of the CC having received that information over the course of the market investigation. We do not agree with the PMI assertion that consultants recommend excessive diagnostics or testing in the private healthcare sector. There is no evidence to suggest that if this were the case, this is a result of incentives of equity partnership arrangements with providers of these services. This would be contrary to Good Medical Practice. As such, it would be inappropriate to recommend that this remedy should be extended as it is not based on evidence that these arrangements (if they exist) affect consultant behaviour or the market. We continue to maintain that consultants should inform patients of any arrangements as required in the GMC's Good Medical Practice. Any financial conflicts of interest, actual or perceived should be avoided by consultants.

5.6. PMIs should be prohibited from operating incentive schemes that reward consultants who recommend cheaper treatments or less expensive hospitals. Referral decisions should be based on the clinical need of the patient and these types of incentives would distort that process and limit patient choice.

(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?

5.7. It should be noted that doctors already have regulatory responsibilities relating to incentives and financial interests through professional regulation. It would be more reasonable to work with the GMC to develop a campaign to ensure that consultants are aware of their obligations under their professional standards.

5.8. While we support the prohibition of incentives, we do not believe that these are so widespread that complex regulation is necessary. The Stark Law in the USA applies only to Medicare referrals, not all healthcare referrals and the private provider market in some areas is so small that regulation may be impracticable. The interface between the NHS and private healthcare in this context is also unique to the UK. Any regulation would have to be considered with that in mind, for example whether a consultant treating a patient in the NHS hospital that they work could constitute a conflict.

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

5.9. It may be necessary to grandfather existing arrangements. While this is not an ideal solution it would ensure that the remedy does not inadvertently destabilise the market and reduce competition in local areas. A targeted campaign about the remedy highlighting consultants' responsibilities under Good Medical Practice may also assist with limiting continued influence on the market.

(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?

5.10. Historically a number of private hospitals have been set up or initiated by local consultants in response to need. It would be unreasonable for consultants to be prevented from investing in the provision of healthcare which increases provider competition and ultimately drives down costs. With the increasing privatisation of the NHS this may become

essential. The safeguards should be by robust regulation not prohibition which will lead to uncontrolled circumventions.

Lack of sufficient publicly available performance information on consultants

Consultant quality

Remedy 5 — We would make a recommendation to the health departments or their equivalent bodies in Scotland, Wales and Northern Ireland that they collect and publish on their most appropriate patient-facing website individual consultant performance indicators to include activity and clinical quality measures across the same or an equivalent range of medical specialties to that included in the NHS England scheme. Data would, as in England, be standardized so as to permit a genuine like-for-like comparison between consultants in the same specialty but working in different parts of the UK.

(a) Is the proposed remedy practicable in all of the nations? Where a consultant practises partly in one nation and partly in another should performance data published in one nation be confined to that relating to performance in that nation?

5.11. The BMA is supportive of initiatives to provide patients increased information about consultant treatment outcomes so long as that information is robust, rigorous, and risk adjusted. However, we do not believe that it is appropriate to mandate the use of NHS data for the private sector and we do not support the remedy as it is proposed. Not all consultants have an NHS practice and the procedures chosen are not performed by every consultant in the specialties that are publishing data. They also do not reflect the nature of the work carried out in the private sector, where the bulk of operations are minor or intermediate and higher risk procedures are not frequently performed.

5.12. We would suggest that a more appropriate indicator of consultant quality would be private hospital Key Performance Indicators (KPIs), such as mortality, return to theatre and readmissions. The Private Healthcare Information Network (PHIN) already collects this data and may have a role in assisting with this.

(b) Is the proposed list of ten specialties for which performance data will be available on an individual clinician basis appropriate?

5.13. Collecting outcome data based on private hospital KPIs would be appropriate for all specialties to some extent and provide more information than proposed in the remedy.

(c) Are the indicators that are currently published for consultants in each of the ten specialties, the way they are presented and the manner of their distribution appropriate? Are they (or some combination thereof) appropriate for other areas of specialty? If not, which indicators would it be appropriate to adopt for each specialty and how should they be presented and distributed?

5.14. As stated above we do not believe that the indicators that are currently published are appropriate for the private healthcare sector. Specialty associations have been asked to publish data showing how many times a consultant has performed a procedure and their mortality rate for that procedure. It is unlikely that mortality rates will be a useful indicator of quality for the majority of patients seeking private medical treatment.

5.15. It is essential that any data that is published is meaningful to patients. There should be a consistent approach to publishing outcome across private hospital providers. We believe that it would be inappropriate for the CC to recommend publication of further information without the relevant clinical expertise and understanding of the complexities of publishing meaningful data.

(d) Does the remedy risk giving rise to unintended consequences? Even with standardized mortality rates, might consultant incentives to treat more seriously ill patients be affected?

- 5.16. Any data must not be too simplistic and must be provided in context. It would be unacceptable if the publication of this data affected the type of patient consultants treated. That is why it is essential that data is provided in context, is robust, rigorous and risk adjusted.

(e) With what frequency should performance indicators be updated?

- 5.17. Data should be statistically robust and should be published annually.

Consultant fees

Remedy 6 — We would require all consultants practising in the private healthcare sector to publish their initial consultation fees on their websites and we would require each private hospital where they have practising rights to publish these fees on their websites. We would, further, require consultants to provide a list of proposed charges to patients in writing, in advance of any treatment.

(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?

- 5.18. We support a transparent approach to consultant fees and we already publish Good Billing Practice guidance that encourages consultants to inform patients of the likely fee that they will be charged in advance of treatment. The recommendation that doctors should provide a list of proposed charges to patients in writing in advance of treatment is supported, but may not be practicable in all cases (see response to d) below). It may be necessary to require PMIs to change the terms of recognition for consultants as some recognition criteria prohibit consultants from communicating directly with patients about their fees.

- 5.19. Not all consultants have websites to market their practice and it would be impracticable to expect them all to do so. Consultants who work in specialist groups should not be required to have individual websites in addition to a website that provides fee information about the group. This should be taken in to account in the wording of the final remedy. On the whole outpatient fees will be fixed and it should be possible to provide an average or range of fees, but there may be some variation depending on the patient's needs. It should also be noted that some consultants are required to agree outpatient fees with some PMIs, most notably Bupa, and this may also account for some variation between patients. We question the relevance of this remedy in the future if PMI control over consultants' fees is not limited.

(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?

- 5.20. It is possible to provide an estimate, but consultants should always make clear that the final fee may vary because of unforeseen circumstances and complications. It would be impractical to suggest a means for adjusting fees as this would depend on the circumstances that arise following the initial fee estimate. It is the responsibility of the consultant to provide estimates of their likely fees and draw attention to other possible charges, such as anaesthetists' fees and radiology. The responsibility for providing a fee estimate should not be transferred to a third party. It should be noted that timescales may make it difficult to provide a written estimate, although consultants should be encouraged to do so whenever possible.

(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?

- 5.21. It is reasonable for all consultants to disclose their outpatient consultation fees. Requiring this for some consultants and not others would be difficult to monitor and would create inequity between consultants.

(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?

5.22. It would be difficult to recommend a timeframe for how far in advance an estimate should be provided as this will vary depending on the needs of the patient, how quickly the procedure will be undertaken following consultation and, if appropriate, the availability of an anaesthetist. It is practical for most procedures for patients to be informed of costs in advance of treatment, but there will be clearly be circumstances where that is not the case, such as urgent care. Consultants should not be responsible for informing the patient of their PMI reimbursement maximum. There is a range of PMI polices and reimbursement maxima and it should be the responsibility of the PMI to make that information available to their subscribers.

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

5.23. As stated above, not all consultants have websites and therefore this element of the proposed remedy may be impracticable. It will be very difficult to enforce this remedy for individual consultants. The GMC is the only organisation that has a relationship with all consultants practising in the private healthcare market. The BMA and specialty associations could have a role in supporting this.

5.24. A more realistic approach is that providing fee data becomes a condition of being granted practising privileges at a private hospital and that the provider group is responsible for overseeing that their hospitals are implementing the remedy by making this information available to patients.

5.25. We believe that PMIs should not have any role in the provision of this information to patients.