PRIVATE HEALTHCARE – IMPLEMENTATION OF ARTICLE 22 OF THE 2014 ORDER

Summary of hearing with the Federation of Independent Practitioner Organisations on 31 March 2017

Introduction

1. The Federation of Independent Practitioner Organisations (FIPO) emphasised that it had always been in favour of remedies requiring the publication of information on both consultants' fees and quality, noting that for the last 12 years its website had provided guidance to consultants about giving patients fee estimates. FIPO said that it had been working closely with the Private Healthcare Information Network (PHIN), a number of specialists, and various other expert bodies to help develop suitable quality outcome measures and fee information for patients.

2. However, FIPO considered that the consultant fees remedy should be extended to include information on private medical insurance (PMI) benefits in order to ensure its effectiveness.

Distortions for insured patients

3. FIPO explained that self-pay patients generally knew what the costs would be in terms of hospital and consultant fees. Therefore this side of the market was working reasonably well. In contrast, FIPO identified various problems with the insured patient pathway, which meant that it did not work well for patients. In particular, FIPO highlighted the following aspects of the market that it considered created distortions:

    - The lack of competition between consultants on fees because these were increasingly standardised and controlled by PMIs (complemented by e-billing and non-recognition).

    - A lack of clarity for patients at the point of buying PMI. For instance regarding the level of benefits/coverage provided by their PMI policy for both consultant and hospital fees, and how this related to the premiums the patient had paid.

- PMI control over patients' treatment options, in terms of the consultants and hospitals used, and the treatments provided, including restrictions on the portability of benefits.

Clarity regarding PMI benefits and PMI control over patient treatment options

4. FIPO noted that when patients bought insurance they did not know what they were going to use it for, which made it difficult to compare benefits. This situation was exacerbated by the large number of PMI policies with different coverage levels. As a result, customers tended to purchase policies based on price without sufficient clarity over the benefits or the coverage provided by the policy they were purchasing.

5. Furthermore, FIPO noted that:

   - procedure benefits varied widely across the major insurers and that higher premiums did not necessarily result in higher benefits;

   - the PMIs did not present their benefits in a comparable and under-standable manner and there was limited information on hospital charges;

   - Insurers had changed the level of benefits offered over time, reducing them significantly; and

   - insurers controlled the patient pathway via their policy terms and their recognition or not of certain providers and/or procedures. Insurers used these tools to divert patients away from certain consultants and/or hospitals based on over-simple analysis covering price and a perceived propensity to treat patients, and not based on quality or suitability to patient needs.

Relationship between the consultants and the PMIs

6. FIPO considered that consultants were inhibited by the constraint PMIs exerted over the level of their fees, noting the CMA's figures that 50 to 70% of consultants were on fixed fees, with PMIs requiring all new consultants to agree to such fees or face failure of recognition.

7. FIPO considered that in order to make the market work well a patient should have the ability to choose their consultant, their treatment and their hospital without being directed by insurers. Instead, insured patients should have 'portable' benefits, which they were able to use towards the costs of treatment

from whichever hospitals/consultants they wished to use. FIPO cited Financial Service Ombudsman rulings in support.

8. FIPO considered that the CMA should allow consultants to charge published independently determined fees. Furthermore it considered that hospitals should set out their charges for a certain number of common procedures on a comparable and understandable basis, with patients free to use their benefits to make a free choice of the consultant and hospital, which was not modified or distorted by the insurer.

Additional elements required for the remedy to be effective

9. FIPO considered that giving information to patients on consultant fees – while welcome – would leave the remedy falling far short of its objectives in terms of equipping patients with meaningful information about the costs that they were going to face. FIPO considered that for insured patients, this was not just a function of fees; but was also a function of the benefits provided to patients by PMIs. Therefore, FIPO stated that the consultant fees remedy should be extended to include detailed information on PMI benefits for a certain number of common procedures on a comparable and understandable basis in line with hospital costs. This would ensure the effectiveness of the fees remedy in terms of informing patients about the costs that they were likely to face and thereby allowing them to make meaningful choices regarding private healthcare, for example, and choosing to top up or to avoid shortfalls.

CMA ability to amend the consultant fees remedy

10. FIPO considered that the CMA had the legal power to amend the consultant fees remedy to require the publication of further information on PMI benefits, noting the following:

- Given that there were aspects that inhibited the remedy – as currently formulated – from achieving the CMA's objectives then it was open to the CMA to issue a second round of consultation which proposed the additional requirements to make the remedy effective.

- If as a result of the consultation it was evidenced that additional information on PMI benefits were required, that could be included in a revised remedy without a further inquiry.

- The current market dynamics (of fee-capping, PMI direction of patients etc) could be seen to give rise to 'special reasons' for re-examining the remedy and reviewing what was needed to achieve its objective.

- Such an approach did not require the CMA to reach the conclusion that there had been a material change of circumstances (MCC), or to find a different or additional AEC (adverse effect on competition) from that set out in the final report, although FIPO maintained that there had been an MCC.