1. Introduction

The British Medical Association (BMA) is the trade union and professional association for doctors and medical students in the UK. We ensure that doctors and medical students have the resources and support to fight for improvements in the workplace and in medical practice for the benefit of ourselves, our colleagues, our patients, and a healthier society. We do this through organising to win and campaigning to influence on the matters of importance to the medical profession. The BMA Private Practice Committee (PPC) considers and reports on matters in the field of private general and consulting practice. The committee represents doctors engaged in private practice (looking after self-pay patients/patients with private medical insurance). This BMA submission led by the Private Practice Committee, responds to the Competition and Markets Authority s Strategic Review of market remedies, focusing specifically on the 1994 Undertaking by the British Medical Association (BMA) prohibiting publication of fee-related information for private medical services. The BMA submits that the continued existence of the 1994 Undertaking is no longer justified as it is deeply understood that the association cannot recommend fees.

2. Market Developments

Since the BMA ceased recommending fees for private medical services in 1994, the private healthcare market has undergone significant structural change. In particular, the market power of private medical insurers (PMIs) has increased, leading to several concerns:

Cost prioritised over quality

PMIs frequently direct patients to consultants who accept insurer-determined low fees.

Reduced patient choice

PMIs such as BUPA and AXA restrict access to consultants through narrow networks (e.g., Platinum Consultant" lists) and open referral pathways, limiting patient autonomy and choice.

Arbitrary classification of Chronic Conditions" and Denial of NICE Approved Treatments

PMIs apply inconsistent and unregulated definitions of chronic conditions, approving treatment for some (e.g. osteoarthritis) while denying others (e.g. rheumatoid arthritis or multiple sclerosis). This leads to delays/ denial of clinically necessary interventions.

Fee suppression and unfair reimbursement

Consultant fees have been progressively reduced, rendering private practice financially unsustainable for many clinicians and prompting withdrawal from PMI work. In addition, insurers now use algorithmic benchmarking and data analytics to identify the lowest fees consultants are willing to accept under insurer-imposed contract terms. Through ownership and control of billing infrastructure — including Healthcode — insurers have access to detailed billing data. This allows them to benchmark consultants against lowfee comparators

and apply systematic downward pressure on reimbursement rates. This data asymmetry did not exist in 1994.

Lack of transparency

Consultants report unexplained network removals and opaque statistical metrics that overlook subspecialist expertise. For example, we are aware that BUPA uses peer group risk-adjusted comparisons to see whether consultants meet their network criteria. BUPA does this by comparing the consultants' clinical practice, patient feedback and the cost of the care for customers under the consultant's care with other consultants in the same specialty and subspecialty. The BMA is not clear how invoice information can sufficiently cover the areas BUPA states it is assessing consultants on.

Increased financial burden on patients

Prohibitions on fee top-ups lead to patients either having to self-fund essential care or accept lower quality alternatives. This is particularly detrimental in areas such as ADHD and autism services. The BMA does not understand why a patient should not be given the choice to top up payments from their insurance policy to access treatment from a consultant if they feel that is the most appropriate treatment for them. We believe that these restrictions on top-up payments which have no clinical basis is further evidence of insurers eroding the doctor patient relationship, limiting patient choice and reducing consultants' ability to set their own fees based on the service that they provide.

Impact on clinical standards

Consultants highlight that current PMI practices undermine patient safety, continuity of care, and overall clinical quality.

Use of misleading terminology

Labels such as Platinum" or Recognised/Derecognised" imply quality assessment yet are based solely on cost metrics and are often perceived as derogatory.

Bundled fee structures and hospital–insurer alignment

Private hospitals increasingly operate bundled fee arrangements for radiology and histopathology services, whereby the hospital bills insurers directly, retains a growing share of the reimbursement, and pays consultants a progressively reduced fee year on year. This vertical alignment between hospital groups and insurers was not a feature of the market in 1994 and represents a structural shift in bargaining power.

Consolidation of medical premises

Currently, most consultants rent space within private hospitals or large clinic groups, creating rental and overhead pressures that were not a feature of private practice in 1994.

Development of required technology/software buy-in

The private hospital, insurance and other systems now require your patient systems to integrate into them, rather than having free choice on using paper/any patient records, again creating fixed costs.

3. Age and Impact of the Remedy

The Undertaking is over 30 years old and predates modern digital pricing systems and algorithmic benchmarking. Its continued effect is asymmetrical, constraining transparency on the provider side while leaving insurer reimbursement practices unrestricted. Furthermore, the market has seen significant developments, including the establishment of the Private Healthcare Information Network (PHIN). As the Information Organisation for private healthcare in the UK, PHIN has a duty to collect data from all providers of privately funded care and publish performance measures to help patients make informed decisions.

The Private Practice Committee remains concerned that the fee section on the PHIN website is all about the self-pay market. It should however be for all patients, including insured patients. This would be helpful in order to open up choice to the patient and provide more transparency.

4. Regulatory Landscape

Independent consultant practice is increasingly constrained by disproportionate regulatory requirements and the growing dominance of corporate providers. Consultants cannot lawfully practise independently without CQC registration in England, which is lengthy and onerous, while non medical practitioners can often work without equivalent oversight. Meanwhile, corporate providers use their CQC registration to provide non doctor led services and capture a significant share of patient fees.

These structural conditions reduce patient clarity about professional accountability and create medicolegal risk. As independent prescribing expands across professions, the misalignment between training, regulation, and clinical responsibility risks eroding consultant scope and compromising patient safety. There are significant risks that patients are being offered care by non-doctors without adequate clinical or regulatory oversight, with that change being driven by corporate practices and finances, not best practice or clinical excellence. Regulatory parity and proportionality are needed to restore an equitable and safe operating environment. The competitive risk profile in today's market lies not in professional transparency, but in concentrated buyer power, data asymmetry, and vertically integrated corporate control.

5. Changes to the Bound Business

The BMA does not set or negotiate fees collectively for doctors engaged in private practice. Its role is representative and advisory. The Undertaking no longer addresses a realistic competition risk associated with the BMA s current activities.

6. Conclusion

The BMA submits that the 1994 Undertaking should be removed or substantively amended to reflect modern market realities. The BMA has not published in any form whatsoever *Private Consultant Work: BMA Guidelines 1992* and does not publish/has no intention of publishing in any form whatsoever any schedule, list or notification which relates to fees charged or to be charged for private medical services and which are similar in effect to the *BMA Guidelines 1992.*

The BMA would urge the CMA to address the fact that contemporary private healthcare market is characterised by insurer buyer power, algorithmic fee suppression, vertical integration of billing systems, bundled hospital payment mechanisms, and increasing corporate concentration — none of which were contemplated in 1994.

For further enquiries, please do not hesitate to contact [✂], chair of the Private Practice Committee or [✂], Lead, Private Practice Committee at [✂]