CMA Markets Strategic Review Provisional Decision Consultation Response from BMA Consultant Doctor D

Dear Sir/Madam,

Non-confidential response to the CMA's Strategic Review of Market Remedies

I am writing in response to the CMA's provisional decision of 12 August 2026 concerning the Strategic Review of Market Remedies, specifically the proposed removal of the Undertaking given by the British Medical Association (BMA) in 1994.

I support the removal of the 1994 Undertaking. However, I believe the CMA should use this review to consider whether the underlying competition concerns in the private medical services market have genuinely disappeared, or whether the market has evolved in a way that has transferred substantial market power from the consultant supply side to a highly concentrated group of private medical insurers (PMIs).

In my view, the central competition issue in 2026 is no longer principally the risk that consultants might collectively influence private medical payments. It is whether a small number of highly concentrated purchasers now possess substantial buyer power over a fragmented consultant supply side, enabling them to determine payments, contractual terms and access to insured patients, with limited countervailing bargaining power.

A fundamental change in market structure

The 1994 Undertaking was introduced in a very different market. It prevented the BMA from publishing schedules or notifications relating to private medical payments because of concerns that collective publication could facilitate anti-competitive coordination between consultants. More than 30 years later, the market has changed fundamentally.

The four major PMIs - Bupa, AXA Health, Aviva and Vitality - now account for approximately 95% of the PMI market, compared with approximately 87% previously. At the same time, the consultant supply side remains highly fragmented, consisting predominantly of individual consultants and small consultant groups.

The independent non-fee-assured (NFA) sector has also progressively contracted. Consultants who are unwilling to accept insurer-controlled payment and contractual arrangements increasingly face a practical choice between accepting those terms and withdrawing from private practice or from significant parts of the insured market.

This creates a self-reinforcing effect. As fewer consultants remain willing and able to operate independently of insurer-controlled arrangements, the alternative to accepting those arrangements becomes less credible and the bargaining power of the major PMIs increases.

There is therefore a significant risk that effective competition in consultant payments has been substantially reduced.

Buyer power and control of consultant payments

Major PMIs establish payment schedules covering large numbers of consultants and procedures. Once a payment has been established for a particular procedure code, an individual consultant may have very limited ability to negotiate a different payment without risking loss of recognition and access to insured patients.

In my experience, this means that PMIs can exercise very substantial influence over procedure code payments. Where a small number of insurers account for approximately 95% of the market, individual consultants have limited ability to substitute between purchasers and therefore limited countervailing bargaining power.

The CMA should examine whether this market structure produces monopsony or monopsony like effects, including suppression of consultant payments through concentrated purchasing power.

The issue is not simply whether an individual consultant considers a particular payment adequate. It is whether payment levels are genuinely determined through competitive negotiation or can instead be imposed by purchasers possessing substantial market power.

Recognition and market access

The issue extends beyond payment levels.

PMIs determine which consultants they recognise, which are fee-assured, what payments they will reimburse and under what contractual conditions. In practice, recognition can therefore operate as a significant gatekeeping mechanism for access to insured patients.

I do not suggest that insurers are statutory professional regulators. The GMC determines whether a doctor is professionally entitled to practise, while professional competence and patient safety are governed through established regulatory and clinical frameworks.

However, PMIs can have a quasi-regulatory effect when determining which appropriately qualified consultants can participate in their networks. In my experience, recognition decisions may ultimately turn on whether a consultant accepts the insurer's financial and contractual terms rather than on objective evidence concerning safety, quality or professional competence.

A consultant may therefore be fully GMC registered, appropriately trained and professionally competent, yet become effectively inaccessible to a substantial population of insured patients because they have declined an insurer's payment arrangements.

The CMA should therefore examine whether recognition arrangements constitute an exercise of buyer power extending beyond purchasing into effective control of market participation.

CCSD and standardisation of payments

The role of the Clinical Coding and Schedule Development (CCSD) system also warrants consideration.

The CCSD provides a common framework through which procedures are coded and mapped to reimbursement arrangements across the private medical insurance market. Standardised coding has obvious legitimate administrative benefits. The competition concern arises where a common coding framework becomes closely linked to standardised payment levels across a highly concentrated purchasing market.

The CMA should therefore consider whether the CCSD framework facilitates standardisation of purchasing terms between competing insurers and whether this reduces meaningful competition between purchasers over the payments offered to consultants.

This does not require an assumption that the CCSD constitutes a cartel or unlawful coordination mechanism. The relevant question is whether its operation may contribute to a market outcome in which competing purchasers adopt highly similar reimbursement structures.

Changes to payment arrangements

Another concern is the ability of insurers to alter payment arrangements during the lifetime of a policy.

There are instances where procedure codes have been downgraded, reclassified or removed from payment schedules during a policy term. A consultant may therefore agree to provide services on the basis of an established reimbursement framework only for the relevant payment arrangement subsequently to change.

Where refusing the revised arrangement risks recognition and access to insured patients, the consultant may have little practical ability to challenge such changes.

The CMA should consider whether the ability to make material unilateral changes to procedure-code payments is evidence of substantial buyer power and whether consultants have meaningful opportunities to challenge such changes.

PMI premiums, hospital pricing and consumer benefit

There is also an important question as to whether extensive control of consultant payments has generated identifiable benefits for consumers.

Consultant payments represent only one component of the total cost of private healthcare. Hospital charges frequently constitute the majority of the cost of an insured episode and can account for 80% or more of total PMI expenditure associated with treatment.

Despite this, considerable attention has been directed towards controlling consultant payments through payment schedules, caps and recognition arrangements.

I am not aware of evidence demonstrating that such control of consultant payments has resulted in a corresponding reduction in PMI premiums or otherwise delivered demonstrable consumer benefits.

The CMA should therefore examine whether savings extracted from consultants have been passed through to policyholders or whether the principal effect has instead been a transfer of economic surplus from the consultant supply side to insurers.

The relative lack of transparency concerning hospital pricing is also relevant. Consultants are subject to extensive scrutiny concerning their own payments, while there is considerably less transparency concerning hospital charges, despite those charges often representing the majority of treatment costs.

This creates a significant information asymmetry between consultants, insurers and patients and warrants consideration from a competition perspective.

Patient choice and market participation

The effects of insurer purchasing power are also apparent in patient choice.

Where an insurer will not reimburse a consultant unless that consultant accepts its payment arrangements, a patient may technically retain the ability to choose that consultant. In practical economic terms, however, the choice may become unrealistic if it results in substantial personal financial exposure.

I have personally encountered circumstances in which patients were effectively required to change anaesthetists because their insurer would not recognise or reimburse the consultant they had originally chosen. This left the patient with a choice between changing an established member of their clinical team, accepting significant personal financial liability, or postponing the procedure. On a number of occasions, surgery was delayed or postponed while an alternative insurer-recognised anaesthetist had to be identified and arranged.

The competition issue is not primarily the individual contractual dispute. It is that insurer purchasing power can determine which consultants can realistically compete for insured patients.

A consultant who declines an insurer's payment arrangements may remain fully entitled to practise but nevertheless lose practical access to a substantial proportion of the insured market. This creates a significant barrier to continued participation and further weakens the bargaining position of the remaining independent consultants.

The changing competition problem

The original 1994 concern was essentially a supply-side competition concern: that collective publication of consultant payments might facilitate coordination between consultants.

The market now presents a materially different picture. PMI purchasing is highly concentrated,

the consultant supply side remains fragmented, the independent NFA sector has contracted, insurers can establish standardised procedure-code payments, recognition arrangements influence access to insured patients, and payment arrangements can be altered or removed. The direction of market power may therefore have fundamentally changed.

The CMA should not assume that removing the 1994 Undertaking addresses the relevant competition problem simply because the original restriction is outdated. The removal may be appropriate, but it should be accompanied by a fresh assessment of where market power now lies.

The central question is whether a small number of highly concentrated purchasers can exercise substantial buyer power over a fragmented professional supply side and determine the commercial terms under which consultants can participate in the insured market.

Key competition questions

I respectfully ask the CMA to consider, as part of its final decision:
1. Whether the original competition rationale for the 1994 Undertaking remains applicable to the current market.
2. Whether the increase in the market share of the four major PMIs to approximately 95% has materially increased their buyer power over consultants.
3. Whether the contraction of the independent NFA sector has significantly reduced effective competition and countervailing bargaining power in consultant payments.
4. Whether major PMIs are now able to determine procedure-code payments rather than genuinely negotiate them.
5. Whether the current market produces monopsony or monopsony-like effects, including reduced consultant payments, reduced independent supply and consultant exit.
6. Whether insurer recognition arrangements operate as effective barriers to market participation for consultants who do not accept insurer payment arrangements.
7. Whether recognition decisions are supported by objective evidence concerning safety, quality and professional competence, or whether financial and contractual acceptance is a significant determinant.
8. Whether the CCSD framework facilitates standardisation of payment levels between competing insurers and warrants competition scrutiny.
9. Whether insurers' ability to downgrade, alter or remove procedure codes during policy terms is consistent with effective competition and meaningful countervailing bargaining power.
10. Whether there is evidence that control of consultant payments has delivered lower PMI premiums or other identifiable consumer benefits.
11. Whether the relative lack of transparency surrounding hospital pricing is competitively appropriate when hospital charges may account for 80% or more of total PMI expenditure.
12. Whether the current market structure creates adverse effects on competition through reduced consultant participation, restricted patient choice and increased barriers to continued participation by independent consultants.

Conclusion

I welcome the proposed removal of the 1994 BMA Undertaking. However, removing an outdated restriction should not be equated with concluding that the underlying competition concerns in the private healthcare market have disappeared.

The market has changed fundamentally since 1994. The four major PMIs now account for approximately 95% of the market, while the consultant supply side remains highly fragmented and the independent NFA sector has progressively contracted. Major insurers can establish standardised procedure-code payments, determine recognition, alter reimbursement arrangements and influence whether individual consultants can realistically access insured patients.

The competition concern may therefore now be the reverse of that which originally motivated the Undertaking. Rather than fragmented consultants possessing excessive collective bargaining power, a small number of highly concentrated purchasers may possess substantial buyer power over a fragmented professional supply side.

This is particularly significant because consultant payments constitute only a relatively small component of total PMI expenditure, while hospital charges can account for 80% or more of the cost of an insured episode. There also appears to be no clear evidence that suppression of consultant payments has translated into lower PMI premiums for consumers.

I would therefore respectfully encourage the CMA to consider whether the current private medical insurance market requires greater scrutiny from the perspective of buyer power, monopsony, market concentration, barriers to market participation, recognition arrangements and consumer benefit.

I would be happy to provide the CMA separately with anonymised evidence of current insurer payment schedules, recognition arrangements, correspondence, mid-term changes to procedure-code payments and examples of consultant payment reductions. Where appropriate, such material could be provided separately on a confidential basis.

Yours faithfully,

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