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PRIVATE HEALTHCARE MARKET INVESTIGATION

FIPO's Reply to Statement of Issues

July 2012

1. The Federation of Independent Practitioner Organisations ("FIPO") welcomes this opportunity to consider the Statement of Issues published by the Competition Commission ("CC"). FIPO is an umbrella organisation for other organisations of consultants. The FIPO Board membership currently comprises representatives of the following organisations:

Association of Anaesthetists of Great Britain & Ireland; Association of Coloproctology of Great Britain & Ireland; Association of Independent Radiologists; Association of Ophthalmologists; British Association for Surgery of the Knee; British Association of Aesthetic Plastic Surgeons; British Association of Plastic, Reconstructive and Aesthetic Surgeons; British Association of Urological Surgeons; British Elbow and Shoulder Society; British Hip Society; British Orthopaedic Association; British Orthopaedic Foot and Ankle Society; British Orthopaedic Trainees Association; British Society of Gastroenterology; ENT-UK ; Group of Anaesthetists in Training; Hospital Consultants and Specialists Association; Independent Doctors' Federation; London Consultants' Association; Society of British Neurological Surgeons; Sussex Association of Consultants.

2. FIPO's role is to provide an all-round resource to the member organisations and to seek the views of the member organisations on issues of importance to them. In this capacity, FIPO is well placed to field questions and collect available evidence and would like once again to offer to the CC a platform from which the CC can more easily contact consultants. In this regard, FIPO notes that there are 67 submissions by individual consultants on the CC website, none of them longer than a few pages. It is difficult for individual consultants to be able to provide the sort of evidence which the CC needs.
3. FIPO is very mindful of the need to provide evidence to support its views. There are a number of difficulties with consultants providing evidence. One is that, unlike large groups such as insurers and hospitals, FIPO does not routinely collect information on the dynamics or economics of this market place. The sort of data needed for a CC investigation is not available to consultants until an organisation (such as FIPO) makes a call for evidence and collects the data so there is inevitably a time lag between asking for information and being

able to collect it. FIPO is in the process of collecting data and will update the records as more information becomes available. The fact that in this reply FIPO may only refer to evidence of certain instances of patients' detriment, for example, is because the collection of data only began relatively recently. Other difficulties with regard to evidence of patients' detriment, but also more generally about evidence of delisting of consultants, are the important issues relating to confidentiality and data protection, which mean that data may be available only in redacted form, and in confidence to the CC. FIPO would welcome the opportunity to discuss with the CC its initiatives, which are briefly described in this submission.

4. The structure of this submission is as follows: in Part A FIPO provides an overview of the marketplace from the perspective of a consultant, as a backdrop to Part B. In Part B, FIPO considers the theories of harm listed in the Statement of Issues, and provides comments on those theories on which it considers that it has something to contribute. FIPO also describes the evidence that it hopes to collect in more detail. FIPO has special concerns about the confidentiality of this submission generally and the data in Part B specifically. FIPO asks that the whole of this submission be treated as confidential and will provide a non-confidential version as soon as possible.

PART A – The Marketplace , the Issues, the Suggested Remedies

Executive Summary

A.1. This Part provides an overview of the marketplace. As set out in more detail below:

A.2. There are features of this marketplace that lead to adverse effects on competition (“AEC”).
These features include:

- i) the existence of insurance contracts where private medical insurers (“PMI”) unilaterally dictate the treatments that patients receive (more precisely, these policies dictate what the PMIs will fund) and where they should receive those treatments;
- ii) the ability of insurers to dictate the terms and conditions under which self-employed consultants may examine their policyholders and provide treatment. Insurers do this through a variety of methods, which they are able to deploy because they are the gateway to the marketplace, and possess the ultimate weapon: the ability to delist consultants without any right on the part of the consultants to know why, to be heard or to have the decision reviewed;
- iii) the difficulty for the policyholder to change insurer. If the policyholder is a member of a corporate policy, a change of insurer will only take place at the group level, after a lot of evidence that patients within the scheme are not receiving appropriate care. The employer’s private healthcare administrator will have a primary budgetary concern, particularly in this economic climate. If the policyholder is a personal subscriber, the ability to switch to a new insurer will be difficult or non-existent under the same terms and conditions in the presence of pre-existing medical problems;
- iv) the consultants are the weakest link in this marketplace. The insurers may find it difficult to dictate terms to hospital groups (although this will doubtless be challenged by some hospitals) but even the simplest game theory illustration will show how consultants cannot withstand any major insurer’s insistence that they will be allowed to charge the patient only the low reimbursement rates decreed by the insurer, under a threat of delisting.

A.3. AECs ensue, including the following:

- i) there is an AEC on the supply side. Existing consultants have seen the reimbursement rates for their patients slashed. If they abide by these changes, as the insurers insist they should, or feel they must or lose these patients due to insurance company redirection, it makes it harder to run a practice in a viable manner. New consultants are required to sign up to onerous contracts with low returns. In high risk specialties the consultants’ professional indemnity insurance and other costs

may outweigh the expected returns from PMIs;

- ii) there is an AEC on innovation by consultants and the purchase of new and often expensive equipment to improve diagnostic and therapeutic options for their patients. Consultants do not have a prospect of getting a reasonable return on their investment due to insurers either providing very low reimbursement or none at all;
- iii) there is an AEC leading to patients having little if any choice regarding which consultant they will see (if indeed they do see a consultant), or where they will be allowed to see someone.

A.4. There is no justification for these practices. There is no justification for the PMIs' actions against consultants, other than the PMIs simply can do it. Reimbursement rates to patients for their consultants' fees have not increased in 20 years. Driving down reimbursement rates and insisting that consultants cannot ask for a top up, goes against innovation and technical development. Consultants' costs are a small percentage of the total cost of treatment. The adverse effects of PMIs' practices on consultants and on the marketplace are totally out of proportion with the savings made.

A.5. Benefits are not passed on to patients. PMIs focus on allegedly delivering "value for money" to their customers. However, private health insurance premiums are increasing year on year, the amounts that PMIs are reimbursing consultants are drastically reducing and BUPA, for example, has announced an 86% increase in surplus in 2011. FIPO seriously questions whether any benefits relating to cost savings are being passed on to patients. BUPA also claim that restrictions on patients' topping up their insurance by paying the difference between a consultant's normal rate and the reimbursement level provide a benefit to customers. FIPO submits that this leads to provision not being directly related to consumption in any way. Ultimately, patients have no choice. Patients who wish to do so must be allowed to top up. The CC should note that patients may be allowed in theory to top up for established consultants who are not in a partnership agreement with the insurers (most likely to be senior doctors with established reputations practising in areas with high overheads) but the PMIs actively divert patients away from these consultants by saying they overcharge.

A.6. Patients are experiencing detriment. Experienced consultants are being forced out of the private healthcare market and junior consultants are dissuaded from entering the sector. Patients are being directed to treatment based on the whim of certain insurers, experiencing both lack of choice and lowering of quality of care. In the health sector, patient detriment can be very serious. There can be no objective justification for reducing the quality of treatment that patients receive.

A.7. The OFT remedies will not work in isolation. Unless the role of the PMIs is properly considered, the other remedies proposed by the OFT will have limited impact. FIPO is working on quality information initiatives as described in Part B but if patients are denied

choice, and GPs are denied the opportunity to direct patients to consultants and facilities, then availability of quality information is of very limited use. The market power of private healthcare providers, if any, needs to be considered against the market power of PMIs. If in some cases private hospitals enter into anti-competitive agreements with consultants, or if some consultants' groups act in anti-competitive manner, then of course anticompetitive agreements and abuses of a dominant position should be considered and appropriately dealt with. This is not a "feature" of this market place but an instance of behaviour which the system recognises as harmful. When harm is proven, then remedies can be imposed but a market investigation reference hopefully will allow the CC to consider all issues as a coherent whole.

Introduction and Conclusions

- A.8. FIPO submits that the most distortive feature in privately funded healthcare services (defined in paragraph A.12 below), leading to a number of AECs and consumer detriment (not countered by consumer benefits), is the action of PMIs. The market in private secondary (consultant) care is unusual in the sense that the personal relationships between the patient and their GP and consultant are not easily quantifiable but based to a large extent on trust. It is for this reason that doctors have regularly been rated as the most trustworthy of all professions or occupations. The structure of the “market” must be understood and reemphasised. GPs generally refer to their consultant of choice (with patient approval): consultants have a duty of care towards their patients and also (in the independent sector) a financial contract which makes the patient responsible for the consultant’s fees. Insurers pay benefits to patients many of whom have exclusions or excesses in their policies and in that case the patient is responsible for the balance of the consultant’s charges. Recent tactics by the major insurers, AXA PPP and Bupa (with a combined market share of around two thirds of all insured patients), are enforcing a new strategy, insisting that all newly appointed consultants should adhere to the schedule imposed by the insurer. In addition Bupa is enforcing various similar tactics for established consultants by insisting that fees should be covered by the insurance policy, without giving patients the option to meet any shortfalls that may arise. FIPO believes that this is an ominous development for the market as a whole, in light of Bupa’s recognised role as market leader.
- A.9. If the CC could only change three features, from the consultants’ perspective FIPO would consider that the CC should impose remedies to:
- (i) allow consultants and other healthcare providers to charge for their services, without fear for their livelihood (remedy 1 – an obligation on insurers to stop interfering in the relationship between a patient and a doctor);
 - (ii) give policyholders the ability to select policy plans and to switch policy provider (remedy 2 - a kind of “policy portability” remedy, similar to the model which FIPO understands has been implemented in Australia); and
 - (iii) ensure that the criteria applied by the insurers when making decisions as to delisting consultants are based on transparent and objective grounds, and that delisted consultants are given a right of an independent appeal or recourse to arbitration (remedy 3). This is particularly the case given the crucial role that insurers have in controlling entry into the provision of consultancy services in the private healthcare sector.
- A.10. If the CC found that there existed specific instances of groups of anaesthetists charging excessive prices (theory of harm 2(c)) or of deals between hospitals and consultants that foreclosed new entrant hospital operators from entering (theory of harm 5(b)), then the CC could issue guidance as to what could be acceptable and what could amount to an abuse of

dominance or other instance of anticompetitive behaviour. FIPO does not express views as to theory of harm 1 (hospital operators in certain areas) and theory of harm 3 (market power of hospital operators during negotiations with insurers). On the latter, FIPO would only like to refer the CC to the evidence in paragraphs B.53 to B.59 below, showing the relative market power of consultants vis-à-vis the insurers. Assuming that the CC found that hospital groups could stand up to the insurers' demands more effectively than single, self-employed consultants, which would seem logical, then it would become clear that the insurers, in their quest to slash costs, have identified the consultants as the weakest link. As the CC recognises, *"different theories of harm are related to each other"*. It would not be surprising to find that in a situation in which, as the evidence in paragraph B.57 shows, the income of consultants has dropped by up to 65% for certain commonly performed procedures in some instances, consultants would be tempted by deals with hospitals allowing them to gain some lost income (theory of harm 5(b)(b)).

A.11. In this overview in Part A, FIPO will focus on those aspects which FIPO considers very relevant but which are not sufficiently covered, in FIPO's view, by the theories of harm identified, or require bringing to the attention of the CC separately. These are:

- the role of insurers in this market place and the fundamental point that competition in the market for the purchasing of policies by policyholders is crucial to an understanding of the identified AECs;
- an overview of some consultant-specific issues (these are then considerably expanded upon in Part B);
- the need to consider policy terms and other ways in which insurers devalue their policies over time (such as coding, see paragraph A.37 below);
- the fact that there is no obvious recourse to other regulators;
- the concern that the most worrying and wide-ranging consequences of Bupa's recent tactics are only just being felt (and therefore the need for the CC to consider potential effects as well as actual effects of such practices as well as noting that other insurers may follow the Bupa example); and
- the lack of justification for the amount of distortions created.

The Marketplace - the role of insurers

A.12. The OFT's terms of reference dated 4 April 2012 defines privately-funded healthcare services as services provided to patients via private facilities/clinics, including private patient units (PPUs) through the services of consultants, medical and clinical professionals who work within such facilities. FIPO notes that the CC states in the Statement of Issues:

"The privately-funded healthcare sector involves a variety of suppliers of services and also the private medical insurers which fund many of the services provided to patients. The suppliers of the services include hospital operators, consultants, GPs, other medical and clinical

professionals and the NHS. Our terms of reference call on us to investigate the various facets of the privately-funded healthcare sector. This will include investigating how competition in the privately-funded healthcare sector is affected by the conduct of private medical insurers although we do not anticipate investigating how competition functions in the private medical insurance market(s). Our investigation covers the whole of the UK and we recognize that we will need to consider any differences between the nations of the UK. We note also that healthcare services funded by the NHS whether carried out in NHS facilities or in privately-operated hospitals are outside the terms of reference” (emphasis added).

- A.13. Presently, the market does not function in a way consistent with the way that competitive markets should work.
- A.14. FIPO’s starting point when looking at the private healthcare market is the patient. The consultants strongly believe that healthcare should be about patients. In a properly functioning market, patients should receive the treatment that they require and must have a choice as to treatment options and consultants. This is why the NHS is driving towards providing patients with greater choice.
- A.15. The patient in the private healthcare sector in the UK is in danger of not receiving the required amount of care. This is first and foremost a funding issue. Funding of treatment in the private healthcare sector is done mostly through insurers. PMI funded patients account for approximately 59% of revenue generated by private healthcare providers and, further, approximately 78% of acute private healthcare purchases are made through PMI policies.¹ Insurers are therefore crucial to the supply of private medical healthcare services.
- A.16. We note that insurers are not included amongst the “suppliers” by the CC (albeit that the list of suppliers in the statement quoted above is not exhaustive). We certainly think of insurers as suppliers of healthcare given the way the market currently operates. As the evidence in paragraphs B.25 and B.26 shows, insurers are directly involved in directing patients to consultants and hospitals (and in the case of Bupa, their own facilities (see paragraph B.98 below)). Additionally, consultants are totally dependent on insurers for entry into the marketplace (see paragraphs B.53 to B.59 below). Over time, in the absence of regulatory intervention, all consultants will be “fee-assured” and unable to set their own charges for treatments. Consultants can be excluded from the market at any time by insurers choosing to delist them without a right of appeal. Patients who have seen the same doctor for a number of years can be denied continuity of care. These are all supply issues.
- A.17. Patients are overwhelmingly policyholders, therefore. Unlike in other markets characterised by the predominance of insurance, though, PMI policyholders are largely captive and do not have the choice to shop around for a policy plan. If their policy is a group policy, the decision

¹ OFT, *Private Healthcare Market Study: report on the market study and final decision to make a market investigation reference*, April 2012 (the “OFT Report”), table 6.4 and paragraph 1.4.

to join a different group policy scheme is taken by the policy administrator. Patients can of course put pressure and bring to the attention of the administrator instances when they feel they have suffered detriment, but they cannot exercise the individual decision to switch. Individual policyholders often do not even have this possibility of a corporate policy switch under the same terms and conditions. The existence of any pre-existing medical problem makes it very difficult for them to find an alternative provider of insurance services. FIPO would urge the CC to collect data about the average age of individual policyholders. Anecdotally, FIPO understands that individual policyholders are likely to be older than the average age of corporate policyholders and therefore potentially vulnerable and certainly more in need of medical care.

- A.18. Further, policyholders do not have information about (i) the amount of benefits that different policy providers would pay; and (ii) the level of benefits covered year on year (the latter is discussed below at paragraphs A.37 to A.45). The policyholders often have no real understanding of the true costs of medical care and do not realise that one insurer will pay part of the cost of a treatment, whereas another insurer in the same position will cover all of the costs. In a properly functioning market, the policyholder would shop around for the best deal but not here.
- A.19. In a properly functioning market, the policyholder would know the reimbursement rate offered by the insurer for the most common instances covered by the insurance policy and would shop around for the best insurance policy. The policyholder would have the opportunity to see their consultant of choice. Complex treatments may well require travelling to specialist facilities and higher payments and such concentration of expertise is promoted in the NHS as best practice. More routine treatment would be open to greater competition. This does not happen here.
- A.20. In a market characterised by the ability of consumers to shop around for a medical insurance policy and to switch provider freely, if an insurer were to insist on policy terms that would bar policyholders from seeing certain consultants (or having treatments in certain hospitals), the insurer would then run the risk of policyholders voting with their feet and being able to select a different insurer. Policyholders could also shop around and decide to pay a higher premium for an insurer who pays higher reimbursement rates towards the cost of their treatment. This cannot currently happen in the UK.

Competition in the PMI market

- A.21. FIPO is therefore puzzled by the CC's statement that the CC investigation "*will include investigating how competition in the privately-funded healthcare sector is affected by the conduct of private medical insurers although we do not anticipate investigating how*

competition functions in the private medical insurance market(s)”.²

- A.22. FIPO agrees with the CC if this statement is meant to mean that there is no need to do a cumbersome market review to establish dominance (i), but urges the CC that there is a need to examine the conditions of purchasing of a policy (ii).

(i) *No need to establish dominance or collective dominance*

- A.23. If the CC intends by this statement that it does not plan to consider the relative market shares of the insurers and the fact that these have remained stable over time, suggesting that, if not entry, certainly expansion is affected, then FIPO is not too concerned. In the context of a market investigation relating to distortive features in privately funded healthcare services, leading to a number of AECs, the CC’s starting point can be the fairly uncontroversial finding that Bupa is the market leader and the industry standard.³

- A.24. An example of Bupa’s leadership potential is to be found in the most draconian form of policy yet, the so-called “Open Referral” policy where the GP is not permitted to recommend a consultant or a hospital, giving Bupa total freedom to direct patients away from consultants, in disregard of General Medical Council guidelines and indeed quality of care. Under Open Referral, Bupa clerks break the link between the consultant and the referring GP at the preauthorisation stage of treatment. The clerks will either recommend or insist that a patient sees a consultant named by Bupa. In cases where the patient has an on-going relationship with a specific consultant, they may be denied the opportunity to see that same consultant again (thus breaching continuity of care), even though that consultant is registered with Bupa. Bupa’s ranking methodology for consultants under its Open Referral scheme is opaque. A letter from Bupa’s Sales Director, Tony Wood, states that Open Referral results in better quality, value, care and satisfaction rates for patients and employers (see Appendix I). The letter states that healthcare costs are increasing because of “*over-testing and over-treatment*” and that “*some orthopaedic consultants are three times more likely to operate on a Bupa member than others*”. It is not clear to FIPO how Bupa has collated this information on consultants. FIPO is aware that some consultants have requested information on Bupa’s ranking system under the Data Protection Act 1998 but, so far as FIPO is aware, Bupa has not responded to these requests. Bupa does not have true “quality” information any more than do other insurers, a fact noted by the OFT. Bupa may claim an understanding of consultant volume of work but some of this information will be severely distorted due to the preference of some consultants to refer certain procedures to their peers rather than perform the procedures themselves. It is unclear to FIPO how this information can be linked to quality, value, care or satisfaction rates, as claimed by Bupa. This is further considered at paragraphs B.93 to B.96 below.

² Statement of Issues, paragraph 3.

³ In this regard, see the OFT Report, paragraph 3.32, footnote 57, paragraph 5.79 and footnote 179.

- A.25. BUPA introduced Open Referral in January 2012 and other insurers have stated they may follow BUPA's example if Bupa succeed in imposing these terms (see Appendix II). Others (AXA PPP) have stated that they would "take a dim view" if their subscribers were charged a different fee to those imposed by Bupa (see the article in the Sunday Telegraph dated 24 June 2012 at Appendix III). There is no reason to doubt it, and no reason to doubt that BUPA will have its way, in the absence of regulatory oversight.
- A.26. Bupa introduced Open Referral in January 2012 and other insurers have off the record told FIPO that if Bupa succeeds in imposing these terms, the other insurers will follow suit. There is no reason to doubt it, and no reason to doubt that Bupa will have its way, in the absence of regulatory oversight.
- A.27. Open Referral is the most pernicious form of insurance-led healthcare provision but some other insurers are engaged in:
- (i) imposing pricing policies for new consultants [X];
 - (ii) extending those imposed pricing policies to established consultants (both Bupa and AXA PPP, the latter imposing pricing policies on a wholly arbitrary basis, paying differential rates for the same treatment and discriminating amongst consultants [X]);
 - (iii) slashing reimbursement rates by threatening to delist non-compliant consultants; and
 - (iv) carrying out enough delisting to scare all consultants into compliance.
- A.28. There is no doubt that other insurers are intent on imposing similar terms. Apart from the evidence provided above (at paragraph A.25), concerning AVIVA and AXA PPP, see also the evidence of Consultant 65 on the CC website concerning PruHealth.
- A.29. It follows that the existence of a small number of main insurers is sufficient to create the conditions of AEC which affect the entire market and the fact that Bupa has more than 40% share and AXA PPP more than 25%⁴ and that these shares have remained largely unaltered over the years is not that crucial. It goes without saying that a market with few players can be characterised by a number of agreements which, taken together, lead to AEC, or concerted practices which lead to AEC and there is no need to consider whether any one insurer is dominant or any insurers together are collectively dominant.
- (ii) *Need to consider the conditions of purchase of a policy*
- A.30. If the CC however intends that this market investigation should not extend to the conditions

⁴ OFT Report, table 6.4.

relating to the purchase of a policy, then, with respect, the CC should reconsider this. If the insurers are entitled to make what are effectively wholesale decisions of access to a network (deciding which consultants can see “their” patients and at what hospitals) without experiencing any adverse effects on their income generating retail operations (because the patients are not able to shop around and in any event are kept ignorant of the true cost of treatment and the true level of reimbursement), then the market simply cannot operate.

Consultants’ specific issues vis-à-vis the insurers

- A.31. Consultants cannot operate in a marketplace where the insurers completely control entry and conditions of supply.
- A.32. New consultants are dependent on insurers for referrals when developing a new practice. These consultants are obliged to agree to extremely low reimbursement rates imposed by AXA PPP and BUPA. Other insurers are likely to follow this pattern of recognition and thus, with the passage of time and as senior consultants retire and new ones are appointed, the insurers would have total control over the fee structure. The patient would be excluded from the equation. At the same time, consultants practising in higher risk fields, such as spinal surgery, are faced with escalating professional indemnity insurance and diminishing returns from insurers. New consultants are faced with the choice of either entering into contracts with the insurers and taking on significant overheads (such as administration and indemnity insurance) in the hope that they will receive sufficient volume of work to break even or at least not suffer excessive losses during their early years, or not going into private practice at all. [X]
- A.33. The insurers also seek more and more to control the conditions of supply of treatments to patients. In this submission, we expand on this in detail. For the purposes of this overview, FIPO will concentrate on two main methods of control.
- A.34. First, as set out above, Bupa has introduced an "open referral" scheme, which other insurers have indicated they will follow if Bupa is successful. Open referral is in fact a very “closed” scheme that offers patients no real choice over who will perform what may be very complicated surgery on them (but only a choice of whom the insurer puts forward). Further, open referral breaks the patient-GP link as GPs are not allowed to recommend specific consultants to their patients. As a result, clerks at Bupa, who are not medically qualified will select the consultant that will be seen by the patient, rather than their GP advising on the appropriate consultant.
- A.35. Second, even when not engaged in Open Referral policies, insurers are controlling the conditions of supply by limiting the availability of treatments to patients. As set out in paragraph B.95 below, Bupa is supposedly focusing on value for money through its open referral scheme and has delisted consultants who it considers perform too many

diagnostic tests on patients. A direct consequence of this is that patients may not receive the comprehensive level of medical attention that they would expect at a private facility. FIPO fears that these changes will lead to commoditised patient care. Ultimately it is the patient that would suffer. Bupa is even attempting to introduce clinical controls. For example, they have issued their own guidelines for knee arthroscopic operations which are contested by the leading UK orthopaedic organisations. Under these “guidelines”, which are being imposed by a rigid method of preauthorisation and review by a Bupa clerk or (more rarely) by an external doctor who has never seen the patient, patients would be denied appropriate care for certain conditions. The practice of insurers adopting an external review by a doctor who has never seen the patient has been roundly condemned by the Royal College of Surgeons

- A.36. In summary, these actions by Bupa spell a Managed Care scenario in which a company engaged in the provision of financial services not only controls who administers the treatment, but how the patient is treated, and where (because the choice of consultant largely dictates at which hospital the patient is treated), as well as how much is paid for the treatment. Such systems of managed care have proved to be expensive to administer and also very unpopular to patients in the USA.

Policy terms and coding issues

- A.37. More generally, policyholders do not have clear information about the level of benefits covered year on year. According to its policy terms Bupa is able to change the terms and conditions of the membership at the renewal date (a copy of the policy terms can be found at Appendix V).
- A.38. The renewal date is typically annual and the contract renews automatically unless terminated. FIPO understands that in practice Bupa changes the terms whenever administratively convenient to it but, even though they may become aware of this breach of contract, the policyholders are powerless to do anything about it, not least because the annual renewal date means that they would only be entitled to continuity of care for a maximum of one year.
- A.39. Even when these changes are implemented on the renewal dates, the insurers’ action is in effect unilateral. The value of the underlying contract is then adjusted, often reduced, while the member premiums remain the same, or, more often, are increased year on year. A policyholder may subscribe to a policy which covers certain treatments and a specific list of recognised consultants, only to find after time that the policy no longer covers that treatment or that consultant. [X]
- A.40. Such unilateral action on behalf of the insurers also takes place beneath the surface of the policy terms, via the use and adjustment of procedural codes, applied to calculate

reimbursement of surgical procedures. Complex codes exist that determine how each PMI calculates their fee schedule (the issue of the complexity of application of these codes is addressed in the article included at Appendix VIII).

- A.41. Codes are decided by a company owned by five major insurers but each company can then interpret and implement the codes as they wish. In addition to these codes being complex and difficult to apply, in practice insurers vary in their approach, with some recognising certain treatments or procedures which others do not recognise. Accordingly, changes to coding can in effect result in changes to reimbursement levels.
- A.42. Bupa's methodology for determining the coding of procedures, and changes to that coding, are unclear. [38] This suggests that Bupa is basing its reimbursement policies upon the advice of consultants who are not in private practice. It is illogical, and symptomatic of Bupa's approach to coding and reimbursement, for Bupa to develop its policies on the recommendation of consultants who are not engaged in private practice and, as such, are not familiar with the practical implications of these policies.
- A.43. This same letter also announced Bupa's intention to abolish the [38] code for local anaesthesia. This means that for certain procedures, which will on occasion involve very extensive surgery, it will not be possible to get reimbursed for essential local anaesthesia. Bupa's claims that the abolition of the [38] code is due to a reduction in the "relative complexity, time and skill required" is unfounded. This is another example of Bupa unilaterally imposing limits on consultants' ability to act in the best interest of their patients.
- A.44. Recently Bupa has published new procedural codes that reduce the level of complexity and therefore the remuneration paid for a large majority of surgical procedures. In the submission to the CC website contributed by "Consultant 38" (a copy of which can be found at Appendix X) the CC already has evidence that via adjustments to the underlying coding the remuneration for the most common procedures has been reduced, whereas in the case of procedures carried out much less frequently the remuneration has been increased. Bupa's alleged rationale is that these codes are adjusted to reflect the type of procedure involved and its complexity, the time taken and the competency level required to carry it out. The rates however have not changed significantly in the last 20 years, meaning that consultants who are obliged or who have agreed to charge at these original level of reimbursement have not received an increase in remuneration reflected in the codes for these procedures. Many have felt obliged to continue at these reimbursement rates so that patients do not have any shortfalls despite the loss to them due to inflation. Over 20 years this equates to a 55% decrease in the purchasing power of consultants charges.
- A.45. Coding also gives rise to issues of "bundling". [38] The way that insurers treat bundling of procedures varies between insurers and is another method by which insurers can reduce reimbursements to patients for consultant fees. Insurers do sometimes accuse consultants of seeking to unbundle unnecessarily (and thus raising more charges) but this may be also

due to the complexity of the codes. Attempts by FIPO to meet with the company responsible for these codes in order to set up a mechanism to discuss and agree what constitutes reasonable bundling have been rejected by the company.

The Role of other Regulators

- A.46. FIPO considers that this market investigation may be the only possible avenue for addressing the issues identified.
- A.47. [REDACTED]
- A.48. Policyholders faced with the continued devaluation of their policy could act against the insurer for breach of contract when the insurer changes the terms of the policy during the course of the life of the insurance. However, policyholders are often unaware that the insurer has changed the terms until they require treatment, and when, as in the case of BUPA, the policy date of renewal is annual, the breach of contract will only be relatively minor, covering a short amount of time. Again, the costs of an action are prohibitive compared to the potential gains.
- A.49. A policyholder confronted with a similar situation can lodge a complaint with the Financial Ombudsman and indeed FIPO is aware of at least one recent instance of such a complaint [REDACTED]. The CC could ask the Financial Ombudsman whether there are more instances of such complaints. It takes a year for the Financial Ombudsman to adjudicate on complaints and decisions are not public.
- A.50. [REDACTED]
- A.51. Indeed, although FIPO applauds the OFT's initiative to cooperate with the FSA to ensure that patients are informed about the possibility of shortfalls (and said so in its initial submission to the CC at paragraph 4.5), there is no timetable, no details of what the OFT and the FSA are discussing in practice and no obvious mechanism by which interested parties can bring to the attention of the FSA that patients are simply denied the possibility to exercise choice and pay a shortfall and that insurers have often used the requirement to inform patients about the possibility of shortfalls as an excuse to divert patients away from their choice of consultants.

Potential effects versus actual effects

- A.52. Because Bupa has engaged in a wide ranging assault on the existing private healthcare system at the beginning of 2012, [REDACTED] the evidence provided to the CC in this submission mostly relates to Bupa's recent practices although of course if Bupa succeeds then the other insurers will follow suit.

A.53. This has a further effect – the most wide-ranging consequences of Bupa’s practices are not yet fully felt. This is one reason why FIPO is collating evidence and will continue to do so in the coming months, as the impact of Bupa’s actions become more quantifiable. FIPO is at the same time concerned and relieved about the CC’s market investigation. FIPO is relieved that the CC investigation is happening at a time when it may not be too late to intervene but FIPO is worried that the CC may focus too much on actual effects of practices that have only just started across the industry. In fact, the effect of these practices started to be felt only a couple of years ago, [§ 4.10]. We would ask the CC to consider the potential effects of these various insurance changes. FIPO will do all it can to collect the evidence of actual effects available.

Justifications?

- A.54. FIPO anticipates that the insurers will try and justify their actions by a perceived need to keep premiums down. Bupa’s initial submission to the CC already plays heavily on a need to keep costs down and deliver “value for money”. It is true that if premiums rise too much and quality of care deteriorates, individual policyholders still have the option not to renew at all (and exit the market for private healthcare altogether).
- A.55. On the cost of provision of private healthcare, FIPO would simply direct the CC to the fact that insurers’ reimbursement rates to their subscribers towards their consultant charges have been lowered over the years, relative to the cost of insurance premiums charged and relative to the rate of inflation. FIPO also notes that insurers, such as Bupa, are recording significant surpluses.⁵
- A.56. If the costs of provision are rising, this is not due solely to the fees charged by consultants. In fact the share of PMI spend on consultants has gone down progressively since 1994 in relation to hospitals. FIPO firmly believes that the insurers have identified the consultants as the weakest link in the chain. Consultants are self-employed individuals, they are easily targeted and there are even illustrations of the prisoners’ dilemma that show this convincingly (see Appendix XV and paragraph B.50 below).
- A.57. However the most important point is that patients and policyholders are not benefitting from these practices in the least. Patients and policyholders are seeing their choice reduced, their premiums raised, and face excruciating sessions with certain insurers’ trained but non-medical staff whose job it is to divert them away from their choice of consultant. FIPO directs the CC to its own evidence (Consultant 55, on the CC website): the Consultant is in possession of a CD recording that shows an insurer spending over an hour trying to persuade a patient to see numerous other consultants other than Consultant 55. [§ 4.11] Extrapolating

⁵ Bupa’s surplus increased 86% in 2011 to £220.0m. See Bupa’s financial statement for year ending 31 December 2011.

from this, it seems obvious what the long term plan is – ensuring that the policyholder will only be able to see a consultant chosen by the insurer, presumably on cost grounds.

- A.58. FIPO is aware of the argument that in a marketplace where consumption and payment are not related, then there is a potential issue with cost control. However, the only instance when consumption and payment are decoupled in the provision of private healthcare occurs when the insurers insist that patients cannot choose a consultant and pay the shortfall.
- A.59. In any event, there cannot be any justification for actions that lead to patient detriment. Healthcare is not just another marketplace: the CC ought to take into account that the consequence of compromising on quality in the private healthcare sector is deterioration of people's health. The OFT's insistence that they could not consider issues of documented inappropriate referrals (and re-referrals) was totally misguided in FIPO's view. In the context of a market investigation of the private healthcare sector, to ignore the fact that, for example, Bupa will only pay for a caesarean section if the health of the mother is in danger but not if the health of the baby is in danger (see Appendix XVI) is to miss the point entirely.

PART B – FIPO’s views on the Theories of Harm

- B.1. The theories of harm identified, which are related and may be considered together in combination, are:
- (a) theory of harm 1: market power of hospital operators in certain local areas;
 - (b) theory of harm 2: market power of individual consultants and/or consultant groups in certain local areas;
 - (c) theory of harm 3: market power of hospital operators during national negotiations with insurers;
 - (d) theory of harm 4: buyer power of insurers in respect of individual consultants;
 - (e) theory of harm 5: barriers to entry at different levels;
 - (f) theory of harm 6: limited information availability; and
 - (g) theory of harm 7: vertical effects.
- B.2. FIPO will comment on theories 2, 4, 5, 6 and 7.

Theory of harm 2: market power of individual consultants and/or consultant groups in certain local areas

- B.3. The CC states that theory of harm 2 hypothesises that consultants or consultant groups in certain local areas could have market power “over their patients”. The CC identifies two aspects to this theory of harm, namely:
- (a) factors that may lead to market power;
 - (b) possible effects, which can be broadly categorised under the headings of “excessive prices” and/or “reduced quality of care”.
- B.4. On the first point, the factors that may lead to market power, the CC identifies factors related to the location of the consultants and, separately, factors related to the way in which privately-funded healthcare services are purchased (broadly, the way that referrals are made, and the possible setting of prices by groups of consultants).

Factors that may lead to market power

(i) Location

- B.5. The history of the dealings between the consultants and the insurers rather suggests that the insurers treat consultants as expendable and fungible, without any consideration of type of treatment or skills of the particular consultant, or location. If consultants had market power vis-à-vis the patients, by virtue of their location or otherwise, one would expect the insurers to be less able to enforce lower reimbursement rates, threats of delisting and managed care against certain consultants. If location was the reason for the consultants' market power, one would expect consultants in certain areas to be less affected by insurers' practices. This is not the case in FIPO's experience.
- B.6. It is also true that the dynamics of the retail insurance market are such that patients have limited ability to switch insurance provider (see paragraph A.17 above) and so insurers are largely insulated from the consequences of their decisions. This therefore leads FIPO to the conclusion that, even if consultants had an element of market power due to location vis-à-vis their patients (which FIPO believes is not the case), given the role of insurers, and the dynamics of private healthcare funding, the consultants would not be able to exercise any market power.
- B.7. Specifically, theory of harm 2 deals with market power "over patients". FIPO considers that it is helpful to think in terms of different categories of treatment. The evidence that FIPO reviewed and the experience of FIPO's members suggests that: patients by and large would be more willing to travel for more complex procedures ("frontline care") whereas, other things being equal, patients would rather minimise travel time for more "routine care". Patients are probably the least willing to travel to a specific consultant who provides "service care" (anaesthetists, radiologists, pathologists), these being consultants who are part of the team normally chosen by the initial "front line" or "routine" consultant such as a surgeon or physician.
- B.8. Frontline care may consist of a basic consultation with no specific follow-up treatment but also refers to high risk procedures: cardiac surgery, neurosurgery and spinal surgery are just some examples. In FIPO's views, based on its members' experience of working in private healthcare, patients accept the need to travel longer distances for high risk procedures and indeed it would not be feasible to require the level of expertise needed to provide frontline care everywhere. However, even those just seeking a second opinion will be prepared to travel so the market for frontline care is certainly geographically wide and location is not an issue.
- B.9. For routine treatments, patients would be more likely to wish to obtain care nearer their location. Two points are important to note here: first, what used to be instances of frontline care, over time tend to become routine. For example, knee replacements, once very complex procedures, have become more common with the passage of time. Indeed there

are now more knee replacements performed in the UK than hip replacements, an operation with a longer history. Another example is laparoscopic (keyhole) surgery which developed in specialised centres and for limited procedures and is now widespread; the advent of robotic (laparoscopic) surgery is a technique now becoming widespread for certain cancers (prostate) in the USA and gaining rapid ground in the UK (although not effectively reimbursed by the major insurers). Thus medical science is constantly changing and innovation brings both costs and savings. This illustrates the point that to characterise the marketplace in which consultants work as a static market, where a consultant gets a qualification and then starts providing a service, would be misleading. Consultants by and large continue to work and improve on their knowledge during their working careers; the whole basis of the new process of revalidation which every doctor must undergo through with the General Medical Council every 5 years is based on a demonstration of continuous personal and professional development through systems of enhanced appraisal and multi-source feedback from patients and colleagues. FIPO would argue that whatever skills or abilities consultants may develop and perfect should be reflected in their standing and their earnings, as a legitimate return on investment.

- B.10. Secondly, also because of the investments that consultants make in their skills, over time more and more consultants acquire the ability to perform complex procedures which therefore become more routine. By definition, more consultants are able to perform routine operations, so it is difficult to see that there could be an element of market power of consultants for the more routine operations. FIPO therefore submits that the larger number of consultants able to perform the operations should counter any argument that the market may be geographically smaller for more routine operations.
- B.11. This is reflected in the comment made by Oxera in its study into market definition and private healthcare that, *“this local element [of market definition] should not be interpreted as meaning that consumers are willing to travel only a certain distance to receive treatment ... The local element to [private healthcare] competition should instead be interpreted as the patient’s preference to minimise their travel time, all else being equal”*.⁶
- B.12. It follows that FIPO agrees with the comments made by the OFT in its referral decision that using 30 minutes’ drive time isochrones,⁷ centred on private health facilities⁸ is an imperfect way of defining the market. The OFT specifically mentions that in some locations the catchment area should be wider (at paragraph 4.47) and sometimes the geographic scope of the market should be defined by the consultants’ willingness to travel to private health facilities (at paragraph 4.65).

⁶ Oxera, *Techniques for defining markets for private healthcare in the UK – literature review*, November 2011, paragraph 2.2.2.

⁷ These isochrones are based on the OFT’s previous decisions relating to mergers in the healthcare sector (e.g. the acquisition by Spire Healthcare Limited of Classic Hospitals Group Limited, 1 July 2008).

⁸ OFT, *Private Healthcare Market Study*, OFT 1412, April 2012, paragraph 4.6.

- B.13. Further, FIPO emphatically subscribes to the OFT's view that an isochrone analysis centred around patients does not take account of GPs' views that, "*one of the most important factors that influenced patients when they made their choice of [private health] facility or consultant was the reputation of the consultant*" (paragraph 4.66). This would suggest that patients who have a choice are willing to travel to see their consultant of choice and the geographic market definition should not too local.
- B.14. It is interesting that a study conducted in 2006 into the distance that NHS patients were willing to travel and the impact of policies that increased patient choice⁹ supports this conclusion. This study demonstrated that patients in more affluent areas travelled further for elective treatments than those in less affluent areas. FIPO has no data about the relative affluence of patients who are covered by a private insurance as compared against affluence of patients who are not but it would seem logical that people covered by insurance may be generally more affluent than people not covered. Therefore, it seems that given the choice to travel, patients that are able to travel will go further for their treatment, and the geographic market definition should not be unduly restrictive. The report notes that one would expect the average distances travelled *to increase* if private facilities were included in the analysis, together with NHS facilities,¹⁰ which also suggests that patients in the private healthcare sector are more willing to travel.
- B.15. Specifically as regards service care, i.e. those clinical support specialties which are required for the provision of both front line and routine care (e.g. the services of anaesthetists, radiologists and pathologists), it seems logical that patients would be less likely to travel and to shop around. Indeed, it may be impossible for a patient to select a clinical support consultant although service care is required for frontline and routine care: in general, because of the nature of subspecialisation within these specialties and because of team work between consultants, any breakup of such units would be detrimental to the patient's wellbeing. The CC should note that MDTs (multidisciplinary team meetings) are now virtually mandated for all cancer cases and common place in the discussion of all cases and thus the emphasis in clinical decision making and care has shifted from a single consultant decision to the decision of a team. In other words, the provision of service care (or the need to call in other consultants from different specialties) should not be considered separately from the provision of the front line care or routine care to which it relates.
- B.16. Attempts by insurers (AXA PPP) in 2008 to enforce a ban on the use of anaesthetists for cataract operations, suggest that the insurers do not fear negative consequences from their interference with availability of service care professionals. At the time, eye surgeons were upset that the use of a small amount of sedation, which is sometimes necessary to enable a patient to have their cataract surgery under local anaesthesia, might not be possible if there

⁹ Propper, Damiani, Leckie and Dixon, "*Distance Travelled in the NHS in England for Inpatient Treatment*" CMPO Working Paper No. 06/162, October 2006.

¹⁰ *Ibid.*, p. 8.

was no reimbursement possible for an anaesthetist. Local anaesthesia is by far the commonest method for this surgery but only an anaesthetist can give the sedation. Eventually AXA PPP backtracked on these plans.

B.17. [✂]

(ii) *The way that referrals are made and consultants selected*

B.18. The CC states:

if patients and their GPs do not shop around before selecting the most appropriate consultant, historic referral patterns could become entrenched and incumbent consultants may face limited competitive pressure. We may look separately at anaesthetists since the process for choosing anaesthetists for a patient appears to differ from that for other consultants

B.19. As regards the anaesthetists, as seen above FIPO notes that they have been singled out but cannot see that there is anything special about the process of selecting an anaesthetist, separate from the process of selecting other categories of consultants involved in service care. All “service specialties” (anaesthesia, radiology, pathology) are provided by consultants mostly with sub-specialised skills. Thus there is a need to channel patients to the most appropriate service care consultant and this is normally done by the lead consultant (surgeon or physician). Patients are unlikely to travel and to shop around for the services of an anaesthetist prior to an operation, or a radiologist before an X-ray procedure, or a pathologist in cases where a pathology report is needed and yet there is no indication about market power on the part of other providers of service care.

B.20. More generally, FIPO would strongly urge the CC to examine the above statement critically.

B.21. First, it is an inescapable fact that in a sector (private healthcare) in which almost 80% of patients are insured, and patterns of managed care prevail, patients would have limited or no possibility to “shop around” and make a choice.

B.22. It is possible that there may be here an element of Catch 22 thinking. There is an assumption, which appears to be shared by the OFT and now perhaps by the CC, which may be backed by some evidence, although FIPO has not seen this, that patients historically did not shop around when they had the possibility to do so. If the CC is basing some of its thinking on this assumption, it would be good to see the underlying evidence. For example, the CC may wish to consider how self-paying patients, whether from the UK or from overseas, select their consultants and their treatments. There is some anecdotal evidence from consultants that patients who are self-paying do shop around because of price. Extrapolating from that, patients required to meet a shortfall are likely to do the same, when properly informed about what their policies cover and what their policies do not cover.

- B.23. Whatever the historical patterns, in the days of the internet and chat rooms, it would be surprising to see patients with a real choice not looking for alternatives. Indeed, based on anecdotal evidence, the members of FIPO know that the number of patients who come to a consultation with a view as to their condition and prepared to discuss treatment options with their consultant, has increased in recent years, and this is to be welcomed. The fact that a patient would know less than a doctor (and a consultant) about medicine is also an inescapable fact (on which we comment further at paragraphs B.88 and B.89 below). Asymmetry of information occurs in many cases where there is a relationship in a professional setting, the person seeking the professional advice being in some ways reliant on the professional selected. In this regard, medicine is no different from other professional fields, such as law, accountancy or architecture.
- B.24. Secondly, the statement above refers to GPs not “shopping around” and to historic referral patterns becoming entrenched. FIPO has observed with increasing alarm the apparent devaluing of the expertise of GPs. Already in FIPO’s first submission (at paragraph 5.6), FIPO referred the CC back to the OFT Decision document and the one single paragraph in praise of the GPs (paragraph 5.64) that the OFT inserted at the last minute in a document otherwise full of remarks pointing to a negative view of what the OFT calls the GPs’ “soft skills” (paragraph 5.68). On the contrary, GPs are active on the ground, referring patients whom they know to a consultant whom they also know. They follow their patients through their journey, know how many patients have to return to hospital after a procedure, know the possible complications and, most of all, they understand the psychology of their patients. For evidence of that, the CC has only to consider the role of GPs and their professional skills in identifying issues and referring patients on to further care. FIPO strongly believes that if the result of this investigation is to condemn GPs to a lifetime of “open referrals”, then the CC requires very strong evidence that indeed GPs do not, to use the language in the Issues Statement, “shop around” and that indeed historic referral patterns become entrenched. Open referral would be a breach of all recommended practice and guidelines for primary and secondary care.
- B.25. The CC should also compare the situation of a GP deploying his or her expertise and knowledge to refer a patient to the appropriate consultant with the alternative. FIPO has asked its members to provide evidence of what happens when the GP to consultant path is broken in practice. Evidence is becoming available and hopefully more evidence will be available to the CC; however there are difficulties here to do with patients’ confidentiality and therefore the evidence will likely need to be anonymised and confidential. The picture that is emerging is one where patients are either redirected on pre-authorisation or the GPs are altogether forbidden from directing their patients to named consultants, with in some cases untoward results. FIPO directs the CC to its own evidence (Consultant 55, on the CC website): the Consultant is in possession of a CD recording that shows an insurer spending over an hour trying to persuade a patient to see numerous other consultants other than Consultant 55. From the published evidence, it seems that the patient required a shoulder specialist but none of the suggested doctors were even shoulder specialists. Consultant 49

must also have some interesting evidence and the CC may want to follow up on this.

B.26. [REDACTED]

B.27. Apart from direct evidence from patients, FIPO is collecting evidence from doctors about what patients are telling them and urging the doctors to follow up and collect direct evidence whenever possible [REDACTED].

B.28. It follows that FIPO cannot see how the traditional, proven and trusted route of GP to consultant referral can lead to market power on the part of the consultants, especially in the age of the Internet. The remarks made at paragraph B.5 above are also relevant here. If some consultants in some areas had market power, one would expect to see some better treatment by the insurers of the consultants with market power in some areas. There is no indication that this happens. Last but not least, independent research conducted by ComRes for FIPO has shown that the majority of patients still prefer the GP to refer them to the consultants [REDACTED].

The joint setting of prices (for anaesthetists)

B.29. The CC states that they are aware that anaesthetists jointly set prices but are “*not aware of the existence of such arrangements in respect of other consultant groups*”. The anaesthetists will have to reply to any concerns raised by their price setting practices, if any.

B.30. FIPO can only take note that competition law exists to consider issues of anticompetitive agreements and abuses of dominance. Groups of anaesthetists have been investigated by the OFT in the past and cleared of any wrong doing. If groups of anaesthetists are setting prices anticompetitively, then the OFT can surely deal with it.

B.31. Therefore, it hardly seems to FIPO that this is a “feature of this marketplace” to be considered as part of a market investigation inquiry, particularly when this marketplace is characterised by so many features requiring attention. Consultants may wish to enter into partnership with other consultants as a way to share costs, knowledge and pool resources. If groups of consultants act anticompetitively, the OFT has the powers to deal with it. FIPO is aware that the CC does not have powers to investigate abuses of the Chapter I or Chapter II prohibitions and therefore may wish to consider these practices as part of a market investigation. Going forward, however, the new Competition and Markets Authority will have all the powers to investigate in detail any anticompetitive practices that may arise.

B.32. As already stated in the original FIPO submission (at paragraph 10) if anaesthetists are to be considered specifically, FIPO would urge the CC to consider the time and effort that it takes to qualify and to practice as a consultant anaesthetist and the kind of essential work that anaesthetists perform in the operating theatre, the intensive care unit, the trauma and emergency situations and in the general post-operative care of patients.

Possible effects of market power

- B.33. The CC goes on to consider the possible effects of consultants “having local market power”. For the reasons above, FIPO cannot see that consultants generally have any market power, local or otherwise in relation to the insurers. If local market power is an issue then perhaps the CC could ask questions about the local areas affected and then of course what are the anticompetitive effects of this market power.
- B.34. For the time being, assuming that there would be consultants having local market power somewhere, the CC hypothesises that the effects could be different “*depending on the type of patient being considered*”, as follows:
- (a) if insured patients’ policies include a limit on consultants’ fees, insured patients may have to make additional payments. If a consultant’s fees are covered by the insurer, high fees are likely to lead to high insurance premiums; and*
- (b) self-pay patients may also face high charges; and*
- (c) both self-pay and insured patients may suffer from a reduced quality of service.*
- (a) Insured patients may have to make additional payments*
- B.35. FIPO notes that, in most markets, consumptions and payment are related. In most markets where insurance is a feature, the insured person bears the excess, and there are in the policy contract some exceptions and some conditions. An example may help to clarify this. The home insurance company used by the writer of this submission recently refused to pay the costs of rebuilding a wall, because the policy did not cover that eventuality. This was not an instance of market power on the part of the stone mason. It was a consequence of a bad choice of home insurance policy on the part of the writer of this submission and no doubt on renewal a different policy will be selected, which may have a higher premium because it will cover more eventualities.
- B.36. FIPO considers that the attempt by insurers to persuade and coerce all consultants so that their fees be covered by the insurer, is one of the most uniquely distortive features in this market place. FIPO utterly fails to understand how this insistence could be characterised as a possible effect of “local market power” by consultants. This feature also leads to possible patient detriment as insurers steer patients away from consultants, often those with the greatest experience and reputation, who do not charge within insurance reimbursement rates.
- B.37. The insistence on the part of the insurers that (i) consultants’ fees should be covered in full (and capped at unrealistically low levels – see Theory of Harm 7 for a comparison with the fees charged by Bupa facilities), and (ii) policyholders be kept in the dark as to the true costs of treatment, also has the consequence that insurers become more and more insulated from

the working of a properly functioning competitive retail market for the selling of insurance policies. There are so many issues about the way in which the retail insurance market works for medical insurance that, as seen above, FIPO cannot see how the CC could investigate this marketplace without considering it. To the facts that: (i) most patients are covered by a group policy (and therefore are dependent on their employers' choices of policy); and (ii) self-insured patients often are locked-in anyway (because of pre-existing conditions) and therefore could not change their policy even if they wanted to; one needs to add the fact that (iii) patients who do not know about shortfalls cannot in any event make an informed choice based on the levels of reimbursements paid by their insurers, relative to the level of reimbursements paid by competitors of the insurers.

- B.38. In this context, FIPO noticed the cryptic remark in the Issues Statement that the CC *“also note that consultants usually (at least in the case of insured patients) provide a separate bill specifying their charges”* (this is commented upon further, at paragraph B.88 below). FIPO is not sure about the significance of this statement. Although on the face of it the statement is neutral, it seems to FIPO to be significant that the CC felt a need to state what should be obvious. In fact, the provision of a bill specifying the charges to the patients is an important instrument for patients to be able to understand the true cost of healthcare provision and indeed, in a context in which they were able to select their consultant (and pay any shortfall that they may be required to pay) to be able to “shop around” amongst consultants for the best deal. A properly functioning competitive market would be one where a patient is properly informed that their contract of insurance only covers up to a certain amount of the cost of treatment and that there may be an extra payment due, and as a consequence the patient would have an incentive to look for the best deal both in terms of the best insurance product for his or her needs and the best consultant to treat him or her.

(b) self-pay patients may also face high charges

- B.39. The CC hypothesises that self-pay patients may “also” face high charges. It seems to FIPO that the CC is thinking about some consultants with market power charging excessive prices. What would be an excessive price in the circumstances of medical treatment?
- B.40. Reimbursement rates by insurers have not increased in the past 20 years. At confidential Appendix XVII FIPO provides a spreadsheet with details of just some of the recent cuts by Bupa by specialty; other specialties have followed including the whole of gastro-intestinal surgery. [X<]
- B.41. AXA PPP did not until recently produced a schedule of reimbursements but has on an individual basis forced consultants to accept lowered fees. Reimbursement rates have not kept up with inflation (but premiums have increased more than inflation).
- B.42. It seems to FIPO that the evidence suggests that, uniquely in this marketplace, rates and fees progressively *decrease* over time and are therefore unlikely to be excessive.

(c) *Patient Detriment*

- B.43. Patient detriment is a particular worry of FIPO's member organisations. Patient detriment arises as a consequence of insurers breaking the referral pattern and suggesting unsuitable or simply wrong alternatives to appropriate care. In fact, the evidence mentioned in paragraph B.26 above suggests that patients are already being denied proper care. The evidence that we are collecting in relation to Theory of Harm 7 will show how some insurers are vertically integrating into "alternative structures" and directing patients in need of, say, an operation, to one of these alternative structures.
- B.44. There are three reasons for the concerns of FIPO. The first is that these tactics devalue the professionalism of consultants. As seen above, consultants spend their careers continuously improving their skills and knowledge and their aim is to be able to offer a good quality of care to patients. If the professionalism of consultants is not recognised then the reasons to invest become less cogent.
- B.45. The second reason is that a consultant denied the ability to select the best treatment for his or her patients, needs to worry about potential liability issues. The consultant who has performed a cataract operation without an anaesthetist, to use the example above, will not be able to point to AXA PPP should this result in a suboptimal outcome for the patient or outright patient detriment.
- B.46. The third reason is more intangible and yet it goes to the core of what consultants do. By and large, people become doctors (and consultants) out of a desire to treat patients. To take away from a consultant the ability to select the best treatment for the patient is akin to taking away the reason why somebody has become a consultant in the first place.

Theory of harm 4: buyer power of insurers in respect of individual consultants

- B.47. The CC states:

We understand that it is common for insurers to stipulate in their policies that there is a maximum reimbursement rate that they will pay consultants for a given treatment. Consultants may charge more than this amount for their services, in which case the insured patient is obliged to pay the excess. This may be subject to the terms of the agreement between the consultant and the insurer. We understand that some insurers stipulate that in order for certain consultants to be recognized to treat their policyholders, the consultant must agree not to charge more than the amount specified by the insurer.

Caps on the reimbursement of fees may be used by insurers to limit overcharging by consultants (see theory of harm 2). However, this theory of harm hypothesizes that insurers may possess buyer power in relation to consultants which results in consultant fees being too low.

B.48. FIPO welcomes this partial overview of the buyer power of insurers in respect of individual consultants and offers the following comments which will hopefully help the CC to build a fuller picture. In this section, FIPO (i) considers the market power of insurers vis-à-vis the individual consultants; (ii) considers the effects of the insurers' market power; and (iii) refers to the above statement and provides comments on it.

(i) *market power of insurers vis-à-vis the individual consultants*

B.49. In assessing the relative market power of insurers and consultants, it is important to ask the following two questions. What are the consequences for the consultants of not accepting the terms dictated by the insurers? Insurers' buyer power over consultants manifests itself in different ways. At the most extreme end of the scale, consultants may be delisted but even consultants that accept these rates have no absolute guarantee of increased referrals but certainly a need to work more for the same return. Please see point (ii) below for a full discussion of the effects of insurers' power over consultants.

B.50. On the other hand, what are the consequences for the insurers if the consultant refuses to agree to reduced rates? FIPO submits, none. FIPO knows that there may be some very high risk complex operations that can only be performed by a limited number of surgeons, for example brachial plexus surgery (which for the avoidance of doubt would not constitute an instance of the particular surgeon having market power but would be the return expected from the investment made by the surgeon in his skills and abilities to deal with an unusual and complex clinical problem). The reality however is that for most procedures the insurer will find other individual consultants prepared to accept the terms of the *diktat* [§<]. And because, as seen at paragraph A.30 above, medical insurers are largely insulated from the effects on their retail market (for the sale and purchase of policies) of what one could consider wholesale decisions (the decision to recognise a consultant instead of another or a facility instead of another), then the relative bargaining power of the insurer in this negotiating situation is such that there is no question of the individual consultant being able to stand up to the insurer. The CC is referred again to the illustration of the prisoner's dilemma in Appendix XV.

(ii) *the effects of insurer buyer power over consultants*

B.51. The CC states:

if insurers are suppressing consultant fees to a level below those which would prevail in a competitive market, this could lead to a reduction in the quality of service provided by consultants to patients and affect the incentives to innovate. In addition, there may be distortions to competition between consultants when caps on the reimbursement of fees are applied to some consultants (e.g. newer or junior consultants) and not to others (e.g. more experienced ones). In the longer term, this may result in a shortage of consultants willing to practice and in a reduction in the potential output of the sector.

- B.52. FIPO agrees. There is no doubt that fees are too low, that an increasing number of patients are experiencing some form of anxiety, delay or outright physical detriment, that consultants are feeling powerless to stop the onslaught and that new consultants are opting in increasing numbers not to start providing the services.
- B.53. Insurers, such as Bupa and AXA PPP, act as a barrier to entry into the private healthcare market for *prospective new consultants* and can – and do – foreclose *established consultants* from the market. New consultants entering the private healthcare market will not have a reputation for expertise and will lack the range of experience of more established consultants. Given that about 80% of private healthcare patients are funded by insurers, new consultants are dependent on insurers to develop a private healthcare practice. New consultants seeking registration by Bupa, AXA PPP and now also other insurers are required to sign up to onerous terms and fixed reimbursement rates (see examples of letters sent to new consultants in confidential Appendix XVIII in relation to certain out-patient diagnostic tests). As shown in paragraphs B.100 to B.102 below, Bupa’s own rates for providing services to patients at Bupa facilities are significantly higher than the reimbursement rates imposed on new consultants. However, it is difficult to see that new consultants have any choice but to sign up for these general reimbursement rates which are low if they wish to enter the profession.
- B.54. This difficult choice also applies to more experienced consultants. Bupa has taken to sending demands to experienced consultants, insisting that they accept reduced reimbursement rates or face delisting by Bupa [REDACTED]. In some cases, experienced consultants are being required to agree reimbursement rates lower than those that Bupa has offered to new consultants.
- B.55. Bupa uses a standard template for its correspondence: the insurers claim that a consultant is charging significantly in excess of other consultants. However, there is no supporting evidence of these statements; if the consultant obtains from a hospital or elsewhere a reassurance that the fees charged are not out of line with the fees charged by others, for example, there is no follow up on the part of the insurer or only a perfunctory follow up.
- B.56. As seen in confidential Appendix XIX, Bupa refuses to engage with the consultants in any useful discussions regarding reimbursement rates. Where consultants have written detailed explanations of the basis of their charges [REDACTED], Bupa responds by insisting that the reimbursement rates are reduced, without responding to any of the points raised by the consultant. [REDACTED]
- B.57. Consultants who receive these demands are faced with a stark choice. Consultants that refuse the insurer’s terms will lose a substantial amount of their income, the amount relating to the proportion of the practice which relates to seeing the patients insured by that particular insurer. If the practice in question mirrors the percentage of patients insured by Bupa and AXA PPP in the UK generally, and both Bupa and AXA PPP impose cuts in fees and a

consultant refuses, that consultant will lose 65% of his or her income for these commonly performed procedures. In fact the damage to the consultant's reputation locally and through his/her referring GPs may be such that there is a knock on effect which extends far beyond the percentage of work lost directly through an insurer and so the impact of a delisting may be greater than imagined. Much of this is hard to quantify and it is uncertain whether or not FIPO can get more than some case studies showing loss of income over a period, following delisting.

B.58. Even if they accept the reimbursement cuts, consultants will be severely affected. Again, FIPO is hoping to collect information about the extent to which consultants are affected but it is clear that the proposed cuts in reimbursement rates by Bupa are significant. As shown in confidential Appendix XVII, Bupa are insisting on slashing patient reimbursement for consultants' fees for certain procedures [§<].

B.59. The introduction of BUPA's Open Referral policies adds a further dimension: consultants not only have to be recognised, they have to be "preferred" (see paragraph B.77 below).

(iii) *the CC statement above*

B.60. The first sentence in the CC statement above ("*we understand that it is common for insurers to stipulate in their policies that there is a maximum reimbursement rate that they will pay consultants for a given treatment. Consultants may charge more than this amount for their services, in which case the insured patient is obliged to pay the excess*") shows that something is not right here.

B.61. Why should an insurer agree to pay a consultant for a given treatment? Consultants charge their patients a fee: insurers pay patients a benefit. The terms of an insurance policy between an insurer and a policyholder are a matter for the insurer and the policyholder. The consultant is not party to the agreement. The appropriate way to think about this marketplace would be to say that the consultant would charge the patient for the treatment and the patient would then be reimbursed in accordance with the terms of the policy.

B.62. So, if a policyholder is happy or is forced to enter into a policy whose terms include the ability for the insurer to change the terms of the policy unilaterally on renewal, and then in practice allows the insurer to change the terms whenever the insurer feels like it, this should not be a concern of the consultant. The insured patient is not "obliged to pay the excess". The insured patient is obliged to pay for the treatment received. In fact, in a properly functioning retail market for the purchase of policies, the amount of the benefits covered by the policy would be reflected in the policyholder shopping around for a new policy, something that cannot happen in the case of medical insurance in the UK as seen above.

B.63. The CC then states: "*We understand that some insurers stipulate that in order for certain consultants to be recognized to treat their policyholders, the consultant must agree not to charge more than the amount specified by the insurer*".

- B.64. In fact, both AXA PPP and Bupa stipulate this for new (junior) consultants (so called “fee assured” consultants in the case of Bupa). Because new consultants wishing to enter private practice need to be recognised by the insurers, the insurers control new entry to this marketplace (see below, under “barriers to entry”). As a result of the economics of running a consultancy, some new consultants are already opting not to enter the private healthcare market. On this, FIPO is attempting to collate information from various sources. The aim of the research is to track the costs of running a consultancy against the fees that insurers are willing to pay.
- B.65. For established consultants, the situation is one in which the insurers periodically attempt to cajole consultants into a similar deal (in any event, as all new consultants are obliged to enter into fee assured contracts, it is only a matter of time before all consultants will be on a “fee assured” contract).
- B.66. Even established consultants with years of practice behind them are not immune. Often they receive a letter in the form of the letter at confidential Appendix XIX and if consultants do not enter into a deal like this, they can be delisted. FIPO is collating data about delisted consultants: understandably consultants are reluctant to volunteer such sensitive information and spread it too widely. FIPO will try and get a sense of the percentage of consultants actually de-listed in recent years. Previous FIPO studies have shown that delisting of consultants was relatively low and that AXA PPP was the most aggressive in this respect but the CC should note that: (i) there is a trend on the part of some other insurers to be much more aggressive, so FIPO expects that going forward more consultants will be affected; and (ii) the threat of delisting is very powerful. Almost in all cases, targeted consultants cave in and reduce their rates.
- B.67. This means that insurers control conditions of supply and hold the ultimate weapon, the ability to decide who can enter a marketplace.

Theory of harm 5: barriers to entry

- B.68. The CC identified four classes of potential barriers to entry:
- (a) barriers to entry into privately-funded healthcare provision resulting from national bargaining between insurers and hospital operators;
 - (b) barriers to entry into privately-funded healthcare provision resulting from the relationships between hospital operators and consultants or GPs;
 - (c) other barriers to entry into privately-funded healthcare provision; and
 - (d) barriers to entry into the provision of consultant services in private practice.

B.69. FIPO will deal with 5(b) and 5(d).

5(b) barriers to entry into privately-funded healthcare services resulting from the relationships between hospital operators, consultants or GPs

B.70. FIPO will only be able to comment on some limited aspects of this theory of harm.

B.71. The CC considers that barriers to entry may arise due to:

(a) the need for a new entrant to obtain commitment from consultants to work in the new hospital in order to get insurer network recognition and, more generally, sufficient 'demand' for its services and, on the other hand, the need to guarantee enough demand by insured and self-pay patients to attract consultants away from incumbents' facilities;

(b) incentives provided by hospital operators to consultants; and

(c) incentives provided by hospital operators or consultants to GPs.

B.72. On point (a), the CC identifies that consultants may play a major role in bringing patients into a hospital and generating revenue for the hospital operator. The CC states that *"where consultants tend to focus their work at one main hospital this may make it particularly important for hospitals to attract key consultants"*.

B.73. FIPO is collating evidence about consultants and the number of hospitals in which they work. Practical considerations suggest that the majority of consultants would choose to operate from a limited number of hospitals, two or three as a maximum. Further, the hospitals should be within a reasonable distance from their home. There is nothing sinister about this and there is nothing sinister in consultants wishing to take advantage of better facilities and quality of care. In fact, the provision of better services to consultants (i.e. improved equipment, specific specialist nurses, intensive care facilities) by a private healthcare provider would attract consultants because it gives consultants the ability to care better for their patients. FIPO welcomes the availability of better facilities as a positive initiative.

B.74. If, as the CC suggests, *"an incumbent hospital may deter consultants from committing to switch to a new entrant, or even committing part of their time to the proposed hospital"*, and if this has foreclosure effects, then this would be a classic case of exclusionary behaviour on the part of a dominant operator. So if dominance and abuse occur, then the system of competition law has a mechanism to deal with that.

5(d) barriers to entry into the provision of consultant services in private practice

B.75. The CC states:

Theory of harm 2 hypothesizes that consultants may have market power in certain local areas. In part this may derive from a shortage of consultants in these local areas or from the existence of consultant groups collectively setting their fee. This theory of harm is closely related to theory of harm 2 and hypothesizes that there may be barriers to entry into the provision of consultant services in private hospitals that may prevent new consultants entering in response to the high prices and thus protecting the market power of incumbents.

B.76. FIPO is not aware of any barrier to entry for new consultants arising from consultant groups collectively setting fees or through local consultants having market power.

B.77. As seen in paragraphs A.24 and B.53 above, FIPO considers that the major barriers to entry into the provision of consultant services in private practice relate to the control exercised by the insurers on entry. The insurers are able to control access to the private healthcare market through selecting which consultants will be referred patients. First, the insurers exclude those consultants that do not agree to be bound by the low reimbursement rates imposed by the insurers, including those consultants who wish to charge a "top-up" fee to those patients that have chosen them for their expertise. In some cases an insurer (AXA PPP) will reimburse a patient less for seeing one consultant as opposed to seeing another, an instance of discriminatory pricing [36]. Second, Bupa is leading other insurers in introducing "managed care" policies, whereby the insurer names which consultant a patient may see. In this way, Bupa creates a second tier of recognition amongst consultants, identifying preferred consultants who will receive the majority of referrals through a managed care policy. It is not enough for a consultant to be recognised by Bupa but, in order to receive referrals it will be increasingly important to be on Bupa's referral list. The selection process by Bupa when referring patients on a managed care policy is wholly opaque. Therefore, not only are new consultants reliant on the insurers if they intend to enter the private healthcare market, but it is also not clear to these consultants how they can successfully enter the market.

B.78. Bupa's ranking system appears to be imposing a *de facto* quantitative restriction on entry into the profession as it limits the number of consultants to whom patients will be referred. As the CC will be aware, as a matter of law and economics quantitative restrictions are more likely to reduce competition and are less likely to be justifiable than restrictions based on qualitative criteria.¹¹

B.79. Control of entry by the insurers is comparable to the situation where entry is controlled by a professional or quasi-professional body decides on admission and exclusion. The organisation in question needs to apply entry and recognition criteria which are transparent, objectively justified and must provide a right of appeal (see further paragraph B.92 below).

¹¹ European Commission, *Report on Competition in Professional Services*, 9 February 2004, paragraph 56.

- B.80. For example, it is clear from the decisions of the European Commission that entry rules for associations must be open and non-discriminatory. In the *Sarabex* case,¹² a company complained to the Commission, as it was prevented from trading in certain currencies that were reserved only to members of an association called the Foreign Exchange Brokers Association, which was recognised by the Bank of England. Several UK banks had agreed to use only members for specified foreign exchange transactions, who charged an agreed commission. Failure to obtain membership meant that entry to this particular market was blocked. Here the Commission required the introduction of objective criteria for membership, and on refusal, a right of appeal.
- B.81. In *London Sugar Futures Market* OJ 1985 L369/25, following representations by the European Commission, the association's membership rules were amended in order to make it clear that membership was open and that the criteria for membership were objective. An appeals procedure and a requirement for the Management Committee to give reasons after making decisions that affect membership rights were also introduced.
- B.82. Even if membership rules were found to be indispensable, and therefore possibly capable of being exempted under Art 101(3) TFEU, the Commission has clarified that for this exemption to apply the rules must be sufficiently clear and determinate and capable of non-discriminatory application (see T-528/93 *Métropole Télévision v European Commission*).
- B.83. FIPO did attempt to discuss with the insurers the adoption at least of a voluntary code of practice providing for an arbitration mechanism but, in the absence of any market power of leverage on the part of the consultants, the insurers simply ignored the requests.

Theory of harm 6: limited information availability

- B.84. The CC states:

This theory of harm argues that information asymmetries and the limited information available to patients (as well as GPs and possibly insurers) may distort competition as they limit a patient's ability to make an informed choice about the most appropriate hospital/consultant for their condition.

Limited accessible, standardized and comparable information appears to be available that could assist either patients or their GPs (and possibly insurers) to select the most suitable consultant and/or hospital. In particular:

(a) There appears to be limited comparable information on either price or quality that self-pay patients could use in order to choose the consultant and/or hospital that best meets their

¹² The Eighth Report on Competition Policy (1978), points 35-37 [1979] 1 CMLR 262.

requirements.

(b) Insured patients are less likely to focus on price at the point of selecting which hospital/consultant to use. This is because of the separation between those paying for the treatment and those who decide on the need for treatment. However, they do have an incentive to select the hospital/consultant based on the quality of the services provided. There appears to be limited comparable information on quality that would enable them or their GPs to make an informed choice as to the most suitable consultant and/or hospital to meet their needs. In relation to price, the limited information on the quality of care provided by consultants also means that insured patients cannot judge the value for money offered by agreeing to pay a top-up fee directly to a consultant if the charges exceed what the insurer is willing to pay. On the other hand, if insurers were able to direct their insured patients to recognized consultants (e.g. through 'managed care'), there appears to be a risk of patients being directed to cheaper rather than better consultants due to information asymmetries between patients and insurers.

The limited information available to patients may compromise the patient's (and GP's) ability to choose the best hospital/consultant for their condition and, as a consequence, may result in:

- (a) GPs' recommendations relying on informal information and relationships, which may in turn strengthen the position of incumbents. This could lead to consumers paying higher prices or receiving lower quality services;*
- (b) a reduced incentive for hospital operators/consultants to compete aggressively to attract patients directly on the basis of either price or quality;*
- (c) higher search costs for: (i) self-pay patients when seeking to compare the breakdown of treatment costs in different hospital operators' hospitals; and (ii) all patients when seeking to choose a consultant and hospital operator; and*
- (d) higher search costs for GPs when making a referral.*

B.85. The CC is focusing on issues of information asymmetry (about quality and price) as a theory of harm. FIPO has already noted in its first submission (at paragraph 8.2) that limited information on price is more easily addressed than limited information on quality. If information on price is the only yardstick, further distortions arise.

B.86. FIPO considers that the statement quoted above gives an incomplete picture of the issues surrounding information asymmetries and focuses unduly on asymmetry of information between a patient and a doctor as regards quality. This is not to deny that better information on quality is desirable in a marketplace and in fact FIPO is actively involved in an initiative to improve the information on quality available to patients and GPs. FIPO's concern is that this considerable amount of work will be of no value unless patients who are

policyholders have a choice of consultants and facilities at which to be treated.

- B.87. In the next paragraphs FIPO will (i) consider issues of asymmetry of information between a patient and a consultant, in terms of price and quality; (ii) provide an overview of the initiatives already being discussed to improve information about quality of care; (iii) consider issues of asymmetry of information between an insurer and a consultant; and (iv) consider issues of asymmetry of information between an insurer and a policyholder.

Asymmetry of information between a patient and a consultant

- B.88. In terms of price, FIPO has always recommended that all members give information on fees and provide estimates whenever possible to their patients. Indeed, in paragraph 8.2 of its original submission, FIPO referred the CC to the fact that the OFT has acknowledged FIPO's role in increasing fee visibility in this marketplace. Further, FIPO would like to draw the attention of the CC to the fact that patients who are not billed for their treatment will never know the true cost of treatment. In paragraph B.38 above we explain our puzzlement at the CC's cryptic remark that consultants usually "*provide a separate bill specifying their charges*" and give our views that information about the true cost of treatment is essential for patients to be able to shop around. It would be unfortunate if the CC believed that patients should not be issued with a bill specifying consultants' charges.
- B.89. In terms of quality (and to an extent, also price) information asymmetry is a feature of all professions. There is asymmetry of information between any professional and their client, e.g. a lawyer or accountant would be expected to have more information than their clients. This feature is central to the nature of a profession as the professional trades on their knowledge and the client requires the professional for that knowledge. It does not follow that information asymmetry restricts patients' choice of surgeons. The European Commission has recognised that customers may find it difficult to judge the quality of services provided by professionals.¹³ This is one of the reasons why there are qualitative entry requirements into a profession and mechanisms to exclude from a profession people who do not meet quality standards (in the case of the medical profession, this role is played by the General Medical Council). In fact, the European Commission in its Report on Competition in Professional Services recognises that professions require some form of qualitative entry criteria but warns that qualitative restrictions and licensing regimes should not be excessive as they can restrict competition. FIPO contends that the General Medical Council's criteria ensure that quality standards are maintained. If any insurer or other person should be concerned about quality issues, the appropriate route would be to involve the local hospital's governance system, the hospital CEO or medical director, the Chairman of the Medical Advisory Committee, the Responsible Officer (for revalidation) or the General Medical Council. There are ample routes to ensure a regulated and controlled profession.

¹³ European Commission, *Report on Competition in Professional Services*, 9 February 2004, paragraph 25.

Current initiatives on availability of information on quality

- B.90. FIPO is actively involved in discussions with private healthcare providers about availability of quality information. The aim of these initiatives is to ensure that: (i) independent hospitals declare in comparable format the facilities and services they offer, coupled with some agreed patient feedback information; (ii) the hospitals aggregate their statutory KPIs (readmissions, returns to theatre, etc.) and (iii) information on quality of consultants' work is made available. This is a difficult area. Whilst for cardiac surgery and ITU care, statistics on deaths may be a proxy, in other cases it is much more difficult to come up with yardsticks for quality that would be meaningful.

Asymmetry of information between an insurer and a consultant

- B.91. As seen at paragraph B.54 above, consultants can be delisted at whim by the insurers and have no idea as to the criteria adopted for delisting, nor do they have any recourse to an appeal mechanism against the decision. This is a serious asymmetry.
- B.92. Further, as mentioned in paragraph B.77 above, Bupa's open referral scheme introduces another layer of consultants, those who are "preferred". Restrictions imposed by Bupa in its open referral policy effectively create a two-tier recognition system. Consultants that do not rank at the top of Bupa's "quality" database are effectively restricted from seeing patients. First it should be noted that Bupa does not have the authority of a nationally recognised professional body and therefore should not impose entry restrictions on a profession. Second, Bupa's assessment process is opaque (both in terms of how consultants are ranked and even which consultants are recognised under open referral) and does not provide consultants with any objective way of challenging Bupa's decision. Even where Bupa has deregistered consultants entirely they have frequently refused to engage with those consultants on their reasoning for doing so [36]. Consultants have made requests for this information to Bupa and hopefully this area will become clearer. We will keep the CC informed of developments.

Asymmetry of information between an insurer and a policyholder

- B.93. On price, policyholders who are not told the true cost of their treatment are not able to make choices (this is the same point made above, at paragraph B.77). Further, policyholders in this situation will never be able to compare the amount of benefits available from different insurers under different policy plans (a point that only becomes relevant if policyholders can change insurer).
- B.94. On quality, Bupa is now making unsubstantiated claims, such as that they select consultants that provide a better quality of care (Bupa states in an open letter that its "*comprehensive database of consultants and hospitals gives [them] and insight into which consultants provide a higher quality of care*"; see Appendix I). Bupa claims therefore that it is in a better position than a GP to assess how the needs of a patient may be met [37]. The OFT in its report

stated that the insurers do NOT have any quality information and one of the medical directors at Bupa admitted this at an OFT Round Table meeting last year.

- B.95. Bupa's so-called qualitative assessment criteria are completely hidden from patients (and consultants). Indeed, there is a concern that the criteria may not be linked to quality at all but rather to the consultant's history or using diagnostic tests. As set out at paragraph A.35 above, Bupa downgrades consultants that undertake more thorough testing. Similarly, Bupa's focus on "value" may mean that patients are being referred to consultants on the basis of those consultants' fees rather than the quality of care that they provide.
- B.96. Some insurers fail to recognise certain changing techniques; some reimburse for some procedure which others do not; some insist on bundling of procedures and all decline to discuss these issues with the profession. These are factors which are totally hidden from the policyholders who usually only find this out at the time when they require treatment and when they are at their most vulnerable (see paragraphs A.37 to A.45 above).

Theory of harm 7: vertical effects

- B.97. The CC states:

The only insurer that is vertically integrated is BUPA, through ownership of the Cromwell hospital in London. BUPA and possibly some of the other insurers may also own some primary care facilities.

At this stage we do not believe that these vertical linkages are likely to lead to significant harm to competition. However, we are keeping an open mind to any potential vertical theory of harm as we learn more about the market.

- B.98. We welcome the statement by the CC that they are keeping an open mind to vertical theories of harm. As the CC notes, Bupa is the only insurer that is vertically integrated. In addition to owning the Cromwell Hospital in London, Bupa acts as a provider of private healthcare through its home chemotherapy service and through its forty-five centres that offer a range of treatments from physiotherapy to radiology and diagnostic ultrasound. FIPO believes that patients are being directed away from consultants operating in third party private healthcare facilities, towards BUPA's own vertically integrated structures. FIPO is collecting evidence to substantiate this view.
- B.99. Additionally, Bupa operates a Healthcare Access scheme that is advertised for people without private health insurance or for those who require a treatment that is excluded from their insurance plan (Appendix XX). The Access Scheme includes, amongst other treatments, hip and knee replacements, cataract operations and arthroscopies.
- B.100. It is instructive to see the rates that Bupa considers reasonable for private healthcare charges

to self-paying patients when Bupa is the provider. For example, Bupa publishes a price list for musculoskeletal treatment at its centres (Appendix XXI). These prices demonstrate the degree by which Bupa is squeezing the margins of consultants operating from third party private healthcare facilities. The rates for treatments at Bupa's own centres are significantly higher than the reimbursement rates that Bupa imposes on many consultants operating out of third party private healthcare facilities. FIPO believes that the difference in rates cannot be justified by the overhead charges incurred by Bupa in running its own facilities, although FIPO will of course not be able to collect this kind of data.

B.101. For example, Bupa charge £115 for a soft-tissue, intra-articular or facet joint injection at one of its London clinics. Bupa have recently reduced the consultants' reimbursement rates for this treatment [X]. Similarly, Bupa's charge of £417 for an ultrasound-guided injection by a radiologist is [X] higher than the [X] reimbursement rate for surgeons performing an arthroscopic knee operation, a much more complex operation requiring uncommon level of skills.

B.102. The price differentials charged in Bupa's facilities alone demonstrates that the reimbursement rates forced upon consultants are unfeasibly low.

EAL/JRL
Watson Farley & Williams LLP
July 2012

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IV.	Confidential: [X]
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Appendix I



Open referral letter

Letter from Tony Wood

Dear Intermediary Partner

The purpose of this letter is to detail how Bupa can help your clients receive access to better standards of healthcare and to remove the burden of shortfalls, whilst ensuring that prices remain at sustainable levels. We hope you find this innovative solution both relevant and timely.

It has been a challenging year for everyone in the UK. Both the Government and the Bank of England say that the economic downturn is showing little sign of recovery and could be with us for the long term. This is forcing British businesses to continue to operate in an extremely difficult environment. At the same time, the NHS is going through a period of uncertainty and change as the debate about its reform continues. Despite all this however, the desire for high quality healthcare is as strong as ever.

We have listened to feedback from our customers who want to see us innovate and lead the market by driving through solutions that continue to offer them access to high quality healthcare and value for money. This cannot happen without tackling hospital and consultants' costs. These are the main drivers of medical inflation which continues to rise, driving up prices at an unsustainable rate and threatening the long-term future of private healthcare.

Our focus is on improving the healthcare experience and health outcomes for our customers. We also want to keep private healthcare affordable for the long-term and would like to work with you to deliver better care and value for money for your clients and their employees.

Open referral – better quality, better value

From January 2012, we are introducing our Open Referral Service as a standard enhancement to our Corporate Select product.

This service delivers several improvements to your clients and their employees:

- There are variations in clinical practice and the treatment a patient receives often depends on which consultant they see. For example, some orthopaedic consultants are three times more likely to operate on a Bupa member than others. The Open Referral Service enables us to ensure your clients and their employees do not see consultants whose care practices differ from respected norms.
- GPs often refer patients to consultants with little or no objective data about a consultant's care practices or private patient charges. This sometimes leads to patients facing unexpected bills because some consultants charge above average.
- With the Open Referral Service, we can offer your clients and their employees a choice of consultants and no unexpected shortfalls.
- Healthcare costs for employers are increasing because of cases of over-testing and over-treatment.
- Many Bupa customers are increasingly asking us for help and guidance about which consultants they should see.

How does the Open Referral Service work?

It's simple. Members requiring diagnosis or treatment will need to:

- Ask their GP for an open referral – it will no longer be necessary for GPs to specify a named consultant at a particular hospital for Bupa members.
- Call the Bupa Helpline to authorise diagnosis or treatment, so that we can offer the member a choice of consultant who will provide the most appropriate care and ensure that the costs will be covered by the member's Bupa scheme. This significantly improves the member's experience and helps control costs for clients.

Better care, better satisfaction rates

The benefits of our Open Referral Service are that patients are given a choice of consultants to see at a hospital that is convenient for them. Our comprehensive database of consultants and hospitals gives us insight into which consultants provide higher quality care. It also means that we can offer your clients a choice of consultant, faster access to care and greater financial certainty because there will be no unexpected shortfalls on their consultant's charges. Your clients benefit by having greater cost control - in 2012, as a result of this innovation, their premium increase will be below inflation* for the first time in many years.

The initial phase of our Open Referral Service has delivered some excellent results with 93% of customers reporting that they were comfortable with Bupa recommending a hospital and consultant**. By the end of this year, more than 30,000 patients will have enjoyed the benefits of this new service.

By taking a more active role in providing patients with a choice of consultants and hospitals, who we know deliver high quality care against strict clinical guidelines, we can be confident that your clients and their employees will be more satisfied and receive good quality care.

High quality affordable healthcare

We have developed a number of initiatives to meet our clients' needs for high quality affordable healthcare for their employees. The Open Referral Service is just one example. Here are some more:

- In **February 2011** we launched the Bupa Mental Health Therapist Network, raising the standard of therapists that we recognise and ensuring reasonable costs for our customers. We also fully launched our Mental Health and Wellbeing Specialist Support Team which gives members even easier access to therapy when they need it.
- In **April 2011** we launched our new Cancer Cash Benefit. This gives Bupa members with full cancer cover, the opportunity to choose where to receive their cancer treatment. It also offers them a cash sum for every day or night spent having NHS treatment in an NHS facility. Not only does this provide patients with an element of choice, it gives them more control over their healthcare and helps clients reduce their claims costs.
- In **May 2011** we took steps to address variations in the treatment received by our members by introducing a medical review process, to evaluate whether the recommended course of treatment was in line with our policy of only funding clinical best practice. This initiative related specifically to Bupa patients being referred for a knee arthroscopy and we have extended this to the surgical removal of teeth.
- In **September 2011** we launched our Specialist Cardiac Patient Support Team which is helping to ensure patients get the right treatment, and that they are fully informed about how they can support their own care.
- In **October 2011** we are introducing NHS Cancer Cover Plus – an option for clients who want to ensure that their employees will have full treatment available for their cancer and who wish to use NHS centres of excellence. Under this option, a member newly diagnosed with cancer will be treated in the NHS, with telephonesupport from Bupa's Oncology Support Team and nurses. Private cover will be available for any treatment that is not available through the NHS.

We are committed to improving the healthcare experience and health outcomes for our customers and to keeping private healthcare affordable for our customers in years to come. We will continue to work hard to ensure that your clients continue to have access to high quality healthcare and

ensure that we deliver the best value by tackling consultant and hospital costs that are the main drivers of medical inflation. You will be seeing more initiatives that deliver on this in the coming months.

What are the next steps?

All of our people have been fully trained to support you and your clients with the Open Referral Service and would welcome the opportunity to engage your teams.

We are now actively looking at schemes with a January 2012 renewal date and would like to discuss what Open Referral means to you and your clients as soon as possible.

We look forward to working with you to drive this initiative forward. In the meantime, please contact your Bupa Account Manager who will be able to answer any questions you have.

Yours sincerely,

Tony Wood
Sales Director

Next steps

• **Contact us**

Call the intermediary sales centre on **0800 33 2000**

Lines are open 8am to 6pm, Monday to Friday

* This will depend on their claims in 2011. Reference is to medical inflation.

** High level Synovate results: Summarised Q3 2011 results

Appendix II

AMII 2012: Rising healthcare costs could kill individual PMI market, Aviva's Noble warns

- Tuesday 03 July 2012
- by Tessa Norman
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- [PMI](#)
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Brakes need to be put on after costs soar 40% over past 10 years

The individual private medical insurance (PMI) market faces huge challenges unless the industry gets to grips with rising costs, according to Mark Noble, health and group risk director at Aviva UK Health.

Speaking at today's Association of Medical Insurance Intermediaries Annual Private Healthcare Summit, Noble (*pictured*) told delegates that while the corporate PMI market is performing well, he is concerned about the individual market.

He said: "The individual market has shrunk significantly, and unless we get a hold of rising costs I think this will be a huge challenge for us going forward."

Noble pointed out that the cost of PMI has gone up 40% in the past ten years and said that unless the brakes are put on rising prices, it could soon become "unaffordable".

PMI providers are increasingly looking at different ways of keeping costs down in order to make cover affordable for individuals.

While different cost containment strategies apply to the individual, SME and corporate markets, they have included the introduction of hospital networks and so-called 'open referral' options which give insurers greater control over which hospital consultant can treat the individual member.

Noble said today: "I think that hospital networks and open referral is the way the market has got to go. That will be really difficult for some people because it is going to reduce choice, but otherwise costs are going to run away from us."

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- **Publish date:** Tuesday 03 July 2012

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Appendix III

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Sunday Telegraph
24 June 2012
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Beware shortfalls on your private ops

Bupa is cutting the maximum amount it will pay doctors, says **Teresa Hunter**

The cost of many routine operations, such as hip replacements or knee surgery, looks set to soar by hundreds of pounds per procedure for private patients. Bupa, the leading medical insurer, is in the process of slashing claims payouts, leaving policyholders to pick up substantial shortfalls.

One in four people living in London and the South East is covered by medical insurance, with nearly a fifth elsewhere in Britain enjoying the benefit, mainly as part of employment packages, on which they pay tax.

But problems can arise when policyholders require treatment and need to make a claim. Sometimes, consultants and anaesthetists charge more than the insurance company is prepared to pay. This leaves the policyholder facing a shortfall. And now shortfalls look set to become more frequent and much larger because Bupa, which underwrites more than 40pc of cover, is cutting its maximum reimbursement schedules by up to 60pc.

On average, reimbursements to patients will fall by a third, potentially leaving them with an average £213 shortfall, according to the Federation of Independent Practitioner Organisations (Fipo).

Bupa says it will be up to consultants to decide if patients have to pay more. Natalie-Jane Macdonald, Bupa's managing director, said: "If consultants

readjust charges in line with our reimbursement schedules, there should not be any shortfalls."

And other insurers could well follow suit. Fergus Craig, the commercial director at Axa PPP, said it had no plans to cut reimbursement rates at this point, but he could not rule it out.

He said: "We would take a very dim view if we discovered consultants were charging one set of customers a lower rate than our policyholders, or discriminating against them in any way."

Under the new Bupa schedule, the payment that consultants receive for a basic hip replacement, for example, is falling by only £55, from £837

to £782. However, if there are complications, and the operation needs to be revised, patients could find themselves stamping up £685, as the consultant's payment falls from £1,725 to £1,040.

Similarly, consultants will get £299 less for a knee arthroscopy, where an endoscope is used to examine the knee. Here their payment falls from £548 to £249.

Another big cut faces consultants using high-intensity ultrasound to treat prostate cancer. The payment falls from £1,370 to £690, leaving policyholders with a potential shortfall of £680.

Patients could be hit hard, according to Geoffrey Glazer, Fipo's chairman, who said: "Patients will face greater shortfalls, but this has been

created by the insurers. Around 70pc to 80pc of consultants currently charge within the Bupa reimbursement scales, but this will not be the case now."

Brian Walters, the vice-chair of the Association of Medical Insurance Intermediaries, added that widespread shortfalls would

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be a "dreadful thing" for patients. "Private medical insurance is a good product, but it isn't cheap. People pay hefty premiums, and some policyholders have excesses and no claims discounts," he said.

"Now they could face the situation where their doctor is effectively saying to them, 'I know you pay £3,000 a year for your policy, and you will have to pay £350 more next year because you will lose your no claims discount, and there will be an excess to pay on top. Now, you will also have to find another £500 because your insurer will not cover my bill.'"

Bupa's move is the latest in a long-running battle over funding between insurers, consultants and private hospitals. The payment to a doctor is a small proportion of the overall cost of any treatment.

The total bill for a typical hip replacement, for example, is £12,000, with payments going to a range of health-care professionals, as well as to the clinics and hospitals.

Last month, the Competition Commission launched an investigation into the private



We have a duty to make sure that doctors' charges are competitive

health industry, after a hard-hitting report from the Office of Fair Trading criticised charging structures, including incentives paid to consultants, which it said had the potential to lead to patients being overcharged.

Consultants complain that Bupa has not increased its rates for nearly 20 years, while insurers

are adamant that costs must be controlled to avoid private medical insurance becoming unaffordable.

The numbers buying medical insurance have been in decline since tax relief on premiums was

abolished in 1998, and are falling by around 5pc a year.

Mr Craig said: "We are seeing the biggest decline in the retired age group, who might have enjoyed and valued medical insurance during their working lives. But with their income being squeezed on so many fronts, it is a luxury many can no longer afford."

Ms Macdonald added: "Our focus is on making sure our members can afford subscriptions into the future, particularly as they get older. We know many of them are very concerned about the soaring cost of cover. We have a duty to make sure doctors' charges are competitive.

"We make changes in our reimbursement scales from time to time to reflect changes in technology, and the fact that many procedures which were once very complex and time-consuming

have become significantly simpler thanks to medical advances.

"There are two new cancer drugs, one for skin cancer and the other for prostate, coming on stream. We want to be able to give our members the opportunity to benefit from these drugs, but estimate that the cost will be between £6m and £10m. This money has to be found."

Ray Stanbridge, a medical accountant who works across all parties in the private medical industry, said the truth about pricing and funding was complex.

Many consultants are prospering, he said, with the average earning £90,000 from the NHS and £65,000 from private work, according to the British Medical Association.

Mr Stanbridge said: "Medicine is a dynamic sector where the technology is constantly changing. There is far less invasive surgery, for example. But as people are living longer there is more demand than ever for consultants' services. So although payments for particular procedures may not have gone up, and some are going

down, overall many consultants are prospering."

Bupa has increased the reimbursement schedule for a

few operations, but Mr Glazer said these procedures were rarely undertaken compared with the most common operations, which are taking the biggest hit.

Patients who need certainty about costs can always turn to the 10,000 consultants whom Bupa has signed up to guarantee that there will be no shortfall. However, this group may not include an experienced consultant of your choice.

"We have no vendetta against doctors," said Ms Macdonald, "but we have to balance our books, so that reimbursement scales to doctors reflect not just the cost of individual treatments but also the number of treatments carried out.

"Take a knee arthroscopy. Some doctors see 10 patients and do two or three arthroscopies. Others will do nine. So a consultant's overall remuneration will depend not just on the payment per treatment but on the number of treatments, too."

OUTCOME CUTTING

PIELLE
CONSULTING

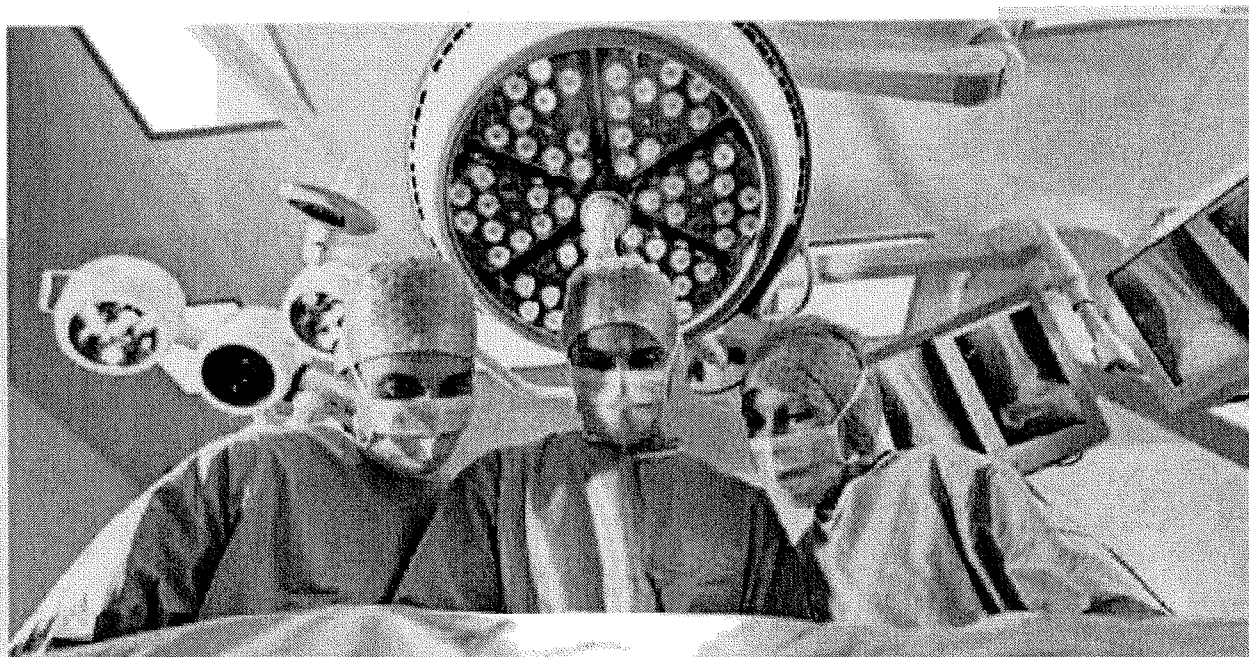
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Consultants sometimes charge more than the insurance company is prepared to pay, leaving the policyholder facing a shortfall. It could be £600 for prostate cancer treatment, for example.

Appendix IV

CONFIDENTIAL

Appendix V



Your Bupa Personal Membership Guide

Essential information
explaining your Bupa cover
Please retain



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Contacting us

Please see your membership certificate for details of the Bupa helpline number and correspondence address.

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Thank you for being with Bupa - the UK's number one private health cover provider

About this guide

Welcome to your Bupa Membership Guide. This booklet, along with your membership certificate contains the terms of your Bupa cover. We hope the guide is useful as a handy point of reference as it takes you through every aspect of your membership, from explaining how your cover works and what you're covered for, to how to claim should you fall ill.

If there's anything you don't understand, there's a glossary of terms at the back of the booklet that should help guide you through some of our terminology, but if you're still not sure of anything, please call the helpline number. You'll find the helpline number and other contact details on your membership certificate.

The information in this guide complements your membership certificate which sets out essential details about your cover including your hospital access and certain benefit limits. Before making a claim it would be advisable to read through the relevant areas of both documents, however we're always at the other end of the phone should you require any further clarification on anything.

Reading your membership certificate and Bupa Membership Guide

It is important that you read your membership certificate and membership guide together. This ensures you fully understand how your policy works in case you need to arrange treatment at any time.

Cross-referencing your documents

Your membership certificate cross-references benefit notes that relate to the corresponding section of the membership guide, outlining Bupa's cover in more detail. The following are examples only; however, this example of cover may not specifically apply to you. Please refer to your membership certificate for the benefits applicable to you.

Benefit 1 Out-patient
This benefit 1 explains the type of benefits you are covered for in your membership certificate. You are not covered for out-patient treatment as no membership certificate is in place.

Benefit 5 Psychiatric treatment
You are only covered for this benefit if you are not covered for psychiatric treatment under your previous scheme as it has been included there has been no change in the policy.

Finding out what is wrong and being treated as an out-patient

Type of cover	Benefit note	Cover	Limits for each member (subject to benefit note)
our patient consultations, therapies and diagnostic tests	1.1, 1.2, 1.4	Yes	up to £500 combined limit each year
our patient complementary medicines	1.3	Yes	up to £250 each year from within your available out-patient limit
our patient MRI, CT and PET scans	1.5	Yes	recognised facility, paid in full

Out-patient treatment
In this example the benefit amount is £500. Your membership certificate will show the benefit limits specific to your scheme.

Psychiatric treatment
In this example psychiatric treatment is excluded. If it is included on your policy it will be shown on your membership certificate.

Type of cover	Benefit note	Cover	Limits for each member (subject to benefit note)
Psychiatric treatment	1.5	Not covered	

Please check the benefits listed on your membership certificate and cross-reference them with the relevant sections of your membership guide. This will help you understand exactly what you're covered for if you need to make a claim. Only benefits stated on your membership certificate are included in your policy.

What to do if you need treatment

We understand that it's only natural to feel anxious at a time of ill health, so we will do everything we can to help make arranging your treatment as simple and straightforward as possible. Always call us before arranging any consultation, diagnostic tests or treatment: we will then explain the cover available to you and help to arrange your treatment.

Helping us to help you

Before you call us, it would be useful for you to have to hand where possible the information below so that we can process your claim more efficiently. We can also confirm whether your proposed treatment, diagnostic tests, consultant or hospital are covered under your scheme.

- Your Bupa membership number.
- The condition you are suffering from.
- Details of when your symptoms first began.
- Details of when you first consulted your GP about your condition.
- Details of the treatment that has been recommended.
- Date/s on which you are to receive the treatment.
- The name of the consultant or other healthcare practitioner involved.
- Details of where your proposed treatment will take place.
- Your expected length of stay in hospital.

A step-by-step guide to making a claim

- 1 In most cases you will need to see your GP first who will determine whether you need to see a consultant or healthcare professional.
- 2 If you need to see a consultant or healthcare professional, let your GP know that you have Bupa cover and they will either refer you to one or suggest that you contact us if you want a choice of consultants or healthcare professionals.
- 3 Once you know the name of the consultant or healthcare professional you are going to see, please call us so we can confirm whether you are covered under your Bupa membership. We will also let you know what you need to do next and if you are a moratorium member we will send you a pre-treatment form to complete - please refer to the 'Claiming' section for more details about this.
- 4 When we have confirmed that your treatment is covered, we will discuss your claim with you and issue you with a 'pre-authorisation' number. You will then need to contact your consultant or healthcare professional to arrange an appointment that suits you.
- 5 It is recommended that you give your 'pre-authorisation' number to the consultant or healthcare professional for the invoice to be sent to us directly. If for any reason you are sent the invoice, just send this on to us addressed to our Claims Department at Bupa, Anchorage Quay, Salford Quays, M50 3XL.
- 6 Once we have made payment towards your claim we will send you a summary of your claim and treatment details. This will let you know if you need to do anything further.
Please note payment may take a number of weeks, depending on how quickly invoices are submitted to Bupa.

Effective from 1 December 2009

These are the rules and benefits that apply to **Bupa members**. By this **we** mean a member covered under one of the following Bupa private medical insurance products as shown on their **membership certificate**:

- BupaCare, LocalCare, EssentialCare, Local HospitalCare, SeniorCare, Senior EssentialCare, EmployeeChoice, EmployeeChoice Essential, LocalCare Direct, Fixed Price Cover
- Heartbeat - cover options Health care select 1, 2, 3 Plus, 3 and 4.

They apply to **Bupa members** who join or whose membership is renewed on or after the 'effective from' date:

- For anyone joining Bupa they apply from their **start date**.
- For anyone whose Bupa membership is renewed they apply for the period from the first **renewal date** on or after the 'effective from' date.

Words and phrases in bold and italic in this membership guide are defined terms which have a specific meaning. You should check their meaning in the glossary.

Important note - please read this note before you read the rest of this membership guide as it explains how this membership guide and your membership certificate work together. This Bupa Membership Guide and your **membership certificate** together set out full details of your **benefits**. They should not be read as separate documents.

This membership guide is a generic guide. It contains the general membership terms that apply to **Bupa members**. It also sets out all the elements of cover that are available for **Bupa members** under all their **schemes**. This means that you may not have all the cover set out in this membership guide. It is your **membership certificate** that shows the cover that is specific to your **benefits** and **scheme**. Any elements of cover in this membership guide that are either:

- shown in your **membership certificate** as 'not covered' or
- do not appear in your **membership certificate**

you are not covered for and you should therefore ignore them when reading this membership guide. Your **membership certificate** could also show some changes to the terms of cover set out in this membership guide particularly in the 'Further details' section of your **membership certificate**.

When reading this membership guide and your **membership certificate**, it is your **membership certificate** which is personal to you. This means that if your **membership certificate** contradicts this membership guide it is your **membership certificate** that will take priority.

Always call the helpline if you are unsure of your cover.

The agreement between you and us

In return for **you**, the **main member**, paying **us** subscriptions, **we** agree to provide **you** and **your dependants** (if any) with cover under the terms of our **agreement**.

Only **you** and **Bupa** have legal rights under our **agreement**. Although **we** will allow anyone who is covered under **your** membership complete access to **our** complaints process (see 'If you have cause for complaint' in this section).

The following documents make up our **agreement**. These documents must be read together as a whole, they should not be read as separate documents.

- **This Bupa Membership Guide:** this sets out the general terms and conditions of membership (including exclusions) and all the elements of cover that are available for **Bupa members** under all their **schemes**.
- **Your membership certificate:** this shows **your** current membership details including:
 - who is covered by your Bupa membership, the dates when cover started and when your membership is due for renewal
 - the cover that is specific to your **benefits**, including the limits that apply, any variations to the benefits, terms or conditions explained in this membership guide
 - the subscriptions **you** will be paying and the method of payment **you** have chosen
 - whether an **excess** or **co-insurance** applies to your cover and if it does the amount and how it applies
 - any **special conditions** which apply to **you** or anyone covered under **your** membership
 - **your** chosen **scale of cover** (if one applies)
 - the type of underwriting that applies to your membership.
- **Your application for cover:** this includes any quote request, applications for cover for **you** and **your dependants** (if any) and the declarations that **you** made during the application process.
- For Heartbeat members with Additional Cover Options included in their **benefits**, the Bupa Heartbeat Additional Cover Options Membership Guide.

Payment of benefits

We only pay for **treatment** that you receive, or the **benefits** that you are entitled to, while you are covered under the **agreement** and **we** only pay in accordance with the **agreement**. **We** also only pay the **benefits** that applied to you on the date you received your **treatment** or the date that you became entitled to those **benefits**.

When you receive private medical treatment you have a contract with the providers of your **treatment**. You are responsible for the costs you incur in having private **treatment**. However, if your **treatment** is **eligible treatment** we pay the costs that are covered under your **benefits**. Any costs, including **eligible treatment** costs, that are not covered under your **benefits** are your sole responsibility.

The provider might, for example, be a **consultant**, a **recognised facility** or both. Sometimes one provider may have arrangements with other providers involved in your care and, therefore, be entitled to receive all the costs associated with your **treatment**. For example a **recognised facility** may charge for **recognised facility** charges, **consultants' fees** and **diagnostic tests** all together.

In many cases **we** have arrangements with providers about how much they charge **our** members for **treatment** and how **we** pay them. For **treatment** costs covered under your **benefits** **we** will, in most cases, pay the provider of your **treatment** direct - such as the **recognised facility** or **consultant** - or whichever other person or facility is entitled to receive the payment. Otherwise **we** will pay the **main member**. **We** will write to tell the **main member** how **we** have dealt with any claim.

Please also see the section 'Claiming'.

When your membership starts, renews and ends

Starting membership

Your cover starts on **your start date**.

Your dependants' cover starts on their **start date**. **Your start date** and **your dependants' start date(s)** may not be the same.

Covering a new born baby: you may apply to include **your** newborn baby under **your** membership as one of **your dependants**, free of charge, until your first **renewal date** after their birth.

If **you** have been a Bupa member for at least 12 continuous months before the baby's birth and **you** include **your** baby under **your** membership within three months of the baby's birth and **your** baby's membership under the **scheme** would be as:

- an **undenwritten member**, **we** will not apply any **special conditions** to the baby's cover
- a **moratorium member**, **we** will not exclude **moratorium conditions** from the baby's cover – see exclusion 33 in the section 'What is not covered'.

In which case if **we** agree to cover **your** baby it will be from their date of birth.

Your right to cancel

You may cancel **your** membership for any reason by writing to **us** within 21 days of receiving the first membership certificate **we** send **you** each **year** confirming **your** cover. As long as **you** have not made any claims **we** will refund all of **your** subscriptions for that **year** and, any sums **you** have paid for future years (if any).

You may cancel any of **your dependants'** membership for any reason by writing to **us** within 21 days of receiving the first membership certificate **we** send **you** each **year** confirming their cover. As long as no claims have been made in respect of their cover **we** will refund all **your** subscriptions paid in respect of that **dependant's** cover for that **year** and any sums paid in respect of that **dependant** for future years (if any).

Renewing your membership

Our **agreement** is an annual one and your membership must be renewed each **year** on **your renewal date**, subject to the rule 'Making changes' in this section.

Your membership will renew automatically as long as **you** continue to pay **your** subscriptions and any other charges unless:

- **you** decide to end **your** membership
- **we** decide to end the **scheme**, or
- if your cover is arranged by a **group sponsor**, **we** do not agree to **your** membership or the membership of any of **your dependants** renewing.

If **we** decide to end the **scheme** or if **your** cover is arranged by a **group sponsor** and **we** do not agree to **your** membership or the membership of any of **your dependants** renewing, **we** will write to let **you** know at least 28 days before **your renewal date**.

How membership can end

You can end **your** membership or the membership of any of **your dependants** at any time by writing to **us**. If **your** membership ends the membership of all **your dependants** will also end. **Your** membership and that of all **your dependants** will automatically end if:

- **you** do not renew **your** membership
- **you** do not pay **your** subscriptions, or any other payment **you** have to make in respect of the cover, on or before the date they are due
- **you** stop living in the **UK** (**you** must inform **us** if **you** stop living in the **UK**)
- **you** die, or
- **we** decide to end **your scheme**.

A **dependant's** membership will automatically end if:

- **your** membership ends
- **you** do not renew the membership of that **dependant**
- that **dependant** stops living in the **UK** (**you** must inform **us** if a **dependant** stops living in the **UK**)
- that **dependant** dies, or
- **we** decide to end their **scheme**.

If **your** membership of the **scheme** is based on **you** being either:

- employed by the **group sponsor**, or
- a member of the **group sponsor**

and the **group sponsor** has agreed with **us** that **your** membership and that of **your dependants** will end if:

- **you** cease to be employed by the **group sponsor**, or
- **you** cease to be a member of the **group sponsor**

as applicable, **we** will end **your** membership of the **scheme** at the end of the month in which **we** are advised or determine that **you** are no longer employed by or a member of that **group sponsor**.

You should call **your** helpline to confirm if your **scheme** is arranged by a **group sponsor**.

Joining another Bupa scheme

If **we** decide to close the **scheme**, or if your cover is arranged by a **group sponsor** and **we** do not agree to **your** membership being renewed, **we** may offer **you** the opportunity to join another **Bupa** private medical scheme on the basis of the terms and conditions of the new scheme that **we** offer **you**. If you are an **underwritten member** and transfer within one month **we** will not add any **special conditions** to **your** membership or that of any of **your dependants**, if they are **underwritten members**, under the new scheme other than those that apply under this **scheme**.

If your membership ends for any other reason you may apply to join another **Bupa** private medical scheme. You may only do this as long as your membership didn't end because you misled **us** or attempted to mislead **us**. **We** will consider your application at **our** sole discretion.

Paying subscriptions and other charges

You must pay subscriptions to **us** in advance for **you** and **your dependants** throughout **your** membership. The amount **you** must pay and **your** method of payment is shown on **your membership certificate**.

If **your** cover is arranged by a **group sponsor** and **you** have agreed with the **group sponsor** that **your** subscriptions are collected by them and paid to **us** on **your** behalf (eg by payroll deduction) the **group sponsor** will act as **your** paying agent.

Refund of subscriptions if your membership ends

If **your** membership ends for any reason **we** will refund any subscriptions **you** have paid which relate to a period after **your** cover ends.

If **your dependants'** membership ends for any reason **we** will refund any subscriptions **you** have paid in respect of that **dependant** which relate to a period after their cover ends.

Making changes

Changes we can make

We can change the terms and conditions of the membership at **your renewal date**. These changes could affect:

- how **we** calculate subscriptions, the amount **you** have to pay, how often **you** pay them and the method of payment (the cost of subscriptions has typically risen higher than the retail price index (RPI) over the same period, but this does not mean that they will increase by the same rate in the future), and
- the amount and type of cover provided under the **scheme**.

If **your** cover is arranged by a **group sponsor**, at **your renewal date** **we** may also change or withdraw the amount of any discount or preferential rates.

If **you** agreed with **us** that either a five or ten year fixed term subscription will apply to your cover:

- **we** will only change how **we** calculate subscriptions, the amount **you** have to pay, how often **you** pay them and the method of payment at **your subscription review date**. If your product is Heartbeat and you have agreed a fixed term subscription with **us**, the fixed term does not apply to any part of **your** subscription that relates to cover for any Additional Cover Options.
- **your** fixed term will end:
 - on **your subscription review date**
 - if **you** decide not to continue with your fixed term subscription, or
 - if you make any changes to your cover which affect the subscription which you have to pay. If your product is Heartbeat this does not apply if your subscription changes because you have added or removed any Additional Cover Options.

We can, at any time, change the amount **you** have to pay **us** in respect of IPT or any other taxes, levies or charges that may be introduced and which are payable in respect of your cover if there is a change in the rate of IPT or if any such taxes, levies or charges are introduced.

We will not add any **special conditions** to someone's cover for medical conditions that started after their **start date** provided they gave **us** all the information **we** asked for before their **start date**.

If **we** do make any changes to the terms and conditions of **your** membership **we** will write to tell **you** at least 28 days before the change takes effect.

If **your** cover is arranged by a **group sponsor**, **we** may make changes to the terms and conditions of **your** membership on **your renewal date** and if **you** do not accept any of the changes **you** can end **your** membership either:

- within 28 days of the date on which the change takes effect, or
- within 28 days of us telling **you** about the change.

whichever is later, and if **you** do end **your** membership within the 28 days **we** will treat the changes as not having been made.

Changes you can make

At **your renewal date** **you** can apply to:

- add, remove or change an **excess** or **co-insurance**
- change your **scale of cover** (if any)

if such options are available under your **scheme**. **We** will consider **your** application at **our** sole discretion. If **you** apply to increase cover under the **scheme** **we** may ask **you** to agree to **special conditions** before **we** accept **your** application.

These changes may also affect the subscriptions **you** have to pay.

If you have cause for complaint

Making a complaint

If something has gone wrong, **we** want to do everything **we** can to put it right. Here's a simple procedure to ensure your concerns are dealt with as quickly and effectively as possible:

- If you have any complaints the helpline is always the first number to call. You can find the helpline number and other contact details on your **membership certificate**.
- For members with special needs **we** offer a choice of Braille, large print or audio for correspondence. Please let **us** know which you would prefer.
- If **we** have not been able to resolve the problem and you wish to take your complaint further, you can contact **our** Customer Relations Department.
Please call: **0845 6066 726** between 8am and 5.30pm Monday to Friday,
calls may be recorded and may be monitored. Or write to: Bupa, Anchorage Quay,
Salford Quays, M50 3XL or fax us on 01784 465 232.
- It's very rare that **we** can't settle a complaint, but if this does happen, you may refer your complaint to the Financial Ombudsman Service. You can write to them at: South Quay Plaza, 183 Marsh Wall, London E14 9SR or call them on 0800 0 234 567.

Please let **us** know if you want a full copy of **our** complaints procedure.

None of these procedures affect your legal rights.

Applicable law

The **agreement** is governed by English law.

The Financial Services Compensation Scheme (FSCS)

In the unlikely event that **we** cannot meet our financial obligations, you may be entitled to compensation from the Financial Services Compensation Scheme. This will depend on the type of business and the circumstances of your claim. The FSCS may arrange to transfer your policy to another insurer, provide a new policy or, where appropriate, provide compensation

Further information about compensation scheme arrangements is available from the FSCS on 020 7892 7301 or on its website <http://www.fscs.org.uk/>

Changes your authorised signatory can make

If you have agreed with **us** that **your partner** has the authority to make changes to cover, **your partner** can make changes to the cover of anyone included under **your** membership as if **your partner** were the **main member**. However, **your partner** may not end the cover.

Other parties

No other person is allowed to make or confirm any changes to your membership or your **benefits** on **our** behalf or decide not to enforce any of **our** rights. Equally, no change to your membership or your **benefits** will be valid unless it is specifically agreed between the **main member** and **us** and confirmed in writing.

General information

Change of address

You should call or write to tell **us** if you change **your** address. If **you** do not contact **us** to tell **us** you have changed **your** address and **you** pay **your** subscriptions by direct debit, **your** membership of the **scheme** will automatically end on **your** next **renewal date** if **we** cannot contact **you**.

Correspondence and documents

All correspondence and membership documents are sent to the **main member**.

When you send documents to **us**, **we** cannot return original documents to you. However **we** will send **you** copies if you ask **us** to do so at the time you give **us** the documents.

Letters between **us** must be sent with the postage costs paid before posting. We can each assume that the letter will be received three days after posting.

A Making a claim

A1 Claims other than Cash benefits

We recommend that you always contact **us** before arranging or receiving any **treatment**. This is the only way that **we** can confirm the **benefits** that are available to you before you incur any costs for your **treatment**. Any costs you incur that are not covered under your **benefits** are your responsibility.

For moratorium members

When you joined the **scheme** you agreed you would not be covered for any **moratorium conditions**. Each time you make a claim you must provide **us** with information so **we** can confirm whether your proposed **treatment** is covered under your **benefits**.

When you call **us** we will send you a pre-treatment form to complete giving details of the history of the medical condition you are claiming for, including information that you will need to ask your **GP** or **consultant** for. Your **GP** or **consultant** may charge you a fee for providing a report which **we** do not pay. Each claim you make during your membership will be assessed on this information and any further information **we** ask you to provide to **us** at the time you claim. Once **we** receive all the information **we** ask you for **we** will:

- confirm whether your proposed **treatment**, medical provider or treatment facility will be eligible under your **benefits**
- the level of **benefits** available to you, and
- if you wish to make a claim, tell you whether you will need to complete a claim form.

If you do not need to complete a claim form **we** will treat your submission of your pre-treatment form to **us** as your claim once **we** are notified that you have received your consultation or **treatment**. In most cases **we** will be notified that you have received your consultation or **treatment** by your **consultant** or the provider of your **treatment**.

If you do need to complete a claim form you will need to return the fully completed claim form to **us** as soon as possible and in any event within six months of receiving the **treatment** for which you are claiming unless this was not reasonably possible

For underwritten members

When you call **us** we will:

- confirm whether your proposed **treatment**, medical provider or treatment facility will be eligible under your **benefits**
- the level of **benefits** available to you, and
- if you wish to make a claim, tell you whether you will need to complete a claim form.

If you do not need to complete a claim form, **we** will treat your call to **us** as your claim once **we** are notified that you have received your consultation or **treatment**. In most cases **we** will be notified that you have received your consultation or **treatment** by your **consultant** or the provider of your **treatment**.

If you do need to complete a claim form you will need to return the fully completed claim form to **us** as soon as possible and in any event within six months of receiving the **treatment** for which you are claiming unless this was not reasonably possible.

A2 Claims for Cash benefits

Call the helpline to check your **benefits**. **We** will confirm your **benefits** and tell you whether you need to complete a claim form. You must send **us** either:

- your completed claim form if you need to complete one - please note that for NHS cash benefit you will need to take your claim form with you to the hospital and ask them to complete the hospital sections

or

- if you do not need a claim form, a covering letter giving your name, address and membership number

together with your original invoices and receipts.

A3 Treatment needed because of someone else's fault

When you claim for **treatment** you need because of an injury or medical condition that was caused by or was the fault of someone else (a 'third party'), for example, an injury suffered in a road accident in which you are a victim, all of the following conditions apply when you make such a claim:

- you agree you are responsible for the payment of any costs which may ultimately be recovered from the third party
- you must notify **us** as soon as possible that your **treatment** was needed as a result of a third party. You can notify **us** either by writing to **us** or completing the appropriate section on your claim form. You must provide **us** with any further details that **we** reasonably ask you for

- you must take any reasonable steps *we* ask of you to recover from the third party the cost of the **treatment** paid for by *us* and claim interest if you are entitled to do so
- you (or your solicitor) must keep *us* fully informed in writing of the progress and outcome of your claim
- if you recover the cost of any **treatment** paid for by *us*, you must repay the amount and any interest to *us*.

A4 Other insurance cover

If you have other insurance cover for the cost of the **treatment** or services that you are claiming from *us* you must provide *us* with full details of that other insurance policy as soon as possible. You must do this either by writing to *us* or by completing the appropriate section on your claim form. In which case *we* will only pay *our* share of the cost of the **eligible treatment** for which you are claiming.

B How we will deal with your claim

B1 General information

We only pay for **treatment** that you receive, or the **benefits** that you are entitled to, while you are covered under the **agreement** and *we* only pay in accordance with the **agreement**. *We* also only pay the **benefits** that applied to you on the date you received your **treatment** or the date that you became entitled to those **benefits**.

Except for NHS cash benefit, *we* only pay eligible costs and expenses actually incurred by you for **treatment** you receive.

We do not have to pay a claim if you break any terms and conditions of your membership.

Unless *we* tell you otherwise, your claim form and proof to support your claim must be sent to *us*.

B2 Providing us with information

You will need to provide *us* with information to help *us* assess your claim if *we* make a reasonable request for you to do so. For example, *we* may ask you for one or more of the following:

- medical reports and other information about the **treatment** for which you are claiming
- the results of any independent medical examination which *we* may ask you to undergo at *our* expense
- original accounts and invoices in connection with your claim (including any related to **treatment** costs covered by your **excess** or **co-insurance** - if any). *We* cannot accept photocopies of accounts or invoices or originals that have had alterations made to them.

If you do not provide *us* with any information *we* reasonably ask you for *we* will be unable to assess your claim.

B3 How we pay your claim

Claims other than cash benefits: for **treatment** costs covered under your **benefits we** will, in most cases, pay the provider of your **treatment** direct - such as the **recognised facility** or **consultant** - or whichever other person or facility is entitled to receive the payment. Otherwise *we* will pay the **main member**. *We* will write to tell the **main member** how *we* have dealt with any claim.

Claims for cash benefits: *we* pay eligible claims by cheque to the **main member**.

C If you want to withdraw a claim

If, for any reason, you wish to withdraw your claim for the costs of **treatment** you have received, you should call the helpline to tell *us* as soon as possible. You will be unable to withdraw your claim if *we* have already paid your claim.

If you do withdraw your claim you will be responsible for paying the costs of that **treatment**.

D Ex-gratia payments

If *we* agree to pay for the costs of **treatment** to which you are not entitled under your **benefits**, i.e. an 'ex-gratia payment', this payment will still count towards the maximum amount *we* will pay under your **benefits**. Making these payments does not oblige *us* to make them in the future.

E If you have an excess or co-insurance

You may have agreed with *us* that either an **excess** or **co-insurance** shall apply to your **benefits**. Your **membership certificate** shows if one does apply and if so:

- the amount
- who it applies to
- what type of **treatment** it is applied to, and
- the period for which the **excess** or **co-insurance** will apply.

Some further details of how an **excess** or **co-insurance** works are set out below and should be read together with your **membership certificate**.

If you are unsure whether an **excess** or **co-insurance** does apply to you please refer to your **membership certificate** or contact the helpline.

E1 How an excess or co-insurance works

Having an **excess** or **co-insurance** means that you have to pay part of any eligible **treatment** costs that would otherwise be paid by us up to the amount of your **excess** or **co-insurance**. By eligible **treatment** costs we mean costs that would have been payable under your **benefits** if you had not had an **excess** or **co-insurance**. Costs you incur for **treatment** that are not payable under your **benefits** do not count towards your **excess**.

If your **excess** or **co-insurance** applies each **year** it starts at the beginning of each **year** even if your **treatment** is ongoing. So, your **excess** or **co-insurance** could apply twice to a single course of **treatment** if your **treatment** begins in one **year** and continues into the next **year**.

You are responsible for paying any **excess** amounts. We will write to the **main member** to tell them who you should pay the **excess** or **co-insurance** to, for example, your **consultant, therapist** or **recognised facility**. The **excess** or **co-insurance** must be paid direct to them - not to Bupa. We will also write to tell the **main member** the amount of the **excess** or **co-insurance** that remains (if any).

You should always make a claim for eligible **treatment** costs even if we will not pay the claim because of your **excess** or **co-insurance**. Otherwise the amount will not be counted towards your **excess** or **co-insurance** and you may lose out should you need to claim again.

E2 How the excess or co-insurance applies to your benefits

Unless we say otherwise in your **membership certificate**:

- we apply the **excess** or **co-insurance** to your claims in the order in which we process those claims
- when you claim for eligible **treatment** costs under a **benefit** that has a benefit limit your **excess** or **co-insurance** amount will count towards your total benefit limit for that **benefit** - see the example below.
- the **excess** or **co-insurance** does not apply to Cash benefits.

Example: this is an example only and assumes an excess of £500 a year and a benefit limit of £500 a year for **therapists** fees for **out-patient treatment** and that all costs are eligible

treatment costs	
out-patient benefit limit for therapists fees for the year	£500
you incur costs for physiotherapy	£500
we pay your therapist	£0
we notify you of excess amount you pay direct to your therapist	£500
Your remaining benefit for therapists fees for out-patient treatment for the rest of the year	£0
Your remaining excess for the rest of the year	£0

Important note - please read this note before you read the rest of this membership guide as it explains how this membership guide and your membership certificate work together.

This Bupa Membership Guide and your **membership certificate** together set out full details of your **benefits**. They should not be read as separate documents.

This membership guide is a generic guide. It contains the general membership terms that apply to **Bupa members**. It also sets out all the elements of cover that are available for **Bupa members** under all their **schemes**. This means that you may not have all the cover set out in this membership guide. It is your **membership certificate** that shows the cover that is specific to your **benefits** and **scheme**. Any elements of cover in this membership guide that are either:

- shown in your **membership certificate** as 'not covered' or
- do not appear in your **membership certificate**

you are not covered for and you should therefore ignore them when reading this membership guide. Your **membership certificate** could also show some changes to the terms of cover set out in this membership guide particularly in the 'Further details' section of your **membership certificate**.

When reading this membership guide and your **membership certificate**, it is your **membership certificate** which is personal to you. This means that if your **membership certificate** contradicts this membership guide it is your **membership certificate** that will take priority.

Always call the helpline if you are unsure of your cover.

This section explains the type of charges we pay for **eligible treatment** subject to your medical condition, the type of **treatment** you need and your chosen medical practitioners and/or treatment facility all being eligible under your **benefits**.

Notes on benefits

The following notes apply equally to all the benefits and should be read together with those benefits.

Restrictions and/or limitations to benefits

Your cover may be limited or restricted through one or more of the following:

- **benefit limits:** these are limits on the amounts *we* will pay and/or restrictions on the cover you have under your **benefits**. Your **membership certificate** shows the benefit limits and/or restrictions that apply to your **benefits**
- **excess or co-insurance:** these are explained in rule E in the section 'Claiming'. Your **membership certificate** shows if an **excess** or **co-insurance** applies to your **benefits**. If one does apply, your benefit limits shown in your **membership certificate** will be subject to your **excess** or **co-insurance**
- **waiting periods:** **waiting periods** apply to certain benefits and certain exceptions as set out in this membership guide. Your **membership certificate** shows if **waiting periods** apply to your **benefits** and if so how long your **waiting periods** are
- **exclusions** apply to your cover; the general exclusions are set out in the section 'What is not covered'. Some exclusions also apply in this section and there may also be exclusions in your **membership certificate**.

Being referred for treatment and Bupa recognised medical practitioners and recognised facilities

Your consultation or **treatment** must follow an initial referral by a **GP** after you have seen the **GP** in person. However, for **day-patient treatment** or **in-patient treatment** provided by a **consultant** such referral is not required in the case of a medical emergency.

You are only covered for **eligible treatment** carried out in the **UK**. Please see the glossary section for what we mean by **eligible treatment**.

Your cover for **eligible treatment** costs depends on you using certain **Bupa** recognised medical and other health practitioners and **recognised facilities**. Please note:

- the medical practitioners, other healthcare professionals and **recognised facilities** you use can affect the level of benefits *we* pay you
- certain medical practitioners, other healthcare professionals and **recognised facilities** that *we* recognise may only be recognised by *us* for certain types of **treatment** or treating certain medical conditions or certain levels of benefits
- the medical practitioners, other healthcare professionals and **recognised facilities** that *we* recognise and the type of medical condition and/or type of **treatment** and/or level of benefit that *we* recognise them for can change from time to time.

Your **treatment** costs are only covered when:

- the person who has overall responsibility for your **treatment** is a **consultant**. If the person who has overall responsibility for your **treatment** is not a **consultant** then none of your **treatment** costs are covered - the only exception to this is where a **GP** refers you for **out-patient treatment** by a **therapist** or **complementary medicine practitioner**
- the medical practitioner or other healthcare professional and the **recognised facility** are recognised by *us* for treating the medical condition you have and for providing the type of **treatment** you need.

Important: Always call *us* before arranging any **treatment** to check your **benefits** and whether your chosen medical practitioner or other health care professional or **recognised facility** is recognised by *us* for both treating the medical condition you have and for providing the type of **treatment** you need. Any **treatment** costs you incur that are not covered under your **benefits** are your responsibility.

Reasonable and customary charges

We only pay **eligible treatment** charges that are reasonable and customary. This means that the amount you are charged by medical practitioners, other health care professionals and/or treatment facilities and what you are charged for have to be in line with what the majority of our other members are charged for similar **treatment** or services.

What you are covered for

Finding out what is wrong and being treated as an out-patient

Benefit 1 out-patient consultations and treatment

This benefit 1 explains the type of charges *we* pay for **out-patient treatment**. The benefits you are covered for and the amounts *we* pay are shown on your **membership certificate**. You are not covered for any benefits that are either shown on your **membership certificate** as 'not covered' or do not appear in your **membership certificate**.

benefit 1.1 out-patient consultations

We pay **consultants'** fees for out-patient consultations that are to assess your **acute condition** when carried out as **out-patient treatment** and you are referred for the consultation by your **GP** or **consultant**.

We may agree to pay a **consultant** or **recognised facility** charge for the use of a consulting room used during your consultation, where *we* do agree *we* pay the charge under this benefit note 1.1.

benefit 1.2 out-patient therapies and charges related to out-patient treatment

Out-patient therapies

We pay *therapists'* fees for *out-patient treatment* when you are referred for the *treatment* by your *GP* or *consultant*.

If your *consultant* refers you to a medical or health practitioner who is not a *therapist* we may pay the charges as if the practitioner were a *therapist* if all of the following apply:

- your *consultant* refers you to the practitioner before the *out-patient treatment* takes place and remains in overall charge of your care, and
- the practitioner has applied for *Bupa* recognition and we have not written to say he/she is not recognised by *Bupa*.

Charges related to out-patient treatment

We pay provider charges for *out-patient treatment* which is related to and is an integral part of your *out-patient treatment*. We treat these charges as falling under this benefit 1.2 and subject to its benefit limit.

benefit 1.3 out-patient complementary medicine treatment

We pay *complementary medicine practitioners'* fees for *out-patient treatment* when you are referred for the *treatment* by your *GP* or *consultant*.

We do not pay for any complementary or alternative products, preparations or remedies.

Please see Exclusion 14, 'Drugs and dressings for out-patient or take-home use and complementary and alternative products' in the section 'What is not covered'.

benefit 1.4 diagnostic tests

When requested by your *consultant* to help determine or assess your condition as part of *out-patient treatment* we pay *recognised facility* charges (including the charge for interpretation of the results) for *diagnostic tests*.

We do not pay charges for *diagnostic tests* that are not from the *recognised facility*.

(MRI, CT and PET scans are not paid under this benefit - see benefit 1.5.)

benefit 1.5 out-patient MRI, CT and PET scans

When requested by your *consultant* to help determine or assess your condition as part of *out-patient treatment* we pay *recognised facility* charges (including the charge for interpretation of the results), for:

- MRI scans (magnetic resonance imaging)
- CT scans (computed tomography)
- PET scans (positron emission tomography).

We do not pay charges for MRI, CT and PET scans that are not from the *recognised facility*.

Being treated in hospital

Benefit 2 Consultants' fees for surgical and medical hospital treatment

This benefit 2 explains the type of *consultants'* fees we pay for *eligible treatment*. The benefits you are covered for and the amounts we pay are shown on your *membership certificate*. You are not covered for any benefits that are either shown on your *membership certificate* as 'not covered' or do not appear in your *membership certificate*.

benefit 2.1 surgeons and anaesthetists

We pay *consultant* surgeons' fees and *consultant* anaesthetists' fees for *eligible surgical operations* carried out in a *recognised facility*.

benefit 2.2 physicians

We pay *consultant* physicians' fees for *day-patient treatment* or *in-patient treatment* carried out in a *recognised facility* if your *treatment* does not include a *surgical operation* or *cancer treatment*.

If your *treatment* does include an *eligible surgical operation* we only pay *consultant* physicians' fees if the attendance of a physician is medically necessary because of your *eligible surgical operation*.

If your *benefits* include cover for *cancer treatment* and your *treatment* does include *eligible cancer treatment* we only pay *consultant* physicians' fees if the attendance of a *consultant* physician is medically necessary because of your *eligible cancer treatment*, for example, if you develop an infection that requires *in-patient treatment*.

Benefit 3 Recognised facility charges

This benefit 3 explains the type of facility charges we pay for *eligible treatment*. The benefits you are covered for, including your *facility access* and the amount we pay are shown in your *membership certificate*. You are not covered for any benefits that are either shown on your *membership certificate* as 'not covered' or do not appear in your *membership certificate*.

Important: the *recognised facility* that you use for your *eligible treatment* must be recognised by us for treating both the medical condition you have and the type of *treatment* you need otherwise benefits may be restricted or not payable. Always call your helpline before arranging any *treatment* to check whether your chosen treatment facility is recognised by us for both treating your medical condition and carrying out your proposed *treatment*.

benefit 3.1 out-patient surgical operations

We pay recognised facility charges for eligible surgical operations carried out as out-patient treatment. We pay for theatre use, including equipment, and drugs and surgical dressings used during the surgical operation.

benefit 3.2 day-patient and in-patient treatment

We pay recognised facility charges for day-patient treatment and in-patient treatment and the charges we pay for are set out in 3.2.1 to 3.2.7.

Please note: your cover for **recognised facility** charges may also depend on your **scale of cover**. Some **recognised facilities** have three categories of accommodation - A, B and C - with A being the higher and C the lower. If your **scale of cover** is:

- Scale A: you are covered for category A, B and C accommodation
- Scale B: you are covered for category B and C accommodation
- Scale C: you are covered for category C accommodation.

Your membership certificate will show if a **scale of cover** applies to your **benefits**.

Using a non-recognised facility

If, for medical reasons, your proposed **day-patient treatment** or **in-patient treatment** cannot take place in a **recognised facility** we may agree to your **treatment** being carried out in a treatment facility that is not a **recognised facility**. We need full clinical details from your **consultant** before we can give our decision. If we do agree, we pay benefits for the **treatment** as if the treatment facility had been a **recognised facility**. When you contact us we will check your cover and help you to find a suitable alternative Bupa recognised treatment facility.

benefit 3.2.1 accommodation

We pay for your recognised facility accommodation including your own meals and refreshments while you are receiving your **treatment**.

We do not pay for personal items such as telephone calls, newspapers, guest meals and refreshments or personal laundry.

We do not pay recognised facility charges for accommodation if:

- the charge is for an overnight stay for **treatment** that would normally be carried out as **out-patient treatment** or **day-patient treatment**
- the charge is for use of a bed for **treatment** that would normally be carried out as **out-patient treatment**
- the accommodation is primarily used for any of the following purposes:

- convalescence, rehabilitation, supervision or any purpose other than receiving **eligible treatment**
- receiving general nursing care or any other services which could have been provided in a nursing home or in any other establishment which is not a **recognised facility**
- receiving services from a **therapist** or **complementary medicine practitioner**.

benefit 3.2.2 parent accommodation

We pay for each night a parent needs to stay in the **recognised facility** with their child. **We only pay for one parent each night**. This benefit applies to the child's cover and any charges are payable from the child's **benefits**. The child must be:

- a member under the **agreement**,
- under the age limit shown against parent accommodation on the **membership certificate** that applies to the child's **benefits**, and
- receiving **in-patient treatment**.

benefit 3.2.3 theatre charges, nursing care, drugs and surgical dressings

We pay for use of the operating theatre and for nursing care, drugs and surgical dressings when needed as an essential part of your **day-patient treatment** or **in-patient treatment**.

We do not pay for extra nursing services in addition to those that the **recognised facility** would usually provide as part of normal patient care without making any extra charge.

We do not pay for drugs and surgical dressings used for **out-patient treatment** or for you to use after your stay in the **recognised facility** except for out-patient cancer drugs as set out in benefit 4. Please also see Exclusion 14, 'Drugs and dressings for out-patient or take-home use and complementary and alternative products' in the section 'What is not covered'.

benefit 3.2.4 intensive care

We pay for intensive care when needed as an essential part of your **day-patient treatment** or **in-patient treatment** but we only pay if all the following conditions are met:

- the **intensive care** is required routinely by patients undergoing the same type of **treatment** as yours
- you are receiving private **eligible treatment** in a **recognised facility** equipped with a **critical care unit**
- the **intensive care** is carried out in the **critical care unit**, and
- it follows your planned admission to the **recognised facility** for private **treatment**.

We also pay for **intensive care** for **day-patient treatment** or **in-patient treatment** if unforeseen circumstances arise from a medical or surgical procedure which does not routinely require **intensive care** as part of the **treatment** but only if:

- you are receiving private **eligible treatment** in a **recognised facility** equipped with a **critical care unit**, and
- the **intensive care** is carried out in the **critical care unit**

in which case your **consultant** or **recognised facility** should contact **us** at the earliest opportunity.

We do not pay for any **intensive care** in any of the following circumstances:

- it follows an unplanned or an emergency admission to an **NHS** hospital or facility
- it follows a transfer (whether on an emergency basis or not) to an **NHS** hospital or facility from a private **recognised facility**
- it is carried out in a unit or facility which is not a **critical care unit**.

Please also see Exclusion 19, 'Intensive care' in the section 'What is not covered'.

benefit 3.2.5 diagnostic tests and MRI, CT and PET scans

When recommended by your **consultant** to help determine or assess your condition as part of **day-patient treatment** or **in-patient treatment** we pay **recognised facility** charges for:

- **diagnostic tests** (such as ECGs, X-rays and checking blood and urine samples)
- MRI scans (magnetic resonance imaging)
- CT scans (computed tomography), and
- PET scans (positron emission tomography).

benefit 3.2.6 therapies

We pay **recognised facility** charges for **eligible treatment** provided by **therapists** when needed as part of your **day-patient treatment** or **in-patient treatment**.

benefit 3.2.7 prostheses and appliances

We pay **recognised facility** charges for a **prosthesis** or **appliance** needed as part of your **day-patient treatment** or **in-patient treatment**.

We do not pay for any **treatment** which is for or associated with or related to a prosthesis or appliance that you are not covered for under your **benefits**.

Benefits for specific medical conditions

Benefit 4 Cancer treatment

You are only covered for this benefit if your **membership certificate** shows it is covered.

This benefit 4 explains what **we** pay for:

- **out-patient treatment** for **cancer**
- out-patient drugs for **eligible treatment** for **cancer**.

For all other **eligible treatment** for **cancer**, including out-patient MRI, CT and PET scans, you are covered on the same basis and up to the same limits as your **benefits** for other **eligible treatment** as set out in benefits 1.5, 2, 3, 6, 7 and 8 in this section

benefit 4.1 out-patient consultations for cancer

We pay **consultants'** fees for consultations that are to assess your **acute condition of cancer** when carried out as **out-patient treatment** and you are referred for the **out-patient** consultation by your **GP** or **consultant**.

We may agree to pay a **consultant** or **recognised facility** charge for the use of a consulting room used during your **out-patient** consultation, where **we** do agree **we** pay the charge under this benefit 4.1.

benefit 4.2 out-patient therapies and charges related to out-patient treatment for cancer

Out-patient therapies

We pay **therapists'** fees for **eligible out-patient treatment** for **cancer** when you are referred for the **treatment** by your **GP** or **consultant**.

If your **consultant** refers you to a medical or health practitioner who is not a **therapist** we may pay the charges as if the practitioner were a **therapist** if all of the following apply:

- your **consultant** refers you to the practitioner before the **out-patient treatment** takes place and remains in overall charge of your care, and
- the practitioner has applied for **Bupa** recognition and **we** have not written to say he/she is not recognised by **Bupa**.

Charges related to out-patient treatment

We pay provider charges for **out-patient treatment** when the **treatment** is related to, and is an integral part of, your **out-patient treatment** or **out-patient** consultation for **cancer**.

benefit 4.3 out-patient complementary medicine treatment for cancer

We pay complementary medicine practitioners' fees for out-patient treatment for cancer when you are referred for the **treatment** by your **GP** or **consultant**.

We do not pay for any complementary or alternative products, preparations or remedies - see Exclusion 14 in the section 'What is not covered'.

benefit 4.4 out-patient diagnostic tests for cancer

When requested by your **consultant** to help determine or assess your condition as part of **out-patient treatment for cancer** we pay **recognised facility** charges (including the charge for interpretation of the results) for **diagnostic tests**. **We** do not pay charges for **diagnostic tests** that are not from the **recognised facility**.

(MRI, CT and PET scans are not paid under this benefit - see benefit 1.5.)

benefit 4.5 out-patient cancer drugs

We pay **recognised facility** charges for drugs (such as cytotoxic drugs) that are related specifically to planning and carrying out **out-patient treatment for cancer**.

We do not pay for any complementary, homeopathic or alternative products, preparations or remedies for **treatment of cancer**.

Please see Exclusion 14, 'Drugs and dressings for out-patient and take home use and complementary and alternative products' in the section 'What is not covered'.

Benefit 5 Psychiatric treatment

You are only covered for this benefit if your **membership certificate** shows it is covered.

Waiting period: if a **waiting period** applies to your **benefits for psychiatric treatment** we will not consider paying for any **psychiatric treatment** during your **waiting period**. If you had cover for **psychiatric treatment** under a **previous scheme** we will take this into account when assessing your **waiting period** provided there has been no break in your cover for **psychiatric treatment** under this **scheme** and the **previous scheme**.

We may, at our discretion, pay for **psychiatric treatment** that you receive from a **consultant** or **psychologist** but only as set out in this benefit 5. Before receiving any **psychiatric treatment** you must ask your **consultant** to get our written agreement. Otherwise we will not be obliged to pay the **consultants' or psychologists' fees**, or the **recognised facility** charges or any other charges. **We** need full clinical details from your **consultant** before we can give our decision.

Psychiatric treatment that is not covered

We do not pay for **treatment** of a **psychiatric condition** in the following circumstances:

- a) if you have received two episodes of **treatment** for any **psychiatric condition** during your membership of any **Bupa** scheme with cover for **psychiatric treatment** (including under the **agreement**) whether your membership is continuous or not. By an episode of **treatment** we mean:
 - seven nights or more **treatment** received as an **in-patient** whether consecutive or not, or
 - 20 or more separate attendances for **treatment** received as a **day-patient** or **out-patient** in any 12 month period;
- b) if either before or during your membership of the **scheme** you suffer from any **psychiatric condition** and/or symptoms of any **psychiatric condition** over a period of two years or more. The **psychiatric condition** and/or symptoms need not be ongoing or continuous.

What we pay for psychiatric treatment

If we agree to pay for **psychiatric treatment** we pay **consultants' and psychologists' fees** and **recognised facility** charges as follows:

benefit 5.1 out-patient psychiatric treatment

If we agree to pay for **out-patient psychiatric treatment** we pay fees and charges as set out in benefits 5.1.1 to 5.1.3.

benefit 5.1.1 consultants' fees

We pay **consultants' fees** for **out-patient** consultations to assess your **psychiatric condition** and for **out-patient psychiatric treatment**.

benefit 5.1.2 psychologists' fees

We pay **psychologists' fees** for **out-patient psychiatric treatment** when the **treatment** is recommended by your **GP** or **consultant**.

If your **consultant** refers you to a medical or health practitioner who is not a **psychologist** we may pay the charges as if the practitioner were a **psychologist** if all of the following apply:

- your **consultant** refers you to the practitioner before the **out-patient treatment** takes place and remains in overall charge of your care, and
- the practitioner has applied for **Bupa** recognition and we have not written to say he/she is not recognised by **Bupa**.

benefit 5.1.3 diagnostic tests

When requested by your **consultant** to help determine or assess your condition as part of **out-patient psychiatric treatment** we pay **recognised facility** charges (including the charge for interpretation of the results) for **diagnostic tests**.

We do not pay charges for **diagnostic tests** that are not from the **recognised facility**.

(MRI, CT and PET scans are not paid under this benefit – see benefit 1.5.)

benefit 5.2 day-patient and in-patient psychiatric treatment

Your **membership certificate** shows the maximum number of days that we may pay up to for **psychiatric day-patient treatment** and **psychiatric in-patient treatment** under your **benefits**. If we agree to pay for **psychiatric day-patient treatment** or **psychiatric in-patient treatment** we pay **consultants' fees** and **recognised facility** charges as set out below.

Consultants' fees

If we agree we pay **consultants' fees** for **psychiatric treatment** carried out in a **recognised facility**.

Recognised facility charges

If we agree we pay the type of **recognised facility** charges we say we pay for in benefit 3. Please also see **Exclusion 6 'Chronic conditions' and Exclusion 29, 'Telephone consultations'** in the section 'What is not covered'.

Additional benefits

Benefit 6 Treatment at home

You are only covered for this benefit if your **membership certificate** shows it is covered.

We may, at our discretion, pay for you to receive **eligible treatment** at **home**. You must have our written agreement before the **treatment** starts and we need full clinical details from your **consultant** before we can make our decision. We will only consider **treatment** at **home** if all the following apply:

- your **consultant** has recommended that you receive the **treatment** at **home** and remains in overall charge of your **treatment**
- if you did not have the **treatment** at **home** then, for medical reasons, you would need to receive the **treatment** in a **recognised facility**, and
- the **treatment** is provided to you by a **medical treatment provider**.

We do not pay for any fees or charges for **treatment** at **home** that has not been provided to you by the **medical treatment provider**.

Benefit 7 Home nursing after private eligible in-patient treatment

If this benefit does not appear on your **membership certificate** then you do not have cover for this benefit.

We pay for home nursing immediately following private **in-patient treatment** if the home nursing:

- is for **eligible treatment**
- is needed for medical reasons ie not domestic or social reasons
- is necessary ie without it you would have to remain in the **recognised facility**
- starts immediately after you leave the **recognised facility**
- is provided by a **nurse** in your own **home**, and
- is carried out under the supervision of your **consultant**.

You must have our written agreement before the **treatment** starts and we need full clinical details from your **consultant** before we can make our decision.

We do not pay for home nursing provided by a community psychiatric nurse.

Benefit 8 Private ambulance charges

If this benefit does not appear on your **membership certificate** then you do not have cover for this benefit.

We pay for travel by private road ambulance if you need private **day-patient treatment** or **in-patient treatment**, and it is medically necessary for you to travel by ambulance:

- from your home or place of work to a **recognised facility**
- between **recognised facilities** when you are discharged from one **recognised facility** and admitted to another **recognised facility** for **in-patient treatment**
- from a **recognised facility** to home, or
- between an airport or seaport and a **recognised facility**.

Benefits numbered 9 and 10 do not apply to your cover

Benefit 11 Nursing home benefit

If this benefit does not appear on your *membership certificate* then you do not have cover for this benefit.

We may pay nursing home charges for a nursing home stay that immediately follows either:

- private *eligible in-patient treatment* in a *recognised facility*, or
- private *eligible cancer treatment* carried out as *day-patient treatment* in a *recognised facility*.

We only pay if the nursing home stay:

- is on the recommendation of your *consultant*
- is needed for medical reasons ie not domestic or social reasons
- is necessary ie without it you would have to remain in the *recognised facility*, and
- starts immediately after you leave the *recognised facility*.

You will need *our* written agreement before your move to the nursing home takes place and *we* need full clinical details from your *consultant* before *we* can give *our* decision. By a nursing home *we* mean a care home as defined by the Care Standards Act 2000 and which, at the time of your stay, is recognised by *us* as a nursing home for the purpose of your *scheme*.

Benefit 12 Chiroprody treatment on GP referral

If this benefit does not appear on your *membership certificate* then you do not have cover for this benefit.

We pay *chiroprodists'* fees for routine chiroprody *treatment* if

- it is for *eligible treatment*, and
- is on the recommendation of your *GP*.

Benefit CB1 NHS cash benefit for NHS hospital in-patient treatment

If this benefit does not appear on your *membership certificate* then you do not have cover for this benefit.

We pay NHS cash benefit for each night you receive *in-patient treatment* provided to you free under your *NHS*. We only pay NHS cash benefit if your *treatment* would otherwise have been covered for private *in-patient treatment* under your *benefits*.

Any costs you incur for choosing to occupy an amenity bed while receiving your *in-patient treatment* are not covered under your *benefits*. By an amenity bed *we* mean a bed for which the hospital makes a charge but where your *treatment* is still provided free under your *NHS*.

Important note - please read this note before you read the rest of this section as it explains how this membership guide and your membership certificate work together.

This Bupa Membership Guide and your **membership certificate** together set out full details of your **benefits**. They should not be read as separate documents.

This membership guide is a generic guide. It contains the general membership terms, including the general exclusions that apply to **Bupa members**. This means that you may not have all the cover set out in this membership guide. It is your **membership certificate** that shows the cover that is specific to your **benefits** and **scheme**. Your **membership certificate** could also show some changes to the terms of cover, including the exclusions, set out in this membership guide particularly in the 'Further details' section of your **membership certificate**.

When reading this membership guide and your **membership certificate**, it is your **membership certificate** which is personal to you. This means that if your **membership certificate** contradicts this membership guide it is your **membership certificate** that will take priority.

Always call the helpline if you are unsure of your cover.

This section explains the **treatment**, services and charges that are not covered. The exclusions are grouped under headings. The headings are just signposts, they are not part of the exclusion. If there is an exception to an exclusion this is shown. In the exceptions where, as an example, **we** refer to specific treatments or medical conditions these are examples only and not evidence that it is covered under your **benefits**.

This section does not contain all the limits and exclusions to cover. For example the benefits, set out in the section 'Benefits', also describe some limitations and restrictions for particular types of **treatment**, services and charges. There may also be some exclusions in your **membership certificate**.

Exclusion 1 Ageing, menopause and puberty

We do not pay for **treatment** to relieve symptoms commonly associated with any bodily change arising from any physiological or natural cause such as ageing, menopause or puberty and which is not due to any underlying disease, illness or injury.

Exclusion 2 AIDS/HIV

We do not pay for **treatment** for, related to or arising from, AIDS or HIV including any condition which is related to, or results from, AIDS or HIV.

Exception: **We** pay for **eligible treatment** for or arising from AIDS or HIV if the person with AIDS or HIV:

- became infected five years or more after their current continuous membership began, or
- has been covered for this type of **treatment** under a **Bupa** private medical insurance scheme (including under the **agreement**) since at least July 1987 without a break in their cover.

Exclusion 3 Allergies or allergic disorders

We do not pay for **treatment** to de-sensitise or neutralise any allergic condition or disorder.

Exclusion 4 Benefits that not covered and/or are above your benefit limits

We do not pay for any **treatment**, services or charges that are not covered under your **benefits**. **We** also do not pay for any **treatment** costs in excess of the amounts for which you are covered under your **benefits**.

Exclusion 5 Birth control, conception, sexual problems and sex changes

We do not pay for **treatment** for any type of:

- contraception, sterilisation
- sexual problems (including impotence, whatever the cause)
- assisted reproduction (eg IVF **treatment**), surrogacy, the harvesting of donor eggs or donor insemination
- sex changes or gender reassignments

or **treatment** for or arising from any of these.

Exception for main member and partner only:

Waiting period: if a **waiting period** applies to your cover for **treatment** for infertility investigations **we** will not pay benefits under this exception during your **waiting period**. If you had cover for **treatment** for infertility investigations under a **previous scheme** **we** will take this into account when assessing your **waiting period** provided there has been no break in your cover for **treatment** for infertility investigations under this **scheme** and the **previous scheme**.

For a **main member** and/or **partner** **we** pay for **eligible treatment** for reasonable investigations into the medical cause of infertility if your **consultant** considers that there are symptoms and/or medical evidence to suggest that you are infertile. Once the cause is confirmed, no further payment is made for additional investigations or **treatment** in the future.

Please also see 'Pregnancy and childbirth' in this section.

Exclusion 6 Chronic conditions

We do not pay for *treatment* of *chronic conditions*. By this, **we** mean a disease, illness or injury which has at least one of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back.

Exception: **We** pay for **eligible treatment** arising out of a **chronic condition**, or for **treatment** of acute symptoms of a **chronic condition** that flare up. However, **we** only pay if the **treatment** is likely to lead quickly to a complete recovery or to you being restored fully to your previous state of health, without you having to receive prolonged **treatment**. For example, **we** pay for **treatment** following a heart attack arising out of chronic heart disease. This exception does not apply to **treatment** of a **psychiatric condition**.

Please note: in some cases it might not be clear, at the time of **treatment**, that the disease, illness or injury being treated is a **chronic condition**. **We** are not obliged to pay the ongoing costs of continuing, or similar, **treatment**. This is the case even where **we** have previously paid for this type of or similar **treatment**.

Please also see 'Temporary relief of symptoms' in this section.

Exclusion 7 Complications from excluded conditions/ treatment and experimental treatment

We do not pay any **treatment** costs, including any increased **treatment** costs, you incur because of complications caused by a disease, illness, injury or **treatment** for which cover has been excluded or restricted from your membership. For example, if cover for diabetes is excluded by a **special condition**, and you have to spend any extra days in hospital or a treatment facility after an operation because you have diabetes, **we** would not pay for these extra days.

We do not pay any **treatment** costs you incur because of any complications arising or resulting from experimental **treatment** that you receive or for any subsequent **treatment** you may need as a result of you undergoing any experimental **treatment**.

Exclusion 8 Contamination, wars, riots and terrorist acts

We do not pay for **treatment** for any disease, illness or injury resulting from nuclear or chemical contamination, war, riot, revolution, terrorist act or any similar event.

Exclusion 9 Convalescence, rehabilitation and general nursing care

We do not pay for **recognised facility** accommodation if it is primarily used for any of the following purposes:

- convalescence, rehabilitation, supervision or any purpose other than receiving **eligible treatment**
- receiving general nursing care or any other services which could have been provided in a nursing home or in any other establishment which is not a **recognised facility**
- receiving services from a **therapist, complementary medicine practitioner** or **psychologist**.

Exception: **We** may, at **our** discretion, pay for **eligible treatment** for rehabilitation. By rehabilitation **we** mean **treatment** which is aimed at restoring health or mobility or to allow you to live an independent life, such as after a stroke. **We** will only consider cases where the rehabilitation:

- is an integral part of **in-patient treatment**
- starts within 42 days from and including the date you first receive that **in-patient treatment**, and
- takes place in a **recognised facility**.

You must have **our** written agreement before the rehabilitation starts and **we** need full clinical details from your **consultant** before **we** can give **our** decision. If **we** agree **we** pay for up to a maximum of 21 consecutive days rehabilitation.

Exclusion 10 Cosmetic, reconstructive or weight loss treatment

We do not pay for **treatment** to change your appearance, such as a remodelled nose or facelift whether or not it is needed for medical or psychological reasons.

We do not pay for breast enlargement or reduction or any other **treatment** or procedure to change the shape or appearance of your breast(s) whether or not it is needed for medical or psychological reasons, for example, for backache or gynaecomastia (which is the enlargement of breasts in males).

We do not pay for any **treatment**, including surgery,

- which is for or involves the removal of healthy tissue (i.e. tissue which is not diseased), or the removal of surplus or fat tissue, or
- where the intention of the **treatment**, whether directly or indirectly, is the reduction or removal of surplus or fat tissue including weight loss (for example, surgery related to obesity including morbid obesity)

whether or not the **treatment** is needed for medical or psychological reasons.

We do not pay for **treatment** of keloid scars. **We** also do not pay for scar revision.

Exception: **We** pay for an **eligible surgical operation** to restore your appearance after:

- an accident, or
- if your **benefits** include cover for **cancer treatment**, as a direct result of surgery for **cancer**.

We only pay if the accident or the **cancer** surgery takes place during your current continuous period of cover under this **scheme** and any other **Bupa** scheme provided there has been no break in your cover between this **scheme** and the other **Bupa** scheme. **We** will only pay if this is part of the original **eligible treatment** resulting from the accident or **cancer** surgery and you have obtained **our** written agreement before receiving the **treatment**.

Please also see 'Screening, monitoring and preventive treatment' in this section.

Exclusion 11 Deafness

We do not pay for **treatment** for or arising from deafness caused by a congenital abnormality, maturing or ageing.

Exclusion 12 Dental/oral treatment

We do not pay for any dental or oral **treatment** including:

- the provision of dental implants or dentures, the repair or replacement of damaged teeth (including crowns, bridges, dentures, or any dental prosthesis made by a laboratory technician)
- the management of, or any **treatment** related to, jaw shrinkage or loss as a result of dental extractions or gum disease
- the **treatment** of bone disease when related to gum disease or tooth disease or damage.

Exception 1: **We** pay for an **eligible surgical operation** carried out by a **consultant** to:

- put a natural tooth back into a jaw bone after it is knocked out or dislodged in an unexpected accidental injury
- treat a jaw bone cyst, but not if it is related to a cyst or abscess on the tooth root or any other tooth or gum disease or damage.

Exception 2: **We** pay for an **eligible surgical operation** carried out by a **consultant** to surgically remove a complicated, buried or impacted tooth root, such as an impacted wisdom tooth, but not if the purpose is to facilitate dentures or the **acute condition** relates to a **pre-existing condition** or a **moratorium condition**.

Exclusion 13 Dialysis

We do not pay for **treatment** for or associated with kidney dialysis (haemodialysis), meaning the removal of waste matter from your blood by passing it through a kidney machine or dialyser.

We do not pay for **treatment** for or associated with peritoneal dialysis, meaning the removal of waste matter from your blood by introducing fluid into your abdomen which acts as a filter.

Exception 1: **We** pay for **eligible treatment** for short-term kidney dialysis or peritoneal dialysis if the dialysis is needed temporarily for sudden kidney failure resulting from a disease, illness or injury affecting another part of your body.

Exception 2: **We** pay for **eligible treatment** for short-term kidney dialysis or peritoneal dialysis if you need this immediately before or after a kidney transplant.

Exclusion 14 Drugs and dressings for out-patient or take-home use and complementary and alternative products

We do not pay for any drugs or surgical dressings provided or prescribed for **out-patient treatment** or for you to take home with you on leaving hospital or a treatment facility.

We do not pay for any complementary or alternative therapy products or preparations, including but not limited to homeopathic remedies or substances, regardless of who they are prescribed or provided by or the type of **treatment** or medical condition they are used or prescribed for.

Exception: If your **benefits** include cover for **cancer treatment**, **we** pay for **out-patient** drugs (such as cytotoxic drugs) for **eligible treatment** of **cancer** but only as set out in benefit 4 in the section 'Benefits'.

Please also see 'Experimental drugs and treatment' in this section.

Exclusion 15 Excluded treatment or medical conditions

We do not pay for:

- **treatment** of any medical condition, or
- any type of **treatment** that is specifically excluded from your **benefits**.

Exclusion 16 Experimental drugs and treatment

We do not pay for **treatment** or procedures which, in **our** reasonable opinion, are experimental or unproved based on established medical practice in the **United Kingdom**, such as drugs outside the terms of their licence or procedures which have not been satisfactorily reviewed by NICE (National Institute for Clinical Excellence).

Exception: **We** may pay for this type of **treatment** of an **acute condition**. However, you will need **our** written agreement before the **treatment** is received and **we** need full clinical details from your **consultant** before **we** can give **our** decision.

Please also see 'Complications from excluded conditions/treatment and experimental treatment' and 'Drugs and dressings for out-patient or take-home use and complementary and alternative products' in this section.

Exclusion 17 Eyesight

We do not pay for **treatment** to correct your eyesight, for example for long or short sight or failing eyesight due to ageing, including spectacles or contact lenses.

Exception: **We** pay for **eligible treatment** for your eyesight if it is needed as a result of an injury or an **acute condition**, such as a detached retina.

Exclusion 18 HRT and bone densitometry

We do not pay for **treatment** for hormone replacement therapy (HRT) or bone densitometry.

Exception: **We** may pay for bone densitometry recommended by your **consultant** to help determine or assess your condition as part of **eligible treatment**. However, **we** need full clinical details from your **consultant** before **we** can give **our** decision. If **we** agree to pay for bone densitometry **we** only pay for an initial bone densitometry scan and for one follow-up scan if this is carried out:

- within three years of you starting **treatment**, and
- during your current continuous period of membership under the **scheme**.

Please also see 'Ageing, menopause and puberty' in this section.

Exclusion 19 Intensive care (other than routinely needed after private day-patient treatment or in-patient treatment)

We do not pay for any **intensive care** if:

- it follows an unplanned or an emergency admission to an **NHS** hospital or facility
- it follows a transfer (whether on an emergency basis or not) to an **NHS** hospital or facility from a private **recognised facility**
- it is carried out in a unit or facility which is not a **critical care unit**.

We do not pay for any **intensive care**, or any other **treatment** in a **critical care unit**, if it is not routinely required as a medically essential part of the **eligible treatment** being carried out.

Exception: **We** pay for **eligible treatment** for **intensive care** but only as set out in benefit 3 in the section 'Benefits'.

Exclusion 20 Learning difficulties, behavioural and developmental problems

We do not pay for **treatment** related to learning difficulties, such as dyslexia, or behavioural problems, such as attention deficit hyperactivity disorder (ADHD), or developmental problems, such as shortness of stature.

Exclusion 21 Overseas treatment or repatriation

We do not pay for **treatment** that you receive outside the **United Kingdom** or for repatriation to the **United Kingdom** or any other country.

Exclusion 22 Physical aids and devices

We do not pay for supplying or fitting physical aids and devices (eg hearing aids, spectacles, contact lenses, crutches, walking sticks, etc).

Exception: **We** pay for **prostheses** and **appliances** as set out in benefit 3, in the section 'Benefits'.

Exclusion 23 Pre-existing conditions

For **underwritten members** **we** do not pay for **treatment** of a **pre-existing condition**, or a disease, illness or injury that results from or is related to a **pre-existing condition**.

Exception: For **underwritten members** **we** pay for **eligible treatment** of a **pre-existing condition**, or a disease, illness or injury which results from or is related to a **pre-existing condition**, if all the following requirements have been met:

- you have been sent your **membership certificate** which lists the person with the **pre-existing condition** (whether this is **you** or one of **your dependants**)
- you gave **us** all the information **we** asked you for, before **we** sent you your first membership certificate listing the person with the **pre-existing condition** for their current continuous period of cover under the **scheme**
- neither you nor the person with the **pre-existing condition** knew about it before **we** sent you your first membership certificate which lists the person with the **pre-existing condition** for their current continuous period of cover under the **scheme**, and
- **we** did not exclude cover (for example under a **special condition**) for the costs of the **treatment**, when **we** sent you your **membership certificate**.

Exclusion 24 Pregnancy and childbirth

We do not pay for **treatment** for:

- pregnancy or childbirth, including **treatment** of an embryo or foetus
- termination of pregnancy, or any condition arising from termination of pregnancy.

Exception 1: **We pay for *eligible treatment*** of the following conditions:

- miscarriage or when the foetus has died and remains with the placenta in the womb
- still birth
- hydatidiform mole (abnormal cell growth in the womb)
- foetus growing outside the womb (ectopic pregnancy)
- heavy bleeding in the hours and days immediately after childbirth (post-partum haemorrhage)
- afterbirth left in the womb after delivery of the baby (retained placental membrane)
- complications following any of the above conditions.

Exception 2: **Waiting period:** if a *waiting period* applies to your **benefits for *treatment*** for caesarean sections **we** will not consider paying benefits under this exception 2 during your *waiting period*. If you had cover for **treatment** for caesarean sections under a *previous scheme* **we** will take this into account when assessing your *waiting period* provided there has been no break in your cover for **treatment** for caesarean sections under the *previous scheme* and this *scheme*.

We may pay for **eligible treatment** for delivering a baby by caesarean section. However, **we** need full clinical details from your **consultant** before **we** can give **our** decision.

Exception 3: **We** pay for **eligible treatment** of an *acute condition* that relates to pregnancy or childbirth but only if all the following apply:

- the **treatment** is required due to a flare-up of the medical condition, and
- the **treatment** is likely to lead quickly to a complete recovery or to you being restored fully to your state of health prior to the flare-up of the condition without you needing to receive prolonged **treatment**.

Please also see 'Birth control, conception, sexual problems and sex changes', 'Screening, monitoring and preventive treatment' and 'Chronic conditions' in this section.

Exclusion 25 Screening, monitoring and preventive treatment

We do not pay for:

- health checks or health screening, by health screening **we** mean where you may not be aware you are at risk of, or are affected by, a disease or its complications but are asked questions or have tests to find out if you are and which may lead to you needing further tests or **treatment**
- routine tests, or monitoring of medical conditions, including:
- routine antenatal care or screening for and monitoring of medical conditions of the mother or foetus during pregnancy

- routine checks or monitoring of **chronic conditions** such as diabetes mellitus or hypertension
- tests or procedures which, in **our** reasonable opinion based on established clinical and medical practice, are carried out for screening or monitoring purposes, such as endoscopies when no symptoms are present
- preventive **treatment**, procedures or medical services, for example, removing breast tissue when there is no disease or tumour present.

Please also see, 'Chronic conditions' and 'Pregnancy and childbirth' in this section.

Exclusion 26 Sleep problems and disorders

We do not pay for **treatment** for or arising from sleep problems or disorders such as insomnia, snoring or sleep apnoea (temporarily stopping breathing during sleep).

Exclusion 27 Special conditions

For **underwritten members** **we** do not pay for **treatment** directly or indirectly relating to **special conditions**.

For **underwritten members** **we** are willing, at your **renewal date**, to review certain **special conditions**. **We** will do this if, in **our** opinion, no **treatment** is likely to be needed in the future, directly or indirectly, relating to the disease, illness or injury referred to in the **special condition** or for a related disease, illness or injury. However, there are some **special conditions** which **we** do not review. If you would like **us** to consider a review of your **special conditions** please call the helpline prior to your **renewal date**. **We** will only determine whether a **special condition** can be removed or not, once **we** have received full current clinical details from your **GP** or **consultant**. If you incur costs for providing the clinical details to **us** you are responsible for those costs, they are not covered under your **benefits**.

Please also see the 'Covering your new-born baby' rule in the section 'How your membership works'.

Exclusion 28 Speech disorders

We do not pay for **treatment** for or relating to any speech disorder, for example stammering.

Exception: **We** may, at **our** discretion, pay for short-term speech therapy when it is part of **eligible treatment**. The speech therapy must be provided by a **therapist** who is a member of the Royal College of Speech and Language Therapists.

Exclusion 29 Telephone consultations

We do not pay for any consultation with a **consultant**, **therapist**, **psychologist** or any other healthcare professional when the consultation is not carried out on a face-to-face basis, for example, if it is carried out by telephone or any other remote medium.

Exclusion 30 Temporary relief of symptoms

We do not pay for **treatment**, the main purpose or effect of which is to provide temporary relief of symptoms or which is for the ongoing management of a condition.

Exception: **We** may pay for this type of **treatment** if you need it to relieve the symptoms of a terminal disease or illness.

Exclusion 31 Treatment in a treatment facility that is not a recognised facility

We do not pay **consultants'** fees for **treatment** that you receive in a hospital or any other type of treatment facility that is not a **recognised facility**.

If your **facility access** is:

- **partnership facility**
- **local access facility**
- **national access facility**
- **extended access facility**

we also do not pay for facility charges for **treatment** that you receive in a hospital or any other type of treatment facility that is not a **recognised facility**.

Exception: **We** may pay **consultants'** fees and facility charges for **eligible treatment** in a treatment facility that is not a **recognised facility** when your proposed **treatment** cannot take place in a **recognised facility** for medical reasons. However, you will need **our** written agreement before the **treatment** is received and **we** need full clinical details from your **consultant** before **we** can give **our** decision.

Please also see the section 'Benefits'.

Exclusion 32 Unrecognised medical practitioners, providers and facilities

We do not pay for any of your **treatment** if the consultant who is in overall charge of your **treatment** is not recognised by **Bupa**.

We also do not pay for **treatment** if any of the following apply:

- the consultant, medical practitioner, therapist, complementary medicine practitioner, psychologist or other healthcare professional is:
 - not recognised by **Bupa** for treating the medical condition you have and/or for providing the type of **treatment** you need, and/or
 - is not in the list of **recognised practitioners** that applies to your **benefits**
 - the hospital or treatment facility is:
 - not recognised by **Bupa** for treating the medical condition you have and/or for providing the type of **treatment** you need, and/or
 - is not in the **facility access** list that applies to your **benefits**

- the hospital or treatment facility or any other provider of services is not recognised by **us** and/or **we** have sent a written notice saying that **we** no longer recognise them for the purpose of **our** private medical insurance schemes.

Bupa does not recognise consultants, therapists, complementary medicine practitioners, psychologists or other healthcare professionals in the following circumstances:

- where **we** do not recognise them as having specialised knowledge of, or expertise in, the **treatment** of the disease, illness or injury being treated
- where **we** do not recognise them as having specialised expertise and ongoing experience in carrying out the type of **treatment** or procedure needed
- where **we** have sent a written notice to them saying that **we** no longer recognise them for the purposes of **our** schemes.

Exclusion 33 Moratorium conditions

For **moratorium members** **we** do not pay for **treatment** of a **moratorium condition**, or a disease, illness or injury that results from or is related to a **moratorium condition**.

Exception 1: For **moratorium members**, **we** pay for **treatment** of a **moratorium condition** if at any time after your **start date** you do not:

- receive any medication for
- ask for or receive any medical advice or **treatment** for, or
- experience symptoms of

that **moratorium condition** for a continuous period of two years cover under the **scheme**. **We** may take your cover under a **previous scheme** into account when assessing your claim for a **moratorium condition** but only if **we** specifically agreed that **we** would do this when you joined the **scheme**.

Exception 2: If you apply to add your new born baby as a **dependant** under your membership and the baby's membership would be as a **moratorium member** **we** will not apply this exclusion to the baby's cover if **you** have been a member under your **scheme** for at least 12 continuous months before the baby's birth and **you** include the baby as a **dependant** within three months of their birth.

Please also see 'Covering a new born baby' in the section 'How your membership works'.

Words and phrases printed in bold and italic in these rules and benefits have the meanings set out below.

Word / Phrase	Meaning
Acute condition	a disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.
Agreement	the agreement between the main member and us to provide cover for you and your dependants (if any) under the terms and conditions set out in the documents referred to under the heading 'The agreement between you and us' in the section 'How your membership works'.
Appliance	any appliance which is in our list of appliances for your benefits at the time you receive your treatment . The list of appliances may change from time to time. Details of the appliances are available on request.
Benefits	the benefits specified in your membership certificate for which you are entitled as an individual under the scheme subject to the terms and conditions that apply to your membership in this Bupa Membership Guide including all exclusions.
Bupa	Bupa Insurance Limited. Registered in England and Wales No 3956433. Registered office: Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA. Bupa provides the cover:
Bupa member/ Bupa members	A member covered under one of the following Bupa products as shown on their membership certificate : <ul style="list-style-type: none"> • BupaCare, LocalCare, EssentialCare, Local HospitalCare, SeniorCare, Senior EssentialCare, EmployeeChoice, EmployeeChoice Essential, LocalCare Direct, Fixed Price Cover • Heartbeat - cover options Health care select 1, 2, 3 Plus, 3 and 4.
Cancer	a malignant tumour, tissues or cells characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Chiroprapist	a chiroprapist who is a recognised practitioner . You can contact us to find out if a chiroprapist is a recognised practitioner .
Chronic condition	a disease, illness or injury which has one or more of the following characteristics: <ul style="list-style-type: none"> • it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests • it needs ongoing or long-term control or relief of symptoms • it requires rehabilitation or for you to be specially trained to cope with it • it continues indefinitely • it has no known cure • it comes back or is likely to come back.
Co-insurance	the amount that you have to pay towards the cost of treatment that you receive that would otherwise have been payable under your benefits .
Complementary medicine practitioner	an acupuncturist, chiropractor, homoeopath or osteopath who is a recognised practitioner . You can contact us to find out if a practitioner is a recognised practitioner and the type of treatment we recognise them for.
Consultant	a registered medical or dental practitioner who, at the time you receive your treatment : <ul style="list-style-type: none"> • is recognised by us as a consultant and has received written confirmation from us of this, unless we recognised him or her as being a consultant before 30 June 1996 • is recognised by us both for treating the medical condition you have and for providing the type of treatment you need, and • is in our list of consultants that applies to your benefits. You can contact us to find out if a medical or dental practitioner is recognised by us as a consultant and the type of treatment we recognise them for.

Consultant fees schedule	<p>the schedule used by Bupa for the purpose of providing benefits which sets out the benefit limits for consultants' fees based on:</p> <ul style="list-style-type: none"> • the type of treatment carried out • for surgical operations, the type and complexity of the surgical operation according to the schedule of procedures - the benefits available for consultant surgeons and consultant anaesthetists may differ for the same surgical operation • the Bupa recognition status of the consultant, and • where the treatment is carried out both in terms of the treatment facility and the location. <p>The schedule may change from time to time. Details of the schedule are available on request.</p>
Critical care unit	<p>any intensive care unit, intensive therapy unit, high dependency unit, coronary care unit or progressive care unit which is in our list of critical care units and recognised by us for the type of intensive care that you require at the time you receive your treatment. The units on the list and the type of intensive care that we recognise each unit for may change from time to time. Details of these critical care units are available on request.</p>
Day-patient	<p>a patient who is admitted to a hospital, treatment facility or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.</p>
Day-patient treatment	<p>eligible treatment, that, for medical reasons, is received as a day-patient.</p>
Dependant	<p>your partner and any child of yours who is a member of the scheme and named on your membership certificate.</p>
Diagnostic tests	<p>investigations, such as X-rays or blood tests, to find or to help to find the cause of your symptoms.</p>
Eligible surgical operation	<p>eligible treatment carried out as a surgical operation.</p>

Eligible treatment	<p>treatment of an acute condition together with the products and equipment used as part of the treatment that:</p> <ul style="list-style-type: none"> • are consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the UK • are clinically appropriate in terms of type, frequency, extent, duration and the facility or location where the services are provided • are demonstrated through scientific evidence to be effective in improving health outcomes, and • are not provided or used primarily for the expediency of you or your consultant or other healthcare professional <p>and the treatment, services or charges are not excluded under your benefits.</p>
Excess	<p>the amount that you have to pay towards the cost of treatment that you receive that would otherwise have been payable under your benefits.</p>
Extended access facility	<ul style="list-style-type: none"> • a hospital or a treatment facility, centre or unit that, at the time you receive your eligible treatment, is in our extended access facility list that applies to your benefits and is recognised by us for both: <ul style="list-style-type: none"> • treating the medical condition you have, and • carrying out the type of treatment you need. • any other establishment which we may decide to treat as an extended access facility for the purpose of the scheme. <p>The hospitals, treatment facilities, centres and units in the list and the medical conditions and types of treatment we recognise them for may change from time to time. Details of the facilities in the list and the medical conditions and types of treatment we recognise them for are available on request.</p>

Facility access	the network of recognised facilities for which you are covered under your benefits as shown on your membership certificate and being either: <ul style="list-style-type: none"> • participating facility • partnership facility • extended access facility • local access facility, or • national access facility.
GP	a doctor who, at the time he/she refers you for your consultation or treatment , is on the UK General Medical Council's General Practitioner Register .
Group sponsor	the company, association, organisation or group (of which the main member is an employee or member) for whose employees or members we have agreed to operate the scheme for the time being. Please contact your helpline to check if your cover has been arranged by a group sponsor .
Home	<ul style="list-style-type: none"> • the place where you normally live, or • any other establishment, including a non-healthcare setting, which we may decide to treat as a home for the purpose of your benefits.
In-patient	a patient who is admitted to a hospital or treatment facility and who occupies a bed overnight or longer for medical reasons.
In-patient treatment	eligible treatment that, for medical reasons, is received as an in-patient .
Intensive care	eligible treatment for intensive care, intensive therapy, high dependency care, coronary care or progressive care.

Local access facility	<ul style="list-style-type: none"> • a hospital or a treatment facility, centre or unit that, at the time you receive your eligible treatment, is in our local access facility list that applies to your benefits and is recognised by us for both: <ul style="list-style-type: none"> • treating the medical condition you have, and • carrying out the type of treatment you need. • any other establishment which we may decide to treat as a local access facility for the purpose of the scheme. <p>The hospitals, treatment facilities, centres and units in the list and the medical conditions and types of treatment we recognise them for may change from time to time. Details of the facilities in the list and the medical conditions and types of treatment we recognise them for are available on request.</p>
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Main member	the person named as the main member on the membership certificate .
Medical treatment provider	a person or company who is recognised by us as a medical treatment provider for the type of treatment at home that you need at the time you receive your treatment . These medical treatment providers and the type of treatment we recognise them for may change from time to time. Details of these medical treatment providers and the type of treatment we recognise them for are available on request.
Membership certificate	the most recent membership certificate that we issue to you for your current continuous period of membership of the scheme .
Moratorium condition	any disease, illness or injury or related condition, whether diagnosed or not, which you: <ul style="list-style-type: none"> • received medication for, • asked for or received, medical advice or treatment for, • experienced symptoms of, or • were to the best of your knowledge aware existed <p>in the five years before your start date. By a related condition we mean any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury.</p> <p>We may take the start date of your cover under a previous scheme into account when assessing whether a medical condition is a moratorium condition but only if we specifically agreed we would do this when you joined the scheme.</p>

<i>Moratorium member</i>	a member whose membership certificate shows the underwriting method applied to them is moratorium.
<i>National access facility</i>	<ul style="list-style-type: none"> a hospital or a treatment facility, centre or unit that, at the time you receive your eligible treatment, is in our national access facility list that applies to your benefits and is recognised by us for both: <ul style="list-style-type: none"> treating the medical condition you have, and carrying out the type of treatment you need. any other establishment which we may decide to treat as a national access facility for the purpose of the scheme. <p>The hospitals, treatment facilities, centres and units in the list and the medical conditions and types of treatment we recognise them for may change from time to time. Details of the facilities in the list and the medical conditions and types of treatment we recognise them for are available on request.</p>
<i>NHS</i>	<ul style="list-style-type: none"> the national health service operated in Great Britain and Northern Ireland, or the healthcare scheme that is operated by the relevant authorities of the Channel Islands, or the healthcare scheme that is operated by the relevant authorities of the Isle of Man.
<i>Nurse</i>	a qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.
<i>Out-patient</i>	a patient who attends a hospital, consulting room, out-patient clinic or treatment facility and is not admitted as a day-patient or an in-patient .
<i>Out-patient surgical operation</i>	an eligible surgical operation received as an out-patient .
<i>Out-patient treatment</i>	eligible treatment that, for medical reasons, is received as an out-patient .

<i>Participating facility</i>	<ul style="list-style-type: none"> a hospital or a treatment facility, centre or unit that, at the time you receive your eligible treatment, is in our participating facility list that applies to your benefits, and is recognised by us for both: <ul style="list-style-type: none"> treating the medical condition you have, and carrying out the type of treatment you need. any other establishment which we may decide to treat as a participating facility for the purpose of the scheme. <p>The hospitals, treatment facilities, centres or units in the list and the categories of accommodation, medical conditions and types of treatment we recognise them for may change from time to time. Details of the facilities in the list and the categories of accommodation, the medical conditions and types of treatment we recognise them for are available on request.</p>
<i>Partner</i>	your husband or wife or civil partner or the person you live with in a relationship similar to that of a husband and wife whether of the opposite sex or not.
<i>Partnership consultant</i>	a consultant who, at the time you receive your treatment , is recognised by us as a partnership consultant. You can contact us to find out if a consultant is a partnership consultant.
<i>Partnership facility</i>	<ul style="list-style-type: none"> a hospital or a treatment facility, centre or unit that, at the time you receive your eligible treatment, is in our partnership facility list that applies to your benefits and is recognised by us for both: <ul style="list-style-type: none"> treating the medical condition you have, and carrying out the type of treatment you need. any other establishment which we may decide to treat as a partnership facility for the purpose of the scheme. <p>The hospitals, treatment facilities, centres and units in the list and the medical conditions and types of treatment we recognise them for may change from time to time. Details of the facilities in the list and the medical conditions and types of treatment we recognise them for are available on request.</p>

Pre-existing condition	any disease, illness or injury for which in the 7 years before your start date : <ul style="list-style-type: none"> • you have received medication, advice or treatment, or • you have experienced symptoms whether the condition was diagnosed or not.
Previous scheme	<ul style="list-style-type: none"> • another Bupa private medical insurance scheme, or • a private medical insurance scheme or medical healthcare trust provided or administered by another insurer that you were covered under without a break between that previous scheme and this scheme that we specifically agree will be treated as a previous scheme for the purpose of assessing waiting periods or continuous periods of cover.
Prosthesis	any prosthesis which is in our list of prostheses for both your benefits and your type of treatment at the time you receive your treatment . The prostheses on the list may change from time to time. Details of the prostheses covered under your benefits for your type of treatment are available on request.
Psychiatric condition	a mental or addictive condition, including alcoholism, drug addiction and eating disorders.
Psychiatric day-patient treatment	psychiatric treatment which for medical reasons means you have to be admitted to a recognised facility because you need a period of clinically-supervised psychiatric treatment as a day case but do not have to occupy a bed overnight and the psychiatric treatment is provided on either an individual or group basis.
Psychiatric in-patient treatment	psychiatric treatment that, for medical reasons, is received as an in-patient .
Psychiatric treatment	eligible treatment of a psychiatric condition .
Psychologist	a Chartered Psychologist registered with the British Psychological Society who is a recognised practitioner . You can contact us to find out if a practitioner is a recognised practitioner and the type of treatment we recognise them for.

Recognised facility	the: <ul style="list-style-type: none"> • participating facility • partnership facility • national access facility • local access facility, or • extended network facility in accordance with your facility access that applies to your benefits .
Recognised practitioner	a healthcare practitioner who at the time of your treatment : <ul style="list-style-type: none"> • is recognised by us for the purpose of our private medical insurance schemes for treating the medical condition you have and for providing the type of treatment you need, and • is in our list of recognised practitioners that applies to your benefits.
Renewal date	<ul style="list-style-type: none"> • each anniversary of your start date, or • if you are a member under a group scheme arrangement with a common renewal date for all members of the group, your renewal date will be the common renewal date for the group.
Scale of cover	the scale that specifies: <ul style="list-style-type: none"> • which <ul style="list-style-type: none"> • participating facility • partnership facility, • national access facility, • local access facility, or • extended network facility list applies to your benefits • the category of accommodation for recognised facilities that applies to your benefits • the practitioner lists that apply to your benefits. Your membership certificate shows if a scale of cover applies to your benefits.

Schedule of procedures the schedule used by **Bupa** for the purpose of providing **benefits** which classifies **surgical operations** according to their type and complexity. The schedule may change from time to time. Not all procedures listed in the schedule are covered under **Bupa** schemes. Further information on the schedule is available on request.

Scheme	the cover and benefits we provide as shown on your membership certificate together with this Bupa membership guide subject to the terms and conditions of the agreement .
Session	periods of 24 hours during which the specified type of treatment is received for an acute condition .
Special condition	any exclusions or restrictions to cover that are personal to an individual based on the medical history given to us for that individual. If special conditions apply to an underwritten member's cover these are shown in the 'Special conditions' section for that underwritten member in your membership certificate .
Start date	the date you started your current continuous period of cover under the scheme as shown on your membership certificate .
Subscription review date	<ul style="list-style-type: none"> if you have agreed a five year subscription review option with us, every fifth renewal date after the date we agreed the five year subscription review with you, or if you have agreed a ten year subscription review option with us, every tenth renewal date after the date that we agreed the ten year subscription review with you.
Surgical operation	a surgical procedure or complex investigative/diagnostic procedure including all medically necessary treatment related to the procedure and all consultations carried out from the time you are admitted to a recognised facility until the time you are discharged, or if it is carried out as out-patient treatment , all medically necessary treatment related to the operation and any consultation on the same day which is integral to the operation.

Therapist

- a chartered physiotherapist
 - a British Association of Occupational Therapists registered occupational therapist
 - a British and Irish Orthoptic Society registered orthoptist, or
 - a Royal College of Speech and Language Therapists registered speech and language therapist
- who is Health Professions Council Registered and is a **recognised practitioner**. You can contact **us** to find out if a practitioner is a **recognised practitioner** and the type of **treatment** **we** recognise them for.

Treatment	surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.
Underwritten member	a member whose membership certificate shows the underwriting method applied to them is underwritten.
United Kingdom/UK	Great Britain, Northern Ireland, the Channel Islands and the Isle of Man.
Waiting period	a period of continuous cover during which benefits are not payable. The length of any waiting periods that apply to your benefits are shown under the 'Waiting periods' section in your membership certificate .
We/our/us	Bupa .
Year	the period beginning on your start date and ending on the day before your renewal date .
You/your	this means the main member only.

Confidentiality: The confidentiality of patient and member information is of paramount concern to the companies in the Bupa group. To this end, Bupa fully complies with Data Protection Legislation and Medical Confidentiality Guidelines. Bupa sometimes uses third parties to process data on its behalf. Such processing, which may be outside of the European Economic Area, is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

Medical information: Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including your GP, or to their agents, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents.

Member details: All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the main member.

Telephone calls: In the interest of continuously improving our service to members, your call may be recorded and may be monitored.

Research: Anonymised or aggregated data may be used by Bupa, or disclosed to others, for research or statistical purposes.

Fraud: Information may be disclosed to others with a view to preventing fraudulent or improper claims.

Names and addresses: Bupa does not make the names and addresses of members or patients available to other organisations.

Keeping you informed: Bupa would, on occasion, like to keep you informed of Bupa products and services which it considers may be of interest to you.

Contact address: If you do not wish to receive information about Bupa's products and services, or have any other Data Protection queries please write to the Bupa Head of Information Governance, at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA or at DataProtection@Bupa.com.

As a Bupa member if you have any queries or questions about your health call our confidential 24-hour Bupa HealthLine where our qualified nursing team have the time to listen and the skills to help whatever your health question or concern.

Call the Bupa HealthLine on 0845 60 40 537†

† Calls to this number may be recorded and may be monitored.

For your notes

For your notes

Appendix VI

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Appendix VII

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Appendix VIII

ADVICE ON BILLING

Cracking the codes

There is a lot of confusion among independent practitioners when it comes to insurance coding. Garry Chapman explains how it works and unlocks some of the complications

MANY CONSULTANTS may think that billing their clinical information for their private practice work is a straightforward process but in reality this is often not the case.

My company's analysis shows that in the practices of over 90% of consultants that join us we find there is a large element of their billing which is not being done correctly.

This is not surprising due to the complex rules that exist within the PMI structure which is based upon the Clinical Coding and Schedule Development (CCSD) schedule and the way each private medical insurer (PMI) calculates their schedule of fees.

I will try and articulate some of the complexities that exist within the market and explain why it is so difficult for the private practice to manage these – especially as they can change on a regular basis.

CCSD codes

The CCSD codes that the industry use were created by a group of PMIs – Bupa, AXA PPP, Aviva, Pru Health and Simply Health. Representatives from these organisations sit on the board of this group which is managed by Capita Health.

The CCSD schedule, which stands for Clinical Coding and Schedule Development, was launched in 2006 and now has 2,070 codes that are constantly reviewed and can be updated on a monthly basis.

This can take the form of a just a narrative change or it can be more significant such as not allowing particular codes to be billed together – commonly referred to as bundling and unbundling – or

it can also be a new or replacement code.

One of the interesting things is that the CCSD schedule and its rules are not mandatory; it is down to each PMI and they can either adopt the CCSD schedule in whole or in part.

Due to this, you get the situation where a PMI can decide that they do not recognise a specific code or have their own rules

regarding using multiple codes together which override the CCSD guidelines.

Fees schedules

In conjunction with the above complexities, each PMI decides upon the amount of money that they will contribute for each CCSD code, commonly referred to as their schedule of fees.

This fee can be for a specific

code or it can be for a particular classification where the PMI will place CCSD codes into classifications such as minor, inter and major for pricing purposes.

The fee schedule can differ quite widely between each PMI and, in some cases, these prices can deviate by up to 100% for the same code.

On top of this, when you bill multiple codes, not only do you have to identify that the codes can be billed together, you then need to apply a specific formula that each PMI will have in order to calculate the correct fee.

I have listed just three examples below in order to illustrate the differences:

EXAMPLE 1. PMI formula – If three codes are used, you multiply the price of the first code by 40% and add that figure to the price of the first code. If two codes are used, then multiply the price of the first code by 25% and then add that to the first code.

EXAMPLE 2. PMI formula – If three codes are used, you take the first code price and add 50% of the second code price and then add 25% of the third code price

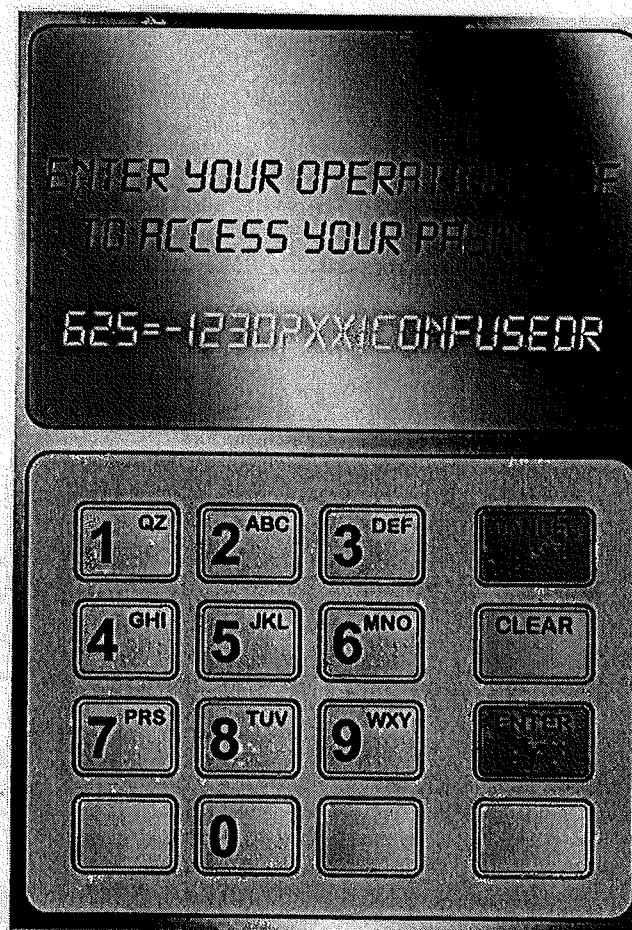
EXAMPLE 3. As in example two, but you cannot charge for the third code.

Insurers' variables

In conjunction with the above, there are many variables that you need to know in order to bill correctly.

These include, but are not limited to, the following:

One PMI will not allow a follow-up consultation or inpatient care to be billed within ten days of surgery, as they determine that



Keeping up to date with all of the changes that occur both within the CCSD schedule and each insurer's schedule of fees is an onerous task at the best of times

the CCSD price includes the post-op element of care.

Another PMI will allow follow-up consultations to be billed without any time limits, but the number of inpatient care days which is included within the CCSD code can differ, depending upon the specific CCSD code performed in surgery.

All other PMIs will allow inpatient care to be billed without any of the above restrictions.

A PMI will allow a local anaes-

thetic (AC100) to be billed with selected minor procedures, but they do not publish which CCSD codes where this rule applies.

A PMI will only allow certain codes to be billed in conjunction with a follow-up consultation.

Recent changes

On top of the complexities mentioned above – which, as previously stated, can change on a regular basis – you also have to keep an eye on the PMI fee schedules, as they can also change quite frequently too.

I have highlighted below some of the changes in the past 12 months:

In February 2012, a PMI recently moved two common ENT codes (E3680 & D1510) into a lower category, resulting in the fee being reduced by 50%;

In August 2011, a PMI increased a common urology code (M4510) by 10%;

In April 2011, a PMI increased all anaesthetist fees by 20% in early 2011.

It is difficult to keep up to date with all these changes, particularly where the price increases, as some insurer are better than others at communicating this information.

In summary

Keeping up to date with all of the changes that occur both within the CCSD schedule and each PMI's schedule of fees is an onerous task at the best of times.

But it is particularly difficult within the current climate and it is no surprise when we find out that it is not being done correctly.

As it is the consultant's responsibility to ensure that their billing is done correctly, they need to ensure that the following happens within the practice – or use a professional medical billing company to manage this process for them.

You need to understand the complexities of the CCSD schedule including what codes can be billed together (bundling and unbundling rules);

You need to ensure that you code correctly by understanding the variables that exist within each PMI and their schedule of fees;

You need to understand the different formulas involved for each PMI for multiple codes;

You need to be aware of the different rules each PMI has over and above the CCSD schedule.

While the above is an administrative burden on the practice, if it is not done properly and on a regular basis, at best you are probably losing thousands of pounds and at worst you are running the risk of being derecognised by the PMI due to incorrect billing.

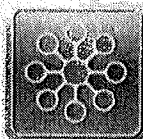
Garry Chapman is managing director at Medical Billing & Collection



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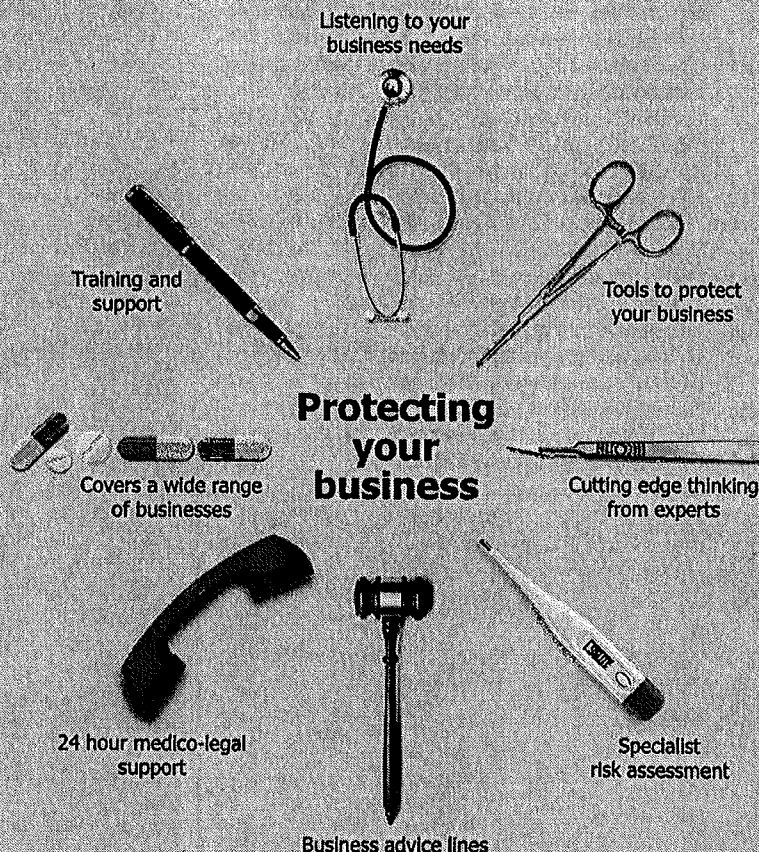
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Appendix IX

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Consultant 38

2 May 2012

To Whom It May Concern,

Please find below my concerns with the recently published "new BUPA procedural codes" and my concerns for the private medical insurance market as a whole.

BUPA has recently published new procedural codes that reduce significantly the level of complexity and therefore the remuneration paid for a vast majority of orthopaedic surgical procedures.

They have sought to identify the most common procedures and have reduced these in some instances by as much as 35-45%. In a very small percent of procedures, not commonly performed, they have been seen to increase the remuneration for these procedures by 10-20%.

In their letter of instruction, BUPA allude to the fact that this is done to provide high quality care and good value healthcare. "The schedule of procedure classifies surgical procedures according to their type and complexity, the time taken and competency level required to carry out each procedure."

These codes have not changed significantly in 12-15 years resulting in the orthopaedic surgeon not receiving an increase in remuneration per code for this period.

Furthermore, in the last approximately 5 years, BUPA has bundled a number of codes into one, eg. Arthroscopic codes; in order that the fee provided to the surgeon is reduced. They have now acted to significantly reduce these fees further.

This is an [X] taken by a major healthcare provider to drive down surgeons fees under the pretext that somehow these surgical procedures have suddenly become less complex while requiring a lower level of competency to perform. I believe this is entirely inappropriate. As a specialist orthopaedic surgeon with a sub-specialist foot and ankle interest, who now performs 90-100% only foot and ankle work both on the NHS and in private practice, I consider myself to have developed a level of competency that far outweighs the general orthopaedic surgeon. This experience and expertise allows me to do more complex procedures, obtain better results and would therefore expect to attract a higher, rather than a lower, procedural code and remuneration package.

[X] BUPA are not allowing their members to see those consultants who do not sign up to the BUPA partnership or who continue to charge outside of the BUPA fee schedule. Moreover, they have threatened not to pay the hospital costs of such a member, if the member decides to pay the chosen consultants fees themselves.

Another area of concern in the PRIVATE HEALTHCARE MARKET (PHM), is the increasingly common practice of the health insurance company to direct members to consultants of their choice rather than the choice of the patient or the general practitioner. The insurance company may refer patients to one of their providers who may or may not be the appropriate specialist for the complaint. This then becomes a managed care pathway created and controlled by the insurance company. The GMC guidelines on private practice state that GP's should be the gatekeepers and triage patients according to their symptoms thereby ensuring that they see the correct specialist rather than the

one who charges the least. The insurance companies are restricting patient choice in accessing consultants.

I understand that the Competition Commission is to investigate the private healthcare market and I firmly believe that these huge companies are driving the private healthcare sector according to financial rewards for the companies, rather than for good medical practice in which the doctor-patient relationship and contract is disregarded.

Appendix XI

CONFIDENTIAL

Appendix XII

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Appendix XIII

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Appendix XIV

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Appendix XV



The Orthopaedic Forum



TOPICS IN MEDICAL ECONOMICS: LESSONS OF THE PRISONER'S DILEMMA*

The jousting between surgeons and insurance companies over fees can be fierce, and to the outside observer it seems anything but playful. Nevertheless, the insights that surgeons need to prevail in this battle may lie in a branch of theoretical economics called game theory.

The word *game* typically refers to a sport or contest, with the implicit connotation of recreation. The technical definition of a game, however, omits any notion of amusement. A game is defined as an encounter in which players execute plans of action under a set of rules to maximize their score — points, money, territory, whatever is at stake. Game theory, then, is the study of strategy and tactics. Game theory can be used to plan the moves of a chess game but can also be applied to any real-world situation in which the interaction between “players” satisfies the definition of a game. In fact, one of the first practical applications of game theory was far removed from the realm of fun and play: the Allied forces used game-theory methods to allocate resources and choose targets in World War II.

The negotiations between buyers and sellers (such as insurance companies and doctors, food-makers and farmers, or automobile manufacturers and steel mills), the posturing of military opponents, or even the debate between a couple over the evening's entertain-

ment plan can take on the trappings of a game. Each side can make moves to maximize its “score.”

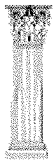
Some scenarios in life and the strategies that they evoke can be reduced, in broad terms at least, to familiar game-theory concepts. When a situation under study resembles a particular game type or position, we say that the situation is isomorphic with the game. The usefulness of isomorphism is that, once a particular situation is recognized as a familiar game, many of the insights derived from careful study of the game can be applied to the situation at hand without repeated detailed analysis.

From my perspective, the current imbroglio between managed-care companies and surgeons over payment for surgical work resembles a classic game-theory problem called the prisoner's dilemma³. It should take no leap of the imagination to guess that it is the beleaguered doctor who plays the role of the prisoner here, yet I do not offer this comparison to make doctors feel even more besieged. Rather, I intend to share some of the analyses to resolve the prisoner's dilemma offered over the years to help doctors cope with their obviously difficult situation.

The prisoner's dilemma is the prototype of a class of games in which use of a reasoned and logical strategy (the so-called dominant solution) leads to a sub-optimal result. (In their book *Decisions, Decisions: Game Theory and You*, Bell and Coplans² entitled the chapter on the prisoner's dilemma “Morons Do Better Than Logicians,” and they may be right.) I believe that the use of logical reasoning by doctors responding to the advent of managed care has made their position worse. I further believe that this logic was not faulty; rather, it was the use of logic itself that caused

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the problem. Let's look at the prisoner's dilemma to see why.

The classic prisoner's dilemma goes as follows: Smith and Jones are both accused of grand larceny and are taken to jail and placed in separate cells. The district attorney approaches them individually and offers a deal. "We don't have enough evidence to convict you of grand larceny — only breaking and entering," she says, "so I offer you the following deal: turn state's evidence on your partner. If you confess, and he remains silent, I will let you go. But I warn you, if you remain silent, and he confesses, you will get the maximum ten-year sentence. Now, if you both confess, I can't let both of you go, so you each will get a five-year term, and if you both remain silent, I am sure we can lock you up for a year on the breaking-and-entering charge. By the way, I have offered the same deal to your partner and told him that I was talking to you."

The various combinations of responses and the sentences that the prisoners could receive are described in the table below, a so-called payoff matrix. (By tradition, acting in the interest of the other player is termed "cooperation" and acting against that interest is "defection," though one is not formally cooperating or defecting, since no communication is allowed.)

	Jones Confesses ("Defection")	Jones Remains Silent ("Cooperation")
Smith Confesses ("Defection")	Smith gets five years Jones gets five years	Smith goes free Jones gets ten years
Smith Remains Silent ("Cooperation")	Smith gets ten years Jones goes free	Smith gets one year Jones gets one year

The dilemma for each is stark: if only the prisoners could communicate — or, more to the point, trust the good intentions of the other — they would guarantee themselves a one-year sentence by remaining silent. But since they cannot communicate (and may not trust the other even if they could) they must employ logic, and logic gets them in trouble.

Smith could say to himself, "What should I do?

Well, let's see: maybe Jones will confess. In that case, I could confess too and get five years, or I could remain silent and get ten. If Jones confesses, confessing is clearly my best option. On the other hand, maybe Jones will remain silent. In that case, I could remain silent and we'd both get one year, or I could confess and go free. If Jones remains silent, confessing is the best option then too. Thus, no matter what Jones does, I am better off confessing."

This logic can be applied with equal validity by Jones, and he too will come to the same conclusion: confessing is better. Thus, using unassailable logic, both Smith and Jones will confess, and both will get five years. If only both had remained silent, they would have gotten only a one-year term, but logic would not let them. And, indeed, if Smith had unilaterally decided to remain silent, odds are that Jones would have confessed and Smith would be facing ten years instead of five. The logic is frustrating, but it is not wrong.

The prisoner's dilemma looks a lot like the situation offered to doctors by managed-care companies entering a new market. Consider, for example, a town with two orthopaedic surgeons, Dr. Smith and Dr. Jones. (This is the simple case, but the results can be generalized to a more realistic setting in which many doctors are at work.) Let's say that Dr. Smith and Dr. Jones each have 50 percent of the market and get paid the same fees for their work. They both earn a nice salary but would like to earn more, and each feels that he could care for additional patients. In fact, both think that they could double their effort.

A managed-care company can approach Dr. Smith and say, "Sign up with us. The rates we offer are lower than what you are used to, but if you sign up with us and Dr. Jones doesn't, you can have the entire market. You will make a lot more money. But take note: Dr. Jones may sign up. In that case, if you don't sign up with us, you will have nothing. Of course, if both of you sign up, your market share remains unchanged and your pay goes down. If both of you refuse to sign up, well, then we would be forced to pay you your usual fees, more than we currently offer."

Clearly, the doctors will be best off if they could agree to not sign, keeping things the way they are. But federal antitrust laws put Smith and Jones in separate cells — they are forbidden by law to collude — and they may not trust each other, to boot. Thus, the same logic that drives the prisoners to confess thrives here. Logic coerces both Dr. Smith and Dr. Jones to sign, with a net result of lower fees and no increase in market share.



Here is the payoff matrix:

	Jones Signs with HMO ("Defection")	Jones Refuses to Sign ("Cooperation")
Smith Signs with HMO ("Defection")	Smith retains his original 50 percent of the market but at lower fees, and Smith's income goes down Jones retains his original 50 percent of the market but at lower fees, and Jones's income goes down	Smith gets 100 percent of the market. The lower fees are more than offset by higher volume, and Smith's income goes up Jones loses his patient base, and Jones's income goes down substantially
Smith Refuses to Sign ("Cooperation")	Smith loses his patient base, and Smith's income goes down substantially Jones gets 100 percent of the market. The lower fees are more than offset by higher volume, and Jones's income goes up	Smith retains his original 50 percent of the market at his usual rates, and Smith's income remains the same Jones retains his original 50 percent of the market at his usual rates, and Jones's income remains the same

Let's see what Dr. Smith would say to himself. "What should I do? Maybe Dr. Jones will sign. In that case, I have two choices: to sign or to refuse. If I sign, at least I get to keep my patients, even if my income will go down. But if he signs and I don't, I get shut out. Clearly, if Dr. Jones will sign, I should sign too. What happens if Dr. Jones refuses to sign? In that case, I could refuse too, and we'll both do OK, keeping our market share with no loss of income. But I could sign and steal his market share. If I sign and he refuses, I'd make a lot more money. Signing, then, is the best option, independent of Dr. Jones's action."

This logic can be applied with equal validity by Dr. Jones, and he too will come to the same conclusion. Thus, using unassailable logic, both Dr. Smith and Dr. Jones will sign with the HMO and both will get lower fees without an increase in market share. If only both had refused to sign they would have gotten a much better deal, but logic would not let them. Thus, managed care offers doctors a prisoner's dilemma.

The game of the prisoner's dilemma can be made a little more interesting if it is played not once but many consecutive times by two players who can remember how the other player behaved in previous encounters. Here, a history of prior behavior and the opportunity for payback in the future may influence the choices that each player makes. Logic may insist

that defecting (confessing to the district attorney or signing with the HMO) is the right thing to do if the choice is made only once, but if good behavior may be rewarded, or lack of cooperation may be punished, the correct choice may be different. This version of the game is called the iterated prisoner's dilemma, and it not only is subtler from the game-theory point of view, but it more closely resembles the situation that doctors encounter in real life. For example, contracts have to be renewed.

The iterated prisoner's dilemma invites a higher level of analysis by each player. One must not only calculate the effect that a choice has on the current payoff but also estimate the behavior that a given action will engender from the other player in future encounters. This new analysis was provided by Axelrod and Hamilton¹, who reported their work in a landmark paper entitled "The Evolution of Cooperation" in the journal *Science* in 1981. The authors opened a contest to various strategies for the iterated prisoner's dilemma. Contestants sent in their strategy as a simple computer program, and all strategies encountered each other for an arbitrary number of rounds. Points were assigned for each interaction, corresponding to the length of the prison sentence in the original description. (The actual point values are arbitrary and can be positive or negative, as long as they are in the same relation as in the original.) The program with the highest point total was declared the winner.

To the surprise of many, a simple strategy named Tit-for-Tat was the victor. Tit-for-Tat does not machinate over its decisions; it does not use complex stochastic models. It simply cooperates with the other player in its first encounter — keeping silent or, if you prefer, refusing to sign with the HMO — and then subsequently acts exactly as the opponent did in the last previous encounter. Over the long run, this turned out to be better than a strategy of always cooperating, always defecting, or any variant in between.

Even more striking was the outcome from a second contest conducted after results from the first were announced. In this one too Tit-for-Tat was the winner. New contestants, informed that Tit-for-Tat had won the last time and explicitly told that it would be re-entered in the contest, still could not beat it. The game theoreticians were impressed. They wondered what made Tit-for-Tat so good.

Tit-for-Tat, along with other strategies that also did well in the contest, was dissected, and four features were seen to be essential to winning an iterated prisoner's dilemma. The first is "niceness," which means, simply, refraining from defecting first. Defec-



tion tends to breed ill will from the other players and produces a course of mutual destruction. Being nice proved helpful. On the other hand, Tit-for-Tat was better than an "always cooperate" approach, indicating that provocability — that is, the ability to respond when the other player is not nice — is essential too; there is no point in being a dupe for others. And since players do better when both are cooperating, as compared with when both are defecting, the willingness to return to cooperation once the other side does first (a feature termed "forgiveness") is likewise important. The final feature gleaned was "clarity" — it must be obvious to other players that you are nice, provokable, and forgiving for those traits to serve you well.

The relevance of the prisoner's dilemma for the orthopaedic surgeon is, to my mind, uncontested. Managed-care companies approach surgeons with an offer that cannot be refused, or so it seems. They frame the option "sign with us!" in such a way that no other action seems reasonable. Signing with HMOs, in the absence of legalized (and enforceable) cooperation, seems to be the only way to survive. But clearly, if all doctors sign, none can gain market share and all become losers, and if no doctor signs, none can lose. Only the tantalizing prospect of cannibalizing a fellow doctor's practice or the fear of being eaten oneself obscures that undeniable fact.

When a managed-care company approaches with what seems to be an opportunity to kill or be killed, consider the payoff matrix. If you recognize a prisoner's dilemma lurking in it, remember that the best response has been proven. You must be nice and forgiving, yet provokable and clear. In your first encounter, at least, "cooperate" with your fellow doctor and assume that he or she will as well. Of course, retaliate when struck, but also be quick to return to niceness.

And one more thing: limit your envy to your fellow doctor's golf handicap. Envy can ruin a coop-

erative environment. In the iterated prisoner's dilemma contest, Tit-for-Tat did not outscore every individual strategy in one-on-one encounters; in fact, it did not outscore any. Its victory was based on the fact that in all such encounters Tit-for-Tat was satisfied with a tie — mutual success. That apparent meekness was enough to keep it on top overall. The lesson here is that surgeons must be satisfied to do only as well as (but no better than) their fellow doctors. The urge to outscore an opponent rather than to do as well as a colleague invites a downward spiral of defection and shared disadvantage.

Most orthopaedic surgeons are currently working harder than ever, and making less for it. How did we get there? Weren't all of our actions logical? Of course they were, but we did not realize that we were mired in a prisoner's dilemma and that logic is not the answer. So let's try a new way: cooperation. If we cooperate with each other, we may not trounce our rivals, but we won't get trounced ourselves. This strategy is not only nice, it is wise.

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3. Hofstadter, D. R.: The prisoner's dilemma computer tournaments and the evolution of cooperation. In *Metamagical Themas: Questions for the Essence of Mind and Pattern*, pp. 715-734. New York, Basic Books, 1985.

Appendix XVI

- foetus growing outside the womb (ectopic pregnancy)
- heavy bleeding in the hours and days immediately after childbirth (post-partum haemorrhage)
- after-birth left in the womb after delivery of the baby (retained placental membrane)
- complications following any of the above conditions.

Exception 2: We may pay for **eligible treatment** for delivering a baby by caesarean section. However, we need full clinical details from your **consultant** before we can give our decision.

Exception 3: We pay for **eligible treatment** of an **acute condition** of the mother that relates to pregnancy or childbirth but only if all the following apply:

- the **treatment** is required due to a flare-up of the medical condition, and
- the **treatment** is likely to lead quickly to a complete recovery or to you being restored fully to your state of health prior to the flare-up of the condition without you needing to receive prolonged **treatment**.

Please also see 'Birth control, conception, sexual problems and sex changes', 'Screening, monitoring and preventive treatment' and 'Chronic conditions' in this section.

Exclusion 25 Screening, monitoring and preventive treatment

We do not pay for:

- health checks or health screening, by health screening we mean where you may not be aware you are at risk of, or are affected by, a disease or its complications but are asked questions or have tests to find out if you are and which may lead to you needing further tests or **treatment**
- routine tests, or monitoring of medical conditions, including:
 - routine antenatal care or screening for and monitoring of medical conditions of the mother or foetus during pregnancy
 - routine checks or monitoring of **chronic conditions** such as diabetes mellitus or hypertension
 - tests or procedures which, in our reasonable opinion based on established clinical and medical practice, are carried out for screening or monitoring purposes, such as endoscopies when no symptoms are present
 - preventive **treatment**, procedures or medical services, for example, removing breast tissue when there is no disease or tumour present.

Please also see, 'Chronic conditions' and 'Pregnancy and childbirth' in this section.

Exclusion 26 Sleep problems and disorders

We do not pay for **treatment** for or arising from sleep problems or disorders such as insomnia, snoring or sleep apnoea (temporarily stopping breathing during sleep).

Exclusion 27 Special conditions

For **underwritten members** we do not pay for **treatment** directly or indirectly relating to **special conditions**.

For **underwritten members** we are willing, at your **renewal date**, to review certain **special conditions**. We will do this if, in our opinion, no **treatment** is likely to be needed in the future, directly or indirectly, relating to the disease, illness or injury referred to in the **special condition** or for a related disease, illness or injury. However, there are some **special conditions** which we do not review. If you would like us to consider a review of your **special conditions** please call the helpline prior to your **renewal date**. We will only determine whether a **special condition** can be removed or not, once we have received full current clinical details from your **GP** or **consultant**. If you incur costs for providing the clinical details to us you are responsible for those costs, they are not covered under your **benefits**.

Please also see the 'Covering your new-born baby' rule in the section 'How your membership works'.

Exclusion 28 Speech disorders

We do not pay for **treatment** for or relating to any speech disorder, for example stammering.

Exception: We may, at our discretion, pay for short-term speech therapy when it is part of **eligible treatment**. The speech therapy must be provided by a **therapist** who is a member of the Royal College of Speech and Language Therapists.

Exclusion 29 Telephone consultations

We do not pay for any consultation with a **consultant, therapist, mental health and wellbeing therapist** or any other healthcare professional when the consultation is not carried out on a face-to-face basis, for example, if it is carried out by telephone or any other remote medium.

Exclusion 30 Temporary relief of symptoms

We do not pay for **treatment**, the main purpose or effect of which is to provide temporary relief of symptoms or which is for the ongoing management of a condition.

Exception: We may pay for this type of **treatment** if you need it to relieve the symptoms of a terminal disease or illness.

Exclusion 31 Treatment in a treatment facility that is not a recognised facility

We do not pay **consultants' fees** for **treatment** that you receive in a hospital or any other type of treatment facility that is not a **recognised facility**. If your **facility access** is:

- **partnership facility**
- **local access facility**
- **national access facility**
- **extended access facility**

Appendix XVII

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Appendix XVIII

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Appendix XIX

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Appendix XX



Bupa Healthcare Access

Private treatment with Bupa has many advantages – a wide choice of hospitals, prompt access to care, a private en-suite room for overnight stays (where possible) and a treatment schedule that suits your timetable. But most important of all, it helps puts you in control of your health and allows you to make decisions that are right for you.

Bupa Healthcare Access is for people who don't have health insurance, or who are excluded from certain treatments on their current plan. It's a one-off, fixed price option that gives you all the standard Bupa benefits.

Your route to private healthcare

Included in the price:

- ✔ initial consultation
- ✔ any out-patient and pre-operative tests (excluding MRI or CT scans)
- ✔ hospital charges
- ✔ in-patient drugs and dressings during your stay (excluding some take-home drugs, dressing and appliances such as walking sticks and crutches)
- ✔ consultant specialist and anaesthetist fees
- ✔ a follow-up consultation
- ✔ medical emergencies and extended stay in hospital
- ✔ relevant re-admission within 30 days of treatment

Post operative treatments such as physiotherapy and further ongoing consultations can be arranged for you at an additional cost.

Why choose Bupa Healthcare Access?

We recognise that paying for private healthcare treatment yourself can be confusing, so our aim is to make it as simple and as certain as possible, whilst giving you the best choice and experience we can.

That's why we'll give you the same terms, the same price and the same quality no matter what hospital you decide to be treated in within our approved networks. That means no hidden costs - you pay a fixed price depending on the treatment type.

More than that, we will also give you:

- ✔ your own dedicated adviser, who will personally manage your bookings and be a point of contact should you have any questions
- ✔ access to the Bupa Treatment Options Service (where appropriate) – a helpline that explains what medical choices are available to you so that you can be sure you're making the right decision
- ✔ access to the Bupa Anytime HealthLine – around the clock, unlimited telephone consultations with our team of GPs and nurses.

We can help you with:

- hip and knee replacements
- cataract operations
- hernias
- gall bladder surgery
- hysterectomies
- arthroscopies
- cruciate ligament surgery
- wisdom teeth removal
- pain injections and epidurals
- carpal tunnel releases
- colonoscopies
- gastroscopies
- diagnostic scans, physiotherapy, and much more besides

Should you need a procedure that is not listed above, we may still be able to help.

Next steps

- **Call us today**

To find out more about our Healthcare Access Scheme for you or someone close to you please call **08000 778 931*** and speak to one of our advisers. If you have an immediate health concern we may also be able to book a consultation at a time and location to suit you.

- **Email an enquiry**

Send us an [email enquiry \(/individuals/self-pay-treatments/healthcare-access/healthcare-access-contact\)](#) today

*Calls may be monitored and recorded.

Appendix XXI



Price guide

It is important to consider not only the price of each session but also the number of sessions needed to complete your course of treatment - you may need more than one.

Musculoskeletal Appointment Prices		
Service	London	Regional
Orthopaedic physician		
Initial consultation	£212	£181
Follow-up consultation	£134	£127
Short follow-up consultation	£68	£114
Opinion & report	£280	£280
Physiotherapy and Osteopathy		
Initial consultation	£84	£72
Follow-up consultation	£59	£45
Initial Isokinetic testing	£155	-
Follow-up Isokinetic testing	£81	-
Consultant radiologist		
Diagnostic ultrasound	£222	-
Ultrasound-guided injection	£417	-
Podiatrist		
Podiatry biomechanical assessment	£179	-
Podiatry 30 minute consultation	£82	-
Podiatry short follow-up consultaion	£42	-
Additional procedures		
Soft-tissue, intra-articular or facet joint injections	£115	-
Diagnostic ultrasound	£150	-
Ultrasound guided injection	£265	-
Caudal epidural injection	£192	-

Musculoskeletal Appointment Prices		
Paravertebral nerve block	£290	£290

The price for X-rays and blood tests is variable. Your doctor will be able to advise you of the cost, depending on what you require.

A fee will be charged for non-attendance and when cancelling an appointment without giving 72 hours' notice for orthopaedic physician appointments or 24 hours' notice for all other appointments.

Next steps

- **Book your initial assessment**

Call us on **0845 600 4778*** for more information or to make a booking.

- **Where to find us**

[Find your nearest Bupa centre \(/individuals/self-pay-treatments/physiotherapy-sports-medicine/where-to-find-us\)](#) offering physiotherapy services including the [Bupa Run Check \(/individuals/self-pay-treatments/physiotherapy-sports-medicine/bupa-run-check\)](#)

- **Musculoskeletal brochure**

[Download more information \(/jahia/webdav/site/bupacouk/shared/Documents/PDFs/Individual/self-pay-treatments/WEB%202235861%20MSK%20Brochure_091211.pdf\)](#) about our musculoskeletal treatments(pdf, 2mb).

*Calls may be recorded and may be monitored