Comment on the Provisional Findings Report of The Competition Commission's Private Healthcare Market Investigation

Summary

1	The provisional findings of the report are extremely disappointing, for they do not bear at all on the problems which are encountered by St. Anthony's and other small hospitals.
2	The report is unbalanced and partial in the amount of space and consideration given to the activities of private health insurers as against the activities of non-chain hospitals.
3	The Competition Commission has failed in its undertaking to protect the interests of the individual patient through its concentration on chain hospitals and the corporate insured market.
4	The report is academic, doctrinaire and over-absorbed in the Competition Commission's own intellectual theories of harm.
5	In many places the language employed is disconcertingly similar to that used by PMI companies, particularly BUPA. It is apparent that the Competition Commission is content to "parrot" the insurers' line, without investigation the justice of comments made.
6	The report shows a misunderstanding of the way the market works. To those who work in Private Healthcare, the content of the report is surprisingly counter-intuitive.
7	Fruitless discussions have taken place with the OFT over the past 18 years about the activities of PMI companies. 18 years ago, I told the OFT that unless they were to become more involved in the activities of private medical insurers, they would, in due course, have to undertake an enquiry into the monopoly power of chain hospitals. This is what has happened. The need for this report is the result of the failure of the Competition Commission / OFT to take action.

The following comments support these broad assertions:

	Imbalance / Bias
14	In paragraph 14, the report acknowledges that a PMI may have buyer power over individual consultants. There is no theory of harm put forward that PMI may have buyer power over small hospitals. The position of a small hospital vis-a-vis the PMI company is similar to that of the individual consultant.

7.77	At paragraph 7.77 the Competition Commission acknowledges that "PMIs increasingly determine not only fee levels but also which consultants a patient may see". PMI companies therefore not only set prices, but also exert sanctions, delist consultants and hospitals and direct patients to their own choice of hospital. This market power is greater than anything at the disposal of the chain hospitals. Yet the report is silent on this plight of small hospitals.
	The Competition Commission acknowledges that there is greater consolidation in the insurer market than in the provider market. There is therefore correspondingly greater power. The report is wrong to suggest that there are higher barriers to entry into the less consolidated market (hospitals) than there is to the insured market. Several insurers have left UK operations but new providers have come into the UK market.
41	It is accordingly, very surprising to read at paragraph 41 "We found that no PMI had countervailing buyer power that could fully offset the market power of those historical operators that have it". At the level of the small independent hospital, it is evident who has the power and who wields it, as I have so repeatedly made clear to the OFT / Commission.
34 And 6.1.7	One consistent theme of the report appears to be an attempt to diminish the real effect of insurers' threat to delist. Paragraph 34 states that it is not possible to evaluate what net benefit BUPA derived from delisting. On page 200 (paragraph 6.1.7) the report states "it is not possible to predict the outcome of future negotiations...on the basis of this one delisting event". The Competition Commission appears to be trying not to have to say what it surely knows is true, which is the one delisting event is insignificant in itself but it has established the precedent which allows the insurer to threaten providers and consultants. This constitutes unacceptable market power.
	The second point which the Competition Commission should not have turned away from, is the clear implication of its own statement that "It is not possible to evaluate what net benefit BUPA derived from the delisting". The only conclusion to be drawn is that BUPA has chosen this action in order to give credibility to its future threats.
60	Paragraph 60 states that the PMIs generally condemned incentive schemes. It is clear that the Competition Commission has not looked into the way PMI have sold their "plan-assured" policies. There are clear incentives here. The report is partial on this point. It is also partial in the way it reproduced a graph at figure 2.2 of hospital revenue and specialist fees without providing any similar graph on PMI.
2.38 And 6.164	The comments made at 2.38 (page 39) and 6.164 (page 199) do not ring true, firstly, on account of the extremely good results recently released by BUPA and, secondly, at 6.164 BUPA has told us just the opposite: corporate customers do not want access to a full range of hospitals, but to ones which are cheaper.
2.44	The notion, at paragraph 2.44, that GPs are keen to know whether their patient's consultant is recognised by the private medical insurance company is not one which accords with our experience. It depends on how the question to the GP is phrased and this idea is likely to have been suggested either by the Competition Commission or the insurers. From my experience, GPs are interested in a clinical referral and prefer to steer clear of insurance issues.

2.1	Under the regulatory regime which starts at 2.1, it is interesting to read that there are 12 paragraphs devoted to hospital regulation and 10 paragraphs to consultant regulation. For PMI companies there are only 3 paragraphs, the first of which, 2.86, is scarcely comprehensible. This paragraph should be read in conjunction with my comment at paragraph 7.77 above.
2.87	At 2.87 would it not have been correct for the Competition Commission to state that the Financial Ombudsman has received 1405 complaints about private medical insurance since April 2013, an 82% rise compared to the same period in 2010? I attach the cutting.
3.76	3.76 illustrates another instance whereby the Competition Commission is too ready to accept the party line of the insurer, in its reference to an employer appointing a PMI "to administer the process". The "process" should not extend to the PMI company determining to whom and to which hospital the patient should be directed. But it does.
3.78	3.78 refers to the increase in the cost of private medical insurance. No attempt is made to penetrate these reasons. The CC's scrutiny of the rationale of large hospitals contrasts with the acceptance by the Competition Commission of this point.
Pg 98	The analysis of "The main characteristics of the market" is partial and there is little in the Competition Commission's description that would not characterise a commodity. By contrast, the private healthcare market is local, complex, personnel-orientated and involves long-standing, often intense, relationships. These characteristics have been ignored by the formulaic approach of the CC.
4.7	At 4.7 the report acknowledges that the insured patient makes his or her decision primarily on clinical and convenience grounds. The "clinical" is important, but it is not addressed in the report. Bear in mind also, 5.63 of the OFT report, in which PMI contributors are quoted as stating that they knew nothing about clinical expertise of the consultants. The real concerns of patients, as described by the Competition Commission itself, have all too often not been addressed.
6.169	This paragraph acknowledges that the credibility of the delisting threat depends on the relative strengths of the PMI and the hospital operator. It does not go on to address those clear cases of David and Goliath, when small freestanding hospitals, such as St. Anthony's, have no option but to accede to what the insurer demands. It is one thing for the report to blandly acknowledge this position but another to fail to point out that this contravenes the prohibitions laid out in the Competition Act.
6.179	I was extremely surprised to see that the Competition Commission has seen no evidence that "PMI have .... (diverted) significant numbers of patients from....a specific operator's hospital". We have sent voluminous evidence of this.
6.189	Even more startling is the comment at 6.189 that "PMIs do have scope to take some business away from hospital operators but does that not of itself constitute buying power." This seems to be such a glaring error that I believe it should be removed.
6.284	The report refers to its "finding of excess profitability". While I understand that the main focus of the report is on the provision rather than the insurer side, it should be noted that the

	insurance companies can also be accused of excessive profitability, particular BUPA whose huge international empire has been built on the back of UK subscribers' premiums.
6.291	In this paragraph the word "all" in the penultimate line suggests collaboration between hospital operators. Is that intended? This paragraph also shows that the focus of the report is purely on the large chain hospitals and disregards the plight of smaller hospitals; otherwise, this sentence could not have been written.
7.44	(Page 269) This is one of the several examples when information from the insurer seems to be quoted, almost on a cut-and-paste basis. I invite you to consider the many references in sections dealing with PMI matters, where the word "may" is used, in this case concerning a consultant who "**may**" charge the patient the difference. This use of the word "may" in sections concerned with PMI is slippery and the Competition Commission should have penetrated the doubt inherent in the phrase. For in this particular case, that statement is more often wrong than right. The insurer usually forbids the consultant from charging the patient the difference. This is a term of the Premier contract to which consultants are apparently being forcibly migrated if they wish to continue to see BUPA patients.
7.55	The Competition Commission, by appearing to endorse the final sentence, is confusing "data" with "information". The "comprehensive database" does not give information on the "quality" of a consultant's performance. Scarcely more than a year ago, the PMIs confirmed (paragraph 5.63, again, of the OFT report) that they did not know about the quality of consultants' work.
7.64	It is not clear why the Competition Commission thinks it is appropriate to give a theoretical defence of the PMI's drive to reduce charges: "Thus it would not be in the PMI's own interest to drive consultants' charges so low that quality and innovation is.. affected."... In any event I believe that we have sent more than enough material to the Competition Commission to show that the quality given to patients is indeed negatively affected, given the CC's own assessment of what patients are looking for in their treatment.
7.69	The report acknowledges that BUPA and PPP have buyer power in relation to consultants. Why does it not make the same acknowledgement about small hospitals? Once more small hospitals have been ignored.
9	This deals with Information Asymmetry, a long-established fixation of the OFT / Competition Commission. This recommendation appears to be contradicted by the reality of paragraph 9.48, which acknowledges that there is a significant amount of information available to patients, but they do not currently make use of it and, furthermore, that a "large proportion of patients rely on their consultant's recommendation regarding treatment options". The determination of the Competition Commission to stick to their information asymmetry thesis runs against the evidence of the wishes and inclinations of patients. It is also clear that paragraph 9.7 sounds good but is disingenuous insofar as what BUPA have suggested cannot currently be achieved, particularly bearing in mind the confusion between tick-box data and real information on Quality. I believe that BUPA knows this and we have made the point to them.
9.13	This shows that the Competition Commission's own survey of patients indicated that clinical expertise and reputation were the most common priorities for patients. This priority appears to

	have been ignored by the report.
9.25	There have been several allegations made at St. Anthony's of unwarranted treatment. In every case, without exception, the insurer has had to change their mind, when the detail of the individual condition or conditions of the patient has been explained by the consultant. The concept of "unwarranted conditions" is a tick box system developed by BUPA from the Californian Healthcare Company. There appears to be an assumption that the comparator of health systems in the USA or of the NHS must be preferable to the existing arrangements within private healthcare in the UK. Neither is a satisfactory comparator, as in America clinical quality is subject to HMO strictures, which prevent a consultant from ordering a common test without the approval of the insurance company and in the NHS the ability of consultants to undertake the necessary diagnostic tests is severely constrained by economic considerations. It may pain the CC to say it, but could it not acknowledge that the current system in the UK may be the best for patients? I fear that the narrow doctrinaire approach adopted will preclude any such possibility.

	Academic Approach of the Competition Commission and the Understanding of the Market
	The report shows a very limited concept of consumer detriment, for it focuses only on the narrow academic model of established competition theories. This leads to simplistic generalisations.
7.60	In paragraph 7.60 on page 276, for example, PMI is "characterised as the buyer of the services". This role is only undertaken, however, with subscribers' money, on behalf of the subscriber and only with the consent and the agreement of the subscriber. PMIs often fail to meet these criteria.
53	The recommendation that policy holders are provided with the reasons why PMIs recommend some consultants or the reasons for advising against the use of other consultants is key. This means that by recommending less expensive consultants, the PMI company, more often than not will be recommending a consultant who will have had one-third of the patient contact during their training compared with the "established" consultants from whom efforts are being made to divert patients. The Commission should recommend that patients are made aware of these crucial differences.
1.14	Paragraph 1.14 is surprising in the small number of site visits to hospitals and PMI companies.
2.48	There is confusion in the second sentence as the Outpatient consultations are not a private hospital issue but a consultant issue. To say therefore that private hospitals are recognised for outpatient consultations obscures the reality that when a PMI company delists an outpatient consultant who practises largely at one hospital (and the report shows that this is very common) that PMI company is also effectively delisting the Hospital for that patient. Note also, in the third sentence, the use of "may" again.

Pg 46	Figure 2.7 shows an alternative consumer pathway to private healthcare. It is important that this should be described as "Alternative," as your paragraph 2.6 so describes it. It is interesting that as it stands it should be presented as the normal consumer pathway to private healthcare and secondly that the Competition Commission has thought it appropriate to give a diagram to the "alternative" route but has not given a diagram to the standard one. This is uneven handling of the issue.
2.83	IHAS is relevant to hospital regulation and should be in that section.
3.92	The Competition Commission is already out of date. The fee-assured consultant has been overtaken by the "plan-assured" consultant who works to the Premier Contract. It is now commonplace for fee-assured consultants to have patients diverted away from them to a premier consultant. This is the way BUPA works, constantly changing the criteria.
5.11	This is also wrong in regulatory terms, even if the PMI ignores the FSA requirements; these are – and acknowledged by BUPA – that PMI **may not** reject a treatment if it has not been pre-authorised; pre-authorisation has no standing and the FSA has made it quite clear that the question of whether a treatment may or may not be reimbursed by the insurer can be determined only by the rules of the scheme and not by any notion of pre-authorisation. We have made this point on several occasions and I am surprised that the Competition Commission has not included it.
6.213	I think the Competition Commission could have tried harder; a clear way of linking quality and cost is through nurse ratios. This sentence shows again that the whole issue of quality has not been considered by the Competition Commission. Yet its own reports states that quality of clinical care is what the patients wish to have.
7.49	(Page 271) Reference is made to the closure of the consultant partnership by BUPA. As you know, this involved a 10% rebate (some have called it a bribe) to consultants at the end of the year. What you have not mentioned is that when this scheme was closed, the 10% in question has not gone to benefit subscribers and their premiums. It has been pocketed by BUPA which continued to increase the premiums by 10%. A similar point has been made earlier in the report by BMI, where it states that it is concerned that the discounts it has given to BUPA have not benefited subscribers.
6.178	This shows folie de grandeur in the comments made by BUPA in that the open referral service was not yet able "to provide effective discipline on hospitals". The absence of any comment in the report on this statement suggests that the Competition Commission may not disagree with it. This is not the role of the PMI companies but is shows their hubris. The role of hospital and consultant is to treat the patient for which there is a charge and the role of the insurance company is to provide funding for that purpose. It is surprising that the report does not address an issue which is central to the very reasons of this enquiry being launched in the first place: that is that the PMI company will not permit patients to top-up the charges of hospitals and has consistently set its face against the reasonable hypothesis that a certain amount of premium will buy a certain amount of cover. If a subscriber wishes to go to a hospital where extra funds are required, it is up to them, they are free to top-up; this would ensure complete freedom of choice. The current position, ironically enough, is that in the NHS there is greater freedom of choice than if you were to have an insurance policy by BUPA or PPP in the private

	sector. Yet Private Health is founded on the notion of choice.

	Conduct of Private Medical Insurance Companies
	For many years the conduct of private medical insurance companies has not been regulated; nobody has had oversight. I have already sent to the Competition Commission many instances of the bullying approach of PMI companies, insisting over the course of a full year's negotiation that the Hospital should reduce its prices or St. Anthony's will receive no BUPA patients. This is a repeated theme. It may well be that the PMIs feel that they have little ability to reduce prices in the chain hospitals for reasons which you have identified, but it cannot be right, within what I hoped would be the even-handedness of the Competition Commission report, that the PMIs therefore seek to achieve disproportionate price reductions from small independent freestanding hospitals as a result. This has received no consideration by the Commission.
51	As paragraph 51 makes clear, there have been many complaints about the conduct of PMIs from consultants and many from policyholders. The attached Sunday Times article endorses this. These have been ignored by the Competition Commission.
2.5	This states that 76% of consultants said they had treated 75% of their patients at one hospital. This is clear evidence therefore that the process of delisting a consultant has the potential considerably to harm a hospital. I should have thought that the Competition Commission would have taken a greater interest in a third party being adversely affected by the strictures of an insurer on the consultant. This shows that the current structure of the market is not working properly and it is very disappointing that the Competition Commission has not sought to address it.
2.52	The paragraph Is also out of date. The words "recognised" and "approved" have been variously substituted by "fee-assured", "not one of ours", "not on our list" or "not plan-assured". It is not acceptable for private medical insurers to dream up labels, all of which must carry significance, if those labels are to warrant delisting of consultants or hospitals.
3.87	The reference at 3.87 to provident associations shows that issues which I have raised with the OFT on several occasions have not been resolved. Some 20 PDFs were sent to the OFT with evidence that BUPA is a Provident Association and that BUPA never has been a Provident Association. Neither BUPA nor the OFT have responded to what seems to me to be a fundamental point. It is fundamental to patients; invariably patients, with whom we have discussed this matter, have stated that they believe that BUPA is a Provident Association. In reality, whatever the past Chairmen of BUPA may have said to the contrary, it is not and never has been. The point here is that BUPA is happy to continue to sell their policies on a misapprehension. Note also that previous Competition and OFT reports on BUPA have stated that BUPA is a Provident Association. That same misapprehension was inflicted on the Commission.
4.12	This paragraph speaks of PMIs approving or recognising hospitals, facilities and consultants. To

	be fair, the report should feature the PMIs' practice also in delisting consultants and hospitals. This can happen at a moment's notice. It makes a mockery of the many hours spent in negotiating prices and terms with BUPA / PPP if at a stroke, the insurer can choose to take any amount of work away at any time. Open referral drives a coach and horses through all these painstaking negotiations. This is also the opinion of our legal advisors and it is surprising that the Competition Commission believes that this is an acceptable practice. The purpose of a contract is to provide certainty of operation on both sides; this is simply not possible under the existing open referral arrangements.
7.42	This high-handed approach is exemplified in paragraph 7.42 (page 268) where "BUPA explained that they do not generally consult on, or otherwise discuss their benefit maxima levels".

I am sorry to have written at such length but I hope that my comments have shown how disappointed we are with this report. While I acknowledge that the main focus was on the provision rather than the insurance, the repeated assertions of the Competition Commission that it is in existence to protect consumer interests do not ring true, except with regard to cost only. The report acknowledges that the issue of quality is unknowable to the Competition Commission and that it has therefore produced a report entirely on a financial basis. This is fundamentally to misunderstand the market and the need for the individual suffering patient to be able to obtain high-quality treatment for his ailments.

I make no apology for reminding you that this whole enquiry is a self-inflicted wound, brought about by the combined failure of the OFT and the Competition Commission to deal with the practices of private medical insurers. The practices of the PMI companies constitute the first issue. The Consolidation of the provider market has followed, often as a response to these practices. Whatever remedies the Competition Commission decides to implement as a result of this enquiry, the trajectory is set: there will be more and more hospitals owned by fewer and fewer organisations and the Commission will be engaged in more and more enquiries. That pattern of activity will continue until either the Competition Commission or some other body produces reasonable regulation and oversight of the dominant private medical insurance companies in this country.

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