

BRITISH MEDICAL ASSOCIATION RESPONSE TO THE COMPETITION COMMISSION PRIVATE HEALTHCARE MARKET INVESTIGATION PROVISIONAL DECISION ON REMEDIES

February 2014

1. About the BMA

- 1.1. The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine all over the UK. With a membership of over 153,000 worldwide, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

2. Introduction

- 2.1. The BMA welcomes the opportunity to comment on the Competition Commission's (CC) provisional decision on remedies report. However, as with the provisional findings report and notice of proposed remedies, the publication of the provisional decision on remedies report has been delayed and the timetable for returning comments to the CC has been constrained. We are concerned therefore that there is limited scope to influence the investigation at this late stage. We hope this is not the case and that this is reflected in the CC's final report and remedies.
- 2.2. We have set out our comments in three main areas: an executive summary, comments on Private Medical Insurer (PMI) fee schedules and detailed comments on the proposed provisional remedies that apply to consultants.

3. Executive summary

- 3.1. Our response to the provisional decision on remedies report is as follows:
- The BMA is disappointed that the CC has not proposed remedies that address the influence that PMI's have over consultant fees. We have restated our reasons why we believe this should be addressed in the CC's final report and remedies.
 - Services that are of low value that do not influence consultant behaviour should not be limited through a de minimis value, provided these are offered equitably to all consultants with practising privileges at a hospital. Patients should be informed of this arrangement through the hospital's website.

- We agree that services of higher value, such as consultation rooms and secretarial support should be offered equitably to all consultants with practising privileges at a hospital, at fair market value. However, further consideration needs to be given to the extent that this may restrict new consultant entrants to the market.
- The limit of a 3 per cent per cent stake in equity participation schemes is set too low and may result in reduced consultant engagement with private hospitals and other facilities. The limit should be raised to a level that encourages innovation while still ensuring that the equity stake does not influence referral or commissioning behaviour.
- The establishment of an information organisation is supported. It is essential that the organisation is truly independent from the influence of PMIs and hospital providers and that consultants and their representatives are meaningfully involved in the analysis and presentation of consultant quality data.
- The BMA already encourages consultants to provide patients advance information about their fees. Due to the complexity of procedures, the possibility of unforeseen circumstances and the restrictions placed on consultants by PMIs, any fee information should be provided as a range.

4. Private Medical Insurer fee schedules

- 4.1. We would like to record our concern that the CC has not recommended that PMI influence over consultants' fees should be addressed as part of the investigation. This is despite our submissions throughout the course of the investigation outlining our concerns in this area, including in our most recent submission to the CC's provisional findings and remedy report. That this is not commented on in the provisional findings report raises questions about the effectiveness of the market investigation consultation process.
- 4.2. As we have stated in previous submissions, preventing consultants from charging top-up fees leads to a reduced choice of consultants available to patients insured by Bupa and AXA PPP. If this were allowed to continue other PMIs would introduce similar policies which would further reduce the choice of consultant available to patients.
- 4.3. The CC has not provided sufficient explanation why the comment in the Annotated Issues Statement that "If extensively and rigidly applied, fee-capping consultants could lead to distortions in competition and to reduced consumer choice. Fee-capping ... has the potential to increase the disincentives on consultants from setting fees to reflect their costs, experience, expertise and the local market conditions"¹ has not been investigated further.
- 4.4. The consequence of prohibiting top-up fees is that "Bupa's Benefit Maxima, as the industry standard in particular clearly operates in practice for many consultants as both a maximum and a minimum fee schedule."² This means that Bupa is able to engage in price fixing for all consultants in private practice. Were this done collusively, this would be a breach of the Chapter I prohibition under the Competition Act 1998. That this is done by the largest PMI with a dominant position through its over 40% market share, which is also vertically integrated through its ownership of the Bupa Cromwell hospital, makes no difference to the economic effect.

¹ Competition Commission, Private Healthcare Market Investigation, Annotated Issues Statement, February 2013, ¶7.70

²*Ibid.* ¶7.69

- 4.5. These practices can be expected to lead to a reduced choice of consultants available to patients insured by these insurers and that purchasers' of private medical insurance response to this may be muted, especially since the market share of Bupa is over 40% and the combined market share of Bupa and AXA PPP is around 65%. While the CC states that "in the absence of the PMIs constraining consultants' fees, it is unclear how such fees would be constrained"³, we believe that the constraint on consultant fees would be by the market – by what consumers are willing to pay in order to have their consultant of choice.
- 4.6. There has also not been adequate consideration given to the effect that preventing top-up fees has on quality of service. A PMI subscriber may wish to pay a top-up fee in order to secure the services of a consultant with particular expertise or who uses a particular piece of equipment. That would provide an incentive for consultants to develop expertise and to compete on quality. This adversely affects not only consultants but also consumers because it limits their ability to select the consultant of their choice having regard to their quality and expertise.
- 4.7. We request that the CC reconsiders the consequences of PMIs preventing consultants from charging top-up fees and particularly the conclusion in the Annotated Issues Statement that "it is not evident to us that patients are disadvantaged by top-up fees if they know about them in advance and if this would allow them to choose the consultant they prefer. Allowing such fees might provide greater patient choice."⁴

Our detailed comments on the provisional decisions on remedies are outlined below.

5. Prohibition and restrictions on clinician incentive schemes

- 5.1. The BMA supports restrictions being placed on clinician incentive schemes that encourage patients' referrals to particular facilities or for particular treatments or tests. All referrals should be based on the clinical need of the patient.

Services of low value

- 5.2. We agree that the services of low value that are listed in the provisional decision on remedies report are unlikely to influence consultant behaviour. However, the proposed £500 annual limit of the cumulative cost of these services is too low to not result in a regulatory burden. We would suggest that services of low value (such as those listed in the provisional decision on remedies report) should be explicitly defined as part of the remedy, but not be subject to any limit. A statement could then be published on the hospital's website informing patients that all doctors' with practising privileges at the hospital have access to these services. This would ensure that hospitals could not circumvent the remedy in relation to services of higher value that might influence consultant behaviour, but also ensure that the OFT/CMA were not required to ensure compliance relating to services that are unlikely to influence behaviour.

Services of higher value

- 5.3. We agree that consultation rooms and secretarial support should be offered equitably to all consultants with practising privileges at a private hospital, rather than allocated selectively. If these services are provided at fair market value, they cannot be seen as an inducement or an incentive to practise from or refer to one hospital over another. Therefore the requirement to

³ *Ibid.* ¶17.60

⁴ *Ibid.* ¶111

publish information on the hospital operator's website about which consultants pay for these services is unnecessary. A statement on the hospitals' website of how much the hospital charges for these services is all that is required.

- 5.4. The CC's assessment of the costs associated with this aspect of the proposed remedy states that for hospital providers there will be reduced costs as they will receive the revenue for these services that they previously provided for free or at a reduced cost. While this may be the case, there has been no real assessment of the impact of the remedy on consultant costs. We note the statement that as consultation rooms and secretarial assistance will be provided at fair market value this will also result in lower costs for consultants. This assumes that the consultants who paid for these services previously, were paying above what will be fair market value in the future. It also does not take in to account consultants who received these services for free or at a reduced cost for a limited period when they were initially setting up in private practice. At a time when consultant private practice income is falling and expenses are increasing, there is a risk that the cost of these services will become prohibitive to new consultants even at fair market value. This could have the unintended consequence of reducing the number of consultants entering the market and consolidating the position of incumbents.
- 5.5. The CC has not presented any evidence that doctors who receive remuneration for an employed position at a hospital change their referral behaviour or that this affects competition in the market. It is not clear how the proposal that a summary of their duties and information about their salary is published on the hospital website would address any concerns related to this. This aspect of the proposed remedy is therefore disproportionate and would disadvantage doctors compared to other employees. We recommend that a list of doctors who are employed by a hospital should appear on the hospital provider's website, accompanied by a disclosure of interests, such as whether they also have practising privileges at the employing hospital. This would ensure that patients were aware of any potential conflicts of interest, should they exist, and would also effectively address any concerns about influences on referral or commissioning behaviour.

Schemes which incentivise patient referrals

- 5.6. We agree that schemes which incentivise doctors to treat or refer private (and NHS waiting list) patients for tests at its hospital or hospitals should be prohibited outright.

Equity participation schemes

- 5.7. The limit of a 3 per cent share of an equity stake in a hospital or equipment at which a consultant has practising privileges or the ability to commission tests is set at a level that is too low to encourage consultants to become engaged in the running of a hospital. A minimum stake of 10 per cent is more likely to encourage innovation while still ensuring that the equity stake does not influence referral or commissioning behaviour.
- 5.8. There is also no consideration as to whether there is a sufficient market for existing shares, should existing arrangements have to be unwound (or suitably amended) as proposed. As such, we believe that the proposed 6 month period from the final date of the order arising from the inquiry is insufficient and should be amended to a minimum of at least 12 months.

6. Publishing information on hospital and consultant performance

Design considerations

- 6.1. We agree that a single remedy should be developed to cover both consultant and hospital quality information and that hospital providers should be required to provide the relevant information to an independent information organisation. We have provided comments on the different aspects of the remedy below.

Information requirements

- 6.2. On the whole we agree with the information requirements as outlined. However, it is not clear why it is necessary to submit patient NHS number data. This raises issues around patient confidentiality and whether the patient would be identifiable. We would welcome reassurances that this will be addressed by the final design of the remedy. It should also be noted that it will not be possible to provide the NHS number for all individuals that may receive treatment, as international visitors who come to the UK will not be provided with an NHS number.
- 6.3. We agree that to make comparison between private healthcare and NHS performance data it will be necessary for the private healthcare coding system to come in to line with NHS coding procedures. This will also assist consultants in ensuring that their coding activity is consistent across their NHS and independent practice roles. We are concerned that the CC has suggested that the deadline for PMIs to move from the Clinical Coding & Schedule Development (CCSD) coding system to the OPCS system should be extended to 2019 to mitigate the costs associated with this aspect of the remedy. We believe that this may disincentivise PMIs to start to make the necessary amendments to their systems before that deadline and limit the effectiveness of this remedy until then. We would therefore recommend that the deadline for compliance to moving to OPCS coding should be brought forward to 2016 to coincide with the publication of consultant fee data. This would ensure that the information organisation is operational with consistent, easily comparable data from that date and remove the necessity for a second change later on.
- 6.4. We agree with the assessment that the information organisation should be the primary data source for patients for information about the quality of hospitals and consultants. It is essential that the decision about choice of consultant is returned to the patient and their GP and not unduly influenced by PMIs. The requirement that PMIs should include a standard clause in their communications to patients providing information about the information organisation will assist with redressing this, but the remedy should go further to ensure that once the information organisation has started publishing consultant quality and fee data, PMIs cannot direct patients to consultants of their choice.

Information organisation

- 6.5. We agree with the principles and proposed structure of the information organisation. Expanding PHIN's membership should provide a suitable organisation, as long as it is truly independent from hospital providers and PMIs and that consultant representatives have an equal role on the board of the organisation. Individual consultants and their representatives should also be able to meaningfully influence the interpretation and presentation of consultant data.
- 6.6. Consultant representatives on the information organisation should include Specialty Associations to provide advice about the interpretation and presentation of consultant data, including risk adjustment and the minimum data required to be statistically significant and

useful for patients. The BMA, as the recognised trade union and professional association for doctors, with over 80 per cent of consultants in the UK as members, should also have an active role in the organisation to ensure all doctors' interests are effectively represented.

- 6.7. The BMA has previously proposed that an independent body of insurers, providers and doctors' representatives should be set up to deal with disputes about practising privileges, PMI recognition and consultant fees when they arise. While we note that this is not the intention of the information organisation at this stage, we believe that over time the remit of the organisation could be expanded to the benefit of all participants in the market.

7. Providing consultant fee information

Modified remedy 6

- 7.1. We support the modified remedy. The BMA already encourages doctors to provide patients with a written estimate of their fee prior to a procedure. Doctors have a professional and contractual arrangement with their patients, rather than a third party and therefore it is right that they should inform patients of the charges they are likely to incur. As noted, this should be an estimate, or a range as the final cost may differ depending on a number of factors including: complexity of procedures, the possibility of unforeseen circumstances and the restrictions placed on consultants by PMIs. This is particularly important for patients with private medical insurance as the range may be dependent on the level of reimbursement available to individual subscribers and/or consultants. In addition to the content of the letters suggested by the CC, patients should also be reminded of their responsibility for meeting the consultant's fee in its entirety.
- 7.2. While we support the proposal that fee information is to be submitted to the information organisation from 2016 to assist patients decisions about consultants based on both quality and fee information, it is essential that the information is provided independently from hospital providers and PMIs. As with quality data, individual consultants and their doctor representatives should be consulted on the presentation of any data.

Effectiveness

- 7.3. We question the effectiveness of this remedy with regards to patients experiencing the benefits through lower insurance premiums. There has been no evidence that any of the savings that PMIs have made as a result of introducing fee schedules for new consultants have been passed on to patients. Bupa has reduced the level of reimbursement available for the most common procedures, while at the same time increasing subscriber premiums, therefore reducing the value of their subscriber policies. While we note that the CC has stated that this should be brought to the attention of the Advertising Standards Authority, there is patently a lack of competition between PMIs. With the absence of any remedies to address competition in the PMI market, this remedy will not have the intended effect.