

# **Private medical services**

A report on agreements and practices relating to charges  
for the supply of private medical services by NHS consultants



MONOPOLIES AND MERGERS COMMISSION

# Private medical services

A report on agreements and practices relating to charges for the supply of private medical services by NHS consultants

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<sup>1</sup>These members formed the group which was responsible for this report under the chairmanship of Mr P H Dean.

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# 1 Summary

## **Introduction**

1.1. We have been asked to investigate the supply of private medical services in the UK by medical practitioners who hold or have held appointments as consultants within the National Health Service (NHS). We refer to these services as PMS. Our inquiry does not extend to other elements of private healthcare, eg the services provided by private hospitals, or by specialists other than consultants. It is limited to agreements and practices relating to charges made or quoted for PMS.

## **The complex monopoly situation**

1.2. We find that a complex monopoly situation, within the meaning of the Fair Trading Act 1973, exists in the supply of PMS in the UK because certain consultants fix their charges by reference to either the British Medical Association (BMA) Guidelines' rates or the benefit maxima in The British United Provident Association Limited (BUPA) Table of Benefits. In 1992 about 6,600 consultants followed the BUPA benefit maxima and about 3,400 followed the BMA Guidelines. Both are treated by the consultants concerned as tariffs, and we conclude that close following of them constitutes conduct which prevents, restricts or distorts competition. We say more about the BMA Guidelines and the BUPA benefit maxima in paragraphs 1.7 and 1.11.

## **Background**

1.3. The NHS dominates healthcare in the UK. Without it private elective and acute healthcare would not exist in its present form, and it must be seen in this context. Expenditure on the NHS in 1992/93 was some £34 billion, including about £19 billion on the hospital service. Expenditure on private healthcare approached £10 billion in 1992. We estimate that £1.8 billion was spent on private elective and acute healthcare in 1992, of which consultants' charges were £550 million. The balance was the cost of private hospital and clinic services. Elective healthcare provides treatment for conditions that cause discomfort, such as hernias, haemorrhoids and varicose veins. Many consultants' private practice is concerned with conditions of this description.

1.4. Over the last decade expenditure on private elective and acute healthcare has expanded greatly, matching-and strongly influenced by-the growth of private medical insurance. About two-thirds of PMS are paid for by private medical insurers. About 40 per cent of the persons covered by insurance are individual subscribers and their dependants; the remainder are employees and their dependants, covered by employers' schemes.

1.5. Until the mid-1980s the private medical insurance market was in the hands of long-established provident associations, led by BUPA. These accounted for over 96 per cent of the market in 1985, but for under 81 per cent in 1992, commercial insurers having entered the market on a substantial scale. There is now a fiercely competitive insurance market, with a wide variety of products and much innovation.

1.6. Most private medical services are provided by consultants whose main commitment is to their NHS duties. Much private practice is undertaken outside normal working hours. The supply of consultants is controlled by NHS requirements, determined locally. In 1992 there were about 23,100 consultants within our terms of reference, of whom about 2,500 had retired from NHS or medical school employment. We concluded that about 17,100 consultants engaged in private practice in 1992, and that about 6,000 did none. Opportunities for private practice vary greatly by occupation, specialty and location. There is little private practice in the community health service and only a limited amount in medical schools. In some specialties, for example accident and emergency, there is little or no opportunity for private practice. Most private practice is concentrated in central London, the South-East and the Midlands. There is little private practice in Scotland, Wales and Northern Ireland, outside the principal cities.

1.7. We have defined the complex monopoly situation in terms of consultants fixing their charges by reference to the BMA Guidelines and BUPA benefit maxima, but these two forms of guidance have different origins and serve different purposes. The BMA is a trade union representing medical practitioners. It developed its Guidelines, first published in 1989, in response to concern expressed by its consultant members in 1985 that BUPA was holding down consultants' fees because it had not increased its benefit maxima in the three preceding years. The Guidelines were conceived and developed as a body of recommendations and we believe they are widely regarded as such by consultants, even though the BMA has disclaimed that intent. BUPA, on the other hand, sets benefit maxima to inform its policy-holders of the amounts it will reimburse for given procedures.

1.8. The market for PMS is highly imperfect. Most patients want to be treated in a local hospital. Outside London and the larger urban areas the PMS market comprises a large number of local markets in most of which the choice of consultant or hospital is limited. The patient is likely to be unwell, apprehensive, lacking in relevant knowledge and dependent on the medical profession for both advice and treatment. He will normally first see his general practitioner (GP) who may decide to refer him to a consultant. There is unlikely to be much discussion of the cost. Even when the patient reaches the consultant any discussion of charges will usually be in the context of the level of the patient's insurance cover. As most patients pay nothing directly towards the cost of treatment they have no immediate incentive to control it. It is the private medical insurers that have the greatest incentive to promote a competitive PMS market.

1.9. The background is changing rapidly. Since 1991 extensive changes have been introduced into the NHS which may have profound implications for PMS: the establishment of an internal market means that there will no longer be the same clear distinction between the private and public elements in the supply of health services. The Tomlinson Report points to the need for restructuring of London consultants' services. The training of UK consultants in a manner compatible with EC Directives has been considered in the Calman Report. Its recommendations, if implemented, are likely to mean that specialists trained within the NHS will qualify much earlier than they do at present, and that the number potentially available for private practice will increase.

## **Public interest issues**

1.10. We identify five main issues:

- (a) the effects of the BMA Guidelines and BUPA benefit maxima;
- (b) constraints on entry to and engaging in private medical practice at consultant level;
- (c) transparency of consultants' charges;
- (d) price competition between consultants; and

(e) whether consultants' remuneration for private medical services is excessive.

1.11. We draw a distinction between the following of the BMA Guidelines and the following of BUPA's benefit maxima. We find that the practice of consultants in following the BMA Guidelines is against the public interest. Publication of the BMA Guidelines has led to consultants' charges being higher than they otherwise would have been. The Guidelines represent an attempt on behalf of consultants to organize the PMS market. We also find that the practice of the BMA in publishing the Guidelines is against the public interest, and we recommend that publication should be prohibited. On the other hand we find that the setting of the BUPA benefit maxima is a legitimate step by BUPA in carrying out its functions as an insurer. Insurers must be able to inform policy-holders of the benefits they will receive if they claim for events that are covered by their policies. BUPA and the other insurers are the principal counterweight to the consultants, given the weak position of patients. The BUPA benefit maxima have had a restraining effect on consultants' charges.

1.12. It is difficult to become a consultant, and there are constraints on entry to and engaging in private medical practice. Implementation of the Calman Report may go some way to meet this problem by increasing the number of consultants and so, incidentally, increasing the number who may engage in private practice. One constraint on consultants' private practice is the GP's 'gatekeeper'<sup>1</sup> role. There are strong arguments for retaining this role and we accept that they are right. We identified other constraints, but again we thought there were good reasons for them.

1.13. Lack of transparency of consultants' charges takes two forms. First, there is a failure on the part of many consultants to provide information to patients about the likely level of their charges and to provide adequately detailed final bills. Second, many consultants fail to notify their scales of charges in advance to relevant GPs to assist them in advising their patients. Many consultants believe, mistakenly, that they are barred by the rules of the General Medical Council (GMC) from making their charges known to GPs. We welcome the assurance which the GMC has given us that it will take the earliest opportunity to clarify its rules and draw consultants' attention to the clarification. There is strong support from all quarters for openness about charges. We urge organizations representing consultants to co-operate in promoting it, perhaps by introducing a code of practice.

1.14. There is virtually no evidence of price competition among consultants, but we see no reason why its benefits should not in principle apply to private elective and acute healthcare. We understand fears that the quality of PMS might decline, but we believe price competition is not inimical to quality. Prohibition of the BMA Guidelines may help to stimulate price competition, and the recent changes introduced into the NHS may provide further stimuli.

1.15. Consultants' aggregate earnings from private practice (net of expenses) have increased substantially over the last decade. We estimate that the median earnings in 1992 of a consultant on a maximum part-time NHS contract and engaging in private practice were £42,000 from the NHS and £17,000 from private practice, net of expenses, giving a total income of £59,000 before tax. But there are extremely wide variations in private practice earnings. In 1992 about 6,000, or one-quarter, of all consultants had none and a further 2,000 earned less than £1,000. There is no exact comparator in other occupations for consultants engaging in private practice.

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<sup>1</sup>The term commonly used to describe the role exercised by a GP in deciding whether a patient should be referred to a consultant, and which consultant should be chosen.

## Overview

1.16. We found there was a marked paucity of authoritative information about consultants in private practice. We have had to make extensive enquiries of the parties concerned. This has been a substantial undertaking and we believe that the results, set out in this report, will be a valuable record.

1.17. Consultants enjoy a strong position in the private medical services market. The patient seeking PMS is vulnerable. He is usually insured and so is not greatly interested in prices. It is therefore unsurprising that we have seen no evidence of significant pressure on consultants' charges exerted by either the patient or the GP in his role as gatekeeper, and virtually no evidence of price competition between consultants.

1.18. In this situation the countervailing power of the insurers is of crucial importance. The evidence suggests that until recently they have been less than robust in using it. For over 30 years the medical insurance market was overwhelmingly dominated by BUPA, and even now it has wide influence. It is only with the significant entry of commercial insurance companies and the need to contain rising costs that competition in the insurance market has become fierce. This has encouraged all insurers to be innovative in cutting the costs of private elective and acute healthcare, and hence cutting their prices to consumers.

1.19. There is an intimate and complex relationship between the NHS and PMS. The NHS is undergoing profound changes following the introduction of the internal market, and the Calman Report may lead to further change. The achievement of fully competitive charges for PMS depends on full and fair competition between all providers of elective and acute healthcare.

1.20. Taken together we believe that the changes we have described afford the prospect that market forces will increasingly be brought to bear on consultants' charges, which are the particular focus of our inquiry. We hope this report will facilitate the process.