

11 Conclusions

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Introduction

11.1. In this inquiry we are concerned with whether a monopoly situation exists in relation to the supply of private medical services by registered medical practitioners who hold or have held appointments as consultants within the National Health Service (NHS). We refer to these services as 'PMS' and to those practitioners as 'consultants'. We refer to other registered medical practitioners at consultant level as 'specialists'.

11.2. We are limited in the inquiry to consideration of agreements and practices relating to the charges made or quoted for PMS. These consultants' charges account for about one-third of the costs of private elective and acute healthcare (see paragraph 3.23 and Table 3.2). The remaining costs arise from charges for hospital services. These are not within the scope of our inquiry although we received many representations about them.

11.3. In addition to the question raised in paragraph 11.1, we are required to report:

- (a) by virtue of which provisions of the Fair Trading Act 1973 (the Act) any monopoly situation we find is to be taken to exist;
- (b) in favour of what person or persons that monopoly situation exists;
- (c) whether any steps (by way of uncompetitive practices or otherwise) are being taken by that person or those persons for the purpose of exploiting or maintaining the monopoly situation and, if so, by what uncompetitive practices or in what other way;
- (d) whether any action or omission on the part of that person or those persons is attributable to the existence of the monopoly situation and, if so, what action or omission and in what way it is so attributable; and
- (e) whether any facts found by us in pursuance of our investigations under the preceding provisions of this paragraph operate, or may be expected to operate, against the public interest.

Our full terms of reference are set out in Annex A to Appendix 2.1. They contain more detailed definitions of 'medical practitioner' and 'private medical services'. In the course of the inquiry, two variations of the reference were made by the Director General of Fair Trading (DGFT) under section 52(1) of the Act, in order to confirm and clarify that we should investigate and report on the supply of private medical services in the UK by consultants only.

11.4. We set out our conclusions on the existence of a monopoly situation and the persons in whose favour the situation exists (questions 11.1, 11.3(a) and (b)) in paragraphs 11.26 and 11.27. Our conclusions on questions 11.3(c) to (e) are given in paragraphs 11.119, 11.121 and 11.120.

The complex monopoly situation

11.5. Under the provisions of section 7(1)(c) and (2) of the Act a complex monopoly situation is taken to exist when at least one-quarter of the supply of services of a particular description, which are supplied in the UK, are supplied by or to members of one and the same group consisting of two or more persons (not being a group of interconnected bodies corporate) who, whether voluntarily or not and whether by agreement or not, so conduct their respective affairs as in any way to prevent, restrict or distort competition in connection with the supply of these services.

Provisional conclusions

11.6. In July 1993, in our issues letters (see paragraph 11.105), we notified the BMA, BUPA, PPP, and all consultants whom we had identified as suppliers of private medical services in the UK in 1992, that provisionally we considered there to be such a group (the group), consisting of those consultants who for the private medical services which they supplied set 50 per cent or more of their charges at or within 2 per cent of the levels indicated in:

- (a) the British Medical Association (BMA) Guidelines (see paragraph 11.7(a)); or
- (b) the scales related to The British United Provident Association Limited (BUPA) Schedule of Procedures (see paragraph 11.7(b)); or
- (c) the scales related to the Private Patients Plan Group Limited (PPP) Schedule of Procedures (see paragraph 11.7(b));

together with the BMA, BUPA and PPP, all of whom so conducted their respective affairs as to prevent, restrict or distort competition in connection with the supply of private medical services. We were satisfied that the consultants who were members of the group supplied at least one-quarter by value of the private medical services supplied in the UK in 1992 (see Annex F to Appendix 2.1).

11.7. Our issues letters went on to say that the BMA, BUPA and PPP were not suppliers of private medical services but were members of the group, because:

- (a) the BMA, which represents the majority¹ of the consultants, publishes Guidelines on charges made for medical and surgical procedures; and
- (b) BUPA and PPP, in the course of providing private medical insurance, publish Schedules of Procedures classifying medical and surgical procedures in groups to each of which are related maximum amounts which they are willing to reimburse to their subscribers in respect of charges for private medical services. These Schedules and the related maximum amounts taken together were treated by certain consultants as tariffs for charges which they made for private medical services supplied by them.

¹We have since revised this estimate to 'about one-half'.

11.8. We said we were satisfied that the manner in which affairs were conducted, as described in paragraphs 11.6 and 11.7, was through 'agreements and practices relating to the charges made or quoted for private medical services by suppliers of such services ...' for the purpose of the reference (see the third paragraph of our terms of reference, in Annex A of Appendix 2.1).

11.9. We therefore provisionally concluded that a complex monopoly situation existed in relation to the supply of private medical services within the UK by consultants, and that the persons in whose favour that monopoly situation existed were the consultants identified in paragraph 11.6, together with the BMA, BUPA and PPP.

11.10. As is evident from paragraph 11.7, we took the view that membership of the group, for the purpose of section 7(2) of the Act, was not limited to the suppliers of private medical services we had identified. A similar question arose in our investigation into *Credit Card Services* and, in paragraph 7.24 of our report¹ in that case, we said:

We consider, and are advised, that section 7(1)(c) of the Act does not require that the group should consist solely of persons who supply the services. It requires only that those who supply at least a quarter of the total supply of the services shall be members of the group. This leaves the possibility that there may be others who do not themselves supply the services but are in some way closely enough connected to those who do for all of them together to be regarded as a group.

In proceedings arising from that report,² this passage was quoted by Lord Justice Dillon, giving the principal judgment of the Court of Appeal, where he stated that there was 'no justification for construing subsection 7(2) in the limited sense that each of the persons must itself individually be supplying reference services'.

Evidence supporting and qualifying the provisional conclusions

11.11. The evidence supporting our provisional conclusions was derived from the responses to two surveys of consultants that we carried out in March 1993. These surveys took the form of a postal questionnaire sent to 4,650 consultants and of interviews with a further 571. These two groups were derived from a common sample, stratified by gross earnings and specialty. A note on the sampling methodology is in Annex B to Appendix 2.1. The sample was limited to consultants who we had reason to think earned more than £1,000 from private practice in 1992.

11.12. The postal questionnaire was concerned chiefly with establishing the extent to which consultants fixed their charges, by reference to published scales, and in particular those set out in the BMA Guidelines or those related to the BUPA Schedule of Procedures or other forms of guidance. The questionnaire also sought information on consultants' gross earnings from private practice and on the expenses of that practice. These responses were grossed-up by applying ratios appropriate to the stratified sample. The initial analysis of the results (see Annex F of Appendix 2.1) indicated that in 1992:

- (a) over 3,400 consultants set 50 per cent or more of their charges at or within 2 per cent of the BMA Guidelines' figures and that their aggregated income accounted for over 19 per cent of the value of the market; and
- (b) over 6,600 consultants set 50 per cent or more of their charges at or within 2 per cent of the scale maxima³ related to the BUPA Schedule and that their aggregated income accounted for over 50 per cent of the value of the market.

¹ Cm 718, August 1989; the paragraph contained a reference back to a similar conclusion in our report on *Greyhound Racing*, Cmnd 9834, July 1986, paragraph 8.7.

² *R v Monopolies and Mergers Commission and Others, ex parte Visa International Service Association* [1991] CCLR 13, page 22.

³ We use the expression 'benefit maxima' from this point on.

Subsequently the initial analysis was refined: see Annex G of Appendix 2.1. This reinforced the provisional conclusions.

11.13. At that time we valued the 1992 market at £585 million,¹ and our survey showed that £410 million¹ of that sum represented services provided by consultants who set 50 per cent or more of their charges as described in paragraph 11.12. Analysis of the postal questionnaire in relation to PPP was still incomplete when the issues letter was despatched, but we noted that at least 283 respondents referred to PPP benefit maxima² in setting their charges for private medical services. We thought it reasonable to suppose that some consultants in this group set 50 per cent or more of their charges in this way. Subsequent to the despatch of the issues letter further analysis of consultants' responses to our postal questionnaire showed that 85 consultants fixed 50 per cent or more of their charges in 1992 at or within 2 per cent of PPP guidance. In Annex B of Appendix 2.1 we describe the grossing-up method used to derive estimates of the total number of consultants imputed by any particular number of consultants within our sample. On this basis, the 85 consultants in the sample who said that they followed PPP guidance are equivalent to less than 2 per cent of our estimate of the total number of consultants earning more than £1,000 from private practice in 1992. This figure can be compared with our estimates, in Annex G of Appendix 2.1, that the proportions of consultants following the BUPA benefit maxima and the BMA Guidelines' rates are 39.7 and 20.5 per cent respectively.

The position of BUPA

11.14. In the normal course of business an insurer needs to inform its policy-holders of the benefits they will receive if they claim for events covered by their policies. It follows that if such benefits are specific to events identified by defined medical procedures then a published list of benefits may become a form of guidance to consultants in fixing their charges and that this may prevent, restrict or distort competition. An insurer's action in publishing its benefits may also incidentally prevent, restrict or distort competition.

11.15. In response to our issues letter BUPA put legal arguments and other representations to us. BUPA said that its published benefit maxima set the 'going rate' for the consultants' charges. It argued, however, that although the consultants might choose to treat its benefit maxima as a tariff, that was not their intended purpose. And, if the consultants used the benefit maxima as the basis for their own anti-competitive conduct, that did not establish the 'close connection' (see paragraph 11.10) between the consultants and BUPA that would be necessary for BUPA's inclusion in the complex monopoly as a non-supplier. Moreover, BUPA said that its benefit maxima were pro-competitive in that they provided information to consumers which assisted their choice of insurer. BUPA submitted that, in any event, the limitation in the reference (see paragraph 11.2) precluded the treatment of conduct by BUPA as conduct of the kind mentioned in section 7(2) of the Act, and thus precluded a finding that BUPA was a member of the group (see paragraphs 11.6 and 11.7).

11.16. We accept the test of 'close connection' referred to by BUPA. We consider that its application is to be determined by us as a question of fact and degree. As we have already stated, BUPA is fully aware of the influence that its benefit maxima have on consultants' charging practices: its booklet, *A Guide to Private Consultant Practice*, says (column 1, page 15) that 'it is known, from market research conducted amongst consultants, that 85 per cent of specialists use BUPA's scales as the main influence in determining the fee levels that they charge'.

11.17. However, we have had careful regard to BUPA's argument that the use of its benefit maxima as a tariff and as a basis for anti-competitive conduct by the consultants (a point which we address in paragraph 11.25) does not in itself establish the 'close connection'. In the present circumstances we think it right to examine the question of 'close connection' separately from that of any anti-competitive effects resulting from the publication of BUPA's benefit maxima. We regard such publication as a reasonable step taken by BUPA in carrying out its functions as an insurer. The question is not straightforward, but we have concluded that, as a matter of fact and degree, BUPA's action in publishing the benefit maxima was not sufficiently

¹We subsequently revised £585 million to £550 million, and £410 million to £405 million.

²For convenience we refer to PPP's published maximum reimbursements as 'PPP benefit maxima'.

closely connected with the consultants who acted upon them for us to find that BUPA should be included within the group. We discuss the effects of BUPA's benefit maxima in paragraphs 11.121 to 11.125.

11.18. In reaching this conclusion we are not accepting the correctness of BUPA's legal argument that the limitation in the reference precluded our finding that BUPA was a member of the group (see paragraph 11.15). But in view of the nature of our finding it is unnecessary to elaborate on the point.

The position of PPP

11.19. The basis of PPP's guidance is in some respects similar to that of BUPA. The latest edition of its published Schedule of Procedures contains codes for, and descriptions of, procedures identical to those of BUPA Schedule. However, PPP's published benefit maxima, unlike BUPA's, do not separate the surgeon's from the anaesthetist's charge and have only five categories of complexity compared with 25 in BUPA's Schedule. Moreover, PPP's published benefit maxima relate to schemes covering only 15 per cent of its subscribers. Consultants' charges in respect of the other 85 per cent of subscribers are reimbursed against 'reasonable and necessary' limits. PPP argued that there was circumstantial evidence to suggest that the consultants who were identified in our survey as following PPP guidance were in fact referring to its 'reasonable and necessary' limits. The number of consultants who claimed to follow PPP guidance was consistent with the number of consultants who had had their fees limited by reference to its reasonable and necessary limits. There was no direct evidence to indicate what the consultants meant when they stated that they followed PPP guidance. We accept that the evidence we have received from the consultants is ambiguous regarding their following of PPP's published benefit maxima. Against this background, we do not consider that the evidence demonstrates, in respect of PPP, the 'close connection', to which we have referred in paragraphs 11.10 and 11.15. In consequence, we conclude that PPP is not a member of the group.

Other insurers

11.20. Three respondents to our postal survey mentioned guidance from Norwich Union Healthcare Limited (NUH), which publicly declares that it follows the BMA Guidelines. Another nine respondents mentioned 'other insurers' as a class but without identifying its members. We are not aware of any other insurers who publish their own schedules of procedures and related maximum reimbursements. We have therefore not pursued further the question of including other insurers in the complex monopoly.

The position of the BMA

11.21. In response to our issues letter the BMA did not immediately contest our view that it was a member of the provisional complex monopoly situation and that the monopoly situation was in its favour.

11.22. Subsequently we drew to the BMA's attention the legal argument advanced by BUPA that the limitation in our terms of reference restricted the complex monopoly to suppliers of private medical services (see paragraph 11.15). In response the BMA, while not commenting specifically on that argument, submitted that our pursuit of a complex monopoly inquiry was 'redundant'. Furthermore it said that it would wish to take issue with our provisional finding that the complex monopoly we had provisionally established was in favour of the BMA. In the BMA's view, it was not a party to the market in the same way as those consultants undertaking private practice or the insurance companies operating between the patient and the consultant.

11.23. We noted the BMA's views but decided that they afforded no grounds for revising our provisional conclusion. The BMA represents about one-half of the 23,100 consultants within our terms of reference. It prepared its Guidelines on charges made for medical and surgical procedures in response to the wishes of consultants within its membership, who were dissatisfied with the BUPA Table of Benefits (see paragraph 11.65). The records of the BMA's internal proceedings in the period prior to the first publication of the Guidelines in 1989 clearly show that the Guidelines' charges were intended to be recommendations. In view of the foregoing, we conclude that a sufficiently 'close connection' exists between the BMA and the consultants for the BMA to be included as a member of the group. The Guidelines, as our surveys show, are taken

by many consultants to be a tariff. In our view it follows that the BMA's action in publishing its Guidelines prevents, restricts or distorts competition in the supply of private medical services.

The position of the consultants

11.24. In response to our issues letter we received over 1,000 letters from consultants, and we took oral evidence from eight of them. We also received extensive written submissions from 21 bodies representing, in various ways, the interests of consultants, and from many other bodies concerned with the reference.

11.25. None of these representations offered any evidence to suggest that our survey results were incorrect in showing that over one-quarter of private medical services by value were provided by consultants who fixed 50 per cent or more of their charges at or within 2 per cent of the levels indicated by BUPA benefit maxima or the BMA Guidelines' rates. Some representations were made that this practice did not distort competition, but we were unable to accept these arguments. The treatment by certain consultants of BUPA's benefit maxima and the BMA Guidelines' rates as tariffs clearly distorts price competition. We also decided that in view of the ambiguity of consultants' references to PPP guidance (see paragraph 11.19) such consultants could not be regarded as members of the group. But we saw no reason to amend our view that the consultants following the BMA Guidelines and BUPA maxima were members of the group constituting the complex monopoly situation, and this conclusion was reinforced by the further analysis we had by then undertaken of consultants' responses to our postal questionnaire (see Annex G of Appendix 2.1). We established from a random sample that a substantial proportion of the consultants following the BMA Guidelines were BMA members (see Appendix 2.1).

Conclusion on the complex monopoly situation

11.26. We conclude that a complex monopoly situation exists by virtue of section 7(1)(c) and (2) of the Act in relation to the supply of private medical services, the group concerned consisting of the BMA and those consultants who for the private medical services which they supplied set 50 per cent or more of their charges at or within 2 per cent of the levels indicated in the BMA Guidelines or the benefit maxima of the Table of Benefits related to the BUPA Schedule of Procedures. They are persons who so conduct their respective affairs as to prevent, restrict or distort competition in the supply of private medical services in the UK. The consultants in the group supplied over one-quarter (and, we estimate, nearly three-quarters) of private medical services by value in the UK in 1992.

11.27. We conclude that the monopoly situation exists in favour of those consultants within the group who follow the BMA Guidelines because it assists them to command higher fees than they would enjoy if they did not set their charges in the way we have described. The monopoly situation exists in favour of the BMA because the publication of its Guidelines benefits its members and so strengthens its position as the principal body representing consultants.

11.28. The BMA Guidelines' rates are generally higher than the BUPA benefit maxima, which have themselves declined in real terms since 1991. We are persuaded by the evidence that the BUPA benefit maxima have had a restraining effect on consultants' charges. In consequence, we conclude that the monopoly situation does not exist in favour of consultants who follow the BUPA benefit maxima in setting their charges.

Background to the inquiry

The provision of healthcare in the UK

The role and size of the NHS

11.29. The NHS dominates healthcare in the UK. Without the NHS private healthcare would not exist in its present form, and private medical services must be seen in this context. Net expenditure on the NHS in 1992/93 was some £34 billion. It provides two types of service: first, the Family Health Services Authority

provides services by contracted general practitioners (GPs), dentists, other professionals and technical ancillaries; and second, the hospital and community health services in which salaried staff treat patients in hospitals and hospital out-patient departments and provide a range of services covering, amongst other things, child health, mental handicap and family planning. The NHS hospital service, which cost about £19 billion in 1992, may be compared in some respects with the elective and acute treatment element of private healthcare. Obvious differences are that most NHS hospitals provide an accident and emergency service and extensive training facilities, whereas private hospitals do not.

The role and size of private elective and acute healthcare

11.30. We estimate that expenditure on private healthcare approached £10 billion in 1992 and elective and acute care accounted for about £1.8 billion of it. Elective conditions are those that cause discomfort and require medical treatment but are not life-threatening, such as hernias, haemorrhoids and varicose veins. Many consultants' private practice is of this kind. All elective conditions can be treated in the NHS but the waiting period is often lengthy and the patient will have little choice in the selection of hospital. Acute cases vary from those which require urgent treatment but are not usually life-threatening, such as fractures, to those which demand an immediate response, such as heart attacks. Although acute cases may be treated privately the great majority are treated within the NHS, especially where intensive care is required.

11.31. There are three other relatively minor elements of private healthcare within our terms of reference: treatment of short-term acute psychiatric conditions, and drug and alcohol abuse; screening and diagnostic facilities; and fertility regulation, including termination of pregnancy. Only the last of these involves consultants to any great extent.

11.32. The remaining elements of the private healthcare market account for expenditure of about £8 billion. They are nursing and residential care services, mainly of the elderly, physically disabled and chronically ill; private dental, ophthalmic and GP services; therapists' services; and pharmaceuticals and medical equipment. Any consultant involvement in these areas is subsumed elsewhere within private medical services.

11.33. In addition there is 'Category 2 work'. Under their conditions of service consultants may undertake certain non-clinical duties for which they may charge. This work is not treated by the NHS as private practice but it falls within the definition of private medical services in our terms of reference. We estimate that it generated charges of some £30 million in 1992. Most of it entails medical examinations related to, and the preparation of, reports for insurance or legal or employment purposes. We decided not to investigate agreements or practices relating to the standard charges negotiated by the BMA which are made or quoted for many Category 2 services.

11.34. When deflated by the increase in Hospital and Community Health Services pay and other input prices, total expenditure on private elective and acute healthcare services, which is the area with which we are concerned, increased at an average rate of 7 per cent a year between 1986 and 1991 but declined by about 1 per cent in 1992. The proportion of expenditure on these services received by consultants and specialists declined from about 35 per cent in 1986 to some 33 per cent in 1992.

11.35. In considering the role and size of private medical services it should be noted that there is a marked paucity of authoritative information about consultants in private practice. We have had to make extensive enquiries among the parties concerned. All were most helpful. But it was a substantial undertaking.

Consultants' total numbers

11.36. There were about 23,100 consultants in 1992. We found it difficult to make a close estimate of how many of them engaged in private practice in that year, but we concluded that the total was not fewer than 17,100 (see Appendix 3.1).

Private hospitals

11.37. Private hospitals that have an operating theatre are called 'acute' (unless they are fertility or psychiatric clinics) to distinguish them from establishments concerned exclusively with providing nursing facilities and long-term care (which do not much involve consultants in private practice). We estimate that in January 1993 the 221 acute private hospitals accounted for about 7 per cent of total UK acute hospital beds.

11.38. Our survey of private hospitals indicated that in 1992 their total revenue was £950 million. They classified 70 per cent of their procedures as minor or intermediate, reflecting the general nature of elective surgery, their primary activity. The remainder were classified as major.¹

11.39. The survey showed that about 80 per cent of private hospitals offered fixed-price contracts covering the total costs of treatment for defined conditions. Some of these identified the surgeon's and anaesthetist's charges separately within the total price.

NHS 'pay-beds' and Trust hospitals

11.40. A 'pay-bed' is one of a specified number in an NHS hospital that may be used for the treatment of private patients, but which if not required for that purpose may be used for NHS patients. In 1991 there were about 3,000 'pay-beds' but they were occupied by private patients for only 32 per cent of the time. However, this regime is rapidly being overtaken by the freedom of NHS Trust hospitals to make available dedicated private patient units. During the last two years the number of such units has increased from 25 to 80. The Department of Health (DoH) expects 95 per cent of NHS hospitals to have acquired Trust status by April 1994. Private patient revenue received by the NHS increased from about £100 million in 1989 to some £150 million in 1992.

Private medical insurers

11.41. We estimate that about two-thirds of consultants' charges for private medical services are paid for by private medical insurers. The level of an insurer's reimbursement for a defined procedure is an important influence on the charge that a consultant makes for it. Reimbursement is usually made dependent upon the claimant having been referred to a specialist by a GP (see paragraph 11.49).

11.42. There has been substantial growth in private medical insurance since 1965 and between 11 and 12 per cent of the UK population is now covered. There was a setback in growth in 1992 and 1993 but a resumption is expected. About 39 per cent of the private medical insurance market was accounted for by individual subscribers in 1990 and 61 per cent by employers' schemes. Since then the proportion of people covered by employers' schemes has declined slightly.

11.43. During the 1970s and 1980s the private medical insurance market was developed by the long-established provident associations, led by BUPA and PPP and followed by WPA. In total, provident associations accounted for over 96 per cent of the market in 1985, but in 1992 for under 81 per cent. BUPA in particular lost a substantial share of the market as the commercial insurers entered, led by NUH, Prime Health Limited and Sun Alliance Insurance UK Ltd. But the size of the market increased greatly and BUPA's turnover increased with it. There is now fierce competition, particularly for employers' schemes. Pressure on the costs of employer-subscribers has led to the development of third party administrators which manage private medical insurance schemes on behalf of commercial insurers or companies which self-insure.

11.44. PPP and, later, the commercial insurers gained market share partly by offering lower-priced, but often more restrictive, policies than some of the provident associations. The latter have responded by offering similarly restricted policies at competitive prices.

¹For example, minor procedures included grommet insertion, dilation of cervix uteri and curettage of uterus, and manipulation of leg or large joint; intermediate procedures included surgical removal of impacted tooth, ligation of varicose veins, and haemorrhoidectomy; and major procedures included replacement of coronary arteries, hip replacement and hysterectomy.

Constraints on entry to, and engaging in, private medical practice at consultant level

NHS controls on numbers of consultants' posts

11.45. It is extremely hard for a specialist to succeed at consultant level in private practice unless he holds, or has held, a consultant post. So decisions on the total number of consultants, and the numbers in each specialty, constrain entry to the private medical services market. These numbers are not set centrally by the National Health Service Management Executive (NHSME): they are determined locally, for the most part by each District Health Authority (DHA) or hospital Trust acting on its judgment of the requirements of, and finance available from, the purchasers of its services. Demand within specialties changes more rapidly than can be readily accommodated by NHS manpower planning decisions, because of the lengthy training that every specialty requires.

Medical Royal Colleges' standards

11.46. Post-registration training for consultants ranges from four to 10 years, including two to six years of higher specialist training. Medical Royal Colleges (MedRCs) lay down the requirements for this training and play an important role in supervising and monitoring it to see that standards are maintained. At the successful conclusion of such training the appropriate MedRC will award a certificate of accreditation signifying that the trainee is, in the MedRC's opinion, a suitable person to be appointed to a consultant post. (Pathologists and psychiatrists, however, are not subject to accreditation.) But this does not automatically result in appointment to a consultant post. The statutory regulations governing these appointments (see paragraphs 4.1 to 4.4) do not stipulate that a candidate for a post should have been accredited. Appointing authorities in the NHS, however, are required to establish an Advisory Appointments Committee (AAC) before making a consultant appointment, and in England and Wales every AAC must include a MedRC assessor, so it is unusual for candidates who do not hold accreditation to be short-listed for a consultant post. We were told that appointments of such candidates were made only when there was a shortage of accredited candidates for consultants' posts. The accreditation process, reflecting as it does the training standards of the MedRCs, is a constraint on the achievement of consultant status and therefore on entry to the private medical services market.

Contractual constraints on whole-time consultants

11.47. NHS Trusts are free to negotiate terms and conditions of service with any staff whom they recruit. But staff who were in post before a Trust was formed retain their NHS terms and conditions of service, which cannot be changed unilaterally. Under those terms and conditions a consultant who has a whole-time contract may engage in private practice. But if his earnings from it exceed 10 per cent of his pay (plus any merit award) he must notify his employing authority. If, at the end of the financial year following such notification, his private practice earnings still exceed the 10 per cent limit he will be required to accept a maximum part-time contract. He may then undertake unlimited private practice, but he will lose one-eleventh of the pay, and in due course of the pension, that he would have received with a whole-time contract. If, for whatever reason, his private practice fell away, or could not be sustained, the consultant could not quickly revert to his previous whole-time status. So the 10 per cent rule acts as a constraint on a consultant extending his commitment to the private medical services market.

Medical schools' constraints on private practice by senior clinical academic staff

11.48. There are some 2,000 senior clinical academic staff in UK medical schools who hold honorary consultant posts, reflecting their work in NHS (now mainly Trust) hospitals. The Medical Committee of the Committee of Vice-Chancellors and Principals is, as a general proposition, opposed to the staff of medical schools undertaking any significant amount of private practice for personal gain. It fears this could have serious consequences for the quality and quantity of medical teaching and research. The Medical Committee, however, recognizes that its stance may need to be modified to meet local needs. This has led to a diversity

of rules. Five medical schools permit no private practice while others impose various constraints ranging from surrender of all private practice earnings to the school to the forgoing of one-tenth of school salary and surrender of one-half of the earnings. These arrangements result in varying degrees of constraint on entry to the private medical services market by senior clinical academic staff.

GPs' referral of patients to consultants

11.49. In the UK, in the normal course, GPs provide primary care for the patients for whom they are responsible and they decide whether patients should be referred elsewhere for treatment. This is known as the GPs' 'gatekeeper' role, and in exercising it a GP with a contract for service with the NHS may refer patients to consultants in private practice. It follows that it is necessary for a consultant in private practice to be known to the GPs in his locality and that they should have confidence in him. This does not present any difficulty for an established consultant starting in private practice because he will be known from referrals of the GPs' NHS patients, but it is a constraint on specialists without that supportive background.

11.50. The General Medical Council (GMC), the BMA and other representative bodies, and the DoH, favoured GP referral as a general principle, and with only a few well-recognized exceptions in practice, such as overseas patients, sufferers from AIDS or venereal disease, and others who were reluctant, or simply not prepared, to seek their GPs' advice. The chief reasons advanced in favour of GP referral were that:

- (a) a patient would not know the relative merits of consultants; nor would he know the suitability of a specialist's skills for the treatment of his self-diagnosed condition;
- (b) it was essential that the consultant should know the patient's medical history and be able to inform the GP of the course of treatment he proposed;
- (c) it was essential, within the NHS, as a management discipline; self-referral in private practice would diminish its effectiveness;
- (d) non-referral undermined the GP's responsibility for his patient; and
- (e) self-referral would lead to a waste of resources as the patient went from consultant to consultant.

11.51. Many of the 1,000 or so consultants who wrote to us in response to our issues letter did not think GP referral was detrimental to competition. A small number took the opposite view. We obtained GPs' views from responses to a postal questionnaire survey of 100 practices. The great majority favoured GP referral although many indicated that they were not entirely secure in their knowledge of relevant consultants and their charges. Insurers told us that they strongly favoured GP referral.

Rights to admit patients to private hospitals

11.52. If a consultant or specialist cannot gain patient admission rights to private hospitals it may effectively deny him entry to the private medical services market. We received several complaints about this. The decision to grant or withhold admission rights to a private hospital lies with its management, normally acting on the advice of a Medical Advisory Committee (MAC) largely drawn from senior representatives of the existing consultants at the hospital. We had some complaints about arbitrary MAC decisions. It appears, from our survey of 210 private hospitals, that most would be prepared to grant rights to any consultant, and that senior registrars with a certificate of completion of higher specialist training might not have too much difficulty. The overwhelming majority of those who responded to our issues letter did not favour any relaxation of admission rights, on the grounds that the public had every right to expect that the services offered were of the highest standard.

Insurers' rules on specialists' qualifications

11.53. We received a number of complaints from specialists about the refusal of insurers to reimburse claims in respect of their services. In general, insurers will not reimburse policy-holders for services by specialists who do not possess a certificate of higher specialist training, and at least one important insurer will reimburse only in respect of consultants' services. Since the costs of about two-thirds of all private medical services are met by insurers these limitations on specialists are important constraints on entry to the market. Insurers apply these constraints because it is in their interest, as well as that of the insured, that the private medical services which are the subject of a claim for reimbursement are of high quality. Most insurers believe that the only practicable way of ensuring this is to require, as a condition of reimbursement, that specialists should meet the standards for consultant appointments that are set by the recognized authorities.

Independent specialists

11.54. There are perhaps only 200 or so specialists wholly in private practice who have never held a consultant's post. As we have already indicated, they are not within our terms of reference.

Possible effects of changes in the organization of the NHS

The development of an internal market in the NHS

11.55. The NHS is undergoing rapid structural change, reflecting the Government's policy of promoting an 'internal market'. The element of this policy that bears most closely on the provision of PMS is the advent of Trusts, charged with managing NHS hospitals (and other NHS units) within financial limits largely determined by the flow of income from the health authorities and GP 'fund-holders' that use their services. The Trusts must meet the needs of their NHS patients, but subject to that, and to the availability of funds, they may provide dedicated private patient facilities that are likely to be highly competitive with those of private hospitals. The Trusts are obliged to retain the contractual terms of their existing NHS employees (at all levels) but they may seek to renegotiate those terms and they are free to negotiate such terms as they wish with new employees. Thus Trust managements could develop attractive new private facilities, staffed by consultants whose contracts provided incentives for them to bring all their private work within the facilities.

The Calman Report

11.56. In July 1992 the Secretary of State for Health established a Working Group under the Chairmanship of her Department's Chief Medical Officer, Dr Kenneth Calman, to consider the present UK arrangements for postgraduate medical education and the scope for further harmonization of specialist qualifications in the UK with those in the rest of the EC. This reflected the EC Commission's concern that the UK system for the recognition of other EC member states' specialist medical qualifications does not comply with the EC Medical Directives of 1975. The Working Group's report (usually known as the Calman Report) appeared in April 1993.

11.57. Its recommendations, set out in Appendix 8.2, cover a wide range of specialist training and certification matters. When we completed our inquiry the Secretary of State was still considering these recommendations but had not yet announced the Government's policy towards them. If they were accepted their primary effects would be felt in the grading structure of consultants and of specialists under training in the NHS. The effects on consultants' private practice would be secondary, and difficult to forecast. It is clear that the shortening of specialists' training periods envisaged in the recommendations, leading to the award of a UK Certificate of Completion of Specialist Training, coupled with the possible ingress of other EC member states' nationals holding corresponding (and acceptable) qualifications, could greatly increase the number of potential consultants available. That is not to say that there would necessarily be a corresponding increase in the number of consultants engaged in private practice. Much would depend on the policies adopted by the private hospitals on admission rights and by the insurers on recognition of qualifications.

However, both would have a strong incentive to take advantage of the increased availability of practitioners at consultant level.

The Tomlinson Report

11.58. In 1991 the Secretaries of State for Health and Education appointed a committee, under the chairmanship of Sir Bernard Tomlinson, to advise them on health care in inner London.

11.59. The committee's report (known as the Tomlinson Report¹) pointed to the overcapacity of the older inner London hospitals and the overstaffing at consultant level beyond that justified by existing or future service requirements or academic commitments. Implementation of the report could lead to the loss of 450 consultant posts. If the trend in the reduction in the number of patients using the inner London hospitals continues, the figure could increase to 480 posts. This has potential implications for private practice, particularly in central London.

Consultants' specialties and work patterns

11.60. Consultants' specialties are described in detail in Appendix 4.7. They can be divided broadly into nine groups: general medicine (principally general medicine, rheumatology, dermatology, geriatric medicine and paediatrics); surgery (principally general surgery, cosmetic surgery, ophthalmology, urology, and trauma and orthopaedic surgery); anaesthetics; radiology; radiotherapy; pathology (principally histopathology); obstetrics and gynaecology; psychiatry; and accident and emergency. Private practice is not a significant option for some specialties. We think there may be about 6,000 consultant posts (chiefly in the medical schools, the public health and community services and in the paediatrics, pathology, psychiatric, and accident and emergency specialties) that offer little or no opportunity for it. In other specialties, particularly in surgery, the holding of a consultant's post may open up wide prospects. But in all specialties much depends on location: the distribution over the UK of consultants in private practice is extremely uneven. There is a heavy concentration in central London, and a lesser concentration in the South-East and the Midlands. In contrast, there is little private practice in the north of England and in most of Scotland, Wales and Northern Ireland outside the principal cities.

11.61. Typically a consultant will be on the staff of an NHS district or Trust hospital. He will see his private patients in his consulting rooms, which may be at his home or in rented accommodation at a private hospital. He will usually carry out any necessary treatment of patients in a private hospital but may make use of an NHS 'pay-bed' (see paragraph 11.40). A consultant's contract permits him to be flexible in meeting his NHS commitments, but in general consultants undertake much of their private practice outside normal working hours. Many consultants in private practice have to travel for several hours a week between NHS and private hospitals and between those hospitals and consulting rooms. Apart from the risk of disruption of a consultant's NHS work, which has been the subject of some comment to us, such travelling can add substantially to his workload and is not an efficient use of his time.

Group practice

11.62. Some consultants, particularly anaesthetists and pathologists, engage in group practice. In the case of anaesthetists we received some complaints regarding their fixing of charges.

11.63. Our survey of 30 group practices (25 of them those of anaesthetists) revealed a wide variety of behaviour. Some groups have formed legal partnerships or, occasionally, companies, but most are loose associations. Some groups fix common charges which are levied by a central billing system, but in other groups members decide their own individual charges. A common feature is the designation of a member, or a secretary, to act as a single contact point for information on the availability of each member of the group, whether for private or NHS practice.

¹ *Report of the inquiry into London's health service, medical education and research*, HMSO, October 1992.

11.64. We were told that in areas where anaesthetists worked in groups it was difficult for surgeons to secure services other than from the groups. They were in a strong position to increase prices and it was difficult to negotiate with them. However, we have seen no evidence of widespread abuse and there has been no criticism of the activities of groups in other specialties.

Published guidance on consultants' charges

The BMA Guidelines

11.65. Until the early 1980s the BMA appears to have accepted without demur the provident associations' provisions for meeting consultants' fees. However, by 1985 there had been no increase in BUPA's benefit maxima for three years and there was concern among the BMA's consultant members that the provident associations were holding down consultants' fees to offset rising hospital costs. This led to a resolution being passed at the 1985 BMA Annual Representative Meeting 'that this conference believes that the BMA should publish a scale of recommended fees for private consultant work', which in turn led to the setting up of the BMA's Private Consultant Fees Working Party, whose work over the next three years resulted in the Guidelines.

11.66. The Working Party's main concerns were with procedural structure and relativities rather than fee levels. The central issue was whether to seek an acceptable variation of BUPA categorization or to adopt a 'relative values' system such as the List of Medical Services and Fees produced by the Australian Medical Association (AMA), which attributes units of value to procedures. The Working Party decided that, although a comprehensive relative values system was more complex, it was likely to raise fewer demarcation issues than a categorization system, and would allow for more sensitive adjustments to accommodate changes in surgical procedures.

11.67. The AMA approach also provided a basis for separating anaesthetists' charges from surgeons' fees. The inclusion of separate anaesthetists' fees in the first edition of the Guidelines led in 1990 to the Association of Anaesthetists discontinuing publication of its own guidance and recommending that its members follow the Guidelines.

11.68. For fee-charging purposes in Australia the unit values attached to procedures in the AMA List were expressed in Australian dollars. The exchange rate in January 1989 was 2.2 Australian dollars to the pound sterling, but for the purpose of expressing values, and hence fees, in the Guidelines the Working Party adopted parity. This approach resulted in levels of reward that were roughly double those prevailing in Australia, but yielded the remuneration the Working Party thought appropriate to the UK: it was anxious that the conversion should not lead to loss of income for consultants. No recommendation was made on the factors that might be taken into account in any periodic revision.

11.69. The Guidelines published in 1989 reflected these decisions. The 1990 and 1992 editions incorporated specific amendments suggested by individual consultants, specialty groups and health insurers, particularly in the light of new practices and procedures. More significantly, the periodic revision has taken the form of annual general increases, of 9.5 per cent in 1990, 10.5 per cent in 1991, and 5.5 per cent in 1992, reflecting the annual increases in consultants' pay recommended by the Review Body on Doctors' and Dentists' Remuneration (RBDDR), and of 2.0 per cent in 1993. (The RBDDR has refused to report in 1993 because of the Government's 1.5 per cent constraint on public sector pay.) General increases of this sort tend progressively to reduce the validity of the structure of procedural values. Moreover the application of such percentage increases does not necessarily bear any close relationship to current charging practices, although the Guidelines 'are designed to offer an "average" taking consultant private practice across the country as a whole'.

11.70. It is clear that at all times the Working Party regarded the prospective Guidelines as a body of recommendations. Nevertheless, the first edition of the Guidelines said 'it is essential to stress that this document is only to be used by practitioners as a guide'. No mention was made then, or in later editions, of 'recommendations'. However, our surveys showed that the Guidelines' rates are taken by many consultants to be a tariff.

BUPA Schedule of Procedures and Table of Benefits

11.71. BUPA publishes a Schedule of Procedures and a Table of Benefits. The Schedule categorizes procedures in five bands-Minor, Intermediate, Major, Major Plus, and Complex Major-each with five subdivisions. The Table of Benefits indicates the maximum sums that will be reimbursed for the services of the surgeon and of the anaesthetist, separately, for procedures within each of the 25 subdivisions. BUPA reminds consultants in the Notes to the Schedule that 'it is the responsibility of the medical profession to levy fees that are reasonable and customary'. BUPA told us that it tried to set benefit maxima that were fair and reasonable and to resist the upward pressure on fees which would be brought about by a consultant's close observance of BMA Guidelines. But it accepted that its benefit maxima set the 'going rate' for consultants' fees (see paragraph 11.15).

11.72. BUPA told us that its decisions on banding of procedures were taken after wide consultation. The results of consultation could, for example, be seen in:

- (a) the common use of the Office of Population Censuses and Surveys (OPCS) classification codings by BUPA, PPP and the BMA;
- (b) BUPA's use of the Australian relative values system in expanding the categorization of procedures; and
- (c) the extended discussions with the Association of Anaesthetists over BUPA's reintroduction in 1990 of separate categorization and benefit maxima for anaesthetists.

11.73. Specialists' fees represented 34 per cent of BUPA's total reimbursements in 1992. BUPA told us that it aimed to set benefit maxima at levels that did not jeopardize its financial position but ensured that the frequency and extent of its subscribers' shortfalls were kept to the minimum.

PPP Schedule of Procedures and limits to benefits

11.74. PPP classifies procedures in five categories (Minor, Intermediate, Major, Extra Major and Complex). Only 15 per cent of PPP's subscribers are covered by schemes with published benefit maxima, eg some of those within the Family Health Plan (FHP). The rest of PPP's subscribers are covered by schemes which offer 'full refund' of consultants' charges, but only within limits which PPP considers 'reasonable and necessary' (see paragraph 11.19).

11.75. PPP told us how these limits were determined, but said that they had never been published. The maximum benefits set within the FHP were based on a broad judgment of the proportion of the total number of claims that could be afforded when FHP subscription rates had been set at commercially justifiable levels to provide clients with products they would see as providing value for money.

Regional variation in consultants' charges

11.76. It was suggested to us that the practice of rate following by consultants and rate publishing by the BMA and insurers had led to a marked reduction in regional variations in consultants' charges. This was not disputed, but we were told that it was a natural corollary of having national rates of pay for consultants. Such rates tended to support the aim of uniform quality of consultants' services throughout the UK. If there were regional differences in NHS remuneration the most highly-skilled consultants would be encouraged to work in regions where the rates were highest, and this would apply by extension to private medical services. We do not find this a very convincing argument. It would be reasonable for regional variations in costs to be reflected in charges.

11.77. Comparison of procedures (and hence of procedural costs) is not at all easy but we studied detailed claims data provided by BUPA for five procedures over the years 1988 to 1992 to see whether there was any regional pattern in consultants' levels of charges.

11.78. For surgeons, the only significant difference we found was that in 1988 their charges in inner London¹ were on average 19 per cent above the average for the UK. There was also a tendency for surgeons' charges in southern and eastern areas of England to be higher than elsewhere. Between 1988 and 1992 there was a marked reduction in these regional differences. Charges in inner London fell relative to the rest of the UK and charges in regions which had had lower charges in 1988 increased to the national average. Anaesthetists' charges in 1988 in inner London were nearly 8 per cent higher than in the rest of the UK. By 1990 the differential had increased to nearly 13 per cent but by 1992 it had fallen back to 5 per cent.

11.79. The results of the study are unsurprising, since the BMA Guidelines and BUPA maxima apply nationally.

Transparency of consultants' charges

11.80. We received a number of complaints concerning the lack of transparency of consultants' charges. It was put to us that patients were rarely aware of what they would have to pay and that some consultants refused to disclose fee levels before treatment. Final bills lacked relevant information. It was frequently suggested that each consultant should publish his charges, but no useful advice was offered on how it should be done, or on how it could be done at all sensibly in large urban areas.

11.81. We think GPs might have an enhanced role in improving the transparency of consultants' charges. However, our survey of GPs suggested that they were less than well-informed about them. This is understandable, the more so since many consultants told us that they thought the GMC's rules on advertising forbade their giving their scales of charges to GPs. The GMC assured us that there was no such prohibition and that it would take the earliest opportunity to clarify its rules in this respect and to draw consultants' attention to the clarification. We welcomed this.

Consultants' earnings

Earnings from the NHS

11.82. Consultants' pay is determined (subject to the Government's approval) by the recommendations of the RBDDR; they are paid on an incremental scale applying nationally (apart from London weighting) across all specialties. An individual consultant's salary depends upon the terms of his contract: all contracts are based on the number of 'notional half days' (NHDs) to which he has committed himself. A whole-time contract is for 11 NHDs; a maximum part-time contract is for 10 NHDs. A consultant with a maximum part-time contract is 'expected to devote substantially the whole of his professional time' to his duties in the NHS. In broad terms, and subject to some qualifications, the earnings from private practice of a consultant with a whole-time contract are limited to 10 per cent of the aggregate of his salary and any distinction award but are unlimited (in so far as is consistent with his NHS commitments) for a consultant with any sort of part-time contract.

11.83. In addition to his salary, which was £37,905 to £48,945 in 1992/93 (increased to £38,475 to £49,680 from 1 April 1993), a consultant may be paid for one or (occasionally) two extra NHDs for management or clinical supervisory responsibilities. He may also receive a distinction award. In 1993 some 35 per cent of all consultants received such awards: 21 per cent received grade C awards of £9,935; 9 per cent were grade B awards of £19,875; 4 per cent were grade A awards of £34,775; and 1 per cent were grade A+ awards of £47,200.

¹ Defined by the inner London postal districts.

Earnings from Category 2 work

11.84. Contracts consultants may undertake 'Category 2' work for which they may charge fees. As we have already indicated, such activity contributed an estimated £30 million to consultants' earnings in 1992. The main beneficiaries of these fees were histopathologists, radiologists and orthopaedic surgeons.

Earnings from private practice

11.85. Our postal survey suggested that of the 17,100 consultants who engaged in private practice in 1992 about 40 received gross earnings from it of £400,000, but 2,000 received less than £1,000. Private earnings by main specialty, ranked by median gross private earnings bands, in descending order, were: plastic surgery (£50,000 to £75,000); orthopaedic surgery; ear, nose and throat surgery; urology; ophthalmics; general surgery; obstetrics and gynaecology; cardio-thoracic surgery; and anaesthetics (£20,000 to £30,000). Expenses would have reduced these earnings by about 30 per cent. As we have shown, a high proportion of consultants adhere to either the BMA Guidelines or the BUPA benefit maxima, which implies that there is little likelihood of significant variation in the level of fees charged between regions. This accords with our study of regional variations: see paragraphs 11.76 to 11.79.

11.86. Consultants' NHS pay increased by 7.8 per cent a year between 1980 and 1992, about midway between the retail price index over this period, of 6.1 per cent a year, and the All Earnings Index for non-manual workers, of 9.3 per cent a year. However, when private practice earnings are added to NHS pay, consultants' total earnings increased by 9.8 per cent a year. The increase in private practice earnings reflects both higher levels of charge and increased hours of work. By way of comparison, according to an independent survey of top salaries, the pay of executives outside the financial sector increased by 10.9 per cent a year over this period. Again this figure has not been adjusted for any increases in hours of work. It is clear that the increase in private practice earnings between 1980 and 1992 helped some of the consultants who engaged in private practice to keep up with the earnings of other occupational groups.

Consultants' implied hourly rates of remuneration

11.87. According to a survey carried out in 1989 by the Office of Manpower Economics, whole-time and maximum part-time consultants worked on average a 50-hour week for the NHS. Our interview survey showed a similar result. We also found, from that survey, that although the extremes of private practice hours were 5 and 75 per week, 92 per cent of consultants devoted not more than 25 hours per week to it. Mean weekly private practice hours were just under 9.

11.88. If we assume that a whole-time consultant has a working year of 44 weeks in the NHS, and that he works 50 hours a week, then his implied hourly NHS rate in 1992 ranged from £17 to £22. If such a consultant had one extra NHD for additional responsibilities, and a grade C distinction award, then at the maximum of the scale his implied hourly rate would be £28.70. In private practice the implied gross hourly earnings, before expenses, ranged from £60 to £195 an hour (see paragraph 7.29).

The market for private medical services

Imperfections in the market for private medical services

11.89. The market for private medical services is highly imperfect. Most patients want to be treated in a local hospital. For this reason the private medical services market may be considered (with the exception of London and a few other dense urban areas) as a series of local markets in which the choice of consultant or hospital may be limited. The patient is likely to be unwell, apprehensive, lacking in relevant knowledge, and dependent on the medical profession for both advice and treatment. In the normal course advice will first be provided by a GP who, acting as gatekeeper, may decide to refer the patient to a consultant. At this stage there is not likely to be much discussion of cost. Most private patients are insured and, in any event, the GP is not necessarily aware of the consultants' charges.

11.90. Even when the patient reaches the consultant he is unlikely to have cost in the forefront of his mind. Discussion of charges with the consultant (or more commonly his secretary) will usually be in the context of the level of the patient's insurance cover. This may bear on the choice of hospital, since hospital charges are usually about two-thirds of the total bill. Once the patient is confident that the cost of treatment will be covered by his insurance, he is likely to lose whatever interest he may have had in the price. It follows that as most patients pay nothing directly towards the cost of treatment, or only a small proportion of it, there is a lack of immediate incentive for the patient to control the cost of private medical services. A further factor reducing market pressures on consultants' fees is that they represent only about one-third of the total cost of treatment. Thus the market for consultants' services is not one in which market forces are likely to be fully effective. Nevertheless, we recognize that insurers are able to exert some downward pressure on consultants' fees by restricting the amounts they are prepared to reimburse. Many consultants told us that they were reluctant to seek to recover the resulting shortfalls from their patients.

11.91. We heard little from patients directly about these imperfections in the market. However, we were able to draw on two surveys, one of private patients and the other of subscribers to private medical insurance (see paragraphs 3.55 to 3.59). One of the surveys reported that the GP usually made the choice of consultant for the patient but that he gave a reason for his choice in only 40 per cent of cases. Both surveys found that the main reason for respondents seeking private treatment was to avoid what were feared to be lengthy NHS delays.

Demand for, and supply of, consultants

11.92. The growth of private elective and acute healthcare from the 1960s onwards brought with it a differentiation in both demand for, and supply of, specialists. Important reasons for the rapid growth in this demand between 1960 and 1990 were the growing popularity of health insurance as part of the employee remuneration package and the length of NHS waiting lists (see paragraph 11.96).

11.93. According to a study carried out on behalf of NUH the demand for health insurance was not sensitive to the level of insurance premiums (an elasticity of -0.26 was estimated).

11.94. The increased demand for private elective and acute healthcare inescapably entailed a corresponding demand for the services of consultants. It is the personal attention of the consultant (as distinct, in the NHS, from a senior registrar or registrar) that the patient seeks: it is this which is at the heart of private medical services. Moreover, private hospitals are usually small and, in contrast to the NHS, offer virtually no scope for specialists under training to work in mixed teams of different levels of skill and experience.

11.95. The supply of consultants continues to be controlled by the NHS. Its requirement is translated into supply by the arrangements for medical training: these seek to ensure that there will be an appropriate number of trainees available and that there is the capacity to produce the planned numbers of consultants in each of the specialties. The remuneration of consultants is also arranged by administrative means: pay rates are set on the advice of the RBDDR.

11.96. The demand for, and supply of, consultants are thus both arranged by administrative means. This is not intended to be a market system. Demand is not sensitive to the cost of consultants' services. Excess demand for consultants' services is reflected in extended NHS waiting lists. Patients' concerns about the length of NHS waiting lists are one of the main factors influencing the growth of private medical services.

11.97. It is difficult to estimate how much spare capacity consultants have. The wide variety of hours worked in private practice suggests that the supply constraint is still some way off.

Comparisons of consultants' earnings with those of other professionals

11.98. There is no exact basis for comparing consultants' total earnings with those of any other professional group. It is also misleading to think of consultants as an homogeneous group for this purpose: there are about 20,560 in post in NHS hospitals, the NHS community service, and medical schools, of whom we believe about 6,000 have no private practice and about 2,000 have earnings of less than £1,000. About

2,500 of the consultants who have private practice earnings have retired from the NHS or medical schools. Comparisons of consultants' earnings with those of other professional groups have to be seen in the light of this wide distribution of opportunities and earnings. Subject to this important reservation, the present median total remuneration of a maximum part-time consultant engaging in private practice would appear to be distinctly lower than that of a Queen's Counsel. Moreover, a comparison of life-time earnings (discounted back from an assumed retirement age of 65 to 18, when the choice of career is made) of such a consultant with company-employed solicitors and accountants shows that his rewards were up to 14 per cent greater than theirs when their company benefits (eg a car) were disregarded. But when those benefits were included the consultant's rewards were as much as 11 per cent lower than theirs. It is difficult to draw firm conclusions from comparisons of life-time earnings because of the uncertainty relating to the individual's valuation of his 'time preference'.

Developments in the private medical services market

11.99. The introduction of the 'internal market' into the NHS means that there will no longer be the same clear distinction between the services provided by public and private healthcare. This may result in changes to the terms and conditions of service of consultants, both in the NHS and in the private sector. It is not easy to forecast the likely effect of such changes. The first initiatives may come from Trust hospitals, which are now able to negotiate new conditions for future consultant appointments. They will have the incentive to try and win private medical services business by negotiating 'preferred provider' arrangements with insurers and consultants that may involve a lower level of charges than those current in private practice, or more efficient use of the consultants' time, or both. How far Trust hospitals will be able to progress in these areas may depend on the relative strengths of the hospitals and consultants concerned. To the extent that Trust hospitals succeed, there will be an effect on the private hospitals, which would need to respond in like fashion to avoid losing business. In this way it is possible that there may be a downward drift in the level of specialist fees in the private elective and acute healthcare sector. It also seems likely that there could be a corresponding upward pressure on pay rates for consultants within the Trust sector as a result of these changes. For as long as the RBDDR continues to disregard private practice earnings in reaching its conclusions this pressure cannot be reflected in the pay of consultants who were in post before their Trust employer was established. But given the Trusts' freedom to negotiate terms for new appointees the influence of the RBDDR may gradually diminish.

11.100. If charges for private medical services declined in real terms, and there were no increase in hospital charges, the total cost of private elective and acute healthcare would also decline. We would then expect private demand to rise, reflecting lower insurance premiums or the direct effect on the pockets of uninsured patients. There would also be some effect on the balance of demand between private medical services and the NHS.

11.101. It is too soon to say how far the demand for private medical services is likely in future to be met by Trust hospitals, or indeed, how far NHS demand might be met by private practice. The NHS and private medical services remain separate, and the terms and conditions of consultants' service in the former continue to differ markedly from what consultants look for from the latter.

11.102. If the Calman Report (see paragraphs 11.56 and 11.57) is implemented practitioners trained within the NHS system will qualify as specialists earlier than they do at present. It is not clear what the effect of this will be on the structure and numbers of the consultant body. But it seems likely that there will be a larger number of practitioners holding a certificate of higher specialist training available for work in both the NHS and in the private sector. Patients in the NHS may thus receive more attention from practitioners at consultant level than hitherto. The increase in supply of such practitioners may also mean a fall in the level of consultants' fees in private practice, and again a small corresponding increase in the volume of services provided. Much will depend on the attitude of the insurers and the private hospital groups to these specialists in terms of recognition of qualifications and admission rights respectively.

11.103. Given the increased competition between insurers we believe they are likely to seize every opportunity to reduce costs. There are already signs that preferred provider and managed care arrangements will be pursued with increasing vigour in future.

The public interest issues

The issues letters

11.104. In our issues letter we said that we had found a provisional complex monopoly situation on the basis of a sample of consultants. But it was impracticable for us to identify all the consultants who might materially be affected by our ultimate findings. There was a further problem that there was no representative body, nor any group of such bodies, that had all the consultants as members. We accordingly decided that all the consultants we knew to have engaged in private practice in 1992 should be told of the issues arising from our inquiry and given an opportunity to let us have their comments. We did not, however, think it reasonable to burden them with the large amount of background information which customarily accompanies the MMC's issues letters. They were simply told of the provisional monopoly finding, the issues and the possible remedies and given the opportunity to ask for the full statement. On this basis we sent some 16,700 short issues letters to consultants and specialists engaged in private practice and about 170 full statements to bodies representing them, to NHS bodies, to insurers, to private hospitals, to the GMC, to the MedRCS, to medical schools and to consultants who requested it in response to the short issues letter.

11.105. The issues and remedies set out in the issues letter are reproduced in Annex 2 to Annex E of Appendix 2.1.

The main issues

11.106. There was a voluminous response to our letters, including over 1,000 replies from individual consultants (see paragraphs 9.2 to 9.11). In addition we took evidence from consultants at eight hearings.

11.107. The following main issues emerged:

- (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 PMS is excessive.

The effects of the BMA Guidelines and BUPA benefit maxima

11.108. BUPA has published a Schedule of Procedures and Table of Benefits for many years (see paragraphs 5.16 to 5.19). The BMA Guidelines first appeared in September 1989. Since 1989 both have based their procedure codings on the coding structure devised by the OPCS, but they have each made many detailed changes to their schedules, so that it was often difficult, and sometimes impossible, for us to be sure that charging data could be unambiguously correlated from year to year. This has made the determination of the effects of the BMA Guidelines and the BUPA benefit maxima far from straightforward.

The BMA Guidelines

11.109. The BMA prepared the Guidelines in response to the concern of its consultant members that BUPA was seeking to hold down consultants' fees to offset rising hospital costs. It may be inferred that the expectation of the BMA's members was that the existence of the Guidelines would enable consultants to increase their fees beyond the levels laid down by the provident associations, particularly BUPA and PPP, which between them had over 80 per cent of the insured market in the mid-1980s. Despite the BMA's contention to the contrary to the OFT we are clear that the Guidelines were intended, and have in practice been taken, as a body of recommendations.

11.110. As would be expected from a trade union looking after the interests of its consultant members, the BMA was anxious that its decision to adopt a 'relative values' system such as that produced by the AMA should not lead to loss of income for those members. For this reason its approach in 1989 to converting the unit values attached to procedures in the AMA List was to assume parity between the pound sterling and the Australian dollar, thus achieving roughly double the Australian levels of reward. Thus the Guidelines' levels of fees roughly reflected the BMA's understanding of UK consultants' levels of reward at that time. There have since been four general adjustments, reflecting the annual increases in consultants' pay. Our surveys showed that the Guidelines' rates are taken by many consultants to be a tariff.

11.111. The BMA and many of the consultants who gave evidence to us saw the Guidelines as an important counterbalance to BUPA's market power as the leading insurer. They also suggested, not entirely consistently, that prohibition of the Guidelines would be more likely to increase consultants' charges than reduce them. In the BMA's view the Guidelines assisted the patient and restrained consultants who charged unreasonable fees.

11.112. The evidence of those insurers who publish their commitment to reimburse their subscribers at BMA rates was mixed. Western Provident Association Ltd (WPA) told us that it strongly supported the continued publication of the Guidelines. It accepted them 'as a general professional consensus upon which to determine the maximum benefit'. It believed the Guidelines had been helpful in controlling some excessive charges, but said that there was growing evidence that procedures were overvalued and that income from private practice might be too high. However, WPA thought that on balance prohibition of the Guidelines would be likely to result in an increase in consultants' charges. It also said that projection of its costs would be more difficult in the absence of the Guidelines. Production of its own scales would be onerous, bearing in mind particularly that the frequent advances in medical techniques and procedures required a continual process of updating.

11.113. NUH, which also follows the BMA Guidelines, referred to its survey in 1992 of average earnings of specialists (see paragraph 10.381). It said that it remained its concern 'that the level at which the BMA (and others') rates are set offers the prospect of earnings at sixfold the level which is accepted by the profession for NHS consultant pay'. Another survey it had commissioned had found that the surgeon's charge for one procedure, and the surgeon's and anaesthetist's charges for another, were the only instances where the differential between the BMA rates and BUPA benefit maxima was sufficiently wide to allow the effect of the BMA rates to be clearly observed. There was good evidence that the BMA rates significantly affected price-setting behaviour, and that rates tended to become objectives, not maxima. NUH concluded that the BMA Guidelines had tended to restrict competition and raise prices against the public interest.

11.114. Only one of the other insurers committed to reimbursement at the BMA Guidelines' rates objected to the prohibition of the Guidelines; the rest offered no opinion.

11.115. BUPA told us that the BMA Guidelines represented an attempt by the providers of PMS to raise prices to a level that was higher than would otherwise be the case. BUPA argued that the rate of inflation of the Guidelines had been considerably in excess of its own benefit maxima. Our calculations suggest that the BMA Guidelines increased by some 9.6 per cent per annum between 1989 and 1992 whilst BUPA's benefit maxima grew by 6.3 per cent per annum and the RPI by 6.3 per cent per annum (see Table 6.1). BUPA told us that if it had set its benefit maxima at the Guidelines' rates in 1992 the extra cost would have been almost £25 million (or 8.5 per cent). Its calculations confirm the fact that the Guidelines' figures are now generally higher than the BUPA maxima.

11.116. We noted also that in 1992 the BMA Guidelines' charges for surgeons were on average some 9 per cent higher than the corresponding BUPA maxima, and those for anaesthetists were about 11 per cent higher (again see Table 6.1).

11.117. BUPA also argued that the BMA Guidelines' levels, being in general higher than the BUPA maxima, exerted a 'magnetic' effect on consultants' charges. This is similar to the view of NUH.

11.118. The statistical evidence is difficult to interpret and provides only weak support for such a contention, but the *a priori* arguments are persuasive that the publication of the BMA Guidelines has led to charges being higher than they would otherwise have been. BMA members who enter the PMS market may feel under pressure to adopt the Guidelines because they are there. In the absence of the Guidelines claims would tend to be lower because of greater convergence around the (lower) BUPA benefit maxima.

The effects of the BMA Guidelines: public interest conclusions

11.119. We have examined the effect on the public interest of the BMA Guidelines, both as regards the consultants who followed them and the BMA. We have done so in terms of the approach required by the Act and the specific questions which we are required to answer (see paragraph 11.3). For the sake of clarity we defer to a later stage (paragraphs 11.150 to 11.157) the detailed legal reasoning leading to our conclusions. We confine ourselves at this stage to setting out these conclusions so far as they relate to the public interest.

11.120. These conclusions are:

- (a) With regard to consultants who follow the BMA Guidelines, we have identified a fact which operates and may be expected to operate against the public interest, by reason of the particular effect adverse to the public interest that the following of the Guidelines enables the consultants to charge fees for private medical services higher than they would otherwise have been.
- (b) With regard to the BMA, we have identified a fact which operates and may be expected to operate against the public interest, by reason of the particular effect adverse to the public interest that the publication of the Guidelines enables consultants who follow them to charge fees for private medical services higher than they would otherwise have been.

Insurers' benefit maxima

11.121. BUPA is the largest UK private medical insurer: in 1992 it had a market share of about 44 per cent, based on subscription income. It has argued that its benefit maxima are pro-competitive in that they provide information to consumers which assists their choice of insurer. It has accepted, however, that in practice its maxima set the 'going rate' for consultants' charges. In fact PPP, the second largest private medical insurer (with a 1992 market share of some 28 per cent based on subscription income) thinks the effect of this is such that publication of the BUPA benefit maxima should be prohibited together with the Guidelines. PPP also publishes benefit maxima, but they are applicable to only about 15 per cent of its business and we found that they had a very limited influence (see paragraph 11.19).

11.122. NUH, a relatively new entrant to the private medical insurance market, recognized that the arguments it had deployed against publication of the BMA Guidelines could be applied to the BUPA benefit maxima (since the latter, as BUPA conceded, also became targets). However, NUH advanced the compelling argument that insurers had 'to publish the terms on which they undertake to reimburse policy holders, in return for the premiums they take'.

11.123. We believe that a distinction should be drawn between insurers' benefits, the publication of which we accept is a proper step for the carrying out of their functions as insurers, and the BMA Guidelines, which are designed to help organize the market. In common with other medical insurers, BUPA has developed its business on the basis of specific procedural reimbursements, which is the type of medical insurance most consumers desire. It is clear that insurers do not want to change this regime to one of coverage for an overall sum, which they see as commercially much less attractive.

11.124. The system of specific procedural reimbursement leads to insurers' benefit maxima being taken as a tariff. This restricts competition. We considered carefully whether there would be a balance of advantage to the public interest if this system were replaced by a maximum indemnity limit for all claims, providing overall cover on the analogy of a simple house contents policy. We decided we would not be justified in proposing the abandonment of the system preferred by most consumers.

11.125. There is strong competition in the private medical insurance market, particularly in the provision of employers' schemes, and BUPA itself has incurred a substantial loss of market share over the last few years, although not a loss of turnover. We do not think that BUPA is able now to dominate this market in the way that it did until the later 1980s. Neither does it have the market power to use its strength in a predatory way against competing insurers. Nor do we think that it can, through the publication of its benefit maxima, impose on consultants an unreasonable level of remuneration, though its benefit maxima have had a restraining effect on their charges. Given the weak bargaining position of patients and the comparatively strong position of many consultants each within his own area in negotiating with both hospitals and insurers, we expect that consultants would be able to resist any attempts by insurers-and even an insurer of the size of BUPA-to reduce their charges below a competitive market level. While, therefore, the setting of benefit maxima does have a restrictive effect, we are satisfied that it provides a safeguard against overcharging by consultants but does not, and is not likely to, unreasonably depress their charges.

Constraints on entry to, and engaging in, private medical practice at consultant level

11.126. We described constraints on entry to, and engaging in, private medical practice at consultant level in paragraphs 11.45 to 11.53.

11.127. The controls on the number of consultant posts (see paragraph 11.45) are clearly an administrative necessity. There could be no question of increasing that number merely to increase the numbers of consultants likely to engage in private practice.

11.128. Demanding qualifications are required for appointment to a consultant post. A certificate of higher specialist training is not sufficient on its own. Appointment usually depends on accreditation by the relevant MedRC, after meeting its exacting training standards. We note that these standards may be affected if the recommendations of the Calman Report are implemented.

11.129. The contractual constraints imposed by the NHS on the private practice earnings of a consultant with a whole-time contract seem to us to be reasonable.

11.130. A consultant starting in private practice a couple of years after appointment is likely to be known to GPs from referrals of his NHS patients, but a specialist without that supportive background suffers a severe constraint. The great bulk of the evidence we received on the GPs' gate-keeper role favoured its continuation. We see no grounds for dissenting from this (see paragraphs 11.49 to 11.51). We are satisfied that the gatekeeper system makes a valuable contribution to the care of the patient.

11.131. Gaining admission rights to private hospitals is an important factor in establishing private practice. However, the overwhelming majority of respondents to our issues letter did not favour any relaxation of admission rights, on quality grounds. It is quite possible that from time to time an MAC may behave unreasonably about admission rights to private hospitals, but we have seen no evidence that this is a significant problem. Such behaviour would not be in the interests of the hospitals concerned and we were assured that they would take any necessary corrective action.

11.132. Recognition by insurers is crucial to the success of most private practice. In general, insurers will not reimburse policy-holders for services by a specialist who is not a holder or a former holder of a consultant post, or who does not possess a certificate of higher specialist training. It is reasonable for insurers to believe that the only practicable way of ensuring high-quality services is to reimburse their subscribers only for the services of specialists, and to stipulate that those specialists should meet the standards set by the recognized authorities.

11.133. Entry to private practice at consultant level is clearly not easy. The shortening of specialists' training periods envisaged in the Calman Report may help to meet the problem by increasing the potential availability of consultants for private practice. As we have said, too, much will depend on the attitudes of the private hospitals and the insurers.

11.134. A subsidiary constraint on entry to private practice was drawn to our attention: medical schools' rules concerning senior academic clinical staff. These rules are diverse, ranging from a total ban on private practice to constraints such as surrender of all private practice earnings or the forgoing of one-tenth of school salary and surrender of one-half of private practice earnings. These restrictions reflect the medical schools' fears that unlimited private practice could have serious consequences for the maintenance of academic excellence. The primary tasks of the medical schools' senior academic clinical staff are teaching, research and NHS clinical practice. We think the schools are justified in restricting private practice according to their circumstances and needs.

Lack of transparency of consultants' charges

11.135. We noted considerable concern about the lack of transparency of many consultants' charges. This has two aspects: first, the consultant's provision of information to patients about the likely level of his charges before treatment commences, and his subsequent provision of adequately detailed bills; and second, the consultant making known his scale of charges to relevant GPs to assist them in advising their patients.

11.136. As to the first aspect, practice varied from provision of a written estimate to oral communication by the consultant, or the consultant's secretary, of the likely level of charge and the extent to which it would be covered by the patient's insurance. We had complaints that the final bill often lacked relevant detail and our survey of GPs indicated that many of them were uncertain about consultants' charges. There was strong support from all quarters for consultants to be open about their charges. But several consultants pointed to the difficulty of providing an estimate of their charges when they first saw a patient.

11.137. As to the second aspect, many consultants believed—quite mistakenly—that they were barred by the GMC's rules on advertising from making their charges known to GPs. The GMC has agreed to make the position clear at the earliest opportunity. We welcome this. Greater openness about charges should help to bring market forces into play.

Price competition between consultants

11.138. It is clear from the evidence we have received that many consultants find price competition distasteful, even unethical. However, they believed that they competed by means of their reputation, and we accept this.

11.139. Within the NHS all consultants are paid—London weighting apart—on a common scale, supplemented for some by distinction awards and payments for additional responsibilities. The longstanding purpose of the common scale is to ensure an even spread of highly-qualified consultants throughout the UK. There is also a tendency for consultants providing private medical services to be paid much the same fees irrespective of location or level of skill. This is unlikely to encourage price competition. We can see no reason why the benefits of competition, particularly price competition, should not in principle apply to private elective and acute healthcare as much as to other markets. We understand fears that the quality of PMS might decline, but we believe price competition is not inimical to quality. The benefits we should expect to flow from such competition include improved quality, innovation, promotion of efficiency, economies of scale and useful price differentiation. Prohibition of the BMA Guidelines may help to stimulate price competition. The more active role of Trust hospitals in promoting the provision of PMS and the development of preferred provider services and managed care may provide further stimuli.

Whether consultants' remuneration for private medical services is excessive

11.140. Our inquiry is concerned with agreements and practices relating to charges made or quoted for PMS. We have made no attempt to assess whether any particular charge is too high: that must entail technical judgments we are not qualified to undertake. But one way to judge the reasonableness of charges is to look at the earnings derived from them. Evidence about such earnings must be interpreted with care because of the intimate and complex relationship between the NHS and private elective and acute healthcare. Consultants' earnings need therefore to be considered in their totality.

11.141. In aggregate, and on average, consultants in post who engaged in private practice derived about three-quarters of their gross earnings from the NHS in 1992 and one-quarter (net of expenses) from private work. We estimate that the median earnings of a consultant on a maximum part-time contract in that year were £42,000 from the NHS and £17,000 from private practice, net of expenses, giving a combined income of £59,000 before tax. But there are wide variations in private practice earnings: we estimate that about 6,000 consultants within our terms of reference had none in 1992 and another 2,000 earned less than £1,000 in that year. It must be noted, too, that about 2,500 of the consultants who engaged in private practice in 1992 had retired from the NHS or medical schools.

11.142. In a competitive market remuneration would be kept in line in the medium to long term with that of comparable occupations by changes in demand or supply being reflected in price changes. Thus shortages would lead to substantial increases in remuneration, attracting new entrants to the group; and an excess supply would have the opposite effect. This market mechanism would ensure that, in the longer term at least, earnings were not too low. By contrast in elective and acute healthcare within the NHS there is no standard mechanism to prevent prices going too high. Indeed it has not hitherto operated as a market: the NHS planning system has determined demand and supply. The supply of consultants is determined by the requirements of the NHS and it is not possible for this supply to be increased merely because more medical practitioners would like to become consultants (or indeed because more young people would like to become medical practitioners and then consultants).

11.143. There was a rapid increase in the 1980s in the aggregate earnings of consultants in private practice. However, because of constraints on public sector pay that are of general application, over the period as a whole the rate of increase of consultants' total earnings has not kept pace with that of senior executives.

11.144. The implied hourly rates of consultants in private practice are generally much higher than those implied in the NHS. The median gross earnings of consultants engaged in private practice in 1992 varied from £195 per hour for orthopaedic surgeons to £60 for psychiatrists. By contrast, we estimated that a consultant with a maximum part-time contract and a C level distinction award, who was at the top point of his pay scale, would be paid about £25 per hour for his NHS work.

11.145. A direct comparison cannot be made between the rates of reward in the two sectors for reasons on both the demand and supply side. The functions carried out by consultants differ between the sectors and the private sector is dependent on the NHS for the provision of many services and the training and experience provided within its hospitals. The NHS provides the core of a consultant's employment; it requires his time in the standard hours of the working week; it generates opportunities for gaining further technical and professional knowledge; and it confers security. By contrast a consultant's private work, although lucrative, is essentially an ancillary activity; it is relatively unpredictable; much of it is undertaken largely outside the standard working week; it comprises mainly routine operations; and it generates substantial expenses: 28 per cent on average.

11.146. There are no significant pressures on private practice charges exerted by either the GP or the patient at the time when treatment is contemplated or chosen, and the only pressures that are at all effective are those of the insurers. There are two reasons for thinking that, for at least much of the 1980s, the insurers have not been very effective in exerting these pressures. First, there was for many years before then little competition in the insurance market, which was dominated by BUPA. It is only in more recent years that competitors have taken significant market share. Second, for several years of the 1980s demand for health insurance was increasing rapidly, reflecting a much greater interest in private elective and acute healthcare, and this is likely to have reduced the pressure on insurers, and BUPA in particular, to take on the difficult task of reducing the cost of consultants.

11.147. In these circumstances it may be seen as predictable that in the 1990s, with greater competition in the insurance market and stagnation in demand, the insurers, especially BUPA, have become more active in seeking to cut costs, and hence, as described in paragraph 6.6, that benefit maxima have been somewhat reduced in real terms. The reduction in benefit maxima may have some way further to go, assisted by the market-oriented changes in the NHS and the implementation of the Calman Report. But this is likely to be a long-term process.

Other issues

The fixing of common charges by groups of consultants

11.148. We received complaints about the activities of groups of anaesthetists regarding the fixing of charges, but our survey did not reveal any widespread abuse (see paragraphs 11.62 to 11.64). We recognize that some groups of anaesthetists may have a monopoly of local anaesthetists' services. Should any group abuse its position it would, in our view, be a suitable matter for investigation by the DGFT under the Competition Act 1980.

Charging discrimination in favour of uninsured patients

11.149. Many consultants waive or reduce their fees when they provide private medical services for colleagues and their families, or in cases of hardship: this is quite reasonable and was not a subject of complaint.

Detailed legal reasoning

11.150. We have completed our substantive consideration of the public interest. Before going on to consider the question of remedies for the adverse effects we have identified, we now turn (see paragraph 11.119) to our detailed reasoning on the remaining statutory questions (see paragraph 11.3) which we have to consider. It may be helpful if we set them out afresh. They are:

- (a) whether any steps (by way of uncompetitive practices or otherwise) are being taken by the consultants who follow the BMA Guidelines, and by the BMA, for the purpose of exploiting or maintaining the monopoly situation and if so, by what uncompetitive practices or in what other way;
- (b) whether any action or omission on the part of ... those persons is attributable to the existence of the monopoly situation and, if so, what action or omission and in what way it is so attributable; and
- (c) whether any facts found by us in pursuance of our investigations ... operate, or may be expected to operate, against the public interest.

11.151. We have taken account of the formulation, in our recent report on the supply of gas (the Gas report),¹ on the distinction between 'steps' and 'actions or omissions' in section 48(c) and (d) of the Act, ie that 'steps' (see paragraph 11.3(c)) are 'identifiable only where the person concerned ... is taking them for the purpose mentioned (exploiting or maintaining the monopoly situation)' whereas it is sufficient, for the identification of an 'action or omission' (see paragraph 11.3(d)), if it is attributable to the monopoly situation, no purpose having necessarily to be shown.

11.152. We have found no 'steps' being taken by consultants, who follow the BMA Guidelines, for the purpose of exploiting or maintaining the monopoly situation. We have considered whether there has been any 'action or omission' on the part of these consultants and we give our conclusions below.

11.153. We have first considered the practice, on the part of consultants, of following the BMA Guidelines. In this connection we have found no such 'omission' but consider that the practice constitutes such an 'action' (ie by each consultant who follows it). We have found (eg paragraph 11.25) that in doing so the consultants treat the BMA Guidelines as a tariff. This seems to us to be a consequence of the monopoly situation since the consultants in whose favour the situation exists form a substantial body both numerically and in terms of the value of services represented (see paragraph 11.12). To express it another way, the ability

¹Gas, Cm 2314, August 1993, paragraph 2.57 of Volume 1.

of so numerous a body of suppliers of services to apply the BMA Guidelines in this way seems to us inseparable from the situation which we have found to exist in respect of the services so supplied.

11.154. We next have to consider whether the action which we have identified in paragraph 11.153 constitutes a fact which operates or may be expected to operate against the public interest. As we have already indicated (see paragraph 11.120(a)), we conclude that this is the case, by reason of the particular effect adverse to the public interest which we believe to be that the following of the BMA Guidelines, by the consultants, enables them to charge fees for private medical services higher than they would have been otherwise.

11.155. Having considered the effect of the BMA Guidelines on consultants' charges we have also considered the effect of the BMA Guidelines as regards the BMA itself. In publishing the Guidelines, the BMA was acting in response to the wishes of consultants within its membership for recommendations on the level of fees which they should charge (see paragraph 11.65). We consider that the BMA's conduct in publishing the Guidelines, in the sense not only of their original publication but of their remaining in being, is an action attributable to the monopoly situation. We have indicated, in paragraph 11.153, that the following by the consultants of the Guidelines is so attributable. Consequently, the continuing publication, in the sense mentioned above, of the Guidelines may reasonably be regarded as a continuing response to the wishes of members who in fact follow them. Accordingly, this conduct is likely to continue. It involves (whether by members or non-members who in fact follow the Guidelines) conduct which is, we believe, dependent on the monopoly situation. There seems therefore to be the necessary element of attribution. We have, however, found no omission on the part of the BMA attributable to the existence of the monopoly situation, nor any steps which are being taken by the BMA for the purpose of exploiting or maintaining the monopoly situation.

11.156. We next have to consider whether the action which we have identified in paragraph 11.155 constitutes a fact which operates or may be expected to operate against the public interest. As we have already indicated, we conclude that this is the case, by reason of the particular effect adverse to the public interest which we believe the publication by the BMA of its Guidelines involves, namely that it enables consultants who follow the Guidelines to charge fees for private medical services that are higher than they would have been otherwise.

11.157. We should add that, if this were a course open to us, we would identify the conduct of the consultants (paragraph 11.153) and the BMA (paragraph 11.155) as constituting facts which operate and may be expected to operate against the public interest, irrespective of their separate identification as 'actions' within the meaning of the Act. In this connection we have taken account of, and adopt the reasoning set out in, the Gas report.¹ Having regard to this, we believe we have correctly identified as actions, and as facts found in pursuance of our investigation which operate or may be expected to operate against the public interest, the conduct referred to in paragraphs 11.153 and 11.155, and that independently of those findings they are facts so found by us which so operate and may be expected to so operate.

Recommendations and proposals

11.158. Having identified particular effects adverse to the public interest concerning the conduct of the BMA and some consultants, we have to consider what action (if any) should be taken to remedy or prevent these effects.

¹The relevant paragraphs are 2.58, 2.59, 2.67 and 2.68. Paragraph 2.58 refers to the question of whether it is open to the MMC to make an adverse public interest finding unless this is based on a fact found by the MMC in direct answer to a question specified in section 48 of the Act (for example, whether there is an action attributable to the monopoly situation). We understand that this has now been considered by the Court of Appeal, in the proceedings mentioned in that paragraph, but the Court's judgment has been reserved and there is no present indication of when it will be delivered.

11.159. In our consideration of this matter we have been conscious of the fact that there is little competition between consultants in the setting of their fees. It was put to us by the BMA and many consultants that there was a danger that prohibition of the publication of the BMA Guidelines could lead to an increase in charges.

11.160. However, most of the leading insurers favoured prohibition. They said that although the influence of the BMA Guidelines could not be expected to disappear rapidly, prohibition could be expected to lead to a lower average price for consultants' services. On balance we incline to this view. The Guidelines are in their nature anti-competitive and reduce the willingness of consultants to accept lower fees; they represent an attempt on behalf of consultants to organize the PMS market.

11.161. We see no merit in the BMA continuing to publish its schedule of procedures but without any indication of monetary values. We have received no evidence to persuade us that the publication of an extensive statement of the relative values of procedures has any purpose other than to provide a basis for consultants' charges, so that the statement can be used directly as a tariff.

11.162. We believe that the balance of advantage to the public interest lies in prohibition of publication of the BMA Guidelines and that this advantage would be reinforced by improved transparency in consultants' charges. We therefore recommend that with a view to remedying the adverse effects identified in relation both to consultants and the BMA, the BMA should be prohibited from publishing its Guidelines, and from publishing similar guidance in the future.

11.163. We considered, as a further remedy to the adverse effect of the publication of the BMA Guidelines, whether consultants should be prohibited from fixing their charges by reference to them. We concluded that such a recommendation would not be sensible, nor indeed practicable in view of the number and the dispersion of the persons involved, and consequently the difficulty of ensuring compliance with the requirement.

11.164. We believe consultants should make their charges known to their patients at the earliest sensible opportunity; they should make their charges transparent by showing the elements that make up what would otherwise appear only as aggregate charges; and they should make their charges known to relevant GPs. But arrangements for disseminating information on consultants' charges and for promoting transparency are likely to be successful only if they have the full backing of consultants and GPs. We urge all the bodies representing the interests concerned to co-operate in promoting transparency in consultants' charges, perhaps by agreeing on the terms of a code of practice.

Overview

11.165. We have noted that consultants enjoy a strong position in the private medical services market which, apart from a few dense urban areas, may be considered as a series of local markets where choice of either consultant or hospital may be limited. The patient seeking PMS is vulnerable. He depends on the medical profession for both advice and treatment, but he is usually insured and for that reason not greatly interested in prices. It is therefore not surprising that we have seen no evidence of significant pressure on consultants' charges exerted by the patient and virtually no evidence of price competition between consultants.

11.166. We have drawn attention to the intimate and complex relationship between the NHS and PMS. The bulk of private practice is carried out by consultants, much of it outside normal working hours. Private medical services have grown rapidly in recent years and can make substantial demands on consultants' time, but only a small minority of the consultants we interviewed said that they had any difficulty in meeting both NHS and private practice demands.

11.167. The NHS is undergoing profound changes following the introduction of the internal market. The Calman Report's recommendations, covering a wide range of training and certification matters, are likely if implemented to add to these changes and so increase the number of potential consultants who, incidentally, may be available for work in the private sector.

11.168. In a situation where there is little pressure on charges by the purchaser, the countervailing power of the insurers is of crucial importance. The evidence suggests that until recently the insurers have been less than robust in exercising it. For over 30 years there was little competition in a medical insurance market overwhelmingly dominated by BUPA. It is only with the significant entry of commercial insurance companies and the need to contain rising costs that competition 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.

11.169. The achievement of fully competitive PMS charges depends on full and fair competition between all providers of elective and acute healthcare. Taken together we believe the changes we have described afford the prospect that market forces will increasingly be brought to bear on practices and agreements relating to PMS, which are the particular focus of this inquiry. Our proposals are intended to facilitate this process.

P H DEAN (*Chairman*)

A FERRY

N F MATTHEWS

A P L MINFORD

J D MONTGOMERY

A J NIEDUSZYNSKI (*Secretary*)

7 December 1993