Confidential

Public and Private Healthcare – Challenges for sustainability in the post-COVID era

Overview

1. The study would review the current market and regulatory climate for the provision of healthcare in the UK, with a focus on the relationship between the public and private sectors. It is important to take into account key aspects, including consumer choice, financial viability, quality, the role of insurance companies and interactions with the NHS. The aim is to sensitivity test potential future funding models that would tackle the range of issues, many of which have been given added imperative by the effect of the outbreak of COVID-19 on NHS waiting lists

Current market and regulatory context

2. Some aspects of private healthcare provision, including hospital providers and consultants, were the subject of a market investigation reference (MIR) in the UK by the now Competition and Markets Authority (2012-2014). The role of the private medical insurers was not formally referred or mandated by the Office of Fair Trading in the brief to the Competition Commission (the forerunner of the CMA). The CMA's final report concluded that certain features of the markets for privately-funded healthcare services led to adverse effects on competition. The CMA introduced a number of remedies, including transparency remedies about private hospitals' performance for patients and reducing incentives offered to referring clinicians. The CMA also required HCA International (HCA) to divest one or two of its London hospitals. However, this aspect of the report was challenged successfully in the Competition Appeal Tribunal. A separate challenge was lodged by the Federation of Independent Practitioner Organisations (FIPO) in relation to the requirement for consultants to publish fee information, in view of the fact that private medical insurance companies were already potentially price fixing. Despite a dissenting report from one of the judges, FIPO's approved challenge in the Court of Appeal failed. The Fee Remedy is now in the process of being implemented but there has been reluctance by some consultants to publish this data. The other remedy to affect consultants was the requirement to provide clinical outcomes data. At present, only about 20% of consultants have validated their data because of difficulties in ensuring reliability and accuracy of the data.

3. The CMA identified a number of competition and consumer welfare concerns, which might be potentially problematic if they were "*extensively and rigidly applied*". Since

the final report, the subsequent behaviour of all the major insurance companies has led to worsening of these competition and consumer welfare concerns. Consultants have attempted to have the issues subsequently reviewed by the CMA and the FCA, using a variety of legal tools (market study, MIR and a super-complaint). These attempts have met administrative priority objections. However, while the original MIR was limited to a dataset on market dynamics prevailing up to 2012, there does not appear to be appetite on the part of the CMA to conduct another root and branch investigation.

4. The key issues of current concern are as follows:

    a. Increasingly, insured patients are having their freedom of choice removed, in terms of their right to see the consultant of their choice, if that consultant is not 'Fee-assured'. PMIs are preferentially directing patients to the cheapest doctors to save themselves costs and to increase their profit, and some PMI companies are refusing to allow patients the right to 'top up' their insurance policy reimbursements to cover the medical fees of non-'Fee-assured' consultants. The CMA identified a ban on top-up fees as a practice of concern which, if "*extensively and rigidly applied*", would produce adverse effects on competition.
    b. Low PMI reimbursement levels for 'Fee-assured' consultants (which apply to all younger consultants given recognition since 2010) in conjunction with escalating expenses has made private practice increasingly financially non-viable. There have been no reimbursement increases since the early 1990s, with significant reductions in many of the reimbursements for the most common surgical procedures. As older non-'Fee-assured' consultants retire, the remaining generation of 'price-fixed' consultants will be unable to charge rates higher than those enforced by the PMIs. They will be unable to adjust their fees to reflect their greater experience and expertise, or to reflect the increased costs that the location of their practice may dictate.
    c. Senior consultants, who are highly trained and experienced specialists, are being de-listed by PMIs purely on cost grounds, with PMIs simply citing that the consultants are charging in the top 10% range as the reason for de-listing.
    d. Consultants believe that the PMIs are abusing the use of a discretionary rather than mandatory recognition of appropriately qualified doctors (unlike the position in some other countries).
    e. PMIs are arbitrarily removing consultant recognition with no right of appeal.

f. Particularly outside London and the M25, NHS waiting list initiatives are becoming a more attractive option to many consultants, when compared to private practice.

The impact of COVID-19

5. The outbreak of COVID-19 has raised further questions about sustainability.

   a. There is likely to be a continued demand for prolonged co-operation between the Independent Sector (IS) and the NHS, with the ongoing use of IS facilities by the NHS. This may lead to reduced access and increased waiting times within the IS, and increased levels of dissatisfaction for private patients, who will increasingly question the value of private medical insurance.
   b. There are currently increased costs for the delivery of each patient episode (outpatient, diagnostics, surgery) due to ongoing COVID-19 requirements for personal protective equipment, cleaning, additional theatre precautions etc. Who will pay for this? The PMIs have said they will not.
   c. There has been a reduction in the efficiency and throughput of operating theatres due to the new COVID-19 protocols which combined with cessation of most elective surgery during the first lockdown has resulted in a huge increase in NHS waiting lists.
   d. The significant economic downturn that is anticipated will lead to fewer lives insured with the PMIs, which may lead to uncertainty regarding their potential viability. In addition, there will be less disposable income for the self-pay market where patients fund their private healthcare themselves.
   e. Many newly-appointed consultants are now choosing not to enter into private practice, and significant numbers of existing consultants are now choosing to leave private practice, as it becomes increasingly financially non-viable. This will lead to reduced consumer choice, reduced access to specialists and loss of specialised clinical expertise.

Outline research areas

6. The following are outline research areas that would be explored, with a view to developing a sustainable solution to these problems.

a. National survey of consultants in private practice, to ascertain present and future intentions to continue in private practice, or not, and the reasons for their decisions. There should be a particular focus on anaesthetists' views, as their continued availability is vital for the continuation of private operating theatre activity. The demands of treating Covid patients had a profound effect on their availability during the pandemic peaks.
b. Survey of consumers, both current PMI policy holders and non-policy holders, to examine 1) likely consumer intentions on private sector use, given great lengthening of NHS waiting lists; 2) consumer attitudes on acceptable waiting times for surgery within the IS; 3) consumer attitudes on acceptable access, e.g. distance to travel to see a specialist (especially important in the provinces); 4) consumer views on cost and whether cost in itself is a major determinant of which specialist the patient might choose to see; (5) patients' attitudes to paying top-ups to see the consultant of their choice i.e. having portability of benefit.
c. Modelling the effect of varying levels of private insurance or increased self-pay use on demands for NHS treatment and NHS waiting lists.
d. Economic modelling of the benefit to HM Treasury of patients choosing to have treatment privately, instead of relying on the NHS.

Tentative future options

7. The following are potential tentative future options which could be explored as potential solutions to some of these challenges in terms of what government and the private sector would need to do to realise them.
    a. Exploring the option of again giving consumers tax relief on PMI premiums, in order to encourage use of the IS in order to unburden NHS waiting lists.
    b. Exploring possible models of NHS token payment schemes (e.g. making a small proportion of an Healthcare Resource Group (HRG) episode cost 'portable') to encourage patients to use the IS where possible, instead of relying on the NHS for surgery/treatment (i.e. an incentive model for patients to seek 'assisted self-funded' care.
    c. Exploring the potential to create a statutory body specifically to oversee the actions of the PMIs with respect to any potential impact on clinical care.
    d. Exploring the option of a statutory body also being responsible for issuing consultant specialist recognition across all PMIs, along with a mechanism to allow for an independent appeals process with regard to any potential loss of consultant regulation.

e. Exploring the option of the PMIs being mandated to allow patients portability of benefits, so that all patients have the right to see the appropriate consultant of their choice, along with the right to pay a top-up fee if/when necessary, if they so choose.

8. Given the background and sequencing of this project, it is anticipated that it would be funded on a multi-source basis. This outline proposal has been informed by data provided by FIPO. FIPO was represented on the CMA investigation and further regulatory and judicial challenges by Professor Suzanne Rab (lead researcher on this project).

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