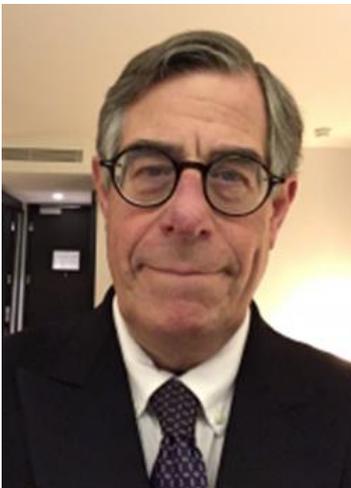


## FIPO Chairman's review

Richard Packard MD DO FRCS FRCOphth FEBOS-CR



As I predicted last year, the demand for treatment in the private sector has rebounded this year. This has been largely led by the self-pay market, up by 29% on 2019 figures as patients, frustrated with very long NHS waiting lists, opt to pay for their treatment themselves.

In fact, the volume of patients using insurance to pay has diminished by 16% – the reasons for this are not clear. In terms of regional variations, the biggest increases in self-pay patients have been in Wales and Scotland, 90% and 83% respectively. London has seen the smallest increase at 20%. This probably reflects the capital's higher percentage of insured patients.

What is more surprising from figures released by PHIN has been the significant reduction in consultants working in the private sector, down by about 12%. We believe that this is due to retirements and the failure to replace by young consultants opting not to enter private practice but preferring to do NHS waiting list initiative lists, without the start-up costs in the independent sector. Time will tell if this is a trend that will continue.

As always, FIPO has been working hard for our member organisations. In this newsletter you have the latest information about PHIN and their new plan to deliver the CMA order on outcome data and fees for consultants. FIPO has been involved, advising PHIN and commenting on this new strategy. The CMA is determined that the Order will be delivered and is prepared to act against those that do not engage. The developments at PHIN are discussed in greater detail elsewhere in this edition.

We are including here an update on our dealings with the CMA and their initial disappointing response to our approaches to them. This particularly in relation to the evidence of PMI behaviour that they, the CMA, stated expressly they did not wish to see come to pass:

“If extensively and rigidly applied, fee-capping consultants could lead to distortions in competition between consultants and to reduced consumer choice. Fee-capping (and derecognition of consultants who do not agree to abide by the insurer's fee schedule) has the potential to increase the disincentives on consultants from setting fees to reflect their costs, experience, expertise and the local market conditions. This distortion may potentially be increased, the greater the number of insured patients on policies that require open referrals from GPs as policyholders are channelled to lower cost consultants.”

This is an excerpt from the 2014 CMA Report, and we all know that unfortunately this is the current situation. However, I believe that by providing further evidence of PMI behaviour, we may get a more sympathetic hearing. [Please keep telling FIPO about your members' experiences in this regard.](#)

We have been working with the Independent Hospitals Provider Network (IHPN) on revisions to the Medical Practitioners Assurance Framework (MPAF). Our Board Member **Charlie Chan**, who sits on the committee on behalf of FIPO, provides an update in this issue.



FIPO's **Rosemary Hittinger** has been invited as a panellist to the October [LaingBuisson Private Healthcare conference](#). FIPO will be represented by Charlie Chan to ask the awkward questions.

Later in the autumn, I will be giving a talk at the [BMA Private Practice Committee Conference](#) on the current state of private practice.



Finally, I was contacted by a colleague who has recently been the subject of bullying by a hospital group and whom he has successfully sued. He has with other colleagues created a group called [The Society for Healthcare Reform](#). They have compiled a survey to assess the amount and the nature of bullying of healthcare professionals across the NHS and private healthcare sectors. Their letter to colleagues, with a link to complete the survey, is shared here in this Newsletter. It is of interest that in a recent *Financial Times* weekend magazine, Gillian Tett mentioned HCP bullying in the UK as an issue that rarely sees the light of day. FIPO Council Members are invited to distribute the letter and survey link to your members. This is a survey for all doctors, senior and junior, in all sectors of the profession, NHS and private.

## Chairman's Review, Summer 2022

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## Survey investigating bullying of healthcare professionals in the UK

FIPO's assistance has been requested to share and disseminate this letter and the associated survey. Please give this as wide distribution as possible at all seniority levels:

Dear Colleague,

Please complete our brief, anonymised survey on the treatment of doctors in the workplace. This survey will close on **30 September 2022**. Please share this survey with your colleagues and friends within the medical profession:

<https://tinyurl.com/healthcarereformsurvey>

You will not be identified. All data is anonymised and is intended to be used to lobby and represent doctors' views on suspension, bullying and investigation.

Every response we receive really does matter.

Thank you for your support.

**The Society for Healthcare Reform, with support from Doctors Association UK**

# Catching up with the CMA

Chris Khoo, FIPO Vice-Chairman

## CMA's new Mergers and Markets Executive Director



**David Stewart** joined the Competition and Markets Authority (CMA) in January 2022 as Executive Director, Mergers and Markets, charged with ensuring “strategic leadership of the CMA’s merger control and markets regimes”, to provide value to markets and consumers.

A lawyer, he had been a partner at Towerhouse LLP, a specialist regulatory and competition Law Firm in London, as well as practising in Australia. He has been Competition Policy Director at Ofcom, and worked as Ofcom’s Director of Investigations, enforcing competition and consumer law in the communications sector, having previously worked for network operators Energis and Cable and Wireless.

## CMA Open Letter to private healthcare providers and consultants on The Private Healthcare Market Investigation Order, Oct 2014

In his first general communication on 16 March 2022, an open letter to healthcare providers and consultants, **David Stewart** stated that one of his top priorities was to ensure “full and timely implementation of The Order”.

Originally this had required that the official Information Organisation – the Private Healthcare Information Network (PHIN) – would publish by 30 April 2019 performance measures of private healthcare facilities, as well as performance measures and fees of those consultants providing privately funded healthcare services. His open letter acknowledged that “delivering full compliance has been more complicated than anyone – including the CMA – thought it would be at the outset”.

David Stewart had attended the new Partnership Forum on 22 February 2022, convened by PHIN with the help of the Independent Healthcare Provider Network (IHPN), at which he explained the CMA’s priority to ensure that private healthcare patients receive the full benefits arising from the full implementation of the Order.

He advised on several challenges and issues, and asked PHIN to produce an agreed plan for compliance by the end of June 2022, and to deliver full compliance by June 2026.



From private healthcare providers and consultants Stewart made clear he expected commitment to the strategic plan: they should engage with PHIN to confirm their status and be informed of any action required. The CMA will actively review progress and intervene where progress does not meet the CMA’s expectations. The CMA is also taking stock of what enforcement action, if any, might need to be taken against market participants who have not engaged properly with the order.

## Our responses to the CMA – FIPO’s ‘short letter’

On **4 April 2022**, FIPO Chair Richard Packard responded. FIPO’s ‘short letter’ reiterated our role as an overarching body for the specialist and other medical committees acting on behalf of the profession in the independent sector and representing most UK professional medical organisations with private practice committees. Before Mr Stewart’s recent appointment to the CMA, FIPO had given extensive evidence to the CMA’s investigation, and had also challenged some of the Report’s conclusions, particularly in relation to the behaviour of the private medical insurers (PMIs).

Whilst entirely endorsing the CMA’s aim to address the information deficit for patients contemplating treatment in the independent sector, FIPO and the profession have concerns that the CMA’s mandate had still not been fulfilled after eight years. Escalating costs have been a problem, and there are also difficulties in the way in which the Remedy’s aim of providing patients with the information needed to make informed choices had been approached. Constraints imposed by the PMIs made it difficult for patients to choose their treatment pathway. They disincentivised and distorted competition and removed the ability of patients to make those personal choices for which they had chosen to pay. These factors acted against the operation of a free market, key conditions of which are freedom of choice with an absence of coerced transactions and imposed conditions. It is all very well for patients to have information, but it does not help them if they are prevented from making the choices that the information supports.

## FIPO’s ‘long letter’

FIPO followed this initial response with a more detailed letter on **20 April 2022**. Our ‘long letter’ included FIPO’s slide presentation to the CMA in March 2017: “Creating meaningful choice for patients”.

Our letter again endorsed the CMA’s aim to address the information deficit for patients in the independent sector and to enable patients to evaluate the treatment costs of consultants and their clinical outcomes. We detailed FIPO’s continuing concerns about the behaviour of the PMIs, the capability of PHIN to complete the tasks mandated by the CMA, and the effects on consumer choice and competition by consultants in the healthcare market.

Some key issues highlighted in the FIPO letter include:

### ❖ PHIN: achieving the CMA’s remit

Only limited data on patient volumes and length of stay had been published, for a small number of consultants. Published data had to show statistical validity and should not be open to misinterpretation – such as adverse events, which might not be due to an individual consultant.

### ❖ Costs: Consultants and Hospitals

The CMA aims to show patients individual consultant costs (though strangely, not hospital costs). It is a mistaken assumption that consultants can compete on price. Most private patients are funded by PMIs and are subject to their rules on what consultants are allowed to charge, including fee capping. Package prices bundle in consultant charges, so comparisons are difficult to make. Subscribers to PMI are not aware of the actual reimbursement levels, so overall there is a lack of transparency, which does not help informed decision making, even within the constraints imposed on PMI subscribers.

### ❖ PMIs: Market Power and Patient Choice

Since the CMA Market Investigation’s final report in April 2014, there has been considerable consolidation between the providers of private healthcare insurance, which has led to an increase in the market power of the Private Medical Insurers. The four biggest PMIs are an oligopoly who control 94% of the market.

Consultants who treat PMI-funded patients must accept ‘fee assured’ terms and have no control over fees according to the normal parameters of competition, nor have they the independent ability to choose the hospital at which they will care for the patient. Furthermore, patient choice of consultant is increasingly constrained by ‘fee-capping’, while ‘open referral’ directs clinical pathways and flies in the face of the CMA’s concerns that *“If extensively and rigidly applied ... fee capping (and derecognition of consultants who do not agree to abide by the insurer’s fee schedule) has the potential to increase the disincentives on consultants from setting fees to reflect their costs, experience, expertise and the local market conditions”*.

FIPO has pointed out that such practices are already “extensively and rigidly applied”, as at least 80% of corporate policies are subject to fee-capping or other restrictive practices.

#### ❖ PMIs: Consolidation between Competitors

FIPO has highlighted concerns about price-fixing arrangements by Aviva and Vitality in their Healthcare Purchasing Alliance (HPA), which affects consultants working in BMI and Circle hospitals. Consultants were given three weeks to opt into a fixed-price scheme for hip and knee surgery, offering reduced reimbursement, and free follow-up consultations. If consultants were not in the scheme, they would not be able to see any Aviva/Vitality patients at BMI/Circle hospitals. Thus, the patient is not free to choose the consultant, nor able to pay for services over and above those covered by their PMI.

Aviva and Vitality control around 23% of the market, whilst BUPA (37%) and AXA (34%) have a combined share of 71%. It would be helpful for the CMA to be fully aware of the fee and other constraints imposed on consultants.

#### ❖ Limitations on Patient choice

More than one restriction may be in effect, including:

- Denial of preferred treatment
- Reduction in level of specific treatment to what the PMI is prepared to fund
- Denial of preferred consultant
- Denial of preferred facility

FIPO fully supports the CMA’s intention that its 2014 Report should benefit patients and promote the better working of the private healthcare market. However, the intended benefits of the Information Remedy are surely negated by constraints on consultant competition, the effect of price-fixing by the PMIs on negating competition, as well as the loss of patients’ freedom of choice.

#### ❖ Independent consulting practice: the future

Because of the restrictions on clinical practice, the Covid pandemic, and the cost of starting and maintaining a private practice, there has been a reduction in the number of consultants undertaking private work. Newly appointed consultants are tied to low reimbursement rates. As older consultants retire, new consultants are finding the barriers to entering the market too daunting. The reduction in consultant numbers will further diminish patient choice.

## The CMA response

In June, FIPO wrote again to the CMA about this issue and its effects for patients and their ability to choose their consultant. The further evidence we cited, reflecting what we hear from consultants all the time, concerned direct threats of delisting a senior consultant if their fees were not reduced.

The CMA replied: “Having considered this material, our view remains as set out by the CMA’s Chief Executive, Andrea Coscelli, in his letter to you of 16 February 2021 – that is, that the information you have provided does not provide sufficient grounds for us to carry out a market study at this time. This does not constrain our ability to conduct a market study in future, depending on the evidence and market conditions at the time. We would be happy to continue to receive information from you regarding any significant further developments in relation to this market.”

Needless to say, this response is a disappointment. However, it does provide a window to accrue further evidence from consultants of the behaviour of the Private Medical Insurers (PMIs) who intimidate consultants by insisting that fees are set by the PMI and may not be exceeded. [We would ask any consultants who have been treated in a similar way by any PMI to get in touch with FIPO. Anything you send to us will, of course, be redacted if we add it to our data file on these matters.](#)

## CMA response 4 May 2022

Writing on 4 May 2022, the CMA’s Executive Director noted that FIPO had explained our concerns about PHIN’s ability to deliver the requirements of the CMA’s order, as well as wider concerns about the behaviour of private medical insurance and its effect on consumer choice.

Mr Stewart acknowledged the points relating to the overall private medical insurance market, which might have changed since the CMA’s previous investigation. However, whenever the CMA responds to complaints about the market, its response and potential action is considered in the context of the organisation’s strategic priorities which inform decisions on whether to undertake work, such as a further review.

## Further FIPO action

On 3 May 2022, FIPO met again with **PHIN**, noting that with the resignation of two senior PHIN appointments PHIN’s approach to interpreting the CMA’s mandate had changed. Writing to its specialist members, FIPO encouraged engagement with PHIN who had realised that their existing strategy for the collection and presentation of individual consultant data would be unlikely to provide meaningful information for patients.

At that time only 25% of consultants had validated their data, leading to the realisation that there needed to be a significant re-evaluation of PHIN’s interpretation of the Information Remedy mandated by the CMA. PHIN would now be reaching out to stakeholders, inviting their input for a revised strategy to produce an information outcome that is meaningful and helpful for patients. [Input from FIPO members would be helpful.](#)

## A development

At the end of May, FIPO shared with the CMA details of two well-established senior consultants who had been sent letters by a PMI which noted that they charged more than that PMI was prepared to reimburse. If the consultants did not lower their charges, they would be derecognised. Although such ‘fee capping’ is familiar to the profession, and strongly disapproved of by the CMA, FIPO’s clear example of what is “extensively and rigidly applied” fee capping appears to have acted as a wake-up call to the CMA, who despite their previous disinclination to prioritise this aspect of the profession’s many concerns, have now indicated that they will want to see further evidence but then may investigate and take action.

# Private Healthcare Information Network (PHIN) update

Rosemary Hittinger, FIPO Board Member

FIPO is supportive of the requirements of the CMA 2014 Order arising from their Private Healthcare Market Investigation and continues to encourage consultants to engage with PHIN, as the authorised information organisation, to achieve sector-wide compliance.

As you are all aware, the CMA have become impatient with the speed at which the private healthcare sector has complied. The CMA Order is legally enforceable and hospital providers as well as consultants are subject to the requirements. PHIN has had a change of senior leadership and published a revised strategy and roadmap to achieve full compliance by 2026. At the PHIN AGM in July, FIPO along with other voting members, agreed the revised strategy, despite a number of misgivings that we had made clear to PHIN and the CMA. Amongst other issues, it is clear that statistical validity to demonstrate variation is unlikely to be reached, due to the comparatively small volumes.

The purpose of the CMA Order was to address ‘imbalances in the market’ and to allow patients choice on the basis of quality and cost. Whilst usage of the PHIN website has increased, only limited choices are allowed by the PMIs to their subscribers and hospital package prices were not subject to the order, meaning that ‘patient choice’ remains an aspirational concept.

However, it should be emphasised that for any consultant who admits private patients, there is a legal requirement to provide their fee ranges to PHIN for publication. Compliance remains variable, with approximately 75% of consultants providing consultation and/or procedure fees, but fewer than 24% are checking and approving their volume and LoS figures.



The CMA has indicated they will now pursue those high-volume consultants who have not provided their fee information. It seems likely that if the lack of engagement continues after they have sent a warning letter to the individual consultants, the CMA will refer the individuals to the GMC for further action.

To date, PHIN has stated that they would not publish information that has not been approved by the consultants, but to comply with the Order and deliver on publication within the newly agreed timeframe, PHIN is exploring a ‘presumed publication’ option, whereby data will be published as it is received from the hospitals. FIPO has been informed by our members that even those consultants who have engaged have had difficulty getting their information corrected, and there is a general mistrust as to how this information will be used. But it is in the interests of the sector as a whole that the CMA issues are addressed. FIPO is hopeful that the CMA will then take on the PMI issues that we have raised with them.

FIPO continues to work with PHIN in an advisory capacity and is trying to identify benefits and processes that would encourage and facilitate compliance. [If you have any comments or suggestions, please contact FIPO at \[office@fipo.org\]\(mailto:office@fipo.org\).](#)

# MPAF report

Charlie Chan, FIPO Board Member

The **Medical Practitioners Assurance Framework (MPAF)** was launched in late 2019. This guidance from the Independent Hospitals Provider Network (IHPN) is designed to improve the safety and quality of care patients in the independent sector.



MPAF is mainly addresses private providers (such as hospitals, clinics etc), although this inevitably affects doctors working in the independent sector. The key areas include clinical governance structures, patient safety, clinical quality and continuous improvement, whole practice appraisal, and raising and responding to concerns.

Following the publication of the Paterson and Cumberledge Reports, MPAF decided to update the framework. The reference group included representatives from the GMC, the Department of Health, CQC, independent hospital providers, FIPO, the Cleveland Clinic, and others. There have to date been three meetings: in November 2021, February 2022, and June 2022.

The recommendations of the Paterson and Cumberledge reports have been considered and incorporated where necessary. For instance, the role of MDTs and the transfer of the relevant clinical information is highlighted. The introduction of new techniques and materials are also covered in the update.

While MPAF is a framework primarily for independent hospital and other providers, the new changes will inevitably become more onerous for doctors. For example, the revision will require doctors to engage with PHIN in line with the CMA Information Remedy.

However, the Reference Group accepted that it would be unreasonable for doctors to approve incorrect data for publication. The new document will be circulated for final review in October this year, with a view to publication in the Autumn.

**FIPO**  
federation of independent  
practitioner organisations

Dedicated to quality, safety, and patient  
choice within the Independent Healthcare

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