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**Swansea University**  
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A study of the dynamics of the private health  
care market in the United Kingdom with  
particular reference to the impact of British  
United Provident Association (Bupa)  
Provider and benefit initiatives

**Robert Gregory Royce**

*A thesis presented for the degree of  
Doctor of Philosophy*

Faculty of the School of Health Science

**2011**

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## **Abstract**

The private health care market in the United Kingdom is a multi-billion pound industry whose dynamics remain largely unexamined. This is so even though the boundaries between the public and private sectors are becoming increasingly blurred, particularly in England. Given the growing importance of this sector, the policy community needs to know more about the nature of private health care in the UK, how well the private market operates and how successful have been the various attempts within it to improve value for money and health care quality, given that private health care has traditionally been seen by many citizens as unaffordable.

In particular this thesis traces recent efforts by the British United Provident Association (Bupa) to reshape the UK private healthcare market. The account provided draws on the author's experience as a senior Bupa manager involved in planning and implementing such changes. The thesis describes a series of Bupa initiatives designed to change provider behaviour in pursuit of improved quality and value-for-money, and the difficulties and obstacles encountered. The latter often centred on tensions or confrontation between the insurer and professional providers that are discussed in relation to the wider literature on the social and economic organisation of health care markets.

An attempt has been made to draw some general conclusions via an empirical study of the role and limitations of market-based changes within the UK private sector. The broad conclusion is that the private market in the UK exemplifies those features of health care seen throughout the developed world that create imperfect market conditions. As such the market is highly resistant to insurer initiatives that would reverse the longstanding trend for premiums to rise above the rate of inflation. It is considered unlikely given the current market structure that any insurer, including Bupa, can escape these constraints in the short term. However, Bupa has implemented some successful initiatives that suggest that longer-term incremental change is possible.

## **DECLARATION AND STATEMENTS**

### **DECLARATION**

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed: (candidate)

Date: 1 June 2011

### **STATEMENT 1**

This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote(s).

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed: (candidate)

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### **STATEMENT 2**

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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Date: 1 June 2011

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## List of Abbreviations

AAPPO American Association of Preferred Provider Organizations

AXA PPP Private Patients Plan

Note: AXA is not an acronym for anything

ABI Association of British Insurers

AIR Association of Independent Radiologists

AAGBI Association of Anaesthetists of Great Britain and Ireland

ASGBI Association of Surgeons of Great Britain and Ireland

ASM Anaesthetic, Sedation and Monitoring Services

AWP 'Any Willing Provider'

BM Benefit Maxima

BMA British Medical Association

BOA British Orthopaedic Association

BOFSS British Orthopaedic Foot Surgery Society

BTE Bridges To Excellence

<b>Bupa</b>	<b>British United Provident Association</b>
<b>CABG</b>	<b>Coronary Artery Bypass Graft</b>
<b>CC</b>	<b>Competition Commission</b>
<b>CIGNA</b>	<b>Connecticut General Life Insurance Company</b>
<b>CMS</b>	<b>Centre for Medicine and Medicaid Services</b>
<b>CORESS</b>	<b>Confidential Reporting System in Surgery</b>
<b>CPR</b>	<b>Chartered Society of Physiotherapists</b>
<b>CQUIN</b>	<b>Commissioning for Quality and Innovation</b>
<b>CSSD</b>	<b>Clinical Classification and Schedule Development Group</b>
<b>DNV</b>	<b>Det Norske Veritas Healthcare Inc</b>
<b>DoH</b>	<b>Department of Health</b>
<b>DRG</b>	<b>Diagnosis Related Groups</b>
<b>EEC</b>	<b>European Economic Community</b>
<b>FIPO</b>	<b>Federation of Independent Practitioner Organisations</b>
<b>FOS</b>	<b>Financial Ombudsman Service</b>

FSA	Financial Services Authority
GA	General Anaesthetic
GDP	Gross Domestic Product
GHG	General Healthcare Group (Note: BMI Healthcare is part of GHG but the acronym BMI does not stand for anything)
GMS	General Medical Services
GP	General Practitioner
GSup	General Supplemental Funding Projects
HCA	Hospital Corporation of America
HCAN	Health Care For America Now
HCHC	House of Commons Health Committee
HCP	Health Care Partnerships
HES	Hospital Episode Statistics
HFAP	Healthcare Facilities Accreditation Program
HIV	Human Immunodeficiency Virus
HMN	Healthcare Market News

HRG	Health Care Resource Group
HSA	Health Savings Account
HSJ	Health Service Journal
ICD-9	International Classification of Diseases Version Nine
ICD-10	International Classification of Diseases Version Ten
IHE	Integrated Healthcare Association
IOM	Institute of Medicine
ISTC	Independent Sector Treatment Centre
IT	Information Technology
JCAHO	Joint Commission on Accreditation of Health Care Organisations (now known as the Joint Commission)
LA	Local Anaesthetic
LCA	London Consultants Association
MMC	Monopolies and Mergers Commission
MORI	Market and Opinion Research International
MRI	Magnetic Resonance Image

NERA	National Economic Consultants
NHS	National Health Service
NICE	National Institute of Clinical Excellence
OFT	Office of Fair Trading
OPCS	Offices of Population, Census and Surveys Classification of Surgical Operations and Procedures
PA	Programmed Activity
PAD	Provider Assessment Document
PBR	Payment by Results
PCT	Primary Care Trust
PI	Procedural Interventions
PMI	Private Medical Insurance
PMS	Private Medical Services
PPO	Preferred Provider Organisation
PPP	Private Patients Plan
RBRVS	Resource-Based Relative Value Scale

<b>ROI</b>	<b>Return On Investment</b>
<b>ROIC</b>	<b>Return On Invested Capital</b>
<b>RPI</b>	<b>Retail Price Index</b>
<b>RTT</b>	<b>Referral to Treatment</b>
<b>RVR</b>	<b>Relative Value Review</b>
<b>SARS</b>	<b>Severe Acute Respiratory Syndrome</b>
<b>SHA</b>	<b>Strategic Health Authority</b>
<b>UKM</b>	<b>United Kingdom Management</b>
<b>USP</b>	<b>Unique Selling Point</b>
<b>WHO</b>	<b>World Health Organisation</b>
<b>WPA</b>	<b>Western Provident Association</b>



# **A study of the dynamics of the private healthcare market in the United Kingdom with particular reference to the impact of British United Provident Association (Bupa) provider and benefit initiatives**

## **Chapter 1 Introduction**

### **Thesis Outline**

This thesis sets out to examine the dynamics of the private health care market in the United Kingdom. In doing so it discusses a number of initiatives undertaken within that market by British United Provident Association (Bupa) that had the express purpose of delivering price or quality improvements. This thesis is primarily an empirical study with the central aim of exploring how the UK private health market currently works, what forces drive it and how these translate into particular market features. Throughout, the recent experiences of the dominant UK insurer (Bupa) are traced via an examination of its various attempts to shape, or react to, the market over the last decade.

The theoretical background to this thesis is set both by the general characteristics of demand for healthcare and the nature of healthcare provision in the developed world. More specifically there are particular features of the demand for private healthcare, private medical insurance and provider delivery that are set out in the ensuing chapters. There is a particular aim of assessing how effective market-based initiatives which aim to deliver lower prices/higher quality in the UK private sector have been.

Such a study requires both breadth - with an overview of approaches and experience that are at times necessarily international, so as to give sufficient context - and detailed case studies. The latter are provided using examples from Bupa's UK health insurance arm - United Kingdom Membership (hereafter called UKM for ease of reference).

The various case studies highlight a number of health policy issues that surface as recurring themes for investigation in health care studies.

- (i) The degree to which transactional relationships represent the most appropriate way of achieving desired changes in provider behaviour;
- (ii) The nature of the doctor/patient relationship in private healthcare and how that relationship impacted upon insurer/purchaser initiatives to change care delivery;
- (iii) The role and impact of information asymmetry;
- (iv) The role and impact of professional power;
- (v) The theory of countervailing powers between commissioners and providers

The case studies shed light on the characteristics of private healthcare in the UK and hopefully contribute new insights affecting a number of the areas above. They provide an empirical reference point which helps us to assess the applicability of theories from the wider health policy literature to the specifics of UK private healthcare. Private healthcare in the UK has been the subject of relatively little research, although the general literature on the above subjects is quite extensive. This thesis sets out to describe the current dynamics of the UK private healthcare market, its particular characteristics and how these are both shaping and limiting market based initiatives. It pays special attention to the impact of current funding and payment arrangements on patient, insurer and provider behaviour, as revealed in the initiatives described in the case studies. This allows an element of empirical testing of the various theories of provider, patient and payer behaviours set out in the earlier chapters, at least in terms of their general plausibility as theories that are more or less consistent with observed events.

## **Methodology**

The UK private sector, and the working practices of the companies that make it up, are not easy topics to research. Unlike the public sector in the UK, there is limited published material to draw upon. This is in part a reflection of a more fundamental obstacle; the reluctance of insurers and private providers to expose themselves to potentially critical scrutiny, primarily because of the possible commercial ramifications of any negative reports. From the perspective of the organisations in question this position is unsurprising. Generally speaking, the risks of research typically outweigh the perceived benefits.

This renders very difficult many of the traditional lines of academic research. Structured interviews and questionnaires are unlikely to elicit much in the way of meaningful results because firstly, the organisations concerned are unlikely to agree to such enquiries and secondly, even if they did, commercial considerations (and the associated need for confidentiality) limit the value of the answers provided. In a similar way, recourse to published documents will only provide a partial picture. Commercial enterprises rarely make public statements about either their intentions or internal/market weaknesses that might aid potential competitors. To a lesser degree the same applies to access to internal documents as commercial organisations are acutely aware that such papers may end up in the hands of competitors. In this regard the author notes that it was one of the distinguishing features of Bupa compared to the NHS that the company's strategy was essentially conveyed verbally. There was no 'strategy document' as such (or if there was it was restricted to a level above his pay grade), as would be a routine feature of NHS organisations.

It might be argued that this problem can be overcome by giving assurances that the research in question would have a bar on access when finally published. This may well assist the researcher to gain better access and more revealing answers to questions, but arguably the central problem remains. The commercial entities involved would in all probability view research in terms of commercial risks versus benefits, and conclude the primary goal is to increase shareholder value rather than assist researchers in the pursuit of knowledge (compare, Bakan 2004). In organisations that are heavily 'brand' driven, such as Bupa, this view is likely to be even more pronounced, as any publicity (negative or positive) is considered likely to affect customer and investor perceptions.

Does the fact that Bupa does not have shareholders and reinvests its profits into the business undermine the above point? The bonus system for managers in operation at Bupa UKM (which the author participated in from February 2002 to February 2006) closely resembled the incentive schemes from more overtly commercial companies. Around 70% of the bonus was dependent on UKM and the wider Bupa Group meeting profit targets, with approximately 20% based on UKM specific objectives around customer growth and the remaining percentage on customer and consultant satisfaction scores. As a result commercial considerations remain a central managerial preoccupation.

A doctoral thesis requires the author to demonstrate that he or she has made an original contribution to knowledge. In the present context, this required the author to undertake an original investigation, as opposed to a review of what is already written about private healthcare in the UK. With regard to the latter there was relatively little in the way of published material to draw upon in any case. This basic problem became even more pronounced when considering the action of a particular company within the market. These restrictions dictated the approach taken for the thesis. This was to gather data on the structure of the market and the behaviour of market actors by concentrating on the events surrounding a series of known Bupa initiatives, which were reported in the general and 'trade' press. Close examination and interpretation of these events was made possible by the author's own role in the organisation at that time.

The author has been fortunate to occupy relatively senior managerial positions in both the NHS and in the private sector. He was Head of Policy, Quality and Provider Relations within Bupa's UK Insurance Division between February 2002 and February 2006. The author worked within UKM's Health Care Partnerships (HCP) department - the part of UKM charged with shaping and conducting contractual negotiations with hospitals, consultants and other health professionals. This afforded the author considerable exposure with regard to the core of this thesis – how the private market works in the UK, and what dynamics underlie it.

This approach might be considered partly ethnographic in nature, in that the research undertaken had elements of fieldwork within it. For a number of Bupa case studies the author was either leading the initiative in question – or heavily involved in its design/implementation. In the author's opinion, it would have been difficult to present the case studies in the correct context without the insights provided from working within the Association, and the exposure that provided both to key decision makers and the prevailing managerial culture. Within the NHS two books by Brian Edwards (Edwards, 1995; Edwards and Fall, 2005) have utilised approaches similar to that of the author by drawing on experiences gained as a senior manager to interpret the events described. In similar vein, John Spiers relied on managerial experience to write a book subtitled 'An Insider's Commentary on the NHS Reforms' (Spiers, 1995).

However, the ethnographic component has been strictly curtailed because a conventional presentation describing interactions and events in 'blow by blow' detail would, in the

author's opinion have given rise to major problems with ethical, commercial and possibly legal dimensions.

Although Bupa senior managers were aware that the author was conducting a doctoral project on financing and reimbursement mechanisms in healthcare and how these affected cost containment and quality improvement, most colleagues would not have known that material from ongoing work interactions might appear in a study, and use of this kind of information would have posed troubling issues of informed consent. It is always difficult to draw the line on the permissible level of disclosure and consent in research in organisational settings. It is not so much that there are covert versus overt studies but that there exists a 'continuum with different degrees of openness' (Brewer, 2000 p.84). Many apparently open studies gloss over covert practices (Calvey, 2008; McKenzie, 2009). The author preferred to steer away as much as possible from use of data that might be seen to betray individual confidences or reveal the content of meetings which colleagues believed to be confidential.

Moreover, more than mere disloyalty to colleagues might be involved if the author had attempted an ethnographic presentation that 'told all' about Bupa's internal operations. There were real issues of commercial confidentiality where information on the detail of Bupa's perspectives and strategies in respect of particular issues might be of benefit to other players in the market place. The author had a good relationship with colleagues at Bupa and was grateful for the support provided to begin this study. He left on good terms and had no desire to damage the Association. It must also be admitted that any actual damage to Bupa might have highly negative consequences for the author himself, both in terms of the destruction of personal relationships and in the extreme the possibility of litigation (Mello Studdert and Brennan, 2003).

The above gave rise to a difficult dilemma. The author felt that much of what he had observed would provide valuable insights on the working of the UK private medical insurance (PMI) market that would be of interest to policy analysts generally and indeed to policy makers in organisations like Bupa. Yet the strongest data at the author's disposal – his direct observation of several initiatives relevant to the thesis topic - could not be reported in detail without raising the major problems described above.

The imperfect solution adopted has been to try to strike a balance between fair use of the insights gained as a result of the author's insider role and ensuring that appropriate commercial confidentiality is maintained. What is offered is a study describing a series of key Bupa initiatives, in which the ethnography remains in the background, but is used to help interpret information about events that is already in the public domain.

In line with the above, the thesis does not attempt to reconstruct the content of meetings or to quote what individuals at Bupa may have said behind closed doors. In his four years at Bupa, the author sat through many discussions on the state of the market, the relative strength of parties engaged in contractual negotiations, the profitability or otherwise of certain products and so on, but using this material would raise the issues of informed consent, trust and commercial confidentiality already mentioned. Consequently quotations from individuals at Bupa (or other figures within private healthcare sector) are included only when they are available from conference presentations, media reports, published articles, letters, and press releases which were all in the public domain. In any case, the thesis is less concerned with Bupa's internal operations and self perceptions, than with the company's interaction with the market. The principal question under consideration is not how Bupa operated *per se*, but rather what an examination of how the company interacted with its customers and providers in the UK's private healthcare system might tell us about the dynamics of that market?

Overall it is more accurate to characterise the present study as a study of a sensitive subject (Brannen, 1988; Lee and Renzetti, 1990; Renzetti and Lee 1993; Lee, 1993; ) than a covert study. Seiber and Stanley (1988, p. 49) write that 'socially sensitive research refers to studies in which there are potential social consequences or implications, either directly for the participants in the research or for the class of people represented by the research.' This includes potential consequences for the organisation and researcher. While much of the published literature highlights that such studies can have psychological or emotional consequences for subjects and researcher, (Johnson and Clarke, 2003. Dickson-Swift et al., 2008; 2009) the present study shows that in the organisational domain, hard-nosed commercial and legal considerations also enter the picture. As stated above commercial confidentiality was a paramount preoccupation, and this is quintessentially a study where the dissemination of observational research data in raw form would involve a substantial threat to the researched and the researcher. The study also conforms to a pattern, described by Dickson-Swift and associates (2006) as common in research on sensitive topics, where there

is a blurring of boundaries between the group under study and the researcher, in the present case because much of the analysis relies on an insider perspective.

Because many sensitive subjects raise problems of access and ethics, non-standard approaches to study design are often utilised. In many instances such studies provide an imperfect glimpse into the life of a social group or organisational domain about which no research reports would otherwise exist. For that reason studies that make methodological compromises or are undertaken on a smaller scale than is ideally desirable nevertheless serve a useful role (Hughes, 2004). The present study uses such an unconventional approach and the observational component is necessarily truncated, in a way that clearly would be undesirable in normal circumstances. But these compromises, which the author considered necessary to complete an academic research project within a commercial environment, do make it possible to shine a light into an area of business practice which has not been reported elsewhere. In the author's view an approach dictated by circumstances, does nevertheless deliver an account of the operation of UK private health care that will be of interest to policy makers and policy scholars.

The author has had to consider the possibility that his own biases and beliefs have influenced the reporting and analysis of the events described, which is a potential weakness of observational studies (Le Compte and Goetz, 1982; Rohner, Dewalt and Ness, 1973). Two possible biases need to be declared by the author. The first relates to the author's historical support for market mechanisms being used in certain areas of healthcare funding and provision (Royce, 1995; 1997). The second relates to his personal involvement in some of the Bupa initiatives described. The author believed at the time that these initiatives had a real potential to improve the quality of patient care and/or control costs and hence had some emotional attachment to those schemes – especially some of those deemed ultimately unsuccessful.

To help counter the above biases, the author has tried to assemble multiple sources of evidence concerning the Bupa market initiatives discussed, so that a more complete picture can be drawn of the nature of each particular initiative and the reactions to it. Extensive use is made of written documents and accounts from third parties with whom he has no connection. This helps to ensure that both the initiatives themselves and the reactions of key players, such as hospital groups and professional associations, have been adequately represented.

Even allowing for the steps taken to keep Bupa's internal meetings and interactions in the background, some readers who adhere to strict interpretations of informed consent may feel that the author has strayed (the background analysis does after all rely on interactions with some who did not realise a research study was being conducted). However, the author takes the view that informed consent must be balanced against wider conceptions of the public interest (Dingwall, 2008). He believes that no harm has been done to the managers concerned, and that it is ethically acceptable for him to offer assessments of the significance of the Bupa initiatives examined, based on his insider knowledge. The research did not come under the auspices of a NHS Research Ethics Committee and the University of Wales did not have an internal Ethics Committee at the time when this study was undertaken. The author decided on an appropriate ethical stance taking account of his own judgment and advice from his supervisor.

## **Public and Private Healthcare in the developed world**

Academic studies of the structure and dynamics of healthcare in the developed world typically highlight a number of common issues. These include:

- Widespread use of third party payment (with its associated moral hazard risks);
- Asymmetry of information between those consuming and those delivering care reinforced by inadequate transparency of quality and outcomes and resulting in a difficulty in making legitimate price/value comparisons;
- The unusual degree of emotional (and physical) dependence of the healthcare consumer on those providing the service;
- Health care is a labour intensive industry with delivery dependent upon professionals;
- Clinicians have essentially a common core training programme based on a dominant medical scientific paradigm and an ethics based on their primary responsibility being to the individual patient;
- Health care is subject to rapid advances in treatments through the application of scientific knowledge and a worldwide pharmaceutical/medical appliances industry that has a strong commercial interest in promoting new developments;

- Significant barriers to entry through a combination of governmental and professional regulation, and - in the case of purchasing and provider organisations - high set up and running costs;
- Rising societal expectations of health care underpinned by rising standards of living and faith in science;
- Significant technical difficulties in relating reimbursement of providers to the outcomes of the services rendered.

The above issues mean that the dynamics of health care are closer to those of other professional service domains – law, architecture, higher education – than to non-professional service or production industries such as computer support or car manufacturing. Whilst these common issues are often readily acknowledged there is considerably less consensus on how health care should be organised and what combination of market and governmental planning or regulation is desirable. Such disputes are not confined to academia but are in part reflections of ideological positions.

Economists writing with regard to health care typically highlight the above features to make the point that the demand for, and provision of healthcare, departs significantly from the neo-classical economic models associated with theorists such as Ricardo (1817). Indeed ‘health’ itself is not tradeable (McGuire, A; Henderson, J. and Mooney, G; 1988, p.33), but healthcare is. Consumers have demand for health but cannot directly purchase it. They must purchase health care services that are used to produce health. Michael Grossman (1972) first discussed the idea that health care has a derived, rather than a direct, demand.

Light (1994) argues that professional work fits poorly into an economic market model because it is difficult to judge how well the work undertaken has been performed. In this regard Weisbrod (1978) makes the telling point that for the bulk of healthcare the patient/buyer has great difficulty in assessing quality, not only before the purchase (a situation that exists with many products) but also after the purchase/intervention.. Whilst this is not entirely unique to healthcare, the difficulty in judging quality both *ex ante* and *ex post* is a characteristic feature of this domain.

As described later in this chapter, information asymmetry combines with transactional cost issues and psychological dependency to provide a foundation for what Light describes as

“protected markets” and which he asserts generate a “capitalists’ heaven” (Light p.36). Light (1991) had previously argued that the goal of competitors is generally to minimize competition – not to promote it - and that in this regard healthcare often represents the antithesis of the basic conditions for a functioning competitive market. This provides one explanation for the relative price inelasticity of healthcare. A RAND sponsored study by Ringel et al (2000) states that:

‘Despite a wide variety of empirical methods and data sources, the estimates of the demand for healthcare...are consistently found to be price inelastic (pg 20)’

This phenomena is fuelled by third party payment mechanisms which (as discussed below) generate moral hazard issues.( Zweifel and Manning, 2000).

Despite the above, in recent years a large literature has emerged on the potential of markets and competition to transform both predominantly private and public health care systems (Baumol, 1995; Herzlinger, 1997; Fuchs, 1988; Smith, 2000; Gaynor, Haas-Wilson and Vogt, 2000; Nichols et al, 2004; Maynard, 2005; Berenson, 2005; Porter and Teisberg 2006; Wigger and Anlauf, 2007;) Porter and Teisberg’s (2006) influential book ‘Redefining Health Care’ highlights the problems of rising costs and poor quality affecting US health care, and argue that the root cause is an absence of real competition. They suggest that:

‘In a normal market, competition drives relentless improvements in quality and cost. Rapid innovation leads to rapid diffusion of new technologies and better ways of doing this..... Quality adjusted prices fall, value improves...’

For these writers the operation of the health sector is very different. Costs rise, while quality problems persist. They argue that the extent of market failure is evident from the large variations observable in costs and quality across providers and geographical areas, and the slow diffusion of technological innovations.

Arguably however, the problems identified by Porter and Teisberg are not confined to the United States, and may not even be the preserve of pure market systems, since the features described also affect planned systems and collaborative models. To reinforce this point, let us examine a summary of the benefits of normal market competition compared with the failed

version found in health care (below) provided by Porter and Teisberg. The argument made in this thesis is that whilst this is correct in so far as it applies to the U.S system, the authors do not recognise that they are also describing health care delivery in ‘socialised’ systems such as the pre-internal market NHS as well as well as the UK’s current private sector.

Table 1. The Relevance of Porter and Teisberg’s ‘Imperatives for Policy Makers: Improving the Structure of Health Care Delivery’	UK Private	UK NHS
<b>Enable Universal Results Information</b> Establish a process for defining outcome measures Enact mandatory results reporting Establishing information collection and dissemination infrastructure	√ √ √	√ √ √
<b>Improve Pricing Practices</b> Establish episode and care-cycle pricing Set limits on price discrimination	√ X	√ X
<b>Open up Competition at the Right Level</b> Reduce artificial barriers to practice area integration Require a value justification for captive referrals or treatment involving an economic interest Eliminate artificial restrictions to new entry Institute results-based license renewal Strictly enforce antitrust policies Curtail anticompetitive buying-group practices Eliminate barriers to competition across geography	√ √ √ √ √ √ √	√ x √ √ √ x √
<b>Establish Standards and Rules that enable Information Technology and Information Sharing</b> Develop standards for interoperability of hardware and software Develop standards for medical data Enhance identification and security procedures Provide incentives for adoption of information technology	√ √ √ √	√ √ √ √
<b>Reform the Malpractice System</b>	√	√
<b>Redesign Medicare Policies and Practices</b> Make Medicare a health plan, not a payer or a regulator Modify counterproductive pricing practices Improve Medicare pay for performance Lead the move to bundled pricing models Require results-based referrals Allow providers to set prices	x √ √ √ √ √	x √ √ √ √ √
<b>Align Medicaid with Medicare</b>	X	X
<b>Invest in Medical and Clinical Research</b>	√	√
√ = applicable      x = non-applicable		

In considering the options for reform in the various areas cited above, health policy makers keep returning to the central question of what role market mechanisms should play in health care funding and delivery and the respective roles and size of the public and private sectors. The issue of how healthcare is to be funded and provided is not merely a technical one but tends to be an emotional affair, underpinned by ideology, culture and nationalism.

This thesis aims to contribute to that debate by examining in detail the results of a series of market based approaches to reform within the private healthcare market in the UK. The author in doing so wishes (as far as possible given what was previously written on potential biases) to resist any ideological pre-determination as to what the success or otherwise of such a programme is likely to have been. Moreover it is acknowledged at the outset that the findings will be conditioned by the prevailing circumstances in the country being studied. Approaches and solutions have to be seen within the context of the particular context in which they have arisen. What may work for country, or even organisation 'A' will not necessarily work in 'B'. It is thus acknowledged at the outset that the UK's health system has unique features, including the particular role the private sector plays. Unless the historical development and existing relationships between the various components of the UK's private sector are properly understood, analysis of their predicted future development is likely to be faulty.

## **Individuals, Risk and Market Failure**

Whilst the determination of the primary objective of a public (or indeed private) health system can be difficult, certain economists have considered that the motivation of any particular individual with regard to health care can be stated with some certainty. Arrow outlined their essential position as follows:

'...there are two kinds of risks involved in medical care: the risk of becoming ill, and the risk of total or incomplete or delayed recovery...From the point of view of the welfare economics of uncertainty both losses are risks against which individuals would like to insure' (Arrow, 1963, p.959).

In this analysis individuals are looking to a health care system to deliver them from both risks – with the latter likely to be their primary objective as many people are quite fatalistic about

the chances of them becoming ill, or suffering an accident (Niederdeppe and Levy, 2007; Nelson et al 2002; Liang et al 2004; Margolis et al 2003).

It might be objected that Arrow's delivers an overly reductionist approach which depends upon the traditional model of 'home economicus' that behavioural psychology research has increasingly questioned (Simon, 1956, 1957, 1987a, 1987b; Kahneman, Slovik and Tversky, 1982; Kahneman and Tversky, 2000). However such risks exist even if the importance assigned to them by individuals can be debated, and how they (and societies as a whole) insure against those risks can - and does - take a multitude of forms. Within civil society an individual's personal objective may be superseded for a variety of reasons. These include (but are not confined to) utilitarian or social solidarity notions that give less priority to the welfare of any given individual in favour of the collective benefit of society as a whole (Bentham, 1789; Rawls, 1971; Hahn 1982; Weale, 1983).

Now it has to be acknowledged that individuals - like governments - do not desire only one thing in isolation. The 'health' objective described above competes with other objectives, some of which draw resources away in their pursuit. There are circumstances when the 'health' objective might override all others-when an individual is in severe pain for example. However, even when we are faced with a life threatening illness, the focus on recovery may be set against competing desires. These might include concern not to be a burden on relations, concern that medical fees will erode sibling's inheritances, or simply a conviction that a subsequent poor quality of life will not make recovery worthwhile.

It is the contention of most economists working in the field of 'welfare economics' that all other things being equal, individuals would rather transfer the risk of attaining their desired states (including health) to third parties rather than bear them directly. If individuals could transfer these costs as well then so much the better. Both inclinations have a particular resonance in health where risks and costs can be high and consumer uncertainty on both is typically a significant factor. From these basic premises Arrow claimed much of the particular non-market features of health care flow.

Closely associated with a desire to transfer risk sits an information asymmetry problem that generates a number of moral hazard issues for healthcare (Arrow, 1965, Robinson, 2001). As will be seen these have a particular relevance to private health insurance. The inherent

problems with insurance (regardless of whether they are public or private schemes, voluntary or compulsory) are well known, have a significant literature, and can be summarised as follows:

Firstly, people are more likely to use services if they are insured - a phenomenon commonly known as moral hazard (Arrow, 1965; Pauly, 1968; Zeckhauser, 1970; Spence and Zeckhauser, 1971; Kotowitz, 1987). Over-consumption can occur because people can be less attentive to their health in the expectation that the insurer (government or private body) to pay for their care. It can also occur because those insured do not bear the marginal cost of care when they consume it. Pauly (1968) provides a particularly cogent exposition of this problem and in doing so help provide an economic basis for price rationing (user charges) to help produce a more efficient solution to matching demand to available resources.

As Farrington and Coelho (2008) note, insurance – both public and private- is a compromise between the inefficiencies created by moral hazard and the benefits of improved risk sharing. Risk sharing can also be inherently problematic. Different individuals represent different risk types. If insurers are not fully capable of distinguishing those who are relatively sick from those who are relatively healthy they run a risk that those seeking insurance will pretend to be healthier than they are. This is possible because of information asymmetry because typically the person seeking insurance knows more about their health status than the insurer.

The above problem is known as adverse selection and again is well documented in the literature (Rothschild and Stiglitz, 1976; Wilson 1977, Cutler and Zeckhauser 2000). Essentially a potential for health insurance market failure emerges because either people opt for the wrong plans because of an insufficient understanding of their risks and probabilities of illness and insurers have an incentive to attract low risk and repel high risks (Robinson, 2002). Even if these problems could be overcome and all insurance was sold at actuarially fair prices (that is truly reflecting buyer's risk profiles) and there were no adverse selection problems it would be in the self interest of both high and low risk individuals to purchase insurance coverage in line with their specific risk type. This implies high risks paying substantially more for insurance than low risks; which not only creates risk segmentation but also at some point practically compromises the practical basis on which insurance springs - namely that the demands of the few are covered by the many.

These problems of risk segmentation and adverse selection create market failures that create a case for government intervention and a number of authors argue strongly that regulation by itself will not offset such problems (Cutler and Reber, 1998; Cutler, 2002; Colombo and Tapay, 2004). These authors argue that mandatory coverage is required to prevent the healthy from declining coverage, and a single health plan is needed to prevent sorting by risk.

This thesis does no attempt to debate this issue further but instead the point is merely made that even if the above is accepted it does not follow that all healthcare expenditure should be channelled through a national insurance plan. The reasons why this is not necessarily so (indeed certain economists such as Pauly (1968) would say they have demonstrated quite definitively that it cannot be so) can be summarised as follows.

Firstly, as previously indicated, the problem of moral hazard is not merely an issue for private insurance schemes but also applies (perhaps even more so) to public insurance systems. This creates an economic argument for some costs to be borne by the individual in some circumstances – typically some form of co-payment or deductible- to counter excessive demand/ lack of attention by the individual to maintaining their own health. Secondly, individuals differ in the value they attach to different forms of healthcare consumption and also in their ability/willingness to pay. Where a single insurance plan sets uniform entitlements, this makes no allowance for individuals to express their preferences to purchase higher (or lower) levels of entitlement. Arguably, the ability to purchase healthcare privately running alongside a national plan such as the NHS increases ‘allocative efficiency’ (Hall and Jones 2007); This also helps explain why individuals and companies choose to purchase private medical insurance/care, despite the existence of the NHS. The studies by Higgins and Wiles (1992; 1996), Thorogood (1992), and Cant and Calnan (1992) reinforce that point. Some individuals with disposable income decide that sole reliance on the NHS is not a palatable proposition. In effect they are willing to pay for healthcare consumption at a price that exceeds that set by the universal scheme (the NHS).

The issues outlined above forms part of the conceptual framework for this thesis –especially the question as to the degree to which consumers should be given direct incentives to restrict their demands for care, and to choose cheaper or higher quality providers.

The thesis also discusses certain other aspects of health care organisation that limit the efficient working of markets. The current literature contains many references to ‘distortions’ arising from factors such as professional power, lack of price/quality transparency, anti competitive behaviour and the psychological dependency of the patient on the provider. The above, both individually and collectively generate considerable debate as to whether these represent terminal flaws in any market based solution (Reinhardt 2001, 2007; Freidman, 1991; Culyer, 1989; Hubbard, Cogan, and Kessler, 2005), as does the question as to whether healthcare should be seen as a consumer good at all?

All of the above are examined within the thesis in subsequent chapters. To help set a foundation for the later discussion, a brief review of the current literature is provided below.

### **The Influence of Health Professionals**

The influence that health professionals have on healthcare organisation and delivery is well documented in both the sociological and economic literatures. Accounts of the history of the NHS chart the significant role of the medical profession in determining the form of the service (Powell, 1966; Pater, 1981; Webster, 1988; Owen, 1988; Rivett, 1998;) as well as the ‘implicit concordat’ by which the profession was given substantial autonomy and powers of self-regulation in return for managing the provision of care within available resources (Jacob, 1988; Klein, 1990; Allsop and Sacks, 2002). To a considerable extent, the position of the British medical profession resembled the professional dominance reported in the classic American literature (Kessel, 1958; Freidson, 1970a; 1970b; Abbott, 1988; Mechanic, 1991), even if there were also echoes of the erosion of power over time via increased regulation and the rise of countervailing powers (Light, 2000). The tension between professional autonomy and state or managerial control is particularly well documented (Freddi and Bjorkman, 1988; Scrivens, 1988; Wolinsky, 1993; Harrison and Pollitt, 1994; Ferlie, 1997).

Major NHS reforms from the Griffiths general management reforms of the 1980s onwards have commonly been conceptualised as attempts to undermine professional autonomy and self regulation (Harrison and Ahmad, 2000; Davies and Harrison 2003.). In the eyes of some commentators recent developments associated with clinical governance and contracting threaten the original ‘compact’ between doctors and the state, and suggest a diminution of medical autonomy in a bureaucratised NHS (Klein 1998; Griffiths and Hughes, 2000).

Private-sector practice seems to provide an illuminating window on the extent of any reduction in professional power across the system as a whole, but the author has been unable to locate any studies that explore relations between insurers and the doctors who contract with them to provide private medical services, and the extent of any parallel tensions. This thesis provides an opportunity to examine the interplay of purchaser and professional power in the private sector context.

The ability of doctors to exert collective resistance to attempted reform rests also on their demonstration of a 'knowledge mandate' (Halliday, 1987); a point that applies equally whether the body attempting the reform is government, insurer or even hospital management. Doctors have long relied on their cultural authority (Starr, 1982) and the indeterminacy and mystique of clinical judgment (Jamous and Peloille, 1970) to counter attempts to impose standardised rules or protocols affecting care delivery.

As will be seen this thesis provides further evidence – should any be required – of the power of that knowledge mandate. In that respect it is worth considering at the outset that insurers' nervousness as to the clinicians' reactions to proposed change typically has two foundations. One is the negative impact of *de facto* clinical embargoes which create problems for patients attempting to access services. The second concerns public perceptions and the negative impact for an insurer that is likely to follow from an open dispute with doctors. This dynamic applies to a commercial company such as Bupa, just as much as to a Department of Health civil servant or an individual manager in an NHS Trust.

## **Psychological Dependency**

The particular characteristics of information asymmetry and psychological dependency between patient and provider are closely associated with the professional status of the medical profession in the developed world. Hall (2001) argues that the psychologically traumatic nature of serious illness and the vulnerability it creates means that trust is a central psychological phenomena in healthcare...regardless of its desirability. Parsons' (1939, 1951) seminal theoretical work on the doctor/patient relationship emphasised that patients were helpless, anxious, vulnerable and lacking technical competence (1951, and were subject to "very complex non -and irrational reactions". .Parsons also noted the cultural expectation to

‘do something’, and for him ‘magical thinking’ could be found in both patients and physicians. However, this view of the physician as the agent of patients’ desire to ‘do everything possible’ needs to be tempered by the findings of a number of studies through time that vulnerable, poor, sick patients are discriminated against (Falk, 1933; Anderson, Collette and Feldman, 1960; Freidson and Feldman, 1963; Roth 1969).

Notwithstanding these concerns, Mulley (2009) and Newman (2008) have highlighted the post-enlightenment belief that science mediated by the expert clinician objectively determines what is the best medical care for each patient. This confers natural authority for decision making on clinicians, and absolution from responsibility on patients.

Probably this account risks caricaturing real-world clinical encounters, not least because decision making in healthcare typically takes place as a series of conditional probabilities which become clearer over time (Groopman, 2008). Uncertainty in medical practice has been one of the classic themes of health sociology, so that Fox (1999) asserts that uncertainty, variability and interactions increase as medicine progresses. Studies have shown that many clinicians are not adept at dealing with such probabilities and communicating the resulting uncertainty (Eddy, 1984). This is one explanation for the variations in clinical activity and outcomes reported worldwide (Glover, 1938; McPherson et al, 1982; Fisher, 2003; Wennberg and Cooper, 2009) though by no means the only one. Patient expectations and commercial considerations (Gawande 2009) also feature in the literature and this thesis will see these issues played out in relation to areas such as incidence of particular procedures (chapter 4), accreditation to undertake particular operations and length of stay (chapter 7).

### **Lack of Price/Quality Transparency**

Third-party payment typically generates problems with price transparency because often the service is free at the point of consumption (most notably with the NHS but also for many with zero-excess insurance) (Herrick and Goodman, 2007).

Transparency problems commonly take two forms. The first is concerned with the person utilising the service not being made aware of the cost of that service or of the different prices that different providers would charge for the same service. Research suggests that neither the

general public or clinicians have good knowledge of the actual costs of healthcare (Allan, Lexchin and Wiebe 2007; Herrick and Goodman, 2007; Cooke 2010)

The second issue relates to the non-transparency of provider prices. This links to the ability to discern the quality of the service(s) on offer. Both are information asymmetry issues as previously noted – especially the latter as it relates to the technical complexity of presenting many quality issues in healthcare. These may relate to issues of quality assurance, professional competence and trust that cannot be easily monitored by a purchaser, but there are also issues concerned with breakdowns of price against activity performed and quality reporting, that appear to be more easily resolvable, but remain endemic. This area is closely related to price discrimination issues covered in the next section and authors tend to cover both issues in their treatment of the subject (Kessel, 1958; Anderson, 2007; Reinhardt, 2006; Dobson, DaVanzo and Namrata, 2006).

The problems with quality reporting are extensively covered in Chapter 6 and in their practical application mirror the problems of price transparency.

### **Anti –competitive behaviours and countervailing powers**

Kessel's (1958) discussion of price discrimination remains the foundation for economic analysis of the behaviour of providers - particularly doctors. The argument in essence is that members of the medical profession will typically behave as discriminating monopolists. That is to say they will seek to extract surplus profits by charging what a particular market segment will bear. This is aided by information asymmetries and the lack of price transparency discussed above. Likewise Miller (1992) noted that UK doctors have routinely engaged in anti-competitive behaviour. It should be noted that geographical and service monopolies or quasi monopolies are also possible for hospital and other type of service providers (Evans-Cueller and Gertler,2003; Propper, Burgess and Green 2004).

Hostility to price or other forms of competition can also be seen in the ban on doctors advertising (General Medical Council,1993). Writers like Kessel (1958) and Herrick and

Goodman (2007) argue that there is also a strong cultural bias within the medical profession against overt competition amongst doctors.

The influence of health professionals, psychological dependency, anti-competitive behaviour and the concept of countervailing power are interlinked. The first three generate the foundation from which medical practitioners continue to exercise professional power in the face of the countervailing powers of those who wish to control their freedom of action and their incomes (most typically hospital management, insurers and government).

Countervailing power is a theory of political modification of markets, credited to John Kenneth Galbraith (1952). It describes the balancing of the market power of one group by another group. An example would be a supermarket chain uses its buying power to counter the price rises imposed by a large supplier

Subsequently the theory has been much explored in healthcare - especially in the USA. Light (2000, 2004) has provided several detailed reviews of the issue within the context of the development of the US healthcare system. Yet it remains unclear whether the image of a balance of opposing forces has entirely displaced the older theory of professional dominance (Friedson, 1970a, 1970b; Starr, 1982), which makes a more direct connection between professional expertise and market power (Larson, 1977; Weller, 1983). Both theories transcend national boundaries and might apply in broad outline to the public and private sectors in the UK.

Whilst professional and hospital resistance to efforts by insurers to reduce prices and set quality thresholds are manifest in the events described in this thesis, it should be emphasised that countervailing power is a two-way process. As such the insurer initiatives described in this thesis can be represented as attempts to counter the power of the medical profession to decide how services will be provided and set prices. These insurer initiatives can be seen as the UK private healthcare equivalent of what Light described in the USA as “the revolt of payers as countervailing powers” (2004 pg.206) in the face of escalating costs and diminishing returns. Light describes this change as being characterised by:

“...a growing distrust of doctors’ values, decisions, and even competence, as evidence mounted of overtreatment, medical errors and uneven quality, and large variations in practice style. This has led to a profoundly threatening shift, from granting physicians

exclusive control over how they practiced medicine, to close monitoring of their practice.” (Light 2004, p.206).

Despite the fact that Light presents this within the context of what he considers to be a particularly American malaise, and which forms part of a wider critique of the US health care system, the quotation above could just as well apply to UK private and even public healthcare.

Countervailing powers as a model focuses attention on the interactions of powerful actors who are inherently interdependent, but have distinct interests and constituencies. The events described in this thesis provide testimony to its descriptive power, but there is also some support for the idea that, although now facing more sustained challenges, professional power remains very significant. As will be shown, the period studied saw a series of moves by insurers and counter-moves by the medical consultant bodies, in which - for the time being at least - the latter were largely successful in safeguarding their interests

### **The Dynamics of Patient Choice**

The above factors impact on the capability of patients to exercise choice, especially informed choice. Those authors most sympathetic to markets in healthcare place great store not only on the intrinsic importance of choice as an expression of sovereignty but also on the potential of consumer choice to reform healthcare (Herzlinger, 1997; Enthoven, 2004; Porter and Teisberg, 2006). Against this there is a strong counter-current in the UK policy commentary which argues that choice detracts from other forms of public engagement and makes the case for a wider conception of voice (Forster and Gabe, 2008; Hunter, 2009; Hughes, Mullen and Vincent-Jones, 2009)

Patient propensity and ability not only to discern differences in providers but also to travel to different provider locations are clearly crucial in this regard. Evidence that they are actually prepared to do so is however mixed. In the UK whilst some studies (MORI, 2006) signal a degree of willingness by patients to move between hospitals and a MORI poll of 1,982 adults in 2002 for the BMA reported 27% as saying they would go anywhere in the UK and 15% anywhere in Europe the evidence from actual schemes tends to support a more conservative view (MORI, 2002). In Wales for example take up of the ‘second offer’ (an opportunity to be treated within the waiting time target by moving to an alternative provider) by patients in

2003/4 (the last year statistics were made available) 828 patients out of 3750 declined the opportunity of earlier treatment and at another hospital. Of those who declined the offer 262 said it was because they did not want to travel, 92 wanted to stay with their consultant, while 299 said it was to do with social reasons such as they may not be able to be visited by friends or relatives (Hutt, 2004).

As will be demonstrated later in this thesis, willingness to travel and mechanisms for discriminating between providers are also extremely important issues in private healthcare. Indeed, as the volatility of patient flows is an important determinant of the elasticity of demand for healthcare from a particular provider (or more pertinently its inelasticity), this is central to the question as to the extent to which an efficient market can operate in healthcare.

## **Transaction Costs**

A final factor that will play out throughout this thesis relates to the issue of the transactional costs associated with attempts to change existing relationships between providers and insurer(s) through contractual arrangements and the use of tenders. All forms of exchange involve transaction costs which depend on three features associated with the goods or services exchanged: asset specificity, uncertainty and frequency of exchange. (Coase, 1937; Williamson, 1975). Transaction cost theory predicts that in exchanges characterised by high complexity, uncertainty, asymmetry of information, specificity of investment and frequency of exchange, buying goods and services from an external party will generate high transaction costs. At some point this becomes such an inefficient way of procuring goods and services (because of the high transaction costs involved in negotiating, drafting and monitoring highly complex and detailed contracts) that left to their own devices such arrangements are likely to evolve gradually into integrated hierarchical structures (Williamson, 1975).

Various economists (Coase R. 1937; Williamson, 1975) have commented on healthcare being an arena where transaction costs are likely to be quite prominent due to the inherent difficulty in determining complete ex ante contracts due to factors such as information asymmetry and technical difficulties in measuring quality. The theory has been specifically applied to healthcare reform in the UK public sector (Crosson, 1988; Dixon, Le Grand and

Smith, 2003; Edwards, 2005; Marini and Street, 2007, Paton, 2010) where as described above the costs of formal contractual arrangements against 'collaborative' behaviours have typically attracted negative comment.

This thesis provides an opportunity to review the issue within the context of the private sector. For UK private sector insurers these difficulties are generally less acute than for NHS commissioners because the uncertainty inherent in prospectively determining demand and case mix in contracts with providers is limited by various clauses within the policies issued by the insurer to the policy holder (the patient). Thus treatments are typically discrete episodes with insurers not covering chronic conditions and often setting financial thresholds in terms of utilisation (for example with regard to outpatient visits and therapies and in some cases with regard to the cost of an operation/treatment).

Transaction costs can be split into four separate cost elements relating to the transaction in question (Williamson, 1985). Search costs, which include the costs of gathering information to identify and evaluate potential trading partners. Contracting costs, which relate to the costs of negotiating and documenting the agreements. Monitoring costs which refer to the costs associated with ensuring (through monitoring) that each party is fulfilling its obligations and enforcement costs which refer to the costs associated with ex post bargaining and sanctioning where there is considered to be a performance issue relating to the agreement. Opportunistic behaviour by either party needs to be guarded against but in attempting to do so transaction costs rise (Klein, Crawford and Alchian, 1978). As noted above the cost dynamic behind transaction costs is such that at some point the costs of contracting in a certain way become prohibitive for one or both parties. Later chapters will serve to illustrate how this issue (and the other themes) play out within the context of private healthcare in the UK and in particular with Bupa's approach to speciality contracting and quality assurance

## **The Literature of the UK Health Market**

The healthcare market in the United States has generated extensive research and a voluminous literature written over several decades. There are scholarly accounts of: US health care's development as a pluralistic rather than a national health insurance system (Béland and Hacker, 2004 ; Quadagno, 2005); the changing regulatory environment (Jost,

1988; Weissert and Weissert, 1996); relations between corporatized medicine and physicians (Starr, 1982; Light, 2004); oscillation between periods of increased regulation and enhanced market competition (Altman and Rodwin, 1988); shifts in the market power of buyers, sellers and consumers (Hafferty and Light, 1995; Quadagno, 2004); trends towards vertical integration versus specialist 'carve outs' (Shortell et al., 1994; Frank et al., 1995); and attempts by purchasers to use buying power to drive quality improvements (Bodenheimer, 1999;). Doctoral research on any of these topics could draw on a plethora of published studies beyond the indicative examples provided. By contrast the literature on the UK private healthcare sector is thin and leaves many gaps.

The most comprehensive recent account can be found in Foubister and colleagues (2005) descriptive overview of UK private medical insurance (PMI), which aims to set the British system in European context. The authors note that previous published British research has centred mainly on surveys of the demand for PMI, with relatively little written about the product or the health insurance industry. They describe the UK as an often-cited international exemplar of supplementary voluntary health insurance, which however has not been documented in detail apart from industry reports. The descriptive account provided is based on such reports as well as data gathered from the main industry analysts Laing and Buisson, and single interviews with representatives of AXA PPP, BUPA, Norwich Union Healthcare and Standard Life Healthcare.

The study describes the two PMI sub-markets - the individual and corporate markets, the basic features of underwriting and pricing, policy types and common exclusions, and the regulatory framework, including the roles of the General Insurance Standards Council (GISC - a form of industry self-regulation) and the Financial Services Authority. The authors chart the changing patterns of demand for PMI services noting the declining numbers of individual subscribers and the relatively stronger performance of the corporate business. They suggest that the principal factors affecting such uptake are perceptions of the quality of NHS treatments and the price of private insurance. The study points to certain recent changes in the industry such as the entry of for-profit commercial companies in the 1990s, the entry of insurers on an underwriting-only basis, and the entry of PMI carriers without an underwriting capacity of their own. The authors note that premium income continues to exceed claims expenditure, but that this has depended on increases in premiums rather than extra customers. Overall this study provides a valuable synoptic review of recent trends in the UK PMI

market, which however relies mainly on industry reports and does not move beyond description to consider the issues discussed in this thesis.

Other available material on the UK private market is heterogeneous and now largely outdated. The growth from the late 1970s onwards of the numbers of private hospital beds and subscribers to private insurance prompted a flurry of early studies (Day and Klein, 1985; Grant, 1985; Mohan, 1986; Raynor, 1987; Griffith, Iliffe and Rayner, 1987; Higgins, 1988; Propper and Maynard, 1989). The emphasis was on understanding increasing demand and other factors that would explain the emergence of a private healthcare sector in the shadow of the NHS, and describing the nature of the market and the providers. Thus Joan Higgins' influential book charts the transition of private health insurance from 'cottage industry' to commercial business, noting the growing role of for-profit (predominantly American) insurers and hospitals in the 1980s and offering an assessment of the 'winners and losers' as private health care expanded. Two interesting early publications by Bryant (1968) and Robb and Brown (1984) document the history of Bupa from 1947-83, but describe a very different environment from that applying at the time of the present study.

In the twenty years or so since the first batch of studies, a number of authors have attempted to chart the further growth and development of private insurance and provision (Salter 1995; Mohan, 1991; Yates, 1995; Higgins, 2004; Chapman, 2004). Mohan (1991) further explores the trend towards commercialisation and internationalism discussed by Higgins, noting that though the involvement of multi-nationals was more evident their overall impact on the UK health care market remained quite limited (a perceptive assessment considering the continuing pre-eminence of a provident association – Bupa – to the present date). Saltman (2003) made the interesting point (also mentioned by Foubister and associates) that the line between the public and private sectors was becoming less clear in the UK, again observations that have been borne out by subsequent developments.

The nature of demand was a central preoccupation of the work of Higgins and other early writers, and was researched further in the 1990s (Saunders and Harris, 1989; Busfield, 1990; Higgins and Wiles, 1992; Cant and Calnan, 1992; Thorogood, 1992; Calnan et al, 1993a; 1993b; Black, 1993; Wiles, 1993; Wiles and Higgins, 1996). These studies examine which groups use private care, what factors make private care attractive, why women were more likely than men to go private, why Black women in particular made greater than

average use of private GP consultations, the degree to which patients operated as consumers with knowledge of options and outcomes, the role of GPs in steering patients towards private options, and the nature of the private consultation and the balance between mutuality and consumerism. Writing from an economics perspective, Besley and colleagues (1999) and Propper, Rees and Green (1999) investigated the significance of NHS waiting lists for private demand. Some of the findings and theories from this body of work are discussed in Chapter 2.

An additional paper which provides background information relevant to this thesis is Thomson and associates (2004) discussion of regulation and quality control in UK private healthcare. These authors discuss the roles of the Independent Healthcare Association (IHA) and the National Care Standards Commission, and discuss the IHA's initiative to establish a set of key performance indicators to support quality improvement. They note that private insurers are increasingly pressing hospitals to participate in quality improvement programmes, and predict that the trend towards commissioning NHS care in independent hospitals may also mean that hospitals must become increasingly attentive to purchasers' quality requirements.

Farrington-Douglas and Coelho (2008) provide a useful summary of the current place private spending occupies within the UK health system and make a case for its continuation within a system dominated by public funding and provision but once again this is more of a general macro economic analysis than an attempt to understand the dynamics of the UK private healthcare sector. Commercial reports by the likes of industry commentators Laing and Buisson do attempt such an analysis but are not in the public domain and expensive to purchase. For example Laing's Healthcare Market Review 2010 costs £390, whilst Market and Business Development's 'UK Private Healthcare Market Research Report 2009' costs £600.

## **Plan of the Thesis**

The thesis attempts to answer the following questions:

1. How has the UK private healthcare market operated historically? What dynamic has underpinned the operation of this market?

2. How has Bupa as the dominant UK insurer tried to influence that market?
3. How successful has it been in this regard and what lessons can be drawn from this?

The subsequent layout of this thesis attempts to address these questions as follows:

## **Chapter 2: The Structure of the United Kingdom's Public and Private Health System**

This chapter examines the key structural elements of the UK private health system, highlighting those features of the private sector deemed particular to the UK. It explores the impact of the historical relationship between the public and private sectors on the development of private sector and of market based initiatives within it.

## **Chapter 3: Market Reforms and the Hospital Sector in the UK**

This chapter examines the current structure and dynamics of the private hospital sector, with a particular emphasis on the historical forces that have shaped it. These characteristics are explored in terms of the response of hospital providers to attempts by insurers (particularly Bupa UKM) to establish networks and reduce prices (or price inflation).

## **Chapter 4: Consultant Reimbursement and the Prospects for Cost Control**

This chapter examines the principal methods of reimbursing consultants in the NHS and the UK private sector. It discusses insurer initiatives to reform consultant reimbursement by introducing relative value scales and to exert downward pressure on costs by use of benefit maxima schedules. The high level of consultant charges in the UK PMI market is examined, and an explanation is offered of why payers have been largely ineffective in pushing prices down. An assessment is undertaken of the prospects for reform that would lead to lower prices without sacrificing clinical quality. Particular reference is made in this chapter to the approach adopted by Bupa Health Insurance in relation to these issues. This represents the first published account of a major insurer's reimbursement methodology, and its attempts to influence prices and the general market for clinical services.

## **Chapter 5: Bupa's Specialty Network Initiatives**

This chapter discusses recent initiatives by UK insurers to establish specialty networks. The main case study presented is Bupa UKM's attempt to introduce an ophthalmology network, and the resistance it provoked from providers. The chapter also considers AXA/PPP's

successful roll out of a more limited cataract surgery network with less professional resistance, and Bupa's recent establishment of a physiotherapy network.

### **Chapter 6: Promoting Clinical Quality: Concepts, Issues and Experiences in the USA and the British NHS**

This chapter discusses the concept of quality in health care and some of the key issues in this area. It moves on to examine the approaches to quality in the pluralistic US health care system (where notions of purchasing for quality originate) and the NHS (the public system that now offers significant opportunities for an expansion of UK private sector activity).

This chapter sets the scene for a detailed study of the promotion of clinical quality in UK's private sector.

### **Chapter 7: Quality and the UK Private Sector**

This chapter describes how quality issues are currently dealt with within the UK's private sector. Central to this are a series of case studies which review Bupa's quality initiatives over the last decade.

### **Chapter 8: Conclusions**

This chapter draws together the evidence presented in the thesis and presents conclusions.

## CHAPTER 2

### The Structure of the UK Public and Private Health Systems

#### Introduction

This chapter sets out to examine:

- (i) The key structural elements of the UK public and private health systems;
- (ii) Features of the private sector particular to the UK;
- (iii) The impact of the historical relationship between the two sectors on the issues under consideration in this thesis.

The main aim is to highlight key features of the environment that Bupa UKM operates within, rather than provide a detailed review of either the public and private system *per se*. The subsequent chapters, which examine the particular characteristics of the UK ‘markets’ for both hospitals and doctors provide more detail in any case.

#### UK Public Health Care

Since its formal establishment on the 5<sup>th</sup> July 1948, health care in the UK has been dominated by the National Health Service (NHS). The National Health Service Act, 1946, aimed to create a comprehensive health service and although there have been changes (of increasing frequency) in the administrative arrangements for delivering these services, the operative provisions of the initial legislation remain essentially in force.

As such the fundamental characteristics of the NHS were set over 60 years ago. These might be summarised as follows:

- A single payer system (government) principally funded by taxation;
- Comprehensive care, universally provided;
- Hospitals owned and operated by the public sector;

- With the exception of general practitioners, dentists and opticians (who are mostly independent practitioners supplying services to the NHS) staff (including hospital doctors) are salaried;
- Ministerial accountability for the funding and operation of the NHS;
- Most care is provided free at the point of treatment..

The architects of the NHS wanted to create a healthcare system that provided care based purely on relative need - not ability to pay. Aneurin Bevan (1952 p.100) stated that:

‘The collective principle asserts that.... No society can legitimately call itself civilized if a sick person is denied medical aid because of lack of means’.

That vision still remains essentially intact with co-payment charges restricted to primary-care prescribed drugs (even these became free in Wales from April 2<sup>nd</sup> 2007), dentistry and spectacles. A large number of UK citizens (those claiming disability or unemployment benefits, children, pensioners, pregnant women) have always been exempt in any case.

Unsurprisingly, such a radical and comprehensive state funded and administered system has dominated health care in the UK. Until comparatively recently the conventional wisdom, publicly expressed by successive health ministers was that the NHS, as a public sector monopoly supplier of health services, represented the best value for money health system in the developed world. The private sector and the notion of market based competition had little or nothing to offer. The emphasis was squarely on central planning and a reliance on political direction coupled with clinical autonomy to deliver operational objectives. Whilst the attempt by Margaret Thatcher’s Conservative administration to introduce both an internal market and general management to the NHS in the early 1990s signalled that this mindset was changing, it was not until the second Blair administration that there was any serious questioning of the NHS as a monopoly provider or indication that market mechanisms might have a wider role to play.

The manner in which the NHS was established also effectively set the shape and nature of the private sector. For the most part they have been separate systems - with the private sector acting as a substitute service (mainly for elective care) rather than the kind of supplementary insurance role operating in a number of European countries. This had been aided by a traditional hostility from many to any mixing of the two sectors. Despite this, a central

feature of private healthcare in the UK has been the dependence on staff who have been trained by the NHS and more particularly on consultants who spend much of their working week employed by the NHS.

This historical relationship was set by the compromises Aneurin Bevan (the first Minister for Health) considered were required to get the NHS established in the first place. He had to overcome political opposition not only from the Conservative Party and sections of his own party, but also from the British Medical Association (BMA). The absence of professional support threatened to derail the NHS before it was created. After a protracted period (18 months) of ongoing dispute between the Ministry of Health and the BMA, Bevan finally managed to successfully win over the support of the majority of the medical profession by offering what may have seemed then as relatively minor concessions. Bevan allegedly uttered the now oft quoted remark to a colleague that in order to broker the deal he 'stuffed their mouths with gold'. The essence of that deal was to allow consultants considerable autonomy of practice and freedom to treat patients privately in their spare time, in return for their becoming salaried doctors within hospitals. General Practitioners (GP's) remained private contractors albeit with a near monopoly payer - the State.

The legacy of that 'deal' has had far reaching consequences. Whether Bevan needed to reach such a seemingly generous arrangement with consultants is a moot point as many consultants, unlike GP's, needed (and continue to require to this day) large teams and costly buildings and equipment to do their work. Nationalization of the hospitals meant most consultants would have had nowhere else to go. Like it or not - and most of them certainly did not – realistically they needed the means of production (hospitals) that only the State could provide. However one consequence of that agreement has been that until recently most NHS medical salaries had arguably been set below the level which a doctor might expect to earn in a market that was not dominated by a single organisational employer. Against this there is the potential counter-argument that the medical profession in the developed world has been highly successful in harnessing the support of the State to create barriers to entry and regulate workforce numbers so as to ensure higher income than otherwise would be the case in an unregulated labour market. Overall, the degree to which doctors operate within the context of a monopoly employer or not is secondary to their ability to exert influence in the manner described above. This phenomenon has been discussed in an extensive literature – especially as it relates to the USA (Johnson, 1972; Larson, 1977;Freddi, 1989; Rosner, 1982;

Torstendahl and Burrage, 1990; Light 2000, 2004) but also with regard to other developed countries, including the UK ( Larkin, 1983; Rivett, 1988; Willis, 1989; Wilsford, 1991; Immergut, 1992; Yates,1995)

However, with regard to the UK, the implicit expectation was that consultants (particularly in the ‘demand’ specialities - such as orthopaedics, surgery, and anaesthetics) would make up *any* potential ‘shortfall’ between their NHS salary and the income a consultant expected, by recourse to private practice. This dynamic is explored in detail in chapter 4 and for the present we shall confine ourselves merely to noting its existence. Such a ‘laissez faire’ attitude to employment practices and potential conflicts of interest for consultants had been a marked feature of the UK health system. Recent changes (not least the cost inflation brought about by the 2005 Consultant and GP contracts) have brought these ‘understandings’ under increasingly critical scrutiny. However to date they still remain largely in force.

## **The Private Sector**

Bevan had been prepared to allow private practice to persist as part of the ‘compact’ with the doctors, but it is unlikely that he would have anticipated the growth of private provision in the 1970s and 1980s. The private sector has had to exist in competition with a huge competitor that provides free (and for the most part) comprehensive care. As previously noted, the doctors who work for the private sector are almost exclusively NHS consultants (thus reducing claims of a quality differential). Private insurance is considered by much of the population to be prohibitively expensive (as is self pay) (Propper, Rees and Green 1989; Propper and Maynard 1993). This does not sound an encouraging basis from which to generate profits. However the very fact that for much of its history the UK private health sector has not been considered a serious rival to the NHS in service terms but rather a niche provider, gives it a number of advantages compared to the same sector in other developed nations.

First and foremost, both private providers and insurers have for most of their history been subject to considerably less regulation than in other developed countries. Health insurers in particular, enjoy a very ‘light touch’ compared to their European and American counterparts. Insurers have not been bound by the usual restrictions of community rating, risk equalisation,

comprehensive cover, 'Any Willing Provider' (AWP) reimbursement, obligations to offer insurance to anyone seeking it, caps on profits etcetera that are features of health insurance regulation in many countries.

Secondly, although the Competition Commission has intervened occasionally to veto or investigate proposed takeovers (such as Bupa's proposed purchase of Community Hospital Ltd in 2000), (Competition Commission, 2000) for the most part the industry has not been subject to the same kind of scrutiny that one finds elsewhere - especially in the USA. Whilst only 29% of private beds were in commercial hands in 1949 this proportion had increased to 56% in 1979 (Busfield, 1992) and the trend continues. Recent evidence to support the assertion that this shift has taken place with relatively little interference from the regulatory authorities will be subsequently supplied in both the hospital and consultant chapters in this thesis.

Thirdly, the cost of building or acquiring a hospital is typically considered to represent a considerable barrier to entry. In the UK private market this has been compounded by the network policies of most insurers (described in some detail in the next chapter). In addition hospitals compete for a limited supply of NHS consultants - a position that often favours incumbent providers.

Fourthly, there are the historical 'failings' of the NHS - long wait times, relatively poor physical environment and food, a reliance on junior medical staff to perform much direct medical care. Underpinning this has been a culture that still owes more to paternalism than the kind of customer-centric focus typically seen in other service industries. This has made for a ready market of potential subscribers, with arguably the principal limitation being the cost of premiums rather than ideological rejection of private healthcare *per se*.

Certainly it was the conventional wisdom at Bupa that many people in the UK would wish to arrange cover with a private health insurer (and particularly with Bupa) only if they considered themselves to have sufficient disposable income to do so. Whether this was indeed the case is debatable. It contrasts with the argument advanced by Calnan, Cant and Gabe (1993) that the majority of the UK public prefer the NHS, and would not use the private sector if there were sufficient improvements in that sector and/or their employer had not made health insurance a feature of their overall benefits package.

The characteristics of consumer demand for private health care that results from a health system dominated by a public sector provider, funded by general taxation and free at the point of delivery, is somewhat different from one where much greater plurality of funding mechanisms and service provision occurs (such as in much of mainland Europe). In the former case private health care is much more likely to be seen as a luxury good (Propper 2000). Economists define a luxury good as one where demand rises more than proportionately as income increases, and where the consumer exercises discretion to purchase a higher level of service or product than is available to the majority of the population. By contrast in a mixed pluralistic system, use of the private sector is more likely to be regarded as part of a gamut of choices available to almost everybody, based on traditional notions of relative price/value of competing 'products'. This is an important difference between the health care 'market' in the UK and most other developed nations. One consequence of the above has been to channel private providers and insurers to make their profits through operating in a niche market, with only limited overlap with the larger public health care system.

Following on from this we have a fifth 'advantage' - namely that the public and private sectors had been operating for most of the last 60 plus years in parallel areas of healthcare but with little crossover or point of contact beyond a reliance on the same consultants. This general lack of a symbiotic interrelationship between sectors reinforced a marked propensity of both sectors to develop distinct organisational cultures, operating methods, and target audiences. It also meant that historically the two sectors had little or no tradition of competing against each other, aside from some (very) limited competition between private hospitals and the private patient units of NHS hospitals. As will be noted later in this thesis, the Blair/Brown governments made it a central plank of NHS reform in England to create more competition via the use of the private sector - a policy that increased competitive threats for the current incumbents of the private as well as the public sector – and which looks set to continue under the present coalition government (DoH, 2010a). However this has been a relatively recent innovation - and stands in stark contrast to the situation that had been in place for most of the post-war period, where the overall structure of the UK health system not only subdued competitive forces but also ensured that the great majority of the British public had no experience of healthcare as an area in which to make consumer choices. Again this

has been a distinguishing feature of the UK health system compared to many other developed countries.

The above left both the NHS and private sectors with a dearth of experience in terms of providing services in each other's traditional area of operations. Private hospitals are typically very small by NHS standards, reflecting the fact that they concentrate on elective procedures and diagnostics for a relatively small percentage of the local population. They are also often of a noticeably higher aesthetic standard. NHS Hospitals - by contrast - are usually much larger, reflecting a significantly wider range of specialties, case mix, patient volumes and need to balance elective work against emergency demands.

The dominant private sector contract currency has been (and remains) fee-for-service, sometimes also using a *per diem* methodology. This results in a degree of uncertainty about future income levels, which is very different from the traditional NHS situation. For many years NHS hospitals' income was effectively fixed through a series of block contracts, which guaranteed a lump sum payment irrespective of the precise volume of patients treated. A similar lack of shared experience and expertise can be found amongst purchasers. UK private health insurers can effectively choose what they will and will not cover and as a result have little or no experience in purchasing services that provide for those with either emergency or chronic conditions. They do have expertise in actuarial analysis - which is almost completely absent amongst NHS commissioners. They are used to regarding their members as customers who can take their business elsewhere. As such the prevailing culture is of a service industry - something typically lacking amongst NHS commissioners who will have a propensity to view themselves as an agency of government.

A point of similarity is that both insurers and NHS commissioners undertake negotiations with providers. Historically health insurers had greater experience of undertaking 'real' negotiations – particularly with clinicians - as in reality much of this is negotiated centrally in the NHS. However, NHS hospital managers are becoming increasingly experienced in forging local agreements with clinicians to undertake work outside of their contracted hours, and determining the content of their job plans in contracted hours. NHS hospital negotiations take place against a backdrop of centrally-determined inflation and productivity clauses, defined tariffs, and a mediation process whereby the Strategic Health Authority or the Welsh, Scottish and Northern Irish equivalents are expected to resolve major points of dispute.

Notwithstanding this, the negotiations between commissioners and Foundation Trusts result in legally-binding contracts and so have the potential to take on an increasingly commercial character. Documented evidence to support this view is less than conclusive despite it being a widely held belief amongst NHS managers (the author has witnessed on a number of occasions the commercial enforcement of contracts being put forward as a significant advantage of securing Foundation Trust (FT) status. Monitor have issued a series of statements reinforcing the point that FT contracts are legally enforceable and that consequently commissioners cannot subsequently refuse to pay charges set out in those contracts -regardless of their financial position (Harding, 1997; Monitor, 2011). In contrast Hughes et al's 2011 study concluded that there were few differences in the way de facto dispute resolution arrangements involving Foundation Trusts and conventional Trusts worked in practice.

One conclusion that can be drawn from the above is that this has left the UK private sector rather less well placed to take advantage of the desire of the Government to inject private sector expertise into the commissioning of NHS services than might first be imagined. As a result the immediate beneficiaries of this policy were largely overseas (often American) companies such as United Health Group, Action and Evercare with regard to disease management and Nations Healthcare and Netcare in relation to provision. The UK-based companies - including Bupa - had to play 'catch up' and are still in a situation where their claims of significant expertise in the areas above struggle to remain credible under detailed scrutiny. In the area of commissioning, Bupa has evidently been working hard to do so, as they were one of 14 companies appointed onto the Framework for External Support to Commissioning (FESC) in 2007. (See Appendix 1).

This has a direct bearing on the overall thrust of this thesis because it indicates that the historical development of the UK private health care market has been such that those operating within it are relatively ill-prepared to take advantage of potential market-based solutions to any perceived shortcomings of the public sector. This will become even more apparent when we consider in more detail the dynamics of private health insurance in the UK.

## The Health Insurance Market in the UK

Despite what might be considered an highly unfavorable starting position for marketing private health insurance - namely that a comprehensive 'free at the point of consumption' health service (the NHS) exists which all citizens contribute towards through taxation on a progressive basis relative to income - private healthcare in the UK has mostly grown steadily (if slowly) since 1948. This can be measured both by numbers insured, and private sector beds. Over that time the proportion of people using the private sector via health insurance has also grown. In 1975, 40 per cent of private sector bills were still being paid by patients rather than insurance companies. By 1989 it had fallen to 30% and half of those were overseas patients (Calnan, Cant and Gabe, 1993). The proportion of out-of-pocket payments from patients has continued to fall since then (Laing and Buisson, 2008), but may well be set to rise again as cosmetic procedures (which are rarely covered by insurance) gain in popularity. One of the most marked features of UK private health care is its high cost. This is reflected both in the reported high charges made by both hospitals and consultants (see Nuffield Nera report quoted in chapter 4 as an example of this) and also the long-term trend of above general inflation premium rises charged by insurers. Industry data shows that individual subscribers have born a disproportionate brunt of these increases (see table below):

Table 2. Private Medical Insurance (PMI) inflation versus Retail Price Index (RPI) inflation 1999-2004 (Laing and Buisson, 2005)

YEAR	RPI	PMI INFLATION TOTAL	PMI INFLATION INDIVIDUAL	PMI INFLATION CORPORATE
1999	100	100	100	100
2000	103	105	113	101
2001	105	117	120	118
2002	107	125	132	125
2003	110	132	137	132
2004	112	137	141	137

Further evidence that this long established trend continues can be seen from Datamonitor's 2010 report on UK Private Medical Insurance. This shows that whilst average premium rates for both group and individual policies continued to grow in 2009, that rate of growth varied significantly for different types of policies - being 2.2% for group policies versus 7.2% for individuals (Datamonitor 2010).

Company (and particularly corporate) subscribers achieve better rates through a combination of use of brokers and the simple buying power that numbers bring. They also tend to have an actuarially more attractive base than individual subscribers, as typically the average age of their workforce (and dependents) will be below that of the average private subscriber. The margins - and hence profitability - of the company and corporate market are significantly below that of the individual market, but they do bring volume - and hence negotiating power, and an improved cash flow. In Bupa UK Membership for example, in 2006 approximately 51% of its business was within the corporate sector, 28% in company (defined as 2 to 10 covered lives) and just 21% with individual subscribers (Laing and Buisson, 2008).

Unsurprisingly, with the combination of above inflation premium rises and the abolition of tax breaks for private medical insurance in 1997, the market for individual subscribers has been steadily shrinking. Bupa has been relatively successful in protecting this important market segment, but with average price increases of 11% between 1999 and 2003 alone, many managers regard this as an unsustainable trend. On this argument either price increases must fall back into line with general inflation or this valuable market will eventually wither away. It is the individual market that is usually considered the most directly threatened by improvements in the NHS. This sets the background against which many of the changes examined in this thesis have been, and continue to be, played out.

### *Changes in Market Share*

Within the general trends noted above there have been some changes in the relative fortunes of individual companies in terms of market share (although we should take care not to assume that this automatically translates to profitability). During the 1950s three insurance companies dominated the small private insurance market (Higgins, 1988). This market catered for only about 1.2% of the general population in 1955 slowly rising to 2.7% in 1965 (Calnan, Cant and Gabe, 1993, p.2). However, as private health care continued to expand it attracted new entrants, and that put the incumbent insurers under increased pressure. The three largest - British United Provident Association (Bupa), Private Patients Plan (PPP) and Western Provident Association (WPA) were all provident associations (see box) and these came under growing threat from commercial companies such as Norwich Union and Sun Alliance. By 1991 there were 28 private health insurers in the UK market and Bupa's share had fallen from 80% in the 1970s to under 50% by 1990 (Calnan, Cant and Gabe, 1993, p.13). Bupa's fortunes continued to take a downward turn when it followed up its first recorded loss in 1981 with a record loss of £63 million in 1990.

It was evident that the company needed to adopt a more commercial attitude and the appointment of a new Group Chief Executive (Val Gooding) recruited from British Airways in August 1998 saw a change in fortunes. The twin pillars of that success were a sustained focus on customer service and steep rises in premiums (an average 20% rise in 1991 alone) (Calnan, Cant and Gabe, 1993, p.14). The latter recovered the company's finances whilst the former helped mitigate the loss of customers. However it did mean that Bupa continued to lose market share in the early 1990's even whilst its profitability recovered.

## **Provident Associations**

Provident Associations are a type of legal organisational undertaking whose principle characteristics are:

There are no shareholders;

Any profits are reinvested in the company;

Funding cannot be obtained from the stock market (as there are no shares that can be sold). Instead funds have to be raised either from profits raised or from loans

Provident Associations were a favoured organisational form for the original private insurers/not-for-profit organisations that emerged following the creation of the National Health Service. Provident Associations included Bupa and Western Provident Association (WPA).

In Bupa's case oversight is provided by a Board of Directors and 100 'members' who have no direct economic interest in the company. Members in this context should not be confused with the general term 'member' used by Bupa to describe its insured customers in the UK.

In 2006 Bupa changed its legal status to that of a company limited by guarantee. In British company law this is an alternative type of corporation used primarily for non-profit organisations that require legal personality. A guarantee company does not have share capital, but has members who are guarantors instead of shareholders. The guarantors give an undertaking to contribute a nominal amount (typically £1) towards the winding up of the company in the event of a shortfall upon cessation of business. It cannot distribute its profits to its members, and is therefore eligible to apply for charitable status if necessary. Conceptually this appears near identical to Provident status.

Bupa UKM saw subscription income grow by 47% between 1999 and 2002 compared to an industry wide increase of 29%. A proportion of this was because of UKM's success in recovering some of the lost market share from earlier years. As of 2009 the division covered

around 2.6 million people and has 1.4 million subscribers - approximately 17% higher than in 1999 (Bupa, 2009).

This leads to two further observations. Firstly, Bupa has been relatively successful in the UK market compared to other insurers- as overall in that period UK PMI subscribers had increased by only 4%. Secondly, that as subscription income had grown, and with it the profitability margin (which had risen from -5% in 1999 to +5% in 2003 (Laing and Buisson, Bupa, 2005) in a market with relatively little overall growth, the principal cause of increased profitability related to premium increases. This illustrates the (historically) notably inelastic nature of private healthcare demand in the UK- and particularly as far as Bupa is concerned.

The only other viable explanation would be a falling cost base, but this is not the case. The continued growth of medical expenses - both hospitals and clinicians – is a recurring concern of all UK insurers. This is compounded by medical costs having a relatively high baseline. UK private healthcare has long been relatively expensive compared to most other developed countries (Bramley-Hawker and Adam, 2003) and further rises makes the gap worse.

All of the above has left the marketing and sales executives of Bupa and their commercial rivals with a persistent challenge. The cost of their product is rising year on year. Demand (generally) has remained (surprisingly) buoyant but the personal market ‘cake’ continues to shrink. How does any insurer convince customers (a) that they should purchase/retain insurance cover and (b) to choose its company instead of a rival?

A characteristic of insurance products, like financial products, is that they are largely invisible to the purchaser for much of the time. This creates two inter-connected problems. How to convince the purchaser of their utility (both initially and over time), and how to differentiate between insurance companies? The nature of these two issues is such that *prima facie* one might expect health insurance products to have very low net profitability. Yet this is generally not the case.

In the US some critics of the insurance industry have claimed that insurers enjoy good profits because of monopolistic pricing – in part through company consolidation and also because the regulatory system makes it difficult for insurers to compete across states (HCAN, 2009; Cannon, 2009). Given the large geographical size and populations of most US states, this

does not seem a particularly convincing reason for local monopolies to emerge, although insurer consolidation is an issue. In fact, insurers had a history of profitability prior to the recent wave of mergers. This suggests that profitability is not solely dependent on insurers' ability to create monopolistic provision, but can arise from factors such as their ability to forecast likely claims and set premiums accordingly, the already noted price inelasticity of health care consumption, and the ability to limit claims expenditure through underwriting and utilisation review. Moreover the above drivers are not mutually exclusive.

The median 2009 net profit margin of 11 major US healthcare insurers was 3.9% (the range was -0.3% to + 8.4%) ( Flynn, 2010). This is roughly in line with Perry's (2009) ranking of health insurance as the 86<sup>th</sup> most profitable industry in the USA. However 'The Economist' (2010) recently made the point that:

'...the better measurement is not profit, but return on invested capital (ROIC). ROIC measures how much money it takes to set up and run an insurance company, versus how much profit it brings in. Unfortunately it's not so easy to find good ROIC figures. The closest equivalent Yahoo business has is return on equity (ROE), but that can vary according to whether firms are financed through equity or debt. Still, across the entire industry this hopefully evens out a bit, and what it shows is that ROE in health insurance is about 16.1%, roughly the same as for the health-care industry as a whole, and a good deal higher than the average ROE in most sectors of the economy.'

Admittedly profitability is by no means certain in health insurance. Companies can – and do – make losses. But what is being highlighted here is the ability of most insurers to generate profits or ROIC in an industry in which – on the surface - competitors should struggle to differentiate their products. As such economic theory would predict that profits would be low as pricing moves towards a situation where marginal cost and marginal income converge. One does not have to rely entirely on explanations centring on monopolistic pricing (in either the USA or UK) to explain insurer profits. Other major determinants as previously noted include the aforementioned lack of price transparency, inelasticity of demand, and an ability to control claims expenditure. In the UK, where private health insurance is additional to the NHS and brings no tax benefits, the ability to generate profits may also be plausibly linked to the growth of the domestic economy.

Notwithstanding this, part of the explanation for insurer profitability also lies in the barriers to entry for new insurers wishing to enter the market. The principal barriers are the financial reserves required by the regulator – the Financial Services Authority (FSA) – the set up costs of marketing and sales and the complexities of attempting to obtain favourable contract terms with the major private hospital chains. Added to this is the innate conservatism of the traditional Private Medical Insurance (PMI) buyer in both the private and commercial markets in the UK. This latter characteristic also helps to explain the price inelasticity of insurance. For a company such as Bupa its ‘brand value’ - the recognition and positive associations associated with the name Bupa – directly translates into enhanced profitability and customer loyalty. The UK private health insurance market remains dominated by a few companies, of which Bupa has always been the biggest. Three companies, Bupa, AXA PPP and Aviva (formerly Norwich Union), share over 81% of the UK PMI market (Datamonitor 2009)

To help counter the ‘invisibility’ of the product, the approach at Bupa throughout the time that the author was an employee was to welcome a certain level of customer claims, particularly in the first year or two of purchase. The logic of this was that claiming against insurance reinforced its value to the claimant and also provided an opportunity for a favourable impression to be gained of the company via contact with service centre staff. Clearly there is a risk this experience will be unfavourable through long waits for the call to be answered, rude or incompetent staff, denial of the claim and so on. This is why (as will be highlighted once again in Chapter 7) Bupa’s senior executives placed such an importance on the culture and operation of the service centres.

This relative ‘permissiveness’ in response to claims was felt by the author to be one of the defining features of Bupa’s culture during his period with the company. The attitude itself inevitably brings a degree of tension between those whose primary mission sits within customer service/recruitment/retention/sales and those charged with managing claims costs. A sub-plot of that same dynamic was a relative readiness to accommodate relatively small-cost claims (for example, physiotherapy consultations) which may fall under the ‘chronic conditions’ exclusion found in most PMI rule books.

Such ‘permissiveness’ varies between companies, and this reflects the ‘image’ each company attempts to portray to the market. This functions as a differentiator in a market which sells

products that are not easily distinguishable. The 'market' itself can be broken down into relatively discreet segments. The personal market (as the name suggests) makes no use of intermediaries and is dominated by direct marketing and selling to the individual. Decisions within the small company market are also likely to be dominated by a single decision-maker, but a wider number of considerations are required to be balanced by that person. Larger company/corporate accounts make much greater use of brokers and typically delegate decisions to committees.

Within the UK the way companies have approached the differentiation issue is quite interesting. An attempt to characterize the 'brand' position of a number of the players has been made below:

Bupa	The 'IBM' of PMI. Peace of mind. Price premium but high customer satisfaction levels. Liberal interpretation of rules. Higher claims cost balanced by price management of providers by virtue of its size and expertise. Quality health care is a priority.
CIGNA	Corporate PMI specialists. Call centre manned by nurses. Managed care expertise. Niche insurer.
AXA PPP	Comprehensive, price competitive. Assertive with providers. Value for money. Strong on networks. Commercial 'nous'.
WPA	Alliance not conflict with doctors/hospitals. Customer centric. Anti managed care.
HSA	Affordable. No frills. What you see is what you get. Defined cover for limited procedures.
Prudential Health	Innovative. Rewards good health. Aimed at younger market. New player with fresh ideas.

The point is not whether these characterizations are especially accurate but rather that attempts have been made to create market segments and company 'branding'. The above positions also represent different assessments by companies of their relative strengths and weaknesses, opportunities to compete and the durability of particular segments of the market. The relative willingness - or lack of it - to highlight the company's approach to health care quality issues as a *unique selling point* (USP) is worth noting.

## **Is UK Membership acting like a Preferred Provider Organisation (PPO)?**

The key characteristics of UK private healthcare described above affect the way the PMI market operates. Furthermore the present dynamics of the private market suggest that, if current private sector practices were applied to the NHS, efficiency gains would be much less than claimed by the champions of neo-liberalism.

To this analysis one needs to add a further, more specific question - in what manner are UK insurers actually operating in relation to providers? The answer will indicate to what degree these insurers have an ability to discharge a larger role in a more pluralistic health economy - which is an important question within this thesis. The author's contention is that insurers like Bupa UKM are currently operating in a manner akin to that of Preferred Provider Organisations (PPO's) in the USA. That is to say they do not much resemble the more robust examples of US managed care organizations – the health maintenance organizations (HMO's).

The prime reason for this is that Bupa and other more traditional UK insurers do not consider the resultant behaviors would be welcomed by their customers, so that it would be commercially disadvantageous to move too far towards use of managed care techniques.. This is one of the central observations of this thesis. There is an enduring tension between the desire to undertake initiatives that aim to reduce provider costs or drive quality improvement, and concern that these will provoke an adverse customer reaction. This runs throughout the subsequent chapters where specific Bupa initiatives with regard to the market are examined.

### ***Characteristics of a PPO***

To understand what a PPO is, and why the concept is relevant to the UK, we need to make a brief diversion to the USA. Preferred Provider Organisations (also sometimes referred to as Participating Provider Organisations) have been enjoying rapid growth in the USA for some time, so that 69% of people with private health care benefits, or more than 198 million

Americans, now receive their care through these arrangements (AAPPO, 2010). This number far outstrips enrollment in HMO's. However as Hurley, Bradley and White (2004) observe in their article on the 'puzzling popularity of the PPO', the appeal of such organizations appears to lie in the PPO's ability to characterize itself by 'what it is not - namely an HMO' (p.56). According to these authors, the added value that the PPO arrangement provides to customers remains unclear: it appears more than anything to be the beneficiary of a consumer backlash against the restrictions imposed by 'a discredited HMO product' (Hurley, Bradley and White, 2004, p.56).

The precise definition of what a PPO is, and how it differs from indemnity insurance on the one hand, and HMO-style managed care on the other, is not easy to grasp. Hurley et al describe it thus:

'The PPO health benefit option is best understood as a configuration of benefit design features offered through a contracted network (its major distinction from indemnity options) that can be assembled in many different ways' (Hurley, Bradley and White, 2004, p.58).

The idea of a preferred provider organization is to bring together insurers and providers for their mutual benefit. Within the PPO network, providers (doctors, hospitals, and other health professionals) contract with one or more insurers to provide care at a lower than normal rate. The insurers will be billed at a reduced rate when insured members utilise the services of the PPO preferred providers, and the providers will gain increased business as subscribers are directed towards services offered within the PPO. The insured members should also benefit, as lower costs to the insurer should result in lower rates of increase in premiums. That at least is the theory.

A PPO earns money by charging an access fee to the insurance company for the use of its network. The PPO negotiates with providers to set fee schedules, and handles disputes between insurers and providers.

The differences between HMO's and PPO's are not clear cut but rather represent a difference in scale. Thus whilst some HMO products would provide little or no benefit should their members use a non-network provider, PPO members will be reimbursed for utilization of

non-preferred providers, albeit at a reduced rate. Features such as utilization review and pre-certification requirements which have been linked to the consumer backlash against HMO's (Lesser, Ginsberg and Devers, 2003; Robinson, 2004.) are present in PPO's but typically implemented less aggressively.

PPO's are the opposite of the 'one size fits all' rigidity that HMO's gained a reputation for, and which appears to have resulted in a sharp fall in market share. Through PPO alliances, national networks can be created and their malleability allows their component parts to be shaped into a near infinite set of arrangements covering broad or narrow networks, expansive or meager benefits, intrusive or minimal medical management, greater or lesser cost-sharing and so on. Such flexibility is popular with both employers and those being insured. However this does nothing to control the notorious complexity of US healthcare administration. Nor by its nature is it likely to be an effective mechanism for cost control, beyond offering low-cost insurance options (via cost sharing and/or limited benefits) for some customers.

The nature of PPO networks also reduces the ability of PPO's to drive large discounts. Their very liberalism tends to mean that they have broad networks - which dissipate the advantages of membership for providers, making them less inclined to offer discounts. UK examples of the same problem are a recurring theme in subsequent chapters.

The above may reflect an interesting dynamic of US healthcare, but what is its relevance to the UK? In fact, a great deal, because the above is an almost perfect description of the dominant business model in the UK for private health insurers. In plain terms, UK insurers - including Bupa UKM - either operate in a manner akin to PPO's or simply provide indemnity insurance. The technical objection that PPO's are not insurers at all but rather a provider network may be true, but rather misses the point. The customer proposition offered by Bupa is essentially the same as a US insurer offering a PPO-based suite of products to a US consumer. Traditionally the UK approach has been grounded in enhanced choice and quick access with minimal or no utilisation review. This is essentially the marketing strategy many US PPO's have adopted to counter the consumer backlash against HMO's. But as Hurley and colleagues (2004) point out, this has weakened the ability of PPO's to contain costs or hold providers accountable for quality:

‘Preferred provider network developers are not doing much to hold providers more accountable or position themselves to systematically improve care. Many such networks perceive this as being beyond the scope of their responsibility, and some even take comfort in the fact that their limited field of vision in care delivery absolves them of a need for a stronger sense of responsibility’ (Hurley, Bradley and White, 2004, p.67).

The above quotation could apply equally to the attitudes of many UK insurers. It is to Bupa UKM’s credit that they have adopted a somewhat more proactive approach than most others (as examined later in Chapter 6). However the above throws into question the ability of *any* UK insurer to break out of the pattern of providing a PPO-style set of customer products, and to use market levers to improve health care provision. The later chapters return to this issue, as they seek to answer the question set at the outset of this thesis; namely, ‘what might the role and limits of market based solutions be within the context of UK healthcare, and what does Bupa’s experience in this regard tell us about the current market dynamic’?

For Bupa UKM, a further crucial question is whether it too will face a consumer backlash to its attempts to implement initiatives centred around proactive cost and quality management of providers and (to a lesser extent) subscribers. The author would hypothesise that the closer the UK private health market mirrors that of the United States, the less likely are the chances that Bupa UKM will succeed in such initiatives, notwithstanding its large market share and countrywide sphere of operations.

The background provided above on the experience of US PPO’s should help us to see the claims and counter-claims of the various actors in the UK PMI market in proper perspective. Thus when the Federation of Independent Practitioners (FIPO) suggests that Bupa is ‘...proposing a managed-care scenario’ (Glazer, October 2005), we need to recognise that whilst BUPA’s approach can resemble certain HMO-type practices in practice this is not a ‘black or white’ issue. FIPO’s stated rejection of ‘...the concept that an insurance company should control or influence clinical decision making’ captures the opposition of many within the provider community to any attempt by purchasers to use buying power to change the way health care is delivered. Actually, however, it seems that most UK insurers are largely comfortable to operate in a world of indemnity and PPO-like insurance, and that even Bupa (which has been more innovative than most) has only attempted a limited number of modest

initiatives in this area.. Nevertheless, these initiatives do provide valuable insights into what is currently possible, and the extent to which it may be viable to use market levers either to improve the UK private sector or the NHS.

The current stance of UK insurers is determined by assessments of what motivates UK citizens (and companies) to purchase health insurance. If, as seems likely, that motivation lies in strongly held views about the importance of choice, traditional notions of what constitutes a high-quality doctor and a preference for privately run, aesthetically pleasing hospitals, then the current standard operating model meets the market demand. However that model is relatively indifferent to the supposed price/quality advantages of 'managed care'. Ironically this rejection of economic rationalism also helps to explain the surprising resilience of the private sector in the face of increased investment in the NHS and reduced waiting times. This may also help explain the findings of a number of studies that have examined what drives the purchase of private medical insurance.

Propper, Rees and Green's (1999) study into the demand for PMI in the UK concluded that NHS waiting list changes did not have a significant effect on purchase of PMI; concluding that many PMI users are suspicious of government claims of falling NHS waiting times and rising quality. This links with the observation that:

'The NHS is a highly supported institution in the UK. Its political nature means that use of the private sector has been seen as a political statement.' (Propper, Rees and Green, 1999, p.6).

The same article also observed generational changes in attitude to private health care with younger generations more likely to purchase insurance than older ones. The findings of this study are at odds with earlier work by Besley, Hall and Preston (1999) that stated that there was a relationship between waiting times and PMI purchase. King and Mossialos also concluded that '...a key motivating factor in choosing to purchase PMI is to avoid waiting for treatment within the NHS' (2005, p.198) yet there is clearly more to the decision to purchase (and retain) PMI than simply a desire to obtain faster treatment. The sociological and demographic profile of the average subscriber has been alluded to earlier and King and Mossialos profile is that of '.....a well-educated individual, most likely male, who politically

supports the centre-right and comes to consider PMI as his or her age makes health care needs more likely' (King and Mossialos, 2005, p.209).

The above has translated into a subscriber base with a 'surprisingly' inelastic demand curve. The word 'surprisingly' is used because many within (and outside of) PMI have expected the imminent collapse of PMI as premiums year on year have risen above inflation, and the NHS have reported 'quality' improvements such as falling waiting times (DoH,2010d). King and Mossialos (2005) calculated it as being 0.50 (that is, a one percent increase in price would result in a 0.5 percent decrease in demand for PMI). Other authors agree that demand to date has been relatively price inelastic although unsurprisingly they vary somewhat as to what precisely that figure is. This reflects in part the different time periods when these studies were undertaken. Propper and Maynard (1989) for example, calculated the short term price elasticity to be 0.6 rising to 2.55 in the long run. These authors made the astute observation (given the subsequent history of provider price increases) that:

'The low value for the estimate of the short run elasticity implies that if providers raised their charges aggressively and these costs were passed on in high premise, market demand would decline by a relatively small amount.' (Propper and Maynard, 1989, Abstract p.ii).

Propper and Maynard offer the tentative conclusion that providers could be 'aggressive price makers with little risk of losing market share' (1989, Abstract p.ii). This prediction has been borne out by the experience of the subsequent 20 years. It is against this backdrop that we next examine the hospital sector.

## **CHAPTER 3**

### **The Dynamics of the UK Hospital Market**

#### **Introduction**

The purpose of this chapter is to examine how far a market is operating in the provision of private hospital services in the UK and to assess, in association with subsequent chapters, the degree to which purchasers are able to influence provider behaviour. As part of this, the chapter considers whether market mechanisms will be able to deliver care of the same (or higher) quality at a lower price for those purchasing private healthcare in the UK. In doing so an assessment is made as to what degree the cost base and operating philosophies of hospital providers reflect the specific characteristics of demand for private healthcare in the UK, and how this is likely to impact on attempts to make changes to the hospital market. Case studies based on the experience of Bupa's UKM Division will be used to illuminate these issues.

## UK Private Hospital Providers: An Overview

### i. *Composition of the Hospital Market*

The UK private hospital sector is not large and most of the hospitals are owned by one of five hospital chains. These five independent providers constitute 80% of the private hospital market. This can be demonstrated by looking at Table 1 below:

**Table 3: Major acute medical/surgical hospital operators with number of medical/surgical hospitals and number of beds, UK (Ranked by revenue) as of June 2009**

Source: Laing and Buisson HMN Date: June 2009

Operator	Hospitals	Beds	Day Beds	Operating Theatres	Latest Annual Revenues (£m)
BMI Healthcare	57	2,729	226	156	717.4
Spire Healthcare	36	1,808	210	112	460
Nuffield Hospital	30	1,300	116	94	450
NHS Pay Bed Units	79	1,275	151	N/A	408
Ramsay Health Care UK	32	934	124	63	398
HCA Healthcare	6	749	86	36	369
The London Clinic	1	202	N/A	12	95
Care UK (incorporating PHG)	8	125	99	20	94
Covenant Health Care	8	133	0	9	73.3
Circle	6	0	22	11	70
Aspen Health Care	3	121	18	11	66
Bupa Wellness (Cromwell Hospital)	1	128	27	6	61
Hospital of St John & St Elizabeth	1	155	13	5	33
Interhealth Care Services	2	52	32	5	29
The Hospital Medical Group	1	31	N/A	4	26
UK Specialist Hospitals	1	34	N/A	4	25.3
Netcare Health Care (UK) Ltd	3	69	N/A	6	24
British Pregnancy Advisory Services Grp	19	30	70	8	23
The Benenden Hospital	1	100	20	3	22

NHS pay beds/units (not counted here as one of these five) account for 1275 beds-some 13% of overall bed availability. Moreover these beds – and NHS hospitals in general - are often used for the most complex operations (as most private hospitals are not equipped or staffed to safely undertake them). However unlike the hospital groups, NHS trusts do not operate as a single corporate entity in contract negotiations.

Whilst there are periodic changes to the ownership of hospital chains and the precise number of hospitals contained within them, the essential structure and dynamic of the market has remained unchanged for some time. That dynamic has been driven by a desire of the dominant players to establish a chain of hospitals that provide either effective local geographic dominance of private provision and/or a significant presence in the major population centres of PMI cover. The net result is to make the private hospital providers (in the words of the OFT) ‘...practically indispensable trading partners for PMI’s of all sizes’ (OFT, 2001a). This, coupled with the characteristics of demand for private healthcare that were outlined in Chapter 2 have arguably generated a strong degree of subsequent ‘path dependency’. The theory of path dependency argues that antecedent conditions substantially shape subsequent developments, so that, for example, predictable amplifications of small differences at an initial starting point can lead to subsequent entrenchment of a particular solution. One often cited (though disputed) example is the success of QWERTY over the Dvorak keyboard layout (David 1985).

Since 1980 capacity in private hospitals has increased substantially. In 1980, some 154 hospitals supplied 7,035 beds. When the OFT reported its investigation into private medical insurance in 2001 this had increased to 227 hospitals and 11681 beds (OFT, 2001b). Interestingly, private hospital beds had been growing throughout a time when the NHS had made significant reductions in its bed stock.

Once established, these private hospital chains produced a market in which there has been an interdependence between insurers and these groups, with an uneasy ‘balance’ existing between demand and supply forces, reinforced by network agreements (as will be described later in this chapter) This meant relatively stable groupings of hospitals and insurers (although who actually owns the hospital groups has been subject to change), with the OFT/Competition Commission periodically being asked to determine if any of these companies can increase their market share by acquisition of smaller companies.

### *General Health Care Group*

The history and recent acquisition of the UK's largest private hospital provider General Health Care Group (GHG) illustrates this general trend and gives an insight into the complex and fast moving financing/ownership arrangements that often underpin company structures. GHG evolved through the development and acquisition of a number of private healthcare organizations since 1970. The history of the group started when AMI, a leading US for-profit hospital provider, entered the market with the purchase of its first UK hospital, The Harley Street Clinic, in 1970. By 1983, through a combination of acquisitions and a new building programme, the group had grown to 13 hospitals. In 1988 the group was floated on the London Stock Exchange as AMI Healthcare Group.

In 1990 Generale des Eaux acquired the Group through its sister company Generale de Sante. In 1993 the hospital operating company changed its name to BMI Healthcare and General Healthcare Group (GHG) was chosen as the new corporate group name.

In 1997 the Group was acquired by funds managed by Cinven Ltd. In the same year GHG was merged with Amicus Healthcare Group Ltd, which had developed its 15 hospitals between 1982 and 1995 under the ownership of Grand Metropolitan Plc and Compass Group Plc. Cinven funds had acquired Amicus in 1995 at which time it ranked fourth largest amongst all private acute care hospital providers in the UK.

The group's portfolio of over 40 hospitals expanded further, and in 2000 a majority shareholding was acquired by BC Partners, a private Equity Company. In May 2006 the company was bought by a consortium led by Network Healthcare Holdings Limited (Netcare). Network Healthcare Holdings Limited, a South African public company, now has the controlling interest in the combined business.

### *Bupa Hospitals Ltd*

Bupa Hospitals by contrast had its plans to increase its hospital base by acquisition rejected by the competition authorities. In 2000 its planned acquisition of Community Hospitals Group was vetoed by the Monopolies and Mergers Commission (now known as the Competition Commission). The Commission's conclusion is interesting:

'Bupa said that competition should be looked at in terms of local markets and suggested that any problems could be dealt with by divestments. We conducted our own analysis of local markets and identified some areas where competition would be adversely affected. However, we found that the much more important adverse effects of the proposed merger would be a reduction of competition in the PMS market and higher prices for PMI and PMS than would otherwise have been the case, and hence that the proposed merger would be adverse to the public interest.

Bupa told us of its care to ensure the integrity of the separation of PMI and PMS functions and said that it proposed to take various measures to separate its PMI and PMS businesses still further, while retaining both within its ownership and control. We considered these arrangements carefully but in the light of our finding we concluded that nothing short of putting the businesses under separate ownership and control would meet the case satisfactorily. However, Bupa told us that it would not proceed with the merger on that basis' (Competition Commission, 2000, p.4).

With their hopes of expansion via acquisition thwarted, Bupa initially decided on a different course of action - disposal of its smaller hospitals. In 2005 Bupa hospitals sold nine of its hospitals (leaving it with twenty-six) to the newly formed Classic Hospitals Group - which became the fifth largest private hospital provider in the UK in the process. The financial backers of Classic were Legal and General Ventures. This was significant in that Classic, like General Healthcare Group was principally owned by venture capital organizations (increasingly called private equity investors). Their principal aim can be characterised as building up the value of the company for eventual sale to another organisation-hence the seemingly bewildering changes in ownership within the brief history of GHG presented above.

The above considerations provide an insight into the likely business strategy of such organisations - including how they are likely to approach contract negotiations. A proposition

from insurers based on reducing prices in the short to medium term for the potential of longer term growth is unlikely to elicit a positive response from companies operating in this highly leveraged environment backed by private equity investors.

When Bupa disposed of nine hospitals in 2005 most industry observers thought that no further restructuring of the hospital business was likely for some time, Bupa Group therefore surprised many observers by announcing in April 2007 that it was seeking buyers for the rest of BHL. As if to reinforce the above point, Classic Hospitals was subsequently sold to Spire Healthcare in February 2008 reuniting it with Bupa's other hospitals (see below). Bupa subsequently sold its 25 UK hospitals to the European private equity firm Cinven for £1.44 billion (Bupa Group Press Release, 2007). The reason for the sale was given by Val Gooding (then Bupa Group Chief Executive) as follows:

'The reason we invested in hospitals in the 70s was because there was insufficient capacity of the right quality for privately-insured patients. Since then there has been a significant increase in the number of quality private hospital facilities – with a choice in most localities'.

The sale was the source of some controversy within Bupa, with the Chairman of Bupa Group (Bryan Sanderson) resigning in protest over the decision (Pfeifer, 2007a). The Board's decision to sell its hospital business provoked speculation that this could be a precursor to an eventual sale of the entire business to private equity groups (Pfeifer, 2007b).

There was a further surprise in store for analysts when Bupa announced in March 2008 that it had purchased the Cromwell Hospital in central London for £90 million (Bupa Group Press Release, 2008a). This move was clearly intended to create a 'flagship' hospital that would be a preferred location for Bupa-insured customers and challenge the traditional hegemony of HCA and other private providers in London. At 128 beds the Cromwell Hospital is large by UK private hospital standards and has an established 'brand' reputation. The sale of Bupa hospitals allowed the Cromwell hospital to be purchased without fear of the acquisition being blocked by the OFT and thus signaled a further round in the continual struggle between the insurer and providers in the nation's capital.

## **ii. Determinants of Success in the Private Hospital Market**

Evidence of high prices and inelastic demand may make it appear that it is relatively easy to make substantial profits from running private hospitals in the UK. Whilst the continued interest of investors would appear to give credence to this assertion, it should also be noted that private hospitals periodically go out of business (for example the North Wales Medical Centre in September 2006). Clearly it is not a simple case of opening a facility and watching the profits walk through the door.

As will be subsequently illustrated in Chapters 6 and 7 on healthcare quality, private hospitals in the UK firmly subscribe to the idea that most customers/patients' sense of quality healthcare is bound up in the aesthetics of buildings, staff attitudes and convenience. These attributes have been the foundation stones of the UK private market from the outset. Another critical success factor will be considered in Chapter 4 on the consultant market - the ability to attract the right consultants to work at the hospital - so much so that it is often said within the industry that private hospitals do not so much compete for the same pool of patients as for the same pool of consultants. This is bound up with the idea that it is consultants that largely determine where patients will be initially seen and treated, not the patients themselves. Thus the Competition Commission summarised evidence received from Bupa regarding this point thus:

‘Running a hospital was about attracting consultants to use it. Their importance in the private hospitals market could not be overstated. They were the key determinant of hospital choice...’ (Competition Commission, 2000, p.125).

### **The Rise of Hospital Networks**

Another major determinant of the financial viability of a private hospital has been considered to be whether it is included in the networks of the major insurers. Networks constructed by insurers have been a controversial issue within the industry. Their creation was initially resisted by most of the major hospital groups who feared that - as in the USA - deep discounting would be a condition of membership. Latterly, the uncertainty as to whether networks are a good or bad idea has moved increasingly to the insurers themselves.

Networks are a reasonably recent development in the UK private healthcare market, first being introduced during the mid 1990s. Up to that point, insurance products were traditionally based on full indemnity with the policy holder able to go to almost any provider for treatment. Bupa UK Membership (UKM) was the first major insurer to successfully develop a hospital network in May 1996 (there had been an initial, abortive attempt to do so in 1992). The network scheme offered members a lower premium price in return for a reduced choice of hospitals.

For hospitals the proposed network was a double-edged sword. On the one hand they were being asked to reduce their charges in order to be included in the network. However, the insurer had emphasized the supposed advantages of being in that network—namely, increased patient volumes as a preferred provider. The flip side of non-network status was supposed to be a significant reduction in patient volume as insurers sold increasing numbers of network policies; and those members would only be eligible to access network products. The advantages and disadvantages of network members were nearly identical for any provider—bar those who were able to attract a significant percentage of their revenues from self-pay patients. A key factor in the overall assessment from the hospital side was the perceived ability (or otherwise) of the insurer to shift traditional volumes towards hospitals in the network and away from those outside.

Network skeptics had a number of criticisms of the scheme - many of which were reflected in submissions to the Competition Commission. With regard to the UKM initiative, providers were suspicious that the construction of a network was both a ploy to drive increased volume into Bupa-owned hospitals and was concerned only with price, not quality. These were charges that Bupa has always strenuously denied. The Competition Commission summarized evidence presented by Bupa in the following terms:

‘Bupa denied that non-Bupa hospitals were less likely to be selected for inclusion in the Bupa PMI network if there was a Bupa PMS-owned hospital in the same area. There were examples of Bupa and non-Bupa hospitals in keen competition that were both included in the Bupa PMI network, for example in the Cambridge and Brentwood areas. Where non-Bupa hospitals in competition with Bupa owned hospitals were excluded from the network, there were valid reasons for it’ (Competition Commission, 2000, p.127).

The decision to include or exclude a hospital from a network was ostensibly based on objective criteria relating to clinical quality, servicing, price and overall value. Ownership was supposedly not relevant. However the Competition Commission was not convinced by this explanation, or the assurance by Bupa that it operated a strict 'Chinese wall' policy between its hospital and insurance businesses (Competition Commission, 2000, p.123), and subsequently ruled that the company would have to put its hospital business under separate ownership if it wished to acquire further hospitals.

The robustness of Bupa's quality criteria will be considered in some detail in Chapter 7 on quality. For the present it is simply worth noting that in the evidence provided above, Bupa sketched out a situation where both a Bupa and an independent hospital might sit within the network but failed to provide an example where a Bupa hospital had been excluded. However from the author's experience in the company, internal organisational pressures would have made it very difficult for UKM to have excluded a Bupa facility from the network. There would be the impact on the 'brand' of advising members that their local Bupa hospital was not available, and there was also a management reporting structure that saw both the heads of Bupa hospitals and UKM reporting directly to the Chief Executive of Bupa Group.

The Competition Commission noted that Bupa UKM had stated that it took a different approach to network construction from that of AXA/PPP. The Commission summarized Bupa's position in the following statement.

'Bupa PMI said that PPP's network was built up on a tendering process in contrast to its own which was based on a process of selection and negotiation. The other insurers with networks, Norwich Union and Standard Life, followed Bupa PMI's approach. Bupa PMI had initially attempted to put together a network by tender, but the lessons that had been learned had caused it to move to its present approach. All insurers sought additional discounts from hospitals for their network products in order to keep costs down. Bupa PMI believed that on balance its judgment on building networks this way had been vindicated - customers could now choose a network product and over one million had done so, making material savings as a consequence. Bupa

believed that networks had also helped to drive up standards' (Competition Commission, 2000, p.128).

It is a moot point as to what really separates a tendering process from one based on selection and negotiation. The implied difference is that tenders concentrate primarily on price and represent a fixed offer against a formal specification; whilst selection is more quality-based and negotiation uses an iterative process to produce a non-confrontational means to an agreement. None of the above is necessarily true. In practice, the major hospital chains' response to this type of negotiating process was to try and insist firstly, that all their hospitals were of a high quality (and thus should be in the network) and secondly that Bupa UKM would have to agree a contract based on all hospitals being in the network ...or out of it. Most hospital groups also negotiated from a position that they wanted a single schedule of charges to apply across all the hospitals of that group, thus negating any opportunities the insurer may have to take advantage of local market conditions across the UK by agreeing hospital specific prices.

It is difficult to reach an assessment of whether insurer or hospital groups came out on top in the negotiations over networks that Bupa initiated. The Competition Commission summed up the picture emerging from Bupa's evidence by suggesting that the major chains ended up playing a central role, largely on their own preferred terms:

'When the current Bupa PMI network product was put together in May 1996 the major chains had provided the central spine of the network and independents had tended to be included in areas not covered by them' (Competition Commission, 2000, p.127).

Network products have subsequently proved popular with customers and for some time UKM executives considered the network they had created as clearly beneficial to the company's fortunes and a major contributor to keeping costs down. Aside from the discounts negotiated from participating network hospitals, the view was that the existence of the network was acting as a significant barrier to new providers. It is certainly true that it did erect a significant further barrier to entry - as a new entrant would much prefer access to all PMI customers, and unless it could gain entry into the network, a significant percentage of PMI patients would be denied to them. Network incumbents were particularly watchful of any attempt by the insurer

to add providers to the network, as it would increase competition and reduce the value of network membership.

This barrier to entry was supposedly keeping hospital costs under control by firstly, persuading network hospitals that it was worthwhile to continue providing discounts, and secondly, avoiding local medical 'arms races' between existing incumbents and new entrants - with both chasing the same patients and with two sets of running costs to cover. Partly as a result of insurers' network initiatives the number of private beds actually dropped from 11,600 in 1993 to 9,800 in 2003 (the high point was 11,800 in 1995), whilst the value of the private market grew from £1.8 billion to £4.4 billion over the same period (Laing and Buisson, 2005). The June 2009 figure stood at 9975 beds, although it should be noted that in addition to the 9975 inpatient beds some 1214 day beds are also reported (Laing and Buisson, 2009).

However, over the time that the author was employed at Bupa many senior managers formed a more jaundiced view of the impact of the network, holding that it had a number of significant disadvantages and had effectively 'gone past its sell by date'. There was, firstly, a perception that a network consisting of 369 hospitals (of which 180 were 'partnership' hospitals) was arguably too large. The network allowed members to access practically all the private hospitals that a member on a non-network product had access to. As a result, there was very little added value to customers on a premium-priced product compared to those who had purchased a budget policy. For example, the only private hospital in London that a Bupa network customer did not have access to compared to an A scale member (see Box) was Cromwell hospital, and even that hospital became available in 2005.

### Scale Products and 'Price Targeting'

The lack of a significant differential between a network versus a 'Scale A' product was a source of constant concern to many managers within UK Membership. Scale A products carried a significant price premium and thus the company was keen to retain members on them. At the same time sales and customer service staff would be asking, 'What can I say are the advantages of Scale A, what is the differential?'

The price inelasticity of the A scale policy is probably best explained as an example of 'price-targeting' by consumers. Tim Harford (2006) uses the analogy of the coffee shop to describe this process. The Scale A customer 'on average' was saying 'I'm not sensitive to price. I want the full package....because I can'. The concern was always that the actual difference between product offerings was too small. However the focus needs to be on the customer perception of that differential and why they pay it? Harford says that the difference in the real cost of a cappuccino and a Venti White Chocolate Mocha is very small compared to the price differential (£1.85 to £3.09), but people pay this because they know it is an indulgence - 'hey I'm special, I feel greedy and I deserve it'. In economist's jargon they are not price sensitive at this point. In private healthcare this is reinforced by information asymmetry. Unlike the quality of coffee which can at least be tasted, the quality of healthcare is hard for the average consumer to assess. Consequently people tend to use price as a proxy, reasoning that expensive care must be high quality care.

In fact at the time of writing UKM has by far the largest number of network hospitals of any UK insurer. Norwich Union's network is the next biggest with 305 hospitals, followed by Standard Life Healthcare's network of 270 hospitals and AXA PPP's network of 226 hospitals.

The second perceived problem was that network hospitals had expected to see an increase in patient volumes, which for many failed to materialize. Several hospitals subsequently

attempted to raise prices to compensate. This also resulted to some provider skepticism about the benefits of subsequent initiatives that were network based.

A third problem was that a wide network made it difficult to exclude the more expensive hospital providers. Members could access these hospitals regardless of their relative costs - a decided advantage for members on network products but not helpful to cost control within Bupa.

A fourth difficulty was that failure to establish a tight network resulted in members effectively being able to access all registered clinicians with little or no attempt by UKM to influence patient choice, again something which tended to increase costs.

Finally there was the observation that the conscious restriction of new providers into the market was not only inherently anti-competitive, but was also likely to hamper attempts to force existing providers to reduce their prices. It is interesting that the DoH and UKM had diametrically opposite policies with regard to new providers. The DoH has pursued a conscious policy of positively encouraging new providers and creating capacity - and through this it has hoped to provoke competition. The expectation is that this would (amongst other things) help contain prices. UKM, (as seen above) spent much of the 1990s and the first five years of the 21<sup>st</sup> century trying to do the opposite. In fact Bupa's approach has been closer to that of Governments, such as the Netherlands and Germany which have tried to limit provider numbers as a mechanism of cost control (Lewis et al 2006).

One analysis of the situation familiar to senior Bupa managers was that provider costs were unacceptably high in the UK and that this was a reflection in part of relatively weak purchaser power. But tackling this would require significant changes to way UKM dealt with both hospitals and consultants. Central to the debate within Bupa was the idea that UKM could not realistically hope to obtain price reductions from providers – and hence make PMI more affordable - unless the company was able to bring to bear a significant degree of 'directionality' to those members who had purchased a network product (i.e. channeling these patients to a narrower group of providers). Furthermore, the gains to providers - both hospitals and clinicians - of being a member of the network had to translate into increased patient volume. This would require a tighter network e.g. a smaller number of hospitals and clinicians. At the same time this would reinvigorate the premium-priced products that offered

members unrestricted access, as there would now be 'clear blue water' between these customer propositions.

Enthusiasm for a policy geared to lower provider prices was counterbalanced by anxiety that this would impose choice restrictions on members and result in conflict with powerful providers. The outcome of this policy debate was a series of initiatives subsequently described in this thesis. Throughout, UKM tried to convince both its members and highly skeptical-and often outright hostile-providers, that these initiatives were about re-invigorating the private healthcare market, and concerned with quality healthcare, rather than price reductions *per se*, and/or increased profits for Bupa.

## **NHS Driven Changes to the Private Sector**

Whilst Bupa UKM were considering how it could influence providers and reduce costs, there was arguably a much more significant series of changes taking place as a by-product of government reforms directed at the NHS. The net result was that the private hospital providers were faced with a number of new opportunities and threats specifically derived from government policy initiatives for NHS patients. These came in two forms.

One was the potential threat to the existing private market from an improving NHS - particularly lower waiting times. Another consisted of the opportunities that would arise from an increasing use of private providers to deliver services for NHS patients. Most private hospitals had undertaken some NHS waiting-list initiatives work in the past - effectively as the provider of last resort for NHS commissioners desperate to meet a wait-time target. This work was typically unplanned and opportunistic in character. The difference now was both one of scale, and that the government had signaled it wanted to get into a longer-term relationship with the private sector.

Successive governments have been keen to encourage private sector involvement in the provision of NHS services for four main reasons:

- (i) As a mechanism to rapidly increase capacity so as to tackle problems in specialities/areas with long waiting times for treatment;
- (ii) To increase the number of potential providers so as to stimulate competition;

- (iii) To accelerate reform within the NHS. Timmins (2005 p1193) states that whilst private sector treatments for NHS patients have ‘... had a limited effect on the numbers, they have had a huge effect on behaviour. Faced by the threat of competition... surgeons and NHS managers have raised their game.’
- (iv) As part of 1-3 above, to create a stronger labour market, especially for services provided by doctors (and weaken the power of consultants and their professional bodies).

The impact of that involvement is considerably greater than the actual statistics of treatment in private sector facilities would indicate. The first wave of independent treatment centers (ISTC's) provided around 170,000 procedures a year over a five-year period. The NHS was to purchase a further 250,000 annual treatments, but this number looks set to be considerably smaller as a number of these schemes have been cancelled (Timmins, 2007). The original aim of government was that the ISTC's would provide 7-8% of non-emergency procedures by 2008 (the NHS undertakes about 5.5m elective procedures per year). In May 2005 the Secretary of State for Health (Patricia Hewitt) announced an intention that £3 billion would be spent on 1.7 million elective operations over the next five years. This would bring the proportion of NHS operations undertaken within the private sector up to 11%. (Kmietowicz, 2005).

Actually the volume of NHS work performed of ISTC's until April 2006 appears to have been lower than anticipated. Moore (2007) calculated that the new private centers had done only 59% of the average annual number of operations planned (Moore, 2007). A subsequent *Health Service Journal* article by the same author estimated the value of the gap between guaranteed payments and actual patients treated at £350million (Moore, 2008). However as *The Economist* pointed out, the debate about the waste associated with funded treatments that were never completed neglected a second policy aim.

‘It also misses their most important purpose: to break the monopoly of provision within the NHS. That is why so many health-service staff dislike them. And that is why they are so vital if the whole of the NHS is to deliver better value for money’ (The Economist, 2006, p.27).

Commentators have differed in their assessments of the strength of the Government's commitment to the growth of the private health care sector. As the authors of a recent Kings Fund report noted:

‘...it is not clear whether the government is fully committed to a supplier market, or whether it merely wants to use the stimulus of limited competition from the independent sector as a tool intended to improve the performance of NHS-run organizations’ (Parston et al., 2006, p.7).

Nevertheless the size and potential profitability of the ISTC program was such that most private providers did not feel they could simply ignore this ‘new’ market. However, the companies that dominated the UK private hospital market received an unpleasant shock when none of them were awarded contracts for the first round of treatment centers (with the exception of the Bupa/NHS joint venture at Redhill which opened in January 2003, predating the national procurement of treatment centers and was not followed by any further contracts awarded to Bupa in that first phase).

Instead, a new wave of providers such as Nations Healthcare, Netcare, Care UK, Afrox and Mercury received preferred bidder status. Five of these companies were overseas-based (from South Africa, the USA and Canada) and only two from the UK. Industry insiders believed that one of the reasons that the DoH had chosen ‘non traditional’ providers was to challenge the traditional hegemony of the UK private hospital groups, and of NHS consultants who supplied clinical services to them. A significant attraction of the overseas companies to the DoH was their willingness to recruit overseas doctors to operate in the treatment centers. This was to become a controversial issue among NHS consultants, who were quick to raise concerns about the quality of the treatment undertaken at treatment centers and call for the publication of clinical audits (Wallace, 2006).

This unexpected loss to new providers meant existing hospital groups needed to consider both their current business propositions and whether they wished to seriously compete in the new market. The companies concerned - BMI, Nuffield, Capio, (now called Ramsey Healthcare following Capio's acquisition in November 2007) HCA and Bupa hospitals - took different approaches.

## **Nuffield Hospitals' Approach**

Both Nuffield and Capio viewed the prospect of NHS work as a significant business opportunity and quickly developed a strategy for working in partnership with the NHS. As part of this they cut their prices to the NHS to near HRG tariff rates.

Concurrently Nuffield gave notice to insurers with whom it had existing contracts that new prices would apply from 1<sup>st</sup> January 2006. Nuffield's new pricing structure involved three tiers of prices (T1 to T3) based on different service propositions.

T1 would be the NHS HRG tariff and would be restricted to the NHS until at least 2008. It would also be an all-inclusive price, thus requiring Nuffield to tackle the long-standing preference of consultants to bill separately (see chapter 4). The service model underpinning these prices was based on the principle that payers would have restricted access based on time of treatment, requiring advanced booking with treatment dates that would be set by Nuffield hospitals. In addition there was to be no guarantee of continuity of consultant, with care based on standardized pathways and limited 'peripheral' customer services.

T2 pricing would be set at a level higher than T1. It would be more flexible and guarantee treatment within a shorter time-scale than T1. However payers would still have restricted access based on time-to-treatment, requiring advanced booking, and a treatment date set by Nuffield Hospitals. There would be a guarantee of a consultant undertaking the treatment, but Nuffield would choose that clinician - not the patient. Standardized care pathways would be used. Discounts on T2 prices would be available to insurers who offered guaranteed levels of volume and purchasing patterns.

T3 pricing would be set at a higher level again from T2 (Nuffield talked about this being in the region of 15%) and would be based on the current 'bespoke' approach that was the dominant idiom of private healthcare in the UK. It would allow unrestricted choice of consultant, hospital and treatment dates. Discounts would not be available to any purchaser. Whereas T1 and T2 pricing would be procedure-based and inclusive of consultant fees (with a view to moving to episode based pricing), T3 would continue the practice of separate

billing by hospitals and consultants. Nuffield also stated that the charging structure for all tiers would change to more accurately reflect the cost of providing various treatments (which by implication meant that Nuffield believed the prices charged/reimbursed for both consultants and hospitals for many procedures inadequately reflected actual costs).

Nuffield's new strategy was an unwelcome challenge to insurers. They feared that their current insurance products would lose in competition with the cheaper Nuffield service proposition (T1 and T2). Insurance policies have defined benefits – including where members can be treated and what prior authorization (if any) is required from the insurer. These are potentially expensive to change with costs being incurred in everything from legal fees and printing through to staff training and software adaptations. Customers typically view changes to their policies with suspicion, with the risk of non-renewal. The pace of Nuffield's proposed changes thus confronted the insurers with the unwelcome prospect of re-designing their 'products' within a six months timescale that most considered inadequate to transfer their customers across to new terms

Another issue was that Nuffield's service proposition for T1 and T2 pricing was considered to offer a lesser standard of service than that currently enjoyed by insured patients. Nuffield's approach was thought to be reducing the 'clear blue water' between private insurance and reliance on the NHS. Although Nuffield did not enjoy national dominance, the distribution of private hospital ownership meant that there were few alternative providers in certain geographical areas. The question raised by some senior insurance company managers was: would customers in those areas conclude that there was insufficient differential between private and NHS care to justify the cost of private insurance?

There was also a particular concern for Bupa UKM both as the market leader, and because the company believed it was currently benefiting from the best prices from Nuffield. This was that Bupa would lose its existing advantage if prices for T2 and T3 care went up and were uniformly applied across all insurers in line with Nuffield's proposal. It appeared that Nuffield was proposing a price increase well-above inflation for T2 patients on a single rate that would ignore whether members were in a network product or not. Thus from an insurer's perspective Nuffield's proposals could be interpreted as offering its members a lesser service at a higher cost. Nuffield was in effect saying that it believed its long-term future lay less with the traditional insured patient, but rather 'in partnership' with the NHS. Moreover,

unless prices to deliver the traditional PMI care model went up it was likely to wind down that side of the business.

Nuffield's actions indicated that they considered the discounted prices offered in recent years had not brought sufficient benefit in terms of increased patient volumes. It is worth noting that we have returned to the issue of the benefits (or otherwise) of the network and also to the question as to the degree to which price signals apply in this market? For UKM members with network policies it made no difference if they used a Nuffield hospital or a more expensive provider, as long as those hospitals were in the network. There was no financial benefit or cost in such a 'decision' as these price differences were invisible to the member.

Negotiations between Nuffield and Bupa UKM continued for many months, with neither party wishing to provoke conflict but neither conceding ground. In early January 2006 (almost twelve months after Nuffield gave UKM six months notice of changes to existing contracts) there was a flurry of activity as Nuffield signalled that in the absence of an agreement it was going to unilaterally raise prices. UKM retaliated by making it clear that this action would cause it to de-recognise a number of Nuffield hospitals from its network and that further hospitals could follow. At the same time UKM wrote to consultants who had billed Bupa in the last year for work undertaken in a Nuffield hospital making it clear that, if the dispute with Nuffield was not resolved, the consultants would need to make alternative arrangements to get UKM members treated at other hospitals.

The threat and counter-threat brought the parties back 'to the table' and within about a week, a new contract was agreed. Who was the main beneficiary? Commercial confidentiality does not allow an analysis of the agreed contract. However it is likely that both parties felt they had achieved some of their aims. For UKM however there was also a palpable sense that hospital groups were starting to take the initiative and that the company needed to become more proactive. Traditional certainties about product propositions and who should deliver them were being challenged. This helps set a context for the UKM's initiatives described later in this thesis.

## **The Hospital/Insurer Dynamic: HCA International /UKM Case Study**

Of the five major hospital chains, HCA was the one company that consistently made it clear that it had little interest in changing its core business to accommodate NHS work. In contrast, during 2004/2005 both BMI and Bupa hospitals had effectively shifted their stances by explicitly changing elements of their service proposition to accommodate NHS patients and thus win contracts. BMI created a new division - Amicus Healthcare - which according to its website was created ‘...to meet the specific needs of public health sector patient contracts and in the future will have its own separate staff teams working in dedicated facilities’ (BMI, 2005). BMI’s strategy was to keep its NHS and private healthcare patients separate - both physically and in terms of the actual care processes. Its fear was that mixing the two in the same hospitals would effectively lead to ‘cross contamination’ with insured patients becoming dissatisfied with having to share facilities with NHS patients, whilst cost escalations would occur on NHS cases because the same care processes would be applied. The NHS contracts would have much tighter profit margins and therefore would require stricter adherence to cost-effective care pathways.

Bupa Hospitals, by contrast, believed it could accommodate this ‘mixed economy’ of NHS and privately insured patients within its existing hospitals. Managers reasoned that the rigour associated with defined patient care pathways for NHS cases could also be applied (in part or in whole) to insured cases on the assumption that this was also a quality assurance process. In fact Bupa hospitals had been slowly adopting care pathways for a number of years.

Given the above, HCA’s decision to continue with its existing business model meant that it bucked the general trend. This put the company on a collision course with insurers who were looking to all providers to contain or reduce costs. As UKM was the largest insurer in the UK, and its senior executives had publicly stated that the industry needed to tackle rising costs, the stage was set for a confrontation as to which view would ultimately prevail.

### *Relationships between UKM and HCA*

During the time the author was at Bupa the relationship between HCA and UKM deteriorated into a series of wrangles over contractual terms, and culminated in protracted disputes over

UKM's tenders for Magnetic Resonance Imaging and subsequently, for Ophthalmology services (described later in this thesis).

The seeds of this poor relationship lie in two sets of figures. UKM has about 43% share of the PMI market, whilst HCA Healthcare is a major player in the London area where it operates 6 private hospitals totalling 749 beds (Laing and Buisson, 2010a). HCA healthcare (UK) is part of the large 'for profit' hospital chain HCA, based in the USA. The company has a reputation both for commercial acumen and aggressive price negotiating. Its approach to overseas ventures probably mimics its US operation and might be summarised as: 'Buy good hospitals, get as large a market share in any area as possible, attract consultants with a good reputation, give them good quality equipment and facilities and they will bring the customer base. For that you can charge 'premium prices'.

This is a simple strategy which has proved effective and commercially resilient. HCA's 749 beds dominate London's private sector provision. There are only 5 other dedicated private hospitals in London. It is worth noting that with the exception of BMI's London Independent (which is in East London) the major UK hospital chains do not own any private hospital in London. The afore-mentioned purchase by Bupa of the Cromwell hospital in 2007 was after Bupa Group had sold its Hospital's Division. HCA in aggregate is almost four times larger than its largest competitor, the London Clinic which has 202 beds.

The juxtaposition of dominant provider versus dominant insurer creates an interesting dynamic. This is particularly so when set against to the peculiarities of the London marketplace - which might be regarded as somewhat atypical of the rest of the UK for the following reasons:

1. The insurance component of private practice is smaller than elsewhere because of the large number of overseas/self-pay patients attracted both by the clinical reputation of the London hospitals and the general amenities of the city;
2. London has more doctors undertaking private practice than elsewhere but also has a larger percentage of consultants with significant private practice earnings. These 'prestigious' doctors secure considerable business, as they attract many referrals. They are key to hospital revenue generation (hence the wisdom of a hospital strategy that majors on attracting and retaining such consultants). This also leads to duplication of expensive equipment as hospitals try to retain consultant favour

by ensuring that have access to the latest technology. Although the above might be regarded as implicit in private practice throughout the UK, it is most marked in London;

3. Although some NHS hospitals in London have better established private practice facilities than many NHS hospitals elsewhere in the UK (dedicated private practice units (PPUs) for example) they remain ill equipped, both physically and culturally, to meet the total private practice demand. Insurers are thus very reliant on private hospitals to meet the demands of their members;
4. London-based corporate customers are a particularly important segment of the PMI market. Such clients are often highly demanding - expecting access to the 'best' hospitals and consultants. As will be illustrated in Chapters 4, 6 and 7, this often translates into the notion that 'expensive must equal best';
5. Finally, HCA's size relative to the overall market - especially in certain key specialities such orthopaedics and cardiology/cardiac surgery - creates significant barriers to entry for other providers.

Whilst a case can be made that UKM's market share could force HCA to discount prices, based on UKM's purchasing power as the largest insurer, the experience to date has been very different. HCA prices are known throughout the insurance industry as the most expensive of the hospital chains. Whilst commercial confidentiality does not allow price comparisons to be published, the history of frequent disputes over time between UKM and HCA reinforces the view that UKM has historically been forced to be a price 'taker' rather than acting as the price 'setter'. Further evidence on this point will be presented later in this chapter. The following should also be considered in interpreting the subsequent actions of the two parties.

Firstly, as previously noted, HCA had been successful in capturing a significant percentage of London's private sector capacity and also of 'prestigious' consultants. Any insurer that excluded - or was excluded from - HCA's hospitals, would be vulnerable to an exodus of corporate and individual customers to competitor insurers.

Secondly HCA, like most other hospital chains, tried to negotiate on an 'all in or all out' basis with respect to hospitals being 'in network'. Attempts by insurers to purchase only the

capacity they truly need for each local area is thwarted by such a stance (if it is allowed to prevail).

Thirdly, UKM was well aware that any conflict with HCA would be likely to result in some loss of customers. Organisations that reward performance on the basis of in-year customer growth and profits will tend to produce managers who tend to avoid conflicts that will result in short-term losses, even if they might bring long-term gain.

The above led to an ongoing internal debate within Bupa. On the one hand there were those managers who believed that private medical insurance (PMI) was on a 'burning platform' of declining membership, revenues, and net profitability, caused by the year-on-year above retail price inflation (RPI) costs of premiums and shortening NHS wait-times. The other camp consisted of those who considered PMI to have an inelastic demand curve that would persist even under worsening market conditions. The public pronouncements of Bupa senior management, for instance Fergus Kee's (then Chief Executive of UKM) speech at the Laing and Buisson 2005 PMI conference (Kee, 2005) and Bupa Group Financial Director's Ray Kings's 2006 interview with Healthcare Market News (Healthcare Market News 2006), emphasised the former viewpoint. However, the dominant culture within the company (arguably reflecting the conventional wisdom of the UK PMI industry) remained one of commercial conservatism closer to the second view.

This was based on the core idea that the UK private healthcare market was both essentially stable (and static) with customer demands relatively unchanging over time. Those demands were considered to be well-known and already being met by the existing 'product proposition'. The foundation of this belief was that customer support for PMI delivering private healthcare in the 'traditional' manner remained strong. The term 'commercial conservatism' has been used to express an aversion to 'risk-taking', especially with regard to activities that might damage or devalue the Bupa brand. From this perspective, engaging in a high profile conflict with a major hospital group would be regarded as just such an activity. It would raise difficulties with the strong emphasis on customer satisfaction as defined by minimum inconvenience – as customers would be affected by events such as de-recognising hospitals, and threaten the corporate focus on achieving the aforementioned growth and profitability targets. These attitudes and arguments will re-surface many times in later chapters when we examine UKM's relationship with doctors and its approach to quality.

They help explain why UKM (and indeed all insurers and providers) have historically operated as they do in the UK PMI marketplace.

A further debate within Bupa centred around whether the increased investment in the NHS and the increasing plurality of public sector provision coupled with the downturn in the general economic downturn has led to a fundamental change in market conditions and the demand for PMI, or whether this will turn out to just temporary 'noise' that leaves matters essentially unchanged. Public statements tended to support the former view but actual decisions and behaviours again remained broadly 'conservative'; reflecting a more cautious interpretation of the market.

The public statements tended to emphasise the changes that were occurring in PMI and the adjustments by insurers that would be necessary. For example, the UKM Managing Director's speech at the aforementioned 2005 Conference (Kee, 2005), contained the following statements:

'Bupa insurance conducted a strategic business review last year. One of the main conclusions from that review was that future premium increases are a bigger threat to the future of private healthcare than an improving NHS. We have to slow the rate of premium increase to the levels that customers accept with other things they buy - that means at least halving the historic rate of increase. We cannot just accept medical inflation as a given and simply continue to pass it on to the customer. The only way to address this fundamental issue is for insurers and providers - hospitals and consultants - to work together. Most funders and, I believe, the majority of providers now recognise the need for change.'

And:

'It is...disappointing that some private hospital providers still seem to believe that consumers will simply keep on paying more and more for the same thing. I'm sorry, but they won't. We have to ruthlessly drive for clinical quality and value for money.'

### *Sowing the Seeds of Conflict: UKM/HCA's 2002 Contract*

UKM considered HCA an expensive provider of services, but for the reasons mentioned above was reluctant to take decisive action to challenge HCA's hegemony in London. However a series of contractual wrangles meant that a major dispute did blow up.

UK private hospital contracts with insurers are typically fee-for-service, per diem contracts. Prospective payment systems, such as DRG's, HRG's, or simple per-case payments, are the exception rather than the rule, although contracts between the NHS and Independent Sector Treatment Centres (ISTC's) operate on prospectively based prices (based on HRG plus an agreed percentage rate). When the author worked at UKM the main reason he heard for the company not adopting case rates or DRG's more generally, was that these might be set at too high a rate, thus allowing hospitals to make large profits. Sitting alongside this was usually an optimistic view of the ability of the company to control provider costs; especially via detailed scrutiny of hospital invoices to ensure that only agreed items were charged, and at the correct rate.

There are clearly advantages and disadvantages for any particular contractual arrangement and its associated currency. However as previously noted by the author (Royce, 1997) it is one thing to agree particular contract arrangement and another to administer them. Those negotiating and those administering contracts are rarely the same people. For example, a contract agreement that 'carves out' an item – for example, a drug or type of prosthesis - from the main contract for payment based on a particular rate, presupposes that those compiling hospital invoices can identify and separately charge the items in question (a risk for the provider) and that the insurer is able in turn to identify, and correctly process for payment, the item in question. The former is a risk to the provider, the latter to the insurer. There is a risk that those setting the contract do not ask those who create and receive invoices whether such an arrangement is practical to administer on a routine basis.

For insurers, this can lead to situations where invoices are received that the organisation cannot properly administer. In those circumstances the decision may be made that such invoices have to default to automatic payment - the alternative being hundreds, or even thousands, of invoices that stack up 'in suspense' with the result that members are then chased by hospitals/doctors for payment.

The above needs to be borne in mind when discussing the manner in which hospital negotiations take place. Typically, a private hospital contract will have the following components:

Bed-day rate;

Theatre charges;

Prosthesis;

Consumables;

High cost drugs;

Special Nursing;

Critical care;

Day case charges;

Outpatients;

Radiology;

Pathology;

Payment terms.

A central point of contention is likely to be the rate of inflation (or very rarely deflation) that will be applied to the main tariff. That inflation element is likely to apply - at a minimum - to the bed-day rate. The bed-day rate is (seemingly) easy to understand and both those negotiating the contract, and the managers they report to, may well focus on this element of the contract. A contracts manager on the insurer side may be instructed not to go beyond a certain percentage inflation increase.

Any increase above this figure applied to the bed-day rate is easily identified, and easily modelled by the finance department.

However the cost impact of other elements of the contract may be less transparent. For example, the cost of consumables, prostheses, and 'high cost' drugs are very heavily influenced by consultant choice. Moreover, accessing the impact of a change to either the agreed 'mark up' on such items and/or of what is deemed eligible as a 'high cost' drug is not easy to model.

This is a source of risk in contract negotiations. The negotiator may agree what are considered to be low bed-day rates and a low inflation increase, but find costs arising from other poorly-specified areas of the contract to be much higher than anticipated.

This is complicated because there is no consistency in private healthcare in the pricing of consumables, prostheses and drugs. What, for example, is considered to be a 'high cost drug'? One hospital may have negotiated a threshold of £100 at which a drug becomes a separately chargeable item; another as little as £10. There may also be different definitions of what the £100 or £10 applies to – for example, per dose, per day or per episode of treatment. Furthermore, there may not be certainty about whether the cut off point for the drug is the actual cost to the hospital, or its list-price, or indeed the price after a mark up has been applied to the list price. The mark up for drugs/prosthesis etc allowed within the contract might be three times the list price. If drugs above £10 - after mark up - are all allowed to be separately charged, then a long list of billable items may be presented to the payer. Such an arrangement also provides a perverse incentive to the provider to use the most expensive drugs, prostheses and consumables possible.

It is also likely that not all elements of a hospital contract will receive the same scrutiny, reflecting - in part - the strengths and weaknesses of the administrative systems used to pay invoices and monitor contracts. There is a natural bias to focus on the highest-cost items. As such, inpatients normally receive more attention than day cases, which in turn will tend to receive more attention than outpatients. Outpatients consist of a large number of (relatively) small cost items. Pathology items dwarf even outpatients in terms of volume. The degree to which the payer is able to compare what is charged against what is in the contract is dependent upon the administrative systems in place. Some contracts may not even attempt to set prices but merely agree to pay 'all reasonable charges', or simply to pay whatever is billed. Whilst it might be expected that hospitals would be required to provide 'charge masters' showing the prices against which they should be charging, the author encountered many instances where they do not. A similar problem can occur with doctors' charges in relation to the relative scrutiny given to outpatients in comparison to inpatient charges -as will be noted in the next chapter on consultant reimbursement. In the USA hospital charge masters (the list of billable items) range between 12,000 and 45,000 items (Davis, 2010) which provides an indication of the potential administrative task, even assuming that better invoicing systems are developed

Returning to UKM's contract with HCA, although specific details cannot be given, some problems of this type arose. There were also interesting issues in this case about the delay in re-negotiating the UKM/HCA contract. Not having a signed contract can have a number of advantages. Minimum notice periods for a change in provider status, or for new prices, no longer apply. Accordingly, it is not surprising that in the period before and after the expiry of the 2002 contract, the contract negotiation process between HCA and UKM dragged on for many months. After a period when agreement could not be reached the two parties went to (non-binding) mediation by a third party. This process also went on for months, but without an agreed outcome. During these contract negotiations HCA raised their tariffs and (tellingly) UKM decided to pay such charges in full rather than enter in an escalating dispute.

Ultimately some at UKM rationalised HCA's charges as acceptable, as long as every other insurer was paying even more, on the basis that this was likely to hurt the smaller insurers more than UKM. The logic works (to a point) presupposing that other insurers are actually paying more. The claim is based on the assumption that Bupa would be obtaining the lowest prices because it was the largest insurer. For example, Bupa told the Competition Commission in 2006 that it obtained discounts of 25-35 per cent from hospitals' standard master charge rates (Laing and Buisson 2006). Information on whether HCA did in fact give Bupa a relative price advantage, despite the price rise, is not in the public domain and not known to the author.

The above case suggests that UKM was far from successful in its efforts to counteract HCA prices and practices despite its 40% plus market share. UKM's reluctance to engage in confrontation reflected both a business strategy which determined that the risks out-weighed the benefits, and a cultural predisposition to delay the fight until 'another day'. While customers remained prepared to pay the resultant premiums this strategy remained viable, though its sustainability into the future was less clear.

## **UKM's Magnetic Resonance Imaging Tender**

It is within the above context that one can best understand the response of HCA and other providers to UKM's decision to undertake a national tendering exercise for Magnetic

Resonance Imaging (MRI) services. *Hospital Doctor* reported this in April 2006 under the headline ‘HCA starts legal action in Bupa MRI network dispute,’ noting that:

‘HCA has been negotiating on its overall contract with the insurer for almost two years. These talks are believed to have collapsed in mid-march, although Bupa patients are still being treated at HCA hospitals’ (2006b, p.2).

To understand the background to the issuing of a tender for MRI services (and HCA and other providers reaction to it) it is necessary to take account of the following. Firstly, there were significant variations in price (in excess of 250% from lowest to highest cost) that existed in private MRI scanning in the UK. Secondly, such charges had a significant impact on overall costs given that UKM was billed for over 80,000 scans a year. Finally, considerable growth in MRI capacity in the UK had taken place over the previous decade. This latter development had been given further impetus by the decision of the DoH to purchase a large number of MRI scans from private providers. In October 2004 Alliance Medical Ltd were awarded a five year contract to deliver 650,000 scans. The DoH’s actions served to further commoditise a procedure that lends itself to tendering. About 90 per cent of scans are performed as outpatient procedures and in many parts of the UK a genuine market with choice of provider exist, or could easily be created by the use of mobile scanners.

For UKM, an attraction of tendering the service was to make it a contractual condition for providers to provide composite bills – to submit a single bill covering both the fee for the equipment and the radiologist’s fee. This not only simplified the billing process, but would avoid the common problem of radiologists’ fee exceeding the insurer’s proposed reimbursement, leading to a ‘shortfall’ which the patient must pay (see chapter 4). Thus from UKM’s perspective the MRI tender had the potential to deliver that all too rare prize in healthcare - a reduction in costs.

UKM was careful to frame its tender as being essentially concerned with the promotion (and assurance) of a quality service. *Healthcare Market News* (HMN) reported a claim by Bupa that:

‘...over 60% of the evaluation for the new MRI network related to quality standards and patient service criteria and just one third related to commercial criteria’ (2006 p.85).

Unsurprisingly, providers were quick to suggest a different interpretation - that the tender was solely concerned at price cutting, regardless of quality. The *HMN* article contains a number of quotes from providers to this effect. HCA Commercial Director Raj Vasudevan told *HMN*:

‘Bupa said the scheme was about quality control but they are talking about hospitals with no MRI services so how they have quality assured them is a mystery’ (2006, p.87).

At that time *HMN* reported that UKM had not put HCA’s MRI facilities onto their list of approved network facilities. At the same time St Anthony’s hospital in Cheam (a 91 bed private hospital that had only recently emerged from a prolonged contractual dispute with UKM that had seen the hospital de-recognised at one point) was not included in the MRI network. Hospital Director Brian Clarke was quoted in *HMN* as saying:

‘The whole thing has been done in an extraordinary and unsatisfactory way. Bupa talks about improving quality and access for its members when in fact it has done the reverse and eliminated the two golden horses in the healthcare stable-access and choice’ (2006, p.87).

Opposition to the tender was also reported as follows by the London Consultants’ Association on its website:

‘HCA Hospitals in London and St Anthony’s Hospital, Cheam in conflict with Bupa Insurance over the MRI tender. It has just been announced that the HCA group of hospitals in central London has not been recognized by Bupa Insurance in their recent MRI tender. Many consultants will have received a letter from Bupa Insurance that puts the blame for this entirely onto HCA hospitals. HCA for their part has denied this and is seeking to clarify this matter through the Courts.

The LCA has been assured by HCA that this is not an issue of price as their bid for MRI work was initially accepted by Bupa Insurance.

The London Consultants’ Association does not believe that the first rate consultants who work in the HCA radiology departments can be criticized for the quality of their

professional work, indeed many have international reputations. Nor do we believe that the service, provision and delivery by the various MRI units in the HCA group are unsatisfactory.

We are, therefore, driven to the conclusion that Bupa Insurance's action masks some other undisclosed agenda. This is supported by the fact that at least one hospital in the new approved Bupa Insurance network does not actually have its own MRI machine and others have services provided by a mobile MRI which can only provide limited appointment times.

Another hospital to be left out of the MRI network is St Anthony's Hospital in Cheam. St Anthony's is also well known for its up to date technology and high standards of care. Neither the hospital nor its consultants can understand why it has been left out of the network and its questions to Bupa Insurance remain unanswered.

The London Consultants' Association believes that this is a clear example of what may increasingly happen if tendering for front line specialty services goes ahead for orthopedics, ophthalmology and then others at a time when the notions of choice and access are very topical issues in the NHS. Bupa Insurance appears to be disregarding both' (London Consultants Association, 2006).

The LCA's stance is essentially identical not only to the hospital providers quoted above, but also to that of FIPO (of which it is a constituent member). FIPO and The Association of Independent Radiologists (AIR) also conducted a questionnaire of AIR members on the UKM tender in December 2005 (see Appendix 2). The survey, based on the views of 357 Consultant Radiologists, showed that a majority disagreed with the tendering initiative and with insurers having any role in driving clinical quality.

Despite the manifest unhappiness of certain hospitals and consultants - Bupa Group was able to put out a press statement on the 10<sup>th</sup> March 2006 announcing that the UK's 'first ever specialist MRI network' would be operational by April (Bupa Group Press Release, 2008b). This stated that more than 400 sites across the UK had applied to become Bupa approved units and around 230 private and NHS hospitals and imaging facilities would make up the network. Patients would be able to get an out-patient appointment for an MRI scan within 48 hours, with their report returned to their consultant within another two working days.

The network included some of the units operated by private hospital providers like BMI, Catio, Nuffield and Bupa Hospitals. Around 50 NHS hospitals were also included. The large number of applicants illustrates that despite the public opposition of some providers, MRI was becoming a 'commoditised' service. As such it was difficult even for a company such as HCA to successfully boycott the tender.

*Hospital Doctor* (2006c, p3) reported on the 3<sup>rd</sup> August 2006 that:

'Bupa and HCA have resolved their dispute over their contract and the inclusion of HCA hospitals in the insurer's MRI network. Three HCA hospitals have been included in the network, but the Princess Grace Hospital is not included.'

It is reasonable to conclude that UKM was the victor in this particular power struggle with HCA. It was able to establish a lower-priced national MRI network and Derek Machin, the Chairman of the BMA Private Practice Committee, was quoted as saying that there was evidence that consultants' fees had been reduced by between '18 and 40 per cent' (Fox, 2006). UKM was also able to exclude a key HCA hospital from its network. That inclusion of three HCA hospitals into the network may be seen as a concession on UKM's part, but the exclusion of the Princess Grace broke with the traditional negotiating position of 'all in or all out' and appeared to be a setback for HCA.

Further evidence of the commoditisation of MRI was provided by the announcement in April 2008 that Bupa had managed the not inconsiderable feat of both increasing the number of MRI units within the network by one-third, and a claimed reduction in MRI costs of 20 percent (Bupa Group Press Release, 2008b). This extended network included the aforementioned St Anthony's in Cheam and although Bupa's press release contains no details on individual pricing, it seems reasonable to conclude that we have observed a rare phenomenon – the extension of the size of a network coupled with price deflation.

From Bupa's perspective, the MRI network initiative was judged successful because prices fell. Providers had to adjust to new market conditions, namely, that for MRI at least, it was a buyers' market. Providers who have attempted to retain higher prices found their customer base disappearing. Local evidence for this can be found in the following from the Clinical Director of Radiology in a Welsh NHS Trust on the subject of contract negotiations with Bupa.

‘...we are losing a shedful of private work in our Trust as our rates are way too high. All the private suppliers have drastically cut costs, in particular of MRI. You can get a scan plus report for £250 in some areas of South Wales now...you can go to Cheltenham and have a report and scan for C.£300, reported by top musculo-skeletal guys from Bristol’ (Evans, 2008).

Notwithstanding the above case, there is a need to reserve judgment on the prospects for change in the hospital market until both the particulars of consultant reimbursement for services (in the next chapter) and further attempts to create networks (in particular for ophthalmology) are explored. These are the subjects of the next two chapters.

## **Conclusion**

The general dynamic between hospital groups and the larger insurers can be understood as a manifestation of the theory of countervailing powers as outlined in Chapter 1. To this general position needs to be added the leverage that near monopsony market share that providers in certain geographical locations enjoy. HCA’s commercial success (and premium pricing) reflects not only managerial acumen but also the negotiating power that controlling such a large percentage of Central London’s private beds provides. It is noteworthy that those negotiations often take an adversarial form; with both parties threatening economic sanctions on the other. Insurers threaten de-recognition of hospitals –wholly or partly, for some, or all of their members. Providers threaten to unilaterally increase prices, directly bill patients for any resultant shortfalls and state to those patients that their insurer is being unreasonable (both actions threaten defection to competitors). .

These are market based responses from both parties, but interestingly Galbraith (1952) speculated that one conclusion of such a relationship could be the abandonment of competitive behaviour in favour of oligopoly or crypto-monopoly:

Galbraith saw this as a market failure, which however much it might suit the individual parties (both provider and purchaser), created a sub optimal equilibrium-and that without outside intervention, this equilibrium might persist. Galbraith makes it clear that this might require government intervention in the market place through regulation. Interestingly there is

no indication that the UK government has ever considered such a course of action with regard to the private health sector -beyond periodic investigations by the OFT into proposed hospital acquisitions by various hospital chains.

Indeed an alternative way of interpreting the UK insurer/hospital dynamic is that the actuality of adversarial action is relatively infrequently seen (although often threatened), and that historically the more common position has been for the insurer and provider to settle on a position that allows both parties to operate with significant surpluses above operating costs.. The sustainability of that position is speculated upon at various points in this thesis bound up as it is with questions as to the elasticity of demand for private health insurance/care and the state of the UK economy.

The position with regard to MRI was different because its increasing supply and resulting commoditisation shifted the balance of power in favour of the purchaser. This allowed price competition to apply in a way essentially as predicted by classical economic theory

## **CHAPTER 4**

### **Consultant Reimbursement and the Prospects for Cost Control**

#### **Introduction**

The previous chapter discussed how payers reimburse UK private hospitals, and the thesis now turns to the parallel system of payments to consultants. This chapter is divided into a number of sections. First it describes how NHS consultants are paid, and then reviews the principal methods of reimbursing consultants in the UK private sector. Next it examines two insurer initiatives aimed in part at cost control: (a) an initiative to reform the reimbursement mechanism, based on the development of relative value scales, and (b) the use of benefit maxima schedules (maximum amounts payable for given procedures). In the penultimate section, the chapter discusses the high level of consultant charges in the UK PMI market and suggests an explanation of why insurers have been unable to use purchasing power to apply downward pressure on consultant charges. Finally, the chapter assesses the prospects for future reform of the UK PMI market that might lead to lower prices without sacrificing clinical quality.

Once again, particular reference has been made to the approach adopted by Bupa Health Insurance with regard to the above issues. Given that Bupa is the largest purchaser in the UK PMI market, its approach has been highly influential and illustrates some of the main approaches to cost control that have been tried.

An examination of consultant reimbursement provides important insights into the relative sophistication - or otherwise - of the market mechanisms in place, and of the relationship between purchasers and providers in the UK PMI market.

#### **Reimbursing Consultants in the NHS**

As a reference point, let us briefly consider the mechanisms for paying consultants in the NHS. Employment in the NHS is underpinned by a national contract which casts consultants in the role of employees working for a salary, albeit with the possibility of augmenting the basic salary with payment for additional sessions and of being selected for a distinction

award. In general a consultant's pay does not vary according to the volume of treatments provided or the quality of outcomes. The new NHS consultant contract introduced in 2003 provided a substantial pay rise to consultants (an almost 50% increase between 2001 and 2005), but left the basic position unchanged and made no attempt to link remuneration to activity. The contract has prompted considerable debate and suggestions that current pay mechanisms do nothing to address variations in consultant activity and productivity (Bloor, Maynard and Freemantle , 2004; Williams and Buchan, 2006).

Currently the NHS does not reimburse the costs of consultant inputs as a separate item. Such costs are subsumed under whatever contracting currency a hospital has in place, for example block, cost and volume plus finished consultant episodes, or HRG's and provider spells. Having stated this, the increased focus on meeting various waiting times targets and the opportunity for consultants to undertake additional work within the NHS to tackle them, has prompted greater attention to contractual terms. In the author's recent experience (gained from working for three NHS Trusts in the last four years) this issue generates considerable discussion of the rate that should apply for additional work, with consultants sometimes putting forward private sector fee-for-service- rates as a benchmark and NHS managers typically seeking a lower cost solution.

Historically NHS consultant contracts, which combined comparatively low salaries with freedom to practice privately, resulted in a system in which overall salaries were boosted by significant volumes of private work (Yates, 1995). Of course not every consultant undertakes private work: 30% of consultants effectively do none and 20% of consultants gross less than £10,000 from this source (Ford, 2004). Nevertheless the majority of consultants working in the UK PMI market also hold NHS contracts. Where NHS work is almost exclusively rewarded by a fixed salary that does not vary with volume of activity, private work is reimbursed in quite a different way, according to the work undertaken.

## **Reimbursement in the Private Sector**

The most common form of consultant payment methodology in the UK private sector is fee-for-service according to a schedule of procedures and services. Whilst the USA has seen various attempts to bring in more sophisticated forms of reimbursement for doctors, including

risk sharing arrangements and capitation (Zuvekas and Cohen, 2010), changes to the methodology by which consultant payments are made in the UK private sector have had the more modest aim of simply updating the procedure codes that underpin reimbursement. At the same time the industry set out to obtain much greater consistency between procedures in terms of the value assigned to them. Examining why this aim proved so problematic will help to illustrate some of the key dynamics and limitations of the current UK private sector, in terms of its ability to establish clearer links between the cost of care and the prices charged. It will also illustrate a recurring theme in the ongoing debate about the best method by which to pay providers - whether to base this on published, pre-set tariffs, or allow floating, negotiable prices.

Across the world, there had been few attempts to establish a systematic methodological basis for setting consultant charges. Some doctors may have had specified fees for certain interventions. Others charged based on time taken up 'caring' for the patient, or per visit. Still others varied their charges based on what they thought the patient would pay (Kessel, 1958; Anderson, 2007). Over time, some informal links were probably established between the size of fees and the complexity of the case, but it was not until after the advent of organised insurance that institutional pressure grew to systematise and regulate such fees. Indeed, one can still observe discernible variations in fee setting within the UK self-pay market, which allows the judicious 'spot' purchaser of healthcare to shop around for the 'best' price.

For insurers, the desirability of establishing a recognised system whereby clinicians billing for particular treatments receive a standard payment is bound up with the importance of predictability in assigning and managing risk - a feature underpinning all insurance based activities. Such predictability is also desirable in helping to mitigate the financial risk associated with policy terms that state that bills from doctors will be paid in full. If there is no direct connection between the services a clinician provides and what is charged, then the insurer's task of managing the risks associated with the insured population in question becomes more difficult.

It is also the case that the updating of condition categories and pricing codes is necessary because of the changing nature of medical practice. New diseases such as Severe Acute Respiratory Syndrome (SARS) and new treatments appear. Internationally, this updating is undertaken via modification of the International Classification of Diseases (the most current

being Version Ten). The NHS utilises this classification, but much of the private sector in the UK uses a customised procedure-based system - a version of International Classification of Diseases, Version Nine (ICD-9).

This system had become gradually out-dated to the point where clinicians were increasingly vocal about the need to review and update the procedures. In response a group of insurers announced in 1997 that it had commissioned a 'Relative Values Review' aimed at establishing a new reimbursement mechanism. Newchurch (a healthcare consulting company that is now part of Tribal Group) were commissioned to undertake the work on behalf the six participating insurers: BCWA, Bupa, Connecticut General Life Insurance Company, Norwich Union, Royal Sun Alliance and Standard Life Healthcare. The exercise was overseen by a Clinical Classifications and Schedule Development (CSSD) group formed by the insurers.

### *The Relative Values Review*

The principal objective of the Relative Values Review (RVR) was to develop a scale of procedures whereby the position of each procedure on the scale reflected its clinical complexity relative to other procedures. These relative values could then be used to form the basis of an alternative to the existing systems for reimbursing clinical activity. The RVR also represented the first major improvement in the coding description of private sector clinical activity for a decade.

The RVR only covered inpatient and day case interventions, with two separate scales covering respectively:

- Procedural Interventions (PI);
- Anaesthetic, Sedation and Monitoring Services (ASM)

These were based on the methodology of the Harvard resource-based relative value scale (RBRVS), developed by Hsiao and colleagues (1999) to derive a fee schedule for the US Federal Medicare programme.

The two scales covered over 1,600 procedures and were developed with the assistance of over 130 clinicians working in both single and cross-speciality groups. As a result of this process it was hoped that RVR would be regarded as robust, transparent, independent, and having clinical credibility.

### *Insurer Opposition to RVR*

Not all insurers were in favour of such a review. AXA Private Patient Plan (AXA PPP) publicly opposed the review on the grounds that it believed that use of such a scale would cause price inflation. In October 2001 the Office of Fair-Trading (OFT) received a complaint that adoption of RVR by insurers would lead to convergence of pricing by both insurers and consultants and would lead to higher medical fees. The complainant (widely thought in the industry to be AXA PPP) suggested that an increase in payments to clinicians and/or 'price fixing' would be detrimental to the interests of consumers.

The OFT complaint argued that the RVR process would be inflationary for two reasons. Firstly, clinicians were likely to expect that the baseline for future reimbursement would be set on the basis of the least complex procedures. In practice many of these procedures had, overtime, become 'overvalued', with regard to their relative complexity vis-à-vis other procedures, and it seemed likely that doctors would oppose any re-basing that involved 'deflating' current prices for non-complex treatments, even if other prices were raised. Secondly, the complainant was concerned that in situations where single procedures were sub-divided into a number of procedures with different levels of complexity, a phenomenon of 'code creep' might result. The fear was that if the relative value scales were implemented very few cases would now be recorded at the lower level of complexity.

### *The Office of Fair Trading Decision*

Despite the arguments of those opposed to RVR, the OFT decided that an industry standard methodology for assigning weights to procedures was not anti-competitive *per se*. However they added a caveat. Each insurer had to set its own values to those weights (and reimbursable amount) to each procedure independently of other insurers. To do otherwise was deemed anti-competitive by the OFT. The judgement undermined the key rationale for having a system of publicly-weighted procedures. Specifically, that both clinicians and patients could immediately tell by reference to a chart how one procedure was weighted against another and hence come to a judgement as to the 'fairness' or otherwise of the proposed reimbursements. By separating out the industry wide weighting from the reimbursement assigned by any particular insurer it re-opened the ability of an insurer to have a reimbursement schedule that ignored the weightings.

### *The Diminishing Attractiveness of the RVR Initiative*

Other developments were occurring as the RVR was underway that reduced its attractiveness.

Delays in implementation meant that some medical consultants came to see the RVR as a mechanism used by insurers to delay raising reimbursement rates. During the author's time at Bupa, reference was often made to the review as a justification for not allowing an increase in rates for particular procedures at that time. Part of the delay was due to the need to consult with the medical profession and the somewhat Byzantine organisation of the clinical sub-committees of the various specialties.

The methodology for creating relative-value weightings contains both objective and subjective elements, relating to the 'value' of each procedure, and it was unsurprising that this generated considerable debate. It soon became apparent that there was a limited appetite for the creation of a set of relative weights that would rank *all* procedures, regardless of speciality, against one another. For example, it took considerable debate to get the 14 sub-speciality committees of the British Orthopaedics Association to agree weightings within orthopaedics, let alone compare those weightings against non-orthopaedic procedures. Thus although RVR was initially promoted as a methodology that would transcend speciality-based values, it became apparent that it was likely to apply only to those procedures that span more than one speciality.

Whilst AXA PPP had consistently been opposed to RVR, a number of other insurers had reserved their positions. Providers unsurprisingly wanted all insurers to adopt the same system - so as to minimise the administrative load of servicing more than one system. Discussions on this issue took many months. Eventually even AXA PPP announced that it would adopt the new schedule. However a further delay to the implementation schedule was required to allow AXA PPP to prepare for the changes. Time passed as providers and insurers woke up to financial implications and the impact on their administration and billing systems. Clinicians started to complain that some new codes were already out of date, alleging in some instances that inappropriate professional advice had been given on their weighting and construction.

### *Healthcare Resource Groups – a Viable Alternative?*

Meanwhile, another - largely unanticipated - development further undermined the appeal of relative values as Healthcare Resource Groups (HRG's) were introduced as the main contract currency in the English NHS. The significance of HRG's was boosted both by the Concordat between the NHS and private sector (Maynard, 2000) and the announcement that a fixed, HRG payment would apply both to NHS Trusts and private hospitals contracting with the NHS (DoH, 2000). Traditionally the private sector had virtually ignored the NHS' pricing regime. However increasing use of private hospitals by the NHS and a belief that a more genuine mixed economy model was likely in the future was leading to a reappraisal at the time the author was with Bupa.

One option for an insurer like Bupa was to move over to HRG's (rather than relative values) as the payment method for clinicians. However this raised two sets of problems.

Firstly, HRG's are principally determined according to the amount of health care resources a typical patient is likely to 'consume' in hospital, and are influenced by the age and co-morbidities of the patient, and weighted by length of stay in hospital. This often fails to capture in great detail the input of the consultant (and especially the surgeon or anaesthetist), whose contact is typically greater towards the beginning of the patient's hospital stay. In contrast the relative value scales had been specifically designed to reflect consultant time and effort for each procedure. and is arguably a better measure of this.

Secondly, there are far fewer HRG's than there are RVR codes. The 558 HRG's are designed to cover nearly all NHS activity whereas there are 1,628 RVR codes focused principally on those procedures most often undertaken in the private sector - which means they are dominated by descriptions of elective surgical procedures. This meant that conversion to HRG's involved a difficult translation exercise from many to few codes which raises new issues of relative weightings of procedures (Bloor and Maynard (2007)). There were fears that clinicians might favour those interventions that are more generously weighted (in effect the less complex procedures) and avoid the less well compensated (complex) procedures.

From the foregoing, the obstacles facing either the private or public sector in moving over to the other's coding/weighting system are all too apparent.

### *Bupa's Implementation of the RVR*

In the event Bupa eventually decided that it would introduce a limited version of the relative value scales, but without any material change to consultant reimbursement levels. The Clinical Classifications and Schedule Development (CSSD) group (which had been overseeing RVR) had developed a schedule of procedural interventions that was adopted by Bupa in January 2006. This was made public in a letter and briefing note to Speciality Associations (signed by the author in his then capacity as Head of Policy, Quality and Provider Relations) and the following explanation given:

‘We have stated for the past seven years that we will never again uplift fees across the whole range of procedures within the Schedule. We would like to be able to adjust fees to reward at a higher level those procedures that are worthy of higher reimbursement. In order for this to be affordable to our members, we would expect this to be accompanied by reductions in the Benefit Maxima for procedures that have become technically quicker and simpler over time. Despite extensive consultation and discussion with the profession over recent years, we do not believe that consultants would change their charging practice to reduce their fees for more simple procedures. The overall consequence of reducing our Benefit Maxima for these procedures would be that it would lead to a much higher rate of member shortfalls, which is unacceptable. Bupa has therefore reluctantly concluded that we cannot use the new Schedule to introduce widespread changes to reimbursement across all specialities and procedures. Therefore we have neither introduced significant uplifts to Benefit Maxima nor have we reduced the Maxima for any procedures’

On the subject of procedures with multiple codes the following was said:

‘After review we have decided not to differentiate the fee where a single procedure has been split into a number of different codes. Experience in the past has been that where this has been tried, both here and in other countries, it leads towards what is called “code-creep”. This is where the code for the higher classified procedure, attracting the higher fee rate, is used out of proportion to the number of the higher classified procedures actually being conducted. We have seen this in the UK in relation to gastrointestinal biopsy, for example’ (Royce, 2005).

This was followed up by an article in *Independent Practitioner* (also in the author's name) which reiterated the message and talked about the need to find,

'...a mechanism which allows us [Bupa] to adjust fees to reward at a higher level those procedures worthy of higher reimbursement. However for our PMI members to be able to afford this, the mechanism would need to allow for reductions in reimbursement for procedures that have become simpler over time. But after extensive discussions with the profession, we are convinced that consultants would not accept this approach and Bupa has reluctantly concluded that we cannot use the new schedule to introduce widespread changes to reimbursement across all specialities and procedures' (Royce, 2006).

### *Consultant Reaction*

Such an approach was never likely to curry favour from the consultant community. This was particularly so given the widespread expectation that the introduction of the new schedule was going to be the occasion when historical anomalies in fee reimbursement would be tackled to consultants' satisfaction (which meant that such reimbursements were expected to rise).

Reaction from consultants was probably less vocal than was expected - perhaps because many of them had long doubted that Bupa would undertake large scale increases in the Benefit Maxima. However one exception to this was the reaction of the foot and ankle consultant community. A flavour of the correspondence on the issue can be gauged from the following letter. Nicholas Geary, a previous president of the British Orthopaedic Foot Surgery Society (BOFSS) wrote a long letter to Bupa (copied extensively to BOFSS members) detailing objections to the reimbursement UKM was proposing against the new schedule.

'...It is disappointing that Bupa do not have the courage of their convictions. If you commission a study to judge the relative worth of procedures and get agreement from all specialist groups, if there is a financial constraint on your remuneration levels to your clients, you should perhaps distribute the finances broadly across all subspecialties in line with the relative values agreed between the subspecialties. This would mean downgrading the remuneration levels for some procedures. It would be

far more honest to give up the pretence that Bupa cover indemnifies patients against the complete costs of surgery and state that the Bupa policy makes a contribution towards surgery at a certain level' (Geary, 2005).

This response highlights the consequential nature of Bupa's decision at the outset of the RVR to give assurances that there would be no procedures for which the maximum amount reimbursable was reduced. This created an inflationary pressure because it meant that 'over-valued', non-complex procedures could not be visibly downgraded, and that increased differentiation between simple and complex procedures could only be achieved by raising the value of the latter.

Part of the reason why Bupa ended up with so little room for manoeuvre was that another long-term initiative to get consultants to price in accord with Benefit Maxima (already discussed in the last chapter in relation to hospitals) had only had limited success. So far this chapter has been concerned with attempts to improve the methodology by which reimbursement rates for given procedures are determined in the private sector. The events described above show that insurers have found it very difficult to reform the traditional fee-per-service system based on a schedule of charges to achieve fairer relative pricing. That said, Appendix 9 illustrates that post RVR the values (if not the actual reimbursement) insurers assign to particular procedures remain generally –but not completely- consistent. We will now turn to consider the fate of Bupa's parallel drive to control consultant charges within that system, using the Benefits Maxima.

## **Bupa's Benefit Maxima**

Bupa's Benefit Maxima (BM), the published schedule of maximum amounts reimbursable for particular interventions/services, are not designed to engineer any change in the relative pricing of procedures. The BM are, however, intended to apply general downward pressure on consultant fees by limiting what the Association will pay.

Unsurprisingly, this is a source of tension with consultants. Many hold the position that their 'contract' is solely with the patient, who they regard as the one ultimately liable for any bill for services. The insurer is considered merely a financial intermediary in the process. Many

doctors believe they have the right to bill whatever they feel the 'market' can stand. As such they may bill over and above the amount that an insurer will reimburse and ultimately will hold the patient responsible for settling the resulting 'shortfall'. By contrast, insurers are keen for doctors to waive this 'right', agree to charge to a defined reimbursement schedule, and bill the insurer direct. Although technically patient shortfalls are the patient's problem, in reality they are disliked by insurers. Members who experience shortfalls tend to complain, and have a greater propensity not to renew their insurance. Insurers would prefer to eliminate such shortfalls and get providers to accept the reimbursement rates they offer.

### *UKM's Consultant Partnership*

Bupa's initial efforts in this area centred on the launch of the 'Consultant Partnership' programme in 1999 (which is still in operation). Consultants were invited to apply to become 'partners'. Partners enjoy certain financial and service benefits, such as a bonus payable on top of the total annual value of invoiced activity and access to a fund to support clinical audit. In return they agree to bill within Bupa's Benefit Maxima in normal circumstances. Where a consultant feels there might be special circumstances justifying billing above Benefit Maxima - a case with unusual complications for example requiring substantially longer time in theatre - they commit to contacting UKM to discuss extra payment rather than simply billing the patient any extra charge.

Despite the inducements offered many consultants were - and remain - suspicious of Bupa 'Partnership' arrangement, and the BMA was publicly opposed to its creation. Nevertheless by 2005 around 8300 consultants had joined the Partnership (out of a total of 19,000 'Bupa recognised' consultants) and these individuals performed approximately 70% of all episodes of care. Generally speaking, consultants were more prepared to join the partnership (and hence fix their fees to a pre-set upper limit) in specialities with the lowest demand for private healthcare and in those areas of the UK where private medical insurance cover was lowest. Partnership coverage was relatively low in orthopaedics (only 46% of episodes in 2005) and particularly low in Southeast England. Anaesthetists require special mention as a group with low numbers in the partnership. In 2005 over 40% were billing above benefit maxima (shortfalling members). This reflects three factors:

Firstly, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) had a long-standing objective of actively seeking fee parity with surgeons. Within Bupa's benefit

maxima and more widely in the private sector, anaesthetists' reimbursement rates are set at a lower rate than surgeons - for an example see the fee schedules discussed previously for cataract surgery. Many anaesthetists feel strongly that the fee limits set by Bupa (and other insurers) are too low (see: Hospital Doctor, 2006a, p.3; Harrop-Griffiths, Prineas and Grant, 2010)

Secondly, anaesthetists unlike many other consultants, have relatively little face-to-face contact with private patients. The patient may well not have any contact prior to admission. Because of the historical reticence of private hospitals either to employ or enter into arrangements to charge on behalf of consultants, the patient is often left not knowing who the anaesthetist is going to be, and whether their fee will be above that paid by the insurer.

Thirdly, anaesthetists have a reputation both within the NHS and the private sector, for being a speciality whose members have been better able to organise themselves into groups. In the case of private practice they have often formed formal partnerships. This has led to a widespread suspicion that one function of such 'groups' is to act as a mechanism for local fee setting.

#### *The Office of Fair Trading Investigation of Anaesthetists Groups*

In May 2001 the OFT started an investigation following a complaint that anaesthetists in a number of local areas had formed themselves into groups, and agreed within each group the prices that each anaesthetist would charge. The OFT examined the operation of 10 different anaesthetic groups. The OFT's eventual judgement - after a year long investigation - was complex and the logic questionable, but its outcome was simple. The anaesthetic groups were found not guilty of infringing the Competition Act 1998.

The judgement was made public on the OFT website (OFT, 2003). In essence the OFT considered that the anaesthetic groups (with one exception) operated as a single undertaking for the purposes of competition law. It followed from this determination that an agreement between the members of each group (within their respective groups) as to the levels of fees to be charged for their private professional services, would not amount to an agreement between undertakings. The resulting conclusion was that no 'price fixing' as defined by the Act had taken place.

Whatever the 'rights or wrongs' of the ruling, the current legal position therefore supports the activities of anaesthetists and other consultant groups who wish to agree a common price in a local market. In such an environment it is unsurprising that large numbers of consultants continue to set fees above that which insurers have set. The position taken by the OFT on both RVR and anaesthetic groups thus in effect undermined insurers' efforts to bring downward pressure on consultant rates.

However insurers are not entirely powerless to counter a particular specialty group in a local area, should they consider their fees unreasonable. There are in theory a number of options available to an insurer in such a situation. These include:

- (i) Threaten to de-recognise some /all of the group in terms of their ability to treat members unless they revise their fees;
- (ii) Give hospitals and/or surgeons an incentive to take on responsibility for the anaesthetist component of the overall bill;
- (iii) Direct members to a network comprising only those anaesthetists who have agreed rates with the insurer;
- (iv) 'Parachute' into a local area alternative providers.

All of the above require considerable effort (and resources) on the part of an individual insurer (co-ordinated action between insurers is not possible as this would be deemed anti-competitive) and carries a very real risk of a damaging dispute with consultants that would negatively impact on customers/patients. Consequently, although the industry as a whole might want to gain better control of fees nobody wants to risk being a first mover. Apart from the opportunities this would afford competitors to 'poach' disgruntled members; it is also likely that other insurers would benefit from any changes in the market that such an action would produce. This classic 'moral hazard' helps sustain an environment that strongly favours the indefinite continuation of the '*status quo*'.

#### *Fee setting and the British Medical Association*

The BMA does not negotiate fee structures for its members, largely because it has been judged unlawful for it to do so. In 1994 the Monopolies and Mergers Commission (MMC) (now known as the Competition Commission) ruled that the BMA's attempts to set guidelines on fees for private work amounted to an attempt to create a 'complex monopoly' (MMC 1994)

Then, as now, Bupa's use of the benefit maxima was being resisted by the medical profession. The reasons why the MMC recommended prohibiting the BMA guidelines, while at the same time allowing insurers to publish reimbursement schedules such as such as Bupa's Benefit Maxima, were essentially twofold.

First, the MMC accepted that it was legitimate for insurers to publish maxima scales in order to inform their subscribers of what their entitlements were under a medical insurance contract. Second, the MMC took the view that while Bupa's maxima may have had a restraining effect on consultant fees, Bupa itself did not have sufficient market power to impose on consultants an unreasonable level of remuneration. In essence, the MMC view was that private patients are in a weak bargaining position *vis-a-vis* consultants over fees and that it was of 'crucial importance' that insurers should continue to exercise their 'countervailing power' on behalf of their subscribers.

#### *The Benefit Maxima as a Mechanism for Cost Control*

The consultants' biggest complaint against Bupa UKM has long been that the company has failed to sufficiently increase reimbursement rates since the inception of the Benefit Maxima (BM). This is countered by UKM's claim that the BM has been a highly effective instrument of consultant cost control. Both claims contain an element of truth, but are subject to important caveats.

Consultants often claim that BM reimbursements have remained essentially unchanged for over 15 years (Stubbs, Ward and Pandit 2010). The author heard doctors on many occasions state that Bupa's behaviour has been unreasonable in not raising BM in line with inflation. For many consultants the continued above-inflation rise in premiums and insurer profits set against a refusal to increase reimbursement levels - despite rising malpractice insurance and office costs - was evidence of insurers' unreasonable behaviour. Statements that there had been no increase in Bupa's reimbursement rates were not strictly factually accurate, as over a ten year period (1995-2005) overall maxima payments increased by just below 3%. Much of this had taken place between 2000 and 2003 with a total of £14.5m put into rate increases.

Such monies were applied by analysing the volume and value of procedures. Maxima monies were targeted at particular procedures, rather than in terms of a general uplift, 'shortfalled'

payments, considering the values given through the RVR process, and through discussions with, and guidance from relevant speciality groups and associations. As a result some increases had been made in response to historically high levels of patient shortfalls for certain procedures.

For example, over the period 1998 to 2002 the amount Bupa paid consultants increased from £197m to £282m (an increase of 43% before inflation). Whilst some of this will be related to increases in the numbers of Bupa members over that period, the proportion of overall benefit spend paid to consultants had remained broadly the same. In an industry that experienced well above-average inflation with regards to hospital and drug costs over that period, this points to a more complex picture than the simple claim that 'our reimbursement rates haven't risen for a decade' would suggest.

The two main confounding factors were likely to be a rise in clinical incidence and outpatient fees. Rising incidence has a number of possible causes - one of which (theoretically at least) can be that the health of the presenting population was worsening. However Bupa's membership is solidly grounded in social classes I and II, who enjoy above UK average health status (Black, 1980). Also, whilst the ability to treat more disease grows over time there is little to suggest that this potential increased that significantly in the above time period (Dybczak and Przywara, 2010).

The more likely explanation is that there had been some changes to the threshold for clinical intervention either generated by clinicians or from patients and/or clinicians were seeing the patient on more occasions when they did decide to treat. Were such behavioural changes to take place it would most likely to be reflected in an increasing number of outpatient attendance's. This fits with the general pattern of clinician behaviour with fee for service medicine elsewhere (Brodheimer, 1999). It should also be noted that rising incidence means in effect that consultants have to work harder (or at the very least differently) so as to see more patients... or the same patients more often.

The rising outpatients costs in this period have to be set alongside the fact that a significant proportion of consultants continued to 'shortfall patients' (40 % of Bupa's patients faced a shortfall in their consultant fee reimbursement according to an article published in the Sunday Times, 27th January 2002). This suggests that the success of BM in controlling consultant

costs has been at best partial. Nevertheless, when the OFT ruled in 1999 that the private medical insurance (PMI) and private medical services (PMS) markets were indeed competitive, it stated that:

‘The Monopolies and Mergers Commission’s (MMC’s) 1994 conclusions on the Bupa Benefit Maxima remain valid and that the removal of Bupa’s Benefit Maxima, with no comparable replacement, would lead to significant increases in consultants’ fees’ (OFT, 1999).

The earlier 1994 MMC judgement - as previously noted - had held that Bupa’s publishing of a national upper-limit on fees did not operate against the public interest. The MMC had also suggested that there was ‘...virtually no price competition between consultants’. Moreover, because of the power of consultants ‘...the countervailing power of the insurers is of crucial importance. The evidence suggests that until recently they have been less than robust in using it.’ (Monopolies and Mergers Commission, 1994, p.4).

The evidence presented in this thesis helps demonstrate that the MMC’s judgement was accurate. Bupa’s BM had the potential to counter the power of the providers but the evidence of effective use of ‘countervailing power’ to date is quite limited.

#### *Other Insurers’ Use of Reimbursement Schedules*

Bupa was not the only insurer that published a reimbursement schedule. Cigna, Aviva, Pru Health and Western Provident Association (WPA) also publish such schedules.

Yet historically the use of such schedules has been controversial within the UK PMI industry. Bupa’s BM have been a particular focus for controversy. Some insurers believe that Bupa, in publishing its BM rates was not setting a maximum fee level (as the term maxima suggests), but rather had established the minimum level that consultants would charge. The argument goes that consultants know that they can charge up to that amount and will be paid in full. Not only does this give them no incentive whatsoever to charge less, but as Bupa has approximately 40% of the market share that it has *de facto* set the minimum market rate.

Historically AXA PPP did not publish its reimbursement schedule. Instead its terms referred to reimbursing consultants within the confines of ‘reasonable and necessary limits’. The usual

interpretation of this is that if a fee submitted by a consultant falls within the normal range as set by peers it will be paid in full. However because a fee schedule is not published this gives the insurer the freedom to vary reimbursement rates between practitioners and to take advantage of any geographical differences in fees charged and/or patient demand for that particular consultant's services. From an economics perspective, this approach might be considered the one more likely to stimulate market-driven fee setting. However the degree to which real differences in fees charged - and paid - would occur across the UK may well be less than classical market theory would lead one to believe. Whether there are real gains to be had from this approach relates in part to the established propensity of many consultants to charge either to a standard rate to all insurers and/or to charge the same rate as their colleagues in a certain geographical area (Kessel, 1958; Herrick and Goodman, 2007). Standard charges are administratively convenient, particularly if those rates are paid in full by insurers, whilst aligning prices with those of colleagues has the self-protective effect of removing any local price competition.

The AXA PPP approach theoretically allows an insurer to make differential payments to consultants on any number of grounds - volume, market power, reputation, outcomes, economy of use of resources, length of stay, etcetera. Adherence to published tariffs would seem to unduly restrict a purchaser from adopting innovative reimbursement methods for clinicians. That historically so few insurers have attempted to adopt such differential payments is illuminating in terms of assessing the relative 'assertiveness' of UK private healthcare sector contracting with clinicians.

A significant constraint has been the desire of insurers to limit both the incidence and size of any shortfall between what a consultant charges and what the insurer is prepared to pay. Uncertainty on this issue is a major source of customer dissatisfaction with the insurer in question, and this is the main concern behind Bupa's attempts to limit shortfalls and thus give increased confidence to members that their care will be fully covered. The growth of regulation in the insurance industry seems set to push in the same direction. The Financial Services Authority (FSA) has increased pressure over time via regulatory requirements for insurers to make 'transparent' to their members their benefits entitlement. If members are not certain whether an insurer is going to cover in full any aspect of their treatment (including consultant fees), prior to treatment, then arguably their benefits are not 'transparent'. This



raises questions about the long-term viability of a consultant reimbursement system based on non-published rates.

Such an approach would be sustainable if member policies guarantee a full refund on consultant fees. The problem for insurers with this approach (historically) is that such guarantees attract a higher premium unless they are also accompanied with significant restrictions on which consultants can be seen and/or what conditions are covered. In the meantime for members who do not have such guarantees, the limits of coverage remain uncertain. This is an area likely to come under further regulatory scrutiny in future.

### **Controlling the Level of Consultant Fees**

Earlier sections have dealt with the limited efforts by UK insurers to control consultant costs via reforming the reimbursement mechanism and use of Benefit Maxima. This section assesses the level of consultant fees and discusses why insurers have been unable to push them lower.

Mention has already been made of the historically high cost of private healthcare in the UK, and how this is supported by the willingness of insurers to reimburse at those levels. When an expression such as 'high fee level' is used, the objection might be raised that a subjective judgement is being made in respect of what is in fact merely a price determined by supply and demand. However, there is good reason to suppose that the current market for consultant services in the UK private market is organised so as to create pricing mechanisms that depart significantly from the classical economics model as espoused by the likes of Ricardo (1817).

#### *The Economics of the Market for Consultant Services*

In a well functioning market - as envisaged within classical micro-economics - fees paid to private specialists would be expected to be set at a market-clearing rate that equalled the marginal cost of the service provided. However such a market requires well-informed consumers (be it patients or their agents such as insurers) with perfect knowledge of fees charged by other specialists, who base their choice of a particular specialist solely on perceptions of price and quality. Of course such an ideal market bears little resemblance to

the actual UK PMI market, or indeed to most real-world health care markets. Among the confounding factors likely to be observed are:

i. Asymmetry of information - as previously noted in the introductory chapter - typically the provider knows considerably more about the illness and proposed treatment than the patient. Whilst there are some signs (Health Care Advisory Board, 2007) that the internet in particular is being increasingly used by patients to help educate them, this imbalance looks set to remain the norm. This is often accentuated by the emotional vulnerability of patients who deem themselves (often rightly but sometimes just perceived) as suffering from an 'illness' requiring medical treatment. This area, and indeed the wider subject of market failure through the existence of uncertainty in the incidence of disease and the efficacy of treatment, remains essentially as highlighted by Kenneth Arrow (1963);

ii. Demand decisions tend not to be driven by price considerations, partly for reasons outlined in (i) above but also because in the developed world many patients are either fully insured, or funded via public healthcare schemes, and thus do not generally worry about fee levels for their care;

iii. Payers (government and insurers) tend to use standard fee rates for reimbursing specialists rather than negotiating individual arrangements;

iv. In the UK the choice of specialist is often driven by the general practitioner (GP) making the initial referral. The GP has no direct incentive to consider the price/fee charged by that specialist. Moreover as will be subsequently illustrated in Chapter 6, general practitioners often do not have ready access to objective knowledge of the quality of the clinical services being provided (although he or she may have accumulated some knowledge based on the outcome of previous referrals for the more common procedures);

v. There are high barriers to entry in the market for private consultants because:

a. There are long training periods, plus a traditionally restricted volume of consultant posts and medical school places, all affecting the supply of doctors in the short/medium term and;

b. More specifically to the UK, it is normally the case that consultants wishing to undertake private practice are required to have been or currently hold a consultant NHS post to be

recognised by insurers as eligible to treat their policy holders. Moreover, patient referrals are often based in part on relationships with local general practitioners developed through NHS work.

The above are general factors which suggest the existence of weak demand-side mechanisms and supplier dominance. To these must be added some additional features which help explain the high level of UK private sector consultant fees. We will now examine this further using the example of cataract surgery fees.

#### *Case Study: Cataract Surgery Specialist Fees*

There are two significant grounds for believing that many consultants are charging relatively high prices for undertaking cataract surgery and that overall (hospital and consultant charges combined) the prices being paid for such surgery in the UK are abnormally high. The first relates to the output of the RVR, which (unsurprisingly) adjudged that cataract surgery had a relatively low complexity score compared to many other procedures. This may not be entirely conclusive, since some consultants argue that cataract prices appear relatively high because the more complex procedures are undervalued.

However the second reason is more telling in that it relates not to any subjective view as to 'fairness' but from observations of both the cost of the procedure in other developed countries and self-pay prices in the UK. Overseas prices, as one might expect, vary considerably, but one is hard pressed to find a healthcare system that pays more for this procedure than the UK private sector. Set out below are clinician reimbursement rates for a variety of countries that were the subject of a study by NERA on behalf of Norwich Union and the Financial Times (Bramley-Hawker and Aslam, 2003).

**Table 4. INTERNATIONAL COMPARISON OF SPECIALIST FEES 2002**

OPCS Code	Procedure	UK	USA	Canada	Germany	Spain	Australia
National currency units		£	\$	C\$	€	€	A\$
Q0740	Total abdominal hysterectomy	636	909	386	161-371	519	1,185
T2000	Inguinal hernia	360	468	327	75-173	n.a.	725
W3710	Total hip replacement	864	1,343	695	216-496	714	2,515
G6500	Endoscopy	156	338	95	70-161	n.a.	380
H5100	Haemorrhoidectomy	312	392	270	54-124	227	650
K4100	Coronary artery bypass graft	2,304	1,936	1,281	437-1,005	1,298	3,160
F3440	Tonsillectomy adult	360	271	175	43-99	162	565
L8510	Varicose veins	420	364**	291	70-161**	292	950
C7120	Cataracts	780	673	417	204-469	389	n.a.
US\$ purchasing power parity rate							
Q0740	Total abdominal hysterectomy	978	909	322	168-387	674	871
T2000	Inguinal hernia	554	468	273	78-180	n.a.	533
W3710	Total hip replacement	1,329	1,343	579	225-517	927	1,849
G6500	Endoscopy	240	338	79	73-168	n.a.	279
H5100	Haemorrhoidectomy	480	392	225	56-129	295	478
K4100	Coronary artery bypass graft	3,545	1,936	1,068	455-1,047	1,686	2,324
F3440	Tonsillectomy adult	554	271	146	45-103	211	415
L8510	Varicose veins	646	364**	243	73-168**	379	699
C7120	Cataracts	1,200	673	347	213-489	506	n.a.

Notes:

\*\* Current data is a poor match to the OPCS codes or the previous data

As can be seen above, when the \$US purchasing parity rate is applied, the UK cataract removal price is almost twice as high as that in the United States, and represents an even bigger premium over the prices charged in Spain, Germany and Canada.

The Federation of Independent Professional Organisations (FIPO) reaction was to dismiss the NERA report. It quoted the British Medical Association (BMA) Health Policy and Economic Research Unit which had regarded the systems of healthcare in the overseas areas chosen by the NERA researchers as 'inappropriate'. FIPO said that this 'refuted' the report: 'essentially the NERA report is comparing apples with oranges and quite apart from the differences in general prices, taxation and economies it is inappropriate to compare consultants' earnings in a nationalised or government sponsored healthcare system with those in a fee paying service' (FIPO, 2006a).

However as Laing's Healthcare Market Review pointed out, the NERA findings were supported by other research. Specifically:

'A study carried out by Laing and Buisson a decade before in 1992, also funded by Norwich Union (UK Private Sector Fees-is the Price Right? (Laing and Buisson, 1992) also found that UK private specialists' fees were the highest in the developed world at that time' (Laing and Buisson, 2005).

Within the UK the cost of self-pay treatment provides further evidence that Bupa's BM for cataract surgery procedures were significantly over-valued. Prices vary significantly but are often below those historically paid by UKM. In 2003 Optimax Ltd was advertising self-pay cataract service at £2010 (both eyes) or £1055 for a single cataract (Optimax, 2003). The Coplow clinic was quoting £1,450 (Coplow, 2003). By 2007 some prices had dropped. Optimax prices were £995 for a single cataract – inclusive of up to one year's aftercare (Optimax, 2007). In contrast (as already noted earlier) Bupa's BM to the surgeon and anaesthetist at that time (hospital fees to be added) for a single cataract operation was £1011.

This is hardly what one would expect if prices were determined by market purchasing power. Bupa is the market leader in terms of PMI membership. On that basis one might expect it to command the lowest prices. What can account for the failure of the private sector in general,

and Bupa in particular, to get consultants to reduce their fees? Why does the main purchaser often get a worse price than an individual seeking a self-pay option?

The explanation most commonly afforded is that those in the self-pay market are purchasing marginal capacity, and that providers offer lower prices secure in the knowledge that their fixed costs are already covered through the cases paid for by the insurance industry. This may indeed be what is happening but it does not explain why insurers allow it to happen? It is not a purchasing pattern often seen in other industries, nor is it seen in US healthcare where the uninsured are typically charged considerably more than those covered by insurance for the same procedures (Barlett and Steele, 2004; Reinhardt, 2006).

Three explanations (by no means mutually exclusive) can be proffered for this state of affairs. They might be summarised as:

- A reluctance to direct patients to certain providers;
- The profit UK insurers currently make (leading to an insufficient desire to change);
- Not wanting to upset providers given their perceived influence on members.

These are explored in more detail below.

### *Consultants' Influence on Patients*

Insurers do not consider consultants to be passive suppliers of services. As previously noted, the doctor/patient relationship is typically characterised by a major power imbalance. There is often considerable trust displayed by the patient with regard to the wisdom and integrity of the doctor. Despite some erosion in that faith since Arrow's observation (Schlesinger, 2002), it remains the conventional wisdom that patients trust their doctor more than their insurer (Hall, 2001).

As previously noted - one consequence of this has been to regard the consultant as *de facto* the 'customer' as he or she is seen as instrumental in bringing the patient to that particular hospital. For insurers this translates into a belief that consultants have the ability to influence patients to renew or lapse their membership on the basis of how well-disposed the consultant is to the insurance company in question. The theory is that consultants can put up barriers such as:

'If you're with company 'X' I'm afraid that you'll have to pay in advance and claim your money back from them, as I have terrible trouble with that company'

Conversely they might praise a company along the lines of:

'You're with company 'Y', that's good, I find them very helpful'.

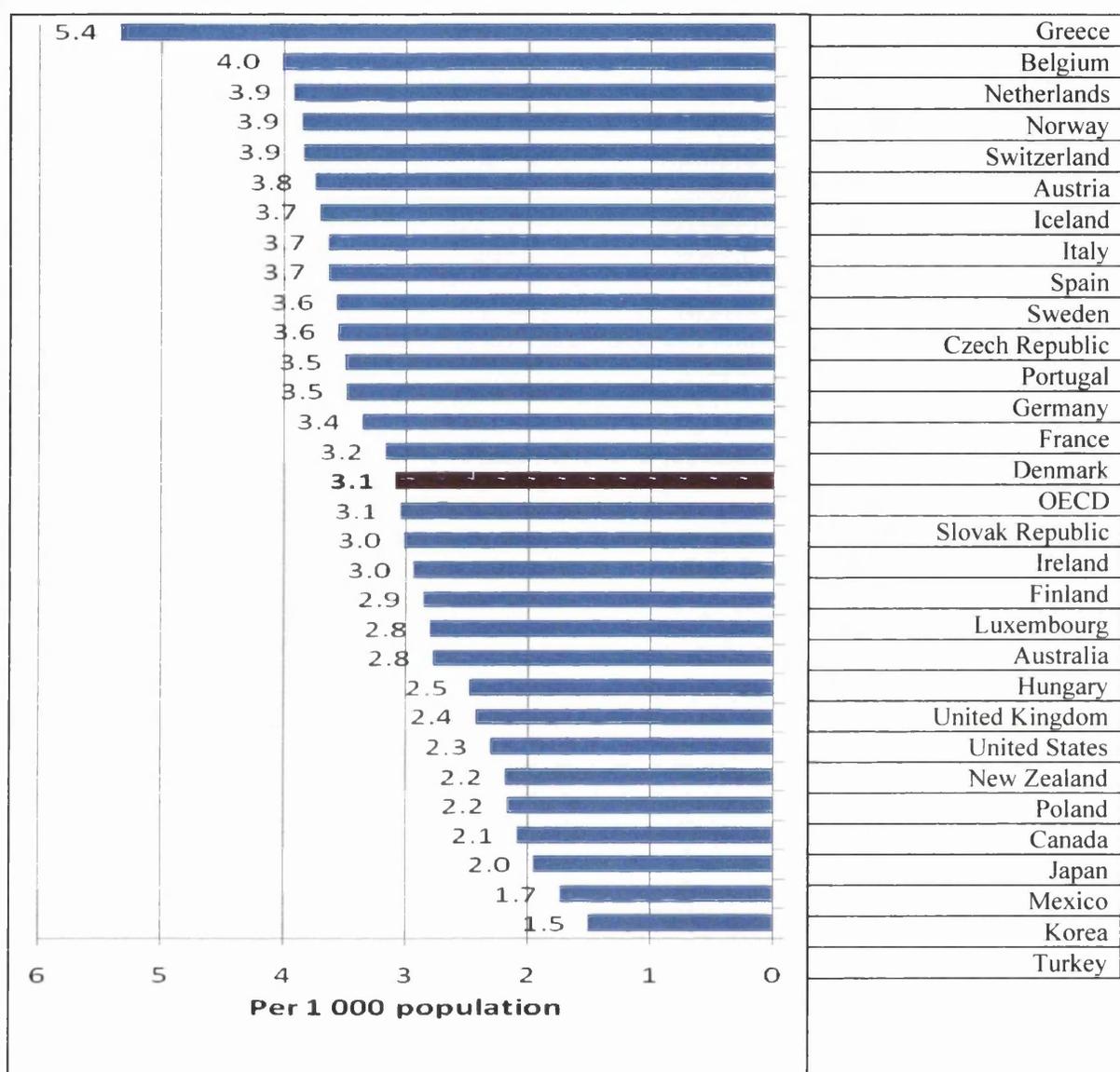
The conventional wisdom within the PMI industry is that such conversations are relatively commonplace and that this impacts on patients' propensity to renew their insurance with a particular company.

One result of this is that most insurers subscribe to an annual randomised survey of consultants called 'Silver Fern'. The survey is undertaken by an independent market research company and tracks consultant satisfaction across a number of areas. These include their views on reimbursement levels, and the service they receive from insurers in terms of time taken for invoices to be paid, telephone service etcetera. During the time the author worked for them, both Bupa Group and UK Membership set considerable store upon the results of Silver Fern - including setting year on year improvements of certain scores as a corporate objective.

Significantly, in 2004 UKM had a corporate objective of increasing the Silver Fern score by 1%, and in 2005 of it not dropping. This made it extremely difficult for insurance executives to push hard on initiatives that were attracting professional opposition.

Both insurance and hospital executives are well aware that consultant power in the UK derives in part by a relative shortage of supply. The UK has considerably fewer doctors per 1000 population than almost any other developed country (see table below).

**Table 5. Practising Physicians per 1,000 Population, 2007 (OECD, 2009)**



By the time of the publication of the NHS Plan in 2000 (DoH, 2000) the Labour government had identified the consultant workforce shortage as a key weakness in its ability to improve the NHS (and also reduce the power of the medical profession). The result has been a drive to increase doctor numbers in the longer term through increased medical school places. This was initially accompanied by shorter term initiatives to increase overseas recruitment and entice qualified doctors (particularly those who had left to have children) back to the NHS. These measures had some success but were significantly undermined to a degree by the following:

- The combined impacts of the European Working Times Directive/Junior Doctors Hours both of which effectively reduce the amount of time doctors are available to work (Temple 2010);
- The changing ratio of male: female doctors in favour of the latter. Female doctors have been shown to be more likely to either go part-time or leave medicine altogether. The principal reason for this remains that associated with the demands of childcare, but other changes within western society also means that the traditional notion of choosing a 'career for life' is no longer so applicable-even in medicine (Goldacre, Lambert and Davidson, 2001);
- The tranche of doctors recruited from overseas in the 1960's are approaching retirement. This has a particular impact on general practice (Taylor and Esmail 1999);
- The impact of the NHS 2004 Consultant Contract, which has given a positive inducement for consultants to identify any work they were performing above their contracted sessions. Where such additional work has been deemed unaffordable in terms of its inclusion in the new contract, workload has often dropped. If included, the resultant cost pressure can ultimately result in reduced clinical activity as a means by which NHS Trusts try to keep within their budgets (Williams and Buchan, 2006);
- Restrictions on the recruitment of overseas doctors from outside the EEC. This has had a particularly significant negative impact on NHS hospitals' ability to staff junior and middle grade medical rotas in a number of specialties (BMA 2009).

The traditional barriers to entry into the medical marketplace have already been noted. For the private sector in the UK the three elements most likely to liberalise the labour market are:

- (i) The introduction of Independent Sector Treatment Centres (ISTC's) and the use of overseas medical teams;
- (ii) Greater use of general practitioners (GP) and specialist nurses to undertake tasks which previously only a consultant had sole recognition to perform;
- (iii) Selective contracting with doctors based on an explicit price/quality matrix.

These innovations are all somewhat problematic for the private sector (and insurers in particular). Whilst they may well reduce the costs of healthcare, the following concerns are typically aired by insurance executives. Firstly, that the use of non-consultants undermines the 'brand'. At Bupa this was associated by the claim that members are treated by

consultants. Historically this was always felt an important selling point as it conveyed a clear notion of a superior service compared to the NHS where treatment by a doctor still in training is common. Secondly, that any use of overseas recruited teams would raise concerns (both perceived and sometimes actual) about their quality and finally, that the use of GPs and nurse practitioners would not only undermine the ‘consultant only’ treatment proposition but might also lead to an increase in the volume of treatments provided. The basis of this latter argument is an interesting one as it is founded upon the suspicion that although unit costs would drop, total costs would increase as clinicians would in effect lower the clinical threshold for which treatment would be offered.

### *Why Don't insurers Use Alternative Providers to Reduce Costs?*

The historic reluctance to utilise alternative suppliers, or encourage new suppliers into the market has already been noted. This seemingly paradoxical feature of a UK marketplace given historic supplier costs is best explained by reference to a number of factors which combine into a near overwhelming inertia. Arguably, chief amongst these factors is probably the sustained profitability of private health insurance for its main players. At its simplest, if ‘the business’ in terms of profitability/margins were in a more difficult environment, there would be greater downward pressure on fees. However the long-term ability of much of UK private healthcare to remain profitable in future is an open question.

The three greatest threats to profitability are as follows. Firstly, that those purchasing PMI will view the NHS as improving, so they consider private insurance unnecessary. Secondly, that the above-inflation premium increases seen in the past continue into the future. Laing’s Healthcare Market Review estimated that the average premium paid by a UK personal subscriber increased from £373 in 1989 to £1261 in 2004 (Laing and Buisson, 2005, p139). Thirdly, that there is a sustained economic downturn which results in individuals lapsing due to reductions in their disposal income, and corporate clients either lapsing their membership entirely or reducing the value of their policies.

The latter appears to be happening as a consequence of the severe slump in financial markets worldwide in 2008/09 that has subsequently triggered a general economic downturn. As the economy contracted sharply in 2009, the number of insured members covered by PMI and employers’ medical insurance schemes, fell by 4.8% from the previous year to reach 4,112,000 at the start of 2010 (Laing and Buisson, 2010b)

Whilst company-funded policies (covering both PMI and employers' schemes) fell by 4.7% in 2009, the number of individual subscribers fell by 5.2% in 2009 to reach a new low of 1,062,000 at the start of 2010 (Laing and Buisson 2010b). According to Laing and Buisson, Corporate PMI revenue and individual PMI revenue fell equally. Claims costs from medical insurance grew in 2009 (up 1% in real terms), and insurer margins dropped sharply to their lowest level since 2000.

Should insurer's profits continue to get squeezed and translate into losses, it is unlikely that suppliers would remain untouched. One consequence may be that insurers become more proactive in fee-setting negotiations, and in particular seek to have more influence regarding which provider sees and treats their members. Chapter 3 highlighted the trend towards developing hospital networks. As previously noted, these had the effect of discouraging new entrants from building private hospitals or otherwise generating additional capacity. The conventional wisdom had been that additional capacity would have to be paid for, and that would translate into increased incidence of claims. Any reduction in charges from increased competition would be more than wiped out by the overall increase in health-related expenditures. This has been very much the traditional view of healthcare dynamics in the UK. In short, there was a particular scepticism about the ability of competition to reduce costs, or indeed that much genuine competition would ever be generated.

Members buying hospital network-based products are bound by certain restrictions as to where they will be treated. However, this may or may not limit the choice of consultant. The impact of hospitals networks on consultant options varies geographically and by specialty. The effect is likely to be greatest where there is more than one private provider in an area (i.e. where some genuine competition might occur) and in a high volume specialty (for example, in orthopaedics as opposed to neurosurgery).

In such an environment the consultant in question may find that s/he cannot admit a patient to his/her preferred hospital - as it is not in the network. Some consultants have admitting privileges to more than one hospital so that this represents an inconvenience rather than a genuine threat to their income, and does not affect the fee charged. However, where there is a surplus of a given specialty in a particular geographical area it would be possible for the network hospital in question to make fee-setting a factor in determining consultants'

admitting privileges. In practice this happens infrequently, as to date there is usually no pressing market requirement to do so.

Furthermore, there are many parts of the UK where the network hospital effectively picks itself (being the only private hospital in the area or is part of a chain where admission of the network has been negotiated as part of an agreement between a hospital group and the insurer). In these circumstances there is no pressing need for consultants to adjust their behaviour with regard to the status of the hospital beyond the relative local supply of competing consultants in that speciality.

### *Consultant Networks?*

Given the limited potential of the current hospital networks to moderate consultant fees, why are insurers not more active in creating a restricted consultant network whereby members would be actively directed to consultants who were prepared to charge lower fees?

Dependent upon the quality criteria used, such networks have the potential to help ensure and promote quality healthcare. Economic theory would lead one to believe that:

- (i) Providers need patient volume to stay in business;
- (ii) The ability to bring (or reduce) patient volume to the provider is a powerful negotiating tool;
- (iii) Providers will trade price for volume - particularly if that volume can be 'guaranteed'.

Clinicians might be expected to oppose such an initiative (and they do) on the basis that it says nothing about clinical quality. However there is nothing *per se* in such an approach that excludes taking definable quality issues into account as a legitimate discriminator. The key word is 'definable'. The profession's historical failure to make such quality differentiators either explicit, or routinely collected, has in-part led purchasers to discriminate principally on price. After all, the consultant pool is made up of 'registered' consultants. In subsequent chapters the general issue of the measurement of quality and the degree to which it acts as an effective point of differentiation between providers is explored in more detail.

However in the UK to date this approach has been notable largely by its absence. Why are insurers so loath to adopt policies that restrict access only to those considered to be of high

quality and/or those offering lower fees? As previously stated, the quality issue will be explored in depth later in this thesis, but what of lower fees?

We have already seen that insurers display a marked reticence for upsetting the provider community. Somewhat paradoxically, insurers have been loath to take on such vested interests in pursuit of lower fees because they believe it would also be unpopular with their members. It may seem counter-intuitive that a measure designed to lower costs - and hence premiums - is not pursued because it would be too unpopular with members whose biggest complaint is the increase in premiums. On the surface this takes some explaining.

The most rational explanation - beyond lack of a sufficient market requirement to change - is that the particular nature of UK private healthcare has traditionally militated against an aggressive approach to consultant selection into a network. As previously noted, people typically obtain private medical insurance to increase their choice - for place of treatment, by whom and when. Private medical insurance is often expensive, and becomes progressively so as the member ages.

Restrictions on choice of provider will tend to be viewed very negatively, unless a compelling case can be made for them... perhaps not even then. For those who obtain their PMI via their employer this is usually seen as a perk-a status symbol within a company and/or as an attractive feature of employment with the company in question. Unsurprisingly then (when these factors are added to the previously noted moral hazard features of third party payment) few employees will be particularly motivated to keep the costs of *their* particular treatment down. Employers do have such an interest but this is counterbalanced (in part) by their concern to keep their workforce content with the benefits offered. For employers the historical evidence is that they are more likely to pursue reducing absolute numbers of employees eligible for PMI or trading down their level of cover (Laing and Buisson, 2010a).

The end result is that the primacy of 'choice' - which in practice more often than not means choice for the referring GP, as many patients will take a passive role in such matters - has become the conventional wisdom for those designing PMI products in the UK. The dominance of 'choice' - which is a concept easily understood by consumers - is in part a reflection of the difficulties and relative lack of attention given to 'quality and value for

money' issues...both for purchasers and consumers of healthcare. This is a subject that we shall return to. For the present one can merely observe the end result. Namely, UK insurers have a particularly strong predilection to believe that their members will not tolerate any significant restriction in their choice of provider - despite the potential benefits in terms of cost and quality control. Historically the cost/benefit (including dealing with consultant opposition) equation has favoured inertia. Whether declining profits will force insurers (and providers) to be more radical is an open question. Logically the answer would be 'yes' but no one wants to be the first mover...and risk widespread customer lapses to other insurers.

We have returned to the observation made in Chapter 2, namely that the particular dynamics of the UK's private healthcare market encourage insurers to act in a manner akin to that of PPO's in the United States. Ultimately a greater premium is placed within the industry on retaining 'choice' than tackling the cost structure...and the result is an expensive healthcare system.

Even if insurers were convinced of a favourable member response, the legality of limiting recognition principally (or purely) on economic grounds is not altogether certain. No insurer wants to risk the cost and unfavourable publicity of a legal challenge (probably on the grounds of undue restriction of trade). Insurers could try the approach of asking consultants to respond to tenders for services (e.g. 'we wish to channel anaesthetist services in each part of the UK only to anaesthetists meeting certain price and quality criteria'). This is a realistic option only for the largest insurers, and perhaps not even then, as examination of Bupa's efforts in this area in chapters 5 and 7 will demonstrate. Arguably this is what the Department of Health did when it first tendered for independent sector treatment centre work. In doing so it appears to have made the decision not to use incumbent private providers from supplying the service on the basis that they were unlikely to generate genuinely new capacity, new methods of working or a lower cost structure.

In the case of a tender undertaken by a private insurer there is a question as to whether consultants in areas where there is widespread above benefit maxima charging would actually respond to the tender. Insurers might attempt to 'parachute' in alternative consultant supply to problem areas. ISTC's are an example of this principle. For insurers the use of the ISTC's is a seemingly attractive option, as they offer opportunities to negotiate lower prices. However, the lack of differentiation arising from the use of ISTC's by the NHS is seen as a

problem, as is their use of non-NHS consultants to undertake operations. Bringing in new consultants is expensive and there are also concerns as to whether local GPs would refer to them.

Interestingly the requirement for GP-based referral even within private practice is a characteristic of UK healthcare not found in many overseas PMI markets. UK insurers tend to insist upon GP referral to consultants ostensibly as a mechanism for controlling incidence. However, perhaps because of the dominant NHS model British subscribers rarely appear to see the requirement for a GP referral as a matter for complaint.. Whether this really exerts much control on referral volumes is open to question, given that GPs have no incentive to control referrals. All the above initiatives are only really practical for the largest insurers to employ. In any case they require both a large customer base so as to make it worthwhile for alternative providers to bid for the work and a significant infrastructure to support such initiatives. Many insurers are not in this position and are thus ‘price takers’ in the PMI market.

## **Conclusion**

From the foregoing it can be seen that the market conditions prevalent within the UK’s private sector are peculiarly conducive to the maintenance of ‘high’ medical fees. At one level this should not be that surprising. It had been the unwritten understanding at the establishment of the NHS that consultants would be paid by the NHS below the rate one would expect for their skills and length of training in return for the opportunity to supplement their income via private practice. That insurers (and ultimately private patients) should permit such generous remuneration for this private work is less easy to understand. However, the structure of the PMI market and the power asymmetries alluded to earlier are major factors.

Undoubtedly the position of private practice as a profitable niche market (serving corporate customers and comparatively wealthy private individuals), against a backdrop of an NHS which historically had a poor reputation for consumer responsiveness, created a market notably indifferent to cost efficiency. Those who chose private healthcare as a substitute for the NHS overwhelmingly had higher than average incomes. Both Arrow (1963) and Kessel (1958) have noted the propensity of medical professionals to display ‘...extensive price

discrimination by income' (Arrow, 1963, p953) and the UK market represents a further example of his point.

For consultants there is more at stake than abstract notions of their freedom to practice as they choose. For many, their private practice income is a substantial proportion of their total earnings. There are differing estimates of just how much is involved. The Monopolies and Merger's Commission's (1994) investigation, based on a postal survey of consultants, found that mean gross private practice earnings varied from £49,000 in the south east region to £18,000 in Northern Ireland. In most regions the range was £33,000 to £45,000 a year. However, this was distorted by the top earners, 10% of whom received more than £67,000 a year and 1% whom earned over £150,000 a year.

In 1992 median NHS earnings were about £42,000 compared to a median private practice income of £25,000 a year. The MMC estimated the gross earnings per hour from private and NHS practice from these figures at £133 and £25 respectively (with some significant variation by speciality). These figures although nearly two decades old, help illustrate the gulf between private and NHS practice hourly rates and thus the importance placed on private practice by many consultants.

This picture is supported by more recent figures published in Independent Practitioner (a supplement published by Hospital Doctor) in November 2007 (Standbridge, 2007) that give the average gross and net incomes from private practice by speciality. These range from a gross income of £166,000 (before expenses) for Orthopaedic surgeons down to £56,000 (also before expenses) for anaesthetists.

Finally, the BMA (2004) has itself estimated that private practice income for those consultants who do private work was, on average, approximately 50% of their NHS income in 2004

This chapter has discussed certain factors that explain the generally high consultant charges seen in the UK private sector and the barriers to reform that exist. It has been suggested that insurers' efforts to exert downward pressure on charges have been quite limited and that those initiatives attempted have had only mixed success. Given that medical cost inflation is likely to be a continuing problem for insurers and subscribers in future years,, what are the

prospects of such reforms taking place from the 'voluntary' actions of those in the marketplace as opposed to through compulsion /pressure via regulatory change or government intervention?

The experience of the UK PMI market to date would lead one to conclude that a number of conditions would need to be present for any meaningful reform to take place. These are:

1. By far the most likely lead agency would be a major insurer. Small insurers lack sufficient purchasing power to cause providers to make the required changes. Hospital groups are unlikely to take forward the necessary innovation to reduce fees on their own as:

- (i) They will fear that key consultants will move to a competitor hospital (see hospital chapter) and they will lose the patient income they bring;
- (ii) They see little pressing reason (in the absence of insurer pressure to do otherwise) to make substantial changes to their business model or operational processes.

2. The increasing use of private sector providers by the NHS might persuade one or more hospital groups that they need to dramatically change their relationship with consultants so as to be able to compete (profitably) for General Supplement Funding Projects (GSup) and patient choice contracts. This issue was discussed in Chapter 3. For the purposes of the present chapter the question is whether such initiatives as working strictly to clinical protocols, limited prosthesis lists and reduced fees/session payments/salaries, for NHS contracts are going to transfer across to private sector work - particularly involving insured patients. This is dependent, in large part, on the degree of support from insurers, as without it they are once again in danger of key consultants moving to a rival hospital that retains the existing model.

3. At some point the volume of NHS business to a particular hospital group may become so significant (in terms of overall revenue/profitability) that it will make a decision (as Nuffield Hospitals appears to have done) to change fundamentally its operational model. The question then becomes whether that hospital group then becomes a marginal provider of private care or whether the changes it makes are going to significantly impact on the private market.

4. At least one major insurer makes the strategic decision that its current business model - as it relates to its relationship with consultants and costs - is unsustainable. This is likely to

centre on reducing fees and/or making clinical quality more transparent. In doing so that insurer will have to be prepared to endure some short to medium term ‘pain’ in the forms of consultant opposition, negative publicity, member complaints, loss of some corporate and individual subscribers to rivals, etcetera. Such negative consequences are extremely likely because the changes to the *status quo* will undermine member confidence in the security of that insurance product and is aggravated by a likely reduction in choice of consultant as the insurer tries to promote a particular consultant network. As mitigation of risk is a key driving force in purchasing insurance and choice is a key selling point in UK private health insurance these are substantial hurdles to overcome.

The above should not be interpreted as saying that insurers are making no attempts to control medical costs or that all their attempts are unsuccessful. Bupa itself has made some inroads as we have seen with its implementation of the CSSD schedule in this chapter. In the next chapter we will consider another example in the shape of Bupa’s attempt to create an ophthalmology network.

In 2008 AXA PPP announced a major change in its historical approach to reimbursing consultants by enforcing a Schedule of Fees and new Terms and Conditions that would apply to newly appointed consultants. This is the first time the company has published a Fee Schedule. Unsurprisingly this elicited a strong negative reaction from FIPO (FIPO, 2008) who noted both that the fees were lower and that consultants bound by these new terms and conditions would not be able to charge the patient for any shortfall. In March 2010 AXA PPP followed this up with a letter to a number of previously recognised consultants which in the words to the FIPO website:

‘...suggests that they should comply with a new fixed fee schedule issued by AXA PPP and which is exactly the same as the schedule enforced on newly appointed consultants for the last 18 months. Broadly speaking the fee reimbursements for patients are lower than current BUPA rates’ (FIPO, 2010b).

AXA PPP has yet to directly link acceptance of these fees to recognition for currently accredited consultants although this may well be the next step. In the meantime the company has requested consultants to give patients an estimate of their potential fees. The implication is that AXA PPP will use this information to make patients aware of any potential shortfall,

should a consultant fail to agree to charge at the new lower fee rate and a patient insists on seeing that consultant.

Perhaps emboldened by the AXA PPP approach, BUPA announced in July 2010 new terms and conditions for new consultants applying for recognition (FIPO, 2010c). Those seeking BUPA Insurance recognition would be required to adhere to the BUPA Maxima for in-patient fees, and additionally there would be discussion about outpatient consultation fees with each consultant. These consultants would be required to sign a contract which allows BUPA to request detailed personal, administrative and clinical details (audits, work analysis, complications, clinical incidents, complaints, appraisals) at any stage.

FIPO complained that the documents appeared to suggest that established consultants, as well as those seeking recognition for the first time, would be covered by these arrangements, although BUPA stated there were no immediate plans to alter established consultant fee arrangements. Taken together the above indicates the direction of travel that insurers such as Bupa and AXA PPP appear to be taking in an attempt to control (and even reduce) consultant fees although the pace of change remains quite slow.

Taking the issues set out in the chapter as a whole it can be seen that whilst change is more likely today than in the past, there are still substantial 'hurdles' to overcome. Moreover the historical record of the private sector in both the promotion of clinical quality (see Chapter 7) and demonstrable value for money has been open to question. From this it is fair to conclude that there is no built-in logic in private healthcare in the UK that will ensure that these issues of 'market failure' are addressed. Indeed this author would contend that features of the UK private healthcare make it particularly difficult for a market-based solution to force changes in provider behaviour. We might hypothesize that, as long as the PMI market remains profitable, the present equilibrium will persist and the power of private sector purchasers to force cost and quality improvements will have been shown to be severely limited.

In Chapter 5 this hypothesis is further tested by reference to the experience of Bupa UKM's attempts to introduce an ophthalmology network. This draws together threads from both the hospital and consultant reimbursement chapters, and presents further evidence on the relative power of purchasers and providers in the UK PMI market.

## **CHAPTER 5**

### **Bupa's Specialty Network Initiatives**

#### **Introduction**

This chapter returns to key themes explored in the previous two chapters on the markets for hospital and consultant services, and adds depth to the analysis by discussing a small number of initiatives by UK insurers in recent years to establish specialty networks. The main case study presented is Bupa UKM's attempt to introduce an ophthalmology network, an initiative noteworthy for the intense professional opposition that it provoked. However, the chapter also considers AXA/PPP's successful roll out of a more limited cataract surgery network with less professional resistance, and Bupa's recent establishment of a physiotherapy network.

The main theme of the chapter is the considerable resistance offered by consultant organisations and some hospital providers to insurer initiatives aimed at lowering prices or improving quality, though it is noted that Bupa and AXA/PPP have had some measure of success with more limited forms of network organisation. The chapter shows that such insurer-initiated 'reforms' have high opportunity costs, take up much time and resources, face difficult implementation problems, and have an uncertain outcome.

#### **The Ophthalmology Network Proposal and the Professional Reaction**

If provider opposition to the Bupa MRI tender discussed in Chapter 3 was muted by competitive realities, the same cannot be said for Bupa UKM's next initiative - the proposed creation of an ophthalmology network. The opposition to this initiative was noticeably greater and of a more sustained nature than with the MRI network. This may reflect a number of subtle differences between the two.

Firstly, different treatment modalities are involved (MRI being heavily technology/equipment driven, whilst ophthalmology services conforms much more to the traditional clinician driven model of health care). Secondly, as previously noted, MRI services have been progressively ‘commoditised’. Thirdly, ophthalmology services represent a traditional part of the core private provider market. An attempt to create a new network would impact on ophthalmologists, anaesthetists and hospitals and was perceived by consultants as a threat not only to all ophthalmology-related work but also to traditional work practices and contractual arrangements across *all* specialities. By contrast MRI is a more self-contained, equipment-based treatment modality which lends itself to discrete ‘spot’ contracting. These features that also help explain why the DoH chose MRI as one of its first services to involve the private sector in the provision of services to NHS patients.

Ophthalmology may seem initially to be a strange choice, in that it is by no means the speciality that has the biggest spend or the greatest patient volume. Actually these very factors may help explain why UKM selected ophthalmology for a tendering initiative. The risks were less than would have been the case, for example, with orthopaedics (with bigger volumes and more members involved), or cancer services (which though not presenting large numbers of claims is a highly emotive area of healthcare). However the principal reason for choosing ophthalmology is that one procedure (cataract surgery) represents such a large percentage of the 21,000 ophthalmology procedures Bupa were funding back in 2004 at a cost of £32 million (Bupa Group Press Release, 2006a).

Cataract surgery had become a commonplace intervention, capable in most cases of being performed as an outpatient or day case procedure. The reimbursement assigned to the procedure for both hospitals and consultants was widely regarded as significantly overvalued. Bupa faced charges of up to £3,500 from private providers compared to the NHS tariff cost of between £702 and £1,015 (Bupa Group Press Release, 2006b). £3,500 represented the ‘high end’ of a wide spectrum of charges, and if one utilises the price guide within WPA’s ‘Flexible Health’ product literature (Western Provident Association, 2005) a more typical private sector cost at that time would be in the range of £2,190 to £2,680. As was noted in Chapter 4 these concerns were amplified by the propensity of many ophthalmologists to charge above the rate paid by UKM and thus to ‘shortfall’ the member. With new providers entering the ophthalmology market via the DoH-led independent treatment centre initiative, Bupa saw both an opportunity and a pressing need to make changes in this area.

UKM's ophthalmology initiative had a long gestation (the author being involved in extended discussions on options for his first three years at UKM and intimately involved in detailed project planning in his final year). The initiative was not actually 'launched' until May 2006 (a further three months having elapsed from when the author left UKM). Despite attempts during the planning phase to persuade both consultants and hospital groups of the benefits of change, the subsequent reaction of large sections of the provider community quickly dashed any hopes there might have been that implementation would be either smooth or quick.

UKM's intention was to invite both existing and new providers to tender for the delivery of ophthalmology services. From these submissions UKM intended to create a preferred provider network. As with MRI there would be explicit quality criteria and a 'value for money' test. The hope was that a tender exercise would engender price competition-at least in most parts of the UK. There were certain parts of the country where the relative scarcity of providers (either ophthalmologists and/or hospitals) created opportunities for monopolistic pricing, but if this materialised active encouragement to get members to travel to other providers, or introduce new providers, could be initiated. Senior Bupa executives believed that there was a real prospect of creating a more price-sensitive market for ophthalmology services (particularly for cataracts), and it may have been the very practicability of the plan that provoked such sustained opposition from providers who knew they had much to lose.

FIPO and the BMA signalled their opposition to the network proposals from the outset and have maintained that position. This well-publicized resistance from the consultant lobby allowed the hospital groups to take more of a backseat in the subsequent 'war of words'. The FIPO website put the organisation's concerns in the following terms:

'Bupa Insurance is currently trying to implement the Ophthalmology Approved Network in two phases and all relevant consultants and hospitals will have received information about this. Phase 1 requires private hospitals or other facilities to combine with local consultant ophthalmologists and anaesthetists to form 'teams' and then to submit detailed documentation about their services.

In the case of consultants this document is extremely complex and involves professional issues that have never been requested before by any insurance company. It also requires consultants to sign a declaration (in essence a contract) which is one

sided and totally biased in favour of the Insurer. As an example, it would allow Bupa Insurance to de-list consultants on the basis of complaints (number and content unspecified) by Bupa personnel or patients without any independent appeals process.

If hospitals and their consultants do in fact agree to apply together for this Bupa Insurance 'Approval' they will move in to Phase 2 of the process which will involve the agreement of a price for their combined services with Bupa Insurance. Those hospitals not recognized will be unable to treat Bupa subscribers and similarly with consultants (although there may be just a few patients that can be seen by so called "Bupa Recognized" consultants).

The impact of this tendering process, if completed nationally, would be a limited number of preferred providers, restriction of choice for the patients, loss of independence for the profession and Bupa control of the referral patterns of patients. There are also clinical "guidelines" suggested by Bupa for the care of patients. This is a Managed Care Scenario (although this is denied by Bupa)' (FIPO, 2006b).

Concerted opposition to these proposals manifested itself in a joint letter to all consultants of the 12<sup>th</sup> June 2006 signed by the heads of the BMA, FIPO, the Associations of Anaesthetists and Ophthalmologists, the British Ophthalmic Anaesthesia Society, the Independent Doctors Forum and the Society of Cataract and Refractive Surgeons.

In the letter they set out their principal concerns including the following:

- 'The accreditation of consultants is the role of the Royal medical colleges, post-graduate deaneries and the GMC and not that of a medical insurer;
- Private medical insurers should not be regulating healthcare facilities which is the remit of the Healthcare commission;
- Quality guidelines are drawn up by the profession and the royal medical colleges. The quality criteria documents that form part of Bupa Insurance Limited's ophthalmology network procedure have misrepresented guidelines issued by the Royal college of Ophthalmologists;
- Audit assessment of consultants is a local hospital governance issue and not the remit of a medical insurer;

- The network is detrimental to patient choice...;
- The network may interfere with the existing doctor-patient relationships;
- The network could result in a reduction of fees paid to ophthalmologists and anaesthetists as it is the overall cost of treatment that is assessed for Bupa 'approval'. It is likely that private hospitals will offer ophthalmologists and anaesthetists a set fee for undertaking work. The network will therefore give hospital providers control over consultants;
- The contractual relationship has always been and should remain between the patient and their doctor and not between the insurance company and the doctor and the proposed network will interfere with this.

We have concerns that this initiative will be followed by similar networks in other clinical specialties and believe this misguided initiative should be terminated

In light of these concerns we would advise you not to take part in the initiative...a robust united front by ophthalmologists and anaesthetists, and all other consultants in rejecting the proposal will defeat it. In the past Bupa Insurance Limited attempted to control hip and knee surgery, but this initiative was successfully defeated by the profession.'

This position was largely mirrored by the Royal Colleges:

'Our position remains that it is inappropriate for Bupa to act as a regulator for one sector of practice and the College does not intend to assist in the implementation of Bupa's plans'..

And:

'We are content that you may refer to our publications in any discussions you have or in your own documents, but we must ask that you refrain from construing this as our endorsement of your processes. In addition, while being grateful for sight of your publication 'Creating an Approved Ophthalmology Network' we have not been involved in its creation nor have we had the opportunity to pass comment on it, therefore please again note this document cannot be endorsed by us' (McLaughlin, 2006).

The nature and depth of doctors' opposition to any attempt to change their working practices, fees, or impose external scrutiny upon the quality of that work is clear enough and is a recurring theme in this study. In essence the consultants opposed any erosion of their traditional right to self-regulation, objected to the idea that an insurance company could impose quality requirements, and questioned whether it was competent to interpret clinical guidelines. The literature on the professions reviewed in Chapter 1 suggests that the medical profession will not easily relinquish its control over the organisation of medical care. FIPO's statement in particular appears to assert the traditional cultural authority of the consultants and present the proposed change as a threat to the doctor-patient relationship. A key question for the thesis is how far market mechanisms are able to successfully deliver change in the UK private health sector: the strength of professional and provider opposition is clearly one of the most important factors preventing movement from the '*status quo*'.

Of interest in this regard is the approach of the UK government with regard to reform of the NHS. Whilst in England there has been an attempt to harness market forces to assist and reinforce this programme, one may argue that many of its core features owe more to central direction than to market levers. Despite the furore surrounding the introduction of private sector providers, the numbers of NHS patients actually treated by such providers remain quite limited. Hospitals are paid by centrally-determined and uniform HRG payments. Consultant's salaries are nationally negotiated. Quality initiatives such as the introduction of the Healthcare Commission (now the Care Quality Commission) have been centrally mandated. The new Conservative/Liberal Democrat administration has indicated in its recent NHS White Paper (DoH 2010a) that the development of a market is to be further encouraged, principally through enforcement of an 'Any Willing Provider' (AWP) process to ensure contestability. However, at the time of writing, reliance on market mechanisms to create change within the NHS remains secondary to bureaucratic control.

Clearly the government is more powerful than an individual insurer, and whilst all insurance companies acting in unison would be a formidable force, the Competition Commission would most likely veto any such 'collusion'. It is apparent from the foregoing that this is a market with considerable 'structural' inertia to attempts to change the fundamentals by which price and quality are determined and regulated.

## **Bupa's Attempt to Implement the Network**

The subsequent history of the attempts to establish an ophthalmology network illustrated the depth of professional opposition. FIPO and the BMA presented a common front in challenging Bupa's proposals. Their web sites posted a series of open letters, advising their members of the latest position with regard to negotiations with UKM.

A BMA post in mid July stated that there was evidence of an 'overwhelming rejection' of the network by members, and advised individual consultants concerned about a possible loss of Bupa practice to band together with local colleagues to oppose the proposals:

'...The network represents a further measure to control/depress income from private practice. If you doubt this, consider what has happened since the Bupa consultant partnership was introduced - no increase in most benefit levels and a depressant effect on fees across the whole private sector with the result that the relative value of fee income has dramatically decreased since 1990. The effect of the network would be much worse as any attempt to increase fees would then result in expulsion and exclusion from treating any Bupa insured patients rather than merely losing out on a 10% procedural bonus... We must point out that it takes two to negotiate and that it may not be possible to reach an acceptable agreement with Bupa, in which case our advice to decline to be involved in the network would stand. The evidence we have from our surveys indicate that there is an overwhelming rejection of the network by both consultant ophthalmologists and anaesthetists. We are aware, however, that individual ophthalmologists may get nervous about their Bupa practice and we would advise that colleagues in each area agree between themselves not to join the network - no doctors = no network. You are more powerful than you believe' (Machin and Daniel, 2006).

On the same day (17<sup>th</sup> July 2006), Machin and Daniel wrote to UKM on behalf of the BMA, reiterating the argument that the proposed network was not necessary in order to achieve UKM's objectives regarding quality assurance and cost effective practice. The letter stated that the BMA did not accept that there was a problem with the quality of ophthalmological surgery in the UK and believed there were only limited opportunities to improve cost

effectiveness in the specialty. The letter went on to say that ophthalmologists' representatives were 'very willing to work with Bupa on cost effective practice and have identified length of stay, list planning and prostheses as areas where progress could be made...The willingness to progress this issue is dependent on an agreement that the intention is to substitute the network proposals with this initiative proposed by the profession' (Machin and Daniel, 2006).

Bupa executives were skeptical about how the BMA proposed to apply such 'cost effective practice' to the PMI market, given that the profession opposed 'managed care' guidelines and collective fee setting. Nevertheless, negotiations continued.

On 28<sup>th</sup> July 2006 the BMA reported to its members that:

'[The Association is] pleased to report that we have reached a provisional agreement with Bupa Insurance Limited. They have accepted our argument that consultants do not find the concept of belonging to a network acceptable. In its place, they have agreed to our proposals for joint working at national and subsequently at a local level on cost effective practice and the equitable distribution of the benefits which accrue...

The achievement of this agreement was entirely down to the unanimity of purpose demonstrated by the profession and its successful implementation is wholly dependent on the outcome of the upcoming national negotiations which will be carried out by your representatives'. (Machin, 2006).

In fact, the BMA's conclusion that UKM had dropped its ophthalmology network proposals was incorrect. In November, Hospital Doctor, under the title 'Bupa drives on with approved providers', reported that:

'Bupa Health Insurance's controversial plan for a network of approved ophthalmology providers and consultants has re-emerged. Bupa is now asking individual hospitals to make combined applications, with individual doctors or consultant groups, to become approved providers. In information to applicants, Bupa said it would take 'all opportunity' to ensure subscribers are aware of any financial consequences of them using unapproved providers.

Bupa is asking one hospital or consultant group to head up the bid as 'lead provider'. The other doctors in the combined submissions should contract their services to the lead provider, the insurer suggests. Bupa could then contract with the lead provider for a range of services, with the provider submitting a composite invoice.

Bupa says it will continue to recognise consultant anaesthetists for reimbursement, but does not want to hold contracts for providing ophthalmic anaesthetic services. Lead providers will be responsible for subcontracting anaesthetic services and for making sure that all involved have agreed to pricing.

While recognised anaesthetists who do not have a subcontract with a Bupa-approved facility may still invoice the insurer directly, Bupa said: "It will not be in the approved facility's or approved ophthalmologist's best interests" to use non-approved anaesthetists. Bupa said individual submissions would be considered when "specifically invited" (Newman, 2006).

This was a wholly unwelcome development as far as the consultants were concerned, and this was reflected in the response from the BMA and FIPO. There was a further flurry of open letters to their members reaffirming their opposition to the network. At the same time the profession was trying to marshal support from the wider provider community. A letter issued in December 2006 made reference to the position of one of the major hospital chains, BMI, on the issue:

'You may be interested to know that BMI Healthcare Limited has advised us that having canvassed the opinion of specialists in relation to Bupa's request for a "team" submission, the BMI hospital group will not be making a team submission. They do not agree to subcontract the anaesthetists' charges and have confirmed that Bupa will need to negotiate with individual specialists in respect of their fees. The BMA continues to be resolutely opposed to the establishment of networks which benefit only Bupa...' (Machin and Daniel, 2006 ).

As 2006 drew to a close 'The Times' ran an article 'Bupa takes a stand against 'poor surgeons who charge excessive fees' (Hawkes, 2006) which demonstrated that UKM was having more success convincing elements of the national press of the merits of its proposals than it was

having with providers: The Times article also reported on figures supplied by Bupa which reaffirmed points previously made in this thesis as follows:

‘The survey (by Bupa) also found huge variations in the prices charged by private hospitals. The NHS tariff for a cataract operation is between £702 and £1,015. But in some cases Bupa was being asked to pay £3,500 for an operation in the private sector. These prices have a direct effect on premiums. Bupa said that a typical policy-holder, aged 32, who was paying £655 a year for medical insurance cover in January 2004, will be paying nearly £867 by January.’ (Hawkes, 2006)

### *Halfway to a Network?*

At the time of writing (November 2010) UKM has still not succeeded in establishing a national ophthalmology network as originally envisaged. Active and highly vocal resistance from doctors groups (and some of the hospital groups) had been sustained throughout what became an extended period of negotiations and ‘stand offs’. Successive due dates for announcement of the network came and went.

However, that is not to say that UKM was unable to create a *de facto* network of a kind. What happened on the ground was that UKM directed a significant proportion of members (though not all) via Bupa’s customer service centers to those providers with whom it had negotiated a pricing agreement - in effect creating an *ad hoc* network. Whilst the need to direct customers on a case-by-case basis created operational pressures for those call centers, UKM appears to have favoured this low-key approach as an alternative to a push towards a position where it could publicly announce a formal network arrangement. Whilst Bupa’s website makes no mention of a network, it does contain a list of approved ophthalmic units searchable by geographical area which reinforces the view that there is an informal arrangement with network characteristics. Bupa issued a letter to intermediaries (brokers) stating that from 1<sup>st</sup> August 2007 there would be more than 100 Bupa-approved Ophthalmic Units and that any member treated at these hospitals would have their costs met in full.

This did not escape the attention of the consultants, who argued that the arrangement disadvantaged patients. According to FIPO (FIPO, 2007a) if the patient decided to go to a ‘non-approved’ facility the reimbursement would be:

‘...approximately 50% for the consultant fees and thus the patient will be penalised. Whilst this is a big step back by Bupa Insurance from their original proposals which envisaged package pricing and more control of the referral pathways it is not as yet satisfactory because many hospitals including (at this precise date) the whole BMI group (the largest in the country) have been excluded from the “approved” network.

In some areas of the country there are very few (if any) “approved” options available for Bupa subscribers to have their cataract or eye treatment. This means that many patients are being referred to awkward or distant locations for their treatment, often under a consultant who is not their first choice’.

The reference to UKM’s dispute with BMI pointed towards another problem for Bupa: that the largest hospital group had decided that it was not going to co-operate with UKM in its attempt to lower prices. FIPO also stated that, in response to UKM previous suggestions of poor quality in UK ophthalmic surgery, it was setting up a national cataract audit in the independent sector. FIPO was confident that audit would refute UKM’s allegations.

However, at the time of writing (almost three years after this announcement) FIPO have yet to announce its results

FIPO’s ‘December Update’ (2007b) reported that the Bupa ophthalmology network ‘has not been implemented’. Under the arrangement that had emerged, UKM had reduced the benefit maxima reimbursable to non-approved consultants for cataracts by some 50%, from £741 to £386 (Fox, 2007b). This appears at first sight to be a radical move and a clear statement of intent that the company was going to be a price setter in the cataract market. However on closer inspection the announcement may neither be as brave, nor as radical, as one might assume. The reduced reimbursement applied only to non-recognised providers. Recognised providers can still charge higher amounts - the implication being that they these can be agreed at the point of being recognized and may differ between providers. The degree to which Bupa’s move would generate a real price decrease would be ultimately dependent upon:

- (i) What prices are agreed with the recognized providers - if they are close to the historical BM levels the actual gain is negligible;
- (ii) How many providers are not recognized and thus subject to the lower reimbursements;

(iii) How many Bupa members were still treated by non-recognised providers.

On this last point such members may well end up paying the difference between the new BM and the consultants' historical prices/old BM which represents a real out-of-pocket price increase for those patients.

Unfortunately, although almost three years have passed, none of the above information is in the public domain and the author no longer has access to Bupa's internal deliberations.

Whilst UKM's website now lists Approved Ophthalmic Units, there is no corresponding list of doctors. This means that Bupa members who have already seen a GP or optometrist who has made a referral, must then contact a call centre to determine whether the consultant named in the referral is recognized and whether they will face a shortfall. Historically this would have been highly problematic to UKM as it undermines the customer-centric service proposition that helped underpin the company's brand.

It seems likely that UKM will have tried to minimize such disruption by recognizing most providers and paying the historical BM (or close to it). However, the absence of vocal opposition from organizations such as FIPO and the BMA gives credence to the view that for most providers it has essentially been 'business as usual'. One change the above does signal, however, is a move away from uniform reimbursement via published tariffs to a system much more akin to that historically used by insurers such as AXA PPP, where individual price agreements become important.

The same FIPO update noted that the dispute between BMI healthcare and UKM had yet to be resolved and stated that:

'... a number of Bupa subscribers [are] being forced to transfer their care to alternative venues not of their choosing and under consultants who may be perfectly satisfactory but with whom they have had no previous contact or relationship' (2007b).

Bupa executives were aware that geographical gaps in provision would have negative marketing implications, and they continued negotiations with certain large hospital groups, including BMI. The author understands from industry informants that eventually Bupa and BMI reached an agreement acceptable to both sides. BMI hospitals are now included on Bupa's list of approved units, as are a number of HCA hospitals.

It is too early to state with certainty who has come out on top in this extended contest between providers and insurer. Perhaps immediate advantage is less important than engineering limited change and building upon that foundation in the longer term. But it is yet unclear whether any gains made by Bupa will have cumulative benefits for insurers. At one level, the wrangle between Bupa and the consultant bodies may be taken as a conflict between two interest groups with different 'world views'. However there is the alternative, more mundane explanation that heated rhetoric masks the traditional manner of negotiating between insurers and providers in healthcare, where both parties compete to capture the moral high ground before the court of public/patient opinion and their own constituencies over what in reality are marginal gains or losses.

### **AXA/PPP Network Initiatives**

Bupa have not been the only company to attempt to establish a specialty network. In October 2007 AXA PPP started to roll out its own network for cataract surgery. This network was different in conception from the Bupa ophthalmology model because it depended on contracts between the insurer and the hospital group, which was then responsible for ensuring that its subcontractors (the consultants) complied with insurer requirements. Patients were directed to AXA PPP network hospitals according to whether they lived within a particular catchment area, defined by travel time.

FIPO reported this development thus:

'...Hospitals that have joined the network so far include the Nuffield Hospital Group and some other small independent units. The Nuffield Hospital management has written out to their local consultants suggesting that new arrangements will have to be made between the hospital and the profession if these ophthalmologists wish to continue to treat this group of PPP subscribers in Nuffield Hospitals for cataract procedures.

Undoubtedly this will mean package pricing and will pass the choice of consultant to the hospital manager who will then select from a smaller group of consultants.

...In effect this is similar to the Bupa plan and, if implemented, will again restrict patient choice, destroy continuity of care and break the GP to consultant referral pathway' (FIPO, 2007b).

PPP appears to have had fewer problems implementing its network than Bupa. The author believes this was primarily because PPP had a history of being more assertive with providers, For example they de-recognised more consultants than Bupa during the period the author worked at UKM, a position that has been confirmed by a FIPO consultant survey (FIPO, 2010a). PPP appears to have a corporate culture more conducive to managing the conflict with providers associated with such initiatives.

FIPO reported in May 2009 that Ramsay (previously Capiro) hospitals had agreed new fee arrangements for cataract surgery and had thus been successful in *regaining entry* to the PPP cataract network. The FIPO letter included details of the fee levels involved whilst making the point that were '...lower than the Bupa Benefit Maxima and presumably would not allow consultants to charge directly for any top-up fees' (Glazer and Packard, 2009).

Set out below are those fees compared to the Bupa Benefit Maxima *prior* to Bupa's own ophthalmology initiative, to give an indication to what degree insurer initiatives had reduced fees in this area.

**Table 6. Bupa and AXA PPP cataract reimbursement**

	PPP £	Bupa £
Surgeon Fee Cataract GA	600	741
Surgeon Fee Cataract LA	775	926
Biometry	75	n/a
Pre & Post Consultations	0 (included within surgical fee)	No limit given – can be charged separately

These are significant decreases but it is not clear if they result from the specific creation of a network, or just reflect a historical over-pricing which reduced when competing providers

willingly came forward to deliver the service at a lower price. To be more specific the same result may well have occurred simply by imposing lower reimbursement levels. If enough providers had accepted the new reimbursement level and not subsequently ‘shortfalled’ the patient, the net effect would be the same. This is an interesting question but cannot be proven one way or the other because it is not possible to isolate the impact of creating the network from the fee reduction amongst the ‘first movers’ (AXA PPP and Bupa). Once a new *de facto* market rate is set that a sizeable number of providers will adhere to, other insurers can adjust their fee schedules (based on the historical relationship their fee schedule –either paying more or less than Bupa or AXA PPP with some degree of security and without creating a network.

The reductions also need to be viewed in the light of what other health systems, were paying. The 2009 NHS HRG tariff for Phaco-emulsification cataract extraction and lens implant was £947 for day cases (which accounts for around 98% of all cases) and £1,387 for inpatients (DoH, 2009a). Private sector prices remain well above these rates and continue to show marked variation. The website Private Healthcare UK quotes self-pay cataract removal costs of £1,800-£2,900 for Spire Healthcare Hospitals, and £1,950-£2,600 for Nuffield Hospitals (Private Healthcare UK, 2009). Bupa Cromwell Hospital in central London quotes £1,625 for a cataract (single, local anaesthetic) and £1,725 for a cataract (single, general anaesthetic) both as day cases and both *excluding* doctor’s fees (Cromwell Hospital website). Parkside Hospital, also in London, quotes £2,705-£2,855 *inclusive* (Parkside Hospital website). The Coplow Day Case Cataract Unit quotes £1,380 which covers surgery on one eye, all post-op visits and eye drops (Coplow Day Case Cataract Unit website).

Contrast the above with the prices mentioned in the following quote from a junior doctor practicing in the USA:

‘...look at how compensation has fallen over the last 10 years alone. One Attending has told me that when he started about 10 years ago cataract reimbursement was \$1,800, and no-one could foresee it falling below \$1,000. Now, Medicare is currently paying around \$650 a case, and if you are co-managing, this puts your personal collection at about \$500’ (Student Doctor Network website).

\$500 is around £300 at current exchange rates (October 2010) which perhaps puts UK consultant fees into perspective given US Healthcare's reputation as one of the most expensive health care systems in the world.

However, the above does not mean that Bupa will not make any attempts to reduce provider costs. Despite likely sustained provider opposition Bupa probably continue to pursue a strategy based on establishing specialty and/or condition specific networks; but on a piecemeal basis.

### **Bupa's Latest Initiative: the Physiotherapy Network**

The latest initiative of this kind is the establishment of a Bupa physiotherapy network. The tender process commenced in March 2008 and the network went 'live' in May 2009. The rationale for pursuing a network in physiotherapy was highlighted by Bupa (Bupa Group, 2009) in a press release, which explained that the insurer was encountering a variation of around 200% variation in the costs of a physiotherapy session, and that the number of sessions provided for the same condition varied from one to sixteen.

Unsurprisingly there was opposition to the initiative from the physiotherapy community led by the Chartered Society of Physiotherapy, and Physio First (previously known as the Organisation of Chartered Physiotherapists in Private Practice) This included (unsuccessful) complaints to the OFT and the FSA. However, the network has been established, initially covering 3,000 clinics and practices. Whilst this is considerably less than the 6,500 practitioners that Bupa originally recognised to treat Bupa members, it is likely that the network will grow. The CSP reported that Bupa had:

'...backed away from their previously stated position of seeking to cut radically the number of private practitioners treating Bupa patients..... They have stated that they expect that a similar number to the current 6,500 practitioners to be included (subject to their tender process)' (Grey, 2009)

This initiative very much fits with Bupa's historical approach. Achieving lower prices with little diminution of member access is a highly desirable outcome for any insurer, but

particularly so for Bupa. All the signs are that the physiotherapy network initiative has been successful. What then will happen to the other specialty network proposals? These will be probably be further modified, partly as Bupa learn from previous initiatives, it may be that such networks will be aimed at a sub-stratum of Bupa members who choose a more restricted network product.

What explanation can be offered for the apparent ease by which Bupa established a physiotherapy network? There appears to be four interconnected reasons:

Firstly, physiotherapists have little experience or history of operating as an organised body with regard to collective bargaining/action with insurers;

Secondly, physiotherapists are unlikely in general to consider themselves as powerful as consultants in either their individual or collective negotiating with insurers;

Thirdly physiotherapists are unlikely to see themselves (in general) as generating as significant psychological dependency (or agent relationship) amongst patients as consultants;

Fourthly, many physiotherapy interventions for patients are discrete and time limited (often relating to post operative mobilisation and recovery). The patient may well regard such physiotherapy input as commoditised (if physiotherapist A is unavailable I shall simply see physiotherapist B). Moreover those patients who see physiotherapists for an extended period (and are more likely to build up a substantive relationship) are liable to have those interventions reviewed under the 'chronic condition exclusion' commonly found in insurance policies (see page.199). Physiotherapists may well be more aware of this vulnerability than the patient.

Collectively the above translates into a relatively weak negotiating position- and carries with the threat of defection by individual physiotherapists and practice groups.

## Conclusion

The reader is liable to be struck by the amount of time and resources that it has taken for Bupa to try and create something resembling a *de facto* ophthalmology network. Since this speciality is dominated (in terms of volume and reimbursement) by one well-defined procedure, it might be concluded that the problems would be even greater in other areas of clinical practice.

Cataract surgery is the most commonly performed elective operation in the NHS and waiting times have fallen so significantly combined with increasing activity that a recent paper questioned whether the procedure is now undertaken too readily in the public sector (Keenan et al, 2007). The above would seem a particularly poor foundation from which to resist the attempts of an insurer with 40% private market share to reduce reimbursement levels. Yet that resistance has been sustained, and if not entirely successful it has meant that the network Bupa created was less comprehensive than intended. On balance the incumbent providers are likely to feel quite satisfied with the limited progress Bupa have made, and the time it has taken to achieve the limited gains realised.

What conclusions can we draw from the protracted struggle to establish speciality-specific networks? Firstly it illustrates just how difficult it is for an insurer to engineer a significant change in the way providers deliver services. The experience of Bupa, as the largest player in the UK PMI market, must be seen as reflecting the dominant trend. However, it must be acknowledged that AXA PPP encountered less opposition when it established a 'direct referral' process for both oral surgery and ophthalmology, whereby the member is referred to a network hospital rather than a consultant. Probably consultant organisations felt less threatened because of the smaller scale of the AXA PPP initiative compared to that of Bupa UKM, as the market leader. It is also possible that Bupa were considered more vulnerable than AXA PPP to confrontational tactics because of its traditionally permissive approach to consultant price setting.

Secondly, the structure of the current UK provider market is dominated by powerful provider and insurer groups. Each has an interdependence with the other which creates an uneasy equilibrium of sorts. The furious reaction of both hospital providers like HCA and the

doctors' groups to Bupa's specialty network proposals was in part based on a realisation that UKM were attempting to disturb that interdependence and realign relationships so as to reduce the power of the traditional providers.

The chapter suggests that there are a number of options for driving down provider costs. One approach is to introduce new providers into the market as demonstrated by the UK government's use of ISTC's. A second approach is simply to reduce reimbursement levels and encourage members to seek out providers who will deliver services at the lower prices. This would put the onus on members to seek out those providers who would bill at the reduced prices. Historically this has not been in line with UKM's customer culture but the events described in this thesis suggest that in reality this might have been the simplest way to reduce UKM's costs, albeit at a possible cost to 'shortfalled' members.

The third approach examined in this chapter of creating a formal network of 'lower cost' providers appears from the Bupa experience to require a sustained effort and carry significant transaction costs. As outlined in Chapter 3, the attempt to create specialty networks gives us an opportunity to examine the transaction costs of a formal contracting/tendering approach.

Transaction cost economics helps explain why health care commissioning in this manner generates significant overheads and opportunity costs (Williamson, 1985; Dixon, Le Grand, and Smith, 2003; Edwards, 2005; Marini and Street, 2007). The events set out in this thesis provide a demonstration that an approach based on constructing tenders which providers bid against has to deliver significant gains to justify the investment the commissioner has to make in pursuing such a strategy. This is not to say that tenders are not worthwhile, merely that commissioners need to carefully consider the effort involved in that approach against the possible gains.

In that regard it is noteworthy how much time (and resources) Bupa has committed in its efforts to create a single specialty network; a specialty moreover that is dominated (in terms of volume and reimbursement) by one well defined procedure. Furthermore, that procedure has been subject to a significant expansion of provider capacity within the NHS, with a commensurate fall in waiting times. Indeed cataract surgery is the most commonly performed elective operation in the NHS and waiting times have fallen so significantly

combined with increasing activity that a recent paper questioned whether the procedure is now undertaken too readily in the public sector (Keenan et al, 2007).

The above would seem a particularly poor foundation from which to resist the attempts of an insurer with 40% market share to reduce reimbursement levels. Yet that resistance has been sustained, and if not entirely successful it can be hardly characterised as a rush to respond to new economic realities. On balance the incumbent providers are likely to feel quite satisfied with the limited progress Bupa have made...and the time it has taken to achieve what gains have been achieved.

Indeed the most significant point is the amount of time it has taken Bupa to get where they are, rather than to question whether prices will eventually fall in private sector cataract surgery. The author believes they are falling and will continue to do so – largely because their starting point enabled providers to significantly reduce prices and still make a profit. Moreover arguably prices would have fallen even if Bupa had done nothing. In this context a reform programme stretching well past half a decade for a partial implementation of one specialty network is frankly underwhelming.

A fourth option is to seek an alliance with either the hospital or the consultant as the primary contractor and expect them to drive down the costs of subordinate parties. The AXA PPP oral surgery and ophthalmology networks, which used the hospital as the prime contractor, are examples of this approach. Bupa UKM had reservations about this strategy because it was concerned that it might alienate doctors and would also deliver more power to the hospital chains, thus further strengthening their negotiating position.

Finally we must return to the questions posed at the outset of this chapter. Specifically: to what extent is a market operating in the provision of private healthcare in the UK, and can insurers use market mechanisms to encourage providers to change behaviour to bring about quality and price improvements?

On the first question there is undoubtedly a market operating in the private sector for hospital (and consultant) services. On the question of the degree to which purchasers are able to influence this market, the reality is that it is actually very difficult for even an insurer as large as Bupa UKM to effect significant change in provider behaviour. As the UK PMI market is

delivering health care at a price significantly above that of many other developed countries we might deduce that market mechanisms are currently performing poorly in this regard. A rejoinder to this is the objection that the prices charged reflect supply and demand and in this regard the market is simply doing what all markets This may be so but the point is that the particular structure of the UK private market is keeping prices higher than they could be and is to that extent is operating in a suboptimal manner. The next two chapters will examine the private sector's record on quality issues.

## **Chapter 6**

### **Promoting Clinical Quality: Concepts, Issues and Experiences in the USA and the British NHS**

#### **Introduction**

This chapter provides the context for a detailed examination in Chapter 7 of the UK private sector's approach to quality issues, and in particular Bupa's clinical quality initiatives. The present chapter commences with a general discussion of the concept of quality in health care and some of the key issues in this area. The sections that follow deal respectively with quality in the pluralistic US health care system (where notions of purchasing for quality originate) and quality in the NHS (the public system that now offers significant opportunities for an expansion of UK private sector activity).

Chapters 6 and 7 taken together shed light on the degree of influence that purchasers can exert on providers to improve the quality of the care provided in the US and in the UK public and private systems. The two chapters will help us to assess whether the UK private sector has a higher regard for clinical quality than the public sector, and whether the private sector is better able to take forward the clinical quality agenda.

There is little evidence from the material presented so far that either the selection of provider or the amount payable for services depends on patient or purchaser assessments of the quality of the clinical care provided. Nor do insurance companies place much emphasis on demonstrating high quality care as a way of differentiating their product from that of competitors. This chapter and the next will attempt to explain why that has been so historically and to what degree the situation may be changing.

## Health Care Quality: Concepts and Issues

### *What is Quality?*

This is a deceptively simple question, for a number of answers can be given and each has implications for how health systems are to be judged. The US Institute of Medicine (IOM) defines quality in healthcare as follows:

‘Quality is the extent to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge’ (Institute of Medicine, 1990).

This definition has a number of strengths, but as will be demonstrated below, sometimes bears little relation to consumer notions of what quality health care should be. Textbook definitions, such as those found in the books by Siren and Laffell (1996) and Folland, Goodman and Stano (2001), often cite Donabedian’s (1980) ‘three stage’ criteria for health care quality assessment. The three stages in this model are:

Structure: the quality and appropriateness of the available inputs and their organisation;

Process: the quality of the delivery of care;

Outcome: measurement of the ultimate quality of care.

It should be noted that the literature associated with the definition and measurement of quality in relation to health care is formidably extensive. While both the Institute of Medicine’s definition and Donabedian’s criteria might be useful starting points, there is a long list of factors said to influence ‘perceptions’ of quality. What is significant is that quality in relation to health care *could* be considered as one (or more) of *any* of the following:

- i. Fully meeting the expectations of the patient in relation to the service being delivered (patient satisfaction);
- ii. Fully meeting the expectations of the funding agent in relation to the services being provided to a patient (satisfaction of the funding agent - which may or may not be the same as (i) above);
- iii. Zero errors in the service supplied;

- iv. Compliance with a defined set of standards (that may or may not include a defined range of errors);
- v. Meeting the expected health outcome;
- vi. Peer approval of the service provided.

Donabedian's three stage criteria can be mapped against the above, but the list introduces additional elements. Adherence to any one of the above (or indeed a combination of elements) could result in a different judgement as to whether quality health care is being delivered.

It is also possible under any of the above definitions to deliver high-quality health care to a section of the population and something less to the rest. If there is a desire to bring equity of access to services as a criteria this can be done, but we are then introducing a political value into the discussion. In practice, discussions on quality in health care are often bound up with access and affordability issues. Moreover if a health system is set the objective of providing a certain level of access and subsequently it transpires that this is not being achieved, then this becomes a performance/quality issue. For this thesis, focusing as it does on the private sector, equity considerations lie largely outside of the immediate discussion. Accordingly this section will concentrate on the 'technical' aspects of defining and securing quality care.

#### *Quality Assurance in Health: A Universal Problem?*

Most observers consider assuring health care quality to be a problem in all health care systems - regardless of how they are funded, organised and delivered. The argument might be summarised as being that the delivery of quality health care is too variable and inconsistent, particularly given the large sums of money that all developed countries are spending on health care. Some of the deficits in this regard were brought into stark relief by Chassin (1998). Reflecting that companies such as Motorola work towards (and achieve) a defect rate of no more than 3.4 per million - otherwise known as six sigma quality - he noted that:

'...only 21% of eligible elderly heart attack survivors were taking beta blockers following their illness, a treatment that has been shown to save lives. This amounts to a defect rate of 790,000 per million, or less than 1 sigma. In that study, patients who did not receive the drugs experienced a 75% higher death rate than those who did. Another study showed that 58% of patients with clinical depression were either poorly

evaluated or inadequately treated, a defect rate of 580,000 per million...The Harvard Medical Practice Study estimated that hospitalised patients were injured because of negligence in about 1% of all admissions, a figure that was characterised as comfortingly low by some observers when the study appeared. To Motorola, however, these failures translate into 10,000 defects per million, 3000 times worse than the Six Sigma goal...At a defect rate of 20%, which occurs in the use of antibiotics for colds, the credit card industry would make daily mistakes on nine million transactions; banks would deposit 36 million checks in the wrong accounts every day; and deaths from plane crashes would increase one thousand fold' (Chassin, 1998, p.567).

This dissatisfaction is compounded by difficulties in developing and gaining access to meaningful measures of quality. One result has been the reliance on 'trust' in the absence of precise measurements of provider competence and performance (Arrow, 1963).

Significantly, Coye's observation of 'highly variable patterns of care, widespread failure to implement recognised best practices and standards of care, and persistent inability of provider systems to achieve substantive changes in patterns of practice' (Coye, 2001) could have applied to any country (she was referring to the USA). Further evidence that there are common quality concerns to be found in health systems world-wide comes from Blendon et al's study (2003) of health care experiences in five developed countries - the USA, Canada, UK, Australia and New Zealand.

The authors state that:

'...despite clear structural differences among the systems, findings in all five countries reveal consistent dissatisfaction among surveyed populations with general health system quality, stemming from problems associated with medical errors, inadequate patient-physician communication, and insufficient co-ordination of care' (Blendon et al, 2003, p.106).

It should be noted that these problems were identified from a survey of the experiences of sicker adults in these five countries. Other patient (and non-patient) population groups might very well report different quality concerns. Moreover it was not the case that the survey found all countries to be equally bad or that there were no national differences reported in

what was considered the greatest problem. Hussey et al's (2004) study reinforced this when it looked at the same five countries, using different indicators, and found that no single country scored consistently as the best or worst overall. The method utilised by these authors relied upon statistical indicators, such as thirty-day case fatality rates after myocardial infarction and stroke, breast screening rates and so on, rather than a survey.

We also have Coulter and Clary's (2001) analysis of patient experiences of hospital care in Germany, Sweden, Switzerland, the UK and the USA, based on a mail survey. The highest satisfaction ratings were reported by patients in Switzerland and the lowest by patients in the UK. Overall, however, the authors concluded that:

‘...the results offer compelling evidence that there are major deficits in the quality of hospital care in all of the countries studied’ (Coulter and Cleary, 2001, p.250).

Geographical variations in the use of treatments provide further evidence of uneven quality. US variations are presented in considerable detail in the Dartmouth Atlas (Wennberg and Cooper, 1999) but this is not a problem confined to the USA. McPherson et al (1982) demonstrated this with a study of variations in common surgical procedures and further evidence was provided by (Chassin et al, 1987). The all too-convenient assumption that low-rate regions had it right turned out not to be the case. A more complicated picture has emerged. For example, the Trent region in the UK, although performing far fewer cardiac operations per head of population than the USA, was judged to have inappropriate rates for coronary angioplasty (51 percent) and coronary artery bypass graft (42 percent) (Chassin et al, 1987, p.2535).

A BMJ editorial summed up the problem thus:

‘Health care systems fail to provide treatments that are known to work, persist in using treatments that don't work, enforce delays, and tolerate high levels of error’ (Smith, 2001).

All of the above help to illustrate the problems that exist with assuring health care quality, and suggest that these are not confined to a particular funding or delivery system.

### *Quality and Health System Performance*

Coulter and Cleary's (2001) article made reference to the World Health Organisation's (controversial) ranking of health systems around the world, (WHO, 2000) on the basis that much of it was concerned with client orientation and respect for persons. Views of how a particular health system was performing on such matters were seen as broadly determinant of health care quality. When France was named as top of the rankings, headline writers were quick to dub France as having 'the best health care system in the world'.

Health care quality and overall system performance are not the same thing, although given the uncertainty regarding definitions of quality noted earlier, the terms are often conflated. McGlynn (2004) in an article entitled 'There is no perfect health system' stated at the outset that:

'Extensive research into quality of care in different countries yields no conclusive findings that one system is better or worse than others. Quality does not necessarily vary with financing mechanisms; even countries with single-payer systems have variations in quality. Quality is not directly related to the amount spent on health care, since the highest-spending country (the United States) does not have measurably better outcomes' (McGlynn, 2004, p.100).

Whilst not necessarily disagreeing with McGlynn's overall conclusion, a criticism that can be levelled against the article is that it fails to distinguish clearly between quality and overall system performance. McGlynn also makes an explicit assumption that outcomes are the definitive measure of quality in health care. Whilst this thesis strongly supports the importance of outcomes, it is important to understand that different audiences may perceive outcomes in different ways. Thus public perceptions of what makes for good health care quality may not be the same as those of either healthcare professionals or academics. This helps to explain why some health care systems promote certain 'quality' features significantly more than others. Alongside this there is the associated observation that the value systems of different societies (and sub groups within a particular society) may also create different perceptions of what constitutes quality health care.

*Promoting and Rewarding Quality: The Story so Far*

One might paraphrase the challenges facing those who wish to promote quality health care as follows:

- How do you effectively measure quality?
- How do you communicate the results in a way that is meaningful to non-statisticians?
- How do you promote and reward good quality care and discourage poor practice?
- How do you get people to care about it?

The latter issue might be rephrased as ‘the lack of a business case for quality’.

On the first issue, the problem can be illustrated (in part) by the previously cited article by Hussey et al (2004). Hussey and colleagues started with about 1000 quality measures collected in one or more of the countries studied and ended up with just sixteen measures that could be applied in all five. As McGlynn notes:

‘The measures themselves are, by the authors’ own admission, an opportunistic set that does not give a comprehensive picture of quality in any of these countries. To understand better how each country’s health system works, we all need to invest in measurement’ (McGlynn, 2004, p.100).

None of countries studied by Hussey routinely and comprehensively measured quality. McGlynn correctly states that:

‘For quality of care to improve, health professionals and consumers need to know what should be done differently and how much of a difference is necessary to get a better result. This means that we need much more comprehensive measures of quality than are available routinely in any of these countries’ (2004, p.10).

The methodological problems in capturing and then comparing health care quality are well-documented and apply to both public and private systems. There is insufficient space to explore these methodological issues in this thesis. The general concern that they are still so prevalent and persistent despite the importance and cost of health care to modern societies was captured in a *Health Affairs* editorial: ‘Given the vast societal investment in medical care, it’s incredible that so few ways exist for evaluating performance’ (Iglehart, 2002 p.7).

Having considered what quality means and some current controversies, the chapter now moves on to describe trends in the United States and the British National Health Service. The first deals with a system where ideas about using purchasing to improve quality have attracted increasing interest, whilst the second covers a public service, which however, now provides opportunities for expansion of the UK private health care sector. Both might therefore be likely to be major influences on the approach of UK insurers and private hospitals.

## **Quality in the United States**

### *General Trends*

Quality in the US system has traditionally been assumed to be 'guaranteed' by systems of individual and institutional accreditation, certification and licensure (Ferlie and Shortell 2001). At the hospital level, early steps in developing accreditation included the establishment of the Healthcare Facilities Accreditation Program (HFAP) in 1945 and the Joint Commission on Accreditation of Hospitals (JCAH) in 1950. By the mid-sixties the Federal Government determined that accredited hospitals would be deemed to meet the conditions for automatic participation in the new Medicare and Medicaid programs, effectively giving the independent accreditation bodies an institutional role as 'deeming authorities'. Currently US hospital accreditation is dominated by the 'big three' of the Joint Commission (the successor to JCAH), HFAP and Det Norske Veritas Healthcare Inc (DNV), a new player that gained deeming authority from the Centers for Medicare and Medicaid Services (CMS) in 2008. Many private-sector payers (employers groups, HMO's, PPO's and insurers) now insist on provider accreditation.

The traditional stance of private purchasers in the US market towards quality has been to require a combination of provider accreditation and public reporting of quality information (Rosenthal et al, 2004). Efforts in the latter area have generally been quite limited. Jost and colleagues (1995) analysed the content of US purchaser/provider contracts and found that, apart from a standard requirement for accreditation, few contracts made reference to process or outcome measures of quality. While many contracts contained a section on utilisation and

quality review, more attention was paid to utilisation than quality with just a few contracts requiring physician profiling or compliance with practice protocols.

Confidence in the US quality assurance system was shaken by a succession of studies showing wide variations in practice and a high rate of medical errors (Kohn et al, 2000; Institute of Medicine, 2001; McGlynn et al, 2003; Healthgrades, 2004). This resulted in several governmental and voluntary sector initiatives to improve quality. These included a National Practitioner Data bank (recording information on physician malpractice), a National Forum for Quality, and a Forum for Health Care Quality Measurement and Reporting (Ferlie and Shortell, 2001). In 1999 the Agency for Healthcare Policy Research (part of the US Department of Health and Human Services) was reconstituted as the Agency for Healthcare Research and Quality (AHRQ), with a remit to support research and develop policy to improve health care quality. However, the Institute of Medicine's recommendation to create a Centre for Patient Safety and a nationwide reporting system within AHRQ was not implemented. The private, non-profit National Committee for Quality Assurance (NCQA) was established in 1990 to accredit health plans and promote quality, and has developed a Health Plan and Employer Data and Information Set (HEDIS) for this purpose.

A more recent development among US payers – and the aspect of the US system most directly relevant to this thesis - involves offering enhanced payments to reward compliance with quality requirements (Rosenthal et al, 2004). 'Pay for performance' (also known as P4P or value-based purchasing) has excited widespread interest and influenced developments in other countries, such as the NHS CQUIN initiative. The CMS has introduced a number of demonstration projects, which (typically) reward hospitals for reporting specified quality information (Hillman et al., 1999; Lindenauer et al 2007), and this approach has also been taken up by private sector purchasers. Rosenthal and associates (2004) identified thirty-seven payment-for-quality programs that linked physician or hospital incentive payment (usually bonuses) to specified compliance with purchaser requirements.

Nearly half these programs were run by employer purchasing coalitions, such as the Integrated Healthcare Association (IHE), Bridges To Excellence (BTE), and the Leapfrog Group, but insurers like Aetna, Cigna and several companies from the Blue Cross Blue Shield Association were also well represented. Three years later Epstein (2007) reported that more than half the private sector HMO's had initiated P4P programs, covering more than 80% of HMO enrollees. Evaluations suggest that P4P has been successful in areas such as improving

smoking cessation and immunisation rates (Kouides et al., 1998; Fairbrother et al., 1999; 2001; Amundson et al., 2003; Roski et al., 2003), but evidence on hospital quality outcomes has been more mixed. While Lindenauer et al. (2007) found quality gains in the CMS pilot projects, Rosenthal et al (2005) conclude that paying providers to achieve fixed performance targets produces few quality gains and tends to reward those with higher performance at baseline. Epstein's NEJM editorial commenting on the CMS pilots stated that pay-for-performance '...is fundamentally a social experiment likely to have only modest incremental value' (2007, p.517). Furthermore a 2007 study analysing Medicare beneficiaries' healthcare visits showed that a median of two primary care physicians and five specialists provide care for a single patient and the authors doubted that pay-for-performance systems could accurately attribute responsibility for the outcome of care for such patients (Pham et al, 2007). Although the above illustrates that there is considerable debate about the precise benefits (and practicality) of P4P, commentators such as Rosenthal et al (2006) and Epstein (2007) predict that its use by purchasers will continue to increase.

The sub-sections that follow look in more detail at the trends by which purchasers increasingly require reporting of quality information and seek to link payments to compliance with purchaser quality requirements, and the arguments surrounding these issues.

### *Public Reporting of Quality Information*

Marshall et al consider public reporting in the USA to be very much like overall health care delivery in that country:

'It is diverse, is primarily market-based, and lacks an overarching organisational structure or strategic plan. Public reporting systems vary in what they measure, how they measure it, and how (and when) it is reported' (Marshall et al, 2003, p.136).

Given that much of US healthcare operates within an open market it is of particular interest to this thesis to consider what is driving the provision of quality information into the public arena. Marshall and colleagues consider there to be two main factors. First, they argue that there is a 'business case for quality' which says that high quality care will lower costs to payers (whether insurers, employers or government). Second, they identify a growing interest in the use of 'tiered pricing' - the coupling of a portion of the health care costs that a person pays to the price charged by the provider for the health care. For example a person may face

no personal costs to have treatment at a hospital that is 'preferred' by a health insurer, but face a cost of say two hundred dollars a day if they choose a 'non-preferred' hospital.

As Marshall et al point out, historically price has been the dominant factor determining which hospitals are 'preferred', but '...because of concern from employers and patients, publicly-reported quality information is starting to play a part. The goal is to promote the use of providers that deliver the best quality for price ("value-based purchasing")' (2003, p.137).

Explaining why progress in both areas has not been as great as many hoped will help bring us back to one of the central questions addressed by the thesis: the role (and limitations) of markets in promoting high quality care.

Marshall et al conclude that there is:

'...a growing body of evidence to suggest that many consumers, purchasers, health professionals, and to a lesser extent, provider organisations are either ambivalent, apathetic, or actively antagonistic towards report cards' (2003, p.140).

Providers, perhaps more than purchasers, are rooted in a culture that might be considered sympathetic to quality improvement. The oft-noted influence of professionalism in health-care (Kessel, 1958; Blumenthal, 1994) makes for an environment where clinical quality is considered important, as does the threat of negligence litigation (Quam, Fenn and Dingwell, 1987). Even if public performance data is not leading to the adoption of quality assurance programmes of the kind mentioned above, it may be promoting aspects of quality that are rewarded in the market. Hibbard, Stockard and Tusler's review (2005) is instructive in this regard. Whilst acknowledging that several studies have produced mixed results, the authors also quoted their earlier work (using a controlled experimental design) which produced strong evidence of the effectiveness of public reporting on quality improvement. The authors noted that '...most public reports are complex and difficult to interpret and therefore do little to enhance or threaten institutional reputations' (Hibbard, Stockard and Tusler, 2005, p.1150). They found that public reporting stimulated quality improvements, but what was also significant was that there were no observable shifts of patients away from low-rated hospitals to higher-rated ones over the period in question. In effect this echoed the earlier study

undertaken by the same authors (Hibbard, Stockard and Tusler, 2003) that hospitals viewed such reports as affecting their public image but not their market share.

Studies have shown that patients have low awareness that quality information exists, have poor knowledge of the information relating to the provider they are using, and have a low degree of interest in such information (Chernew and Scanlon, 1998; Scanlon et al, 1998; Beaulieu, 2002). Schneider and Epstein's (1998) survey of Pennsylvanian patients who had actually undergone CABG surgery found a surprising lack of interest in coronary artery bypass graft (CABG) report cards. Only 1% to 2% said such reports were a major or moderate influence in their choice of hospital or surgeon. Moreover Erickson et al (2000) found that New York health plans do not use performance data to choose high-performance centres for CABG surgery (Erickson et al, 2000). At the same time we should acknowledge that the CABG report card has been credited with removing low-volume surgeons in New York. Chassin (2002) credits the use of public report cards for the decision of 27 low-volume surgeons to cease performing CABG surgery in the state between 1989 and 1992.

In the case of the public, there appears to be an apparently contradictory desire for more information on provider performance (Edgman-Levitan and Clearly, 1996). Marshall and associates (2003, p.141) note however that 'when this information is published, the public does not search it out, does not understand it, distrusts it, and fails to make use of it'. A similar point was made in memorable fashion by Dr David Katz (2005) when he told the 2005 Annual Meeting of the Council of International Hospitals: 'Americans take a lot more time to choose their next car than their doctor'. Against this, some modest progress was reported by a Kaiser Family Foundation study that found that the percentage of respondents reporting using information comparing quality among health plans, hospitals or physicians in the past year had increased from 12% in 2000, to 19% four years later (Kaiser Family Foundation, 2004).

### *Problems with Public Disclosure*

Despite the momentum for more information about quality to be made publicly available, not everyone believes this is a good idea. Werner and Asch (2005) highlighted a number of unintended consequences of public disclosure. They point out that despite considerable support for public release of performance measures there has been little research on its effect, and no attention to possible negative consequences on health care.

While the studies cited above showed that CABG mortality rates in New York had dropped, and attributed this to the CABG report card, Werner and Asch (2005) noted that there have been simultaneous reports of surgeons turning away the sickest patients in an effort to avoid poor outcomes. They question whether public reporting is really improving the quality of health care, and point out that:

‘...if quality report cards cause physicians to select patients based on risk profile, the quality of care and outcomes of people eligible for CABG may worsen even as mortality rates among those who receive CABG improves’ (Werner and Asch, 2005, p.1242).

The key word is *if*, and highlights an important point. Unless the scoring system is robust, and adjusts for case mix, it will lack professional credibility and may well discourage doctors (and hospitals) from treating certain types of patients. As these are most definitely not an intended outcome of public quality reporting these are issues of substance.

Werner and Asch acknowledge that public reporting has an important role to play in providing accountability and enhancing trust, and that these are issues considered important by the public. One study showed that 92% of Americans felt that the reporting of serious medical errors should be required, and over 60% wanted this information released publicly (Blendon et al, 2002). It is likely that similar results would be replicated in the UK. If reporting (public or otherwise) is to promote and not interfere with its ultimate goal of improving care, current processes will need to improve. One of them - as Werner and Asch propose - is that participation must be mandatory; not least because otherwise low scoring providers may stop disclosing their quality data (McCormick et al, 2002). These quality measures and the way they are reported must also be universally mandated and uniformly applied.

#### *Why Purchasers and the Public Neglect Quality*

Explanations for the relative lack of interest of purchasers and the public in reported quality measures include:

- The information is not easily understandable;

- The information is not meaningful;
- What is collected is what is easily measured, not what is important.

Beyond this there the issue of the importance afforded to 'trust' in health care. As previously noted, Hall's (2001) view is that the psychologically traumatic nature of illness and the vulnerability it creates, makes trust a central aspect of social relationships in health care. On this explanation the public might like the general idea of quality reporting and provider accountability, but when it comes to their personal care they prefer not to think about such matters. The patient does not seek to substitute his/her personal judgment for the judgment of the physician; the trusted agent the patient has selected to make decisions on his/her behalf.

The norms of the doctor/patient relationship may help to account for public neglect of quality information, but do not explain why purchasing organisations (both private and governmental) fail to make greater use of quality reporting. As Marshall et al noted:

'Purchaser organisations ...with some notable exceptions...seem to be remarkably passive in scrutinising the quality of care for their patients' (2003, p.145).

This is an important issue because it strikes at the heart of a key question - can you rely on the market to drive quality in healthcare? As was the case with price reduction (in the previous chapter), the answer on the available evidence appears to be that to date purchasers have been relatively ineffective in forcing quality improvements through the use of market forces. Most of the evidence considered so far comes from the US policy commentary, but we will try to test this funding with more detailed evidence from the UK in this and the next chapter.

### *Is There a Business Case for Quality?*

Some American commentators have drawn unfavourable comparisons between quality control in manufacturing industry and in health care (e.g. Coye, 2001). Businesses invest in quality for a number of reasons aside from any notion of an ethical desire to do so. Modern quality control mechanisms - six sigma, quality circles, Total Quality Management (TQM), Lean Production and so on, have their origins in industrial manufacturing and their large-scale adoption is connected to the efficiency advantages of doing so. They help to ensure that

a product meets consumer quality/price expectations, while also keeping production costs low.

Coye argues that the relative absence of scientific manufacturing processes in health care keeps costs higher than they otherwise would be, and also results in a weakness in quality control mechanisms:

‘The health sector has been exceptionally untouched by the transforming principles of quality management that revolutionised manufacturing and service industries in the 1980s. For those sectors, quality management became the core task of executive leadership and the defining competency of a successful organisation.’ (Coye, 2001, pp.44-45).

In health care - by contrast - the prevailing wisdom is that the investments required in high (and consistent) quality are largely not justified in terms of increased revenue, profits, customer loyalty...or even the kudos and brand reinforcement that the resultant media coverage might bring. Providers in the US do set great store on ratings, such as ‘The top 100 best hospitals’. But these tend to rest on subjective factors such as reputation rather than any systematic assessment of performance and quality outcomes (Sehgal, 2010).

Investing in quality within a commercial healthcare operation carries a measure of risk. In business terms managers must believe either that the consumer/purchaser wishes for higher quality criteria than are currently being made public, or that by highlighting a quality differential ‘new demand’ will be created. Additional expenditure without additional demand or revenue would result in decreased profits.

There is a school of thought that argues that high quality medicine ultimately equates to cheaper medicine, but this is a controversial hypothesis, especially in the private health care industry. Fireman, Bartlett and Selby (2004) in a recent study of the impact of disease management initiatives in the USA state that:

‘The great hopes engendered by disease management – that more consistent intervention in chronic illnesses and better treatment using clinical guidelines from

evidence-based medicine would lower costs - have yet to be realised. Health care, like many other institutions and agencies, has found that “better” and “cheaper” do not always partner well’ (Fireman, Bartlett and Selby, 2004, p.63).

These authors concluded that although disease management remained a promising approach to quality improvement it did not reduce costs.

The alternative route to profitability, should cost reduction not be possible, would be higher prices for higher-quality care. Coye articulates this second understanding of what a business case for quality would mean when she says:

‘In practical terms, this would mean that health care organisations achieving superior quality outcomes could expect to gain a higher price. Purchasers would pay a higher premium and insurers would pay higher fees or capitation rates...’ (Coye, 2001, p.45).

Coye’s argument would depend on payers reaching a reasoned judgment that members provided with information on improved outcomes would be prepared to pay increased premiums rather than transferring to other schemes and this seems to run counter to the findings of the studies of public or patient interest in quality information mentioned earlier.

To some extent the prospects for higher prices would be dependent on costs not falling, since purchasers would be unlikely to pay more against the background of a decreasing cost base. The evidence on the prospects for cost savings remains scant.

Kilpatrick et al’s (2005) comprehensive review of peer-reviewed literature found that only a small number of studies met their inclusion criteria and gave no conclusive answer.

Moreover, there is a further complication for the quality = low cost school. Whilst a quality-based approach may make best sense to a health system overall, it may be financially disadvantageous to individual players. This point can be illustrated by reference to Casalino’s (2001) study of Californian physician groups. Casalino explains that proponents of prepaid group practice believed that capitation would incentivise physician groups to invest in improving quality, since healthier patients would be more profitable. However, patient mobility meant that projected cost savings in future years did not go to the organisation that

had made the initial investment. Furthermore, organisations that gained a reputation for high quality might attract sicker patients, but do not receive higher capitation rates to pay for the care of these patients. Casalino concluded that physician groups and HMO's would not develop organised processes to improve quality if they lost money in the short term by making that investment. This view is supported by Leatherman et al (2003) who state that

‘...the financial benefit often did not return to the initial investor or was greatly delayed’ (Leatherman et al, 2003, p17.).

Similar problems arise at the level of the payer/insurer. As Rosenthal and associates (2004) argue, quality improvement has some elements of a public-good problem. An investment made by one payer results in benefits to other payers because of non-exclusive contracting. This discourages individual payers from making investments or taking other risks associated with purchaser initiatives that put unwelcome pressure on providers to improve quality. Purchasing alliances such as the IHA, BTE, and the Leapfrog Group partially overcome this problem because of their large market share in certain geographical areas, but initiatives from conventional insurers carry a downside and face formidable obstacles in breaking out of established fee-for-service reimbursement arrangements.

### *Gaining Market Leverage*

In practice, providers principally attempt to squeeze higher prices from purchasers, not by demonstrating higher quality, but by striving for increased market leverage. Classical economic theory suggests that an organisation's attempts to squeeze higher prices by gaining market leverage is doomed to failure in competitive markets, (as in the long run, if an organisation tries to maintain its prices at a level much higher than costs, other organisations will enter the market and draw those customers away by offering lower prices). But as Casalino acknowledges, health care markets are far from perfect. As a result:

‘Physician group, hospital, and HMO leaders, who are interested in surviving in the short run in an imperfect market rather than on theoretical predictions about the long run in a perfect market, strategize constantly about market leverage’ (Casalino, 2001, p.103).

Schaeffer and McMurty go further and state bluntly that:

‘In the current system, poor quality pays: physicians are reimbursed for both incorrect treatment and effective therapy’ (2004, p.118).

Leatherman et al make the same point when they say that one of the key impediments to quality improvements is:

‘...failure to pay for quality, while paying for defects...In effect, the rewards in the payment system are perverse; ordinary, even defective care receives the same payment as optimal care’ (2003, p.25).

Whilst Medicare, Medicaid and many insurers are no longer paying for ‘never events’(CMS, 2008), a relatively recent study by Harvard researchers concluded that US hospitals were still passing on 78% of the costs of all adverse events and 70% of the cost of negligent injuries (Mello et al, 2007).

### *Incentives for Quality in Health*

Literature from the USA typically points to the lack of incentives (particularly financial) to energetically pursue quality goals. In ‘Crossing the Quality Chasm’ the conclusion was that

‘Payment policies (must) be aligned to encourage and support quality improvement to encourage threshold improvements in quality’ (Institute of Medicine, 2001 p.2).

The conventional wisdom in the USA is that providers of all types - clinicians and hospitals - respond to financial incentives. Coye (2001, p.50) notes that:

‘Clinical quality measures are latecomers to the incentive mix for physicians, at least as far as health plans and purchasers are concerned, and are non-existent in the fee-for-service (FFS) world’.

She also states that:

‘A business case for quality would require that purchasers, users, and providers recognise and value advancements in quality outcomes. Purchasers and users would

reward improvement in outcomes with either greater volume or higher payment. Providers would strive to produce higher-quality care to enhance earnings and to reduce costs’.

The tone of Coye’s article is one of regret that such practices have yet to take place. It is not difficult to find authors making similar points. Joseph Newhouse’s article ‘Why is there a Quality Chasm?’ (2002, p.23) has the following conclusion:

‘Physicians want to practice good quality medicine. But there are costs to keeping up, and in many cases the rewards for using the best technique are weak or even negative. The design of better incentives thus should be a higher priority’.

Coye and Detmer (1998) argue that US purchasers currently hold providers accountable only for price and need to include more requirements on quality in contracted health plans. Yet this has proved difficult because studies suggest that providers are less interested in quality improvements than in achieving increased treatment volumes. Thus Pham et al (2004) found that:

‘...physicians tried to raise prices and considered investing in organised quality improvement processes to be of lower priority than increasing service volume. A few respondents reported on medical groups’ efforts to improve efficiency by consolidating practice sites, using physician “extenders” (such as nurse practitioners), or instituting open-access scheduling (queuing patients on a walk-in basis without appointments) to minimise waiting times. Even fewer respondents mentioned efforts to improve clinical quality. Few were using patient satisfaction surveys, implementing quality improvement projects, or establishing quality performance incentives...Many physicians cited the lack of financial incentives from plans or purchasers as a deterrent to groups’ committing sizeable resources to quality improvement, and they perceived little consumer to compete on quality’ (Pham et al, 2004, pp.75-76).

These authors concluded that physicians respond to pressures in practice, not by increasing efficiency or quality, but by seeking to increase the volume of services provided and the prices charged.

We need to be clear that what is being observed is not a set of abnormal behaviours peculiar to health care providers (or insurers) either in the USA...or elsewhere. It is in fact a normal response to a particular set of market conditions. Players in other (non-health care) markets would behave in the same manner if their particular markets allowed them to do so. Fortunately for the modern consumer the prevalent market conditions for most companies are not conducive to such a response.

From the foregoing this may sound like a series of problems peculiar to private health care markets in general and the USA in particular. Unfortunately this is not the case. The above issues appear to some degree in the United Kingdom as will be demonstrated in the next chapter.

### *The Impact of Regulation*

Devers, Pham and Liu's (2004) study suggests that three general mechanisms can stimulate hospitals to improve patient safety specifically and quality more broadly: professionalism, regulation and markets. Their study of the handling of patient safety issues in twelve communities led to the conclusion that currently in the USA, the most significant mechanism - by some way - is regulation. In particular, the work of accreditation organisations such as the Joint Commission (JC) was cited as more influential than any market-driven changes. This was because hospitals have to be accredited by such organisations, or undergo regulatory review by the Centres for Medicare and Medicaid Services (CMS), to be eligible to treat Medicare patients. With Medicare accounting for around 40% of hospitals' revenues (Devers, Pham and Liu, 2004 p.109), hospitals have a strong incentive to meet JC requirements.

Respondents cited the absence of strong local market incentives for hospitals to improve patient safety. As the authors noted:

‘...employers and insurance brokers who work with them reported relatively little interest in hospital patient safety. Employers were most concerned about premium increases, and although reduction in medical error might reduce costs, few employers connected the two issues’ (Devers, Pham and Liu, 2004 p.110).

The authors also noted features of the market, directly pertinent to Bupa's experience, namely:

'...health plans (being) unable to provide hospitals with a strong incentive for improvement because of consumers' demands for broad provider networks, the demise of risk contracting, and hospitals consolidation and capacity constraints' (2004, p.110).

Overall they found that non-hospital respondents were generally sceptical that hospitals had made real progress in improving patient safety (2004, p.108)

### *Summary*

In the USA continuing efforts, especially by CMS and large employer alliances, to utilise market mechanisms to improve health care quality are being seen. At the same time there are significant obstacles to the wider adoption of pay-for-performance, because of vested interests in fee-for-service and a lack of clear incentives for quality initiatives in hospitals and by conventional insurers. Initially developments in the USA were aimed at promoting the collection and publication of information on outcomes, but are now shifting to rewarding high quality care itself - and its corollary - penalising poor care. For example, CMS has started to decline payment for 'never events' from April 2008 (CMS, 2008). Interestingly, it is often a governmental organisation that is setting such targets and defining incentives - rather than the 'invisible hand of the market'.

Having reviewed developments in the USA, we turn in the next section to how these issues - fragmented and non-mandatory reporting standards, low public expectations, inadequate reimbursement mechanisms and poor market leverage - play out in the United Kingdom's public NHS.

## Quality in the NHS

### *General Trends*

Despite being considered a recent development, public disclosure of health care performance data dates back in the UK to at least the middle of the 19<sup>th</sup> century, when Florence Nightingale (1860) highlighted differences in mortality rates of patients in London hospitals. Ferlie and Shortell (2001) trace the modern concern with quality back to the Griffiths Report of 1983, and sporadic attempts over the next decade or two to introduce quality circles or total quality management. Performance indicators in the NHS date back to a similar time (Pollitt, 1988), and although focusing mainly on efficiency and activity, have included clinical indicators with a quality dimension (Giuffrida, Gravelle and Roland, 1999; Mullen, 2004). However, clinical audit in the 1980s and 1990s remained a professionally-driven exercise in which doctors were largely successful in protecting their own version of quality from outside scrutiny (Pollitt, 1993).

The creation of the NHS internal market in 1991 split the NHS into purchaser and provider sides, and opened up the possibility of NHS purchasers using buying power to achieve price and quality improvements in a way which might occur in private markets (Enthoven, 1985; Jost et al, 1995). The NHS had always contracted for services provided by general practitioners, though not originally within an explicit purchaser/provider relationship. The creation of the NHS internal market created a clearer structure for contractual relationships with GPs, and also made it possible for NHS commissioners to apply leverage to hospitals via the purchasing function. Quality improvement was one of the expressed objectives of the internal market reforms (Mays, Mulligan and Goodwin 2000), and associated initiatives such as the Patient's Charter introduced targets with a quality dimension, particularly with regard to waiting times (Montgomery 1996). Jost and associates (1995) report the widespread use of quality schedules in NHS purchaser/provider contracts in the 1990s, though often with little precision regarding required outcomes.

Quality and safety concerns were brought near the top of the policy agenda by a series of high-profile medical scandals that struck the UK in the 1990s; the paediatric cardiac surgery deaths at the Bristol Royal Infirmary, the Harold Shipman murders, and the incompetent operations performed by Rodney Ledward, to name the three best known examples. All three

cases highlighted substantial deficiencies in NHS quality reporting, monitoring, and capacity to take remedial action.

These scandals created fierce media criticism and public anxiety. Two extensive public inquiries were set in motion (DoH, 2002; Dame Janet Smith, 2005). Both made far-ranging recommendations in terms of clinical governance and reporting of untoward incidents. The Bristol Royal Infirmary Inquiry led to the creation of the independent quality monitoring organisation that is now known as the Care Quality Commission.

Yet to date the promises made at the time by Ministers that hospitals and individual clinicians would be required to report publicly on clinical quality and outcomes, remain largely unrealised. The principal obstacles appear to have been a combination of governmental reluctance to make earmarked resources available, and a marked reticence by some of the Royal Colleges/Specialty Associations to collect outcomes data and especially to make data public.

NHS purchasers have so far only introduced limited public reporting requirements. The main developments in the area of purchaser payment incentives for quality have come in two areas. Experiments with a form of pay-for-performance in primary care began in about 2004 and more recently attempts have been made to introduce contractual incentives for quality in secondary care.

The Quality and Outcomes framework (QOF) was introduced in primary care in April 2004 as part of the new General Medical Services contract (Doran et al, 2006). The QOF allows GPs to accumulate QOF points based on their achievements against approximately 140 indicators, which determine the level of reimbursement. It resulted in substantial increases in income when the majority of GPs achieved high points scores (Timmons, 2005). The clinical indicators include practice immunisation rates and measures such as percentage of patients at risk from coronary artery disease who have had cholesterol levels measured.

In the English NHS a new payment framework, known as Commissioning for Quality and Innovation (CQUIN), was announced in 2008 to reward quality improvements in health care (DoH, 2008c; Sussex, 2009; Hughes et al, 2011). CQUIN encourages commissioners to initiate local schemes which link a specific element of provider income – currently around

1.5% of the total - to agreed quality measures. A number of Primary Care Trusts had already been doing so with local quality schemes, and CQUIN was intended to roll this out across the English NHS.

Having sketched out the main trends, the chapter now turns to consider in more detail reporting standards, public expectations, market leverage and reimbursement mechanisms.

### *Reporting Standards*

Marshall et al (2003) in a comprehensive review of the state of current public reporting in the USA and UK noted that there are broadly two reasons for putting performance data into the public domain. The first is to increase the accountability of health care organisations, professionals and managers. The second is to maintain/ improve quality of care. Both are applicable to the private sector but the first has greater salience in the public sector.

Marshall and colleagues (2003) suggest that effective public reporting needs to be mandatory and minimum data sets uniformly applied, and these requirements seem at face value easier to meet in an integrated NHS than a fragmented mixed system. The UK should have the unassailable advantages of central government enforced data standardisation and system-wide coverage. Yet it is only recently that these advantages have started to be exploited.

Whilst it is true that some information about NHS hospital performance has been in the public domain since the early 1980s, the UK until recently had relatively few examples of purposeful release of information about quality of care. Of late the position has improved significantly. A number of quality indicators now form part of NHS Trust performance indicators and the NHS Information Centre (2009) has produced Indicators for Quality Improvement which has over 200 indicators (examples of which are provided in Appendix 7). The English NHS Standard contract also contains a number of quality indicators (see Appendix 8). Following Lord Darzi's report (Lord Darzi of Denham, 2008), NHS Trusts will be required to include quality accounts in annual reports. Quality accounts come into operation in 2010/11, though some fear that they may become an annual 'box ticking' exercise (West, 2009). The quality account includes performance against a number of self-selected indicators from the 'Indicators for Quality Improvement' list, as well as against national priorities. For the present overall public reporting (although systematic in relation to the above performance indicators) remains relatively hamstrung by a combination of poor

data quality and, until the publication of the recent White Paper (DoH 2010a), a marked reluctance to mandate public reporting on health outcomes at consultant or procedural level.

The Society of Cardiothoracic Surgeons has been the most committed to such reporting (prompted by the scrutiny which followed the Bristol Royal Infirmary Inquiry). However in 2003, a study of UK cardiac surgery data (Fine et al, 2003) demonstrated large inconsistencies among various data sources even for an outcome as apparently unequivocal as death. Not unnaturally this created legitimate anxiety amongst clinicians about possible miss-representation of their true results, as well as proper allowance for case mix. Despite this, in 2005 the individual performance data for all the cardiac surgeons in the North West Region of England was published. Interestingly however, this landmark event was prompted by a request from the *Guardian* newspaper -using new legislation (The Freedom of Information Act, 2000) - for the performance results. The authors decided that it would be more responsible of them to present their individual performance data in a medical journal, as they believed case mix would be given fuller consideration (Bridgewater, 2005).

Other specialties continue to move at a slower pace. The general reluctance to install a transparent system where providers can be readily identified is noteworthy; and as will be seen in the next chapter problems with both the adequacy and transparency of outcome data extends to the UK private sector.

The development of medical audit after the establishment of the internal market was limited both by practical implementation problems (Black and Thompson, 1993; Giaimo, 1995; Grol and Wensing, 1995), as well as a measure of professional resistance (Pollitt, 1993; Harrison and Ahmad, 2000; Harrison 2002; Exworthy et al, 2003). As mentioned earlier, audit in the early 1990s was a professionally-led process and attempts by the state and managers to align it with the wider performance management agenda had at best mixed success. Although doctors perceive their autonomy to be threatened, the profession continues to have considerable influence in areas such as the public reporting of quality information.

The BBC programme 'Trust Me, I'm a Doctor' (BBC 2, 2000) illustrated the limitations of the current approach to audit. Barry Jackson, then President of the Association of Surgeons of Great Britain and Ireland (ASGBI) was asked what mechanisms were in place that would stop surgeons from undertaking operations beyond their competence. His answer (as

subsequently reported in the BMJ (Berger, 2000) was as follows: ‘a ‘surgeon’s conscience’ would prevent that happening... Mr Jackson was also asked what proportion of surgeons knew their outcome figures. ‘I would think less than 50%’ he said’.

Unfortunately there is good evidence to believe that ‘a surgeon’s conscience’ will not stop some doctors from performing procedures beyond their competence or too infrequently to attain/retain competence (Gawande, 2003; 2009; Groopman 2008).

The above highlights the ambivalent attitudes to public reporting from the various parties that might collectively be described as ‘the medical establishment’. Overall surprisingly little substantive progress on quality occurred from the publication of the BRI Report until the Darzi Review (Lord Darzi of Denham, 2008). Lord Darzi’s report unquestionably promoted the importance of high quality care. It remains to be seen if this can be sustained in the face of a much tighter fiscal environment.

In concluding this section it is worth noting that a five country survey of hospital executives (Blendon et al, 2004) found that UK respondents were the most receptive to the information on clinical quality being made publicly available. They were also more inclined to believe that their government had an effective policy that was designed to improve quality of care.

#### *Public Expectations*

Research suggests that public expectations in the UK largely mirror those of the USA. There appears to be support for publishing clinical quality information - including outcomes - but relatively little interest in using it to determine which provider to see. A large-scale study recently completed by the Kings Fund in four areas of England showed that, in principle, patients valued aspects of quality when choosing a hospital. However, most patients chose to be treated by their local provider, and few consulted published performance information on quality to help them choose, instead relying on past experience and their GP’s advice (Dixon, et al 2010).

The King’s Fund study paints a similar picture to that emerging from an earlier Market and Opinion Research International survey of public attitudes. MORI’s Ben Page writing in the *Health Service Journal* noted that:

‘Only a minority want to know about technical aspects of performance. For example 55% want to know how budgets break down, but only 10% want to know about morbidity or mortality rates’ (Page, 2004a, p.22).

With regard to provider quality in general, again the British public essentially mirrors US views as to what is regarded as important. However, one might speculate that there will be different ‘tolerance’ levels as to what would be regarded as an unacceptable standard in relation to décor, quality of food, waiting time to see a doctor and so on. Nevertheless, to quote Ben Page once more:

‘Actual medical success alone seems to have little to do with perceived patient experience. There is no relationship between in hospital Mortality Ratios and patient perceptions. Regardless of death rates, those who survive to fill in surveys seem equally positive or negative...Similarly, there is no relationship at all between how CHI star ratings rate different Trusts and public perceptions of performance - with only 2 percentage points difference in terms of average patient perceptions of zero-stars and three-starred trusts.’ (Page, 2004b, p.23).

With the incidence of MRSA and other hospital acquired infections in NHS hospitals subject to considerable media attention it is unsurprising that concerns over cleanliness have grown to over shadow many other quality issues. Thus a recent MORI survey on patient choice states that:

‘The general reputation of a hospital would not be the single most important factor the 40+ age group takes into account when choosing where to go for treatment or an operation; rather it is cleanliness, followed by the length of waiting lists’ (MORI, 2006, p.3 ).

The table below illustrates the point in more detail. Particularly noteworthy is the relatively low rate of respondents (26%) who considered ‘operation success’ rate to be the most important factor.

**Table 7. MORI Questionnaire (MORI 2006, p.17)**

**Which two or three of these would be most important to you in choosing which hospital to use for treatment or an operation?**

	%
Cleanliness	54
The length of time I'd have to wait for an operation or treatment	50
Reputation of the hospital	34
Operation success rates	26
Being treated with dignity and respect by staff	24
The convenience of the location / transport facilities	20
Reputation of consultants	18
Being able to set my own date and time to see a consultant or specialist	13
Having a choice of consultant	10
Whether I can have more care at home rather than in hospital	7
The environment I am treated in (e.g. in a private room or on a ward)	6
The option of having alternative / complementary therapies	5
Other	1
None of these	1
Don't know	1

Deaths associated with poor cleanliness on wards at Tunbridge Wells and Maidstone NHS Trust in 2006 was extensively reported in the national media and undoubtedly reinforced public concerns in this area. The subsequent scandal at Mid Staffordshire Foundation Trust (Francis, 2010) has done the same with regard to basic clinical care and the treatment of patients with dignity.

### *Market Leverage*

In a unified national health system one might think that public purchasers would have few problems in applying substantial market leverage on providers to ensure that quality health care is delivered. The American commentators Leatherman and Sutherland (2003, 2004) considered that the Labour government's Quality Agenda was the most ambitious, comprehensive and systematic effort to create sustainable capacity for improving the quality of a nation's health care system to date, and presumably judged that the commissioning arrangements in place could deliver the plan.

Yet, commentators such as Walshe, et al (2004), as well as the author (Royce, 2000), have raised concerns that the commissioning function is inadequate to perform the tasks assigned to it. There is a view that PCT's are not strong enough to stand up to large NHS trusts in tough contract negotiations and too small to fulfil their public health responsibilities. Given this lack of leverage with larger trusts, few PCT's have been able to press providers effectively over quality issues (Light, 1998; Curry, et al, 2008).

The House of Commons Health Committee's recent report on Commissioning (HCHC, 2010) reiterated the view that there was an imbalance of power between PCT's and trusts and a lack of levers. The report quoted a submission from the King's Fund, highlighting findings from a Birmingham university study which suggested that recent NHS reforms might have exacerbated the problem:

'For elective care, the payment by results tariff, patient choice and the "any willing provider" requirement mean that PCT's have little control over what they pay or where patients are treated while quality standards are set nationally. The increasing concentration of some services in specialist centres effectively creates more local monopolies and large acute hospital trusts can be even more dominant in their local provider markets [...] The ability of commissioning to be an effective lever for change has, therefore, yet to be proven' (HCHC, 2010: para 96).

It was noted that the imbalance in size and resources was generally accompanied by an imbalance in clinical information available, with the providers having much more knowledge about the quantum of care delivered, thus making it difficult for purchasers to challenge hospital trusts (HCHC, 2010, para 78). The Committee also drew attention to problems in the

staffing of PCT's arising from inadequate skills, and the effects of organisational turbulence created by the succession of NHS reforms.

In evidence to the HCHC, the DoH conceded that in the past:

‘...the necessary system levers and enablers were not in place to support, resulting in unbalanced relationships and influence between providers and commissioners’  
(HCHC, 2010, para 99).

The fact that both quality requirements and tariffs were fixed nationally was felt by the Committee to leave local purchasers with few levers that could influence their providers. Generally the pursuit of centralised commissioning policies, with mandatory use of a standard template contract and central targets, tended to reduce the importance of local elements in contractual agreements (Hughes et al, 2011).

It is less than clear that the proposed abolition of PCT's and their replacement by GP commissioning groups, (DoH 2010) which are likely to be smaller organisational entities than PCT's, will redress this imbalance.

#### *Reimbursement Mechanisms*

The most interesting features of reimbursement mechanisms relating to the promotion of quality in the NHS are the current difference of approach between primary and secondary care. The use of earmarked payments for ‘quality measures’ within the GP GMS contract has been previously noted. In contrast, until the Darzi reforms (2008) made reference to the possibility of introducing a differential payment for quality reimbursements in the hospital sector, incentive payments in secondary care had been limited to some discretionary allocations. Indeed, as the HCHC report suggested, one of the main features of PbR has been the supposed abolition of price considerations within the general contracting framework altogether. By this is meant the promotion of a standard tariff for procedures under PbR. In theory trusts then compete on ‘quality’ rather than price, as the price paid is meant to be standard between providers. The actual system is somewhat more complex than this - with market forces adjustments, phasing in and so on, but the principle is of a standard tariff. Again, in contrast to primary care, no attempt has been made to link NHS consultant

payments to the achievement of specific quality measures (despite the fact that both contracts were centrally negotiated essentially in parallel by the DoH).

To date, competing on quality within the acute sector of the NHS appears to have principally consisted of competing on access times for treatment. Critics of this approach include those, like Appleby (2005), Coulter, Le Maistre and Henderson (2005) and Burge et al (2004), who argue that these may not be the features that truly interest patients. Instead, they believe the public care about:

‘...quality, reputation, and other similar concepts often top the public's lists of desirable features of health services - often in preference to specific criteria such as shorter waiting times and greater choice’ (Appleby, 2005, p.63).

Until recently there was little in NHS payment mechanisms that could be regarded as providing a positive incentive to delivering high quality services to patients. As previously noted, critics of US health care has tended to complain that the payment system rewards poor practice. However such criticism could also apply to the NHS. Likewise the problems of uniform reimbursement rates such as those cited for Medicare (DRG's and CMS) are amplified for the English NHS given that HRG-based reimbursement remains the basis on which the overwhelming majority of an NHS trust's income will be derived.

Trusts are unable to charge a premium price from either being associated with (or actually delivering) a higher quality service than other providers. In theory those trusts operating the shortest wait times (which can be seen as a quality indicator) will be rewarded with more patient referrals and thus more income. Whether such cases are profitable is another matter. The same also applies to more ‘natural’ quality criteria (hygiene factors such as MRSA rates and patient satisfaction ratings) which private providers will feel confident they can score well on. Patients may be attracted to those hospitals, and can even demonstrate that preference through ‘choose and book’, but prices are fixed regardless of demand.

Following Lord Darzi's review, the new CQUIN payment framework mentioned at the beginning of this section was introduced (DoH, 2008c), It allows purchasers to make a small proportion of contractual payments dependant on achieving quality requirements. As the guidance states:

‘Providers will have a right to have the opportunity to earn this money through a locally agreed scheme, but it will not automatically flow through to providers as it would in previous years’ (DoH, 2008c, p.14).

There are four features of CQUIN that should be noted. Firstly, CQUIN monies are not additional to the general NHS allocation but form a ring-fenced part of the reimbursement to providers via PbR and the other contracts arranged between PCT’s and providers. Secondly, in 2010/11 the CQUIN payment framework covered just 1.5% of a provider’s annual contract income. Thirdly the DoH expected that in its first years of operation the main focus would most likely be on rewarding data collection. This has led to criticism that CQUIN payments are currently being used to reward the achievement of minimum standards rather than high quality care (Healthmandate, 2010). Finally, CQUIN also applies to NHS commissioning with private sector providers.

CQUIN is similar to the ‘pay-for-performance’ initiatives in the USA that also attempt to encourage higher quality care through the use of financial incentives. Whether the sums on offer are sufficient to achieve that aim is debatable, but the aspiration and direction of travel are clear enough, and are unlikely to be reversed. In the 2011/12 Operating Framework the DoH announced that reimbursement for an emergency admission within 30 days of an elective procedure would not attract any reimbursement (DoH, 2011).

The other recent development in NHS reimbursement methodology with a quality dimension has involved giving enhanced tariff payments to those providers who can demonstrate that they are meeting defined standards (DoH 2010b). The number of procedures where enhanced tariffs would apply was extended in the 2011/12 Operating Framework (DoH, 2011).

## Conclusion

This chapter has highlighted the difficulties in defining and operationalising concepts of health care quality, and discussed approaches to quality in the market-based US system and the public NHS.

Quality is in many ways a complex and elusive phenomenon that both US private health care and the NHS have struggled to implement, and yet there are developments in both systems that suggest routes to quality improvement and might provide lessons for other systems, such as the UK private sector.

The US health care system is one of the most entrepreneurial in the world and, more than other system, might be expected to harness the potential of market incentives and levers to force quality improvements. In fact as we have seen the 'business case for quality' is less clear-cut than might be expected. Research suggests that short term-investment does not necessarily translate into long-term gain for the purchaser making the investments. Nor is it easy for payers to challenge the established framework of fee-for-service remuneration from which providers and physicians have much to gain. A US insurer that pushes providers hard to change behaviour runs the risks of incurring high short-term costs, while long-term gains are dispersed right across the market. For this reason it is unsurprising that many of the innovations in purchasing have come from the CMS or purchasing alliances which have a large market share in certain geographical areas and are less affected by this phenomenon. Overall though, pay-for-performance is a growing trend in the United States, so that more than half of private-sector HMO's now make use of 'P4P' in some areas. This means that there are a wide range of models that observers such as managers in the UK private system can review and perhaps emulate.

The NHS has also become increasingly interested in quality, with some policy advisors drawing explicitly on US experiences (e.g. Ham, 2005). As we have seen one problem is that lip-service to quality has often been subordinated to concerns with cost containment, efficiency and activity. Paradoxically, the Labour Government's attempts to support an English supply-side market by use of standard tariffs and central steering of commissioning via a standard contract, may have reduced the ability of NHS purchasers to use market levers

to achieve local quality improvements. The structure of the English NHS, with an imbalance of power between PCT's and NHS trusts, also appears to be a barrier to developing value-based purchasing. However as we have seen there are significant developments in both primary and secondary care, which may change this picture. The QOF, CQUIN and enhanced tariffs for quality (DoH, 2010b; 2011), all have the potential to provide lessons about whether pay-for-performance works and how it might be developed. Given the potential importance of NHS activity to the UK private sector, these might again be of interest for managers in private-sector payers, such as Bupa, when they consider their own strategies towards quality improvement.

In the next chapter we consider some of the issues discussed in this chapter in relation to the UK private sector, and recount the experience of some of Bupa's main quality initiatives.

# Chapter 7

## Quality and the UK Private Sector

### Introduction

This chapter begins with a general discussion of the conceptualisation of quality in the UK private health care sector, including its marketing against the backdrop of the public NHS, the limits of quality-based competition, the arguments for and against directing patients to selected providers, and the presentation of quality in advertising. Later sections of the chapter describe a major Bupa quality initiative where professional opposition to insurer attempts to improve quality was evident, and (in less detail) the experience of four other Bupa quality initiatives.

More generally the purpose of the chapter is to explore arguments about the potential of the UK private market to secure quality improvements (returning to certain themes touched upon in earlier chapters), and specifically to investigate how far a large purchaser such as Bupa can use buying power to change provider behaviour.

### How the UK Private Sector Markets Quality

#### *Counterposing Private Sector Quality and NHS Care*

As was initially noted in Chapter 2, both the scope of the private sector in the UK and some of its key dynamics have been defined by the relative strengths and weaknesses of the NHS. The same applies with regard to quality. This largely defines what it is about health insurance in the UK that makes it attractive to potential buyers (what is often spoken of within the industry as ‘the customer proposition’), and to what degree insurers (and providers) can differentiate themselves - both from the NHS and from each other. With regard to this, a number of features are worth noting.

Firstly, it had traditionally been considered that the main point of distinction of the private sector from the NHS had been the ability of people with health insurance to receive prompt

treatment for a wide range of elective conditions. As such, a key assertion that health insurers sought to demonstrate was that private insurance was necessary and/or desirable because of long NHS waiting times (Besley, Hall and Preston, 1999; Propper, Rees and Green, 1999; Higgins 2004). Latterly, this assertion has been under threat due to the sustained focus on reducing NHS wait times and the recent success in doing so.

With regard to this it is interesting to note the difference between the DoH and private insurers in the attention given to providing a wait time guarantee and subsequently measuring patient waits. The government have invested considerable resources in an attempt to deliver referral to treatment times, as is evident when one views the DoH's '18 weeks: Delivering the 18 week patient pathway' website (2009b). In contrast, the private sector does not provide any guarantees, and makes no attempt to systematically measure customer wait-times. In fact, although it would appear that the conventional wisdom is that waiting times are not a problem for private patients, certain individuals may well have an unpleasant surprise in store for them should they choose a particularly well-known consultant - both in terms of the time they will have to wait before he/she can perform the operation, and also the size of the 'shortfall' that the insured member will have to pay.

The second feature is closely related to the first. The NHS was established to provide a fully comprehensive health service funded from taxation and free at the point of use. As there are no tax advantages relating to the purchasing of health insurance, private insurers have sought to highlight failures in the NHS's ability to meet individual expectations and the advantages of the service delivered by private healthcare. This includes waiting times, but also extends to other key areas such as physical environment, cleanliness, the quality of food, access to a particular consultant, staff attitudes and consumer sovereignty.

Finally, private insurers have been eager to highlight that their policyholders receive consultant-delivered treatment (in terms of whom they see for their outpatient consultation, and who performs the operation). The use of non-consultant grade doctors in private healthcare (outside of ISTC's) has historically been very limited - mainly to the presence of a resident duty doctor at night in private hospitals. This contrasts with the position in the NHS where much care is undertaken by doctors in training grades. As previously noted this places the consultant at the apex of private care with much resulting power and influence and reinforces the natural authority that the consultant exercises. Arguably, the cultural authority

of senior professionals has not been eroded in the UK to the extent that may have occurred in the USA (Schlesinger, 2002).

The above translates into a customer proposition that has three foundations:

- Access - quick treatment;
- Quality - consultant-led care in a comfortable, safe environment;
- Convenience - treatment at a convenient facility with greater say as to who undertakes treatment and when it takes place.

This trinity of advantage coalesces to create peace of mind – a feature often emphasised in PMI advertising, especially by Bupa. Consumers on both sides of the Atlantic often appear to make purchasing decisions on an emotional basis, and wish to be sure that treatment will be available without barriers when necessary (Cordina, Pellathy and Singhai 2009). For the UK private sector this proposition has remained essentially unchanged since the creation of the NHS and its durability is testament to its strength and enduring attraction.

For insurers two of the main threats to market share come from the narrowing gap with NHS care and rising premiums, but a third lies in the difficulty of differentiating between companies. Failure to convince consumers of the existence of a difference in the service provided carries the risk that perceived product homogeneity will lead to fierce competition on price.

Insurers try to counter this in a number of ways. There are many insurance products available on the market. For example Moneysupermarket.com website claims that its database will search 450 health insurance products (Moneysupermarket.com, 2009). Numerous product variations exist but some of the most common differences are shown below:

- What conditions/treatments are covered;
- Whether costs are fully refunded or some form of co-pay is required;
- Whether there is a moratorium on treatment (a wait period before you can claim after joining);
- The degree to which there are restrictions on who you can see and where you will receive treatment;

- The standard of accommodation (guaranteed single room, for example).

Such variations provide consumers with a considerable number of choices, but also make comparisons between insurers' products difficult. This fact helps account for the existence of specialised firms of brokers, who market their ability to make such comparisons and negotiate (on the client's behalf) 'best value' insurance cover.

Given the above, one may ask how insurers have been able to maintain profitability in what should (at first sight) be an extremely price-sensitive market. In economic parlance their ability to extract sizeable economic rent from what seem to be fairly homogeneous products is somewhat puzzling. Part of the explanation may lie in the very fact that private health insurance has been considered unaffordable by much of the UK population. Whilst this has limited the potential customer base it allows premium prices to be charged because it is seen as a 'luxury product'- rather like 'prestige' cars.

However, this does not explain why companies do not make more strenuous efforts to increase market share by cutting prices. At one level this is exactly what company executives say they are doing, and that year on year it is harder to deliver targeted financial returns. As we have seen in previous chapters, insurers rarely compete on the basis of price or detailed quality information, but they may use reputation to justify high prices. In the case of UKM, the Bupa brand is itself a powerful tool used by managers to maintain profit margins. This is explored in more detail - along with Bupa's approach to quality - in the next section.

### *Competing on Quality: The Bupa Experience*

As previously noted, Bupa is both the largest and best-known private healthcare company in the UK. The term private healthcare company is deliberate because Bupa is far from being just a health insurer. Until recently (2007) it was also the third largest private hospital provider and it remains the largest care home company in the UK. The Bupa brand helps both to sell Bupa products and maintain a price premium. Successful brands carry positive associations in the minds of purchasers. In the case of Bupa that association might be characterised as ensuring high quality, dependable medical care is delivered from a friendly company you can 'trust'. Indeed the Bupa brand is so ubiquitous within private healthcare that it was commonplace to hear that Bupa members, when contacting a Bupa service centre,

were surprised that the private hospital to which they were being admitted was not owned by Bupa.

Given the importance of brand reputation to Bupa and what that brand is associated with, it is unsurprising that 'quality' is used as a key element of Bupa's marketing stance. It is also considered an important source of brand differentiation and a mechanism for generating positive media stories. However a strong association of the brand with positive quality in the minds of potential and current members creates two problems. The first is the idea that the brand can be ahead of reality. In other words, if customers already think they are getting very high quality healthcare, the company will struggle to get the recognition (and market advantage) they might hope for in subsequently undertaking quality assurance/improvement initiatives. To use an analogy drawn from the stock market, it is as if customers have assimilated these features into the value they assign to the product and thus already incorporated them into the price they are prepared to pay. Under such circumstances, insurer quality initiatives call for fine judgement as to how these will be presented to customers. Far from being welcomed - as an indication of professionalism and helping to justify the price premium - customers may express displeasure that the initiative in question is not already in place.

The other problem is that the public's definition of 'quality' has been shown to focus primarily on the 'aesthetics' of care. This is unsurprising given what has already been noted in the earlier sections concerned with the US system and the NHS. Insurers such as Bupa may decide to undertake measures to improve (or assure) quality simply because they believe this is the 'right thing to do'. However, as commercial entities they are perhaps more likely to decide that there is no good competitive reason to do so. The essential dynamics behind such decision-making has previously been noted in the previous chapter's discussion on 'the business case for quality'.

If insurance scheme members/private patients perceive quality as principally being about speed of access, choice of provider and physical environment, then that is what providers will promote and provide. Successful insurers and providers respond to market demand. The popularity and profitability of companies like Bupa, HCA, and BMI has been a testament to their ability to set, and meet, customers' expectations of quality healthcare defined in such

terms. In terms of these demands, their internal organisation is 'incentive compatible' and well adapted to the environment.

For Bupa's UK insurance division, this creates something of a conundrum. Quality initiatives above and beyond the 'hygiene' factors referred to above may help the company to set itself apart from its competitors. For example, it might claim that it is the only company undertaking a specific quality initiative (such as establishing an accredited cancer network). However, it is not clear that this has any direct impact on the decision to purchase or renew for the reasons cited above. The conventional wisdom in the UK PMI industry (as illustrated by the marketing literature of both insurers and private providers) is that the concept of quality will be primarily driven by a combination of:

- speed of access;
- a large choice of potential providers;
- the 'hygiene' factors associated with private care (such as clean hospitals, private rooms);
- the more personal care that is a consequence of staff having more time and being more customer focused than in the NHS;
- the ease and quality of the administration process (pre-authorisation, payment of claim etc).

The concept of quality in relation to clinical credentials is considered secondary (beyond the emphasis on consultant care). Indeed it is debatable whether many purchasers of health insurance in the UK actually see this as the legitimate province of insurers. The dominance of the NHS may be a factor with this issue perhaps being seen as an area that the NHS would naturally lead, and the same applies with regard to the CQC which regulates provider quality in both sectors. There is also the role of Royal Colleges and Professional Associations which together reinforce the idea that quality will be determined and safeguarded by the self-regulated activities of clinical professionals. As a result, the quality of consultants is usually taken as a matter of faith, and in the case of hospitals judgements are often made from external appearances.

Insurers regularly commission agencies to undertake surveys and run focus groups of existing and potential members to ascertain their views on the quality of the service provided to them.

However the results are commercially sensitive and thus not publicly available. One can assume that these identify a number of concerns and that a successful company will look to address them. If it did not make commercial sense to do so, they would be concentrating on other quality measures. This is not to say that there is no interest in more advanced /different quality measures but these have not reached any sort of critical mass.

### *Directing Patients to Providers*

The notion that some hospitals and doctors provide a superior service to others and that it is therefore in the best interests of the patient to utilise them, can seem both a simple and fundamentally attractive proposition. However in reality the proposal to direct patients to such providers (and thus limit the extent of free choice) has been a controversial issue on both sides of the Atlantic. In the UK the whole issue of 'choice' and access to local services as it relates to the NHS has generated considerable debate. Ironically in the UK the government have been trying to promote more choice of provider (DoH, 2007, DoH 2010a) for NHS patients at a time when many some private health insurers have been seeking to limit care to networked providers, or doctors who undertake not to charge above benefit maxima. In the USA, the initial rise and subsequent backlash against managed care had, as one of its main features, the issue of restricting choice of provider (Hurley, Bradley and White, 2004). In the UK, the promotion of choice has historically been one of the central planks of the private healthcare 'proposition'. Any insurer (in any country) that wishes to direct its members towards a narrower group of providers has four major hurdles to overcome.

The first is that the concept that an insurer can decide which consultant or hospital is used and what treatment is provided may be at odds with members' expectations about the insurer's role. Whilst some people might welcome additional information to help them to determine where to receive best care, many will be resistant to the idea that a party other than their GP or consultant should provide advice or direction about their care. This will be particularly so if such advice/instructions conflicts with that given by 'their' clinician. Essentially, this is about 'trust' and as previously noted most people are well-inclined towards the professionals who treat them. Insurers must also overcome suspicion from members that the insurer's motivation is more about saving money than promoting quality. Moreover many consumers find the idea of variable quality of doctors and the treatments they provide difficult to contemplate. When emotionally vulnerable it is unpleasant to consider the consequences of not being able to put your trust in one's doctor or hospital.

Secondly purchasers face a practical problem. How do they actually determine who are the good (and poor) quality providers and how is that information to be conveyed? Much of the previous chapter was devoted to the problems in collecting and utilising valid quality information and that discussion will not be repeated.

Thirdly, we have already established that many people purchase PMI because it provides more choice, sovereignty and autonomy. Any diminution of these factors - for whatever reason - is seen to undermine the rationale for purchasing PMI in the first place. Finally, even if all these problems could be overcome, insurers have the problem of how to explain why such measures are not already in place. They are fearful of reactions such as: 'I thought I had bought the best, now you're telling me that many of the providers you recognised weren't up to the job?' Expectation management is crucial if the insurer is not to end up in the undesirable situation of being lambasted for initiating quality improvements (on the basis that the consumer already thought that level of service was in place when they purchased the product).

#### *Advertising and Product Material*

Space does not allow an extensive review of medical insurers' use of advertising/product material so this section will be confined to a few salient observations. The first is that medical insurers tend to promote the same features - shorter wait times, consultant care, clean hospitals, convenience and consumer sovereignty. Because of this marketing agencies struggle to differentiate their clients. Some will put more emphasis on 'affordable care' (budget schemes), others will use the traditional messages but attempt to be more aggressive in their tone.

For example, in August 2004 Norwich Union ran a print advertising campaign in London headlined 'health scare or health care?' with the words set against a picture of a culture of microbes. The advertisement went on to say:

'With all the latest scare stories about levels of hygiene in London's hospitals you might want to consider all the alternatives available. We can provide you with a wide range of health insurance policies that will give you access to high quality, private hospitals and you won't have to wait to be seen' (Norwich Union, 2004).

Other insurers, including Bupa, try to lay claim to the notion that the customer is purchasing 'peace of mind' by 'buying the best'. In effect they look to address the second of the 'risks' identified by Arrow (1963) and discussed in Chapter 1 – the risk of incomplete or delayed recovery. Bupa's adverts are a good example of this. Aside from sometimes highlighting specific components of Bupa Group such as insurance, care homes, and health screening they seek to convey a message of 'safe in our hands'. Indeed the long-running advert used through much of 2005 'Kissing baby better' (Bupa, 2005a) featured images of young and old taking comfort from the security provided by Bupa cover, with a soothing folk song playing in the background, but with no specific product information provided.

The contrast with Prudential Health's advertising is striking. Prudential Health is a relatively new entrant to the UK health insurance market having commenced operations in 2005. The company has attempted to distinguish itself from existing insurers by focusing its advertising (and product proposition) on the idea that customers should be rewarded for their efforts to keep healthy – a UK version of the consumer-directed healthcare programs that are being promoted within US healthcare (Cogan, Hubbard and Kessler, 2005; Feldstein, 2006). Thus the Prudential health advert for October 2005 reads as follows:

'Just got the bill from my health insurance. How come if I fit a burglar alarm, I pay less on my contents insurance, if I keep my car on the drive, I pay less on my car insurance, yet if I try and look after myself what happens to my health insurance? Nothing. My premiums still go up and so does my blood pressure. PruHealth is a revolutionary type of health insurance that rewards you for looking after yourself. About time. Fair health insurance, it's all part of the plan from Pru' (Prudential Health, 2005).

Whether soft focus or hard-hitting advertising is more effective in attracting and retaining customers is not the main topic of this thesis. However the above should give a flavour of the type of advertising seen in the UK, and what place clinical quality has within it. In respect of this the final example comes from Bupa's poster campaign (Bupa, 2005b) launched in September 2005. This featured four separate posters as follows:

Expert: Our specialists make you feel better;

Clean: Our hospitals make you feel better;

Quick: Prompt treatment makes you feel better;

Choice: The latest treatments make you feel better.

The documentation that potential and existing members receive reinforces the kind of 'traditional' PMI values and advantages outlined above. It aims to reassure the reader that they have made a wise choice, that the hospitals they have access to are of a high quality, and the consultants (being consultants) are specialists. High quality is defined in terms of facilities, cleanliness and convenience. The only attempt likely to be made to define a specialist is that, as consultants they have trained for at least seven years. A typical example of the language used is shown below. The source document is the Bupa membership Guide for the product known as Health Care Select 1 - one of a suite of product offerings available to personal customers. It has been chosen because it is typical of the genre. Under the section headed 'our commitment' (Bupa, 2003a, p.5) it states:

'The Bupa commitment always includes: Setting quality standards and monitoring all aspects of our service, to make sure you always receive the best possible care and attention.'

Under 'Hospitals' (Bupa, 2003a, p.65) the following statement is made:

'We want to make sure that when our members receive treatment in any hospital recognised by Bupa in the UK they will receive consistently high standards of clinical and customer care. That is why we select hospitals that are committed to high standards and customer service.'

The author has never seen within either Bupa or literature from competitors any explicit linkages made between outcomes, clinical quality, and the characteristics of the providers recognised to treat members. Quality assurance in the PMI sector thus seems to be process rather than outcome driven. However, this does not tell the whole story. For a more complete picture it is necessary to examine in some detail what approach Bupa has taken to promote clinical quality and how this sits within its current customer proposition.

## **Bupa UK Membership's Quality Initiatives**

Historically the cornerstone of UKM's quality assurance process consisted of:

- i. For hospitals and clinics, the requirement to undertake (and pass) a Provider Assessment Document (PAD) and subsequent physical inspection;
- ii. For doctors, the need to meet Bupa's recognition process, central to which is the requirement that doctors must hold, or have held, a substantive NHS consultant post.

The consultant recognition process has remained essentially unchanged over time. However, managerial enthusiasm for undertaking labour-intensive (and thus costly) hospital inspections on a routine basis diminished to the point whereby during the authors last three years at UKM few (if any) routine inspections took place. As the Health Care Commission (HCC) took over responsibility for regulating both the private and public sectors there was a desire within UKM that the company reduce its own quality-assurance documentation, with the aim of using the general assessment of hospital standards undertaken by the Healthcare Commission. It is understandable that both UKM and providers would be keen to avoid unnecessary duplication. Moreover, hospitals would understandably be reluctant to co-operate with insurer-based accreditation if they perceived that there was no added-value. However the decision begs the question as to how rigorous and reliable Healthcare Commission assessment was going to be. Whatever the actual answer to this might be, for the purposes of this thesis the relevant point is that senior managers were confident that for Bupa members this level of general quality assurance would be deemed satisfactory.

Whilst the level of routine quality assessment and surveillance undertaken by UKM on providers might be considered somewhat perfunctory (and perhaps rather less than members would expect given the statements in the documents quoted previously), the company has a more impressive record in setting and regulating quality criteria for a number of specialist conditions. This is of considerable interest for this thesis both in terms of the reasoning behind such initiatives, how they have been implemented, and providers' reactions to them. Specifically it is of central importance with regard to one of the central objectives of this thesis: undertaking an assessment of the ability and willingness of the private sector in the UK to promote and improve health care quality.

Over approximately the last decade UKM have undertaken a number of specific ‘quality’ initiatives with the aim of improving the quality of care for its members and to assist the company in positively differentiating itself from the NHS, and from other insurers. Some (but not all) of these initiatives have also had an element of cost management within them. The main initiatives directly relating to clinical quality have been:

- Introduction of a Magnetic Resonance Imaging (MRI) network;
- Introduction of an Ophthalmology network;
- Introduction of a Physiotherapy network;
- Best practice for hip and knee arthroplasty;
- Critical care unit accreditation;
- Introduction of a provider network for Bone Marrow Transplants;
- Introduction of accredited units for breast, bowel, and gynaecology cancer services;
- Best practice for the management of back pain;
- Patient Satisfaction questionnaire;
- Patient complaints database;
- Supply of SF 36 and VF14 Outcome data from providers.

Of these, the establishment of MRI, Ophthalmology and Physiotherapy networks have all been previously discussed. This chapter will consider another initiative with particular significance for the thesis topic – concerned with hip and knee arthroplasty - in detail, and then describe more briefly four of the remaining initiatives.

## **Best Practice for Hip and Knee Arthroplasty**

### *Background to the Initiative*

Hip and knee arthroplasty (replacement) surgery is one of the mainstays of private practice in the UK, and there is considerable variation in both length of stay and cost between providers. This was therefore a natural issue for UKM to focus on. With over 5000 such operations being undertaken annually on UKM members it was a material and high profile area. The author was intimately involved in the project almost from the outset, being charged with leading the initiative. Essentially the aims boiled down to two objectives:

1. Setting out quality criteria that would improve/ assure care for Bupa members;

2. Establishing an expectation about length of stay (and associated care process) which, if implemented, should lead to cost savings.

The approach was to produce a document from which to engage hospitals and consultants that would draw heavily on clinical references on current good practice. Attempts to engage providers (both clinicians and hospitals) in a constructive debate about such issues always carry a cost, both financially and in terms of opportunity costs. Based on the results of the various engagement exercises charted in this thesis, whether the results of such 'engagement' justifies their costs appears questionable.

In October 2002 UKM circulated '*Ensuring high quality care in major joint surgery; A discussion document with the profession and hospitals*' (Bupa, 2002b). The document was circulated to professional associations, hospital groups and other major orthopaedic providers. Additionally, the top 30 Hip and Knee arthroplasty surgeons (by volume of Bupa members treated) were sent personal copies of the document and copies were made available to any consultant/body that requested it.

Following receipt of these comments UKM issued a revised document '*Ensuring High Quality Care in Hip and Knee Arthroplasty Surgery*' (Bupa, 2003b). This document was discussed at a series of regional meetings (19 in total) undertaken across the UK. Every surgeon and anaesthetist who had billed Bupa for a hip or knee replacement during the previous year was invited to the meetings, and 191 consultants attended.

Following those meetings UKM then produced a revised (and final version) of its proposals entitled '*Ensuring high quality care for hip and knee arthroplasty surgery*' (Bupa, 2004) in February 2004. This included an appendix with comments received from the 72 consultants who had responded to the previous documents. This process has been outlined to illustrate both the lengthy timescale and the extended nature of the engagement process.

#### *Minimum Volumes: a Controversial Proposal*

Much of the document was a reflection of best practice as set out in literature such as the British Orthopaedic Association (BOA) publications on best practice for total hip and knee replacements (BOA, 1999). The sections 'observations on good practice' and 'health outcomes' were well received, as was the proposed tightening of hospital standards (by

consultants if not necessarily by hospital managers). However, other elements proved considerably more problematical. A key element was the proposal to introduce minimum volumes that any consultant would have to achieve before being authorised to carry out such operations on Bupa members. Whilst it was accepted that minimum volumes were not the sole measure of quality, UKM's contention was that the evidence clearly showed that there was a minimum volume below which outcome was likely to be (negatively) affected. The establishment of minimum volumes at that time was considered to represent a highly visible quality differential with both the NHS and other insurers.

The proposal to establish minimum volumes provoked considerable discussion with clinicians. The author took part in many debates on the subject - both through correspondence and face-to-face. These discussions were marked by a distinct lack of consensus. This is best illustrated by reference to various positions taken by consultants in letters to Bupa that appeared in the Appendix of the document (see Appendix 6).

The proposal that provoked much reaction was for a minimum volume to be set for hip and knee replacements, and also for knee revisions. The justification for doing so was set out in the document with 21 supporting clinical references (Bupa, 2004).

#### *The Response of the Professional Associations*

Whilst the views of individual consultants varied and were often encouraging (as can be seen from the written comments in Appendix 6), the responses from the British Orthopaedic Association (BOA) and the British Association (for) Surgery Knee (BASK) were essentially negative. Their position could be summarised as:

- A. We are against insurers trying to establish quality standards for doctors. This is best left for professional bodies to do;
- B. We are in favour of promoting high-quality practice but determining what actually constitutes good and poor practice is very difficult, as is what is required for someone to be considered competent. If minimum volumes are to be set it is for the professional bodies to undertake this. However currently it is too technically problematic to do so.

Despite numerous meetings and exchanges of correspondence over a prolonged period the author saw no discernible change in this position. Moreover that stance has not modified

since. However, the most strident criticisms of the proposals emanated from FIPO. A statement on its website said:

‘...there was no evidence whatsoever that the arbitrary numbers chosen by Bupa would in any way reflect quality of care. There are fundamental objections to an insurer developing a preferred provider list of consultants and acting as a quasi-regulator...FIPO in conjunction with BOA, BASK and BOTA sent out a questionnaire to 1,700 orthopaedic consultants throughout the UK. There was an overwhelming response of 858 consultants representing 50 % of all orthopaedic surgeons...88% of consultants believed the Bupa proposal was driven primarily by financial consideration and 18 % believe it driven by quality’(FIPO, 2006a).

### *Management of LOS and other Issues*

The disagreements over minimum volumes rather overshadowed reaction to the other proposals in the document. One of these related to the establishment of length of stay (LOS) ‘targets’. The document quoted the current range - from an average of 5.8 days to 18.2 days for hip arthroplasties and 5.5 days to 16.2 days for primary knee arthroplasty of Bupa members treated for these conditions (Bupa, 2004). For patients without significant co-morbidities the proposals were:

- Six days for primary hip arthroplasty;
- Six days for hip resurfacing;
- Nine days for hip revision;
- Seven days for primary knee arthroplasty;
- Ten days for knee revision.

The document was at pains to state that the Bupa ‘targets’ did not represent a maximum LOS after which reimbursement to providers would not be made. They would merely trigger discussions between Bupa and providers when high LOS was identified. The length of stay ‘targets’ did not appear over-ambitious as a number of private and NHS providers already had LOS below these for the procedures in question. The NAO in its 2003 publication ‘Hip Replacements: an update’ (NAO, 2003) quoted the Orthopaedic Services Collaborative (part of the now defunct NHS Modernisation Agency) recommendation that a primary hip replacement without complications should have an expected length of stay of only five days.

Nevertheless there was disquiet about what some consultants saw as the introduction of US style 'managed care'.

With regard to the other key proposals, professional opinion was firmly in favour of Bupa making it mandatory for hospitals performing hip /knee arthroplasties to have laminar flow systems in the operating theatre (not all had). They were also generally enthusiastic about comprehensive pre-operative assessment. With regard to outcomes the document had stated that:

'Bupa's general position will be to support follow up appointments and x-rays for hip and knee arthroplasty where they are undertaken as part of a long term outcome programme as follows; six months post surgery, one year, five years, ten years and then five yearly thereafter (assuming that the member remains a Bupa member)' (Bupa, 2004, p.14).

This was welcomed by providers but was the source of some anxiety within UKM. A commitment to long-term follow-up potentially increased claims expenditure and increased the difficulty in distinguishing between acute and chronic care. In this regard the cynicism of those 88% of consultants (quoted by FIPO above) about the motives behind the initiative may have had some grounds.

In earlier versions of the document UKM had also proposed some form of differential reimbursement based on numbers of cases treated, outcomes and/or work performed at designated specialist centres. By the time of the final document this had been abandoned in the face of limited professional enthusiasm and internal concerns as to the administrative complexity (and cost) of implementing and operating such a scheme.

### *Loss of Momentum*

It was soon evident that UKM would have to either implement its proposals in the face of sustained professional opposition or quietly drop them. The professional associations were not going to change their stance. The position of the hospital groups was more equivocal but there was some concern within UKM that implementation of the standards would adversely impact on member access and would lead to pressure for increased prices to cover the costs of implementation.

In the face of such obstacles, UKM did not take forward its proposals. This leads one to question how committed the organisation was to the stated aims of the initiative at the outset. Given the not inconsiderable costs that had been expended getting to this point this may seem a somewhat perverse question. However, the high volumes of hip and knee replacements funded by Bupa added to the perceived risks of the initiative and resulted in a degree of managerial uncertainty once it became obvious that professional opposition would not soften.

The decision to 'hang fire' was made easier by developments in the NHS. In April 2000 the National Audit Office (NAO) produced a report in which, when referring to consultants who undertook very low volumes, stated that:

'...many of the consultants who responded to our survey commented that the numbers being performed are, in many cases, insufficient to ensure that the skill and experience levels are such as to maximise the chances of a successful outcome for the patient' (NAO, 2000).

Both the NAO and DoH were interested in the content and outcome of UKM initiatives, particularly following the recommendations contained in The House of Commons Public Accounts Committee report 'Hip replacements; an update' (2004) which had noted that half the consultants undertaking primary hip replacements did less than the equivalent of one a week. They had recommended that the DoH:

'...should gain a good understanding of the relationship between the number of operations carried out by individual surgeons and their outcomes. It should then set minimal annual volumes of primary and revision hip replacements to be undertaken by surgeons who work in the NHS' (The House of Commons Public Accounts Committee, 2004, p.6).

This was considered a fortuitous development by UKM, particularly when a representative from Bupa (initially the author) was invited to join the DoH Orthopaedic Working Party established as a response to the Public Accounts report. There was a hope that UKM's aims would be largely met without having to engage in conflict with the providers. Indeed, there now seemed a genuine possibility that the orthopaedic community would be forced to either

establish minimum volume measures itself as a way of self-regulating or that government would impose its own criteria.

UKM's proposals were held in abeyance (ostensibly until the DoH Working party had completed its deliberations). At the point the author left Bupa (February 24<sup>th</sup> 2006) no further action had been taken by UKM in taking forward its recommendations.

The DoH Working Party commissioned a report to look at the relationship between volume and outcome (Judge et al, 2006). The conclusion that low volume units were more likely to have poorer outcomes made the front page of Hospital Doctor (Newman, 2005, p.1) and was reported as follows:

'A Government-backed report linking numbers of hip and knee replacement operations with outcomes may lead to closure of units performing low volumes of these procedures, Hospital Doctor can reveal... The findings have potential implications for the private sector, which did not supply data for the study... The DoH asked the researchers not to investigate links between outcomes and individual volumes although their literature review found that for hip replacement, surgeon volumes may be more important than unit volumes. Prof Dieppe said: "We firmly believe that the whole functioning of the unit is most important to outcomes". The paper was submitted to the DoH in August, which told the team it would publish its response shortly'.

The article was written in 2005 yet the response of both the DoH and indeed of Bupa has still not appeared as of the date of submission of this thesis. It would seem that the implications of adopting the report's recommendations remain too radical for either party.

## **Other Bupa Quality Initiatives**

### *The Initiatives Covered*

Four of the most interesting remaining initiatives will be outlined and their central characteristics highlighted (the remaining three generic initiatives are described in Appendix 10). One feature runs through many of them - the dichotomy between the company's desire

to establish quality networks, and the marked reluctance to mandate members to use them. This will become evident as each initiative is examined.

### *Critical Care Accreditation*

The objective of this initiative was to ensure that members who were having procedures that were likely to require a period in a critical care unit were only treated in hospitals that had the appropriate facilities. This seems both straightforward and sensible but as will be seen implementation turned out to be problematic.

A process of inspection of crucial care units, using the Intensive Care Society to undertake the work on behalf of UKM was undertaken. However, a significant obstacle to timely completion of that process was that not all private hospitals took up the offer of an inspection. A number of hospital groups were reluctant to engage in the accreditation process, arguing that it would take up their staff's time and they saw no commercial benefit in co-operating. Crucial to this was the uncertainty as to whether accredited units were going to see more patient volume at the expense of non-accredited units. In short: was UKM going to direct its members to have their treatment at accredited units? UKM was unwilling to offer a guarantee of additional volume.

The decision not to do so primarily centred on a reluctance to challenge the referral decisions of GPs and consultants, and the problems this would generate for call-centre staff of difficult 'clinical' conversations with members/doctors. This was compounded by uncertainty as to what clinical procedures should be dealt with in this way. Underpinning all of this was concern that restricting member choice would raise members' anxiety about the procedure they were to receive, and that this would undermine a core component of the company's product proposition.

The result was an inspection process that took years to undertake and indecision on the crucial issue of what was going to happen to non-accredited units. This was compounded by the decision at the outset that only those hospitals with at least 5 critical care admissions per annum were to be included in the inspection process.

This raises a key issue with regard to the entire critical care initiative. A meaningful accreditation process for critical care implied that non-accredited hospitals would be restricted in the type of cases they could treat. This in turn implied direction of members away from non-accredited facilities. Even if these principles were accepted, for an accreditation process to work properly it needed to be kept up-to-date and cover all hospitals. However as time went on it became apparent that the commitment to such a time-consuming and expensive process were lacking, and in the absence of a decision to actively exclude non-accredited units the project lost momentum. One result of this was that UKM found itself in the strange position of having a quality initiative it could not easily promote to members, as to do so raised the possibility of receiving awkward questions about the status of non-accredited units.

Three years after the commencement of the project it was agreed that UKM would not attempt to establish a directional critical care network and moving forward, that UKM would look to the Healthcare Commission to ensure that critical care facilities in private and NHS facilities were adequate. Bupa would not pursue a separate accreditation process for critical care. Instead UKM would confine itself to the following activities:

- For those units that had already been inspected, UKM would publicise the network on the basis that it had undertaken an inspection of these units and was satisfied that they met the standards set by the Intensive Care Society. It was intended that hospitals in this category would in due course be highlighted on the members' website. Should a member note that they were being referred to a hospital not on the list for a complex procedure they would be advised to check with the consultant/hospital for an assurance that adequate critical care arrangements were in place;
- Where UKM had committed to inspection visit(s), these would continue, reflecting the fact that considerable effort had already been expended getting hospital groups to agree to these visits;
- Moving forward, UKM would not continue with a separate accreditation process but instead liaise with the Healthcare Commission to determine which hospitals have met their standards for critical care. UKM could then promote these units as having appropriate critical care facilities. It was proposed that any hospital failing the Healthcare

Commission standards would not be allowed to admit patients requiring critical care level 2 or 3 and these could be dealt with on an ad-hoc basis should they come to light;

- An analysis of activity in hospitals that had not been accredited against the listing of procedures known to routinely require level 2 or 3 care would be undertaken. If any were found, letters would be sent to the hospitals in question highlighting the issue and suggesting to them that they may wish to satisfy themselves that they would meet the Healthcare Commission standards in this area. The letters and any replies would be copied to the Healthcare Commission.

Thus UKM's critical care initiative eventually petered out. This is a good example of the practical issues that surround a quality initiative for any organisation, and particularly so for a commercial company. Such initiatives may look attractive and relatively simple to undertake when first discussed but actually require sustained effort and resources - both to establish and maintain. If an organisation is not fully signed-up to all the implications of running a quality network (or does not recognise that doing so will mean real changes for staff, customers and providers) then it is likely to compromise the chances of success. In the case of critical care it would seem that UKM embarked on an enterprise that it was neither operationally, nor culturally ready to see through to its planned conclusion.

#### *Establishing a Bone Marrow/Stem Cell Transplant Network*

One reason UKM may have decided to go ahead with critical care accreditation related to the comparative ease with which it had previously established specialist centres for bone marrow/stem cell transplants (BMT's). Unlike critical care, attendance at these units was mandatory (with a specific clause in members' policy booklets stating this). However there were key differences between the two schemes which help to explain why establishing (and policing) a BMT network was relatively easy compared to other conditions. Bone marrow/stem cell transplants are expensive treatments that only a very small number of members require each year and few providers have the clinical infrastructure to provide. Patients requiring such transplants would most likely already be well aware that few centres undertook them and their GP/consultant would have referred accordingly. In summary, units effectively self selected themselves, with few hospitals able to provide this service. In such an environment establishing a network was non-controversial and easy to administer. It might be pointed out that given the factors described above, any claims that a mandatory network is

evidence of a true commitment to clinical quality has rather less meaning than might otherwise be supposed, as patients would in all probability go to these hospitals in any case.

### *Breast, Bowel and Gynaecological Cancer Networks*

At the time of writing Bupa remains the only UK insurer that has created national networks for breast, bowel, gynaecological cancers (Cancer BACUP, 2004). The establishment of accredited breast cancer units from 1998 (subsequently followed by bowel and gynaecological cancer networks in 2001 and 2005 respectively) has been UKM's most significant 'clinical quality' undertaking to date. The drive to do so was in response to the increasing evidence that patients with certain forms of cancer received higher quality diagnosis, treatment and care when they were treated by dedicated teams of consultants, nurses and other clinicians with specialist skills (NHS Executive, 1997).

UKM worked closely with professional bodies such as the Association of Breast Surgeons and The British Society of Blood and Marrow Transplantation to develop assessment questionnaires for hospitals. The assessment process was comprehensive, involving considerable work for both providers and UKM. In the case of the Breast units these were re-assessed using updated criteria in 2002. However the issue - as ever - was what would happen to the non-accredited units. At that time Bupa did not put in place any internal mechanism to direct members to accredited units and the non-accredited hospitals largely continued to admit patients for breast and bowel surgery.

UKM took a number of actions over a number of years to try and get the non-accredited units to stop treating Bupa members for the conditions in question. These included writing to non-approved hospitals requesting that they to stop treating Bupa members, mailing GPs to inform them which were approved hospitals, promoting the approved units on the Bupa website and supporting the marketing undertaken by these hospitals. None of these actions made any measurable difference.

This begs the question why UKM did not simply de-recognise the non-approved units. There were probably two reasons. The first is technical in that UKM's administrative systems at that time effectively only allowed consultants and hospitals to be either recognised for everything, or not recognised at all. Undertaking procedure/condition specific recognition was technically difficult (and expensive) to programme into the system. The other reason

related to UK Membership's previously noted aversion to establishing mandatory networks. This was motivated not only by concerns over member reaction but also by a quasi-philosophical position with regard to customer sovereignty ('If members choose to go to a non-approved unit should we stop them, isn't PMI all about greater choice?'). Added to these concerns was a desire to avoid potential conflict with major hospital groups should one or more of their hospitals be excluded.

It is particularly noteworthy that appeals to hospitals' (and surgeons') clinical governance responsibilities did not work. Non-approved surgeons and hospitals were written to, pointing out that they had either failed the recognition process - or more often - had failed to apply. Bupa requested - on clinical governance grounds - that they stop treating breast/bowel cancer cases, as UKM did not consider that they had the suitable facilities in place. The providers in question may have reflected that if UKM really thought this, they should stop agreeing to their members being treated at the hospitals in question (and paying the resultant claims) when those members contacted UKM to pre-authorise treatment. In any case the behaviours displayed were essentially as described/predicted by writers such as Rodwin (1993), Chaix-Coultier, Durand-Zaleski and Duieux (2000) and Le Grand (2003).

This was a considerable source of frustration to UKM managers who were keen to pursue the clinical quality agenda. In February 2005 a process known as 'financial re-directionality' was implemented. This entailed writing to non-approved providers stating that from a given date UKM would recoup any payment made to them for any breast or bowel cases treated. Patients requiring this surgery should instead be referred to their nearest UKM-approved Breast or Bowel Cancer Hospital (all within 20 miles of a non-approved unit). The aim was to establish a natural re-referral process of members to approved hospitals and consultants. The hospitals were also advised that UKM expected the member to be 'held harmless' (a term meaning that the member would not be pursued for any charges, instead any payment issues being conducted with the insurer). As such, under no circumstances should the member be required by the provider to directly settle any charges.

Letters went to:

- 72 non-approved hospitals still providing Bupa members with breast surgery;
- 121 surgeons providing the breast surgery at the non-approved hospitals;

- 100 non-approved hospitals still providing Bupa members with bowel cancer surgery;
- 195 surgeons providing the bowel cancer surgery at the non-approved hospitals;
- 49 Bupa Approved Breast Cancer Hospitals who had allowed a non-specialist breast surgeon to perform breast cancer surgery;
- 50 Bupa Approved Bowel Cancer Hospitals who had allowed a non-specialist bowel surgeon to perform bowel cancer surgery.

In all cases there was an appropriate Bupa-Approved Cancer Hospital within 20 miles. The letters offered each hospital the opportunity to apply/reapply for approval if appropriate. The numbers are quoted in this thesis to illustrate the scale of provider non-compliance prior to the implementation of that policy.

The threat of imposing financial penalties appeared to immediately focus management attention within the hospitals concerned on this ‘clinical governance’ issue. For example, in March 2005 (before the new policy had come into effect) the percentage of patients treated in approved units was 78% for breast and 62% for bowel. By October 2005 this had increased to 89% and 79% respectively. The reason that it was not 100% reflected the fact that the imposition of ‘financial re-directionality’ was undertaken via a phased hospital group roll out. The practical reason for this was to accommodate the work generated by non-approved hospitals deciding upon receiving the letter that they now wished to apply for accreditation.

Although the process was convoluted, it seems reasonable to conclude that a meaningful quality network has finally been created and enforced. The time and effort required to do so should be noted. In the case of gynaecological cancers the network of approved units only came into being in 2005 and a further period was to elapse before financial re-directionality was to be applied to them.

The cancer approved centres formed the centrepiece of UKM’s claim to be the market leader on healthcare quality. Such initiatives form part of the company’s marketing and sales presentations although what influence they had on decisions to either purchase or renew membership cannot be determined. During the author’s time at Bupa many within UKM were frankly sceptical that they had much effect beyond reinforcing existing notions about what sits behind the brand. They would argue that as people generally believed such quality

measures were already in place as an inherent component of private healthcare there was no commercial gain to be had from expending resources on establishing such networks. It is perhaps noteworthy then that the last of these was established some five years ago with no further cancer or condition specific networks being put in place since then.

### *Promoting an Evidence-Based Approach to Back Pain*

Running in parallel to the creation of approved cancer units was a drive by UKM to promote an evidence-based approach to the use of certain procedures in the management of back pain. The approach was set out in the UKM document 'Evidence-based approach to back pain' published in August 2002 and stated that:

'When a condition is covered the funding of effective healthcare will be evidence-based and delivered efficiently as soon as possible. Emphasis will be placed on funding diagnostic and treatment services that have been demonstrated to be effective. The funding of indeterminate diagnostic procedures and processes, and ineffective treatments, will be subjected to increased scrutiny and managed by establishing mutually agreed treatment goals, progress reviews, and limiting the duration and/or number of treatments. Bupa is concerned that the delivery of serial ineffective treatments results in prolonged delays without positive outcome for patients and that this potentially contributes to their overall suffering through demoralisation and adoption of a passive sick role.

The funding of treatments and procedures that have been demonstrated to be deleterious or harmful will cease.

Funding for experimental or unproven techniques and procedures will only occur as part of a recognised and ethically approved clinical trial as described in the Government's Research Governance Framework' (Bupa, 2002a).

This was a comprehensive document for the procedures examined, and had been subject to lengthy discussion with various professional bodies. It was 39 pages long, with 126 clinical references. Invariably when the subject of back pain is considered in the context of UK health insurance the question of whether it should be regarded as an 'acute' versus a 'chronic' condition arises. In common with other UK insurers, most UKM policies stated that they did not cover treatment for a 'chronic condition'. However what is actually considered a chronic

condition is the subject of much debate and ambiguity, both between insurers and providers, and within a company (in relation to how particular claims are adjudicated). A significant consequence of such 'cut offs' is that any attempt to produce an evidence-based approach to what treatments should be covered (and with it the natural desire to confer clinical legitimacy to those policies), run up against the natural suspicion of clinicians and patients that the prime motivation is cost reduction. This view is made all the more likely because clinically the cut-off point for funding may make little sense. This tension aside, in the case of UKM's policy every effort was made to justify the guidance by the application of clinical evidence - hence the 126 references and the extensive consultation process.

In summary, interventions were classified into three categories. Those that did not need clinical pre-authorisation by UKM's 'back pain' team; those that did, and a third category of interventions that UKM would no longer fund (see Appendix 3).

In the case of spinal fusion the documentation was particularly extensive. Defined clinical criteria and clinical pathways were set out that had to be met before a member would be eligible for funding. This set up an administrative burden on both the provider and insurer, as such criteria (if they are to have any meaning) required policing. The full text is shown in Appendix 4 (Bupa, 2002a *ibid*).

In October 2003 UKM produced a second document 'Evidence-Based Approach for Lumbar Surgery and Invasive Procedures' (Bupa, 2003c). This followed the same format and approach as the 2002 document consisting as it did of 41 pages and 135 clinical references. This serves to highlight the point that such initiatives are considerable undertakings. The funding matrix is shown in Appendix 5.

This is a much more proactive management of commissioned care than one currently finds in the NHS and represented as sophisticated an approach to evidence-based medicine as anywhere in the developed world. However, the next intervention reviewed in the document was the use of implantable/intrathecal infusion pumps. Here the document suddenly became brief, simply stating that Bupa's policy was not to fund:

‘Bupa recognises that these devices may be useful for some cases in the management of persistent (chronic) pain. However, this currently falls outside the remit of private medical insurance’ (Bupa, 2002a).

However it should be noted that UKM was at the same time funding implantable /intra-thecal infusion pumps where the patient concerned was suffering from chronic pain relating to cancer. The rationale for this was that it had an overarching commitment (and associated customer proposition) that all secondary care aspects of cancer-related treatments were covered. Unsurprisingly many clinicians (and patients) found this reasoning difficult to accept. Whilst such a policy may be commercially defensible, it undermines - perhaps fatally - the moral and intellectual authority of an insurer to challenge clinical decision making.

As well as containing proposals to make funding conditional on the safety of the procedure, the 2003 document proposed to make it dependent on the status of the surgeon and centre in which surgery was carried out:

‘Bupa is signalling an intention to explore avenues for funding spine surgery on the basis of two variables. The first involves the determination about the effectiveness and safety of specific procedures. Each procedure has been assigned to one of: “Red List”, “Yellow List”, or “Green List”. The second variable will involve assigning each surgeon to one of two categories “Bupa-Recognised”, or “working in a Bupa-Recognised Spinal Centre”. Bupa is undertaking further development work on defining these categories’ (Bupa, 2002a *ibid*).

The recognised Spinal Centres would receive automatic authorisation for ‘Yellow’ list procedures, so long as they were performed within the specific Bupa policy for that procedure. However, other Bupa-recognised surgeons would need to provide clinical information about the reasons for surgery or investigation.

Again this proposal ran into opposition from the profession. At the date of submission of this thesis spinal centres have not been established and no specialist network has been created. Moreover no further work was been undertaken following the October 2003 publication to take forward implementation of the spinal centres. Bupa has established a ‘back pain’ team of nurses operating out of one its service centres to deal with queries from providers and

members about its policies and once again it should be noted that designing and then operating such a policy carries a significant overhead. The degree to which Bupa succeeded in policing the level of interventions with a low evidence base is not known, but its ability to do so was undoubtedly somewhat constrained by the challenges some providers and indeed members made to Bupa's right to set such policies at all, as explored in the next section.

## **Challenges to Policy**

UKM has experienced problems with certain clinicians and members challenging the right of the insurer to deny funding for 'experimental' procedures. Essentially there are two points of interest here with regard to the wider quality agenda. The first is that certain clinicians challenged UKM's policy not to fund a particular procedure on the basis that can be summarised as 'the published evidence may not support this intervention but I believe it can be effective'. Moreover these clinicians usually supported their arguments by stating that they were currently performing the procedure in the NHS.

A second development was that that some members were challenging UKM's funding decisions. These complaints were normally related to a refusal to fund either an intervention deemed 'experimental', outside of the terms of the policy, or related to overseas treatment. Ultimately such complaints (if not resolved) are considered by the Financial Ombudsman Service (FOS). Crucially the FOS is increasingly finding in favour of the complainant. The Ombudsman's view appears to be that UKM is essentially an indemnity insurer. As such, UKM (and other insurers) are seen as having no real part to play in determining or assuring healthcare standards for their customers. The philosophy underlying the FOS' position is that the consumer should be sovereign at all times. If the consumer decides to use providers that their insurer considers sub-standard or to undergo a procedure that is categorised as 'experimental' or even unsafe, then providing they have been informed of the insurer's concerns it is for the customer to decide what to do. The insurer should pay for the procedure equivalent to what they would have paid to an approved provider for a 'traditional' procedure. By doing so FOS argues the insurer is not 'out of pocket', as it would have paid the member to have an approved procedure from an approved provider. The Ombudsmen does not appear to have a problem with insurers stating to the member that should they pursue such a course they will not be covered for any subsequent complications.

The same logic applies to overseas treatments. Insurers may have specific clauses within their rules stating that members are not covered for overseas treatments (the reason given was normally that the insurer could not quality assure overseas providers). However the Ombudsman increasingly takes the view that such exclusions are contrary to the spirit of the insurance agreement.

These judgements are creating *de facto* precedents and FOS is putting pressure on insurers not to contest cases of this type, given that the Ombudsman's position is already known. In effect, if a complaint is received from a member who has been denied an experimental treatment, or the option of going abroad for treatment, then the insurer is under pressure to pay up to the level that would have been payable if the claim had been undertaken in the UK, or for a traditional procedure. When it comes to procedures proscribed in UKM's back pain documents, the FOS seems to take the view that if consultants believe the procedure is going to help the member then it is not for FOS (or the insurer) to challenge them. Clearly the insurer's position is not helped when consultants say that they undertake the procedure in question within the NHS.

The Ombudsman's stance presents all insurers – but particularly UKM - with two significant problems. Firstly, it undermines control of costs in that restricted clinical networks (including quality-based networks) may be overridden by members determined to go to an alternative provider. Although such members would only be reimbursed at the network cost rate, if enough of them were to do this, that would undermine one of the main advantages of such networks - discounts based on expected volumes (as discussed in Chapter 3). To date this has not been a major threat as few members insist on going 'out of network' and fewer still pursue their cases as far as the Ombudsman.

The second threat is both more relevant and serious - particularly for an insurer marketing its product on 'clinical quality' grounds. If FOS regards all UK health insurance as being essentially of an indemnity nature then the ability of insurers to differentiate their product via the promotion of clinical quality is compromised. A perennial debate within UKM was whether the organisation was a health care company first or an insurer? As far as FOS is concerned there is no debate. UKM is an insurer.

## Conclusion

What conclusions can be drawn from this examination of UKM's approach to quality in general and in particular their actions over the last decade? Certainly several initiatives have had a measure of success from the perspective of the insurer, and may have brought some quality improvements. If reality did not always quite match the rhetoric, Bupa did indeed appear to be the market leader in relation to promotion of health care quality issues. However the baseline for quality improvement was generally low.

Whether the UK private sector is able to move healthcare quality onto the next stage, envisaged by the likes of the IOM, or to deliver six-sigma quality is questionable. Currently the private sector in the UK seems largely ready to follow public expectations of health care quality rather than try to change them. The author would speculate that this inertia has its root cause in a combination of a lack of a 'burning platform' in terms of business performance, combined with a degree of complacency as to the true quality gap. By the former is meant that the traditional business model, emphasising 'traditional' notions of quality continues to dominate thinking and until the latest economic downturn this was undeniably a successful business strategy. In the case of UKM the potential 'burning platform' was stiffer competition from an improving NHS or from other insurers. But the general view among senior managers was that this competition was not strong enough to require Bupa to demonstrate a clearer quality advantage to justify its premium pricing and the 'brand'.

Building reputation via quality improvement would have benefits for the insurer but was vulnerable to a countervailing pressure to increase profitability. The Bupa Group has multi-national interests and ambitions to further increase its overseas presence. To do this it has utilised domestic 'profits' to assist in financing the expansion of overseas operations. Over the last two decades UKM generated significant profits without making large capital investments in UK hospitals or care homes.

Faced with a choice between making potentially destabilising changes that might translate into long term profits at the cost of short-term problems, versus leaving things essentially unchanged, Bupa's senior management tended towards the latter (whatever their public statements to the contrary). In the absence of an immediate threat to market share or profits, radical change would depend on significant risk taking by managers who appeared generally risk adverse.

Much of this inertia can be explained by the sustained opposition that insurers - and particularly Bupa - faced from providers and professionals when efforts were made to promote quality programmes or develop quality standards. This chapter has provided several empirical case studies that support this observation. That opposition, coupled with the transactional costs associated with formal quality assurance processes, led to the abandonment of several quality initiatives.

All of the above essentially replicates the pattern of past responses of providers and insurers described in the literature, and provides further empirical reinforcement to various predictions as to how healthcare operates with regards to quality initiatives. Firstly it has been difficult to make 'the business case for quality' in the UK private market in a similar way to that described previously by Coye (2001) Casalino (2001) Marshall (2003) and Sehgal (2010) in the USA.

The provider –and especially physician–resistance described in this chapter to third party 'interference' with clinical autonomy, referral patterns and reimbursement conditions has effectively mirrored that documented over many years by writers like Kessel (1958), Freidson, 1970a; 1970b; Abbott, 1988; Mechanic, 1991 and Light (2000, 2004). This chapter thus proves a further illustration of the continuing tension between professional autonomy and managerial control previously documented by the above authors as well as Freddi and Bjorkman, (1988) Scrivens, (1988) Wolinsky (1993) Harrison and Pollitt, (1994) and Ferlie(1997).

Bupa's quality initiatives can also be conceptualised in part as an attempt to undermine professional autonomy and self regulation, a theme previously explored by Harrison and Ahmad (2000) and Davies and Harrison (2003). As such, this chapter has provided a further opportunity to examine the interplay of purchaser and professional power, specifically in the

private sector context. Part of this has centred on perceived or actual threats to the 'knowledge mandate' (Halliday, 1987) enjoyed by doctors. A particular case in point being the reaction of the orthopaedic community to Bupa's hip and knee proposals.

## **Chapter 8 - Conclusion**

This thesis set out to accomplish a number of objectives.

1. To establish how the UK private healthcare market has operated to date and provide a detailed review of the current dynamics of UK private healthcare;
2. To catalogue and then assess how Bupa as the largest UK insurer has tried to make changes within that market;
3. To assess to what degree market levers and incentives are being utilised by Bupa (and other insurers) to make desired changes to the current *status quo*, that is to say, to reduce prices and raise quality;

This has primarily been an empirical study drawing on the experience of Bupa as the largest private medical insurer. The company had attempted to undertake a number of initiatives utilising new incentives and purchasing levers, in what analysts generally consider to be the market environment of the UK PMI sector. There has thus been an opportunity to test a number of hypotheses concerning the functioning of markets in healthcare by drawing upon the recent experience of Bupa.

### **The Nature of Market Failure in Healthcare**

The introductory chapter set the context against which the events described in subsequent chapters were to be understood. It was noted that the academic literature on UK private healthcare was quite sparse. The thesis reviewed the findings of authors such as Foubister et al (2005) with regard to the dynamics of the UK private market, and Higgins (1988), Propper and Maynard (1989) and Propper, Rees and Green (1999) on the determinants of PMI demand. Previous academic studies have not explored the strategy of any individual company operating within UK PMI; a topic examined in this thesis.

Chapter 1 also noted the tendency toward market failure in healthcare noted by many authors (Fuchs, 1988 ;Baumol, 1995; Herzlinger, 1997; Smith, 2000; Gaynor, Haas-Wilson and Vogt, 2000; Nichols et al, 2004; Maynard, 2005; Berenson, 2005; Porter and Teisberg 2006; Wigger and Anlauf, 2007). This thesis provides further evidence that particular features of healthcare that undermine efficient market functioning noted by the likes of Kessel (1958) and Arrow (1968) remain relevant today.

However, market failure is not generally an absolute, 'all or nothing' phenomenon. What has been described in the thesis is not a complete breakdown of market forces, but rather sub-optimal functioning and little indication that the market operates as a self-improving system. Other industries provide numerous examples that competition can work effectively to deliver high quality and low price products that fully meet customer expectations. Significantly however, the market environments in which they operate are not characterised by the combination of features encountered in healthcare and which the UK PMI market exemplifies. The traditional UK private health sector exhibits all the features that contribute to market failure such as the lack of visibility of price signals to individuals engendered by insurance and third party payment, moral hazard, information asymmetry and psychological dependence.

The partial control of the supply of healthcare by a strong and largely self-regulating professional group is a particularly important factor not present in most other production industries. Here the issues are not just information asymmetry arising from the medical profession's 'knowledge mandate' (Halliday, 1987), or 'knavish' behaviour by individual practitioners (LeGrand, 2003), but the organised, institutionalised power of the profession (Freidson, 1970a; 1970b; Abbott, 1988). Although Bupa's various attempts to use market levers to change provider behaviour did generate negative reactions from individual doctors, the opposition of the consultant representative bodies such as FIPO, the BMA, the Royal Colleges and other professional associations was a crucial factor in blocking or attenuating proposed changes. The events reported in the thesis suggest that professional bodies were often able to build alliances with hospital chains in opposition to purchaser initiatives. Although such alliances were not always present, and anyway could sometimes be undermined as purchasers offered their own carrots to hospital groups, medical professionals still appeared to exercise considerable cultural authority (Starr, 1982) which made it difficult

for the hospital providers to oppose consultant opinion. Overall, as will be discussed below, the degree of countervailing power exercised by UK insurers was quite limited.

To this must be added the particular nature of how private healthcare in the UK has been historically funded and delivered, and who actually purchases clinical services. Chapter 2 noted that private healthcare has operated for over 60 years in the long shadow cast by the free NHS. The UK offers no tax incentives to purchase private medical insurance and UK insurance premiums have historically risen above the general rate of inflation, in addition to increasing with age. Problems of affordability of private healthcare in general and PMI in particular has been highlighted by several commentators (Higgins, 1988; Besley, Hall and Preston, 1999; Foubister et al, 2005; Farrington-Douglas and Coelho, 2008). These studies of demand for PMI show that subscribers continue to be concentrated among individuals of higher income, higher occupational status and predominantly of middle age.

As noted in Chapters 5 and 7, this has led the industry to place strong emphasis on patient choice, and encouraged providers to mount a fierce defence of their clinical freedom to engage in private practice. Chapter 3 demonstrated that the major hospital groups for their part have a symbiotic relationship with professionals and insurers that made them equally resistant to delivering significant price reductions.

Foubister and colleagues had previously noted that the PMI market in the UK appears to

‘...behave as predicted by economic theory, namely, in a form that approximates monopolistic competition, with insurers competing through product differentiation (and proliferation) rather than simply on the basis of quality and price’ (2005, p.79).

This thesis shows that the position remained substantially unchanged even after some five years of effort by the largest insurer – Bupa - to change provider behaviour so as to influence price and quality, and open the way for such competition.

Interestingly, there appear to be parallels between the operation of the UK private health care market and what took place in US health care about a decade previously. In many respects Bupa UKM’s experience of trying to push through various reform initiatives mirrored that of the US managed care pioneers mentioned in Chapter 2 and discussed more fully in Chapter 7. Just as payer initiatives were adjudged to have largely failed in the USA, so the fate of

Bupa's initiatives now looks decidedly precarious – although no American company has the dominant position and national presence that Bupa enjoys in the UK.

## **Purchaser Scale and Power**

As noted above, Bupa's size did not generally translate into power to force either consultants or hospital groups to accept its view of required changes in the market. There were exceptions and the establishment of the MRI and physiotherapy networks, and accreditation of the breast, bowel and gynaecological cancer units were notable successes. However, several other high-profile initiatives failed, and more importantly the essential price dynamic of UK private healthcare remains substantially unchanged. Despite the then Bupa UK Insurance Managing Director stating six years ago that the status quo was not an option and there was a pressing need to “ruthlessly drive for clinical quality and value for money” (Kee, 2005), this has not yet happened. Indeed in the area of clinical quality the last major initiative by Bupa (the establishment of the gynaecological cancer network) was completed five years ago.

Whilst there has not been a fundamental shift in the price/quality dynamic of private healthcare, AXA PPP appears to have had more success with its reimbursement reductions aimed at consultants despite having a smaller market share than Bupa. The reasons for this were discussed in Chapter 5 and might be summarised as the presence of a virtuous combination of a greater internal resilience to confrontation with providers, coupled with AXA PPP's initiatives being regarded as somewhat less threatening to the provider community because it was not considered the PMI 'brand carrier' that Bupa is commonly regarded as being.

## **Purchasers' Ability to Influence Price**

The cost of health insurance is determined by four factors: provider charges, claims incidence, the costs of operating the business and the desired profit margin. Claims represent the largest component of an insurer's costs (Foubister et al, 2005), and attempts to reduce them take a variety of forms, including initial underwriting, moratorium periods and various types of utilisation review. The degree to which particular insurers employ such measures

varies, among other things depending on their willingness to be associated with measures like utilisation review that are commonly associated with 'managed care'. In both the USA and UK the factors that influence price play out in what can be characterised as market environments, but environments that involve only imperfect competition. This thesis has described attempts by payers to reduce provider charges and the provider responses encountered. For example, Chapter 4 noted that one common tactic used by providers was to respond to price controls on reimbursement rates by increasing incidence. Evidence was presented from both sides of the Atlantic to show that this has indeed occurred in the past.

Notwithstanding this, the efforts to use of market mechanisms to reduce provider prices in UK private healthcare traced in this thesis have usually failed to achieve their desired aim. It is true that some individual initiatives have been successful. MRI is the clearest example, with some other significant gains for the insurer vis-à-vis price reductions for a few procedures such as cataract surgery. However these have not been enough in themselves to affect the sharp rate of increase of premiums in private healthcare. Bramley-Hawker and Aslam's (2003) study, reported in Chapter 4, demonstrated that the UK has high provider costs for private healthcare compared to most other developed countries, and there is no indication that this has changed. Crucially Laing and Buisson have not reported any deflation in premium rates.

The mechanisms utilised to try to exert downward pressure on prices fall into two main categories. One has relied on the creation of preferred provider networks, latterly through formal tender processes. For Bupa, the MRI, physiotherapy, ophthalmology, and hip and knee schemes all fall under this category, as does the original creation of hospital networks. Results, as reported in Chapters 3, 4, 5 and 7, have been decidedly mixed, although all have required substantial resources and time-intensive effort from dedicated teams. All have involved a large degree of sustained engagement with providers, which typically led to confrontation. In short the transaction costs have been significant. Perhaps because of this, Bupa's enthusiasm for such initiatives appears to have declined, although this is not to say it has been wholly abandoned the quest for better price and quality. Bupa had originally intended to follow up the establishment of the ophthalmology network with a series of speciality tenders – orthopaedics was planned to be next - but in the event has not undertaken any further network initiatives after the establishment of the physiotherapy network.

The second approach to the reduction of provider prices has been for insurers to require consultants to use an adjusted fee schedule (chapter 4). AXA PPP made recognition of consultants to deliver services to its patients conditional on use of a new fee schedule (FIPO 2010a), a lead subsequently followed by Bupa (FIPO, 2010b). There are two features that should be noted with regard to these developments. The first is that they incur far lower implementation costs for an insurer than attempts to create preferred provider networks via formal tendering exercises. As a mechanism for change, making access to patients dependent on acceptance of the insurer's fee schedule seems to offer a better cost/benefit ratio. The second feature is that this approach tends to push the cost of non-compliance by a provider on to the insured patient seeking treatment. By establishing a *de facto* provider network based on provider acceptance of the reduced fees the choice available to patients will most likely be reduced. Moreover, where the network allows a doctor or hospital to retain insurer recognition but only receive reimbursement at the lower level, patients choosing that doctor or hospital will be required to pay the resultant 'shortfall'. Thus insurer initiatives of this kind may have the consequence of restricting patient choice of provider and leaving patients with extra bills. In both cases, risk is being transferred by the insurer to the person insured. This is a market mechanism in itself as theoretically it gives the insured patient a direct incentive to choose a provider who will accept the insurer's fee schedule.

This may well prove the most effective mechanism to pressurise consultants to accept lower fees. Left to their own devices there is little reason to suppose that consultant fees would fall for reasons set out as long ago as Kessel (1958) Arrow (1968) and Miller (1992).

Paradoxically, although the opposition of consultants to any reductions in their fee schedule has been accompanied by a considerable amount of public complaint (see FIPO web site as an example) it may well be that the major hospital groups will ultimately prove the more difficult to obtain price deflation from. Some years ago the Monopolies and Mergers Commission (1994) commented upon the favourable effects of Bupa's benefit maxima on prices and expressed the view that prices would be even higher without the countervailing power of insurers. However, as Chapter 3 demonstrated, the major hospital groups have now established a series of network agreements with insurers that often reinforce geographical quasi-monopolies and their financing structure, and have proved unreceptive to calls for price reductions.

Chapter 6 discussed the ability of the US private sector and the public NHS to drive forward quality improvements, whilst chapter 7 examined Bupa's quality initiatives. A conclusion that can be drawn from both the US and UK private sector experience is payers and providers offer consumers the type of health care that matches the conceptions of quality members understand – typically linked to attractive rooms, hygiene, convenience, accessibility and patient sovereignty rather than clinical outcomes.

## Bupa's Ability to Drive Quality Improvements

Bupa have undertaken a number of quality-based initiatives which were reviewed in detail in chapter 7. They provide evidence of the limits of purchaser leverage to change provider behaviour, and in some cases also the limitations of particular approaches to network creation. Table 8 below summarises the outcomes of the main initiatives discussed.

**Table 8. Outcomes of Major Bupa Quality Initiatives**

Initiative	Outcome	Evidence of Purchaser leverage?
MRI network	Network established. HCA forced to accept that not all group hospitals automatically included, 20% reduction in MRI prices achieved.	Yes
Ophthalmology network	Not the planned national network but <i>ad hoc</i> partial network in some areas. Patients still treated in non-approved units	Partial
Physiotherapy network	Network established, though initially about half planned size.	Yes
Hip and knee arthroplasty (best practice)	Proposals dropped. Both private insurer and government initiative have failed to bring real progress on minimum numbers.	No
CCU accreditation	Initiative discontinued. Bupa phased out own inspections and relied on those of HCC.	No
Bone Marrow Transplants Network	Network established, but easy because small number of centres and treatments.	Partial
Accredited units for breast, bowel, and gynaecology cancer services	Network established. Initial campaign of persuading rather than requiring non-accredited units not to perform surgery largely failed. Threat of non payment to non-accredited units was successful.	Yes
Management of back pain (best practice)	Funding made more dependent on meeting clinical criteria, with some 'red list' procedures no longer funded, but idea of accredited spinal centres dropped.	Partial

There were notable successes in the area of the MRI network, and also the physiotherapy network and accredited cancer units. However, a critic might argue that Bupa had still not managed to force through a major quality initiative in a mainstream acute speciality that would impinge significantly on the interests/incomes of powerful medical consultants. The MRI success related to an area of medical technology especially suitable for tendering. The physiotherapy network affected a para-profession rather than the medical profession itself. Arguably the cancer services initiative impacted most directly on the medical profession. Significant gains were made, but the initial strategy of persuasion and appeals to clinical governance was ineffective and, only when a direct threat to reimbursement to the provider was utilised was there movement from non-accredited hospitals and consultants. This initiative consumed substantial resources, and Bupa has not repeated anything similar in a major acute specialty since the gynaecological cancer network.

Regardless of the fate of particular schemes, Bupa remains the insurer most closely associated with the promotion of clinical quality in private healthcare. Other insurers and the provider community appear prepared to rely on more traditional notions of healthcare quality in private care associated with access, aesthetics and patient choice.

The perceived quality differential between private hospitals and the NHS has long been one of the main selling points for PMI. Whether the prominence given to NHS quality in the Darzi Report' (Lord Darzi of Denham, 2008) will change the situation by closing the quality gap with the private sector is an open question. The quality agenda now has a more significant place in NHS thinking and reporting than previously, and it is certainly the case that the public sector now reports on a wider range of quality indicators than the private sector. However, one may suspect that 'quality scandals' such as Mid Staffordshire (Health Care Commission, 2009) and Tunbridge Wells (Health Care Commission, 2007) leave a deeper impression in the public mind than any number of routinely reported NHS quality measures.

So far the private sector has avoided adverse events and bad publicity on anything like that scale, and without such disasters its present public image of 'higher quality' is likely to remain. As was seen in chapters 6 and 7, the belief that private healthcare provides higher-quality care in the UK is not supported in any comparative studies on outcomes or even waiting times (as no research exists). The available evidence of satisfaction with private

health care comes from high approval ratings in patient surveys on questions such as the quality of the food, décor, etcetera, and whether the consultant, nursing and other staff were friendly and attentive to the patient's needs. These are quality criteria of a kind and are important, but the absence of clinical outcomes data makes an objective comparison between the two sectors difficult.

As noted in Chapter 6, the NHS is currently doing more to promote outcome reporting (through PROMS) than the UK private sector, and is starting to enforce minimum volumes for a number of surgical procedures in cancer and vascular surgery (although not yet for hip and knee replacements). Bupa initially led the way with its cancer networks for breast bowel and gynaecological cancers but dropped its proposals for minimum volumes in hip and knee surgery and has yet to reinstate them. The other insurers have made no attempt to follow Bupa's lead in this area.

## **Opposition of Healthcare Providers to Reform**

An often-reported characteristic of incumbent health care providers and especially physicians – whether in the public or private sectors, and regardless of geography – is their suspicion of, and general opposition to almost any changes to the *status quo*. This thesis has provided substantial further evidence to support this general observation.

The struggle between the state and the medical profession for control of the health service had previously been well documented (Harrison and Pollitt, 1994; Freddi and Bjorkman, 1988; Scrivens, 1988; Wolinsky, 1993; Ferlie, 1997). Many of the reforms introduced by governments have commonly been conceptualised as undermining professional autonomy and self regulation. This thesis provided an opportunity to view the same dynamic unfolding in the UK private sector. Chapter 1 noted that the ability of the medical profession to exert collective resistance to attempted reform rests partly on its monopolistic control over supply (Kessel, 1958, Freidson, 1970a; Miller, 1992; Herrick and Goodman, 2007), but also on the profession's demonstration of a 'knowledge mandate' (Halliday, 1987) and its cultural authority (Starr, 1982). From the evidence of this study, these points apply equally whether the body attempting the reform is government, NHS managers or private insurer.

This thesis provides further evidence of the strength of professional resistance. In that respect it is worth considering that Bupa's nervousness as to the clinicians' reactions to their various initiatives had two foundations. One was the negative impact of *de facto* clinical embargoes which – if realised – would create problems for Bupa's customers in accessing services. The second was the negative impact on Bupa customers' perceptions on the company of a public dispute with doctors.

Insurers seeking to change market conditions must have a strategy not only to nullify provider attempts to determine prices but also to tackle professional resistance to challenges to their knowledge mandate. As noted earlier, the locus of such resistance is not just individual consultants, but the representative professional organisations. When the author was at Bupa the approach with regard to the latter issue was rooted in an attempt to engage professional representatives in a rational discourse on the merits of Bupa's initiatives – such as minimum volumes for hip and knee surgery by citing supporting clinical studies. Subsequent events, as described in this thesis have shown that this strategy did not work.

There are a number of reasons why professional bodies such as the BOA and organisations such as the BMA and FIPO were unlikely to abandon their opposition to Bupa's proposals. Aside from economic self-interest they were also aware that a number of those initiatives were direct assaults of the medical profession's knowledge mandate – a key source of doctor's considerable influence and economic bargaining power – and to be protected accordingly.

Much of both public and private health care 'reform' can be understood as attempts to increase control and bring doctors under a common framework of accountability, and are typically considered important to the ongoing project of reducing (or at least controlling) costs. Direct assaults on both the 'knowledge mandate' and the centrality of doctor/patient trust have proved problematic which is one reason why attempts have been made to dilute their importance through increasing the supply of potential providers (ISTC's being the clearest example of this). Bupa were late converts to this approach appearing to have concerns about the possible degradation of key elements of the Bupa 'brand'. Although the creation of networks appears to have the opposite outcome – in that the number of providers typically reduces – the viability of networks actually depends on a starting position of over-

supply of the service in question. Encouraging new entrants into the market makes the establishment of networks offering lower prices more feasible.

As has been repeatedly demonstrated in the chapters charting Bupa's attempts to implement quality and contracting initiatives, the extent of provider opposition has sorely tested the resolve and power of the leading UK insurer to engineer significant change in the market. The jury remains very much out on whether Bupa has either the determination or the means to see through its initiatives in these areas. If Bupa cannot do so, it is unlikely that a smaller insurer will attempt anything similar in terms of national networks. From the author's experience, the prevailing view of managers in many of the key organisations is that such efforts will not bring sufficient reward in terms of market share and/or increased profitability to justify the risk of being the first mover.

The first mover problem has been a major issue for Bupa. The gains from reform appear long term and uncertain, whilst the costs are highly visible and much more immediate. Moreover it is far from clear that the UK private 'market' either requires or will reward such behaviour. It was noted in the thesis that in addition to its market share Bupa had a corporate structure that potentially made it better placed to see through long-term policies. As noted in Chapter 2, Bupa has no shareholders but is overseen by the board and 100 'members' who have no direct economic interest in the company. Surpluses are reinvested in the business. This allows Bupa considerably more latitude in planning a long-term business strategy than would normally be found in publicly quoted companies. In short, it would be expected that senior executives can more readily take the 'long view' and see this through.

However, as discussed in Chapters 2 and 3, there are good reasons to believe that the strategic interests of Bupa Group's Board lie as much in developing Bupa's international interests as in 'reforming' the domestic private health care market. The share of total revenues and profits attributable to international operations has seen rapid growth over the last decade such that the UK component now represents less than 50% of overall profits. The decision in April 2007 by Bupa to put all its UK hospitals up for sale was evidence that the company believed its long-term future was best served by reducing its dependence on the UK private health market. Although UK hospitals accounted for 11% of Bupa's revenues and around 12% of profits, hospitals are capital-intensive operations to maintain. We have seen that the hospital sector has been facing a period of uncertainty and change, largely as a result of government

reforms to the NHS. Selling Bupa hospitals raised considerable monies that could either be invested abroad, or in a further significant expansion of the UK care home sector. Some commentators believe that Bupa's long-term goal may be to become a medical research charity along the lines of the Wellcome Trust (Waples and O'Connell, 2007).

This author believes that the former options are more likely than the latter, and that ultimately an attempt to turn Bupa into a publicly-listed company remains a distinct possibility. In such an environment, the role of UK Membership will most likely be to continue to serve as a brand 'standard bearer' and generate profits for the Group. Such a strategy would make any radical action that threatens to undermine either objective unlikely. Certainly Bupa cannot be accused of rushing implementation of any of the controversial policies described. Indeed, the thesis has underlined how slow and piecemeal reform of the UK private health care sector has been to date. To cite but one example – the ophthalmology network – a gestation period of the best part of ten years is considerably in excess of the entire product cycle of some industries.

Investment of time and resources on that scale throws up obvious questions about whether the benefit justifies the cost. The ophthalmology initiative has to date produced only a part network for cataracts, so that some Bupa members continue to use providers charging above network reimbursement rates. From the standpoint of Bupa managers, the important question with regard to this is not so much the time it took to get to this point, or that it consists only of one part of one specialty, but whether the network will have a positive domino effect on other specialties, in terms of their pricing and quality. If the network changes provider behaviour and makes subsequent specialty networks/initiatives quicker and cheaper to implement, managers would judge that the investment had been justified.

This looks an unlikely outcome. The more general view within the industry is likely to be that the initiative has been costly, its impact limited and that new network initiatives will be undermined by professional resistance. Crucially many see the existing 'business model' as being viable for the foreseeable future. To managers of this more conventional mindset, Bupa initiatives are not just an irritant, but illogical and unnecessary disruptions to a UK PMI market that continues to generate good profits.

## Limitations of the Study

The main limitations of the study arise from the scope of the evidence assembled, and certain restrictions on the presentation of data arising from the history of the project, the author's position and problems of research ethics and commercial confidentiality. It is also worth mentioning the timing of completion of the thesis and the uncertainties that arise because the implications of important NHS reforms now underway are not yet clear.

Although some wider contextual data was presented, the main empirical contribution of the thesis relates to developments initiated by Bupa, and specifically UKM. Bupa is the largest UK private insurer with a dominant position in the PMI market, but it clearly does not constitute the entire UK PMI industry. Additionally, the author was a participant in many of the events described and, although attempts have been made to minimise bias, readers should bear in mind that he was very much in the insurer camp in transactions with hospital providers and consultants. Arguably the present study leans more towards the purchaser, as opposed to the provider view.

There is therefore obvious scope for further studies that flesh out the account of the UK private sector market. Future research could describe in more detail the different approaches, relationships and interactions between the major insurers, as well as the hospital groups, and their strategies and positions in the UK private market. For the reasons given in Chapter 1 when discussing methodology, such studies would face considerable challenges in terms of access and co-operation, and the author doubts that this gap will be filled quickly.

The problem of setting limits on the data presented is a difficult one for the author, and more than a merely academic issue in terms of possible risks to personal relationships, to the organisation studied, and ultimately to the author - in the event that the information disclosed could be shown to have damaging consequences for Bupa. Undoubtedly, a more conventional ethnographic study would provide more vivid and colourful insights into the internal workings of the insurer, as well as the inside story on some of the events reported. As mentioned in Chapter 1, there were issues of ethics, personal trust and commercial confidentiality that ruled out that option. Unfortunately the risks would have been too great.

Although presenting a more limited picture of events, the account offered in the thesis nevertheless describes the main factors influencing major Bupa initiatives and gives a good sense of the dynamics of the PMI market. It provides an imperfect, but still useful, view into a black box that otherwise would remain un-researched.

As the thesis was being completed, a further major round of NHS reform awaits implementation, which in the view of some commentators will mark the most fundamental change in the NHS since 1948. The changes in NHS commissioning arrangements foreshadowed, as well as continued support for provider pluralism and a greater focus on quality, suggest that the NHS reforms will have consequences for the UK PMI market, but it is still too early to say exactly what these will be. The conclusions of the present study may therefore need some updating as the mist lifts from the new landscape of British healthcare.

## **Forces for Change**

As noted throughout this thesis the UK private sector has a strong operating presumption in favour of maintaining the *status quo*, both in terms of a stable customer proposition and with regard to provider opposition to any downward pressure on reimbursement rates or the terms with which it does business. The consultant organisations in particular are also opposed to any increased role for insurers in terms of accreditation, quality assurance or utilisation review. Perhaps correctly, they see it as the attempted imposition of elements of the managed care approach developed in the United States. Foubister and colleagues (2005) noted that Bupa's proposals on hip and knee surgery attempted to combine two core elements of that approach – the preferred provider concept and utilisation review - and that this helps explain the negative response from the profession. This thesis provides substantial further evidence in support of that assessment.

One of the characteristics of the private sector has been the durability of its central business model – both for insurers and providers. The sector has largely continued operating as it always has done throughout over two decades of major NHS reforms. One of the most interesting questions at the present time is whether recent developments in the NHS may begin to change the private health care sector, and whether quasi-market incentives and levers

utilised in the NHS may force through some of the changes in behaviour that the Bupa initiatives set out to achieve.

In terms of the general impact of NHS reform on the private sector, both hospital groups and insurers have adapted. Although the UK private sector's ability to take advantage of provider opportunities under NHS Choices, or to step forward as expert purchasers supporting NHS commissioners, has been hampered by the niche-market history of the British PMI sector, some organisations are beginning to re-position themselves to take advantage of such opportunities. BMI's creation of a separate division for NHS patients, Nuffield's T1 to T3 pricing model, Ramsey Healthcare's expansion of NHS work to provide 30 percent of its income (Davies, 2010), and Bupa's attempt to capture some of the treatment centre market are significant examples. This is happening at a time when the volume of corporate health insurance business is threatened by economic recession, and when some corporate buyers are seeking to cut costs via competitive procurement exercises (Davies, 2010).

However, for the substantial bulk of PMI business, the essential dynamics and drivers remain unchanged. BMI, the largest hospital group, still derives ninety per cent of its income from private sector sources (Davies, 2010). This means that what worked in the 1980s is still working in the first decade of the 21<sup>st</sup> century. Private health care in the UK remains a luxury product with a market characteristic defined by the way private health care is viewed by its recipients. A recent editorial in *Health Market News* captured that essence when it stated that:

‘.....if private health care was food, Harrods food halls would be popping up in every town in the country’ (Davies, 2009).

With regard to the impact of NHS reform on the regulatory environment and the framework of standards in which private healthcare must operate, some significant changes may be underway. As was described in Chapter 7, several recent innovations in US private healthcare have come about as a result of the requirements of the accreditation agencies or CMS, so that it is the regulatory bodies rather than the market that is driving change. In the UK context, the role of CQC after the next round of NHS reform (post-2010 White Paper) and the further development of the Darzi quality agenda via development of quality reporting and contractual quality incentives within the NHS may be expected to have a knock-on effect for the private sector.

Overall, the experience of use of market forces in private health care offers mixed lessons for policy makers. The evidence from both the USA and the UK is that market forces will actively promote and deliver certain quality measures that are valued by customers, but that these are not generally related to clinical outcomes. Purchaser attempts to use buying power to change provider behaviour have very often failed. Against this, the successful initiatives that have been undertaken suggest that - when purchasers provide clear signals and incentives, and engage effectively with obstacles such as professional opposition - changes in provider behaviour can be secured. What the UK PMI market as a whole is unlikely to do is to lead the quality agenda beyond traditional quality concerns. The existing market dynamic is not set to develop sophisticated quality criteria and innovative 'products' that exploit them, in the way, say that the market for computing software does. Rather it has displayed a marked tendency towards an equilibrium whereby those wishing to pursue additional quality criteria either have to move beyond the conventional wisdom of the market place (as arguably Bupa tried to do with orthopaedic minimum volumes) or sit outside the market – as government does.

One particular focus of interest for policy makers is likely to be whether the UK private sector can provide commissioning expertise for GP consortia in the post-White Paper reform NHS. The reforms look set to open the way for consortia to buy in commissioning support, perhaps by subcontracting specific tasks such as procurement, contracting, or strategic planning to external agencies (BMA, 2010). Some commercial companies such as Assura Medical (2010) are already marketing support services in this area. It may be that private companies will quite rapidly develop expertise in this field, but based on the evidence presented in this thesis the main established purchasers in the UK PMI market are starting from a low base – arising from the special nature of that niche market. Policy makers should therefore be cautious about assuming the competence of private sector players in this field, and may find that a reconfiguration of existing NHS expertise carries fewer risks.

This thesis has sought to explain the way the UK private sector operates and, in doing so, to explain how this particular health care market operates. Though the current environment is characterised by monopolistic competition, with a large degree of shared provider control over price, a market of a kind operates in private health care in the UK. Indeed it is a lightly-regulated market by both European and US standards. Nevertheless it is largely an

indifferent performer in terms of the value and quality provided. From the evidence presented in this thesis, that is unlikely to change in the near future.

# Appendix 1

## FRAMEWORK FOR PROCURING EXTERNAL SUPPORT FOR COMMISSIONERS (FESC)

FESC is a means that NHS organisations (effectively PCT's and SHA's) can use to bring in support for their commissioning activities, using independent organisations with pre-assessed skills in different aspects of the commissioning cycle.

FESC is one tool that the NHS can use to help address gaps in their commissioning capability or capacity and is the result of Department of Health concern as to the current ability of NHS organisations to deliver 'World Class Commissioning'.

The FESC frame work itself attempts to bring two key benefits to the NHS:

- i. FESC removes the need for PCT's to undertake a lengthy and costly public procurement;
- ii. FESC offers a package of components that not only ensures that governance requirements are met but also provides greater assurance of value for money.

The suppliers currently on the FESC framework are:

Aetna UK;

AXA PPP Healthcare;

BupaHealth Dialog (Note: Bupa purchased the US firm HealthDialog in December 2007 for £310million);

CHKS;

Dr Foster Intelligence;

Humana Europe UK;

KPMG LLP;

McKesson;

McKinsey and Co. Inc.;

Navigant;

Tribal Health Commissioning;

United Health (Europe) Ltd.;

WG Consulting

## Appendix 2

### Association of Independent Radiologists 2005 Survey

	Yes	No	Don't Know
Do you think it appropriate that an insurance company should be involved in clinical issues?	8%	86%	6%
Do you think it appropriate that an insurer should become a regulator of radiologists?	4%	96%	0%
Do you believe that the present Bupa Insurance MRI Tender initiative is based more on cost considerations rather than quality considerations?	90%	4%	6%
Do you think that Bupa Insurance policies, if implemented, could affect patient care?	93%	2%	5%
Do you think if implemented, Bupa Insurance's proposals could damage the direct relationship between the referring consultant and the radiologist?	94%	2%	4%
Do you think that the Bupa Insurance initiative could adversely affect patient choice?	93%	2%	5%
Would you agree to take part in an audit of your immediate colleague's work on behalf of Bupa Insurance?	10%	75%	15%
Would you be prepared to audit the work of colleagues in other hospitals or facilities on behalf of Bupa Insurance?	12%	72%	16%
Would you agree to have your audit data included in to a professionally led and nationally agreed and confidential project?	69%	15%	16%
Do you think that the Bupa Insurance MRI tender could lead to conflict between radiologists and independent hospital providers?	92%	2%	6%
Do you believe that the Bupa Insurance MRI tender arrangements would ultimately lead to progressively lower radiological fees?	96%	0%	4%
Do you overall support the concept of MRI tendering as proposed by Bupa Insurance?	3%	95%	2%

## Appendix 3

Bupa process for determining whether diagnosis /procedures for back pain would be funded as set out in ‘Evidence-based approach to back pain’.

<b>Diagnostic Procedures for Back Pain</b>	
Pre-authorisation by Bupa Back Pain Team <i>Not</i> Required	Plain x-ray (Note: normally NOT required unless there are Red Flags, including trauma) CT Scan MRI Myelography Injections (diagnostic) – facet joint
Pre-authorisation by Bupa Back Pain Team Required	Second MRI, CT, myelogram (within 12-months) Second diagnostic injections – facet joint
<i>Not</i> Funded*	Sacroiliac joint arthrography

<b>Interventions/Treatments for Back Pain</b>	
Pre-authorisation by Bupa Back Pain Team <i>Never</i> required	Manual/Physio-Therapy (including spinal manipulation) (NB Max 8 per year)
Pre-authorisation by Bupa Back Pain Team <i>Not</i> Required for patients with documented Nerve Root Pain, Cauda Equina Syndrome, or who is being investigated for Red Flags	Where clinically indicated the following may be used: Epidural injections (Max 3) Facet joint injections (Max 3) Trigger Point injections/Dry Needling (Max 3) Sacroiliac joint injections (Max 3)
Pre-authorisation by Bupa Back Pain Team <i>Required</i> in all cases	Back Pain/Functional Restoration Programmes RF facet denervation Manual/Physio-Therapy (including spinal manipulation) >8 Treatments within 12-months
Pre-authorisation <i>Required</i> for simple backache	Epidural injections (> 3) Facet joint injections (> 3) Trigger Point injections/Dry Needling (> 3) Sacroiliac joint injections (>3)
<i>Not</i> Funded *	Acupuncture (currently no supporting evidence for use in back pain) Bed Rest Biofeedback (electromyographic – EMG) Corsets/back belts Transdermal drug delivery systems (e.g. Duragesic, Transtec), outpatient drugs are not funded

	<p>Exercise equipment</p> <p>Hyaluronic acid (SynVisc, Hyalgan, Supartz)</p> <p>Hydrotherapy</p> <p>Indwelling epidural (Racz) catheter</p> <p>Intradiscal electrothermal treatment (IDET)</p> <p>Lumbar extenders</p> <p>Magnetic therapy</p> <p>Manipulation under anaesthesia/sedation (MUA, includes “nerve stretching”, “neural mobilization”)</p> <p>Plaster jackets</p> <p>Prolotherapy</p> <p>TENS -(Transcutaneous electrical nerve stimulator)</p> <p>Therapeutic beds, pillows and cushions</p> <p>Traction</p> <p>Traction with bed rest</p> <p>VAX-D (Vertebral Axial Decompression)</p>
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\*Procedures/Treatments of potential benefit may be funded if the member is taking part in a recognised and ethically approved clinical trial. Authorisation by the Bupa Back Pain Team is required.

## Appendix 4

### Fusion (Arthrodesis)

Fusion of the interdiscal space following decompression may be done to provide support to an unstable area. Spinal fusion surgery is designed to stop the motion at a painful vertebral segment, which in turn should decrease pain generated from the joint. All spinal fusion surgery involves adding bone graft to an area of the spine to set up a biological response that causes the bone graft to grow between the two vertebral elements and thereby stop the motion at that segment. At each level in the spine, there is a disc space in the front and paired facet joints in the back. Working together, these structures define a motion segment and permit multiple degrees of motion. Two vertebral segments need to be fused to stop the motion at one segment, so that an L4-L5 (lumbar segment 4 and lumbar segment 5) spinal fusion is actually a one-level spinal fusion. Current information suggests that a lumbar spinal fusion is most effective for those conditions involving only one vertebral segment. Most patients will not notice any limitation in motion after a one-level fusion. When necessary, fusing two segments of the spine may be a reasonable option. However, spinal fusion of more than two segments is less likely to provide pain relief because it removes too much of the normal motion in the back and places too much stress across the remaining joints. There are several types of spinal fusion techniques including posterolateral gutter fusion, posterior lumbar interbody fusion (PLIF), anterior lumbar interbody fusion (ALIF), and anterior/posterior spinal fusion. Spinal fusion of any type is generally performed when well-defined instabilities have been identified, in patients undergoing laminectomy and have spondylolisthesis, or patients with adult scoliosis. Controversy exists as to indications for fusion in cases of painful motion segments of discogenic origin. Pedicle screws, spine cages, wires, and other instrumentation used as an adjunct to fusion is often recommended when the affected area shows evidence of instability or has had additional destabilising procedures, such as a discectomy or facetectomy. Spinal fusion is generally not necessary for a routine decompressive laminectomy for lumbar stenosis.

During recent decades surgical fusion of the lumbar spine has been performed increasingly on patients whose pain is of unknown etiology. There are several types of spinal fusion techniques including posterolateral gutter fusion, posterior lumbar interbody fusion (PLIF),

anterior lumbar interbody fusion (ALIF), and anterior/posterior spinal fusion. Until very recently it was commonly observed that “the lack of a randomised, prospective study and difficulty in comparing outcomes between studies has made it difficult to draw {conclusions} from the literature” about the effectiveness of intervertebral body fusion devices. However, a recent RCT which compared three types of lumbar fusion with conservative therapy concluded that “lumbar fusion in a well-informed and selected group of patients with severe CLBP can diminish pain and decrease disability more efficiently than commonly used non-surgical treatment”. The same researchers reported that there was no difference in outcomes between the different types of fusion techniques. Another recent RCT compared lumbar fusion with “cognitive intervention and exercises” in a group of 64 patients with CLBP and disc degeneration, and found no significant differences in outcomes between the two groups.

### *Safety*

**Note:** there are many methods of achieving spinal fusion, and these vary enormously in their complexity, degree of risk, and potential for complications. The technique is always to be selected by the surgeon. However, Bupa suggests that current information indicates that uninstrumented posterolateral fusion is the safest method.

### *Bupa Policy*

Fusion (arthrodesis), lumbar spinal fusion is funded when the following criteria are met.

Indications are for **all** patients:

- >3 months of appropriate conservative therapy such as physiotherapy, NSAIDs, other manual therapy such as manipulation or mobilisation, facet or epidural injections;
- Surgeon must evaluate patient on at least 2 occasions;
- Clinical psychological or psychiatric evaluation is recommended to identify any possible risk factors for poor outcome, or barriers to recovery following lumbar fusion surgery.
- In addition, patients with **no** prior spinal surgery should also have **one** of:
  - Mechanical (non-radicular) low back pain with instability;
  - Spondylolysis with objective symptoms/signs of neurogenic claudication or of unilateral or bilateral radiculopathy symptoms/signs corroborated by neurologic examination and by MRI or CT (with or without myelography) or with instability.

In addition, patients **with** prior spinal surgery (Laminectomy, Discectomy, or other Decompression Procedure) should have **one** of:

- Mechanical (non-radicular) low back pain with instability;
- Mechanical (non-radicular) low back pain with pseudospondylolisthesis, rotational deformity or other condition leading to progressive (measurable) deformity;
- Objective signs of neurogenic claudication or bilateral lumbar radiculopathy, confirmed by MRI or CT/myelography and by detailed clinical neurological examination or neurological/neurosurgical consultation.

In addition, patients **with** prior spinal surgery (Lumbar fusion at the **same** level) should have **one** of:

- Objective evidence (e.g. CT) of pseudoarthrosis;
- Objective signs of neurologic claudication or bilateral lumbar radiculopathy, confirmed by MRI or CT/myelography and by detailed clinical neurological examination or neurological/neurosurgical consultation.

In addition, patients **with** prior spinal surgery (Lumbar fusion at an **adjacent** level) should have **one** of:

- Mechanical (non-radicular) low back pain with instability;
- Spondylolisthesis with objective symptoms/signs of neurogenic claudication or of unilateral or bilateral radiculopathy symptoms/signs corroborated by neurologic examination and by MRI or CT (with or without myelography) or with instability.

Instability of the lumbar segment is defined as at least 4mm of anterior/posterior translation at L3-4 and L4-5, or 5mm of translation at L5-S1 or 11 degrees greater end plate angular change at a single level compared to an adjacent level on adequate flexion/extension films.

Bupa acknowledges that the diagnosis of instability is imperfect.

Contraindications. The relative contraindications for Lumbar Fusion include the following:

- Severe physical deconditioning;
- Current smoking;

- Multiple level degenerative disease of the lumbar spine;
- Obesity (>120% of ideal body weight);
- >12 months off work, not engaged in usual productive activities;
- If prior spine surgery, then no evidence of functional recovery (such as return to work) for >6 months following most recent spine surgery;
- Psychosocial factors correlated with poor outcome such as:
  - History of substance abuse;
  - High somatic focus on evaluation;
  - History of major psychiatric disorder prior to injury/onset.

Limitations. Lumbar fusion is *not* indicated with an initial laminectomy/discectomy related to unilateral compression of a lumbar nerve root.

Provocative discography, diagnostic facet joint injections, and pain relief during the use of a rigid spinal brace are not definitive indications for fusion

**All** patients should be supplied with the following information:

- The chance of returning to work following a fusion is about 1 in 3;
- More than half people who undergo fusions feel no better or worse;
- Overall rate of re-operation for fusions is about 20% within 2 years;
- Smoking at the time of fusion greatly increase risk of pseudoarthrosis;
- Pain relief, even when present, is unlikely to be complete.

## Appendix 5

Funding matrix in ‘*Evidence-Based Approach for Lumbar Surgery and Invasive Procedures*’.

<b>Diagnostic Procedures</b>	
Pre-authorisation*** by Bupa Back Pain Team <i>Not Required</i>	Plain x-ray (Note: normally NOT required unless there are Red Flags, including trauma) CT Scan MRI Myelography Injections (diagnostic) – facet joint, S-I joint**
Pre-authorisation*** by Bupa Back Pain Team <i>Required</i>	Second MRI, CT, myelogram (within 12-months) Second diagnostic injections – facet joint
<i>Not Funded*</i>	

Notes

\* Procedures/Treatments of potential benefit *may* be funded if the member is taking part in a recognised and ethically approved clinical trial. Authorisation by the Bupa Back Pain Team is required.

\*\* Diagnostic Injections to the facet/ zygapophyseal joint was previously incorporated in the Bupa document (August 2002) entitled *Evidence Based Approach to Back Pain*<sup>1</sup>. For policy details see the document Bupa Policy Summary (August 2002) *Diagnostic Facet Joint Injections for Low Back Pain*<sup>2</sup>, and *Diagnostic S-I Joint Injections for Low Back Pain*.

\*\*\* For the purposes of this document “pre-authorisation” means referral to the Bupa Back Pain Team for authorisation of funding.

## Lumbar Surgery and Procedures for Lumbar Spine

Pre-authorisation*** by Bupa Back Pain Team <i>Not Required</i>	Decompression (entrapment of single lumbar nerve root/roots)
Pre-authorisation*** by Bupa Back Pain Team <i>Required</i>	Chymopapain chemonucleolysis (CNL) Fusion (arthrodesis) Laser-assisted disc decompression Pedicle screws for spinal fixation Percutaneous lumbar discectomy RF facet denervation**
<i>Not Funded*</i>	Endoscopic anterior spinal surgery Endoscopic spinal surgery Epiduroscopy Implantable/intrathecal infusion pumps Indwelling epidural catheter Intradiscal electrothermal therapy/annuloplasty (IDET) Kyphoplasty Sacroiliac fusion Spinal cord stimulators Vertebroplasty

### Notes

\* Procedures/Treatments of potential benefit may be funded if the member is taking part in a recognised and ethically approved clinical trial. Authorisation by the Bupa Back Pain Team is required.

\*\*Radiofrequency Facet Denervation was previously incorporated in the Bupa document (August 2002) entitled *Evidence Based Approach to Back Pain*<sup>1</sup>. For policy details see the document Bupa Policy Summary (August 2002) *Radio Frequency Denervation Procedures for Low Back Pain*<sup>3</sup>.

\*\*\* For the purposes of this document “pre-authorisation” means referral to the Bupa Back Pain Team for authorisation of funding.

***New technology:*** Bupa will continue policy development about new surgical technologies. This includes procedures such as disc replacement with prostheses, and products such as artificial bone graft materials. These techniques and procedures are not currently funded.

Where interventions were no longer going to be funded an extended rationale was given. As example is shown below:

### **Endoscopic Anterior Spinal Surgery**

Anterior endoscopic spine surgery has been described as feasible and promising (Assaker, Clinquin, Cotton and Lejeune, 2001) and (Assaker, Reyns, Pertruzon and Lejeune, 2001). It has been suggested that the anterior endoscopic approach to the lumbar spine involves minor trauma, results in rapid recovery and less pain, and produces good results aesthetically. (Burgos, Rapariz, Gonzalez-Herranz, 1998). For this reason, some believe that the endoscopic approach to anterior spinal reconstructive surgery has advantages over open approaches. Although the endoscopic approach does appear to be technically feasible, probably with immediate complication rates similar to open procedures, there are no studies available of anterior endoscopic spinal surgery that compares this procedure with an open approach. Furthermore, there is no data yet available on long-term outcomes. Therefore this procedure is considered to be still under investigation since there are no effectiveness studies available.

There is currently inadequate evidence to endorse funding for this procedure or its adoption into regular clinical practice.

#### *Bupa Policy*

Not funded. Bupa may provide funding for patients who are part of an ethically approved and scientifically appropriate clinical trial (such as a randomised controlled trial).

## Appendix 6

Selection of consultant responses to 'Ensuring High Quality Care in Hip and Knee Arthroplasty Surgery'.

*Surgical volumes is a very vexed question. I would be against setting minimum volumes, as there are so many factors affecting the outcome. The general principle, of course, is correct that the more one does a thing the better one becomes at it. Take however, the case of an older surgeon such as myself who has done thousands of joint replacements. Volume is not likely to be critical factor until my facilities fail. Once one has done three to five hundred knee or hip replacements one could be considered to have learned most of the tricks, in which case whether you do five or fifty is probably irrelevant. Another factor is innate surgical skill.*

*Surgeon 1*

*I think the minimum volumes for hip and knee replacement should be 12 i.e. not less than one a month on average.*

*Surgeon 2*

*Consultants should be doing at least 10 hip replacements, resurfacings or knee replacements a year to treat Bupa members. If they do not they are not in practice and are not up to date.*

*Surgeon 5*

*With regard to the volumes of surgery done I think the numbers are ridiculously small myself and I certainly do not believe that somebody who is doing only ten hip replacements a year should be considered to be doing any resurfacing...I think it is perfectly reasonable to come up with these targets*

*Surgeon 6*

*...issues are incredibly controversial but clearly of relevance. In the aviation industry ...you have to maintain currency ... on a regular basis. ... the same arguments can be*

*applied to joint replacement or indeed any other type of surgery...The problem you face however is that by limiting numbers and the way you wish to you may be accused of restricting practices.*

*Surgeon 6*

*With regard to minimum volumes, I would think that if one includes NHS practice and private practice 10 hip replacements and 10 knee replacements are far too low. My recommendation therefore would be 50 hip replacements and 50 knee replacements per annum based on four-year average of combined NHS/private caseload.*

*Surgeon 17*

*These case volumes are not enough. I would put hip replacement and resurfacing together and say about 40 – 50 and the same for knees. The situation is clouded however when you look at past experience. A surgeon who has done say 1000 primaries over 10 – 15 years will be fine doing just 10, a new consultant who has done perhaps 25 by himself would not.*

*Surgeon 19*

*Your suggestion that the surgeon should do a minimum of ten hip and knee replacements to be acceptable by Bupa is reasonable, if anything a little on the low side. The suggestion that the surgeon should do ten re-surfacings to be acceptable is, in my view, on the high side, and if implemented would encourage some surgeons to broaden their indication for hip re-surfacing in order to meet the numbers.*

*Resurfacing hip surgery has the potential to be a huge disaster if performed only occasionally-it is difficult to do and requires a certain degree of experience. Numbers here are relevant. I am not sure 10 per year is enough!*

*Surgeon 24*

*The American studies linking volume with best outcomes are in a number of cases flawed and quite apart from this apply to a completely different health care system where the average Orthopaedist will do a mere handful of joint replacements each year. This does not equate with UK practice where Consultants who are involved in both NHS and private work such that provided their private work reflects their NHS case mix there is no justification in restricting their private surgery. A further flaw with the concept of volume*

*is that an experienced surgeon may have been doing total hip replacement regularly for 10 or 15 years but as his special interest evolves in the NHS into for example knee surgery, he may then do much fewer hip replacements but require a minimal volume to remain skilled and perfectly safe to continue to do hip replacements provided of course that he is using the current best practice techniques. Finally, it is inappropriate to consider that when a Consultant is assisting a trainee with a certain procedure that this does not count towards volume. The idea is ludicrous.*

*Surgeon 30*

*The Consultants here at Hospital X would easily qualify in this respect for hip and knee surgery but despite this we would not support the concept of minimum volumes.*

*Surgeon 30*

## Appendix 7

### Selection of NHS Quality Indicators

(NHS Information Centre, 2009)

#### Acute Care

1. CV13 - Acute units with 5/6 key characteristics (continuous physiological monitoring; access to scanning within 3 hours of admission/24 hour brain imaging; policy for direct admission from A&E; specialist ward round at least 5 times a week; acute stroke protocols/guidelines)
2. CV14 - Acute units with access to scanning for patients with a stroke within 3 hours of admission
3. RA26 - Emergency re-admissions to hospital following aortic aneurysm surgery (Timescale: within 28 days of discharge)
4. RA25 - Emergency re-admissions to hospital following cholecystectomy surgery (Timescale: within 28 days of discharge)
5. RA18 - Emergency readmissions to hospital within 28 days of discharge: fractured proximal femur
6. RA17 - Emergency readmissions to hospital within 28 days of discharge: hip replacement surgery
7. RA24 - Emergency readmissions to hospital within 28 days of discharge: hysterectomy
8. RA20 - Emergency readmissions to hospital within 28 days of discharge: stroke
9. CV35 - Percentage of ST-elevation myocardial infarction (STEMI) patients who received primary angioplasty within 120 minutes of call (call to balloon time)
10. CV34 - Percentage of ST-elevation myocardial infarction (STEMI) patients who received thrombolytic treatment within 60 minutes of call (call to needle time)
11. CV36 - Percentage of ST-elevation myocardial infarction (STEMI) patients who received thrombolytic treatment within 60 minutes of call (call to needle time) PLUS percentage of STEMI patients who received primary angioplasty within 120 minutes of call (call to balloon time)

12. CV02 - Proportion of stroke patients given a brain scan within 24 hours of stroke
13. CV06 - Proportion of stroke patients given a swallow screening, visual fields and sensory testing within 24 hours of admission (note there are exceptions see details)
14. CV01 - Proportion of stroke patients given Aspirin or alternative e.g. clopidogrel within 48 hours of stroke (secondary prevention)
15. CV10 - Quality stroke care (outcome - reduction in stroke related mortality and disability)
16. CV20 - Sites offering thrombolysis to stroke patients.

## **Planned Care**

1. PS09 - Alerts - acute trusts compliant with safety standards - Healthcare Commission's Annual Health Check data
2. PS24 - Availability of hand washing facilities
3. HC12 - Bloodstream infections - Central line
4. NRLS 1 - Consistent reporting of patient safety events reported to the National Reporting and Learning System (NRLS)
5. PS13 - Devices (4b) - acute trusts compliant with safety standards - Healthcare Commission's Annual Health Check data
6. PS14 - Devices (4c) - acute trusts compliant with safety standards - Healthcare Commission's Annual Health Check data
7. PS11 - Guidance - acute trusts compliant with safety standards - Healthcare Commission's Annual Health Check data
8. VSA03 - Incidence of clostridium difficile
9. VSA01 - Incidence of MRSA bacteraemia
10. PS08 - Incidents - acute trusts compliant with safety standards - Healthcare Commission's Annual Health Check data
11. PS12 - Infection - acute trusts compliant with safety standards - Healthcare Commission's Annual Health Check data
12. PS15 - Medicines - acute trusts compliant with safety standards - Healthcare Commission's Annual Health Check data
13. NRLS 3 - Rate of patient safety events occurring in trusts that were submitted to the Reporting and Learning System (RLS)
14. PS37 - Sickness Absence Rate

15. HC21 - Surgical site infections - Orthopaedic

16. NRLS 2 – Timely reporting of patient safety events reported to the Reporting and Learning System (RLS)

Example of detail within quality indicator:

Ref. <https://mqi.ic.nhs.uk/IndicatorDefaultView.aspx?ref=3.02.02>

Incidence of MRSA bacteraemia

Library Reference Number/Identifier

VSA01

Subject

NHS Operating Framework - Vital Signs

Category

National Requirement Tier 1

Detailed Descriptor

MRSA numbers and rates per 10,000 bed days

Rationale

This indicator is also a national target.

Definition

Aggregated data for annual periods dating back to April 2001. These comprise reports and rates, as well as confidence intervals for the most recent period. The MRSA bacteraemia rate per 10,000 bed-days for each Trust is calculated as:

((Number of MRSA bacteraemia reports from that Trust for the time period) divided by (average daily bed occupancy multiplied by number of days in the time period)) multiplied by 10,000.

The denominator is overnight bed occupancy data, from the KH03 dataset provided by the Department of Health (DH). This is available at

[http://www.performance.doh.gov.uk/hospitalactivity/data\\_requ...](http://www.performance.doh.gov.uk/hospitalactivity/data_requ...)

The latest available denominator data are for the financial year 2007/08 (April to March).

Units

Rate per 10,000 bed days

Coverage

England

## Source

HCAI Data Capture System

## Calculations/ Formula/ Methodology

Aggregated data for annual periods dating back to April 2001. These comprise reports and rates, as well as confidence intervals for the most recent period. The MRSA bacteraemia rate per 10,000 bed-days for each Trust is calculated as:

(Number of MRSA bacteraemia reports from that Trust for the time period) divided by (average daily bed occupancy multiplied by number of days in the time period) multiplied by 10,000

The denominator is overnight bed occupancy data, from the KH03 dataset provided by the Department of Health (DH). This is available at

[http://www.performance.doh.gov.uk/hospitalactivity/data\\_requ...](http://www.performance.doh.gov.uk/hospitalactivity/data_requ...)

The latest available denominator data are for the financial year 2007/08 (April to March).

## Creator / Producer

Health Protection Agency (HPA)

## Status

In use

## Quality

As this is mandatory data we believe that it is ~100% complete. The MRSA indicator also has Chief Ex sign-off (at the acute trust level) each month. We also believe that we are capturing most (if not all) MRSA bloodstream infections.

## Date

2005

## Version History

The MRSA indicator is subject to review as the Department of Health (DH) is considering new ""objectives"" for MRSA.

## Update frequency

Quarterly

## Accessibility

This data is available from

[http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb\\_C...](http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C...)

Publisher / Owner

Health Protection Agency (HPA)

Other related PI's (relation)

WCC 3.03

## Appendix 8

### NHS England Standard Contract 2009/10 (DoH 2008d).

#### Clinical Quality Performance Indicators and Consequences

Clinical Quality Performance Indicator	Threshold	Method of Measurement	Consequence per breach
MRSA bacteraemia	[Insert the Provider's centrally set trajectory for reduction in incidences of MRSA]	[Insert as per local determination]	[Insert as per local determination]
Clostridium difficile	[Insert the Provider's centrally set trajectory for reduction in incidences of Clostridium difficile]	[Insert as per local determination]	Without prejudice to the provisions of paragraph 9 of Schedule 3 Part 1, no consequence other than the issue of an Exception Report under clause 33.16.2
Services provided requiring rectification	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
[where the Provider provides abortion services under this Agreement : improving access to contraception advice and treatment during delivery of abortion services, including follow up]	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
[Others for local agreement]	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]

## Performance Indicators and Consequences

<b>Performance Indicator</b>	<b>Threshold</b>	<b>Method of Measurement</b>	<b>Consequence per breach</b>
Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
Provider failure to ensure that "sufficient appointment slots" are made available on the Choose and Book system	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
4 hour maximum wait in A&E from arrival to admission, transfer or discharge (operating standard of 98%)	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
Maximum wait of 11 weeks for revascularisation	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
Maximum waiting time of 31 days from diagnosis to treatment for all cancers (operating standard 98%)	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
Maximum waiting time of 62 days from urgent referral to treatment for all cancers (operating standard of 95%)	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
2 weeks maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
2 weeks maximum wait for rapid access chest pain clinic	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
Percentage of SUS data altered in period between (a) 5 Operational Days after	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]

<b>Performance Indicator</b>	<b>Threshold</b>	<b>Method of Measurement</b>	<b>Consequence per breach</b>
month-end, and (b) the relevant Reconciliation Point			
Satisfaction of the Provider's obligations under each A&E/Ambulance Services Handover Plan	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
Satisfaction of the Provider's obligations under the Mixed Sex Accommodation Reduction Plan	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]
[Others for local agreement]	[Insert as per local determination]	[Insert as per local determination]	[Insert as per local determination]

#### Quality Performance Incentive Scheme Indicators and Consequences

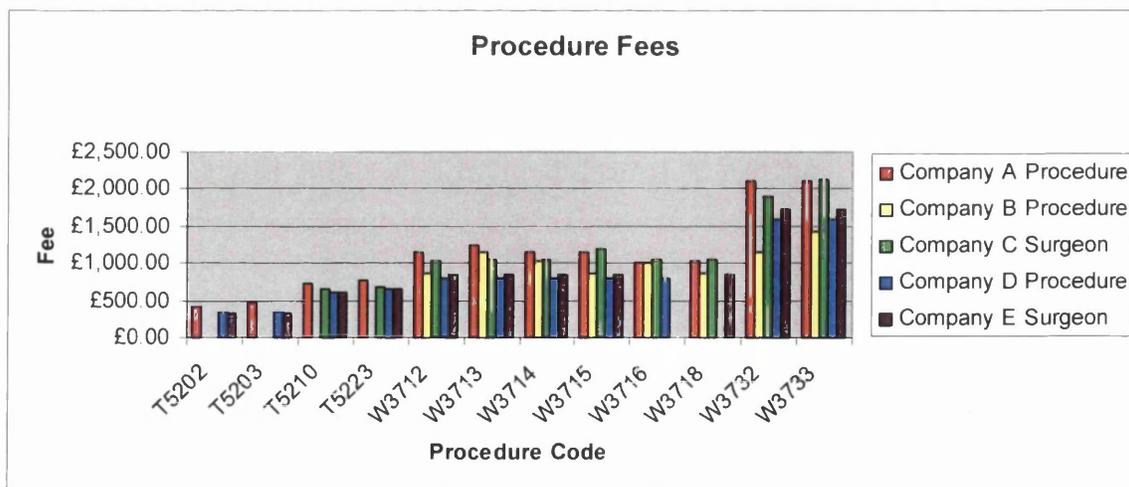
<b>CQUIN Indicator</b>	<b>Threshold</b>	<b>Method of Measurement</b>	<b>Period of Activity Covered</b>	<b>Payment for Achievement</b>
[Insert as per local determination]				

## Appendix 9 Insurer Fee Schedules

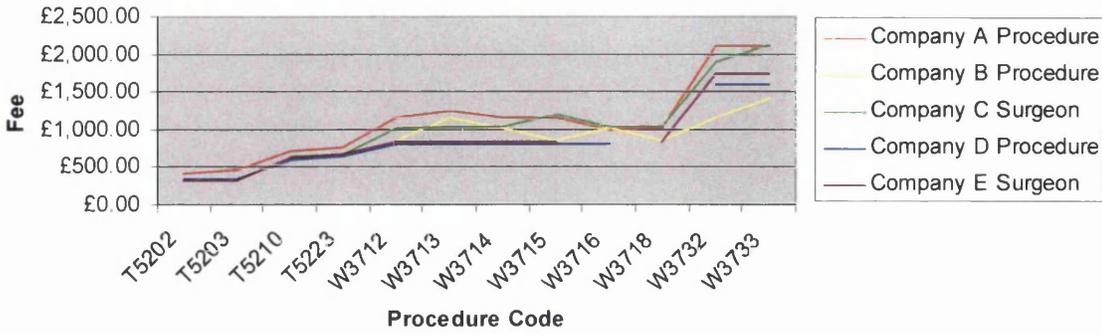
The tables below show the fee schedules of 5 insurers for a variety of orthopaedic procedures. The procedures are shown by their OPCS codes within RVR. All but one is available to the public on the internet with one only made available to doctors recognised by that insurer. As a result in the table below the companies are anonymous.

The tables demonstrate four things:

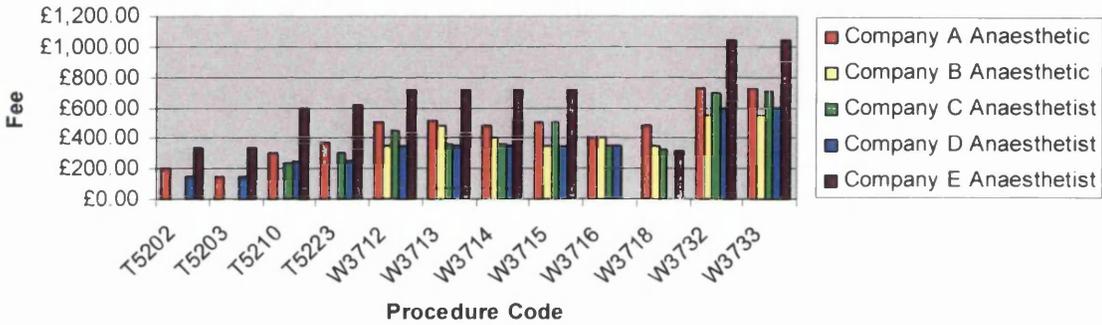
- That reimbursement schedules often differ significantly between the highest and lowest paying insurers;
- Differentials between the highest and lowest paying insurers remain generally consistent;
- Insurers are generally consistent in the relative values they assign to particular procedures (perhaps as a result of RVR). However this correlation is not followed absolutely. For example, for procedure W3715 company C pays the highest amount compared to the other insurers but does not do so for the other 11 procedures;
- Reimbursement to anaesthetists are generally considerably below that paid to surgeons and also vary between insurers.



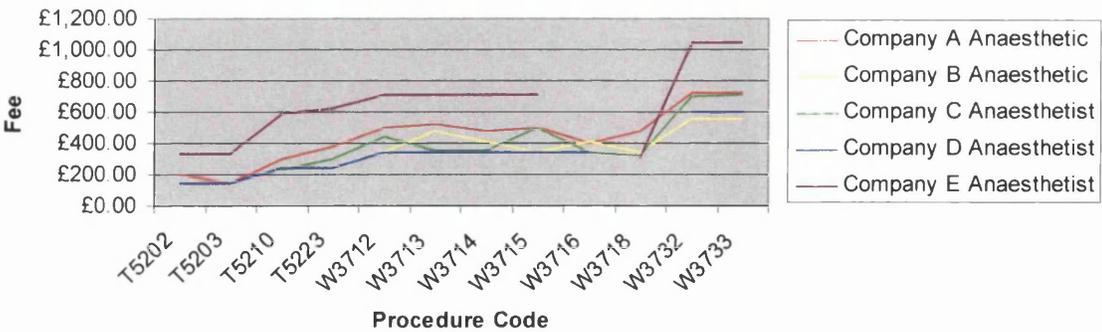
### Procedure Fees



### Anaesthetic Fees



### Anaesthetic Fees



## **Appendix 10 Additional Quality Initiatives Undertaken by Bupa**

This appendix contains information on three additional quality initiatives undertaken by Bupa that did not relate to networks or specific condition groups. The information was not included in the main text because of the large number of initiatives already considered.

However appendix 10 does provide additional background on Bupa's stance towards quality.

The initiatives discussed are Bupa's:

- Patient Satisfaction questionnaire;
- Patient complaints database;
- Supply of SF 36 and VF14 outcome data from providers.

### **Patient Satisfaction Questionnaire**

Bupa takes member satisfaction seriously but what UKM has historically been most concerned to discover with regard to customer perspectives is illuminating.

One of the central planks of Bupa's customer proposition was the delivery of excellent customer service from the UKM's call centres. Evidence for this (and what is considered important to customers) is provided by the customer satisfaction surveys undertaken by UKM.

For example an independent survey in 2005 of 600 members who had made a claim showed a satisfaction rating of 95% with 40% stating that they considered the service as 'excellent', 43% 'very good' and 12% 'quite good' (Bupa, 2005c). Of 200 personal members interviewed, 48% rated the claims process 'excellent', 32% 'very good' and a further 13% 'quite good'. In the same survey 96% of personal members interviewed rated ease of contact either 'excellent' (47%), 'very good' (35%), or 'quite good' (14%). This shows a company that took care to ensure members were not left waiting on the phone for very long and that staff were trained to be polite and competent to deal with most member queries. Some 92% of those interviewed, considered Bupa staff to be caring. It is worth bearing in mind that most of these customers' exposure to Bupa staff would only be through their contact with the call centre.

Such surveys had been undertaken since the 1990s (at least) but there was no questioning as to the quality of the clinical care the customer had received. In 2005, UKM introduced a systematic process for gauging patient satisfaction, having decided that such reporting was an integral part of demonstrating the company's commitment to clinical quality and a patient centric approach. Until that point, UKM had not been measuring members' experience of the treatment they received. It was likely that there was an expectation by members that such monitoring was already in place. Bupa felt it needed to take active steps to ensure that it was able to give members some credible evidence of provider quality. It is understood that to date no other insurer has introduced a similar initiative.

The questionnaire was sent to 60,000 members per annum, all of whom had received hospital treatment with 85% of members rating the overall service as excellent or very good. Some 94% of members said the service met or exceeded their expectations. There were questions on the quality of the food, accommodation and car parking. Moreover, over 84% of members rated the hospital as very clean.

The survey also asked some questions related more directly to the clinical care received. Thus 85% rated the nursing service as either excellent or very good (48% and 37% respectively), with 81% also rating nursing staff as either excellent or very good for keeping them informed about treatment. Consultants scored even better with 89% rated as excellent or very good for listening very carefully, 93% for their general attitude against the same ratings and 91% for the level of information provided (64% excellent/21% very good). Finally, some 97% would recommend the hospital to a friend or relative.

This survey illustrates that questions about quality of service continued to cluster around the aesthetics of the immediate care experience.

## **Complaints Process**

The implementation of a systematic reporting process for recording member complaints took place during 2003, primarily in response to the need to conform to tighter regulatory requirements from FOS around the recording and resolution of complaints. UKM introduced a computerised recording system known as 'Resolve' that recorded and tracked all types of

customer complaints (both clinical and non-clinical). When the author joined the company in 2001 it did not have a mechanism for systematically recording clinical complaints.

At one level this was of relatively little consequence as the standard response to clinical (as opposed to administrative) complaints was that the member should take the matter up directly with the provider. The reasoning behind this was that UKM as an insurer had no real role to play in such disputes. Despite this being the standard response within the PMI industry this was evidently unsatisfactory at a number of levels, both from a customer perspective but also in terms of UKM's quality agenda and its ambitions to be viewed as a broader healthcare company. In consequence a more proactive approach was adopted from 2003 onwards. As a result UKM had a growing capability to view customer satisfaction and complaint levels at hospital level and some ability to pick up trends with regard to consultants. Ironically this was partly a direct result of a FOS regulatory requirement; yet as the thesis has noted FOS itself was making judgements that effectively forestalled insurers' attempts to take a proactive role regarding clinical issues.

## **The use of Outcomes Data**

Bupa has a long-standing involvement in the collection of outcomes data. In 2002 Bupa Group's Medical and Associate Medical Director were able to write an article for the *British Journal of Healthcare Management* stating that:

'In 1998, Bupa launched a national programme to routinely monitor clinical outcomes using the SF-36 questionnaire within each of its 35 hospitals and, more recently, throughout many of the 'network' hospitals recognised by its insurance division. To date, over 70 hospitals have joined the programme and the database records the SF-36 outcomes associated with more than 90,000 elective cases' (Owen and Cubbin, 2002)..

This begs the question as to what use was being made of that data to influence clinical practice and promote quality? At the time of writing the article the authors were able to state that 57.8% of eligible patients received and completed the baseline SF-36 questionnaire (VF-14 for cataracts) (Owen and Cubbin, 2002, p.413). Significantly, the results at both hospital

and consultant level were anonymous. This meant that not only are all hospitals anonymous as far as UKM was concerned, but also that neither hospitals nor UKM knew the results for individual consultants. Individual hospitals receive results for their own organisation, but these are not broken down to individual clinician level. The explanation given for this in the article was that confidentiality had been assured “to facilitate the development of trust” (2002, p.415).

In a section entitled ‘What next? Disseminating results’ the authors asked:

‘Having measured outcomes, how should they be used? The aims are not just to be able to identify and investigate potentially poor performance. The system should be able to examine and disseminate the lessons from excellent practice’ (Owen and Cubbin, 2002, p.415)..

However it is not clear either how poor performance could be investigated or good practice disseminated, when the only person knowing the identity of the good or poorly performing hospital or consultant was the party in question. This was the same problem highlighted in Chapter 6 on outcomes tracking within professional bodies. The point was not lost on UKM (who were paying 50% of the cost of the scheme -which in 2002 was reported at approximately £3 per patient (Owen and Cubbin, 2002, p.413) - but were receiving effectively no information that they could use. Furthermore, despite the upbeat tone of the article, enthusiasm from providers towards the scheme typically ranged from the lukewarm to openly hostile. The article acknowledged wide variations in reporting rates between hospitals (2002, p.413). Such variations were seen between consultants in the same hospital, hospitals in the same group and between groups.

Moreover, because of anonymity one was unable to tell who was, and was not, participating. Given that it was likely that those not taking part were the ones that it was most important to see outcomes from, the scheme was another illustration of the flaws in voluntary reporting. In the same way, Bupa Hospitals’ participation (perhaps unsurprising given that this was a Group Medical sponsored initiative) was not matched by the other major private hospital chains. This was unlikely to change unless it was made a contractual requirement to participate and this was a step that UKM were unwilling to take. The reasons for not doing so are not fully known to the author, but were likely to include a basic calculation that this was

not an issue worth falling out with providers on. Besides, extending participation would cost more money, and the end result remained a series of anonymous reports of little practical use to hospitals, and even less to UKM.

In 2002 the Group Medical Director wrote to the major hospital groups to canvas their views on restructuring confidentiality agreements to allow participating hospitals and consultants to be identified. This was duly done but one can only speculate that the responses were not favourable. The author believes that UKM no longer collects outcome data from providers following the sale of Bupa hospitals in 2007. However, it has recommenced a voluntary data collection process for Ophthalmology consultants of patient outcome questionnaires.

The second technical obstacle that undermined the entire process was that even if providers had fully participated in providing outcome data, the results at consultant level would typically only represent a percentage (often small) of their overall workload. Aside from the fact that Bupa-insured patients would typically only constitute around 40% of a consultant's insured cases, most of these consultants also hold NHS posts. To be really useful, what was (and is) required is an ability to see the outcomes relating to an individual's entire caseload. This also allows sufficient numbers to be generated to allow statistically significant comparisons against peers.

To do so requires a degree of public/private co-operation that has historically been lacking in the UK. However there are recent signs that this is an area that may be about to gain some momentum.

The 'Operating Framework for the NHS in England 2008/09' (DoH, 2008a) includes a requirement for NHS providers of hip and knee replacements, groin hernia surgery and varicose vein procedures to collect and report patient reported outcomes measures (PROMS) from April 2009 (DoH, 2008b) .

This framework also set out both generic and condition-specific recommended methodologies (Oxford Hip score, Aberdeen varicose vein questionnaire, etcetera). These have subsequently become part of the CQUIN payments system (DoH, 2008c).

The above represents the first attempt by the DoH to systematically address what the document itself acknowledged was a fundamental gap in knowledge – namely what the clinical outcomes of these services were in terms of the patients’ perception.

On the 16<sup>th</sup> June 2008 Bupa Group’s Medical Director (Dr Andrew Vallance-Owen) used the opportunity of a speech at the Royal College of Surgeons to call for the compulsory collection of PROMs data from the private sector. This would allow comparable information between the two sectors of patient perceptions of their treatment. In Dr Vallance-Owen’s opinion “.....such a shared database would ensure fair comparisons and true patient choice” (Bupa Group Press Release 2008c). Such an initiative is necessary if the UK is to achieve comprehensive outcome collection and reporting across both sectors but remains unfulfilled. In the absence of a compulsory scheme, the private sector has not responded with voluntary participation.

Ultimately, the position of the public sector with regard to publishing identifiable outcomes data, or perhaps an edict from the CQC, may determine the position of the private sector. However, if that is the case it is of a market following, not leading, a quality initiative.

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