Theory of harm 2: Anaesthetist groups

Introduction

1. This appendix relates to theory of harm 2. It sets out our price analysis of anaesthetist groups to date and summarizes the relevant findings from our survey of consultants. Several insurers told us that some anaesthetists had formed groups that collectively set prices and shared revenue. In some cases these groups accounted for a very large proportion of anaesthetic treatments in one or more hospitals. This, according to several insurers, resulted in higher prices set by anaesthetist groups compared with individual anaesthetists, and in turn, to higher average prices set by anaesthetists. We have had similar complaints about other consultants forming groups and setting higher prices.

Price analysis of anaesthetist groups

2. As we do not have enough information on the anaesthetist groups' presence across UK hospitals to test systematically their possible impact on average fees charged by anaesthetists, we have focused our analysis on a number of hospitals in local geographic areas where the presence of anaesthetist groups is high, which we refer to as case studies. Our chosen areas are the ones the insurers complained about as these are likely to be among the most problematic areas. This appendix covers our analysis of three case studies. We are intending to carry out six more case studies, which will cover all of the areas for which we have received complaints.

3. We have used anaesthetist data at the treatment level for the period 2006 to 2012, containing information on each treatment—ie type of treatment,[1] the invoiced price, the hospital in which the treatment was administered and the consultant who administered the treatment. The source of the data is the Insurer database which includes all insurers except Pruhealth, which we will include at a later date.[2] We have removed some outliers for each treatment by excluding all observations for which the fees charged by consultant anaesthetists in each treatment are in the top or bottom 1 per cent.

4. We received questionnaire responses from over 100 anaesthetist groups, informing us of the names of their members and the private hospitals in which they served private patients. We used this information to identify the consultants in the Insurer database that are in the groups under study. These groups also told us the rationale for their groups, their main centralized activities, requirements for group membership, any arrangements with hospitals and insurers and how they set their fees.

5. A key aspect of the analysis is to find an appropriate control group that allows us to compare the fees for treatments administered by anaesthetists that belong to a certain group with the fees of the control group. The more similar the circumstances that affect the fee level of the treatment offered by the two groups, the more likely

[1] The database contains codes which refer to each treatment. In most cases these refer to standardized treatments (eg knee replacement), though there may be some variation within the same treatment (eg different types of anaesthetic treatments for knee replacement). This may be one of the factors (alongside regional differences, the type of hospital, presence and importance of groups etc) that explain some of the price variation within the same treatment and which we have not accounted for.
[2] The composition of the database in terms of anaesthetic treatments is: 59 per cent for BUPA, 25 per cent for AXA, 13 per cent for Aviva, 2.5 per cent for WPA and 0.5 per cent for Simplyhealth.

that any difference in prices can be attributed to the presence of the anaesthetist group.

6. Where possible, we have used the top six anaesthetic treatments[3] in the UK by volume (they are in the top 11 by value).

7. Depending on the information available and the facts in each case study, we carried out the following pieces of analysis:

   (a) We compared the price levels over time of anaesthetist groups with a regional average (where we exclude from the regional average areas where we know there is a group which accounts for a substantial proportion of anaesthetist services).

   (b) We compared the price change of anaesthetist groups pre- and post-formation of the groups (where the group was formed within the period covered by our data) with the price change of a regional average.

   (c) We compared the average prices of anaesthetist groups with independent anaesthetists (ie not belonging to the group) in the same geographic area.

   (d) We compared prices in hospitals where the anaesthetist groups' presence is significant with those in nearby hospitals where groups are not present or are not present to the same extent.

8. Our analysis of prices, which is not complete, shows some evidence that prices charged by anaesthetist groups may be higher than those charged by non-groups, but there could be other explanations for these differences, which we are still investigating.

9. We now show the results from each of our case studies.

Case study A

10. The anaesthetist group in this area has a high share of all anaesthetic treatments—over 80 per cent by volume.

11. The preliminary findings for case study A are:

   (a) Average fees for the anaesthetist group for each of the six treatments are higher than the regional average fees for the period 2006 to 2012.

   (b) There is more variation in fees for each of the six treatments before the group was formed than after it was formed.

   (c) The increase in average fees of the anaesthetist group when the group was formed was higher than the increase in regional average fees for five treatments and lower for one treatment.

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[3] Multiple arthroscopic operation on knee (including meniscectomy, chondroplasty, drilling or microfracture) (w8500); Arthroscopic meniscectomy (including debridement) (w8200); Phakoemulsification of lens with implant—unilateral (c7122); Local anaesthetic blockade of major nerve trunk (including occipital block, spheno-palatine block, diagnostic block of trigeminal branch, intercostal nerve block & supra-scapular nerve block) (A7350); Hysteroscopy including biopsy, dilatation, curettage and polypectomy with/without mirena coil insertion (Q1800); and Epidural injection (lumbar/caudal) (A5210).

(d) The level of fees for the anaesthetist group and independent anaesthetists in the same hospitals for two treatments are broadly the same. It is difficult to make comparisons for three treatments due to the low number of observations for the non-groups.[4] We are unable to compare fees for one treatment.

(e) There are higher average fees in one hospital, where the anaesthetist group operates, compared with two other hospitals in nearby areas, belonging to the same hospital group and where the group does not operate for two treatments for all years, for one treatment apart from 2012 (when the fees are broadly the same), for one treatment for one nearby area and broadly the same for the other nearby area, and a mixed picture for one treatment. We were unable to make comparisons for one treatment.[5]

(f) We carried out a similar comparison to that reported on in *(a)*. However, this comparison differs from *(a)* in that it compares average fees for the area where the anaesthetist group operates with average fees in two comparable nearby areas. [6] This comparison found higher average fees for five treatments in the area where the anaesthetist group operates compared with two comparable areas where the anaesthetist group under study does not operate for 2006 to 2012. We were unable to compare fees for one treatment.

Case study B

12. The anaesthetist group we have analysed in this area has a high share of all anaesthetic treatments in two hospitals in the area—over 80 per cent by volume and a small share in another hospital in a nearby area (where we understand another anaesthetist group has a large share).

13. The preliminary findings for case study B are:

(a) Average fees for the anaesthetist group are higher than the regional average fees for one treatment for the period 2006 to 2012, for another treatment but only to 2010 and for another but only to 2008.

(b) The level of fees for three treatments for the anaesthetist group and independent anaesthetists working in the same two hospitals are broadly the same.

(c) There are higher average fees for three treatments in one hospital, where the anaesthetist group operates, compared with two other hospitals in two nearby areas (one belongs to the same hospital group where the anaesthetist group does not operate and one belongs to a different hospital group where a few members of the anaesthetist group have small size of operation).[7]

Case study C

14. The anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—about 60 per cent by volume.

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[4] There are few observations for anaesthetists not in groups for all treatments where we have made comparisons.
[5] We are aware that there are some anaesthetist groups in our two control groups but as yet we do not know the extent of the anaesthetist groups.
[6] We are aware that there are some anaesthetist groups in our two control areas. Evidence so far suggests that these anaesthetist groups in the control areas account for a smaller share of anaesthetist services in their local areas than the share of anaesthetist services accounted for b y the group under study in its local area.
[7] We are aware that there are some anaesthetist groups in our two control groups but as yet we do not know the extent of the anaesthetist groups.

15. The preliminary findings for case study C are:

(a) Average fees for the anaesthetist group are higher than the regional average fees for one treatment for the period 2006 to 2012, for another treatment but only to 2011 and for another but only in 2012.

(b) The increase in average fees of the anaesthetist group when the group was formed was higher than the increase in regional average fees for all six treatments.

(c) There were higher fees for the anaesthetist group than independent anaesthetists at the same hospital for two treatments and broadly the same fees for the other treatment.

Consultants survey

16. Our survey of consultants found that:

(a) 39 per cent of anaesthetists were in groups. 22 per cent of other consultants were in groups.[8] 60 per cent of anaesthetists in a group said that they used the guidelines set by the group to set their fees. The proportion for other consultants was 51 per cent.[9]

(b) In terms of all anaesthetists (ie those in and not in groups), 24 per cent said that they used the guidelines set by the group to set their fees (14 per cent at the level specified by the group and 10 per cent with reference to the guidelines specified by the group). The proportions for other consultants are: 10 per cent (split 4 per cent and 6 per cent).[10]

(c) 10 per cent of those in consultant groups and aware of consultants not in a group said that those in groups (anaesthetists and other consultants) charged higher prices than those not in groups. Allocating 'don't knows' increases this proportion to 16 per cent.[11]

(d) For those not in consultant groups, aware of one and of other consultants not in a group, the proportions are 16 per cent and 37 per cent.[12]

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[8] Source: E2/4, Consultants survey.
[9] Source: E3, Consultants Survey.
[10] Source: E3, Consultants Survey.
[11] Source: E6, Consultants Survey.
[12] Source: E6, Consultants Survey.