



LONDON CONSULTANTS' ASSOCIATION

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Julie Hawes
Inquiry Coordinator
Competition Commission
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Dear Ms Hawes

As the CC is aware, LCA has been following the private healthcare market investigation closely and has written to and engaged with the CC in response to questions posed in July 2012. Since our last letter in January 2013 we continue to be very concerned as the situation for both patients and consultants in private healthcare is further deteriorating.

Since our last letter there have been several important developments.

Bupa as an arbiter of clinical pathways

LCA understands that during the last 5-6 weeks Bupa's policyholders have been informed that as a condition of preauthorisation a copy of their consultant's letter to their GP must be faxed or emailed to Bupa. Presumably this is done so that someone within Bupa has a chance to redirect the patient away from the referral pathway and clinical management of the patient agreed between the GP and the consultant, with obvious risk to the patient.

Coding

LCA would like to draw the CC's attention specifically to the issue of coding. The term "coding" refers to the process by which surgical procedures are allocated a specific procedure code according to which reimbursement is calculated.

Historically, where two separate codes existed for two (distinct) procedures, both were reimbursed individually, even if performed under the same anaesthetic. There was a formula by which a percentage of the patient's benefits were paid for the second (or even third) procedure. This is no longer the case for an increasing number of procedures, since PMIs have in many instances adjusted the codes so that one code will cover two procedures when they are performed under the same anaesthetic even if they are entirely different operations. The result is a situation where patients will not be reimbursed for their consultant's fees and will just receive benefits for one procedure, instead of two, despite there being no clinical grounds for the change. If both procedures are billed for individually, the PMIs now regard this as 'unbundling' and do not allow it.

These coding practices of the PMIs are now being increasingly coupled with the threat of derecognition, and this has become a powerful means of control over medical practice and is an issue the CC may wish to consider when discussing remedies.

Many PMIs have engaged in this particular strategy and the LCA is aware of recent instances exemplifying this.

Example 1

Pruhealth wrote to ✂ consultant to inform him that it has changed the procedure coding so that a ✂ performed in combination with a ✂ can now only be reimbursed separately when performed at different times: according to PruHealth "billing for ✂ and ✂ in combination is not eligible for funding". This is despite the fact that these procedures are related and often performed together, where it makes clinical sense to do so. LCA is very concerned that patients (who are not given the choice whether to meet a shortfall) may have to be asked to see their doctor twice when once would have sufficed.

Pruhealth claim they do not pass on any shortfalls to patients. In fact (no differently from BUPA) they threaten consultants with deregistration if they charge fees in excess of what Pruhealth are willing to reimburse along the lines of: "we reserve the right to remove recognition from a consultant whose billing practice we deem inappropriate".

Example 2

LCA has been made aware that insurers are introducing new codes by changing descriptors (resulting in lower fees) at will.

We understand from X, a Consultant X that specifically the code X is no longer deemed acceptable by Pruhealth or AXA PPP for a X as they have recently introduced a new code (X) for this procedure along with a lower fee, despite this being the same procedure as before.

In another example provided by the same consultant, Aviva have changed the descriptor for X from "X" to "X". This means that a X, which is a more difficult procedure than "X", can no longer be coded for as such. The surgical definition of the X is "X" so this change does not make clinical sense.

However, these actions do make economic sense from the perspective of the insurer and shows once again how consultants in the vast majority of cases have to accept the decisions of the PMIs which are the gatekeepers of the consultants' private healthcare practice. Unfortunately this has now gone beyond economic matters, into medical judgment, with an obvious risk of detriment to patients.

De-listing Threats to Consultants over Consultation Fees

The LCA continues to receive complaints from its members about the actions of Bupa in particular in suggesting to consultants that their consultation fees are "in the top 10%". Of course there are bound to be some consultants whose fees are in the top 10% just as there will be those in the lowest 10%.

We were encouraged by the Commission's statement that it sees nothing inherently wrong in "Top up fees" for consultants. The LCA does not encourage or promote excessive fees but we do hope that the CC will provide for this in its remedies. Our members are largely based in London where the costs of practice are much higher than elsewhere so they are particularly affected by this. The fixed fee structure which is applied by the two major insurers to newly appointed consultants is particularly difficult for them.

The consequences of these actions on consultant practice are starting to be felt as it is becoming increasingly difficult for young consultants to start in practice in London and, we understand, more widely in the UK.

Yours sincerely