Private Healthcare Market Investigation: a submission from the Association of Anaesthetists of Great Britain and Ireland (1 May 2012)

With more than 10,000 members, the Association of Anaesthetists of Great Britain & Ireland (AAGBI) is the largest medical specialty representative organisation in the UK, and has as members the substantial majority of consultant anaesthetists working in the NHS and in private practice. In turn, anaesthesia is the largest medical subspecialty active in both the NHS [1] and in private medical practice in the UK [2]. The AAGBI welcomes the Office of Fair Trading's (OFT's) decision to refer the private healthcare (PH) market to the Competition Commission (CC), and is committed to supporting the CC's investigation. In this short submission, the AAGBI highlights four key issues in the OFT's Market Study Report [3] which the AAGBI believes to be the most important areas for closer examination in the CC's investigation.

Information asymmetries

The AAGBI supports the OFT's assertion that there exist marked information asymmetries in the PH market. The Association's guidance for its members underlines the importance of providing patients with accurate and complete information about expected fees in advance of treatment whenever possible [4], and is pleased that the inadequate and on occasion misleading information about benefit restrictions provided by some Private Medical Insurers (PMIs) to their customers will receive attention from the Financial Services Authority.

While endorsing the OFT's support for the publication of quality and outcome information by PH providers and consultants, the AAGBI is concerned about undue reliance on the provision of such data when trying to promote competition and patient choice. Firstly, it may be very difficult for medical subspecialties other than those with high mortality rates, such as cardiac surgery, to develop reliable outcome data. Secondly, a drive for such data might stray towards what has been called the "McNamara Fallacy", i.e. that which can be easily measured will be reported, even if it is not important to patient outcome and choice, whilst that which cannot easily be measured may be ignored even if it is in reality important. The AAGBI will engage with the CC in proposing reliable systems that report validated outcome data for anaesthetists if this is felt to be feasible and desirable.

Top-up fees (payments to cover insurance benefit shortfalls)

The OFT's report refers to evidence that "anaesthetics constitutes a clinical specialty with a high rate of shortfalling and payment of top-up fees as compared to other specialties" [5]. Further, the OFT refers to the AAGBI's evidence that there is a "historical disparity between anaesthetist and surgical fees which (is) not justified in modern healthcare, but remains a feature of (PMI providers' benefit schedules)" [6].

The AAGBI asks the CC to examine the hourly income (net of reasonable practice expenses) of consultants practising surgery and anaesthesia in the PH sector as set by PMI benefit schedules, and to question whether the significant benefit disparity [7] between these two medical consultant groups (and both between and within other specialties) is justified, given the marked similarity between consultant groups in terms of training, responsibility and expertise, *and the fact that they are rewarded equally in other professional areas such as the NHS, the armed forces and legal services* [8]. The AAGBI avers that the reported greater number of insurance shortfalls associated with anaesthetists' fees is a result of unjustified benefit discrimination and would welcome the opportunity to participate in a detailed assessment of specialty benefit disparities that derive from PMI benefits based on historical differences. The AAGBI believes that the competitiveness and cost effectiveness of PH might be well served by a re-evaluation of benefit levels across and between medical specialties and subspecialties.

Concentration of anaesthetists (Anaesthetic Groups)

An AAGBI survey conducted for the OFT shows that an increasing number of anaesthetists are members of legally constituted Anaesthetic Groups (AGs), a trend based in part on a response to the OFT's own conclusions after an investigation of AGs in 2003 [9]. The OFT linked the trend in AG growth to its assertion that "anaesthetists are the sub-specialty with which the PH patient is most likely to experience a shortfall" [10]. The AAGBI argues that this statistical association does not imply causation, and believes that shortfalls relate more to PMI benefit discrimination as described above. In previous submissions to the OFT, the AAGBI has outlined the significant advantages for quality of patient care offered by AGs, notably the reliability of clinical service provision, especially in acute emergency and out-of-hours situations.

Further, the AAGBI suggests that any differences in fees charged by anaesthetists in AGs and those who are not may be explained not only by regional variations in practice expenses and overheads, but also by the added value service that AGs can provide, which is associated with better care for patients and improved outcome [11]., The AAGBI is very concerned that attempts to break up local concentrations of anaesthetists in order to combat any perceived market distortion may have unintended adverse effects on patient safety and the quality of care.

Consultant incentives (barriers to entry and expansion)

The AAGBI opposes consultant incentives provided by PH providers as set out in the OFT's report [12], but wishes the CC to examine a further incentive payment that the OFT omitted to consider and which is becoming increasingly prevalent – and increasingly significant – as more NHS-funded elective surgery is performed in PH facilities, a trend that will be further accelerated by the provisions of the Health and Social Care Act.

Surgeons and anaesthetists (and consultants from all medical specialties) are paid identical hourly rates for treating NHS patients in NHS hospitals – a founding principle of the NHS since its inception in 1948 that has been endorsed and supported on countless occasions in the ensuing 64 years. However, when NHS patients undergo surgery in PH facilities, there is an increasing trend for the pay of surgeons and anaesthetists to reflect the marked pay disparity found in PMI benefit schedules and, as a result, *surgeons can be paid up to three times the amount paid to anaesthetists for treating the same patient for the same period of time*. This disparity is not justified by the larger practice expenses paid by surgeons, as private consulting rooms, private secretaries and non-NHS medical indemnity are not usually involved in the care and management of these patients. The AAGBI argues that this is a form of covert incentive paid by PH providers who have contracts with the NHS to induce surgeons to bring privately funded patients to their PH facilities, and asks the CC to take action against this and other costly and anti-competitive incentives.

Further information: see Independent Practice AAGBI
http://www.aagbi.org/professionals/independent-practice

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2) Morris S, Elliott B, Ma A, et al. Analysis of consultants' NHS and private incomes in England in 2003/4. *Journal of the Royal Society of Medicine* 2008; **101**: 372–80.

3) OFT: Report on the market study and final decision to make a market investigation reference (April 2012). http://www.oft.gov.uk/OFTwork/markets-work/private-healthcare/ (accessed 30/4/12).

4) AAGBI: Voluntary Code of Practice for Billing Private Patients (2008). http://www.aagbi.org/sites/default/files/code_of_practice_08.pdf (accessed 30/4/12).

5) Reference 3, section 5.60.

6) Reference 3, section 7.9.

7) Stubbs D, Ward ME and Pandit JJ. Estimating hourly anaesthetic and surgical reimbursement from private medical insurers' benefit maxima: implications for pricing services and for incentives. *Anaesthesia* 2009; **65**: 396-408.

8) http://www.legalservices.gov.uk/docs/cls_main/The_Community_Legal_Service_(Funding)(Amendment_No.2)_Order_2011.pdf (accessed 30/4/12).

9) http://www.oft.gov.uk/OFTwork/competition-act-and-cartels/ca98/decisions/anaesthetists-groups (accessed 30/4/12).

10) Reference 3, section 7.6.

11) Reference 3, section 7.5

12) Reference 3, section 8.63.