

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with the Association of Anaesthetists of Great Britain and Ireland held on 22 April 2013

Background

1. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) advised that its primary values were safety, education and research. Member benefits were also one of the organization's values but were considered a lower priority. It published guidance that was recognized as being authoritative but not binding upon all anaesthetists in the UK. It currently had more than 60 documents in print. It also had more than 10,500 members, making it the largest representative, professional medical society in the UK.
2. Anaesthetists were the largest sub-specialty group of consultants, active in both the NHS and the private medical sector. The AAGBI acknowledged that patients generally had relatively little input into the selection of their anaesthetist, but that this was similar to many other clinical specialists. Many medical procedures resulted from doctor-to-doctor referrals.
3. The AAGBI offered information from Ray Stanbridge that demonstrated that anaesthetists earned less than every other clinical speciality. They were fully qualified consultants with training similar in duration and complexity to other consultants. They were paid the same as other consultants in the NHS, the Armed Forces and when acting for Court Services. However, they were paid considerably less than other consultants in the private sector even though they had similar skills, experience and responsibilities. This was mainly as a result of the private medical insurers' (PMIs') benefit maxima for anaesthetists, which were inequitable for primarily historical reasons and had not changed since the 1990s. Anaesthetists' fees were a very small proportion of the amount spent on private healthcare, whether by individuals or PMIs.
4. The AAGBI drew attention to its guidance that 'consultants should charge transparent and reasonable fees and should make every effort to inform their patients of the fees before surgery'. The AAGBI advised that patients should be given fee estimates before any procedures. It also indicated that the fee charged should ideally include the totality of the care involved in the planned procedure. Any additional fees should normally be disclosed to the patient. The guidance was considered best practice within the industry rather than being legally binding.
5. Anaesthetic groups should be referred to as Independent Departments of Anaesthesia (IDAs), as this reflected the nature of groups more accurately in terms of the range of services they could deliver.
6. The main issue in the inquiry relating to anaesthesia seemed to be that it was asserted (primarily by PMIs) that IDAs charged more than the average fee rate, either locally or nationally, and that this assertion arose as a result of patient complaints. The AAGBI had no evidence to suggest this was correct, but proposed that anticipated top-up requirements (as opposed to unanticipated shortfalls) were not a source of complaint. Further, it seemed reasonable that some anaesthetists charged more than others, just as some lawyers charged more than others. What mattered was that the patient could make a choice based on clear information given in advance.

Comments on CC annotated issues statement

7. There were problems in the Competition Commission's (CC's) approach to analysing data on IDAs, including only using case studies from nine IDAs identified as being potentially problematic out of the 100 IDAs surveyed. The AAGBI voiced doubts that such a partial analysis was sufficient to assess IDAs properly. Further, there were problems with the CC's coding of medical procedures, discussed in more detail in the AAGBI's [response to the annotated issues statement](#).
8. Where the CC identified IDAs charging more than the local geographic average, the AAGBI believed that the alleged 5 per cent difference in prices reported by PruHealth represented excellent value for money for the additional safety of care and enhanced services that the IDAs provided to patients.
9. The AAGBI did not accept the suggestion that individual solus hospitals were being held to ransom by individual IDAs. The AAGBI's survey results indicated that all IDAs had at least some competitors. The AAGBI believed that there were alternatives and that the patient ultimately had choice: they paid the higher price (paid the top-up fee) or they went to another team in another hospital and received a lower cost service. This was realistic because if a surgeon began to lose clients because of unduly high anaesthetist fees, they could look to engage a cheaper anaesthetist—so fees would be controlled.
10. It was reasonable for PMIs to say that consultants were 'benefit-assured' or not 'benefit-assured'. However, by saying that consultants were 'unrecognized' if they did not agree to abide by a PMI's fee schedule, they effectively restricted consultants' practice and misled patients who might wrongly have thought that the consultant was not sufficiently qualified. As a result, consultants were unable to access some 75 per cent of the market, the proportion of the market controlled by the three largest PMIs, which all insisted on benefit assurance for recognition. This was a particular problem for new consultants, who might have felt inhibited from entering the market.
11. Patients who were dissatisfied with unexpected defects in the insurance cover they thought they had should have been able more easily to switch PMIs to receive a better service.
12. The AAGBI saw some insurers potentially misleading their customers with unintended misinformation at the point of sale, suggesting that all professional fees would be covered in the event of a claim. This was particularly the case for corporate clients who either failed to recognize this inaccuracy, or failed to inform employees accordingly. The AAGBI told us that it would be useful to know the outcome of discussions between the Financial Services Authority and the Association of British Insurers about introducing additional clarity of the benefits of PMI policies that subscribers were purchasing.
13. The AAGBI saw PMI premiums going up by far more than inflation, and in some cases by more than 10 per cent a year. At the same time, benefit maxima for consultant fees had remained stable.

The work of anaesthetists

14. The AAGBI advised that traditionally, the vast majority of anaesthetists were engaged by the surgeon or physician undertaking a procedure. In general, the surgeon would invite an anaesthetist in whom they had confidence to work in the private sector. The anaesthetist would then apply to the private hospital for admitting rights and those admitting rights would be granted if they fulfilled the fairly stringent

criteria applied by the hospitals. Anaesthetists might also be directly engaged by a hospital.

15. When a patient selected a surgeon, they were normally selecting a team—surgeon plus anaesthetist and other professionals, although requests for particular anaesthetists might have been accommodated. In general, the majority of private anaesthetists worked at particular NHS hospitals and were then invited to work at particular local private hospitals by their surgeons, while others worked at other NHS and more distant private hospitals.
16. The AAGBI indicated that the anaesthetic benefit maxima set by insurers was based on surgical complexity rather than anaesthetic complexity. Thus, similar anaesthetic benefit maxima applied even when the complexities of anaesthetic treatments might have been very different. In terms of the differences in anaesthetists' fees when they set them themselves, factors such as years of experience, sub-specialty expertise, outcome data, practice costs, location and PMI benefits, all might have played a part in explaining them. This would have explained the fee variations for similar surgical procedures across the UK. Moreover, insurers were increasingly bundling multiple surgical procedures into a single CCSD code, which might have further increased fee variation.

Benefits of IDAs

17. IDAs had the ability to mount a 24-hour on-call service for emergency care. The requirement for emergency care after surgery was extremely unpredictable, and if care provided to patients in independent hospitals was to match that provided in NHS hospitals, some form of on-call cover should be the norm.
18. Other benefits a group could offer, as had been highlighted by the AAGBI, included efficient scheduling, matching skills where a sub-specialty skill was required, and providing unanticipated services, for example sedation of patients. IDAs might also have provided a reliable pre-assessment service, and post-operative visits could be coordinated.
19. As a result of IDAs, protocols, procedures and guidelines had been developed over time to improve care and patient safety. The AAGBI also told us that IDAs had systems in place to provide information to patients.
20. The AAGBI pointed to the CC's own survey in which 60 per cent of anaesthetists in a group said that they used the fee-setting guidelines set by the group. In the AAGBI's survey, 66 per cent used the level agreed by the group, so these results were similar. The AAGBI believed that this was not a high proportion.
21. Increased net incomes and cost savings usually came from sharing overheads. So, for example, the AAGBI illustrated that a group of 20 anaesthetists might have shared a secretary and would therefore have shared the billing overheads. As a result, there might have been considerable savings in overheads by being a member of an IDA. However, these savings might have been offset or exceeded by the costs of the enhanced services offered.
22. The AAGBI stated that any price effect deriving from the setting of fees by IDAs was small, and that as the overall fees charged by anaesthetists were relatively low, there was no cause for concern, even if IDAs were charging slightly higher fees. Additionally, patients benefited from anaesthetists being members of IDAs, and this might be taken to justify any fee differential that might exist.

Code of practice on billing

23. The AAGBI Code of Practice was introduced in 2008 at a time when there were differences in billing practices between AAGBI members. There were significant differences between PMI benefits and actual fees, and anaesthetists were sometimes charging top-up fees. The AAGBI saw the code as being of benefit to both members and patients but admitted there was not 100 per cent compliance, as the code was voluntary.

Switching between PMIs

24. Switching occurred when customers were not satisfied with their PMI. This was illustrated by the AAGBI noting that Bupa had experienced a significant reduction in its subscriber numbers in recent times, leading to a decrease in profitability, whilst other PMIs with less restrictive benefits had seen an increase.
25. The majority of PMI products were purchased via third parties such as employers, and so the beneficiaries exercised substantially lower control over the choice of private medical insurance.
26. The AAGBI ideally would like to have seen unlimited choice, by which the purchaser could exercise choice with clearly defined and portable benefits, as opposed to the PMI exercising that choice on their behalf.
27. The AAGBI did not agree with PMIs not reimbursing the surgical fee or the hospital fee if the anaesthetist was 'unrecognized', ie not reimbursing the patient for any costs associated with a surgical procedure if any person involved in that surgical procedure was 'unrecognized' by them.
28. The AAGBI believed that redirecting patients away from one consultant to another purely on the basis of cost had led, did lead and would lead to adverse patient outcomes. PMIs claimed to make referrals on the basis of providing high-quality care based on the evidence that they had collected on outcomes and high-quality care, but the AAGBI had been unable to see any evidence of those outcomes—instead, the referral pathway appeared entirely dependent on cost.

Future of anaesthetists

29. Anaesthetists' private income might be at a critical point because insurers were exercising their buyer power in such a way that the result might be an exodus of anaesthetists from the private sector.
30. The AAGBI argued that although there was no clear evidence that there were shortages of anaesthetists at current fee levels, this could change, as there was a noticeable trend towards this eventuality. Some difficulties were already being encountered in acquiring anaesthetists to care for patients undergoing emergency surgery in the private sector, particularly in high-overhead areas such as London.
31. The AAGBI as an organization was absolutely and implacably opposed to incentives in the private sector. Hospitals incentivized surgeons to bring them private work by paying markedly different fees to surgeons and anaesthetists for NHS work conducted in private hospital that would normally be reimbursed on the equitable basis established in the NHS. The AAGBI saw this as a clear abuse in which NHS money was used by private hospitals to persuade surgeons to bring them more

private patients. Such incentives were an abuse of NHS funds and prevented other surgeons and anaesthetists from entering the private sector.

Final comments

32. In terms of information that could be made available to patients, in addition to information about top-up fees, information that the anaesthetist was required to provide for their NHS appraisal could be offered, for instance in an easily accessible website. There could also be evidence of clinical excellence awards and patient outcomes.
33. The AABGI concluded by stating that the IDAs could be seen as a model for good and responsible care when they were run properly.