

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with the Federation of Independent Practitioner Organisations held on 17 April 2013

Background

1. The Federation of Independent Practitioner Organisations (FIPO) was founded in 2000 to bring together a number of private practice committees that existed throughout the UK, including specialist groups. Initially, approximately 40 doctors representing many different specialist private practice committees and consultant associations met at the Royal Society of Medicine leading to the formation of FIPO.
2. FIPO told us that it was a not-for-profit company fully audited and accounted. There were no reimbursements and no board members received any payments. There were about 20 professional associations that were members. FIPO was not open to individual consultants. Some groups, like the Hospital Consultants and Specialists Association, which was an official trade union for about 5,000 or 6,000 consultants, had subsumed their private practice committee into FIPO.
3. FIPO had a charter that was set up in 2007. This was initially launched by the Health Minister in Westminster and supported by Royal Colleges and Specialist Associations as well as the General Medical Council (GMC) and Patients Association. It set the standards and quality that FIPO aspired to. The charter defined the relationships that consultants had with patients including the contract with the patient, the duty of care and the provision of fee information.
4. FIPO was also involved in appraisals for doctors leading to their revalidation. It held regular meetings for the profession around such matters, the last being at the Royal College of Obstetricians and Gynaecologists.
5. Every member organization of FIPO had a seat on the board as a director and took part at regular board meetings. They all participated in decision-making. Included on the board were a number of Medical Advisory Committee Chairmen from different private hospital groups. FIPO provided overall guidance to its members based on consensus from board meetings but did not dictate their actions or decisions.

Concerns

6. Doctors in clinical practice always had patients as their first priority. FIPO was increasingly concerned about potential and actual detriment that could affect patients. This was particularly in relation to patients who were subscribers of the medical insurers and did not know that their policies had been changed until they came to claim.
7. FIPO was particularly concerned about the open referral system, where a GP was no longer able to refer the patient to a particular consultant of the GP's and the patient's choice if the consultant was not on the insurer's prescribed lists. Instead, the patient was referred to a fee-assured consultant. This had led to inappropriate referrals and delays in treatment.
8. Bundling of procedure codes was another concern. Insurers did not want doctors to charge separately for different aspects of a procedure even though within the NHS

these would be coded separately. However, there were complexities and differences between procedures, and some operations involved more than one separate procedure. Bundling in the private sector did not recognize this or allow consultants to tailor their charges, because private medical insurers controlled the coding in a way that fitted with insurance requirements. FIPO advised that there was a group owned by five insurers that met and decided what the codes were, but different insurers still interpreted the codes differently, which added to the complexity. In addition, some insurers recognized a coded procedure for reimbursement whereas others did not.

9. In relation to top-up fees, to make the market work better for patients, FIPO believed that it was important that a patient should be able to take whatever benefit they got from their insurer to whichever consultant or hospital they wished. Although top-ups were not allowed in some circumstances, excesses did not suffer from the same problem, and patients routinely paid an excess on policies. Excesses were in a sense a top-up.
10. FIPO believed that many of the distortions in the market would actually disappear if the above trend were to evolve, as patients would feel empowered to use their available benefits.
11. FIPO highlighted a National Audit Office survey showing that the actual numbers of consultants who were involved in private healthcare had diminished. As a proportion it went down from 67 per cent in 2000 to 39 per cent currently. FIPO believed that this could be in part due to the salary of NHS consultants increasing over the same period.
12. FIPO objected to the lack of an independent appeals or arbitration process for consultants deregistered by an insurer, especially where consultants had been deregistered due to the level of their fees.
13. FIPO saw some insurers imposing fee maxima on newly appointed consultants which were tied to insurer recognition, which significantly reduced remuneration. It saw this as unfair practice.

Profitability

14. The main results from FIPO's profitability (net earnings before tax) analysis related to fee income and expenses. Fees appeared to have remained stable but had actually decreased in real terms between 2009 and 2011. Administrative costs, including secretarial support, office rental etc had risen over the past three years. Costs in London were generally higher. The frequency of malpractice claims and the cost of dealing with them was going up. The recent reduction in benefits introduced by insurers coupled with the anticipated rise in professional indemnity charges for all specialties meant that the sustainability of current net earnings before tax was looking doubtful for many consultants when viewed with a trend analysis.

Competition

15. FIPO noted that it was important for hospitals and clinics to invest in facilities in order to attract consultants and maintain standards, and that competition for consultants also depended on the range of specialities the facility focused on investing in. FIPO also said that whether Private Patient Units (PPUs) or NHS private beds provided an alternative to a full-service private hospital was geographically dependent. The fact that PPUs outside London had not developed in the same way as those within London was due in part to the reputation (nationally and internationally) and

concentration of the London specialist and teaching hospitals and in part to the market.

Consultants

16. FIPO was also of the view that there was reasonable information about consultants available which generally allowed patients to take decisions on cost and clinical grounds. Information from friends and relations was often allied with the opinion of the GP when making decisions about which consultant to choose, based in part on that consultant's reputation and track record with that GP.
17. When comparing consultants it could be extremely difficult to measure quality and many specialties were immeasurable. However, FIPO was working as the professional interface with the Private Healthcare Information Network to produce the clinical outcome measures in the private sector. This would enhance patient information although it was recognized that the interpretation of broad outcome measures could be misleading without case mix information.
18. Insurers should not be dictating their fees to consultants. Insurers paid benefits to patients and consultants charged fees to patients. Consultants should and largely did give patients fee estimates; the insurers could set the reimbursement at the level they wished, and patients could decide if they wanted to pay the shortfall for a particular consultant if one existed, or go to another one. FIPO's information from insurers had shown that the rate of shortfalling of consultants' fees was very low. The policyholder would be able to choose if they wanted to stay within the limit. FIPO did not necessarily agree that there was a risk that patients would equate quality with cost due to the imprecise methods of measuring quality data. It also pointed out that there were geographical variations in consultant charges based on higher practice costs in certain areas such as London.
19. FIPO's view was that 'open referrals' were made by insurers on a poor information base. The patients' choice and that of their GP was being removed but if patients wished to change insurer the market could not rebalance itself they could not switch as they were often locked into their policies, particularly if they had a pre-existing condition.
20. FIPO strongly advocated an 'any willing provider' approach so that a patient could take their benefits and see the consultant of their choice at their chosen hospital. FIPO saw Bupa's system as not being 'open referral' but rather 'closed referral' which was a flawed system. This essentially amounted to a fully managed care package, ie telling the patient where they got treated, how they were treated, who treated them, what treatment they would have and how much they would be paid. This was to control costs rather than for the patient's benefit.
21. With respect to incentive schemes, for example hospital incentives to consultants, FIPO was against this practice.
22. As part of revalidation to continue to hold a licence to practise, a system of enhanced annual appraisals for consultants was now in place. Responsible Officers at Designated Bodies were obliged to share information about a doctor's whole practice. This should be a further relevant way of assessing a doctor's fitness to practise.
23. FIPO said that BUPA was saying that doctors over 70 must be appraised by a consultant in their own specialty. There was no GMC rule about this at all. FIPO did not know why BUPA was intruding into these professional matters as these doctors had

been appraised formally under GMC guidelines and they would also have to pay again if Bupa was unwilling to accept their first appraisal.

24. FIPO saw the decline in consultants in private practice (from 67 per cent in 2000 to 39 per cent in 2012) as a gradual trend which would result in a significant reduction in the number of consultants undertaking private practice. According to FIPO, this could be attributed to a number of factors including the 2003 contract and work-life balance issues. However, the economics of private practice were now changing due to recent insurer's strategies and this would exacerbate this trend.

Consultant groups

25. FIPO saw clinical value in having consultant groups. These were in terms of the clinical practice such as holiday cover, emergency cover and sub-specialization cover.

Final comments

26. FIPO advised that it would like to see a completely open market in healthcare with improved quality information, which it was working towards. It felt that there should be portability of benefits for patients to enable them to use 'any willing provider'. FIPO also felt that there should be less intrusion by private healthcare insurers into clinical issues and patient management which were not the province of a Financial Conduct Authority regulated company. FIPO felt strongly that this was often leading to patient delays and detriment.