Consultant 50

28 June 2012

Dear Sir/Madam,

As a newly appointed substantative consultant in the NHS from [✂] I would like to bring to your attention my observations of the Private healthcare market.

1. Recognition of new consultants- BUPA and AXA have imposed conditions for me to join them. Without signing to those terms I could not have seen their patients. I understand that they cover nearly 70% of the market.

I did not join them for several months as I did not feel comfortable with their terms of recognition as it was against the spirit of the doctor-patient relationship.

But then 2 of my NHS patients said to me that they wanted me to do their surgery privately as they had full faith in me but I was not recognised by their insurer. This made me reconsider my position as it prevented me from treating my patients.

2. I then signed up to their terms of recognition but I have done so in protest as I have no choice in this matter and my patients choice is being restricted here.

3. These insurers have a separate schedule of fees for new consultants where they stipulate how much they will pay for consultations and procedures. These fees are in many cases 50% of the fees for the existing consultants.

This I feel is totally unfair as for the same work effectively I am being discriminated as a new consultant. I cannot according to their terms pass on these short falls to the patients as well.

I am told that BUPA have not increased their reimbursements for the last 10-20 years for what they pay for the procedures and now by having these restrictions and caps they have reduced the reimbursements by nearly 50% and more recently they have downgraded several procedures so the reimbursements are likely to fall even further.

Considering that the cost of practice rentals, secretarial and administrative services, indemnity insurance keep rising, in certain cases it is not even worth the time and effort in providing private services to the patients.

4. In my unit I know that all three of our recently appointed consultants in 2011-2012 have not joined BUPA as they feel that it is not worth it. This I feel limits the availability of future practitioners and reduces the choice available to the patients.

5. I have noticed that even if I am charging for the consultation and procedures as per the restrictive schedule stipulated by these insurers, they do not cover the cost of procedures and their follow up fully and pass on the short fall to the patients. In some cases I have known this to be nearly 50% of the amount.

I do not think that the patients are informed clearly in advance by the insurers that this is likely to be the case and that the patients will have to meet the significant shortfall. This leads to strain in doctor-patient relationship as the patient may think that this doctor is charging more than what is generally practised. The reality is totally different as I am charging for the procedure as stipulated by the insurer in their schedule of fees (which have not been revised and already very low for myself as a new consultant).

6. Certain conditions are considered chronic by the insurer so although they will cover the patient for the procedure but they do not cover them for follow up. To give you an example- for glaucoma (which is the second leading cause of blindness in the world and in the UK)- insurers do not cover follow ups. It is an asymptomatic condition so patient is not aware that they have a problem and that it is getting worse unless it is regularly monitored by the clinician. So in effect these patients cannot have private insurance based care for this condition.

Insurers cover for the surgery but generally cover the patients for only 0-2 follow ups. After glaucoma surgery at least 6-7 follow ups are required in the first 3 months. This has the potential to lead to failure of the operation if the patient is not followed up as per the required schedule.

The patient then becomes reluctant to come for follow up and this has the potential to lead to reduced quality of care.

7. Certain procedures are not adequately coded and funded by insurers. I know of procedures which are very complex and take 4-5 times time than some other procedures but they are coded at the same level of reimbursement or sometime even less. This puts off the hospitals and physicians to provide these vital services.

8. Insurers might argue that they have reduced the fees to keep the premiums low but in fact when I talk to patients their premiums have been going up year on year. As I see it they are reducing the reimbursements to the doctors and to the hospitals so it is very clear who is benefiting from these restrictive practices.

I will be grateful if the competition commission looks in to these issues in details and comes up with recommendations that reduce/eliminate such restrictive practices from the UK private healthcare service.