Consultant 77

19 July 2012

Sirs,
I am a full time Consultant in Orthopaedics and Trauma. I qualified in medicine in [✂] at the [✂]. I spent [✂] years working for the NHS and while I fully support the NHS I am now in full time private practice.

I became a consultant in the NHS in [✂] which is when I started in private practice as well. My specialist field is Orthopaedics and Trauma with subspecialties in knee surgery and hand surgery.

By [✂] senior colleagues like [✂] were charging up to £2,500 for an Arthroscopy on the knee. These colleagues have now retired. I have kept my fees increasing by on balance a small percentage each year taking into account many of the normal market forces that determine remuneration.

I would like to make you aware of some potential market failures that could be preventing, restricting or distorting competition.

The four largest private medical insurers BUPA, AXA PPP, Aviva and Cigna account for approximately 87% of premium revenue. Insurers have some influence on the selection and delivery of services through factors such as:

1. (a) approving hospital consultants: I was approved by all of these when I became a Consultant in [✂]. I did not sign a contract to restrict my fees in the insurance market. I know of one colleague in a sparsely populated area who told me that he began around the same time as me but he was threatened by one of these four insurance companies that if he did not sign up to a restricted fee structure he would not be recommended by that particular insurance company. I presume the same pressure was not put on me because [✂] has a large number of alternative Consultants in Orthopaedics and Trauma.
2. (b) restrictions in insurance products, limiting access to particular services or consultants: In [✂] of AXA PPP removed my provider status because he wrote that my fees were above what AXA was prepared to fund. I have lost many patients since that were insured through AXA even though they were prepared to fund the difference between my fees and the remuneration AXA offered against other consultants. AXA began to tell clients that they would not fund hospital fees or my fees if patients decided to stay with me. This has distorted my practice since before the letter in [✂].
3. (c) setting financial caps for individual treatments and/or involvement in the selection of treatment: none of the PMI providers have increased fees over the last 20 years even in line with inflation. The PMI providers have sought to distort remuneration through a jointly financed group called CCSD. CCSD combine well recognised clinical coding (OPCS 4) so that more complex surgical procedures cannot be claimed. I tend to continue to believe my contract is with the patient and not his or her insurer and so use the codes that accurately reflect the complexity of the procedure and individually negotiate the fees depending on my published schedule of fees and the complexity of the case. I have been told by other colleagues that they are over influenced by the insurers as to what they can offer a patient because of the reimbursement provided. I addition as the fees for some common operations (W8200) for example have dropped for those limited to provider fees over the last 20 years they have to operate on as many as 10 times the number of patients to achieve the same remuneration as I do. I have observed that these colleagues are operating

on as many as five patients needing a (W8200) in the same four hour period as I will operate on three. I know that this will not achieve that same quality of outcome achieved on fewer patients. My practice includes patients who have had missed diagnoses untreated come for second opinions and require second operations.

I agree with the idf in their summary copied below:

The theories of harm identified are as follows:

1. Market power of hospital operators in certain local areas eg a limited number of hospitals in certain geographical areas or a limited access to specific facilities in an area.
2. Market power of individual consultants and/or consultant groups in certain local areas. In part this may derive from a shortage of consultants in these areas or the existence of consultant groups collectively setting their fees.
3. Market power of hospital operators during national negotiations with insurers.

4. Buyer power of insurers in respect of individual consultants (see below).
5. Barriers to entry at different levels such as the bargaining power between insurers and hospital operators creating barriers to new local entrants or negotiating higher fees for procedures throughout the country based on limited provision in some areas.
6. The limited information available to patients, GPs and insurers, may distort competition and limit informed choice.
7. Vertical effects eg. Bupa's ownership of the Cromwell Hospital.

Buyer power of insurers in respect of individual consultants:

We understand that it is common for insurers to stipulate in their policies that there is a maximum reimbursement rate that they will pay consultants for a given treatment. Consultants may charge more than this amount for their services, in which case the insured patient is obliged to pay the excess. This may be subject to the terms of the agreement between the consultant and the insurer. We understand that some insurers stipulate that in order for certain consultants to be recognized to treat their policyholders, the consultant must agree not to charge more than the amount specified by the insurer.

Caps on the reimbursement of fees may be used by insurers to limit overcharging by consultants. However, this theory of harm hypothesizes that insurers may possess buyer power in relation to consultants which results in consultant fees being too low.

Effects of insurer buyer power over consultants

If insurers are suppressing consultant fees to a level below those which would prevail in a competitive market, this could lead to a reduction in the quality of service pro- vided by consultants to patients and affect the incentives to innovate. In addition, there may be distortions to competition between consultants when caps on the reimbursement of fees are applied to some consultants (eg newer or junior consultants) and not to others (eg more experienced ones). In the longer term, this may result in a shortage of consultants willing to practise and in a reduction in the potential output of the sector.

The IDF believes that caps on the reimbursement of fees restrict unfairly and, often covertly, a free market. Such caps are used by insurers to limit fees charged by consultants and that insurers may possess buyer power in relation to consultants which are anti-competitive and which could lead to a reduction in the quality of service provided and affect incentives to innovate.

The caps on reimbursement of fees applied to newer, junior consultants combined with the increase in costs, such as professional indemnity, secretarial fees, consulting room charges, CQC registration, etc may well result in a shortage of consultants willing to practice in the independent sector in the future, which in turn will be anti-competitive. Insurers are also limiting new consultants' access to an open competitive market, restricting their right to operate freely – which in turn restricts patient access to consultants who will not "comply". It is entirely possible that many of the best consultants are deterred by this policy which in some cases places profit before quality.

The IDF are opposed to "open referral", which we believe is in itself a misleading term, deliberately designed to obfuscate. As a system of referral it is poor medicine and one which may lead to insurers referring patients inappropriately to the wrong specialty or sub-specialty.

GPs provide the relevant information, past history and present medication, all of which may not be available to the PMI and which may well be vital to the specialist. The insurer may claim that their referral is made on issues such as quality rather than cost, but all agree that quality is not easy to measure. As well as that it is often obvious, but difficult to prove, that the hidden motive is selection by cost – as profit is surely a motivating factor in corporate policy. The GP, however, is in a good position to judge patient reported outcome as well as monitoring any significant complications. Where an insurer, refers a patient to a specialist who is "recognised" by that insurer and for treatment, within a hospital owned by the insurer, there appears to be a conflict of interest. Not only should there be a declaration to the patient by the insurer, but surely the patient should be offered an alternative specialist in a non – aligned hospital.

The IDF remain opposed to the concept of specialists being not "recognised", delisted etc purely on the basis of cost. Cost is a factor and may be an important one for many patients and they should be informed in advance of all costs and shortfalls. However, for PMIs to inform patients that a specialist is not "recognised" or has been "delisted" may well give the false impression that a doctor is no longer recognised or has been delisted by the GMC (struck off the register).

Please do not hesitate to contact me for more information regarding the lack of a free and open market because of the influence of the PMI companies.