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19 July 2012

I have been a Consultant involved in Private Gynaecological practice for the past [✂] years.

In that time the costs associated with my private practice have risen inexorably, as would be expected though sometimes at a higher rate than inflation.

The remuneration by BUPA however has not risen at all, though the patient subscriptions have indeed increased. On top of that BUPA has now unilaterally restricted the maxima paid for an outpatient consultation. Attached is the threat that any Consultant not adhering to this dictat will be de-recognised and patients not referred by BUPA to them – however excellent the care and appropriate for the patient this referral may be. As BUPA is one of the major providers this view has undoubtedly reduced the freedom of choice for the patients, often without their clear understanding of the real reasons behind this.

As a consequence the impact of Consultants who do, like myself, follow the BUPA maxima has been to drive down the costs of clinical care at least in respect of the central activity – that of a patient consultation and resultant clinical treatment by an expert. The well recognised overall increased costs in the private medical sector MUST therefore be extraneous to the treatment of a patient by the Consultant. Understanding the increase would need a perceptive focus on the insurance companies and the hospital costs. From the perspective of the individual Consultant the whole (voluntary) involvement in PH will depend entirely upon the profit margin available for what would otherwise (for the NHS Consultant) be leisure/family time. No or insufficient profit will result in far fewer or even no Consultants practising in this way. Patient choice thus is diminished or absent and BUPA will have effectively destroyed its own market.

BUPA have never expressed any kind of clinical excellence agenda, though this data is routinely collected and now forms part of the annual appraisal and in due course the revalidation process. The fee for service model used by BUPA does undoubtedly influence the model of care in PH – for that is what it was designed to do. Reducing the remuneration to the clinician may, in certain circumstances, increase the chance of (clinically correct) interventions in order that that particular patient interaction is a financially viable one. Arguing for increased competition amongst Consultants (and hospitals) on the basis of a tightly controlled and less than market value fee for service model will ensure a driving down of clinical standards and a real risk that excessive and inappropriate interventions will be recommended so that the Consultant and Hospital can be financially successful. As noted above with a remuneration scale artificially fixed (and now lower than it would be in a free market) even this change in practice would, of itself, have little impact on the overall cost of healthcare. The greatest costs would still be those of the insurers and the hospitals.

A different economic model that severely reduces the financial burden of the insurers to the patient whilst ensuring that the hospitals can function in a profitable manner would be hugely desirable. The key interaction will always be that of the patient – Consultant which again has to be financially profitable for the Consultant. Reducing the overall costs of a private practice to the Consultant would be difficult – the hospital costs and administrative costs have increased as per the market. Indemnity insurance has also increased as per the market and is unlikely to see any major reduction. The challenge is ensuring that patients receive the quantity and quality of care that their condition requires as the primary driver of the process. There is now a process for doing that through annual appraisal together with collection and peer review of case management data by the private hospital senior clinical committee. Financial competition, as argued by BUPA is not the correct driver if clinical excellence and patient safety are paramount.