Consultant 79

23 July 2012

Dear Sirs,

I would like to make some comments regarding the private insurance companies support for systemic cancer therapies.

I am a consultant medical oncologist with nearly [✂] years clinical experience in both NHS and private care.

There are a number of restrictive practices that affect my freedom to practice in the private sector and also the quality and choice of care offered to patients.

Firstly, the agreed maxima for the supervision of chemotherapy and other supportive therapies have hardly changed over a number of years. They do not reflect the increasing complexity of care and changes in toxicity caused by new agents, nor the work that is required to supervise their administration. The rates are probably appropriate to adjuvant (post-surgical) therapies in fit patients but do not provide adequate recompense for the care of ill patients with advanced disease and multiple symptoms from their cancers.

The only recent change by some companies has been to offer an increased rate to consultants who arrange for treatment to be administered at home by one of the private providers, rather than as a hospital-based day-case treatment. This reduces costs for the private medical insurance companies (PMIs) (through VAT benefits).

Most patients prefer treatment at home when it is safe and available, but some do not and some patients need to have their treatment within a hospital environment for safety reasons. The perverse outcome, from the consultants' perspective, is that we are, therefore, paid less to supervise more problematic and complex therapies in hospital than we are to support less toxic therapies in the community. There is also a pressure to arrange therapies in the patients' home (through marketing of this service to patients by insurers) when many consultants would prefer the therapies to be provided within a safer environment.

Secondly, it is quite frequent, in my experience, that PMIs attract patients into expensive insurance policies, then when they come to claim, particularly for an expensive systemic biological therapy, bribe the patients to accept NHS care rather than to utilise the insurance that they have paid for. This distorts the market, although it clearly keeps costs down for the PMIs.

Thirdly, there are a number of expensive biological therapies, often administered along-side conventional cytotoxic therapies, that are licensed to be administered continually until the patient's cancer shows signs of progression (i.e. no longer benefiting from therapy). Several companies sell policies that do not make it clear to patients that funding of such therapies will be limited to an arbitrary time such as 12 months. This has no basis in clinical evidence an leads to patients with confidence in an existing private provider having to switch to the NHS (if the treatment is available there) or stop a beneficial treatment.

Finally, the support for patients with advanced disease is limited in a number of ways. Patients, who have developed long-term relationships with their private medical consultants and hospitals often find themselves completely unsupported by their PMIs when they reach late stages of disease. They are not covered for "palliative therapy" or symptom control as in-patients. These admissions can only be arranged if they are re-labelled as for investigation, and the duration of the admission is then limited by the insurers, leading to

switches to NHS care against the wishes of the patient. Essential components of care such as private ambulance transfer are not covered by the patients' policies.