Consultant 80

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Consultant fees, professionalism, competition and opening up the PMI market

The OFT has indicated its dissatisfaction with the potential for competition between consultants, with the opaque nature of the fee structures and the limited ability of PMIs and patients to access data on which to base choices.

- The background to the apparently opaque workings of consultant private practice is the historic code of conduct among doctors whereby they have been loath to openly compete with colleagues or to advertise in the media. This has been supported by the GMC. Rather, referrals to consultants in the NHS and in private practice have depended on their developing reputation in treating patients effectively and well. It has not been a perfect system, but it has avoided the worst of marketing excesses. Also, it has meant that more experienced or potentially better clinicians were likely to be referred more work – as would likely be desired by private patients.

- Bupa, a dominant force in the market, has manipulated consultants working in private practice to prevent the normal workings of the market by restricting or limiting the choice of consultants available to patients and their GPs and by preventing or threatening to restrict access of large numbers of consultants to a large section of the PMI market.

- In a fair and open system consultants would compete with each other for a share of private practice. Private Hospitals would compete among themselves for a share of the private practice work. Private medical insurers would compete with each other for market share of the insured patients. *There would be no need for contracts, informal arrangements, restrictions or incentives between any of the 3 groups.*

- Consultants should actually have no fear of competing openly in the PMI market. Individual consultants should be free to set their fees, and to publish their fees, procedure costs, areas of clinical expertise and clinical outcomes where these are available. The Competition Commission should encourage them to do so.

- Open competition between manufacturers of cars or bread have improved the quality of both and have not been associated with a drop in the price of either long term. Free competition in the market is likely to be fair to the consumer and the provider.

- In contrast, the price of private medical care especially with regard to operations by surgeons and anaesthetists has been held down by holding consultants to unfair and anti-competitive contracts with PMIs. The PMIs are neither consumer nor provider but are currently distorting the market for their own advantage.

- Consultants need to shake free of all anti-competitive contractual arrangements with PMIs. All consultants who are judged competent to hold a substantive NHS post should be free to enter and compete in private practice setting their fees at levels that they believe that the market will bear.

- The PMIs should be prohibited from using withdrawal of recognition or "derecognition" as a strategy or threat to force consultants into fee-reducing contracts which run contrary to market forces. "Recognition" should be accorded based on clinical standing and withdrawn only for reasons of questionable clinical competence or lack of probity – as originally intended.

Private health insurers and consultant reimbursement

Background

- Everyone in the UK is entitled to high quality health care through the NHS. The NHS has improved immeasurably over the past 20 years with more consultants, greater specialization, centralization of services, targets which limit the wait for treatment and through improved pathways of care for serious illness e.g. cancer.

- In this context, private health care is an option for those who wish to pay for it. It is an extra, a luxury, not an essential for health. It is a choice made by patients who want something different from the NHS. Often what they want is a guarantee of consultant treatment, a consultant of their/their GPs choice, continuity of care, a hospital that is more pleasant than the NHS one and treatment at a time that suits them.
- Consultants provide medical care to private patients. The great majority of such consultants hold substantive NHS consultant posts. Some have a small private practice, some a larger one. There are many consultants who do no private practice, many who do could do more.

The nature of consultant work in the private sector and the justification for fee levels

What does the work involve and what justifies what consultants are paid?

- The consultant caring for a patient in private practice does so in isolation from the normal support staff and structures of the NHS.

- In the case of a surgeon performing a removal of the right side of the colon for cancer, the care that he is expected to provide includes:

    - Consenting the patient for operation,
    - arranging all necessary preoperative tests and workup, arranging admission, booking theatre time, discussing with the anaesthetist,
    - arranging for an assistant and paying that assistant (typically 10% of the consultants fee),
    - carrying out the operation which may take 3 hours;
    - reviewing the patient later that day to discuss findings and plan,
    - visiting, often twice a day and at least once a day for every day that the patient is in hospital, - each of these visits usually involves a drive from home or NHS hospital base at the start or end of the NHS day. Each visit involves the consultant checking the patient's observations, fluid balance, blood results, and examining the patient for evidence of recovery or complications
    - During this period, which can last a week, the consultant has to be available at all times day and night for calls regarding the private patient and can expect to be called if the patients gets pain, fever, vomits or is otherwise unwell - whether these issues are serious or not – because there is only the consultant to deal with them – no junior staff. That is what the patient expects and it is the deal that the consultant makes with the patient in engaging in private medical practice.

- The surgeon's fee for this "procedure" according to the Bupa maxima is £741 in 2012. This compares with £690 allowed to the surgeon 15 years ago in 1997. And if the surgeon brings an assistant he will be expected to pay 10% of the fee to the assistant, funded by himself.

- The consultant surgeon's responsibilities are comprehensive, available 24/7 and personally delivered. They extend way beyond the "procedure"

How the market has traditionally worked in respect of fees charged

- Private medical care begins when the patient wishing to have treatment privately rather than in the NHS advises his / her GP of this and the GP refers the patient to a consultant of his / her choice.

- Consultants working in the private sector mostly do so as "sole traders" who are paid on a "case by case" basis. They need to pay medical defence fees as well as the costs of private consulting rooms, secretaries and pension contributions to cover their income from private practice.

    - Consultants have to apply to the major insurance companies for permission to treat their insured patients – "recognition". They have no effective representation in discussions with the PMIs regarding terms and conditions. They are not employed by the PMIs.

- The primary contract in private medical care has been between the patient seeking private medical care and the doctor providing it. The level of fees charged has been left to the discretion of the doctor providing the care.

- In 1992 BUPA invested a lot of effort into streamlining the fee structure for operations by indicating in an extensive schedule a gradation of procedures from minor to complex major and a corresponding schedule of "benefit maxima" – the maximum payment that the company would make for these procedures with regard to surgeons and anaesthetic fees.

- Other insurers devised slightly varying benefit/fee schedules.

- The insurers, especially BUPA, encouraged consultants to work within the benefit maxima i.e. to bill within the maxima so that their members premiums would fully cover the costs of treatment. However, BUPA respected the consultants freedom to set fees as he / she determined within the market. There was no obligation to set fees within BUPA maxima. However it was clear that such consultants would need to discuss their higher rates with patients who would have to pay the balance (shortfall).

- BUPA introduced the "Consultant Partnership" as an inducement to consultants to work within their benefit maxima in return for a percentage reward at the end of each year (10% for operations, 20% for non-operative treatment). Many consultants signed up to the Partnership.

- BUPA maintained a list of consultants who were "recognized" and a list of those who were also "fee assured" – indicating that they worked

within the BUPA benefit maxima. This list is available on the BUPA website and is freely accessible to GPs and the public.

BUPA pressures on consultant fees

PMIs aim to keep premiums down. A key mechanism has been to drive down fees paid to consultants. In this regard BUPA have acted aggressively but are being followed by some of the other PMIs notably AXA-PPP

BUPA's approach to reducing consultant fees has included:

- Generating bad press for consultants. BUPA claim that *"over 80% of BUPA client premiums are paid out in medical costs. It is medical inflation that drives the annual premium increases that our clients face each year"* (in fact the OFT found that in 2010, £1.59 bn of the £4.92 bn spent on PH went on consultant fees – 32%).

- Pretty much freezing benefit maxima since 1995: Having got agreement from most consultants that they would charge within BUPA's benefit maxima the company has not allowed these maxima to keep pace with inflation or CPI or other measures. Whereas a few procedures have increased in fee value the overall effect has been a freeze on fees paid to consultants for 17 years

- In an act of bad faith with consultants who had agreed to work within the BUPA benefit maxima BUPA have recently begun a programme of fee *reductions* e.g

    - disallowing payment of a follow-up consultation fee if a procedure is carried out – only the procedure fee is now paid – an effective fee reduction of perhaps £80-100 to the consultant.
    - Bundling or combining of procedures previously paid for separately to reduce the fee paid.
    - Downgrading the accepted complexity of procedures to reduce the fee they attract
    - Stopping payment for local anaesthesia given by the surgeon for an operation under LA.
    - The net result of these changes is a reduction in payment for the same work by 20 – 30%
    - These changes have been made without discussion or negotiation with the consultants.

- Where consultants have attempted to increase their fees for treatments or procedures beyond BUPA maxima rates or to continue to charge at the rates they agreed with BUPA before the above changes, patients understand (1) that the insurer will not pay the difference and (2) that the patient is not expected to pay it either – thus clearly curtailing the consultant's ability to set his / her level of fees.

- By reducing the fees payable for procedures Bupa have created a position where "shortfalls" are inevitable but appear to be caused by consultant.

- In 2010 BUPA introduced a new "recognition" process. New consultants have to sign an agreement indicating that their procedure fees will be within BUPA benefit maxima. Their consultation fees are also specified with an allowance that they increase by 2% on 30th September 2012. "Increases after this period will be notified to you following a market review by us". It is made clear that consultants signing this agreement will be "derecognized" if their fees exceed the agreed maxima. BUPA now have a workforce of consultants recruited since 2010 whom they have coerced to agree to accept whatever fees BUPA decides to pay them on pain of exclusion from treating BUPA members.

- In the "Terms for BUPA Recognized Consultants (newly recognized from 2010)" are the following clauses:

    - "You agree to ensure that any referrals to other consultants are made to BUPA recognized consultants"
    - "You agree to promote referrals to BUPA recognized providers whenever clinically appropriate"
    - each of these clauses is in breach of competition law!

- Whereas derecognition was formerly only applied if there were serious concerns about a consultant's competence in private practice or in the NHS, or if he was involved in fraud / serious issues of probity; now it is being used as a means to prevent consultants setting their own fees. It is being used to restrict GP/patient choice and to undermine the legal contractual relationship between the patient seeking private care and the consultant providing it.

- In the survey of the Association of Anaesthetists of GB & I 24% had been threatened with derecognition over fees and 5% had been derecognized. The PMIs most likely to act in this way were AXA-PPP, Bupa and Aviva.

- The threat of derecognition is a powerful tool being used by PMIs, not simply to protect patients from incompetent or fraudulent doctors as was originally intended, but in a cynical move, to control the fees paid to consultants and increasingly to control the entry of and access of consultants to the private healthcare market. It breaches competition law.

- BUPA have introduced an "Open Referral" process whereby members of BUPA Corporate Select policies will contact BUPA and be given a choice of consultants recommended by the insurer. This policy directs patients only to "fee-assured" consultants. Whereas older established consultants abide by the Bupa maxima for procedures they have to date been free to set their own consultation fees. Newer consultants "recognized" since 2010 will have been obliged to accept low consultation fees and will fit the criteria for "open referral". As a result, Open Referral will restrict choice of consultant and will favour the cheapest least experienced consultants.

Proposal for determining consultant fees in the Private Healthcare Market

- a response to the investigation of the Office of Fair Trading into the Market

The Private Healthcare (PH) industry is in chaos.

Consultants are being increasingly squeezed by imposed fee reductions especially so in the case of Bupa.

Private patients want to see chosen named consultants but Bupa are trying to convert many to an "Open Referral" policy

Bupa admit that they receive 1,000 calls a week from members unhappy about their subscriptions and about "shortfalls"

The PH market has been investigated by the OFT and found to be likely in breach of competition law.

The PH Market has been referred to the Competition Commission.

Patients, Consultants and Private Medical Insurers are all unhappy.

Meanwhile the NHS is getting better, nobody really needs Private Healthcare, the proportion of the population taking out PMI is dropping.

If we do not sort this out there will be no Private Healthcare Market to discuss.

Solution

"Fee setting" by trade or professional groups would appear to run counter to competition law and against consumer interests. However, where there is scope for excessive fee levels or inadequate reimbursement for providers it can be justified (this proposal suggests this mechanism as an interim solution)

> The Law Society publishes recommendations on fee levels in relation to aspects of "non-contentious" work e.g. conveyancing, probate. The scale advises solicitors of the percentage of property value or estate value that can be claimed in fees apart from time based and paperwork-based charges. Essentially the major part of the fee that can be charged is regulated or advised through the Law Society. This means that clients can know up front what the major charges are likely to be in their legal costs.
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> In a very different scenario, the Competition Commission determined that a scale of fees arbitrated by an *independent assessor* was an appropriate way to agree the reimbursement of car hire organizations for replacement cars following accidents in which the non-responsible driver could claim against the responsible drivers insurance for the expense of car hire during repairs. The background here was the potential and history of excessive charges to be made by one insurance company against another.

These settings have parallels with, and act as precedents for, Private Healthcare and consultant fee levels. The issue for Consultants in Private Practice is that they have pretty much lost their ability to set fees and so to compete (if they wished) because of arguably unfair and inappropriate practices by the major PMIs (see Appendix). On the other hand, information allowing choice of consultants by GPs and patients based on quality and price is clearly inadequate (OFT). Patients with an illness are in a poor position to choose who to see especially given the inadequate data currently available.

This proposal aims to provide a basis for agreeing consultant fee levels now and a mechanism for moving forward to a better informed, competitive consultant market as part of a more functional Private Healthcare industry. It addresses many of the issues raised by patients, consultants, PMIs and the OFT in a fair and practical manner.

Proposal for determining consultant fees in the Private Healthcare market

Phase 1

1. PMIs and consultant groups to agree to an **arbitration panel with an independent chair** to determine fee levels for Consultants in Private Practice based on Bupa scale or similar.

2. Arbitration Panel to advise on appropriate fee levels for procedures as now, and also for consultations (new and follow up) taking account of real concerns of the parties.

3. Same scale to be applied to uninsured patients seeking private medical care

4. Scale of fees to be agreed nationally and available on the Internet and in GP surgeries.

5. *Consultants free to opt in or out of the scheme*

6. Aim to include all specialities e.g anaesthetists

7. Panel to be authorized to investigate complaints of excessive fees, inappropriate fees or excessive use of consultations, investigations treatments or procedures by consultants.

8. Consultants to supply Arbitration Panel with data on key quality indicators and clinical outcomes from NHS and private practice relevant to their particular speciality. Measures to be determined but to include at least the indicators of quality used by their NHS units.

Phase 2

9. Panel to monitor outcome data for key quality indicators to inform re a potential uplift in fee levels for consultants achieving high percentage of best quality outcomes. No uplift for most, perhaps reduced fees for those not providing data or with worst results (or stop them!).

10. Revised fee schedule incorporating individualized results for quality assessments to be available to GPs at point of consultant choice – in the GP surgery and on internet.

What would this achieve ?

1. Remove the threat to patients of generic referral to consultants: Patients and their GPs value the ability, in private practice, to choose their consultant even if the criteria available are "soft". The present proposal equalizes fees and therefore eliminates or greatly reduces the incentive for PMIs to pursue "Open Referral" policies. This may strengthen the PH market.

2. New, more comprehensive fee structure for consultants covering consultations, follow up appointments, and procedures / operations and including self-funding patients.

3. Clarity of fee structure for GPs, patients and PMIs.

4. Same clarity of fee structure for self-funding patients who up to now have not had the "protection" of a PMI.

5. Control of / avoidance of unpredicted or excessive fee levels: Agreed fee levels would be covered by PMIs.

6. Patients and GPs would remain free to choose non-participating consultants (-competition)

7. Elimination of anti-competitive deals / incentives to consultants from PMIs or facilities e.g. BUPA Consultant Partnership

8. Avoidance of inappropriate tactics by PMIs to unreasonably hold down or reduce consultant fees. Equally, inappropriately high fees would be impossible except with consultants outside the scheme

9. Fair payment for consultants: The more successful consultants gaining more referrals would earn more but the cost / payment per procedure would be the same. Given the lack of outcome data it seems fair that the same operation bills at the same rate regardless of who is doing it – but this will change once evidence accrues.

10. Incentive to consultants and providers to determine appropriate quality endpoints and to meet them. In time, there would be increased remuneration for better-achieving consultants with data on which to judge clinical outcomes. This should lead to a revised / upgraded fee structure more closely relating fees to clinical competence/outcomes.

11. In time, (5 years) the development of a better PH market with competition more informed by clinical outcome, patient experience and costs as well as the GP's advice on who to see.

What would it not achieve (at least initially)?

1. A competitive market among consultants from the start: The OFT has correctly identified the current difficulty in choosing a consultant because prices are obscure and clinical outcome data is inadequate. The OFT advises that PMIs have little to go on other than price in selecting consultants. This could be seen as an encouragement to PMIs to ratchet down prices - as they have been doing. However, this is bullying rather than competition. Encouraging consultants to compete on price is difficult because their code of conduct / GMC restrict their ability to self-promote, advertise or denigrate their colleagues. As in 3 (below) the intention is to combine a phase of fee-setting with data collection leading to a new fee structure reflecting individual consultants outcomes.

   Consultants will be free to join the scheme or not to and patients and their GPs will be free to choose consultants who are outside the scheme and who bill at their own rates. This ensures that the market with regard to consultant choice is open and favours competition on price. This small group of consultants might charge in excess of agreed levels of PMI cover and patients would have to be advised and prepared to meet the shortfall.

2. Lowering of consultant fees: An independent panel is unlikely to support fee levels for procedures or operations that date from 1992 !. A modest increase in the fees allowed is likely. However, the PH market is struggling and consultants want it to succeed as much as any other party. So, consultant representatives will be reasonable in their claims regarding fees. Also, while baseline fees may be expected to rise, elimination of excessive fees and shortfalls will make for a better, more predictable experience for PH patients. This in turn will help to maintain subscription numbers.

3. Greater clarity regarding choice of consultant – at least initially. Later, with data accruing and incentives to supply the data, GPs and patients will be much more informed and there will at that stage be a price difference between those who have good outcome data versus those who have not collected data or whose outcomes are poor. Just as in the NHS, clinicians who are not very good at something will either stop that area of practice or be advised that they must stop or retrain.

4. Scale of excellence for all consultants for all treatments/procedures. It should be possible to identify better versus worse outcomes for common major operations or treatments but it will not be possible to grade consultants in every aspect of the care they provide – it would be impractical and too cumbersome. Therefore there will be a reasonable assumption that consultants level of practice in the key areas relevant to their speciality is likely to reflect their ability across the breadth of their speciality.