Consultant 105

17 July

Dear Sir,

I write as a consultant surgeon of [✂] years standing and as an individual who has purchased private health insurance for my family for the last [✂] years. There are many aspects of PHI provision that are not in the consumers (patients) interests and in very general terms it is clear that those parties that have enjoyed ever rising revenues are the beneficiaries of these biases. The CC enquiry is a once in a generation opportunity to reset these biases for the future and should be seized upon without compromise.

As a purchaser of healthcare insurance during the last decade I have seen constantly rising premiums irrespective of claims history. There has been increasing control over my patient "journey" by the insurer and terms of cover have been changed both during a policy year and at renewal. On the other hand the efficiency of claims handling has been improved and the choice of providers in the market has risen dramatically. However this apparent choice of insurer is misleading, the exclusion of previous medical conditions seriously limits choice and allows the insurer to lock you to their existing policies, and providers, for life. It reminds me of the difficulty I used to have changing bank account, mobile phone provider or even utility supplier, but more is much more important and really impossible to circumvent.

It is also clear that different insurance policies have different levels of cover, and this is reflected in price but is opaque at the time of purchase. As a provider as well as a customer I can carefully research this to obtain the right cover for myself, but the general consumer cannot. Further corporate policies are used as an employment "perk" and the end user cannot really choose cover level, so insurers can lower cover to be attractive to coporate purchasers but maintain their own margins at the expense of the consumer and the providers. Some restrictions are particularly opaque. For instance very few hospitals will treat small infants under 3 years age, but in London most of these hospitals are considered "premium" and are excluded from many policies, but purchasers with young children on their policies are not aware of this until they claim.

As a provider I have generally been surprised at the conduct of multi-national insurance companies, who use their considerable power to make your life difficult as a provider. When I started private practice I was very pleased to be given "recognition" by the insurers. My status as an NHS consultant was enough, which I thought quite reasonable, given the very high standard of regulation and responsibility taken over this appointment, and the subsequent maintenance of GMC registration.

My first surprise was the difficulty we initially encountered in getting payment. The insurers wanted to be billed directly, though of course the "contract" is with the patient. This allows the insurer to pay the amount they want to and then pass on the excess or reject the claim, leaving you to pursue the consumer for the deficit. This confuses and upsets the patient and delays the payment. Sadly many payments are "lost" when settled by the insurer. You receive a payment list at the end of the month and then have to check each patient to see that how much the insurer has paid and what is due. From our perspective we should be better off billing the patient directly, but we recognise that this is difficult for the patient. If the insurers want the benefit of direct billing, effectively having a contract with us, then they should recoup the excesses from their client themselves.

More recently dealings with the largest insurers have been confrontational. The issues I would like to mention are:

1. Threat of derecognition

After [✂] years of BUPA recognition, and having not increased my outpatient consultation fees for over [✂] years I recieved a letter in April 2012 claiming that my charges were higher than "average" and should be reduced to a specified level immediately. [✂] As a consultant most of us are single handed businesses and cannot afford to lose our livelyhoods, we are easily bullied and do not feel that negotiation is a realistic option. Unsurprisingly I reduced my fees but of course it may become necessary to limit the slots available to this insurer, which is to the patients disadvantage and out of their control.

Derecognition seems to have no relationship to quality of service, expertise or qualification. It would be so much more transparent to the consumer if the insurer stated what they are prepared to pay, then those of us who want to provide a premium service can do so, and patients can choose as they want. Yes, information availability is an issue, but the system discourages consumer driven choice by keeping the negotiation at the insurer level. I could for instance offer differential pricing for appointments in the evening or "off peak", but this is not possible with our current insurance company driven arrangements. Quality in healthcare has many aspects, the professional bodies like the GMC and College of Surgeons monitor clinical care, but patients also choose care for convenience, facilities, time available, backup facilities, reputation, personal recommendation, interpersonal confidence in the doctor etc. Consumers do this for lawyers, dentists, builders, plumbers etc, but the insurers want to remove all these factors so they can direct work based on their own needs, mostly around cost, as we have seen. They do not have the experience, data, independence or authority to monitor clinical standards, nor do they provide any transparent assessment criteria or appeals process. It is totally unclear to me what measures of quality I must aim to provide to maintain registration, other than reduce my fees.

2. Control of operation coding

The initial and central step in developing a charge for an operation is to work out what codes are appropriate for the procedure. These descriptions are through the CCSD, which is an insurer controlled organisation. They claim that each company can then set its own reimbursement but they seem to "co-operate" in deciding which procedures constitute unbundling. This system creates a perverse incentive for them to limit coding practice to control fees, and as all insurers publish their fee maxima per procedure freely, price fixing can occur. There is virtually no price competition as we will all usually charge the maximum that the insurance company allows. Coding practice becomes complex. Surely the decision over what constitutes "unbunding" must be taken by an independent body, or based on the existing NHS coding system, which is not subject to this manipulation.

3. The NHS benefits the private insurance company. Because of NHS comprehensive cover the insurance companies can tailor their policies to predictable elective care only. Most policies exclude obstetrics and congenital disease. As a parent of a child with treated congenital illness it is frustrating that she will never be insurable for this. Complications are dealt with by the NHS, and procedural pricing is structured to significantly discourage the treatment of complex problems in the private sector. The insurance companies know that by reducing fee levels for complex surgery we, the providers, will tend to keep private practice cases simple. This keeps PHI away from the hospital and investigation costs of treating difficult cases (which are much greater than the surgical fees).

The fee schedules are very similar between insurance companies for all operative procedures. However it is very apparent that for example, a "Mastectomy and immediate reconstruction of breast using expandable prosthesis" should be much more costly than 4 X "Drainage of breast abscess including haematoma and seroma", given the complexity of the surgery, the skills needed and the aftercare required. Can all the insurance companies have independently made the same level of error in setting reimbursement, or is there covert price setting ?

4. Care of the patient

The doctor has a duty of care to the patient. This is entrenched in practice, regulated, monitored and constantly reviewed by competent authorities. Our patients are our first priority. If we care for them inappropriately we can be sued, be investigated by the GMC or lose our right to practice after decades of training. More importantly we are driven to care for patient in their best interests, this is what builds your reputation in medicine and provides your job satisfaction. Decisions over care should stay in the hands of the patients and the doctors they deal with. Insurance companies constantly talk about protecting consumer interests, value for money, and keeping private healthcare affordable. This is disingenuous, they want to stay in business and keep profits up. Directors renumeration in these companies is significant, and is company performance driven, not patient care driven. For the sick individual the only person who has a regulated duty of care to them is their doctor, insurers should not interfere with this except through the regulatory systems that exist already.