Consultant 146

11 October 2012

Dear Sir,

Further to my previous submission and the submissions published on your website I have thought of a number of points that I think merit consideration. I write as a consultant surgeon of [✂] years standing.

1. Inducements

It seems to me necessary to quantify the degree of inducement being offered by providers (Specialists) to insurance companies in order to be "recognised" or seen as fee assured. Whilst the insurer may claim this reflects value for money, it actually acts as a brake on fair competition. A discount offered (under duress) to an insurer (eg BUPA) of 10-20% per consultation in order for recognition is a significant inducement for the insurer to promote that provider and lower their costs. Neither the insurer or provider tell the customer that this is the situation. In addition the effect of this forced discount is that other smaller insurers cannot enter the market at a competitive level. The insurer is not benefitting from a fair "volume" discount, as there is no guaranteed volume of work involved, just guaranteed discount. The specialists may unwittingly be "inducing" the insurer to refer to them. The discounts involved quickly mount up and are recurring year on year.

Clearly the insurer will benefit from having fixed lower charges from "fee assured" specialists, but because of the oligopoly enjoyed by BUPA/ AXA it is likely that the insurer will force the prices to the lowest level at which they can deliver any kind of service. By insisting that "new" consultants sign up to these levels they are being highly opportunistic. When you first begin your practice you have very few overheads and very few patients. Your NHS income is your mainstay, and you can subsidise your developing private practice with it. It is tolerable to work for very low fees in the hope that it will allow you to become more established and then generate work by reputation and word of mouth. I think that the current new consultants who have signed these restrictive agreements duing the last 12-24 months will only really begin to regret their position in 24-36 months time, when they are very busy, with significant overheads, trying to stay afloat. At that time if the difference between private charges (after admin, insurance etc) is not greatly above the level of overtime pay in the NHS (which involves no extra admin and no rise in indeminty), then the temptation to leave or limit private practice will be apparent, but a new group of unwitting "new "consultants will be ready to subsidise the insurers in the hope of growing a successful practice. The permanent lack of experienced doctors will eventually damage PH, and mean that patients no longer can access experienced doctors.

Because of this abuse of their undoubted market power the policy of letting insurers set recognition criteria linked to fees cannot be fair. If there were many insurers then we could "opt out" of those with low fees, but for BUPA and AXA this is not realistic, as no one can survive without their business, and despite knowingly enjoying their monopoly employer status they have attempted to squeeze the provider to generate greater margins.

The insurers are also trying to influence other matters of care by linking recognition to financially driven decisions. For example BUPA's new "Premier Consultant Partnership" requires that you refer to BUPA recognised consultants, use only BUPA recognised facilities and anaesthetists, unless you can make a clear clinical case not to. In practice this will drive work internally to BUPA, and dissuade you from making the normal decisions you would if not tied to BUPA recognition. This surely is abuse of market power at work.

2. Comissioning

Bupa have puported themselves to be comissioners of healthcare services for their members, not just insurance providers. Where is their commissioning policy ? The NHS comissioners (primary care trusts until next year) have clear, transparent policies on what is being comissioned under what circumsnces (http://www.commissioningboard.nhs.uk/files/2012/06/fact-comm-dev.pdf). They also have a statutatory duty to provide healthcare services, and an enforceable appeals policy for comissiong desicions that are seen as unfair. They have to abide by NICE criteria and if a patient is disadvantaged by a comissioning decision then it is clear where legal responsibility for the outcome lies. BUPA wish to use the title, without accepting the responsibility that goes with it.

3. Vertical Integration

I fail to understand see why has BUPA not pursued this at their own BUPA- Cromwell hospital. Surely for anaesthetics, which they see as a contractually difficult specialty, it would be simple to employ full time private consultants paid on a sessional rather than fee per item basis ? Patients could be looked after on a rota, as in the NHS. I suggest they realise that the true costs of such a system are very high, if they want to attract the highly trained professionals away from the NHS with the long term benefits it offers. Perhaps also they suspect that patients would not choose this method of care without a significant incentive, or realise that then they would truly be responsible for delivering that element of healthcare and have to satisfy the CQC etc of their ability and competence. In reality the current system continues because it offers very high quality to the customer with minimal managerial burden/ responsibility on the insurer.

It should be noted that BUPA now advertise the services of their hospital through their insurance website, especially in Paediatrics.

4. Costs of treatment

[✂]

For other conditions the bill might be kept down by not offering investigations or treatments though a lack of ability or knowlege of that condition. The treatment "episode" would be closed and this consultant would appear good value, but the condition might resurface and initiate another claim weeks or months later. In clinical studies the follow up period for treatment is a crucial determinant of the reliabilty of the study (eg cancer survival, back pain control). For some conditions a follow up of 5 years plus is needed to determine if a treatment is effective. Does Bupa have peer reviewed scientific data of treatment to determine what is best practice, or is the bill the only proxy that is required ?

Medical professionals build their reputations on good practice, keeping up with trends in treatment, providing defensible, high quality care. There are many systems in place to ensure this, but the use of fee restriction to recognise consultants prevents these existing drivers from promoting medical excellence. It is much harder to achieve a national reputation for treating a certain condition than it is to be "fee assured". Maintaining excellence is expensive, as it is very time consuming to pursue research, attend international conferences, teach and lecture. Previously these activities built your reputation and drove referrals to you. If you cannot charge a higher fee in compensation for this comittment then the market is being driven to lower quality care at lowest cost, not market driven to higher quality.

5. Re-direction of patients by BUPA with Open Referral

Bupa claim that they are better placed than GPs to direct patients as they have information on consultant practice with previous patients. This is an indefensible point of view. Using the BUPA website it is now possible to see this information displayed for their fee assured consultants(only), the detail available is very limited and not validated as respresentative of any consultants actual interests or abilities. BUPA themselves acknowlege that private practice makes up a small part of most consultants total clinical workload. For most full time NHS consultants private patient numbers will equal only a few percent of total clinical activity. BUPA represents a large proportion of this, but not all of it. So they have a very limited sample to view a consultants work. Further the tendency for private practice to discourage the treatment of complex conditions (by making it uneconomical for the provider to care for complex patients) means that they have a very biased selection of patients to base these decisions on.

Training and regulation of our profession is very rigourous and demanding. Brief summaries of some of the requiremnts can be found at http://www.jcst.org/quality_assurance/cct_guidelines . It is clear that neither BUPA, nor any other insurer for that matter, cannot hope to match the quality of this assessment, and their claims are designed to defend what is actually a method of minimising payouts by restricting choice.

6. Regulation

The insurers have moved their functions to include directly influencing and sometimes controlling patient care, but they are only regulated as Financial institutions. For example, they now decide that many procedures can only be undertaken as daycases, and will not authorise the allocation of an overnight bed for the postoperative care of the patient. To my mind this now means that they are involved in a "Regulated Activity", the post operative care of a patient, as defined by the cqc.org.uk/sites Surgical Procedures guidance issued by the CQC (www.cqc.org.uk/sites_7_surgical_procedures_0.pdf), but the CQC may be unaware of this change in the activity of the insurers.

7. The rising cost of private care

The insurers want private medicine to flourish, so do the providers. Given that our fees have risen so little in the last decade it seems another explantation must be found for the rising cost of private healthcare. Perhaps it is related to the increasing use of high cost treatments and investigations, or perhaps the large amount spent on advertising by the insurers. As more treatments become available it is inevitable that premiums must rise if cover is to include all of these new treatments, or the level of cover must be controlled. It is unreasonable to suggest that the only way keep private medicine affordable is by reducing what you pay the provider, for providing ever more complex care. Ultimately this prevents the market for newer, more costly or intensive treatments from emerging.

It is clearly advantageous to the PHI industry to insist that all treatments are fully evidence based, but they expect the NHS to provide the experience and research base to allow this. In practice this shifts the cost of complex new treatments to the NHS, and keeps UK PHI profitable. It is clearly reasonable that truly unproven treatments are part of controlled research, appropriately funded. However many treatments in medicine are established worldwide practice, but do not have a clear evidence base. Not all treatments need a full evidence base (see "Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomised controlled trials." *BMJ2003;327doi: 10.1136/bmj.327.7429.1459(Published 18 December 2003).*

PH insurers manipulate these realities to restrict choice of treatment and provider. They insist on following NHS guidance on treatment where it suits them (eg NICE), but then invent new restrictions when they cannot find existing published NHS guidance to control access to

treatments (eg arthroscopy). Does the conflict of interest they inevitably have with profit motives prevent them from being objective about this ?

8. Changing Policies to Patient Detriment

Having withdrawn from the BUPA partnership, but still being recognised I was recently contacted by a patient of 4 years standing. I had previously operated on her, and see her from time to time when she has new acute problems. On this occasion she was not allowed to see me, but directed by BUPA to another consultant. She did not want this, and despite pleading was not allowed to see me. My charges for outpatient consultations have been agreed with BUPA for some time. She was told that her company policy had now become "open referral only" and BUPA would choose who she could see. This prevents continuity of care, and goes against her interests. Further as my outpatient charges have been agreed, there does not seem to be a value consideration here, but BUPA want the ability to advertise that no shortfall will ever exist on Open referral policies. As a patient subject to corporate policies she had no role in this process. I would be happy to ask her if she would like to talk to the CC if you would like to speak to her.

Many thanks for your consideration of these points.