Consultant 170

16 November 2012

Dear sir,

I would like to submit my personal views on the issue of Private Healthcare market.

I am a consultant orthopaedic surgeon, and have been in private practice for over [✂] years. Over the years, certain facts have become obvious.

There are a variety of avenues for a patient to find out who would be an appropriate consultant for the given condition. The most qualified source may be the local GP. Every private hospital has their consultants' profiles on their websites. Word of mouth from other satisfied or dissatisfied patients is a very powerful source. The hospitals staff also provide guidance to the patients. Many consultants have their own website providing factual information, which is also governed by certain rules. All of these are more authentic sources than the fee based criteria the insurers have been using to guide the patients in the recent years.

Consultants have never been able to or allowed to collaborate as one body and work out the cost of their time and service offered. As a result, BUPA schedule of procedures gradually became a standard document dictating the prices for some decades. This was largely (in fact, only) due to the market dominance of BUPA. The document has always remained inadequate in terms of encompassing the variety of clinical interventions, leaving the discretion in the hands of less qualified staff. We all know that the effort and complexity can be vastly different even between two similarly coded procedures. Besides, the hierarchy of procedures seem to be illogical in some cases e.g. W7420 v/s W7480 in the BUPA schedule. It is a well known fact that the procedure bundle costs based on their frequency has drastically lagged behind the RPI or cost of living or house price index for 10-20 years. It is hardly recognised that the net gain for consultants after medical defence costs, practice expenses and taxes can be as low as 30% or less of the gross income from the private practice.

There are reasons for the variation in the costs between consultants, e.g. experience, specialist knowledge and skills, time allocated for consultations, geographically driven living costs etc. Consultants in London, south and south east are therefore even more disadvantaged through such low imbursement schedules brought about by the largest of the insurance companies.

Consultants' consultation fees information is available in many settings, but not all. This may be the task for each private hospital for the future, mainly through their website, as there is no other universal access point for the patients to find this.

If the consultants are not allowed to collaborate, it is unlikely they can decide the appropriate universal fees levels for individual procedures based on their in-depth knowledge. This should be the task for British Orthopaedic Association (in input from specialist societies) in orthopaedics, and respective specialty body for the others. As in the HRG tariff, market forces factors can be added for regional variations. Consultations can also be standardised based on the allocated time. Occasional variations should be subject to evidence.

The contract for services exists between the patient and the clinician, tightly governed through the GMC guidelines for quality, including confidentiality. The cost control should be governed by the specialty organisation guidelines. The insurers have a contract with the patient to reimburse them for the costs of treatment, including consultant charges, hospital

charges etc. Under no circumstances, there should be breach of these obligations through a direct or indirect interference of an insurance company, in terms of the choice of consultant based on their costs. This will be easier with universal price levels as above. Besides, there are no safeguards against breach of confidentiality when the consultants are required to submit the clinical codes to insurers, as often insurance companies are switched by the patients without the knowledge of the consultants. Of course taking a formal consent for this adds to the administrative burden for the consultants, requiring additional time off the clinical care. Under ideal circumstances therefore, patients should pay their fees up front, and then claim the costs from the insurers.

In line with the need for transparency in consultant costs, similar transparency should exists for private hospitals to publish their costs (which already exists for most hospitals). More importantly, there should be transparency of reimbursement levels allowed by an insurance company for their clients. This is a hugely deficient area currently. As a result, major insurance companies tend to attract more business through highlighting their dominance rather than the true benefit to the patients. In order to guide the client, specialty associations and all other media (as in comparisons for mortgages, utilities, appliances etc.) should be given the comparative reimbursement levels for the procedures to be published widely, for all insurers and their different policies including their limitations, with overall figures based on the frequency of a given procedure.

Observation is made that the reimbursement levels are inversely proportionate to the market dominance of an insurance company, in their published schedules, even for similarly priced policies. This does not allow for a fair competition between the insurers based on their services, and allows for more profits per episode for the already established dominant companies, to support their continued dominance.

I hope the principles herein are felt to be fair to all parties in the PMI market.

Many thanks.