Consultant 171

16 November 2012

Response to competition commission investigation to PMI.

Dear Commissioner,

It is already clear that BUPA has the dominant position in PMI in the UK, at the moment, and is using this dominance to affect competition rather than promote it. As a physician in Respiratory Medicine my work in the private sector is dominated by outpatient activity. Both the numbers of patients seen and hence revenue generated from PMI are not on the same scale as some surgical specialties, with their inevitable in patient activity.

Reading the documents generated by both the OFT and now the competition commission it appears that BUPA has initially flagged certain consultant groups and decided to apply 'rules' on a blanket basis to kerb their costs and prevent (in)appropriate referrals. From my own prospective I have not increased my fees in over seven years, but the cost of consulting rooms; administration and secretarial support have all risen with inflation. There will be come appoint where my actual consultation will become non-viable and I refuse to have substandard admin support to reduce costs further. This is all part of good governance which we must adhere to. My contract is with the patient as recommended by the GMC and the Royal Colleges and not with the PMI Company. I am providing a consultation and investigation recommendation on the basis of current guidance and evidence. Whether the patient's PMI covers this is a completely separate issue.

This statement from the OFT report is interesting 'Top-up fees are also a more flexible tool for controlling PMI costs as, in principle, they allow those patients who wish to pay a consultant fee above the PMI fee schedule, in return for higher quality treatment to do so. However, the OFT considers that the lack of access to standardised, comparable information about quality of care provided by consultants makes it difficult for PMI providers to control costs in ways that might be more flexible such as top-up fees or more graduated consultant fee structures.' The second part implies that there is a lack of appropriate information about a Clinicians practice. From a physician's point of view this is just not the case. It is very clear that physicians in the NHS are heavily performance managed with a vast array of data collected some of which is already public. Revalidation/appraisal requires information from all practice, which includes private practice. BUPA is skewing the argument for its own interests. My outpatient practice does not differ whether for the NHS or for the private sector.

The more I consider the arguments here the more the parallels with either PPI or the milk supply chain become apparent.

PPI Buy this insurance so that you are covered when you are unwell, but when the patient comes to use it does not cover the consultation fees expected. This indicates that the PMI was miss sold (if the patient is unaware that there may be a shortfall fee), with the patient having to cover the short fall. Instead we now have a situation where the shortfall is being foisted onto the Consultant either by threats of de listing or the use of the 'fee assured' scheme.

Milk Buy this insurance so that you are covered when you are unwell. Actually we have been taking your monthly fee but you are not actually fully covered at all. We will bully our individual supplier/clinician so that things are kept as cheap as possible. This is exactly the same process that has been occurring with dairy farmers. e.g the supermarkets dictate that they want to sell milk at a given price. Unfortunately it costs more to produce than the price

that they are willing to pay. Due to the monopoly in place the farmers have no choice, close the business or make a loss.

According to the published accounts BUPA PMI made 255.3 million pounds in the first half of 2012. This is an increase on last year. It is clear that revenue from policies far exceeds pay outs on PMI policies. If a ruling occurs that allows BUPA to expand on its current line of policy then all that will occur is an increase in their profits and a potential fall in the standard of care that is available.
The last point I would like to address is the 'fee assured' scheme that BUPA is using to manipulate access for patients. I am all for clear charging structures for both the patients and insurers. I don't know of any medical colleague who doesn't discuss cost with the patient depending on what is covered by their individual PMI policy. The problem with the fee assured scheme is that it is not an open process. For physicians the maximum reimbursable fee for consultation and review is not clear or unavailable on the BUPA website (yesterday at least). When requested by email it is not forthcoming. The 'schedules of procedure' document appears only accessible once you have entered the 'fee assured' process and even then General Internal Medicine specialties such as Respiratory are not even included in the Specialist's fees section.

BUPA and other PMI companies are large providers of insurance. They on the whole are not providers of medical services. Medical expertise/services in the UK are provided by individual clinicians with the support of private hospital providers, the latter have maintained their profit margins substantially. These large PMI corporations should not be allowed to continue to bully individuals who are ultimately providing the clinical expertise. The actions of BUPA and AXA/PPP with almost 70% of the healthcare market in the UK are anticompetitive. In other industries they would be broken up into smaller companies and sold off, therefore offering real competition in the healthcare market.