

Consultant 218

8 March 2013

I wish to contribute to the Competition Commission call for evidence in relation to private medical practice.

Background

I am a consultant anaesthetist with nearly 20 years experience of medical private practice. I work in [redacted]. The principal facilities for carrying out private medical practice in this region with a resident catchment population of around [redacted] are a single hospital with around sixty inpatient beds, along with its smaller satellite day care facility, and a recently opened, much smaller clinic with no overnight facilities. The nearest alternative facilities are around 40 miles away.

I am a member of a group of anaesthetists, all based at the same nearby NHS hospital, who have a co-operative working arrangement. In the region, two other anaesthesia groups exist (one based at each of the other local NHS hospitals) as well as a number of anaesthetists who carry out private practice independently from these groups.

How “The Market” operates in a region such as ours

There is a limited amount of medical private practice (PP) available and almost all consultants active in PP have whole time contracts in the NHS. For most, this restricts their availability for PP to one or two half day sessions per week. In each surgical speciality, there are typically no more than around half a dozen surgeons who participate regularly in PP and most patients seem to prefer to be referred to their local facility, so choice is fairly limited.

Patients are referred by their general practitioner (GP). Referrals are either to a named specialist, familiar to the GP through NHS activity, or to an outpatient clinic, with no specialist specified. It is my impression that it is only rarely that the patient expresses a preference to be referred to a particular consultant, although this is more likely with cosmetic surgery, where word of mouth recommendations from friends seem more common. If the patient proceeds to surgery, the choice of anaesthetist is also limited by availability. Surgeons who operate at regular times each week or fortnight usually have a working relationship with a consultant anaesthetist who is normally available at that time. In most cases, surgeon and anaesthetist are familiar to each other as a result of working together in the NHS. Only very rarely does a patient express a wish to be anaesthetised by a particular consultant; such requests are usually a result of them having been managed by that same anaesthetist in the past.

Although the local hospital activity is near to its capacity for carrying out PP, growth has been slow throughout my career. Occasionally, a potential competitor to the local hospital has made itself known, but I believe it would take a great leap of faith for an alternative provider to make the major investment required to attract a substantial amount of business away from the current principal facility.

How our anaesthesia group functions

Ours is a “sham partnership” with no partnership agreement and no mutual liability, as group members carry out clinical practice independently of each other. All of the consultant anaesthetists at our NHS hospital who wish to be involved in PP are offered admission to the

group. We work mostly with the surgeons who are also based at our NHS hospital. We try to preserve working relationships with surgeons and anaesthetists who are familiar with each other's working practices through the NHS work they do together. Such familiarity is a major contributory factor in ensuring quality and safety for our patients, as well as improving efficiency. Available PP is distributed in a reasonably equitable fashion amongst our group members, primarily according to availability for timetabled operations, but with regard for mutual familiarity with the surgeon's and anaesthetist's practices, as stated.

The function of the group is administrative. We ensure all cases listed by the surgeons with whom we usually work are covered, providing cross-cover for anaesthetic colleagues when necessary. We share secretarial and accounting facilities. Although patient accounts are sent out in the name of the group, each of our members sets their own fees. In setting fees, some members normally adhere to the patient's insurance company's benefit maxima; others exceed these when they feel this is justified, whilst some newer members are tied into billing restrictions imposed upon them by one insurance company (Bupa) in order to be included on that company's list of "recognised specialists". The group divides income amongst its members, proportionate to the work each has done. I believe the flexibility, availability and reliability of service which our group provides is very much to the advantage of the patients of the surgeons with whom we work. Over and above private medical practice, our mutually supportive working relationships and the flexibility this allows also promote a cohesive department in our NHS practice, to the benefit of our NHS patients.

Some comments on restrictive practices of some medical insurance companies

I believe the practice of some insurance companies, most notably Bupa, to publish lists of "recognised" consultants restricts patient choice and at the same time restricts the ability of some consultants to develop their private practice. In the United Kingdom, the GMC specialist register is an adequate indication that a doctor is suitably qualified to work independently as a consultant. Bupa's list and the restrictions it imposes on both patients and doctors is designed to control its costs, with no regard to choice or quality.

Bupa's policy holders are required to use a consultant from Bupa's list of recognised doctors. The patient is not given the option of choosing another doctor, even if that doctor agrees to charge within Bupa's maximum benefit for that condition, or if the patient is willing to pay for any excess charge above that maximum limit. Now, new consultants are only admitted to that list if they agree to a number of strict conditions regarding method of billing and an undertaking never to charge more than Bupa dictates for a condition ("Fee Assured"). This Fee Assured status is also indicated on Bupa's list. More established consultants, who have been "approved" by Bupa since before they introduced these restrictions, may be disadvantaged by not being marked as Fee Assured, even although it may be their practice to charge no more than the maximum benefit. As a result, patients may be directed towards less experienced consultants, who are more likely to appear on the Fee Assured list.

For most medical conditions, Bupa has frozen the benefit payable for more than fifteen years. Recently, for certain interventions, this benefit has been cut. Following Bupa's unilateral decision to reduce benefit by 60%, a colleague judged the new fee available to be inadequate. Being wary of Bupa's reluctance to enter into constructive discussion and unwilling to have embarrassing conversations with patients about the inadequacy of their insurance cover, that colleague decided to no longer accept referrals of Bupa patients in that category. Bupa responded in an aggressive and bullying manner, with accusations of a "Serious Breach of GMC Good Medical Practice Standards" and a threat to remove the doctor from their approved list.

For all specialists, failure to appear on Bupa's approved list may have indirect consequences, should non-Bupa patients view their omission from that list as a comment on their clinical competence. For anaesthetists, their omission may lead to a surgeon, as a

matter of expediency, overlooking them for a whole session of operative activity if a single Bupa patient on the operating list insists on a Bupa approved anaesthetist.

In summary, I believe the publication of approved lists of consultants by insurance companies is a tool to control the market, rather than to address any quality issues. Such lists restrict patient choice and may seriously impair the ability of a consultant to develop a comprehensive private medical practice.