Consultant 230

16 April 2013

Dear Competition Commission,

Thank you for your invitation to submit evidence with regards to private medical care for your consideration.

In my view the business conduct of some of the larger private medical insurers deserves close scrutiny and I welcome the review.

When I started in private practice [✂] years ago I worked at a BUPA Hospital.
The outpatient consulting facility had been paid for by a small group of consultants and subsequently integrated into the BUPA [✂] hospital.

I quickly realised that insured patients who received services in the hospital were often charged excessively for these services.

The most extreme example of this was a charge of £245 for a two simple blood tests - at a time when the local NHS hospital charge for the same tests to private patients was less than £20. Even insured patients, who didn't have to pay, complained at these fees. Clearly there was then, a conflict of interest with BUPA charging the patient for insurance and then paying the excessive charges raised in a BUPA hospital.

A different variation on this was discovering that insurers such as BUPA discount the fees they pay to private hospitals - so forcing them to accept contracts with 10% discount or more. This became more apparent when the BUPA hospitals were sold to Spire and run independently from the insurer.
Yet patients who pay their own costs are expected to pay the full amount to the hospital.

Discounting of consultant's fees occurs not infrequently and a group of insurers has formed, in my opinion, a cartel, the CSSD group which periodically revises the value of medical and surgical procedures.

These revisions are almost invariably a reduction in the fee maxima for procedures. Sometimes individual insurers will reduce the fee they will pay for one procedure disproportionately - for example a small flap repair - and offer perhaps only 25% of the previous fee or that paid by other insurers.
If a consultant has the temerity to argue against this, the insurer either removes them from their list of approved specialists or constantly warns patients that this consultant may charge more than their allowance, creating concern for the patient and perhaps leading them to question the consultant's character.

I experienced this when I complained about such a devaluation and then found all subsequent patients were concerned that I might overcharge them. I felt this verged on defamation of my character by the insurer. The implication to the patient that I was not 'approved' suggested much more than that I did not agree with a forced excessive reduction in the fee for one procedure which I undertook.

The insurer's like to portray themselves as purveyors, purchasers or suppliers of healthcare - and much that they do suggests this role to the patient. In reality, however, lists of 'approved specialists' which a patient might construe as being recognition of good standing or excellence - are nothing more than a list of those doctors who have agreed to abide by the insurer's fees.

I have many more concerning examples where the insurer has conveyed a 'medical explanation' to the patient as justification for not paying for their treatment - when this 'medical' explanation is quite unjustified and inaccurate.

Amongst the many examples I would cite:

Patients with acne presenting for the first time being told the insurer does not pay for this because it is a chronic condition. (It will only become chronic if it is not treated).

Patients who develop a cyst on the skin being told that the insurer will not pay for this because it is not diseased tissue.

Patients being told they cannot be seen for a follow up consultation to discuss the results of tests and treatment - because their GP can do this.

Patients being told that minor skin complaints should be treated by their GP
- even though the patient has private insurance and GPs increasingly do not have the time to undertake minor surgical procedures.

I have had patients who have been refused removal of a mole when I thought is was suspicious. On two recent occasions the patients indicated that they wished to proceed on my recommendation - and on both occasions the mole was shown to be a malignant melanoma. Upon receiving this diagnosis the insurer agreed to fund further treatment - but they were prepared to argue against the opinion of a specialist when they know nothing about the patient's condition.

One insurer (BUPA) treats patients so badly when they ask to make a claim that almost invariably the first thing the patient tells me is how difficult the insurer made it for them to get approval for the consultation.

I could go on with many further examples, but my conclusion is that opacity of fees and fee-charging has been encouraged by private medical insurers as a method of promoting their business and that they have unjustifiably portrayed to their clients expertise in medicine which they do not possess and have over exaggerated the financial costs of private medical care to further their business. In these times of financial stringency we are seeing insurers indicating to patients that their conditions are either 'non-medical' or do not qualify for private treatment for unjustifiable reasons.

One of the greatest disappointments for my recently retired patients who may have had a working lifetime of private medical insurance and made few claims is the enormous inflation in premiums which the private medical insurers demand of them as they get older. There are no, 'no-claims' benefits.

I frequently suggest to such patients that they stop private medical insurance but commit themselves to saving the same amount as the insurance premium in a savings account and keep this as an emergency fund for private medical care. I have been consistently thanked for this suggestion - often many years later when the patient has saved a lot of money and acquired a substantial amount of savings. Most patients did not realise how little savings are required to cover the costs of most private medical care.

In my opinion, the private medical insurers are no different from other insurance service or financial service in function, but they have cloaked themselves in an unjustified 'respectabilty' of medical care and supposed 'knowledge' of medicine and purported to be providers of healthcare services. This is not helped by the lack of transparency about private medical fees and charges.

Most patients would be better served by having a simple savings scheme which could be accessed for private medical care, and by having complete transparency about all the fees they would be charged for any episode of private care. Perhaps there could be incentives to make savings for private medical care funds -rather like ISAs or Pension plans.

The choice of specialists should be determined by local GPs, or recommendations of friends or family - not by private medical insurers.

I can see no justification for according private medical insurers any special status. Specialists and hospitals should be encouraged or even obliged to provide / publish a full list of fees and 'medical' insurers should be obliged to give clear information about their fees and the financial benefits payable for each claim. Greater transparency and publication of fees for private medical care would have a further, wider benefit in that the general public would have a greater appreciation of the costs of medical care and, as a result, may more realistically value the care they receive from the NHS.

I look forward to your review of these matters.