Consultant 237

9 May 2013

Dear Ms Hawes

Private Healthcare Market Investigation

I am a Consultant Anaesthetist in Central London, and I would like to submit comments to the Competition Commission (CC) in relation to the ongoing private healthcare market investigation. I understand that I may have missed the deadline for submission.

The issues I would like to raise generally relate to the larger insurance companies who I believe control about 80% of the private healthcare market, although other insurers do often follow suit. I have been **threatened** with “de-recognition” if I do not agree to a fee structure set by the Insurance Company for many if not most surgical procedures. I have also been the target for derogatory and defamatory comments by Insurance Companies intermittently over many years. These are often made by telephone administrative staff to patients, when they are seeking advice about reimbursements based on their own personal Insurance policies, and requests for transcripts of these conversations are generally denied on the basis of patient confidentiality. Indeed, patients have recounted details of these conversations to me in writing. The maximum reimbursement structure set by major insurers is often set well below professional fees charged, and this structure is used by the major insurers to inform their clients, that they are being “overcharged”. I live and practise in Central London, and my personal fee structure is generally well within the guidance set by the BMA (from 1990), and recent guidance from professional bodies e.g. the association of anaesthetists, UK. This insurance reimbursement structure is used to restrict patient choice for both clinician and hospital settings.

Patients are being told that I personally “overcharge” and that I am “expensive”, although there is little evidence for this statement. My fee structure for insured patients is well within published guidelines of other insurers, and well below other clinicians of equal seniority and training. Patients are have been told that “they would not recommend the use my services”, because of the expense. Patients are told to seek services from alternative anaesthetists. I believe this information is anti-competitive and destroys the team structure in which I work with regular surgeons. I have a number of regular surgeons with whom I work, and the whole surgical episode is dependent on that team structure. I have a number of letters from patients over the last 10 or 15 years where patients have been directly given derogatory information about my level of care, based solely on financial information of fees charged. This has been damaging to my professional reputation, and inaccurate on the part of the insurance companies. I also have many complimentary letters from patients thanking me for my expertise and compassion, most particularly from other medical colleagues.

I believe that some major insurance companies have taken a similar approach with other consultants, and I am aware that some surgical and anaesthetic colleagues are “blacklisted” from being referred patients if they are insured with certain insurance companies. If I were to fall foul of these “rules”, this would have a serious effect on my livelihood. I believe this conduct is entirely anti-competitive, and adverse to the interests of patients, and of course myself. It severely restricts patient’s choice of specialist, and directly affects the level of care they may subsequently receive.

I am a teaching hospital consultant anaesthetist at [✂], and I work part-time for the NHS, and part-time in private practice. I began private practice in [✂], when fees were initially referenced by the BMA, on the basis of a country-wide consensus of individual fees charged at that time. This suggested “fee-schedule” was subsequently withdrawn on the advice of the

“Monopolies and Mergers” commission, on the basis of the private healthcare market being a complex monopoly, at the behest of the major insurance companies. Subsequently, each insurance company has produced its own “reimbursement schedule”, and many reimbursements have fallen dramatically. These reimbursement schedules have subsequently become “fee schedules” set by insurance companies against which medical fees are judged. This has subsequently become the insurance markets definition of “overcharging”. There is little reference to the individual level of support or care being given to the paying-patient. Some insurance companies have even taken over the direct referral practice normally obtained between GP and specialist. Specialists are now judged on the basis of finance, not medical care. I trust that insurance company referrals made on this basis will be held accountable when care is deemed not to have been appropriate.

I endeavour to set my own fees for private work, based on time, complexity of surgery, and on the pre-morbid condition of the individual patient, and the requirement for postoperative follow-up, but this is often only possible after the surgical event. An estimate of fees can always be given in advance to patients, via the surgical secretaries, or these days via many and varied websites. Perhaps individual “clinician websites” should be encouraged, even though this was previously discouraged as direct marketing of individual practice was initially frowned upon. The “contract” for medical services and their reimbursement, should remain an issue between clinician and patient. Any third party reimbursement should be the responsibility between the patient and his/her insurance company. The level of reimbursement should not be dictated by the major insurance companies as I believe this restricts patient choice.

Patients are currently free to decide to meet any difference between medical fees and their insurance company’s reimbursement schedule. However some of the insurers, firstly re-direct patients away from clinicians whom they consider to “over-charge”, and secondly patients are informed that they should not pay difference between the insurer’s reimbursement schedule and the medical fee charged. Thirdly, they are also informed that should there be difference in the fee charged to the one reimbursed, that they will not meet <u>any</u> of the cost of that medical episode, if any one of the fees exceeds the insurer’s reimbursement schedule. This is tantamount to “insurance blackmail”, and is definitely not in the patient’s best interests.

The ability of Insurance Companies to “ban” their clients from paying the difference between medical fees and reimbursement schedules (set by Insurance Companies themselves), makes a mockery of a competitive health care market. This reduces patient choice and is detrimental to a competitive market.

A new initiative from the major insurers is one of de-recognition. “De-recognition” by a major insurer would mean that the Insurer would now control all the medical and surgical referrals that I receive, and would effectively exclude me from 40-50% of my workload. Being “de-recognised” would thus have a direct effect on my reputation and income, as this would be misconstrued as “incompetence”. Indeed, I am often asked if I am “recognised” by a major insurer. The implication being that my clinical competence is assessed by the Insurance Company. The insurance companies are not in a position to assess my competence, as I understood that this was a function of the GMC. But patients are led to believe that their insurer has some sort of “premier” list that defines clinical competence. This is misleading at best, and complete fallacy at worst.

I am extremely concerned that major insurance companies who control almost 80% of the private healthcare market are able to influence <u>clinical decisions</u> relating to healthcare, when they have never actually assessed the patient.

It is clear to me that the major insurers are seeking to use their buyer power to try to force medical fees to fit their own reimbursement structures. This is to be achieved through the process of de-recognising any medical specialist who dares to set fees that are out with their

own reimbursement schedule. It is clear to me that financial choice is used as a surrogate for clinical choice.

The devastating effect of “de-recognition” by a major insurer on financial grounds are disastrous, and this is blackmail. “De-recognition” by a major Insurer would mean that many consultants would no longer be available to patients insured by that Insurer. This has to be detrimental to patient choice and clinical care.

Medical fees should be set by Clinicians undertaking the clinical episode. Reimbursement schedules may be available from insurers, but the contract of payment must return to a relationship between the patient and his/her clinician. It is the patient who is insured, not the clinician. Patients should be given free choice of clinician, and not be restricted by preferred providers based solely on financial grounds by insurance companies.

Many insurance companies have “deals” with both hospitals and clinical providers. Indeed at least one major insurance company offers financial incentives to clinicians who only charge within their reimbursement schedule maxima. This affects patient choice and decision making. Patients are not informed of this relationship at the time of their claim for reimbursement.

Also I would provide you with a statement produced by the Assistant Director of BUPA Liaison in **July 1990**,

> *“The benefits published for our members represent a* ***contribution*** *towards the cost of service provided by specialists and are not intended to be recommended professional fees such as those suggested by the association of anaesthetists.”*

Over the last 22 years, this statement has been forgotten and **reimbursement schedules** have become **insurance fee schedules,** which have been pushed in a downward direction only. By innuendo and blackmail this has resulted in a reduction for patient choice and competition.

Please do contact me if I may be of further assistance.