Consultant 238

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I am writing to inform the Competition Commission of my experience with several insurance companies in relation to my patients. I am very concerned that my patients have and continue to suffer harm and detriment as a consequence of their actions and others are denied choice when they are referred to me, but are sent elsewhere.

I am a consultant cardiologist and have had a private practice for the last [✂]yrs. About [✂] years ago, I began to work exclusively as an independent practitioner. Prior to this change I held two substantive NHS posts, then held a full time locum for [✂] years and a part-time locum appointment lasting over [✂] years. I am now totally dependent on my private practice.

I work in various hospitals in the UK. I have not changed my practice significantly, using my own diagnostic equipment where possible and hospital facilities as necessary. My fee structure and rates are published and over the years have increased modestly in line with inflation.

I have followed advice from my professional bodies and charge the same fee to self-pay and insured patients and my fee is the same wherever my patients see me. My fees are advertised and patients are advised to check with their insurance company for 'authorisation' and benefits under their policy, before undergoing investigations. I advise patients where known, if there will be a shortfall.

The 'fee schedules' of several major insurance companies (e.g Bupa, AXA-PPP, AVIVA) for reimbursing members has been radically changed in the last 2 to 3 years. Also, the recognition of 'senior' consultants has been removed or threatened to be if they do not agree to a 'contract' with the insurer and not to charge a short-fall to patients who do not have fees fully reimbursed, in effect significantly reduce their fees. New consultants have only been recognised as providers if they sign up to the agreements offered on a 'take it or leave it' basis. Bupa for example has delisted cardiologists as recognised providers of outpatient diagnostics so they can no longer have their tests in consulting rooms and have to go to a designated hospital, or pay for the tests directly. This rule is applied such a way to benefit some consultants and not others, effectively to 'divide and rule'.

The consequences have been that patients currently under my care and new referrals have been directed away from me or wrongly advised that I 'over charge' (do not adhere to their current schedule) or am not fee-assured. This is despite my published fees and the fact that they reimbursed the same fees historically.

Recently larger providers of private hospital facilities have made agreements with insurers for 'packaged' prices for services. They have not included the consultants providing the services in discussions and invariably offer a 'split fee' that is significantly lower than customary fees that are often unchanged over many years.

I have submitted specific details of these cases by separate cover, but examples are summarised below.

Insurer A.

1. A patient had been seeing me for cardiac arrhythmias over [✂] years and then the insurer would not cover their current condition as it deemed it chronic. They agreed he could be seen for acute exacerbations. The patient had an urgent appointment to see me as he had

new chest pain. He was given authorisation at 10.45 that morning and on the way to see me then had a call back to say I was no longer recognised by the insurer. The patient was told not to see me and to make an appointment with a GP and get a referral to another cardiologist! This patient had specifically come to see me because they did not have confidence in a previous doctor. He rang in real distress and of course I saw him. I had not been informed that I had been "de-listed" and later I found a letter had arrived that day after I had left for work.

2. A patient was authorised to see me urgently and have tests, despite approaching their outpatient limit, but after arriving in clinic I was called to say they were not allowed to go ahead. This led to a lot of anxiety.

Insurer B.

3. A patient who had a policy with "full cover" for 30yrs had seen me [✂] years previously and was referred back urgently with new symptoms. The patient had authorisation from the insurer to see me and have any relevant tests. I explained that they would not be reimbursed for my fees, as I was no longer a 'recognised provider' of outpatient diagnostic tests with this company. I also explained that even though I was using hospital equipment they would not reimburse my fees. The patient was misled and told the hospital pays the consultant, but there is no such agreement. After over an hour on the phone, hanging on for supervisors etc, the insurer agreed to pay and the consultation and tests were eventually done. They were told they would be covered for only acute exacerbations, then later that they no longer be covered for the condition even if there were acute episodes.

4. A patient who was a member for a considerable number of years had been unwell for 6 months and was eventually airlifted from an island to hospital on the mainland, suffering from a suspected heart attack and discharged. I was conducting various tests to find out the cause of their illness. Some of the tests needed authorisation numbers and the patient obtained these from the insurer. I cautioned the patient that the insurer might not authorise payment despite authorisation, but one was issued and the tests duly conducted. The insurer then refused reimbursement for my fees. Subsequently the patient rang the insurer and eventually spoke with the cardiac team and the payment made, only because he had not been made aware of a change of policy.

This patient was unduly worried about unpaid consultants fees when they were already ill and suffering from anxiety and should be informed that even if they obtain an authorisation number, bills might not be paid.

5. A patient I had seen for an arrhythmia the previous year had an acute attack and was admitted overnight and discharged from an NHS hospital. He came to see me for advice and investigations and obtained authorisation for tests as usual. I advised him that since I last saw him I was no longer a 'recognised provider' of outpatient diagnostic tests with this company. After giving my name he was given authorisation. When he arrived I said we should check as I did not trust their word and true to form the person answering the phone said I was not a 'recognised provider'. It was late on a Friday evening after a lot of discussion and hanging on the phone they agreed I would be reimbursed for my monitoring. The patient rang to complain and was later told that he would not have to pay and they would 'sort it out' with me. 3 months have passed and despite ringing and writing they have not honoured their promise and I have not yet been paid.

6. A patient was referred to see me for tests and had an authorisation number. I explained that they would not be reimbursed for my fees, as I was no longer a recognised provider of outpatient diagnostic tests with this company. I also explained that even though I was using hospital equipment they would not be reimbursed. The patient was again misled and told the hospital pays the consultant, but there was no such agreement. After a very stressful extra

90 minutes with the patient on the phone to the insurer, they asked me to suggest someone. I said I could not as I had no knowledge of who was a recognised provider! They then provided 2 names and the patient left untreated to return the next day to see a different cardiologist. The patient in fact could not see either of the 2 consultants and saw a third. This consultant, unlike me, could not do the next in-patient test (an angiogram) and referred him to another, who did the final tests and treatment. Had this third consultant been referred the patient initially, he would not have been reimbursed, as he also was no longer a recognised provider of outpatient diagnostic tests with this company. The patient felt rushed with limited time to see the new consultant and was very stressed. This was associated with vasovagal attack and an unnecessarily prolonged intervention.

7. A patient was authorised for diagnostic tests with me. I explained that they would not be reimbursed for my fees, as I was no longer a 'recognised provider' of outpatient diagnostic tests with this company. I also explained that even though I was using hospital equipment they would not reimburse my fees. The other issues were a. I wanted to do a day case procedure as femoral access was preferred and b. the insurer would only pay for it as an outpatient. The only convenient hospital for the patient where tests were to be done did not have an agreement as it had been in dispute with the insurer. The patient rightly did not want to pay extra. After a lot of hassle we got around this. Next I referred the patient for a specialised percutaneous procedure that I do not do. The insurer rang to clarify and asked me who I would refer to and accepted the only two doctors that do this intervention in her area. A week later I had an e-mail from the patient giving the name of a different doctor who was 'out of the country' at the time, but unlike the 2 names I proposed (that were accepted) was 'fee assured' so she would not have a shortfall. This 'doctor' was in fact 'Mr', a cardiac surgeon and obviously unsuitable. It took another call from me to sort this out.

I think this insurer was trying to cut costs and redirected my patient against prior medical advice. This was totally inappropriate and it was just fortunate the patient advised me before she appeared in his clinic!

8. A patient who was referred was authorised for an ECHO test with me. I explained that they would not be reimbursed for my fees, as I was no longer a 'recognised provider' of outpatient diagnostic tests with this company. The insurer agreed to pay for the consultation as he was sitting with me in my consulting room. Based on my assessment the ECHO was not required and advised he should have a baseline ECG, expecting it to be normal too. I rang the surgery so this could be arranged as an NHS patient and he would not have to pay extra, but I would include this in a report. I later learned from the patient that he was referred to another cardiology colleague at the same private hospital for an ECG because the GP 'did not do ECGs'. In fact he was sent for ECHO, not an ECG. This consultant was 'fee assured' and his fee was paid. The ECHO was normal as predicted. These two episodes cost the insurer more than my fee for an ECHO!

9. A patient I had seen and treated for a cardiac problems had a CT angiogram and an incidental finding was a benign looking lung lesion, protocol advised a 6 month repeat scan. He was due to see me anyway at this time for his cardiac follow-up and have a CT lung scan at the same clinic prior to the visit. I advised he get a new authorisation but the insurer, told him without them consulting me that he had to go to a chest physician at another hospital. This was arranged before I could comment. I would have referred him after the CT if necessary (the repeat scan was benign) and continuity of care was disrupted.

10. A patient in whom I had inserted a pacemaker booked in for the first annual pacing check. I explained that I was no longer a recognised provider of outpatient diagnostic tests with this company and to seek authorisation. He was told my fees would not be covered and as he did not want to pay extra, he was a given name of 3 alternative cardiologists who were recognised providers. I asked to be informed so I could forward his details. Two were unsuitable as they did not do pacing and one of these worked at a hospital that did not have

the facilities. The third was qualified but based over 150 miles away. The patient paid to see me. This demonstrates how the patient is disadvantaged by the insurer and put through unnecessary stress and financial burden. Loss if continuity was avoided.

Insurer C.

11. A patient of mine who had previously been investigated and referred by me for cardiac surgery was re-referred by an orthopaedic surgeon for pre-op cardiac assessment. I saw him and advised tests. The insurer would not cover this under his 'pre-op package' even though requested by the surgeon. He did not want to pay and therefore did not come back to me to have the tests. I only learned of this when he was referred as an in-patient post-operatively. Again the insurer told him they would not cover my fees for investigation and misled the patient saying the hospital paid my fees. There was no such agreement. Fortunately he came to no harm but I am concerned that the insurers are putting patients at risk by irrational and selective authorisation of policies.

12. A patient with arrhythmias and cardioverted by me on 2 previous occasions came back for scheduled review. I advised him that since I last saw him I was told I could no longer invoice the patient and they would only accept invoices from the hospital. He was misled when the insurer said the hospital have an agreement to pay the consultant fees from their remuneration. This was not true and confirmed in writing by the head office of this private provider hospital. I invoiced as usual.

Several issues are raised by these examples and need consideration the Competition Commission in regard to the best interest of patients.

Patients go to the private sector for many reasons. Important reasons commonly given include an early appointment, poor experience in the NHS, wanting a choice of a specialist, a second opinion, more time with the doctor, continuity and for a more convenient time in their schedules.

1. The contract is between the consultant and the patient. The insurer should not interfere in this arrangement and bypass the consultant. The contract with the insurer is for insurance and is different from the professional contract a doctor has with their patient.

2. The insurer should not be restricting the choice of patients or preventing a consultant from seeing their patients or continuity of care is lost.

3. Removing consultants from their list on cost alone is wrong and it is also apparent that this is being applied somewhat inconsistently.

4. The insurer should provide benefits towards the consultant's fees and the cost of any investigations according the policy purchased.

5. The insurer should not determine our fees by their monopoly share in the market.

6. Hospital providers should not enter into agreements with the larger insurers and impose their fee structures on consultants.

7. Patients should be able to chose to pay extra if their policies have inadequate cover.

8. Fees should be made transparent by the hospital and the consultant so patients can make an informed choice.

Many patients experience a worse patient journey than in the NHS and have less choice than in the NHS, despite paying for private insurance. It is not surprising the percentage of patients self-funding is on the increase as a result.

Many consultants are finding that their practice is threatened or even lost. It is a restriction of free trade