**Consultant 248**

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These comments are from my own personal experience. I work as a consultant anaesthetist at a district general hospital, and as partner in an anaesthetic group that provides anaesthetic services at two local private hospitals and the District General Hospital which is the base hospital for all the consultant anaesthetists who are partners in the private anaesthetic group.

I claim no financial expertise, but I do claim clinical expertise having had experience working in NHS teaching hospitals in and out of London as well as NHS district general hospitals outside London.

My principal concern about the competition commission's investigation is that the investigators will have enormous financial expertise, and so the commission's primary concern will be the marketplace and this will be prioritised over the clinical care! The prioritisation of finance over clinical care was cited in the Midstaffordshire report, and has recently been commented on in private care homes.

My personal desire to become a consultant in a hospital which has a syndicated private practice was entirely based on clinical reasons and the financial aspects of syndication remain of minimal importance to me. I would be very distressed if the competition commissions report removes the clinical advantages of a group practice for financial reasons alone (particularly when I think these are probably minimal)

So this was my experience. As a trainee, I worked in a large London teaching hospital. There was no anaesthetic group practice in this hospital. As a consequence, the consultant anaesthetists were always seeking to cultivate their relationship with consultant surgeons as this was their only mechanism of accessing the private healthcare market. As a direct consequence of this, consultants were frequently late arriving at their NHS lists having done an early morning case at a private clinic, and should their lists overrun, would leave early in order to get to their private evening lists on time. Trainees would complete the lists.

Additionally, some anaesthetists would never take holiday, unless the consultant surgeon they worked with in the private sector were also on holiday, for fear of giving another anaesthetist access to "their surgeon". This is clinically important for NHS patients because there is a financial incentive for anaesthetists working in the private sector to compromise the care of patients in the NHS sector. Additionally I saw that many anaesthetists would be unwilling to criticise any aspect of the consultant surgeon's practice because of fear of compromising access to the private market. My experience was that these departments without open access to a syndicated private practice were more likely to be unhappy and jealous places to work.

As a consequence of this, I determined that when I became a consultant, I wanted to work in a hospital that had an anaesthetic group practice open to all consultant anaesthetists within the hospital, regardless of whether or not I wanted to participate in that group.

When I eventually did become consultant, I was and remain very pleased with my choice of NHS hospital. I did not join the anaesthetic private group practice initially, but I am a member now. My expectations of the advantage of a group practice to the NHS were reinforced. In addition I become aware of further benefits for patients and surgeons in the private medical sector of having an anaesthetic group practice. These include

- Provision of a 24 hour 365 day a year emergency cover for all private patients.

- Ease of administration for consultant surgeons
- Easy access of information for patients
- Ability of the group to provide appropriate skill mix for particular cases (which neither the PMI or individual patients can easily do)
- Maintenance of standards within the group
- Education for the theatre staff in the private hospitals
- Sharing of guidelines that are established within the NHS hospital with the private hospitals

I would encourage the Competition commission to ask anaesthetic trainees who have worked in NHS hospitals with and without anaesthetic practices open to all NHS consultants, about the effect of private healthcare on NHS patients.
The financial aspects I haven't mentioned because they are not my prime concern. However while happily deferring to the commissions greater expertise on the finances, my understanding of the financial aspects of group practice and indeed the current referral to the completion commission can be thought about as a on-going battle on who has the primary role in gatekeeping the access to the private medical market.

For anaesthetist the primary gatekeepers are our surgical colleagues. It is they who select us, and invite us to look after their patients. They have some knowledge of our clinical expertise, availability and affability. (The clinical expertise and availability are improved with group practices!) Fortunately major clinical disasters are rare with anaesthetics, and outcome measures of nausea rates, pain management and recovery times are difficult to assess and even harder to separate from the influence of the surgery. So having objective measures for patients to make selection is hard, and patients quite rightly want the correct surgeon and make the presumption that he will be working with an appropriate anaesthetist. It is probably unwise for a patient to selecting an anaesthetist purely by price and it would be an unworkable solution as it would potentially mean changing anaesthetists for each case on a list!

The surgeon's gate keepers are primarily the GPs, although they are sometimes selected on other recommendations. Again this is because the GPs have some knowledge of the surgeons, their clinical skills and their demeanour. It is difficult for patients to select surgeons on the basis of personal knowledge.

For financial reasons, the PMIs want to become the gatekeepers for surgeons and anaesthetists. Although the PMIs sometimes claim that they have personal knowledge of the surgeons, they leave all aspects and costs of appraisal and revalidation to the NHS. There are numerous examples of PMIs recommending surgeons to carry out particular procedures in which the surgeons have no expertise. This is a result of recommendation based purely on financial reasons.

However the desire of the PMIs to become the gatekeepers is presumably in order to control their costs. While this is understandable, their costs could of course be controlled simply by stating the limit on their benefits and telling patients that they are liable for any cost over and above that limit. This used to be common practice with the PMIs, but they have moved away from this, and the only reason that I understand for this, is the desire to become the definitive gatekeeper.

Once they have achieved sufficient market share, the PMIs will be able to drive the costs to any level. Many of my colleagues are already opting out of the private healthcare – which is presumably market forces in action!

The anaesthetic group practices I think have been able to resist the gatekeeping from the PMIs to a slightly greater extent, although this is changing. All our new partners have signed the consultant contract with AXAPPP and BUPA, and agree to charge by their rates. This will gradually work its way through the group. It is possibly more difficult for the insurers to withdraw work from anaesthetists within a group practice as there are fewer anaesthetists available for the surgeons to use, but in our practice the consultants who have not signed up to the PMIs fee structure, will comply with it when requested to do so by the consultant surgeon they are working with.

It is administratively difficult having different consultants within one partnership charging different prices. We have offered to the PMIs to charge a fee that is based on the average charge of consultants within the fixed price contract and those outside it – so there would be no net change in costs. However the PMIs have refused to contemplate this – and example I think of intransigence rather than costs driving decisions!

I think that the prices charged by age matched consultants inside and outside group practices very minimally. If this is so –and it would be a sensible bit of research – then I can see no reason to disrupt the current group practice models with their clinical advantages. If there is a minimal difference in cost then one has to ask if the clinical advantages justify the extra remuneration. If the group practices earn less than the age matched comparators, it emphasises that the reason that group practices have become so popular is nothing to do with the financial rewards!

Finally I think it important to consider the “big picture”. The PMIs are huge. They have huge resources to influence organisations such as the competition commission. Their profits have increased steadily. The charges to their customers have increased steadily over the last 20 years, but the remuneration that they offer to medical professionals for common procedures have changed little in 20 years (and in some have decreased dramatically).

As a generality the gatekeepers make the most money. Hence the PMIs income has increased more than the surgeons, who earn significantly more than the anaesthetists even though the training for both posts is similar in its duration and complexity.

Regardless of the financial aspects, I would urge the completion commission to be very mindful of the effects of their recommendations on the clinical care of both private and NHS patients both of whom are potentially vulnerable to the completion commissions decisions.