**Consultant 17**

16 September 2013

Dear Sir,

I have previously submitted information to the commission. I am a surgeon of [✂] years consultant standing.

In keeping with most of my colleagues I was disappointed that the issue of top up fees, which was covered well in the annotated statement, was largely dropped from the provisional remedy report. I think this is a great disservice to the patient and the field of private healthcare generally. The use of directed referral mandates reconsideration of this area. By controlling referral the PMI can leverage providers into restricted, uneconomic fees and without the ability to react with a top up fee the provider is left only with an all in /all out option. For BUPA / AXA this effectively means withdrawing from private practice entirely. The CC would argue that there has not been strong evidence that this has happened yet. However these PMI initiatives are recent, and many of us are fighting reduced incomes in the hope of a timely resolution. In a few years there will be attrition of those unable to make practice work, or indeed those who find that extra NHS work, with no overheads, especially no income related indemnity premium, more attractive. I agree that ultimately the PMI would not want to lose too many providers, as it might make PMI unattractive to subscribers. However losing subscribers will take years, but saving money by reducing fees will show on balance sheets quickly. BUPA's huge rise in UK profits is testament to this.

As a consumer of healthcare I cannot easily change out of existing policies. I tried this year when my BUPA subscription rose 20% or so, but with a previous medical condition I had no option but to stay with them. So consumer movement is muted (as recognised by the CC in the annotated statement), allowing PMIs to lower service standards by reducing choice of consultant, with impunity. We cannot afford to lose our right to treat BUPA/AXA patients, and many customers can't realistically move policy. So PMI's can raise premiums (as evidenced), lower reimbursements (as seen already) and raise profits on a stagnant consumer base. Is this a fair, dynamic market ?

My second point is related, but involves patient safety and healthcare regulation. I was relieved to read in section 2.75-2.88 that the CC recognises that medical practitioners are regulated by the GMC, and that the Royal Colleges and specialty associations provide guidance on quality and governance issues. Also it is clear that PMI institutions are regulated by the FCA.

Previously all segments of a patients clinical care were regulated. The GP was GMC regulated, as was the specialist. The hospital was CQC regulated. The financial aspects were FSA regulated.

Now PMI's direct referrals, and create treatment pathways, "commission healthcare", and authorise defined aspects of treatment, not just eligibility for cover. Examples of this include deciding whether procedure is a day case or not, deciding what pathway is appropriate for back pain etc. This activity is totally unregulated.

The CC will argue that this does not affect competition and is not within their remit. However these concerns over patient safety have been raised by dozens of specialists, the specialist associations and other bodies, to the CC in response to the CC's request for information. The CC as a consequence has a unique repository of data highlighting this, and other patient safety concerns.

Where is an individual clinician to turn when they see an inappropriate referral, or have their management pathway changed by an unqualified insurance company employee ? Not the FCA or the GMC.

The CC is a public institution and as such must act in some way to address this risk. The Francis report into the failings of care at the Mid Staffordshire hospital trust clearly demonstrated that ignoring ongoing problems can lead to disasters. As the owner of this information, the CC should refer the topic of whether PMI's are authorised/qualified to perform this medical activity to a competent authority.