Consultant 40

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I am a Consultant Orthopaedic Surgeon practicing in [✂], where the private healthcare market is small in scale. Fewer than half of the consultants in my department undertake private practice.

This is in large part because the barriers to entry and operating costs are too high, and the terms imposed by the major insurance companies too restrictive, for surgeons who carry out relatively small volumes of private work.

These difficulties restrict choice of consultant for patients in areas where geography and population density already dictate there is a much lower choice of consultants than in more densely populated areas.

PRICING POWER OF THE INSURANCE COMPANIES OVER CONSULTANT FEES

I was surprised to read the initial conclusions of the competition commission enquiry in which it was found that the private medical insurance companies hold limited pricing power over consultants. For all consultants starting in private practice after 2010, BUPA has complete control over consultant fees as these consultants are only allowed to treat BUPA patients if they sign a contract allowing BUPA to set their fees. As BUPA are by far the biggest force in the market, it is not possible to set up a viable private practice without being recognized by BUPA, and being delisted by BUPA would make private practice non-viable for many. All consultants joining BUPA after 2010 are tied in to this fixed schedule of fees. If they charge above these fees they will be de-recognised by BUPA (threatening their livelihoods). BUPA reserve the right to unilaterally cut these fees at will, and have done so, in some cases by over 70%. For example they cut the fee for extracorporeal shockwave therapy for plantar fasciitis from £335 to £107. This represents total control over consultant fees by a single major insurance company.

Traditionally the contract used to be between the consultant and the patient. The actions of BUPA means that the financial contract is now between the insurer and the consultant which removes any pricing power the consultant had.

This leaves consultants at risk of having either to charge different fees to patients of different insurers or seeing cuts across the board to their fees at the whim of a single company. It is of concern that other insurance companies have followed suit and started to cut their fee maxima, because they have seen consultants are powerless to challenge the actions of BUPA. For example Aviva have cut the reimbursement for knee arthroscopy by over 25% in 2012. Unlike with BUPA, consultants treating Aviva patients retain the right to pass on the surcharge to the patient. However a unilateral cut in cover level, probably never explained by the insurer to the patient and leaving them with an unexpected bill, is not in the patient's interest.

AXA PPP have stated that any consultant registered after 2008 can charge no more than £120 for a consultation. Again there is the threat of being de-registered for those who try to change their fee structure. Other insurance companies have intimated that if the Competition Commission review finds in favour of BUPA's current contract with consultants registered after 2010, that they will impose the same terms for treatment of their own policyholders. Consultants will have no power to prevent this happening and will see a further reduction of fee income, which could be reduced at any time in the future at the wish of the insurer.

THE PROBLEMS OF LOW FEES AND BARRIERS TO ENTRY FOR CONSULTANTS

Although at first glance the fee reimbursement maxima might still seem high to the outside observer, it is important to consider that these fees are gross, before deduction of all business costs, and so the net amount the consultant will earn – after costs but before tax - is, for some, unacceptably low. With no facility to pass on the higher costs, these low, ever reducing fees over which consultants have no control, are preventing some surgeons undertaking private practice in low volume areas.

Indemnity insurance costs for consultant surgeons with a small private practice can reach as high as 70% of turnover. My own indemnity costs 30% of the fees I invoice. These costs rise by approximately 10% per year. Reimbursement for surgeons is falling from year to year in real terms and in some cases in absolute terms. This means that each year increasing numbers of surgical specialties are not financially viable for private practice for surgeons in areas such as mine. I personally know of four orthopaedic surgeons in my department of eleven surgeons who have withdrawn from private practice in recent years as they can no longer cover the high costs with the reimbursement on offer. It must be remembered that in addition to indemnity costs, there are multiple other business costs to be paid, including consultation room rental, secretarial costs, courses, conferences and other professional updates, billing costs, book keeping and accountancy and professional subscriptions.

To take one example, the BUPA tariff for excision of a ganglion has been cut from £289 to £167. This procedure, while admittedly simple, requires a general anaesthetic and about an hour of operating theatre time as well as the pre-operative and post-operative review by the consultant. In addition, for many procedures there is time spent dealing with patient enquiries before admission, time spent arranging the admission and organizing follow up, scheduling theatre, arranging equipment, note keeping and other administrative tasks. In total this requires more than 2 hours. When indemnity, travel and secretarial costs are factored in it is simply not worth a surgeon's time to provide such services for the resulting rate of about £30 per hour before tax. Any attempt to pass on the extra cost is invariably met with bullying tactics from BUPA and the threat of derecognition - which is a further threat to patient choice and a clear threat to the consultant's livelihood.

Once this time is taken into account, the current BUPA rates (and those from some other insurers) will, for many consultants in my region, not match the rates which consultants can earn from medicolegal work or even often from doing non-contracted additional NHS work. Consultants are therefore choosing to undertake medicolegal work rather than private practice. This means they are not entering the market in my region and this reduces patient choice by denying patients access to those consultants.

STRATEGIES BY BUPA TO MISLEAD PATIENTS AND RESTRICT ACCESS TO CARE

BUPA are misleading their customers by labeling surgeons as “BUPA assured”. Patients are led to believe that this is a measure of the quality of the service these surgeons will provide. In fact the term “BUPA assured” merely means that the surgeon has, through choice or compulsion, agreed to BUPA’s fee schedule and so is “BUPA fee assured”. Surgeons are answerable to the General Medical Council and the Royal Colleges of Surgeons. For BUPA to claim they are in some way responsible for vetting and accrediting surgical standards is misleading.

BUPA’s open access policy structure can further mislead patients. I have been sent patients by BUPA who have been told by BUPA that I am a leading expert in areas in which I have far less experience than some of my local colleagues. BUPA are doing this because I am tied in to their fixed fee structure when my more senior colleagues are not. This is misrepresentation and is clearly misleading to patients.

BUPA are also introducing strategies to try to ration access to treatment which is delaying access to surgery for their patients. I have a patient who has a meniscal tear of the knee, proven on a MRI scan, who requires a knee arthroscopic meniscectomy operation. I offered to perform the surgery for him the following week. However BUPA insisted that they should review all his medical records before authorizing his treatment. They have not authorized his treatment in a timely fashion which has resulted in a delay in his treatment, prolonging his pain.

The CCSD

The balance of power between the consultants and insurers is firmly stacked in favour of the insurers. Insurers collectively run the “Clinical Coding and Schedule Development Group” (CCSD), which sets the codes for all surgery and fees are determined from this. It is my opinion that the CCSD acts as a cartel run by the insurance companies. Periodically codes will be "bundled" or the descriptors altered to the consultants' disadvantage and without consultation. Consultants have no choice but to accept this. However if consultants attempt to use the original descriptors and codes they can be accused of "unbundling", misrepresentation and even fraud.

For example the introduction of the fee code W0321 for Scarf and Akin osteotomy to correct hallux valgus (bunions) has reduced reimbursement for a procedure that was previously classed as code W0300 (multiple procedures on forefoot) or W7910 and W1040 (first metatarsal osteotomy and osteotomy of small bone of foot). The latter has now been classed as an “unacceptable coding combination” and as a result the CCSD has unilaterally reduced the fees for a common procedure.