Consultant 4

30 January 2014

Dear Mr Witcomb

I am a consultant with private practices in central London hospitals. I have been following your private healthcare market investigation with interest and would like to express my disappointment with the many provisional findings and decisions on remedies.

Firstly, I have been disappointed by your lack of focus on the insurers and their asymmetrical relationship with consultants. There have been multiple submissions showing the effect of insurers using their power to coerce consultants in to lowering fees without any evidence of care quality. Ultimately, forcing everyone to charge the same is profoundly anti-competitive. In the same way that insurers are given the freedom to choose how much to reimburse for fees, one would also expect that individual consultants should also be able to base their fees on open competition and a free market. The recognition and de-recognition of consultants should not be based on fees charged. We all agree that patients deserve value for money and costs need to be controlled, however PMIs attempting to ensure that all doctors charge the same is obviously anti-competitive. As you have heard new consultants need to charge the rates set by some major insurers, namely BUPA and AXA in order to be recognised by them. Any new consultant cannot reasonably be expected to establish a private practice without recognition by the major insurers.

BUPA has the largest market share of any PMI and its reimbursement for procedures was unchanged between 1993 and early 2012. Since then the reimbursement for most procedures has reduced on average by over 30%. Practice costs rise over time and are not immune to the effects of inflation. This means that consultants are overall reimbursed significantly less for procedures now than over 20 years ago, despite notable increases in practice costs. Therefore it is important to appreciate that consultant reimbursement for procedures cannot be a major factor in the rising cost of healthcare.

On purely financial grounds, some major insurers have interfered with clinical decisions made by GPs and consultants and controlled the patient pathway using “open referral” which limits patient choice. Again this seems to be anti-competitive. I agree that costs should be more transparent to patients. However this should also apply to insurers so that patients know exactly how much procedures will be reimbursed. Whilst most consultants will adhere to insurer fee schedules, there should be nothing inherently wrong in a patient choosing to pay a “top-up” to see a particular consultant. This does not add costs for the insurer since they still pay out the same but the patient has more choice. In your final report, I urge you to ensure that a free and openly competitive market can operate in this regard ie ensure that PMIs cannot prevent top-fees or deny recognition of consultants purely based on the fees they charge.

Finally, a consultant generally chooses which private facility to work from based on the quality of service that he/she believes it can provide. I base much of my private practice at The Lister Hospital (an HCA facility) because of the type of procedures and equipment available to me there and the excellent nursing support provided. This allows me to offer a sub-specialist service that I cannot provide in other central London private hospitals where I also work. This hospital has pioneered and invested in certain services such as cutaneous lasers. Furthermore the network of HCA hospitals has facilitated multidisciplinary working. A notable example was the HCA initiative to develop tumour boards for different cancer groups, in order to ensure collaboration between specialists across their hospitals to provide the highest possible standards of care. There have been no financial incentives to work there.

I look forward to these issues being adequately addressed.