Consultant 74

4 February 2014

Sirs

I would like to comment solely on the Competition Commission's findings on clinician incentives in its Private Healthcare Market Investigation. I am a full-time consultant anaesthetist in private practice in central London. [✂]

I fully support the Competition Commission's recommendations on limiting clinician incentives. I have been surprised to learn of the frequency and variety of incentive which only became apparent as clinicians approached [✂] for admitting rights. They are a disincentive to competition not only amongst clinicians, but also hospital providers as we found it difficult to deal with the demands made by some clinicians to match incentives made by others as a condition for them using our facilities. They were a barrier to entry. Incentives are given not only by hospital providers but also others such as laboratories, marketing organisations and purchasers. Your restrictions should apply to the receiving clinician and not the organisation giving the incentive if they are to be effective.

Incentives have undoubtedly helped younger consultants attempting to establish themselves in private practice and without HCA in particular some consultants would not be available to private patients. Nevertheless, there is considerable danger in your recommendations to allow incentives provided they are available to all consultants. Anaesthetists in particular are unable to take advantage of many of these incentives such as subsidised or free consulting rooms. This produces a further disparity between specialties and their profitability. The disadvantaged specialty constricts, reducing choice, which I will expand on in the following paragraph.

Incentives may do no harm in themselves but may produce disincentives elsewhere which adversely affect patients and so UK PMIs should also be prevented from providing incentives. A number of insurers have agreed increased consulting rates for surgeons or allowed surgeons to charge above their fee maxima but anaesthetists cannot benefit from the former and are more commonly denied the latter. The result is a further increase in the differential between surgical and anaesthetic fees. The latter are now often at or below practice costs and well below the salaries offered by the NHS which is resulting in a significant shortage of anaesthetists in central London. This not only reduces patient choice but also impacts on clinical quality when anaesthetists are working outside their subspecialty; we are now seeing situations where patient care is being delayed because of insufficient anaesthetic manpower. There is some evidence that hospitals may therefore enforce restrictions on anaesthetists to prevent them working elsewhere, not by incentive but by diktat, and this will have exactly the same effect as tying in surgeons by incentives which you rightly criticise.

I would question but one recommendation that has been made namely the limitation that clinicians cannot own more than 3% of the equity in a hospital provider. It is difficult to understand why any hospital provider should seek financing from a clinician as opposed to more orthodox channels other than to tie that clinician into a particular hospital. Whilst there is significant benefit in doctors working in teams and working mostly in one particular hospital, the clinician's choice of hospital should be made on the basis of quality and not financial gain so the ownership of any equity in an establish hospital provider by clinicians is difficult to justify. However this is quite different from a situation where a clinician sets up a company or invests his own money in a commercial venture taking risk to build his practice or a company. If a surgeon can purchase property for his consulting rooms and own the equity in that building, I submit that he should also be able to do the same with a hospital.

[✂]

3% is arbitrary and unfair. 3% of the larger providers is a massive amount so those companies could continue with considerable incentives without censure, whilst the smaller companies struggling to compete or enter the market would be unfairly handicapped because 3% of their equity would represent such a small value so as to prevent them entering into an identical arrangement.

I suggest it would be preferable to disallow any equity holding in an established healthcare provider, be it a hospital, radiology centre, laboratory or cosmetic/bariatric agency save purchased as part of a normal investment portfolio of shares unless the individual obtained those shares as part of a bone fide business venture in which he took an equal level of risk to the other investors and where there was an identifiable need for the company to approach a clinician in preference to an alternative investor. This condition would not be met if the company had sufficient resources or access to loans to simply undertake the venture with no outside financial support. However, where these conditions are met a clinician should to be restricted in his share ownership as long as it is properly disclosed.