Consultant 3

25 October 2012

At the time of writing (October 2012), only 150 consultants have submitted their views to the Commission. The small number of submissions suggests consultants are broadly content with the current changes occurring in the relationship between insurers, providers and patients. However, as a member of the Medical Advisory Committee of a private hospital for several years, I believe it is in fact due to (a) widespread ignorance of the existence of the investigation (b) failure to recognize its importance, (c) lack of time and (d) resignation or "*Que sera, sera!*".

I am a consultant surgeon with an average private practice, working in the NHS and the private sector. I wish to submit my observations on those parts of the investigation that particularly affect consultants and I hope these will assist the Commission. Using your structured approach they concern:

- theory of harm 2: market power of individual consultants and/or consultant groups in certain local areas;
- theory of harm 4: buyer power of insurers in respect of individual consultants;
- theory of harm 5: barriers to entry at different levels;
- theory of harm 6: limited information availability

Theory of harm 2

Market power of individual consultants and/or consultant groups in certain local areas

(a) Admitting rights to private hospitals are granted by the Hospital Manager after advice from the Medical Advisory Committee (MAC). The Manager has the final say and will naturally take account of commercial interests. Apart from possessing the right qualifications, applicants who intend to admit and treat inpatients (rather than only conduct outpatient clinics) are required to live sufficiently close to able to attend them swiftly in an emergency. This can explain objections to non-local applicants. Competing interests of other consultants should not be a consideration.

The majority of applicants hold consultant appointments at local NHS hospitals (I am not considering wholly independent practitioners). This is regarded as a reliable measure of quality as the NHS appointment process is extremely rigorous and competitive and yearly appraisals are compulsory (and must be disclosed to the private hospital). The limited number of consultants in the private sector reflects the shortage of NHS consultant posts nationally.

(b) The prevalent view that GPs and consultants enjoy a cosy relationship with regard to private referrals is largely myth. GPs do tend to refer patients privately to the same consultants they use in the NHS. Their choices depend on the range of local NHS options available to them and the experience they and their patients have of these options. GPs are in an excellent position to appreciate the special interests of the consultants to whom they refer (e.g. surgeons who specialize in backs or shoulders) and their judgement in these matters deserves to be respected. Indeed, the current NHS reforms[1] are based crucially on the premise that GPs are best placed to decide on referral practices. Why should this be any different in private practice?

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[1]Health & Social Care Act 2012.

(c) Many consultants are happy to abide with insurers fee schedules even though, astonishingly, these have barely changed for two decades. Recently, however, insurers have sought to reduce their remuneration without explaining how, in the face of rising patient expectations, the procedures have suddenly become less demanding or challenging, and (to considerable understandable annoyance) without even informing their members. They have also introduced arbitrary new rules such as only paying for a part of complex procedures. For example, a consultant told me he recently saw a woman with cancer in both breasts but her insurer only agreed to pay for surgery to one side. This cannot be right. It leaves consultants with the choices of (a) only undertaking the procedure covered, which would represent inexcusably poor clinical practice, (b) charging a shortfall to someone who believed s/he was covered (c) accepting a loss in the face of mounting costs (see below) and (d) declining to undertake the procedure on the terms offered, which would be inconceivably distressing. Patients and doctors should never be presented with this kind of dilemma.

Theory of harm 4

Buyer power of insurers in respect of individual consultants

(a) I would argue that the role of insurers is to help finance their members' healthcare choices - not to make choices for them. It is perfectly reasonable for insurers to determine their maximum reimbursement rate. As independent practitioners, on the other hand, consultants are free to charge what they like. Many abide by the existing fee schedules, and if they don't they need to justify why not (e.g. hefty insurance premiums in some specialities - *see below*). The Commission must appreciate however, that like company directors, consultants are not interchangeable commodities. Some may possess skills others do not (e.g. keyhole bowel or hernia surgery). In particular, some choose to subspecialize and acquire a reputation in specific areas; they are not confined to teaching hospitals any longer.

Reimbursement by insurers covers hospital costs as well as consultants' fees, which account for around 25 per cent of the total cost - a percentage that continues to fall as private hospitals increase charges to maximize profit, reducing the amount remaining for consultants. The vast majority of the cost is consumed the hospital, a fact that is seldom appreciated by insured patients who do not see a breakdown of charges.

(b) "Approval" of consultants by insurers is simply a mechanism for driving down costs. Whatever other criteria are used, consultants are less likely to be "approved" if they do not accept the insurer's fee schedule. Whilst this is understandable, it inevitably reduces consumer choice - excluding perhaps more experienced specialists - and it is certainly not transparent for consumers. It also takes no account of the clinical judgement of the referring GP. There are already worrying stories circulating about patients not seeing the most appropriate specialist in the opinion of the referring doctor, because the specialist was not "approved" by the insurer.

Similarly, consultants who are not listed as "fee-assured" by some insurers are excluded from specialty or post-code on-line searches and ranked lower on insurers' websites, again reducing consumer choice and ignoring GPs' judgement, without any transparency.

(c) "Open" (i.e. un-named) referral is another potentially unsatisfactory new practice. For example, a patient was recently referred by a GP back to a consultant who had seen her previously for a similar problem. The GP was required by her insurer to complete a form requesting an "open" referral, without which remuneration would be withheld, that could result in the patient being seen by another consultant with no information about her previous relevant history, an arrangement that would certainly not be in her best interests.

GPs should be able to choose to direct referrals based on their assessment of what is in their patient's best interest and insurers should not compromise their clinical judgement by insisting they make an "open" referral. Open referral should be optional, not mandatory.

(d) Regulation and accreditation of doctors is the statutory duty of the General Medical Council[2] assisted by the Royal Colleges, which have the appropriate competencies. It is not a function of private insurers. Almost certainly, consumers are likely to mistake "approval" by insurers as a measure solely of clinical expertise, unrelated to cost. As long as consultants provide clear evidence of their qualifications, revalidation, expertise and fees, choices should be left completely to the consumer, who still deserves to be informed why some consultants charge more than others.

(e) "Managed care", to the extent that it discourages wildly inconsistent practice, is not unreasonable (e.g. day case surgery for breast cancer, gallstones and hernias). But there is a risk that innovation will be stifled and that parsimony will prevail (e.g. using the cheapest mesh to repair hernias even if it is more likely to be felt than more expensive varieties; discouraging keyhole hernia repair because of cost). This could conflict with the consultant's preferred choice of treatment, which should be one of the major advantages of choosing private healthcare.

(f) Whilst the interests of consumers are paramount for the Competition Commission, it needs to appreciate that private practice is fundamentally a business. Unless the Commission fully understands this point, there is a distinct possibility that its recommendations will lead to the collapse of private healthcare in the UK, precisely contrary to its fundamental objectives of extending consumer choice.

After large insurance premiums (over £70,000 a year in some high risk specialties like spinal surgery) increasing secretarial and administrative costs, room rentals and tax, most consultants keep around 20 to 30 per cent of what they earn. As the new NHS consultant contract eliminates flexibility, more private work has to be done out of hours while consultants are expected to be on call for their private patients 24 hours a day, 7 days a week, 365 days a year. Increased NHS work, with potential Clinical Excellence Awards which may be pensionable, extra-contractual lists, and the option of private work in NHS Foundation Trusts, looks increasingly attractive. Why take on independent private work? Is it worth the effort? For the first time ever, new consultants are being advised to consider carefully whether independent private practice is actually in their interests.

Theory of harm 5

Barriers to entry

(a) Competing interests of other consultants or groups of consultants should not be a consideration in granting admitting rights to a private hospital. Most Hospital Managers would be unlikely to support objections on these grounds.

(b) Offering financial incentives to GPs to refer patients is in my opinion unethical, and should be deplored.

Theory of harm 6

Limited information availability

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[2] Medical Act 1983.

(a) Traditionally, the medical profession has deprecated advertising and self-promotion as unprofessional, playing down the commercial aspects of private healthcare. This attitude goes some way to explain the current lack of information about private practice, rather than it being the result of a deliberate intention to conceal anything. Nevertheless it does not serve consumers well. Both private and NHS hospitals are increasingly aware of the importance of publishing quality indicators, such as infection rates. There is also mounting pressure to publish individual consultant information, but exactly what this should be is controversial. Should private and NHS data be conflated, for example, including volumes of NHS work and possession of national NHS awards? Undoubtedly details of current practice and fees should be transparent to both patient and GP.

(b) One new activity the Commission might like to scrutinize is that of some freely distributed, privately produced healthcare magazines. Consumers may well assume that contributors have been invited to contribute because of their expertise, whereas in fact they have paid the magazine several thousand pounds to display their details as a means of advertising. Surely magazines should disclose in the small print that contributors have paid for the privilege, or fund their product by subscription.

CONCLUSIONS

- Patients choose private healthcare for many reasons. These include the assurances that a specific consultant will deal with them personally using the best techniques available, at a convenient time and in a safe and comfortable environment.

- GPs choose consultants usually on the basis of their experience of NHS care and on clinical judgements about what is in their patients' best interests. The recent NHS reforms acknowledge GPs are best placed to decide on referral pathways.

- Consultants choose to work in the private sector because it is more personal than the NHS, allows greater freedom of practice, and generates an income.

- Lack of transparency means that insured patients seldom realize how much of their costs are consumed by hospital charges, not by surgeons' and anaesthetists' fees.

- The practices of open-referral, approved consultant lists, managed-care and fee-capping threaten to eliminate the special benefits of private care for both patients and doctors.

Open referral and approved consultant lists interfere directly with the clinical judgement of GPs' in making referrals to the most appropriate specialist, and are practices entirely devoid of transparency. Managed-care eliminates consultants' preferences in providing treatment, while fee-capping restricts the choice of consumers and may exclude access to the most experienced practitioners. Insurers should not be allowed to subvert the role of medical professionals in determining the best interests of their patients.

- Political parties of all hues seem to be in favour of a greater involvement in healthcare by independent providers.

- Insurers are creating significant disincentives to private practice and seem reluctant to accept that private practice is wholly dependent on consultants without whom it would cease to exist. Private healthcare is supposed to fulfill a worthwhile function. If the Competition Commission reaches the same conclusion, it will hopefully recognize that consultants are its most valuable asset, and that without incentives, there is nothing to stop them abandoning it for greener pastures.

- I hope other consultants will contribute to this investigation. Complacency at this time would be a mistake.