THE LONDON CONSULTANTS' ASSOCIATION
14 QUEEN ANNE'S GATE • LONDON SW1H 9AA
Tel 020 7222 0975 • Fax 020 7222 4424 • Email info@london-consultants.org • Web www.london-consultants.org

Julie Hawes
Inquiry Coordinator
Competition Commission
Victoria House
Southampton Row
London
WC1B 4AD

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Dear Ms Hawes

Private Healthcare Market Investigation

A. Introduction

In July 2012, the London Consultants' Association ("LCA") replied to questions posed by the Competition Commission ("CC") about the status of competition in the private healthcare sector in the UK. The LCA has since been following the CC investigation closely.

As the CC is aware, the LCA does not have the resources to gather evidence and provide detailed submissions and, for this reason, in our July submission we explained that we make our views known through the Federation of Independent Practitioner Organisations ("FIPO"), of which we are a member. To date FIPO has made three submissions to the CC, and the LCA has been involved in so far as the issues and arguments raised by FIPO concern LCA members.

The reason why we are engaging with the CC directly through this second short submission is that, since July, we have become aware of what appears to us to be a considerable worsening of the situation in which consultants operate, with continued and often, in our view, unjustified interference by the main private medical insurers (PMIs) in the patients' clinical path, with negative consequences on patients' choice and continuity of care.

The LCA is increasingly worried that the CC investigation may have the unintended consequence that PMIs are attempting to establish new practices which will be considered the norm by the time that the CC concludes this investigation in 2014. If that happens, then it could be too late for any remedies to be capable of reversing the situation.

We would urge the CC to take this aspect into account in any interim statement that the CC may plan to issue prior to the conclusion of this investigation.

B. Executive summary

In this brief submission, the LCA highlights four main concerns which, in our view, require further analysis. The first is that delisting is becoming, it seems to us, more prevalent. The second is that imposing low fees seems to be deterring consultants from entering the market. The third is that the PMIs' "managed care" is eroding the factors that used to differentiate private practice. The fourth is that PMIs are showing an increased tendency to challenge clinical decisions made by consultants, not on the basis of established medical guidelines, but according to their own agenda and standards.

C. Delisting

The practice of delisting consultants continues apace and seems to have become more common. The reasons given for delisting are mainly due to allegations of excessive consultant fees (which we would dispute) and some times in relation to variations in treatment. Consultants must justify to the PMI their credentials or levels of expertise which are then ignored by the insurer (Bupa in particular). Variations in an individual consultant's practice when compared with others may be explicable but again is often ignored by the insurer.

The random nature of the process of delisting and the absence of proper reasoning for it are further exacerbated by the lack of an opportunity for consultants to appeal a delisting decision.

D. Effects on entry

For some consultants the practices of insurers act as a barrier to entry to private medical practice entirely. LCA found it interesting to read the individual submission of Consultant 175 on the CC website. This consultant highlights what LCA suspects is becoming a widespread feeling. To become an approved Bupa provider, this consultant would have to agree to Bupa's reduced rates for both consultation and surgery. After careful consideration, he concluded that he could not sustain a practice, as this would be unlikely to cover its costs, given the volume of patients that he would be likely to see during the first few years. He has, therefore, opted not to offer a service to privately insured or self-paying patients.

Whilst this is indicative of a worrying trend in terms of entry to the private healthcare sector, neither the LCA, nor other (better resourced) organisations such as FIPO would likely be able to provide evidence of it. Due to the nature of organisations of consultants operating in private practice they cannot reach out to those who have opted not to enter the sector. This could probably be done more easily by the CC.

E. Other "managed care" practices – cash for NHS treatments

"Managed Care" seems to have spiralled out of control in other ways too. For example, the LCA believes that Bupa has been openly offering patients cash incentives to have their treatments funded by the NHS. In the LCA's view, the very *raison d'être* of private healthcare is under attack: patients are losing the option to see a consultant of choice in their hospital of choice, at a time when it is convenient to them. If (hypothetically) it became widespread practice that, on needing medical care, a privately insured patient were given the choice of either seeing a consultant chosen by the insurer in predetermined location, or being given cash to be treated at the local hospital by the NHS, then the differentiating factors between NHS and private healthcare would become very blurred. The question must then be why would someone choose to pay for a private healthcare insurance? This in turn would seemingly give rise to more managed care practices and further erosion of the viability of private healthcare, to the detriment of all.

If patients, who wish to continue their treatment with a consultant with whom they have established a relationship, and who has an in-depth understanding of their condition, are not given the option to meet any shortfall in fees, even where they are able and willing to do so, then patients do not have any choice in the matter of their own care. Anecdotally, the LCA has heard that delisted consultants cannot even volunteer to operate for free on their patients, as Bupa refuses to cover the anaesthetic and hospital fees.

F. Clinical Guidelines and GMC issues – Bupa Involvement

The General Medical Council (GMC) is the independent regulator for doctors in the UK and exists to maintain proper standards in the practice of medicine. The GMC publishes guidelines on Good Medical Practice and acts as the body which governs the profession. To protect patients from harm, the GMC controls entry to the medical register and takes action - if necessary, by removing the doctor from the register and removing their right to practise medicine - where it considers the required standards have not been met.

Clinical guidelines, which advise on patient management, are not set in stone but are meant to simply suggest a most evidenced method of treatment from which a doctor may digress if the clinical situation dictates. There are many existing guidelines which are produced by NICE, the Royal Colleges and other specialist professional bodies. It is worrying to see insurers creating their own clinical guidelines and challenging consultant clinical decisions for reasons which seem more motivated by cost considerations rather than sound clinical evidence.

I mention these two issues because Bupa (an FSA regulated company) is intruding into these territories. For example Bupa is stating that consultants over 70 must have an appraisal by a consultant in their own specialty but this is not a GMC recommendation. In terms of clinical guidelines Bupa is setting its own guidelines for example in arthroscopy, which run counter to the best evidence guidelines produced by specialist orthopaedic associations. In addition, Bupa is reviewing consultant orthopaedic opinion by external assessments from clerks or doctors who have never seen or examined the patient and this has been expressly rejected as best practice by the Royal College of Surgeons of England.

The LCA refer the CC to the submission of consultant 134 on the CC website, an orthopaedic surgeon who had historically only seen patients referred by their own GP in accordance with accepted professional principles. Recently three patients were referred to him personally for advice and treatment by their GP but Bupa would not fund the consultation and advised the patient to see another surgeon. On one of these occasions a patient with a hip problem was referred to a knee surgeon.

According to consultant 3 on the CC's website, BUPA has (effective as of 30th April 2012) excluded Pain Medicine Consultants (PMCs) from their list of approved consultants to perform anti-inflammatory spinal injections, so that prior approval from another consultant (often less qualified, and from a different speciality) is required. This is not in the best interests of the patients as the delays prolong their pain. In addition, since there are certain injections that only PMCs are trained to perform, if approval is not granted these injections will not be available to those patients insured by BUPA. This leaves them open to the risk that they may instead be offered more invasive surgery, and may not make an informed choice.

Yours sincerely,

Duncan Dymond
Chairman of the London Consultants' Association

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