Consultant 160

25 October 2012

Dear Commissioner,

I am a consultant surgeon working in private and state health systems and have done so for more than [✄] years. I hope you can consider my comments in your investigations of the private healthcare industry.

The current set up with private healthcare insurers and private hospital providers leads to a gross unfairness when dealing with individual practitioners be they surgeons or medical physicians. Ultimately, care and contractual obligations are between the patient and the medical or surgical practitioner. This has in the past meant that charges for professional service were directed to patients, who would seek remuneration from their health insurance company. This model has been changed by coercion from health insurers to a new model, where the practitioner charges or invoices the company directly, and if there is a "shortfall" leave the practitioner to deal with the patient directly to chase this up. This invariably leads to black listing of practitioners even if they are working in high costs areas such as central London. Another change is of the referral system for patients to practioners of the GP's or patients choice, they are now setting up care providers and preferred practitioners (who adhere to their charge levels irrespective of the experience, skill of the practitioner or the needs and choice of the patient) ultimately they decide rather than general practitioners, who patients should be referred to.

Private medical insurers unilaterally without providing any evidence decide to de list or de recognise practitioners even if these practitioners are registered with the appropriate professional bodies and GMC, on he specialist register, hold CCT certification.

Private medical insurers change tariffs for health care provision:

1 Operative procedure codes are changed without apparent consultation with relevant health professional organisations. They have taken to simplify procedures by preventing multiple procedure codes being charged for a single patient. Though most insurance companies restrict surgery procedure codes to 3, occasionally a patient may have a complex operation which results in much tooing and froing before the multiple and complex procedure remuneration and codes are agreed. This is now being reduced to 2 procedures per patient.

2 They also decide that where individual procedure codes are for the same area of the body, that they amount to the same operation and refuse to pay for complex procedures where more than one operation is undertaken in the same area. This occurs despite procedures codes describe distinct and different operations to multiple organs in a specified area of the body. This decision is unilateral and has not been successfully challenged by professional bodies.

3 Where a patient has had a complex operation which means the patient remains in hospital for more than a few days, cannot be charged for by practitioners though of course hospital in patient daily charges are paid. Essentially the regular and daily attendance to the hospital and review of the patient is not paid for at least the first 7 to 10 days. The claim being that the operation remuneration would cover this period of in patient care. The issue, is however, a complex operation takes a long time and so the time for surgery is barely covered by the procedure tariff, especially in light of the above points of reduced remuneration for the procedure and the reduction in the number of procedure codes allowed for any patient.

4 The costs for practitioners are rising with medical inflation as well as general inflation the former being higher than the latter. Unfortunately, procedure remuneration for the bulk of ENT procedures have remained unchanged for at least the 10 years I have practised private medicine.

Though outpatient consultation fees have increased, there has been a significant reduction in payment or remuneration of professional fees for any outpatient based minor procedures. This occurred unilaterally without any negotiations. For those practitioners who have purchased equipment or loan equipment from companies, it makes maintainance and service of such equipment untenable. The practitioners are usually not allowed to invoice service charges for use of the equipment and so are reliant on professional fees alone. Interestingly, where such equipment, is provided and maintained by private health facilities or hospitals, they can and do charge much higher service charges, which are in excess of the professional fees charged by practitioners, and seem to be paid without any such restrictions. This is separate to the professional charge for providing the procedure. This imbalance is difficult to explain.

I am sure that this is not an exhaustive list of issues faced by practitioners. We aim to provide a high quality service for patients. But the current economic climate and restrictive practice of medical insurance companies has placed most if not all the burden of cost reduction on surgeons and physicians, whilst raising insurance premiums.