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federation of independent practitioner organisations

FIPO NEWSLETTER – January 2014

To all Consultants

Dear Colleague,

The Competition Commission Provisional Report on Remedies

The Competition Commission (CC) has produced its Provisional Remedies Report at; http://www.competition-commission.org.uk/our-work/directory-of-all-inquiries/private-healthcare-market-investigation

There is a short period for comments on this and then the final report will be issued at the beginning of April 2014 but is unlikely to show major changes. These remedies will be legally enforceable.

The report is positive in some ways but disappointing in the sense that the CC has looked predominantly at the macroeconomics of the situation i.e. the relationship between the insurers (PMIs) and the hospital providers and has largely ignored the issues of patient detriment and consultant relationships with the private medical insurers (PMIs).

This is a summary of the CC's report. A more detailed analysis of the report is given in the Appendix to this letter together with FIPO's comments. For the profession, perhaps the key thing to note is that the failure of the CC to address the influence of the medical insurance companies has resulted in an effective endorsement for BUPA to pursue vigorously its campaign to persuade consultants to sign up to its partnership arrangements and a schedule of fees which in the long term will make private practice uneconomic for the majority and by default for patient choice to be decimated.

Summary - Competition Commission's Provisional Remedies

Remedy 1 - Divestiture of nine private hospitals
In order to induce more local competition HCA must divest two hospitals and BMI seven hospitals because of local dominance. This may be challenged by the companies.

Remedy 3 – NHS PPU arrangements with private hospital operators
Private hospitals cannot contract with NHS PPUs if they are already dominant in that geographical area.

Remedy 4 - Ban on clinician incentives
Hospital inducements to consultants are banned (up to £500 per annum allowed). An individual consultant's equity share in hospitals owned by private hospital groups at which the consultant has practising rights or the ability to commission tests is limited to 3%. These must be bought at market price and must not be linked to any obligation to refer patients. There are no apparent restrictions on

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doctors owning clinics, X-ray units etc., where there is no private hospital involvement.

Remedies 5 and 7 – Clinical outcome data
PHIN (Private Healthcare Information Network) will be supported by hospitals and PMIs who will share in the collection and publication of information on hospital and consultant performance. The structure of PHIN will be mandated and there will be professional input.

Remedy 6 – Fee Information from consultants.
Consultants will be obliged to provide consultation and procedure fees in advance where possible to patients in a prescribed written format. Hospitals will monitor that this is being done for all in-patients. Ultimately in 2 -3 years when more "quality" information is available fees will be more directly related to consultant performance, and will be published on hospital websites.

The Current Situation

The Competition Commission

The Private Patient Forum (PPF) and FIPO have submitted evidence to the Commission about patient detriment as have individual consultants and other professional groups. There is very little in the CC's Provisional Report on Remedies which deal with patient detriment and loss of choice. The CC does however say *"We have not, at this stage, made a final decision regarding customer detriment"*. We hope that patient detriment will be properly addressed in the final report.

In terms of consultant issues FIPO, along with many organisations (including the BMA, LCA, IDF, AAGBI and others) and consultants has submitted evidence about:

- The impact of "open referral" on patient care
- The changing terms and conditions of some PMI contracts for patients
- The dominance of PMIs vis a vis the consultants
- The de-recognition of consultants on dubious financial grounds
- The relentless attack on fees and reduction of patient benefits
- The barriers to entry for new consultants on fixed and very low fees
- The future economic unsustainably of consultant practice

This evidence seems to have been largely ignored. Some of it, the CC says, has fallen outside the remit of the CC's inquiry. However, there is reference to the fee charging arrangements for consultants (See Appendix). Whilst there remains a question about where and how fee information should be published, any such list would make no sense if fees are set by the PMIs. In a "fee assured" system, which does not allow subscribers to top-up or co-pay, the consultant submits his/her account to the PMI, thus totally bypassing the patient. Fee information then becomes irrelevant as under these circumstances there can be no competition on costs.

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Insurance Issues

During the Commission's work during the last 18 months or more the major insurers (Bupa and PPP) have continued to enforce their fixed fee schedules on young consultants and are trying to persuade or pressurise senior consultants to become "fee assured." Bupa is leading on this but other PMIs are following a similar strategy.

At the moment approximately 50% of consultants are Bupa "fee assured" and of those a substantial proportion, possibly 15 -20%, are newly appointed younger consultants who appear to have no option in this matter. The pressure on established consultants from Bupa is often based on the allegation that their consultation fees are in the top 10%, although in many instances this seems most unlikely. Of course in any free market there will always be some consultants who are in the top 10% (just as there will always be half the consultants who charge above average!).

Consultants must make a personal decision about how they react to the Bupa pressure but they should be clear about the meaning of this. Those who become "fee assured" should realise that they are **losing their contract with the patient**. The patient no longer has responsibility for any part of their fees.

Consultants may become "fee assured" because they are asked to just lower their consultation fees by a small amount and some have said they are still getting more than a colleague; others may feel that they are temporarily gaining patient referrals.

Of course it is clear that if the larger PMIs are ultimately successful not only will all PMIs follow suit and lower their benefits (which is already happening) but any temporary gain in volume will vanish as the general pool of patients will remain the same but the number of consultants dealing with them will have increased. This is a "no win" situation for any consultant and it will lead to quite severe economic difficulties for many.

FIPO has written to consultants previously about theses issues which can be seen here; http://www.fipo.org/docs/FIPO-Surveys.htm. Please see the "Gaming Theory" and a slide demonstration that is shown under **'Can consultants negotiate fees with insurers – an extension of game theory?'**

Consultants have asked why Bupa are trying to coerce them in to signing up to consultation fees, which may be higher or sometimes already even lower than a colleague in the same specialty that has not been approached. The point is that this is just the start of the process and the actual fee is irrelevant; it is the contract between the consultant and the PMI which matters and the patient is now no longer involved.

FIPO has calculated that the initial and follow up consultation fees for the new young consultants has been fixed at 40% below the average fees charged by established consultants. These doctors will gradually increase in number (although those going in to private practice are far less than previously) and senior doctors

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will retire. Once the PMIs reach a tipping point with the vast majority of consultants signed up (whether young or senior consultants) then experience in the USA has shown that the insurer will gradually ratchet down the benefits for all and those who fail to comply will simply be delisted.

We have given extensive evidence to the CC about the PMI actions and the economic impact of this strategy from the PMIs. We know that there are barriers to entry now for young consultants, particularly in high-risk specialities (high indemnity and general costs and low fixed fees). This information has largely been ignored by the Commission.

Future Professional Actions

Established" consultants should discuss all these matters with their local colleagues. Mostly consultants are sole traders and may not act in concert or form cartels. Each consultant must make his/her own decision. However, the full implication of these PMI approaches should be perfectly clear. FIPO does not advocate unreasonable fees and we ask always that patients are informed of their likely charges.

FIPO will go back to the Competition Commission but it seems unlikely at this late stage that they will change their position. However, we will wait to see the final outcome of the report in April and then depending on circumstances we will consider whether or not there is any formal challenge we can make at that stage.

This has been a disappointing report for both patients and the profession, as the actions of the PMIs and the resulting detrimental effect on patients has been side-lined. The FIPO board has discussed this matter in detail and we would be grateful if you would circulate this letter to all your colleagues. Do not hesitate to let us have your views and of course this does not prevent you writing to the Competition Commission at the address below to express any views you may have. If you do this then would you kindly keep us informed?

The competition may be approached through their coordinators
Julia Hawes Julie.Hawes@cc.gsi.gov.uk or
Christiane Kent Christiane.Kent@cc.gsi.gov.uk

Or write to: Ms. Julie Hawes
Inquiry Coordinator
Competition Commission
Victoria House
Southampton Row
London WC1B 4AD

Please let us have your views on any of these issues.

From The FIPO Board

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APPENDIX TO THE FIPO NEWSLETTER JANUARY 2014

The Competition Commission Provisional Report on Remedies

The Competition Commission (CC) has produced its Provisional Remedies Report at; http://www.competition-commission.org.uk/our-work/directory-of-all-inquiries/private-healthcare-market-investigation

This is an analysis of the main Remedies with FIPO comments.

Remedy 1 - Divestiture of nine private hospitals

The CC has looked at areas of alleged dominance of hospitals in different areas and has proposed that certain groups should divest their hospitals as follows:

2 HCA Hospitals

- London Bridge
- Princess Grace Hospitals

7 BMI Hospitals

- Bishopswood and Clementine Churchill
- Cavell or Kings Oak
- Shelburne or Chiltern
- Shelsfield Park and Sloane or Shirley Oaks
- Saxon Clinic or the Shires and Highfield

In this divestment the CC have imposed the following commitments:

- The hospital operator must not move consultants or offer them inducements to bring all their work to the properties which remain after divestiture
- PMIs are to recognise divested hospitals at the same rates
- A monitoring trustee will be appointed to oversee compliance

Remedy 3 - NHS PPU arrangements with private hospital operators

- Parties required to notify all such arrangements
- Proposed transactions between NHS Trusts and private hospital operators for the operation of a PPU to be evaluated on a case by case basis on their merits (to prevent local monopolies)

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- CMA (the new Competition and Markets Authority) to review arrangements and apply "Substantial Lessening of Competition" test even where they do not qualify as a "merger" situation.

FIPO Comment on Remedies 1 and 3

FIPO's understanding is that the hospital groups affected will challenge this CC ruling and will submit further evidence. The final CC report will be published at the beginning of April and thereafter we will see if further legal challenges by hospital groups will occur. The benefit of these hospital divestitures for patients is hard to see as any economic saving is going to be very limited and unlikely to be reflected in lowered premiums. The impact on patient care and clinical quality is immeasurable and there could be less investment by hospitals.

Consultants may decide that these divestments could affect their patients and work practices. If consultants from these hospitals feel that they can comment about the 'quality', 'innovation' or the 'provision of facilities' that they are currently offered then they should give this information either directly to the Competition Commission or to the hospital authorities.

NHS PPUs are likely to increase their workloads after the cap on the amount of private income a Trust could earn as a result of the Health and Social Care Act 2012 was lifted. The involvement of independent sector hospital providers will give some expertise that is often lacking in the NHS and this is broadly welcomed. The need for competition in any given area is reasonable.

Remedy 4 - Ban on clinician incentives - subject to certain exceptions

There has been a prohibition of or restrictions on certain clinician incentive schemes but

- Equity participation by consultants in consultant owned clinics not given further consideration
- Less hard-line approach to equity in hospitals provided that the financial rewards are NOT linked in some way to consultant conduct (i.e. shares according to the amount of revenue a consultant generates).

Hospitals supplying services to consultants are restricted. Services of low value such as stationery, coffee etc. are permitted if the cumulative annual value is less than £500. Services of higher value > £500 such as secretarial services or consulting rooms must be:

- Charged at fair market value
- Available to all with practice rights at the facility
- Disclosed along with the FAIR MARKET VALUE on the hospital's website.

Consultant equity ownership is permitted under certain conditions. If not, these must be unwound within 6 months of final Report on remedies from CC.

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The CC state; "*Where a company which owns, directly or indirectly, one or more hospitals is involved (i.e. the equity participation is a stake in a hospital, or in a joint venture in which a private hospital also has a stake) then the equity stake of any individual clinician with practising rights at or the ability to commission tests at the facility concerned should be limited to 3 per cent.*"

The conditions are:

- Consultant equity stakes are paid up front at Fair Market Value (not using loans for example)
- Each individual consultant stake in facilities owned by hospital groups is limited to 3%
- No contingency on a referral obligation, a practice commitment, time period or conditions for equipment use
- All equity holders are disclosed on the hospital's website.

The private hospital operators must disclose:

- The nature and market value of services provided to clinicians
- The payments made to clinicians in return for services
- The details of clinicians' equity (including in equipment).

The CMA will monitor this.

FIPO Comment on Remedy 4

FIPO agrees with the remedy on incentivisation to consultants. We had argued strongly that equity partnerships in hospitals should be allowed and we do not think that these should be linked to patient referral pathways. We also argued on behalf of many consultants who now own their facilities such as consulting rooms, clinics etc as we could see no anti-competitive issues. These are going to continue without, it would seem, any changes being applied.

Remedies 5 and 7 - Collection and publication of information on hospital and consultant performance

Information about hospitals and consultants are addressed via a single remedy. PHIN (Private Healthcare Information Network) will be in charge of this initiative. It will be expanded and made more independent in terms of governance and funding. PHIN will become the main resource for clinical outcomes and quality. Currently this group, headed by Matt James, is hospital funded but this will now change. The CC has stated:

- PHIN to be jointly funded by private hospital operators and PMIs

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- The information will have to be in a prescribed content and format
- ICD-10 diagnostic coding (then ICD-11) to become mandatory by April 2019
- OPCS and CCSD procedure coding to both be used for next 5 years but CCSD to be phased out
- CMA to review effectiveness of this remedy 5 years after implementation

Quality information to be given to PATIENTS and the PMIs are required to inform policyholders that they will be able to find this information from PHIN - Para 2.468:

"We will require that the PMIs include standard wording in the correspondence sent to customers on taking out or renewing a private medical insurance policy informing them that they will be able to obtain quality information on consultants and hospitals from the website of the information organization. In addition, patients should be directed to this website when they call to obtain pre-authorization for treatment and whenever advising a policyholder on potential providers".

Remedy 6 - Obligation on consultants to provide fee information to patients

- Consultants must provide a written estimate of fees in a standard fashion; a suggested format produced by WPA is given in an Appendix to the report
- This will be a complete fee quote including the initial consultation fees
- Post diagnosis, a written quote, is to be provided if possible
- Hospitals will monitor this process and will have to check that all consultants do provide fee information to patients who are admitted
- CC thinks that consultants posting consultation charges will drive up costs, and so will wait until December 2016 - by which time 'quality' data should also be available
- Consultants will be required to provide fee information for publication on the hospital's website by 2016 and this will be a condition of practice at the relevant facility.

FIPO Comment on Remedy 5, 6 and 7 - Quality and Fee Structures

The PMIs will have to change their coding systems and the CC has specifically said "*We will require the insurers to adapt their IT and billing systems to use OPCS coding, allowing the private hospitals to submit invoices with a single procedure code.*"

FIPO believes that this will enhance clarity and comparisons with the NHS but of course the benefits payable remain at the PMIs discretion.

FIPO has been working with PHIN for 3 years and we hope to continue this relationship. PHIN is gathering data from independent hospitals predominantly on volumes and some basic outcome measures and is starting to collate information

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from national audits and registries. This information is becoming quite sophisticated.

The CC has ruled that the insurers should now join the hospitals to fund PHIN and this will give them access, along with others, to an increasing amount of "quality" information. There will be professional input to PHIN and the structure of the company has been assured through the CC report with external directors. This will change the way in which quality data is handled. Clearly volumes in the independent sector are lower than the NHS and FIPO is concerned about the potential inferences and the statistical conclusions that may be drawn over consultant outcomes in certain procedures. The result of this could be

- Minimum experience to be allowed to practice (based mainly on a minimum number of cases per year)
- As a consequence a smaller number of consultants will be recognised and it may be difficult for new consultants to achieve recognition or for very experienced consultants to continue after retiring from the NHS
- The involvement of the PMIs may mean that far fewer designated clinicians will get all the work, but at a specified and probably lower rate.

FIPO has never argued about the need for a clear definition of a consultant's scope of practice but maintains that local hospital clinical governance should monitor clinical work patterns, the scope of practice and the experience and outcomes of consultants.

In terms of fees FIPO was clear in our evidence to the CC that fee estimates should be given whenever possible in advance of treatment. In fact the majority of consultants do this. The CC has laid out a new very bureaucratic method and has essentially asked the hospital to become the regulator of fee estimates. This means that the hospital will need to check with the patients who are admitted for treatment that in fact a fee estimate has been given. It is unclear what will happen if this has not occurred. Of course there is little point in giving fee estimates if in fact all consultants become "fee assured" in which case the patient does not see their bill as this is simply paid by the insurer.

Whether or not fees should be published either on a general or individual consultant websites is unclear and will need clarification. However the CC recognises that fees alone will be of no value unless there is some quality outcome against which they can be measured. Therefore the Commission is looking towards the production of quality outcomes so that patients can evaluate the cost/quality equation. The CC accepts that this is unlikely to happen for 2-3 years.

FIPO's concern here is that the Commission has failed to recognise the particularly personal nature of the doctor/patient relationship and the fact that true quality judgements are extremely hard to make on statistical grounds and in various medial specialties. FIPO will discuss this further with the Commission.