

9 Views of main parties

Contents

	<i>Page</i>
Introduction	65
Individual consultants	65
The BMA	71
The HCSA	76
The A of A	79
The A of S	85
Other medical associations representing consultants	88

Introduction

9.1. The members of the complex monopoly, ie the 'main parties', are certain consultants and the BMA. But we know the names of only about one-third of the consultants concerned and so for convenience we have included, within this chapter, the views of all the consultants who wrote to us or whom we saw, and the views of all the bodies that represent consultants' interests. The BMA is the principal body in that group but it also represents the interests of GPs (who are third parties) and is itself within the complex monopoly in its capacity as publisher of the BMA Guidelines. Again for convenience, the BMA's views in all three capacities are set out under a single heading in this chapter.

Individual consultants

9.2. We wrote to the 17,100 consultants whom we identified as having engaged in private practice in 1992, inviting them to comment on a short version of our issues letter: a copy is at Annex C to Appendix 2.1. A 'full statement' was sent to representative bodies and to insurers, hospitals and other corporate bodies. It was available to consultants on request. It set out the legal and factual justification for the provisional complex monopoly situation, an explanation of the statistical methods used, and a summary of complaints received. Both the short version and the full statement set out issues relevant to the public interest and possible remedies.

9.3. We received replies from 1,002 consultants. Many of their letters ran to several thousand words. Two hundred and five consultants asked for, and were sent, the full statement, but only nine replies appeared to have been written with knowledge of its contents. The vast majority of responses were concerned only with the issues and remedies. Many consultants did not address all of them but concentrated on those matters that they thought most important.

9.4. The distribution of respondents by NHS region is shown in Table 9.1.

TABLE 9.1 Consultants responding to the issues letter, by NHS region

<i>NHS region</i>	<i>Number of respondents</i>	<i>% of UK total</i>
East Anglia	44	4.4
Mersey	46	4.6
North East Thames	140	14.0
Northern	24	2.4
North Western	58	5.8
North West Thames	65	6.5
Oxford	61	6.1
South East Thames	68	6.8
South Western	52	5.2
South West Thames	88	8.8
Trent	49	4.9
West Midlands	89	8.9
Wessex	61	6.1
Yorkshire	<u>67</u>	<u>6.7</u>
England	912	91.0
Scotland	39	3.9
Wales	36	3.6
Northern Ireland	<u>15</u>	<u>1.5</u>
UK total	1,002	100.0

Source: MMC.

The relative under-representation of northern England, Scotland, Wales and Northern Ireland reflects their relatively lower volume of PMS, and the higher representation of the four Thames regions reflects the concentration of PMS in south-east England.

9.5. The distribution of respondents between specialties is shown in Table 9.2.

TABLE 9.2 Consultants responding to the issues letter, by specialty

<i>Specialty</i>	<i>Number of respondents</i>	<i>% of total</i>
Anaesthetics	95	9.5
Accident and emergency	4	0.4
General medicine	138	13.8
Other medical specialties	133	13.3
General surgery	167	16.7
Other surgical specialties	267	26.7
Obstetrics and gynaecology	79	7.9
Pathology	30	3.0
Psychiatry	51	5.1
Radiology and radiotherapy	<u>38</u>	<u>3.8</u>
Total	1,002	100.0

Source: MMC.

9.6. Of the 1,002 respondents, 946 were in NHS hospitals and 56 in medical schools (a notably low proportion, about 4 per cent of the schools' honorary consultant strength, perhaps reflecting a relatively lower concern with private practice).

Issues

9.7. An analysis of the responses to the issues is set out below. The numbering of the issues is the same as that in the issues letter, but for convenience each issue (or group of linked issues) has been set out with the responses relating to it. Several of the issues and remedies addressed the same subjects, so many consultants replied to one or the other but not both. This had the effect of considerably enhancing the proportion of 'no comment' responses.

Issue 1

Whether it is detrimental to competition and against the public interest for consultants to fix their charges for PMS by reference to the levels indicated in the BMA Guidelines or the scales relating to the BUPA and PPP Schedules of Procedures.

Issue 2

Whether it is detrimental to competition and against the public interest for:

- (a) **the BMA to publish guidance on the level of fees that may be charged;**
- (b) **BUPA and PPP to publish information that in effect constitutes guidance on the level of fees that may be charged.**

Issue 3

Whether the practices of fee-scale following by consultants and fee-scale publishing by the BMA, BUPA and PPP have led to:

- (a) **charges for PMS being higher than would otherwise have been the case;**

	<i>No comment</i>	<i>Disagreed</i>	<i>per cent</i> <i>Agreed</i>
Issue 1	43.5	52.5	4.0
Issue 2(a)	44.1	50.5	5.4
Issue 2(b)	43.0	54.9	4.1
Issue 3(a)	61.3	36.0	2.7

A large number of consultants said that for them to use guidance produced by an insurer, concerned with minimizing payments, had the effect of keeping charges down, not up. Many said that without the guidance their charges would rise. They thought their procedures deserved higher recompense, but most said that it was not worth the trouble to try to collect an extra £10 or £20 from the patient for a charge above the insurer's limit.

- (b) **a reduction in, or the elimination of, regional variations in charges for PMS.**

	<i>No comment</i>	<i>Disagreed</i>	<i>per cent</i> <i>Agreed</i>
Issue 3(b)	89.7	3.6	6.7

Little comment was made on this aspect, but it was accepted that Harley Street costs were generally higher than those in the rest of the country. Eighty-two consultants (8.1 per cent) had consulting rooms in Harley Street or nearby. Apart from the common complaint of the high cost of running a Harley Street practice the comments of consultants in that area accorded with those of colleagues in the rest of the country.

Issue 4

Whether any of the following practices by consultants are detrimental to competition and against the public interest:

(a) failing to quote, or quote sufficiently early, or quote in sufficient detail, charges to patients for the PMS they recommend;

	<i>per cent</i>		
	<i>No comment</i>	<i>Disagreed</i>	<i>Agreed</i>
Issue 4(a)	62.9	7.1	30.0

There was general agreement that the patient should be given full details of charges at the earliest opportunity. Some consultants said that it was not always possible to tell exactly what was needed before an operation began, but they should be able to give outside limits. In most cases anaesthetists would not see the patient until shortly before an operation. This was not a suitable time to discuss charges, so they often relied on the surgeon to pursue the matter.

(b) making or quoting charges for PMS that discriminate in favour of uninsured patients;

	<i>per cent</i>		
	<i>No comment</i>	<i>Disagreed</i>	<i>Agreed</i>
Issue 4(b)	69.3	21.3	9.4

12.7 per cent of the consultants said that they would not accept any erosion of their right to charge as little as they liked, or indeed nothing at all. In particular, many said that they never charged, or charged reduced fees, to colleagues, clergy, or long-standing patients in reduced circumstances who could not now afford full private fees.

(c) failing to ensure that GPs within their area of practice are aware of the charges they quote for PMS;

	<i>per cent</i>		
	<i>No comment</i>	<i>Disagreed</i>	<i>Agreed</i>
Issue 4(c)	72.7	15.4	11.9

5.8 per cent of the consultants said that they believed making their charges known to GPs within their area of practice would be advertising and therefore prohibited by the GMC. Consultants who were opposed to issuing a list of their charges to GPs said that in some areas there could be very many sets of charges from different consultants sent to each GP. There were several suggestions that it would suffice if a consultant said that he charged BUPA rates.

(d) in the case of certain categories of consultants, eg anaesthetists, pathologists and radiologists, who work in groups, fixing common charges for the private medical services supplied;

	<i>per cent</i>		
	<i>No comment</i>	<i>Disagreed</i>	<i>Agreed</i>
Issue 4(d)	81.9	14.3	3.8

Many pathologists working in groups said that they saw only the specimen, not the patient. They gave a 24-hour service on a rota basis and consultants expected a standard charge. Much the same was said by radiologists and, to a lesser extent, by anaesthetists. Most groups accepted new consultants in the area, although at least one group was alleged to act as a cartel and monopolize all the local private work.

(e) requiring patients seeking PMS to be referred by a GP.

	<i>per cent</i>		
	<i>No comment</i>	<i>Disagreed</i>	<i>Agreed</i>
Issue 4(e)	50.6	43.6	5.8

Only 4.0 per cent were in favour of a change to self-referral. A further 1.8 per cent did not have strong views either way but were mildly in favour of self-referral in some circumstances. There was considerable feeling on this subject, with several responses dealing with it exclusively. Many said that GP referral was a cornerstone of UK medicine and the envy of much of the rest of the world.

Issue 5

Whether the following practices by private medical insurers are detrimental to competition and against the public interest:

- (a) **making reimbursement of consultants' charges for private medical services dependent upon reference by a GP;**
- (b) **declining to reimburse claims in respect of private medical services which are not provided by NHS consultants or holders of a certificate of recognized higher specialist training.**

	<i>per cent</i>		
	<i>No comment</i>	<i>Disagreed</i>	<i>Agreed</i>
Issue 5(a)	80.6	15.6	3.8
Issue 5(b)	73.3	23.8	2.9

Issue 6

Whether the arrangements under which consultants are obliged to surrender to the medical schools that employ them all or some of their earnings from private medical services, restrict the supply of such services, with the result that charges generally for such services are higher than would be the case in the absence of those arrangements.

	<i>per cent</i>		
	<i>No comment</i>	<i>Disagreed</i>	<i>Agreed</i>
Issue 6	89.2	5.2	5.6

Issue 7

Whether any benefits to the public interest result from the practices of fee-scale following by consultants or fee-scale publishing by the BMA, BUPA and PPP.

	<i>per cent</i>		
	<i>No comment</i>	<i>Disagreed</i>	<i>Agreed</i>
Issue 7	82.0	1.7	16.3

It was generally contended by those replying that fee-scale following and fee-scale publishing were in the public interest.

Possible remedies

9.8. Under this heading in the issues letter we asked:

Whether any effects adverse to the public interest which might arise from the above issues may be remedied in any of the following ways:

- (a) **the BMA being prohibited from publishing its Guidelines;**
- (b) **consultants being prohibited from fixing charges by reference to any published guidance, other than guidance agreed between private medical insurers and the BMA and established**

according to objective criteria including costs (eg by reference to comparable NHS costs), levels of difficulty and skills involved;

- (c) private medical insurers being prohibited from reimbursing claims according to a tariff or schedule of procedures;
- (d) consultants being required to make their charges known to the patient at the earliest sensible opportunity;
- (e) consultants being required to make their charges transparent, ie showing the separate elements that make up what would otherwise appear only as an aggregate charge;
- (f) consultants being prohibited from differentiating between insured and non-insured patients;
- (g) consultants being required to make their charges known to GPs within their area of practice;
- (h) consultants who work in groups being prohibited from fixing common charges;
- (i) consultants being prohibited from refusing to treat a patient not referred by a GP;
- (j) private medical insurers being prohibited from making reimbursement of consultants' charges dependent upon reference by a GP;
- (k) private medical insurers being prohibited from declining to reimburse claims in respect of private medical services on the grounds that such services are not provided by consultants or holders of a certificate of recognized higher specialist training;
- (l) action by a Government Department or other public authority, for example to amend any of the regulations which directly or indirectly affect the supply of PMS.

Consultants' responses were:

Remedy	<i>per cent</i>		
	No comment	Disagreed	Agreed
(a)	72.8	21.4	5.8
(b)	73.0	19.7	7.3
(c)	79.8	15.4	4.8
(d)	71.6	3.5	24.9
(e)	72.5	5.7	21.8
(f)	71.4	18.4	10.2
(g)	76.5	10.6	12.9
(h)	79.7	15.3	5.0
(i)	63.2	30.6	6.2
(j)	74.2	19.2	6.6
(k)	70.3	26.0	3.7
(l)	89.9	7.0	3.1

Comments on other matters

9.9. Eleven consultants were concerned about BUPA's decision not to reimburse claims in respect of the services of consultants aged 70 or over.

9.10. One consultant said that he limited himself to private practice because he did not think he could do justice to both private and NHS work. One was opposed to the treatment of private patients within NHS hospitals. One said that a 'significant proportion' of consultants engaged in private practice in London and some other places were not fulfilling their NHS obligations as a matter of routine. One said that there should be stricter control over private practice in NHS time.

9.11. Seven consultants at a south-eastern hospital, presenting a collective view, said that the current systems and procedures for PMS were satisfactory.

The BMA

9.12. The BMA is a trade union and the professional association of the UK medical profession. It is the sole recognized negotiating body on terms and conditions of service for medical practitioners employed in the NHS; its members include about 12,000 consultants (about one-half of the 23,100 who we believe engaged in private practice in 1992).

The complex monopoly

9.13. Initially the BMA told us that it did not wish to take issue with our interpretation of the Fair Trading Act 1973. Later, however, it told us that a scale monopoly existed in that at least 25 per cent of goods and services supplied to consumers in the private healthcare market were supplied by a single company, namely BUPA. (Subsequently the BMA said the suggestion that private healthcare is supplied by BUPA could be viewed as misleading, but that private medical services are provided for provident associations who buy in the services of consultants.) Under those circumstances, it appeared to the BMA that the pursuit of a complex monopoly was 'redundant'. It considered that the domination of the market by BUPA was such as to minimize the impact of any other parties to it.

9.14. It had been advised that the provisional complex monopoly that we had identified did not exist in favour of the BMA. It believed the current operation of the market did not in any way operate in favour of the BMA. The BMA was not party to the market in the same way as consultants undertaking private practice or the insurers.

9.15. It did not think the PMS market operated against the public interest.

Private healthcare in the UK

9.16. The BMA said that not all patients who chose PMS did so because of NHS delays. Some patients preferred private treatment on grounds of comfort, privacy and personal treatment by a consultant.

9.17. Consultants tended to treat most of their private patients in only one or two private hospitals. It believed this was of benefit to patients, particularly in an emergency when a consultant could be recalled easily.

9.18. It was essential that clinical responsibility for private medical services should be assumed by a fully-trained specialist. The BMA said that this was normal practice in the NHS and it saw merit in carrying the same standard of clinical care across to the private sector. It would be concerned about supervision should some of the commoner surgical procedures be carried out more often by practitioners other than consultants, or those recognized as specialists or eligible to be consultants. It saw no objection, in principle, to senior registrars engaging in private practice once they were qualified to hold consultant posts.

9.19. The DoH should remove the 10 per cent earnings limit on private practice by whole-time consultants: this would increase their availability to engage in private practice. But it would not reduce their commitment to the NHS since performance was now monitored in relation to individual job plans.

9.20. The senior clinical academic staff of medical schools should not be contractually prohibited from undertaking private practice. The BMA had pressed universities to permit such staff to carry out private practice with a 10 per cent income limit on a comparable basis with their whole-time NHS colleagues.

9.21. It was concerned that some NHS Trusts had sought to introduce clauses into the contracts of newly-appointed consultants limiting the amount of private practice they could undertake other than in Trust hospitals. It believed its efforts to remove this restriction had been successful.

Competition and the market

9.22. The market for private medical services was self-regulated by medical ethics and peer review. It was wrong to assume that price competition between specialists would benefit patients. The suitability of a consultant should be determined by the appropriateness of expertise, accessibility of treatment and quality of service. Competition related to quality of work rather than cost, and competition in costs might seriously compromise the quality of patient care. Any such conduct would run counter to GMC guidance.

9.23. The GMC guidance did not forbid price competition between consultants but the BMA thought the provision of PMS was not a true market because patients had no basis for making comparisons. Another safeguard was that the GMC imposed strict guidance on advertising and consultants were forbidden from offering financial or other incentives.

9.24. In a market without the constraints of professional responsibility some registered medical practitioners would use the vulnerability of the patient to charge excessively high fees. It was still possible for this to occur, but there had been fewer complaints about overcharging since the publication of the BMA Guidelines. Some consultants now sought advice on their charges from the BMA.

9.25. It was concerned that the range of charges which could be levied presented patients with the difficulty of judging whether the differences reflected skills or market factors. It would not like to see a situation develop where there was seen to be a market for a certain procedure and a specialist, not necessarily the best, dropped his price to gain the work. The BMA believed that this would lead to a fall in standards.

9.26. It would be happy with the market level at which fees stabilized. To its knowledge, no successful model had been developed to provide for the pricing of professional expertise and clinical responsibility (which, it contended, represented the major part of the fee charged by a consultant).

9.27. The insurers' prescribed rates of charges distorted the market. When a patient paid for treatment himself there was implicitly a price agreed reflecting what the consultant thought he was worth and what the patient was prepared to pay.

9.28. It did not object to the practice of some consultants offering a lower fee to uninsured patients for fixed-price treatments for defined procedures, although it considered that problems could arise in more complex cases. It was concerned, however, that an extension of this sort of preferred market system would reduce the insured patient's choice. This would not be acceptable to the public: its use of private medical insurance was governed by the wish for a less anonymous service than that provided by the NHS.

9.29. The publication of data by the BMA, BUPA and PPP was the start of a process of providing further information to registered medical practitioners and the public, enabling them to make informed choices in the market-place.

Origins and purpose of the BMA Guidelines

9.30. A full account of the origins and purpose of the BMA Guidelines is set out in paragraphs 5.4 to 5.12. In addition the BMA told us that its decision to produce the Guidelines had been taken because it believed consultants should have more involvement in decisions made by the insurers over the level of fees and the types of cases eligible for reimbursement. It said that its wish had not been to put upward pressure on fees but to move to a different basis for determining them. It had broached the subject with the insurers but they had refused to discuss the matter on the grounds that it was not the BMA's business.

9.31. The President of the GMC had expressed concern to it over complaints to the GMC about consultants overcharging for their services. He had asked the BMA what it could do to stop this happening. It decided, therefore, that it was desirable for a responsible body such as itself to issue guidance as to what appropriate fee levels were.

9.32. The Guidelines did not advise consultants on what to charge. The fee levels quoted were the average of what consultants were charging in the UK and were updated from time to time.

Effects of the BMA Guidelines

9.33. The BMA did not think the Guidelines were inflationary or against the public interest. One of the results of their publication had been that consultants now discussed their fees more openly with patients.

9.34. Nor had the Guidelines restricted competition or distorted the PMS market. They did not have the effect of maintaining fees at a higher level than might otherwise have been the case. The BMA noted our findings that the majority of consultants appeared to follow the values set by BUPA rather than those set by the Guidelines. It suggested that consultants who preferred to use the Guidelines might, in practice, have done so only when the BMA rate was lower than the BUPA counterpart.

9.35. The BMA recognized that patients might not know of the existence of the Guidelines, but said that GPs were able to refer to them when discussing costs of treatment with patients, so that both consultants and patients were able to put the charges into context.

9.36. It said that there was no obligation for consultants to follow the Guidelines but it considered that those consultants who did charge unreasonable fees might have been constrained since the Guidelines had been published. The BMA did not believe the maximum fees recommended in the Guidelines had become normal. It thought there would always be those consultants who would charge more, those who would charge less and those who would modify their charges according to the patient's ability to pay. Consequently some fees had gone up and some had gone down.

9.37. The BMA believed a measurable effect of the Guidelines had been a widening of the classification of treatment eligible for reimbursement by the insurers.

Consultants' charges

9.38. The BMA did not believe it was against the public interest for consultants, when setting their charges, to take account of levels indicated by the insurers or the BMA. It said that consultants were often reluctant to approach patients for any shortfall in fees. Consequently, it was not surprising that they were influenced by the fee levels which insurers were prepared to reimburse their subscribers. It was not general practice for consultants to vary their charges, depending on the insurer involved.

9.39. The BMA said that there was no evidence that the Guidelines had reduced the variation in fees being charged. It believed that the main cause for the narrowing of charges was the maximum reimbursement limits set by the insurers.

9.40. The BMA noted our finding that consultants' fees had declined as a percentage of total spending on acute private treatment since 1986. This invalidated the insurers' view that consultants' fees had been the reason for rising costs.

9.41. The BMA said that it would welcome an improvement in the transparency of consultants' charging, and it was confident that a majority of consultants openly discussed their charges with patients. It recognized that there was sometimes an unwillingness on both sides to discuss charges but it would not want to encourage patients to seek out the least expensive service. It unreservedly condemned the charging of unreasonable fees.

9.42. There were clear benefits to patients when certain categories of consultants, for example anaesthetists, pathologists and radiologists, worked in groups. This facilitated the sharing of equipment and the provision of continuous service, including emergency cover, to colleagues in other specialties. In these circumstances it might be equitable and justifiable for a group to fix a standard fee.

9.43. It was appropriate for consultants to add together fees when performing more than one procedure, provided the procedures were different and separate. It said that most consultants did not add charges together and that, since the publication of the Guidelines, there had been a greater understanding of this issue.

9.44. The BMA did not think charges for minor procedures were often excessive. A procedure which appeared minor to the patient might have carried a substantial risk and required a high degree of skill. It might also have required the same anaesthetic as a major procedure.

9.45. The BMA had no direct evidence of regional variations in professional fees. It would expect there to be little variation in consultants' fees, a situation which it regarded as no different from that pertaining in other professions. NHS salaries were standardized across the UK, and it believed it was appropriate that this should be reflected in private practice. Evidence it had collected had shown that there had been little regional variation in charges before the Guidelines had been produced.

9.46. Consultants should be able to preserve their right to waive or reduce fees in particular circumstances. It accepted that there might be some minor discrimination in favour of uninsured patients, but it considered that this was a burden on the consultants rather than the insurers.

The referral process

9.47. The BMA believed referral to a consultant should be through a GP. It was prudent of the insurers to insist on this as a condition for reimbursement of policy-holders. GP referral had proved cost-effective in comparison with other countries where access to specialists was unrestricted.

9.48. The GP was the most suitable source of advice to a patient on the choice of consultant. The GP acted as a gatekeeper to ensure that only those conditions which required specialist treatment were referred. He had knowledge of the patient and access to his medical records, and was aware of the quality and availability of local consultants.

9.49. The involvement of GPs in the referral process safeguarded patients' interests. The GP was the principal guarantee of continuity of care and the process reduced the risk of a patient receiving treatment from several specialists at once.

9.50. Costs were not a major factor for a GP when deciding which consultant would be most appropriate. The BMA believed that patients, and hence GPs, were more concerned with waiting times and quality of service. Consultants, too, tended to sub-specialize, so it was important for GPs to be able to choose the right one rather than have to concern themselves about cost.

9.51. Patients wanted to know whether they could afford the treatment being recommended or whether the insurer was going to pay. But patients did not necessarily want to be referred to a consultant on the basis of cost: it was more important to receive reassurance from the GP about the quality of the consultant he recommended.

9.52. Consultants should be encouraged to tell GPs of the services they offered, and of their charges. But dissemination of this information could pose problems: the lack of suitable computer software for GPs was a difficulty.

9.53. The names of consultants, their qualifications, posts held and publications, were readily available from the *Medical Directory*, which was held in most public libraries. It was widely accepted that there was no satisfactory methodology for measuring consultants' performance, and as referrals were usually made through GPs it was not clear what purpose a performance table would serve.

9.54. Patterns of referrals by GPs to consultants reflected GPs' evaluations of the quality of service consultants provided. It did not accept that referral was a reward to consultants but rather it was evidence of GPs' regard for the patients' interests. This encouraged healthy competition and was to the patients' benefit.

9.55. To prohibit a consultant from refusing to treat a patient not referred by a GP would be a breach of the GMC's guidance¹ that 'a specialist should not usually accept a patient without a reference from the patient's GP'.

Relationship between consultant and patient

9.56. The BMA's view was that medical advice could not be compared with a commercial transaction. The professional relationship should be based on trust and clinical responsibility and not on commercial considerations.

9.57. One of the factors the GP had to consider in the referral process was the likelihood of a good rapport being established between the consultant and the patient. Without it the treatment could fail.

Private medical insurance

9.58. The BMA thought it essential for insurers to publish benefit maxima so that subscribers should be aware of the cover available. The alternative would be medical insurance policies whose cover was a specified overall limit. The BMA believed this would increase fees and premiums.

9.59. It did not support engaging insurance assessors or loss adjusters to assess claims. Patients needed to secure treatment quickly without seeking insurers' prior approval. In effect, the GP acted as a loss adjuster, making decisions on quality as well as price at the referral stage.

9.60. Insurers owed a duty to subscribers to ensure that they were not misled into accepting treatment from unsuitable practitioners. The insurers were right to stipulate that treatment would be reimbursable only if provided by practitioners who held a consultant appointment or the qualifications required for it.

9.61. BUPA benefit maxima had failed to keep up with cost increases in the UK over recent years. The BMA believed they had been held down artificially.

9.62. The BMA was concerned that hospital charges and the cost of drugs would increase out of control. This had happened in other countries where there was unlimited insurance cover. But it might be possible for the insurers to build in safeguards and the BMA urged that this be explored.

9.63. The BMA thought preferred provider schemes removed the power of a GP to choose the consultant he considered best qualified for a particular task. The BMA had always held the view that the GP and the patient should be free to decide between them on the appropriate course of treatment.

9.64. The BMA believed that insurance schemes that stipulated overall benefit limits, but with no limits on procedures, would lead to a contraction in the private medical insurance market. Where doubt existed about the possible diagnosis a GP would be more reluctant to refer a patient lest the overall benefit maximum should be reached before treatment had been completed.

Remedies

9.65. Taking the remedies in the order in which they are set out in paragraph 9.8, the BMA made the following points:

- (a) If publication of its Guidelines were to be prohibited consultants relying on them would either charge on the basis of the insurers' schedules or would charge without reference to any guidance. In either case the BMA thought the result would be an increase in fees.

¹ *Professional Conduct and Discipline: Fitness to Practice*, GMC, January 1992.

- (b) It was willing to explore further the suggestion that consultants might be prohibited from fixing charges other than by reference to guidance agreed between insurers and itself. This guidance could be based on objective criteria, including costs, levels of difficulty and skills. But the BMA did not accept the NHS as an appropriate and realistic comparator on costs as it believed the value of PMS was largely determined by public sector pay policy.
- (c) No comment.
- (d) Consultants should be encouraged, but not required, to make their charges known to patients at the earliest sensible opportunity. The BMA had been recommending this since 1984.
- (e) It foresaw practical problems if a consultant were to be required to show the separate elements of an aggregate charge. But it believed a patient should be provided with an itemized bill that allowed him to differentiate between charges for consultations and those for procedures.
- (f) It would not be in patients' interests to prohibit consultants from differentiating in their charges between the insured and the uninsured.
- (g) It would be beneficial to patients if consultants made their charges known to GPs within their area of practice. But it would prefer this to be encouraged rather than made mandatory.
- (h) It would be detrimental to the interests of both patients and consultants if consultants working in groups were to be prohibited from fixing common charges.
- (i) Consultants should not be prohibited from refusing to treat a patient not referred by a GP.
- (j) Private medical insurers should not be prohibited from making reimbursement of charges dependent upon referral by a GP.
- (k) It was a critical safeguard for patients that consultants should be appropriately trained and qualified. Private medical insurers should not be prohibited from declining to reimburse claims from subscribers seeking treatment from persons other than consultants or holders of certificates of recognized higher specialist training.
- (l) No comment.

The HCSA

9.66. The HCSA is a trade union that represents the interests of senior hospital doctors in some NHS Trust hospitals. It told us that it had 2,271 consultants in membership.

Competition

9.67. The HCSA saw competition as a matter of quality and not of price. Insurers seeking to negotiate preferred provider schemes had run into difficulties because they had been unable to assess the differences in quality of the services on offer.

Charges and tariffs

9.68. There was no evidence to suggest that a patient chose a consultant according to the charge he made, except perhaps to avoid one who charged very high fees. Most patients wanted an assurance that the costs would be covered by their insurance, so it was in the public interest that consultants should refer to the insurers' benefit maxima when setting their charges.

9.69. It did not accept that there had been deliberate fee-scale following by consultants. The ceilings on benefits imposed by the insurers were primarily responsible for the current level of costs for PMS. A shortfall was not good for the image of the insurer and it was a major irritant for a consultant to have to press a patient for supplementary payment. In consequence, fees tended to settle at the insurers' maxima.

9.70. Fees charged for PMS should be higher on a pro-rata basis than the levels of remuneration received through the NHS. This was partly because NHS salaries had fallen behind those in other professions and also because of the greater involvement by the consultant in the care of the private patient. The long-standing assumption about security of tenure in the NHS being traded against a lower salary was no longer appropriate, as some consultants had been faced with redundancy and this was likely to continue.

9.71. It did not have firm evidence of regional variations in consultants' charges. In London it believed insurers' maxima were often ignored and that patients were told this beforehand. Elsewhere fees were probably on a common level. The HCSA had undertaken a survey of its members during 1993 to gauge levels of fees being charged by them.

9.72. It encouraged consultants to be open with information about fees. It had produced an information card, for use in consultants' waiting rooms, giving patients advice on asking for estimates of costs.

9.73. Uninsured patients should not receive discounted rates: fees should relate to the work done and not to the status of the patient or insurance. It might be said to be against the public interest for consultants to discriminate between patients on the basis of their ability to pay.

9.74. The HCSA accepted that groups of specialists, generally in provincial towns, fixed common charges, but believed that in general this provided availability, service and reassurance for patients who might otherwise be worried about the expense.

9.75. Prior to the introduction of the BMA Guidelines anaesthetists, in particular, were subject to much downward pressure on their fees. Most insurers had imposed a combined limit on benefit for the surgeon's and anaesthetist's fees. This was redressed by the publication of separate limits by BUPA and the BMA Guidelines.

9.76. Private hospitals sometimes offered fixed-price surgery which included the surgeon's fee. This could be beneficial to the consultant who had to concern himself only with his professional role and not worry about administration. It was sometimes possible, in these circumstances, to accept a lower fee. The HCSA saw no reason why this type of service should not be available to insured as well as uninsured patients.

9.77. It was becoming difficult to separate some aspects of private elective and acute healthcare from the NHS. Some consultants were faced with ethical considerations as NHS Trusts contracted NHS work to private hospitals. In his NHS role a consultant might have recommended a particular procedure to a patient involving treatment which later became part of an agreement made between a Trust and a private hospital. The consultant could then find himself operating on that patient as part of his contractual arrangement with the private hospital.

9.78. Alternatively, a patient might be on an NHS waiting list awaiting treatment from a particular consultant, and if a private hospital were to offer a reduced rate to the patient to have the treatment done privately and this were accepted, the same consultant could find himself operating on his patient privately. This was not new as such but the changing factor was that such situations could cause friction between the consultant and his NHS Trust employer.

9.79. In most cases it was not reasonable to charge maximum fees for each procedure when multiple procedures were performed. The BMA Guidelines had begun to work out a satisfactory discount system but the BUPA system was often grossly unfair. In the case of minor procedures, the time taken was often disproportionate to the apparent complexity of the case and fees reflected this.

Accommodation and facilities

9.80. The HCSA said that any savings achieved by consultants from the use of subsidized consulting rooms in private hospitals were small. It was not unreasonable for a hospital to charge for the use of its facilities.

9.81. Patients were better served when the consultant attended only one or two hospitals. It made visiting easier and the consultant had the benefit of familiarity with the surroundings and equipment.

9.82. The HCSA was opposed to the actions of certain NHS Trusts that had sought to impose restrictions on private practice being undertaken outside the hospital in which the consultant was employed.

BMA Guidelines and insurers' schedules

9.83. There would be difficulties for patients if there were no published scales of benefits. Insurers ought to compete by publishing their own guidance. Those that did not do so encouraged an unwritten scale.

9.84. The HCSA did not consider that the insurers' benefit maxima constituted tariffs. The BMA Guidelines and the BUPA benefit maxima had markedly reduced the possibility of overcharging. This had been to the benefit of patients and was certainly in the public interest. Eventually, however, all charges would rise to the BUPA benefit maxima, creating a near monopoly.

GP referrals

9.85. The HCSA agreed with the policy of the insurers of insisting on referral through GPs. This coincided with the GMC's guidance and was clearly in the interests of all concerned. GPs made referrals on the basis of their experience of a particular consultant through NHS and private referrals, and it was right that consultants who were known to be doing a good job should reap the results.

9.86. GPs should be provided with information on fees if they so wished, but there were some practical difficulties. The HCSA believed GPs were chiefly concerned with quality of service and rarely worried about charges.

9.87. It did not think it necessary for a list of consultants and their individual performance to be published. The GP was the best arbiter, able to match the skills and character of the consultant to the needs of the patient. The published audit of a specialist's performance was fraught with possible misinterpretations.

Remedies

9.88. The BMA should not be prevented from publishing its Guidelines: they contributed towards a sensible balance and avoided a monopoly situation being created by the insurers.

9.89. The NHS should not be used as a comparator for costs: the NHS had a monopoly employer's ability to depress its employees' salaries.

9.90. It would be impracticable to prohibit private medical insurers from reimbursing claims according to a tariff. There would be no effective ceiling on fees and insurance premiums would escalate. This would be against the public interest.

9.91. It was wholly reasonable to require consultants to make their charges known to patients at the earliest sensible opportunity. But the emphasis should be on estimates rather than quotations.

9.92. If it was thought helpful to patients the HCSA would support itemization of the separate elements of a consultant's account. But this might draw a consultant's attention to a deficit and lead to an increased overall fee.

9.93. Consultants should not be prohibited from differentiating between insured and uninsured patients. Such a prohibition would restrict the ethical basis underlying the profession's whole philosophy, and prevent a consultant, as happened on some occasions, from making no charge for his services.

9.94. The HCSA agreed with the principle of requiring consultants to make their charges known to GPs, but it did not believe that referral patterns would change on price alone. Expertise and reputation influenced a GP much more than cost.

9.95. It would probably be unlawful to prohibit a consultant from refusing to treat a patient who had not been referred by a GP. It was certainly against the ethics declared by the GMC. Patients would be able to go from specialist to specialist obtaining a mixture of prescriptions with disastrous results. In other countries the ratios of consultants to patients were far lower than in the UK, but this had led to a dilution of standards. The same considerations would apply to private medical insurers being prohibited from making reimbursement of consultants' charges conditional upon reference by a GP.

9.96. It would be wrong to prohibit private medical insurers from restricting reimbursement to treatment provided by a registered medical practitioner of consultant status. The principal reason many people subscribed to medical insurance schemes was that they knew they would be treated by a consultant. This ensured high standards and value for money. It was not correct to assume that some of the commoner procedures could be carried out as well by other registered medical practitioners. Routine procedures were sometimes more complicated than at first indicated.

The A of A

9.97. The A of A is a charitable body devoted to pioneering developments in the service of anaesthesia and to raising the standards of anaesthetic practice. It is not a trade union, but it offers advice to its members on matters of importance to the specialty, particularly on clinical workloads. It has about 2,500 consultant members (about 85 per cent of the consultant anaesthetists practising in the UK).

9.98. The A of A told us that anaesthesia was a rapidly evolving medical specialty. It was much younger than surgery or medicine, having only come into existence 150 years ago. Higher training of a formal nature in anaesthetics had been available only since the 1930s. The Fellowship in Anaesthesia had been in existence for only 50 years and the College of Anaesthetists did not secure its Royal Charter until 1992. There had been significant developments in the art and science of anaesthesia in recent years and as a result, anaesthetists were required to know more and do more, especially in respect of patient care before, during and after the anaesthetic.

Training

9.99. Only fully-trained, qualified and experienced anaesthetists should undertake private practice. Some trainee juniors did work in private practice, although usually only as assistants to consultants in circumstances that required it. An anaesthetist who was not fully experienced could get into difficulties even though the anaesthetic appeared at the start of the procedure to be safe and straightforward; in this respect anaesthesia was less predictable than most surgery. Within the NHS most anaesthetists practised in hospitals where there would be a consultant available if difficulties arose. It was a routine practice for junior anaesthetists within the NHS to call for the assistance of someone more experienced if necessary. By contrast it was much more likely that in private practice the anaesthetist would be working in isolation and should therefore be of consultant standard.

The health insurance market

9.100. The PMS market was highly fragmented on the supply side and heavily concentrated (through the insurers) on the demand side; hence medical insurers had considerable market power. They paid for most private elective and acute treatment, were comparatively few in number and included some, such as BUPA, with large market shares. BUPA's share had fallen over the last ten years, but this was attributable to an increase in the size of the market coupled with new entry, rather than any loss of volume by BUPA.

Arrangements with medical schools

9.101. There were fewer than 50 academic consultants in anaesthesia in the UK. There was no evidence that their private practice charges were higher because of the constraints to which they were subject. The theory underlying the constraints was that if academics were to engage in private practice as well as their clinical commitments within the teaching hospital they would not have enough time for academic work. Possibly they were to some extent compensated by a more rapid progress through the merit award system. Most academics found that discharging their obligations to research and teaching within a medical school left little time to undertake extensive private practice, and some expressed little or no interest in it.

Information on consultants

9.102. Most public libraries had a copy of the *Medical Directory* listing (among much other information) all the anaesthetists at the local hospital. It was doubtful whether patients wanted such information since they would presumably accept the surgeon's choice. The A of A thought the publication of inadequate and misleading statistics on consultants' performance (which was all that would be available in most cases at the moment) was not in the public interest. At present there was no agreed measure of performance.

Contractual arrangements

9.103. The consultant surgeon would normally choose the anaesthetist, but the contract was between the patient and the anaesthetist. It did not favour a situation where the surgeon contracted the services of the anaesthetist. This might well have the effect of reducing anaesthetists' fees but would not necessarily reduce the cost to the patient.

Group practices

9.104. The A of A supported group practice in principle. It believed it improved the service to surgeons and patients, since without a group the availability of an anaesthetist could be a problem and the administrative work could be a burden. It added that, by ensuring efficient use of consultants' time, group practice was also in the best interests of the NHS. However, it emphasized that it had no formal policy concerning the existence of group practice, nor did it have, or seek, control over the way in which members conducted their practices.

9.105. There were many advantages of group practice in anaesthesia:

- (a) the existence of groups enabled anaesthetists to provide a reliable service of consistently high quality;
- (b) group rotas could be structured to ensure that there was no conflict with NHS commitments;
- (c) groups could construct a rota which ensured that an experienced, accredited anaesthetist was available at all times; this increased patient safety and was helpful to surgeons and hospitals when treatment was being planned and discussed with patients;

- (d) groups could optimize the quality of patient care by ensuring that an appropriate anaesthetist was free of all other duties to provide good pre- and post-operative care;
- (e) groups could make flexible arrangements so that appropriately experienced anaesthetists were available for specialist operative procedures;
- (f) group practice could ensure the availability, in the private sector, of the continuity and consistently high quality of care which were features of the NHS;
- (g) the sharing of administrative arrangements could decrease overall costs, and promote the efficiency of the service provided; the group secretary was available during office hours to provide patients with information on administrative matters, including anaesthetists' fees;
- (h) groups could enable anaesthetists to provide planned cover for sickness and holidays, thus ensuring continuity of safe patient care;
- (i) groups could make arrangements for provision of sick pay, which increased the security of practitioners involved; and
- (j) group practices could limit membership and so protect patients from anaesthetists without accreditation or appropriate experience.

9.106. There were many sorts of group and it was difficult to comment on them in general terms. They had many advantages, but there was nothing to stop a surgeon using an anaesthetist outside a group. There was no evidence of groups seeking to use their position to increase prices, and their ability to do so was just as heavily constrained by the BUPA scales as that of non-group members.

9.107. In many groups there were no common charges. An anaesthetist who worked a great deal with a particular surgeon would normally work with someone else only if circumstance compelled it. This applied both to private practice and the NHS. Generally, GPs were not aware of the qualities of particular anaesthetists, and would not necessarily know them at all.

Fees and charges

9.108. The A of A, in calculating its own previously recommended guidelines for fees, had taken account of the relatively long time that the anaesthetist spent caring for the patient, in comparison with the surgeon. To minimize the risk of shortfall it had also taken into account the insurers' benefit maxima. Between 1982 and 1990 it had issued its own fee guidance, but after 1990 it recommended that its members follow the BMA Guidelines.

9.109. It was not true that consultants' fees were outside the insurers' control: the reverse was the case. The insurers had absolute power to limit the levels of fees they would indemnify. All insurers used this power; some were prepared to pay fees at the level of the BMA Guidelines, while BUPA adhered to its own benefit maxima.

9.110. There were indications that consultants' fees had fallen; there was nothing to support the assumption that there had been an increase in consultants' fees in recent years, or that there had been fee-scale following.

9.111. Anaesthetists' median gross private earnings in 1992 had been estimated (in our issues letter) at £24,000, but it should be noted that the earnings were not pensionable so that, if a consultant wished to enjoy a level of pension higher than that generated by the NHS superannuation scheme, part of these earnings would be needed for pension contributions. It also noted that private work was insecure and often was carried out at unsocial hours. It required secretarial support and carried no sickness benefit.

9.112. Some measure of bargaining power was preserved for consultants as a result of the fact that, while insurers could control the levels of fees against which they indemnified the insured, they could not prohibit consultants from charging a higher fee to the patient. This freedom was constrained in practice by the difficulty of charging a fee which the insurers deemed excessive, and the balance of which had to be found by the patient.

9.113. The A of A said the issues letter indicated that consultants' fees had decreased as a proportion of spending on elective and acute healthcare from 35 per cent in 1986 to 33 per cent in 1992. This was despite the development in the use of the techniques of minimally invasive and endoscopic surgery which had the incidental effect of reducing the length of the patient's stay in hospital. Improved techniques of analgesia, which were labour-intensive for consultants, had the same effect. For this reason, and because the new techniques were more complex, consultants' fees should have increased as a proportion of total expenditure.

9.114. The ability of a professional body to publish its own scales was an important counterweight to the power of the insurers who had a commercial interest in reducing the level of fees as much as possible: the A of A said that the fact that a particular level of fee was published by an insurer did not necessarily mean that it was adequate.

9.115. The A of A said that it was not aware of any discrimination by consultants in favour of uninsured patients. What was offered to the uninsured patient reflected his particular need for certainty about the cost, but the A of A did not believe that the fixed-price treatments that were offered to patients were usually accompanied by a lower fee for the consultant. The arrangements were made by private hospitals and it was not the consultant who quoted charges to patients.

9.116. Groups of employers could act together to use their market power to negotiate lower fees; an example was BUPA's 'preferred provider' scheme where fees were related to the number of employees committed to the scheme by the employer. Anaesthetists taking part could be obliged to give discounts of as much as 25 per cent in those schemes that had 4,000 members or more.

9.117. It was the GP who advised the patient whether it was necessary to consult a specialist at all: no one else could do this. Prospective private patients were given disinterested advice before they spent their own or their insurer's money. It was hard to see that abolition of the requirement for GP referral would have any desirable effects upon the levels of consultants' charges.

9.118. The A of A did not believe consultants in private practice were over-rewarded by reference to comparable NHS costs. Private medical treatment involved a great deal more post-operative care of the patients and did not have benefits such as superannuation, security of employment and roughly predictable working hours. Leaving aside the significant responsibility which the anaesthetist carried and the skill involved in his work, a private procedure-probably involving 1½ hours of attendance on the patient and a commitment to continuous on-call availability-might be rewarded by no more than £37 after tax and expenses. But £120 was typical for a procedure.

9.119. Nor did it believe that consultants performing more than one procedure sometimes added together the relevant fees for each. However, it was appropriate that a higher fee should be paid when two procedures were performed under the same anaesthetic: the duration was longer, the risk was greater, there were more complicated anaesthetic techniques and more complicated post-operative management.

9.120. A patient concerned about costs would ask the consultant about them. But insurers paid for the majority of treatments and were very ready to question fees and to use their market power to drive fees down. The A of A, however, agreed that consultants should publish prices and that patients should be aware of what they would have to pay.

9.121. The pay of consultants was low by comparison with the rewards of other professions. This was partly because of the pre-NHS practice of appointing honorary consultants to hospitals, and partly because of the market power of the NHS as a monopoly employer. The disparity between what the state paid and what could be commanded in the market-place was far less than in certain other professions. Other matters affected this disparity, such as security in the NHS, anti-social hours, increased travelling times, and overheads in private practice.

9.122. Because fees for anaesthetists were not high, shortfalls were relatively small, so that an anaesthetist might be directly charging a patient as little as £12. Not only was the cost of sending out an extra bill of that size a disincentive to pursuing the matter but anaesthetists were unwilling to spoil their relationships with patients by so doing. BUPA, being aware of this, effectively capped the fee, whereas the other insurers would honour the fee provided it was seen as fair and reasonable.

9.123. In the 1980s BUPA and other provident societies had agreed with the A of A on the level of fees, and the concept of a 2:1 split of fees between surgeon and anaesthetist was accepted. In 1990 BUPA had decided to drive down the fees that it had originally accepted. The effect was that for a given case an anaesthetist was paid £100 in one week and £84 the next: thus BUPA came into conflict with the guidance, produced initially by the A of A and later by the BMA, which the profession had considered fair and reasonable. There was little or no conflict with other insurers.

Insurers' practices

9.124. The publication by BUPA in 1989 of detailed benefit maxima, coupled with the separation of surgeons' and anaesthetists' fees, effectively reduced the benefit applicable to anaesthesia: other insurers were increasingly following BUPA's lead and seeking special terms on consultants' fees.

9.125. If all insurers were to adopt rigid benefit maxima, such as those of BUPA, there would be little consultants could do to resist the downward pressure on their fees. Similarly, if all the insurers reduced their benefit maxima consultants would be virtually powerless to resist an erosion of their rates of private remuneration.

9.126. There was at present a difference between insurers' benefit maxima, those of BUPA generally being lower than those of other insurers.

9.127. The A of A thought BUPA's scales were designed to cut the fees paid to anaesthetists: unlike other health insurers, it had held its benefit maxima constant since 1990 and refused to indemnify its members against a higher fee. PPP had its own scales, whereas other insurers generally followed the BMA Guidelines which the A of A thought offered reasonable fees for anaesthetists.

9.128. The justification for a differential in the remuneration of surgeons and anaesthetists was much less than it used to be. In many cases any great difference between the two was a reflection only of the more powerful market position of the surgeons.

9.129. Up to 1989 a 2:1 ratio seemed to be developing between the fees charged by surgeons and those charged by anaesthetists. This was challenged by BUPA which, the A of A thought, had decided that anaesthetists were vulnerable to pressure, and had used its benefit levels to reduce their remuneration.

9.130. There was no reason to suggest that regional variations in fees were greater before 1989. Nor was there any reason to expect such variations since the complexities, hazards, precautions and overheads of anaesthesia were the same everywhere. The NHS consultants' pay scale, too, was common to all regions.

9.131. It would be feasible to prohibit insurers from using a tariff or schedule of procedures for reimbursing their members' claims. BUPA did not publish rigid scales before 1989 and other insurers still did not do so, as they accepted the reasonableness of the BMA Guidelines, which had seemed to work sufficiently well. However, given the determination of a powerful insurer such as BUPA to limit the amount it paid in fees, the A of A feared that the use of published benefit maxima in practice would be unavoidable and so would have to be accepted, provided that the BMA's weaker voice in the debate was not silenced.

9.132. The A of A noted that anaesthetists were paid at the full BMA rates by NUH, and PPP also gave full reimbursement at the higher level of cover: there was a transparency in the PPP figures that was absent from those of some other insurers. It said that the impression that BUPA gave was one of full reimbursement, until it came to payment.

Effects on competition

9.133. Competition in the medical insurance market had become more intense as a result of the entry of commercial insurers, but the market was still dominated by a small number of extremely sophisticated purchasers. Unlike the consultants, the insurers had large resources and an overview of the market. This gave them the ability to compare different consultants' fees across the supplier population, to make their own assessment of a particular fee level, and to refuse to pay levels of fees which, rightly or wrongly, they considered excessive.

9.134. Nevertheless, it was disadvantageous to an insurer's competitive position in the medical insurance market if its benefit maxima were lower than the prevailing rates of consultants' fees, particularly where competing insurers indemnified at a higher level. Accordingly there was at present some incentive for an insurer not to set its maxima unduly low.

9.135. If an insurer was prohibited from limiting cover by reference to published benefit maxima it would be bound to continue to use internal scales. These would inevitably become known to consultants who, if they so desired, could set their fees at the highest level the insurer would allow. However, in the absence of published benefit maxima, patients, and to some extent consultants, would not know what level of indemnity the insurer would grant. This could lead to delay in treatment and wrangling over fees afterwards.

9.136. The A of A feared that with the small number of insurers, each concerned to constrain its own costs and knowing the maximum fee levels of its few competitors, the only counterweight was competition between them.

9.137. In general there was very little price competition between anaesthetists: they charged what they thought was fair and reasonable. The main stimulus for price competition came from those hospitals which invited surgeons to compete on price by agreeing to discounting.

The complex monopoly situation

9.138. The A of A accepted that more than 25 per cent of PMS by value was provided by members of a group who set at least 50 per cent of their charges by reference to the BUPA benefit maxima. It accepted that if such behaviour prevented, restricted or distorted competition then a complex monopoly situation existed, the relevant group consisting of BUPA and the consultants who set their fees in this way.

9.139. The small proportion of private medical services provided by consultants who referred to PPP scales could not be sufficient to give rise to a complex monopoly. The same was true of followers of the BMA Guidelines.

9.140. Notwithstanding the wide terms of the Act, the A of A did not consider it permissible to aggregate users of the BMA Guidelines with users of the BUPA benefit maxima for the purpose of establishing a complex monopoly. The nature and effects of the two practices were very different and it was oversimplistic to describe them as 'scale-following'. In the case of BUPA, followers were setting fees by reference to what the customer was willing to pay, whereas followers of the BMA Guidelines were setting fees by reference to what a professional body considered to be reasonable levels of charges. Since less than 25 per cent of PMS by value was provided by followers of the BMA Guidelines, a complex monopoly could not be based on their aggregation with other consultants setting their fees by different criteria, such as insurers' benefit maxima.

Remedies

9.141. The A of A did not think the public interest required any further interference with the freedom of consultants to set their fees. If reimbursement ceased to be adequate the resulting decrease in consultants' overall remuneration would reduce the attractiveness of the specialty to those capable of reaching the highest levels of medical practice in the UK. This would be a loss to the NHS, to private medicine and to the public interest.

9.142. It was in the public interest that consultants should be free to charge fees at levels different from insurers' benefit maxima. The A of A viewed with particular concern any suggestion that consultants might be prohibited from charging fees by reference to a scale other than one agreed by insurers.

9.143. It was in the public interest, too, that insurers should publish rates and the BMA should publish the Guidelines. The publication of a rate of fees by a professional body gave consultants as well as patients an indication of the prevailing range of fees and was a strong disincentive to the charging of a higher fee.

9.144. A prohibition on consultants fixing charges by reference to published guidance other than guidance agreed between private medical insurers and the BMA would have two undesirable effects. First, it would remove the voice of the BMA in the debate over rates of charge since it would be unable to publish Guideline figures except at levels agreed by insurance companies. This would remove an important corrective to the power of the insurance companies to lay down maximum levels of payment related to non-medical criteria. Secondly, levels agreed between all insurers would effectively create a cartel.

9.145. It would be unjustifiable to prohibit consultants in groups from fixing common charges. Consultants working in groups remained subject to ceilings imposed by insurers' benefit maxima. In so far as groups departed from BUPA tariffs, they were departing from conduct giving rise to a complex monopoly situation.

9.146. If insurers were prohibited from setting benefit maxima they might choose to write insurance on the basis of reimbursement up to an annual limit. This would cause distress to patients, particularly when they knew they were reaching a limit but treatment had not been completed. If, in private practice, complications developed during a relatively simple procedure, eg reduction of a hernia, it could not be assumed that the NHS would assist.

9.147. The ability of the BMA to publish purely indicative Guidelines was not contrary to the public interest. The A of A would view with the greatest concern a situation in which the BMA Guidelines were prohibited and BUPA was allowed to continue to published its tariff.

The A of S

9.148. The A of S is a professional association representing the great majority of the 1,000 or so consultant general surgeons in the UK. Its main aim is to advance the art and science of surgery. It is not a trade union and many of its members are also members of the BMA or the HCSA.

The consultant general surgeon

9.149. The A of S said that general surgeons in the UK were all consultants with sub-specialist interests, a situation not found in other parts of Europe and North America, where many practitioners who practised surgery also had a role as a GP. As a consequence, UK general surgeons depended more heavily on their relationship with GPs in providing selection and appropriate referral, so ensuring a degree of quality control which did not apply in other countries.

9.150. In a recent publication in the *British Journal of Surgery* it had suggested that in some sub-specialties of general surgery there was only one-sixth of the number of consultant surgeons available to provide the required level of service. It would be possible to increase numbers by at least 60 per cent without risking oversupply. It was confident that an increase of this proportion would not lead to an excess of

surgical interventions over other suitable treatment (as had occurred in the USA). It had put proposals to the Chief Medical Officer at the DoH urging an expansion in consultant numbers.

9.151. The very high fees which some surgeons were able to command were restricted to a small minority with international practices. However, consultant surgeons had a relatively short maximum-earning period which averaged out into a reasonable balance of total earnings in a lifetime. Surgeons were not normally appointed before the age of 38 and might retire before the age of 65.

9.152. The policy of the insurers to reimburse claims only where treatment had been provided by consultants was known and considered by individual hospitals when appointing surgeons to work in them. In private practice the surgeon normally worked without the supporting team to be found in NHS hospitals, so it was essential that he should be fully trained. Surgical expertise involved decisions on when to operate and which operations to perform. Technical ability by itself was no substitute for expertise. If surgeons in training worked in the private sector doing the less demanding procedures they would have to be supervised by a consultant, as in the NHS. As the contractual arrangements between NHS hospitals and fund-holding GPs were moving towards a greater use of consultants, it would be curious if that trend were to be reversed in private practice.

Competition

9.153. In matters of finance surgeons were not by nature competitive. Competition existed in the quality of care provided and it was by those means alone that surgeons attracted custom. Indicative pricing helped to regulate the market and provided a necessary guide for GPs.

9.154. We were later told that a surgeon might tend to charge slightly more for those procedures in which he regarded himself as having a specialist expertise or might consider charging less, for example, if he were qualified to undertake an operation using traditional methods but not trained in using the latest technological intervention.

The BMA Guidelines and insurers' schedules

9.155. The A of S thought fee scales held down charges and maintained standards. This regulation of the market was extremely important because it was the only way in which surgeons were able to assess, using the comparative data available, what they should charge. It was not detrimental nor against the public interest for the BMA, BUPA or PPP to publish information on the level of fees to be charged.

9.156. The A of S believed that until 1979 many patients opting for private elective and acute healthcare paid the fees themselves. The expansion in insured private healthcare, which began in the 1980s, introduced a new type of client who was not able, or willing, to meet any shortfall over and above the maximum levels of reimbursement of the insurer.

9.157. There was a period thereafter during which consultants experienced significant problems with patients not paying their fees despite having been reimbursed by the insurer. BUPA had suggested to the profession that it could employ a system of direct settlement and in return the profession would have to agree to abide by its schedule of fees. Some consultants had been against this proposal, which they had seen as price-fixing, but the majority eventually accepted in view of the incidence of fraud occurring.

9.158. The A of S recognized that many patients would not be in a position to afford PMS costing more than the sum for which they were insured. This was a principal reason why the profession had maintained its fees within the levels set by BUPA.

9.159. The A of S's survey had indicated that 16.7 per cent of its members used the BMA Guidelines in conjunction with other schedules in setting charges; 65 per cent used the BUPA Schedule of Procedures only; 4 per cent used the BMA Guidelines only; and 3.5 per cent used no guidelines.

Charges and tariffs

9.160. The A of S did not accept that a tariff existed. The BMA Guidelines were based on what was being charged rather than what should be charged. PMS operated in an imperfect market which had been thrown into sharp focus by Government reforms. These had created unexpected tensions and conflicts but the A of S believed that the present system, of referral by GPs who were not financially involved could not be bettered.

9.161. Regional variation in fees was not an issue. The A of S's survey had shown that there were regional variations in consultation fees but little variation in the costs of procedures. A major advance in the NHS over the last 40 years had been to secure an even distribution of trained surgeons throughout the UK, so that expertise was no longer restricted to London and a few other centres.

9.162. The A of S supported the view that patients should be made aware at an early stage of the charges involved in treatment and believed that most surgeons provided this information.

9.163. It wished to reserve the surgeon's right to be flexible in the setting of charges. The patient's ability to pay was a factor and the option should be retained to waive or reduce fees according to circumstances. Fixed-cost operations were offered by some private hospitals to non-insured patients during quiet periods and the agreement between the hospital and the consultant might involve a reduction in his fee. More frequently the consultant might agree to a fixed-price consultation fee for patients who were subsequently referred for treatment through the NHS.

9.164. Information to GPs on surgeons' special expertise was provided by them through post-graduate meetings, care plans and letters making GPs aware of recent advances and the services which were available. Charges for these services were readily available in the schedules provided by the insurance companies or the BMA.

GP referral

9.165. The system of GP referral was well-established and should be maintained. Although patients were referred to specialists for consultation, it was the GP who retained responsibility for the patient and acted as a regulator in the market. The GP was able to act in the patient's interest without direct financial reward and could quickly identify those surgeons whose charges were too high. The A of S supported the insurers in their insistence that reimbursement be conditional upon referral through a GP.

Remedies

9.166. The A of S said that the BMA should not be prohibited from publishing its Guidelines. Prohibition could result in a covert pricing system. The Guidelines provided transparency against which extremes could be measured.

9.167. It was not in favour of using the NHS as a comparator should objective criteria for establishing guidance on fee charging be agreed between the BMA and the insurers. The NHS did not yet have standardized and accurate costings of all procedures.

9.168. It did not think insurers would be able to assess claims without having established schedules of procedures.

9.169. It agreed that consultants should make their charges known to patients at the earliest possible opportunity.

9.170. Previous attempts to itemize separate elements within an aggregate charge had led to an escalation of fees for multiple procedures. A composite fee was often in the patient's best interest.

9.171. It did not agree that consultants should be prohibited from differentiating between insured and uninsured patients when setting charges. Its view was that market forces should prevail and that the consultant should have a right to waive fees in certain cases.

9.172. It agreed that consultants should make their charges known to GPs within their area of practice.

9.173. It did not wish to comment on the question of groups of specialists fixing common charges, as this rarely applied to surgeons.

9.174. It believed the system of GP referrals had helped to overcome the risk of hospitals advertising for patients, which could lead to surgery being undertaken by surgeons of unproven competence and consequently an increase in litigation.

9.175. It did not agree that insurers should be prohibited from restricting reimbursement to treatment carried out by consultants.

9.176. It did not believe that an expansion in the number of clinical academic staff able to undertake private practice would have very much effect. The clinical academic, because of his university responsibility and honorary NHS contract, was already under pressure from his medical school to achieve high research output and from the NHS to increase the number of operations he undertook.

9.177. Government departments and public authorities had no part to play in the supply of private medical services.

Other medical associations representing consultants

Association of British Neurologists

9.178. The Association of British Neurologists had no evidence that any steps had been taken by its members to exploit or maintain a monopoly situation or to restrict competition. Its chief concern was that there should be provision of quality healthcare at the point of need, whether in the NHS or in the private sector.

British Association of Dermatologists

9.179. The British Association of Dermatologists, which promotes the study and teaching of dermatology, told us that its members were free to set their own fees for private practice. Although insurance companies such as BUPA and PPP set their own limits on reimbursement it was for individual practitioners to decide whether to adhere to them.

9.180. Many consultants charged fees at the BMA Guidelines' or BUPA scales' levels to ensure payment, even if they thought a higher fee was warranted. This was a restriction on free market pricing rather than a restriction on competition. The provident associations were arguably a cartel restricting consultants' charges (which was hardly against the public interest).

9.181. It was difficult to see how groups could avoid having common fee structures. Overheads and consumables would be similar, and the location was common to the group. Any variation between consultants' prices would be difficult to administer and would not be understood by patients. It was not possible to see how consultants working in groups could be prohibited from fixing common charges.

9.182. The requirement for a patient seeking PMS to be referred by a GP was a necessary safeguard. It meant that one practitioner had a comprehensive knowledge of the patient's medical history and was able to advise him on the most appropriate specialist. It also minimized the risk of drug interactions and inappropriate treatment. If this requirement were abandoned there would be a massive increase in specialists' numbers that would affect the entire structure of medical practice and the quality of medical care.

9.183. Insurers should be prohibited from reimbursing claims according to a tariff or schedule of procedures. At present there was a significant disparity between surgical and medical reimbursements and there were some arbitrary decisions by insurers as to what diseases and procedures were eligible. It would be simpler and better if insurers simply allowed reimbursements of medical expenses up to a certain amount each year.

British Association of Oral and Maxillofacial Surgeons

9.184. The British Association of Oral and Maxillofacial Surgeons said that it would be concerned if private patients were not given the same benefits and safeguards as were afforded to NHS patients. The referral system for secondary care within and outside the NHS ensured that complete medical records were maintained, that patients were seen by an appropriate specialist, and that informed advice and continuing care were provided at the primary level. Practitioners possessing a certificate of completion of specialist training would be qualified to undertake independent practice, but they might not be able to provide emergency care or long-term management because of other commitments or because of relocation.

9.185. It was safer for a surgeon to operate predominantly in one hospital. It was not sensible for routine surgical procedures to be carried out by practitioners other than consultants, unless the practitioners had the same level of training and access to the same facilities as the consultant. The reimbursement rates of the provident associations and BMA Guidelines were seen by patients as protection from overcharging. The Association supported the principle of equity of remuneration for consultants across the UK, but did not support regional variations in private practice fees.

British Association of Otolaryngologists

9.186. The British Association of Otolaryngologists had no objection to the BMA being prohibited from publishing its Guidelines, or to consultants being prohibited from fixing charges by reference to published guidance, or to medical insurers being prohibited from reimbursing claims according to a tariff. It accepted that consultants should make their charges known to patients at the earliest opportunity and that their charges should be transparent. It had no objection to prohibiting discrimination between charges for insured and uninsured patients, but thought consultants should be able to charge below the published tariff if they wished.

9.187. It did not think its members should be required to make their charges known to GPs, though it would have no objection to an individual tariff being made available on request. It said that insurers should not decline to reimburse claims for services provided by practitioners other than consultants, but that it was important to maintain standards by insisting that claims should be reimbursed only in respect of services by consultants with suitable qualifications and accreditation.

British Association of Paediatric Surgeons

9.188. The British Association of Paediatric Surgeons told us that it did not provide guidelines on fees for its members. It was for individual paediatric surgeons to set fair rates for their services. Many used the BUPA and PPP scales as guidance on the rates at which insurers would reimburse patients. Some used the BMA Guidelines, but most were not BMA members. It believed that most consultants were constrained because patients would recognize those who overcharged.

British Association of Plastic Surgeons

9.189. The British Association of Plastic Surgeons said that in private practice the fees charged were a matter for agreement between the surgeon and patient. A consultant had freedom to set fees at whatever level he thought fit. The BMA Guidelines and insurers' guidance did not always reflect accurately the technical difficulty of many plastic surgical procedures. It was difficult to accept that its members enjoyed a complex monopoly situation in the supply of private medical services.

9.190. GPs were at liberty to ask what the cost of a private consultation would be but this could be given only in general terms. In general it was advisable that patients should be referred by GPs for private treatment. A GP would know much more about a patient's mental and physical state than the consultant and would be able to advise accordingly. The procedure acted as a safety net so that only patients with genuine problems were treated. Insurers' refusal to reimburse claims for private medical services unless they had been carried out by consultants ensured that patients were treated by adequately trained specialists.

9.191. The Guidelines gave some indication to the patient about what would be reimbursed by insurers for the cost of certain procedures. Patients could then estimate any disparity between the estimated cost of surgery and the sum expected from their insurance. The amount charged was not generally related to whether the patient was insured: it was more closely related to the time set aside and the complexity of the problem and procedures.

9.192. It was generally accepted that it was better for patients to be referred by GPs when they sought private treatment, but if a member of the Association saw a patient without his having been referred by his GP it was expected that the member would write to the GP giving full information about the consultation.

British Association of Urological Surgeons

9.193. The British Association of Urological Surgeons said that fees for PMS were part of the contract between the patient and the consultant. An insurer's benefit maxima told consultants how much insurance cover was provided to its policy-holders. The benefit maxima did not seek to dictate the level of fees. The BMA Guidelines were similarly intended to act only as guidance.

British Society for Haematology

9.194. The British Society for Haematology said that the use of guidance (notably from the BMA) in determining charges was sensible. The information provided by the insurers was also useful guidance in ensuring that the level of fees was not appreciably above that which insurers chose to reimburse, so the tendency would be to keep charges at a lower level. It noted that these levels were not adhered to rigorously, which meant that they were not detrimental to competition. The general public benefited from guidance by various bodies, including the BMA. Guidance in relation to a range of private medical services was sensible and should not be prohibited.

9.195. It did not consider that consultants were behaving in a manner detrimental to competition or the public interest in not quoting charges to patients, or in not making GPs aware of their charges, or by fixing common charges in group practices, or by requiring reference by a GP. Nor did it consider that it was detrimental for insurers to make reimbursement of consultants' charges dependent on reference by a GP, or for them to refuse to reimburse claims for private medical services provided by practitioners other than consultants or holders of a certificate of recognized higher specialist training. However, it had no objection to clarification and quotation of scales of charges or to making them more widely available, and it was reasonable that consultants should be obliged to make their charges known on request.

9.196. It was clearly in the interests of the general public that there should be some constraints on charges for PMS, and an increase in openness on charging might reduce criticism of the private sector.

National Health Service Consultants' Association

9.197. The National Health Service Consultants' Association said that its main purpose was the preservation and enhancement of the basic principles on which the NHS was founded. It saw the role of the private elective and acute healthcare sector as no more than marginal in the UK, and said that demand for it should not be artificially stimulated by inadequate funding of the public sector. Private medicine should be truly independent and in no way subsidized by the use of NHS equipment or personnel at less than full cost. The private sector should make an appropriate contribution to training but, on the other hand, private patients should be protected from exorbitant charges.

9.198. It felt considerable disquiet about the new DoH guidelines which sought to extend the traditional confidentiality regarding patient information to a new category of commercially sensitive information, particularly in respect of agreements and quotations emanating from NHS Trust hospitals in respect of charges for private medical services.

Society of Clinical Psychiatrists

9.199. The Society of Clinical Psychiatrists said that the BMA Guidelines were not binding and did not constitute a monopoly. They might reduce any tendency to overcharging provided they were set on reasonable bases. There was no compulsion to charge at BMA, BUPA or other levels, except that insurers might not reimburse on any other basis. It seemed doubtful whether fee-scale publishing and following had caused fees to be higher than would otherwise have been the case. There was no evidence to suggest that the use of fee scales had reduced or eliminated regional variations in charges.

9.200. It agreed that patients should be aware of charges in advance of treatment. A requirement not to discriminate in favour of uninsured patients in respect of charges would mitigate against the disadvantaged sections of the public. Consultants should make GPs aware of the charges they quote for private medical services, but the fixing of common charges by groups of consultants might not be in the public interest. The requirement for patients seeking PMS to be referred by a GP was against the public interest: if patients were dissatisfied with their progress, or the unwillingness of the GP to refer to a specialist, it was iniquitous that they could not go freely to a consultant.

Society of Public Health Ltd

9.201. The Society of Public Health Ltd, which represents consultants working in the field of public health, believed that those in private practice were independent contractors and should be free to set their own fees.