THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

Ms Christiane Kent
Private Healthcare Inquiry Manager, Competition Commission
Competition Commission
Victoria House
Southampton Row
London WC1B 4AD

27 March 2013

Dear Ms Kent

Private Healthcare Market Investigation: AAGBI response to annotated issues statement

The AAGBI welcomes the opportunity to submit our response to the ongoing investigation. Enclosed is the AAGBI submission which includes

- Detailed comments on the CC's annotated issues statement
- The results of a recent survey of the anaesthetic groups (AGs) carried out by an independent survey company on behalf of the AAGBI (appendix A)
- A defence of the role of AGs, based on quality of patient care and which we now call "Independent Departments of Anaesthesia" (appendix B)

The CC may publish this document (and its appendices) in their entirety should it wish to do so. It contains no confidential information within the definition in Part 9 Enterprise Act

We look forward to discussing the submission further at the panel hearing which has been arranged on 22 April.

In the meantime, the AAGBI is happy to respond to requests for clarification or further information via our Executive Director Karin Pappenheim.

Yours sincerely

Dr William Harrop-Griffiths
President

Competition Commission private healthcare market investigation

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Response from the AAGBI to the Annotated Issues Statement dated 28th February 2013 and Submission in defence of anaesthetic groups

APRIL 2013

THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

The Association of Anaesthetists of Great Britain & Ireland (AAGBI) is a voluntary professional and specialist organisation with >10,000 members that represents the substantial majority of consultant anaesthetists, intensivists and pain physicians clinically active in both the private and NHS healthcare sectors in the UK. Its members comprise the largest consultant specialty group active in the private healthcare market in the UK. The primary objects of the organisation are safety, education and research, and it actively promotes its four key principles with regard to independent practice:

- Putting patient safety first
- Preserving clinical teamwork
- Providing transparent fee estimates and benefit levels
- Promoting fully informed patient choice

The AAGBI welcomes the opportunity to comment on the Competition Commission (CC) annotated issues statement[1]. This submission is structured as follows:

- The main body of the submission contains the AAGBI's comments on the CC's annotated issues statement
- Appendix A contains a recent survey of the anaesthetic groups (AGs) carried out by an independent survey company on behalf of the AAGBI
- Appendix B presents a detailed quality argument in defence of AGs, which we now call "Independent Departments of Anaesthesia"

We wish at the outset to repeat our assertion that the private healthcare market could operate fairly and straightforwardly if all parties acted with honesty, integrity and transparency. Private medical insurers (PMIs) should make the financial benefits of their policies crystal clear to their customers at the point of sale and both before and during subsequent claims. The format should be legally prescribed, so that individuals, agents, employers or other third party representatives can make like-for-like comparisons. Provider hospitals and consultants should be similarly encouraged to publish clear, up-front information on costs and on the quality of care offered in an easily accessible format so that comparisons can readily be made. This should be accessible by patients and their delegated expert representatives, such as their GPs, so that an informed choice can be made without any other restriction. Patients or their representatives could then compare the quality and cost of care with the benefits provided by their PMI and, if they choose to do so, pay a top-up fee to provider hospitals or consultants. If they find their insured benefit to be inadequate, they should be free to move to another insurer without penalty. Market forces will then freely apply both to the cost of providing care and to the provision of medical insurance, driving down the costs of both.

PMIs, provider hospitals and consultants are all integral to this argument, and it is therefore illogical and unsupportable if any one group were to be excluded from further detailed investigation. The buyer power of the PMIs has allowed them to increase premiums by over 10% per annum while driving down the benefits paid to consultants and to many hospitals. This is unreasonable, is unsustainable and ultimately not in the interest of consumers.

We will refer to paragraph numbers in the annotated issues statement in our comments below.

The CC may publish this document (and its appendices) in their entirety should it wish to do so. It contains no confidential information within the definition in Part 9 Enterprise Act.

[1] http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130228_final_ais.pdf

Characteristics of privately funded healthcare

11 It is stated that 80% of UK patients using privately funded healthcare services are insured and the other 20% are self-pay. This fact ignores the increasing NHS use of private facilities, which represents over 25% of revenue, over 35% of capacity and is expanding rapidly. Priority allocation of NHS work to consultants, particularly surgeons, is a powerful tactic used by hospital providers to exert buyer power over them, discouraging them from using rival facilities.

13 We note confirmation of our previous assertion that the two largest PMIs account for 65% of the market. In this respect, we are surprised that the PMIs have not been considered to have considerable buyer power in relation to all their suppliers in the CC issues statement theories of harm[2].

Insured patients

14 Most insured patients are indeed covered by policies provided by their employers, but what is not stated is that they have very little knowledge of the insured benefits, simply assuming that "everything is covered". They are not encouraged or incentivised to find out the limits of their cover until treatment becomes necessary. This is the responsibility of both PMIs and employers. The detailed benefits of insured cover must be made explicit. The CC's focus seems to be on how this affects the market power of hospital groups. We ask the CC also to consider how separation of the immediate buyer (the employer) and the patient (the employee) creates an adverse effect on competition as regards the resulting incentives and behaviour of the PMIs.

15 It is stated that self-insured patients "have very limited need to consider the costs of healthcare". This is a situation brought about primarily by the PMIs by their failure to provide transparent information at the point of sale and subsequent claim. The OFT referred this matter to the FSA, but we are unaware of any action arising[3]. PMI policy purchasers are led to believe all costs will be covered, when this is often not true.

18 The charge made by the consultant is not "subject to a schedule of maximum payments operated by the insurer". Rather, the amount reimbursed by the PMI in payment of a consultant's fee is determined by such schedules. There should be no obligate relationship between a consultant's fee and a PMI's benefits. Newly appointed consultants may have "agreed" to charge no more than Bupa's and AXA PPP's benefit maxima, but this agreement is not a contract entered into willingly, and represents an adverse effect on competition. It is important to recognise that the "shortfall" referred to is a shortfall of insured benefit. We agree that there is a "top-up fee" chargeable if this has been agreed in advance.

24 We note the comment that the available information on consultants and private hospitals is "limited", and would challenge the CC to provide evidence of private healthcare markets elsewhere in the world in which more comprehensive information is available.

25 The list of interactions between the NHSs and the privately funded healthcare system ignores the fact that the NHSs are largely responsible for setting governance standards in both public and private healthcare systems.

Market definition

30 It should be recognised that if patients choose to live in more rural areas, they often have to travel to access a wide variety of services, including healthcare. This is for many a lifestyle choice, and the travel requirements associated with rural life are accepted by most. The concepts and definitions of the "Solus" hospitals are potentially erroneous in this context, as such facilities are usually rural and their customers will be content to travel considerable distances to obtain choice if necessary, or stay local and pay more for it.

[2] http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/120622_issues_statement.pdf
[3] OFT press release 2011. http://www.oft.gov.uk/news-and-updates/press/2011/132-11

Product markets

33 The CC welcomes evidence to suggest specialities for investigation. We suggest the CC looks at a sample of the inpatient cosmetic surgery market as an example of how a free health market economy operates, without the influence of the PMIs. Cosmetic surgery has been specifically excluded at the outset of the CC's inquiry, but it is a healthy, thriving and highly competitive marketplace, based on self-pay. No PMI covers cosmetic surgery. Customers shop around on the basis of quality and price and it would be interesting to examine the advantages and disadvantages of this model when compared to one controlled by PMIs.

Profitability

41 The CC has not carried out profitability analyses for consultants. The AAGBI considers this an omission, as this is a major influence on the sector (v.i.). Despite anaesthetists already being the lowest paid consultant group (Table 1), more than a third of Anaesthetic Groups (AGs) have noted a decrease in income over the last five years, while less than a fifth have seen an increase[4]. At the same time, expenses have increased for more than half of the AGs, with less than 10% seeing a decrease[5]. It is not therefore surprising that >90% of partnerships have seen partners leaving private practice before retirement, with 28% of AGs losing three or more partners[6]. Almost half of AGs include partners who have chosen to decrease their private practice activity[7]. The AAGBI concludes that profitability in anaesthetic practice is at an all time low and is close to the pivot point at which provision of expert care in the private sector may decrease below demand.

Consultant anaesthetists represent excellent value, charging fees that are less than those charged by consultants in other specialties whose training, experience, skills and time commitment are similar. Anaesthesia represents the “bottom of the market”, and a decreasing commitment from anaesthetists to private practice can be taken to indicate that the downward pressure on incomes by PMIs has an adverse impact on the market. This makes it particularly surprising that there is such a focus on AGs – with good value being offered by all anaesthetists and the profitability of AGs being compromised, it seems to us illogical that PMI profitability is ignored but the reasonable fees of anaesthetists are examined in great detail. We are greatly surprised by the statement that PMI profitability analysis is “of less relevance as their revenues are obtained outside of the market for privately-funded healthcare”. The PMI revenues are the basis of 80% of privately funded healthcare (para 11) and therefore must be very relevant. In this respect, it is surely notable that PMI premiums rise in excess of 10% per annum, whilst consultant fees are stationary, or decreasing.

Theories of harm

50 We note that the CC has not seen persuasive evidence that PMIs have buyer power over hospital operators that is harmful. We would be interested to see the evidence relating to this area that the Commission feels is not persuasive.

Theory of harm 2: Market power of individual consultants and/or consultant groups in certain local areas

76 The AAGBI notes that the CC has concentrated their investigations of consultant groups on anaesthetists because “patients in practice typically have relatively little input into the selection of the anaesthetist” and because the CC has received “the most complaints about the conduct of these groups”.

Firstly, we would like to question the selection of anaesthetists for investigation when other professional groups who are in a similar position to anaesthetists in terms of patient choice input have not been subjected to further enquiry, e.g. radiologists, pathologists and haematologists. The CC's investigation should be guided by the economic evidence rather than by counting which interest group has complained the loudest.

[4] Please see the survey of AGs recently undertaken by the AAGBI, attached at Appendix A. Fig 13
[5] Appendix A. Fig 16
[6] Appendix A. Fig 34 and comments
[7] Appendix A. Fig 35 and comments

Secondly, we request that the Commission publish the number of complaints made about this area of the market study and to identify from whom the complaints derived: primarily patients or PMIs. The AAGBI would welcome the opportunity to respond to these complaints (anonymised as appropriate).

Thirdly, we challenge the CC to justify their focus on a group of consultants that offers exceptional value when compared with other consultant groups. We accept that patients may complain about shortfalls and top-up payments to anaesthetists. However, we assert that this derives primarily from the PMIs' contracts with their customers, which anaesthetists obviously have no control over, and from a historical and no longer justified inequity between the benefits allowed for surgeons and anaesthetists. Given that these two groups have similar training, experience, expertise, responsibility, and time input, and enjoy identical pay in the NHS and from services to other government bodies such as the Courts and armed forces, it is illogical that the benefit levels differ by up to 300%, particularly given the additional, substantial sources of income that surgeons enjoy, e.g. outpatient activity. Such differences cannot be justified by the admittedly different costs of these two groups, as even after the deduction of reasonable expenses, the private practice income of surgeons far exceeds that of anaesthetists (v.i.). It may be that the CC has been supplied with anecdotal evidence of a minority of Anaesthetic Groups charging higher fees than anaesthetists in a similar geographical area who are not members of groups. However, in addition to the fact that this reflects the additional services offered by groups, the fees of both group and non-group anaesthetists represent exceptional value, and the differences are small in comparison to the overall market picture.

78 The AAGBI notes that a significant number of non-anaesthetist consultants work in groups (22%), but none of these consultants has been surveyed, or their billing practices analysed against the PMI database, even though their numbers will be greater overall than those of anaesthetists, and the gross sum billed by these 22% will most likely be considerably greater. A number of assumptions have been made about AGs that may be equally applicable to other consultant groups. It is therefore suggested that some of these groups be surveyed as a comparator. Similarly, it has been assumed that AGs function differently to independent anaesthetists who are not in AGs, but these independent anaesthetists have not been surveyed. Conclusions have been made on an analysis of a PMI-derived database, cross referencing names identified in the CC survey. This methodology could be unreliable in accurately identifying group or non-group membership. We strongly recommend that the same survey sent to AGs be sent to a representative sample of independent anaesthetists in each relevant area before any firm conclusions are made about the function of AGs.

The difference of 9% between anaesthetic groups and other consultant groups in using guidelines to set fees is not a significant difference. However we fail to see the relevance of how groups set their fees. Most AGs are single undertakings with the right to set the level of fees charged by its members (as found by the OFT in its 2003 decision[8]), so it is remarkable that only 24% of anaesthetists make reference to the AG's fee schedules or guidelines (by way of comparison, consider an equivalent situation in a law firm, economics consultancy, or pharmaceutical company). In any case, the relevant fact is the fees actually charged and whether these fees are reasonable in terms of the quality of service delivered.

We disagree with the misleading use of the following statistics, which have seemingly been included to support the CC's concerns that AGs have market power, but actually show the opposite: "*10 per cent of those in consultant groups and aware of consultants not in a group said that those in groups charge higher prices than those not in groups" and "for those not in consultant groups, aware of one and of other consultants not in a group---- the proportion was 16 per cent"*. This actually means that 84-90% thought there was no significant difference, or that group fees were lower, or that they didn't know. It is clearly inappropriate to allocate all the "don't knows" to support the argument that anaesthetic groups charge higher fees.

79 From the foregoing, it might be concluded that there is a small amount of evidence of dubious quality presented to conclude that **some** anaesthetic groups (10-16%) appear likely to have market power, but the evidence more importantly suggests that the substantial majority (84-90%) do not. We are glad that the CC intends to analyse this area further. The AAGBI would be pleased to assist the CC in doing so, noting that if we had been consulted, the data might be significantly more robust. In this respect, we note that in the methodology described in appendix C[9], six procedure codes were chosen to determine the relative fees charged. One third of these codes are completely inappropriate: *local*

[8] http://www.oft.gov.uk/OFTwork/competition-act-and-cartels/ca98/decisions/anaesthetists-groups
[9] http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/ais_app_c_toh_2.pdf

anaesthetic blockade of major nerve trunk (including occipital block, spheno-palatine block, diagnostic block of trigeminal branch, intercostal nerve block & supra-scapular nerve block) (A7350); epidural injection (lumbar/caudal) (A5210). These codes are most commonly used by anaesthetists as secondary procedures performed in addition to the primary procedure under general anaesthesia, in order to provide optimal pain relief after, for example, major joint surgery. In these cases, it is the primary procedure code that should have been examined, as these additional codes increasingly attract no additional fees. When these codes are used alone, they are used primarily by chronic pain consultants to treat a primary chronic pain problem awake or under sedation, using the operator or "surgeon" code for remuneration. Chronic pain consultants are usually consultant anaesthetists as well, so this factor might be the cause of confusion. Chronic pain work is only rarely part of Anaesthetic Group practice. We question the claim that these 6 codes represent the top six anaesthetic treatments in the UK by frequency or value. As such, the data described in appendix C is significantly flawed, open to appeal and should be urgently re-examined with appropriate codes, perhaps as we stated in our original submission to the OFT[10], in which we described the top 10 surgical procedures performed under general anaesthesia.

Even taking all this into account, in only one of the three case studies was there evidence that the Anaesthetic Group concerned charged more than the regional average for the majority of procedures. As the three groups concerned were targeted because they were representative of the 9 groups that the PMIs were most concerned about, there is likely to be even less evidence that the remaining 91 groups surveyed charge fees that are significantly greater than the regional average. As consultant fees are only 22% of the cost of private healthcare (v.i, table 2) and as anaesthetic fees are only 12% of this (2.6% of the total cost)[11] the AAGBI concludes that the issue of anaesthetic fee shortfalls is insignificant, that there is no suggestion of an adverse effect on competition in this area and that the CC might consider spending its resources on other more concerning aspects of the market investigation.

Even if AGs do tend to charge more than the regional average, we describe in appendix B how this might be justified on the basis of the quality of service and additional services provided. The CC has made no attempt to define the quality of service delivered. Private medicine is not just about the cost of treatment. Indeed, the CC patient survey concluded that "Clinical Expertise" was the single most important consideration affecting choice, not cost[12].

In Appendix B, the AAGBI presents a detailed quality argument in defence of Anaesthetic Groups, which we now call "Independent Departments of Anaesthesia". We suggest that some form of group practice should be the norm on the basis that it enhances patient safety. We are very concerned that any attempt to disrupt such efficient working arrangements could have negative consequences that would result in lower standards of care in the private sector than are available in the NHS.

80 The AAGBI accepts that the CC analysis "has provided some evidence that prices charged by anaesthetic groups **may** be higher than those charged by non-groups", but considers that this evidence is poor, is flawed, applies to the minority, and is inadequate to justify any future conclusions that might disrupt the function of AGs and thus compromise patient safety. On its own, the fact that **some** AGs **might** charge more than **some** solo anaesthetists is arguably of little relevance without an analysis of the services and standard of care being purchased.

Theory of harm 4: Buyer power of insurers in respect of individual consultants

100 The CC states that "in the absence of insurer action… it is not clear that there would be effective constraints on the fees charged for insured patients". We refer to our introductory paragraph. It is the strong view of the AAGBI that there is no reason why simple market forces could not be applied to this sector, both in terms of the health insurance market and the health provider market. With open, honest and transparent information about insurance benefits and costs, together with the cost of healthcare and the quality of care provided, customers could shop around for the best value for money of both insurance and healthcare. Market forces would act as the natural constraint the CC rightly desires on behalf of consumers, driving down the costs of both insurance and healthcare. There is no reason why the PMIs should be allowed to abuse their oligopoly to control the market, particularly when these companies fail to inform their customers fully about the insurance benefits provided and use coercive

[10] http://www.aagbi.org/sites/default/files/AAGBI%20FINAL%20response%20to%20OFT.pdf
[11] WPA data (full ref to follow)
[12] CC customer survey

tactics to control consultant fees. Consultants and hospitals must also be required to be far more transparent about the cost and quality of treatment so that patients can make an informed choice.

Consultant fees

104 Bupa's argument about efficiency gains is worth exploring in more detail. In essence, it is argued that as some procedures have become quicker to perform (speed being blindly equated to cost), they should attract lower fees. If this is held to be a cogent argument, then the corollary is that if procedures take longer, they should attract larger fees. The advent of laparoscopic and robotic surgery has increased the duration of many surgical procedures. The introduction of safety checklists has led to more time being spent in the operating theatre conducting procedures that are in the interests of overall patient outcome. Increased awareness of the importance of scrupulous attention to hand hygiene has also added time to work patterns. It is highly likely that the process of safe surgery and anaesthesia takes longer now than before. We recommend that studies be conducted to address this important issue, but it is our view that risks, skills and outcomes should be far more important considerations than time in determining professional fees.

105 If the CC seeks information on changes in the correct remuneration of consultants, it need look no farther than the Doctors and Dentists Remuneration Body (DDRB), an objective and highly respected group that advises the NHS on pay for consultants. In the period 1994 to 2012, consultant pay increased by 50% on the advice of the DDRB. Meanwhile, PMI benefits have been frozen for at least 15 of these 18 years by the major PMIs, and actual consultant income from the private sector, without adjustment for inflation, has decreased or remained the same.

There exist data available about private practice consultant income over time, and the CC is referred to Stanbridge Associates Ltd (v.i.) who have been collating these data for many years. Table 1 shows that since 2007, the gross private income of most consultants has not increased, whilst practice expenses (particularly indemnity insurance) and inflation have increased significantly[5]. Net income is therefore declining and because of increasing taxation, disposable income has reduced dramatically.

Table 1

It is notable from the above table that anaesthetists are particularly disadvantaged, as the lowest earners in the sector, despite spending more time in the operating theatre than surgeons, with similar training, skill levels and responsibilities and with similar postoperative commitments.

In the AAGBI survey, 38% of anaesthetists in AGs reported that net income has declined over the last five years, 44% said it has remained stable, whilst only 19% experienced an increase[4]. 58% reported an increase in expenses, whilst only 9% saw a decrease[5]

Table 2 shows that the hospital: consultant fee ratio has increased from 2.48 in 1994 to 3.53 in 2010, a 42% increase in favour of the private hospitals. This is in the context of PMI premium increases in excess of 10% year on year and increasing hospital charges that in 2010 represented 78% of the cost of private healthcare. The AAGBI considers the question of anaesthetic fees to be inconsequential in this respect and suggests that the CC question the relative value being offered to consumers by the PMIs and the hospitals, when compared to that provided by consultants, and in particular, consultant anaesthetists. In the latter consideration, the quality of the services offered should also be examined, noting the substantial improvements in healthcare outcomes and reductions in hospital length of stay, driven and delivered largely by consultants and by anaesthetists in particular. In this context, the AAGBI asserts that the approach to consultant fees shown by the PMIs is unjustified and that this is driven by the perceived corporate weakness of consultant providers when compared to national private hospital networks and the insurance industry.

THE PRIVATE ACUTE HEALTHCARE MARKET IN THE UK (£M)

STANBRIDGE ASSOCIATES LTP

	1994	2004	2005	2006	2007	2008	2009	2010
Independent Hospitals and Clinics	1249	3323	3775	3989	4288	4686	4956	5153
NHS Pay Beds	209	401	417	429	426	439	430	445
	1458	3724	4192	4418	4714	5125	5386	5598
Consultant Fees	586	1270	1363	1424	1492	1590	1585	1587
Total	2044	4994	5555	5842	6206	6715	6971	7185
Consultant Fees as % Total	28.7	25.4	24.5	24.4	24.0	23.7	22.7	22.1
Hospital/Consultant Fees Ratio	2.48	2.93	3.07	3.10	3.16	3.22	3.40	3.53
Independent Hospital/ Consultant Fees Ratio	2.13	2.62	2.77	2.80	2.87	2.95	3.13	3.25

Source: Laings Healthcare Market Review (various)

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Table 2

107 We are not aware of any evidence presented to the CC that defines the impact of declining relative PMI benefit and fee income on the supply of consultants, and anaesthetists in particular. The AAGBI asserts that there is a significant risk of an inadequate supply of anaesthetists causing detriment in the long term, probably because of the factors discussed above. 10 years ago, it was unheard of for partners in AGs to voluntarily reduce their commitments or give up private practice before retirement - they tended toward the opposite approach, giving up NHS work in favour of more private practice. The AAGBI survey shows that 66% of AGs have lost two or more partners in the last five years because of reasons other than retirement[6]. The Chester Group Practice has lost 28% of consultant capacity prematurely and voluntarily, with most of this occurring in the last 18 months. The majority of explanations in the survey suggest that the responsibilities and commitments of private practice are not worth the financial returns[6]. In addition, 47% of AGs had partners who had reduced their private commitments for similar reasons[7]. 28% of AGs noted an increase in the proportion of female to male partners over the last 5 years[13]. It is possible that the increasing feminisation of the medical workforce is increasing consultant part-time NHS working because of work-life balance issues and that this trend is reflected in the private sector. The AAGBI suggests that there is a real possibility that anaesthetic private incomes are now at a critical pivot point resulting in an exponential exodus in favour of the NHS. It is likely that other specialities will follow suit in due course when their pivot point is approached.

[13] Appendix A. Fig 36

Preventing consultants from charging top-up fees

110 The AAGBI is greatly concerned by the use of the term "recognition" to indicate that a commercial contract has been agreed by a consultant and a PMI, particularly as newly appointed consultants have no choice but to accept Bupa, AXA PPP and Aviva's restrictive terms if they wish to have access to more than 25% of patients in the private healthcare market. The term used must not imply that the PMI has in some way approved a consultant's professional qualifications and expertise when the agreement that they have reached is simply about fee levels. Newly "recognised" consultants cannot charge a top-up fee, so as the CC agrees this is unreasonable (para 111), these conditions of "recognition" must be unreasonable as well. The AAGBI have presented evidence above that demonstrates a significant loss of experienced consultant anaesthetists from the sector, who should ideally be replaced by well trained, UK based new entries, in order to grow the future expert private workforce. The restrictive behaviour of the PMIs greatly inhibits this process.

112 Purchasers of private medical insurance might well be expected to switch supplier in response to unexpected charges being levied at the time of a claim, or other dissatisfaction, but few do so because the condition causing the claim will no longer be covered if the customer moves to another insurer. This action greatly inhibits a free market in the purchase of health insurance and customers should be free to move from insurer to insurer, without excessive policy loading for previous conditions.

Other issues

114 The AAGBI assures the CC that the complaints they have received from consultants are indeed highly representative. The majority of consultants have been unaware of the CC's inquiry, as they have not been contacted directly by the CC. It should not be assumed that lack of evidence from individual consultants represents lack of interest or lack of concern. Most consultants look to representative bodies such as the AAGBI to put forward their views. Further, the treatment of consultants' complaints in para 113-114 is in stark constrast to the treatment of complaints about anaesthetists in para 76 as justification for singling out anaesthetists from other categories of consultant.

115 We are disappointed that the complaints summarised in para 113 have been dismissed by the CC without further attempts to obtain the level of evidence required, as we believe these issues are extremely important in the way the PMIs seek to manipulate the market, controlling competition with excessive market share and collusion, and thus reducing customer choice and having a potential adverse impact on the quality of care.

Theory of harm 5: Barriers to entry

140 The AAGBI asserts that a significant barrier to entry is created by the continuous downward pressure exerted by PMIs on consultant fees and their coercive recognition requirements.

Theory of harm 6: Limited information availability

143 The AAGBI agrees that PMIs, consultants and hospitals must improve the standard of information available to prospective customers in order to allow them to exercise informed choice. This criticism applies equally to the PMIs and we are disappointed that the CC has not made this point, particularly as the OFT referred this matter to the FSA for resolution with the ABI[3]. The AAGBI is also concerned by the CC's inference that consultants may put profit above the best interests of patients. This is completely contrary to the requirements of the GMC "Good Medical Practice"[14], and doctors will most certainly face GMC investigation and potential erasure if they are suspected of such actions. We therefore believe that such practice is extremely unusual and cannot be a significant economic aspect of private healthcare.

145 The AAGBI is very concerned by the actions of certain PMIs in restricting treatments and manipulating referral pathways.

[14] GMC Good Medical Practice. http://www.gmc-uk.org/static/documents/content/GMP_0910.pdf

Survey results

146 The AAGBI agrees that patients consider clinical expertise to be the most important consideration in their choice of consultant[13], although we were not able to access the patients survey referred to. The provision of information must therefore focus on this aspect.

147 In the meantime, in the absence of such information, patients should be encouraged to ask the opinion of their GP, whose advice the majority favour[13]. The GP is far better placed than the PMIs to advise on relative clinical expertise, without commercial bias, despite the PMI protestations to the contrary. In this respect, the AAGBI note that we have still not been able to examine PMI claims to have robust data on clinical outcomes, which we doubt they actually possess.

153 The AAGBI agrees that the level of information available to NHS patients is a good benchmark for the private sector to aspire to exceed.

APPENDIX A

The Association of Anaesthetists of Great Britain and Ireland

Anaesthetic Groups Survey

Results

February 2013

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Introduction

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) commissioned Enventure Research to conduct a survey with Anaesthetic Groups to provide useful information to inform a paper being prepared by the AAGBI on the benefits of these groups. The paper is to be submitted to the Competition Commission to inform its inquiry into private healthcare.

This report presents the results of the survey.

Methodology

An online survey was designed by the AAGBI and Enventure Research which contained a series of 50 questions relating to the makeup and operation of Anaesthetic Groups. A copy of the questionnaire can be found in **Appendix A**. A link to the survey was emailed to a database of Anaesthetic Group contact details within an invitation email. A number of targeted reminders were also issued to increase the response rate to the survey.

The survey was live from 21 December 2012 to 4 February 2013. In total, 32 completed responses were received.

Interpretation of the data

This report contains several tables and charts that present survey results. In some instances, the responses may not add up to 100%. There are several reasons why this might happen:

- The question may have allowed each respondent to give more than one answer
- Only the most common responses may be shown in the table
- Individual percentages are rounded to the nearest whole number so the total may come to 99% or 101%
- A response of between 0% and 1% will be shown as 0%.

Additionally, Anaesthetic Groups were not required to answer all questions, meaning that the base size to each question may vary.

Survey Results

In total, 32 Anaesthetic Groups took part in the survey.

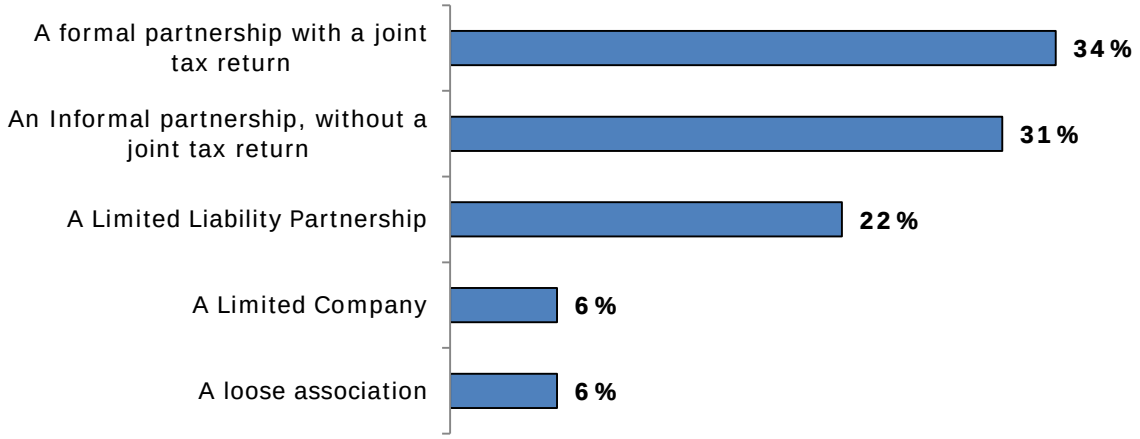
The majority of groups (88%) indicated that they covered between zero and three independent/private hospitals. An average of 2.4 hospitals was covered overall.

Figure 1 – How many independent / private hospitals does your group cover?
Base: 32

Number of independent / private hospitals covered	Number of groups	% of groups
0 to 1	14	44%
2 to 3	14	44%
4 to 5	1	3%
6 to 7	1	3%
8 and above	2	6%

Eleven out of the 32 groups (35%) described themselves as 'a formal partnership with a joint tax return', followed by ten (31%) which described themselves as 'an informal partnership without a joint tax return'.

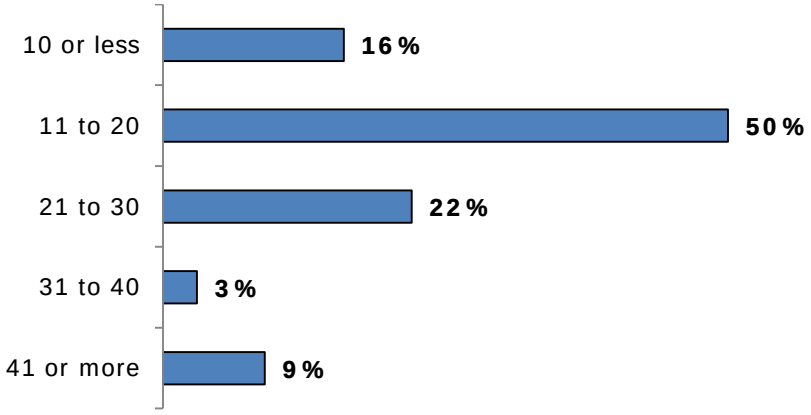
Figure 2 – How would you describe the nature of your Group Practice?
Base: 32



Nature of Group Practice	Number of groups	% of groups
A formal partnership with a joint tax return	11	34%
An Informal partnership, without a joint tax return	10	31%
A Limited Liability Partnership	7	22%
A Limited Company	2	6%
A loose association	2	6%

Anaesthetic Groups reported that they had between six and 63 members. Half of the groups who took part in the survey (16) had between 11 and 20 members. The average number of members across all groups was 20.

Figure 3– How many members does your Anaesthetic Group have?
Base: 32



Number of members	Number of groups	% of groups
10 or less	5	16%
11 to 20	16	50%
21 to 30	7	22%
31 to 40	1	3%
41 or more	3	9%

All but three Anaesthetic Groups indicated that they employed administrative staff. The number of administrative staff employed within these groups ranged from one to four. The majority of groups employed just one (45%) or two (31%) administrative members of staff.

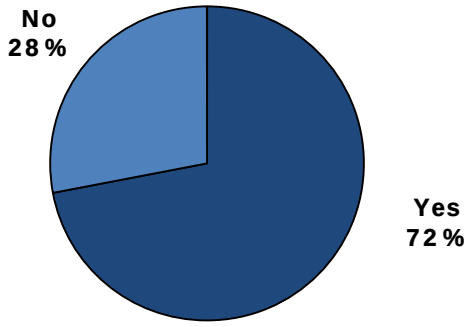
The most common capacity that administrative staff were employed was in secretarial roles, with a smaller number of office/practice managers. Administrative staff were employed working a mixture of full and part time hours.

Figure 4 – How many administrative support staff are employed?
Base: 29

Number of administrative staff employed	Number of groups	% of groups
One	13	45%
Two	9	31%
Three	4	14%
Four	3	10%

Twenty three of the 32 Anaesthetic Groups (72%) had their own premises.

Figure 5– Does your Anaesthetic Group have its own premises?
Base: 32

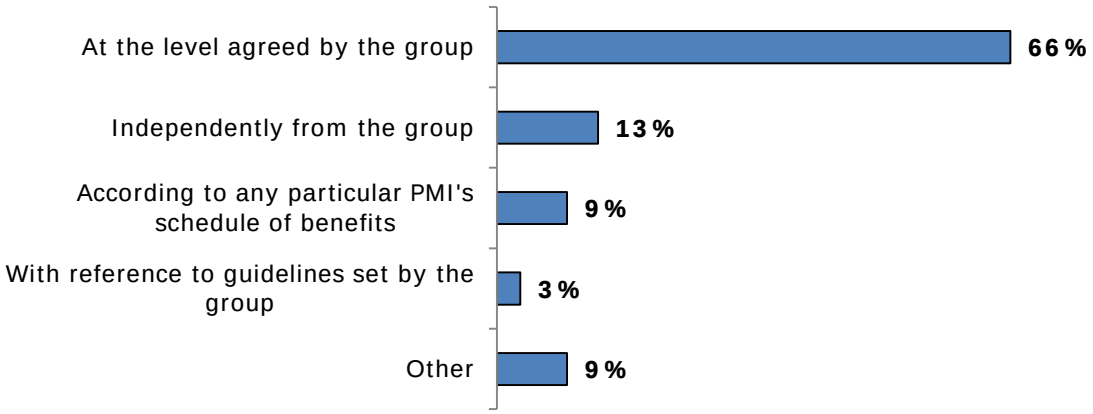


Does your Anaesthetic Group have its own premises?	Number of groups	% of groups
Yes	23	72%
No	9	28%

The majority of groups (66%) indicated that their anaesthetist members typically set their fees for privately funded anaesthetist services 'at the level agreed by the group'. 'Other' ways of setting these fees were provided by three groups, listed below:

- *We have no choice but to bill as per individual insurance company fee schedules*
- *Most are within PMI maxima, but with some individual variation*
- *Newer partners are contracted to the PMI rates, the rest of the group charge at an agreed level*

Figure 6 – How do your anaesthetist members typically set their fees for privately funded anaesthetist services?
Base: 32



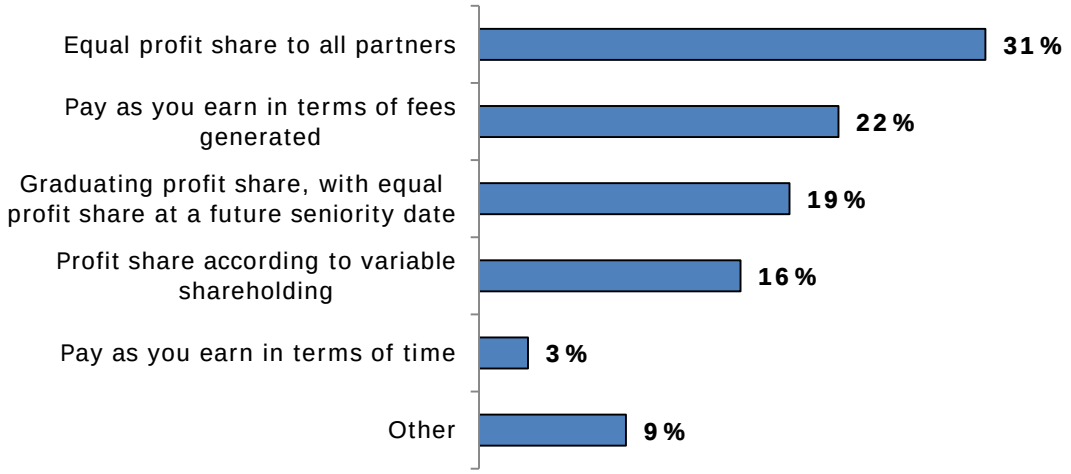
Method of setting fees	Number of groups	% of groups
At the level agreed by the group	21	66%
Independently from the group	4	13%
According to any particular PMI's schedule of benefits	3	9%

With reference to guidelines set by the group (e.g. within a range agreed by the group)	1	3%
Other	3	9%

All groups which indicated their fees were typically set 'according to any particular PMI's schedule of benefits' used WPA to set them.

Anaesthetic Groups were asked how they allocate profits. Ten of the 32 groups (31%) indicated that they used 'equal profit share to all partners', followed by seven groups (22%) who used 'pay as you earn in terms of fees generated' to allocate their profits.

Figure 7 – How does your Group allocate profits?
Base: 32



Number of independent/private hospitals covered	Number of groups	% of groups
Equal profit share to all partners	10	31%
Pay as you earn in terms of fees generated	7	22%
Graduating profit share, with equal profit share at a future seniority date	6	19%
Profit share according to variable shareholding	5	16%
Pay as you earn in terms of time	1	3%
Other	3	9%

Over half of groups (57%) indicated that more than 5% of their group income was earned outside their base hospital.

Figure 8 – What proportion of your group income is earned outside your base hospital?
Base: 30

Proportion of group income	Number of groups	% of groups
Less than 5%	13	43%
5% - 10%	5	17%
11% - 20%	3	10%
21% - 30%	-	-
31% - 40%	1	3%
41% or more	8	27%

43% of Groups indicated that 91% or more of the total anaesthetic fees earned in their base hospital was earned by their group. 23% earned 50% or less.

Figure 9 – What proportion of the total anaesthetic fees earned in your base hospital is earned by your group?
Base: 30

Proportion of total anaesthetic fees	Number of groups	% of groups
Less than 20%	-	-
21% - 30%	1	3%
31% - 40%	3	10%
41% - 50%	3	10%
51% - 60%	1	3%
61% - 70%	2	7%
71% - 80%	3	10%
81% - 90%	4	13%
91% or more	13	43%

The range of patients seen by Anaesthetic Groups each year ranged from 105 to 12,000. The average number of patients seen each year was 3,377.

Figure 10 – How many patients does your Group see each year?
Base: 29

Number of patients seen each year	Number of groups	% of groups
Less than 1,000	6	21%
1,001 to 2,000	6	21%
2,001 to 3,000	7	24%
3,001 to 4,000	2	7%
4,001 to 5,000	2	7%
5,001 to 6,000	1	3%
6,001 to 7,000	1	3%
7,001 or more	4	14%

Groups were asked to indicate what percentage of their patients were:

- Self funded
- Insurance covered
- NHS funded
- Other funded

The ranges and average percentages for each category are shown in the table below.

Figure 11– What percentage of your patients are…?
Base: 29

Method of funding	Lowest %	Highest %	Average %
Self funded	2%	75%	20%
Insurance covered	18%	80%	48%

NHS funded	5%	80%	37%
Other funded	0%	10%	3%

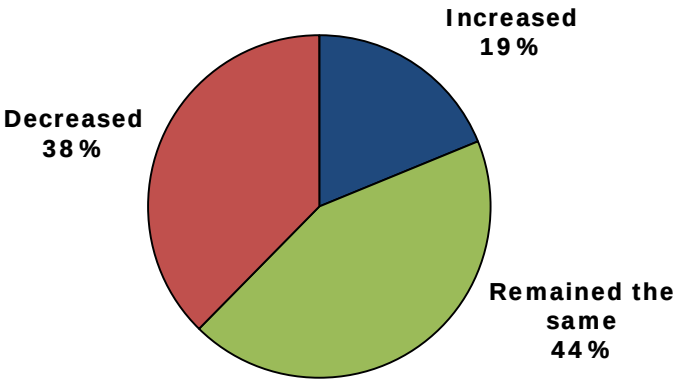
Groups reported that the proportion of insured patients asked to pay a top up fee ranged from 0% to 100%. The average percentage of patients asked to pay a top up fee was 43%.

Figure 12 – What percentage of your insured patients are asked to pay a top up fee?
Base: 30

Proportion of insured patients asked to pay a top up fee	Number of groups	% of groups
0 - 20%	11	37%
21% - 40%	7	23%
41% - 60%	3	10%
61% - 80%	2	7%
81% - 100%	7	23%

Almost half of groups (44%) indicated that their net income earned had remained the same over the last five years. Twelve of the 32 groups indicated that their income had decreased. The majority of these groups (7) reported a decrease of between 11% and 20%. Of the six groups who indicated that their income had increased, half (3) reported an increase of between 11% and 20%.

Figure 13 – Over the last five years how has the net income earned by the practice changed?
Base: 32



Change in income earned	Number of groups	% of groups
Increased	6	19%
Remained the same	14	44%
Decreased	12	38%

Figure 14 – How great is this increase?
Base: 6

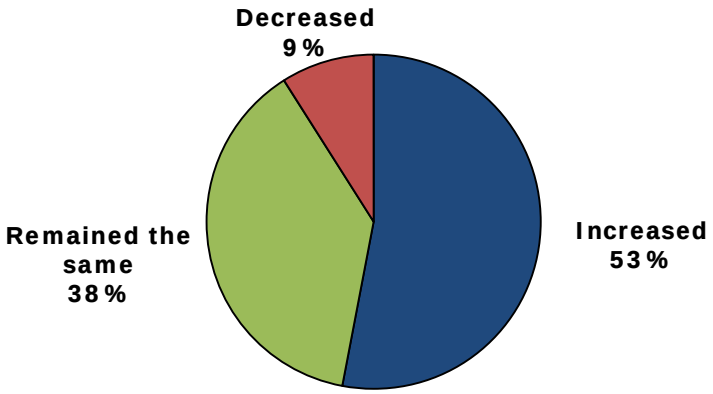
Percentage increase	Number of groups	% of groups
Less than 5%	1	17%
6% to 10%	-	-
11% to 20%	3	50%
21% - 35%	1	17%
36% - 50%	1	17%
51% - 65%	-	-
66% - 80%	-	-
81% or more	-	-

Figure 15 – How great is this decrease?
Base: 12

Percentage decrease	Number of groups	% of groups
Less than 5%	-	-
6% to 10%	1	8%
11% to 20%	7	58%
21% - 35%	2	17%
36% - 50%	1	8%
51% - 65%	-	-
66% - 80%	1	8%
81% or more	-	-

Over half of groups (53%) indicated that the expenses incurred by the practice had increased. Of these groups, the majority (13) indicated that this increase was between 1% and 20%.

Figure 16 – Over the last five years have the expenses incurred by the practice changed?
Base: 32



Change in expenses incurred	Number of groups	% of groups
Increased	17	53%
Remained the same	12	38%

Decreased	3	9%

The majority of groups which reported an increase in their expenses indicated that this was an increase of up to 20% (82%). Just three groups reported that their expenses had decreased, and the proportion of this decrease can be seen in the table below.

Figure 17 – How great is this increase?
Base: 16

Percentage increase	Number of groups	% of groups
Less than 5%	2	13%
6% - 10%	4	25%
11% to 20%	7	44%
21% - 35%	-	-
36% - 50%	-	-
51% - 65%	1	6%
66% - 80%	1	6%
81% or more	1	6%

Figure 18 – How great is this decrease?
Base: 3

Percentage decrease	Number of groups	% of groups
Less than 5%	-	-
6% to 10%	-	-
11% to 20%	1	33%
21% - 35%	1	33%
36% - 50%	-	-
51% - 65%	-	-
66% - 80%	1	33%
81% or more	-	-

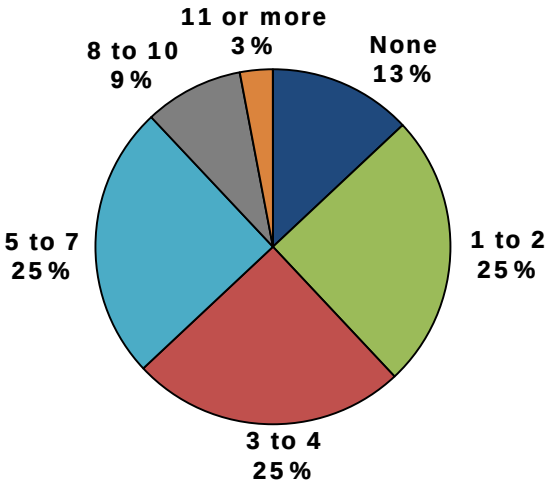
Eighteen of 31 groups (58%) indicated that there was at least one other local hospital at which one of their partners has privileges, where other Anaesthetic Groups were providing services.

Figure 19 – In how many of the hospitals, at which one of your partners has privileges, are there other Anaesthetic Groups providing services?
Base: 31

Number of hospitals	Number of groups	% of groups
None	13	42%
One	7	23%
Two	5	16%
Three	4	13%
Five or more	2	6%

A quarter of groups (8) respectively indicated that at least one of their group partners could practice at 1 or 2 private hospitals if they wished, with 62% having access to 3 or more. Only 4 Anaesthetic Groups (13%) had access to only one private hospital.

Figure 20 – At how many private hospitals could at least one of your group partners practice if they wished, assuming they abide by the hospitals stated restrictions on travelling time, or one hour from your home if you are unsure?
Base: 32



Number of private hospitals	Number of groups	% of groups
None	4	13%
1 to 2	8	25%
3 to 4	8	25%
5 to 7	8	25%
8 to 10	3	9%
11 or more	1	3%

Groups were then asked how many of these hospitals had Anaesthetic Groups. A third (33%) reported that one of these hospitals had an Anaesthetic Group, with a further 59% reporting two or more Anaesthetic Groups operating locally Only 2 Anaesthetic Groups (8%) had no other local Anaesthetic Group competitors.

Figure 21 – How many of these hospitals where your partners could have privileges have Anaesthetic Groups?
Base: 24

Number of hospitals with Anaesthetic Groups	Number of groups	% of groups
None	2	8%
One	8	33%
Two	6	25%
Three	3	13%
Four	2	8%
Five or more	3	13%

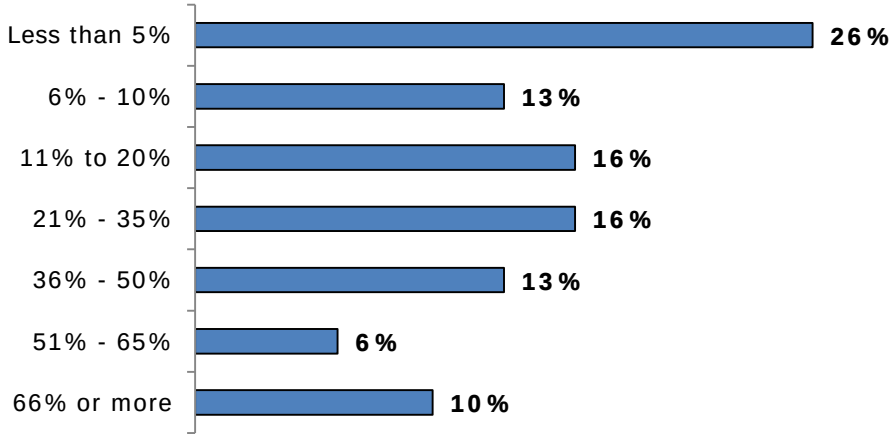
The number of independent consultant anaesthetists who were not members of any Anaesthetic Group, but were working at the Anaesthetic Group's base hospitals ranged from 0 to 70, and the average was 9. 74% had at least one independent competitor working in their base hospital and 49% had 6 or more.

Figure 22 – How many consultant anaesthetists, who are not members of your group or any other group, also work in your base hospital?
Base: 31

Number of consultant anaesthetists	Number of groups	% of groups
None	8	26%
1 to 2	4	13%
3 to 5	4	13%
6 to 10	8	26%
11 to 20	3	10%
20 or more	4	13%

Over a quarter of groups (26%) indicated this number represented less than 5% of the total number of consultant anaesthetists. In 45% of groups, this was 36% or more.

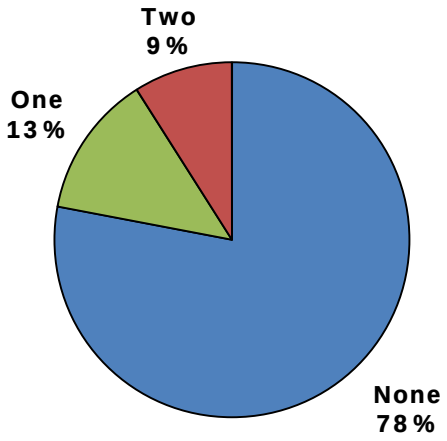
Figure 23 – What percentage of the total number of consultant anaesthetists do they represent?
Base: 31



Percentage of consultant anaesthetists	Number of groups	% of groups
Less than 5%	8	26%
6% - 10%	4	13%
11% to 20%	5	16%
21% - 35%	5	16%
36% - 50%	4	13%
51% - 65%	2	6%
66% or more	3	10%

The majority of Groups indicated that there were no other Anaesthetic Groups also working in their base hospital. Groups that did work alongside other Anaesthetic Groups indicated what percentage of the total number of consultant anaesthetists their members represented, shown in Figure 26.

Figure 24 – How many other groups also work in your base hospital
Base: 32



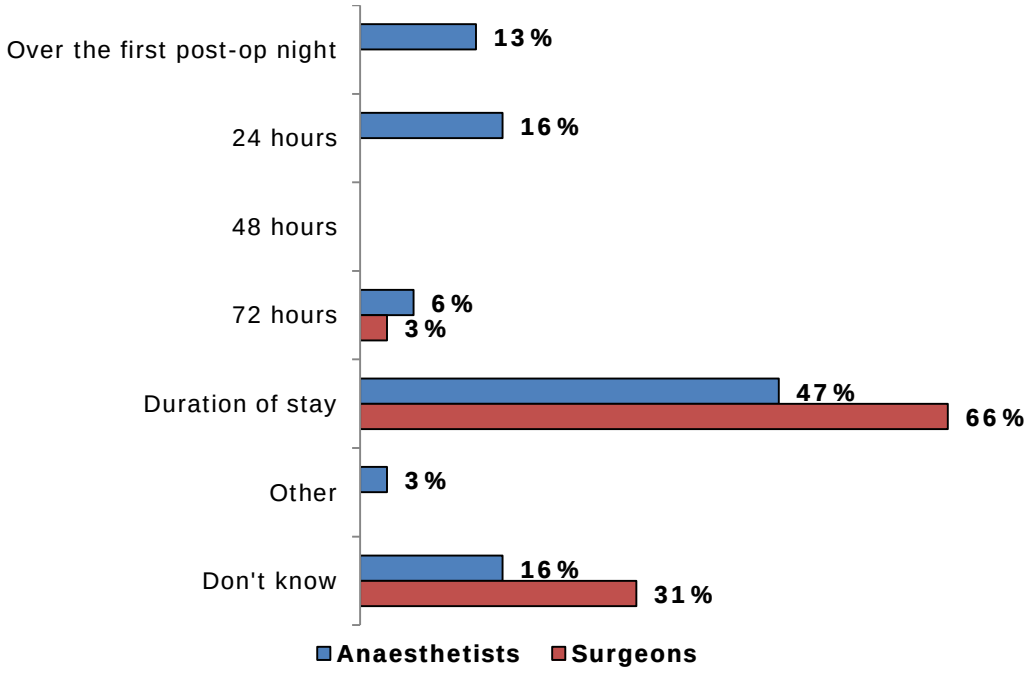
Number of other Anaesthetic Groups	Number of groups	% of groups
None	25	13%
1 to 2	4	25%
3 to 4	3	25%

Figure 25 – And what percentage of the total number of consultant anaesthetists do their members represent?
Base: 7

Number of consultant anaesthetists	Number of groups	% of groups
Less than 5%	1	14%
6% - 10%	2	29%
11% to 20%	-	
21% - 35%	1	14%
36% - 50%	2	29%
51% - 65%	-	
66% - 80%	1	14%
81% or more	-	

The majority of Groups indicated that emergency cover was expected to be provided by both anaesthetists (47%) and surgeons (66%) for the duration of stay.

Figure 26 – What is the duration of emergency cover expected to be provided by anaesthetists and surgeons, as stated in the grant of practice privileges? Base: 32



Duration of emergency cover for anaesthetists	Number of groups	% of groups
Over the first post-op night	4	13%
24 hours	5	16%
48 hours	-	-
72 hours	2	6%
Duration of stay	15	47%
Other	1	3%
Don't know	5	16%

Duration of emergency cover for surgeons	Number of groups	% of groups
Over the first post-op night	-	-
24 hours	-	-
48 hours	-	-
72 hours	1	3%
Duration of stay	21	66%
Other	-	-
Don't know	10	31%

Seven Anaesthetic Groups (47%) indicated that the maximum travel distance expected from the base hospital, as stated in the grant of practice privileges, was 6 to 10 miles. Seventeen groups (57%) indicated that the maximum travel time expected was between 15 and 30 minutes.

Figure 27 – What is the maximum travel *distance* expected from the base hospital, as stated in the grant of practice privileges?
Base: 14

Travel time	Number of groups	% of groups
6 to 10 miles	7	47%
11 to 20 miles	4	27%
21 to 30 miles	4	27%

Figure 28 – What is the maximum travel *time* expected from the base hospital, as stated in the grant of practice privileges?
Base: 30

Distance	Number of groups	% of groups
15 to 30 minutes	17	57%
31 to 45 minutes	8	27%
46 to 60 minutes	5	17%

Almost half of groups (48%) indicated that the maximum travelling time from home to their base hospital for their partners was 15 to 30 minutes, and 63% indicated that this was also the minimum travelling time. Twenty six of the 31 groups (84%) indicated that the average travelling time was less than 15 minutes.

Figure 29 – What is the minimum, maximum and average travelling time from home to base hospital for your partners?
Base: 31

	Less than 15 mins	15 – 30 mins	31 – 45 mins	46 – 60 mins	61 – 90 mins	91 mins or more	Don't know
Maximum	6% (2)	48% (15)	29% (9)	3% (1)	-	3% (1)	10% (3)
Minimum	23% (7)	63% (19)	3% (1)	-	-	-	10% (3)
Average	84% (26)	10% (3)					6% (2)

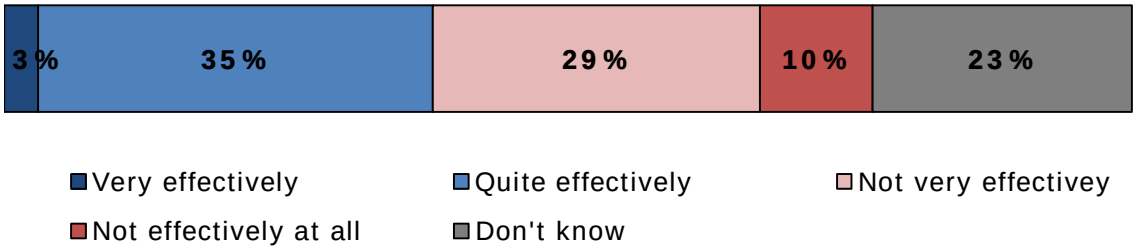
The majority of groups were unaware of the maximum, minimum and average travelling time home to base hospital for other consultant anaesthetists working at their base hospital.

Figure 30 – What is the minimum, maximum and average travelling time home to base hospital for other consultant anaesthetists working at your base hospital?
Base: 30

	Less than 15 mins	15 – 30 mins	31 – 45 mins	46 – 60 mins	61 – 90 mins	91 mins or more	Don't know
Maximum	-	23% (7)	13% (4)	3% (1)	13% (4)	10% (3)	37% (11)
Minimum	7% (2)	31% (9)	14% (4)	7% (2)	-	-	41% (12)
Average	43% (13)	7% (2)	7% (2)	7% (2)	-	-	37% (11)

Twelve Anaesthetic Groups (37%) thought that competition between anaesthetists in their locality operated effectively in some way. 39% did not, and 23% did not know.

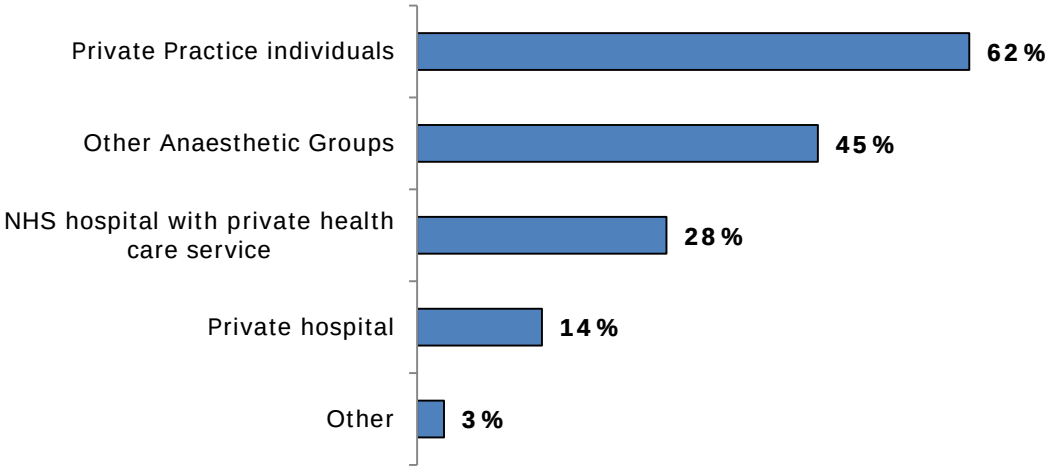
Figure 31 – How effectively do you think competition between anaesthetists operates in the private healthcare market in your locality?
Base: 31



How effectively?	Number of groups	% of groups
Very effectively	1	3%
Quite effectively	11	35%
Not very effectively	9	29%
Not effectively at all	3	10%
Don't know	7	23%

'Private Practice individuals' were seen to be the main competitors by Anaesthetic Groups, suggested by 62% (18 groups). This was followed by 'other Anaesthetic Groups' at 45% (13 groups).

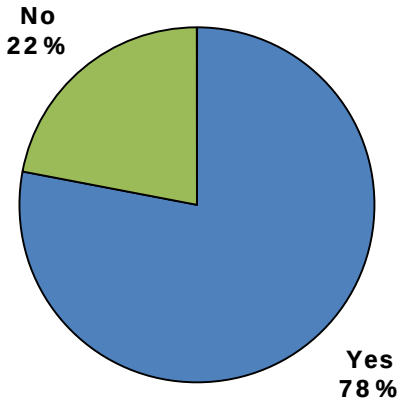
Figure 32 – Who are the main competitors for your group locally?
Base: 29



Main Competitors	Number of groups	% of groups
Private Practice individuals	18	62%
Other Anaesthetic Groups	13	45%
NHS hospital with private health care service	8	28%
Private hospital	4	14%
Other	1	3%

The majority of Anaesthetic Groups (78%) indicated that they provided on call rota and 24/7 emergency cover.

Figure 33 – Do you provide on call rota and 24/7 emergency cover?
Base: 32



Do you provide on call rota and 24/7 emergency cover?	Number of groups	% of groups
Yes	25	78%
No	7	22%

Those groups which did not provide on call rota and 24/7 emergency cover explained what other arrangements they made to provide emergency cover:

- *No rota - partners cover their own cases for 72 hours, or arrange for another partner to cover them if unavailable*
- *We have a rule that the first post operative night is the anaesthetist's responsibility - they arrange a colleague to cover if they can't be available. Weekend cover is nominally the individual who has a Saturday list*
- *No on call rota but Group members always available for emergencies, surgeons contact their regular anaesthetist. Out of hours anaesthetists cover patients they have anaesthetised themselves, unless cross cover has been arranged*
- *The anaesthetist who anaesthetised the patient is always the first point of contact*
- *We cover our own patients*
- *Each do their own*
- *Individual arrangements*

The number of partners that had left the Anaesthetic Group's partnerships over the last five years for reasons other than retirement ranged from zero to five.

Figure 34 – How many partners have left the partnership over the last five years for reasons other than retirement?
Base: 32

Number of partners	Number of groups	% of groups
None	3	9%
One	8	25%
Two	12	38%
Three	3	9%
Four	4	13%
Five	2	6%

Reasons provided for partners leaving included:

- *Deceased*
- *Deceased and another left to pursue individual private practice*
- *Did not wish to do any private practice*
- *Didn't need the extra income and did need the extra time!*
- *Didn't want to get up at night and didn't need the money*
- *Don't need the money. Time too onerous. Partner in full time work as well.*
- *Due to falling income in relation to work carried out (More NHS work and adherence to BUPA insurance rates)*
- *Due to relocation and not finding group work financially viable*
- *Emigration to Canada and to concentrate on pain work as an individual:*
- *Emigration, PP not worthwhile*
- *Improved work life balance and family illness*
- *Increased earnings outside the group (chronic pain practice)*
- *Increased NHS commitments, including management posts*
- *Left the area*
- *More predictable working as has fixed lists.*
- *Moved location*
- *Moving from area Stopping private practice*
- *Moving NHS job. Deciding to work as single practitioner*
- *no need for financial benefit of PP*
- *Not worth the hassle Work-life balance precludes against private practice, with reducing fees and ever more aggressive PMIs and hospitals.*
- *One had a child and did not wish to continue private work. One chose to stop private work to look after his children to allow his wife to return to work.*
- *One has left the practice to concentrate on chronic pain (not covered by the group) One has become Medical Director at the local Trust and withdrew for conflict of interests Three others have withdrawn for social reasons and the declining economic benefits of being committed to private practice. Two others will be withdrawing in the next two months*
- *Personal*
- *Private practice more trouble than the financial return was valued*
- *Stopped doing PP work*
- *To do solo pain*

- *Two wanted to cease independent practice for family reasons and one to pursue solo chronic pain independent practice.*
- *Went part time*
- *Work-life balance*

The number of partners that had left the Anaesthetic Group's partnerships over the last five years for reasons other than retirement ranged from zero to five.

Over half of groups (53%) reported that no partners had reduced their commitment to the partnership over the last five years.

Figure 35 – How many partners have reduced their commitment to the partnership over the last five years?
Base: 32

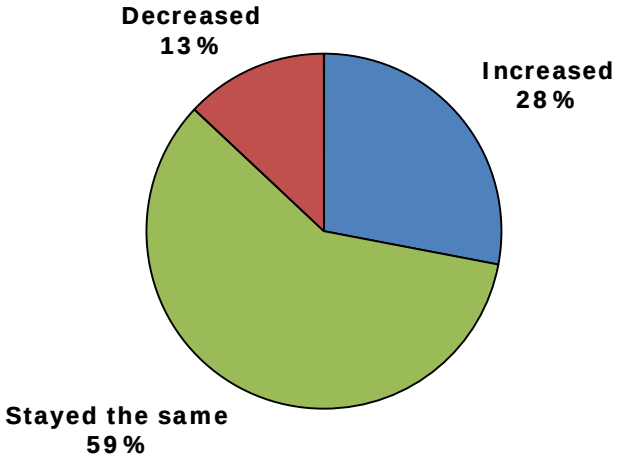
Number of partners	Number of groups	% of groups
None	17	53%
One to two	11	34%
Three to five	4	13%

Reasons provided for partners reducing their commitment included:

- *Age*
- *Didn't want to spend so much time at work*
- *Family - new baby*
- *Family obligations*
- *Increased NHS time commitment*
- *More free time.*
- *More personal time*
- *Not worth the hassle Work-life balance precludes against private practice, with reducing fees and ever more aggressive PMIs and hospitals.*
- *One voluntary sabbatical and one wanted to go to half share*
- *Period of extended unpaid leave for travel*
- *Personal health reasons, family health reasons, opted out of Sunday working, personal choice*
- *Stress*
- *Work life balance*
- *Work life balance, changing NHS commitments*

Over half of Anaesthetic Groups (59%) indicated that the proportion of male to female partners had remained the same over the last five years.

Figure 36 – Has the proportion of male to female partners changed in the last five years?
Base: 32



Change in the proportion of male to female partners	Number of groups	% of groups
Increased	9	28%
Stayed the same	19	59%
Decreased	4	13%

Those who had reported a change in the proportion of male to female partners in the last five years additionally indicated how much this had changed. A third of these groups (31%) said that the proportion had changed by less than 5%.

Figure 37 – By how much has this proportion changed?
Base: 13

Change of proportion	Number of groups	% of groups
Less than 5%	4	31%
6% - 10%	3	23%
11% - 15%	3	23%
16% - 20%	2	15%
41% - 50%	1	8%

COMMENTS

Ten Anaesthetic Groups provided examples of competition between their group and other individual consultants or groups, and the resulting effect on fees. These are shown below:

- *Anaesthetists from other hospitals were specifically approached to provide for NHS lists, and subsequently they have taken on private work that formerly would have we gone to our group*
- *Attempted to agree that Surgeons and Anaesthetists should be paid the same for NHS work. "All" anaesthetists agreed prior to meeting with private hospital. At the meeting non-group anaesthetists stated that they would work for less than their surgeons for NHS work.*
- *BUPA told patients to go to Norwich (one hour away) as they charged within anaesthetic BUPA schedule. Surgeons and BMI hospital (Kings Lynn) put pressure on anaesthetists to charge BUPA rates or they would get anaesthetists from outside. Kings Lynn anaesthetists have agreed to not charge patient excess to BUPA/Aviva and AXA although fees stay the same. Subsequently we have found out Norwich do charge patient excess*
- *None, both groups co-exist harmoniously. We mostly work in different clinical fields (our group is predominantly plastic and cosmetic surgery). We often cross cover each other if partners within the group are unavailable*
- *Other consultants working in the area set their own fee schedules*
- *Our base hospital proposed cosmetic work with very low clinician fees; our group declined the work and the hospital contracted anaesthetists from London*
- *Our group competes within our NHS hospital and within the local private hospital. Another local group recently gained a contract to do dental work, ahead of us*
- *Some insurance companies may advise their patients to go elsewhere as the fees may be lower. Some insurance companies offer cash incentives to the patient to use the NHS. Our fees do not change as there is no discussion between groups on fees*
- *We are in competition with other consultants and other private practice groups. Occasionally we are asked to reduce fees and we usually do. It is up to the individuals within the group as to how they respond*
- *We have significant competition from one other group, but not in our base hospital. However they do work in two NHS sites - our principle NHS hospital and the ISTC nearby. However competition does not seem to be driven by price! In our base hospital we have competition from non partnership members, but not driven by price - rather availability and in one case compatibility*

Ten Anaesthetic Groups provided examples of the relative quality of care provided by individual consultants, compared to that provided by their group. These are shown below:

- *All in one group*
- *All our patients are reviewed routinely which would not be possible if working individually*
- *All the individual consultants live considerably further away than Group members and do not provide cross cover when they have other commitments*

- *'External' consultants were brought in from out of area to do NHS lists. Several clinical concerns were raised including at least one critical incident. This has largely now stopped*
- *Individuals can't cover patients they have anaesthetised 24/7, because of their NHS commitments. We always have an on call consultant available 24/7*
- *Our group provides 24 hour 365 day cover. Some of the individual anaesthetists cannot provide that cover, and we have provided emergency care, and dealt with acute pain issues for patients of our "competitors". At present we do this simply out of good will. Because the group has a fairly constant presence during the week, issues on the wards are frequently dealt with by partners. Advice is also given to the nurse lead pre-assessment service. We also provide an anaesthetic lead pre-assessment service*
- *Specialist anaesthesia matched to patient need e.g. paediatric, orthopaedic etc immediate access to NHS critical care facilities if required emergency cover 24/7*
- *There have been an incident where one was unable to be contacted in an emergency and our group has provided anaesthesia support in the middle of the night*
- *We provide a regular presence in the hospital*
- *We have sorted out problems in recovery or on the wards when the anaesthetist from rival group has been un-contactable or unavailable. We can provide 24 hour 7 day a week availability for our patients in the independent sector as well as offering an evening pre-assessment clinic*

18 Anaesthetic Groups provided examples of clinical incidents affected positively or negatively by their group. These examples are listed below:

- *24 hr emergency cover. No problem finding an anaesthetist. All work in same unit good protocols*
- *A return to theatre for post-thyroidectomy haemorrhage required emergency trachesostomy. A second member of the group was called in (after-hours) to help. There was a very good clinical outcome, helped by the team work created through group membership.*
- *An irregular anaesthetist came in to do an NHS list. Patient bled and needed to go back to theatre later the same evening. Original anaesthetist un-contactable and no-one knew who he was! Local group had to cove the case.*
- *As above - take backs to theatre of bariatric patients with suspected bowel leaks, transfer to local critical care units, helping out if able with cardiac arrest calls on the ward.*
- *Bleeding patient, non Group consultant took over an hour to attend for return to theatre, satisfactory outcome for patient (group members were contacted when initially the consultant could not be raised) Independent consultant was on flight abroad when hospital tried to contact for a treatment enquiry, no cross cover had been arranged. No adverse effects for the patient*
- *Emergency returns to theatre where original anaesthetist not available; emergency transfer to NHS ITU affected by other partners in the group where original anaesthetist not available; guaranteed take back to theatre for cosmetic surgery revisions within 12 months at no extra cost.*

- *Group provides 24 hour cover for the private hospital. There have been occasional critical clinical incidents where the on call anaesthetists have treated the patient before surgeon had seen the patient.*
- *If a patient becomes unwell and needs ICU then one of the intensivists from the group attend the patient for optimal stabilisation and transfer to ICU. We have sub specialities within the group so that patients have the best care, e.g. regional awake work performed by some but not all members of the group, paediatrics covered by paediatric trained anaesthetists, bariatric cases done by bariatric anaesthetists.*
- *On the rare occasions when ITU is required we are able to arrange transfer to our local NHS hospital fairly easily. Also if one of us is unavailable for an unexpected complication, another of us can always be contacted and will come in.*
- *Our internal "on call" system allows prompt response for emergencies. This is not the case for independent anaesthetists. In addition, as a group we manage patients on the HDU's well - there is one critical care consultant in the private sector every day who sees all complex patients from the previous day.*
- *Several examples of immediate availability of expert critical care support for medical emergencies through anaesthetic group.*
- *Taken cases back to theatre for other anaesthetists*
- *Two recent gynaecology patients who had major haemorrhage overnight post surgery; a partner attended within 15 minutes and provided life-saving resuscitation.*
- *We have helped stabilise and transfer patients to the NHS and also anaesthetised patients with complications who were initially anaesthetised by consultants outside the group (who couldn't attend for the emergency operation).*
- *We have provided a 24/7 emergency call out service. With one patient who had arrested post operatively we were able to provide two intensive care specialists and a third anesthetized, and been able to effect a transfer directly into an ITU in an NHS hospital. With local knowledge, we frequently act as liaison to medical opinions for our surgeons.*
- *We provide 24 hour/365 day cover for emergencies and a post anaesthesia high care unit*
- *We provide transport services for patients who become critically unwell (twice in the past year).*
- *Yes, we proved a transfer service to our local ICU and have been called to assist in cardiac arrest situations in medial patients*

APPENDIX B

Independent Departments of Anaesthesia

In its market investigation reference to the Competition Commission (CC), the Office of Fair Trading (OFT) raised the issue of whether consultant anaesthetists who work in groups can distort local markets and are more likely to charge patients 'shortfalls'[1]. The CC presents limited evidence in the annotated issues statement that some Anaesthetic Groups may charge higher fees than independent anaesthetists, but makes no comment on the potential justification for this in terms of quality or safety[2]. Indeed, the CC's views on Anaesthetic Groups seem to be currently based only on the views of complainants. This document seeks to explain the benefits of Anaesthetic Groups so that the CC has a more balanced and detailed understanding of how they function, and why.

In this document, Anaesthetic Groups will be referred to as **Independent Departments of Anaesthesia (IDAs).** This is a term that more accurately describes the nature of a group of consultants who, through working in partnership, are able to bring to their patients in independent hospitals the same range of benefits offered to patients in an NHS hospital by an NHS Department of Anaesthesia. We will address issues relating to competition and clinical governance.

Competition

If IDAs follow the Code of Practice recommended by the Association of Anaesthetists of Great Britain & Ireland (AAGBI)[3] by giving patients estimates in advance of surgery whenever possible and by documenting the quality and scope of care they provide, patients and surgeons are free to accept or reject their services. This applies equally to individual anaesthetists.

The OFT's assertion that "Anaesthetic Groups… may reduce price competition in local markets"[1], a view that also appears in the second theory of harm in the CC's annotated issues statement, is based on evidence provided by Private Medical Insurers (PMIs) that has not, as far as we are aware, been independently verified. We would welcome the opportunity to examine this evidence and comment upon it. The CC's annotated issues statement appendix C[4] suggests that the IDA fees are higher than the regional average in only one of three case studies, using six index procedures, two of which are inappropriate[5]. We look forward to seeing an expansion of these preliminary observations.

The legal and financial arrangements of IDAs vary markedly and it is therefore difficult to generalise about their impact – if any – on local markets. 31% are informal partnerships and 6% are loose associations of individual practitioners who have totally separate fee structures but who share administrative facilities[6]. 62% are legally constituted partnerships, the members of which legitimately charge fees according to a unitary schedule as a 'single undertaking'[7].

IDAs were examined by the OFT; its 2003 report[7] determined that they did not infringe the Competition Act 1998. Little has changed in the structure of IDAs since 2003, other than an increase in the number of these departments on a national basis, a change that was driven in large part by the OFT's report.

74% of hospitals that benefit from the services of an IDA also accommodate individual practitioners, who effectively compete with the IDA on quality and price[8]. The development and consolidation of IDAs has, in turn, encouraged competition between different IDAs whose areas of activity overlap geographically and clinically. 58% of hospitals accommodate more than one IDA and 35% have three or more[9]. 87% of IDAs could compete in neighbouring hospitals outside their base hospital if they wished[10] and 92% of these hospitals have competing IDAs[11]. There is no reason to think that this competition would not continue to

[1] http://www.oft.gov.uk/OFTwork/markets-work/private-healthcare/#.ULY0h4WH9Tc
[2] http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130228_final_ais.pdf
[3] http://www.aagbi.org/sites/default/files/code_of_practice_08.pdf
[4] http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/ais_app_c_toh_2.pdf
[5] AAGBI Response to CC annotated issues statement 2013
[6] Appendix A. Fig 2
[7] http://www.oft.gov.uk/OFTwork/competition-act-and-cartels/ca98/decisions/anaesthetists-groups#.UK5iY4Ux9Tc
[8] Appendix A. Fig 22
[9] Appendix A. Fig 19
[10] Appendix A. Fig 20
[11] Appendix A. Fig 21

increase, particularly if the market distortions caused by the PMIs and hospital operators are remedied by the CC.

The existence of IDAs creates no barriers to the recruitment of consultant anaesthetists to independent hospitals. Medical Advisory Committees do not encourage the existence of 'closed shops', and admitting rights are granted on the basis of training, experience and regulatory criteria, often at the request of a surgeon. If the hospital management, patients and surgeons are happy with the services provided by an IDA, there is no reason to encourage recruitment of other anaesthetists. However, some independent hospitals or surgeons have recruited individual consultant anaesthetists or groups of anaesthetists from outside their area to provide services previously offered by a local IDA[12]. Similarly, most IDAs offer their services to hospitals outside their immediate geographical area, with 30% earning more than 30% of their income in this way[13]. Therefore, it can be argued that IDAs do not prevent competition, but form part of a competitive environment with other IDAs and independent individual anaesthetists. We do not recognise the situation in which a 'solus' hospital is effectively obliged to engage the services of a single IDA that is then at liberty to charge higher than reasonable fees without regard to local competition[14]. In cases where an IDA accounts for a large proportion of a hospital's anaesthetic work, the IDA is effectively constrained by the potential entry of neighbouring IDAs and individual anaesthetists.

The reason that most IDAs are successful in bidding for local work is because of the additional benefits they bring to the patients, the hospitals and the surgeons. These benefits, in terms of patient safety, improved governance, patient convenience and the quality of care, and the constraint from potential competition from neighbouring IDAs, have not been acknowledged in the OFT report[1] or in the CC annotated issues statement[2]. These issues are however critical to an understanding of the relevant market forces and are therefore described below.

Clinical governance and safety

As a result of their structure, shared expertise and ability to provide continuous, flexible cover, IDAs can provide a more consistent, reliable and therefore safer service to patients, surgeons and hospitals than can most individual anaesthetists. In this section, we list some of these benefits of IDAs under ten headings.

(1) Emergency postoperative care, emergency surgery and emergency transfer

Life-threatening complications are not uncommon and can occur even after relatively minor surgery, or in patients who have not undergone surgery[15]. It is standard practice for patients who become acutely ill in NHS hospitals to be attended rapidly by the anaesthetists made available round the clock by the NHS Department of Anaesthesia. The clinical skills needed in these situations, those of resuscitation, intensive therapy and inter-hospital transfer, are possessed by very few surgeons and independent hospital Resident Medical Officers (RMOs). IDAs usually provide reliable and highly experienced 24/7 emergency care for any acute situations that arise in any patient in the independent hospital, including out-patients and non-surgical patients. 78% of IDAs have an "on-call" rota that is wholly separate from any NHS on-call rotas that the members of the IDA may also service, thereby guaranteeing the availability of a skilled clinician around the clock[16]. IDAs do not customarily charge separate, additional fees for this service. The 22% of IDAs that do not have a formal on call rota have systems in place to provide a reliable service, aided by the ability to easily request cross-cover or assistance when necessary[17].

It is standard practice for individual consultant anaesthetists to provide emergency cover to a patient for the first 24 hours or more after surgery in the independent sector[18]. However, in reality, the anaesthetist may well have duties elsewhere within this period, and may therefore be unable to provide such cover reliably. Overnight, if the original individual anaesthetist is unavailable because of other duties and commitments, there can be considerable uncertainty as to whom should be called should a problem arise. Other individual consultant anaesthetists may have an understandable reticence when asked to attend a patient of whom they have no knowledge, for whom they have no responsibility and with whom they have no financial agreement.

Members of an IDA are likely to live close to the hospital for which the IDA provides services, thereby accelerating clinical response times, with an average response time of less than 15 minutes for 84% of IDA

[12] Appendix A.Comments
[13] Appendix A. Fig 8
[14] Appendix A. Comments
[15] Appendix A. Comments
[16] Appendix A. Fig 33
[17] Appendix A. Comments
[18] Appendix A. Fig 26

partners, compared with 43% of independent anaesthetists[19]. The AAGBI's guidance on Independent Practice[20] sets the limit of an anaesthetist's clinical responsibility as the time at which the patient is awake, stable and free from significant pain, nausea and vomiting. After day-case surgery, the patient may reach this status a few minutes after the end of the operation. Even after intermediate and major surgery after which the patient remains in hospital overnight, this status is often reached within the first 24 hours, and the anaesthetist can then legitimately and reasonably cease to be available to the patient as part of the contracted clinical care. At this stage, the consultant surgeon usually takes on overall clinical responsibility[21]. The consultant anaesthetist who gave the anaesthetic but is no longer clinically responsible may not be within a reasonable travelling time at this stage, may not be immediately contactable and, even if contactable, may not be available[17]. This situation is very different from the service provided in the NHS, where reliance is placed on each hospital's Department of Anaesthesia and the 24-hour cover it provides. Indeed, if the care provided to patients in independent hospitals is to match that provided to NHS hospitals, it is arguable that some form of IDA-provided cover should be the norm. As the changes created by the Health and Social Care Act send an increasing number of NHS patients for treatment to independent hospitals, it is important that the standards of clinical care there at least match those in the NHS. There can be no doubt that complications do arise and delays do occur because of the non-availability of consultants and the lack of an effective on-call service[22].

In the event that further emergency surgery is required, an IDA is usually able to provide a suitably skilled consultant anaesthetist very quickly, while individuals, for the reasons described above, may be less able to respond promptly[17]. Significant delays may threaten a patient's health or rarely their life[23]. For *non-surgical emergencies*, an IDA would not only be more likely to provide an anaesthetist quickly, but would also be able to summon a colleague with specialised intensive care and inter-hospital transfer skills were these are necessary[17]. Again, delay and inadequate transfer standards from private hospitals do impact on patient safety[24]. When such transfers are required in a small town or city, it is quite likely that the consultant anaesthetist and NHS intensive care consultants are part of the same IDA[17]. This will facilitate communication and the practicalities of transfer. Surgeons therefore greatly value the reassurance that an IDA can provide in optimising emergency care when it is required. The consequences of delayed or inexperienced management are such that these situations can be life or limb-threatening.

(2) Routine postoperative care, acute pain management, fast-track surgical programmes (Enhanced Recovery)

For the reasons given above, routine postoperative care can be administered effectively and consistently by an IDA. Members of an IDA are nearly always available to visit patients, discuss problems and offer advice to surgeons, RMOs and nurse[17]. A rota is usually implemented to ensure that a named individual is immediately contactable and available during the working day, as well as out of hours[18]. One of the IDA members will almost always be on site during the day, working in the operating theatre. Postoperative visits can be organised and coordinated in a way that is unlikely to be matched by individual practitioners who cannot expect to be available at all times in the postoperative period. Common matters in which consultant anaesthetists are involved after surgery include acute pain management, fluid balance treatment, symptom management and complications of the respiratory or cardiovascular systems[17]. Clearly, these areas demand a reliable and rapid response – IDAs have the capacity to deliver this consistently, thus enhancing the quality of postoperative care. This is especially important in "Enhanced Recovery" or 'fast-track" surgical pathways, in which attention to detail in these aspects of peri-operative care are crucial in achieving excellent outcomes, faster recovery from surgery and early discharge from hospital. Importantly, these fast-track systems are associated with shorter hospital stays and lower morbidity, with consequently lower costs incurred by both hospitals and insurers. An IDA can be pivotal in optimising compliance with these pathways, as they are usually the same protocols used in the local NHS hospitals[17].

(3) Improving the overall standard of care

[19] Appendix A. Figs 29 and 30

[20] http://www.aagbi.org/sites/default/files/independent_practice_08_1.pdf

[21] Appendix A. Fig 26

[22] http://www.telegraph.co.uk/health/healthnews/6840389/Consultants-who-live-too-far-from-hospital-put-patients-at-risk.html. This newspaper article describes a death in a private hospital, when the Consultant Anaesthetist and surgeon could not attend an emergency in a private hospital as quickly as was required. 13 other serious incidents relating to delays in attendance of key staff were also identified.

[23] http://www.harrowtimes.co.uk/news/8460363.Hospital_death_file_handed_to_criminal_prosecutors/. This is a newspaper report describing the death of a patient, where the surgeon could not find an anaesthetist quickly enough, resulting in a manslaughter charge.

[24] http://www.telegraph.co.uk/news/uknews/6968111/Woman-dies-after-catastrophic-blunders-at-private-hospital.html. This is a newspaper report, where poor practice in arranging and carrying out an inter-hospital transfer contributed to the patient's death.

IDAs tend to be closely involved in the governance and development of independent hospital services. IDA members have a broad skill-set to call upon, and often assist in the training of nursing staff, anaesthetic assistants and the induction of RMOs. An IDA will have a large portfolio of specific expertise and is more likely to use learning from NHS departments to drive safety and quality improvements by the provision of protocols replicated from their local NHS institutions, acquisition of appropriate, standardised equipment to enable a high quality service, and developments such as fast-track surgery and Enhanced Recovery[17]. An IDA will usually provide representation on the Medical Advisory Committee (MAC), overseeing appraisal and promotion of clinical governance procedures. An IDA will be able to feed information into a MAC from all its members, provide cohesive feedback from IDA members, and respond actively to identified needs. The benefits in standardisation and reliability of care are clear and cannot be replicated by anaesthetists working in isolation.

(4) Independence from surgical ties

A further benefit of an IDA is that the consultant anaesthetist members will have greater independence from individual surgeons when compared with individual consultants, who are likely to be tied to and dependent upon a limited number of surgeons. This allows the IDA consultant to deliver more patient-centred care.

(5) Pre-assessment

Patients increasingly require anaesthetic assessment before surgery. This decreases the number of last-minute cancellations of operations, which is clearly of benefit to patients, hospitals and insurers. Formal pre-operative assessment may be problematic to organise when the anaesthetist is independent, as only they will assess any patient they may subsequently anaesthetise. With an IDA, as happens in the NHS, pre-operative assessment can be streamlined, made routine and expedited. An IDA member can be made available to field clinical enquiries that can often be resolved on the spot without a formal outpatient assessment. Formal pre-assessment clinics can be organised so that one anaesthetist (often one with a special interest in pre-operative assessment and optimisation) can assess several patients for the coming weeks, optimise their pre-operative preparation and communicate this to their IDA colleagues. The overall quality of the pre-assessment service given to patients is therefore enhanced by the presence of an active IDA.

(6) Efficient scheduling

Most surgeons and consultant anaesthetists are confined by NHS job plans such that their availability is difficult to match. Surgeons working with individual anaesthetists may have to adapt their private commitments to the availability of their preferred anaesthetist. An IDA allows surgeons to work much more flexibly, without having to be limited or delayed by arranging an anaesthetist. This minimises delays for patients, allows optimal theatre scheduling, makes the most efficient use of the surgeon's time and is ideal for hospital management.

It is not infrequent for a patient to request an anaesthetist who has previously anaesthetised them when attending for further surgery. This type of patient-centred care can be accommodated by an IDA but is often more difficult for a lone, independent anaesthetist.

(7) Skills matching

Patients attending independent hospitals are becoming older, and consequently have more co-morbidities and increasingly complex needs. Several patients having the same surgical procedure may benefit from having different anaesthetists, e.g. a patient with severe heart problems may benefit from the skills of a specialist cardiac anaesthetist, another with a 'difficult airway' may require skills this anaesthetist does not possess and a child on the same list may need a paediatric anaesthetist[17]. An IDA will find it easier to match the anaesthetic skills needed to the patient's clinical situation by allocating individual consultant anaesthetists according to clinical requirements. When necessary, an IDA can often provide two anaesthetists to care for complex patients or complex procedures[17]. The benefits of flexibility and skill-mix cannot be overstated. These practices are routine in any NHS hospital and only an IDA can provide this level of flexibility and patient-centred care in the independent sector.

(8) Administration

IDAs usually employ full-time administrators[25]. The department administrator is available to patients, insurers, pre-assessment nurses, surgeons, hospital managers and others to ensure that the necessary information is available to all as quickly as possible. Co-ordination of practice activities is fast and efficient, particularly when an unanticipated problem occurs.
Billing is centralised, so that the hospitals and insurers have lower administrative costs and fewer delays than when dealing with individuals. IDA administration costs may be higher because of these benefits,

[25] Appendix A.Fig 4

compared with individual anaesthetists. In this way, IDA administrative staff help to limit the alleged lack of information that the CC is assessing under its sixth theory of harm.

(9) Patient information and communication

IDAs are more likely than individual practitioners to have systems that provide patients and others with information - these include leaflets, websites, fee calculators, outcome data, anaesthetist profiles, advice on preparation for surgery, and information about anaesthesia and pain-relieving procedures. IDAs are more likely to have the capacity to keep these resources up-to-date. Again, this helps to mitigate against the CC's sixth theory of harm.

(10) Group communication and governance

Communication with and between members of an IDA is simple and effective. Organisational and clinical matters are easily and regularly discussed, and some IDAs are developing Morbidity and Mortality (M&M) meetings and other group learning activities. Most IDAs have regular governance meetings at which group clinical and financial practice can be reviewed, brought up to date and kept in line with best practice. These may include the development of new protocols, equipment and the reporting of problems or critical incidents. These functions serve to strengthen the quality of service provided by IDAs in a reliable and powerful way.

Conclusions

This document should not be taken as a criticism of the standards of care delivered by solo consultant anaesthetists (who according to the CC's survey make up the majority of anaesthetists[26]) in independent hospitals in the UK. It is possible for individual consultants to offer high-quality care, but it is argued here that coordinated and efficient IDAs provide the highest quality of care – a standard of care that can match that provided to NHS and private patients in NHS hospitals. IDAs can also offer extended options for patient care and information that it would be difficult for solo practitioners to provide. We do not argue that the only acceptable model in independent hospitals is the IDA, but we do argue that those hospitals that have IDAs are in a better position to offer enhanced services to patients. The two most important aspects of these enhanced services are round-the-clock and immediately available expert cover, and the matching of extended clinician skillsets to patient needs.

We will not seek to become involved in debate about whether consultants in IDAs charge higher fees than individual consultants, but we will put forward the following two arguments that could be used to justify the fees charged by consultants in IDAs. Firstly, and quite simply, IDAs and their consultant members offer enhanced clinical services to private and NHS patients in independent hospitals, and it is readily arguable that greater and safer services should attract higher fees. Secondly, and particularly in view of these enhanced services, the fees charged by IDA members are still consistently less than those charged by surgeons, whose training and responsibility is now widely accepted to be no different than that of anaesthetists, and whose skills, experience and time input into individual cases is usually no more and often actually less than that of the anaesthetist. Anaesthetists in general offer good value; anaesthetists working in IDAs offer excellent value.

[26] Annotated Issues Statement, para 78(a)