THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

Response to the Competition Commission Draft Consultant Questionnaire

October 10, 2012

General comments

AAGBI are concerned that this survey will provide inadequate data about anaesthetists, the largest speciality working in the private healthcare industry. Therefore, the Competition Commission (CC) may have difficulty in justifying robust conclusions about the way anaesthetists function in this market, particularly if reliance is to be placed on unverified data submitted by the insurers.

Sections C, D, F and G are not applicable to anaesthetists and we suggest the questions have an additional option of "not relevant".

AAGBI would be pleased to assist the CC in creating a survey specifically for anaesthetists, or helping provide additional questions for anaesthetists in this survey.

Comments on individual sections and questions

A. Screener Section

Re 1.1. Although Specialist Registrars and SAS doctors are excluded from this survey, they are the future consultants and the future private healthcare workforce. It might be worth surveying their opinion on some of the issues addressed, particularly regarding their intentions.

Re 1.3. If a consultant does no private work, they are not asked any more questions. It is the AAGBI view that consultants are increasingly giving up private work as it is not worth the additional time, stress and responsibility. This could create a supply problem in the future that will reduce the effect of competition. It would be useful to explore the reasons why consultants don't do private practice, what might encourage them to do it in the future and if they have done private practice in the past, why they have given it up. Some of the following reasons for not doing private practice might be suggested;

No time
No opportunity
Morally opposed
Too stressful
Inadequate hospital facilities
Can't get admitting rights
Not financially worthwhile
Content with current income
De-recognised by insurers

Disapprove of the actions of insurers

Re 1.4. There is no mention of general surgery or vascular surgery. Although this will be picked up under "other", these specialities are larger than most of the others that are specified.

B. Patient Population

Re 1.5. A consultant surgeon will "see" many more patients as outpatients than they treat. Some consultants will only "see" patients because they have presented for treatment or investigation, eg, anaesthetists, radiologists. Treatment is the main income generator. It might be worth clarifying what is meant by "seen", exploring the number of patients seen as outpatients, the number referred for further investigation and the number requiring a treatment procedure.

Re 2.0. This refers to Q 1.5. If this is interpreted as the number of patients "seen" as outpatients, many consultants may not know the funding arrangements of the patients they see who do not proceed to treatment. Some consultants may not know the funding arrangements of patients they treat, as they may regard them all as "self-pay", having no interest in their insurance arrangements, submitting an account to the patients which they are expected to forward to their insurance company if appropriate.
As well as "self-pay" and "private medical insurance", there are other funding arrangements. We suggest a further option, i.e. "other".

Re 2.1. We suggest adding a further option; "I have time available, but do not wish to use it for private work". This is not the same as "I am happy with the amount of private work I do".

Re 2.2. Some options could be inserted, similar to those described above, ie;

Need the time for other activities
Too stressful
Reducing opportunities
Inadequate hospital facilities
Not financially worthwhile
Content with a lower income
De-recognised by insurers
Disapprove of the actions of insurers
Due to retire

Gynaecologists are excluded from the rest of the survey. We suggest this is inappropriate.

C. Relationship between specialist consultants and private facilities.

Re 2.3. We suggest you change option 3 to omit "my own". Many consultants work from rooms that are not owned by them.

Re 3.0. You may wish to specifically ask if any hospital threatens withdrawal of practicing privileges if the consultant promotes the development of local competition and/or has a financial interest in a new competing facility. We understand that such restrictions are in place at a number of private hospitals. If this is the case, consultants may answer "Yes" to Q 3.4 and specify the restriction, but many may not consider this as a relevant restriction and will therefore answer "no".

D. Relationship with patients/hospital

This section only applies to consultants who are directly referred patients, eg surgeons and physicians. Many consultants working in the private sector are in supporting specialities, ie, anaesthesia, radiology and pathology, will have no influence over the choice of private facility and will be unable to answer any of the questions in this section. It is unclear how these consultants should approach this section. They may answer "other" or "don't know", but this will distort the data. We suggest you qualify the questions by making it clear in the stem that this section only applies to consultants who take direct referrals and are the "primary" consultant in the patient journey. Those consultants in supporting specialities should be instructed to go to the next section.

E. Relationship between specialist consultants and insurers

Re 4.1. We are unclear about the reason this question is being asked. In the current format, you will find out how many consultants deal directly with the various insurers, by-passing the patient, and by inference are "recognised" by the insurers. Is this your intention?
Insurers do not reimburse consultants, they reimburse patients, even when they pay consultants directly. This may sound semantic, but it is an important distinction. Many consultants send their invoices direct to the insurer, by-passing the patient at the insurer's request, but this is still "on behalf" of the patient, with whom the consultant often has the only contractual relationship. We suggest the stem is adjusted to; "Which, if any, of the following private medical insurers would partially or fully *pay you directly* for treating the patients they insure?"

Re 5.0. We suggest you carefully define what you mean by a "group", or give a series of options. If this is omitted, it will be difficult to make any realistic conclusions. Everyone could claim that they work as a group in some way or another.

Re 6.0. We suggest a further option; "As a percentage of the surgeon's fee".

Re 10.1. Many consultants set their fees as the maximum the insurance company will pay. Therefore, they should select all of the options 1-7. Although you state "select all that apply", the stem infers that only one or two should be selected. More clarification would be helpful.
It would also be useful to know if consultants have entered into any agreement with insurers that requires them to abide by the insurers published benefit maxima, as this will profoundly influence their answers to this question.

Re 10.2. It would be very useful to know this information according to each insurer. For example, the AAGBI survey showed that fees were almost always within the WPA benefit maxima. We also believe that it is important to define the actual amount the fees are above the insurer benefit maxima, as an absolute amount and/or as a proportion. Otherwise, there is no distinction in the survey between those who charge fees that are 1% and 1000% above the benefit maxima.

Re 10.3. We suggest that rather than asking what "usually" happens, it would be more useful to know how often each of these scenarios apply. In addition, this question assumes that the patient knows the consultant fee in advance of treatment, in accordance with good practice guidance. It would be interesting to know what happens when a top up fee is unanticipated? This would require separate questions, firstly to determine what proportion of patients receive an estimate in advance of treatment and secondly, what happens when they don't. Do consultants then reduce their fees when requested to do so, write off the debt, or seek the outstanding fees by sending reminders, using debt collectors or

taking legal action? It is the AAGBI view that the vast majority of patient dissatisfaction regarding top-up fees, arising because of insurance benefit shortfalls, is when these are not anticipated. If estimates were provided to all, according to AAGBI, BMA and FIPO guidance, we believe this problem would be eliminated.

These questions should indicate the frequency of inadequate insurance benefits experienced by patients. We trust that this data will be matched to research about what patients believe the financial value of their insured benefits are and what the insurers actually tell them at the point of sale. It is our understanding that several insurers encourage patients to believe that all consultant fees will be covered by their policy in full, when this is untrue. The patient only discovers that they are under- insured when they make a claim, perhaps many years later. This is a major cause of patient dissatisfaction and would be straightforward to resolve---Insurers should be legally obliged to be transparent and honest about the benefits they provide.

There are only two questions relating to group practice, which is inadequately defined. The OFT criticised Anaesthetic Groups (AGs) and the Competition Commission Issues Statement specifically addresses AGs in the second Theory of Harm. AAGBI has limited information on the function of AGs compared with individual anaesthetic practitioners, is concerned that the CC may have inadequate data to inform the discussion and that this data has not been independently verified. Therefore, we suggest that this questionnaire is extended to further examine the risks and benefits of group practice:

1. Do groups charge higher professional fees than individual consultants?
2. If they do, is this more evident in some specialities than others?
3. Where groups exist, do they have competitors, either individuals or other groups, within a reasonable distance of the patient's home?
4. In the above respect, what is a reasonable distance/ travelling time, both for consultants and patients?
5. When anticipated, are consultant fees a significant issue affecting patient choice? In this respect, are anaesthetic fees more or less influential than the fees of other specialists? Do patients request an alternative consultant or move to another hospital when anticipated fees are higher than their insurer will pay or they can afford? Is this influenced by speciality?
6. Do groups have any benefits to offer patients, particularly regarding safety, quality of care, and flexibility that might justify any Adverse Effect on Competition?
7. Do groups offer economic advantages that can be passed on to customers?

To some extent, the existing questions will answer 1, 2 and 5, when the results are cross-referenced by speciality and group membership. We suggest that questions 3, 4, 6 and 7 are addressed by additional questions. We would encourage the submission of specific examples where groups claim advantages to patient safety, perhaps in the form of anonymised case histories. We suggest that questions 4-6 are further addressed in the patient survey.

AAGBI will be pleased to assist in the construction of any additional questions.

F. <u>Relations between consultants and GPs</u>

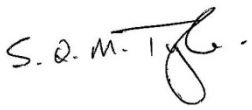
This section will be ignored by consultants in the supporting specialities and like section C, perhaps they should be directed to the next section?

G. Benefits

Consultants are unlikely to disclose this information and unless you are more specific, may not realise they are being offered a benefit. For example, preferential referral of NHS patients from waiting lists or "Choose and Book". Similarly, "Open Referral" by insurers to hospitals rather than individual consultants could result in managers directing patients to consultants in return for loyalty. "Open Referral" by insurers to consultants could also be regarded as a financial inducement. We suggest that you specify the inducements you consider relevant.

H. Demographics

It might be useful to know the age, but this can be inferred from 12.2 and 12.3. It would also be useful to know marital status, together with the employment and income of the partner. If the partner is a higher rate tax payer, consultants are less likely to be doing much private practice. It might also be useful to assess attitudes to work-life balance as it is our impression that younger consultants value free time and leisure more highly than older ones, being less likely to work long hours.



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