THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

Response to Competition Commission invitation to comment on OFT surveys

The Competition Commission (CC) has invited comments by interested parties on the OFT surveys, which they intend to use as evidence in their enquiry of the private healthcare market;

1. The Patient Journey. Opinion Leader August 2011
2. Population Overview. GHK August 2011
3. Survey Analysis Report. GHK August 2011

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) is an "interested party", representing over 10,500 anaesthetists in the UK and Ireland. Consultant Anaesthetists have been specifically mentioned in the OFT report and in the CC Issues statement, particularly regarding the function of Anaesthetic Groups in the marketplace. Therefore, we believe it is essential that accurate and relevant data is collected to inform this enquiry in the above respects and we believe we can greatly assist the CC in achieving this objective. The AAGBI appreciates the opportunity to comment and wishes to assist the CC in this enquiry. The AAGBI would also be interested to comment and assist in the vital content of the survey questionnaires, including the proposed patient survey, but cannot do so as we have not been sent the draft questionnaires.

THE PATIENT JOURNEY

Patients were universally satisfied with the process of referral by GPs, placing considerable trust in their judgement and recommendations, which patients both expected and preferred their GP to make. This is difficult to reconcile with the OFT's negative conclusions about GP referral, which appear to have been influenced by PMI opinion that was unavailable to third parties.

From the AAGBI perspective, it is notable that there were no negative comments about anaesthetists. This supports our view that the negative OFT conclusions about anaesthetists are grossly over-emphasised by the unreferenced PMI evidence and that anaesthetic fees are a minor consideration affecting the choice of surgical team, being most unlikely to influence a move to an alternative provider, when estimated in advance.

It is the AAGBI view that the private medical marketplace could be very simple and is only complex because of PMI obfuscation. The process applied by the self-pay patient should be applied to all. The providers should be encouraged to publish clear up front information on costs and on the quality of care offered, in an easily accessible standardised format, so that comparisons can be easily made. This should be accessible by patients or their delegated expert representative, like their GP, so that an informed choice can be made, without any other restriction. PMIs should make the financial benefits of their policies crystal clear to their customers at the point of sale and subsequent claim. The format should be specified by legislation, so that individuals, agents, employers or other third party representatives can make like for like comparisons. Patients can then compare the quality and cost of care with the benefits provided by their PMI and, if necessary, pay a top up fee. Market forces

will then freely apply both to the cost of providing care and in the provision of medical insurance, driving down the costs of both.

The AAGBI suggests that the proposed patient survey has a sufficient sample size to be statistically valid. Interviews should be carefully structured and standardised, if used at all, without reliance on anecdote. Any questionnaire should be carefully constructed using similar methodology to that used by GHK in the other two OFT surveys. Consideration should be given to addressing the market hypothesis described.

The following questions might be considered;

Q1. You have received a quote for professional fees in advance of surgery. Your insurance company tells you that they will not pay the anaesthetist's fees in full, but they will pay the surgeon's fees. You will be expected to pay £100 to the anaesthetist. The anaesthetist provides evidence indicating that he is an expert in his field. You have full confidence in your surgeon. Would you;

A. Proceed with surgery and pay the anaesthetist?
B. Ask for another anaesthetist whose fee your insurance will cover, but proceed and pay the excess anaesthetic fee if one cannot be found?
C. Ask the anaesthetist to reduce his fee, accept any reduced excess charge and proceed with surgery?
D. Seek surgery with another surgical team in a different hospital within one hour travel time from your home?

Q2. You have received a quote for professional fees in advance of surgery. Your insurance company tells you that they will not pay the surgeon's fees in full. You will be expected to pay £100 to the surgeon. The surgeon provides evidence indicating that he is an expert in his field and you have full confidence in him and his team. Would you;

A. Proceed with surgery and pay the surgeon?
B. Ask for another surgeon whose fee your insurance will cover, but proceed and pay the excess if one cannot be found?
C. Ask the surgeon to reduce his fee, accept any reduced excess charge and proceed with surgery?
D. Seek surgery with another surgical team in a different hospital within one hour travel time from your home?

POPULATION OVERVIEW

The AAGBI notes that since 2010, there have been significant changes in the consultant workforce that the CC will need to update, quantify and use to predict future trends.

The rate of expansion in consultant numbers has slowed and competition for NHS consultant jobs has increased substantially. The number of trainees completing training is likely to exceed the number of jobs available by 2013 and for some specialities, this is already the case.

The number of female consultants doubled between 2001 and 2010 (Fig 3.21). The proportion of female consultants is likely to have grown since 2010 and will continue to do so, as 70% of medical students are female. This will have a major impact on the private sector as female consultants are less likely to do private practice than male consultants, dedicate more time to family life, are more likely to work part-time in the NHS and if they do some private practice currently, are more likely to give it up or reduce their commitment in the future. Anaesthesia is a speciality that has a high proportion of female consultants and so is more likely than others to face a supply problem in the private sector in the future. The CC should investigate these important influences further.

This report identifies the reduction in average basic consultant NHS salaries since 2009, as a result of the pay freeze (Fig 3.28). This reduction in basic salary has been exacerbated since 2010, due to the reduction in locally awarded Clinical Excellence Awards (CEAs) from 0.33 per eligible consultant to 0.2 and the reduction in national CEAs by 50%. In Scotland and N. Ireland, National CEAs have been abolished. In addition, pension payments increased substantially in 2008 and will increase further from 2013 onwards, so that net NHS consultant income will fall substantially.

Net private income (after tax) has reduced significantly as a result of taxation, rising administrative expenses, and stable or reducing fee income. Total NHS and private income between £100,000 and £118,000 is now taxed at 60% due to the loss of the personal allowance, with 50% tax above £150,000.

Anaesthetists are affected by the above taxation issues more than other specialities, as their average earnings are the lowest in the sector, are reducing and have a greater proportion of earnings in the 60% tax band (see below).

In a recent AAGBI survey, 55% of consultant anaesthetists had either given up, or were considering giving up private practice before retirement. 55% said they would give up private practice if PMI benefirs were reduced. Of the 32% who did not do private practice, 71% said it was not worth the hassle.

GROSS PRIVATE PRACTICE INCOME TRENDS (£000)

STANBRIDGE ASSOCIATES LTP

	2007	2008	2009	2010
Gynaecologists	104	105	106	109
Ophthalmologists	128	121	125	128
Orthopaedic Surgeons	171	168	173	168
Cardiologists	107	108	111	111
ENT Surgeons	117	119	129	N/A
General Surgeons	145	146	141	141
Physicians	57	64	68	N/A
Urologists	111	114	108	N/A
Radiologists	94	91	89	86
ANAESTHETISTS	58	62	59	59

Source: Stanbridge Associates Ltd and Sandison Easson & Co

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The CC should update the data from 2010 and also examine net income by speciality, for both NHS and private practice, after deduction of tax and expenses, compared to the time and skills required,

SURVEY ANALYSIS REPORT

This report was generated by contacting ICM Research's list of doctors willing to respond to an online survey. The AAGBI questions the validity of the sample in representing all Consultants active in private practice. Busy, successful Consultants are less likely to have the time or motivation to complete an on-line survey, such that the emphasis is probably on those who are less active, with lower earnings.

It would have been useful to survey consultants who do not do private practice, those who have given up private practice and those who have reduced their private commitments. In particular, it would be useful to know their motivations, gender and specialities in any subsequent survey.

We note a lower proportion of consultants in the 30-44 age group responding to the survey than those employed in the NHS (Fig 3.37). We agree that this could be explained by the fact that younger consultants are less likely to be active in private practice than older consultants. However, as new consultants are required to contract with PMIs to charge within their benefit maxima, in order to be "recognised", the survey may have underestimated the effect of such restrictions on consultant fees. We note that 23% of consultants are forced to charge within PMI benefit maxima (Fig 3.81), that the real figure is probably higher, both in 2010 and currently, and that this will increase further in the future as these younger consultants become a larger proportion of the workforce.

The survey did not report consultant gender. For reasons stated above, this is an important consideration that will influence the data, for example, the proportion working part-time in the NHS (Fig 3.41). We suggest that this factor is examined further.

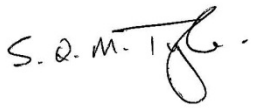
The AAGBI notes that 12% of respondents were consultant anaesthetists (Fig 3.40). Other service specialities represented a further 13%. Only 75% of the sample received primary referrals.

The proportion of time worked in the NHS and private sectors is unclear (Fig 3.47). The data would be better presented to show the relative proportions, linked to speciality and private income. This is particularly important for anaesthetists, as PMI anaesthetic benefit maxima is approximately 40% of the surgical benefit maxima, for similar time and skill. Anaesthetic benefit short falls are therefore more frequent and would be substantially reduced by fairer and more appropriate PMI benefit schedules, linked specifically to anaesthetic rather than surgical complexity. In these respects, it is notable that anaesthetists are paid on the same pay scales as surgeons in the NHS.

Fee estimates were given in advance by 43% (Fig 3.74). It would be useful to subdivide this by speciality and membership of a group practice. It is the AAGBI's view that anaesthetists are more likely to give fee estimates in advance than other specialities, due to AAGBI published advice to do so, the higher risk of PMI benefit shortfalls and the higher proportion of Anaesthetic Group membership. Group practices are more likely to have the required infrastructure to provide this benefit to patients.

The basis for consultant fee schedules could also be reported by speciality. Overall, 38% set fees with complexity and time as the most important considerations, whilst 30% suggest this is the PMI benefit available (Fig 3.77). Anaesthetic PMI benefits are related to surgical complexity, not anaesthetic complexity. We suspect that in anaesthesia, there will be a greater proportion using PMI benefits as the most important consideration in fee setting as there is no mechanism for relating anaesthetic complexity, risk or skill, which is less time-related. Anaesthetists are more likely to use the WPA schedule as a basis for fee setting than other specialities as these rates are considered to more accurately reflect the value of a consultant anaesthetist's time and skill.

The AAGBI note that 16% of respondents were in a group practice (Fig 3.83). Again, it would be interesting to know the proportions by speciality as anaesthetists are more likely to be in a group practice (AAGBI survey 2010). In assessing the benefits of groups, respondents were given a series of options, none of which were clinical benefits and all of which were commercially orientated. Any subsequent survey of consultants should assess the perceived and actual clinical benefits of group practice, by speciality. AAGBI suspect that the most important benefit of group practice to anaesthetists, their patients and their surgeons, is the ability to provide a reliable, safe clinical service, 24/7 emergency cover, Intensive Care transfer and flexibility of sub-specialist skill provision, not commercial advantage.



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