FIPO
Federation of Independent Practitioner Organisations

14 Queen Anne's Gate, London SW1H 9AA
tel 020 7222 0975 fax 020 7222 4424 email info@fipo.org www.fipo.org

BUPA CONSULTANT ORTHOPAEDIC PREFERRED PROVIDER SYSTEM FOR HIP AND KNEE JOINT SURGERY

A RESPONSE BY THE MEDICAL PROFESSION

October 2003

Introduction

BUPA has announced a consultation plan to develop a list of preferred consultant orthopaedic providers who alone amongst orthopaedic surgeons would be "recognised" by BUPA to do hip and knee joint arthroplasty and revision arthroplasty operations. Selection to this preferred list is to be based on a certain minimum number of these procedures performed each year by the consultant (combining NHS and private practice but excluding cases in which the surgeon is training a junior) and then approval ("licensing") by BUPA.

The Profession's Response

The signatories to this statement, who represent all the major UK orthopaedic and independent practice interests, object to this BUPA policy for the following reasons.

1. **BUPA should not dictate medical/surgical referral patterns. This is a fundamental principle.**

   There is a long-standing principle of medical practice in the UK, which is that the patient's General Practitioner should make the referral to a consultant. The GP is the gatekeeper of secondary care and it is the GP who, always acting in the best interests of the patient, should refer to the consultant with the appropriate expertise.

2. **BUPA has no statutory role as a regulator of the profession.**

   BUPA are setting themselves up as a quasi public body to license consultants to carry out specific procedures. There are already in place several regulators and an increasing number of stringent regulations which adequately cover the profession's clinical and ethical practices.

3. **The BUPA concept is not based on firm evidence and it is misleading to suggest that volumes of surgery alone equate with quality in hip or knee surgery.**

   Such evidence as exists in certain other branches of surgery tends to indicate that results are related more to institutional performance rather than an individual surgeon's results. The

evidence in hip and knee surgery regarding volume and quality is not yet based on a statistically proven argument and is not sufficiently rigorous to impose these restrictions. There are, of course, variations in consultant performance and any such persistent trends (in any aspect of surgery) should now be reviewed and controlled through appraisal and professionally led audits in both the NHS and independent sector.

4. **BUPA has selectively modified the good practice guidelines for hip and knee surgery developed by the British Orthopaedic Association (BOA) and the British Association of Surgery of the Knee (BASK).**

   We support appropriate clinical care plans but these must be professionally led and not developed or modified by outside bodies who might be accused of having vested financial interests. It is clear that all guidelines and care plans must be designed with the best clinical interests of the patient in mind. Rigid templates, for example discharge dates from hospital, are inappropriate and will vary according to clinical and social circumstances. We accept that the profession has an obligation to provide cost effective care.

5. **The BUPA proposal includes an extra financial reward for consultants adhering to the specific insurance led plan and this may interfere with the consultant's role as the patient's advocate.**

   A financial bonus is being offered by BUPA to those consultants who adhere to the BUPA plan and also if certain, as yet undefined, quality outcomes are met. The ethics of this extra reimbursement package are questionable. A consultant's fee should be reasonable, transparent and wherever possible outlined to the patient in advance of treatment. GMC guidelines state that any hidden financial payments, interests or inducements must be disclosed to the patient. Such payments could in our view inhibit the consultant's ability to act freely as the patient's advocate.

6. **The BUPA proposal implies a different standard of care for NHS and private patients.**

   If implemented, the BUPA plan would prevent many consultants from operating on BUPA insured patients because they failed to meet BUPA's "quality " and numbers criteria but these same consultants would still be able to operate in the NHS. The profession believes that the same standards should prevail for all patients, whether NHS or private, and regard this as an invidious implication of inadequate NHS care.

7. **The BUPA proposal would exclude many perfectly competent consultants.**

   The BUPA plan would make entry into the system for newly appointed consultants difficult. The plan also fails to address the issue of an experienced surgeon whose workload may reduce for various reasons and in whom there is no evidence of declining operative competence. It would disadvantage female and academic surgeons.

   The advent of DTC's (now called TC's - Treatment Centres) in both the NHS and private sector, with their emphasis on speed and throughput, will not only restrict training but will also make it increasingly difficult for orthopaedic consultants to achieve specific numbers of cases as work is contracted out to foreign surgeons.

8. **The BUPA proposal will be a major disincentive to providing training opportunities for specialist registrars.**

   Clearly a consultant striving to achieve a specific number of procedures may be less inclined to offer training opportunities to his specialist registrar.

9. The BUPA proposal will affect the introduction of new procedures.

New surgical advances such as minimally invasive hip replacements would be hard to introduce under the BUPA proposal. Again, this would place BUPA in the role as a quasi-public body who would approve or otherwise regulate the patient's operation and this is inappropriate.

In summary, therefore, we believe that the BUPA proposal should be rejected because

- the principle of an insurance based consultant preferred provider system is inappropriate,
- it will restrict patient choice,
- it is not based on robust clinical evidence,
- it fails to define suitable outcome measures,
- it will affect training adversely,
- it offers questionable financial bonuses,
- it is inherently unfair to many perfectly competent consultants.

The Way Forward

We accept that there may be variations in clinical practice (which applies to all aspects of medicine and surgery) and have already pledged ourselves to improving standards through professionally agreed audits, reviews and educational programmes.

We would encourage a positive dialogue with BUPA and all insurers and hospital providers on this matter. With suitable funding from these bodies the profession would be prepared to lead an appropriate programme of audit and outcome reviews.

This Statement is presented on behalf of the following groups

FIPO	(Federation of Independent Practitioner Organisations)
BMA PPC	(British Medical Association Private Practice Committee)
BMA OC	(British Medical Association Orthopaedic Sub-Committee of the CCSC)
FSSA IPPC	(Federation of Surgical Specialty Associations Interspecialty Professional Practice Committee)
HCSA PPC	(Hospital Consultants and Specialists Association Private Practice Committee)
BOA	(British Orthopaedic Association)
BASK	(British Association of Surgery of the Knee)
BHS	(British Hip Society)
BOTA	(British Orthopaedic Trainees Association)