FIPO newsletter

Autumn 2019

Dear Council Members,

The year has seen a myriad of news and developments in the private sector and with FIPO. Here is FIPO's report to be shared with your consultants.

FIPO Council Update –

FIPO welcomed back to the Council the Association of Anaesthetists of Great Britain & Ireland (AAGBI) and the British Association for Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS), who will be represented by Dr. Matthew Patteril and Mr. Simon Eccles respectively.

FIPO has had a longstanding working relationship with its sister organisation, the London Consultants' Association (LCA), and will continue to work actively to promote good practice, uphold the Patient Charter and support consultants and medical associations in the private sector. FIPO has invited the LCA's Chairman, Dr. Mark Vanderpump, to sit on the Council better to achieve this mission and ensure that information is cascaded at all levels of private practice.

Orthopaedic and Trauma Specialists Indemnity Scheme (OTSIS) have also aligned with FIPO and will be represented on the Council by our own Vice Chairman, Mr. Ian McDermott.

Dates for the diary

2019 -2020

08.01.2020: LCA 'Influential Speaker Series' dinner – Professor Sir Michael Marmot

26.02.2020: PART II meeting *Future Working Models in Private Practice* – Ian McDermott speaking

FIPO
federation of independent practitioner organisations

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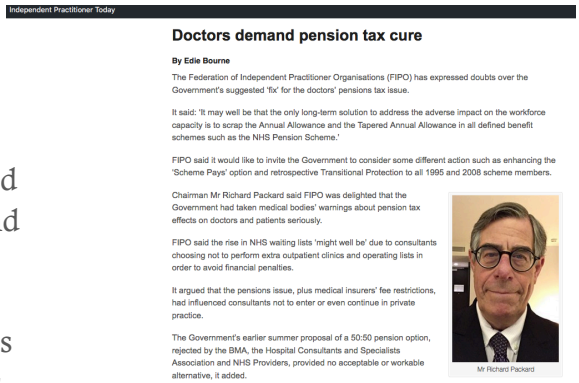
FIPO response to NHS Pension changes for senior clinicians –

FIPO recognises that the primary motivation for those entering medicine is not financial gain. Junior doctors work in a dedicated fashion during their long training in order to become the GPs and consultants that this country needs. It is absurd that when medical professionals have reached the peak of their experience and skill, this new governmental pension policy is having such as detrimental effect on experienced GPs and Hospital Consultants. We are delighted that the government have realised that the warnings they have received from a number of bodies highlighting the effects that the pension changes are substantive.

Senior doctors have always regularly performed additional NHS operations and outpatient clinics to meet rising public demand. The new pension rules mean that senior doctors would face tax bills that exceed what they earn from NHS work carried out to meet waiting list targets. This is because these extra payments mean they breach their annual pension contribution allowance. This situation is further exacerbated by doctors' total income exceeding the new earnings threshold, which activates the tapering of pension contributions. It is ironic that exceptional consultants, who achieve the recognition of a national Clinical Excellence Award with its associated additional payment, may receive instead a large and unexpected tax bill.



Independent Practitioner Today

Doctors demand pension tax cure

By Edie Bourne

The Federation of Independent Practitioner Organisations (FIPO) has expressed doubts over the Government's suggested 'fix' for the doctors' pensions tax issue.

It said: 'It may well be that the only long-term solution to address the adverse impact on the workforce capacity is to scrap the Annual Allowance and the Tapered Annual Allowance in all defined benefit schemes such as the NHS Pension Scheme.'

FIPO said it would like to invite the Government to consider some different action such as enhancing the 'Scheme Pays' option and retrospective Transitional Protection to all 1995 and 2008 scheme members.

Chairman Mr Richard Packard said FIPO was delighted that the Government had taken medical bodies' warnings about pension tax effects on doctors and patients seriously.

FIPO said the rise in NHS waiting lists 'might well be' due to consultants choosing not to perform extra outpatient clinics and operating lists in order to avoid financial penalties.

It argued that the pensions issue, plus medical insurers' fee restrictions, had influenced consultants not to enter or even continue in private practice.

The Government's earlier summer proposal of a 50:50 pension option, rejected by the BMA, the Hospital Consultants and Specialists Association and NHS Providers, provided no acceptable or workable alternative, it added.

Mr Richard Packard

FIPO Chairman, Richard Packard, featured in the Independent Practitioner Today

The FIPO Chairman was recently featured in the Independent Practitioner Today (IPT) September Issue (114) responding to the government's change to the pension scheme in the NHS and the consequent implications for consultants working in the private sector, who offer their services in the NHS.

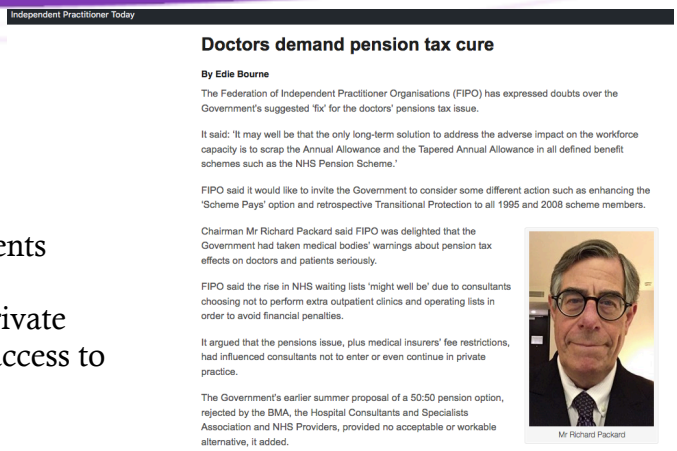
Whilst the effect of this policy is currently being felt most keenly in the NHS, these issues have also affected those consultants who practice purely privately. Anyone with a private pension will not have wanted extra pensionable earnings from the NHS because their total savings would probably exceed the tax-free maximum value of their pension pot and incur extra tax; both of which would be disincentives for those working in the NHS and privately to do anything extra. The commitment and professionalism of medical staff are the basic tenets of care on which the NHS is founded and it should not be compromised by measures like the pension changes.

It is paradoxical that the significant recent increase in NHS waiting lists might well be due to consultants choosing not to perform extra NHS outpatient clinics and operating lists in order to avoid financial penalties. Now that the government have fully understood the implications of the pension changes, senior doctors in the NHS and private sector should be able to continue working in harmony to deliver high quality care across the board without financial penalty.

Continued overleaf

NHS pensions and senior clinicians continued from page 2…

FIPO believes that the pension issue would have, in conjunction with recent restrictions on fee reimbursements imposed by Private Medical Insurers, resulted in many consultants deciding not to enter or even continue in private practice. This could further restrict patient choice and access to the most experienced and skilled consultants.



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FIPO would like to invite the government to consider a number of different options e.g. the enhancement of the "Scheme Pays" option, retrospective "Transitional Protection" to all 1995 and 2008 scheme members, which were previously afforded when the 2015 scheme was imposed only to members closer to retirement age.

The government have proposed that from next April they will be able to set the exact amount they want to go into their pension pot at the start of each financial year. The NHS will be able to recycle the unused pension contribution back into their salary. A new consultation will be launched on the proposals. However, selective protection constitutes age discrimination and there is likely to be an element of "read across" from the judges'/fire fighters'/police cases, where similar arrangements have been made. Those involved in the pension industry are angry that the "Quick fix" by the government has only so far been offered to doctors.

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FIPO's Chairman states *"Appropriate, expert care to allow patients to achieve the best possible personal outcome are at the centre of everything we do as a profession. FIPO is delighted to see movement by the government on the pension issue, so that any decisions affecting the manner in which medicine is practised must ultimately be made with the best interests of the patients at its heart and not affected by financial constraints."*

Mr. Richard Packard was featured in the September issue of the Independent Practitioner Today (IPT 114) as a FIPO representative and later approached by the IPT for further comment relating to the government's response.

Click here for the article.

FIPO, PHIN and your data –

About 6,000 consultants have provided consultation fees and about 5,000 provided procedure fees onto the PHIN website (although about 25,000 consultants are registered with PMIs, PHIN's own data suggest that about 15,500 are active). BMA figures from 2017 suggest that 80% of the work goes to 5,000 consultants.

PROMs will be published shortly and user testing shows that patients favour a "thumbs up" or "thumbs down" approach rather than more complex statistical analysis. Information about adverse events will be published shortly even though the value of this complex data for patient choice is not clear.

Whilst PHIN has published patient satisfaction scores at hospital level, the eventual objective is to publish this at consultant level also. PHIN is liaising with HQIP and National Registries.

The National Registries and Audits are led and designed by specialist societies and associations. As such, they capture relevant, clinically-rich information that is often directly inputted (or at least verified) by the clinician who has carried out the procedure. This has allowed the development of appropriate and robust risk assessment models and an 'ownership' of the information by the individual specialists.

The PHIN data set is derived from Hospital Episode Statistics (HES) which were originally captured for financial, not clinical, purposes. There is little, if any, clinician involvement with this dara capture and clinical coding in the private sector is still in its infancy. In addition, patient procedures in the private sector have needed to be billed using CCSD coding rather than the nationally agreed OPCS procedure coding. The volumes in the private sector are also comparatively low meaning that assumptions derived are likely to be misleading or skewed.

Useful data protection summary

Professor Suzanne Rab of Serle Court London, who often advises FIPO on matters of data protection and GDPR compliance, was featured several times on BBC news speaking on the topic.

Click here to watch her videos clarifying the matter.

There continues to be concern about publication of inaccurate data, the inability to correct data properly and the commercial sensitivities as to how data may be misused and misconstrued.

Industry Updates –

New CMA Investigation into Privately Funded Healthcare

On 3rd July 2019, the CMA launched an investigation into suspected anti-competitive arrangements in relation to the private healthcare sector in the UK, which may infringe Chapter 1 of the Competition Act 1998.
FIPO had previously lodged an unsuccessful appeal against the CMA in 2015, on the grounds that:

- The impact on UK market and NHS had not been considered;
- How had the competitiveness of the market been assessed;
- The CMA had not looked at consumer detriment;
- Patients are not able to act as well-informed consumers;
- There cannot be competition if prices were reduced and then capped;
- The CMA had failed to adequately assess PMI's incentives on healthcare provision;
- The economic reality of healthcare provision was not considered;
- The information remedy, although onerous, will not improve competition as fees were already distorted; and
- Publishing fee information will encourage market uniformity.

The appeal was not upheld as the review was of the legal process, although the economic logic was acknowledged by one of the three judges. Regarding the new investigation, the CMA is not at this stage prepared to disclose the details, but has been made aware and accepts that stakeholders in private healthcare include practitioners, hospitals and PMIs. FIPO has emphasised its active interest as a professional organisation and particularly where patient/practitioner interests tend to be aligned.

Private Medical Insurers

The top four PMIs have 94% market share (Bupa, AXA/PPP, Aviva and Vitality) and younger, newly-appointed consultants are recognised on the basis of contractual agreements with the risk of de-recognition for non-compliance. For example, one of the major four lists its conditions for recognition, which is discretionary and entails not only holding specialist GMC registration, but also:

- Having ≥ 2 years as a consultant in good standing;
- ≥ 2 years unsupervised private practice (≥2 x 3 hour sessions/week);
- Holding practising privileges ≥ one hospital;
- √ £10m insurance cover per occurrence;
- Expected to "understand key features of private healthcare";
- Billing within published fee maxima for new and follow-up patients;
- Not allowed to bill fees greater than allowed by other PMIs;
- Must bill electronically, abiding by the PMI's invoicing and coding rules; and
- Registration with Healthcode & PPR (healthcare "Trip Advisors").

In addition, many senior consultants who are not "Fee Assured" have been written to and told that since they bill in the "top 10%" would they consider adjusting their fees to fall within the maxima and thus continue to be "recognised". Personal top-ups to meet the difference between reimbursement and the fee charged are being discouraged: with electronic billing direct to the PMI. Ultimately, such restrictions interfere with patient referral pathways and patient choice more often than not to the patient's detriment.

LaingBuisson Private Acute Healthcare Conference – 1st October 2019

On the 1st October Mr. Ian McDermott, Vice Chair of FIPO, was invited to speak the LaingBuisson Private Healthcare Conference at the Royal Society of Medicine. The theme of the conference was 'the changing referral pathway: what does it mean for patients, providers and insurers?"

Mr. McDermott gave a talk entitled "Private healthcare: a race to the bottom?" to approximately two hundred senior figures from across the private healthcare sector, including senior management from the various hospital groups and senior figures from the various PMIs.

The main tenets of the talk were that:

- Pursuing 'cheap' is a false economy, which often tends to end up costing more overall in the long-term;
- Patients value a consultant's experience and expertise far higher than any small cost differences, in terms of medical fees;
- Consultants at the top of their field, with years of experience, are being targeted, with PMIs actively diverting patients away to cheaper colleagues;
- First-year consultants with almost no experience are being categorised by the PMIs as 'Premium Consultants' because they have agreed to low fixed fees;
- Artificially lowering doctors' fees is driving adverse behaviour, with many fee-assured consultants now providing shorter clinic appointment times;
- Less time with patients means lower patient satisfaction, lower quality and a higher risk of getting things wrong;
- More junior, less experienced consultants are more likely to have more complications and poorer patient outcomes;
- The current distortion of market forces may actually be driving down quality in the private sector;
- If the private sector fails to focus on quality at an individual patient level then it loses its key USP that differentiates it from NHS Choose and Book provision;
- Finally, patients should not be viewed as 'consumers' and doctors are not 'providers'. Commoditisation of the independent healthcare system is simply unethical! (According to Professor Arthur Caplan, from the Division of Medical Ethics at New York University.)

Despite the talk being well received, later in the day representatives of some of the major PMIs confirmed their commitment to 'Managed Care' and 'Directed Referrals'.

A few words from our FIPO Board

FIPO has been working hard on your behalf in relation to PHIN and the data that they are collecting.

This newsletter is accompanied by the Medical Practitioner Assurance Framework's (MPAF) guidelines, which FIPO had a part in creating.

This will be the way forward for improving communiction across both the private and NHS sectors, standardising how practising privileges are monitored and other governance issues. It is a dynamic document, which will evolve over time.

FIPO has been asked by the Independent Health Practitioner Network (IHPN) to help to update the guidelines for MACs and their chairs. We will keep you informed about this.

Best wishes,

FIPO Executive

Christopher Khoo
FIPO Vice Chair

Richard Packard
FIPO Chair

Ian McDermott
FIPO Vice Chair

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