

# **THE BUPA INITIATIVES**

## **A Short Review from FIPO**

### **BUPA INSURANCE MOVES TO CONTROL CLINICAL DECISIONS**

**In October 2005 BUPA Insurance announced a series of new “Initiatives” which many consultants see as introducing new clinical controls and a potential restriction of choice for the patient and doctor. In essence these are;**

- 1. Tendering for specialist services**
- 2. Preferred providers (networks)**
- 3. Insurance led clinical care plans**
- 4. Coding review but unchanged reimbursements**
- 5. New consultant recognition contract**
- 6. Consultant audit**

Consultants take responsibility for the care of their patients by dint of their qualifications, training and experience. While cost effectiveness is always fundamental, it is self-evident that some patients require more complex and expensive treatment than others.

BUPA Insurance’s new strategies for provider tendering for contracts and detailed clinical care plans may possibly reduce costs, but will certainly increase its control over clinical decision making. Of course, private medical insurers must seek competitively priced premiums for customers, but that must be balanced by continuing best evidence based clinical advice by specialist consultants and the provision of adequate compensation for hospitals and medical professionals. Good patient outcomes cannot be commoditised and care needs cannot be pre-determined nor judged by insurance clerks working to cook-book economics.

#### **Tendering for specialist services**

Private hospitals and other providers will soon have to tender for their place in BUPA Insurance’s approved supplier network. Beginning with Its recently announced MRI network, BUPA is planning further tenders in ophthalmology and orthopaedics with other specialities to follow.

However, strong health care regulation in the UK should give every medical insurer the necessary confidence in the licensed hospitals that treat their clients. By introducing this tender system, BUPA Insurance is shifting the focus of private health care from patient choice and service quality to price.

The MRI tender encroaches on professional judgement by dictating where patients can have a scan and to some extent which radiologist will read it for the referring consultant.

According to survey results from over 350 consultant radiologists from around the UK, analysed by FIPO and the Association of Independent Radiologists (AIR), this process is clearly a concern because:

- Non-networked consultants will be excluded from treating BUPA insured patients, not for clinical reasons but because they are unable to access a networked facility
- Referring consultants may on occasions be obliged to work with unknown radiologists
- Patient confidence in their consultant and hospital is undermined when they are sent elsewhere for an essential MRI scan
- There are undefined audit caveats on consultants in the tender agreement
- Tenders are based on inclusive pricing, meaning that increasingly hospital providers will be drawn into contentious fee negotiations with consultants

Of course many of these issues will also apply when front line clinical services are put under tender. Non-networked hospitals and consultants will only be able to regain BUPA recognition by lowering their prices to beat their competitors.

### **Clinical Decision Making and Care Pathways**

Integral to the tendering process are detailed clinical care pathways, which are being produced in an “anglicised” format by an American company for BUPA Insurance. Though these may increase cost efficiency, the question is whether this should be the determining factor in selecting treatment. This lowest common-denominator approach risks putting profit before patients and fee reductions before clinical outcomes.

The new BUPA coding for procedures contains many errors and no changes in reimbursement to patients for consultant services; they also include BUPA determined lengths of stay. This American approach to Managed Care has proved disastrous in the USA as it compromised patient safety, restricted consultant discretion and limited patient choice.

The same could happen here with:

- Delays in diagnosis or treatment when patients must confirm and re-confirm that their treatment is part of the insurer’s pre-determined care plan.
- Confusion over liability in the event of a poor clinical outcome
- Restriction of patient choice to pre-determined ‘average’ care pathways that have been pre-authorised by an insurer on the basis of price.

- Denial of the latest advances in therapy.

### **Consultant re-registration**

Further concern arises from the requirement that all consultants will need to re-register with BUPA Insurance before being approved to treat their clients. BUPA Insurance may genuinely need to consolidate its information base about consultants, but the re-registration contract goes further than simple administrative data. The contract is biased strongly in favour of BUPA as it;

- Demands details of each consultant's scope of practice
- Allows BUPA to withdraw recognition of a consultant at its own discretion, without scope for appeal and based on seemingly spurious "complaints" from any source
- Allows BUPA to recognise any doctor as a "specialist", opening the door to any sub-consultant or overseas doctor being accepted
- Requires unspecified personal clinical audit information to be provided to the insurer on demand
- Allows BUPA to take control of the GP to consultant referral process, by referring their clients at pre-authorisation to the "most appropriate consultant".

Ultimately Managed Care means that the insurer will control

- **WHO** gets treated
- **WHERE** they get treated
- **HOW** they get treated
- **WHO** carries out the treatment
- **HOW** much is paid for the treatment.

**The FIPO Board representing many different specialties rejects this concept. FIPO fully supports all cost effective and a professional method of care by consultants working to best evidence based guidelines and with the patient's wishes and best interests at heart. To that end FIPO is setting up a Clinical Governance Advisory Committee with the cooperation of most of the major hospital providers which will work through local Medical Advisory Committees (MACs) in the Independent Sector to achieve this goal.**