

## **THE PMI CRISIS – UPDATE FROM IDF CHAIRMAN**

I know from the enormous amount of correspondence we see on the subject of capping, delisting and general payment problems caused by PMI providers that this subject is causing great concern to our members and I would like to update you on the IDF position.

### **Background**

In response to falling revenue the major PMI providers, who between them control over 70% of the insurance market, have adopted a strategy which in public they describe as measures to assure quality of medical care, and which they say has the support of the medical profession, but behind closed doors it seems that their strategy is in fact to increase profit margins by taking in fees and limiting reimbursements. The net effect is to optimise revenue in and minimise pay out.

Their chosen methods of increasing revenue have not been shared with the public or with the medical profession. Yet the PMI companies, who are not qualified doctors, regulators, educators or bodies appointed to pass comment on the skills or knowledge required by doctors, have taken it upon themselves “in the public interest” to make judgements about the relative value of doctors to whom patients turn for assistance. As a result, the PMI companies have given an impression to the public that as a whole the medical profession is worth less than it was in the past, and will be worth less in the future. Would lawyers, accountants, architects or chartered surveyors, for instance, allow insurance companies to dictate their professional standards and fees? How has this happened to us?

### **The present situation**

We have arrived at our present situation because of a number of circumstances.

- Specialists were persuaded to submit their invoices directly to insurers who then promised instant no-quibble settlement and took the responsibility for collection of money off the shoulders of doctors. Of course this is a very attractive arrangement, which effectively removes one member of staff from the payroll of a doctor and guarantees revenue. Sadly it also places power to set fees and levels of remuneration firmly in the hands of the collecting agent. In the process, PMIs have become the direct business link between item of service and payment in the eyes of our patients. Surprisingly, there has been little resistance to this invidious process, nor is there much appetite to reverse it in the future.
- The situation has been made worse by PMI public relations machinery which has persuaded patients that only the insurance companies are able to champion the interest of clients, and make sure that they are in every case seen by a doctor and treated in a facility which is of the very best available standard and yet costs are “minimised”. They have managed to disassociate the link between the amount that you pay and the value of the service that you pay for.
- The PMI companies have perpetrated a policy of divide and conquer, and in the process have driven wedges between newly-appointed consultants and those more established,

between London based specialists and those who work outside the south or east of England and between hospital providers and doctors. The private practice “industry” comprises a number of groups with no cohesion. We are easy to pick off in a fight and we do not have a unified voice to represent our interests or devise a strategy to oppose what is happening to our profession.

- The PMI companies have “negotiated” and “consulted” with doctors but have managed to head off consensus within the profession, and have specifically excluded general practitioners from discussions. As a result patients are being directed to consultants that are selected by insurance companies and GP referrals are being bypassed. **Patients are losing freedom of choice.** They are losing the ability to go to the best specialist and the most appropriate specialist for that patient’s medical condition. For decades the core of British medical excellence has been embodied by the connection between patient / GP / specialist, and the PMIs are effectively undermining the relationship. This is in complete contravention of calls for co-ordinated medical care that have been made in the media and by various professional bodies, and increases the chances of harm to patients.
- **The vast majority of patients are unaware that this restriction is happening.** They are aware of the restriction of using certain hospitals, bandings and limits to yearly outpatient expenditure but do not realise that when they purchase their policy (or join a company scheme) their choice of consultant maybe restricted by delisting etc.
- PMI companies make deals with private hospital providers which result in arrangements which are not always to the advantage of specialists who work in those hospitals. This results in further loss of autonomy and loss of professional self-regulation.
- Public statements from individual doctors expressing concern at the PMIs increasing self appointed powers are often cut off by threats of legal action from PMI legal representatives. Private practitioners, on the other hand, are unable to afford effective legal representation and have no support from organisations such as the Competition Commission which is supposed to guarantee fair play in regulated industries such as ours.
- Our disagreements with PMI providers, our claims of unfair treatment at their hands, our lack of control over our own businesses and financial management, do not find any sympathy with the public, the media or government.

#### **HOW SHOULD WE RESPOND**

It is my opinion that there is no hope of return to what some may think of as the “golden days” of private practice. If we charge for our services we must be able to defend the cost to our clients, and prove the value and quality of our practice to anyone who wishes to scrutinise our data. We can no longer pontificate; we must prove that we are worthy of our reputation for excellence.

Surgeons and hospital-based specialists have a ready way to present their results and make comparisons of their professional activities through involvement in PROMS and the Hellenic project indicators (visit [www.independenthealthcare.org.uk](http://www.independenthealthcare.org.uk) for more information on the Hellenic project). We encourage members of the IDF to embrace these activities, but we would like to stress that the manipulation and use of the data should be under your control; for the benefit of your patients and your personal appraisal / revalidation, and not because a PMI company insists on access to the data before bestowing “recognition”. We agree with the

Federation of Independent Practitioner Organisations (FIPO) that the only arbiters of professional standards are the GMC, the colleges and the MAC of your hospital that oversee governance. With the help of the hospitals, who have voiced their support in this matter, we can and must wrest control of the collection and use of the clinical performance data plus the concept of “recognition” from the grasp of PMI providers. The data is ours and we should use it.

We must also collect similar data to demonstrate the excellence of doctors working in non-hospital environments (i.e. consultants and private non-specialists who do work regularly outside managed environments). In terms of numbers of practitioners this would actually represent the majority of private practice, and they are strangely under-represented, especially when it comes to the collection of evidence that can be used in the proof of quality and excellence.

Specialists, and particularly those who are newly arriving in private practice, should resist coercion and threats from PMIs. Young consultants must be helped to build their private practices patiently, under their own control and with the backing of private hospitals, fellow consultants and GPs. They should not enter into “contracts” with the PMIs as they will surely find themselves in the long run out of pocket and without any freedom of practice. I would ask a hungry young consultant to remember that he who pays the piper also calls the tune. The IDF agrees with FIPO in their statement that “anyone with their CCT should be allowed to practise privately”. This is the reward of education, training and qualification bestowed by colleges, after hard work and recognised experience, and not a gift to be granted on the say-so of an insurance company. If consultants enter into a contract with a PMI they must ask themselves whether they are now practising privately or whether they are now covenanted to the PMI in question. How long does the contract last? How can they appeal against decisions to terminate arrangements? What happens if there is a disagreement between the patient and the contracted doctor? When things go wrong, how much independence of action will the contracted doctor have, and who will defend them? We say if you are contemplating signing an agreement with the PMI, do not do it.

Finally, there must be some way of resisting the actions of PMI companies. We do not believe that the IDF or any of the other organisations that represent doctors in private practice are able to provide effective action alone. There must be a single plan and a single voice. Your chairman and other members of council have been in direct contact with private hospital providers, large companies that provide PM insurance to their employees, representatives of some PMI firms that constitute the remnant 30% of the PMI market, with other organisations such as the London Consultants Association (LCA), FIPO and the private practice committee of the British Medical Association (BMA). As a result, we conclude that we should unite behind the leadership of FIPO on this particular issue and the IDF has joined the organisation as a board member. As a result of this unification private practice will have one voice and a strategy with regards to PMI action. The strategy will include the appointment of our own public relations company, our own legal representatives and further consultation with business consultants, because when all the players join the team we will have enough fire power and financial backing to be effective.

If you admire, respect and already belong to a representative body, make them join FIPO, listen to the future advice, be disciplined and stick together. Precedents have shown that this is an effective way of opposing PMI diktat. However, underlying all the above is the need to

persuade people that we are worth the fees that we are asking for, not through some arrogant right of tenure, but because we have our own proof of quality and excellence and we must engage, but not be in thrall, to the PMIs.

Dr J A T Edmonds MB BS MRCGP  
IDF Chairman