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Medical Fees in the Private Sector - An Explanation for Patients

What is the Federation of Independent Practitioner Organisations?

The Federation of Independent Practitioner Organisations (FIPO) is a non-profit making organisation whose membership includes all the professional groups representing consultants in the different specialities of medicine and surgery. It incorporates the major medical organisations in the UK independent acute healthcare sector including amongst many others the private practice committees of the British Medical Association, the Hospital Consultants and Specialists Association, the London Consultants' Association, together with the Chairmen of a large number of Medical Advisory Committees from different private hospitals in the UK. The objectives of FIPO are to promote the highest possible standards of care in the private medical sector and to preserve the independence and freedom of choice for patient and doctor.

FIPO does not set or recommend medical fees nor does it encourage unreasonable or high charges. Any specific questions on fee levels should be directed to your consultant. FIPO does not accept membership from individual consultants and therefore cannot take responsibility for the actions of individual doctors. However, there are certain factors that govern your fee arrangements, which this document is intended to explain.

Medical Fees – Is there a contract between the patient and consultant?

Any patient who consults or is treated by a specialist (consultant) in the private medical sector will be personally responsible for the payment of all their specialist's fees and a financial contract exists between them. In many instances patients have private medical insurance that will fully partially or reimburse them for their medical fees. However, there are often exclusions within these policies (i.e. specific medical conditions, outpatient allowances, or payment by the patients of an initial excess amount). Sometimes there may be shortfalls in the reimbursement that the patient receives for the consultant's fees. In the event that this occurs it must be borne by the patient who is personally liable to the consultant for his/her fees.

How do I get to see a consultant and do I need pre-authorisation by my insurance company?

Most patients are referred to a consultant on the recommendation of their General Practitioner (GP). This is the traditional route. Your GP will know the specialist interests and abilities of all the consultants to whom he/she refers patients. Some patients will have knowledge of a particular consultant and are fully entitled to ask to see that specialist. A referral letter from your GP is usual. It is at this stage that many insurance companies ask patients to contact them for pre-authorisation. Patients should always insist on seeing the consultant of their choice.

At pre-authorisation the patient may be given a specific claims number for this clinical event which it is advisable to use in correspondence with the insurance company. Occasionally at this stage the insurance company raises queries about the expected level of fees. In such circumstances the patient should always contact the consultant recommended by their GP to clarify the issue. This recommendation and referral was made by the GP on the basis of his/her best clinical judgement of the patient's background and medical problem and was not influenced by any financial motives. Many consultants resist entering in to direct arrangements with certain insurance companies, as they are concerned that this will eventually affect their independence, choice of appropriate facility for their patients and will not be in the best long term clinical interests of their patients.

Can I get a fee estimates before treatment?

It is perfectly reasonable and acceptable to ask your consultant for an estimate of your fees prior to treatment. This can often be furnished for a standard operation (i.e. cataract extraction, hernia repair, hip replacement, hysterectomy etc.). The consultant should also do his/her best to tell you about other potential professional charges, such as the likely anaesthetist's fee. It is possible that you will also have professional care from "back room" consultants (radiologists - x-ray doctors - or pathologists) who are entitled to submit accounts for their services. Your consultant may not be able to give you an exact quote but should be able to assist you in obtaining some information on what these are likely to be.

In some instances however, a fee estimate is impossible to calculate because your diagnosis and treatment is unclear. When complex or in the event of complications other specialists may be called to see you and your primary consultant will choose these doctors with your agreement. Sometimes, in a clinical emergency speed and expedience are critical and neither you nor your relatives may be able to exercise influence over these decisions. In these circumstances, patients should realise that doctors work in regular teams and that this reflects best clinical practice.

Your hospital charges are normally fully covered by your insurance company, who will have negotiated these set prices. However, there may be some restrictions, i.e. cover for a single as opposed to a double room, which are matters for you to resolve with the insurer and the hospital. You may also be charged for certain personal activities such as phone calls.

If your insurer asks for a Claims Form to be completed then either your consultant or GP will do this. It is important that all parts are filled in accurately. You are advised to keep a photocopy of all such forms.

Who pays the consultant's fees?

Your consultant(s) will submit their fees for their services to you (and sometimes directly to your insurer by post or electronically). These fees should be laid out so as to illustrate clearly the services rendered. Normally, an operative fee will include routine post-operative care in the hospital. Separate fees are charged for follow-up consultations after surgery. PPP may now refuse to pay for follow up consultations if these take place within 10 days after discharge from hospital although other insurers will usually cover this charge.

You should note that whilst the insurance companies often settle professional bills directly, they do not pay consultant fees; they reimburse patients for consultant fees. The levels of reimbursements vary between different companies for the same procedure and consultants are not bound by any of these levels. If there are shortfalls then the patient is responsible for this amount, which should be paid directly to the consultant within a reasonable time. In some circumstances the consultant may be able to explain the particular complexity of the procedure to the insurance company and so enable the patient to receive a higher level of reimbursement.

Why are there fee shortfalls?

Some patients' question why they may have to pay shortfalls and this is really based on the economics of private practice. The average patient's insurance premiums have risen by at least 7% per annum for the last 10 years. Hospital prices have risen in line with this, but there has been no similar general movement to assist patients for their consultant fees. During this same period the actual reimbursement for consultant fees by the major insurers has not altered significantly and indeed some insurers may actually be reducing their allowances. Moreover, the costs of running a medical practice have risen dramatically, and these costs are particularly high in London and certain other parts of the country. Unfortunately the insurers give no extra weighting based on these geographical differences. These economic facts mean that more and more patients are facing shortfalls for consultant fees.

Most insurers will publish their actual reimbursements for various operations or treatments either in hard copy or on the internet. However, you should note if you are insured by PPP, that this company will not actually state the precise fee reimbursement for any given procedure but will only pay what it considers "usual and customary". This can sometimes create difficulties for consultants and patients, as there is no published list of benefits payable.

Some Common Patient Questions

- ***Why doesn't my insurer settle all my accounts in full?***

The answer lies in your insurance contract, which limits benefits.

- ***Are there any national guidelines or set tariffs for consultant charges?***

The original guidelines on medical fees published by the British Medical Association were ruled illegal by the Monopolies and Mergers Commission in 1994. Since that time there has been no "official" or other tariff of fees. Furthermore, the Competition Act means that any group of doctors who publish such a list would be in breach of the Act.

- ***What does "fixed price" or "package" surgery actually involve?***

The terms and conditions of these so called "package prices" do vary. In some instances the consultant's fees are included in the price; sometimes they are separate. Patients should always ask what the advantages and disadvantages are for these deals, in particular whether the hospital and consultants will include the costs of any complications and delayed discharges from hospital in the fixed price.

- ***What happens if a complication occurs that necessitates a further operation or intensive care?***

The hospital costs and extra consultant fees would need to be settled either by you if you are not insured or by your insurance company. Companies often question such bills and some demonstrate a reluctance to pay.

- ***What is the meaning of an acute or chronic condition?***

Some conditions may be defined as chronic by the insurers and may not be covered. However some of these conditions may have acute exacerbations and your consultant may be able to assist you in gaining reimbursement from your insurer although this cannot always be guaranteed.