COMPETITION, ORDERS, AND SELF-PAY

Recently, a nonministerial government department in the United Kingdom, the Competition & Markets Authority (CMA), published an order following a long investigation into private medical practice in the United Kingdom.[1] The purpose of the order was to promote transparency of pricing, the abandonment of incentives by hospital groups to doctors to refer patients, and the availability of physician performance data on the UK's Private Healthcare Information Network (PHIN).[2]

At first glance, this can only be good for patients, as the motivation behind the order is to avoid anti-competitive behavior. For many private providers, doctors, and hospitals, however, the provisions could arguably in themselves be anti-competitive as well as too onerous. Between these and dramatic reductions in reimbursement by third-party insurance companies, it is conceivable that many doctors will abandon private practice.

For non-UK readers, the UK model of private care provision is quite different from provisions in other countries: The National Health Service (NHS) provides the bulk of care, with the private sector providing only 16.7% of care in 2013.[3] Currently, most UK ophthalmologists work for the NHS the majority of the time and spend a smaller portion of time in private practice, where income is supplemented and value for time spent is considerably higher. This system has worked well, until recently when insurance companies reduced reimbursement and stopped providing insurance participation to new doctors unless they agreed on a price schedule, with no option for balance billing of patients (ie, top-up)—a practice that is arguably anti-competitive.

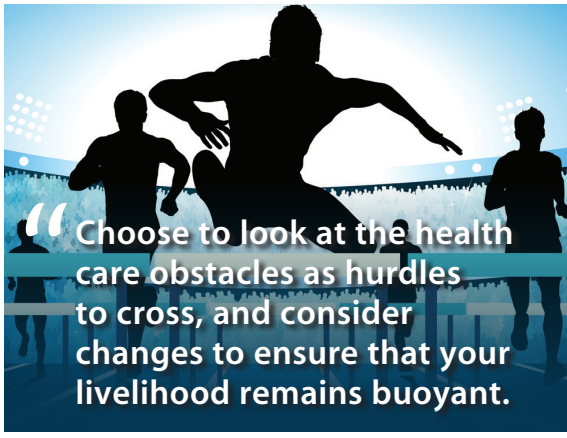
Many specialties are highly dependent on third-party reimbursement, and, for them, private practice is becoming increasingly difficult. We cataract and refractive surgeons should consider ourselves fortunate, as we are less dependent on third-party payers. Services for which patients pay out of pocket—self-pay services—provide a phenomenal level of independence to practitioners, and it is no wonder that similar specialties, such as plastic surgery, dermatology, and bariatric surgery, are looking to our model for guidance. As a result, the discretionary spending market sector is likely to grow phenomenally.

Many in other specialties in which self-pay systems will not work may make the decision to stop practicing privately, especially in areas of the country where private practice is underutilized. However, there is an opportunity for those willing to take a risk to leave the public sector and embrace private practice full-time. This might sound odd, but remember that almost 17% of all care in the United Kingdom is in the private sector.

To succeed in this competitive environment, physicians must deliver to their patients exceptional care with good outcomes and exceptional customer service, which includes being more available—a difficult feat when working simultaneously in the NHS. There is also the issue of cost of entry, which, for ophthalmology, is high. Sustainable independence can be achieved only by collaboration and alliances among doctors who can share capital and revenue costs as well as by making maximal use of assets in order to maximize profitability.

It is refreshing to see this phenomenon beginning in the United Kingdom, although it is not without problems, which, in my observation, stem from inadvertent institutionalization from growing up in the NHS. Most doctors naturally want to remain autonomous, but this desire must be balanced with the practicality of being able to provide world-class care with 21st-century technology and facilities and increased profitability from collaboration.

Success will most likely result from win-win arrangements and acceptance that some aspects of control and leadership must be relinquished. Meanwhile, if doctors do not take control, there is the danger that large corporate groups will begin to surface, offering to employ doctors in collaborative arrangements. These groups will be heavily restricted by the CMA order. I know most colleagues would much prefer to work with some level of personal control.



Although I have discussed the state of play in the United Kingdom, there are surely parallels in other European countries. We would love to learn from you, the readership, what the models of care are in your countries and how private practice has evolved. A letter to the editor, addressed to lstraub@bmctoday.com, would help to shed light on this topic.

For those who have a sense of doom and gloom, consider that, based on the demographics of an aging population, increasing disposable wealth, and shortage of health care resources, the future does look bright for ophthalmology and, in particular, for cataract and refractive surgery. Choose to look at the health care obstacles as hurdles to cross, and consider changes to ensure that your livelihood remains buoyant. ■

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1. Private Healthcare Market Investigation Order 2014. Competition & Markets Authority. https://assets.digital.cabinet-office.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf. Accessed July 6, 2015.
2. The Private Healthcare Information Network (PHIN) is approved as the Competition and Markets Authority's Information Organisation [press release]. The Private Healthcare Information Network. http://www.phin.org.uk/News/PHINApproved-AsTheCMAIO20141201.pdf. Accessed July 6, 2015.
3. Expenditure on Healthcare in the UK, 2013. Office for National Statistics. http://www.ons.gov.uk/ons/dcp171766_399822.pdf. Accessed July 6, 2015.