

HOSPITALS SETTING FEES

# Consultants' fees cuts are highly contagious

So who is next for the pay chop? **Dr Phil Shorvon**, chairman of the Association of Independent Radiologists, warns that what has happened in his specialty could very well come your way next



“The veiled message is that if they do not like it, the hospital will either outsource radiology reporting or get new radiologists in”

BMI, THE LARGEST UK independent hospital group, and the Nuffield group have each unilaterally and almost simultaneously introduced a national radiology fee structure for all their consultant radiologists.

Throughout the independent sector the hospital management is responsible for negotiating the composite fee for all radiological procedures with the insurance companies and thereafter it pays a percentage to the consultants.

This percentage has varied geographically, reflecting local conditions and previously was amicably agreed. These new 'non-negotia-

ble' fee structures have thus affected consultants to a variable extent, but are perceived by all as very dismissive treatment.

The implication of this hospital action is that the radiologists may take or leave it. The veiled message is that if they do not like it, the hospitals will either outsource radiology reporting or get new radiologists in.

**Dangerous message**  
This is a dangerous message and completely fails to appreciate the full role of the clinical radiologist (see the Royal College of Radiologists' publication *How many*

*radiologists do we need?*). This confirms that a considerable proportion of a radiologist's time is devoted to duties other than reporting.

Close clinical liaison and discussion with referring clinicians is the norm and this teamwork is essential for the maintenance of high standards. This is lost in outsourcing, as is the radiologist's advice on the appropriateness and feasibility of radiological investigations. Radiologists play a key role in multidisciplinary teams and, of course, invasive radiological procedures cannot be farmed out.

Another trend unrecognised by

the hospital providers is that emergency radiology is increasing. For example, a patient with an acute abdomen once only had a plain X-ray but now a radiologist often attends for many different tests.

This service applies to many clinical emergencies and has been willingly provided often on a pro bono basis by radiologists, although no doubt many will now be reconsidering their willingness to participate so freely.

What are the commercial issues at stake? Radiologists do not live continuously in darkened rooms and are well aware that hospitals

will negotiate the best prices with insurers.

If the price is forced down, as with BUPA and MRI, then the profession would agree to a proportionate fall in its reimbursement for that procedure.

However, these cutbacks have extended across all radiology and this can only be seen as a brutal method of increasing hospital profits at the expense of their consultants.

Insurers will be happy and if, as has been announced, the average cut in fees is 15% – a questionable figure that we would challenge and which, in any event, covers some cuts of up to 40% – then no doubt the insurers will be coming back for more reductions from the hospitals at their next round of negotiations.

Thus, any hospital gain will be temporary and illusory and, over time, this will impact on new investment in equipment. Ultimately, it is the patient who suffers with a deteriorating service which then reflects poorly on the whole independent sector.

Radiologists caught up in this are reacting in many different ways. All, including those less affected by this hospital strategy, recognise this cut may not be the last one.

Some are taking their patients to other providers or to their local NHS hospital. Others are intent on direct billing. Many clinicians are strongly supporting their radiologists and are referring patients to other provider units and to a specifically named radiologist.

**Patients suffer**  
Radiology is a key factor in patient management and any disruption is likely to cause patients to suffer. As responsible doctors, radiologists will not embark on any action that would directly affect patient care.

However, it remains to be seen how consultants will react and how co-operative they will be in maintaining radiological services at their present levels, providing cover during colleagues absence, plus out-of-hours rotas.

Radiologists are particularly vul-



Headline news: our March edition showed how BMI's policy has grown

nerable to this type of pressure because they are packaged with the hospital in a composite insurer payment. But this concerted action by BMI and Nuffield should serve as a warning to all other specialities, particularly 'service' specialities such as anaesthetics.

Packaging may come in different formats and not just with the hospitals. For example, BUPA is suggesting to orthopaedic surgeons that they take a composite fee (to include anaesthesia, physiotherapy and so on).

Surgeons are rightfully wary of this, as the prices are low and will inevitably lead to tensions and a decreasing standard of care. Other 'middlemen' or brokers are also keen to package clinicians – at a price – but this lesson from radiology should serve as a warning to all. Stay close to the patient!

All such arrangements break the consultant's contract with the patient. Please let us have your views at the Association of Independent Radiologists (AIR). Phone: 0207 222 0975. Email: [air@fipo.org](mailto:air@fipo.org).



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