

Entry and expansion case study 2: The London Clinic

Introduction

1. This paper describes the London Clinic's (TLC's) attempts to grow its share of cancer treatment provision in London through the creation of a custom-built, integrated cancer care centre and the barriers that it encountered in doing so.
2. The paper begins by describing TLC and its main competitors, sets out some of the distinctive characteristics of private healthcare provision in London and outlines TLC's strategy. It then describes how other participants responded to TLC's expansion plans and draws some preliminary conclusions on barriers to expansion.

TLC and its main competitors

The London Clinic

3. The London Clinic opened in 1932 and was granted charitable status in 1935. Its current facilities are located in and around Harley Street in central London and comprise 74 consulting rooms, 13 operating theatres, a level 3 intensive care unit, 181 overnight beds and 59 day-beds. TLC, which describes itself as the largest 'independent'¹ private hospital in London, admitted slightly fewer than [§] patients in 2011.² It provides most of the major clinical specialties with the exception of cardiac surgery, obstetrics and psychiatry. In 2009 TLC opened its Cancer Centre whose development we describe in more detail below.

¹ In the sense that it is independent of the major private hospital groups (BMI, HCA, Nuffield, Ramsay and Spire).

² Admissions figures do not include outpatient consultations. In 2011, TLC held just under [§] outpatient consultations.

4. As a charity, TLC is governed by a Chairman and Board of Trustees, with all surpluses reinvested into the hospital and, like other charities, may benefit from certain tax reliefs and exemptions.³

5. The turnover of TLC grew from £74 million in 2006 to £124 million in 2011, an average annual growth rate of 10.8 per cent. Over the same period EBITDA⁴ increased from £[] to just over []. TLC's revenue is generated largely from insured patients, who account for around [] per cent of the total. The remaining [] per cent of its revenue is split [] between self-pay and international patients, with almost no revenue generated from NHS patients.

Hospital Corporation of America

6. Hospital Corporation of America (HCA) is the third-largest provider of healthcare services in the UK and the largest in London by revenue. In 2011, HCA generated turnover of £585 million and EBITDA of £142 million from its hospital operations in the UK. It admitted around [] patients and treated a further [] on an outpatient basis.

7. HCA began providing private healthcare in the UK in 1996 with its purchase of a 50 per cent share in the Harley Street Clinic, Wellington, Princess Grace and Portland hospitals, in a joint venture with PPP healthcare. HCA expanded significantly in 2000, buying out PPP's share in the joint venture and acquiring St Martin's Healthcare (comprising the London Bridge, Lister and Devonshire hospitals) from the Kuwait Investment Office.⁵

³ See www.hmrc.gov.uk/charities/tax/basics.htm.

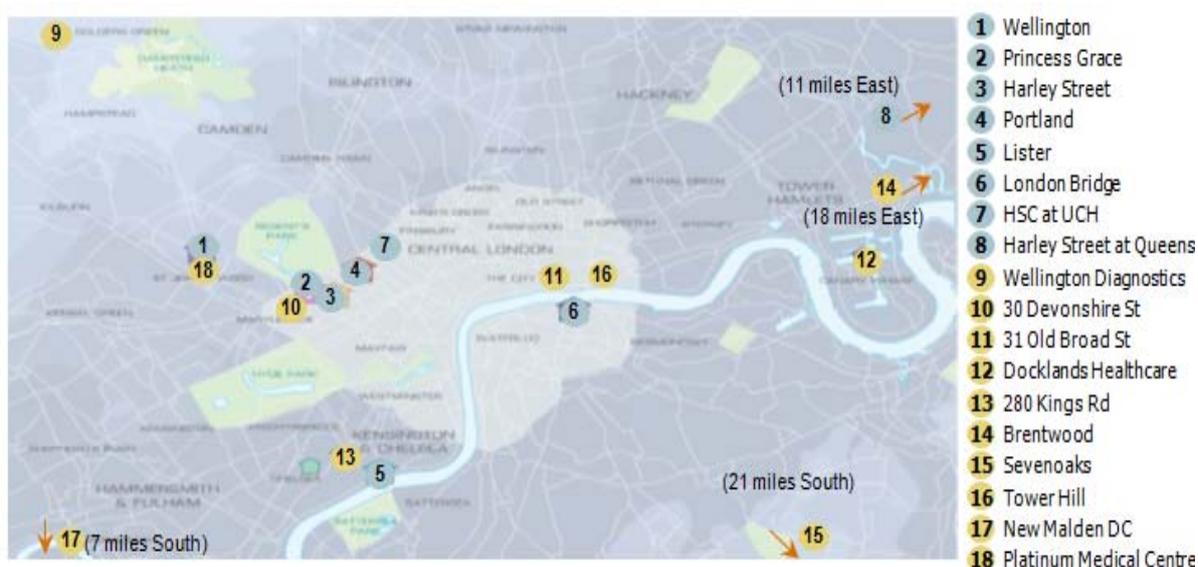
⁴ EBITDA = earnings before interest, taxation, depreciation and amortization.

⁵ HCA website: <http://phx.corporate-ir.net/phoenix.zhtml?c=63489&p=irol-newsArticle&ID=561221&highlight=>,
<http://phx.corporate-ir.net/phoenix.zhtml?c=63489&p=irol-newsArticle&ID=561225&highlight=>.

8. HCA has also created or acquired a number of outpatient and diagnostic clinics, as well as reaching commercial agreements with a number of NHS private patient units (PPUs) including, in London, UCH (incorporating Harley Street at UCH and the MacMillan Cancer Centre for outpatient and day-case treatments),⁶ Queens Hospital (Romford) and, most recently, Guy's and St Thomas' Hospital where HCA will manage a PPU within the Trust's new Cancer Treatment Centre.⁷

FIGURE 1

HCA facilities in the Greater London area



Source: HCA.

9. In 2010, HCA expanded outside the Greater London area for the first time, winning a tender to manage the Christie NHS Foundation Trust PPU in Manchester. The Christie Clinic is the UK's largest specialist cancer hospital outside of London.
10. HCA currently has a total of 416 consulting rooms, 44 theatres, 790 overnight beds and 167 day-beds across its UK hospitals. All of HCA's main hospitals have an intensive care unit and are capable of offering HDU (high dependency unit) services too. These facilities support the high-acuity work carried out at HCA hospitals.

⁶ www.harleystreetatuch.co.uk/the-uch-macmillan-cancer-centre/.

⁷ HCA outpatient clinics include the Platinum, New Malden, Chelsea, Brentwood, City of London, Old Broad Street, Docklands and Sevenoaks medical centres. OFT decision regarding HCA and Guy's and St Thomas' commercial agreement: www.of.gov.uk/shared_of/mergers_ea02/2012/HCA.pdf.

11. In addition to its secondary care facilities, HCA has invested in the primary care sector through its acquisition of a number of private GP surgeries and occupational healthcare providers including, Blossoms Healthcare, Roodlane and General Medical Clinics.

Bupa Cromwell Hospital

12. Bupa, which had previously sold all of its hospitals, acquired the Cromwell hospital in 2008. The 131-bed hospital is located on Cromwell Road in Kensington and provides care across more than 70 subspecialties with a particular focus on oncology, neuroscience, paediatrics, cardiac sciences and orthopaedics. [X]
13. The hospital has five operating theatres and 29 consulting rooms. In 2011, Bupa Cromwell Hospital (BCH) generated £[X] in revenues and £[X] EBITDA. Revenues were split between insured patients ([X] per cent), overseas patients ([X] per cent), self-pay patients ([X] per cent) and NHS-funded patients ([X] per cent).
14. We set out BCH's strategy in cancer care in Appendix 1.

The Royal Marsden NHS Foundation Trust

15. The Royal Marsden Hospital NHS Foundation Trust (The Royal Marsden) specialises in cancer treatment, care and research. It has the largest PPU in the UK with turnover in 2011/12 of £50.3 million and operates from two sites: Chelsea and Sutton in Surrey. It has 34 private overnight beds, 12 day-beds, ten operating theatres (including shared capacity with the NHS), and nine consulting rooms. It has critical care facilities to level 3 and a wide range of advanced diagnostic and treatment equipment including PET/CT scanning and a CyberKnife.

16. [X] per cent of the Royal Marsden's private revenue is derived from UK insured patients, [X] per cent from UK self-pay patients and [X] per cent from overseas (self-pay, embassy or insured) patients.
17. The Royal Marsden is forecast to generate revenue of £[X] in 2012/13 with an expected contribution of £[X].
18. The Royal Marsden told us that when the cap on PPU earnings was lifted it hoped to double the amount of revenue that it generated from private patients but that this would require additional investment in capacity at both its Chelsea and Sutton sites. It also pointed to certain risk factors, [X]. It is currently preparing the business case for additional investment in dedicated private care capacity.

Private healthcare provision in London

19. The Greater London area has a population of around 8.2 million,⁸ 4.9 million of whom live in outer London and 3.2 million live in central London. In addition, a further 1 million people commute into London on a daily basis for work.⁹
20. London is the wealthiest region of the UK, with disposable income per head around 30 per cent greater than the national average as of 2010.¹⁰ The next wealthiest regions are the surrounding South-East and East of England areas.

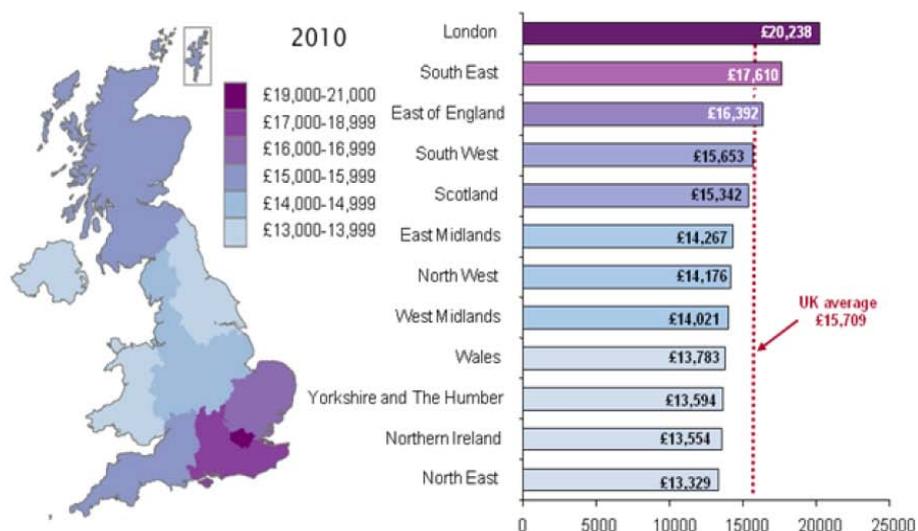
⁸ All demographic data has been sourced from the ONS and is based on the 2011 census: www.ons.gov.uk/ons/publications/reference-tables.html?edition=tcm%3A77-284349.

⁹ <http://londontransportdata.wordpress.com/>.

¹⁰ www.ons.gov.uk/ons/dcp171776_270749.pdf.

FIGURE 2

Disposable income per head in the UK, 2010



Source: ONS.

21. This affluence, together with the presence of major corporations whose employees may benefit from employer healthcare schemes, drives penetration of private medical insurance, with an estimated 17.5 to 18.5 per cent of the population being covered by a policy.¹¹

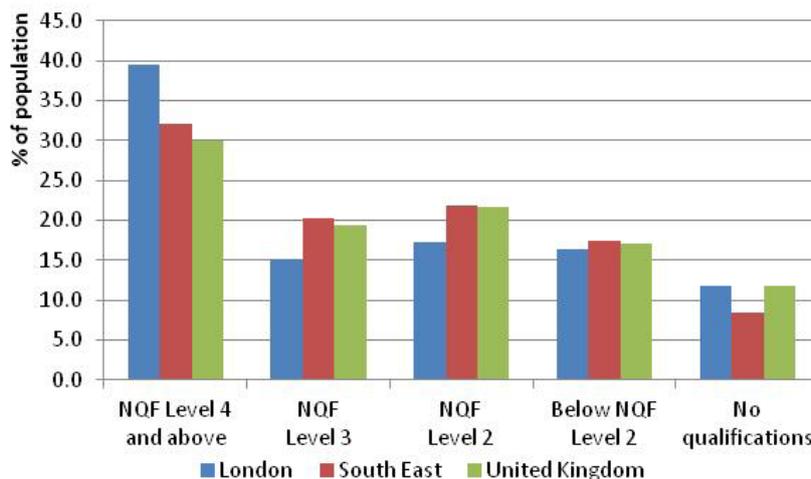
22. London's population is more highly educated than the national average with almost 40 per cent having a qualification at NQF level 4 or above, compared with a national average of around 30 per cent.¹²

¹¹ Source: estimate taken from the Family Resources Survey 2004–2005. This is the latest available estimate by region. At this time around 12 per cent of the UK population was covered by a PMI policy, compared with 10.9 per cent as at the end of 2011.

¹² www.ons.gov.uk/ons/taxonomy/index.html?nscl=Higher+Education+Skills+and+Qualifications.

FIGURE 3

Percentage of population by highest level of qualification (2011)

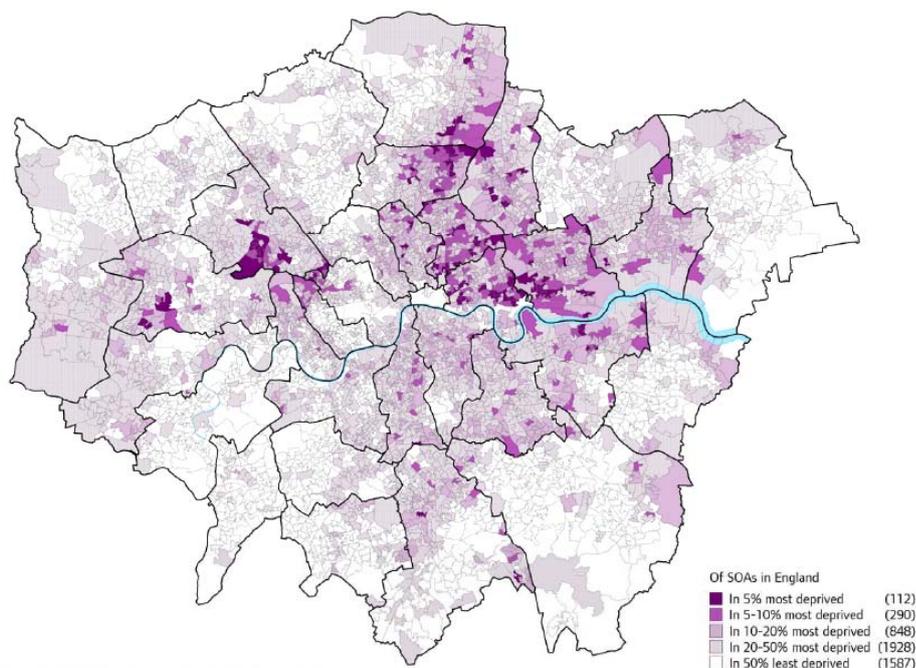


Source: ONS.

23. However, despite its overall affluence and high levels of education, London also demonstrates high levels of inequality with significant pockets of deprivation, particularly in the north and east of the city.

FIGURE 4

Index of multiple deprivation, 2010



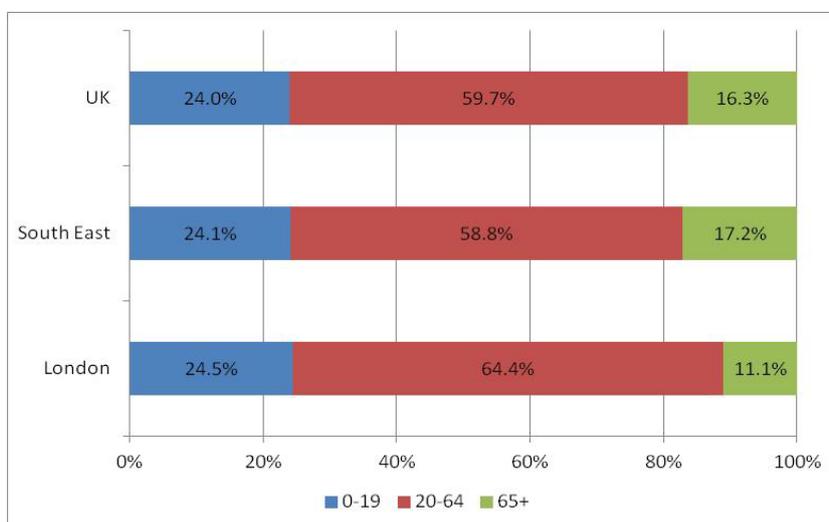
Source: <http://data.london.gov.uk/datastorefiles/documents/ID2010-a-london-perspective.pdf>.

Note: The index of multiple deprivation takes into account deprivation in terms of income, employment, health and disability, education, skills and training, barriers to housing and services, crime and living environment deprivation.

24. This pattern is repeated in unemployment figures, which range from 4.3 per cent in the London Borough of Richmond to 14.3 per cent in Newham. The average for London as a whole is 8.7 per cent, which is slightly above the national average of 8.1 per cent.
25. London's population is significantly younger than the average for the UK, with a particular concentration of working-age people and relatively low levels of those aged 65 years and above.

FIGURE 5

Break-down of population by age, 2011



Source: ONS data, based on 2011 census.

26. The CC has previously viewed conditions for private healthcare provision in the London region as differing markedly from those prevailing elsewhere in the UK and has considered that London should be regarded as a distinct market segment in itself.¹³ Distinguishing characteristics of London it cited in this context persist and include:
- (a) the presence of the UK's main teaching hospitals;

¹³ http://webarchive.nationalarchives.gov.uk/http://www.competition-commission.org.uk/rep_pub/reports/2000/449bupa.htm#full, paragraph 4.68.

- (b) the availability of eminent, including world-ranking, consultants;
- (c) the fact that PPU's appeared to be a more effective competitors than in other parts of the country;
- (d) a large number of self-pay patients, including from overseas;
- (e) in many cases prices were well above the average for the UK;
- (f) different travel patterns in London and higher disposable income; and
- (g) the four main national hospital operators at the time having their hospitals located almost exclusively outside of London.

27. Private hospitals in central London generate revenue of around £1 billion: almost one-third of UK private hospital revenue annually.¹⁴ Private hospital revenue in London has been growing at around 8 per cent a year since 2009.

28. Below, we show the share of total admissions and revenue of the private hospital groups and PPU's in London.

FIGURE 6

Hospital operators' shares of supply by total admissions and total revenue—central London, 2011



Source: CC analysis.

29. HCA as a group generates the most hospital revenue in London with a total market share of approximately [✂] per cent across all specialties or around four times its biggest rival, TLC.

¹⁴ Laing and Buisson Market Review 2011–2012 estimates UK independent hospital revenue at £3,844 million in 2010–11.

TLC's expansion plans and the importance of cancer treatment to it

The Quantum Leap project

30. In the early 2000s, the Trustees of TLC embarked on a fundamental review of its services and facilities which it called the 'Quantum Leap' project. As part of this it commissioned a study from consultants Finnamore¹⁵ to help it prioritize its investments. In the spring of 2002 Finnamore presented a report to the Executive Management Team of TLC making a number of recommendations covering both services already provided by the Clinic as well as services it should look to provide in the medium to long term. One of the areas in the latter category was a recommendation to consider investing in radiotherapy treatment facilities at the clinic and in September 2002 Finnamore presented its assessment of the business case for doing so.

The Finnamore proposals

31. Finnamore began by noting that the ability of TLC to provide a radiotherapy service to complement its existing oncology services was considered vital if it was to maintain and enhance its reputation as a leading private sector provider in the treatment of cancer. It said that the treatment of cancer had become a core business of TLC in recent years but that the inability to provide a comprehensive range of treatments, ie the lack of radiotherapy facilities, represented a considerable threat to TLC's position in the future.
32. Finnamore's reasoning was based on the fact that the cancer 'patient journey' may be somewhat different from that associated with other conditions. A patient may be referred by a GP to a surgeon who, before or after surgery, may refer the patient to a medical or a clinical oncologist for radiotherapy or chemotherapy.¹⁶ It is also common

¹⁵ www.finnamore.co.uk/.

¹⁶ A clinical oncologist will be trained in the use of radio therapy and the use of cytotoxic drugs. Medical oncologists may use chemotherapy, hormone therapy or, increasingly, new molecular targeted therapy.

for the patient's treatment to be managed by a multi-disciplinary team (MDT) including surgeons and oncologists.

33. However, TLC had no radiotherapy facilities, unlike HCA's Harley Street Clinic which had two Linear Accelerators on stream at that time with a third being introduced in 2003 or The Cromwell (two Tomotherapy machines). Other private radiotherapy facilities in or close to London were the Parkside Hospital in Wimbledon and King Edward VII in Midhurst as well as NHS PPUs such as the Royal Marsden.
34. The Finnermore report noted that radiotherapy was an effective treatment in the management and cure of cancer, set out the different types of radiotherapy available, referred to forecasts suggesting that the incidence of cancer was increasing at between 1 and 2 per cent a year and noted that the waiting lists at NHS radiotherapy facilities would be likely to encourage patients to use private facilities.
35. The report recognized the importance of consultant referrals to the business case and that a small number of consultants might be responsible for a large number of patient referrals (and thus hospital revenue). It included in its report the results of a survey of consultants with admitting rights to TLC. It said that roughly half of the consultants that it had approached expressed support for the project. Whilst acknowledging that this should be considered a very strong level of initial support the report said that a key factor would be the number of patients that would be referred by specialist oncologists.
36. Finnermore suggested building in annual patient volumes of [redacted] a year to the business case. From this it derived a base case for a two Linear Accelerator facility the costs of which would amount to capital investment of £22 million together with annual occupancy costs of £[redacted]. The profit and loss account produced by Finnermore

assumed annual income generated by the radiotherapy facility at £[redacted] with an operating margin of [redacted] per cent in year 1.

TLC's response to the Finnermore proposals

37. TLC's trustees and management, partly as a result of exposure to integrated cancer treatment facilities in the USA and with the encouragement of leading oncologists, eventually decided to invest in a much larger scheme: an integrated cancer treatment facility offering radiotherapy (including a CyberKnife¹⁷), chemotherapy, and robotic surgical facilities for cancer patients under one roof.

38. In 2003, TLC began the process of planning, financing the project as initially conceived and acquiring the premises in which to house its Cancer Centre. TLC told us that the process of acquiring the land and obtaining planning permission took [redacted] and that the land acquisition costs were over £[redacted]. It told us that the process was facilitated by existing presence in the Harley Street vicinity and its relationships with landlords. Further, because of the potential safety and environmental hazards associated with the radiotherapy equipment TLC planned to install, consents had to be obtained from a number of agencies and regulatory bodies.

39. The Cancer Centre admitted its first patients in December 2009. It had cost £90 million to build and equip.

¹⁷ [redacted]

FIGURE 6

TLC's Cancer Centre



Source: TLC.

40. The Finnamore report had emphasized the importance of consultant referrals to the success of the Cancer Centre from the outset. Certain oncologists had been identified as a significant source of patient referrals by TLC, in particular those associated with what was to become the London Oncology Clinic (LOC). We discuss the LOC in more detail below, in paragraph 57.

41. In December 2004, five months before the LOC began trading, the TLC trustees discussed investing in it. The proposal was that TLC should make an interest-free loan of £[§] to the LOC business to be invested in growing the practice. One of the terms of the loan the Oncology Clinic Partners would be required to refer their new patients to TLC. At the time only two of the four partners had consulting rooms at TLC: the other partners conducted their outpatient sessions elsewhere. These arrangements were formalized in the Collaboration Agreement approved by the TLC Trustees in March 2005.

42. The Collaboration Agreement obliged the Members, subject to the patient's clinical interests and in particular in compliance with the GMC's Good Medical Practice, to refer to the London Clinic, and use their best endeavours to cause all oncologists working at the LOC to refer there, all new patients requiring in-patient admission and all outpatient and day-case chemotherapy patients who could not be treated at the LOC premises. In addition, the same referral obligations applied to patients requiring radiology and with scanning requirements and, when TLC was able to provide it, PET scanning, all radiotherapy and nuclear medicine imaging including gamma camera and isotope bone scanning. For this, LOC would receive £[redacted] for each MRI or CT scan at TLC arising from referrals from LOC. In addition, the Agreement extended the referral obligations to invasive and non-invasive cardiology investigations and such pathology testing that was not undertaken at the LOC premises. [redacted]

Response of private medical insurers to TLC's expansion plans

43. In our first case study, on Circle's entry into Bath, we identified private medical insurer (PMI) recognition as a potential barrier to entry and expansion. We therefore examined the response of PMIs to TLC's expansion plans.
44. TLC was already operating its hospital in London, the additional radiotherapy treatment facilities it was introducing were adjacent to and connected with those facilities rather than on a new or remote site and were to be used in an area of treatment in which they already offered services. Consequently, recognition did not appear to present a problem to most of the PMIs. AXA PPP, however, told us that it did consider whether or not to recognize the radiotherapy facilities at the cancer centre. We therefore looked at the factors that AXA PPP took into account in coming to a decision on recognition.

AXA PPP

45. The relationship between AXA PPP and HCA at this time could be broadly characterized as reflecting AXA PPP's desire to maintain or lower the prices it paid for radiotherapy treatment in London and by HCA's to maintain and grow the volume of patients using its London radiotherapy facilities, in which it had invested heavily. AXA PPP therefore had an incentive to recognize TLC's additional facilities in London, to create rivalry between these and those of HCA and HCA had an incentive to encourage AXA PPP not to do so.

46. AXA PPP told us that HCA had sought contractual arrangements which would have had the effect of 'locking out' new provision in London and that HCA wanted AXA PPP to 'guarantee not to recognize' the new cancer facilities being developed by TLC.

47. AXA PPP submitted email exchanges between HCA's then Commercial Director and AXA PPP's Head of Provider Management in 2006 in which, on 13 October, HCA set out how it saw the goals of the two parties: 'We are looking to have new facilities recognized and have network integrity within central London in tertiary services, and you are looking for an ability to offer wider access to your members.' AXA PPP told us that 'network integrity' referred to a situation in which AXA PPP should not add further radiotherapy facilities to its current network in London.

48. HCA told us that in the negotiations with AXA PPP which led to the revised 2010 contract there was discussion of a pricing formula based on whether AXA PPP was proposing to recognize TLC's newly opened Cancer Centre and the impact that this would have on the volume of cancer referrals to HCA hospitals. HCA told us that its position reflected its concern that the forecast volume of patients through its radiotherapy facilities, in which it had invested very heavily, might be impacted. As

the economics of capital intensive facilities such as these are very sensitive to volume, additional radiotherapy capacity could therefore undermine their profitability. HCA indicated that, more generally, a hospital operator or a PMI may put forward for negotiation a volume/pricing proposition. Either, for example, may propose exclusive arrangements in order to secure a better price.

49. Negotiations between the two parties over a new contract, [REDACTED].
50. A letter from the CEO of HCA to the CEO of AXA PPP in October 2009 set out the main issues and HCA's proposals [REDACTED].
51. [REDACTED]
52. An internal AXA PPP document described the course of negotiations following this letter. It said that in response, AXA PPP had qualified the restriction as applying to new providers only, 'not extensions, specifically referring to the London Clinic'. It went on to say that: 'At the meeting on 7 November HCA made clear that they were specifically talking about LC [London Clinic] and we agreed to consider whether we could (legally) restrict recognition of additional services provided by an existing network hospital (LC) and then whether we would want to.'
53. AXA PPP's note of a meeting with HCA to take discussions further, [REDACTED].
54. The new agreement between AXA PPP and HCA was signed in 2010. It committed AXA PPP to recognizing new HCA facilities, subject to agreement over charges, but left AXA PPP free to include new network provision at its absolute discretion. If AXA PPP did add or remove providers then either side would have the right to seek to negotiate an adjustment of prices if and only if it could be demonstrated that doing so

had had a material impact on payments made to HCA. 'Material' was defined as [X] per cent.

55. We asked AXA PPP whether, in practice, this had proved a constraint on its ability to vary the provision of its network. It said that the [X] per cent hurdle was sufficiently high to make it unlikely to trigger price negotiations. Despite the apparent relaxation in constraints on AXA PPP as regards recognizing new facilities in London, the contract contained an obligation on AXA PPP to 'use its best endeavours to ensure that no additional radiotherapy providers located in Central London are included in the Directory of Hospitals until after June 2010'. We asked the parties what the origin of this clause was and whether it had affected its recognition of the TLC radiotherapy facilities.
56. AXA PPP told us that the provision, without the cut-off date, had been included by HCA at draft contract stage but that the time limitation had been inserted during negotiations. It told us that since it only reached agreement with TLC on radiotherapy prices in late March 2010 the restriction had little effect in practice since it lasted only around two months, following commencement of the contract.
57. HCA also pointed out that the scope of the restriction was limited to two months and that the provision was added to reflect significant investments made by HCA in its radiotherapy services.

HCA's growth strategy and the place of cancer treatment within it

58. HCA, like TLC/Finnamore, had identified the attractiveness and importance of cancer treatment to its business strategy given the likely growth in demand and the value and profitability of cancer treatment services.

59. HCA's Cancer Strategy document noted that cancer was a top of mind issue for health consumers: 76 per cent of people ranked it as their foremost health concern and 91 per cent gave cancer as their main reason for taking out PMI. It said that demographic data indicated that cancer would be the fastest growing health sector, +26 per cent by 2025. The same document pointed out that cancer treatments accounted for a significant proportion of HCA's activities ([REDACTED] per cent of HCA's net revenue and [REDACTED] per cent of EBITDA).
60. HCA's cancer strategy was based around investment in leading-edge technology and services not generally available privately or in the NHS, recruitment of top consultants and the creation of a cancer treatment network whereby a number of diagnostic and examination facilities would feed referrals to its treatment centres in London and beyond. Again, like TLC, HCA identified the potential benefits to it of closer collaboration with the London Oncology Clinic and set up 'Project Bosun' which would eventually lead to it acquiring a majority stake in the business from its founding partners. We examine in more detail below how relations between TLC, HCA and LOC evolved.

The London Oncology Clinic

61. The LOC was established in 2005 by four founding partners: Peter Harper, Maurice Slevin, Paul Ellis and David Landau. By 2008 it had attracted over 20 leading oncologists to work at its clinic at 95 Harley Street. As noted earlier, in 2005 TLC and LOC signed a Collaboration Agreement the main feature of which was that, in return for an interest-free £[REDACTED] loan to the LOC business, clinicians at LOC were required, subject to the medical interests of their patients, to refer patients to TLC.¹⁸

¹⁸ [REDACTED]

62. The importance that TLC attached to this arrangement was underlined by the degree of scrutiny of LOC's adherence to its obligations. [REDACTED]
63. It is clear from the minutes of senior management meetings that TLC assumed that it would continue to work closely with LOC and its consultants and this assumption was factored into TLC's plan projections. It was also clear how important this was to TLC in revenue terms: [REDACTED].
64. The Collaboration Agreement with LOC was due to expire in February 2010 but TLC wished to retain the relationship and make it even closer with a plan to acquire the LOC business. However, it gradually became apparent to the TLC management that the LOC partners were developing a closer relationship with HCA.
65. Discussions about a possible purchase by TLC of a majority stake in LOC were reported to the TLC Trustees in June 2008. These continued through the summer and autumn of 2008 [REDACTED].
66. Following the June 2008 meeting of the Trustees an offer of £[REDACTED] was put to the Chief Executive of LOC, [REDACTED].
67. LOC told us that it wished to retain managerial and clinical autonomy in order to run the LOC in the way it would best serve the interests of its patients, including the freedom to decide which hospitals to refer patients to for treatment. It told us that this was an aspect on which the LOC partners did not wish to compromise. Accordingly, nothing further was heard from LOC and the TLC offer lapsed.
68. In May 2010 the minutes of the TLC Executive Board confirmed that HCA had entered into a strategic partnership with and acquired a stake in LOC. [REDACTED] LOC told

us that a substantial volume of patients are still admitted by the LOC to TLC for treatment and that it believed that the majority of inpatient referrals generated by the LOC are to TLC. HCA told us two of the LOC founder members took virtually all of their inpatients to TLC in 2012.

69. In July 2010 the TLC Executive Board minutes recorded that further details of the deal between HCA and LOC had emerged. The two organizations had established a joint venture company with Dr Harper as its Chair and which would include the CEO of HCA on its board. [REDACTED]
70. TLC told us that it was concerned that HCA would target TLC consultants to transfer their practice to HCA hospitals. TLC provided an example of this targeting which was reported to the TLC Board in April 2011, ie after the Cancer Clinic had opened. A special meeting of the Board of Trustees was convened to discuss a situation concerning two surgeons. They had informed TLC that they had received an offer, which TLC believed to be from HCA, to transfer their practice to another facility, which TLC believed to be the Platinum Centre at the Wellington. [REDACTED] The Trustees agreed that, exceptionally, management should negotiate a deal to retain these two doctors.
71. Since concluding the original LOC partnership agreement, HCA has applied the LOC 'brand' to other facilities including LOC at the London Bridge, LOC at the Wellington Hospital (Platinum Centre) and LOC at the Christie in Manchester, indicating the value of the LOC association to and the synergy with HCA.
72. Oncology was HCA's fastest growing [REDACTED] areas of care in 2011.

FIGURE 7

HCA revenue growth and gross margin by speciality



Source: HCA.

The TLC Cancer Centre: performance since launch

73. Any restrictions on expansion encountered by TLC in developing its Cancer Centre have not prevented it from operating profitably.
74. Figure 8 shows a forecast turnover and operating profit for the Cancer Centre in its first two years of operations and actual turnover and operating profit for its first two years of operation. [✂]¹⁹

FIGURE 8

TLC Cancer Centre financial performance



Source: []

75. [✂]

76. [✂]

TABLE 4 Revenue and profitability of TLC's radiotherapy department, 2012



Source: TLC.

¹⁹ The other services offered by the Cancer Centre, including surgical and chemo treatments, were an established part of TLC's service offering.

Preliminary conclusions on barriers to entry and expansion

77. In our Bath case study we showed that AXA PPP's decision not to recognize the Circle hospital, because of its broader, national relationship with BMI, restricted Circle Bath's ability to grow profitably. In this case, HCA may have tried to persuade AXA PPP not to recognize TLCs radiotherapy facilities in London but it did not succeed in doing so. As a consequence, PMI recognition did not restrict entry or expansion in this case.

78. There is more evidence to suggest that the ability of hospital groups to identify clinicians who are likely to be significant sources of patient referrals and admissions (and thus revenue) and to then encourage them to admit or refer patients to their hospitals rather than rivals' might restrict entry or expansion.

79. However, this case study has demonstrated that such measures may be available to the entrant as well as the incumbent. TLC, for example, entered into the Collaboration Agreement with LOC to encourage referrals to its radiotherapy facilities. And, in our Bath case study we showed that Circle's equity sharing scheme was effective in attracting consultant support for its new hospital. We therefore do not consider that, on the basis of these two episodes of entry and expansion, that such arrangements necessarily constitute a barrier to entry but do not rule out the possibility that in some circumstances they may do so.

80. We note that, in contrast to Circle in Bath, TLC did encounter quite significant problems in acquiring the necessary land and planning permissions for its Cancer Centre and that the project took over five years to complete. We are not clear whether similar problems would be encountered by a new entrant outside of central London but we do consider that the ability of an entrant to find, acquire and build on

a site in the immediate vicinity of Harley Street may represent a barrier to entry or expansion.

Other hospitals' cancer strategies

Bupa Cromwell Hospital

1. Bupa acquired the Cromwell Hospital in 2008 intending to reverse 'years of underinvestment' with a £[redacted] redevelopment programme. Delays to this project held up progress to the extent that tenders for the construction work were only issued in 2012 and BCH acknowledged that retaining the loyalty of consultants during the disruption of the ensuing building work would be a challenge. Nonetheless, BCH had identified which services it intended to try and develop, which included oncology, and the strengths on which it intended to build. These included its ownership by Bupa though BCH has, in fact, [redacted].
2. BCH's 2012 Business Plan noted that with the direction of open referrals it would increasingly be in a position to provide more patients to consultants which would allow it to attract new consultant users and 'evolve the nature of our relationships with existing ones'. It noted that its top [redacted] consultants [redacted] but conducted [redacted] private practice work at BCH. It said that it intended [redacted].
3. BCH also intended to develop its referral network. It said that it was building up the numbers of its GP liaison staff, was developing GP practices in the mews adjacent to the hospital,²⁰ and would be creating satellite outpatient clinics at Bupa Wellness Centres, the first of which would be at the Barbican.²¹
4. BCH identified oncology as one key area to develop following much the same analysis as both TLC and HCA: the likely continued growth in the incidence of cancer; the importance of cancer treatment as a revenue stream; the high margins it

²⁰ Bupa Cromwell provided accommodation for GPs on its premises with attractive rental terms being made available to the higher referring ones.

²¹ Bupa has since confirmed that the outpatient clinics pilot has been discontinued.

attracted. In addition, its analysis of Bupa claims [redacted], excepting cardiology. Patients could therefore be drawn to London from [redacted] than they could for other forms of treatment. It estimated the value of the London oncology market as around £[redacted] million and BCH's share of this as [redacted] per cent.

5. BCH thus already generated quite significant revenue from cancer care, particularly from [redacted].

FIGURE A1

BCH Oncology net revenue (£m) by payor, 2000 to 2010

[redacted]

Source: Bupa.

6. Internal BCH documents show that although the hospital had previously laid claim to leading-edge technology in the field of clinical oncology it could no longer do so since the acquisition by both TLC and HCA of CyberKnife technology. Nor did it perform well in the, relatively larger, field of medical oncology. In this context it noted that the 'patient journey' in cancer treatment was somewhat different from other conditions in that surgeons would tend to refer patients on to clinical or medical oncologists who would deal with them on a multidisciplinary team basis, particularly in the NHS. Although it had begun using MDTs it said that it [redacted] was more prone to lose referrals to outside facilities. BCH has since confirmed that it has addressed this issue and now treats all patients with an MDT approach.