

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with The London Clinic held on 27 February 2013

Background

1. The London Clinic (TLC), a charity-run hospital built in 1932, was the largest independent hospital in the UK. As a charity, TLC valued honesty and openness, trustworthiness and integrity. It enjoyed a prime location on Harley Street and considered itself at the pinnacle for acute and tertiary care. TLC enjoyed a strong brand in London and in parts of the Middle East, although it was largely unknown outside of the M25.
2. TLC offered a wide range of services which allowed it to treat quite complex conditions. It had 250 beds, 14 operating theatres and 1,200 staff, and 800 consultants used the clinic, many of whom were based in London teaching hospitals. TLC's annual turnover was approximately £130 million and had seen revenue growth of 5 per cent in the last year.
3. Cancer was a particularly important specialty for TLC. Ten years ago the hospital built a new £90 million cancer centre. It consisted of four nursing floors and a full radiotherapy suite and allowed TLC to provide a full range of cancer treatment.
4. TLC believed that consultants had a huge influence on where patients received their treatment. In addition, the international reputation of Harley Street was based on the fact that patients felt that they would be referred from the best to the best without being encumbered by any sort of perverse incentives or influences.
5. TLC worked hard to attract excellent staff and consultants and aimed to deliver outstanding patient care. It hoped it was affordable, competitively priced and delivered effectively and well. It had the highest patient satisfaction in London and had received a glowing report from the Care Quality Commission following a recent inspection.
6. Being a charity inhibited TLC's ability to respond quickly to business opportunities. Although it did not have shareholders, it did have strong governance in place and a board of trustees. The trustees expected TLC to act with great integrity and to be prudent with investments. It acted in a very efficient manner, maximizing the utilization of capacity. There were also some non-financial and financial benefits to being a charity: for example, TLC did not pay dividends or tax. This meant that the hospital could reinvest its surpluses and give a truly competitive position to all its patients.
7. TLC's returns were dependent on the nature of an investment. However, it broadly used a basis of interest rate of return between 12 and 15 per cent on a project.

Competition

8. TLC believed that a lot of investment was required to be successful in London and because of the number of tertiary services on offer, there were significant barriers to entry. In order to be a player in the London market, a provider needed to offer a broad range of services.

9. Outer London hospitals did offer competition to a smaller extent and indeed, some insurers were introducing insurance policies that were less expensive if patients used outer London hospitals. However, on the whole, people who lived or worked in London perceived that the best treatment would be offered in central London hospitals.
10. TLC believed that the market for cardiology had contracted. Outside London a number of hospitals had stopped providing cardiac surgery, and there was an over-supply in London. Unless a provider was attracting a large amount of cases, it was difficult to make cardiology credible.
11. TLC was not aware of other hospitals' prices. Its international work was usually treatment of complex conditions and was priced on a bespoke basis. With the self-pay market, most cases were priced individually and TLC carried out a relatively small amount of such work. TLC would benchmark such cases against either PPU's or HCA.
12. Its main competitor was HCA, which also owned Leaders in Oncology Care (LOC), a grouping of oncologists that had a large impact on how the referral process worked. TLC saw cancer care as crucially important as a specialty which relied on a series of referrals. HCA also owned two PPU's in the large teaching hospitals that were experts in cancer surgery, which meant that HCA controlled 80 to 85 per cent of the market. Other competitors included strong branded PPU's such as the Royal Marsden. TLC did not have a strategic alliance with any teaching hospitals.
13. TLC felt it offered huge competition to HCA in certain specialty areas like cancer surgery. Another area of competition was attracting and retaining the best consultants.

Negotiations

14. TLC had a reputation for offering a good quality of care and a wide range of services. It believed its services were competitively priced compared with HCA. It believed it was in an insurer's best interest to have it as part of its network. Insurers also welcomed a competitor in central London, particularly one that offered lower fees.
15. TLC told us that HCA had more bargaining power against insurers. HCA accounted for over 60 per cent of the London market and also had a high dominance in certain specialty areas (eg oncology). With limited providers in the market, insurers would experience problems if they excluded HCA from their network.
16. One of the reasons that TLC did not charge the same price as HCA was because it was a charity providing a public good and acting in the interest of patients. The other reason was that TLC felt it needed to be competitively priced in order to remain in the insurers' networks. If it were to raise its prices with the intention of matching HCA's, it would risk being delisted.
17. Another important reason to have contracts with insurers was so that consultants practising at TLC could carry out all their work there.
18. TLC was part of an international market which had recently expanded, and patients from the Middle East would now consider going to Singapore, Thailand, Germany or France for their treatment. TLC had to be very competitive and it was not in its interest to price at the top end of the market.

19. Historically, TLC had a framework of charges, eg for a room, use of the theatre etc, and that was how overall pricing was determined with yearly negotiations. This was used to set the price with insurers and to establish a discount against the rack tariff. When new networks were introduced, eg Bupa's MRI network, the fee was a set price and TLC could decide whether to participate. In this case, the discount was effectively determined by the insurer.
20. TLC believed greater availability of data and information would have a big impact on the market. Patients and GPs were not currently able to make informed decisions about the best place for healthcare.
21. TLC welcomed greater transparency in measurable and comparable factors such as outcomes data and infection control rates as these would help to inform patients and allow them to make choices more easily. It was confident that if the market functioned in the interests of patients, it would also be working well for TLC.
22. Structural changes in the marketplace had resulted in more patients coming through as day cases and outpatients, and GPs were moving into providing services for those groups. However, there was a counter-trend in that NHS services were being increasingly financially squeezed and TLC believed this would have an impact on waiting times and perceived quality of care. This might encourage people to consider the private healthcare market.
23. TLC did carry out a limited amount of NHS work, but found it difficult to negotiate with the Trusts.

Incentives

24. Cancer was crucially important as a specialty and relied on a series of referrals. If a patient had surgery and was referred on for further treatment, there were a number of stages in the process where the patient's journey could be influenced. It was TLC's belief that the best care was delivered when the whole patient pathway was completed at one location, and that was very much what the NHS strived to deliver. TLC believed that when that was interrupted just for the convenience of the consultant or because the consultant was incentivized to take a particular route, that could work against the best interests of the patient.
25. There were instances when consultants were offered financial incentives to undertake treatment at HCA or LOC. Such activities should be made transparent to the patient so that an informed decision could be made. The patient should understand that there was a financial incentive in place.
26. There had been one instance when two eminent oncology consultants had wanted to practise at TLC but were offered a significant sum by HCA to practise at their hospitals. TLC's trustees had already committed to the new large cancer centre and considered losing the consultants would be a detriment to the clinic. In this instance, the decision was made to match the terms that HCA had offered, as a defensive move. TLC did not see this as contributing to an arms race around attracting oncologists.
27. As part of TLC's practice agreement, the consultants were allowed to practise at other hospitals, but patient integrity was not to be compromised. If, for any clinical reason, it was appropriate for that care to be provided at a better facility, TLC would not question that. Consultants were required to act in the clinical and best interests of the patient at all times.

28. With regard to consultant partnerships, TLC believed that in London there were so many consultants that any groups were competing with each other. However, oncology care was different in that in London LOC was such a large grouping that it did dominate that market. A relatively small number of people being involved in cancer services, whether it was surgeons, oncologists, radiotherapists etc, could have a huge impact on competition.
29. TLC said that the constraints on fee levels might be making it difficult to make a return in certain specialities but with respect to surgical specialities, TLC still saw a lot of consultants coming through to establish a private practice.
30. TLC had concerns about large GP practices being privately owned by hospital operators, especially when there were influences/incentives to direct a patient to a particular provider. Where it was a smaller part of the market, TLC had much less concern.

Profitability

31. TLC considered its key profitability drivers to be word of mouth, repeat business and ensuring that it provided the best quality of care. It was keen to ensure that there were no barriers to getting access to patients. Another key point was recruiting and retaining consultants. It was important that TLC marketed itself correctly, to give consultants confidence in terms of being recognized by insurers, reputation, growth etc which would help attract more consultants.
32. Another consideration was capacity utilization which was driven largely by consultants' availability. TLC was constantly striving to maximize utilisation, not only of its staff but also of its facilities, eg operating theatres, consulting rooms etc.
33. TLC's radiotherapy and chemotherapy units were both currently working below target. Radiotherapy had a huge capital investment. Influencing a small number of patients could have a huge impact on profitability. Chemotherapy in particular was struggling because of competition from LOC. Losing patients to these services also impacted on the wider hospital, eg pathology, scans etc.
34. With regard to the current reforms in respect of the PPU income cap and earnings from private patient income, TLC welcomed competition based on quality, price and openness so that patients had the freedom to choose where to be treated. The cancer market was internationally something that could be made bigger, and to have a more effective player like, for example, the Royal Marsden was a good thing. Its main concern was the possibility of HCA's dominance being increased by taking control of the PPUs. It was also concerned about covert incentives that patients were not aware of influencing where they ended up being treated.

Recession

35. TLC had not been dramatically affected by the last recession, due to an increase in international business. It had seen a reduction in the self-pay market, particularly where decisions regarding disposable income were made.
36. TLC had found that the biggest impact had been the insurers' confidence. Insurers had found themselves squeezed and as a result were more aggressive in how they directed work, in particular regarding consultants who might charge more than others or shortfall patients. As a result, a number of consultants felt less confident about the future and how they would maintain their income.

Charitable work

37. TLC was currently in the middle of a strategic review of its charity work. It did a wide variety of charity work and was considering how it could widen that further. TLC had a history of attracting international patients and had a high international profile; however, it was virtually unknown outside the M25. TLC had a history of working closely with embassies which were based in the UK, and predominantly from the Middle East. International patients came to London mainly for complex work, eg cancer treatment.

Conclusion

38. The two big issues for TLC were that (a) it believed that the London market was different from other markets with significant barriers to entry but niche opportunities, and (b) that transparency was key for patients and they were not currently receiving a transparent service.