Consultant 43

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Dear Mr Witcomb

Private Healthcare Market Investigation by Competition Commission Proposed "Remedies" – Divestiture by HCA of London Bridge and Princess Grace Hospitals

Patient Choice and Safety

There are without questions, financial economies and diseconomies of scale that are afforded by being part of a large grouping of hospitals such as those belonging to the HCA group within "central" London. Being part of a large group has afforded opportunities to individual hospitals to take risks in investing and developing services for patients such as the Acute Admission Service and new 6-bedded ICU at the Lister Hospital that would not have been prudent nor affordable were the hospital entirely solo. However, this development has given the opportunity to the patients of inner south-west London to access local acute private care that did not previously exist allowing them to be admitted closer to their homes, families and friends. Previously, such patients either had to attend an NHS casualty department or visit the acute care centre at the Princess Grace on the northern border of central London, a considerably longer distance from their homes.

In a similar manner to the NHS, many of the hospitals within the HCA group provide expertise and specialist care in specific areas with some replication across the group such as cardiac services at the London Bridge, Harley Street and Wellington Hospitals and full vascular services at the London Bridge and Wellington Hospitals, but not others such as neuro-rehabilitation at the Wellington alone. The linkages of the hospitals within the group provides the economies of scale that allows the group to provide expert neuro-rehab services to all its patients, albeit within a single site which would be an unaffordable luxury were the Wellington a stand-alone hospital. Equally, the common nature of cardiac disease makes it economically viable to provide cardiac services to the group in more units, giving patients greater choice to access these closer to their homes or commuting entry points.

As a clinician who practices Intensive Care medicine at the Lister, occasionally, I have had to seek additional specialist care for patients that the Lister alone cannot provide such as electro-encephalography or biventricular pacing. Were I practising from a independent solo hospital, I should have to seek a visit from an expert outside the organisation, arrange for either a visitation with granting of temporary practice privileges (clinician to provide CV, indemnity certificate, appraisal documentation, occupational health checks) and then arrange transfer to the hospital elsewhere with a summary care record and CD Rom of the patient images. Within the HCA group, a single phone-call to an appropriate specialist in a sister Hospital can facilitate expert opinion – the electronic record, laboratory records, X-rays and intensive care charts all being visible to colleagues given appropriate authorisation through the HCA central server and if temporary transfer is required there is no loss of information with distillation down to a summary record. Patient safety is enhanced and delays to appropriate treatment are reduced.

The duplication of services on two or more sites also affords greater security for patients by building in contingency for breakdowns, closures during refurbishments and shorter waiting times for investigations. All these factors speed up the process of care and reduce patient distress as well as improving outcomes in time-critical care pathways such as emergency cardiac care or cancer treatments.

The importance of patient choice should not be under-estimated. With the current system in place, were I anaesthetising a patient at the Princess Grace Hospital who unexpectedly developed cardiac complications requiring additional investigation and management, I would have the option of sending them to either the Wellington, the London Bridge or the Harley Street Clinic hospitals for on-going treatment. This choice would often be guided by the patient's home address and thus convenience for their family and friends to visit and for the patient to undergo their follow-up. Patients from South London would normally choose the London Bridge, those from North East London, the Wellington and those from North West London, the Harley Street Clinic.

Regular visits from family and friends improves patient well-being and assists in the recovery process. With the proposed loss of the London Bridge Hospital, a patient from Croydon or Dulwich who chooses to have breast cancer treatment at the world famous London Breast Institute (currently based in the Princess Grace Hospital) who develops cardiac complications may now face a choice of being cared for in a group hospital such as the Harley Street Clinic with immediate access to all their lab, x-ray, electronic notes and history on file but being many miles from friends or being transferred to a more local hospital with printed paper records, CD ROMs for x-rays and no easy search and interrogation system of their medical history. I do not consider this a choice that patients should have to make; enhanced continuity of care with improved safety or easier access for friends and family visitors. HCA has spent many years developing a comprehensive network offering near seamless continuity of care, choice and enhanced safety to patients in London and it appears this is shortly to be severely damaged.

Loss of counter-balance to market distortions induced by oligopoly of insurers – and knock effect to patient safety

One of the problems faced by clinicians providing private healthcare in London is that of PMI behaviour in terms of fee remuneration. The main three insurers routinely refuse to allow a time-based component to clinician remuneration or to recognise different remuneration rates out of hours. To illustrate this point, I offer two examples:

(i) I provided seven hours of continuous bedside care to a critically ill sixteen year old girl who required to be intubated, ventilated and placed on two kidney machines to manage a sever acidosis during acute life-threatening neutropenic sepsis. Two dialysis lines were placed, a further central line as well a sartorial blood pressure monitoring. One of the largest insurers in the UK market refused to pay more than around £250 for these services. Furthermore, they complained that I had not sought pre-authorisation to perform these services in the acute, life-threatening situation where I had been called as a matter of emergency. The patient was admitted intensive care for around three weeks buy happily survived.

(ii) I undertook an emergency paediatric anaesthetic at 23:00hrs on a Saturday night, spending around three hours in the hospital, attracting an anaesthetic fee of around £150 from the same insurer. The insurer refused to recognise the duration of care, the anti-social hours or the specialist nature of the paediatric anaesthesia provided in their remuneration for the case. Their policy is solely based upon a surgical code. I note this fee has barely altered in around 15 years.

In London, certain insurers use their market power to artificially drive down fees threatening de-recognition of consultants who do not agree with their fee structure and creating market distortions. This can make it extremely difficult to secure out-of-hours cover for emergency anaesthetics in many institutions. To counter-balance this, larger hospital groups with their slightly increased bargaining power, lower flux rates in patient referrals and steadier cash flows can afford to contractually employ consultants to be available for on-call emergencies thereby ensuring greater safety for their patients but also making it economically viable for a

consultant to undertake work in the middle of the night, counter-balancing the value distortion that the insurers seeks to impose.

It is a cause of significant concern to me that in seeking to make both HCA and BMI divest themselves of hospitals from their groups, the counter-balance to many of the oligopolistic practices demonstrated by insurers will be lost and the safety of patients will be further reduced.

Reduction in status as London as one of the world's premier medical care centres for international patients

Finally, I wish to express my concern that in forcing HCA to divest itself of the London Bridge and Princess Grace Hospitals, there is potential to do real harms to the reputation and economic success story of London as location for international patients seeking excellent private health care. HCA has spent many years investing in London's healthcare building international relations and a reputation for excellence in such areas as IVF (Lister Hospital), breast care and bariatrics (Princess Grace Hospital), neuro-sciences (Wellington Hospital), cardiac services including paediatrics (Harley Street Clinic), women's services (Portland Hospital) and liver and vascular services (London Bridge Hospital). To suddenly force the group to divest two hospitals sends extremely bad signals into the market-place and is likely to cause investors to question the wisdom of investment in major London healthcare infrastructure. As an advisor on an investment committee, I for one should caution against future investment in this area as a result of this decision.

More worryingly than merely damaging the incentives for forward investment, I am concerned that by actually harming the ability of HCA to provide comprehensive, integrated and geographically appropriate healthcare so appealing to many patients from abroad, we shall lose share of the international patient market currently estimated to be worth in excess of £500 million in London (but in excess of £4 billion globally). To do this at a time of nascent economic recovery would be extremely unfortunate. Indeed, at a time when emerging economies are enjoying disproportionate growth in person wealth compared with their ability to provide population-expected high-quality healthcare, it might be argued prudent that this is an area we should seek to grow in the UK economy rather than attack.

I apologise for the length of my letter and also that I have not addressed many of the extremely interesting concerns surrounding other aspects of private healthcare provision within London including the tensions between competition, safety and quality of provision, costs, insurers, back-door insurer medical regulation and oligopolistic behaviours amongst others. However, I believe that there is demonstrably already great choice for patients and their insurers and that access to most of this is relatively straight-forward. From all the information available to me, I believe that to cause HCA to divest itself of the London Bridge and Princess Grace Hospitals will be bad for patient choice, bad for patient safety, bad for future development of comprehensive models of provision, bad for competition within the marketplace, enhance insurer domination of patient choice, disempower patients, and lead to loss of both reputation and market share in the international patient market.