

PRIVATE HEALTHCARE REMITTAL

Summary of hearing with The London Clinic held on 11 August 2015

Introduction

1. The London Clinic (TLC) stated that it was keen to support the findings of the original market investigation. It was particularly concerned about HCA International Limited (HCA) increasing its dominance in the oncology market in central London, which in its view is facilitated further by HCA's continued acquisition of private patient units, growing involvement in NHS Trusts and current part ownership of the Leaders in Oncology Care.

Quality and complexity

2. Overall TLC did not believe that there were any differences in the quality and complexity of the patients they treated which justified in part, or wholly, the alleged price difference between HCA and TLC.
3. TLC stated that the quality of care they provided for equivalent cases matched or exceeded that provided by HCA. Although most of this is based on anecdotal evidence, it also pointed out that many consultants chose to receive their own treatment at TLC, rather than going elsewhere.
4. In terms of complexity, TLC stated that it offered the same sort of complex treatments as the Wellington and the London Bridge hospitals (although it does not offer cardiac surgery). It did not agree with HCA's assertion that the latter treated more complex patients within the same treatment code: if this were the case, TLC would see their own consultants taking their more complex work elsewhere (which was not the case, as it had many consultants who practiced exclusively with TLC and offered a complex range of services). However, TLC was not able to comment on whether there were any specific treatments or specialties where it did see particular differences in the complexity (and price) of treatments between HCA and themselves, without seeing the comparative data.
5. TLC also refuted the assertion that the number of line items on a hospital invoice could be used as evidence that HCA treated, on average, more complex patients than TLC – differences in the number of line items on an

invoice could simply be reflecting differences in the way in which hospital operators billed for their services rather than the quality of care they provided.

6. TLC believed that the introduction of ICD-10 would improve the measurement of clinical quality in the next two to three years. In the meantime, TLC was not able at this stage to point to any other quantitative or qualitative evidence that would help the CMA assess the comparability of quality for central London hospitals.

Bargaining

7. TLC stated that it did not see any change in the negotiation dynamics with insurers in the last couple of years. [REDACTED].
8. In its view, hospital operators were less impacted by open referrals - this was because open referrals were more about directing patients to less expensive consultants, rather than to less expensive hospitals.

Competitive constraints

9. In relation to whether competitive constraints and the nature of the market in central London had changed, TLC reiterated its concern regarding HCA's growing involvement with Private Patient Units. The primary reason for this was that many of its consultants were still in NHS practice and if a hospital operator was in a position to influence the primary employer then it could also influence where the consultant would practice.
10. TLC did not see the Kent Institute of Medicine and Surgery (KIMS) located in Maidstone, as a competitor – it was well outside London and patients continued to travel into London. It had also not seen any of its consultants taking up positions at KIMS.
11. TLC pointed out that when measuring the level of spare capacity in central London there needed to be consideration regarding throughput as much as physical capacity – this would require looking at spare capacity across high-level intensive care support, theatres, radiotherapy and consultants. It stressed that, as over time the length of stay in hospitals has become shorter, 'beds' are no longer a constraint.
12. In TLC's view, capacity was particularly constrained in tertiary care (which was primarily about oncology and cardiology). However, elsewhere in central London, there may be a degree of spare capacity.

Barriers to entry and expansion

13. In relation to new entry and expansion, TLC noted the three Proton Beam centres that are being proposed for central London (Harley Street, University College Hospital (UCH) and VPS Healthcare (VPS)). It also pointed out that HCA had traditionally being offered first refusal with UCH under the current arrangements.
14. TLC were also aware of VPS's planned entry through the acquisition of the old Masonic Hospital. In its view this hospital might add some competition, but would not have a significant effect on changing the central London market. This was because the hospital site was further out than central London (and Harley Street) and, in its view, only a small proportion of consultants might find it more convenient to work there. TLC also noted that it may take VPS around ten years to both open and reach the point where it would be able to have a significant effect on the central London market. This view was based on its own experience of opening its cancer centre on a site that was supported by a large hospital. This was a straight forward project, but it still took ten years to complete. There was also a question over whether insurers would be able to afford to recognise Proton Beam therapy (which, at the moment, was only suitable for the treatment of certain child cancers) and whether all three machines would be needed.
15. Finally, TLC said that dealing with local authority planning departments was still proving difficult (based on its current experience of refurbishment), despite the government's move towards trying to make planning less of a hurdle for new developments.