Appellant
Name of Witness: Shams Maladwala
First
Date: 19 July 2021

FIRST-TIER TRIBUNAL
(GENERAL REGULATORY CHAMBER)
INFORMATION RIGHTS

Appeal ref: EA.2021.0047

BETWEEN:

THE ROYAL MARSDEN NHS FOUNDATION TRUST

Appellant

and

(1) THE INFORMATION COMMISSIONER
(2) CENTRE FOR HEALTH AND THE PUBLIC INTEREST

Respondents

WITNESS STATEMENT OF: SHAMS MALADWALA

I, **Shams Maladwala**, will say:

1. I am employed as the Managing Director of Private Care at The Royal Marsden NHS Foundation Trust ("the Trust"). I have held this post since March 2014. I have the following qualifications: MBA & BA Business Studies.

2. As the Managing Director of Private Care, I am responsible for overseeing the delivery of all Commercial, Operational and Clinical aspects of the division including the approval of pricing and contract negotiations with private medical insurers. I have direct experience of working for a private medical insurer: I was previously employed at BUPA from 2009 to 2014 as Commercial Director, Bupa Cromwell Hospital.

3. I make this witness statement in support of the Trust's appeal to the Tribunal, in which it argues that it should not have to disclose the profit margins on its Private Care (or Private Patient) Income over recent financial years. This is because the Trust is very concerned that that profit margin data would be used by those with whom it undertakes commercial negotiations – most notably insurers – to drive down prices during those negotiations, resulting in less income for the Trust. My colleagues have provided witness statements

explaining how that harm would be likely to come about, and why it would be harmful in public interest terms, not only as regards the Trust's Private Care work, but also as regards its NHS work. I have read and agree with those statements.

4. In my statement, I supplement and reinforce those concerns from my perspective as Managing Director of Private Care, and drawing on my commercial experience in this sector (including work for a major insurer). I provide details of the service offering and the private care market, the commercial view on the integrated service model, the insurer market and price setting before addressing the commercial impact that publication of the withheld profit margin information would have upon the Trust.

The service offering and the private care market

5. The Royal Marsden Private Care ("RMH") offers an award-winning service, having won the LaingBuisson Best Private Hospital Award for three out of the previous four years. The Trust's overall services have been rated 'Outstanding' by the CQC, and it is one of only a few providers of private care services to achieve such a rating.

6. RMH currently operates across four sites, in Central London, Chelsea, Sutton, and from a Medical Day-care Unit at Kingston Hospital.

7. London has always been seen as a global hub for medical treatment due to the quality of care available and in 2019, due to the continuing growth rate of cancer, oncology replaced orthopaedics as the major source of income for private hospitals in London. It is estimated that oncology accounts for approximately 25% of the overall London private healthcare market and has grown 31% from 2015 to 2018. International patients seeking cancer treatments abroad have been a key market driver, with Kuwaiti patients in particular favouring London over other locations.

8. The mid-term outlook for cancer services in the UK remains firm as demand for immunotherapy and early diagnosis increases. Competition between providers is increasing, with the arrival of new entrants like Genesis and the Cleveland Clinic to London which is likely to result in greater patient choice and increased price pressure. The size of the market and rate of growth makes it a very attractive market for providers, and there is significant competition in this space. The main competitors to RMH in the London market are Leaders in Oncology Care, HCA, The London Clinic, Harley Street at University College Hospital, and the BUPA Cromwell Hospital.

Commercial view on the integrated service model

9. The Trust is an NHS Foundation Trust that operates an integrated shared service model encompassing NHS, private, and research patients. The services to all of these patient groups are provided using shared resources, as part of the same single entity.

10. We believe there are a number of benefits to this integrated model which differentiate us from independent providers that offer private care only. These include:

    a. The shared benefits of research, clinical trials and development activity at the Trust.
    b. The shared benefits of the clinical governance model (e.g. access to MDTs)
    c. The shared benefits of the regulatory framework (CQC inspection, NHSI financial regulation).
    d. The shared benefits of the Trusts ability to attract and retain the highest calibre workforce.
    e. The higher overall quality of care that private patients receive as a result of the above.

11. There are other Private Patient Units in the NHS which have similar integrated models, including Great Ormond Street, Imperial College, The Royal Brompton, and Chelsea and Westminster.

Insurer market

12. The private medical insurance ("PMI") market place is highly competitive, particularly in London, with insurance providers looking to differentiate themselves based on price, breadth of coverage, and member support. PMI growth has stagnated in the UK over the past number of years and insurers must balance the increasing costs of healthcare alongside a low growth in member numbers. This limits revenue growth and means PMI providers are increasingly focused on driving down costs, i.e. most importantly the costs of treatment and medication.

13. Corporate clients are the biggest purchasers of PMI policies (on behalf for their employees). They exert pressure on PMIs to limit price increases and tender for PMI contracts on a regular basis. This price pressure has also resulted in PMIs pressing care providers to reduce or limit price increases whilst improving service and access.

14. Insurers are very commercially focused and have a range of price and performance benchmarking information at a provider level which they use to negotiate rates and / or special network agreements. The last decade has seen insurers increasing their understanding of hospital costs and using this to press for cost reductions.

15. BUPA and AXA especially have a very high market share across the private healthcare market. Combined with the competitiveness of the London oncology private healthcare market, this enables them to exert considerable additional pressure over healthcare providers with regards to pricing and service delivery. Both are commercially driven. Whilst Bupa is a company limited by guarantee (it has no shareholders) it does have bond holders and is looking to obtain commercial returns on their funds.

16. BUPA and AXA are the dominant organisations in the UK Healthcare marketplace and in 2019 their estimated market shares were 37% and 34% respectively. For RMH Private Care, based on 2020/21 forecasts, BUPA accounts for approximately 46% of income from Insurers (32% of all sponsor income) and AXA accounts for 26% of income from Insurers (18% of all sponsor income). So between them BUPA and AXA accounted for half of the Private Care income across all sponsors for 2020/21.

Price Setting

17. The setting of prices for the next contractual period is a significant step in the contract negotiation process and is always the most challenging step. Insurers will make use of any benchmarking or price information to argue their case for holding or reducing prices. They will be focussed on minimising any price uplifts to ensure that profit targets are achieved and that value for their members is delivered.

18. Given the difficulty for insurers to increase their premiums, this is one of the most effective ways in which insurers can generate returns. The majority of the revenue passing through a PMI is claims costs and a change to the underwriting profits can be made by reducing these costs, which leads to a direct return for the insurer. Any information which allows the insurer to challenge a hospital provider and create pressure to reduce prices has very significant value to the insurer, and can be deployed forcefully in negotiations.

19. Currently, insurers only know what they are charged for patient care, not the cost to the healthcare provider. Currently insurers compare the overall cost of RMH with other providers and this has formed the basis on which the existing rates have been negotiated and are

based. Insurers, with the additional (withheld) information would compare the Trust's margins against other London providers (in the private sector, which are published – no other margin data is available for comparable integrated service providers) [redacted]

20. As explained by my colleague Marcus Thorman whose statement I have read and agree with – at paragraphs 17 to 27, and at paragraphs 41 to 46 – RMH's PP specific margins, calculated in accordance with standard NHS costing methodology, are not comparable to the margins of RMH's competitors. They are not a fair or accurate reflection of the cost base for that work in the context of an integrated services model and to compare profit margin data for a purely private offering or indeed a purely public offering with an integrated offering is misleading. The most accurate profit figure is the overall one for the Trust, which is already published.

21. [redacted]

22. As my colleague Marcus Thorman also notes at paragraph 46 of his statement, there are private healthcare providers who provide a mix of services to both private and NHS patients, such as Spire Healthcare. These providers do not publish separate margins for each patient cohort, but like ourselves publish only a single combined margin across all patients.

23. [redacted]

24. [redacted]

25. [redacted]

26. [redacted]

27. Given the purchasing and negotiating strength of the leading insurers, and their importance to the Trust's business model, [redacted].

28. My colleague David Pedrick has provided at paragraphs 40 to 45 of his statement detailed examples of how insurers seek to benchmark pricing and, where available, margin information in order to strengthen their negotiating position and seek reduced prices. The withheld information would only support them further in this respect.

Impact of a reduction in income

29. When considering the detrimental impact of a reduction in the Trust's income, it is important to note that the Trust's operating model relies on the generation of PP income in order to sustain services delivered to its NHS patients.

30. Without revenue generated from PP care, the Trust would face a large funding deficit and would be financially unsustainable as an ongoing operation. It cannot function as it currently does without the essential funding generated by the PP care it provides.

31. Even a relatively small reduction in PP income would have serious consequences for the Trust and its ability to provide high-quality services to all its patients.

32. A loss of [redacted] annually (equivalent to just [redacted] of 2019/20 PP income), which we have assessed as a high probability were the withheld information to be published, would equate roughly to the cost of [redacted], or, in workforce terms, the cost of employing [redacted] qualified nurses. Potentially greater losses, which we have assessed as a medium probability would have correspondingly greater impacts.

33. A reduction in income will directly result in fewer resources being available to all the Trust's patients. It is important to remember that the Trust's motivation for providing PP care services is to maximise benefit for its NHS patients. Any loss of PP income will have a direct consequence on the services and quality of care the Trust is able to provide to those NHS patients. Without it, the Trust's services would not be sustainable as they currently function. It would not be able to invest in the latest technology which would therefore not be accessible to either its NHS or private care patients. The Trust would not be able to contribute as it currently does in the fields of research and education, the facilities that its patients' access could not be maintained, and the Trust may not be able to attract and retain the same calibre of staff.

34. Private Care enables the Trust to invest in the NHS – in people, in services, in kit and in research and development. It is essentially a social enterprise model.

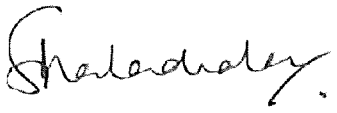
The public interest

35. It is very strongly contrary to the public interest to expose the Trust to such substantial risks of reductions in its PP income. As indicated above, this would have a direct effect on the NHS services the Trust provides unless, as explained at paragraph 53 of my colleague Marcus Thorman's statement, compensatory funding could be secured from the public purse. It would not result simply in a redistribution of funds within the public sector as the Trust is not generally in competition with other NHS PPUs but with private sector healthcare providers. The negative impact would be multiplied were other NHS PPUs similarly required to disclose their margins.

36. There would also be limited public benefit from disclosure from the perspective of assessing the Trust's efficiency and effectiveness, including the quality of its governance processes and the quality of care provided to its patients. As explained in detail in my colleague Marcus Thorman's statement, there is a range of different elements of regulation that already provide a high degree of overview and scrutiny of the Trust's services and the way that the Trust, as a public body, uses its resources.

37. As the Trust operates a single integrated service model there is no differentiation in the scrutiny provided to the NHS and Private Patient services provided. They are regulated as one single entity both from a financial, clinical and governance perspective. The Trust therefore does not accept that disclosure of the withheld information would deliver real public benefit in terms of any accountability or governance shortfall. It would cause commercial harm, without achieving any real good for the public. That is why the Trust asks the Tribunal to allow this appeal.

38. I confirm that the facts stated in this witness statement are true.

Signed: 

Shams Maladwala

Dated: 19 July 2021