# RAMSAY HEALTH CARE UK

# RESPONSE TO THE COMPETITION COMMISSION'S ("CC")

# STATEMENT OF ISSUES DATED 22 JUNE 2012

## PART I: INTRODUCTION AND MARKET CHARACTERISTICS

### 1. RAMSAY

1.1 Ramsay is a subsidiary of Ramsay Health Care Limited, an international health care group operating in Australia, France, Indonesia and the UK from over 100 facilities and employing over 30,000 people.

1.2 Ramsay entered the UK private healthcare market in November 2007 via the acquisition of Capio Healthcare's UK business and subsequently purchased Nottingham Woodthorpe hospital from GHG in March 2008 (pursuant to the "fix it first" remedy implemented by GHG in order to obtain OFT merger control clearance for its acquisition of a group of seven other Nuffield hospitals).

1.3 Ramsay is a private operator of hospitals that deliver services to a range of payor groups, i.e. both private (including self pay) and NHS. According to the Office of Fair Trading's (**"OFT"**) April 2012 Report on the market study and final decision to make a market investigation reference (**"Final Report"**), in 2010 Ramsay was the fifth largest private healthcare (**"PH"**) provider by value in the UK, with a market share of 8.8 per cent, behind GHG (24.4 per cent), Spire (18.2 per cent), HCA (14.3 per cent) and Nuffield (11.4 per cent).[1]

1.4 Ramsay operates 37 facilities in the UK:

(a) 22 private hospitals;

(b) 10 day-case out-patient treatment centres;

(c) the Orwell Private Patient Unit (**"PPU"**) located within the Basildon and Thurrock University Hospitals NHS Foundation Trust, which specialises in tertiary cardiothoracic treatments;

(d) three neurological rehabilitation centres; and

(e) one "close care accommodation" retirement village.

1.5 In addition to the above facilities, Ramsay operates six mobile diagnostic units (five MRI and one CT).

1.6 Ramsay's core business is the provision of acute elective healthcare to both private and NHS patients. In the last financial year (1 July 2011 to 30 June 2012) the split of patients treated by Ramsay by revenue was [✂] [CONFIDENTIAL] per cent private and [✂] [CONFIDENTIAL] per cent NHS. The significant proportion of NHS work carried out by Ramsay reflects its business model, which focuses on capacity utilisation to maximise the use of the high fixed cost asset resources.

### 2. RAMSAY'S RESPONSE TO THE CC'S ISSUES LETTER

2.1 Ramsay has focused its comments in this document upon the two issues that are essential to understanding competition in the PH market, namely:

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[1] OFT Final Report, Table 6.1.

(a) the changed nature of the way private hospitals operate and interact with the NHS and the competitive constraints placed by the NHS as a direct and indirect competitor to PH; and

(b) the buyer power of the private medical insurers (**"PMIs"**).

2.2 The central and pervasive error underlying the OFT's Final Report was the *failure to take any or sufficient account of these two issues* when finding that there are features of the PH market which prevent, restrict or distort competition.

2.3 In particular, the market context is such that the competitive conditions can only be assessed if due regard is given to both the *NHS as a competitor*, and to *the buyer power of the PMIs*, both of which exercise a significant competitive constraint on the PH sector.

2.4 Ramsay welcomes the acknowledgement in the Statement of Issues that the *interface* between the PH sector and, respectively, the NHS and PMIs is relevant to any assessment of competition in PH. This is a partial step forward from the OFT's analysis, which was manifestly partial and incomplete.

2.5 However, the Statement of Issues as currently set out risks repeating the errors in the OFT's analysis. In particular, unless the issues identified by the CC focus more clearly than they presently do upon the *market power* of these two market participants *in and of itself*, the CC is not in a position to accurately assess the degree to which they *interface with* and *place competitive constraints upon* the PH sector nor, ultimately, to reach a sound finding in terms of the conditions of competition in PH.

2.6 In other words, the degree of constraint exercised by PMIs' buyer power and/or the NHS as a competitor cannot be fully understood unless the CC's identified issues address the market power of these two organisations directly.

2.7 Moreover, as a matter of law, these issues will plainly form relevant and material considerations. To fail to focus the CC's analysis upon them will risk rendering any subsequent conclusions reached by the CC unsound.

2.8 Accordingly, in respect of all the points below, Ramsay addresses the questions as to why the market power of both the NHS and PMIs needs to be closely examined as distinct issues if their impacts upon competitive conditions in the PH market are to be properly understood.

## 3. PRIVATE HEALTHCARE AND THE NHS

### NHS and market context

3.1 By way of general introduction to the market context, Ramsay believes the CC needs to recognise that it is increasingly artificial to consider a market for private healthcare in isolation at provider level, as PH providers no longer operate with a clear distinction between different types of healthcare funding (perhaps with the exception of some private hospitals in London).

3.2 Instead of the traditional private hospital model, healthcare in the UK now is a mixed economy: the NHS is buying from the NHS and private providers; and both the NHS and private providers compete to deliver privately funded healthcare. This is compounded by the ongoing NHS reforms, as the current UK health policy seeks to promote competition and create a level playing field between NHS Trusts and privately operated hospitals, thus strengthening the profile of NHS hospitals as a competitive constraint for PH providers. The reforms are designed to increase patient choice and will intensify competition between PH facilities and the NHS.

3.3 This state of affairs is clearly reflected in Ramsay's own operations. As set out above, Ramsay is a private operator of hospitals that deliver services to a range of payor groups, i.e. both private (including self pay) and NHS. In the last financial year [✂] [CONFIDENTIAL] per cent of the patients admitted for treatment at Ramsay's facilities were NHS patients. [✂] [CONFIDENTIAL].

3.4 Ramsay's business model focuses on maximising volumes and efficiencies. [✂] [CONFIDENTIAL]. The quality of the treatment and outcomes for patients is the same whether the patient is an NHS or privately funded patient. From a patient perspective the benefits of being a private patient relate to service, including choice of appointment, choice of consultant, superior hotel services including an a la carte menu and other amenities such as Molton Brown toiletries.[2]

3.5 In the context of this mixed economy, the size of the private health sector in the UK needs to be considered in the context of the total UK healthcare market. According to the OFT's reference decision, the total value of the sector for acute PH in the UK in 2010 was estimated at just over £4.92 billion and of this, £2.89 billion was the amount of revenue received by PH facilities. This is dwarfed in comparison to the NHS where the total Primary Care Trust (NHS commissioners) budget in 2009/2010 was £80 billion[3] of which approximately 40 per cent is spent on acute care (i.e. £32 billion).

3.6 Although the CC states in the Statement of Issues that "*healthcare services funded by the NHS whether carried out in NHS facilities or in privately operated hospitals are outside the terms of reference*"[4] Ramsay considers that the NHS is interlinked with the PH sector to such an extent that the activities of the NHS when carrying out privately or publicly funded work is of fundamental relevance to the market investigation. As the CC recognises at paragraph 14 of the Statement of Issues, there are various aspects to the interaction of the NHS with PH operators. The NHS is a:

(a) customer of the PH operators when NHS patients are treated in PH facilities;

(b) supplier of privately funded healthcare services through PPUs as well as ordinary NHS wards;

(c) partner with PH operators, for example through PPU partnerships, NHS facility management partnerships or through the development/provision of specialist treatments, equipment or research;

(d) supplier of NHS services to patients free at the point of delivery as an alternative to privately funded healthcare – in other words, NHS services compete directly with PH services;

(e) main employer and trainer of most consultants that provide PH services;

(f) main funder and trainer of most GPs; and

(g) source of all training for almost all other medical and clinical professionals.

3.7 Ramsay's observations on some of the above aspects of the NHS' role within the PH sector can be categorised as follows:

(a) the NHS as competitor to PH operators; and

(b) the NHS as customer of PH operators/purchaser of PH services.

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[2] This differentiated level of service is referred to by Ramsay as its "Premium Care" offering.

[3] Source: Department of Health, *National Health Service Landscape Review*, 20 January 2011, Figure 1, page 8.

[4] Paragraph 3, Statement of Issues.

3.8 Each of these points is discussed in turn below.

### (a) The NHS as a competitor for privately funded services

***All NHS Trusts (not just PPUs) are competitors to PH operators***

3.9 In its Statement of Issues, the CC appears to limit its observations on the NHS provision of private treatment to the operation of PPUs. However, the NHS competes with PH operators on a much wider level in that every NHS facility, including ordinary NHS wards, is able to offer private treatment to self-pay and private medical insurance (**"PMI"**) funded patients.

3.10 As highlighted in Laing's Healthcare Market Review 2011-2012, as at mid-2011 there were an estimated 1,123 PPU beds and "[i]*n addition there* [were] *believed to be around 1,500 non-dedicated beds used to treat private patients*",[5] where the latter number, to put it in context, [✂] [CONFIDENTIAL]. It is common for consultants to include private patients at the end of an NHS theatre list, for example, and those patients would then be admitted into a non-dedicated bed. There is one NHS Trust in [✂] [CONFIDENTIAL] which has a large volume of private patient revenue (approximately £[✂] [CONFIDENTIAL] million) but only £[✂] [CONFIDENTIAL] million of this is earned through their dedicated private patient unit.

3.11 It should also be noted that the Laing figures above are likely to underestimate the extent to which the NHS competes with PH operators, as the trend towards outpatient and day-case treatment means that less emphasis is put on the availability of beds (outpatients and day-case patients will typically not be admitted to a bed but instead only use the facility's consultation rooms and/or recovery bays). Every NHS facility competes with PH facilities for PH services, or is at least a potential competitor.

3.12 The competitive pressure exerted by NHS Trusts generally is also evidenced by the existence of PMI policies which not only offer privately funded treatment at PPUs, but also privately funded treatment at NHS Trusts without dedicated PPU facilities. [✂[6][7]] [CONFIDENTIAL]

***Advantages enjoyed by the NHS in relation to private patient activity***

3.13 The role of NHS Trusts as competitors in the provision of PH services is compounded by certain competitive advantages enjoyed by the NHS relative to PH providers, which should be examined by the CC in order to assess the strength of the NHS constraint upon PH providers (and the extent to which the NHS will become an even closer competitive constraint following the ongoing NHS reforms).

3.14 These competitive advantages can broadly be described as follows:

(a) the "consultant drag" effect. The "consultant drag" effect refers to the primary role that consultants play in determining the location where privately funded treatment actually takes place. It is a requirement of the PMIs that in order to obtain recognition the consultant must have or have had a "substantive NHS post". Accordingly, most consultants who operate a private practice also hold an NHS post and conduct their private practice outside of their contracted NHS hours. Consultants will find it particularly convenient for privately funded patients to be treated within the same hospital (whether in a dedicated PPU or within an ordinary NHS ward) as that in which their NHS practice takes place. This saves consultants time in travelling between NHS and PH facilities both for the surgery and follow up care;

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5 Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, page 84.

6 [✂] [CONFIDENTIAL].

7 [✂] [CONFIDENTIAL].

(b) certain financial advantages. The NHS enjoys numerous advantages of a financial nature when competing with PH facilities for privately funded work. These include: state funded facilities and pensions; corporation tax and VAT exemptions; the inclusion of private patient activity within NHS indemnity arrangements; and lower regulatory costs. There are also no standard, transparent accounting systems in place within NHS Trusts to monitor or account for the use of public resources in the delivery of private work; and

(c) access to intensive care and high dependency units. In order to undertake complex surgery access to intensive care and/or high dependency units is required. Most NHS Trusts will include intensive care and high dependency units that were built with state funding and which are then able to be used by the Trust when treating private patients. Maintaining these facilities and appropriately qualified staff requires regular volumes of patients which Trusts also have due to the large volumes of NHS patients they treat but is more difficult for PH providers. A consequence of this is that often the most complex (and expensive) private work will tend to be carried out in NHS Trusts instead of private hospitals as many PH facilities do not currently operate intensive care or high dependency units.

3.15 The CC needs to examine the nature and extent of those advantages to measure the issue of the strength of the NHS constraint upon PH providers.

***The impact of the ongoing NHS reforms and the amendment to the private patient income cap***

3.16 The Health and Social Care Act 2012 (**"HSCA"**) received Royal Assent on 27 March 2012. One of the key changes in respect of private healthcare is that the private patient income cap previously applicable in relation to private treatment carried out by Foundation Trusts has been amended.

3.17 Before the enactment of the HSCA, the private patient income cap had been set as a proportion of the total income that a particular Foundation Trust had derived from private charges during base year 2002-2003 (the year before the first Foundation Trusts were authorised). Foundation Trusts did not have the ability to negotiate a higher cap and no provision was made to allow for a regular re-assessment of the level of the cap.

3.18 Under the HSCA, this restriction on Foundation Trusts' ability to compete for the provision of private services has now been amended so that Foundation Trusts may effectively increase their percentage of revenue from treating private patients up to 49 per cent of overall revenue.[8] This will impact on competition for the provision of PH services as under the previous regime, although individual Foundation Trusts' private patient income cap varied, industry commentators estimated the national average at 2 per cent of total revenue.[9]

3.19 As early as during the passage of the Health and Social Care Bill, there was a notable increase in tenders from NHS Trusts for the management of PPUs by PH operators. In light of the Government's target of reducing spending in the NHS by £20 billion, treating more private patients by creating or expanding PPUs is high on the agenda for Foundation Trusts as a means to generate additional revenue and maximise the use of their facilities.

3.20 Therefore, as the level of competition from NHS Foundation Trusts is set to increase further pursuant to the NHS reforms, the CC needs to consider the PH market in this dynamic context as the proposed changes will have a significant impact on both PH capacity and competition in the PH sector of the market. In the absence of such a

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[8] See section 43(2A) of the National Health Service Act 2006, as amended by section 164(1) of the HSCA.

[9] Source: http://www.bbc.co.uk/news/health-16337904.

consideration, the CC's assessment of the PH market's competitiveness will be fundamentally incomplete.

***NHS funded services as an alternative to PMI funded treatment***

3.21 NHS funded services also compete as an alternative to PMI funded treatment. This is relevant to the CC's assessment of the PH market due to the competitive constraint exerted on PH providers by NHS funded services themselves. In particular, the role of NHS funded services as an alternative to PH is evident at two distinct levels; namely:

(a) as an alternative when PMI policies are purchased; and

(b) the manner in which PMI cover is used.

Initial purchasing of PMI

3.22 The existence of the NHS as a free alternative means that patients will only purchase PMI for private services if they believe, when comparing the options, that the private route gives them real added value. This is compounded by the fact that many patients feel that opting for PH services amounts to being charged twice on the basis that they already pay for NHS services through their taxes.

3.23 The demand for PMI is influenced by the perceived quality and availability of NHS provision at any particular time. The performance of the NHS in relation to a key patient satisfaction measure, waiting times, has significantly improved over the past few years following the Government's 2008 introduction of a requirement that all NHS patients must receive treatment within a maximum of 18 weeks from the date they are referred by a GP. Laing & Buisson's 2009 Report noted the sharp decline in NHS waiting times and linked it with the fall in PMI take up, stating that: "[t]*he main weakness of the private medical insurance market is that the underlying strength of the* […] *product – the difference between the private product and the public sector (NHS) product – is under constant threat by a better NHS*".[10] It is clear that as standards improve in the NHS an impact is felt in terms of PMI take up.

3.24 The CC also noted in its 2008 internal evaluation of the *Bupa/CHG* report[11] that since 2000 "*the market has undergone rapid change and appears to have become more competitive - owing to the increase in private provision of NHS-funded operations through Treatment Centres*".[12] The CC added that the "*primary force behind the improvement in competition and increased entry in PMS* [private medical services] *was the NHS Plan, which led to the expansion in the overall size of the PMS market and further increased the attractiveness of new entry*", and that "*NHS contracting-out also intensified PMS price competition, dampening the vertical effects of PMI networks and consultant referrals, while at the same time placing downward pressure on consultant fees and hospital charges*".[13]

3.25 PMI demand is income sensitive, so that in times of recession, the NHS is seen as the "fallback position" for many patients. As noted in the 2009 Laing & Buisson Report, "*UK economic performance is a key determinant of demand for health and care cover.* […] *The recession leads to a sizeable fall in demand for private medical insurance, as employers and individuals feel the pinch, and the economy takes time to pick up again*".[14]

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10 As quoted in a 4 April 2009 article by the Telegraph, *Recession sees first fall in private health spending in 20 years*: http://www.telegraph.co.uk/health/healthnews/5100101/Recession-sees-first-fall-in-private-health-spending-in-20-years.html. [✂] [CONFIDENTIAL].

11 Evaluation of the CC's past cases, Final Report, January 2008.

12 Paragraph 2.2 of the CC Report.

13 Paragraph 2.16 of the CC Report.

14 As quoted in a 4 April 2009 article by the Telegraph, *Recession sees first fall in private health spending in 20 years*: http://www.telegraph.co.uk/health/healthnews/5100101/Recession-sees-first-fall-in-private-health-spending-in-20-

More recently, Laing & Buisson reiterated this point in relation to PMI demand from individuals: "[t]*rends in individual paid private medical cover spending have closely followed the movement in real household spending in the UK during the 2000s, normally with a lag up to 12 months* […]. *Recently the fall in real household spending in 2009 preceded a similar decline in individual paid private medical cover spending a year later in 2010*".[15]

3.26 In summary, it is well recognised that the quality and availability of NHS funded services represent a competitive constraint when the decision to take PMI cover and thus, ultimately, access PH services as a private patient is taken. This constraint is driven both by perceived improvements in the quality and accessibility of treatment in NHS facilities, and the ability to access PH facilities directly when obtaining NHS funded treatment (see below).

Privately insured patients electing not to use their PMI

3.27 Notwithstanding their insurance, policyholders may still use the option of free treatment on the NHS. This option is made particularly attractive in light of the following considerations:

(a) there is a trend towards the introduction of more restrictive PMI policies which encourage patients to consider whether to use their PMI cover regarding each new healthcare episode. This is achieved in a variety of ways, which include the application of co-payments, annual claim limits and excesses in PMI policies. This trend, together with the increasing prevalence of shortfall payments to consultants and anaesthetists, has meant that there is a direct cost to the patient associated with claiming on PMI policies.

(b) PMI providers are increasingly offering lower cost policies where the terms provide *explicitly* that policyholders may be treated by the NHS provided waiting times are suitable. [✂[1617]] [CONFIDENTIAL]

(c) PMI providers are also increasingly offering hybrid policies which take advantage of healthcare provision in both NHS and PH facilities. [✂[181920]] [CONFIDENTIAL]

3.28 Ramsay also understands that some PMI providers offer payments to policyholders where they obtain treatment on the NHS rather than claiming on their policy. [✂[21]] [CONFIDENTIAL]

3.29 The above considerations arise each and every time a person requires healthcare treatment, notwithstanding that a patient has subscribed for health insurance cover. Therefore, even where a patient has private medical insurance the NHS still competes with PH operators for the provision of treatment at this second level with policyholders electing or being encouraged to use the free treatment alternative available to them via the NHS.

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years.html. [✂] [CONFIDENTIAL].

15 Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, page 179.

16 [✂] [CONFIDENTIAL].

17 [✂] [CONFIDENTIAL].

18 [✂] [CONFIDENTIAL].

19 [✂] [CONFIDENTIAL].

20 [✂] [CONFIDENTIAL].

21 [✂] [CONFIDENTIAL].

### (b) The NHS as customer of PH operators

3.30 It is clear that the NHS plays an important role in the business model of many PH operators with regard to the capacity utilisation (and viability) of PH facilities.[22] In this regard, the OFT stated in its Final Report that NHS patients account for around 25 per cent of PH providers' revenue.[23] However, in Ramsay's case as set out above, NHS patients accounted for [✂]% [CONFIDENTIAL] of revenue in the last financial year and [✂] [CONFIDENTIAL].

3.31 This is relevant to the CC's determination for a number of reasons. First, from the provider side PH and NHS facilities compete against each other for NHS funded work. This further erodes the supply side distinction between PH and NHS providers where both offer the same services to patients.

3.32 The context is a central issue to PH provider operations. [✂]

(a) [✂]

(b) [✂]

(c) [✂[24]] [CONFIDENTIAL]

3.33 Secondly, the availability of NHS funded treatment provided by PH providers conflates, in part, the distinction between PH and NHS in respect of clinical provision from the demand side perspective. In particular, since 2008, all NHS patients needing routine elective care have been able to choose between any NHS and a range of independent private sector providers under the "choice" policy for routine elective care.

3.34 According to the Cooperation and Competition Panel's recent report titled "Review of the operation of 'any willing provider' for the provision of routine elective care", by February 2011 patients could choose between approximately 165 NHS Trusts (including Foundation Trusts) operating from approximately 300 sites as well as around 15 nationally-contracted independent sector providers of routine elective care operating from a further 175 sites.[25]

3.35 Competition between PH providers and the NHS in this area is also set to increase with the implementation of the ongoing NHS reforms. In particular the amendment of the private patient income cap will enable NHS Foundation Trusts to raise significantly more revenue from their extended PH services offering. This will enable the Trusts to reinvest such revenue into the improvement of facilities and services which will improve their offering to both private and NHS funded patients and, in turn, strengthen the NHS' overall competitive position as against PH providers.

3.36 The CC needs to have regard to competition for NHS funded services as this impacts on the PH sector of the market. In the absence of a comprehensive assessment which includes such considerations, the CC's analysis will be fundamentally incomplete.

**Conclusion on the role of the NHS**

3.37 A clear demonstration of the mixed economy and the competitive interaction between PH and NHS facilities for publicly and privately funded work can be seen through the referral decision making process between the patient and their GP when treatment is required. At that stage the patient exercises a choice between a wide range of options, including:

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22 They may be some exceptions, for instance in relation to PH providers operating within the London area.

23 OFT Final Report, paragraph 6.50.

24 [✂] [CONFIDENTIAL].

25 Cooperation and Competition Panel Report, "*Review of the operation of 'any willing provider' for the provision of routine elective care*", 28 July 2011.

(i) NHS funded treatment in an NHS facility;

(ii) NHS funded treatment in a private facility;

(iii) self-pay private treatment in a PH facility;

(iv) self-pay private treatment in an NHS facility;

(v) if insured, calling upon the PMI policy to select PH services for all or part of the treatment in either a private facility or an NHS Facility;

(vi) if insured, deciding not to call on the PMI policy, instead obtaining treatment free of charge through the NHS in either a private facility or an NHS Facility.

3.38 Accordingly, with regard to the above, the interaction between the NHS and the PH sector is plainly relevant to the CC's assessment.

3.39 First, it impacts upon market definition: in particular, given the NHS' ever growing role in the provision of PH services.

3.40 Secondly, it is clear that across a wide number of contexts the NHS operates as a competitive constraint more generally for PH operators, both in relation to private and publicly funded work. Specifically:

(i) the NHS actively competes with PH operators for the provision of both privately and publicly funded services whilst enjoying notable financial and other advantages; and

(ii) the NHS also introduces an important competitive dynamic in the PH sector as it increasingly purchases PH services and enjoys significant buyer power in this regard.

3.41 In the absence of an assessment which includes such considerations, the CC's analysis will be fundamentally incomplete.

## 4. ROLE PLAYED BY PRIVATE MEDICAL INSURERS

### PMIs and market context

4.1 The OFT Final Report also failed to appreciate the range of competitive constraints currently faced by PH providers as a result of the strong countervailing buyer power exercised by PMI providers. Although the CC states that "*we do not anticipate investigating how competition functions in the private medical insurance market(s)*",[26] it does acknowledge that it needs to look at the interface between the PH sector and the PMI market.[27]

4.2 Ramsay considers that the market power of the PMIs is of fundamental importance to the CC's market investigation. As the CC will appreciate, understanding both the nature and degree of market power exercised by the purchaser and how it is exercised in the bargaining interface is particularly important when exploring the possible causes and effects of buyer power (i.e. the ability of large buyers to extract preferential terms from suppliers).

4.3 In this regard, the OFT Final Report is incomplete as it focuses almost exclusively on features relating to the supply of PH services, with very limited consideration of the way in

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[26] Paragraph 3, Statement of Issues.

[27] Paragraph 13, Statement of Issues.

which PH services are acquired, which ultimately imposes a significant competitive constraint on the PH operators. As set out further below, Ramsay considers that there is clear evidence that the PMI providers have substantial buyer power.

**The PMI providers have substantial buyer power**

4.4 The importance of buyer power as a constraint upon the exercise of market power of suppliers has long been recognised by economists and competition authorities alike.[28] The CC's previous market investigation guidelines stated that "*in many markets buyers have some degree of market power*" and that "*buyers may have sufficient bargaining power to prevent the exercise of suppliers' market power*".[29]

4.5 Similarly, many jurisdictions' merger control guidelines emphasise the relevance of buyer power as a possible competitive constraint upon suppliers.[30]

4.6 The economic assessment of buyer power typically focuses on the relative bargaining position of suppliers (i.e. PH operators) relative to buyers (i.e. the PMI providers). In this regard, Ramsay considers that the balance of power in negotiations falls heavily in favour of the PMIs. This is for the following reasons:

(a) the PMI market is highly concentrated;

(b) the PMI operators fulfil a gatekeeper role in relation to access to the end consumer;

(c) the PMIs have the ability to switch and use a range of alternative PH or NHS providers, whereas the PH operators are heavily reliant on the PMIs in order to treat private patients;

(d) the PMIs have the ability to change the rules of the negotiation process with PH operators in order to extract lower prices; and

(e) the PMIs have the ability to constrain PH operators in various ways in order to ensure that low prices apply evenly irrespective of the level of local market concentration.

4.7 Each of these factors is considered in turn below.

***The PMI market is highly concentrated***

4.8 The first point to consider in the assessment of buyer power is the extent to which the buying side of the market is concentrated. This is because buyer power is more likely to arise in situations where the buying side of the market is highly concentrated as suppliers are likely to be heavily reliant on just a few large customers. The CC's market investigation guidelines acknowledge that "*a large market share may confer substantial advantages in bargaining with suppliers upstream…*".[31]

4.9 In this regard, Ramsay considers that it is clear that the PMI market is highly concentrated, and that the levels of concentration have increased in recent years:

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[28] Galbraith observed over 50 years ago that: "*In the typical modern market of a few sellers, the active restraint is provided not by competitors but from the other side of the market by strong buyers … At the end of virtually every channel by which consumers' goods reach the public there is, in practice, a layer of powerful buyers*." J. K. Galbraith, American Capitalism, *The Concept of Countervailing Power*, London, Hamish Hamilton, 1957.

[29] Paragraph 3.37, CC, *Market Investigation References: Competition Commission guidelines*, June 2003.

[30] Such as, for example, those of authorities in the UK, Germany, Canada, Australia, and the European Commission.

[31] Paragraph 172, CC, *Guidelines for Market Investigations - their role, assessment, remedies and procedures*, June 2012.

(a) the four largest PMI providers accounted for 87 per cent of premium revenue in 2010, with Bupa being the largest with a 41 per cent share followed by AXA/PPP with a 25 per cent share. Aviva and PruHealth both have an 11 per cent share each. This compares to a market share of the four largest PMI providers in 1999 of 82.8 per cent (with Bupa being the largest with a market share of 40.1 per cent). This shows that market concentration has increased and that Bupa has maintained its leading market position;[32]

(b) the Herfindahl-Hirschman Index (**"HHI"**) of the top five PMI providers is 2,622, with this high level of concentration persisting since the 1990s.[33] The joint OFT/CC merger assessment guidelines state that any market with a HHI above 2,000 is highly concentrated;[34] and

(c) the significant and growing concentration of PMI providers is also identified by Laing & Buisson in Laing's Healthcare Market Review 2011-2012: "[t]*he largest 4 private medical insurers accounted for an estimated 88% of market value in 2010. This compares with an estimated 'Top 4' share equivalent to 82% some five years ago in 2005, and highlights both the strength of the leading two insurers (Bupa and AXA PPP healthcare) during this time but also the business growth made by Aviva, Standard Life Healthcare, and PruHealth, now one of the 'Top 4'*".[35]

4.10 It is noticeable that by way of comparison, in the CC's groceries inquiry (which ultimately resulted in a code of conduct being introduced in relation to the buyer power of the large supermarkets in the UK), the four largest grocery retailers had a market share of just over 65 per cent of national grocery sales (with the largest supermarket chain, Tesco, having a market share of just 27.4 per cent).[36] This shows that both the level of concentration in the PMI market and the market share of the largest operator (Bupa) is significantly above that observed in the UK groceries sector.

***The PMIs fulfil a gatekeeper role***

4.11 In order to understand the interface between the PH sector and the PMIs, it is also important that CC understands the gatekeeper role that the PMIs have in relation to customers. As set out in the OFT's discussion paper titled "*The competitive effects of buyer groups*", the negotiation position of buyers is substantially strengthened if buyers provide a "gateway" to the market. This is more likely to arise where failure to deal with these buyers would impede the ability of suppliers to access end customers or benefit from achieving economies of scale.[37] The OFT's economic discussion paper also adds that buyers are more likely to have a "gateway" position where they account for a large share of purchases overall.

4.12 In relation to the supply of PH, the PMIs sit between the PH operators and the end customer. This means that the PMIs provide a "gateway" to PH for customers, and they exercise a gatekeeper role over PMI insured customers. This results in the PH operators being heavily dependent on the PMIs in order to treat private patients, which ultimately drive the private demand for PH services.

4.13 Being recognised by each of the PMIs and included on their networks [✂] [CONFIDENTIAL]. The OFT itself accepted that "*the size of the largest PMI providers*

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32 CC Report on the *Bupa/CHG* merger, December 2000, Table 4.2.

33 *Ibid.*

34 Paragraph 5.3.5, *Merger Assessment Guidelines*, *A joint publication of the Competition Commission and the Office of Fair Trading*, September 2010.

35 Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, page 207.

36 Paragraph 3.4, *The supply of groceries in the UK market investigation*, CC Report, April 2008.

37 Paragraph 1.22, OFT Economic Discussion Paper, *The competitive effects by groups*, January 2007.

*appears to provide them with some buyer power in that PH providers are, to an extent, dependent on access to, and inclusion on, the networks of these larger PMI providers for the financial viability of their PH facilities*".[38]

4.14 In addition, being recognised by each of the major PMIs is critical to attract and retain consultants. If a facility is not recognised by one of the PMIs, then consultants cannot treat patients insured by that PMI at that hospital and as a result consultants will be reluctant to practice at that hospital. Consultants need to be able to schedule full theatre lists without restrictions to maximise their efficiency. The consultant is therefore likely to base his/her practice at a hospital that has been recognised by all of the major PMIs and the "drag effect" (discussed above) means that hospital is then likely to receive most, if not all, of the private work from that consultant. [✂] [CONFIDENTIAL].

4.15 In this regard, if the position of PH and PMI providers is to be examined on an even-handed basis, the CC needs to focus on the interaction between the PMI market and the PH sector. The high levels of PMI concentration and the gatekeeper role that the PMIs play in relation to access to the end consumer means that PMIs enjoying substantial negotiating power vis-à-vis the PH providers.

***The PMIs have the ability to use alternative PH providers***

4.16 One of the principal ways in which buyers (i.e. PMIs) typically enjoy countervailing buyer power is that they have the ability to reduce, or credibly threaten to reduce, their reliance on PH providers if they try to increase prices or obtain favourable terms. In contrast, as set out above, the PH providers have a limited choice of alternatives other than to rely on the large PMI providers in circumstances where:

(a) as the CC is aware, a large number of different PH providers are active in the sector;

(b) [✂] [CONFIDENTIAL] and

(c) competition also takes place at different levels of the supply chain. For example, [✂] [CONFIDENTIAL].

4.17 This means that the PMI providers have a choice as to which facilities, for which treatments, in which local areas to include in their networks. To the extent that PMIs want to provide national coverage, this can be achieved by combining certain facilities of different PH providers, which reduces the reliance on any single PH group. The increase in the private patient income cap to 49 per cent of revenue for NHS Foundation Trusts will also further increase the choice of alternatives available to the PMIs. In contrast, as set out above, private patients remains a principal and important source of funding for private hospitals.

4.18 PMI providers are also aware that [✂[39]] [CONFIDENTIAL] An example of PMI providers' market power is the Bupa/BMI dispute when Bupa recently removed 37 BMI hospitals from its approved list. Although the dispute was largely resolved on 18 January 2012, three of BMI's hospitals remain de-listed. The ability of the PMIs to de-list PH facilities is a clear demonstration of PMI providers' buyer power. Whilst the OFT acknowledged that "*this example does show that Bupa, in this instance, was able to credibly threaten to delist a limited number of a GHG's PH facilities*", its conclusions manifestly failed to take account of this clear exercise of buyer power.[40]

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38 Paragraph 1.15, OFT Final Report.

39 [✂] [CONFIDENTIAL].

40 Paragraph 6.64, OFT Final Report.

4.19 [✂] [CONFIDENTIAL]. In contrast, the PMIs have a degree of choice as to which PH facilities they include and recognise on their networks, and have demonstrated in the past that they are prepared to de-list (or threaten to de-list) hospitals in order to obtain preferential terms.

***The PMIs have the ability to change the rules of the bargaining process***

4.20 A further factor relevant to understanding the interface between the PH sector and the PMIs is the extent to which buyers (i.e. the PMIs) have the ability to change the bargaining process in their favour. The efforts that buyers put into the bargaining process can have a major bearing upon the outcome of the negotiating process.[41]

4.21 In this regard, PMI providers have been able to both demonstrate and strengthen their bargaining position by:

(a) developing restricted PMI networks. For example, [✂] [CONFIDENTIAL];

(b) introducing specific "low cost" networks which are lower priced policies aimed at policyholders who are willing to accept a reduced choice of PH facilities.[42] These network policies have been set up by PMI providers in order to allow them to negotiate even lower costs with PH operators. As fewer PH facilities are recognised on these low cost networks, competition between the PH providers involved at the tendering stage is extremely fierce, and increasingly based on offering deep discounts on price;

(c) tendering for separate contracts for specific types of treatment in addition to a main agreement.[43] [✂] [CONFIDENTIAL];

(d) taking an increasingly active role in guiding their policyholders to consultants and PH facilities. For example,[✂[444546]] [CONFIDENTIAL]. Accordingly, Ramsay considers that the move to open referrals clearly shows the additional control that PMIs are trying to obtain over the patient referral pathway, which will ultimately be used to their advantage (e.g. to drive down costs and exert greater influence over the PH operators).

4.22 Accordingly, the PMIs have demonstrated that by changing the rules of the game (i.e. by introducing new and more restricted networks, tendering for specific types of treatment separately, and introducing Open Referrals), they are able to obtain even lower prices and preferential terms from PH providers.

***The PMIs have the ability to constrain PH operators in alternative ways***

4.23 A further relevant factor to understanding the power of the interface between the PH sector and the PMIs is the extent to which the PMIs could credibly threaten to constrain the PH operators (i.e. by either imposing substantial costs on the PH operators or by reducing their revenue). [✂] [CONFIDENTIAL].

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41 Mat Hughes and David Wirth, "*The Buyer Power Defence in Merger Control*", International Comparative Legal Guide to Merger Control, 2008.

42 [✂] [CONFIDENTIAL].

43 For example, AXA PPP contracts separately for oral treatments and cataract surgery; whilst Bupa contracts separately for ophthalmology, including cataract surgery, and MRI scanning as well as having a main agreement in place.

44 [✂] [CONFIDENTIAL].

45 [✂] [CONFIDENTIAL].

46 [✂] [CONFIDENTIAL]

4.24 The PMIs have the ability to constrain the PH operators in various ways in order to obtain preferential terms in the price negotiations. These constraint strategies include:

(a) threatening to delist certain facilities. [✂] [CONFIDENTIAL];

(b) referring more patients to rival hospitals and PPUs, thereby imposing a disciplining effect across all PH facilities. As mentioned above, the PMIs are asserting greater control over the patient referral pathway, which makes such strategies particularly effective;

(c) by further developing restricted PMI networks, which by definition involves restricting access to certain PH facilities; and

(d) adopting strategies whereby the PMIs tender for specific types of treatment in addition to a main agreement, thereby shifting certain types of treatment to rival PH facilities.

4.25 Accordingly, Ramsay considers that there are various means available to the PMIs to create an overall disciplining effect on the PH operators, which ensures that prices remain at the competitive level across all PH facilities, irrespective of the level of competition at the local level.

**20 July 2012**