

## ANNEX 5

### BARGAINING POWER

#### 1. INTRODUCTION

1.1 This annex sets out in detail why, contrary the CC's views as set out in the AIS paragraphs 83 to 96 and Appendix D on Theory of Harm 3: Bargaining, the balance of power in the negotiations between PMIs and PH operators does not lie with PH operators.

1.2 This annex is structured as follows:

- (a) Ramsay's hospitals are not "must have" facilities; and
- (b) reasons why PMI bargaining power is manifestly sufficient to offset residual, if any, local market power.

#### 2. RAMSAY HOSPITALS ARE NOT "MUST HAVE" FACILITIES

2.1 As Ramsay made clear during the Oral Hearing, it does not consider that any of its hospitals are "must have" from the perspective of a PMI.<sup>1</sup>

2.2 As an initial observation, Ramsay refers to section 5 of its response to the AIS and Annexes 2 and 3 which set out in detail why Ramsay's individual hospitals do not have local market power. Hospitals without local market power cannot be "must have" from the perspective of PMIs.<sup>2</sup>

##### **Evidence that Ramsay hospitals are not "must have"**

2.3 The fact that not all Ramsay hospitals are included in the networks of a number of PMIs is in itself clear evidence that Ramsay hospitals are neither individually nor as a collective "must have" from the perspective of PMIs:

- (a) [redacted];
- (b) [redacted];<sup>3</sup>
- (c) [redacted];
- (d) [redacted];<sup>4</sup>
- (e) [redacted];
- (f) [redacted].

2.4 Indeed, all of the Ramsay hospitals that have been identified as being of potential concern as part of the CC's local market analysis, have been excluded from at least one network by at least one PMI. Putting aside [redacted] all but [redacted] of the Ramsay hospitals of "potential

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<sup>1</sup> Indeed, Ramsay made its clear during the Oral Hearing that it does not understand the term "must have" in relation to its hospitals. See Oral Hearing Transcript, page 20.

<sup>2</sup> Ramsay does not repeat here why its hospitals do not have local market power.

<sup>3</sup> The following Ramsay hospitals are excluded [redacted].

<sup>4</sup> [redacted].

concern" have been excluded from at least one network by at least one PMI, i.e. each of the following hospitals have been excluded: [REDACTED].

- 2.5 Further, in some circumstances, [REDACTED].
- 2.6 Other hospital groups have been delisted (either partially or completely), had hospitals not recognised by PMIs generally or had hospitals excluded from low cost networks (either partially or completely). This is further evidence indicating that the CC has over-estimated the extent to which private hospitals are "must have". By way of example:
- (a) As the CC is aware, Bupa temporarily delisted BMI hospitals, the largest private hospital group in the UK, in 2012 during a dispute over contract negotiations;
  - (b) [REDACTED];
  - (c) [REDACTED];
  - (d) [REDACTED].<sup>5</sup>
- 2.7 Given how widespread restricted networks are, and that as a result of large number of hospitals are excluded from certain networks, it would be incorrect for the CC to find that PMIs have little or no choice to contract with private hospitals in relation to all so-called "must have" hospitals. Further it would be incorrect to find that PMIs are able to extend any market power associated with then "must have" hospitals in order to force PMIs to recognise all or most of the private hospital operator's hospitals, including those.<sup>6</sup>

#### **Individual hospitals**

- 2.8 In Ramsay's experience, PMIs have a number of strategies (as set out below) at their disposal which enable them to box around individual hospitals which the CC (erroneously) considers are "must have". These strategies must be considered together, and not in isolation, as PMI routinely manage their relationships with PH providers by engaging in several (or all) of the following strategies at the same time. The fact that PMIs are able to box around these hospitals is evidence that these hospitals cannot be "must have".
- 2.9 First, patients could be treated at a range of facilities that were not captured as part of the CC's local market power assessment, including:
- (a) NHS facilities providing private treatment in NHS beds (i.e. not in PPUs);
  - (b) for a large range of treatments, outpatient and day-patient facilities (see Annex 1 to this submission on the inclusions of outpatient and day-patient care in the relevant product market);
  - (c) hospitals that are located outside of the catchment areas as defined by the CC. This is essentially because the CC-defined catchment areas for each hospital are too narrow and fail to take account of the fact that a significant proportion of PMI patients travel from further afar to receive treatment (20 per cent). Ramsay has set out in Annex 1 in detail why the catchment area has been defined too narrowly. In this regard, Ramsay considers that patients that are members of low cost networks are likely to have an even greater willingness to be treated at hospitals further away. The CC has acknowledged that self pay patients have an average travel time of just under 45 minutes.<sup>7</sup>

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<sup>5</sup> Ramsay refers to MQ Response Part 1, section 36 (response to question 42) which sets out a full list of the main restricted networks.

<sup>6</sup> Contrary to submissions made by some PMIs. See AIS, paragraph 88.

<sup>7</sup> CC Patient Survey, slide 48.

The ability of PMIs to direct patients further afield is demonstrated by Ramsay's [redacted]; and

- (d) publically-funded treatment (through the use of direct financial payments to patients to encourage the use of publically-funded treatments in either NHS facilities or private facilities providing NHS services).

2.10 PMIs are also able to sponsor entry/expansion. The CC refers to active sponsorship of private hospital entry or expansion in paragraph 34 of Appendix D. The CC observes that that one insurer has considered such sponsorship but that it ultimately did not undertake this investment. In response Ramsay observes:

- (a) the CC should not underestimate PMI's willingness to sponsor entry or expansion. [redacted];
- (b) even where the sponsorship was not implemented, the threat of sponsorship of a new, competing facility may be sufficient to constrain an existing private hospital; and
- (c) less direct sponsorship is also relevant, for example informal assurances about directing patients so long as certain quality standards are met.

2.11 PMIs are able to encourage the growth of alternative hospitals. In paragraph 42 of Appendix D of the AIS the CC refers to one example (collaborating with hospitals by identifying consultants and helping consultants to move their practice) and notes that there were practical and legal difficulties with the implementation of that proposal. It strikes Ramsay that just because there were issues with one proposal, this is not to say other proposals would not be effective (indeed, Ramsay refers [redacted]; see paragraph 2.10(a) above).

### **Chain of hospitals**

2.12 The CC states that *"if a hospital operator has market power in its negotiations with the PMI, this is likely to derive, at least in part, from the hospital operators' market power in certain local areas and the scale of its set of hospitals".<sup>8</sup>*

2.13 Ramsay rejects any suggestion that, in the context of national negotiations, it is able to either derive market power or enhance its hypothetical local market power from its ownership of a chain of hospitals. This is for the following reasons:

- (a) first, as mentioned above, Ramsay rejects any suggestion that any of its hospitals have local market power (either individually or collectively);
- (b) second, Ramsay does not have the form of "network" market power discussed by the CC in its local market analysis. This is essentially as a result of Ramsay's facilities being spread over England and, therefore, there are no clusters of Ramsay hospitals which would increase any market power Ramsay might hypothetically have as a result of its individual hospitals; and
- (c) third, none of Ramsay's hospitals are of the size and scale that they are considered to be "must have" hospitals for the PMIs. Indeed, almost all of the Ramsay hospitals that have been identified as being of "potential concern" as part of the CC's local market analysis, have been excluded from at least one network by at least one PMI.

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<sup>8</sup> AIS, paragraph 84(a).

- 2.14 Accordingly, Ramsay rejects any assertion that the ownership of the different hospitals in its estate in some way enhances its bargaining position vis-à-vis the PMIs.
- 2.15 Moreover, Ramsay notes that the CC has not set out any evidence to show that the ownership of a chain of hospitals by Ramsay leads to higher prices (and indeed, the CC's price concentration analysis, which shows the impact of "network" concentration on Ramsay's self-pay prices, shows the exact opposite effect).

### 3. PMI BARGAINING POWER

3.1 The second part of this paper explains why on any objective assessment, the asymmetric buyer power enjoyed by the key PMI providers would be manifestly sufficient to offset any residual market power, which Ramsay does not believe it has, held at the local level. Ramsay makes three initial observations in this regard.

3.2 First, the AIS confirms that "[f]or theory of harm 3 to hold, a private hospital operator would have market power which is not totally offset by any buyer power of the PMI." [emphasis added]<sup>9</sup> Ramsay has two observations on this statement:

- (a) first, the countervailing power of PMIs will undermine Theory of Harm 3 even in circumstances where it does not "totally offset" any hypothetical private hospital operator's market power. The key issue is the relative strength of the parties to a negotiation. It cannot be the case that private hospital operators were able to hold PMIs to ransom in circumstances where they have only a marginally stronger bargaining position than PMIs. Accordingly, the CC is incorrect to require PMI bargaining power to "totally offset" private hospital operator's market power; and
- (b) second, in any event, Ramsay considers that it does not have bargaining power in its negotiations with PMIs (not least because it has [§]). The buyer power of PMIs will, therefore, "totally offset" any buyer power that Ramsay has.

3.3 Secondly, the lack of any "in-balance" with the exception of London is confirmed by insurers themselves and supported by the submissions of AXA PPP. As the CC has observed in AIS, Appendix D, paragraph 30, AXA PPP believes that:

*"negotiating power (outside of London) is to some extent balanced".*

3.4 At the outset, it is extraordinary for the CC to be contemplating pursuing a theory of harm against national PH providers predicated on an imbalance of bargaining power when the submission from the second largest insurer – which would be directly harmed by such a strategy – indicates that there is no such imbalance.

3.5 It would be disproportionate and, Ramsay believes, irrational, to pursue remedies in a case where the second largest operator failed to support the notion upon which the key theory of harm was predicated.

3.6 [§].

3.7 Thirdly, when the various elements which economic theory establishes are likely to inform any assessment of bargaining power are examined, they confirm that on each count the imbalance operates in the PMIs favour.

3.8 However, the fact that the CC has, essentially, failed to examine the issue of PMI bargaining power (having abandoned it as a theory of harm and conducted its own analysis in the most limited fashion), renders the assessment in the AIS fundamentally inadequate. As a result, we question whether the CC will ever be in any position to reach

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<sup>9</sup> AIS, paragraph 87.

a robust view on this topic given the partial and one sided nature of the analysis carried out to date.

- 3.9 This will in and of itself be fatal for Theory of Harm 3, given it is expressly predicated on the proposition that for Theory of Harm 3 to hold, the PH operator must have residual local market power which is not totally offset by the buyer power of the PMI.<sup>10</sup>
- 3.10 However, having: failed to examine PMI costs, prices or margins in detail; failed to draw any clear conclusions or evidence to the attention of Ramsay in connection with alleged use of market power by Ramsay; and failed to state the CC's own conclusions or reasoning on the existence and scale of PMI buyer power in a meaningful way; the CC has failed to conduct the relevant analysis or produce an evidential basis upon which any such theory of harm could be sustained.
- 3.11 The standard aspects of bargaining power that fall to be addressed under this heading are:
- (a) Market context;
  - (b) Incentives
  - (c) Outside options and Punishment mechanisms
  - (d) Information advantages
  - (e) Evidence of negotiations.

#### 4. MARKET CONTEXT

- 4.1 The CC's market investigation guidelines acknowledge that "*a large market share may confer substantial advantages in bargaining with suppliers upstream...*".<sup>11</sup>
- 4.2 As set out in the response to the issues letter, the PMI market is highly concentrated, and the levels of concentration have actually increased in recent years:
- (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;<sup>12</sup>
  - (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.<sup>13</sup> The joint OFT/CC merger assessment guidelines state that any market with a HHI above 2,000 is highly concentrated;<sup>14</sup> and
  - (c) the significant and growing concentration of PMI providers including the smaller operators is also identified by Laing & Buisson in Laing's Healthcare Market Review

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<sup>10</sup> AIS, paragraph 87.

<sup>11</sup> CC, *Guidelines for Market Investigations - their role, assessment, remedies and procedures*, June 2012, paragraph 172.

<sup>12</sup> CC Report on the *Bupa/CHG* merger, December 2000, Table 4.2.

<sup>13</sup> *Ibid.*

<sup>14</sup> *Merger Assessment Guidelines, A joint publication of the Competition Commission and the Office of Fair Trading*, September 2010, paragraph 5.3.5.

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'".<sup>15</sup>

4.3 By way of comparison, in the CC's groceries inquiry (which ultimately resulted in a code of conduct being introduced to mitigate the effects of exceptional buyer power of the large supermarkets in the UK), the four largest grocery retailers had a market share of only 65 per cent of national grocery sales (with the largest supermarket chain, Tesco, having a market share of just 27.4 per cent).<sup>16</sup> In contrast, the share of the top four PMI insurers is 87 per cent, exceeding those of the grocery retailers by over 20 percentage points.

4.4 We do not see how the CC can reasonably conclude other than that the larger PMIs enjoy an exceptionally high level of bargaining power and this, if established principles are applied, should be presumed to be capable of both disciplining and extracting value from their suppliers in the ordinary course of negotiations. Ramsay suggest the CC would need exceptionally strong evidence of harm to intervene [∞] in such circumstances.

## 5. INCENTIVES

5.1 The CC has failed to take into account the incentives private hospital operators have to maximise the provision of PH services (i.e. increase the volume of services provided) and therefore enter into arrangements with PMIs, the ultimate funders of a large proportion of their PH revenue.

### **High fixed costs of PH and the need to maximise volume**

5.2 As the CC is aware, for private hospital operators, the provision of PH services is characterised by high fixed costs and presence of substantial excess capacity. This creates important incentives to maximise the volume of services provided, not least because:

- (a) first, private hospital operators need to ensure that they provide enough services to cover their high fixed cost base. This means that private hospitals need to have significant, ongoing volumes of work in order to remain financially viable and solvent. Any loss of business that would result in fixed costs not being covered would be catastrophic for a private hospital operator;
- (b) second, once fixed costs are covered, each additional treatment/episode provided increases the profit of the private hospital and, therefore, even once fixed costs are covered, private hospitals are incentivised to seek each and every additional treatment/episode in order to increase profit;
- (c) third, as a corollary 5.2(b), the loss of even a small number of episodes/patients treated will have a disproportionately large effect on the financial performance on Ramsay's PH operations. This has a number of important ramifications:
  - (i) Ramsay feels this effect in all of its hospital, i.e. even hospitals which may be characterised as, according to the CC, being "solus" or having "local market power". The financial performance of these hospitals with so-called "local market power" will suffer if they lose only a small amount of business; and

<sup>15</sup> Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, page 207.

<sup>16</sup> *The supply of groceries in the UK market investigation*, CC Report, April 2008, paragraph 3.4.

- (ii) Ramsay has a strong incentive not only to provide services funded by the larger PMIs but also to provide services funded by smaller PMIs; and
- (d) Lastly, given the excess capacity in the market, there is no infrastructural constraint on private hospitals seeking to profit maximise by increasing supply.
- 5.3 This is confirmed by even [§<]. The obvious effect is that if any of the larger insurers have a credible switching alternative for the marginal customer base of each Ramsay hospital (the infra-marginal customer group, which the CC's analysis effectively ignores) they can single-handedly constrain the behaviour of the hospital in question.
- 5.4 In this regard, as Ramsay observed in the Oral Hearing,<sup>17</sup> if Ramsay [§<].<sup>18</sup> Against this background, it is implausible for [§<] that Ramsay, and private hospitals in general (which Ramsay expect would be in the same position), have bargaining power in its negotiations with PMIs.

***PMI are "gatekeepers" that Ramsay needs to contract with in order to access its patient and consultant base***

- 5.5 In order to understand the incentives operating 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.<sup>19</sup> 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.
- 5.6 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.
- 5.7 Being recognised by each of the PMIs and included on their networks is therefore of critical importance for PH providers. Given the high fixed cost of the PH assets (e.g. buildings, facilities and equipment), which must be financed irrespective of the volume of patients treated, Ramsay's business is dependent on maximising patient volumes of all patient groups both private and NHS. Accordingly, PH providers are reliant on each of the PMIs in order to access customers and operate PH facilities efficiently. The OFT itself accepted that "*the size of the largest PMI providers 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*".<sup>20</sup>
- 5.8 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

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<sup>17</sup> Oral Hearing Transcript, page 62.

<sup>18</sup> [§<].

<sup>19</sup> OFT Economic Discussion Paper, *The competitive effects by groups*, January 2007, paragraph 1.22.

<sup>20</sup> OFT Final Report, paragraph 1.15.

the "drag effect" (discussed above) means that hospital is then likely to receive most, if not all, of the private work from that consultant. [REDACTED].

[REDACTED]

5.9 [REDACTED]<sup>21</sup>.

**Evidence of implementation of Ramsay's incentive to supply**

5.10 Lastly, the following examples of negotiations and their outcomes are clear evidence of the fact that Ramsay has an incentive to supply and acts on this incentive in order to retain, and win extra, volume from PMIs:

[REDACTED].

5.11 The net effect of this overriding incentive to maximise volumes, and the fact PMIs account for a significant proportion of Ramsay's hospital revenue (approximately [REDACTED] per cent for the FY ended June 2012), is that PMIs are obligatory trading partners for Ramsay, and private hospital operators generally.<sup>22</sup>

**6. PMI OUTSIDE OPTIONS AND PUNISHMENT MECHANISMS**

6.1 PMIs can constrain private hospital operators via a number of strategies in order to counteract any bargaining power of private hospital operators.

6.2 As noted, to date, the CC has not appropriately considered the extent to which PMIs have buyer power and how this affects negotiations with private hospitals.

6.3 The extent of the CC's analysis is to acknowledge that PMIs "*may have some countervailing power...through two mechanisms*", i.e. delisting hospitals and steering patients away from one private hospital operator to another.

6.4 Ramsay agrees that these are relevant considerations; however the CC's analysis of these considerations is incomplete and the CC has failed to consider a number of other factors which are indicative of PMIs being able to exercise countervailing power. This section sets out:

- (a) CC's failure to consider the "outside option" of private hospital operators;
- (b) why the CC has underestimated the countervailing power PMIs derive from being able to delist hospitals, not recognise hospitals and/or divert patients; and
- (c) other factors that the CC should have taken into account.

**The outside option of private hospitals operators**

6.5 At paragraphs 9 to 10 of Appendix D to the AIS, the CC correctly observes that the parties' respective bargaining power will "*depend in large part on the respective bargaining power of each party's outside option. That is the value of their next best alternative should they fail to reach an agreement.*"<sup>23</sup>

6.6 Ramsay agrees that a consideration of the parties' outside options is important in assessing the relative bargaining power of PMIs and private hospital operators. Unfortunately, however, there is no evidence in the AIS (and related appendices) of the

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<sup>21</sup> [REDACTED].

<sup>22</sup> See Oral Hearing Transcript, from page 19.

<sup>23</sup> AIS, Appendix D, paragraph 9.



CC analysing the outside option of private hospital operators. Rather, the CC has simply observed that *"a hospital operator's outside option might be to work with a different insurer or to pursue more NHS work."* This is wholly deficient.

- 6.7 As discussed in detail in section 5 above, Ramsay has an overriding incentive to maximise the volume supplied to all insurers and [3<]. This must be taken into account when considering the attractiveness of private hospital operators' outside options.
- 6.8 In addition, the outside options for private hospital operators as mentioned by the CC raise considerable practical issues for private hospital operators, which do not appear to have been taken into account by the CC. For example, the CC appears to be suggesting that private hospital operators could switch from patients from one insurer to patients from another insurer. Such a suggestion is based on misapprehensions of the business of private hospital operators. The CC has failed to take into account that private hospital operators are already motivated to supply to as many PMIs as possible and therefore it is not clear to which other PMIs a private hospital could switch. Further, private hospital operators are unable to control which insured patients are treated in their hospitals (the patient pathway is controlled by consultants, GPs, PMIs and patients themselves). As a result, it is not possible simply to switch to patients insured with another PMI. Lastly, the CC has not taken into account the consultant drag effect., i.e. as a result of losing recognition of one PMI, consultants may choose, for reasons of convenience, divert their patients to hospitals where they can treat all their patients. This would lead to the loss of even more patients for the private hospital operator.
- 6.9 Against this background, to the extent that the CC has even considered the outside option of private hospital operators, that outside option appears to over-valued, which results in the bargaining position of private hospital operators vis-à-vis PMIs being over-estimated.

### ***Delisting hospitals***

- 6.10 The CC appears to discount the threat of delisting as an effective bargaining strategy on the basis that the threat *"is often of limited credibility given that taking such a step can cause the insurer serious harm."*<sup>24</sup>. From Ramsay's perspective, the threat of being delisted is a very real threat. Ramsay considers that, given that Bupa was able to delist BMI hospitals (in circumstances where BMI is the largest PH provider in the UK), every and any private hospital is at risk of being delisted.
- 6.11 The CC indicates in paragraphs 22 to 28 of the AIS that there are a range of factors which may dampen a PMIs desire to delist hospitals. Ramsay considers these factors have been overplayed by PMIs. For example, at paragraph 25 the CC observes that hospital operators can actively increase the likelihood of switching by policyholders. No explanation is provided as to how PH providers could do this. Ramsay is not able to increase the likelihood of switching by policyholders.
- 6.12 Ramsay agrees that another option, rather than a full delisting of all hospitals or a single hospital, would be to delist certain specialisms and treatments. The observation that such partial delisting may be ineffective because it would be difficult to communicate to customers that they could only be treated for some specialisms at their local hospital is at odds with the fact that a number of PMIs already have limited networks for certain treatments and that private hospitals often already do not treat every specialism. Accordingly, PMIs must already manage this problem with their customers. There is also no explanation provided as to why a delisted specialism would be "must have" and why this would result in a price increase.
- 6.13 Further, the CC has completely ignored the catastrophic impact that delisting (full or partial) would have on PH operators (see paragraph 5.3 above). Indeed, the serious

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<sup>24</sup> AIS, Appendix D, paragraph 15.

financial consequences for BMI is no doubt why BMI folded in its dispute with Bupa and was relisted (after acceding to Bupa's demands).

***Not recognising new hospitals***

- 6.14 Ramsay agrees that PMIs are able to exercise buyer power by failing to recognise new hospitals. By way of example, Ramsay has had considerable difficulties in getting its [X] facilities recognised. In relation to [Y].

***Ability to divert patients***

- 6.15 In considering the extent to which PMIs can divert patients to other facilities, it appears that the CC may be assuming that significant volumes of patients will have to be diverted in order for the PMIs' actions to have a punitive effect on private hospitals and therefore constrain private hospitals.<sup>25</sup> This is not correct. For the reasons set out above, given the high fixed costs and excess capacity of private hospital operators, private hospital operators have an overriding incentive to maximise volumes supplied and any loss of volume supplied will have a disproportionately negatively impact on the private hospital's bottom line.
- 6.16 Accordingly, PMIs are able to punish (even so-called "must have") private hospital operators by diverting only some patients away to other hospitals. Patients can be diverted through policy conditions and a part of the treatment authorisation process to the following alternatives:<sup>26</sup>
- (a) rival private hospitals, whether within the Ramsay facility's catchment area (as defined by the CC) or further away;
  - (b) NHS facilities providing private treatment in either PPUs or NHS beds;
  - (c) NHS facilities providing public treatments (for example via policies which financially reward policy holders for being treated in the NHS public system; and
  - (d) where appropriate, outpatient and day-patient facilities.

**7. INFORMATION AND RELATED ADVANTAGES**

- 7.1 PMIs have extensive data from across the market at their disposal on the costs and volumes of treatments provide across the range of private hospitals. Access to this information gives PMIs an information advantage in negotiations with private hospital operators.
- 7.2 Ramsay believes that this gives insurers a significant information and related advantages compared to PHs in such negotiations. For example:
- (a) The insurer holds the patient data which informs the particular risk profile;
  - (b) Whilst Ramsay is obviously aware of the prices it charges other insurers, that is effectively the limit of its data. This compares unfavourably with the ability of the insurer to track prices for all providers across the market and compare PH providers against each other on price. As noted below, PMIs have introduced various mechanisms to exploit this data held by them;
  - (c) The insurer constructs and manages the policy held by the insured. This not only permits the insurer to understand and establish the options available to the insured

<sup>25</sup> AIS, Appendix D, paragraph 11: "Unless a buyer can credibly threaten to switch a substantial portion of its purchasing to a rival, its bargaining position going into a negotiation is likely to be weak."

<sup>26</sup> See discussion above for more detail on these strategies.

at the outset, but also to direct and control the patient pathway of the insured at the point in time treatment is delivered. As such, the insurer rather than the PH provider has the key relationship with the customer.

**8. EVIDENCE CONFIRMS THAT RAMSAY DOES NOT HAVE POWER IN NEGOTIATIONS WITH PMIS**

8.1 This section summarises the evidence from Ramsay's negotiations with PMI which indicates that, in the round, bargaining power does not rest with Ramsay when it negotiates with PMIs.

8.2 As an initial observation Ramsay refers to paragraph 90 of the AIS where the CC states that the evidence that it has reviewed "*is consistent with some large hospital groups have market power in some negotiations*". Ramsay is not aware of any evidence it has submitted that would indicate that it have market power in some negotiations. In this regard, the CC has not identified or raised with Ramsay any instances whereby Ramsay has exercised market power in some negotiations with PMIs. On this basis, Ramsay assumes (and considers it correct), that the CC is not referring to Ramsay when it states that "*some large hospital groups have market power in some negotiations*". If the CC is referring to Ramsay here, it is incumbent on the CC to inform Ramsay and indicate on which evidence it is basing this provisional view.

8.3 Ramsay sets out below examples of "game changing" practices that were introduced by, and favour, PMIs. The fact that PMIs have the ability to change the rules of the negotiation process with PH operators in order to extract lower prices is clear evidence that the balance of bargaining power lies with PMIs and not PH operators.

8.4 By way of example, PMI providers have been able to both demonstrate and strengthen their bargaining position by:

- (a) developing restricted PMI networks, for example low cost networks have been implemented PMIs including Bupa, AXA PPP; Aviva, (including in relation to specific corporate customers<sup>27</sup>) PruHealth and Simply Health (see above for more detail);<sup>28</sup>
- (b) tendering for specific restricted 'low cost' networks (which are lower priced policies aimed at policyholders who are willing to accept a reduced choice of PH facilities) with the expectation that PH providers will offer a discount in return for potentially greater volumes due to the restricted nature of the network, for example: Bupa tendered MRI services on this basis;<sup>29</sup>
- (c) [REDACTED]. By way of example, in relation to [REDACTED];<sup>30</sup>
- (d) tendering for separate contracts for specific types of treatment in addition to a main agreement. This has allowed PMI providers to obtain a lower price for that particular treatment by running a stand-alone tender for its provision. For example:
  - (i) Bupa in relation to it MRI services and ophthalmology services [REDACTED];<sup>31</sup> and
  - (ii) AXA PPP in relation to its specialist networks for cataract surgery and oral surgery;

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<sup>27</sup> See Aviva's Response to the Issues Statement, page 31.

<sup>28</sup> See also MQ Response Part 1, section 36.

<sup>29</sup> See also MQ Response Part 1, paragraph 36.2(a).

<sup>30</sup> See also MQ Response Part 1, paragraph 36.2(a).

<sup>31</sup> See also MQ Response Part 1, section 37.

- (e) taking an increasingly active role in guiding their policyholders to consultants and PH facilities, for example:
  - (i) the use of [redacted];<sup>32</sup>
  - (ii) AXA PPP's Corporate Patient Pathway policy which offers corporate clients a discount of up to 15 per cent in return for giving AXA PPP responsibility for choosing a provider to deliver the treatment recommend by a policyholder's GPs;
- (f) requesting more packaged prices, which means that the PH operators take the risk in the event that additional treatment is required that is not covered by that particular package. For example; [redacted].<sup>33</sup>
- (g) in contract renegotiations [redacted].

8.5 The implementation of these game changing practices by PMIs is inconsistent with private hospital operators having market power. It is unlikely that a private hospital with bargaining power over PMIs would accept one or two of the above strategies; it is implausible and inconceivable that that private hospital with bargaining power would be forced to accept all of these practices. Against that background, the fact that PMIs have been able to implement such a broad range of game changing practices is evidence that it is them, and not private hospital operators who are more likely to hold the balance of bargaining power in negotiations.

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<sup>32</sup> See also MQ Response Part 1, section 36.

<sup>33</sup> See also MQ Response Part 2, section 16.