

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with Ramsay held on 13 March 2013

Ramsay's business

1. Ramsay said that in the UK it was the fourth largest private operator by number of hospitals with a portfolio of 36 facilities, mainly hospitals and daycare facilities, but also one private patient unit (PPU), a diagnostic services business and three neurological centres. Ramsay saw itself as different to some of the other operators. It was not private equity backed. It had a very long-term vision focused on operating hospitals providing acute care and saw itself as a core part of the overall UK healthcare system. Ramsay confirmed that its business was currently based in England as the company it had acquired was mainly based in England. There were differences in NHS policy in, for example, Scotland but it was only for historical reasons that Ramsay's business was focused on England.
2. Ramsay believed that over time it had developed a very disciplined approach, including very strong corporate governance processes and procedures that it believed were transferable to the UK. Ramsay believed that it had established internationally a very strong reputation as a quality-focused organization and this reputation was paramount to having a sustainable business in healthcare.
3. Over the past five years a lot of its strategy had been about working with the NHS. All of Ramsay's volume growth since it had been in the UK had been in NHS work. Most of its growth had come through adding additional capacity, adding new services and filling the capacity that already existed within the business. Over 70 per cent of Ramsay's business was now daycare and this required a significant change to its existing traditional hospitals facilities which were focused on inpatient facilities and overnight beds. By freeing up overnight capacity this had also enabled Ramsay to look at introducing new specialties not previously part of the standard general elective care services typical of the private sector historically.

Competition with the NHS

4. As well as being Ramsay's biggest customer, the NHS was its biggest competitor. The NHS was involved in the delivery of private patient work through PPUs and through dedicated beds within the NHS, with well over 1,000 beds, and these were growing now that NHS trusts were able to deliver more private work. There was probably not a trust in the country that was not looking at opportunities to try to generate more private patient revenue. Trusts had a substantial competitive advantage. The consultants were already there, and the trusts had access to resources, to facilities and to staff. It was very hard for Ramsay to compete with PPUs or dedicated NHS private patient beds.
5. Approximately 15 per cent of people who were privately insured were having their care delivered by the NHS.
6. Patients were being directed by the private medical insurers (PMIs) into the NHS. This was directional work, where PMIs paid patients to have that work done within the NHS, because it was a cheaper option for them than using private hospitals.

7. Ramsay said that PPU were across the country. NHS trust hospitals existed in every town and they could all take private patients, or a lot of them could. Ramsay emphasized the non-PPU private work within the NHS, citing Guy's as an example. Patients were treated in normal NHS beds, but were charged. Guy's got about £20 million a year of private revenue. £4 million of that was in the PPU. Bupa had tendered for MRI and had chosen the NHS as its provider for MRI in Truro. Bupa therefore found the NHS to be a credible alternative to Ramsay for the provision of private care.

Private medical insurers

8. The two largest PMIs had 65 per cent of the market and the top four had 87 per cent of the market. As a result they were obligatory trading partners.
9. PMIs had buyer power. They had access to a range of information across the industry that a single hospital operator could not see. If PMIs exercised their buyer power too forcibly this would damage the sustainability of Ramsay's business and the sustainability of the overall private hospital market as well. This would have a detrimental effect on patients.
10. Ramsay did not see PMIs driving costs out and improving efficiencies within their own businesses. PMIs had massive structures in place that needed funding.

Negotiations

11. As insurers launched new products or service line tenders, the insurers would specify a price which was generally non-negotiable. Insurers had also often successfully sought to shift more risk over to the hospitals through, for example, all-in prices, shifting the risk of consultants' charges, patient co-morbidities and length of stay to the hospitals. National negotiations were something the PMIs, not the hospitals, had required. Moreover, under the contracts there was no obligation on the insurer to direct any volume to Ramsay and insurers were constantly changing the rules of the game by introducing restricted and low-cost networks obtaining discounts and then inviting other hospital groups into the network.
12. Ramsay noted that even BMI with its scale had many hospitals delisted by Bupa and thus did not have much clout. Therefore, there was little prospect of the other small operators having any. Ramsay's current price with Bupa in particular was historical and it was difficult for Ramsay to change this.
13. Ramsay worked hard to build good relationships with all of the PMIs, whether large or small. Even the smaller PMIs had the ability to negotiate and sometimes they used the same tactics as the larger ones, because Ramsay had to have relationships with all of the PMIs, whereas the PMIs did not have to have relationships or use all of Ramsay's facilities. Ramsay had had to give discounts to the smaller PMIs.
14. Ramsay was not in a position at all to hold any of the PMIs to ransom. It considered the idea that it had a number of 'must have' hospitals to be bizarre. It did not believe that the question of 'must have' hospitals had ever even come into negotiations.
15. Some PMIs were talking about some double digit inflation in their costs, etc. Bupa had suggested 6 per cent, 7 per cent, 8 per cent, 9 per cent, 10 per cent. Ramsay said that PMIs' claims that hospitals were increasing the private healthcare cost base and thereby hurting the PMIs' business model was not correct—there must be other reasons why PMIs' costs were increasing.

Hospital recognition

16. Within the standard networks (ie not low-cost restricted networks) the vast majority of Ramsay's hospitals were recognized. There were exceptions. AXA-PPP, for example, did not recognize Ramsay's hospital in Nottingham for historical reasons nor any of its treatment centres, but across the general policies and products there was full recognition. Within the low-cost networks there was a lot less recognition. All Ramsay's facilities were recognized by Bupa in its low-cost network but only nine were recognized in AXA PPP's low-cost network and none in its Pathway product network. All but one of Ramsay's hospitals were in the Aviva Fair and Square network. PMIs like PruHealth, WPA, and Cigna did not operate restricted networks and were not interested in directing patients to particular facilities.
17. Ramsay said that the theory of the low-cost networks was that there were fewer hospitals in the network with bigger catchment areas leading to more volume. A discount could be obtained with more volume. A lower price was negotiated in anticipation of higher volume, because it was a selective network, but there were no guarantees to the hospital as to what volume would be delivered. The implied promise of quasi exclusivity from a low-cost network deal was not always kept. PMIs made no volume commitments to Ramsay, although they might for some other providers.

Other

18. Ramsay was concerned about 'open referral', for example, where Bupa directed patients to consultants. It was concerned about the transparency of such referrals and whether such referrals were built on clinical judgement rather than cost. The algorithms used by the insurers only related to consultant costs and did not factor in hospital costs. Bupa had confirmed this to Ramsay very recently. Therefore, Ramsay, whilst being one of the lower-priced hospital providers, had not benefited from Bupa's open referral model. Rather, work was being directed to consultants who would agree to be 'fee assured' despite the fact that the hospital fee was the largest part of the episode payment. In addition, unfortunately the information that PMIs used in their open referral processes was not always correct. Ramsay had sent Bupa a list of about 50 issues where patients had been directed to the wrong hospital, wrong type of specialist etc. The whole system was cost and not quality driven and excluded the largest cost factor, hospital fees. The concerns Ramsay had in relation to open referral referred to the way in which Bupa operated open referrals which was more active and aggressive in directing patients and limiting patient choice. Other insurers were using open referrals but in a more effective way.
19. There were important advantages to both hospital operators and PMIs to having a single national price in terms of transactional processing costs. It gave Ramsay greater scope to get the billing right first time, so there were no errors within the bills that went forward, which just added waste and cost into the whole process. There was a genuine benefit to the sector to have a common price for that reason. National pricing was something that the PMIs had traditionally and typically driven as it reduced their transactional costs.

Local competition

20. Ramsay reiterated that it did not regard any of its hospitals as 'must have' facilities. Its only hospital that did not have other private hospitals close to it was Duchy hospital in Truro and there were some unique geographical issues there. Every one

of its other facilities had a number of different competitors within 30 minutes and other competitors outside of that area.

21. In the South-West of England the number of people who had private insurance was fairly low. The main competitor of the Duchy Hospital in Truro was the NHS trust which was quite aggressive in trying to generate private work. People in this area (and other similar areas such as Cumbria) tended to travel longer distances, whether that was for NHS treatment or private treatment. There was some competition from Nuffield as well and some patients travelled to London.
22. In the East of England there was far greater density of provision of private hospitals, so Spire, BMI and Nuffield were well represented in that area as well. Ramsay's hospital in Colchester competed with the Nuffield facility in Ipswich and BMI facility in Bury St Edmunds.

London

23. Whilst high-end London hospitals might have an advantage in complex oncology or high acuity work, outer London hospitals could compete well with them for lower acuity types of procedure such as orthopaedics.
24. There might be patients that considered that it was better to have their care delivered in London at a major tertiary style hospital. This might be influenced by their GPs. In the Ashted region (on the outskirts of Greater London where Ramsay had a hospital) there was an array of different providers that offered an alternative to London. However, a significant volume of patients from that area still would have their care delivered in London, although not for want of Ramsay advertising its services and the recognized significant price differentials. In relation to NHS competition, this would mainly be from the trusts within the same locality as GPs tended to refer within their local trusts boundaries. In addition, it was not simply a question in investing in high acuity facilities to take advantage of the price differential between central London and greater London/outskirts of London—there needed to be local demand to justify the business case and the right consultants who would bring the patients within the area.
25. The central London hospitals had an effective business model with GPs in the city firms; the employees would see the GPs within the organizations and there was a direct relationship then with the central London hospitals. In attempting to take business from central London hospitals, Ramsay had to compete with that set-up. It would more than happily take patients from central London.
26. Ramsay said that land costs were the main obstacle to setting up a hospital in central London. The cost of land to get a site in the right location to then develop was expensive.

Consultants

27. The main type of consultants that had formed groups were the anaesthetists. They had come together and set their prices. In general, this was an issue for insurers, but for Ramsay this could be an issue with its NHS work. In certain other speciality areas, similar issues arose to anaesthetist groups such as pain management specialists who had managed, not necessarily through groups, to command higher fees.
28. Ramsay explained how payments for NHS work operated and the role of consultants within that.

29. Ramsay said that for the self-pay market it promoted the prices of self-pay to include the consultant fees. It took advice from consultants as to what they wanted to set their fee at, which would typically be at an insured rate; often WPA rates were used, but similarly Bupa, AXA-PPP and others as well. Ramsay incorporated that within the pricing that it offered to self-pay private patients.
30. Consultants in certain specialties where Bupa had actively reduced the fees were very concerned. Consultants were saying that Bupa's levels were not sustainable in terms of the costs of them undertaking private practice, such as Medical Defence Union costs etc. Ramsay had heard claims of 60 to 65 per cent reductions in the level of fees historically paid and regarded these as particularly significant. It was difficult for Ramsay to judge as to where the relativities should exist and whether the consultants were legitimate in their concerns or whether Bupa was right in its concerns. Other than a few consultants who did cataract work, Ramsay had not seen any consultants withdraw completely from the private market due to Bupa's reduction in fees covered.
31. Ramsay opposed models such as the Circle one, where consultants were locked in and had to take their patients to a particular facility, because it took away patient choice. It believed that that model was an unethical one and that patients should be fully informed wherever a doctor had a vested business interest in a facility. In models where consultants had to take 90 to 100 per cent of their work and were locked in to do that, Ramsay thought there was a perverse incentive: to get free equity on the basis of the quantum of referrals made was unethical. In many jurisdictions it was illegal, and to promote the referrals to provide a financial inducement to refer patients to a facility was unethical.
32. Ramsay's management thought that some consultants had previously received some sort of profit share or incentive to work at particular hospitals. Ramsay thought that it had lost some consultants due to it not offering these inducements when it acquired the hospitals. Although there had been changes in the industry on such incentives, Ramsay thought that inappropriate inducements were still being made.
33. Ramsay said that its hospital managers identified that consultants were being offered incentives to take their work elsewhere and wanted to respond with similar schemes. They got concerned if competitors were offering these incentives. However, Ramsay's policy was not to offer such incentives and it took a firm line on that. In many jurisdictions in which Ramsay operated financial inducements to promote referrals were illegal. Ramsay had inherited two schemes in Reading which it dismantled as soon as possible.
34. There had been a problem in Reading where Circle recently entered. There were two half-full hospitals, and there was now a third hospital in that area that had locked doctors in to take patients. Ramsay thought that probably only two hospitals would survive out of that because there was not enough work. Circle had attracted consultants by giving them free equity subject to signing a contract to say that they would take their work there. A lot of doctors now wanted to exit these agreements, but they were locked in.
35. Ramsay had coped in responding to Circle by looking further afield to recruit doctors. It had extended its area and was considering new services. It had spent a significant amount of money refurbishing the hospital.
36. Ramsay regularly experienced competitors poaching consultants by the use of incentives.

37. Ramsay did not have any major concerns with its competitors' vertical integration strategies including acquiring GP practices.

Expansion and growth

38. In the short term Ramsay would not build new facilities to grow its business. The capital costs of building a new facility were high and there was overcapacity within the system. Ramsay would invest in expanding its facilities, into growth and into new services, but not in building a new hospital.
39. In the longer term, if Ramsay was going to move the sector from where it was now, which was more 'boutiquey' elective surgical work, to a more comprehensive facility that provided a full range of services, for example a 300-bed or 400-bed hospital, with intensive care unit, 15-theatres theatre suite, then that would have to be built.
40. Expansion by developing specialist daycare centres could occur because the economics were easier. They tended to be limited to certain specialties (such as ophthalmology, endoscopy and arthroscopy) and were effective because those specialties were principally based around day surgical work. With specialties that were based both on day surgery and inpatient work, specialist daycare centres were less effective. When a consultant went through their theatre list, it was easier for them to integrate day and inpatient work on a theatre list if they had a facility which handled both inpatients and day patients. When they went to a day patient facility, they needed enough volume of the day work to make that convenient for them. For a specialty like orthopaedics, consultants could do arthroscopies in a day surgical facility, but, with hips and knees, then inpatient facilities were needed.

Profitability

41. Ramsay noted some of its specific concerns about the Competition Commission's (CC's) work on profitability, and said that it was surprised and concerned that the CC's approach attributed no value to intangible assets.
42. Ramsay said that it was very hard to look individually procedure by procedure and work out which ones made a profit. Ramsay's approach was to work on filling capacity and volumes. With regard to the profitability of different types of NHS work, it would be dangerous to focus on certain types of NHS work because the tariff could change. Ramsay's philosophy had always been to spread the risk, do the most comprehensive range of procedures that it could and, because it had a long-term perspective, it rode the peaks and troughs of what happened with the tariff.