

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with Ramsay held on 7 October 2013

Divestments

1. Ramsay believed that if the divestment remedy was to be imposed it needed to be structured to ensure that all hospitals could continue to operate as a viable undertaking. The CC needed to take appropriate measures to avoid 'cherry picking' of one or more of the desirable hospitals, leading to one or more of the less attractive hospitals being left over at the end of the process.
2. Delay in selling any hospitals should be avoided, since uncertainty of a hospital's future could be detrimental to its future performance and viability.
3. Ramsay considered there were likely to be purchasers who would be interested in acquiring suitable hospitals the CC considered needed to be divested.
4. Selling all of the hospitals to be divested in one package would give someone the chance to enter or expand in the private healthcare market and become a viable competitor. Selling the hospitals in smaller packages or indeed individually might be less attractive to a potential purchaser. Including any London hospitals would make the package more attractive and clearly added value to the offering.
5. Offering a package of any hospitals to be divested in central London could be more attractive to potential buyers. Having a new owner entering central London would increase competition. Ramsay felt that the London market was a different market, attracting customers from overseas.
6. A new entrant would need to spend time establishing and investing in relationships with GPs, referrers, large employers etc who could refer their private patients to their facility.

Restrictions on expansion into PPU's

7. Ramsay had concerns that in deciding which locations a restriction on expansion by a hospital operator into operating PPU's should be applied, the CC had not considered competitor hospitals situated outside of the catchment area, even where patients were located in overlapping catchments. The CC's decision to rule that two hospitals of similar size in any area did not impose significant constraint on each other was incorrect and improperly applied, particularly where the rival hospital was of a larger size.
8. Restrictions on expansion by hospital operators in solus and duopoly areas into the operation of PPU's, would give rise to a number of negative unintended consequences and it could disqualify more than one hospital operator from bidding for a PPU where it fell within one single or duopoly hospital. It could therefore result in no or only one viable bidder in a tender. Given the relevant local catchment areas of single and duopoly hospitals could vary over time, there was going to be significant uncertainty in relationship to the tendering for PPU's and Ramsay were unsure how the NHS was going to be aware of which hospitals it was going to be able to partner with.

9. With NHS Trusts looking for new revenue streams, and many wanting to start up PPU's, it would be difficult to establish a practical ongoing process of review to actually ensure that this remedy could be applied appropriately.
10. In nearly all of the areas that it operated, there was already significant competition and Ramsay taking control of one or more PPU's in areas where it operated would provide patients with a further choice within that geography.
11. Dominant players should be constrained from expanding via the PPU market. The restriction could be applied in regions where there was a very strong cluster of hospitals owned by the one hospital operator.
12. Finally Ramsay felt that this remedy should only be applied where there were significantly high barriers to entry, probably in markets such as central London.

Incentives

13. Ramsay had concerns about the CC's consideration of endorsing longer-term incentives, such as equity partnerships. This was just another distortion to a competitive market being added when the objective was to do the opposite. The key determinant of whether an incentive gives rise to an adverse effect on competition which might need to be remedied should not be whether it was short term or long term; it should be whether the arrangement was directed at improving the quality of service and care received by patients. It considered that equity participation schemes rewarded consultants for sending patients to a particular facility and was seen to interfere with clinical decision-making to the detriment of patients.
14. There were some incentives that were in patients' interests which should be permissible if they did not interfere with clinical decision-making and if they were not open to abuse by consultants. Some areas, including administrative support and training for consultants could assist in the smooth delivery of services to patients, but again, Ramsay felt that these should only be permissible if the measures were reasonable, not of excess value, not linked to any requirement that the consultant treat the patient at a particular hospital and if no financial payments were made.
15. It would be difficult to design a framework of permitted incentives, particularly based on fair market value. The CC would need to monitor the extent to which fair market price had been applied and set up a mechanism to settle disputes between consultants and private hospitals (or between private hospitals) as to whether what was paid represented a fair market value.
16. Ramsay considered that the current remedy proposed by the CC, which provided an exception for incentives in the form of ownership which results in a reduction in barriers to entry, would result in an unfair distortion of a competitive environment. It might also result in one of the existing facilities becoming unviable and having to exit the market given that there would be no increase in overall demand. This would perversely lead to less or the same amount of choice as prior to the favoured new hospital entering the market given the artificial advantage allowed for the new hospital. If consultants bring in a new provider to the market (through equity partnerships) and artificially stimulate demand in a market, demand might be shifted but at least one of the existing providers was likely to fail. It did not know of any evidence to suggest that new or better facilities could stimulate demand. By hospitals exercising incentives to attract and lock in consultants, many patients were unable to choose which hospital they attended.

17. Of all the offered incentives Ramsay believed it should be able to continue to offer the administrative services or secretarial services, as they were useful to offering hospital and patient support. It also considered genuine consultant training important. However, it was difficult to draw the line as to the type of incentives that were appropriate. Consultants should not be encouraged or tied in to carry out some or all of their work at any particular hospital.
18. Day-case facilities offered competition and this was an area where work was increasing. There was evidence of new entrants to this particular market with day-case facilities appearing in a lot of places. The cost of entry to this market was relatively low compared with that of full inpatient facilities. Ramsay considered that this was a key point, rather than new hospital operators developing a model which relied on the payment of incentives to consultants to enter a market where there was insufficient demand to support that new entrant. The demand was there to support day-case facilities as more and more procedures could be undertaken in a day-case setting.
19. The reason for there being few new entrants in the market was because there was not that underlying demand and generally excess supply. However, the expanding PPU market could provide an opportunity for someone to enter the market.
20. Ramsay agreed with the CC that a monitoring body should be appointed to identify problem areas and deal with disputes.

Pricing

21. National pricing had benefits in terms of both transactional costs and effort between an insurer and hospital provider. However, there were also minuses to national negotiation, particularly when a local dynamic changed. For example, if there were 15 sites in a network and for five of those local dynamics changed, potentially five local discussions would need to be held and then a national discussion for the remaining hospitals. This would generate transactional and administrative difficulties.
22. Ramsay had concerns with regards to remedy 2(b) about the increase in transaction costs that would be involved in negotiating a price schedule for each hospital with each insurer. The administration of these multiple prices would also result in an increase in administrative costs. This would also disadvantage the smaller PMIs concerned with transactional costs and could lead to distortion in the market in favour of the larger PMIs.
23. Ramsay also believed that the smaller PMIs might object to having local pricing since they did not have the infrastructure and organizational structure in order to be able to conduct such negotiations at a local level.
24. A lot of analysis and data would be required to piece together a pricing structure, which would also be difficult to maintain over time.

Information availability

25. Ramsay agreed with the CC that information on the quality of individual consultants should be collected and made available to the general public. Ramsay was a member of PHIN and agreed that it or a similar organization was a suitable body to collate and publish information on consultants. It was difficult to identify the right

information to make available and how to collect information that would make sense to patients. It was concerned that detailed commercially sensitive information should not be made available such as absolute volumes. However, it made sense to be as transparent as possible in terms with regards to information that would help patients make informed choices about the clinical quality of hospitals and consultants.