

**RAMSAY HEALTH CARE (UK) LIMITED ("RAMSAY")**

**COMPETITION COMMISSION'S ("CC") PRIVATE HEALTHCARE MARKET INVESTIGATION**

**RESPONSE TO NOTICE OF POSSIBLE REMEDIES ("REMEDIES NOTICE")**

**1. INTRODUCTION**

- 1.1 This paper sets out Ramsay's preliminary observations on the range of remedies being considered by the CC as set out in the CC's Remedies Notice. Ramsay comments on each of the 7 remedies being considered by the CC in turn below.
- 1.2 In the limited time available,<sup>1</sup> Ramsay has sought to provide its high level views of the remedies being considered by the CC. Ramsay reserves the right to elaborate on the comments set out in this paper, not least in response to any further clarification from the CC as to any remedies that may be imposed.

**2. REMEDY 1: DIVESTMENT OF CERTAIN HOSPITALS**

- 2.1 The CC is consulting on the divestment of certain BMI, HCA and Spire hospitals ("**Remedy 1**"). The CC makes it clear that the purpose of Remedy 1 is to address supposed weak competitive constraints that arise when several hospitals in a local area are wholly or predominantly operated by one operator (which the CC refers to as "clusters").
- 2.2 As Remedy 1 is currently posited, it would apply to fewer than 20 hospitals<sup>2</sup> operated by HCA (in Central London), and BMI and Spire (outside of Central London). Given that Ramsay is not directly affected by Remedy 1, Ramsay makes limited submissions as regards the scope of Remedy 1 and, in particular, whether the proposed divestiture package will satisfactorily address the adverse effect on competition ("**AEC**") as provisionally identified by the CC.
- 2.3 Ramsay will make observations at the Remedies Hearing regarding factors relevant to the effectiveness of Remedy 1 and, in particular, the nature of any divestment package and long term viable operation of the hospitals to be divested.

**3. REMEDY 2: BEHAVIOURAL REMEDIES**

- 3.1 The CC is considering two behavioural remedies aimed at preventing private hospital operators using their market power in certain local areas to tie or bundle services in their national negotiations with PMIs:
- (a) **Remedy 2(a)**: BMI, HCA or Spire would be prevented from raising their prices nationally if a PMI changed its network policy such that patient volumes to the hospital operator concerned were likely to fall; and
- (b) **Remedy 2(b)**: BMI, HCA and Spire would be required to price their hospitals separately and individually to PMIs.
- 3.2 Neither Remedy 2(a) nor Remedy 2(b) would directly apply to Ramsay: these remedies would only apply to BMI, HCA and Spire. Given that the CC has found that Ramsay does

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<sup>1</sup> Not least because the response to the Provisional Findings is due on the same date as this submission and the time taken to arrange disclosure of certain confidential information relevant to the imposition of remedies by the CC.

<sup>2</sup> The CC is considering the divestment of hospitals and/or assets. In this section of the submission, when referring to hospitals that may be subject to divestment, Ramsay is referring to both hospitals and assets as appropriate.

not have market power in its national negotiations with PMIs, we agree that it is unnecessary and inappropriate to apply either of these remedies to Ramsay.

3.3 Nonetheless, even where these remedies only directly apply to BMI, HCA and Spire, they still raise significant concerns for Ramsay, not least because Ramsay believes that [REDACTED] [CONFIDENTIAL].

3.4 Ramsay sets out in more detail below its more specific concerns in relation to Remedies 2(a) and 2(b).

**Remedy 2(a): preventing BMI, HCA and Spire from raising its prices nationally if a PMI changed its network policy such that patient volumes to the hospital operator concerned were likely to fall**

3.5 Remedy 2(a) relates to the bargaining dynamic between BMI, HCA and Spire in relation to the inclusion of hospitals in PMI networks.

3.6 In this regard it is important for the CC to distinguish between:

- (a) terms agreed at the outset of a network; and
- (b) steps by PMIs to alter network arrangements after the terms had been agreed.

3.7 In the original negotiation, Ramsay has never been able to insist that all of its hospitals are included in PMI networks ([REDACTED] [CONFIDENTIAL]<sup>3</sup>). Given that Ramsay is unable to negotiate with PMIs on this basis (notwithstanding the imposition of Remedy 2(b)), Ramsay has no further comment on whether the CC should impose a remedy prohibiting private hospital operators (specifically BMI, HCA and Spire) from adopting an "*all or nothing*" approach in contracts negotiations.

3.8 Ramsay is concerned, however, about Remedy 2(a) enabling [REDACTED] [CONFIDENTIAL]. When a private hospital operator negotiates with PMIs for the inclusion of hospitals in a PMI network, the prices under those contracts reflect the private hospital operator's expectations as regards likely volumes to be supplied under the contract, often with significant volume discounts offered where it has a number of hospitals included in the network and the network is restricted.

3.9 In these circumstances, a private hospital operator would expect to supply higher volumes of services than it would if the network were, for example, less restricted and would generally offer a discount to reflect that expected volume. If, half-way through a contract, a PMI alters the composition of a network such that a private hospital operator will obtain less volume of work (by removing some of its hospitals or by adding hospitals from a competing private hospital operator), it would be unfair and unreasonable to insist that the private hospital operator should continue to supply services at the prices originally set out in the contract (i.e. with the volume discount). Accordingly, in response to PMIs unilaterally changing key terms of the contractual arrangements (i.e. network composition), it is reasonable to enable private hospital operators to adjust terms of supply (such a price) in order to reflect that change.

3.10 [REDACTED] [CONFIDENTIAL], Remedy 2(a) is likely to give rise to a number of unintended consequences which will distort competition. The following non- exhaustive list of unintended consequences indicate that Remedy 2(a) is unlikely to be proportionate:

- (a) Remedy 2(a) will [REDACTED] [CONFIDENTIAL] reducing contractual certainty. Contractual uncertainty can lead to a number of negative consequences, including disincentivising investment and innovation;

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<sup>3</sup> [REDACTED] [CONFIDENTIAL].

- (b) Remedy 2(a) may result in higher overall prices, if not in the short-term, at least in the medium to long term. Where there is no certainty as to volumes provided under a contract, private hospital operators will be discouraged from offering volume discounts to PMIs and are likely to price on the basis that volumes supplied under the contract may not justify a volume discount; and
- (c) Remedy 2(a) will [X] [CONFIDENTIAL]. This would be wholly inappropriate in circumstances where [X] [CONFIDENTIAL]<sup>4</sup> and in circumstances where the CC has not found Ramsay to have bargaining power over PMIs in national negotiations.<sup>5</sup>

3.11 If, notwithstanding the above, the CC were nevertheless minded to implement Remedy 2(a), Ramsay is of the view that the following conditions would, at the least, be necessary:

- (a) first, Remedy 2(a) should only apply to any new contracts entered into after the publication of the CC's final decision. If Remedy 2(a) is applied retrospectively to BMI, HCA and Spire contracts with PMIs, Ramsay considers there is a real risk that [X] [CONFIDENTIAL]; and
- (b) secondly, the CC needs to make clear that PMIs should be required to enable private hospital operators who do not have market power over PMIs in national negotiations, such as Ramsay, to increase its prices nationally if a PMI changed its network policy such that patient volumes were likely to fall.

**Remedy 2(b): Requiring BMI, HCA and Spire to price their hospitals separately and individual to PMIs**

3.12 Before considering the extent to which Remedy 2(b) would be an effective, reasonable and proportionate remedy, Ramsay notes that Remedy 2(b) appears to assume that the national contracts act in the interest of private hospital operators only and to the disadvantage of PMIs. This is inconsistent with Ramsay's experience. As set out in detail in Ramsay's Response to the AIS,<sup>6</sup> national negotiations [X] [CONFIDENTIAL] and operate to the benefit of PMIs, as well as reducing transaction costs generally for both private hospital operators and PMIs.

3.13 Ramsay considers that Remedy 2(b) is likely to give rise to a number of unintended consequences which will distort competition:

- (a) First, hospital-by-hospital negotiations will result in higher transaction, negotiation and administrative costs for both private hospital operators and PMIs. By way of example:
  - (i) [X] [CONFIDENTIAL];
  - (ii) Ramsay and PMIs would lose the significant administrative cost savings resulting from centralised invoicing and pricing (which results in more accurate pricing and invoicing, and reduces the time involved in correcting/processing invoices; in this regard Ramsay notes that a single hospital could have to price and invoice over 1500 treatment codes); and
  - (iii) [X] [CONFIDENTIAL].

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<sup>4</sup> See Response to AIS, section 7 and Annex 5.

<sup>5</sup> Provisional Findings, paragraph 44 to 45. Indeed, PMIs have actually acknowledged that Ramsay does not have such bargaining power. For example, AXA PPP and PruHealth, see Provisional Findings, Annex 6-11, paragraph 14.

<sup>6</sup> See paragraphs 7.21 to 7.25

- (b) Secondly, these higher administration and transaction costs are likely to lead to, in general, higher prices for private hospital services.
- (c) Thirdly, [REDACTED] [CONFIDENTIAL].
- (d) Fourthly, where hospitals are priced differently, this may result in [REDACTED] [CONFIDENTIAL].
- (e) Fifthly, where the prices of treatments vary across hospitals, PMIs might seek to direct patients to the cheaper hospital in order to cut costs and not for clinical reasons. Ramsay has serious misgivings about creating such incentives for PMIs to interfere with clinical decision-making.
- (f) Sixthly, Remedy 2(b) may distort competition in PMI market. Very few PMIs will have the necessary scale and resources to negotiate with private hospital operators on a hospital-by-hospital basis (as noted in paragraph 3.13(a) above, the administrative costs associated with hospital-by-hospital negotiation are very high).<sup>7</sup> Indeed, Ramsay considers that only BUPA may have sufficient scale to be attracted by such an opportunity; other PMIs are unlikely to be in a position to avail themselves of this remedy. Ramsay has serious concerns about the CC implementing a remedy which [REDACTED] [CONFIDENTIAL].

3.14 Given the range of unintended negative consequences, Ramsay has some misgivings about the imposition of a remedy requiring BMI, HCA and Spire to price hospitals separately and individually.

#### 4. **REMEDY 3: PROHIBITING PRIVATE HOSPITAL OPERATORS PARTNERING WITH THE NHS IN RELATION TO CERTAIN PPU**

4.1 The CC is considering prohibiting all owners of a hospital in a single or duopoly local area ("**Single and Duopoly Hospitals**") from partnering with an NHS Trust to operate a PPU in that local area ("**Remedy 3**").

4.2 At present it appears that the CC proposes to apply this remedy to the [REDACTED] [CONFIDENTIAL] Ramsay hospitals that the CC considers give rise to local market issues (referred to as the "[REDACTED] [CONFIDENTIAL] Hospitals" in this submission).<sup>8</sup> This is inappropriate for the following reasons.

##### **It is inappropriate to apply any remedy to Ramsay that would weaken its ability to compete on a local or national level**

4.3 As a general point, we are surprised that the CC is considering the application of any remedy that would weaken Ramsay's ability to compete on a local or national level, given that the CC has already found that Ramsay does not have national market power when dealing with PMIs.

4.4 As such, the CC should be taking great care to avoid any remedies that would hinder Ramsay's ability to grow and fulfil a role as a strong competitive force at the local or national level to challenge the position of the incumbent networks.

##### **There is no legal basis for the CC to apply Remedy 3 to Ramsay**

4.5 In any event, the AEC found by the CC in respect of Ramsay is limited to the potential for adverse impacts upon *self-pay* patients. There is nothing in the CC's analysis or findings that would justify the application of Remedy 3 to Ramsay on that basis.

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<sup>7</sup> This is evidenced by the fact that PMIs have not approached Ramsay seeking hospital-by-hospital pricing.

<sup>8</sup> [REDACTED] [CONFIDENTIAL].

- 4.6 In this regard, paragraph 7 of the Remedies Notice confirms that: (i) high barriers to entry; and (ii) local market power are the basis for the relevant AEC's as found. It is trite that any remedy imposed upon Ramsay must relate to the AEC as identified by the CC.
- 4.7 Importantly, the relevant AEC is described thus:
- "Together the relevant features described in paragraph 6(a) and (b) [namely barriers to entry and insufficient constraints at the local level] give rise to AEC's in the markets for hospital services that are likely to lead to higher prices for self-pay patients in certain local markets and to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and Spire) that have market power in negotiations with insurers."*<sup>9</sup> [emphasis added]
- 4.8 In this passage, which replicates the key statement of finding in the CC's Notice of Provisional Findings,<sup>10</sup> the CC confirms that the identified AEC arising in respect of *insured* patients does not apply to Ramsay, as a function of its lack of national negotiating power.
- 4.9 Accordingly, the AEC that has been identified in respect of Ramsay is limited to alleged adverse impacts, arising from barriers to entry and local market power, in so far as they *"are likely to lead to higher prices for self-pay patients in certain local markets"*.<sup>11</sup> [emphasis added]
- 4.10 Accordingly, in so far as any alleged adverse impacts arise from Ramsay's alleged local market power, they are confined to the self-pay market.
- 4.11 Moreover, it is clear from the Remedies Notice that Remedy 3 is directed at the AEC that is alleged to arise in respect of "Single or Duopoly" areas.
- 4.12 However, the concepts of Single or Duopoly areas have been derived from the CC's local markets analysis (LOCI or fascia) based upon data of insured patient flows.
- 4.13 In this regard, the CC has not carried out an analysis of whether or not Ramsay enjoys Solus or Duopoly status as might lead to adverse effects (and thus justify Remedy 3) in respect of self-pay patients.
- 4.14 This is highly material as self-pay patients drive further for treatment. Thus any finding of "single" or "duopoly" status in respect of insured patient flows is obviously based upon the incorrect catchment area and says nothing about the potential for adverse impacts on self-pay patients. Self evidently, such analysis cannot be used as a basis for a remedy applied to a party that has been found to have no market power in respect of insured patients, particularly where the effect of such a remedy would amount to a direct interference in Ramsay's rights to exploit and grow its existing business.
- 4.15 The materiality of this point is demonstrated where, as set out below, the evidence confirms that the [ⓧ] [CONFIDENTIAL] Ramsay hospitals do not, as a matter of fact, have Single or Duopoly status for self-pay purposes when measured in the correct catchment.

**The evidence confirms that Ramsay's [ⓧ] [CONFIDENTIAL] Hospitals do not lack local constraints, particularly if due regard is had to the wider catchment area for self-pay patients**

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<sup>9</sup> Remedies Notice, paragraph 7.

<sup>10</sup> Paragraph 3.

<sup>11</sup> Notice of Provisional Findings, paragraph 3.

- 4.16 The relevant catchment for self-pay patients (i.e. the only patient category relevant to Ramsay in the context of Remedy 3) is, according to the CC's own analysis, on average just under a 45 minute drive time from the hospital concerned.<sup>12</sup>
- 4.17 [REDACTED] [CONFIDENTIAL].<sup>13</sup>
- 4.18 Given this wider catchment, it is clear that:
- (a) there is no evidence of barriers to entry when considering local areas defined by reference to a 45 minute drive time;
  - (b) as set out in Ramsay's Response to Competition Commission Final Assessment of Private Hospitals dated 21 June 2013 ("**Response to Final Assessment**"), [REDACTED] [CONFIDENTIAL] would fall to be considered as Single Hospital based on catchment area defined by reference to a 45 minute drive time analysis.<sup>14</sup> Given the CC has carried out no analysis of the strong constraints presented by the [REDACTED] [CONFIDENTIAL] in respect of self-pay patients, we do not see how the CC can warrant the application of a non-expansion remedy against even [REDACTED] [CONFIDENTIAL];
  - (c) Ramsay does not accept the concept that a Ramsay hospital facing strong competition from a single in-patient private provider (a so called "Duopoly") could lead to inadequate local market constraints or barriers to entry in respect of self-pay patients. In any event, the CC has failed to model such effects;
  - (d) However, even if the "Duopoly" concern is accepted, based on a 45 minute drive time [REDACTED] [CONFIDENTIAL] Hospitals except for [REDACTED] [CONFIDENTIAL] face at least 2 non-Ramsay private in-patient hospital competitors within the self-pay drive time and thus pass the CC's own test<sup>15</sup>;
  - (e) Moreover, the notion that the CC seeks to impose a non-expansion remedy upon Ramsay to meet concerns arising in respect of self-pay patients becomes truly absurd when it is considered that, in the context of the [REDACTED] [CONFIDENTIAL] Hospitals, within a 45 minutes drive-time and ignoring PPUs: [REDACTED] [CONFIDENTIAL]<sup>16</sup>;
  - (f) Finally, in respect of [REDACTED] [CONFIDENTIAL] which face competition from at least one other private in-patient facility, the CC cannot categorise them as Duopolies as this ignores the competitive constraint of [REDACTED] [CONFIDENTIAL] in the market in the context of self-pay patients, namely the PPUs. For example, [REDACTED] [CONFIDENTIAL].<sup>17</sup> These figures are comparable and provide clear evidence of the competitive constraint provided by PPUs on hospitals such as [REDACTED] [CONFIDENTIAL], particularly in the self-pay context.
- 4.19 As such, and for the reasons set out in detail in Ramsay's response to the Provisional Findings, and contrary to the CC's provisional views, Ramsay does not have local market power in relation to the [REDACTED] [CONFIDENTIAL] Hospitals. On this basis, it would be entirely inappropriate to apply Remedy 3 to Ramsay. Ramsay should be free to partner with NHS Trusts in relation to the local areas of the [REDACTED] [CONFIDENTIAL] Hospitals.

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<sup>12</sup> CC's Patient Survey, page 48.

<sup>13</sup> Ramsay's Response to the Provisional Findings, Annex 1.

<sup>14</sup> See Annex A.

<sup>15</sup> [REDACTED] [CONFIDENTIAL].

<sup>16</sup> Response to Final Assessment, Annex A.

<sup>17</sup> Ramsay Response to Provisional Findings, Annex 3, Appendix 3.

**Remedy 3 is unnecessary save where real barriers to entry exist**

- 4.20 Putting aside the fact that the [X] [CONFIDENTIAL] Hospitals do not give rise to local market issues, Ramsay nevertheless considers that it is unnecessary and inappropriate to impose Remedy 3 on all Single and Duopoly Hospitals. Rather, Ramsay considers that Remedy 3 could only be appropriate and necessary in areas where barriers to entry can reasonably be said to exist.
- 4.21 For example, the Central London private hospital market is characterised by a number of specific features which result in barriers to entry significantly higher than those outside of London, in particular:
- (a) most importantly, it is more difficult for a new entrant to access consultants in Central London (because consultants can be entrenched with incumbent operators). In this regard, the CC has recognised that the need to persuade consultants to commit to a new hospital constitutes a barrier to entry;<sup>18</sup>
  - (b) the market has a large number of hospitals within very close proximity which creates a particularly strong cluster of hospitals;
  - (c) GP and consultant referral patterns in London are particularly entrenched and difficult to break into;
  - (d) higher costs, including higher sunk costs, higher property values and higher cost of operating (e.g. labour costs). The CC has accepted that significant capital costs are a barrier to entry;<sup>19</sup> and
  - (e) London caters to a wider range to customers, including overseas customers, and offers wider range of medical services (including higher acuity services) which needs more investment in technology than a regional hospital would.
- 4.22 Against this background, Ramsay considers that, [X] [CONFIDENTIAL]. Partnering with the NHS to launch a PPU in London would enable new entrants to surmount some of the barriers to entry set out in paragraph 4.21 above. Most importantly, Ramsay believes it would be easier to attract consultants to a PPU than to a new full service hospital because that PPU would be attached to the consultant's existing place of work (i.e. the NHS hospital).
- 4.23 Outside of Central London, Ramsay considers that the CC needs to carry out a careful assessment of whether true barriers to entry exist as would warrant the imposition of a non-expansion remedy. Ramsay notes that some features of the so called "clusters" may replicate, to a degree, some of the features identified in respect of London. However, as Ramsay has been provided with limited data in this regard, it cannot offer comprehensive comments.

**Practical issues**

- 4.24 If the CC were minded to impose Remedy 3 on other providers, it may give rise to a range of negative unintended consequences, including:
- (a) In relation to certain PPUs, Remedy 3 may actually disqualify more than one private hospital operator from bidding (where a PPU falls within the local area of more than one Single or Duopoly hospital);

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<sup>18</sup> Remedies Notice, paragraph 6.77.

<sup>19</sup> Remedies Notice, paragraph 6.79.

- (b) The identification of Single and Duopoly Hospitals and the local areas in which they compete is based on a complex analysis using highly sensitive commercial information which will vary over time depending on the performance of individual hospitals and those hospitals nearby. Given that the local areas of individual hospitals can vary over time, it will be necessary for the CC to adopt a process to keep under review the local areas of all of the Single and Duopoly Hospitals in order to ensure that Remedy 3 is applied appropriately; and
- (c) Given that the relevant local areas of Single and Duopoly Hospitals can vary over time, there will be significant uncertainty in relation to some tenders for PPUs. Indeed, it is not even clear if and how the NHS will be aware which hospitals it will be able to partner with in relation to the launch of specific PPUs.

## 5. **REMEDY 4: PROHIBITING INCENTIVE SCHEMES**

- 5.1 The CC is considering preventing hospital operators from offering consultants any incentives, in cash or in kind, which are intended to or have the effect of encouraging consultants to refer patients to or treat them at their hospitals *except* where such ownership (which might otherwise be caught by this remedy) results in a reduction in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful ("**Remedy 4**"). In this section Ramsay sets out its general position on incentive schemes and then makes some more specific observations on some practical considerations.

### **The correct distinction to draw in principle**

- 5.2 The CC's consideration of incentives schemes is based on a distinction between short-term rewards to consultants whose value will be directly affected by the conduct of an individual consultant and longer-term incentives (such as equity participation) whose value will depend on the conduct of the generality of participants in the scheme.<sup>20</sup>
- 5.3 However, the key determinant of whether an incentive gives rise to an AEC (which may need to be remedied) is not whether it is "short-term" or "longer-term".
- 5.4 In contrast, it is whether the arrangement is directed at improving the quality of service and care received by patients as opposed to an objective which seeks to reward consultants, directly or indirectly, for sending patients to a particular facility. The latter type of incentive can interfere with clinical decision-making to the detriment of patients, whether the incentive is received in the short, medium or long term.

### **Ramsay's position**

- 5.5 Ramsay has led the way in the UK in ending direct payments to consultants for referrals. This reflects Ramsay's practice in Australia and the manner in which it has exported "best in class" principles to the UK. The Provisional Findings fail to reflect the important role Ramsay has played in this regard.
- 5.6 As such, Ramsay does not make financial payments to consultants to reward referrals and consultants are not offered equity interests. Further, Ramsay does not "lock in" consultants to its hospital.

### **Administrative support**

- 5.7 Ramsay does offer administrative support to practitioners where this improves services to Ramsay patients. This includes [X] [CONFIDENTIAL].

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<sup>20</sup> Remedies Notice, paragraph 58.

- 5.8 Ramsay agrees that such measures can, in certain circumstances, be open to abuse. As such, it would be open to the CC to set out principles which should be applied to such support. Such principles might include:
- (a) the measures are reasonable (i.e. a benefit of excessive value is not permissible);
  - (b) the measures are not linked to any requirement or incentive to treat patients (or a proportion of patients) at the specific private hospital; and
  - (c) no financial payment is made to the consultant.
- 5.9 Such restrictions should be applied by exception, as it will be difficult to design a framework of permitted support that will be either comprehensive or capable of practicable application.
- 5.10 For example, although Ramsay has yet to consider in detail how a "fair market price" for administrative support which was not related to improving patient treatment would be calculated, it does, however, envisage that such a "fair market price" rule would give rise to a number of practical issues, including:
- (a) it may be difficult to strip out the costs associated with the services in order to determine a fair market price;
  - (b) it may be administratively costly to calculate the fair market price, especially as that price is likely to vary from hospital to hospital;
  - (c) the CC may need to set up a mechanism to settle disputes between consultants and private hospital operators as to whether the price represents fair market value; and
  - (d) the CC may need to monitor the extent to which a "fair market price" has been paid by consultants to private hospital operators (especially given that private hospital operators and consultants may have an incentive to circumvent the rule by under-charging/under-paying for a service provided).
- 5.11 The CC will also need to give further thought to the issue of who would be best placed to examine complaints regarding measures falling outside of the principles, given that it would appear to fall outside of the immediate jurisdiction of Monitor.

### **Longer term financial incentives**

- 5.12 As noted, CC appears to indicate that it would be minded to impose a remedy prohibiting payments and financial incentives to reward consultants to refer to a particular facility, except *"where such ownership results in reductions in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful"*.
- 5.13 This provisional finding is plainly wrong.
- 5.14 First, at one extreme, it is tantamount to approving the payment of incentives<sup>21</sup> to interfere with important clinical decisions. This is not an appropriate position for the CC to take, whether on the grounds of *"encouraging new entry"* or otherwise. It is completely irrelevant whether the incentive is received by the consultant in the short, medium or longer term.

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<sup>21</sup> See, for example, the Bribery Act 2010, where a bribe will arise if a hospital confers a financial or other advantage upon party B, where B is carrying out a function on behalf of an organisation and is in a position of trust, good faith or expected to act in an impartial way and the hospital has the intention of getting B to perform his function in an improper manner, which in these circumstances may include a choice of referral hospital on grounds that are not in the best clinical interests of a patient.

- 5.15 Second, on any basis, equity schemes (such as the Circle model), are a means of passing a financial advantage to consultants with the direct intention of influencing their clinical decision making. This applies whether a direct "lock-in" in terms of a set number of patients to be received is applied or if the reward is through the offer of share schemes which confer financial benefit upon the consultant in due course.
- 5.16 Such measures are clearly more pernicious than, for example, small scale clinics or GP practices, given the very important role that the *consultant* plays in: (i) recommending the course of expensive secondary care; and (ii) the location where that care should be delivered.
- 5.17 Thirdly, the proposition that such schemes may confer patient benefits through promoting new entry is plainly and demonstrably wrong. The barrier to new entry identified by the CC arises from the cost of funding new facilities in the environment where there is surplus capacity to meet private patient demand. This is a financing issue.
- 5.18 In contrast, the Circle model may sustain a new facility but, in reality, simply replaces the same set of consultant providers serving the particular area in an open and competitive environment (i.e. where they are free to refer patients to the best facility on qualitative grounds) with a situation where a material proportion of those same consultants are locked in to referring patients to a particular facility. If the CC compares the correct counter-factual, in terms of the access of patients to consultants who will refer to the best private hospital provider, it may be seen to reduce competition.
- 5.19 As such, such schemes are not in the interests of patients and, further, may distort competition in the medium term. This is because, pre-entry, consultants will not be tied to the incumbent hospitals and therefore there will be dynamic competition between the incumbent hospitals based on, not least, competition for consultants. Post-entry of a lock-in provider, that competition for consultants will be severely hampered as many consultants will be tied to a single hospital.
- 5.20 This correct (and pernicious) counter-factual from the patient perspective is clearly demonstrated by the [X] [CONFIDENTIAL].
- 5.21 [X] [CONFIDENTIAL].
- 5.22 Finally, the remedy is completely incapable of practicable application. The bold statement "*is likely to be at least as beneficial to competition as any distortion is harmful*" has no evidential basis and, as noted, is without regard to any assessment of the potential clinical impacts.
- 5.23 Moreover, it is basic economics that the extent (if any) of benefits that will flow from new entry will be highly dependent upon the market context. If there is real unmet demand, this should facilitate new entry without recourse to the payment of financial incentives to important clinical decision makers who need to remain impartial and objective. Alternatively, if there is no new demand, as noted, all that is likely to transpire in the medium term is that following the exit of an incumbent facility, free and open competition is replaced with incentive-led provision.
- 5.24 In either case, a detailed assessment would need to be carried out on the facts of each case, which appears deeply impracticable (i.e. is the dearth of provision in this local area sufficient to justify the risk of sub-optimal clinical decisions influenced by financial reward rather than patient need?).
- 5.25 We are extremely surprised to see the CC even begin to contemplate a remedy along these lines and trust that it will be removed quickly.
- 5.26 Moreover, if the CC's finding regarding the *existence* of spare capacity to treat private patients is not accepted by Government, and an urgent need for an "incentive-led" clinical

prescribing system is identified as the only way to introduce new capacity, the appropriate route for such a question to be considered (which involves medical rather than just issues of competition policy) is through legislation duly considered by Parliament.

**6. REMEDY 5: RECOMMENDATION TO HEALTH DEPARTMENTS ON PUBLISHING INFORMATION ON CONSULTANTS**

6.1 The CC is considering recommending to the respective health department in Scotland, Wales and Northern Ireland (or their equivalents) that they collect and publish information on individual consultants (equivalent to that collected and published in England). Apart from observing, from a general perspective, that greater transparency serves the patients' interest (so long as that transparency is implemented in a user-friendly manner), Ramsay makes no further submissions on Remedy 5 as it does not directly affect Ramsay.

**7. REMEDY 6: REQUIRING CONSULTANTS AND PRIVATE HOSPITALS TO PUBLISH CERTAIN INFORMATION ON CONSULTANTS**

7.1 The CC has identified concerns about information relating to consultants' charges not being uniformly made available to patients prior to consultations and/or treatments. To address this, the CC is considering requiring:

- (a) all consultants practising in the private healthcare sector to publish their initial consultation fees on their websites;
- (b) each private hospital where consultants have practising rights to publish these consultant fees on the private hospital website; and
- (c) consultants to provide a list of proposed charges to patients in writing in advance of any treatment.

7.2 Apart from observing, from a general perspective, that greater transparency serves the patients' interest (so long as that transparency is implemented in a user-friendly manner), Ramsay has limited its comments to the parts of this proposed remedy that would directly impact Ramsay, i.e. (b) above which would require Ramsay to publish consultants' fees on its website.

7.3 Ramsay envisages a number of technical and administrative issues would arise if it were required to publish and update consultants' fees on its website. Approximately [REDACTED] [CONFIDENTIAL] consultants have practising rights at Ramsay's private hospitals. This remedy would require Ramsay to upload and update as appropriate fee information for each of these consultants. This is a considerable administrative burden for Ramsay to bear. Further, Ramsay would have obvious concerns about publishing information on its website in circumstances where it is not necessarily possible for Ramsay to confirm and ensure that information is up-to-date and generally accurate. This is especially of concern to Ramsay given that the information may be relied upon by patients.

7.4 In light of these issues, Ramsay considers that the most efficient way to ensure accurate and useful publication of consultants' fee schedules is via a central registry (in much the same way that PHIN information is made available) and not on the individual websites of each private hospital operator. Such a central registry would have a number of benefits, including:

- (a) when consultants change their fees, they would only need to change their fee information at one place (rather than informing each hospital where she/he provides services);
- (b) by making it easier for consultants to ensure their information is up to date, the published fee schedules are more likely to be accurate and therefore patients can be more confident that they are accessing the most up-to-date information;

- (c) private hospital operators would only need to direct patients to the central registry (via a link on their websites) and will avoid the administrative cost and burden of having to publish and update consultant fee information; and
- (d) it will be easier for patients to compare consultants' fees as they will all be available from a single, central source.

7.5 For these reasons, Ramsay would urge the CC to consider a publicly-accessible central registry for information on consultants' fees.

## 8. **REMEDY 7: REQUIRING PRIVATE HOSPITAL OPERATORS TO PUBLISH CERTAIN DATA**

8.1 The CC has identified concerns about the quality of publicly-available information on the quality of services provided by private hospitals (noting that much more information is available in relation to NHS hospitals). In order to address this concern, the CC is considering requiring all private acute hospitals in the UK to collect HES equivalent and PROMs data for private patients and that appropriate arrangements are made for its publication to consumers ("**Remedy 7**").

8.2 Ramsay refers to its submission on information asymmetries as set out in the AIS Response, section 10. Ramsay reiterates those submissions here, in particular Ramsay's key concerns that private hospital operators should not be made responsible for collecting information over which they have no control and the CC should not take any action which might impose an undue and superfluous burden on private hospital operators.

8.3 Against this background, Ramsay makes the following specific observations on Remedy 7:

- (a) Ramsay agrees that greater transparency serves the patient's interests and accordingly Ramsay is already committed to publishing useful data to assist and inform patients, GPs and PMIs;
- (b) Ramsay confirms that it is able to collect HES equivalent and PROMs equivalent data for its hospitals. However, private hospital operators should only be required to publish information insofar as that information is relevant to a decision as to where a patient should be treated and the disclosure of that information will not give rise to, for example, competition issues (for example, certain information which is disclosed in the NHS context may actually distort competition if disclosed in the private healthcare context, such as volumes of treatments per hospital). The information Ramsay currently collects for PHIN meets this criteria;
- (c) Since data collection will impose a heavy administrative burden on private hospital operators, any remedy to collect data should be curtailed to a limited number of categories, which will assist smaller bodies in collecting the necessary data; and
- (d) Private hospital operators should only be required to collate and make appropriate arrangements for publication of the data. Although Ramsay considers that any remedy imposed would be best implemented via PHIN (not least because private hospital operators already have, on their own initiative, committed significant time and resources to improving the extent and quality of comparable information via PHIN), it is not necessary to: (i) stipulate that the information is published via PHIN; and (ii) set up a funding mechanism for PHIN. This is because PHIN may not, in the future, be best placed to implement this Remedy.

## 9. **REMEDIES THE CC IS NOT MINDED TO CONSIDER FURTHER**

9.1 The CC has considered, and provisionally rejected, the imposition of a price control remedy noting that it "*would be complex to design and update , would require the*

*provision of some form of adjudication in the event of disputes and would be likely to have unintended consequences, such as deterring new entry.*"<sup>22</sup>

- 9.2 Ramsay agrees that it would be inappropriate to impose a price control remedy. In this regard, the list of issues identified by the CC seriously under-represents the concerns that a price control remedy would give rise to. Fundamentally, the CC has not considered the real risk of decreased competition as a result of the price control. This is because the maximum prices set by a regulator pursuant to a control mechanism may actually become the prevailing market prices for all providers. In this regard we note that the CC's own analysis in the Provisional Findings indicates that private hospital operators currently compete on price (charging different prices) in relation to private hospital services to both insured and self-pay patients. There is a real risk that any price control mechanism would undermine that competitive dynamic.

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<sup>22</sup> Remedies Notice, paragraph 83.