



RAMSAY HEALTH CARE (UK) LIMITED ("RAMSAY")
COMPETITION COMMISSION'S ("CC") PRIVATE HEALTHCARE MARKET INVESTIGATION
RESPONSE TO PROVISIONAL DECISION ON REMEDIES
6 FEBRUARY 2014

1. INTRODUCTION

- 1.1 This document sets out Ramsay's response to the CC's Provisional Decision on Remedies ("PDR"), which was published on 16 January 2014.
- 1.2 In the limited time available, Ramsay has sought to comment on certain specific aspects of the remedies set out in the PDR, and to highlight some important factors in relation to the effective implementation of those remedies. 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 how the proposed remedies will be implemented.

2. REMEDY 1 – DIVESTMENT OF CERTAIN HOSPITALS

- 2.1 The CC has provisionally concluded that 2 HCA hospitals in Central London (London Bridge and Princess Grace) and 7 BMI hospitals (5 in Greater London, 1 in the Midlands and 1 in the North West)¹ need to be divested in order to remedy the Adverse Effects on Competition ("AEC") identified by the CC in its Provisional Findings Report.
- 2.2 As the divestment remedy does not apply to any of Ramsay's hospitals, Ramsay makes limited submissions as regards the scope of the proposed divestment remedy, and the effectiveness of the remedy at addressing the AEC.
- 2.3 However, in order to ensure a timely and effective divestiture process, Ramsay considers there to be a number of important factors in relation to: (i) the assessment of which operators are considered to be a suitable purchaser; and (ii) an effective divestiture process, which the CC needs to pay close attention to.

Suitable purchasers criteria

- 2.4 The CC has explained in paragraph 2.85 of its PDR how it proposes to apply a suitable purchaser criteria, with the criteria largely following the approach set out in the CC's market investigation guidelines.² The CC considers a suitable purchaser to be one that:
- (a) is independent of the divesting parties;
 - (b) has appropriate financial resources, expertise and assets to enable the divested business to be an effective competitor in the market;

¹ Bishops Wood or Clementine Churchill; Cavell or Kings Oak; Shelburne or Chiltern; Chelsfield Park; Sloane or Shirley Oaks; Saxon Clinic or Three Shires; and Highfield.

² CC's Guidelines for Market Investigations: Their Role, Procedures, Assessment and Remedies (April 2013), Annex B, paragraphs 17-20.

- (c) has an appropriate business plan and objectives for competing in the UK private healthcare market; and
- (d) does not raise further competitive or regulatory concerns.

2.5 Ramsay makes the following comments in respect of the CC's assessment of these criteria:

a) Independent

2.6 Ramsay agrees with the CC's proposal that suitable purchasers should be independent of the divesting parties, and has no further comments on this matter.

b) Financial resources, expertise and assets

2.7 Given the nature of the private healthcare market, and the fact that the health and well-being of patients is at stake, Ramsay considers that it is of paramount importance that the quality of patient care is not adversely affected as a result of the divestiture process.

2.8 The critical nature of the private healthcare market to patient care is a key differentiating factor from the other market investigations in which the CC has considered applying a divestment remedy (e.g. in relation to the divestment of airports in the BAA airports market investigation, or the divestment of a cement plant in the aggregates, cement and ready-mix concrete market investigation). In contrast to these other market investigations, the potential consequences of a flawed divestiture process in this case are particularly severe as lives are directly at stake.

2.9 Accordingly, whilst Ramsay agrees with the broad principles of the CC's suitable purchaser criteria requirement, it considers that there should be significantly greater weight put on the expertise, financial resources and assets of the purchaser, which ultimately has a direct bearing on the quality of patient care provided and provides an assurance that the divestiture process will not adversely affect patient care.

Expertise

2.10 The CC has set out in paragraph 2.85(b) of the PDR that "*appropriate expertise would include expertise and experience in operating hospitals of a level of acuity and specialism appropriate to hospitals being divested.*" The CC also goes on to say that "*in the case of London, we would consider carefully the expertise of the purchaser in operating high acuity facilities in particular*".

2.11 Ramsay broadly agrees with the CC's proposed criteria. Suitable purchasers should be able to demonstrate that they have the experience of delivering high quality patient care across a range of specialisms and treatment types within UK private hospitals. In this regard, it is of note that 17 out of Ramsay's 23 facilities considered as part of the investigation offer ICU level 2 facilities, which either matches or is above all of the BMI hospitals which are proposed to be divested. Moreover, a number of Ramsay's facilities provide treatment across the full range of 17 specialities considered by the CC during the market investigation (which again either matches or is above all the proposed BMI divestment sites), as well as having facilities that provide specialist oncology and cardiothoracic treatment (e.g. Orwell PPU).

2.12 In relation to the proposed divestment of HCA's high acuity facilities in Central London, Ramsay considers that the CC's approach may result in a very narrow pool of potential purchasers if there is a requirement to demonstrate expertise of operating facilities with the highest level of critical care cover (ICU Level 3) within the UK. This reflects the fact that HCA operates around 70 per cent of ICU Level 3 beds in London,³ and the vast

³ CC's Provisional Findings Report, Appendix 6.10, table 10.

majority of hospitals outside of London with the highest level critical care cover are actually PPUs. Moreover, most of the private hospitals outside of London with the highest level critical care cover are operated by the major private hospital operators, which have been identified by the CC as having national market power (see below).

- 2.13 Ramsay believes that there is no reason why it would not be able to operate hospitals with the highest level of critical care cover; most of its facilities are already providing critical care cover to Level 2, whilst it has experience of providing a range of specialist types of treatment (including cardiothoracic surgery at the Orwell PPU), and it has over 50 years of international experience operating facilities providing the full range of acute services with the highest level of critical care cover. Clearly, such international knowledge and know-how could be readily transferred to the UK business.
- 2.14 In addition to the criteria set out above, Ramsay also believes that suitable purchasers should be able to demonstrate knowledge and experience of acquiring and integrating private hospitals. This reflects the very material risk that patient care at the divested hospitals could be adversely affected if there is not a smooth and effective transition during the divestiture process. In this regard, Ramsay has demonstrated through its acquisition of Capio Healthcare's UK business in 2007 and the subsequent purchase of Nottingham Woodthorpe hospital from GHG in 2008 that it is successfully able to integrate newly acquired hospitals into its existing portfolio and, once purchased, invest and develop those hospitals to ensure their long-term viability.
- 2.15 Moreover, if the divestment hospitals are to be a competitive force going forward, suitable purchasers should already have established relationships with the PMIs and have a reputation as being reliable, trustworthy and high quality providers of private healthcare (e.g. as demonstrated by the existing relationships that they already have in place with the PMIs). This is particularly important given that private hospitals are heavily reliant on the PMIs for insured patient volumes, and PMI recognition is extremely important in being able to recruit consultants and compete in the local market (i.e. consultants would generally prefer to practice with an established UK operator with a good reputation). Whilst the CC proposes to require the insurers to roll over their existing contract terms with the divested hospitals for a period of 18 months, this is insufficient to prevent the PMIs from being able to adjust their referral processes away from the divested hospitals if they are acquired by purchasers without an established reputation or existing relationships with the PMIs.
- 2.16 Ramsay believes that it is particularly well placed to meet all of the above criteria.

Financial resources

- 2.17 The CC explains in paragraph 2.85(b) of the PDR that "*appropriate financial resources include a capital structure of the purchaser that permits adequate resources to continue to develop the acquired hospitals as competitive entities*".
- 2.18 Ramsay agrees that it is extremely important that potential purchasers are not too highly leveraged (as has previously been seen in the private healthcare sector) such that they are unable to continue making the necessary investments at the divestment hospitals. The innovative nature of the private healthcare industry means that the level of investment is an important feature of the market, which has a material bearing on the quality of patient care and which can be a key differentiating factor between operators.
- 2.19 Whilst different purchasers may ultimately have different business models for operating the divested facilities, it is important that the CC is mindful of purchasers in highly leveraged positions. This is because such purchasers would create a very material risk that investment at the divestment hospitals would be reduced (either intentionally or because of their parlous financial position), which would result in a worse outcome for patients, even compared to the status quo position (i.e. more local market competition

would only come at the expense of less investment and a poorer quality service to patients).

- 2.20 Ramsay considers that a further relevant factor to consider in relation to the financial resources of the purchaser is whether they are able to make a long term commitment to the private healthcare market in the UK. This is highly relevant because short term institutional and/or equity investors may not take a sufficiently long time horizon to make the necessary investments required in the divestment hospitals (and bring the benefits considered by the CC). Indeed, short term investors may actually have the incentive to run down the assets in the short term (i.e. by under-investing in replacing the assets) in order to make a quick return, which the CC should be mindful to guard against.
- 2.21 In this regard, Ramsay believes that it is in a strong position to be able to demonstrate to the CC that it has the necessary financial resources to be considered a suitable purchaser. In particular, Ramsay is a self-funded private healthcare provider with a reputation for investing in its facilities and providing high quality private healthcare (as is evidenced by its strong relationships with the PMIs, consultants, GPs and the NHS). Moreover, Ramsay also has a long-term UK business model which further highlights its very clear commitment to develop its UK business.

Assets

- 2.22 It is of note that the CC says very little in its PDR about the relevance of assets to its assessment of suitable purchasers.
- 2.23 However, it is noteworthy that both HCA and BMI have suggested that economies of scale and scope efficiencies will be lost if the hospitals are not operated as part of a network/chain of hospitals, which is of direct relevance to the CC's suitable purchaser assessment. In this regard, HCA specifically referred to economies of scale and scope arising from: (i) centralised IT systems; (ii) clinical support services (such as laboratories and patient medical records management); (iii) staff management; and (iv) a range of central support services such as procurement and business development.
- 2.24 Ramsay considers that, whilst the potential loss of economies of scale and scope is relevant to the CC's assessment of a suitable purchaser, it is clear that such efficiency benefits would not be lost if any of the divested hospitals were to be acquired by Ramsay. This reflects the fact that as an established provider of private healthcare in the UK with a portfolio of private hospitals, Ramsay already has established centralised IT systems, established operating processes and procedures, and a range of clinical support services, staff management and central support services already in place.
- 2.25 Ramsay's business model has also demonstrated its ability to generate economies of scale and scope by increasing the amount of NHS-funded treatment at its facilities so as to increase patient volumes (and revenue) across a largely fixed cost asset base. By making the fixed assets work harder (i.e. increasing throughout), the average cost of providing treatment across all patient volumes is lower than that offered either by a small scale provider or one that relied on private patient volumes only.⁴
- 2.26 Moreover, whilst the CC has considered that any economies of scale or efficiency savings derived by BMI and HCA at the divestment facilities would not be passed on to consumers (due to the lack of local market competition), the same cannot apply to a new purchaser (such as Ramsay) who is able to derive similar network efficiencies in a more competitive local market. Accordingly, the acquisition of the divested sites by an operator that is able

⁴ For completeness, Ramsay confirms that increasing the scope of NHS-funded services at its facilities does not negatively impact the provision of privately-funded services. In this regard, Ramsay refers to its Response to the CC's questions from the Remedies Hearing of 12 December 2013 in which Ramsay explained that [§§].

to derive economies of scale or efficiency savings (such as Ramsay) is likely to result in a much more beneficial outcome to patients than either:

- (a) the status quo position (as the benefits would not be passed on to patients); or
- (b) the sale to a small scale operator that will not be able to benefit from such economies of scale or scope in the first place.

c) Business plan and objectives

- 2.27 As set out above, a further factor which the CC proposes to take into account for assessing suitable purchasers is whether they have an appropriate business plan and objectives for competing in the UK private healthcare market.
- 2.28 Although the CC does not provide any further details on what the business plan or objectives may look like, or how it will assess them, it does refer to looking at the business plan as a way to remedy HCA's concern that "*purchasers of the London Bridge and Princess Grace hospitals would offer lower standards of services than HCA or that it would switch its emphasis to lower acuity work*".⁵ Accordingly, this suggests that the CC will expect the business plans and objectives of potential purchasers to set out an intention to run the divested facilities in a similar way to that of the current operator.
- 2.29 However, it is important that the CC does not lose sight of the fact that certain purchasers may actually be able to do certain things better (certainly differently) than the incumbent operator. This reflects the fact that the divested hospitals are in areas where the incumbent has been defined by the CC as having local market power, which can result in the facilities not being operated as efficiently as they otherwise would in a competitive market. Accordingly, not only should the CC consider purchasers to be suitable if they intend to run the divested hospitals along similar lines as the incumbent, but the CC should also pay particular attention to business plans that are able to demonstrate potential cost savings (e.g. through economies of scale or scope or through more efficient use of resources).
- 2.30 In addition, as mentioned above, a further relevant factor for the CC to consider in the assessment of the business plans and objectives of suitable purchasers is whether they provide a sufficiently long term view of the private healthcare market (and commitment to stay in the market). This is highly relevant to both the stability of the divested hospitals, and also the credibility and reputation of those hospitals with consultants, PMIs, GPs and patients. It also ensures that the quality of care will not be adversely affected by short term investors seeking to make a quick return by under-investing in the business.
- 2.31 In this regard, as mentioned above, Ramsay is a self-funded private healthcare provider, which has demonstrated its ability to acquire and integrate private hospitals in the UK. In addition, Ramsay has:
- (a) established a reputation for investing in and expanding its facilities (a number of investment proposals were submitted to the CC in response to the Market Questionnaire);
 - (b) providing high quality private healthcare (as is evidenced by its strong relationships with the PMIs, consultants, GPs and the NHS), and by regular patient satisfaction surveys (also submitted to the CC in response to the Market Questionnaire);
 - (c) has a long-term UK business model which is reflected in its UK business strategy, and which clearly demonstrates its commitment to the UK private healthcare market; and

⁵ PDR, paragraph 2.117.

- (d) has generated pro-competitive efficiency benefits since entering the UK market (through economies of scale of scope) by adapting to changes in the market (e.g. by conducting a healthy mix of private and publicly funded treatment).

D) No new competition concerns

- 2.32 The CC states in paragraph 2.85(d) that a further criteria for assessing whether a purchaser is suitable is whether it raises any further competitive or regulatory concerns. The CC goes on to say that "*we note that existing UK hospital operators with facilities in close proximity to the divestiture facilities are unlikely to be considered to be suitable purchasers.*"
- 2.33 In this regard, Ramsay does not believe that acquisition of any of the divestment hospitals by it would raise any local market concerns, but would be happy to answer any further questions or queries before the CC's final decision.
- 2.34 However, whilst the CC has referred to suitable purchasers not raising any additional local market concerns, Ramsay also considers that it is important that the divestitures do not give rise to any additional national market power concerns which have been identified by the CC in its provisional decision, and which the divestments seek to remedy.
- 2.35 In this regard, it is of note that the CC has provisionally concluded that Ramsay does not have any national market power with insurers. The CC's analysis shows that Ramsay offers the lowest national prices to insurers out of the four national PH operators (across all the different pricing metrics considered by the CC).⁶ In contrast, the CC has concluded that BMI, HCA and Spire do have national market power in negotiations with insurers.⁷ Accordingly, the acquisition of any of the divestment sites by these parties would not remedy the national market power concerns identified by the CC.
- 2.36 Ramsay considers that divesting the relevant hospitals to Ramsay may actually have a more significant pro-competitive effect. This is because the amalgamation of Ramsay's existing private hospital business with the divested assets would create a national private hospital operator that would have the critical mass to be able to compete more effectively with BMI and Spire on a national level (disrupting the existing market dynamics by creating an "outside option" for PMIs). The increased competitive constraint on BMI and Spire would operate to reduce BMI's and Spire's abilities to exercise market power in their national negotiations with PMIs.
- 2.37 In contrast, the divestment of the relevant hospitals to a small scale operator or a new entrant would be unlikely to create sufficient scale to be able to provide a sufficient alternative to BMI and Spire for the PMIs. Just as importantly, a small scale operator or a new entrant would not be able to hold its own in negotiations against a large PMI such as Bupa (which, in a very self-serving manner, has indicated that it does not consider any of the five main private healthcare operators to be a suitable purchaser).
- 2.38 In addition, Ramsay also believes that the divestment of the relevant hospitals to Ramsay would generate significant benefits from the more competitive market structure. In particular, Ramsay would be large enough to be able to benefit from economies of scale and scope from integrating the divestment facilities within its business, whilst operating in competitive local markets would ensure that any cost savings are passed on.

Effective divestiture process

- 2.39 The CC states that an effective divestiture process is one which "*protects the competitive potential of the divestiture package before disposal and enables a suitable purchaser to be*

⁶ CC's Provisional Findings Report, Appendix 6.12, table 15.

⁷ Restated in paragraph 2.1 of the PDR.

secured in an acceptable timeframe whilst enabling the vendor(s) to achieve an appropriate market value from the sale".⁸ The measures considered by the CC to ensure an effective divestiture process fall into the following categories:

- (a) the combination/package of divestment facilities;
- (b) anti-circumvention measures to ensure that the business being divested is maintained in good order so that it will be an effective competitive force post-divestment; and
- (c) the timing of the divestiture process.

2.40 Ramsay has a number of comments on each of these headings.

The combination/package of divestment sites

2.41 The CC is proposing that the hospital divestiture process takes place "*individually and simultaneously, such that purchasers can seek to acquire whichever combination of assets they consider best meets their strategic objectives*".⁹ The CC goes on to say that this ensures that "*an appropriate market price could be achieved by the divesting firms*". However, the CC has failed to recognise that the ability to sell each divested site ultimately depends on: (i) the profitability and financial viability of those individual sites; and (ii) the ability to separate each of those sites so that they can be operated effectively on a stand-alone basis, which the CC has not commented on in the PDR.

2.42 Ramsay considers that the CC's proposed divestiture process raises a serious issue in relation to the potential "cherry-picking" of the most profitable sites, with the risk being that the least profitable hospitals (or hospitals that are not financially viable on a stand-alone basis) will be left behind and potentially not acquired at all. Accordingly, divesting the hospitals "*individually and simultaneously*" as proposed by the CC is likely to:

- (a) delay the overall divestment process (due to the potential difficulty of finding a suitable purchaser for the worst performing hospitals), thereby creating additional uncertainty regarding the operation of all the divestment sites;
- (b) create a material risk that the least profitable and worst performing sites may not be sold at all, thereby failing to address the AEC identified by the CC; and
- (c) raises serious practical issues from a commercial perspective in relation to trying to align multiple transactions to take place simultaneously, which would require significant legal resource and be extremely costly in terms of adviser fees (i.e. the adviser costs of a small transaction are not too dissimilar to the adviser costs of a much larger transaction as many of the costs would be duplicated). Moreover, a number of the proposed BMI divestiture hospitals are relatively small and may not justify the fees if they were to be sold individually.

2.43 In light of the above, Ramsay would encourage the CC to give much more careful thought to the "cherry picking" issue, particularly given the history of oversupply of private treatment in this market, the overleveraging of certain private hospital operators, and the offer to the divesting parties in many cases to sell the less good facility (which are likely to be in much lower demand).

2.44 Ramsay would also encourage the CC to consider adopting a much more structured approach to the divestments by packaging the divestment sites together in order to ensure an effective divestiture process. The cleanest and simplest way in which this could

⁸ PDR, paragraph 2.86.

⁹ PDR, paragraph 2.89(d).

be achieved, which would minimise the costs and disruption of the divestiture process, would be to sell all 9 hospitals as a single package, or to sell all the BMI hospitals and the two HCA hospitals as two separate packages. To the extent that any purchaser raises competition concerns in relation to any of these hospitals, then these can be carved out and sold separately.

- 2.45 An alternative approach considered by Ramsay would be to put together a small number of different packages of hospitals (three packages would be preferable from a practical perspective), all of which would include a mix of different performing assets so that the worst performing hospitals are not left behind. This approach would incentivise purchasers to take on the worst performing hospitals in exchange for acquiring the better performing assets. Again, to the extent that any of the acquired packages raise competition concerns, then these can be carved out and sold separately.

Anti-circumvention measures

- 2.46 Ramsay welcomes the CC's proposals to introduce anti-circumvention measures to prevent the incumbent operator from taking steps to adversely affect the divestment sites. The CC's proposals include:

- (a) undertakings which impose a duty on the incumbent operator to maintain the business being divested in good order and not to undermine its competitive position (including a commitment not to encourage or induce consultants or key nursing or technical staff to move to the group's retained facilities);
- (b) requiring PMIs to roll over their existing contract terms with the divested hospitals for a period of 18 months from the date of divestiture, whilst permitting a shorter period by mutual agreement; and
- (c) the appointment of a monitoring trustee to oversee the compliance with the undertakings.

- 2.47 Ramsay considers that it is extremely important that the divested hospitals are able to operate in the same way as they did prior to the divestment until the full integration has taken place. However, Ramsay is concerned that the CC's proposed anti-circumvention measures do not go far enough, which creates the potential for the assets to be a much weaker competitive force in the market post-divestment.

- 2.48 As the CC will be aware, the operation of a private hospital is an extremely complex business with numerous variables and parameters of competition that could be altered to adversely affect the performance of the divestment sites. It is important, therefore, that the commitments are sufficiently broad ranging to capture the full range of factors that could adversely affect the performance of the divestiture sites. In particular:

- (a) whilst the CC proposes to introduce a "no-poaching" commitment on HCA and BMI in relation to consultants at the divested facilities, there are insufficient measures proposed in the event of a natural migration of consultants (e.g. as a result of the uncertainty created by the divestiture process, or due to the familiarity of working with the incumbent operator such as HCA in London). To the extent that there is a natural loss of consultants at the divestment hospitals, then this could, via the consultant drag effect, have a significant detrimental impact on patient volumes;
- (b) whilst the CC proposes to require the insurers to roll over their existing contract terms with the divested hospitals for a period of 18 months, Ramsay considers that the PMIs should also be under an obligation not to change their referral processes following the divestment. For example, were the PMIs to decide to direct patients to a rival facility (e.g. as a result of the uncertainty caused by the divestment process), the new operator would face a significant and detrimental loss of patient

volumes. Ramsay also considers that the proposed 18 month period may be too short a period to allow the full integration of the business to take place. In this regard, Ramsay would propose that a 2-year time period is more appropriate;

- (c) both HCA and BMI should be required to give an obligation not to open up a rival facility near the divestment sites for a specific period of time (e.g. within central London for HCA and within a specified distance of the divestment facilities for BMI). This would give the new operator of the divestment hospitals sufficient time and certainty to be able to integrate the business and establish relationships with consultants, GPs and the PMIs;
- (d) the CC has not proposed any measures to stop the incumbent operators of the divestment facilities from potentially targeting the patient referral pathways (e.g. through marketing to GP's and PMIs, etc.). In this regard, Ramsay considers that there should be a wider obligation on HCA and BMI not to attempt to target or interfere with the patient referral pathways of the divestment facilities, and third parties should be encouraged not to change their referral patterns as a result of the divestments; and
- (e) in relation to the proposed duty on the incumbent operators (HCA and BMI) "*to maintain the business being divested in good order*", Ramsay is concerned that this wording is insufficiently clear. In particular, what does maintaining a private hospital in "*good order*" actually mean, does the definition include a commitment to maintain all planned investments at the divestment sites (as curtailing investment spending by the incumbent operator is an obvious response to the proposed divestment remedies), and how could this be measured and monitored? Ramsay would encourage the CC to provide much further clarity on this issue in order to provide further transparency and help reduce the circumvention risks.

2.49 The CC has stated that a monitoring trustee should be appointed in order to oversee the divestiture process, which Ramsay welcomes. Given the complex nature of the private healthcare market, it is important that the monitoring trustee has sufficient clinical and management expertise in order to be able to assess whether the parties are complying with the commitments. Moreover, it is also important that the monitoring trustee has sufficient powers to take enforcement action in the event of a breach of those commitments, which is not mentioned in the PDR.

The timing of the divestiture process

2.50 In terms of the timing of the divestiture process, Ramsay considers that any divestment remedy should be implemented as quickly as reasonably possible. Delays to the implementation of the divestment remedy will undermine the efficacy of the remedy, and creates material risks that the performance of the divested facility will be adversely affected by the uncertainty. Where a hospital's future is in doubt, there is a real prospect that the performance of the hospital will deteriorate, which is something that is very difficult to guard against through commitments alone.

3. REMEDY 3: REVIEW OF PPU ARRANGEMENTS WITH PRIVATE HOSPITAL OPERATORS BY THE OFT/CMA

3.1 The CC is proposing to require all private hospital operators proposing to enter into a partnering arrangement with an NHS Trust to operate a private patient unit ("**PPU**") to pre-notify the Competition and Markets Authority ("**CMA**"), in order for the CMA to review such arrangements ("**Remedy 3**"). Should the CMA find that the private hospital faces weak competitive constraints in the relevant local area, the CMA may prohibit the arrangement.

- 3.2 Remedy 3 would complement existing UK and EU merger control provisions and apply only to those arrangements for the management of PPUs which are outside the merger control regimes. The CMA would review the arrangement according to a competition test equivalent to that employed under the existing merger regime.
- 3.3 Ramsay observes that Remedy 3 has changed considerably from the equivalent proposed remedy set out in the Remedies Notice; in this regard, the CC is no longer proposing to prohibit outright hospitals with local market power (including eight Ramsay hospitals¹⁰) from partnering with PPUs in the relevant local areas. Ramsay welcomes the change and refers to its Response to the Remedies Notice in which it set out why a blanket ban on Ramsay entering into PPU arrangements with local NHS Trusts in the relevant eight local areas would not be appropriate.¹¹
- 3.4 Before setting out its views on Remedy 3, Ramsay observes that it will be necessary for the CC to provide guidance on what constitutes a PPU (Ramsay notes the PDR simply refers to "*a right to manager a local PPU*" without any further elaboration on what is a PPU¹²). Although this may seem a straightforward question, in Ramsay's experience, the position can be significantly more nuanced and therefore guidance on the essential features of a PPU for the purposes of Remedy 3 would be helpful.
- 3.5 Ramsay continues to consider that any detailed review (and possible ban) of PPU arrangements between NHS Trusts and private hospital operators should be limited to areas where barriers to entry can reasonably be said to exist, for example in Central London. 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) 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;¹³
 - (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;¹⁴ 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.
- 3.6 Against this background, Ramsay considers that, absent partnering with the NHS to launch a PPU, opportunities to enter into the London market are highly limited. 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 3.4 above. Most importantly, Ramsay believes it would be easier to attract consultants to a PPU than to a new full service hospital because

¹⁰ [X]

¹¹ See paragraphs 4.5 to 4.19.

¹² PDR, paragraph 2.175.

¹³ Remedies Notice, paragraph 6.77.

¹⁴ Remedies Notice, paragraph 6.79.

that PPU would be attached to the consultant's existing place of work (i.e. the NHS hospital).

- 3.7 Given that these barriers are unlikely to exist outside Central London, Ramsay continues to believe that outside Central London the remedy is not necessary. To the extent that the CC intends nonetheless to proceed with Remedy 3 in relation to areas outside of Central London, Ramsay is of the view that a safe harbour provision for such transactions would be necessary in order to ensure that Remedy 3 is proportionate, subject to the 25 per cent safe harbour threshold suggested by the CC in PDR, paragraph 2.250 being increased in order to make it consistent with the analysis in the Provisional Findings.
- 3.8 In particular, in the CC's local market analysis set out in its Provisional Findings, the CC identified hospitals of potential concern if they fail just one of the following tests:
- (a) LOCI (patient share) and/or LOCI (revenue share) is below 0.6 (i.e. equivalent to a market share of 40 per cent or more); and
 - (b) fascia count (set of 16 specialities) and/or fascia count (oncology) is equal to or below 1.¹⁵
- 3.9 Of note, these filters were only used by the CC as an initial screen in order to determine which hospitals needed to be evaluated in more detail. A number of hospitals which failed the initial filters were then subsequently identified as not raising any local market concerns once a more detailed local market analysis had been undertaken.
- 3.10 The CC explained the reasoning behind the thresholds used in these filters in its Provisional Findings Report: *"To determine the LOCI threshold, we considered the market share thresholds that have often been used by the OFT, the CC and the EC to exclude cause of concern, namely less than 40 per cent in undifferentiated product markets... This level corresponds to a LOCI of 0.6. We selected the fascia count threshold on a similar basis: a fascia count of one corresponds to a local area with two competitors, which if evenly sized would imply market shares of 50 per cent."*¹⁶
- 3.11 Accordingly, it is clear from the CC's local market analysis that the proposal to introduce a 25 per cent safe harbour threshold is demonstrably too low (equivalent to a LOCI of just 0.75, or a fascia count of 3 rival fascia) and is totally inconsistent with the analysis undertaken during the market investigation.
- 3.12 Against this background, Ramsay considers that the safe harbour threshold when applied to PPU transactions outside of Central London should be raised to 40 per cent. Raising the safe harbour thresholds would:
- (a) reduce transaction costs for both private hospitals and NHS Trusts in relation to transactions which, even according to the CC's own analysis, are unlikely to raise competition concerns;
 - (b) reduce regulatory review costs of the CMA; and
 - (c) minimise distortion in the PPU tendering process (where the requirement to obtain CMA approval in advance may unnecessarily reduce the value of a bid by a private hospital operator).
- 3.13 For completeness, for the reasons set out in paragraphs 3.4 to 3.6 above, Ramsay considers that all PPU transactions in Central London should be subject to review by the CMA pursuant to either Remedy 3 or UK/EU merger control.

¹⁵ PDR, paragraph 6.99.

¹⁶ PDR, paragraph 6.100.

- 3.14 The CC has also suggested that PPU transactions under a certain *de minimis* threshold would not need to be reviewed. Although a *de minimis* threshold could also operate to reduce transaction and regulatory costs, Ramsay is of the view that the current threshold for tenders to be advertised under EU procurement rules is too low to be effective. In order for the *de minimis* threshold to give rise to any real efficiency benefits the threshold would need to be increased above the EU procurement rules threshold.
- 3.15 In addition, Ramsay has concerns about the CC only requiring a single phase review by the CMA in relation to PPU transactions not caught by the existing UK merger control regime (whereas the UK merger control regime has a two phase review). The length of phase 1 merger reviews by the CMA from 1 April 2014 will be 40 working days. Ramsay considers that, if this 40 working day timetable is applied to non-merger PPU transactions as part of a single phase review process, the CMA's ability to properly assess anything but the simplest of relevant PPU transactions would be significantly limited. As a result:
- (a) more complex transactions may be unnecessarily blocked (or inappropriately cleared) because it could be difficult to undertake the required analysis in the short time period to fully understand a transaction;
 - (b) the CMA may have insufficient time to consult adequately with third parties; and
 - (c) where the CMA is considering prohibiting a PPU transaction, it may have insufficient time to consult adequately with the parties to the PPU and therefore increasing the likelihood that rights of the defence of the parties to the transaction will be breached.
- 3.16 The net effect of these short-comings could be a greater proportion of appeals to the CAT than which currently occur in relation to mergers.
- 3.17 Against this background, Ramsay considers that if a single phase review process is adopted, it is essential that that single phase is sufficiently long (or can be extended so that it is sufficiently long) to enable the CMA to undertake the type of detailed analysis that is often required for more complex merger transactions that are referred for phase 2 review.
- 3.18 Lastly, Ramsay would observe that it is important that the CMA has all the powers it has at its disposal during a merger control review when reviewing PPU transactions not amounting to a merger. In this regard, the power to accept commitments in lieu of a prohibition could be particularly important.

4. **REMEDY 4: PROHIBITING INCENTIVE AND EQUITY PARTICIPATION SCHEMES**

- 4.1 The CC is proposing to place considerable restrictions on the ability of:
- (a) private hospital operators to offer incentive schemes to clinicians which encourage clinicians to treat patients at or commission treatments or tests from their hospitals; and
 - (b) private hospital operators and clinicians to enter into equity sharing arrangements.
- 4.2 Ramsay sets out its views on each of these proposals in turn below. As a preliminary observation, however, Ramsay agrees in principle with the CC's proposal to limit the ability of private hospitals to incentivise referrals from clinicians (whether by direct incentives or by equity participation schemes). In this regard, Ramsay refers to its observations in its Response to the Remedies Notice, in particular that: (i) it has led the way in the UK in banning direct payments to consultants for referrals; (ii) it does not

make financial payments to consultants to reward referrals; and (iii) it does not offer consultants equity interests.¹⁷

- 4.3 In addition, Ramsay would also observe that both proposed remedies do not address the incentives that private hospital operators and clinicians have to enter into such general incentives and equity incentive schemes and therefore private hospital operators and clinicians will have incentives to attempt to game the remedies. This must be taken into account when considering the effectiveness of the remedies and how the remedies will be monitored and enforced.

General incentive schemes

- 4.4 Although Ramsay is supportive of the CC's proposal to prohibit private hospital operators from directly incentivising clinicians to refer patients to their hospitals, Ramsay has a number of concerns about the practicality of the CC's proposed remedy.
- 4.5 As a general principle, Ramsay considers that any prohibition of incentive schemes should be as simple as possible. The inclusion of unnecessary exceptions or qualifications will increase the ability of rival private hospitals to circumvent the remedy ultimately increasing compliance costs, increasing monitoring costs and potentially undermining the remedy.
- 4.6 Ramsay also has a number of more specific observations. First, the CC needs to provide more detailed guidance on what constitutes "*fair market value*" in the context of general incentive schemes. It is clear from the structure of the remedy that the fair market value of each incentive will need to be calculated accurately and consistently across operators (not least to meet the disclosure obligations and to determine whether all incentives offered to a single clinician will in aggregate meet the £500 *de minimis* threshold). However, the value of relevant services could conceivably be calculated on a number of bases and could vary significantly between private hospital operators (and between individual private hospitals owned by a single operator). This guidance is important given that some private hospital operators and clinicians may have significant incentives to circumvent the remedy by under-valuing incentives provided to clinicians.
- 4.7 Secondly, the CC should provide further guidance on how to distinguish between a service to clinicians and a service to the hospital more generally. Some services could, conceivably, fall into both categories (such as booking a patient into the hospital by either hospital or medical secretaries). In this regard, by way of example, the CC should clearly set out what it considers are tasks undertaken by secretaries which are directly and solely related to the care provided by the clinician (such as writing medical notes, correspondence with referring clinicians (i.e. GPs)) and those which could be costs incurred by the hospital more generally, such as patient booking. Costs associated with the latter should not be considered to constitute an incentive. Likewise, training costs (where that training is essential to the safe and efficient operation of the private hospital) should not be considered to constitute an incentive.
- 4.8 Thirdly, the £500 *de minimis* threshold unnecessarily complicates the remedy. Ramsay does not consider that such a *de minimis* threshold provides any efficiency benefits that would warrant its implementation. The fair market value of all incentives will need to be calculated, even for low value incentives, in order to comply with the remedy (i.e. to ensure the incentives do not exceed the £500 limit and in order to meet the disclosure requirements). It is this requirement to calculate the fair market value which will incur the most significant administrative costs. Once this administrative cost is incurred, Ramsay sees no reasons why clinicians should not be charged for each of these incentives.

¹⁷ Response to Remedies Notice, paragraphs 5.5 to 5.6.

- 4.9 Instead of a £500 *de minimis* threshold, Ramsay would suggest that the CC should publish a schedule of minor benefits that private hospitals can offer to consultants free of charge (and are not considered to be "incentives" for the purpose of this remedy). In this regard, the schedule should only include:
- (a) incidental expenditure on basic workplace amenities such as stationery, tea and coffee;
 - (b) in-house training, for example on best-practice and clinical governance; and
 - (c) general hospital marketing.
- 4.10 Fourthly, it is clear that this remedy will need to be robustly monitored and enforced, and the organisation responsible for this will need to have sufficient understanding of the industry. This is because there are a number of very subtle ways in which private hospitals and clinicians may circumvent the remedy. For example, private hospitals could increase fees paid to clinicians in relation to other services in order to compensate for the loss of incentives (such as by increasing fees paid by private hospitals to clinicians for medical services to self-pay and NHS patients). In this regard, the CC has merely stated that the CMA would have responsibility for oversight, however no detail is provided on the extent of their powers, how complaints could be made, investigative processes, etc. This procedural practice needs to be formulated and published in advance of implementation of the remedy.

Equity participation schemes

- 4.11 The CC is proposing to prohibit equity participation schemes between private hospitals and clinicians practicing at or referring patients to the hospitals unless certain conditions are met, specifically:
- (a) the equity stake must be paid for by the clinician up front and at fair market value;
 - (b) where a company which owns, directly or indirectly, one or more hospitals is involved, the equity stake of any individual clinician should be limited to 3 per cent; and
 - (c) the acquisition of an equity stake must not be linked to any requirement on the clinician, express or implied, to refer patients to the private hospital or to conduct a minimum percentage of his private practice at that hospital, or to practise at that hospital for a minimum period, or to commit to providing a given level of throughput in the case of a specialized piece of equipment.
- 4.12 Further, hospital operators will be required to disclose publicly via their websites which, if any, clinicians practising at their hospitals own equity in their facilities (or in equipment within those facilities).
- 4.13 In general, Ramsay supports the CC's proposed equity participation scheme remedy and, in this regard, Ramsay refers to its Response to the Remedies Notice, paragraphs 5.12 to 5.26 which sets out in detail why equity participation schemes can distort competition in relation to private hospital services and are not in the best interests of patients. For completeness, Ramsay confirms that it does not offer equity interests to clinicians.
- 4.14 Ramsay does, however, have a number of discrete concerns about this remedy.
- 4.15 First, the exemption condition for equity stakes paid up front and at fair market value may undermine the effectiveness of the remedy. This is because:
- (a) there is no guidance as to how "*fair market value*" should be calculated in this context and therefore private hospital operators and clinicians will be able to flex

the methodology to best suit their interests in a particular case. Without any guidance, there can be no expectation that "*fair market value*" will be assessed on a consistent and robust basis (especially given the incentives private hospitals and clinicians will have to circumvent the remedy, see paragraph 4.3 above); and

- (b) assessing "*fair market value*" at the launch of a hospital may not accurately reflect the real economic value of an equity participation scheme. At launch, it might be legitimate to place a low market value on the equity share (especially in circumstances where a hospital with such a scheme has a highly leveraged business model). Further, the value of an equity interest could significantly increase over time, for example as a result of a pre-agreed (or otherwise) share buy-back programme. Where the value of the equity interests increases, the incentives of the clinicians to distort their referral patterns to the benefit of the hospital in which they have an equity interest will also increase. Accordingly, by limiting the assessment to fair market value at launch, there is a risk that, even if the scheme does not distort referral patterns to begin with, such distortion could increase significantly over time.

4.16 Second, Ramsay considers that the efficacy of this remedy will depend largely on the extent to which the remedy is effectively policed by the OFT/CMA. In this connection, Ramsay would urge the CC to set out detailed guidance on how the remedy will be monitored and enforced (see also Ramsay's observations as set out in paragraph 4.8 above, which, for completeness it repeats here).

5. **REMEDIES 5-7: REQUIRING PRIVATE HOSPITAL OPERATORS TO PUBLISH CERTAIN INFORMATION ON HOSPITAL AND CONSULTANT PERFORMANCE**

5.1 The CC has identified concerns about the quality of publicly-available information on the quality of services provided by private hospitals and consultants (noting that much more information is available in relation to NHS hospitals). In order to address this concern, the CC is proposing to require:

- (a) all private hospital operators with UK turnover of £5 million or more to provide information in an appropriate format to a suitable information organisation for publication to patients (the "**Information Organisation**"). The CC considers that PHIN, with an expanded membership base (which would include PMIs and consultant representatives) to ensure its independence, is likely to be a suitable Information Organisation for these purposes; and
- (b) consultants to provide fee information to patients at two prescribed stages in the patient pathway and submit their fees schedules to the Information Organisation by December 2016 for publication on the organisation's website alongside consultant and hospital performance information.

5.2 Ramsay refers to its submissions on information asymmetries as out in the AIS Response, section 10 and its submissions on informational remedies as set out in its Response to the Remedies Notice, sections 7 and 8. In particular, Ramsay reiterates its view that greater transparency serves the patients' interests and accordingly Ramsay is already committed to publishing useful data to assist and inform patients, GPs and PMIs.

5.3 In relation to the proposed remedy requiring publication of information on private hospitals, Ramsay confirms that it is generally supportive of the CC's approach, subject to ensuring that:

- (a) the information published directly relates to the quality of the services provided by private hospitals; and

- (b) the publication of that information does not have any unintended anti-competitive effects.
- 5.4 Ramsay has concerns that aspects of the proposed remedy do not meet these two conditions.
- 5.5 First, the CC is proposing to require the publication of information on volumes of procedures undertaken. It strikes Ramsay that this information is not directly relevant to an assessment of the quality of services provided by private hospitals. Indeed, as recent events in the industry have highlighted, a high volume of a specific procedure does not necessarily equate with a high quality of service. Further, the publication of volume figures may distort competition in relation to the supply of specific medical procedures. For example:
- (a) referring clinicians could erroneously equate high volume with quality and therefore have a preference to refer patients to hospitals which undertake a high volume of that specific procedure. The net effect would be to embed hospitals with high volumes of a particular procedure and raise barriers to entry and/or expansion for other hospitals in relation to that specific procedure; and
- (b) access to information on volume of specific procedures could distort competition between private hospital operators. Private hospitals will be able to monitor procedure volumes of rival operators and use that information to adjust the way in which it competes with its rivals.
- 5.6 For these reasons, Ramsay continues to believe that it would be inappropriate, and would serve no tangible benefit, to require publication of data on volume of procedures.
- 5.7 Second, Ramsay considers that the requirement to make raw data available is disproportionate and may distort competition in connected markets, in particular in relation to the provision of PMI. In this regard, BUPA has been the most active champion of including raw data in the published information. Ramsay is not surprised that BUPA is the most vocal proponent in this regard because the publication of raw data is likely to give BUPA, the largest PMI with a market share of approximately 40 per cent¹⁸ and with sophisticated data computation and processing capability, a significant advantage over many of its competitors, most of whom do not have the same capabilities. Ramsay considers that any remedy that gives an additional competitive advantage to the largest provider in a connection market is wholly inappropriate. This is particularly so given that BUPA's reasons, as picked upon by the CC, for requiring the raw data are not particularly persuasive, i.e.:
- (a) to enable BUPA "to carry out a range of more technical analysis on behalf of their customers"¹⁹, although it is not clear what that technical analysis would be and what benefit BUPA's customers would derive; and
- (b) suggestions that PHIN was not an appropriate Information Organisation for this task as it was controlled by the private hospitals. In this regard, Ramsay refers to paragraph 5.8 below.
- 5.8 In addition, Ramsay also believes safeguards need to be put in place to ensure that PHIN as the Information Organisation continues to be an appropriate body to undertake the data collection and publication process. PHIN should be independent and should not be able to be used as a body to further the commercial interests of members. In this regard,

¹⁸ CC's Provisional Findings Report, figure 3.15 (for 2011).

¹⁹ PDR, paragraph 2.415. See also paragraph 2.438, where the CC notes that "BUPA highlighted that PMIs [needed] access to the raw data underlying any quality measures in order to carry out their own analysis, rather than having access to the same outcome measures as patients".

private hospitals and consultants will be required by the remedy to provide certain minimum information and this regulatory obligation will be sufficient to ensure that they do not use PHIN to pursue their own commercial interests. PMIs will not be subject to the same type of limitations and therefore there is a real risk that their membership may be used to further their commercial interests, rather than the regulatory objective of the remedy. Accordingly, Ramsay is of the firm view that it would be inappropriate to include PMIs in the membership base of the Information Organisation.

Related to this point, Ramsay also considers that the constitution of the Information Organisation should also include obligations designed to ensure that it remains independent and cannot be used as a body to further commercial interests (or its members, other parties or itself). This needs to be enshrined in the constitution in order to ensure that the operation of the Information Organisation does not change over time such that it is no longer fit for purpose.