SUBMISSION PRIOR TO THE ISSUES STATEMENT ON BEHALF OF RAMSAY HEALTH CARE UK LIMITED

1. INTRODUCTION

1.1 Ramsay Health Care UK Limited ("**Ramsay**") welcomes the opportunity to submit comments *prior* to the production of the Competition Commission's ("**CC**") Issues Statement.

1.2 Ramsay's views on the *substantive issues* raised by the OFT in its provisional report dated December 2011 (the "**OFT Provisional Report**") are set out in Ramsay's Response to the OFT's Private Healthcare Market Study dated 9 February 2012 (the "**Ramsay OFT Response**").

1.3 In contrast, this submission to the CC is limited to the identification of a number of key issues that Ramsay considers should be central to the CC's investigation. Ramsay will put forward its substantive views on the issues in due course.

1.4 The particular issues Ramsay wishes to highlight at this stage are set out under the headings below.

2. COMPETITION FOR CONSULTANTS

2.1 The need for private healthcare ("**PH**") providers' facilities to attract the business of consultants is a key competitive dynamic in this market.

2.2 When approaching this issue, a clear distinction needs to be drawn between the different types of incentive offered to consultants to attract them to refer patients to a PH facility:

(a) on the one hand, measures such as the offer of high quality facilities and support for the consultant's practice, which benefit patients;

(b) in contrast, direct financial incentives or other schemes that require consultants to commit the majority of their practice to a particular facility, which benefits the relevant PH provider and the consultant, rather than the patient.

2.3 Ramsay considers that arrangements such as those identified in paragraph 2.2(b) above, which it does not itself employ, damage competition for consultants and impact negatively upon patient choice. As such, they should constitute a priority for examination.

2.4 Accordingly, a particular <u>issue</u> for the CC to examine is:

- *the potential for arrangements, which require a consultant to commit the majority of their practice to a particular facility in return for direct financial payments, shares or other incentives, to impact upon competition and/or reduce patient choice.*

3. PRIVATE MEDICAL INSURER NETWORKS

3.1 In the section on "*Availability of remedies*" in the OFT's Private Healthcare Market Study dated April 2012 (the "**OFT Final Report**"), the OFT indicates that potential remedies

might include "*a ban on PH providers using price increases or other means to deter the recognition of new, rival facilities on the network of the PMI provider*".[1]

3.2 In this regard, Ramsay, in common with many industry commentators, considers that the OFT's analysis is flawed as it has focused unduly upon the issue of a secondary *effect* arising from private medical insurer ("**PMI**") networks, and failed to focus sufficiently upon the *cause* of any competitive constraints that may arise from the key issue, which is the use by the PMIs of network policies themselves.

3.3 It is the PMIs that design the networks, govern the rules of participation, limit membership and manage their implementation. In particular, the key impact upon the competitive dynamic is the fact that it is the PMIs who control the PH providers' ability to access the PMIs' policyholders, by choosing whether or not to recognise individual PH facilities on the network concerned. As such, the central issue for the CC to consider is whether or not the steps taken by PMIs when creating and operating selective networks are in the interests of patient choice and competition.

3.4 In contrast, the OFT has focused its analysis upon a secondary effect of the use of network policies by the PMIs. In particular, PMIs design networks that are put out to tender on the basis of a closed network with a limited number of facilities. This is done to leverage larger discounts from PH providers in return for membership of the network and the ability to access patients covered by the PMI's policies. It is unsurprising and reasonable that having competed to obtain access to a network by offering preferential prices and other terms, in circumstances where the PMI will usually retain the right to alter the network, PH providers seek some means of renegotiating prices or other terms if the structure of the network that they have signed up to changes at a later date.

3.5 In this regard, a balanced analysis needs to take account of all of the considerations that apply to the use, or not, of the network model by PMIs. On the one hand, there is the open access policy model under which all insureds are permitted to access all PH facilities. Under this model, the pricing tariff agreed between the PMI and the PH provider will reflect the fact that there will always be greater uncertainty about how many patients will be referred at any particular time. PMI policyholders also tend to pay more to the PMI to reflect the flexibility, access and choice inherent in such policies.

3.6 On the other hand, if PMIs also wish to offer cheaper "network policies" – which PH providers have competed against each other to join by offering lower tariffs in return for access to network patients - no complaint can reasonably be made where PH providers seek to make the continued existence of the network in its original form a condition of the lower tariff or other preferential terms that were originally agreed.

3.7 Accordingly, particular <u>issues</u> for the CC to examine will be:

- *whether or not the steps taken by PMIs to create selective networks are in the interests of patient choice and competition;*
- *where network policies are used, the need for PH providers to have some means of review if the PMI managing the network changes its structure or terms at a later date.*

4. INFORMATION ON CLINICAL OUTCOMES

4.1 In its analysis of "*information asymmetries*", Ramsay believes that the OFT has failed to distinguish sufficiently clearly between information on *PH facilities* (such as MRSA statistics, cleanliness, quality of food and accommodation) as against, in contrast, information on *clinical outcomes* (such as information on patient episodes or procedures carried out by individual consultants).

[1] OFT Final Report, page 153.

4.2 In particular, the OFT has failed to place sufficient weight upon the extent to which information and regulation of clinical outcomes are the primary responsibility of the medical practitioner concerned in conjunction with, and as regulated by, the appropriate clinical authorities.

4.3 As a practical example, any individual PH facility or group will only have contact with (and information about) a limited part of any particular consultant's practice, the majority of which will often be undertaken in an NHS facility and/or spread throughout other PH operators.

4.4 As a general proposition, Ramsay is obviously supportive of measures that increase the quality of clinical outcomes and the availability of information to patients and, indeed, PH providers themselves. However, an important issue for the CC to address is the extent to which it is appropriate either: to focus upon individual PH providers as the *source* for such information; or, to make PH providers *responsible* for the provision of such information. Whilst Ramsay makes it a condition of practising privileges within Ramsay facilities that the practitioner concerned complies with relevant regulatory standards, including the compilation and production of clinical records as required by the relevant clinical authorities, it does not believe that PH providers are the appropriate group of stakeholders to coordinate or supervise the production of such information.

4.5 Accordingly, an issue for the CC to examine will be:

- *to the extent that greater information regarding clinical outcomes is seen as desirable, which bodies and/or individuals should be responsible for the collection, coordination, compilation and/or dissemination of the information concerned.*

Ashurst LLP

3 May 2012