Appellant
Name of Witness: David Pedrick
First
Date: 19 July 2021

FIRST-TIER TRIBUNAL
(GENERAL REGULATORY CHAMBER)
INFORMATION RIGHTS

Appeal ref: EA.2021.0047

BETWEEN:

THE ROYAL MARSDEN NHS FOUNDATION TRUST

Appellant

and

(1) THE INFORMATION COMMISSIONER
(2) CENTRE FOR HEALTH AND THE PUBLIC INTEREST

Respondents

WITNESS STATEMENT OF: DAVID PEDRICK

I, **David Pedrick**, will say:

1. I am the Head of Commercial Finance Private Care at The Royal Marsden NHS Foundation Trust ("TRM" or "the Trust"). I have held this post since February 2017. I am qualified as a Chartered Accountant.

2. As the Head of Commercial Finance for Private Care, I am responsible for managing the prices set for services delivered to private patients. This covers prices for all sponsors including Private Medical Insurers (PMI's), Embassies, and for patients that self-pay for their treatment.

3. In this role I am responsible for negotiations of prices with the PMI's as well as overall financial performance and profitability of the Private Care division. The role also has responsibility for Operational Finance for Private Care including Billing, Credit Control, Systems, Coding and Data Quality, and the Patient Accounts teams.

4. I make this witness statement in support of the Trust's appeal against the decision IC-44907-B6Z1 issued by the Information Commissioner, ordering the public disclosure of the

profit margin on the Trust's Private Patient ("PP") income over the preceding four financial years i.e. 2015 – 2016 to 2018 -2019. The Trust appeals because it firmly believes that the public availability of that PP margin data would cause it significant commercial harm, particularly in the course of negotiations in which prices for the Trust's services are agreed. I explain below how that harm would arise.

Introduction to the sensitivity of PP margin data

5. The broad context is the Trust's integrated shared service model encompassing NHS, private and research patients. As explained by colleagues[1], this benefits both NHS and private care patients, but it has the consequential effect that the financial margins of either/both in isolation from the other are not equivalent to publicly available comparators.

6. Marcus Thorman (Chief Financial Officer at the Trust) addresses this at paragraph 47 of his witness statement. As Mr Thorman explains, the withheld information in this appeal (profit margin data for PP work only) is not a fair or accurate reflection of the cost base for that work in the context of an integrated services model. No other integrated service providers, public or private, publish their profit margin data as split between public and private income, and to compare profit margin data for a purely private offering or a purely public offering with an integrated offering would be misleading.

7. Another crucial aspect of the context for this case is the insurance market and the competitive purchasing of services. I refer in this regard to the witness statement of Shams Maladwala (Managing Director of Private Care at the Trust) at paragraphs 12 – 16 which highlight the competitiveness of the market, particularly in central London, the pressure on insurers to reduce or limit price increases, and the dominance of BUPA and AXA within the private healthcare market.

8. In addition to BUPA and AXA which remain the dominant organisations, TRM Private Care holds contracts with each of the major UK insurers – BUPA, AXA, Aviva, Cigna, Vitality, and WPA. Contracts are also held with some of the smaller providers (e.g., Aetna and Healix) but the 'Big 6' insurers comprise 97% of Private Care's income from insurers. Without those contracts, the Trust would not be entitled to provide services to those insurers' members.

[1] Witness statements: (1) Shams Maladwala at paragraphs 9 – 11; (2) Nicholas van As at paragraphs 5 – 17

9. In that context, the negotiations surrounding contract renewals are particularly important, and particularly vulnerable to pressures that would be created if the withheld information came into the hands of insurers and others with whom the Trust negotiates, as I will now explain.

Contract Renewal Timing & Process

10. In terms of contract renewals there are different times in the year when the contracts need to be renewed. The majority of insurers (AXA, WPA, and Cigna) have contracts that are required to be extended annually effective from the 1st of April. A 3-year deal was negotiated with Aviva and Vitality on the 30th of June 2019, which means that the next contract negotiation for them would be for a contract starting the 1st of July 2022. A 2-year deal was recently negotiated with BUPA effective from the 1st of December 2020 which will last to the 30th of November 2022.

11. Failure to renew a contract may result in a provider becoming a non-recognised location which would mean that the insurers' members would not be able to seek treatment with the provider. Negotiations to renew a contract therefore normally commence two to three months in advance of the termination date to ensure there is sufficient time to cover any contractual issues to be addressed. More complex or challenging negotiations may take between four to six months to complete.

12. Negotiations themselves take place between TRM's Private Care Contracts team and either a Hospital Account Manager or Hospital Commissioning Manager from the insurer or an intermediary employed by the insurer to manage the negotiation.

13. TRM's Private Care Contracts team comprises a Contracts Manager and an Assistant Contracts Manager. The Contracts Manager reports to the Head of Commercial Finance who has ultimate responsibility for the negotiations and contract status and who is also involved in the negotiations.

14. The role of an insurer Hospital Account Manager or Hospital Commissioning Manager includes responsibility for managing a portfolio of Hospital provider contracts and ensuring that best value from the contracts is derived for the insurer. Their responsibilities include retention, renewal, contribution, expansion, pricing discussion, risk and debt management of the providers. They also work closely with their clinical

colleagues to set up any arrangements for networked services that the Insurer has developed in recent years which are aimed at reducing costs.

15. Their expertise is in contract management and negotiations. The Hospital Account Managers have the support of a Business Analytics team who will have access to granular level of Hospital provider activity and billing information. The Analytics teams will use data mining and analysis software to compare pathways and prices across institutions to identify specific areas of focus that the Hospital Account Manager should be looking to address in their next round of negotiations.

Price Benchmarking

16. In terms of the extent of billing data available to the Insurers, all materially sized providers are required to utilise an electronic billing system called "Healthcode" for submitting their bills to insurers.

17. Healthcode provide other services such as practice management tools, secure messaging and clinical coding support but they were originally founded purely to provide electronic billing services in a standardised manner for the Insurers. Healthcode is jointly owned by Aviva, AXA Health, Bupa, Nuffield Health and Vitality and it is a requirement of TRM's contract with the insurers that TRM we submit all our invoices to them via Healthcode.

18. The electronic information submitted includes date of activity, type of activity, quantity, patient reference number, and price. Having all this information available in a standardised manner across all their providers allows the Insurers to analyse, at a granular level, what the range of service prices are across their providers.

19. The Healthcode platform enables standardisation and comparability of pricing between providers. Insurers will use this benchmarking information to challenge back to providers on areas where the providers' prices are towards the higher end of the market average to try and reduce these prices and thereby reduce the cost of their members' treatment.

20. For example, this ability to use data to benchmark prices across providers has been used recently by BUPA in their negotiations with us to reduce our price for PET CT's by 5% (worth £75k annually) and by WPA to freeze our CT and MRI prices (we aimed to achieve 2.0% which would have been worth £7k annually). Both providers highlighted

these specific areas as concerns of theirs where our prices were high compared to other providers and where they would not be willing to support uplifts.

Price Setting

21. Price setting is a significant step in the contract negotiation process and is, in my experience, often the most challenging step. The Hospital Account Manager will be focussed on deriving best value for the Insurer and their members and they will be looking to use any available market benchmarking information or information from their Analytics team to minimise any price uplifts, or preferably, achieve zero uplift or decreases in targeted areas.

22. Given the focus of Insurers' corporate clients on their policy spend, the most effective way for insurers to improve their returns is to manage their claim costs rather than increasing their premiums. Reducing the amounts paid to a healthcare provider will lead to an improvement in returns for the insurer and any information that supports a challenge to a hospital provider would be very valuable to the insurer.

23. The Private Care Contracts team in the hospital is looking to achieve an appropriate return on the hospital assets and will seek an uplift in each contract to cover the cost of medical inflation and ensure that income from Private Care is maximised to reinvest back into the shared service model and ultimately, support the financial sustainability of the Trust.

24. In my experience, the insurer Hospital Account Managers usually take one of two approaches when looking at pricing and will always seek to minimise price uplifts:

    a. They will focus on individual elements of treatment where the Trust's prices are at the higher end of the market e.g. CT and MRI for WPA, PET CT for BUPA, and Radiotherapy for AXA; or
    b. They focus on the overall average cost of treatment for patients in a specific speciality compared to at other institutions. This is usually done on a by speciality approach. For example, in our, to date unsuccessful, attempts to join the BUPA breast specialist network their Hospital Contract Manager stated that based on their analytic team analysis of cost per treatment, our average breast cancer treatment cost was the highest in London.

25. Our usual response to the first approach (24 (a) above) is that they should not only look at individual elements of treatment in isolation and that the overall cost of care needs to be considered.

26. It may be the case that there are individual elements of treatment where the Trust are higher cost but there are other areas of treatment where these are at lower cost e.g. overnight accommodation, and that overall, the Trust believes that, due to its shared service model, it offers great value relative to other market providers, particularly for the high clinical standard of services delivered.

27. Whilst the Trust does on occasions have to concede on individual pricing aspects it is usually a small concession to achieve an overall price increase. For example, the Trust held the CT and MRI pricing for WPA in 2020/21 in exchange for an increase of 2% across all other service lines. Publishing the withheld information would be detrimental to this negotiating position as it would provide the insurers with a view of the Trust's overall internally reported margin that they have not previously had, at least for any NHS Private Patient Unit (PPU) of material size.

28. Please also see the witness statement of Shams Maladwala paragraphs 17 – 27 which I have read and agree with.

29.

30. The insurers' are able to influence which institutions their members are referred to and they would be able to change the direction of their referrals in order to achieve a specific objective. A reduction in referrals could result in TRM missing budgeted income, both for private patients and for Trust as a whole. It could also result in TRM reducing prices, either across the board or at an individual service line level, to remain in contract with the Insurer and to continue to be able to treat their members, thus avoiding any further reduction in referrals.

31. In terms of the Insurers second approach (24 (b) above) of using an average cost per member per speciality the Trust's usual response is to state that, as one of the top cancer centres in the world, the Trust gets a higher proportion of complex cases so will naturally end up with a higher average treatment cost. The Trust states that, in line with higher income related to the complexity, it believes it has a higher cost of treatment.

32. [redacted]

33. [redacted].

34. The importance of margins in the private healthcare market is evidenced by the Competition and Markets Authority ("CMA") investigation into anti-competitive behaviours in the market in 2012. The CMA was appointed to review the London market and assess whether the market dominance of HCA resulted in an adverse effect on competition. Their outcome categories included views on activity pricing, quality, and profitability.

35. Their main finding in respect of the profitability analysis was that "*From our profitability analysis, we concluded that during the period under review BMI, HCA and Spire have been earning returns substantially and persistently in excess of the cost of capital*". The overall conclusion was that weak competitive constraints in central London had led to higher prices being charged by HCA. "Earnings Before Interest, Tax, Depreciation,

Amortisation of goodwill and Rent on leased land and buildings assets ("EBITDAR") comparisons across the main market providers was a key data source utilised by the CMA as proof of excess profit generation.

36. The remedies proposed by the CMA were significant and included the sale of a major hospital site from the HCA portfolio and a restriction on certain benefits and incentive schemes provided by private hospitals to clinicians. These remedies were subsequently removed in 2014 following a challenge process from HCA but the investigation and findings clearly highlighted the sensitivity of the market to disparities in margins and potential consequences thereof. [redacted].

37. Average market profitability at the time of the CMA report was 22% whereas more recent profitability (2018) is around 10% (source - LaingBuisson annual report ("LB report")). [redacted].

38. Another example of the consequences of price or margin disparity was the dispute between BUPA and BMI in 2012/13. BUPA maintained that BMI's prices were approximately 20% higher than other providers and a contract could not be agreed. BUPA took the decision to cut 37 of BMI's hospitals from their list of recognised providers and BUPA members could therefore not get approval for treatment at these sites. Given the volume of BUPA activity this would have had a significant impact on BMI's income and an agreement was subsequently reached shortly after the steps taken by BUPA. [redacted].

39. The Trust has in fact consciously avoided sharing any margin percentage information with Insurers' due to the complexities in understanding the margins (the withheld information) as well as the variation in results across the different sponsor groups.

Example: Using margin comparatives

40. During its 2018/19 negotiations with BUPA, BUPA were insistent that the Trust's prices were towards the top of the market and that they would not support any uplift in the Trust's tariff. The Trust argued that BUPA had one of the best overall rates among all of

the Trust's sponsors and were in fact one of the lowest sponsors in terms of overall profitability.

41. To try and demonstrate this to BUPA, the Trust shared the below range of margin averages by sponsor group that reflected BUPA as being towards the bottom end of the margin scale,

42. It was a conscious decision to exclude any percentages from the graphic below to avoid the complexity of discussing shared service margins and providing them with any additional information that they might be able to use to push for avoiding price uplifts. The negotiation was an extensive one and the Trust finally agreed an overall average uplift of approximately 3% towards the end of 2020.

43. BUPA is the only sponsor we have shared this graphic with and releasing the withheld information would give BUPA the Trust's actual average percentage which would allow them to estimate their own estimated margin.

Example: Drug mark-up negotiations

44. An example of how benchmarking information across providers is used by the Insurers' to drive down prices is provided in the form of drug mark-ups. All providers have a contractually agreed drug mark-up percentage that is added to the cost of prescribed drugs that is charged to the Insurer. This percentage is comparable across providers and is often a specific point of focus in contract negotiations with Insurers. Getting providers to reduce

their mark-ups on drugs, in particular high-cost drugs, passes an immediate cost benefit on to the Insurers.

45. Evidence of sponsor attempts to reduce the Trust's drug mark-ups include examples from contract negotiation correspondence:

    a. Extract from email from BUPA contract manager from negotiations dated 21st of June 2018 - "*We asked for a significant reduction in your mark up to reflect the fact that you have by far the highest in the market*".

    b. Extract from email from HPA contract manager from negotiations dated 24th of March 2017 - "*I have shared with you my concerns about the level of mark ups on drugs, in that these are considerably out of step with the market*".

    c. Extract from email from AXA negotiations in October 2018 to add Kingston and Cavendish Square as new locations to the contract for us to treat patients "*we would need to come to an arrangement with mark-ups before we look to consider Kingston or Cavendish Square.*"

46. Drug margins were also a specific area of focus for healthcare providers to be granted access to a Breast Specialist Network ("the network") agreement that BUPA recently developed. In developing these networks, insurers can push down prices by limiting the number of providers in the network. Providers have the choice of either reducing their prices or potentially losing referral volumes if they decline to enter the network. The commercial requirement to enter the network is determined by the provider e.g., individual procedure price, drug mark-ups, etc.

47.

[redacted] Providers have the choice of either accessing the network and retaining the business at a lower rate or seeing a total reduction in referrals from the Insurer.

48. In the example of the BUPA Breast Specialist Network, it was made a specific condition for the Trust to join the network that its drug mark-up be reduced to 10%. Aviva and Vitality also set up a network for the provision of CT and MRI services in September 2019 which required providers to submit quality, capacity, effectiveness, best practice, and price information in order to access the network. The information submitted was compared to competitors' submissions and some providers received approval whereas others were unsuccessful. Value for money was stated as a critical success factor with prices needing to reflect competitive quality.

49. BUPA have developed other networks over the past four to five years all of which have stipulated a cost of service that needs to be achieved by the providers. TRM has had to reduce prices for outpatient CT and MRI and Endoscopy services to be able to access the networks and retain patients for the full pathway. TRM not being able to access the network would result in the insured members having to have some of their treatment done externally resulting in additional complexity and potential delays in their pathway. Development of these networks has had a material benefit to the Insurers' and clearly evidences their intention to reduce treatment costs for their members.

50. Drug-mark ups are a simple percentage that is directly comparable across providers. This ability to compare providers is used to highlight the providers at the high end of the scale and negotiate their mark-ups down. Publishing the withheld margin information would lead to insurers comparing the margin to other private sector providers who are legally obliged to publish this information due to their corporate structure, for example, private companies, public companies, or interest in joint ventures. The insurers would not concern themselves with the fact that the margins are not directly comparable, and they would just use the new information to challenge TRM's negotiating position to drive price negotiations to the benefit of their members.

51. Whilst the main contract tariff change is negotiated at the point of contract renewal there are other points throughout the year where insurers may look to drive price change. Where a provider develops a new service or location then it needs to be mutually agreed to be added to the contract for the provider to be able to bill for the service or activity at the location. Insurers' may take this opportunity to request targeted price reductions in order

for the service to be added to the contract. For example, AXA's refusal to recognise Kingston as a location for TRM Private Care due to their perception of or drug mark-ups being higher than the market.

52. [redacted].

Third party contract negotiations

53. Whilst the majority of Insurers have their own provider contract management teams, two insurers, Aviva and Vitality Health, created a joint venture organisation to negotiate contract terms with their providers. The joint venture was called "Healthcare Purchasing Alliance" ("HPA") and the objective was to increase their leverage and ability to influence behaviours and prices.

54. Contract renewals with Vitality and Aviva are now negotiated exclusively with HPA who are accountable for delivering value for money for the insurers. This highlights the importance to the insurers of minimising any contract uplifts and trying to drive best value for their members. The Trust's negotiations with HPA have always been challenging due to the extent of focus on costs and comparisons of average treatment cost per member compared to other providers.

55. Historically the Trust achieved lower uplifts during these negotiations than for other providers e.g., [redacted]. In 2019, the Trust greed a 3-year deal with the insurers' to try reducing the emphasis on annual negotiations but again the Trust was pushed hard on rates in order to secure Cavendish Square as a new location within the contract.

56. At present the Trust does not believe there is any way of sponsors estimating what the Private Care margin is. The Trust does publish total income from Private Care but there is no margin information available for them to estimate profitability. The Trust does publish its overall surplus (£25.2m excluding non-recurrent revenue in 19/20) which, on total Trust income of circa £449m (excluding non-recurrent revenue), would give a 'profit' percentage of 5.6%. [redacted]

Commercial impact as a result of publishing RMH margin

57. The target for annual price uplifts varies each year depending on a variety of factors such as market pressures, medical inflation, and individual sponsor opportunities. On average over the past few years, the Trust has targeted a range between 2% and 3.5% for insurer price uplifts. Based on the income from insurers this is an estimated increase of revenue of between £1.2m and £2m.

58.

Embassies

59. International Embassy sponsors have been a significant area of growth for TRM Private Care over the past five to six years. Having accounted for about 22% of income in 2015/16 they grew to about 35% of income in 2019/20. TRM's reputation for clinical excellence is a major factor in this but so is the relationships that have been developed along the Embassy patient referral pathways, both in the UK and abroad.

60. These relationships have been carefully developed over time and management of these relationships is key to further growth of TRM Private Care. Supporting and growing the Embassy business is all about active management of these accounts combined with clinical quality and services for international patients e.g., translators. The personal nature of the account relationships are key and mutual trust and respect are fundamental to these relationships.

61. The Embassies are known to be supporters of the PPU shared service model due to the standards of clinical governance, patient experience, and better value for money.

62. Price negotiations are not as onerous with Embassies as they are with Insurers'. We use a combination of market indexes (AWE - Average Weekly Earnings and RPIX – Retail Price Index excluding Mortgage Interest) to calculate an uplift for the annual Embassy tariff which is communicated in the form of a written letter sent towards the end of March each year.

63. For the more material sponsors the Trust arranges meetings to discuss the overall account (including referrals, patient experience, prices) which are attended by TRM Private Care's Head of International and the Managing Director. Depending on any other topics the Embassy wish to cover (billing, debt) then the meeting may also be attended by the Private Care Head of Commercial Finance.

64. As part of their referral management, the Embassies do compare prices across the different providers. They are funded by government funds from their home country and will have an annual budget figure that they need to utilise as best as possible to support the number of patients requiring international treatment. They do not however have the analytic support or data-driven benchmarking information that the insurers possess so have not been as price sensitive or challenging of uplifts as the insurers.

65. There is however a significant risk in terms of Embassies which is in their support of the PPU model as part of their requirement to manage costs. The Trust positions itself as offering good value for money due to its shared service model, NHS governance, and complexity of cases that it receives from them.

66. The Embassies currently have no means of sourcing the Trust's margins for Private Care and, due to individual case complexity, it can be difficult to compare pricing across providers. [redacted]

67. They have the power of being able to manage where their patients are referred to and any decision to no longer support a provider would result in an immediate cessation in the referrals to that provider.

68. The market for International Embassy patients in London is extremely competitive due to the volume of activity and the higher prices that this sponsor segment can attract. The Trust could have to explain why the margin is misleading and should not be considered as reflective of pricing, .

69. The potential impact in terms of Embassy sponsors may be estimated as follows:

Self-pay patient

70. In terms of self-pay patients, TRM holds a price list of all activities that it charges for. Every year at the end of March, the Trust adjusts the price list based upon a market review. The Trust does try to benchmark its prices against other providers and consider how it wants to position its uplift for the year. The Trust might look to uplift the whole price list by a certain percentage, or it might only uplift specific charges within the pricelist. The Trust might also decide to hold prices or even reduce in certain areas where market information indicates that it is at the top end of pricing.

71. Costs for cancer treatment can be extremely variable based upon individual case complexities and treatment protocols. Due to the potential variation in costs, TRM does not often provide specific quotes for patients but rather requires self-pay patients to have made an advance payment towards their treatment. This is based on an average treatment cost for the type of treatment that the patient requires. The patient's account is then monitored to see when additional funds may be required. Should the final account costs be less than the original advance payment made, then the balance on the account is refunded to the patient.

72. As there are no negotiations for this this sponsor group the risk of disclosure is lower than the other two sponsors.

73.

74.

75. For those reasons, I am confident that the disclosure of the withheld information would expose the Trust to a very significant risk of substantial commercial harm in the ways I have described above. The Trust believes this would be strongly contrary to the public interest.

76. I confirm that the facts stated in this witness statement are true.

Signed:

David Pedrick

Dated: 19 July 2021