

RAMSAY: PRIVATE HEALTHCARE MARKET INVESTIGATION
RESPONSE TO ANNOTATED ISSUES STATEMENT

2 APRIL 2013

1. INTRODUCTION

- 1.1 This paper sets out the Ramsay Health Care UK ("**Ramsay**") response to the Competition Commission's ("**CC**") Annotated Issues Statement ("**AIS**") and related annexes as published on 28 February 2013.
- 1.2 This submission is structured as follows:
- (a) Section 2 sets out an Executive Summary;
 - (b) Section 3 sets out some initial observations on the relevant market context that have not been correctly captured by the CC's analysis in the AIS (role of NHS and PMI and the relevant product market);
 - (c) Section 4 explains why the CC's provisional views on profitability (as set out in the CC's Profitability Analysis working paper of 1 March 2013 ("**Profitability WP**")) are incorrect (see also Annex 2); and
 - (d) Sections 5 to 11 deal with the CC's Theories of Harm 1 to 7 in turn.
- 1.3 In addition the following papers in support of the representations in this submission are annexed to this paper:
- (a) Annex 1: Product Market Definition;
 - (b) Annex 2: Comments on the Profitability Analysis Working Paper;
 - (c) Annex 3: Local Area Analysis;
 - (d) Annex 4: Local fascia count for [X] Ramsay hospitals of potential concern – 45 minute drive time;
 - (e) Annex 5: Bargaining Power;
 - (f) Annex 6: Patient Choice Dynamics in a Mixed Economy; and
 - (g) Annex 7: World Health Organisation Policy Brief - Day Surgery: Making it Happen.

2. EXECUTIVE SUMMARY

- 2.1 This Response to the AIS and annexes summarise Ramsay's position in connection with the theories of harm explored by the CC.
- 2.2 However, this Executive Summary explains why the two key theories of harm explored by the CC in the AIS (1 and 3) have no application as against Ramsay. Given the cost and management resource expended by Ramsay on the market investigation to date, Ramsay would ask that the CC confirms this point as soon as possible.
- 2.3 First, Theory of Harm 3 is predicated on the existence of market power held by Ramsay over key PMI operators which is not "*totally offset by any buyer power of the PMI*".¹ Aside from whether this is the right test upon which to base a finding of adverse effects, which it is not, the notion is inherently implausible. Ramsay is a relatively new entrant with a modest (9 per cent market share by volume) chain of 23 generic acute hospitals spread throughout England. The range of largely generic elective services it offers are replicated to a greater or lesser degree not only by the range of 588 other facilities offering private elective care in the UK, but also by the massive range of NHS hospitals increasingly offering private care in non-dedicated beds.
- 2.4 Moreover, the notion that Ramsay is in any position to leverage market power over any PMI operators is simply not supported by the facts. [§<] where falling demand for PMI and spare capacity of PH to take on more private work is an accepted and well reported fact in this industry. This broader market context of supply and demand is completely inconsistent with a theory of harm that Ramsay is in a position to exploit asymmetric market power over PMIs.
- 2.5 The notion becomes even more implausible when due regard is had to the enormous buyer power of PMIs. The HHI for the PMI sector exceeds the threshold for a highly concentrated market by a margin of 31 per cent.² The market share of the top four PMI's is so concentrated at 87 per cent it exceeds that of the top four UK grocery retailers by over twenty percentage points. Even the second largest PMI itself acknowledges that, outside of London: "*negotiating power is to some extent balanced*". It would be both extraordinary and disproportionate for the CC to contemplate imposing remedies on the basis of a theory of harm whose fundamental assumption, namely a material imbalance in market power, is itself largely discredited by the submissions of those it would be expected to impact upon.
- 2.6 In addition, Ramsay has not found any documents in its records which might correspond to the negotiating conduct that the CC flags as potentially blocking the ability of the PMIs to negotiate lower prices and mitigate PMI market power. Clearly, if Ramsay was engaging in such conduct, this would be evidenced in its internal documents. The fact that it is not further confirms the absence of the theory of harm or anticipated effects in respect of Ramsay's business.
- 2.7 If any further demonstration of the buyer power exerted by PMIs were needed, it may be found in the fact that the fixed cost nature of the assets of running a private hospital mean that PH operators have an overriding incentive to supply/enter into contracts so as to cover the fixed costs of operation. Given that the four largest PMI providers accounted for 87 per cent of premium revenue in 2010, the loss of any of these would severely impact on the profitability and financial viability of a PH facility. In other words, each of the large PMI providers is an essential trading partner for Ramsay whom it can ill afford to lose.

¹ AIS, paragraph 87.

² The HHI of the top five PMI providers is 2,622.

- 2.8 This relationship of dependence is confirmed by even the [§<]. This point alone, as supported by Ramsay's drive time analysis which takes at least some account of the competitor set for infra-marginal customers, should cause the CC to dismiss Theory of Harm 3 as against Ramsay before further costs are thrown away exploring it.
- 2.9 Given this overriding evidence of significant and relevant PMI buyer power in general terms, Theory of Harm 1 (and 3) are advanced on the implausible and vague notion that some PH facilities may enjoy a residual form of "local market power" based upon facing a "limited" number of rival hospitals "nearby".³ It is only the fact that terms such as "limited" or "nearby" remain undefined, even some 3 months from provisional findings, which is unacceptable in itself, that the theory of harm has not been dismissed in respect of Ramsay already. This paper shows why it must be abandoned against Ramsay before further costs are thrown away.
- 2.10 In short, the theory would require the CC to prove that there were insufficient competing facilities within a reasonable drive time of the patients for which the Ramsay facility competes, to constrain the relevant Ramsay hospital in price or quality terms. At the outset, as discussed, this is inherently implausible given that Ramsay operates a relatively modest network of PH hospitals spread throughout England offering, on the whole, general elective care. This is replicated by virtually all other PH facilities, PPUs and NHS facilities offering private non-dedicated beds.
- 2.11 However the theory may be dismissed in definitive terms as against Ramsay even at this stage. This is because the CC's own survey evidence confirms that self-pay patients will drive on average 45 minutes for their treatment.⁴ There is no basis to conclude these patients are exceptional. Indeed, the CC proposes to model self-pay patients' purchasing behaviour on the basis that they are sufficiently analogous to PMI, for its own price concentration analysis (PCA). However, the clear evidence of how far patients will drive to "competing" hospital facilities is fatal for the notion of local market power in connection with the Ramsay portfolio.
- 2.12 In this regard, Annex 4 confirms that when modelled on a highly conservative basis (i.e. treating the 45 minute *average* drive time as a *maximum* travel time), all of Ramsay's facilities face at least 1 other competing PH fascia plus an NHS hospital with beds to provide private treatment. Moreover, all but [§<] of Ramsay's facilities face at least two rival PH fascias plus an NHS hospital. The local conditions of competition faced by these [§<] hospitals are explained within this Response.
- 2.13 In this regard it is, and would be, perverse to find that Ramsay facilities which: (i) face at least two competing PH fascia and one NHS fascia offering dedicated private beds; and (ii) are within the drive time for which the CC's own evidence confirms patients are willing to travel, were in a position to close off patients' "outside options" to a sufficient degree to give rise to adverse effects.
- 2.14 Moreover, there is no sign of the adverse effects the CC indicates would arise if Ramsay local market power existed. This is confirmed by the evidence gathered by the CC. This includes the following:
- (a) To the extent it is relied upon, the CC's own PCA analysis discloses a negative correlation between so called market concentration and self-pay prices at Ramsay's hospitals. This confirms that Theory of Harm 1 cannot apply to Ramsay;

³ AIS, paragraph 52.

⁴ As set out in Annex 3, the CC's catchment area analysis is flawed, which is resulting in some overly-narrow geographic markets. The CC's survey shows that the average travel time for self-pay patients (which better reflects the choices facing patients due to the directional bias of the insured patients), is just under 45 minutes. Accordingly, this has been used as a comparative benchmark.

- (b) All of the Ramsay hospitals identified by the CC as potentially "must have" have, in fact, each been left off at least one PMI network;
 - (c) Ramsay's [X]; and
 - (d) the CC's evidence confirms that Ramsay does not have the form of "network" market power derived from a chain of local hospitals discussed by the CC in its local market analysis. This is clearly shown when Ramsay's "network" LOCI is modelled against its "individual" LOCI in the context of the scatter diagram relied upon by the CC to show network power on the part of other providers. As is the consistent theme, the evidence confirms the absence of any such effects for Ramsay.
- 2.15 Given the above, not only is there no "local market power", but the CC's own evidence manifestly disproves the existence of any adverse effects from Ramsay's own network.
- 2.16 The CC needs to acknowledge this clear conclusion urgently and focus its analysis on more relevant parts of the inquiry. Indeed, it would be unreasonable for the CC to continue to pursue this theory of harm against Ramsay, given the existence of this uncontroversial and determinative evidence even at this stage.
- 2.17 More generally, the glaring errors in the preliminary "filter" carried out by the CC are set out in detail in Annex 3. Whilst the CC acknowledges that further detailed work is required to examine the local conditions of competition faced by the relevant hospitals, the failings of this filter are in fact so fundamental and profound that it is not fit for purpose.
- 2.18 In this regard, to test Theory of Harm 1, the CC needed to examine the extent to which Ramsay's facilities face competition for "infra-marginal" patients from rival PH facilities. However, both the LOCI and Catchment Area Fascia analysis have asked the wrong question. They have modelled the extent to which PMI patients are currently referred by GP's, consultants and the terms of their policies to local hospitals. This local referral pattern confirms a picture of the wide spread availability of local PH facilities and local available spare capacity in respect of which PMI patients presently seek local treatment. In many ways, these local referrals are simply a manifestation of a plethora of available PMI treatment options. However, the analysis says nothing about whether the observed local patient flows operate as a proxy for market power on the part of the PH facilities which receive them or, in particular, the ability of hospitals to compete for infra-marginal patients.
- 2.19 Annex 3 also confirms serious methodological flaws in the CC's analysis more generally:
- (a) Both LOCI (through its weighting) and the fascia analysis (by excluding the 20 per cent of patients drawn from further away) exaggerate the degree of concentration observed at the local level. This is highly material as the most important group of patients to be explored for Theory of Harm 1 – namely those patients at the margins in respect of which Ramsay hospitals face the greatest competition – are excluded from the analysis because the catchment areas (overt and implicit) are drawn too tightly. It is this remaining 20 per cent of patients and those on the margins which ultimately have a material impact on the overall profitability and financial viability of a hospital.
 - (b) The competitor set is obviously and materially incomplete, with the result that relevant competitors are excluded and market shares exaggerated. According to Laing and Buisson, there are 588 sites throughout the UK specialising in the treatment of private patients or outsourced NHS patients (515 are in the independent sector). The CC has included only 223 hospitals in its competitor set and even then disregards 50 of these (23 per cent) due to incomplete invoice

records it has obtained. Ramsay estimates that at least some 25 per cent by volume of the relevant market has been ignored by the CC and in all likelihood it is a much higher percentage. Exaggerated market shares prepared by a third party on such a basis would be disregarded by the CC as misleading and unreliable. There is no reason to adopt a different approach in respect of the CC's own analysis, particularly when it has produced such counter-intuitive results.

- (c) The CC adopts a binary approach in respect of product markets, again with the effect that relevant competitors are excluded. Extraordinarily the CC's initial analysis excludes the competitive impact of day-patient facilities. This is despite the fact that of the treatments performed by Ramsay, only 27 per cent take place in the in-patient setting. This trend is growing: in 2011, there were 304 facilities that provided day surgery only, in the independent sector, representing an increase from just 43 in 2004 and reflecting the transition of treatment from an inpatient to a day case setting. It is an obvious material consideration to take account of this constraint upon general acute elective care, and yet the analysis in the AIS fails to do just that.
- (d) More generally, the CC's analysis appears to suffer from a systematic confirmation bias in favour of seeking to identify competition concerns rather than applying a balanced and objective approach to weighing up the evidence. This confirmation bias is clearly apparent in the following analysis:
 - (i) The CC's price concentration analysis is wholly inconsistent and varies significantly depending on the measure of concentration and methodology used. There is no correlation in respect of fascia count and mixed results for LOCI; yet somehow the CC concludes there is a statistically significant relationship overall. The CC cannot "pick and choose" which results to rely on and ignore evidence to the contrary, as it has done in the AIS.
 - (ii) In relation to the CC's profitability analysis, the CC has adopted an unbalanced approach in relation to each of the material stages of the profitability and WACC calculations applied to Ramsay. The cumulative effect of these errors at each stage is a material systematic confirmation bias towards a finding of high profitability, when simply correcting the obvious errors clearly shows this is not the case for Ramsay.
 - (iii) In relation to the assessment of buyer power, the CC appears to have adopted a very "one-eyed" approach by presenting the arguments put forward by the PMIs, but failing to take into account the key factors relevant to the PH operators.
 - (iv) In relation to the CC's local market assessment, the additive nature in which the CC is applying the various tests is both biased and inconsistent, as the CC focuses only on the specific tests that are failed and ignores all the alternative tests that are passed (i.e. that point to the opposite conclusion as regards whether a hospital has market power). This is simply not a proportionate or appropriate approach, even for a first stage filter.

2.20 Finally, as noted above with regard to profitability, Ramsay has clearly demonstrated that the ROCE analysis carried out by the CC in respect of Ramsay is fundamentally flawed. Even correcting only for obvious error has the effect of reducing the ROCE to a level effectively commensurate with WACC. This low level of ROCE is further corroboration on the part of Ramsay of a lack of market power at the national or local level. Once this data has been accepted by the CC, and the Ramsay ROCE remodelled to confirm Ramsay is not earning profits above the economic norm, the CC needs to accept the implications of this evidence in clear terms.

- 2.21 In summary, and with regard to the above, Ramsay would ask the CC to clarify the application of its theory of harm at the earliest opportunity. Ramsay has responded fully to each and every aspect of the CC's inquiry and should not be required to waste further costs responding to speculative theories of harm which are far-fetched when regard is had to local competition faced by Ramsay hospitals.
- 2.22 Moreover, the CC has clearly identified the indicators it would expect to see present if these theories of harm were present. In particular, a high ROCE in respect of PMI work; a correlation between local concentration and high prices; a correlation between local concentration and low quality; and internal documents evidencing the exercise of buyer power. In respect of Ramsay, the CC has completed its information gathering stage and each and every one of these indicators may be shown to be absent. This places a clear legal obligation upon the CC to expressly distinguish Ramsay from its inquiry at this stage if the CC is to comply with its overriding duty to exercise its statutory powers in a proportionate manner and to avoid Ramsay incurring further wasted costs in respect of the investigation.

3. MARKET CONTEXT

3.1 Before considering each of the theories of harm hypothesised in the AIS, Ramsay observes that the CC's preliminary views do not adequately take into account some very important features of PH, namely:

- (a) the role of the NHS;
- (b) the strong position enjoyed by PMIs; and
- (c) dynamics between different types of care (i.e. inpatient, outpatient and day-patient care) and different specialities.

3.2 The key considerations in relation to each of these features are summarised in turn below.

Role of the NHS

3.3 The CC's analysis does not appreciate the important role played by the NHS:

- (a) as an alternative to PH when PMI policies are purchased;
- (b) in the manner in which PMI cover is used; and
- (c) as a provider of PH.

NHS as an alternative to purchasing PMI

3.4 The existence of the NHS as a free alternative means that patients will only purchase PMI for PH services if they believe, when comparing the options, that the private route gives them real added value. This is compounded by the fact that many patients feel that opting for PH services amounts to being charged twice on the basis that they already pay for NHS services through their taxes.

3.5 As a result, the demand for PMI is influenced by the perceived quality and availability of NHS provision at any particular time, including in their local area. It is clear that as standards improve in the NHS an impact is felt in terms of PMI take up. Further, given that the NHS is seen as the "fallback position" for many patients, PMI demand is income sensitive (for example, in times of recession).

Privately insured patients electing not to use their PMI

3.6 Notwithstanding their insurance, PMI policyholders may and still do use the option of free treatment on the NHS. This option is a real one and is made particularly attractive in light of the following considerations:

- (a) there is a trend towards the introduction of more restrictive PMI policies, which encourage patients to consider whether or not to use their PMI cover regarding each new healthcare episode (for example via co-payments, annual claim limits and excesses in PMI policies);
- (b) PMI providers are increasingly offering lower cost policies where the terms provide *explicitly* that policyholders may be treated by the NHS provided waiting times are suitable;
- (c) PMI providers are also increasingly offering hybrid policies which take advantage of healthcare provision in both NHS and PH facilities; and
- (d) some PMI providers offer payments to policyholders where they obtain treatment on the NHS rather than claiming on their policy.

- 3.7 The above considerations arise each and every time a person requires healthcare treatment, notwithstanding that a patient has subscribed for health insurance cover. Therefore, even where a patient has private medical insurance the NHS still competes with PH operators for the provision of publicly funded treatment at this second level with policyholders electing or being encouraged to use the free treatment alternative available to them via the NHS.

NHS as a provider of PH

- 3.8 The CC has failed to take adequate account of the extent to which the NHS competes with private hospital operators in the provision of PH services. Although the CC has acknowledged that NHS PPUs provide PH services in competition with PH operators, the CC has not taken into account the fact that the NHS competes with PH operators on a much wider level in that every NHS facility, including ordinary NHS wards, is able to offer private treatment to self-pay and PMI funded patients. In Ramsay's view, every NHS facility competes with PH facilities for PH services, or is at least a potential competitor.
- 3.9 NHS provision of PH services in NHS wards (i.e. not in PPUs) should not be dismissed by the CC. By one measure, as at mid-2011 there were an estimated 1,123 PPU beds and "[i]n addition there [were] believed to be around 1,500 non-dedicated beds used to treat private patients"⁵, where the latter number, to put it in context, exceeds the number of beds across Ramsay's entire portfolio. Guys' and St Thomas' Hospital in London which has a large volume of private patient revenue (approximately £20.6 million) but only £4.5 million of this is earned through their dedicated PPU (i.e. 22 per cent).
- 3.10 Lastly, the role of the NHS as a provider of PH services is only set to further increase as a result of ongoing NHS reforms and the amendment to the private patient income cap.
- 3.11 For further detail on the competitive interrelationship between PH and the NHS at every stage, Ramsay refers to the diagram at Annex 6 to this submission and Ramsay's Response to the Issues Statement of 20 July 2012 (section 3).

The market power enjoyed by PMIs

- 3.12 The CC has also failed to appreciate the extent to which the strong position of PMIs as funders of PH and gatekeepers to patients constrains PH providers.
- 3.13 For the reasons set out in Annex 5, Ramsay considers that the market power of the PMIs is of fundamental importance to the CC's market investigation. As the CC will appreciate, understanding both the nature and degree of market power exercised by the purchaser and how it is exercised in the bargaining interface is particularly important when exploring the PH market dynamics.
- 3.14 In this regard, the AIS is incomplete as it disregards the significant competitive constraint that PMIs ultimately impose on PH operators. Ramsay considers that there is clear evidence that the balance of power in negotiations falls heavily in favour of the PMIs and, therefore, the PMI providers have substantial buyer power. This is for the following reasons:
- (a) the PMI market is highly concentrated;
 - (b) the PMI operators fulfil a gatekeeper role in relation to access to the end consumer;
 - (c) the PMIs have the ability to switch and use a range of alternative PH or NHS providers, whereas the PH operators are heavily reliant on the PMIs in order to treat private patients;

⁵ Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, page 84.

- (d) the PMIs have the ability to change the rules of the negotiation process with PH operators in order to extract lower prices; and
- (e) the PMIs have the ability to constrain PH operators in various ways in order to ensure that low prices apply evenly irrespective of the level of local market concentration.

3.15 As noted, more detail on the role of PMIs and the countervailing buyer power is set out in Annex 5 of this submission.

Dynamics between different types of care and specialities

3.16 In its assessment of the relevant product market, the CC has failed to take account of current market dynamics between (i) the different types of care (i.e. inpatient, outpatient and day-patient care); and (ii) between different specialities provided.

3.17 In terms of the type of care, the CC indicates that inpatient, outpatient and day-patient care appear to be distinct markets and that it intends to focus its analysis largely on the provision of inpatient care. If it were to follow this approach, the CC would manifestly fail to take account of the blurring of the boundaries between inpatient, outpatient and day-patient care and the growing importance of day-patient care (which accounts for a significantly greater proportion of Ramsay's business than inpatient care). When these factors are properly considered, it is clear that the relevant product market should include inpatient, outpatient and day-patient care.

3.18 In terms of specialities, the CC has grouped together 16 specialities which it will consider as a cluster (on the basis that each specialism is provided by at least 80 per cent of the relevant private hospitals) and will also consider oncology as a separate cluster. Ramsay considers that the CC's approach to defining the cluster of 16 specialities, and considering oncology separately, is not robust. First the CC's distinction between the "cluster" and other "specialities" approach is largely arbitrary and, secondly, the approach fails to take account of strong supply-side substitutability in the market given the ability of hospitals to expand into new areas of treatment if the demand arose. Accordingly, Ramsay considers that the CC's approach to defining a limited cluster of specialities is unsustainable and, therefore, it is appropriate to broaden the product relevant beyond the 16 specialities as identified by the CC.

3.19 Annex 1 to this submission sets out in detail why the CC's approach to product market definition is incorrect and why that product market should be broadened to capture all forms of cares and specialities outside of the CC's cluster of 16.

4. PROFITABILITY

- 4.1 The CC has undertaken a profitability analysis of the seven largest private hospital operators providing privately-funded healthcare services, by comparing return of capital employed of each of these operators with an estimate of the relevant cost of capital. The CC states that this profitability analysis *"has a number of purposes including (a) as an indicator of whether prices are too high, (b) as evidence about entry conditions, and (c) as evidence of trends in profitability."*⁶
- 4.2 The CC's current thinking is that *"the private hospital operators analysed, on average, are marking profits in excess of the cost of capital, with an average return on capital employed of about 18 per cent compared with a cost of capital of about 9 per cent."*⁷ In relation to Ramsay, the CC has estimated an average ROCE over the five-year reference period of [x] per cent.
- 4.3 However, NHS-funded treatment is included within the CC's profitability analysis, which is a material flaw in the analysis. Given that the majority of Ramsay's business is now in relation to NHS-funded treatment, and it is NHS-funded treatment which has increased and largely driven the improvement in Ramsay's performance, the approach adopted by the CC presents a meaningless measure of profitability in relation to private healthcare services only, which is ultimately the CC's reference market.
- 4.4 In addition, there are obvious material errors and omissions in the CC's profitability calculations, which significantly overstate Ramsay's ROCE and understates its WACC. These errors and omissions are set out in detail in Annex 2 to this submission.
- 4.5 The errors and omissions are of such a magnitude that it appears that the CC has adopted an unbalanced approach in relation to the material stages of the profitability and WACC calculations. The cumulative effect of these errors at each stage is a systematic confirmation bias towards a finding of high profitability, when a more balanced approach shows that this is not the case.
- 4.6 Most importantly, the effect of adjusting even just the most obvious errors and omissions (and even where these adjustments are carried out on a prudent basis) is highly material to the CC's profitability analysis. These corrections, which are uncontroversial and need to be made, effectively remove any justification to assert that Ramsay is somehow earning profits above the competitive norm. Accordingly, there is no evidential basis to conclude that Ramsay is earning profits above the competitive norm and Ramsay requests that the CC concedes this point immediately. Furthermore it has failed to recognise that the derived ROCE is for the whole Ramsay business and not the private element only.

⁶ AIS, paragraph 39.

⁷ AIS, paragraph 49.

5. THEORY OF HARM 1: LOCAL MARKET POWER

CC's analysis

- 5.1 The CC has indicated that its current thinking is that some private hospitals have market power in local areas and, in particular, that it has found a number of areas where hospitals face only limited local competition. Whilst the CC will consider these hospitals of "potential concern" in more detail, it indicates that:

"we consider it likely that a significant number of the "hospitals of potential concern" do have such market power".⁸

- 5.2 The CC has applied two quantitative filters to identify hospitals of so called potential concern: (i) a weighted average market share in excess of 40 per cent; or (ii) less than two other competing fascia within a catchment area within which 80 per cent of a hospitals' patients are drawn.
- 5.3 In respect of Ramsay, the CC has identified [x] hospitals from a portfolio of 23 hospitals examined as potentially having market power at the local level.

Initial observations

- 5.4 The suggestion, however tentatively advanced, that [x] per cent of the Ramsay hospital estate faces limited local competition as may be likely to "confer local market power" is far-fetched when held up against the facts demonstrating the economic and commercial context within which Ramsay operates.
- 5.5 As noted above, when proper regard is had to the contemporaneous documents and Ramsay operating data, there is in fact clear evidence that Ramsay operates without market power on the local or national level. This is entirely expected given: its status as a new entrant; its small market share; the non-specialist nature of the general hospital portfolio it acquired from Capio; [x].
- 5.6 As set out in Annex 3 to the paper, there are numerous other examples, backed by contemporaneous evidence and consistent with Ramsay's financial data, which confirm a lack of market power on the part of Ramsay, whether at the local or national level.
- 5.7 Against, this clear evidence, the suggestion that [x] per cent of Ramsay's portfolio may confer local market power is, in the true legal sense, perverse. The root of the error in respect of the conclusion reached in the AIS may be found in:

- (A) The obvious flaws in the quantitative methodologies employed by the CC when identifying hospitals of "potential concern". These are sufficiently profound so as to render the initial quantitative assessment undertaken unfit for purpose, irrespective of the detailed analysis of local conditions of competition that is to follow. This has serious timing implications for the MIR, when a methodology suffering from such profound flaws is advanced only some three months before provisional findings are due;
- (B) The logic employed in Theory of Harm 1 itself. Namely that local concentration of the levels identified by the CC might lead to the private hospitals enjoying market power *over patients* at the local level. This suggests that any such relationship might somehow translate to market power in negotiations *with PMIs* is dealt with separately in connection with Theory of Harm 3.

⁸ AIS, paragraph 70.

A. The Methodology

- 5.8 Ramsay's comments on the methodology employed by the CC in respect of its analysis of local markets is set out in detail at Annex 3. The key points are summarised below.

The CC has ignored key competitors

- 5.9 The CC's LOCI and fascia analysis both fail to have regard to the relevant competitor set. Ramsay estimates that a minimum of some 25 per cent of capacity for privately funded healthcare which competes directly with Ramsay's facilities has been ignored completely, and the true number is likely to be much higher. Relevant competition which has been omitted includes:
- (a) Patients from no fewer than 50 of the 223 hospitals the CC recognises as relevant, or some 23 per cent of relevant hospitals. There is no basis for assuming that these excluded hospitals for which invoice data was not obtained will not be meaningful competitors at the local level;
 - (b) Non-dedicated NHS hospital capacity which is used and available to provide private care for PMI patients. The number of relevant beds was estimated by Laing & Buisson to be some 1,500 in 2011,⁹ and is in reality much higher given the ability of hospitals to make this capacity available on an ad hoc basis. 1,500 beds exceeds the number of beds across Ramsay's entire portfolio;¹⁰
 - (c) Outpatient and day-patient facilities providing a broad range of elective acute health care services. In excluding such facilities entirely, the CC has committed a fundamental binary error of analysis in respect of product market definition. The error renders even a quantitative "filter" invalid, given that the very significant role played by day-patient and outpatient facilities in competing with inpatient services across virtually the entire spectrum of treatment is acknowledged by third parties, with WHO sponsored research confirming day surgery is fast becoming the norm for nearly all elective surgery.¹¹ Indeed, inpatient care now accounts [3<] of treatments undertaken by Ramsay.
- 5.10 First screen market share analysis presented by a third party which ignored at least 25 per cent (and in all likelihood much more) per cent of the relevant competitor set would be dismissed by the CC as a misleading and inappropriate starting point for any analysis that was to follow. There is no reason to take a different view in this case in respect of the CC's own analysis.

LOCI

- 5.11 Ramsay makes a number of criticisms of the weighting method employed by the CC in this connection. Ramsay may expand on these submissions once the CC has held the roundtable scheduled for 9 April 2013 and Ramsay's economic advisers have had access to the Data Room.
- 5.12 First, the weighting methodology distorts and concentrates market shares. Ramsay demonstrates how, even in a non-extreme example advanced by the CC itself, this can lead to market share differences of up to 20 percentage points as against a non-weighted model. This extreme weighting leads to biased and misleading results when applied in the context of a purported measure of market concentration. First, the key area of competition for hospitals with high fixed costs takes place in respect of patients who are on the margins. This is the category of patients that are specifically underweighted by

⁹ Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, page 84.

¹⁰ Where Ramsay's market share is some 9 per cent by volume.

¹¹ See Annex 7 to this submission.

LOCI. The CC is purporting to use a methodology which will measure concentration in an objective way. Instead, it has selected a measure whose methodology itself concentrates market share through the weighting process which, predictably, leads to results which exaggerate the degree of concentration in the market.

- 5.13 Secondly, the use of LOCI as a measure of concentration is adapted from a predictive Logit model published only in draft academic literature, which seeks to assess the pricing effect of changes in concentration (using a Logit model to represent patient demand and choices). However, the model underpinning the LOCI assessment has in fact been largely discredited as a means to predict the pricing effects that it estimates. It is plainly inappropriate for the CC to adopt such an experimental approach to found one of its two key first stage filters of market concentration. As noted above, it is unsurprising that such a model has thrown up such perverse results in respect of Ramsay. It is very concerning, however, to find that results produced by it are now being advanced so close to the stage when provisional findings are due and has generated no fewer than 122 hospitals of "potential concern" which it is suggested will require examination in further detail.¹²
- 5.14 Third, as set out further below, LOCI has negligible value as a measure of a proxy of market power in this market. It is merely a record of where PMI funded patients are currently directed by the terms of their policy in circumstances where most general insurer policies will include most general PH facilities. As such, in this market, where there is excess capacity and patients are by and large free to choose their closest facility if they follow their GP's recommendation for a local consultant, it simply records that most local hospitals on a PMI's panel mostly draw local patients. The effect of this unsurprising finding is further magnified by the weighting mechanism employed.
- 5.15 However, the application of this weighting mechanism and the pattern of local referrals it produces are not a proxy for market power. This is because it says very little, if anything at all, about where PH facilities are potentially able to compete against each other for patients and, ultimately, to access PMI funded patients.
- 5.16 These are the relevant issues if the CC is to address the central question, namely whether any individual hospital is in a position to exert market power over individual patients that is relevant for Theory of Harm 1. In other words, the fact that a hospital currently draws most of its PMI patients from a tightly bound local area does not mean that it has market power over patients or (even less plausibly) insurers in that area. The rather more obvious explanation is that in circumstances where most private hospitals are available to most PMIs in the context of general policies (albeit with no obligation to use them) – patients tend to be sent by their consultant and their PMI to their local hospital. No valid insight or commentary is given upon the alternatives open to patients if they wished to select an alternative facility, which is the key question that Theory of Harm 1 (and 3) requires to be considered. The implications of this point are considered further below.

Fascia analysis

- 5.17 Ramsay's detailed criticisms of the CC's methodology in respect of the fascia analysis are set out in Annex 3. Two principal points arise.
- 5.18 First, as a general point, the objective of the methodology should be to shed light upon the extent to which PH facilities are capable of competing with each other for patients. By selecting a catchment area on the basis of where patients are currently drawn from (to the 80th percentile) in respect of each hospital, the CC has merely recorded existing PMI referral patterns. This tells the CC very little about where relevant facilities compete (or could compete) at the margin, for the reasons set out above. Rather, for the reasons also noted above, it simply reflects the very wide range of choices and capacity available to

¹² AIS, Appendix B, paragraph 9.

PMI which results in the majority of PMI patients attending a hospital that is very local to them.

- 5.19 [redacted].
- 5.20 The lack of insight as to where hospitals could compete for infra-marginal patients is exacerbated by the absence of alternative catchment area analysis re-centred on the key variables such as major population centres and/or relevant NHS facilities where consultants practice.
- 5.21 Secondly, in contrast to the CC's approach, self-pay patients confirm that if left to their own devices they will travel on average some 45 minutes for private treatment.¹³ Ramsay suggests that this provides an important insight as to the extent patients are reasonably prepared to travel to obtain private treatment and, by implication, sheds light on areas of overlap where hospitals are actually in a position to compete with each other for infra-marginal patients. The use of such a drive time avoids the self-fulfilling aspect of merely modelling PMI existing referral patterns.
- 5.22 In this regard, the fascia analysis conducted on the basis of a 45 minute drive time confirms that all but [redacted] of Ramsay hospitals easily pass the CC's primary test.¹⁴ This is important given that:
- (a) it provides the CC with no reasonable basis to make a finding of local market power against Ramsay in respect of self-pay patients;
 - (b) it provides a fatal blow even on the basis of the CC's own fascia test to any suggestion that Ramsay's hospitals are "must have" with regard to PMI negotiations, unless there is clear evidence to establish that PMI patients must be afforded greater protection than self-pay in respect of travel distances if competitive local markets are to be preserved. This would, of course, be nonsensical (particularly given the market power of PMIs who negotiate cover on their behalf) and would also be inconsistent with the CC's own intention to elide the two customer groups for the purposes of its self-pay analysis; and
 - (c) with regard to the [redacted] residual Ramsay hospitals, Annex 4 provides a clear explanation with regard to the details of actual local competition present in those areas as to why each [redacted] Ramsay hospitals concerned could not exert local market power.
- 5.23 More generally, this analysis should give the CC a great deal of comfort that no Ramsay hospital enjoys local market power, given that this is the case even though a very large part of the competitor set with which Ramsay's hospitals compete is excluded (see above). Ramsay has sought to identify some of these key facilities in Annex 4, and this analysis may be further refined.

Price Concentration Analysis

- 5.24 Ramsay's key points on this issue are set out at Annex 3.
- 5.25 In summary, Ramsay notes that the CC's current thinking is that a statistically significant correlation between so called hospitals of potential concern and pricing is indicative of market power. However, in respect of Ramsay, the CC has in fact found a negative

¹³ This 45 minute drive time is conservative because it is based on average drive times of self-pay patients and does not reflect the fact that many patients would have travelled from further afield.

¹⁴ Ramsay does not consider that even these [redacted] facilities have any local market power. In this regard, the [redacted] facilities concerned easily pass that test when the NHS competition they themselves face is taken into account. Moreover, it is highly relevant that [redacted] these facilities have been identified as delivering high quality care for two of the most popular PH surgical treatments (i.e. hip and knee replacements) [redacted].

correlation. In other words, if the CC's analysis is accepted there is no meaningful relationship between the market concentration of Ramsay hospitals (as measured by the CC) and higher prices. In fact, the CC's analysis confirms the reverse.

- 5.26 More generally, Ramsay does not accept that the so called statistically significant relationships set out in the AIS support Theory of Harm 1 in any meaningful way at all because:
- (a) no relationship is identified when the PCA is applied to the CC's own fascia analysis. Ramsay has serious concerns about the objectivity of the CC's work in this area in circumstances where it ignores evidence that disproves the theory of harm; and
 - (b) even in respect of the PCA analysis conducted with regard to the LOCI measure of concentration, it is clear that for the majority of treatments considered there is in fact no statistically significant correlation at all between the purported concentration measure and pricing. The CC attempts no explanation to explain these results, which in and of themselves render that aspect of the LOCI analysis ambiguous at best.
- 5.27 Accordingly, any attempt to base an adverse finding on the basis of the PCA analysis presented in the AIS will obviously be flawed on the basis of manifest error because the underlying data simply fails to support such a conclusion.

B. The Logic

- 5.28 The CC states that Theory of Harm 1 is predicated on the proposition that a private hospital operator may hold market power as a result of a "limited number" of rural hospitals nearby (a) in a general sense, (b) offering a particular type of treatment or (c) with spare capacity.
- 5.29 The CC indicates it has found a number of hospitals that face only limited local competition and then posits the basis for the Theory of Harm 1, namely:

*"Since distance or travel time is important to patients, we expect this to confer some market power to the operators of these hospitals."*¹⁵

- 5.30 The CC also indicates that:

*"In general, we would expect limited local competition in particular local areas to be likely to lead to higher prices for treatment and/or a lower quantity of service."*¹⁶

- 5.31 As set out below, there are four principal reasons why this theory of harm can be shown, even at this early stage, to have no application as against Ramsay.

Ramsay's hospitals do not face "limited" competition

- 5.32 Whilst the CC's analysis is not yet complete, Ramsay does not believe any of its hospitals can reasonably be described as facing "limited competition" in any of the three senses identified by the CC.
- 5.33 With regard to 5.27 above, almost all of Ramsay's facilities fall into the *generic* category of private hospitals offering a range of acute elective care. Ramsay does not believe there is any basis to find that Ramsay hospitals face limited competition as a result of *specialist* treatment areas which that Ramsay facility, and only that Ramsay facility, is in a position to deliver. Similarly, Ramsay is not aware of any *capacity* constraints, local or otherwise,

¹⁵ AIS, paragraph 69

¹⁶ AIS, paragraph 72.

for the general elective care delivered by its hospitals. [3<] whilst it is accepted by all in the industry that demand for this work has fallen in recent times.

- 5.34 Ramsay has explained elsewhere why the local competition faced by its general acute hospitals cannot in any sense be described as "limited". This conclusion arises primarily as a consequence of the CC's failure to examine the complete competitor set and by failing to adopt realistic catchment areas which are wide enough to include facilities which Ramsay is in competition for infra-marginal patients.

What the CC has measured is not a proxy for market power

- 5.35 As noted above and the CC has measured a hospital's market share or its relative fascia count within, effectively, the area from which it draws the majority of its patients. Hospitals are then identified as of "potential concern" (and the CC concludes a "significant number" are "likely" to have market power) where, within these areas, the market share exceeds 40 per cent or less than two other competing PH fascia is identified.
- 5.36 However, as a question of logic, this simply does not follow. There is no causal connection between what the CC has measured and the potential for market power.
- 5.37 This is because, as noted above, the CC has simply recorded and then, using LOCI, concentrated the existing referral patterns of the PMIs. Such referral patterns shed light upon the ability of PMIs to permit the vast majority of referred patients to attend a hospital in their immediate locality in combination with patient preferences and the tendency of GPs to refer patients to local consultants who practice in local hospitals. These market features are, contrary to the theory of harm, actually a manifestation of the widespread availability of spare capacity in local hospitals and the ability of PMIs and patients to take advantage of it. This would certainly fit with Ramsay's understanding of the market.
- 5.38 However, what the CC has measured in this respect is clearly not a proxy for market power of hospitals over patients in their local area. To analyse this issue, which is the key question for the CC, it is necessary to explore what are the potential available facilities for patients in a relevant area and whether the drive time to those facilities is so significant that it will prevent patients from accessing them. Moreover, the scale of this disincentive must be such that the closer hospital accrues an advantage significant enough to be described as market power. This issue, which is fundamental to Theory of Harm 1, requires the CC to consider at least the following four questions:
- (a) how far will patients reasonably travel;
 - (b) whether there are limited outside options available to patients within that area;
 - (c) whether those options are so limited they may reasonably confer market power upon the remaining hospitals, in the sense of giving rise to materially higher prices or materially lower quality performance;
 - (d) whether any such adverse effects can be proven.
- 5.39 At this stage, and given the failings of the preliminary screen noted above, the analysis in the AIS has failed to establish any of the propositions noted above. Indeed, as a function of the preliminary screen essentially asking the "wrong question" (asking where patients are currently drawn from rather than where they could be drawn from) it is arguable that the CC has yet to undertake the relevant analysis.
- 5.40 The CC must disclose the evidence and basis for any such findings to the main parties before provisional findings are reached. Given that this is yet to occur, we do not see how adverse provisional findings can be reached on these issues against any of the parties on the basis of the statutory timetable.

5.41 In this regard, Theory of Harm 1 dissipates completely as against Ramsay when key questions (b) and (c) noted above are examined below against the facts of the case.

Ramsay's patients have numerous alternative "outside options"

5.42 As noted above, [38]. In this context, the vast majority of Ramsay's potential and actual patients have numerous alternative "outside-options" for general acute healthcare when assessing whether or not to use a particular Ramsay facility.

5.43 In order to establish the existence of even a semblance of market power due to locational reasons, the CC would need to establish that patients did not have access to comparable alternative options to Ramsay facilities within a reasonable drive time. The question of whether a drive time is reasonable for the purposes of this analysis will require the drive time to be sufficiently distant that patients were prepared to accept higher prices and/or lower quality of service at a closer Ramsay facility, rather than viewing the alternative as a viable option which constrained the Ramsay hospital.

5.44 In this regard, the CC has clear evidence that self-pay patients are prepared to undertake an average 45 minute drive time to the hospital of their choice. In other words, the CC's own evidence confirms that substitution and, by implication, competition on price and quality will take place for this category of patients within at least a 45 minute drive time of their own home postcodes.

5.45 As noted above, there is no reason for distinguishing this evidence for self-pay patients from a wider category of patients more generally for the purposes of Theory of Harm 1. Indeed, as noted, the CC itself confirms that the behaviour of self-pay patients will be relevant for the purpose of examining patient preferences more widely in the context of its own PCA analysis. Ramsay returns to this point in connection with Theory of Harm 3.

5.46 Ramsay has set out the alternative options faced by its hospitals within a 45 minute drive time from the relevant Ramsay facility at Annex 4. This confirms that all of the Ramsay facilities face a high number of competing options easily within the "average" area self-pay patients are prepared to drive. The range of alternatives within the "maximum" area will be even higher. Given these very clear findings, it is simply not open to the CC to argue that the competition faced by individual Ramsay facilities is "limited", and certainly in any material sense that would support Theory of Harm 1.

5.47 Thus, in respect of Ramsay, Theory of Harm 1 falls at the first hurdle: Ramsay facilities do not face limited competition within the relevant drive time. This is before the following further questions are even considered: (i) whether competition were limited enough for a degree of market power to arise which, in turn, was (ii) so material it gave rise to adverse effects.

All relevant indicators confirm no market power in respect of Ramsay

5.48 Finally, the CC argues that if Theory of Harm 1 held, it would be expected to give rise to higher prices and lower quality at the local level.¹⁷

5.49 Unsurprisingly, given the facts set out above, the CC's preliminary analysis confirms that none of these factors are present in respect of Ramsay.

5.50 First, the CC's own PCA analysis, to the extent it is to be relied upon, confirms a complete lack of correlation between alleged market concentration and pricing adopted by Ramsay in respect of self-pay patients. On the CC's own evidence and the basis of its own logic, this disproves the operation of Theory of Harm 1 against Ramsay.

¹⁷ AIS paragraph 72.

- 5.51 Secondly, there is no evidence of lower quality standards by any of the Ramsay facilities, generally or at the local level. Ramsay has invested [X] back into its facilities since they were acquired from Capio. This is plainly inconsistent with the notion that [X] per cent of them enjoy market power as might impact adversely on quality. Its patient satisfaction rates are at 95 per cent across its sites. Two of Ramsay's hospitals sit in the top ten facilities for key treatments in the entire UK for patients, namely: Duchy and Mount Stuart. Interestingly, [X]. Similarly, even in respect of Ramsay's [X] the CC has been provided with extensive evidence of significant investment programmes undertaken in respect of this facility, which are completely inconsistent with the notion it might somehow enjoy market power at the local level, never mind a degree of market power that was so material it gave rise to adverse impacts of the type expected by the CC.

C. Conclusion

- 5.52 Theory of Harm 1 simply does not stand up when examined against the facts even at this stage with regard to Ramsay. This is unsurprising given that its hospitals are spread throughout the country and patients in its local areas have numerous alternatives within realistic drive times for the type of generic acute care Ramsay delivers. Moreover, this absence of any basis for local market power is confirmed by a complete lack of evidence of adverse effects as would be expected, on the CC's own theory, if Ramsay held material market power. Indeed the evidence suggests the opposite.
- 5.53 Ramsay has incurred material legal expense and management time dealing with this investigation, which in part has appeared to explore [X]. These complaints and the theories of harm constructed around them have no application, real or imagined, in respect of Ramsay.
- 5.54 The CC has a duty to use its powers in a reasonable and proportionate manner. We suggest it is clear even at this stage that Theory of Harm 1 will not apply against Ramsay and, without it, Theory of Harm 3 will also fall away. Accordingly, we would ask that the CC give consideration to clarifying this lack of application against a small provider such as Ramsay at the earliest possible opportunity in order that further costs in dealing with the inquiry need not be thrown away.

6. THEORY OF HARM 2: CONSULTANT MARKET POWER

- 6.1 This theory of harm hypothesises that consultants or consultant groups in certain local areas have market power over their patients arising from the limited number of consultants in a particular area, the way in which referrals are made and the joint setting of prices by some consultant groups.¹⁸
- 6.2 The CC states that its current position as regards the market power of consultant groups is:
- (a) some anaesthetist groups appear likely to have market power;
 - (b) there is some evidence that prices charged by anaesthetist groups may be higher than those charged by non-groups; and
 - (c) it has not received evidence of any harm resulting from the conduct of consultants acting individually.¹⁹
- 6.3 Ramsay refers to, and reiterates, its previous submissions as regards the consultant/anaesthetist groups, specifically its response to question 60 of the CC's Market Questions,²⁰ which set out:
- (a) the advantages of consultant groups, (i.e.: members of the group providing cover for each other; Ramsay benefiting from efficiencies arising from dealing with a single set of relevant consultants/anaesthetists; and development of expertise in specialities); and
 - (b) the disadvantages of consultant groups (i.e.: higher fees resulting in a shortfall for patients; and difficulties for new consultants to establish their own practices).
- 6.4 These observations are consistent with the CC's analysis of consultant groups in the AIS (including in Appendix C).
- 6.5 Ramsay makes no observations on the market power of consultants acting individually.

¹⁸ AIS, paragraphs 74 to 75.

¹⁹ AIS, paragraphs 79-82.

²⁰ Ramsay response of 17 October 2012 to the CC's Market Questionnaire (Part 2) ("**Response to MQ Part 2**"), section 22 (pages 22 to 23).

7. THEORY OF HARM 3: MARKET POWER OF PRIVATE HOSPITALS IN NEGOTIATIONS WITH PMIS

CC's analysis

- 7.1 Theory of Harm 3 concerns negotiations between the private hospital operators and the PMIs in relation to the national prices to insured patients. The CC's theory of harm is predicated on an assumption that private hospital operators have local market power, and that this local market power, in some way affects the national negotiations with the PMIs.
- 7.2 In addition to the key assumption of local market power, the CC's theory of harm is also predicated on the following:
- (a) the PMIs are so weak that they are unable to resist any potential price increase in relation to these national negotiations (i.e. the PMIs do not have any countervailing buyer power);²¹
 - (b) that the level of profitability earned by the private hospital operators is consistent with some hospital groups having market power in these national negotiations;²²
 - (c) the ownership of a chain of hospitals enhances the market power of the private hospital operators in these negotiations with the PMIs;²³
 - (d) the internal documents of the private hospital operators "*are consistent with some large hospital groups having market power in some negotiations*";²⁴
 - (e) that national negotiations were implemented and enforced by private hospitals operators for the sole benefit of private hospitals.
- 7.3 As discussed further below, it is clear that the key indicators on which this theory of harm is based are unfounded and do not to apply to Ramsay. Moreover, the CC has not set out any evidence to show that this theory of harm is actually leading to higher prices.²⁵

Ramsay does not have local market power

- 7.4 As set out above, the suggestion, however tentatively advanced, that [x] per cent of Ramsay's hospitals are identified as hospitals likely to hold market power is perverse when held up against the facts demonstrating the economic and commercial context within which Ramsay operates. When proper regard is had to the range of available competing facilities, the contemporaneous evidence and Ramsay operating data, there is in fact clear evidence that Ramsay operates without market power on the local or national level.
- 7.5 The fact that, demonstrably, Ramsay does not enjoy market power at the local level for the purposes of Theory of Harm 1 as would prevent patients from selecting comparable facilities within a reasonable drive time, prohibits the application of Theory of Harm 3 as against Ramsay at the outset.

²¹ AIS, paragraphs 87 to 89.

²² AIS, paragraph 93.

²³ AIS, paragraph 83.

²⁴ AIS, paragraph 90.

²⁵ Ramsay is unable to comment on the CC's comparison of prices charged by various hospital operators with different insurers as set out in Part 3 of Appendix D to the AIS as the CC has only published limited information on the methodology adopted and has not published any information on the results. Ramsay reserves its position to comment on that price analysis.

7.6 However, if any further corroboration were needed, it is provided by the fact that when each of the indicators the CC sets out it would expect to see, if Theory of Harm 3 held, are examined against the Ramsay business, they are found not to exist. These are set out below.

Buyer power of the PMIs

7.7 The CC states that *"for theory of harm 3 to hold, a private hospital operator would have market power which is not totally offset by any buyer power of the PMI"*.²⁶ The CC goes on to say that:

- *"PMIs have told us that if a private hospital operator owns some hospitals which confer upon it market power in local areas, the PMI has little or no choice but to contract with a hospital operator and recognize such hospitals"*²⁷; and
- *"the PMIS have also told us that some private hospital operators offer terms in negotiations such that the PMI has little or no choice but to recognise all or most of the private hospital operator's hospitals."*²⁸

7.8 Whilst the CC is correct to identify the buyer power of the PMIs as a key factor to the overall competition assessment, the CC appears to have adopted a very "one-eyed" approach by presenting the arguments put forward by the PMIs, but failing to take into account the key factors relevant to the PH operators.

7.9 The key omissions in the CC's analysis include the following:

- (a) the fixed cost nature of the assets of running a private hospital mean that PH operators have an overriding incentive to supply/enter into contracts so as to cover the fixed costs of operation. The four largest PMI providers accounted for 87 per cent of premium revenue in 2010; the loss of any of these would severely impact on the profitability and financial viability of a facility;
- (b) there is significant excess capacity in the provision of private healthcare services in the UK. This means that insurers have the upper hand in negotiations as they are readily able to switch volumes to rival facilities. Moreover, the excess capacity in the provision of private healthcare services means that PH operators have the incentive to increase volumes so as to increase utilisation rates and provide a contribution to the fixed costs of running the hospital;
- (c) the PMIs fulfil a gatekeeper role by controlling access to the patient. This results in the PH operators being heavily dependent on the PMIs in order to treat private patients.²⁹ In contrast, the PMIs are far less dependent on individual operators or facilities in order to provide insurance policies to customers;
- (d) Ramsay does not have any local market power (as mentioned above). It is implausible that hospitals without local market power could be "must have" from the perspective of the PMIs. Indeed, almost all of the Ramsay hospitals that have been identified as being of "potential concern" as part of the CC's local market analysis, have been excluded from at least one network by at least one PMI, which clearly demonstrates that they are not "must have" facilities;

²⁶ AIS, paragraph 87.

²⁷ AIS, paragraph 88.

²⁸ Ibid.

²⁹ As set out in the OFT's discussion paper titled *"The competitive effects of buyer groups"*, the negotiation position of buyers is substantially strengthened if buyers provide a "gateway" to the market. This is more likely to arise where failure to deal with these buyers would impede the ability of suppliers to access end customers or benefit from achieving economies of scale, as is the case for the PH operators.

- (e) there is clear evidence that the PMIs are able to exercise countervailing buyer power in their negotiations with PH operators [§<]. In particular:
 - (i) the PMIs have demonstrated in the past that they are prepared to de-list (or threaten to de-list) hospitals in order to obtain preferential terms. Given the fixed cost nature of the PH assets, the threat of de-listing will have a significantly larger disciplining effect on the PH operators than the potential loss of a few policyholders to the PMIs;
 - (ii) the PMIs have the ability to change the rules of the negotiation process with PH operators in order to extract lower prices. PMI providers have been able to both demonstrate and strengthen their bargaining position by:
 - (A) developing restricted PMI networks;
 - (B) tendering for specific restricted 'low cost' networks (which are lower priced policies aimed at policyholders who are willing to accept a reduced choice of PH facilities) with the expectation that PH providers will offer a discount in return for potentially greater volumes due to the restricted nature of the network;
 - (C) [§<];
 - (D) tendering for separate contracts for specific types of treatment in addition to a main agreement. This has allowed PMI providers to obtain a lower price for that particular treatment by running a stand-alone tender for its provision;
 - (E) taking an increasingly active role in guiding their policyholders to consultants and PH facilities;
 - (F) requesting more packaged prices, which means that the PH operators take the risk in the event that additional treatment is required that is not covered by that particular package;
- (f) the PMIs are able to sponsor entry/expansion [§<];
- (g) the PMIs have an informational advantage vis-à-vis the PH operators as they have full visibility of patient data, risk profiles, and the prices and price increases suggested by all the different PH operators. In contrast, Ramsay only has visibility of its own costs and prices. This means that the PMI provider is in a much stronger position in order to obtain better terms; and
- (h) [§<].

7.10 Accordingly, when the various elements which economic theory establishes are likely to inform any assessment of bargaining power are examined, they confirm that on each count the imbalance operates strongly in the PMIs favour.

Ramsay is not earning excess profits

7.11 The CC states in paragraph 93 that "*our current thinking on hospital profitability is consistent with some hospital groups having market power in these negotiations*" (i.e. that the CC's profitability assessment supports this specific theory of harm). Ramsay fundamentally disagrees with this finding.

7.12 As set out in Annex 2, there are obvious material errors and omissions in the profitability calculations, which significantly overstate Ramsay's ROCE and understates its WACC. The cumulative effect of these errors at each stage is a systematic confirmation bias towards a

finding of high profitability, when a more balanced approach shows that this is not the case. Most importantly, the effect of adjusting even just the most obvious errors and omissions (and even where these adjustments are carried out on a prudent basis), which are both uncontroversial and need to be made, effectively removes any justification to assert that Ramsay is somehow earning profits above the competitive norm. Furthermore, the ROCE derived represents the whole Ramsay business rather than just the private element and it is obvious to see that without the contribution made from the NHS volumes Ramsay undertakes, the ROCE would be [X].

- 7.13 Overall, Ramsay considers that the data confirms that there is no evidence to support a conclusion that it has earned excessive returns over the five-year period in question. Moreover, the data also confirms that the CC is incorrect to suggest that this analysis supports this theory of harm. On the contrary, the lack of clear evidence demonstrating that Ramsay is earning profits which are persistently and substantially in excess of their cost of capital shows that this Theory of Harm is without merit.

The ownership of a chain of hospitals does not affect Ramsay's bargaining position

- 7.14 The CC states that *"if a hospital operator has market power in its negotiations with the PMI, this is likely to derive, at least in part, from the hospital operators' market power in certain local areas and the scale of its set of hospitals".³⁰*
- 7.15 Ramsay rejects any suggestion that, in the context of national negotiations, it is able to either derive market power or enhance its hypothetical local market power from its ownership of a chain of hospitals. This is for the following reasons:
- (a) first, as mentioned above, Ramsay rejects any suggestion that any of its hospitals have local market power (either individually or collectively);
 - (b) second, Ramsay does not have the form of "network" market power discussed by the CC in its local market analysis. This is essentially as a result of Ramsay's facilities being spread over England and, therefore, there are no clusters of Ramsay hospitals which would increase any market power Ramsay might hypothetically have as a result of its individual hospitals; and
 - (c) third, none of Ramsay's hospitals are of the size and scale that they are considered to be "must have" hospitals for the PMIs. Indeed, almost all of the Ramsay hospitals that have been identified as being of "potential concern" as part of the CC's local market analysis, have been excluded from at least one network by at least one PMI.
- 7.16 Accordingly, Ramsay rejects any assertion that the ownership of the different hospitals in its estate in some way enhances its bargaining position vis-à-vis the PMIs.
- 7.17 Moreover, Ramsay notes that the CC has not set out any evidence to show that the ownership of a chain of hospitals by Ramsay leads to higher prices (and indeed, the CC's price concentration analysis, which shows the impact of "network" concentration on Ramsay's self-pay prices, shows the exact opposite effect).

Ramsay's internal documents do not show that Ramsay has market power in negotiations

- 7.18 The CC states that *"we have analysed an extensive body of internal documents provided by private hospital operators and PMIs relating to the negotiations... We have assessed*

³⁰ Paragraph 84(a), AIS.

this evidence in the round and our view is that it is consistent with some large hospital groups having market power in some negotiations".³¹

- 7.19 Ramsay has not found any documents in its records which might correspond to the negotiating conduct that the CC flags as potentially blocking the ability of the PMIs to negotiate lower prices and mitigate PMI market power. Clearly, if Ramsay was engaging in such conduct, this would be evidenced in its internal documents. The fact that it is not further confirms the absence of the theory of harm or anticipated effects in respect of Ramsay's business.
- 7.20 Moreover, the ability of the PH operators to block the PMIs from negotiating lower prices is inconsistent with the PMIs [§<].

National negotiations were introduced by the PMIs

- 7.21 The CC's analysis appears to accept submissions made by Bupa that national negotiations are implemented and enforced by private hospital operators for the sole benefit of private hospitals. Ramsay's experience does not support this view.
- 7.22 First, it is Ramsay's experience that national pricing contracts are not forced onto PMIs against their wishes, [§<].
- 7.23 In this regard, AXA PPP has explicitly acknowledged that it implemented national tendering structure PH services (see section 8 of AXA PPP's Response to the Issues Statement). [§<].
- 7.24 Second, as discussed at Ramsay's Oral Hearing on 13 March 2013, national negotiations operate for the benefit of both PMIs and private hospital operators. In this regard, both PMIs and private hospital operators benefit from the resulting lower transaction and negotiating costs. In addition PMIs benefit from consistent pricing and invoicing as it means that Ramsay is better able to "get it right first time" as regards pricing and invoicing (i.e. less margin for error compared to the situation where each hospital would invoice separately for a wide range of treatments).
- 7.25 Accordingly, it is simply incorrect to assert that national negotiations were introduced by, and to the benefit of, the PH operators. On the contrary, national negotiations enable PMIs to exert lower prices on the PH operators, irrespective of any local market power.

³¹ Paragraph 90, AIS.

8. THEORY OF HARM 4: BUYER POWER OF INSURERS IN RESPECT OF CONSULTANTS

8.1 Theory of Harm 4 hypothesises that insurers may possess buyer power in relation to consultants. Specifically, the CC has considered:

- (a) whether insurers are suppressing consultant fees to a level below those which would prevail in a competitive market (in particular, in relation to Bupa's fee schedules). The CC states that it has not seen evidence of Bupa's fee schedules distorting competition long-term (for example, no evidence on lower quality of service, lower incentives to innovate, consultants being dissuaded from entering private practice etc.);
- (b) the exercise of buyer power by Bupa, or by Bupa and AXA PPP together, through the prevention of top-up fees. The CC recognises that preventing such top-up fees restricts patient choice in the market for consultants; and
- (c) a range of other complaints by consultants. The CC is of the preliminary view that these other complaints do not significantly effect competition.

8.2 Ramsay has the following limited observations in relation to Theory of Harm 4.

8.3 Ramsay refers the CC to its views on the cap on the reimbursement of fees to consultants by PMIs as set out in MQ Response Part 2, paragraph 19):

- (a) the cap provides further evidence of the significant buyer power of the PMIs (specifically, PMIs are able to dictate the key pricing terms);
- (b) to the extent that the cap has the effect of reducing the number of consultants providing private services (or the amount of private patients they treat), Ramsay's access to consultants will be negatively affected, which in turn detrimentally affects its ability to provide PH services; and
- (c) the cap may mean that clinical judgment is interfered with and patients will not necessarily be seen by the most appropriate consultant. This detrimentally affects the quality and attractiveness of PH and PMI.

8.4 Ramsay's observations as regards fee caps also apply equally to the practice of PMIs preventing top-up fees. Accordingly, for the same reasons as set out in paragraph 8.3 above, Ramsay has concerns about PMIs preventing top-up fees.

8.5 Finally, although the CC has considered separately the specific complaints raised by consultants, Ramsay considers that it is incumbent on CC to consider the cumulative effect of the behaviour of PMIs in their relationships with consultants. It strikes Ramsay that the cumulative effect of all of the PMI behaviours raised by consultants is indicative and supportive of Ramsay's view that PMIs are able to exercise market power in the PH sector. The fact that consultant fees have not, as Ramsay understands, increased over time (and indeed, in many cases they have actually decreased) is indicative of the balance of market power more likely resting with PMIs rather than consultants (and, indeed, reflects PMIs' market power in PH more generally).

9. THEORY OF HARM 5: BARRIERS TO ENTRY

- 9.1 This theory of harm hypothesises that there are barriers to entry which reduce competition, either directly or by providing the necessary conditions for the other theories of harm to have effect.³²
- 9.2 The section sets out Ramsay's view on each of the four broad types of barriers to entry on which the CC has focussed:
- (a) barriers to entry into privately-funded healthcare resulting from bargaining between insurers and hospital chains;
 - (b) barriers to entry into privately-funded healthcare services resulting from the relationships between hospital operators, consultants or GPs;
 - (c) other barriers to entry into the provision of privately-funded healthcare services; and
 - (d) barriers to entry into the provision of consultant services in private practice.³³
- 9.3 However, before discussing these potential barriers to entry, Ramsay observes that the CC's analysis does not adequately take account of the extent to which private hospital operators (in particular) are constrained by the threat of rivals expanding, i.e. whether there are barriers to expansion.
- 9.4 In Ramsay's experience, barriers to expansion for private hospital operators are low and, therefore, the threat of rivals expanding facilities and treatments provided is a real constraint on private hospital operators. The fact that Ramsay has invested significantly in expanding its hospitals and expanding the range of specialities and treatments provided illustrates that barriers to expansion are low.
- 9.5 For further detail on Ramsay's expansion into new treatments and specialities, Ramsay refers to Annex 5 to this submission which sets out detail on Ramsay's recent investments in cardiology, spinal, paediatric, bariatric and hip arthroscopies. In addition, Ramsay refers to MQ Response paragraphs 7.1 to 7.5 on capacity changes, which includes numerous examples of Ramsay expanding via adding capacity to existing facilities.
- 9.6 The CC must, accordingly, update its assessment of barriers to entry into privately-funded healthcare to reflect the fact that barriers to expansion are demonstrably low.

Barriers to entry into privately-funded healthcare resulting from bargaining between insurers and hospital chains

- 9.7 The CC is concerned that bargaining between insurers and hospital chains may result in contractual terms that disincentivise PMIs from recognising new entrants and may lead to a hospital operator placing pressure on PMIs to continue to recognise all the hospital operator's hospitals and not to recognise the hospitals of new entrants.
- 9.8 In this regard, Ramsay agrees with the CC in that it has "seen no evidence that hospital groups have the ability to deter entry by forcing a PMI to deny recognition to an entrant even if they have an incentive to do so."³⁴ [3<]

³² AIS, paragraphs 117 to 140 and Appendix E.

³³ The CC has undertaken a review of three case studies which it uses to underpin its assessment of each of these categories of barriers to entry.

³⁴ AIS, Appendix E, paragraph 47.

Barriers to entry into privately-funded healthcare services resulting from the relationships between hospital operators, consultants or GPs

- 9.9 The CC states that barriers to entry may also arise as a result of incentive schemes³⁵ between hospital operators and consultants, and/or incentive schemes provided by hospital operators or consultants to GPs. The CC is of the view that *"to the extent that incentive schemes and similar aspects of relationships between private hospital operators and consultants either preclude or deter clinicians from working for a rival, we think they may point to a barrier to entry/expansion."*
- 9.10 Ramsay confirms that it does not have any such incentive schemes with either consultants or GPs.³⁶
- 9.11 Ramsay considers that the issue of incentive schemes goes beyond barriers to entry and that such schemes raise serious ethical issues. It is Ramsay's view that consultants and GPs must be free to provide patients with the most appropriate treatment and that clinical judgment should be inviolable. Financial incentives to refer patients to certain hospitals potentially interfere with that clinical judgment and therefore are unethical. Other jurisdictions have recognised that such incentive schemes raise ethical issues and accordingly they are not permitted (see, for example, the USA and Australia).

Other barriers to entry into privately-funded healthcare services

- 9.12 The CC notes that its *"case studies do not suggest that either capital requirements or planning issues constitute a significant barrier."*³⁷ Ramsay agrees that planning permission and access to capital/financing are not barriers to entry.
- 9.13 To the extent that the CC may consider that the significant cost associated with entry may deter "hit-and-run" competition,³⁸ Ramsay observes that, notwithstanding these costs, Circle has built new hospitals in Reading and Bath and therefore the costs associated with greenfield entry are clearly not insurmountable. Further, there has been an explosion in the number of daycase facilities.

Barriers to entry into the provision of consultant services in private practice

- 9.14 The CC states that there may be barriers to entry in the provision of consultant services in private hospitals that may prevent new consultants entering in response to high prices. This is connected to Theory of Harm 2 (i.e. the market power of consultants as a result of limited availability and the use of consultant groups).³⁹ The CC notes that it has seen little evidence that this is a significant problem.⁴⁰ Ramsay has previously observed that one disadvantage of consultant groups is that they may raise difficulties for new consultants to establish their own practices.⁴¹ Ramsay has no further submissions on this issue at this point in time.

³⁵ Incentive schemes could oblige and incentivise consultants to work predominantly or exclusively for one private hospital operators and/or oblige or incentivise consultants or GPs to refer or admit patients to certain facilities.

³⁶ See MQ Response Part 2, paragraph 7.1. See also Draft Oral Transcript, pages 98 to 104.

³⁷ AIS, paragraph 134.

³⁸ The CC refers to, in particular, economies of scale and limited market size, observing that these factors may be more relevant in sparsely populated areas. AIS, Appendix E, paragraph 18.

³⁹ See section 6 above.

⁴⁰ AIS, paragraphs 135 to 136.

⁴¹ Response to MQ Part 2, section 22.

10. THEORY OF HARM 6: INFORMATION AVAILABILITY

- 10.1 This theory of harm postulates that information asymmetries and the limited information available to patients (as well as GPs and possibly PMIs) may distort competition on the basis that they limit a patient's ability to make an informed choice about the most appropriate hospital/consultant for their condition.
- 10.2 According to the CC, the majority of submissions made in the course of the investigation suggest the existence of information asymmetries, the absence of information on the quality and performance of clinicians and facilities in private medicine, and the absence of easily comparable information on both consultant and private hospital charges, particularly for self-pay patients.⁴²
- 10.3 The CC's current view is that limited information availability is likely to distort competition as the patient's ability to make an informed decision is restricted,⁴³ and is investigating further whether the type of information currently collected and the format it is recorded in contributes to the problem.⁴⁴
- 10.4 Ramsay deals with the following points below: (i) information asymmetries are not as extreme as depicted by the CC; (ii) current initiatives which are increasing the comparability of information and will solve this issue; (iii) PH Operators should not be made responsible for collecting information over which they have no control; and (iv) the CC should not take any action which might impose an undue and superfluous burden on PH Operators (in light of their participation in the PHIN initiative).

(i) Information asymmetries - scale of the issue and comments on surveys

Survey results

The results of the CC Surveys and the OFT Surveys indicate that patients and GPs are not as concerned by a lack of availability of information in a comparable format as the CC suggests in the AIS.

CC Surveys

- 10.5 The CC refers to the CC Patient Survey's finding that "*14 per cent of self-pay patients would have liked to have had some further information*", acknowledging that no specific information gaps were identified by the respondents.⁴⁵ Additional survey results suggest that private hospital patients do not necessarily wish to have access to more comparable information on consultants and/or hospital facilities. By way of example:
- (a) only 4 per cent of private hospital patients (i.e. PMI and self-pay patients combined) would have liked to have received comparative information such as track records, ratings, statistics and rankings of hospitals or private consultants;⁴⁶
 - (b) only 2 per cent of private hospital patients would have liked to have received more cost/value information about private consultants or hospitals.⁴⁷

⁴² AIS, paragraphs 141-142.

⁴³ AIS, paragraph 151.

⁴⁴ AIS, paragraph 152.

⁴⁵ AIS, paragraph 150.

⁴⁶ CC Patient Survey, page 64.

⁴⁷ CC Patient Survey, page 64.

OFT Surveys

- 10.6 The OFT's GP and Consultant Survey highlights that the majority of GPs (67 per cent) are of the view that information available on private hospitals is either of the same quality as or better quality than information relating to NHS facilities.⁴⁸
- 10.7 The Opinion Leader research carried out on the Patient Journey on behalf of the OFT in August 2011 (the "**OFT Patient Survey**") indicates more generally that private patients would not welcome the provision of more detailed information such as the number of procedures carried out or mortality rates for these providers: "*most [patients] did not feel equipped to assess such information and did not think it was necessary for the GP to provide this level of detail*".⁴⁹

"Inherent incentive" to over-treat

- 10.8 With reference to paragraph 144 of the AIS, there is no evidence suggesting that Ramsay incentivises consultants to refer patients for unnecessary or more elaborate diagnostic tests or forms of treatment that are not in the patient's best interest ("over-treatment"). For completeness, Ramsay confirms that it does not undertake any such practices.

(ii) Current initiatives to increase the comparability of information***Information collected by PHIN***

- 10.9 The CC notes at paragraph 153 of the AIS that it has seen no evidence that the information available to private patients should not be at least as extensive as that available to patients treated on the NHS. In Ramsay's view, the market-led PHIN initiative (formerly known as the Hellenic Project) will fulfil this aim in the very near future.
- 10.10 PHIN has been established by the main PH Operators to collate data and publish meaningful information and comparative indicators to assist patients in making informed choices in private and independent hospital care. The aim is for this information to also maximise comparability with NHS providers and NHS sources of information, whilst recognising the differences between the NHS and providers of private and independent healthcare.
- 10.11 Ramsay has been submitting information to Dr Foster in relation to all admitted private patients both surgical and medical and day cases and inpatients. The full list of information provided by Ramsay to Dr Foster is set out in the data standards document provided at Annex 27.1 of MQ Response Part 1.
- 10.12 Through its website, PHIN will replicate some of the fields available on the NHS Choices website, with the aim of presenting those fields in a comparable way. The PHIN website is due to be launched by the end of April 2013. A limited range of information and indicators will be available from this date, with more comparable information to be gradually added over time, as data quality issues are resolved.
- 10.13 Ramsay is aware that the CC has been briefed in detail on PHIN as part of the Investigation and would refer the CC to this information.

Comparability of treatment costs at PH facilities for self-pay patients

- 10.14 In parallel to the PHIN initiative, the PH Operators involved in PHIN have also engaged in a process by which each PH Operator will publish for patients indicative tariffs in relation

⁴⁸ OFT's GP and Consultant Survey, page 31.

⁴⁹ OFT Patient Survey, page 27.

to a set of self-pay procedures in a format that is consistent and comparable by the end of April 2013. The following information will be published on an individual basis:

- (a) each hospital group will define its top 50 self-pay procedures by volume, stating what percentage of activity (by volume) the top 25 and top 50 self-pay procedures represent of total self-pay, and indicating if each procedure is an inpatient or day case activity;
- (b) the indicative tariffs will be based on the following agreed key steps in the procedure "care pathway": (i) first consultant appointment; (ii) diagnostics and preparatory investigations and treatment; (iii) index event (main treatment); and (iv) follow up treatment and review;
- (c) pricing elements will be split between total hospital costs and total medical costs (e.g. consultant fees), with tax shown as a separate item.

10.15 This will ensure that self-pay patients are able to "shop around" easily. Moreover, there is nothing preventing a third party from collating the data published on each PH Operator's website and developing a price comparison website should they identify a consumer demand for this service.

(iii) PH Operators should not be made responsible for collecting information over which they have no control

10.16 As previously submitted, Ramsay considers that a clear distinction should be made 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).

10.17 Whilst Ramsay is in a position to collect and provide information on PH facilities, and supportive of this, clinical outcomes information is the responsibility of the medical practitioner concerned in conjunction with, and as regulated by, the appropriate clinical authorities. In particular, Ramsay has no visibility over a consultant's whole practice (the majority of which will often be undertaken in an NHS facility and spread across several PH Operators). Analytical information on clinical outcomes by an individual consultant is a specialist field better addressed by Royal Colleges and Specialist Associations than at PH Operator level and is more likely to emerge through processes such as annual appraisal and five-year review cycle leading to General Medical Council Revalidation.

10.18 Therefore Ramsay wishes to reiterate that the CC should ensure, in devising any remedies relating to information asymmetries, that these are imposed on the appropriate group of stakeholders.

(iv) The CC should not take any action which might impose an undue and superfluous burden on PH Operators

10.19 As the CC is aware, Ramsay and the other main PH Operators have already made a significant commitment of time and resources to improving the extent and quality of comparable information regarding the quality of care offered by different PH facilities, by participating in PHIN (formerly known as the Hellenic Project).

10.20 The CC should therefore be mindful of imposing any requirements on PH Operators which might duplicate or otherwise render superfluous the work that has already been carried out by this initiative. This would place PH operators under an undue burden, both in terms of costs and logistics associated with having to comply and an additional set of data production requirements.

11. **THEORY OF HARM 7: VERTICAL EFFECTS**

11.1 Theory of Harm 7 concerns a number of vertical linkages and the extent to which they raise competition concerns. The CC's analysis has focussed on the following vertical linkages:

- (a) BUPA and its ownership of the Cromwell Hospital in London. The CC considers that this vertical linkage is unlikely to give rise to competitive concerns;
- (b) BUPA and possibly some other PMIs and their ownership of some primary care facilities. The CC has not yet formed a view as to whether such vertical linkages are likely to give rise to competitive concerns; and
- (c) private hospitals groups owner primary care and outpatient diagnostic centres. The CC has not yet formed a view as to whether such vertical linkages are likely to give rise to competitive concerns.

11.2 As discussed at the Oral Hearing, Ramsay does not own primary care or outpatient diagnostic centres given that its business strategy in the UK has been to focus on its core business, the provision of high-acuity PH services. As such, Ramsay is not directly affected by these vertical linkages.

RESPONSE TO ANNOTATED ISSUES STATEMENT

ANNEXES

- Annex 1** Product Market Definition
- Annex 2** Comments on the Profitability Analysis Working Paper
- Annex 3** Local Area Analysis
- Annex 4** Local fascia count for [X] Ramsay hospitals of potential concern – 45 minute drive time
- Annex 5** Bargaining Power
- Annex 6** Patient Choice Dynamics in a Mixed Economy
- Annex 7** World Health Organisation Policy Brief - Day Surgery: Making it Happen