

## ANNEX 1

## PRODUCT MARKET DEFINITION

## 1. INTRODUCTION

- 1.1 In this section Ramsay sets out its views on the CC's approach to defining the product dimension of the relevant market,<sup>1</sup> focussing on the CC's analysis in relation to the provision of hospital services.<sup>2</sup>
- 1.2 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. 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. The CC has only included NHS PPU services in the relevant market (and excluded other NHS provided private services and publicly funded NHS services).
- 1.3 Ramsay has real concerns about the CC's approach. This section explains why:
- (a) the CC's consideration of the type of care does not take sufficient account of the blurring of the boundaries between inpatient, outpatient and day-patient care; and
  - (b) it is appropriate to broaden the product dimension beyond the 16 specialities as identified by the CC.
- 1.4 This section discusses each of these points in turn below. Ramsay also has concerns about the CC's consideration of the NHS as set out in paragraphs 3.3 to 3.11 of the main submission.

## 2. TYPE OF CARE

- 2.1 The CC has concluded that, given the asymmetric constraints among different competitors, inpatient, outpatient and day-patient care appear to be distinct product markets. The CC then essentially limits its analysis on inpatient care on the basis that inpatient care is the most concentrated and most significant in financial terms.
- 2.2 Ramsay has reviewed the CC's analysis on the constraints between inpatient, day-patient and outpatient care and is struck by the lack of detail set out in the AIS (including Appendix 1 and the Annex to that appendix). The CC has not set out in any detail the evidence it relies upon to reach its view that these types of care should be considered to compete in separate markets and therefore it is very difficult to comment on the CC's approach to market definition.
- 2.3 Nonetheless, Ramsay considers that the CC's focus on inpatient care, to a large extent ignoring outpatient and day-patient care, is clearly erroneous. It is Ramsay's view that, based on its experience as a provider of PH services, inpatient, outpatient and day-patient care constrain each other directly and that, with medical advances, the extent to which these types of services constrain each other continues to increase.

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<sup>1</sup> Ramsay's views on the geographic dimension on the relevant market are set out in section 5 on Theory of Harm 1: Local Market Power and Annex 3 to this submission.

<sup>2</sup> Ramsay does not make observations on the relevant product dimension in relation to the provision of consultant services, except to observe that, as implicitly recognised in the CC's analysis as per the AIS, the product dimension as regards consultant services is not determinative of the extent of the product dimension as regards hospital services.

- 2.4 In essence, the CC's analysis has failed to take adequate account of the fact that there has been, and continues to be, a considerable blurring between outpatient, inpatient and day-patient care in the UK to the extent the same treatments provided in the outpatient/day-patient setting materially constrain and otherwise compete with the same treatments delivered through an inpatient stay.
- 2.5 First, the 16 specialities on which the CC has focussed may all involve in whole or part day-patient, outpatient and inpatient treatments. In particular, specific treatments within each speciality are routinely provided on a different number of bases. In other words, the same inpatient treatment may also be provided on an outpatient or day-patient basis. Accordingly, patients requiring treatment as regards a particular speciality, and even as regards a specific treatment, could be treated in facilities offering outpatient, inpatient and/or day-patient care.
- 2.6 The second column in the table in the Appendix 1 to this Annex lists by specialities examples of treatments that are provided on both inpatient and either outpatient and/or day-patient bases. By way of example, knee arthroscopies and ACL reconstructions are undertaken on both inpatient and day-patient bases. The examples in Appendix 1 to this Annex, which focus on surgical procedures, clearly demonstrate the range of treatments that can be provided on a number of different bases. Indeed, World Health Organisation research prepared on behalf of the European Observatory on Health Systems and Policies, observed in a paper that day surgery "*is fast becoming the norm for nearly all elective surgery; in countries such as the United States and Canada, it accounts for nearly 90 per cent of all surgery performed*".<sup>3</sup>
- 2.7 Second, for each speciality, treatments are increasingly being provided on an outpatient or day-patient basis. This is evident from:
- (a) the growth of Ramsay's inpatient, [redacted];<sup>4</sup>
  - (b) the growth of the number of outpatient and day-patient episodes treated by Ramsay [redacted];
  - (c) the growth of daycase surgical facilities in the UK. Appendix 2 to this Annex illustrates that in 2011 daycase surgeries accounted for 59 per cent of private hospital facilities, up from 17 per cent in 2004 (i.e. only 41 per cent of private hospitals have overnight beds, down from 83 per cent in 2004). This has been as a result of the number of daycase surgeries increasing from 43 to 304, whereas the number of private hospital facilities with overnight beds has remained relatively static;<sup>5</sup> and
  - (d) a review of how treatments are provided over time. The third column in the table in the Appendix 1 to this Annex lists by specialities examples of treatments that are increasingly provided on outpatient and/or day-patient basis, rather than on an inpatient basis. By way of example, general surgical procedures such as laparoscopic cholecystectomy and repair of inguinal hernias are traditional common inpatient procedures which are increasingly delivered in the day-care setting. Knee arthroscopy and ACL reconstructions are both increasingly undertaken on day-patient and outpatient bases.
- 2.8 Third, Ramsay is convinced that this blurring is certain to continue, as it has done in other jurisdictions with more and more complex treatments being made available on day-

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<sup>3</sup> See *Policy Brief – Day Surgery: Making it Happen* 2007 attached as Annex 7 to this submission, page 1.

<sup>4</sup> See Ramsay Health Care UK table of revenue over time as handed up to the CC during Ramsay's oral hearing on 13 March 2013.

<sup>5</sup> Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, table 2.8.

patient and/or outpatient bases (as is the case in Australia and the US). Ramsay fully expects that the UK market will follow these developments.

- 2.9 Fourth, in its day-to-day business, Ramsay comes across numerous examples of outpatient and day-patient facilities providing treatments competing directly with treatments provided in Ramsay private hospitals. By way of example, [X] is a daycase surgical facility close to Ramsay's [X] facility owned by a group of consultants. It offers a range of daycase surgeries (including cataracts, endoscopies and general surgery) in competition with [X]. It also has a fixed static MRI. The [X] is a daycase surgical hospital competing with Ramsay's [X] hospital. It offers a range of ophthalmology, cosmetic, gastro and general surgical treatments. For a full list of daycase facilities that Ramsay considers compete with its hospitals, see Annex 4 to this submission.
- 2.10 Although the CC recognises in general terms a move away from inpatient care to day-patient and outpatient care,<sup>6</sup> the CC's product market definition fails to take account of how the current level of substitution and the growing trend confirm that day-patient and inpatient care constrain inpatient care. As the evidence referred to above indicates, day-patient and outpatient care compete directly in relation to the provision of a range of treatments across the various specialities on which the CC has focussed. Further, day-patient and outpatient facilities are incentivised by PMI, the NHS and internal operating efficiencies to undertake as many treatments provided by other PH operators on an inpatient basis as possible. This increases the incentive to innovate to offer treatments on either day-patient and outpatient bases that were previously provided on an inpatient basis. This puts competitive pressure on inpatient providers as they are aware that if they fail to provide good value care in either an inpatient or outpatient setting, day-patient and outpatient facilities will compete successfully for their business across an increasing range of surgical and non-surgical treatments.
- 2.11 Against this background, Ramsay considers that the CC's "bright line" and static approach to defining the boundary between inpatient, outpatient and day-patient care does not even begin to reflect the dynamic nature of competition between inpatient, outpatient and day-patient facilities. Therefore, the CC must broaden the relevant product dimension of the market to incorporate both outpatient and day-patient care across the balance of the range of treatments it is considering or an obvious error of assessment will take place.
- 2.12 The fact that inpatient care is now not the most significant type of care from a financial perspective, contrary to the CC's view, also supports the view that inpatient care is materially constrained and should not be considered separately. In this regard, [X].<sup>7</sup>

### 3. SPECIALITIES<sup>8</sup>

- 3.1 In relation to medical speciality, the CC identified:
- (a) 16 specialities<sup>9</sup> that are offered by at least 80 per cent of private hospitals and PPU's offering inpatient care. The CC is considering this cluster of specialisms together as a single market; and
  - (b) oncology as a separate specialism given that it represents a significant share of patient admissions and revenue.<sup>10</sup>

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<sup>6</sup> AIS, Appendix A, Annex, slide 17.

<sup>7</sup> See Ramsay Health Care UK table of revenue over time as handed up to the CC during Ramsay's oral hearing on 13 March 2013.

<sup>8</sup> For completeness, Ramsay confirms that it does not have further observations as regards demand-side substitutability (from the patient's perspective) of the different specialities.

<sup>9</sup> Obstetrics and gynaecology, general surgery, trauma and orthopaedics, anaesthetists, urology, gastroenterology, ophthalmology, otolaryngology, dermatology, plastic surgery, cardiology, general medicine, neurology, oral and maxillofacial surgery, rheumatology and clinical radiology.

- 3.2 Ramsay considers that the CC's approach to defining the cluster of 16 specialities, and considering oncology separately, is not robust. First the approach is largely arbitrary and secondly the approach fails to take account of strong supply-side substitutability in the market.

***CC's approach is arbitrary***

- 3.3 The CC has not provided adequate justification for only including specialities in the relevant cluster where those specialities are provided by at least 80 per cent of the relevant inpatient facilities.
- 3.4 Further, by only including in the relevant cluster specialities that are offered by at least 80 per cent of the relevant inpatient hospitals, specialities which are offered by a large proportion of the relevant pool of hospitals are unjustifiably excluded. The following specialities have been excluded despite the fact that they are offered by the majority of relevant inpatient facilities:<sup>11</sup>
- (a) 72 per cent of the relevant hospitals provide paediatric services;
  - (b) 72 per cent of the relevant hospitals provide haematology services;
  - (c) 68 per cent of the relevant hospitals provide oncology services;
  - (d) 60 per cent of the relevant hospitals provide neurosurgery services; and
  - (e) 58 per cent of the relevant hospitals provide vascular surgery services.
- 3.5 This should indicate clearly to the CC that these treatments either currently form part of the portfolio of treatments for the vast majority of general private hospital facilities and thus are treatments which by their nature either currently are or, within a reasonable timeframe, could be delivered within any general private hospital facility setting (i.e. because the majority of other general acute hospitals provide them). Put another way, the CC provides no evidential basis for excluding a treatment which is provided in 72 per cent of such facilities but, on the other hand, including another (non-specialist) treatment provided in 82 per cent of such general facilities. Indeed, it is absurd to seek to draw a fundamental distinction regarding market definition on the basis of statistical frequencies which are so similar in relative terms. This would be a clear example of a binary fallacy employed and distorting the results produced.
- 3.6 Further, it is a material omission for the CC's analysis to focus on only this cluster of 16 specialities. Specialities which together account for 25 per cent of the revenue of the relevant hospitals have been excluded from the focus of the CC's analysis.<sup>12</sup> These specialities account for a significant proportion of the business of these hospitals and should be aggregated within the cluster of 16 specialities as part of the CC's analysis.
- 3.7 Against this background, Ramsay considers that the CC's "bright line" cut-off at 80 per cent is largely arbitrary and that the CC's analysis would be more robust if it included, at the least, the additional specialities that it has recognised as being "*non-negligible in terms of admissions and revenue*" (i.e. paediatric, haematology, oncology, neurosurgery and vascular surgery).<sup>13</sup>

***Strong supply-side substitutability***

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<sup>10</sup> The CC has indicated that it may look at other specialisms if necessary. It is considering whether the cluster of specialisms is an appropriate approach.

<sup>11</sup> AIS, Appendix A, Annex, slide 29.

<sup>12</sup> AIS, Appendix A, Annex, slide 28.

<sup>13</sup> AIS, Appendix A, Annex, slide 29.

- 3.8 In Ramsay's experience as a PH operator in the UK (and its internal experience extending back to 1964 in Australia), there is in fact strong supply-side substitutability between the various specialities. In Ramsay's experience and view, it is relatively easy for a PH facility to move into new specialisations. The extent to which a PH operator will do this will depend on:
- (a) the nature of their existing facility including the extent to which their existing facility has excess capacity and/or capacity can be added easily. This is generally not a problem. PH have excess capacity and/or expansion can be undertaken relatively easily;
  - (b) the new speciality being considered, in particular the extent to which that speciality requires specific investment in, for example, equipment and staff, and the cost of that investment;
  - (c) the availability of consultants;
  - (d) whether PMIs will recognise the new service; and
  - (e) demand for the service.
- 3.9 Given that Ramsay generally offers routine elective care across a variety of specialities,<sup>14</sup> it is well-placed to move into other specialities as demonstrated by Ramsay's investments in:
- (a) its [redacted] facility:
    - (i) in order to provide hip arthroscopies (this required [redacted]);<sup>15</sup>
    - (ii) developing further paediatrics speciality - with guidance produced for all hospitals on the regulatory requirements for treating children and the development of specific marketing materials and a Ramsay standard 'care package' including a play area, DVD player and video games etc;
    - (iii) cardiology - which resulted in the current development taking place at [redacted] Hospital and is open to opportunities to open cardiology services in other areas [redacted]. In relation to [redacted], currently cardiology at [redacted] as has been primarily a diagnostic service using a mobile cardiac catheter laboratory ("**Cath Lab**") that comes to the site once a month and carries out angiograms. Where the patient then needed surgery they had to go to another provider, often the local NHS Trust. Part of the development at [redacted] is to install a permanent Cath Lab which will enable the hospital to deliver a range of different procedures including cardio angioplasty and potentially other more complex cardiology procedures. The cardiologists already have practising privileges at [redacted] Hospital and are therefore available to provide the treatment. The only additional service that will be required is the recruitment or 'up skilling' of nursing and theatre staff in order to provide the new types of treatment;
  - (b) spinal services - [redacted] Hospital had a spinal service delivering approximately [redacted] cases per year. In 2011 the hospital was awarded an NHS contract to deliver [redacted] cases per year worth approximately [redacted] per annum. The range of procedures to be delivered under this contract was wider and more complex than [redacted] had been offering previously. The service required the purchase of an image intensifier at a

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<sup>14</sup> [redacted].

<sup>15</sup> See Ramsay responses of 24 September 2012 to the CC's Market Questionnaire (Part 1) ("**MQ Response Part 1**"), page 13 for more details.

cost of [§<] and specialist surgical trays which were purchased second-hand from an NHS Trust for [§<] already had an HDU and the additional work was undertaken by the existing ward and theatre staff. Attached as Annex 9.1 to MQ Response Part 1 is the 'implementation pack' that was issued to all hospitals in relation to developing/expanding spinal services; and

- (c) bariatric services - following the national service line development project, [§<] was established as the 'hub' for bariatric surgery in the [§<] region. In order to provide the service, it was necessary to purchase equipment to accommodate the high body mass index of these patients including a new operating table and specialist chairs and beds and to undertake some renovations to install floor mounted rather than wall mounted toilets. The approximate cost of this equipment was [§<]. A multidisciplinary team consisting of dietetics, counselling and physiotherapy was required as part of the patient pathway. Attached as Annex 9.2 to MQ Response Part 1 is the 'implementation pack' that was issued to all hospitals in relation to developing/expanding bariatric services using a 'hub and spoke' model (i.e. one hospital where the surgery is undertaken and other surrounding hospitals that do outpatient consultations and follow-ups only and feed the surgery into the hub unit).

3.10 Of importance, the investments in cardiology, spinal and bariatric services have enabled Ramsay to offer new and more complex specialities at its existing facilities.

3.11 Lastly, Ramsay observes that, due to supply-side constraints, oncology should not be separated out and treated as a separate market. The considerations a PH operator undertakes when evaluating expansion into oncology services (as set out in paragraph 3.8 above) apply equally to oncology or any other speciality. There are no special considerations that warrant oncology being treated separately. [§<].<sup>16</sup>

#### 4. CONCLUSION

4.1 On the basis of the significant supply-side constraints between specialities within the CC's cluster of 16 specialities as against the vast majority of specialities that have been excluded, it is inappropriate to arbitrarily limit the product dimension to these 16 specialities for the reasons given above. Similarly, given the clear independent evidence that outpatient and day-patient care significantly constrain inpatient care, facilities offering all three types of care should be included in the product market.

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<sup>16</sup> [§<].

**APPENDIX 1 TO ANNEX 1:  
TREATMENT TYPES BY SPECIALITY**

For each of the specialities that the CC has focussed on, the table below sets out non-comprehensive examples of:

- treatments that can, and are, provided on a number of bases (i.e. not limited to inpatient, outpatient or day-patient care); and
- treatments that are increasingly being provided on an outpatient or day-patient case basis rather than on an inpatient care basis.

Ramsay has focussed on surgical treatments as the CC's analysis in the AIS appears to suggest that access to surgical infrastructure (i.e. operating theatres etc), is one of the key reasons why there is limited competition between inpatient, outpatient and day-patient care. The table below demonstrates that this is incorrect as surgical treatments for each of the specialities identified by the CC are also provided on outpatient and day-patient bases, indicating that it is not appropriate to limit the product market to inpatient care. Plainly, the degree of substitution for non-surgical treatments is even greater in the day-patient setting.

<b>SPECIALITY</b>	<b>Treatments that are provided on a number of bases</b>	<b>Treatments that are increasingly being provided on an outpatient or day-patient basis<sup>17</sup></b>
Trauma and orthopaedics	<p>Knee arthroscopies: procedures are performed on both inpatient and day-patient bases.</p> <p>Therapeutic arthroscopy of the shoulder, bunion operations and Dupuytren's fasciectomy: treatment are provided on both inpatient and day-patient care bases.</p>	<p>Knee arthroscopies: some [X] are now performed on an inpatient basis.</p> <p>ACL Reconstruction: historically [X] of cases were treated on an inpatient basis but this [X].</p> <p>Therapeutic arthroscopy of the shoulder, bunion operations and Dupuytren's fasciectomy: the NHS has established incentive tariffs to change treatment methods from inpatient care to day-patient care.</p>
General surgery	<p>The following procedures are performed on both inpatient and day-patient bases: Laparoscopic cholecystectomy, varicose veins, laparoscopic repair of inguinal hernia.</p>	<p>Laparoscopic cholecystectomy: historically [X] of procedures were performed on a day-patient basis but this [X] in 2012.</p> <p>Varicose veins: historically [X] of procedures were performed on a day-patient basis but this [X] in 2012.</p> <p>Laparoscopic repair of inguinal hernia: historically [X] of procedures were performed on a day-patient basis but this [X].</p>

<sup>17</sup> Based on procedures performed by Ramsay hospitals. Unless specifically stated, when historic trends are discussed, they have been calculated on a 3-5 year basis.

SPECIALITY	Treatments that are provided on a number of bases	Treatments that are increasingly being provided on an outpatient or day-patient basis <sup>17</sup>
Obstetrics and gynaecology	Hysteroscopy: procedures are performed on both day-patient and outpatient bases.	Hysteroscopy: historically this was in most cases provided on a day-patient basis but new technologies are available to deliver treatment on an outpatient basis.
Cardiology	Angioplasty: procedures can be performed on both day-patient and outpatient bases.	Angioplasty: historically [30] of procedures were performed on a day-patient basis but this [30].
Urology	Cystoscopy: procedures are performed on both day-patient and outpatient bases.	Cystoscopy: historically performed on a day-patient basis but now this is moving towards delivery by outpatient treatment.
General medicine	Due to its non-surgical nature, treatment can be provided on inpatient, outpatient and day-patient bases.	Due to its non-surgical nature, treatment can be provided on inpatient, outpatient and day-patient bases.
Plastic surgery	Breast augmentations are performed on both inpatient and daycase bases.	In 2000 Ramsay [30] on a daycase basis whereas in 2012 it performed [30] of these procedures on a daycase basis.
Gastroenterology	Colonoscopy and gastroscopy: procedures are performed on both day-patient and outpatient bases.	Colonoscopy and gastroscopy: historically [30] of procedures were performed on a day-patient basis but outpatient treatment has recently commenced on a "walk in walk out" basis.
Ophthalmology	Cataracts: Procedures are performed on both inpatient and outpatient/day-patient bases.	Cataracts: historically [30] of procedures were performed on an inpatient basis but this [30] in 2012.
Otolaryngology	Septoplasty: procedures are performed on both inpatient and outpatient/day-patient bases	Septoplasty: In 2000 [30] of procedures were performed on a daycase basis, [30] in 2012.
Clinical radiology	In Ramsay's experience the vast majority of services undertaken are diagnostic services.	In Ramsay's experience the vast majority of services undertaken are diagnostic outpatient services.
Neurology	Involves a large amount of non-surgical treatment which can be provided on a range of bases.	Involves a large amount of non-surgical treatment which can be provided on a range of bases.
Anaesthetics	Joint injections for pain relief: procedures are performed on both day-patient and outpatient bases.	Joint injections for pain relief: historically performed on a day-patient basis but increasingly provided as outpatient treatment.
Oral and maxillofacial surgery	Surgical removal of teeth: procedures performed on inpatient and day-patient/outpatient bases.	Surgical removal of teeth: historically [30] of procedures were performed on an inpatient

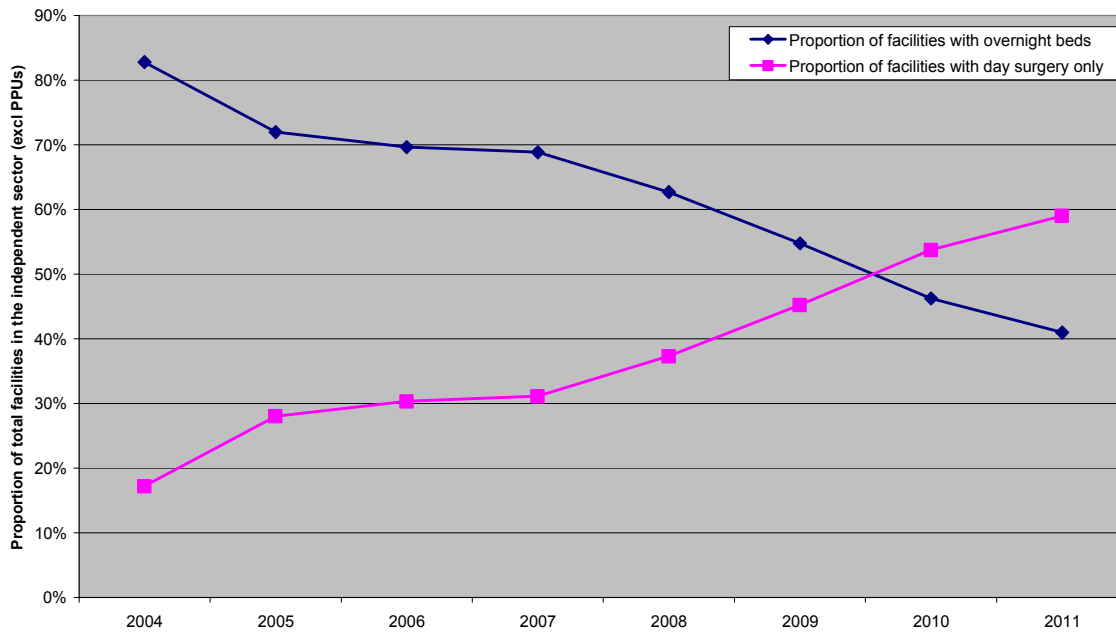


		basis but this has now [X].
Dermatology	Skin excision procedures can be performed on both outpatient and day-patient bases.	Skin excision procedures: are increasingly provided on an outpatient basis rather than an day-patient basis, not least as a result of Bupa mandating an outpatient pathway. Approximately [X] of procedures are now conducted on an outpatient basis.
Rheumatology	Non-surgical treatment and can therefore be provided on inpatient, outpatient and day-patient bases.	Non-surgical treatment and can therefore be provided on inpatient, outpatient and day-patient bases.

APPENDIX 2 TO ANNEX 1

Growth of day surgery centres in the UK

The transition of private facilities from in-patient to day surgery centres



Source: Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, table 2.8.