

**RAMSAY HEALTH CARE (UK) LIMITED**  
**COMPETITION COMMISSION'S PRIVATE HEALTHCARE MARKET INVESTIGATION**

**RESPONSE TO PROVISIONAL FINDINGS ("RESPONSE TO THE PFS")**

**1 October 2013**

## EXECUTIVE SUMMARY

### 1. INTRODUCTION

- 1.1 Whilst Ramsay has been found not to have market power on a national level its rights of defence remain engaged.
- 1.2 In particular, the CC still proposes to:
- (a) reach a finding that [X] [CONFIDENTIAL] of Ramsay's hospitals have market power at the local level (the "[X] [CONFIDENTIAL] **hospitals**"); and
  - (b) apply remedies that would affect Ramsay. In particular, Remedy 3, which would prohibit Ramsay from entering into PPU agreements in the local areas of the [X] [CONFIDENTIAL] hospitals.
- 1.3 As such, Ramsay's Response to the PFs focuses upon the errors in the identification of the [X] [CONFIDENTIAL] hospitals. Ramsay has not, obviously, addressed the issues pertaining to national market power given the clear finding in the PFs that this aspect of the investigation is no longer being pursued against Ramsay.

### 2. THE AEC NOW EXPLORED BY THE CC AGAINST RAMSAY IS CONFINED TO POTENTIAL EFFECTS UPON SELF-PAY PATIENTS

- 2.1 The relevant AEC found by the CC is described thus:

*"Together the relevant features described in paragraph 6(a) and (b) [namely barriers to entry and insufficient constraints at the local level] give rise to AEC's in the markets for hospital services that are likely to lead to higher prices for self-pay patients in certain local markets and to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and Spire) that have market power in negotiations with insurers."*<sup>1</sup> [emphasis added]

- 2.2 In this passage, which replicates the key statement of finding in the Notice of Provisional Findings<sup>2</sup>, the CC confirms that the identified AEC arising in respect of *insured* patients does not apply to Ramsay, as a function of its lack of national negotiating power.
- 2.3 Accordingly, the AEC that has been identified in respect of Ramsay is limited to alleged adverse impacts, arising from barriers to entry and local market power, in so far as they *"are likely to lead to higher prices for self-pay patients in certain local markets"*.<sup>3</sup> [emphasis added]. In so far as any adverse impacts arise from Ramsay's alleged local market power, they are confined to the self-pay segment.

### 3. THE EVIDENCE CONFIRMS THAT HOSPITALS COMPETE FOR SELF-PAY PATIENTS WITHIN A DRIVE-TIME OF AT LEAST 45 MINUTES

- 3.1 The relevant catchment for self-pay patients (i.e. the only patient category relevant to Ramsay in the context of the PFs) is, according to the CC's own analysis, on average just under a 45 minute drive-time from the hospital concerned.<sup>4</sup>

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<sup>1</sup> Remedies Notice, paragraph 7.

<sup>2</sup> PF Notice at paragraph 3.

<sup>3</sup> Ibid at paragraph 3.

<sup>4</sup> See page 48 of the CC's Surveys of Patients – November/December 2012. The survey shows that self-pay patients travel on average for 44.3 minutes.

- 3.2 [X] [CONFIDENTIAL].
- 3.3 [X] [CONFIDENTIAL]. This evidence clearly demonstrates that the CC's local market analysis, which is based on patient locations for insured patients only, materially understates the catchment areas for self-pay patients.
- 3.4 This is highly relevant since, by failing to consider the actual dispersion of Ramsay's self-pay patients, and by largely excluding competition from rival hospitals located outside the catchment area of the Ramsay hospital, the CC has manifestly failed to consider the full range of alternatives facing Ramsay's self-pay patients.
- 3.5 This failure is fundamental when, as the CC now seeks to do, the alleged adverse impacts upon self-pay patients are considered in connection with Ramsay. In particular, the failure has the effect of (i) overstating the degree of local concentration (as a proxy for market power) for Ramsay hospitals in the self-pay segment and (ii) under-estimating (and in many cases disregarding entirely) outside options available to self-pay patients.
4. **THE EVIDENCE CLEARLY SHOWS THE [X] [CONFIDENTIAL] HOSPITALS DO NOT HAVE LOCAL MARKET POWER AS MIGHT LEAD TO AEC FOR SELF-PAY PATIENTS**
- 4.1 When the outside options available to self-pay patients are assessed with regard to the appropriate drive-time, it is clear that Ramsay hospitals do not have market power, in the context of the AEC identified by the CC in respect of Ramsay, whether for the purposes of Remedy 3 or otherwise.
- 4.2 In particular, it is clear from the Remedies Notice that Remedy 3 is directed at the AEC that is alleged to arise in respect of "single or duopoly" areas. In this regard, the concepts of single or duopoly areas have been derived from the CC's local markets analysis (LOCI or fascia count) based upon data of insured patient flows.
- 4.3 However, the CC has not carried out an analysis of whether or not Ramsay enjoys market power (either individually or as part of a duopoly) as might lead to adverse effects (and thus justify Remedy 3) in respect of self-pay patients.
- 4.4 As set out in Annex 2, the evidence confirms that Ramsay's [X] [CONFIDENTIAL] hospitals of concern do not have single or duopoly status or otherwise enjoy the ability to close off outside options for self-pay patients who seek treatment within a 45 minutes catchment area. In particular:
- (a) as set out in Ramsay's Response to Competition Commission Final Assessment of Private Hospitals dated 21 June 2013 ("**Response to Final Assessment**"), [X] [CONFIDENTIAL].<sup>5</sup>
  - (b) Ramsay does not accept the concept that a Ramsay hospital facing strong competition from a single in-patient private provider (a so called "duopoly") could lead to inadequate local market constraints or barriers to entry in respect of self-pay patients. In any event, the CC has failed to model such effects.
  - (c) However, even if the "duopoly" concern is accepted, based on a 45-minute drive-time, [X] [CONFIDENTIAL] hospitals [X] [CONFIDENTIAL] face at least 2 non-Ramsay private in-patient hospital competitors within the self-pay drive-time and thus pass the CC's own "duopoly and single" tests.<sup>6</sup> Importantly, as noted below, if PPU's and NHS hospitals that are carrying out private treatment are also taken into consideration as they should be (particularly for self-pay patients), [X] [CONFIDENTIAL] the CC's duopoly test.

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<sup>5</sup> See Annex A.

<sup>6</sup> [X] [CONFIDENTIAL].

- (d) Moreover, the notion that the CC seeks to impose a non-expansion remedy upon Ramsay to meet concerns arising in respect of self-pay patients becomes truly absurd when it is considered that, in the context of the [REDACTED] [CONFIDENTIAL] Ramsay hospitals, within a 45-minute drive-time and ignoring PPUs: [REDACTED] [CONFIDENTIAL].<sup>7</sup>
- (e) The CC's attempt to categorise [REDACTED] [CONFIDENTIAL] with local market power is plainly incorrect given that [REDACTED] [CONFIDENTIAL]:
- (i) face competition from at least [REDACTED] [CONFIDENTIAL]. In particular, the CC presents no evidence of conditions of tacit coordination as might lead to an AEC in local market conditions as against self-pay patients;
  - (ii) the CC commits a clear error of analysis in dismissing the competitive constraint of the [REDACTED] [CONFIDENTIAL] in the market in the context of self-pay patients for these [REDACTED] [CONFIDENTIAL] hospitals, namely the PPUs. For example, [REDACTED] [CONFIDENTIAL], whilst the two local NHS PPUs attracted a combined private patient revenue [REDACTED] [CONFIDENTIAL].<sup>8</sup> These figures provide clear evidence of the competitive constraint provided by PPUs on hospitals such as [REDACTED] [CONFIDENTIAL], particularly in the self-pay context.
- (f) Finally, in respect of [REDACTED] [CONFIDENTIAL], the CC has:
- (i) carried out no analysis of the strong constraints presented by the [REDACTED] [CONFIDENTIAL] to [REDACTED] [CONFIDENTIAL] in respect of *self-pay* patients;
  - (ii) Annex 1 confirms the long distances [REDACTED] [CONFIDENTIAL] self-pay patients are prepared to travel in the particular context of [REDACTED] [CONFIDENTIAL], which are well in excess of 45 minutes. The CC presents no evidence in this regard and, as such, there is no evidential basis for the CC to impose a non-expansion remedy against [REDACTED] [CONFIDENTIAL] in respect of alleged effects upon self-pay patients alone and which remains speculation at this stage.

## 5. FAILURE TO TAKE SUFFICIENT ACCOUNT OF OVERLAPPING CATCHMENTS

- 5.1 The CC's categorisation of [REDACTED] [CONFIDENTIAL] Ramsay's [REDACTED] [CONFIDENTIAL] hospitals as causing concern is subject to error even when examined on the basis of the analysis of *insured* patient flows undertaken by the CC.
- 5.2 This is because the CC's analysis of insured patient flows fails to take sufficient account of the competitive constraint exercised upon the [REDACTED] [CONFIDENTIAL] Ramsay hospitals by:
- (a) competitor hospitals situated outside of the Ramsay "Core Catchment Area"<sup>9</sup> as modelled by the CC, but whose own Core Catchment Areas overlap in part with the Ramsay hospital's catchment. These hospitals clearly provide patients, whose homes are located within these overlapping catchments, with choices of provider; and
  - (b) PPU facilities (and NHS hospitals that carry out private treatment) that the CC has wrongly disregarded as too small in relative terms, but which play a very important role in offering alternative choices for self-pay patients.

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<sup>7</sup> Response to Final Assessment, Annex A.

<sup>8</sup> The annual reports for the [REDACTED] [CONFIDENTIAL] indicate that combined they derived [REDACTED] [CONFIDENTIAL] from private treatment in 2011/12.

<sup>9</sup> The term "Core Catchment Area" refers to the narrow catchment area modelled by the CC using insured patient flows.

- 5.3 Moreover, a key factor in assessing the competitive constraints on a hospital is whether a sufficient number of patients would be lost in aggregate (including those private patients that drop out of the market altogether) in order to constrain the hospital in question. The CC has blatantly failed to consider the sum of these competitive constraints on Ramsay's [X] [CONFIDENTIAL] hospitals, which represents a major flaw in the CC's local market analysis.
- 5.4 Confidential Annex 3 models the extent to which catchment areas of competing facilities overlap with the [X] [CONFIDENTIAL] Ramsay hospitals of concern.
- 5.5 We have carried out this analysis on the basis of the Catchment Areas defined by the CC (referred throughout this Response to the PFs as the "Core Catchment Areas"). As explained in Annex 1, this understates the catchment areas around the [X] [CONFIDENTIAL] Ramsay hospitals in relation to self-pay patients, which is the relevant theory of harm being applied to Ramsay. Accordingly, the analysis set out in this Annex will actually understate the extent to which the catchment areas for Ramsay's self-pay patients overlap with those of rival hospitals, which will, therefore, understate the choices facing self-pay patients.
- 5.6 Similarly, these calculations are also likely to represent a material understatement of the overlapping catchment areas as they relate only to the information for competitor hospital catchments that has been disclosed to Ramsay's advisers. This excludes a number of facilities whose catchment area are likely to overlap with the [X] [CONFIDENTIAL] hospitals but which have not yet, as at this date, been included in the disclosure.
- 5.7 Nevertheless, this analysis is highly relevant and specific to Ramsay and, in particular, it rebuts the CC's claim that Ramsay's position in [X] [CONFIDENTIAL] local markets is such as to engender effects upon self-pay patients.
- 5.8 In particular, the analysis is relevant for the choices facing Ramsay's self-pay patients because the *infra-marginal self-pay* patients will actually have a much broader catchment area (as shown in Annex 1). As such, they are thus more likely to be located in and around the *boundaries* of the narrow Core Catchment areas constructed using insured patient data, and where those Core Catchment *boundary* areas are brought into focus by the overlaps analysis.
- 5.9 Accordingly, the table below summarises for each such facility the extent to which:
- (a) patients in the Ramsay catchment (based on the CC's overly narrow catchment area approach) have access to one or more competing providers; and
  - (b) the extent to which on a cumulative basis the LOCI catchment areas of neighbouring competing hospitals overlap with the Ramsay facility, expressed as a percentage of the Ramsay catchment area.<sup>10</sup>

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<sup>10</sup> Where the cumulative total may exceed 100 per cent to reflect the fact that in some Ramsay catchment areas patients may fall within 2, 3 or more overlapping catchments for competing facilities. For example, a Ramsay catchment area, 50 per cent of which is overlapped by three different facilities, will give rise to an aggregated figure of 150 per cent on this analysis (see column 3 of Table 1). Reference should also be had to column 2 of Table 1, which identifies the percentage of the Ramsay Core Catchment covered by the catchment of at least one competing private in-patient facility and shows that competition is not confined to just a single part of the Ramsay catchment. These figures are, as noted, a material underestimate as they: exclude competing hospitals whose data has not been provided by the CC; relevant PPUs; and are modelled on insured, rather than self-pay, patient flows.

**Table 1**

Ramsay Hospital Catchment	Core	Percentage of Ramsay Core Catchment overlapped by at least one competitor catchment	Cumulative overlaps for competitor patients expressed as a percentage of the Ramsay catchment
[X] [CONFIDENTIAL]		[X] [CONFIDENTIAL]	[X] [CONFIDENTIAL]

5.10 With regard to these results:

- (a) even on the CC's analysis, it is plainly incorrect to describe any hospital as operating as a "Single" facility when, in fact, the vast majority of its patients fall within the catchment of at least one alternative facility;
- (b) similarly, there is no theoretical or factual basis for asserting that a Ramsay facility enjoys market power as a "duopoly" in the context of a local market analysis where:
  - (i) column 3 of the Appendix Table at [Annex 2](#) shows that a material number of the patients falling within the Ramsay catchment have access to a wide range of alternative providers beyond the single competitor identified by the CC, as would destabilise any theoretical duopoly effect;
  - (ii) as noted, the CC presents no evidence to support the assertion that a "duopoly" modelled on the basis of LOCI, which employed data of insured patient flows, would be capable of giving rise to AEC upon self-pay patients, which the evidence confirms are prepared to travel further;
- (c) more generally, these results are highly conservative as the CC has failed to provide Ramsay with the data relating to significant numbers of competitor hospitals who draw patients from the same areas as the [X] [CONFIDENTIAL] Ramsay hospitals. [X] [CONFIDENTIAL].

## 6. CRITICAL LOSS ANALYSIS AND INFRA-MARGINAL PATIENTS

- 6.1 A key flaw in the CC's local market analysis is that it has failed to take account of how the financial structure of running a hospital ultimately impacts on its incentive to increase volumes, and, [X] [CONFIDENTIAL].
- 6.2 In this regard, critical loss analysis set out in [Annex 5](#) provides a framework for considering how many patients would need to be lost in order to render a price increase unprofitable (i.e. to fully constrain the hospital in question). Given the high fixed cost nature of running a hospital, Ramsay would only need to lose between [X] [CONFIDENTIAL] per cent of sales at the [X] [CONFIDENTIAL] allegedly problematic hospitals.
- 6.3 It is implausible to suggest that these critical values would not be exceeded given the extent of the overlap in catchment areas, and the fact that the CC's local market analysis has specifically failed to consider the choices facing infra-marginal patients.
- 6.4 Crucially, the CC's catchment area specifically excludes the most distant 20 per cent of patients; the loss of [X] [CONFIDENTIAL] of these would be sufficient to constrain the hospital in question. This is particularly material for Ramsay given:

- (a) the extent, as demonstrated in Confidential Annex 3, to which Ramsay's patients are located in catchment areas that overlap with those of rival hospitals and thereby those patients face a range of choices between different facilities; and
- (b) the fact the AEC alleged by the CC in respect of Ramsay focuses upon self-pay patients. The CC has clear evidence (Annex 1) as to the propensity of these patients to travel beyond the constrained Core Catchment Areas modelled by the CC in the context of LOCI.

6.5 Accordingly, critical loss analysis helps to contextualise the magnitude of the loss in patient volumes required to constrain the allegedly problematic [REDACTED] [CONFIDENTIAL] Ramsay hospitals. It further demonstrates that the CC's local market analysis has materially overstated the competition concerns that arise given that, as a result of the CC's focus on narrow catchment areas, the extent to which hospitals compete to win these infra-marginal patients has been ignored.

## 7. INCONSISTENCIES IN THE CC'S REASONING

7.1 Annex 4 sets out four key inconsistencies as they apply to Ramsay:

- (a) First, the CC finds that: *"PMIs will pay higher (lower) prices the weaker (stronger) their outside options. The relationship holds for hospital operators – they will charge higher (lower) prices the stronger (weaker) their outside options"*. However, the CC has found that in fact Ramsay's national prices are the lowest in the market, although we cannot submit by how much as the CC has refused to disclose this relevant information to Ramsay's advisers. Accordingly, Ramsay is deeply concerned that the CC's local market analysis, which claims to have identified [REDACTED] [CONFIDENTIAL] Ramsay hospitals as having local market power, is significantly overstated and entirely inconsistent with its national pricing analysis. It is simply not plausible for Ramsay to have local market power across [REDACTED] [CONFIDENTIAL] per cent of its PH estate, and yet for this not to translate into higher prices for PMI if there were any credibility in the CC's underlying theory in so far as it is directed against Ramsay.
- (b) Secondly, the price concentration analysis ("PCA") conducted by the CC and released in the working papers actually showed that a [REDACTED] [CONFIDENTIAL]. This was completely contrary to the hypothesis being tested by the CC and demonstrated that on the CC's own analysis Ramsay did not have local market power. However, in a highly inappropriate and opaque "remodelling" exercise, the CC now purports to advance a set of PCA results in respect of Ramsay that are the complete opposite of the CC's original findings.<sup>11</sup> However, the large variation in the results of the analysis, and, in particular, the reversal in the new results in respect of the relationship between concentration and prices in relation to the Ramsay hospitals raises a number of very serious issues:
  - (i) as a minimum, the results of any PCA that are this sensitive to last minute adjustments by the CC cannot be considered to be robust on any reasonable measure;
  - (ii) it is noteworthy that the "remodelled" results of the PCA for Ramsay are not statistically significant (whereas the previous calculations reported in the Annotated Issues Statement, which reported no correlation between "higher concentration" and "higher prices" for Ramsay, were statistically significant at the one per cent level).<sup>12</sup> This lack of statistical significance means that the "remodelled" results in the PFs cannot on any accepted basis be used to

<sup>11</sup> Table 13 and paragraph 95, Appendix 6.9 of the PFs.

<sup>12</sup> Table 13, Appendix 6.9 of the PFs.

infer any meaningful positive correlation between local market concentration and prices in relation to Ramsay's hospitals;

- (iii) there has been a substantial reduction in the remodelled analysis in the amount of data points used in the individual operator analysis.<sup>13</sup> By using just 806 data points, the CC has now effectively excluded over 98 per cent of the observations submitted by Ramsay. Therefore, by reducing the size of dataset further, the CC has further compromised the validity of an already questionable PCA;
- (c) Third, in its local market analysis, the CC has used two different measures of concentration, namely LOCI and fascia count, both of which are meant to provide a proxy for market power. Clearly, if the two metrics are reliable indicators of market power, then they should be highly synchronised in relation to the hospitals with market power that they identify. However, the CC's own analysis confirms that there is significant variation between the two measures in terms of the hospitals identified as being of concern, which gives rise to a very clear inconsistency in the CC's local market analysis. In fact, some [REDACTED] [CONFIDENTIAL] per cent of the hospitals of "potential concern" fail one test but pass the other. This is of *particular relevance to Ramsay* where [REDACTED] [CONFIDENTIAL] hospitals in fact pass at least one of the two initial filtering tests employed by the CC [REDACTED] [CONFIDENTIAL]. There is plainly no basis to impose remedies on such facilities where even on the CC's own tests, which are themselves manifestly oversensitive for the reasons set out in Annex 4, [REDACTED] [CONFIDENTIAL] Ramsay hospitals pass the CC's own thresholds.
- (d) Fourth, in its local market assessment, the CC has consistently overstated the relative importance of the [REDACTED] [CONFIDENTIAL] Ramsay hospitals in relation to the provision of private inpatient treatment only, which is the focus of the CC's theory of harm. In particular, the metrics used for comparing the size of different facilities include both NHS-funded (which is outside the scope of the investigation) and private treatment. As Ramsay conducts a higher proportion of NHS-funded treatment than other PH providers, this presents Ramsay as a much larger provider of private inpatient treatment than it actually is.

## 8. CONCLUSION

- 8.1 In summary, the CC has no evidential basis to assert that the Ramsay [REDACTED] [CONFIDENTIAL] hospitals enjoy market power as might give rise to an AEC in respect of self-pay patients.
- 8.2 Such a proposition rests upon the assumption that the market concentration analysis performed by the CC using the discredited LOCI tool (in reliance upon data of insured patient flows), may be used as the basis for a finding that [REDACTED] [CONFIDENTIAL] Ramsay hospitals produce an AEC in respect of likely higher prices for self-pay patients in their local markets.
- 8.3 The reliance upon such an assumption would be obviously unlawful given the clear evidence set out above and in this Response to the PFs that:
  - (a) Ramsay's self-pay patients travel at least as far as 45 minutes to reach the Ramsay facility, and sometimes further [REDACTED] [CONFIDENTIAL]. A finding that is itself corroborated by the CC's own survey data;

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<sup>13</sup> The dataset for Ramsay has been reduced from 1,349 data points to just 806 data points. There were 59,062 episodes of treatment included in the original data set provided by Ramsay (see Table A1 of Appendix 6.9).

- (b) on the basis of a 45 minute catchment area, the evidence demonstrates that depending upon the Ramsay facility concerned, it is at best implausible and, at worst, perverse, to argue that each of the [X] [CONFIDENTIAL] hospitals face so few competitive constraints that self-pay patients are denied outside options when seeking treatment;
  - (c) in any event, the CC has failed to model any such effects in the context of self-pay and is, accordingly, in no position to impose a remedy upon any of Ramsay's facilities on this basis.
- 8.4 More generally, even if the LOCI concentration analysis conducted by the CC using insured data is considered *relevant* in terms of the AEC now alleged against Ramsay, the results fail to make good the CC's arguments.
- 8.5 In particular, when due regard is had to the extent to which the overlapping catchments of competing facilities present patients within Ramsay catchments with one, two or more competing outside options, it becomes increasingly implausible to allege local market power for [X] [CONFIDENTIAL] hospitals, even on the basis of the over-sensitive LOCI modelling.
- 8.6 In particular, the failure of the CC to conduct any meaningful analysis – or at least which has been disclosed to Ramsay – of the impacts of competition from neighbouring hospitals upon infra-marginal patients in the Ramsay Core Catchments is particularly surprising given:
- (a) the critical nature of the loss of even a small number of these infra-marginal patients to [X] [CONFIDENTIAL] hospitals, a factor that the CC has failed to explore despite its obvious relevance;
  - (b) the increased importance of infra-marginal patients in the context of the observed distances self-pay patients will drive for treatment and the relevance, in turn, of this patient group in the context of the AEC alleged against Ramsay; and
  - (c) the failure on behalf of the CC to adequately consider the extent to which the catchment areas for different rival hospitals actually overlap, and thereby provide patients within these overlapping catchment areas with a range of choices.
- 8.7 With regard to the above, the CC has no evidential basis to assert that the Ramsay [X] [CONFIDENTIAL] hospitals give rise to an AEC in connection with self-pay patients alone. This is unsurprising given the focus of the CC's investigation in respect of exploring complaints brought by PMIs with respect to insured patients. It is also consistent with the fact that, when the data concerning the drive-times and choices available to (and actually used by) self-pay patients is explored, it is manifestly obvious that no Ramsay facility is in a position to exploit a lack of outside options in connection with this patient category.

**Ashurst LLP**

**1 October 2013**