NON-CONFIDENTIAL VERSION

ULSTER INDEPENDENT CLINIC

SUBMISSION TO THE COMPETITION COMMISSION IN RESPONSE TO ITS PROVISIONAL FINDINGS REPORT AND THE NOTICE OF POSSIBLE REMEDIES RELATING TO THE PRIVATE HEALTHCARE MARKET INVESTIGATION

1 OCTOBER 2013

Contents

1. EXECUTIVE SUMMARY

Provisional Findings Report

1.1 The Ulster Independent Clinic (**UIC**) believes that the CC's provisional findings in relation to Northern Ireland are flawed as they are based on incomplete and/or misleading evidence. The unique position of Northern Ireland, particularly its physical remoteness from Great Britain, the geographical and cultural links with the Republic of Ireland and the low density of population, do not appear to have been considered by the CC when defining the catchment area of private hospital operators in Northern Ireland or when assessing the AEC.

1.2 UIC believes that patients are willing to travel across Northern Ireland, and to the Republic of Ireland, to access private healthcare. This is, for example, evidenced by the successful link between the Chichester Clinic in Belfast and the St. Francis Private Hospital in Mullingar in the Republic of Ireland and the fact that Benenden Healthcare only had one approved hospital in Northern Ireland until recently.

1.3 UIC's patient data for 2011/2012 shows that, while approximately 80% of UIC's patients came from a radius of [REDACTED] miles, 95% of UIC's patients came from a [REDACTED] mile radius. UIC believes that the latter figure reflects UIC's catchment area more accurately [REDACTED].

1.4 We believe that the UIC faces significant competitive constraints from a number of private hospitals, particularly North West Independent Hospital, Kingsbridge Hospital and the Chichester Clinic/St. Francis Private Hospital.

1.5 UIC is not aware what proportion of Kingsbridge Hospital's and the Chichester Clinic/St. Francis Private Hospital's patients are NHS patients. However, as the CC has itself noted, private hospitals treating NHS patients can switch the utilisation of their capacity from NHS patients to private patients. This means that Kingsbridge Hospital and the Chichester Clinic/St. Francis Private Hospital, which are both full service private hospitals, pose greater competitive constraints than their current number of private patients may suggest. [REDACTED]

1.6 The significant competitive constraints which Kingsbridge Hospital and the Chichester Clinic/St. Francis Private Hospital exert on UIC also stem from the fact that the NHS work these hospitals undertake reduces waiting times for NHS patients, provides them with greater availability of appointment times, a similar level of service/accommodation and the ability to be treated by a consultant. The NHS work performed by these private operators is therefore likely to have a

major impact on the number of patients seeking private hospital treatment in Northern Ireland. [REDACTED].

1.7 Kingsbridge Hospital and the Chichester Clinic are two of the few examples of full service hospitals who have entered the relevant market within the UK in the last five years. This supports UIC's view that barriers to entry are not high, particularly as Kingsbridge Hospital had no difficulty in getting PMI approval and as UIC does not provide any incentives to consultants to continue practising at UIC or to move to UIC from another location.

1.8 UIC's charitable status means that it is required to act in the public benefit and that any surplus from its activities is reinvested into the services it provides to patients. The ROCE data supplied by the UIC shows that UIC has not earned excess surplus over the last five years.

1.9 [REDACTED]

1.10 Even if the CC were to conclude that UIC does not face adequate competitive constraints, there is no evidence to indicate that there has been, or is likely to be, an AEC. [REDACTED].

1.11 For the reasons set out above, UIC submits that it should not be listed as a 'hospital of concern'.

Remedies Notice

1.12 In terms of remedies, UIC does not believe that the proposed prohibition on 'hospitals of concern' to form partnerships with PPUs is an effective remedy as it can lead to serious distortions of competition. UIC believes that this remedy could lead to patient detriment as it may prevent partnerships between 'hospitals of concern' and PPUs, particularly in relation to the introduction of new technologies or expensive treatment options. This would be of particular concern where no other private operators have expressed an interest to enter into such a partnership.

1.13 UIC welcomes the CC's proposal to ban incentives to consultants provided these are prohibited across the board and in relation to all private facilities as well as PMIs.

1.14 In relation to information requirements, the UIC is concerned at the introduction of any obligation on private hospital operators to publish fee information in relation to third parties, i.e. consultants. While UIC believes that it is possible for private hospitals and consultants to publish some information in relation to fees on their website, it does not believe that the comprehensive remedy proposed

by the CC is practicable or in the interests of patients who would ultimately have to bear the cost of collecting and publishing such information.

1.15 In addition, the UIC does not believe that it is practicable for private hospitals to publish HES and PROMS data in the short to medium term in view of the considerable resources required to undertake this task. UIC is concerned that the expenses by private hospitals in the implementation of such a remedy would have to be passed on to patients in the form of higher charges.

1.16 The UIC is not aware of any monitoring body in Northern Ireland which could monitor any of the remedies proposed by the CC in Northern Ireland.

1.17 Finally, UIC agrees with the CC that it would not be appropriate to implement any price control measures on private hospital operators.

2. INTRODUCTION

2.1 The Ulster Independent Clinic (**UIC**) has reviewed the Provisional Findings Report dated 28 August 2013 (**Report**) and the Notice of Possible Remedies (**Notice**) published by the Competition Commission (**CC**) in relation to its Private Healthcare Market Investigation.

2.2 The UIC wishes to make submissions on the Report and the Notice which are set out in this document. Section 3 of this document outlines the position of the UIC in Northern Ireland. Section 4 contains submissions in relation to the CC's decision to include UIC in the list of 'hospitals of concern'. Section 5 outlines UIC's submissions in relation to some of the proposed remedies.

2.3 We have adopted the CC's abbreviations as set out in the Glossary, where appropriate.

3. BACKGROUND

3.1 The UIC opened in 1979. It is a company limited by guarantee and has charitable status. This enables the UIC to reinvest any surplus from its activities in full for the continual development of the hospital. The hospital is governed by a voluntary Board of Directors who ensure that the UIC continues to provide patient choice and a valuable service to the healthcare sector in Northern Ireland.

3.2 Section 1(1) of the Charities Act (Northern Ireland) 2008 defines a charity as "an institution which (a) is established for charitable purposes only, and (b) falls to be subject to the control of the Court in the exercise of its jurisdiction with respect to charities." Section 2 (1) states that a charitable purpose is a purpose which (a) falls within sub-section (2), and (b) is for the public benefit. Sub-section 2 includes the advancement of health or the saving of lives.

3.3 Private hospitals satisfy public benefit in the sense that, although the charging of fees restricts the numbers who can take advantage of such hospitals, the remaining number is more than negligible. In *Re Resch's Will Trusts* (1969)[1], Lord Wilberforce said that the public benefit in private hospitals is to be found in the indirect benefit that they provide in relieving the pressure on the state sector.

3.4 The UIC is registered with and inspected by the Regulation and Quality Improvement Authority (**RQIA**). RQIA was established under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and is an independent body responsible for monitoring and inspecting the quality of health in Northern Ireland.

3.5 Over 400 consultants who cover a wide range of specialties have admitting rights with approximately 180 using the UIC's out-patient consulting rooms. The UIC provides no incentives to consultants to refer work to the hospital nor does it restrict consultants in their ability to work at, or refer work to, other hospitals. For patients undergoing surgery, the UIC is equipped with 6 operating theatres, 70 private en-suite rooms and an experienced nursing team. In addition to the wide range of in-patient and out-patient services, the UIC also offers private appointments for physiotherapy and x-ray diagnostics on-site.

3.6 The UIC offers treatments covered by insurance companies and self-funded procedures including a limited number of fixed price surgery packages. UIC also provides a small amount of NHS waiting list work, [REDACTED].

[1] [1969] 1A.C.514, page 544: "The general benefit to the community of such facilities results from the relief to the beds and medical staff of the general hospital, the availability of a particular type of nursing and treatment which supplements that provided by the general hospital and the benefit to the standard of medical care in the general hospital which arises from the juxtaposition of the two institutions".

3.7 The make-up of UIC's patients is set out in Tables 1 and 2 below:

Table 1: Make-up of all of UIC's Patients

Patient Makeup % (All patients)						
	CC % figure	**2008 UIC % figure**	**2009 UIC % figure**	**2010 UIC % figure**	**2011 UIC % figure**	**2012 UIC % figure**
PMI	56.00%	[ ]	[ ]	[ ]	[ ]	[ ]
SELF	26.00%	[ ]	[ ]	[ ]	[ ]	[ ]
NHS	15.00%	[ ]	[ ]	[ ]	[ ]	[ ]
OVERSEAS	3.00%	[ ]	[ ]	[ ]	[ ]	[ ]
	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table 2: Make-up of UIC's In-patients

Patient Makeup % (In-patients)						
	CC % figure	**2008** UIC % figure	**2009** UIC % figure	**2010** UIC % figure	**2011** UIC % figure	**2012** UIC % figure
PMI	56.00%	[ ]	[ ]	[ ]	[ ]	[ ]
SELF	26.00%	[ ]	[ ]	[ ]	[ ]	[ ]
NHS	15.00%	[ ]	[ ]	[ ]	[ ]	[ ]
OVERSEAS	3.00%	[ ]	[ ]	[ ]	[ ]	[ ]
	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

3.8 [REDACTED].

3.9 [REDACTED].

3.10 Whilst not a statutory requirement, the UIC participates in and has achieved accreditation with the Caspe Heathcare Knowledge System (**CHKS**). The CHKS Programme is a quality assurance tool that sets out a framework of

standards designed to ensure the UIC is providing a high level of service to its patients in every aspect of their care. Accreditation is renewed every three years with an interim evaluation. The significant investment in this programme demonstrates the Board's determination to ensure the delivery of a quality healthcare service.

3.11 Table 3 below shows a list of private hospitals, private clinics and PPUs in Northern Ireland and the Republic of Ireland which UIC regards as its competitors.

Table 3: List of Competitors

Competitor's Name	In-patient Facilities	Day-patient Facilities	Out-patient Facilities
3fivetwo Group/Kingsbridge Private Hospital*	Yes	Yes	Yes
North West Independent Hospital*	Yes	Yes	Yes
Chichester Clinic/St. Francis Private Hospital	Yes	Yes	Yes
Blackrock Clinic* **	Yes	Yes	Yes
Hillsborough Private Clinic	No	Yes	Yes
Fitzwilliam Clinic	No	Yes	Yes
Northern MRI/Malone Private Clinic	No	No	Yes
Orthoderm	No	No	Yes
Malone Medical Chambers	No	No	Yes
Cranmore Medical	No	No	Yes
Bupa Health Screening Centre	No	No	Yes
Dundonald Consulting Rooms	No	No	Yes
Musgrave House	No	No	Yes
Newry Clinic	No	Yes	Yes
Belfast Trust Hospitals*	Yes	Yes	Yes
Southern Trust Hospitals*	Yes	Yes	Yes
South Eastern Trust Hospitals*	Yes	Yes	Yes
Western Trust Hospitals*	Yes	Yes	Yes

* These hospitals offer the following specialist services: Orthopaedics, General, Gynaecology, ENT & Allergy, Urology, Ophthalmic, GI, Thoracic, Paediatric, Plastics, Dental, Neurology, Medical, Maxillo-Facial, Pain Management and Dermatology. Blackrock Clinic and the Belfast Trust Hospitals also offer cardiac surgery.

** The Blackrock Clinic in Dublin is approved by the four biggest Irish healthcare insurance companies, which includes Aviva, as well as BUPA.

4. CATEGORISATION AS A 'HOSPITAL OF CONCERN'

Catchment Area

4.1 UIC is very concerned that it has been listed as a 'hospital of concern' by CC. This is particularly so as there appears to be little or no factual basis for this decision.

4.2 We agree with the submissions made to the Competition Commission by North West Independent Hospital [REDACTED]. However, the CC itself has not provided any evidence or data, whether patient surveys, LOCI or price concentration analysis, which applies to Northern Ireland and which supports its own analysis of competition between private hospital operators in Northern Ireland.

4.3 Paragraph 5.62 of the Report states that the geographic market definition outside London is based on catchment which in turn has been calculated by reference to the area from which 80% of patients are drawn from. We are concerned that the CC has only used 80% of a hospital's patients as a measure for calculating the catchment area. [REDACTED].

4.4 Northern Ireland is the only region for which no Healthcode dataset is available. The CC therefore based UIC's catchment area on the median GB region catchment area which is 17 miles. This is, of course, an entirely arbitrary delineation of the catchment area which does not reflect the actual area from which UIC draws its patients or the particularities of Northern Ireland as the only region which is physically separate from Great Britain. The CC itself has noted, at paragraph 5.66 of its Report that "hospitals are different and some have different size catchment areas, which in turn may depend on a number of factors such as the size of the hospital, the range of specialities/treatments provided (...) and the area where the hospital is located (...)." The lack of any Healthcode data for Northern Ireland and the significant differences between the sizes of catchment areas even within regions means that the total lack of data for Northern Ireland must materially affect the results of the CC's analysis.

4.5 Northern Ireland is the only region which is physically removed from Great Britain and the only region in which none of the hospital groups operate. We have seen no evidence which shows that the CC has considered the particularities of Northern Ireland, including the cultural and geographical links with the Republic of Ireland and the lower density of population, which leads to a need to travel for specialist treatment. The willingness of Northern Irish patients to travel longer distances is, for example, evidenced by the fact that Benenden Healthcare had one approved hospital, North West Independent Hospital, in Northern Ireland until recently. Since then, it has added Kingsbridge

Hospital as an approved hospital. Consultants at the UIC only provide out-patient consultations for Benenden members.[2]

4.6 According to its website[3], Benenden Healthcare has a membership of over 900,000 across the UK and facilitates out-patient consultants and a range of day-patient and in-patient services. While UIC has no information on the number of Benenden Healthcare's members located in Northern Ireland, Benenden Healthcare membership has until recently only been open to public sector and charity employees[4] and the proportion of civil servants and public sector employees is much higher in Northern Ireland than in Great Britain[5].

4.7 UIC has attempted to analyse where its patients are drawn from but, given the extremely short time period available, it has not been able to undertake a comprehensive analysis. Based on UIC's patient records from 2011 and 2012, only [REDACTED] of its patients are drawn from a radius of 17 miles with [REDACTED] of patients drawn from a wider radius. The following pie chart illustrates the break-up of UIC's patients:

[PIE CHART REDACTED]

4.8 According to the same records, [REDACTED]% of patients have come from a catchment area of [REDACTED] miles and [REDACTED]% of patients have come from a catchment area of [REDACTED] miles. [REDACTED]. We are not aware from which radius North West Independent Hospital draws its patients. However, it is likely that this is even larger than the UIC's catchment area as North West Independent Hospital has, until recently, been the only private hospital approved by Benenden Healthcare in Northern Ireland and as approximately two thirds of Northern Ireland's population live in a [REDACTED] radius of UIC[6]. There is therefore likely to be significant overlap between the catchment areas of UIC and North West Independent Hospital.

4.9 In your conclusion on geographic markets at paragraph 5.70(c) of the Report, you note that "[l]ocal geographic markets are defined as the areas covering sets of private hospitals and PPUs competing closely because enough patients consider them to be substitutes in terms of distance". However, we note from the Patient Survey that only one patient in Northern Ireland responded to the

[2] [REDACTED].
[3] www.benenden.co.uk.
[4] Benenden Healthcare reportedly changed its rules in 2012 to open its membership to anyone, regardless of their medical history and employment: http://www.thisismoney.co.uk/money/news/article-2170850/Friendly-society-Benenden-Healthcare-opens-membership-public-sector--hikes-cost-20.html.
[5] According to the Office for National Statistics (www.ons.gov.uk), in September 2012, around 19% of people in employment in the UK worked in the public sector. The percentage of people in employment in Northern Ireland who worked in the public sector was 27.7%.
[6] Please refer to: http://www.ninis2.nisra.gov.uk/public/Home.aspx.

CC's survey[7]. This clearly does not present a representative sample of patients in Northern Ireland and stands in stark contrast to the number of respondents in other regions. Unfortunately, we have not been able to undertake a representative patient survey in the short time available.

4.10 Paragraph 6.93 of your Report states that you have measured radius based on road distances (in miles) between patient home postcodes and hospital postcodes, despite the fact that previous decisions of the OFT and CC refer to travelling time[8]. It is unclear how road distance has been measured in relation to Northern Ireland but it appears from the table included at Appendix 6.8 of the Report that the Irish Sea between Northern Ireland and Great Britain has not been taken into consideration at all. For example, the table shows that the name of the second closest hospital to UIC is BMI in Carrick Glen which is located in Scotland. We believe that it is a gross misrepresentation to include BMI in Carrick Glen as the second closest hospital to UIC when ferry times and/or flight connections are considered. The fact that the Irish Sea lies between UIC and BMI in Carrick Glen is of paramount importance as it adds significant travel time and cost to the journey. Some procedures may even prevent patients from travelling by plane for several days after treatment. Patients may in fact find it more time and cost efficient to travel to private hospitals in the Republic of Ireland, a choice which does not appear to have been considered at all in the Report.

4.11 For these reasons, we submit that the choice of road distance, rather than travel time, to calculate the radius creates severe distortions in relation to hospitals located in Northern Ireland. The second closest hospital to UIC is in fact the Belfast City Hospital. According to our calculations, taking into consideration the hospitals included in Appendix 6.8, BMI at Carrick Glen is only the seventh closest hospital, after Kingsbridge Hospital, Belfast City Hospital, Musgrave Park Hospital, the Royal Hospitals, the Mater Hospital and the North West Independent Hospital (excluding hospitals in the Republic of Ireland, for example the St. Francis Private Hospital).

4.12 Indeed, we note a number of factual inaccuracies in relation to the table. According to our own calculations, the table should look as follows (using only the hospitals listed in Appendix 6.8):

[7] We would also like to point out a discrepancy in the Patient Survey which states that there was only one respondent from Northern Ireland but also states that there was one male and one female respondent and that the respondent was both working and not working. We further note that the patient survey has not been made available to the confidentiality ring, even on an anonymous basis, which prevents our client from analysing its results.

[8] For example Competition Commission, 2005: *Somerfield plc and Wm Morrison Supermarkets plc. A report on the acquisition by Somerfield of 115 stores from Wm Morrison Supermarkets plc.*; Office of Fair Trading, 2008: *Anticipated acquisition by Co-operative Group Limited of Somerfield Limited*; Office of Fair Trading, 2010: *Anticipated acquisition by Asda Stores Limited of Netto Foodstores Limited*; Competition Commission, 2008: *The supply of groceries in the UK market investigation*.

Table 4: Closest Hospitals

Operator Name and Address	Name and Distance* to closest hospital	Name and Distance* to second closest hospital
UIC 245 Stranmillis Road, Belfast, BT9 5JH	Kingsbridge Private Hospital 811 – 815 Lisburn Road, Belfast, BT9 7GX 1.1 miles	Belfast City Hospital 51 Lisburn Road, Belfast, BT9 7AB 1.5 miles
Kingsbridge Private Hospital	Musgrave Park Hospital Stockman's Lane, Belfast, BT9 7JB 0.5 miles	UIC 1.1 miles
Belfast City Hospital	The Royal Hospitals 274 Grosvenor Road Belfast, BT12 6BA 1.3 miles	UIC 1.4 miles
Musgrave Park Hospital	Kingsbridge Private Hospital 0.5 miles	UIC 1.7 miles
The Royal Hospitals	Belfast City Hospital 1.3 miles	Mater Hospital 45-51 Crumlin Road Belfast, BT14 6AB 1.6 miles
Mater Hospital	The Royal Hospitals 1.6 miles	Belfast City Hospital 2.1 miles
North West Independent Hospital Church Hill House Ballykelly, Co Londonderry, BT49 9HS	Mater Hospital 61.8 miles	Kingsbridge Private Hospital 63.7 miles

*Distance based on Google Maps information. Distance is defined as distance to travel by road.

4.13 In addition, the Report does not appear to consider Chichester Clinic as a competitive constraint to the UIC at all. The Chichester Clinic, which is located in Belfast City Centre, provides out-patient care and is contractually linked to St. Francis Private Hospital in the Republic of Ireland where it refers its patients for treatments. According to the website of the Chichester Clinic[9], all of the services provided by the Chichester Clinic are supported and backed up by the

[9] www.chichesterclinic.com.

large acute St. Francis Private Hospital in Ballinderry, Mullingar, County Westmeath in the Republic of Ireland. All transport is provided to the St. Francis Private Hospital from the Chichester Clinic free of charge when diagnostic tests and/or surgical procedures are required. We therefore consider that the Chichester Clinic, in combination with the St. Francis Private Hospital, exerts a strong competitive constraint on UIC.

4.14 We also note that a number of hospitals in Northern Ireland are listed as approved hospitals on the largest PMI websites (BUPA, Aviva and AXAPPP) as being locations for private treatment in Northern Ireland, but do not appear to have been considered by the CC in its analysis. Table 5 sets out a list of these hospitals with an indication of whether the hospital provides in-patient/out-patient and/or day-patient services[10].

[10] We have compiled the table with publicly available information and in response to telephone requests to the hospitals.

Table 5: PMI Approved Hospitals in NI (additional to those listed in Appendix 6.8)

Hospital	In-patient Facilities on site	Out-patient Facilities on site	Day-patient Facilities on site
BUPA			
Whiteabbey Hospital	Yes	Yes	Yes
Antrim Hospital	Yes	Yes	Yes
Mid Ulster Hospital, Magherafelt	The Mid Ulster Hospital largely does rehabilitation work now and does not take on patients for general inpatient / out-patient procedures.		
Causeway Hospital, Coleraine	Yes	Yes	Yes
AVIVA			
Craigavon Hospital	Yes	Yes	Yes
Ulster Hospital, Dundonald	Yes	Yes	Yes
Altnagelvin Area Hospital	Yes	Yes	Yes
AXAPPP			
Antrim Hospital	Yes	Yes	Yes
Ulster Hospital	Yes	Yes	Yes
Erne Hospital, Enniskillen	Yes	Yes	Yes
Mid Ulster Hospital	The Mid Ulster Hospital largely does rehabilitation work now and does not take on patients for general inpatient / out-patient procedures.		
Daisy Hill Hospital, Newry	Yes	Yes	Yes
Ards Hospital, Newtownards	Yes	Yes	Yes

Barriers to Entry and Expansion

4.15 Paragraph 6.11 of the Report notes that "[w]e have observed very few new firms entering the relevant market through the establishment of full service hospitals, the only examples in the last five years being that of Circle and the 3fivetwo Groups's Kingsbridge Hospital". While a case study has been undertaken in relation to Circle, no case study is available for Kingsbridge Hospital. This would have been particularly helpful in light of the lack of data for Northern Ireland.

4.16 We believe that the opening of Kingsbridge Hospital in Belfast is significant as it shows that there are few, if any, barriers to entry. This is further supported by the recent opening of the Chichester Clinic/St. Francis Private Hospital in Belfast which the Report does not mention (see paragraph 4.13 above).

4.17 In paragraph 6.66, the Report notes that two potential strategic restrictions on entry and expansion are (i) the failure by PMI to recognise new healthcare facilities and (ii) arrangements between private healthcare providers and consultants which may deter or prevent consultants from working with the entrant. We believe that neither of these restrictions are existent in Northern Ireland. As far as UIC is aware, Kingsbridge had no difficulty in obtaining PMI recognition for its new full service hospital[11]. In addition, UIC does not deter consultants from seeing patients at other hospitals, nor does it provide any incentives for consultants to bring patients to UIC, to continue practising at UIC or to move to UIC from another location. Equally, there is no constraint on consultants to recommend a different hospital for treatment during an out-patient consultation at the UIC.

4.18 Paragraph 6.86 of the Report states that CC's profitability analyses indicate that "BMI, HCA and Spire have, during the period under review (ie between January 2007 and June 2012) earned returns substantially and persistently in excess of the cost of capital. These firms account for more than half (53 per cent) of the private healthcare industry, indicating that the industry as a whole is likely to be making excess returns on average. ... The extent of entry at the full service hospital level (essentially Circle's two private hospitals) is less than we would expect were there not high barriers to entry...". We submit that this conclusion is not based on any evidence in relation to Northern Ireland. This is particularly so as Northern Ireland is the only region where neither BMI, HCA nor Spire have any hospitals. The excess profits of these hospital groups cannot therefore be considered to be representative of the profits earned by private hospital operators in Northern Ireland.

[11] According to its website, Kingsbridge Hospital is covered by all the main health insurance providers. See http://3fivetwo.com/kingsbridge/private-health-insurance.

4.19 The table in Appendix 3 shows the calculations on return of capital employed (ROCE) by UIC for the years 2008 – 2012. The table shows ROCE ranges from [REDACTED]% to [REDACTED]%. In particular, the figures show a significantly lower ROCE than those of the larger hospital groups set out in Table 6.9 of the Report which indicate a lack of competitive constraint. Paragraph 6.274 of the Reports states that "[w]e estimate a range for the nominal pre-tax cost of capital for a typical stand-alone UK private hospital operator of between 7.2 and 9.9 per cent, with a mid-point estimate of 8.6 per cent". [REDACTED].

4.20 UIC submits that [REDACTED] reflects its charitable status which obliges it to act within the public benefit. The UIC has no requirement for a minimum return on its investments and its only requirement is for a surplus to fund the future development of the hospital and to fulfil its business needs, e.g. pension obligations. This stands in stark contrast to the hospital groups which are responsible to their shareholders for maximising the return on their investment. The lack of excess surplus of UIC shows that effective competitive constraints are imposed on UIC by other private hospitals in Northern Ireland, including the North West Independent Hospital, Kingsbridge Hospital and the Chichester Clinic (in combination with St. Francis Private Hospital). Even if the CC were to conclude that UK does not face adequate competitive constraints, the lack of excess surplus of UIC shows that there is no AEC.

4.21 We would also point out that paragraph 6.86 of the Report neglects to mention the entry of Kingsbridge Hospital in Belfast, which, in footnote 2 on page 144 of the Report, is correctly described as a full service hospital. As noted above, the Report also fails to consider the entry of the Chichester Clinic/St Francis Private Hospital.

Local Competitive Constraints (including Concentration)

4.22 Paragraph 6.89 of the Report sets out the basis for the initial filtering. As set out in paragraph 4.4, the delineation of the catchment area in Northern Ireland is entirely arbitrary and not based on any empirical analysis. This means that both the background data for the competitive assessment of the LOCI and fascia count are entirely arbitrary (see paragraph 6.106 of the Report). We note your assurance that you have "not used any of these concentration measures in a mechanistic way to determine the outcome of our competitive assessment...". Paragraph 6.107 then goes on to list the factors you have considered for each hospital of potential concern and private hospital and PPU. This includes the location and distances between hospitals which is set out in a table in Appendix 6.8. However, as we noted at paragraph 4.11 above, there are a number of factual inaccuracies contained in Appendix 6.8 in relation to Northern Ireland which are partly due to the fact that road distance is not an adequate measurement for the catchment area in Northern Ireland. Paragraph 6.109 of

the Report indicates that road network and transport connections were taken into consideration while paragraph 6.112(b) refers to the characteristics of the local area. We have seen no evidence to suggest that this was the case in relation to Northern Ireland, and in particular between private hospital operators in Northern Ireland and Scotland.

4.23 Appendix 6.5 of the Report considers the initial filtering exercise in more detail. It notes, at paragraph 12, that fascia count includes as competitors all general private hospitals and general PPUs providing in-patient care and offering one or more of the 16 specialties. As noted at paragraph 4.14 above, the report does not list the hospitals listed in Table 5 which are PMI approved hospitals.

4.24 Paragraph 6.112(f) of the Report states that "[a] number of private hospitals utilize a substantial share of their capacity to treat NHS patients. These hospitals may be potentially stronger competitors than their current share of supply of private healthcare services suggests to the extent that they may be able to switch the utilization of their capacity from NHS patients to private patients". UIC understands that this is indeed the case for Kingsbridge Hospital in Belfast which has a large percentage of NHS patients[12]. UIC also understands this to be the case for the Chichester Clinic/St Francis Private Hospital. Moreover, UIC understands that Spire Healthcare and 3fivetwo/Kingsbridge Hospital use NHS facilities to treat NHS patients[13]. This would indicate that Kingsbridge Hospital and the Chichester Clinic/St Francis Private Hospital are in a stronger position than their current shares of supply of private healthcare services suggest and pose an effective competitive restraint on UIC. This means that the CC's assessment of the competitive environment within which the UIC operates is distorted and the competitive constraints to which the UIC are subject are downgraded.

4.25 In addition, faster treatment of NHS patients in private hospitals is likely to decrease the number of patients seeking private healthcare. The CC itself has noted, at paragraph 4.10 of the Report that "[a]ccording to our patient survey key drivers for selecting privately funded healthcare were, excluding having the PMI which was the main reason, reduced waiting times (55%) and greater availability of appointment times (55%)". In addition, paragraph 5.14 states that "[a]mong the reasons for choosing privately funded healthcare, patients have most commonly cited that they wanted to take advantage of the reduced waiting times (76 per cent of insured patients and 75 per cent of self-pay patients), the better comfort and quality of accommodation (54 per cent of insured patients

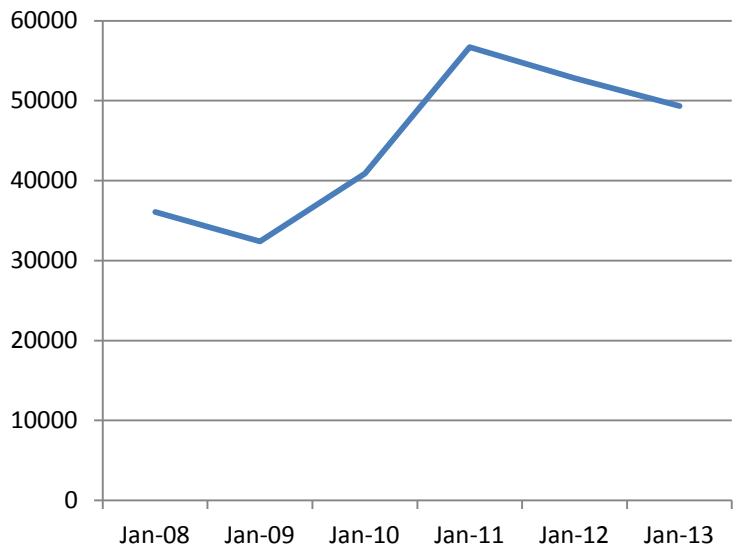
[12] Again, we note the lack of data. The local competitive assessment states, in relation to Kingsbridge Private Hospital, at footnote 2, that "[t]he 2011 data provided by Kingsbridge is from September of that year, the date when the hospital started operating. We have estimated annual data by multiplying by three the data provided by Kingsbridge". We have no way of verifying whether the figure arrived at by multiplying the 2011 data accurately represents the development of Kingsbridge Hospital and its patient base.

[13] See, for example, http://www.spirehealthcare.com/patient-information/nhs-patients/.

and 37 per cent of self-pay patients), the greater availability of appointment times (55 per cent of insured patients and 35 per cent of self-pay patients), and the ability to choose a specific private consultant (39 per cent of insured patients and 42 per cent of self-pay patients)".

4.26 It follows that, for a hospital like UIC, [REDACTED], hospitals like Kingsbridge and Chichester Clinic/St Francis Private Hospital pose a significant competitive constraint as they reduce waiting times for NHS patients, provide the same availability of appointment times, the same or similar quality of accommodation and the ability to be treated by a consultant. The fact that private hospitals in Northern Ireland are performing NHS work is therefore likely to have a major impact on the number of patients seeking private hospital treatment in Northern Ireland. This is particularly so as Northern Ireland has reportedly spent £45 million to have NHS patients treated in private clinics over a 12 month period.[14] This has resulted in significant drop in the number of people in Northern Ireland on NHS waiting lists for all in-patient services as set out in Table 6 below.[15]

Table 6: Number of People on NHS Waiting Lists in NI



4.27 The PPUs in Northern Ireland also exert a competitive constraint on UIC. In its 2012/2013 and 2011/2012 Annual Accounts, the Belfast Heath & Social Care Trust[16] shows income from "Non-HSS:-Private patients" of £3.9 million, an

[14] See http://www.belfasttelegraph.co.uk/news/health/northern-irelands-45m-bill-for-nhs-patients-to-be-treated-privately-29093910.html.

[15] See http://www.dhsspsni.gov.uk/index/stats_research/hospital-stats/waiting_times_main/stats-waiting-times.htm.

[16] http://www.belfasttrust.hscni.net/pdf/Annual_Report_2012_to_2013.pdf, page 81 and http://www.belfasttrust.hscni.net/pdf/Belfast_Health__Social_Care_Trust_Annual_Accounts_2011-12.pdf, page 38.

increase of approximately £716,000 from the previous year.[17] [REDACTED] The Report notes, at paragraph 2.29, that industry observers expect PPU revenue to grow now that the limit on the proportion of the Trusts' gross income that can be earned from private healthcare has been raised to 49%. As set out at paragraph 4.2 above, UIC understands that Spire Healthcare and 3fivetwo/Kingsbridge Hospital currently treat NHS patients in the Trust Hospitals [REDACTED].

4.28 Paragraph 6.113(b) of the Report notes that "we recognize that there may be circumstances where two similar operators may provide adequate constraints. For example, high fixed costs and spare capacity may provide an incentive to price so as to increase volume. We have taken into account the views of, and evidence provided by, the parties on this specific issue in our competitive assessments but unless we have seen evidence of competition (or potential competition), for example, hospitals having adjusted their competitive offering in response to changes made or expected by other hospitals, we do not regard two similar competitors to be sufficient". This paragraph does not take into consideration the fact that an independent private hospital, such as the UIC has little ability to negotiate with the large PMIs who effectively set the prices with very limited negotiation.

4.29 [REDACTED].

4.30 The Report goes on to note, at paragraph 6.114, that the approach in paragraph 6.113 "is supported by the evidence that links local concentration with price outcomes, including the results of our PCA...and our interpretation of what the parties told us and a review of the qualitative evidence as set out in paragraph 5 of Appendix 6.9". We note that the PCA specifically excludes Northern Ireland from its analysis (see paragraph 18 of Appendix 6.9 to the Report) and that UIC has not to date told the CC anything in relation to this issue. Paragraph 5 of Appendix 6.9 states that "hospital operators have told us that self-pay prices are set locally, at the hospital level rather than group level, and with local competitive conditions in mind". The statement shows that the analysis is very much focused on hospital groups and does not adequately reflect the situation for an independent hospital such as the UIC.

Bargaining between PMIs and Hospital Operators

4.31 Paragraph 6.146 of the Report states that "[c]ontracts between a hospital operator and a PMI are typically the product of bilateral negotiations where an agreement is reached over price and the terms on which the parties will trade

[17] See http://www.belfasttrust.hscni.net/pdf/Annual_Accounts_2010-11.pdf, page 35.

with each other". As set out in paragraphs 4.28 and 4.29 above, while this may be the case in relation to the large hospital groups, this is not the case for UIC. In UIC's experience, the large PMIs set the prices and contractual terms with very limited negotiation.

Self-pay Prices

4.32 Paragraph 6.192 of the Report notes that the PCA confirms that prices charged to self-pay patients are higher in areas where private hospitals face fewer competitive constraints. However, the PCA specifically excludes Northern Ireland from its scope and its results cannot therefore be safely transported to Northern Ireland without further evidence.

4.33 [REDACTED].

4.34 [REDACTED].

4.35 [REDACTED].

4.36 The table in Appendix 4 compares UIC's self-pay package prices with those of a number of hospitals in Scotland and England which have published their self-pay prices on their website. [REDACTED].

Insured Prices

4.37 We note the CC's conclusions set out in paragraph 6.2.47(e) regarding the position of the hospital operator in negotiation with PMIs. [REDACTED].

4.38 [REDACTED].

Conclusion

4.39 For the reasons set out above, we entirely reject the CC's provisional finding that UIC is a 'hospital of concern'. Even if the CC were to conclude that UIC does not face adequate competitive constraints, there is no evidence to indicate that there has been, or is likely to be, an AEC. [REDACTED].

5. REMEDIES

5.1 UIC has no comments in relation to Remedies 1, 2 and 5 as it is not part of a hospital group. We set out below our comments in relation to Remedies 3, 4, 6-8.

Remedy 3

5.2 We have already stated at paragraphs 4.15 – 4.21 our concerns in relation to the CC's provisional finding that barriers to entry are high in the private healthcare market in Northern Ireland. We believe that the successful entry of Kingsbridge Hospital in Belfast and the Chichester Clinic/St. Francis Private Hospital show that new entry is possible in Northern Ireland.

5.3 We do not believe that the remedy is sufficiently clearly drafted to enable hospital operators to determine which hospitals are affected by the remedy and what types of partnerships or other business agreements are covered. We understand that the CC is proposing to apply this remedy only to `hospitals of concern'. We are unclear whether the CC considers UIC to operate in a Single or Duopoly area. As set out in paragraph 4.39 above, we refute strongly the CC's provisional finding that UIC should be considered aṡ a hospital of concern' or that UIC operates in a Single or Duopoly area. However, if the CC's final report concludes that UIC is a 'hospital of concern' and that the restriction on expansion proposed in Remedy 3 will apply to it, we have the following comments in relation to Remedy 3.

(a) Would the remedy be effective? In how many and which Single or Duopoly areas is it likely that PPUs will be launched?

5.4 We do not believe that the remedy would be effective unless it is directed at all private hospital operators in a Single or Duopoly area as serious distortions of competitions could otherwise arise. For example, the remedy should also apply to a private hospitals operating in a Single or Duopoly area which treat a large number of NHS patients but which may subsequently switch to treating a majority of private patients.

5.5 UIC is unsure how effective the remedy would be or how many partnerships are likely to be launched. As set out in paragraph 4.24 above, we understand that Spire Healthcare and 3fivetwo Group/Kingsbridge Hospital are currently using NHS facilities to treat NHS patients. [REDACTED]

(b) How practicable would it be for other hospital operators to form PPU partnerships in areas where they did not already operate a hospital?

5.6 We have no comment in relation to this question.

(c) *Would the remedy give rise to unintended consequences or distortions? Would NHS Trusts suffer because they would be unable to partner with an incumbent hospital operator which could offer a financially more attractive arrangement than an entrant?*

5.7 Please refer to paragraph 5.4 above.

(d) *Would customer detriment arise if the incumbent was prevented from partnering in a PPU but no entrant appeared?*

5.8 UIC believes that customer detriment may arise in such circumstances as patients are potentially prevented from benefitting from new technologies, for example imaging technologies and ICU care, as these tend to be extremely expensive and can often only be financed by an effective partnership between hospital operators and PPUs. This is particularly so in a small economy such as Northern Ireland where patients may not be able to travel to Great Britain, either because of the cost and time involved in doing so or because their condition does not allow them to do so.

5.9 The CC should consider whether an alternative remedy may be more effective, for example, an obligation on the NHS Trust to issue a call for expressions of interest in relation to a proposed partnership or business agreement. If no new entrant responds to such a call for competition, the NHS Trust should be free to enter into negotiations with any existing private hospital operators, including 'hospitals of concern'.

(e) *What provisions would need to be made for oversight and enforcement of this remedy and which body should be responsible? Would it, for example, fall within Monitor's remit*?

5.10 Monitor has no remit in Northern Ireland.

5.11 As set out at paragraph 3.4 above, RQIA is an independent body responsible for monitoring and inspecting the quality of health and social care services in Northern Ireland, and encouraging improvements those services. Its role is to ensure that health and social care services in Northern Ireland are accessible, well managed and meet the required standards. RQIA was established under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. The Order also places a statutory duty of quality upon health and social care organisations, and requires the DHSSPS to develop standards against which the quality of services can be measured.

5.12 As RQIA is responsible for the registration and inspection of private hospital operators, a conflict of interest may be created if RQIA were to be given a

monitoring/enforcing role in relation to this remedy. If it were to take on this role, it may well require additional resources.

5.13 UIC is unaware of any regulatory body in Northern Ireland who could oversee and enforce this remedy.

Remedy 4

5.14 We understand and assume that this remedy is directed at all private hospital operators, and not simply `hospitals of concern'. If this assumption is incorrect and the remedy is only directed at `hospitals of concern', it could lead to serious distortions of competition.

(a) Is the remedy practicable? What framework of rules could be used to determine reasonably and practically whether the benefits of an incentive scheme in terms of lowering barriers to entry, outweighed the distortions created? What degree of oversight would be required to monitor compliance and who should fund it and exercise monitoring? How could the 'fair market price' test be monitored and enforced and who would be responsible for doing so?

5.15 We believe that the remedy is only practicable if it is applied across the board to all facilities, whether providing out-patient, in-patient, day-patient or imaging services, and PMIs. If the remedy is only applied to in-patient services, serious distortions of competition are likely to result as it is the out-patient consultation which, in the large majority of cases, determines where the patient goes for treatment. For example, some procedures can be performed on an in-patient or day-patient basis and the availability of incentives may influence how and where a consultant undertakes the procedure.

5.16 We have no firm views on the potential monitoring body for this remedy.

(b) Is the remedy reasonable? Should certain kinds or arrangement still be permitted and, if so, which? Should, for example, those with a value of less than a certain amount, be deemed 'de minimis'? If so, what should this figure be?

5.17 As set out above, we believe that the remedy should apply across the board to all forms of arrangements and to all private facilities and PMIs. We do not believe that it would be practicable to introduce a *de minimis* rule as it would be too difficult to monitor and enforce.

(c) Is the remedy comprehensive? Should it apply to other healthcare service providers such as laboratories or firms supplying diagnostic services such as imaging, for example? Should PMIs be permitted to operate incentive schemes which reward consultants who recommend cheaper treatments or less expensive hospitals?

5.18 We believe that this remedy should not only be directed at private hospital operators providing in-patient services but also at private clinics providing day-patient, out-patient and imaging services. This is because most private hospital operators provide all of these services and, if a private clinic providing one of these services was able to provide incentives but the private hospital operator, as a full service hospital, would not be able to provide such incentives, it could lead to serious distortions of competition.

5.19 As stated above, the remedy should apply equally to all private facilities and PMIs in order to avoid any distortions of competition and to ensure that the consultants' clinical judgement to act in the best interest of the patient is not affected by any type of incentives, regardless of who offers them.

(d) Are there regulatory regimes in other jurisdictions that the CC could learn from in the context of remedy specification and implementation? Would, for example, the Stark Law in the USA, be a useful model as regards restrictions on commercial relationships between healthcare facilities and clinicians and their introduction?

5.20 We understand that the US Stark Law prohibits a physician from making a referral to an entity with which she or her immediate family has a financial relationship if the referral is for the furnishing of designated health services, unless the financial relationship fits into an exception set forth in the statute or impending regulations. We further understand that the type of exceptions in the law include: physician services, in-office ancillary services, ownership in publicly traded securities and mutual funds, rental of office space and equipment, bona fide employment relationship, etc. UIC is not aware of the intricacies of the Stark Law but it appears to be a workable solution for the UK. However, we are unclear which body could effectively monitor the implementation of such a remedy.

(e) What would be the cost of implementing this remedy, particularly in terms of unwinding existing equity sharing arrangements? Would it be necessary or desirable to 'grandfather' existing arrangements?

5.21 We do not know what the implementing cost of this remedy would be. We do not believe that existing arrangements should be grandfathered. A level playing field should be created by applying the same rules to all private facilities and PMIs. However, a short transitional period of up to 1 year could be allowed for existing arrangements.

(f) Particularly in the context of market entry and expansion, are any relevant customer benefits likely to arise from equity participation by consultants in hospitals that would not otherwise be available?

5.22 We have no firm views in relation to this question.

Remedy 6

(a) Is the remedy practicable? Do consultants' out-patient fees vary significantly between different patients such as to render an average fee or a range of fees, unhelpful?

5.23 We do not believe that the remedy is practicable in as far as it would require private hospitals to publish consultants' fees on their websites. Consultants are self-employed and set their own fees without any input from the private hospital operator. There should be no onus on private hospital operators to collate and publish a third party's fees.

5.24 This is particularly so as consultants' fees can differ, depending on the specialty of the consultant, and also between consultants within the same specialty. In addition, consultants' fees vary between insured and self-pay patients and are different for each PMI. For a hospital like UIC, where over 400 consultants have practising privileges, it would be a prohibitive task with significant cost implications to collate the information from consultants, upload it onto the website and keep it up to date. This is particularly so as it would require UIC to employ additional resources in order to collate the information. The timescale for implementation of this remedy would be at least one year. Further, private hospital operators and consultants would need to seek a PMI's consent before publishing rates relating to insured patients.

5.25 UIC's current practice is to provide patients with a fee range for an out-patient consultation within a specialty on request or when they are booking an appointment. This information could be more easily uploaded on the hospital's website.

(b) Is it possible for consultants to estimate fees before undertaking a procedure since unforeseen complications may arise? Would there need to be a means of adjusting fees in response to complications? Are there particular medical specialties where consultants would face particular problems in providing such an estimate in advance? How else might patients be informed of the likely costs of their treatment?

5.26 We believe that, while it is possible for consultants to estimate his/her fees before a procedure, it would be impossible for such fee estimates to take account of all complications which may arise. Indeed, in our experience, consultants already provide information on the cost of a procedure to patients in advance of their treatment. However, in most cases it would not be possible to adjust the fees such are the variety of complications and emergency interventions. In those circumstances, the price tends to be of less concern to patients as it is more important to attend to the complication immediately.

5.27 It is important to note that pricing structures for private hospitals, consultants and anaesthetists are disjointed and vary between different insurance companies. It is therefore difficult, if not impossible, for either the consultants or the hospitals to provide composite fee information for a procedure. Consultants would in most cases not be aware of the hospital fees for a particular treatment or PMI provider and vice versa. The consultant would therefore only be able to give an estimate of his own fees and perhaps the anaesthetist's fees.

5.28 [REDACTED].

(c) Is it reasonable to require all consultants practising in the private sector to disclose their out-patient consultation fees? Should only those earning above a certain level do so?

5.29 UIC believes that all consultants should be subject to the same obligations in relation to information disclosure. Consultants' earnings are not publicly available and it would therefore be impossible to enforce any *de minimis* limit.

(d) How should the remedy be specified? How far in advance of treatment should a consultant be required to provide a patient with an estimate of the proposed fees for treatment? Is it practical, in all cases, to inform patients of costs in advance of treatment? Should any other information or advice be included with the estimate? For example, should the consultant notify the patient of his or her PMI fee maximum for the procedure concerned, or advise the patient to check this him or herself?

5.30 In our experience, the PMI, and not the consultant, informs the patient what their maximum cover is in relation to a consultation or procedure when the patient contacts the PMI for authorisation. Further, in our experience, consultants already provide information on their fees to patients in advance of their treatment. We see no reason or benefit in this changing. As stated above, it may be possible for the private hospital operators to publish a range of consultation fees or fixed price packages on their websites.

(e) What provision would need to be made for the oversight and enforcement of this remedy and which body(s) should be responsible?

5.31 We are not aware of any body in Northern Ireland which could take on the oversight and enforcement of this remedy.

Remedy 7

(a) Is the remedy practicable? Are all private hospitals in the UK capable of collecting the equivalent of HES data? If they are not currently capable of doing so, what would be a reasonable timescale for the implementation of this remedy?

5.32 We do not believe that this remedy is practicable at present and we are unable to estimate a timescale for the implementation of this remedy. The main difficulty with this remedy is that HES data is entirely reliant on consultant information which is not currently available to most private hospital operators.

5.33 As set out in paragraph 3.10, UIC is a member of CHKS which collates information relating to the quality of healthcare provided at UIC and is therefore an effective quality control mechanism.

5.34 Private hospital operators have some data available, e.g. infection rates, which could be published more easily.

(b) Similarly, are all private hospitals in the UK capable of collecting PROMs data for the same procedures that it is collected for NHS England? If they are not currently capable of doing so, what would be a reasonable timescale for the implementation of this remedy?

5.35 We do not believe that this remedy is practicable at present and we are unable to estimate a timescale for the implementation of this remedy. The main difficulty with this remedy is that PROMs data is reliant on consultant assessment which is not currently available to most private hospital operators.

5.36 Private hospital operators have some data available, e.g. infection rates, which could be published more easily.

(c) Besides HES and PROMs equivalent data, what other data should be collected by private hospitals and to whom should it be made available? Would it be appropriate for the CC to specify the coding, for example ICD10, to be used in data collection and classification?

5.37 UIC has recently started to provide information relating to primary joint replacements to the National Joint Registry. DHSSPS made this a requirement for all healthcare providers within Northern Ireland.

5.38 In addition, RQIA reports are publicly available which provide information on inspections of hospitals.

5.39 We do not believe that ICD10 codes should be used in the data collection and classification as there are thousands of codes making the system not user friendly. Any coding system used should be responsive, co-ordinated and standardised across the entire healthcare sector, including the NHS.

(d) What measures could or should he CC adopt in order to ensure that PHIN or its equivalent retains sufficient funding to continue its activities after the completion of the CC investigation?

5.40 We have no comment in relation to this question.

(e) What cost and other factors should the CC take into account in considering the reasonableness and proportionality of this remedy or the timing of its implementation?

5.41 We believe that the initial implementation of this remedy would require UIC to employ additional resources to collate the information. The prohibitive cost of this remedy would otherwise result in increased patient charges.

5.42 We understand that PHIN currently has an annual membership fee. This fee would undoubtedly increase if the scope of PHIN was widened which would again result in higher charges for patients.

5.43 In our opinion, the cost and timescale of implementing this remedy would be similar whether the information is published by the private hospital operators or by PHIN or a similar organisation.

Remedy 8

5.44 We do not believe that the CC should impose any price control measures on private hospital operators.

5.45 As set out at paragraph 4.32 above, the large PMIs effectively set the market prices for non-group hospitals with very limited bargaining power for private independent private hospital operators.

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APPENDIX 1

STATISTICS 2008-2013

[REDACTED]

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APPENDIX 2

TURNOVER 2008 - 2012

[REDACTED]

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APPENDIX 3

RETURN ON CAPITAL EMPLOYED CALCULATIONS

[REDACTED]

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APPENDIX 4

COMPARISON OF FIXED SURGERY PRICES 2009-2013

Procedure	Nuffield Health Glasgow	Nuffield Health Bournemouth	Trustplus	New Victoria Hospital	Spire Roding Hospital	Claremont Private Hospital	Average	UIC	Difference
	£	£	£	£	£	£	£	£	£
Tonsillectomy			1,900		2,313		2,107	[ ]	[ ]
Tonsillectomy & Adenoidectomy - Paeds				1,975			1,975	[ ]	[ ]
Hernia - Inguinal	2,395	2,405	4,000	2,050	2,011		2,572	[ ]	[ ]
Cholecystectomy - Laparoscopic / Open	5,860	4,925				4,721	5,169	[ ]	[ ]
Reversal Vasectomy	2,685	2,980		2,050	1,817	1,895	2,285	[ ]	[ ]
Varicose Veins (Unilateral)	2,635	2,750	1,450	2,300	2,047		2,236	[ ]	[ ]
Varicose Veins (Bilateral)			5,350	4,025			4,688	[ ]	[ ]
Prostatectomy - TURP	5,975	4,765	7,900	4,650		4,444	5,547	[ ]	[ ]
Anterior & Posterior Colporrhophy With Pro-Lift	6,105	4,215		4,025	5,597		4,986	[ ]	[ ]
Hysterectomy - Vaginal & Repair				5,450			5,450	[ ]	[ ]
Hysterectomy - Abdominal +/- BSO	7,070	5,245		5,100		4,750	5,541	[ ]	[ ]
Cruciate Ligament Repair				4,400			4,400	[ ]	[ ]
Shoulder Decompression	3,975	3,480		3,550			3,668	[ ]	[ ]
Total Hip Replacement	9,130	9,515	9,800	*8,200	*7054	*7662	9,482	[ ]	[ ]
Total Knee Replacement	10,130	10,035	13,900	*8,500	*6855	*8424	11,355	[ ]	[ ]
Myringotomy & Grommet Insertion				1,495	1,882	1,619	1,665	[ ]	[ ]
Circumcision				1,325	1,975	1,535	1,612	[ ]	[ ]
Colonoscopy	2,060	1,970		1,525	1,819	1,465	2,946	[ ]	[ ]

OGD	1,375	1,485		995		615	1,118	[ ]	[ ]
Colonoscopy & OGD				1,750			1,750	[ ]	[ ]
Flexible Sigmoidoscopy						1,105	1,105	[ ]	[ ]
Carpel Tunnel Unilateral	1,780	1,860		1,625	1,503	1,322	1,618	[ ]	[ ]
Flexible Cystoscopy			1,900	675		620	1,065	[ ]	[ ]
Cystoscopy +/- dilation with biopsy	1,430	1,575					1,503	[ ]	[ ]
D & C and LETTZ						1,259	1,259	[ ]	[ ]
Hysteroscopy Diagnostic Only	2,195	2,160	1,650			1,494	1,875	[ ]	[ ]
Cataract	2,615	2,100		2,325	2,213	1,745	2,200	[ ]	[ ]
Squint Correction						2,065	2,065	[ ]	[ ]
Wisdom Teeth	2,035	2,125	1,300				1,820	[ ]	[ ]
Knee Arthroscopy	3,210	2,570	2,400	2,750	2,470	2,243	2,607	[ ]	[ ]
Blepharoplasty Uppers & Lowers	4,070	3,800	4,000		3,980		3,963	[ ]	[ ]
Facelift			6,900		7,235	5,690	6,608	[ ]	[ ]
Abdominoplasty	5,370	4,890			5,350	5,015	5,156	[ ]	[ ]
Rhinoplasty	4,120	3,775	4,600		4,085	3,850	4,086	[ ]	[ ]
Breast Augmentation	4,920	4,000			5,045	4,055	4,505	[ ]	[ ]
Breast Reduction	5,370	5,375			5,507	5,385	5,409	[ ]	[ ]
Correction of Prominent Ears Bilateral	3,420	2,990					3,205	[ ]	[ ]
Blepharoplasty Uppers or Lowers (LAOP)						1,425	1,425	[ ]	[ ]

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APPENDIX 5

[REDACTED]