

## PRIVATE HEALTHCARE MARKET INVESTIGATION

### Profitability analysis of private hospital operators: planned methodology

#### Introduction and summary

##### *Purpose of the paper*

1. The purpose of this paper is to set out the Competition Commission's (CC's) proposed approach, together with our reasoning, to assessing the profitability of private hospital operators. Comments on this paper must be submitted no later than noon on **14 November 2012**.
2. We have identified a few areas, summarized in paragraph 5, where we would like to enhance our understanding of the nature of the businesses we are investigating. This will help us to ensure that we appropriately capture their financial implications.

##### *Structure of the paper*

3. We set out below the structure of the paper and provide a brief description of the content of each section.

<i>Title</i>	<i>Purpose</i>	<i>Paragraphs</i>
Introduction and summary	To state the purpose of this paper	1–5
	To summarize our planned treatment of certain accounting transactions	
	To request comments on particular areas identified	
Background	To explain how profitability analysis fits into a market investigation	6–9
	To state the purposes of the profitability analysis	
Framework for profitability assessment	To explain the CC's approach to profitability assessment as set out in the Draft Guidelines for Market Investigations (the Draft Guidelines) <sup>1</sup>	10–12
Specification of parameters articulated in the Draft Guidelines	To define for the purposes of the profitability assessment:	13–30
	• the reference (product) markets;	
	• the geographical scope;	
	• the relevant firms; and	
	• the relevant period of review.	
Selection of profitability measure	To explain the reasons for the selection of the profitability measure(s) chosen	31–41
Scope of relevant operating revenues, costs, assets and liabilities	To give clarity regarding the items we expect to see reflected within the financial information used in the profitability analysis	42–45
Financial information: basis of preparation principles	To set out at a conceptual level the planned basis of preparation of financial information used in this analysis and the reasoning for this	46–63
Financial information: application of basis of preparation principles	To apply the principles articulated in the previous section to the financial information of the private hospital operators	64–94
Context of analysis	To explain briefly how the financial information to be used in the profitability analysis has come into being	95–99
Glossary of financial terms	To define/explain the less familiar terms used in this paper	Appendix

---

<sup>1</sup> [www.competition-commission.org.uk/publications/consultations-open/cc-review-of-market-investigation-references-guidelines](http://www.competition-commission.org.uk/publications/consultations-open/cc-review-of-market-investigation-references-guidelines).

## **Summary of planned treatments**

4. We summarize below our proposed approach to the accounting treatment of the main transactions we consider relevant to private hospital operators.

<i>Accounting entry</i>	<i>Proposed treatment</i>	<i>Paragraphs</i>
Freehold land	To include all freehold land in the capital employed at its market value	71–73
Freehold buildings	To include all freehold buildings in the capital employed at their depreciated replacement cost	74–77
Leasehold land	To include all land held on a long leasehold basis in the capital employed at its market value	67 & 68, 72 & 73
Leasehold buildings	To value buildings held on a long lease as freehold buildings and include in capital employed	67 & 68, 75–77
	To add back any rent charged against such long leaseholds	
	To exclude buildings held on a short lease from capital employed	
Current assets and liabilities	To include current assets and liabilities in the capital base of the businesses at their carrying value	78
Equipment, furniture, fittings	To include all equipment, furniture and fittings in capital employed at their net book value	79
Purchased goodwill	To exclude purchased goodwill from capital employed	80–85
Depreciation of freehold buildings	To depreciate buildings on the basis of their replacement cost	87–90
	To recognize asset holding gains and losses in the profit and loss account	
Transfer pricing and inter-company balances	To exclude any inter-company debtors or creditors to the extent that these relate to financing balances	91–94
	To include any inter-company transactions and debtors or creditors to the extent that these relate to transactions at market prices	

## ***Summary of specific areas on which we would welcome comments***

5. Below, we set out those areas on which the CC would particularly welcome comments. Please refer to the referenced paragraphs for the full context.

<i>Area</i>	<i>Comments requested</i>	<i>Paragraphs</i>
The rationale for and feasibility of isolating the profitability of the reference market	Would there be a significant advantage to be gained from conducting a separate profitability analysis of privately- and publicly-funded healthcare services provided by private hospital operators?  How feasible would it be to provide financial information which separates the costs, revenues and capital employed in providing privately- and publicly-funded healthcare services?	20 & 21
The relevant time period for the profitability analysis	What are the potential issues raised by undertaking profitability analysis over five years rather than a longer time period?	26–30
The feasibility of providing estimates of the remaining useful economic lives of hospital buildings	How feasible would it be for private hospital operators to provide an evidence-based estimate of the remaining useful economic life of their hospital and or clinic buildings on a unit-by-unit basis?	75 & 76
Cost implications of changes in the optimal configuration of a hospital/clinic building	What impact have changes in hospital/clinic configuration had on the cost of building facilities?	77
Existence and valuation of intangible assets	Are there any intangible assets held by the hospital operators that meet the CC's criteria for inclusion within the capital employed?  If so, how might these intangible assets be measured/valued?	83

## **Background**

### ***Statutory framework for market investigations***

6. This paper takes as its starting point the references to profitability assessment in the Draft Guidelines published for consultation on 15 June 2012 as these are likely to be closer to the relevant guidelines in force when we publish our provisional findings

next year than the current guidelines.<sup>2</sup> We note, however, that the current guidelines and the Draft Guidelines are very similar as regards the stated purposes of and approach to profitability analysis.

7. The purpose of a market investigation is to ascertain whether there are competition problems and identify the features causing them. In order to decide whether there is an adverse effect on competition the CC considers, among other issues, the main characteristics of the reference market and the outcomes of the competitive process. One such outcome is the profitability of the firms in the industry.

### ***The purposes of profitability analysis***

8. The Draft Guidelines note that:

Profitability can be a useful indicator of competitive conditions in a market. An efficient firm in a competitive market would generally be able to earn no more than a 'normal' rate of profit—the minimum level of profits required to keep the factors of production in their current use in the long run, ie its rate of return on invested capital for a particular business activity would be equal to its cost of capital for that activity.<sup>3</sup>

9. Our profitability analysis has a number of purposes, which are highlighted in the Draft Guidelines, including:<sup>4</sup>
  - *Indicator of whether prices are too high.* Theories of Harm 1 and 3, as set out in the statement of issues,<sup>5</sup> hypothesize that the private hospital operators may have market power at either the local or national level vis-à-vis the insurers. Profitability analysis may be a useful indicator of the extent to which the private hospital

---

<sup>2</sup> *Market Investigation References: Competition Commission Guidelines, June 2003 (CC3).*

<sup>3</sup> *Draft Guidelines*, paragraph 118.

<sup>4</sup> *Ibid*, paragraphs 119–125.

<sup>5</sup> [www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/120622\\_issues\\_statement.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/120622_issues_statement.pdf).

operators are able to exercise market power to push prices, and hence profits, above the competitive level.

- *Evidence about entry conditions.* Profitability measures may, in particular, provide evidence about barriers to entry (Theory of Harm 5). Evidence of persistent supernormal profits within an industry is generally consistent with a finding that barriers to entry are high preventing potential competitors from entering the market and undermining the profit levels. However, it is neither a necessary nor a sufficient condition for such a finding.
- *Evidence about trends in profitability.* We may also have regard to the trend in profits. Where the size of the gap between the level of profitability and the cost of capital has grown over a period the competitive situation may have worsened. Where that gap has narrowed, competitive conditions may have improved. Where that gap has fluctuated the CC may consider whether, on average, profits have exceeded the cost of capital.

### **Framework for profitability assessment**

10. As explained in paragraph 8, the methodology employed by the CC in assessing the profitability of firms is based on the comparison of the actual rates of return achieved with the cost of capital for those same firms.
11. The CC carefully interprets the level of profitability benchmarked against the cost of capital. Paragraphs 117 to 125 of the Draft Guidelines set out the approach taken by the CC to this analysis. In particular, they note that the CC has regard to the profitability of firms which constitute a 'substantial' part of the market, and that it is interested in whether profits have *persistently* exceeded the cost of capital.<sup>6</sup>

---

<sup>6</sup> These paragraphs are reproduced from the [Draft Guidelines](#), paragraphs 117, 122, 124 & 125.

The... approach to the question of whether prices are too high in a market is to consider the profitability of firms or groups of firms representing a substantial part of it. (In practice, therefore, the CC tends not to be interested in the profits of less significant firms or groups of firms).

The CC will... be interested in whether profits have exceeded the cost of capital over a sustained period (ie persistently<sup>7</sup> high profits). The CC's view about whether high profits have been persistent will be influenced by its assessment of how competition works in the market concerned. The CC considers that the longer that profits have exceeded the cost of capital, and the higher the amount by which they have exceeded the cost of capital, the more likely they are to indicate problems with competition.

The CC may find that profits did not exceed the cost of capital or did not do so for a persistent period. Such a finding would not necessarily signify that competition is not harmed. Low profitability may be concealing ineffective competition.

12. In addition to specifying a relevant profitability measure, we need to define the following parameters for the profitability assessment:
- the reference products, ie the *reference market*;
  - the firms representing a substantial part of the relevant<sup>8</sup> market; and
  - the time frame over which we will test for persistence, ie the *relevant period*.

---

<sup>7</sup> The test of persistence also helps eliminate the possibility of systematic over fulfilment of expectations over a number of years as being the explanation for high profitability (*The Economic Analysis of Accounting Profitability* p58).

<sup>8</sup> See paragraphs 16 to 18. Note that "relevant market" as used in this paper does not refer to the economic relevant market for market definition purposes.

## **Specification of parameters of analysis**

13. As set out in paragraph 12, a number of parameters need to be specified before the profitability assessment is undertaken.

### ***The reference market***

14. The Office of Fair Trading (OFT) has referred to the CC the market for the supply or acquisition of privately-funded healthcare services in the UK. These services are provided to patients by consultants, medical and clinical professionals via private hospitals and clinics, including private patient units.
15. The market for privately-funded healthcare services includes, inter alia, acute medical and surgical healthcare provided in an outpatient or hospital setting, cosmetic surgery, dental services, fertility treatments and mental healthcare.

### ***Reference versus relevant market***

16. There are two respects in which our proposed 'relevant market' for the profitability analysis differs from the reference market.
17. First, we plan to assess the profitability of the provision of acute medical and surgical healthcare services by hospitals and clinics. These services are narrower than the services included in the reference market referred to us by the OFT but correspond with the set of concerns raised by the OFT and the CC's theories of harm set out in its statement of issues. These relate primarily to these narrower services rather than the services for elective cosmetic surgery, dental services, standard maternity and



fertility treatments, and mental healthcare where conditions of both supply and demand are significantly different.<sup>9</sup>

18. This approach would exclude a number of the activities undertaken by the relevant firms (see paragraph 24) through non-acute private healthcare facilities such as mental health, primary care or elective cosmetic surgery clinics. On the other hand, this approach would not exclude any cosmetic or dental surgery undertaken at the acute hospitals of the relevant firms, on the basis that it would be impractical to separate out such services in terms of profits generated.<sup>10</sup>
19. Second, the OFT reference does not include publicly-funded healthcare services delivered by private hospital operators. However, the information that we have received in response to the CC's financial questionnaire (FQ) includes both private and NHS-funded healthcare services provided by the hospital operators.
20. In the first instance, we propose to undertake profitability analysis on the private hospital operators' combined operations, since we consider that it would be extremely difficult to allocate costs and assets between publicly- and privately-funded services given the shared asset base used to provide both. Our current understanding is that services provided on behalf of the NHS may be less profitable than private services and we may look to analyse the relative contributions of each.

*Specific area on which we would welcome comments: the rationale for and feasibility of isolating the profitability of privately-funded healthcare services*

21. We would welcome input, particularly from private hospital operators, regarding:

---

<sup>9</sup> The CC's proposed approach is set out in the Theories of Harm contained in the [statement of issues](#).

<sup>10</sup> We understand that the private hospital operators are able to classify revenues according to the type of medical/surgical treatment but are unable to classify costs on this same basis.

- whether separating out the profitability of privately- and publicly-funded healthcare services would provide significant advantages for our analysis in terms of clarity over differing business models and levels of profitability; and
  - the feasibility of providing financial information which separates the costs, revenues and capital employed in the provision of privately- and publicly-funded healthcare services.
22. Our Theories of Harm identify potential issues arising at both the local and the national level. However, we understand that prices for privately funded healthcare services are generally set via a national negotiation process between insurers and hospital operators and so we plan to assess profitability at the national rather than the local level. We may seek to complement our profitability analysis with margin analysis in particular local markets as appropriate.

### *Geographical scope*

23. In the Terms of Reference the OFT defines the geographical scope of the referred market(s) to be the UK. We consider that for the purposes of our profitability analysis this geographical scope includes all acute private medical and surgical services provided at hospitals and clinics located within the UK, to both British and overseas patients.

### ***The relevant firms***

24. We consider that the seven largest private hospital operators in the UK comprise the relevant firms for the purposes of the profitability assessment. These are: BMI/GHG, Bupa Cromwell, HCA, Nuffield, Ramsay, Spire and The London Clinic.
25. We note that there may be some issues with focusing only on the profitability of these successful firms, where ‘survivorship bias’ may suggest that they are likely to exhibit

profitability levels that are not representative of the profitability of smaller and potentially less-successful firms. While we do not propose to extend our profitability assessment to cover smaller operators, the interpretation of our results will take into account the recent history of the sector, including whether there is any evidence of survivorship bias, considering, for example, evidence of unsuccessful attempts at entry or expansion.

### ***The relevant period***

26. The time frame over which we conduct our profitability assessment should be sufficiently long to detect whether any trends in profitability have been persistent. In previous market investigations, a five-year period has been considered a representative and sufficient period over which the outcome of any competitive process might be demonstrated<sup>11</sup>.
27. Many of the assets employed in the private healthcare industry have long lifespans, in some cases in excess of 50 years as is the case, for example, with the hospital land and buildings. Consequently, an assessment of profitability would usually be conducted over a significantly longer period of time (than five years) to reflect this asset life. We believe that there may be several potential issues with using a five-year time period for our analysis, including a potential distortion arising from analysing profitability over a period that has been characterized by severe economic recession.
28. However, from discussions with the larger private hospital operators we understand that a number of changes in ownership within the industry between 2006 and 2008 make it difficult for them to provide the necessary financial information prior to

---

<sup>11</sup> A five year period was used to assess profitability in the Local bus services market investigation and in the Payment Protection Insurance market investigation.

2006/07. Furthermore, these changes in ownership might be expected to have an impact on the competitive conditions in the sector, making profitability prior to 2007 less relevant to our analysis which focuses on the current workings of the sector.

29. The relevant firms use different year-end dates, including 31 December, 30 June and 30 September. We therefore plan to assess profitability of each firm over the five financial years (FY) that end within the period from 1 January 2007 to 30 June 2012.
30. We would welcome comments in particular from the hospital operators regarding any potential issues that may arise as a result of assessing profitability over a five-year period.

## **Selection of profitability measure**

### ***Nature of the services investigated***

31. The acute private healthcare sector can require significant amounts of capital investment in both facilities (hospitals and clinics) and equipment. In addition, the sector features long investment horizons with a hospital building taking two or more years to plan and construct and then continuing in operation for 50 years or more with periodic refurbishments and replacement of equipment.
32. We understand that advances in medical technology in recent decades have had an effect on the optimal configuration of a hospital/clinic, with increasing demand for day beds and declining demand for overnight accommodation. Although this trend is unlikely to have significantly changed the optimal configuration of healthcare facilities over the relevant period for our profitability analysis, we note that long-lived assets may require significant investment over their lives to avoid obsolescence.

33. Whereas this sector features investment in significant levels of tangible fixed assets, we would expect them to feature relatively low levels of (separable) intangible assets.

### ***Possible profitability measures***

34. There are a number of different ways to measure profitability. The Draft Guidelines primarily refer to the rate of return on capital mentioning both (truncated) internal rate of return (IRR) and return on capital employed (ROCE) as possible alternative approaches<sup>12</sup>.
35. The Draft Guidelines also mention return on sales<sup>13</sup>. However, this would be an unsuitable profitability measure not least because of the capital-intensive nature of the sector. Furthermore, unlike profitability measures based on estimating the rate of return on capital, there is no robust comparator against which to judge the levels of profitability observed.
36. We plan to assess the profitability of the private hospital operators on the basis of the ROCE rather than using the truncated IRR approach. We are necessarily assessing profitability over a relatively limited period of time compared with the overall lifespan of investment in these markets of 50+ years. ROCE offers the advantage of reflecting the value of the capital invested at the intervening year ends, thereby allowing trends in profitability to be observed over the relevant period. It is primarily for this reason that we prefer to assess profitability using ROCE, particularly since capital invested is a significant feature.
37. The truncated IRR methodology does not allow us to identify any trends that may exist in the profitability of the private hospital operators. Moreover, it is particularly

---

<sup>12</sup> Draft Guidelines, paragraphs 8 and 9.

<sup>13</sup> Draft Guidelines, Annex A, Market characteristics and outcomes, paragraph 14.

sensitive to operational decisions, such as the level of capital expenditure made over the period, which may not be representative given the relatively short time period under consideration and the financial crisis and recession experienced during this period.

***ROCE will be assessed against the relevant cost of capital***

38. A competitive market would be expected to generate significant variations in profit levels between firms and over time as supply and demand conditions change, but with an overall tendency towards levels commensurate with the cost of capital of the firms involved.<sup>14</sup>
39. The cost of capital is the minimum expected return that investors in a project would accept over the period of that investment. It is an opportunity cost and can be seen as the the risk-adjusted yield on capital employed in the next best alternative use.
40. In assessing levels of profitability the Draft Guidelines state that the CC will have regard to its view of firms' cost of capital. The CC will generally look to the capital asset pricing model (CAPM) when considering the cost of capital, since this is a widely understood technique with strong theoretical foundations.<sup>15</sup> Within the context of the CAPM, we propose to estimate the cost of capital on a nominal pre-tax basis.
41. As we plan to estimate the private hospital operators' cost of capital in nominal terms, ie before taking into account the impact of general inflation, it is appropriate to measure financial figures in the £s of the period to which they relate.

---

<sup>14</sup> [Draft Guidelines](#), paragraph 121.

<sup>15</sup> [Draft Guidelines](#), Annex A, Market characteristics and outcomes, paragraph 15.

## **Scope of relevant operating revenues, costs, assets and liabilities**

42. The purpose of this section is to set out what type of revenues, costs, assets and liabilities we expect to see reflected in the profitability assessment. The approach adopted in the financial information provided has not always been consistent across the private hospital operators.
43. We determine the ROCE using operational profits and operational capital employed and then compare it with the pre-tax weighted average cost of financing. The general principle is therefore that all revenues, costs, assets and liabilities necessarily arising from the operation of the business in the specified markets should be included. In practice, this means that the following items should be excluded:
- (a) financing costs both of a profit & loss and balance sheet nature, eg interest and sources of finance regardless of whether they are short or long term. These include inter-company loans and cash and bank balances;
  - (b) taxation on income and any associated corporation tax or deferred tax; and
  - (c) inter-company payments that do not reflect the provision of goods or services but that serve to transfer funds between entities.
44. In the interests of both comparability across the relevant firms and simplicity of treatment we plan to exclude all short-term financing items from capital employed.

## ***Seasonality of working capital employed***

45. Our current understanding of the private healthcare industry indicates that the activities of private hospital operators do not fluctuate significantly across the year. Consequently, we are not planning to adjust working capital at the financial year end to reflect a 'normalized' position but use the unadjusted year-end position.

## **Financial information: basis of preparation principles**

### ***Background and general principles***

46. All the relevant firms prepare financial information under the (modified) historical cost accounting (HCA) rules in accordance with UK or international financial reporting standards. Some of the relevant firms have revalued some of their assets from their historic cost to a market value at the date of revaluation, in which case the basis of preparation is described as modified HCA. Such revaluations have been carried out either on a change of control or for financing purposes. We would expect a certain level of consistency in the accounting treatments adopted both between one accounting period and the next and one firm and another as a result of applying UK or international accounting standards.
47. We are interested in economic (or continuing) costs. Economic costs are the costs of resources used at a price they would be traded at in a competitive market, with no significant barriers to entry or exit. In this context, the value of resources consumed and assets used should reflect the market (or arm's length) price, or the appropriate opportunity cost.
48. Similarly, the basis of our analysis is the economic substance of the activities undertaken by the relevant firms in the relevant market(s). We understand that in some cases these activities are divided between a number of separate legal entities creating a range of inter-company transactions. Our analysis will 'look through' all such structures and transactions to assess the profitability of the activities on a consolidated basis. This reflects our desire to understand the profitability of the underlying activity (ie the provision of private healthcare services) and avoid any potential distortions resulting from differences between firms as regards financing or tax structures.



49. Our analysis focuses on services which are, at least in some cases, a sub-set of the relevant firms' total activities. Relevant revenues, costs, assets and liabilities should be attributed to these product markets using the principles of causality and objectivity.

### ***Principles of asset and liability definition***

50. Assets are defined as rights or other access to future economic benefits controlled by an entity as a result of past transactions or events. Liabilities are obligations of an entity to transfer economic benefits as a result of past transactions or events.<sup>16</sup>

### ***Measurement basis for valuation of assets<sup>17</sup>***

51. The current value of an asset can be determined by reference to entry value (replacement cost), exit value (net realizable value (NRV)) or value in use (discounted present value of the cash flows expected from continuing use and ultimate sale by the present owner). For some assets (for example, investments in actively traded securities), these three alternative measures of current value produce very similar amounts, with only small differences due to transaction costs. However, for other assets (for example, fixed assets specific to the business), differences between the alternative measures can be material.
52. The approach to valuing assets should reflect their current *value to the business*, which is the loss the firm would suffer if it were deprived of the asset involved. That measure, which is also referred to as the *deprival value*, or *value to the owner*, will depend on the circumstances involved.

---

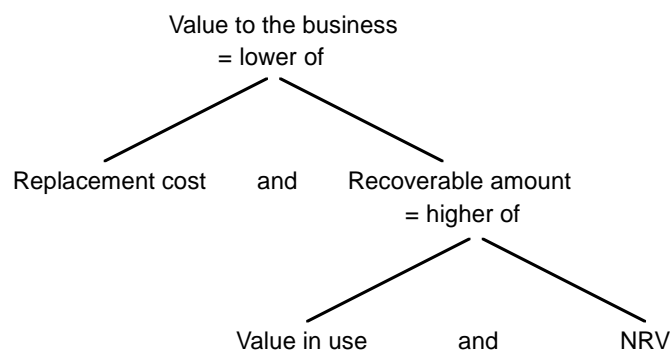
<sup>16</sup> As defined in the Statement of Principles for Financial Reporting (1999), UK Accounting Standards Board.

<sup>17</sup> The following paragraphs draw heavily on the *Alternative Measures of Current Value* section within The Statement of Principles for Financial Reporting (1999), UK Accounting Standards Board, paragraphs 6.6–6.9.

53. In most cases, as the entity will be putting the asset to profitable use, the asset's value in its most profitable use (in other words, its recoverable amount) will exceed its replacement cost. In such circumstances, the entity will, if deprived of the asset, replace it, and the current value of the asset will be its current replacement cost.
54. An asset will not be replaced if the cost of replacing it exceeds its recoverable amount. In such circumstances, the asset's current value is that recoverable amount.
55. When the most profitable use of an asset is to sell it, the asset's recoverable amount will be the amount that can be obtained by selling it, net of selling expenses; in other words, its NRV.
56. When the most profitable use of an asset is to consume it—for example, by continuing to operate it—its recoverable amount will be the present value of the future cash flows obtainable and cash flows obviated as a result of the asset's continued use and ultimate disposal, net of any expenses that would need to be incurred; in other words, its value in use.
57. This can be portrayed diagrammatically as follows:

FIGURE 1

**Establishing which valuation basis for an asset gives its value to the business**



Source: UK Accounting Standards Board, Statement of Principles (1999).

58. Application of these valuation principles consistently across all assets is also called current cost accounting (CCA).

### *Estimation of replacement cost*

59. Where an asset is worth replacing, its value to the business will be its current replacement cost, or more precisely the replacement cost of a modern equivalent asset (MEA) determined in a fully competitive market and allowing for the asset's remaining useful life. The MEA value is the cost of replacing an old asset with a new one with the same service capability allowing for any differences both in the quality of output and in operating costs. The fact that markets are often not fully competitive does not alter the validity of the assumption of competition as a benchmark for measuring costs.
60. This approach is consistent with our Draft Guidelines which state<sup>18</sup> that the CC considers MEA values to be the economically meaningful measure for the purpose of measuring profitability in most cases. The definition<sup>19</sup> given in the Draft Guidelines emphasizes that this valuation should be based on the most efficient technology available at the time and assumes that assets are optimally configured. This is the case even if the assets in question actually use legacy technology and are not ideally situated for current market conditions.

### ***Financial capital maintenance***

61. For our purposes, it is important that we measure the return being made on capital invested. In calculating this return, the whole of the change in the value to the business of its assets (after allowing for acquisitions and disposals) must be charged to the profit and loss account to reflect the continuing costs of supply.

---

<sup>18</sup> [Draft Guidelines](#), Annex A, paragraph 13.

<sup>19</sup> The MEA value is the current cost of acquiring assets which yield equivalent services to those currently used by the firm, based on the most efficient technology and optimal configuration.

62. This proposition follows from the definition of continuing costs in terms of the prices of inputs which would arise in a highly competitive market with easy entry and exit for new producers. No commercial competitors would come into an industry if they did not expect to be able to recover the decline in values of their assets, as well as earn a normal profit (the opportunity cost of capital). They would measure their return on investment after recovery of funds sufficient to maintain the real value of the financial capital they had invested.
63. This system of accounting is called financial capital maintenance (FCM).<sup>20</sup>

### **Financial information: application of basis of preparation principles**

64. Our position is that information prepared under HCA in accordance with either UK or international accounting standards will be a good starting point for our purposes in certain, although not all, cases.<sup>21</sup> For example, for many assets and liabilities which are quickly turned over such as trade debtors and creditors the CCA values will not differ significantly from the HCA values when general inflation is low.
65. In this section therefore, we set out the principal categories of assets and liabilities, together with our proposed treatment of those items, and we highlight potential exceptions to using the figures contained in the financial statements. For each potential exception we set out the context, the current accounting treatment used by the private hospital operators, and the planned treatment for our analysis.
66. Note, however, that the general principles outlined in paragraphs 46 to 63 apply regardless of whether any particular issue is specifically considered below.

---

<sup>20</sup> FCM is a system of accounting which regards the capital of the business as a fund attributable to the proprietors and profit as the surplus arising after that fund has been maintained. Assets are stated at their value to the business.

<sup>21</sup> [Draft Guidelines](#), Annex A, paragraph 8.

## ***Recognition of tangible fixed assets***

### *Leasehold land and buildings*

67. A number of the relevant firms lease some or all of their hospitals and/or clinics from third party landlords.<sup>22</sup> These properties are leased under various arrangements, from long leaseholds at peppercorn rents at one end of the scale to short leaseholds at market rents at the other. The appropriate accounting treatment of leases will vary according to the nature of the lease contract, ie whether the lease is capitalized and depreciated over time or treated as a rental expense in the profit and loss account.
68. For the purposes of our profitability analysis, we plan to follow the accounting treatment as regards which properties to recognize within the capital base of the business and which to exclude on the basis that their value is reflected in the rental payments made.

## ***Measurement basis for valuation of tangible fixed assets***

69. As noted in paragraph 31, the provision of private healthcare services is a capital-intensive business, with tangible fixed assets comprising a significant proportion of total capital employed.
70. The standard approach to the valuation of all tangible fixed assets is that they are stated at historical cost or revalued amount, net of accumulated depreciation and any provisions for impairment. Any revalued amounts have typically been frozen at some point in the past and therefore do not necessarily reflect the current value to the business. Neither freehold land nor assets in the course of construction (AICC) are depreciated. However, all other tangible assets are depreciated based on their historical cost (or valuation) less their estimated residual value.

---

<sup>22</sup> Any properties that are leased by an operating company from a property company in intra-group transactions will be treated as freehold properties for the purposes of this analysis. This reflects the economic substance of the arrangement rather than the legal structuring put in place for financing purposes.

## *Freehold land*

71. The standard approach to the valuation of freehold land does not, in our view, provide a suitably accurate estimate of the MEA value of the plots of land owned by the relevant firms. Historic costs will generally undervalue land as a result of both general inflation and changes in the real value of assets in the years since acquisition. This is a particular concern where land was purchased a number of years ago, as is frequently the case in this industry. On the other hand, market values that have been derived from the enterprise value of the hospital located on that land may overstate the land value and introduce issues of circularity into profitability analysis.<sup>23</sup> Finally, the different approaches to valuation taken by the private hospital operators also raise issues of comparability across the industry.
72. In order to obtain comparable and objective valuations, we believe that the MEA value of the freehold (and long leasehold<sup>24</sup>) plots of land could be proxied by their current market value as estimated by a third party expert.<sup>25</sup> These valuations will be estimated with reference to recent transactions and potential alternative uses, and will be based on the assumption of a willing buyer and seller, exchanging plots of land with appropriate planning permission for an acute hospital facility of the (actual) size and (approximate) location of the plots held by the relevant firms. These land values may be adjusted with reference to a land price index to reflect changes in value over the relevant period. We would welcome comment on which land price index may be the most suitable for these purposes.

---

<sup>23</sup> We understand that some of the private hospital operators revalued their land and building assets either shortly prior to or during the relevant period for our analysis. The market value of the land that generally forms the basis of such revaluations was, in at least some cases, derived from the enterprise value of the hospital facility as a whole, with a proportion of the total enterprise value allocated to the land. However, where the profitability of a hospital is used to estimate the value of its assets, which is then used to estimate profitability, there is a risk of introducing circularity. The ability of a business to earn excess profits may inflate the value of the capital base of the business, reducing the level of profitability calculated with reference to that capital base.

<sup>24</sup> 'Long leasehold' land refers to those plots recognized in the accounts of the private hospital operators, as discussed in paragraphs 68 & 69.

<sup>25</sup> The CC has instructed DTZ to carry out a number of land valuations on this basis.

73. Where there is a rental charge payable against (long) leasehold land which has been capitalized at its full market value (as described above), this rent should be excluded from costs to avoid 'double-counting' of the land value.

### *Freehold buildings*

74. The relevant firms hold their freehold buildings in their financial statements at either depreciated historic cost or at a revalued level (to which depreciation has subsequently been applied). In addition to issues of comparability across firms, it is unlikely that these carrying values will approximate the MEA value of the hospital buildings. Where buildings are held at a depreciated historic cost, both inflation and, potentially, real increases in the costs of construction may result in a value that is below the MEA value. Where buildings were revalued to a 'market' level in recent years, this may overstate their true MEA value since it may take into account the potential of the assets to earn profits in excess of the normal level.
75. Therefore, there appear to be two potential approaches that could be adopted to arrive at an MEA value for the hospital buildings. The first is to commission an expert opinion on the depreciated replacement cost of the buildings. The second, and our planned approach, is to value all freehold (and long leasehold<sup>26</sup>) buildings according to their reinstatement costs, as estimated by chartered surveyors for insurance purposes. The relevant firms have provided us with these estimates for all their properties in response to the FQ. These reinstatement costs will be adjusted for changes in a construction price index and VAT rates over the relevant period, and will be depreciated according to the age and remaining useful economic life of the building. We believe that this second approach should provide the same level of

---

<sup>26</sup> As with leasehold land, any rental charges made against leasehold buildings that are capitalized should be added back to profits. This is consistent with including these leasehold buildings at their full freehold value in the capital base of the business.

accuracy as the first since in both cases the valuations are carried out by suitably-qualified experts.

*Specific area on which we would welcome comments: the feasibility of providing estimates of the useful economic life of hospital buildings*

76. We would welcome input, particularly from hospital operators, regarding how feasible it would be for them to provide estimates of the remaining useful economic life of each of their freehold hospitals/clinics.
77. We are aware that the 'optimal' configuration of a hospital building has changed over time, in particular as a result of the trend towards fewer inpatient admissions and shorter average stays in hospital. As a result, older hospitals may have a greater number of overnight beds and, relatively, fewer theatres, consulting rooms and day beds than a modern equivalent. Moreover, we understand that the reinstatement values estimated for insurance purposes may not have been adjusted to reflect the cost of replacing an existing building with an MEA. Our current view is that such changes in configuration would not be expected significantly to change the replacement cost of a hospital building but we would welcome input from in particular the private hospital operators on this issue.

#### *Current assets and liabilities*

78. Our planned approach is to value these assets and liabilities at their carrying value in the relevant firms' financial statements. As noted in paragraph 43 financing balances, including cash, should be excluded.

#### *Equipment, fixtures and fittings*

79. Our planned approach is to value all equipment (both medical and non-medical), furnishings, fixtures and fittings at their net book values in the relevant firms' accounts. We understand that the large majority of these assets have useful



economic lives of ten years or less and are depreciated accordingly, such that their net book value provides a reasonable approximation of their depreciated replacement cost.

### ***Recognition of intangible fixed assets***

#### *Purchased goodwill*

80. Firms can grow either organically or through acquisition. A number of the relevant firms have either been acquired or made acquisitions. Purchased goodwill is the part of a parent firm's investment in its subsidiary that it has not been able to attribute to separately identifiable assets and liabilities. Although it is not an asset in itself, it is *part of a larger asset (the investment)*.<sup>27</sup>
81. In the consolidated financial statements, the practice is to recognize this purchased goodwill as an intangible fixed asset which is then subject to an annual impairment review.<sup>28</sup>
82. We recognize that some element of purchased goodwill may reflect non-separable but nevertheless important assets, such as relationships with insurers and consultants or, potentially, start-up losses made whilst the hospital establishes itself, that a new entrant into the market setting up its own operations would need to invest in to develop. Our Draft Guidelines set out the criteria that must be met for the CC to consider including a tangible asset in capital employed, notably:
- it must comprise a cost that has been incurred primarily to obtain earnings in the future;
  - this cost must be additional to costs necessarily incurred at the time in running the business; and

---

<sup>27</sup> Statement of Principles (1999), UK Accounting Standard Board, paragraph 8.13.

<sup>28</sup> FRS11 *Impairment of Fixed Assets and Goodwill* (1998), UK Accounting Standards Board.

— it must be identifiable as creating such an asset separate from any arising from the general running of the business.<sup>29</sup>

83. We would welcome views, particularly from the relevant firms, on which, if any, intangible assets within their businesses may meet these criteria and how any such assets might be appropriately measured/valued according to the principles articulated in paragraphs 46 to 63.
84. However, we also note that purchased goodwill may reflect the capitalization of future super-normal profits.<sup>30</sup> This situation may arise when a purchaser recognizes that the business will be able to make profits in excess of its cost of capital in the longer run and is prepared to pay a premium to the seller on this basis. To allow purchased goodwill to be included within the capital employed, in this case, would introduce circularity into the analysis.
85. In light of this concern, our view is that it would be inappropriate to include any element of purchased goodwill within capital employed when assessing the level of underlying profitability, unless there is strong evidence that it relates to a clearly-identifiable and measurable intangible asset that meets the criteria set out above.

### ***Measurement of economic costs and revenues within profit and loss account***

86. As set out at paragraph 47 economic (or continuing) costs are the costs of resources used at a price they would be traded at in a competitive market, where there are no barriers to entry or exit.

---

<sup>29</sup> [Draft Guidelines](#), Annex A, paragraph 13.

<sup>30</sup> A measure of expectations of profits in excess of the cost of capital.

## *Depreciation*

87. Standard practice is to depreciate the gross value of the asset (historical cost or revalued amount) at rates calculated to write this value (less any estimated residual value) off evenly over its expected useful life. It is also standard practice when a fixed asset is impaired to charge to the profit and loss account the reduction in its carrying amount.
88. There is no charge to the profit and loss for fully depreciated assets.
89. As set out in paragraph 52 we state that assets should be valued at their value to the business. As a result depreciation charges to profit and loss account should be based on these values, and not on their historical costs or revalued amounts. However, the approach to depreciating assets should not otherwise change, for example, the asset should be depreciated over the same time period. This element of depreciation is called the current cost depreciation charge. Likewise impairments to the value of assets should also flow through the profit and loss in the period in which they occur.
90. As already noted in paragraph 61 in relation to describing the FCM concept, the whole of the change in the value to the business of its assets over the period (after allowing for acquisitions and disposals) must be charged to the profit and loss account to reflect the continuing costs of supply. As a result, gains or losses in the value to the business not ascribable to either current cost depreciation or impairment should also flow to the profit and loss. These charges would arise from either changes in the benchmark MEA or changes in the replacement cost of an identical asset due to asset price inflation or deflation. These charges are sometimes referred to as asset holding gains or losses.

### *Transfer charging and inter-company balances*

91. Some of the relevant firms have operations in a number of sectors, not all of which are subject to this market investigation. Furthermore some of these firms are part of global groups where other parts of the business, particularly the headquarters function, may provide services causally related to the provision of reference products but for which the relevant subsidiaries are not charged.
92. For the purposes of this market investigation, we requested that the relevant firms separate for accounting purposes their UK-based, acute private hospital operations from all their other operations.
93. This issue for the profitability assessment is that there may be transactions between the reference products and other parts of their business which should reflect the market price of the products or services traded. An example of this would be recharges for central costs from group HQ.
94. Transfer charging may give rise to debtor and creditor balances to reflect the terms on which firms operating in a competitive market do business with one another. These inter-company balances, and only these balances, should be included within trade debtors and creditors.

### **Context of analysis**

95. As explained under the discussion of transfer charging in paragraphs 91 to 94 we have requested that the relevant firms separate for accounting purposes their UK acute private hospital operations from all their other operations.
96. These firms, in common with all other limited liability companies operating in the UK over a certain size, are required to prepare, have independently audited and publicly

file financial statements drawn up in accordance with UK or international accounting standards. Differences between UK and international accounting standards largely<sup>31</sup> relate to presentational matters such as how transactions are labelled, classified and aggregated.

97. All firms also produce management financial statements to help them run their businesses profitably. These management accounts are tailored to the particular informational requirements of each individual firm and can look very different from a firm's statutory financial statements. Nevertheless both sets of statements will be ultimately derived from the same basic accounting records for the transactions undertaken by the firm. Because the basic accounting records reflect the firm's chosen accounting policies and treatments, unless a firm has specifically made adjustments to reflect a different accounting treatment for its management information, the basis of preparation for management accounting information, if not its detailed presentation, will reflect the requirements of UK or international accounting standards.
98. It has been a one-off exercise for the relevant firms to supply us with the financial information requested. In order to do this they have modified and augmented their existing management accounting information covering the period 2007 to 2012 in order to generate the separation of accounts between their acute private hospital and other activities on a basis in the first instance consistent with their existing accounting policies and practices.
99. As such the information supplied by the relevant firms has neither been audited nor otherwise independently reviewed before being submitted to us. However, we do expect the base information provided to us described in paragraph 98 in terms of the

---

<sup>31</sup> There are exceptions, most notably the treatment of financial instruments, which for the purposes of this analysis are, as explained in paragraphs 45 & 46, out of scope.

accounting policies adopted (if not the presentation) to be consistent with the accounting policies and treatment adopted in its statutory financial statements unless we have been explicitly informed otherwise. We may wish to review reconciliations of the figures provided to management and/or statutory information prior to finalizing our analysis.

## Glossary of terms

1. We use a number of specialist financial terms throughout this paper. The glossary brings together those terms which are used more than once within this paper and the explanations provided are specific to the context of this paper. Where the terms are introduced and discussed we also give cross references to the relevant paragraphs.

<i>Term</i>	<i>Explanation</i>	<i>Paragraphs</i>
<b>AICC</b>	Assets in the course of construction	70
<b>CCA</b>	Current cost accounting. A system of accounting which consistently applies <b>value to the business</b> valuation principles to assets and liabilities.	58
<b>Cost of capital</b>	The minimum return that investors in a project expect to receive over the period of that investment. It is an opportunity cost and can be seen as the the yield on capital employed in the next best alternative use.	39
<b>Draft Guidelines</b>	Draft Guidelines for Market Investigations published for consultation by the CC on 15 June 2012.	6
<b>Economic costs</b>	The costs of resources used at a price they would be traded at in a highly competitive market, where entry to and exit from the market is easy. The value of resources consumed and assets utilized should reflect their current <b>value to the business</b> , not their historical cost.	47
<b>FCM</b>	Financial capital maintenance. A system of accounting which regards the capital of the business as a fund attributable to the owner and profit as the surplus arising after that fund has been maintained. Assets are stated at their <b>value to the business</b> .	61–63
<b>FQ</b>	Financial questionnaire. The FQ addressed to the relevant firms in which the CC requested financial information relating to the period 2006 to 2012.	19
<b>HCA</b>	Historical cost accounting. A system of accounting which values assets and liabilities at their historical cost.	46
<b>MEA</b>	Modern equivalent asset. The MEA value is the cost of replacing an old asset with a new one with the same service capability, allowing for any differences both in the quality of output and in operating costs.	59 & 60

<b>NRV</b>	Net realizable value. The amount that can be obtained by selling an asset net of selling expenses.	55
<b>Recoverable amount</b>	The higher of an asset's value in use and its <b>NRV</b> .	53–57
<b>ROCE</b>	Return on capital employed, a measure of profitability = profit for a period divided by net assets relevant to the same period expressed as a percentage.	34–36
<b>Value in use</b>	The discounted present value of the cash flows expected from continuing use and ultimate sale of an asset by the present owner.	51 & 54
<b>Value to the business</b>	The loss an entity would suffer if it were deprived of an asset. Also referred to as <i>deprival value</i> or <i>value to the owner</i> .	52