

ANNEX 2

COMMENTS BY RAMSAY ON THE COMPETITION COMMISSION'S PROVISION OF PRIVATE HEALTHCARE SERVICES PROFITABILITY ANALYSIS WORKING PAPER

1. INTRODUCTION AND SUMMARY

- 1.1 This memorandum is a response by Ramsay Health Care UK ("**Ramsay**") to the Competition Commission's ("**CC**") working paper which sets out the results of its profitability analysis. The purpose of the working paper is to determine whether the seven largest private hospital operators ("**Relevant Firms**") are persistently earning profits which are substantially in excess of their cost of capital.
- 1.2 In order to determine whether this is the case, the working paper compares the CC's estimates of Ramsay's profitability (and the profitability of the other Relevant Firms), against the weighted average cost of capital ("**WACC**") of a typical UK stand-alone private healthcare provider. The CC's preliminary analysis concludes that:
- (a) the weighted average return across all of the private healthcare providers between January 2007 and June 2012 was 18 per cent. This compares to an average industry WACC of around 9 per cent (i.e. in a range of 7.3 to 10.0 per cent);
 - (b) in relation to Ramsay, the CC's analysis concludes that Ramsay made an average return of [x] per cent over the same 5 year period, against the same average industry WACC of around 9 per cent; and
 - (c) the same analysis records Ramsay's financial performance as improving in the last 3 years, with its returns [x] per cent in 2010, [x] per cent in 2011 and [x] per cent in 2012.
- 1.3 The CC concludes that this profitability analysis shows that *"the Relevant Firms are, on average, making returns in excess of the cost of capital"*.¹ The CC also suggests that this finding is consistent with its preliminary conclusions of market power in certain local areas² and that it is consistent with some hospital groups having market power in national price negotiations (i.e. that it is consistent with Theories of Harm 1 and 3).³
- 1.4 However, NHS-funded treatment is included within the CC's profitability analysis, which is a material flaw in the analysis. Given that [x] the approach adopted by the CC presents a meaningless measure of profitability in relation to private healthcare services only, which is ultimately the CC's reference market.
- 1.5 In addition, there are obvious material errors and omissions in the profitability calculations, which significantly overstate Ramsay's ROCE and understates its WACC. It appears that the CC has adopted an unbalanced approach in relation to the material stages of the profitability and WACC calculations. The cumulative effect of these errors at each stage is a systematic confirmation bias towards a finding of high profitability, when a more balanced approach shows that this is not the case. The errors and omissions in the CC's ROCE calculations include the following:
- (a) Following Ramsay's acquisition of the Nottingham Woodthorpe hospital in 2008, the CC has pro-rated the capital value from the date of acquisition. This is contrary to

¹ Paragraph 4.

² Paragraph 71, AIS.

³ Paragraph 71, AIS.

standard accounting practice. Adjusting for this error reduces Ramsay's average ROCE by [x] percentage points;

- (b) Although the CC has taken Ramsay's centralised UK corporate costs into consideration in its calculations, it has failed to take into account the depreciation of those centralised assets. Including the depreciation charge for centralised assets reduces Ramsay's average ROCE by a further [x] percentage points.
 - (c) The CC has failed to make any adjustment for the assets in Ramsay's business that are fully depreciated in its accounts but are still in use. This reflects the fact that they were depreciated too rapidly in the early years (i.e. the asset lives used in the accounts did not match the actual economic life of those assets). This adjustment, even on a very prudent basis, reduces Ramsay's average ROCE by a further [x] percentage points (and reduces the ROCE by [x] percentage points in 2010, 2011 and 2012, respectively).
 - (d) The CC has not applied any asset value to Ramsay's business for intangible assets. This is simply implausible given that the healthcare sector is a professional services and knowledge-based industry. If a discounted cash flow ("**DCF**") model is used to value these intangible assets, this reduces Ramsay's average ROCE by a further [x] percentage points. Even if the CC assumes that only 20-30 per cent of this value is relevant for calculating intangible assets, it still reduces Ramsay's ROCE by [x] percentage points.
 - (e) Whilst the CC has sought to estimate the Modern Equivalent Asset ("**MEA**") value (i.e. replacement cost) of the freehold land and buildings, it has not made an equivalent adjustment to rents and leases, which is an inconsistent approach. As most of Ramsay's facilities are leased, replacing historic rent costs with rent at current market values results in further material reduction in Ramsay's average ROCE.
 - (f) The CC has not sought to make any adjustment for the MEA value (i.e. replacement cost) of equipment, fittings and fixtures. The cost of replacing these assets can generally be expected to increase over time (e.g. due to inflation and technological advances), and therefore using historic book cost will understate the capital employed in its business. At the very least, the CC should revalue these assets to take account of inflation (e.g. using RPI or CPI).
 - (g) The increase in Ramsay's ROCE in 2012 reflects a transitional change in the way Ramsay is being paid by the NHS, which has led to [x] in Ramsay's working capital (from [x] in 2011 to [x] in 2012). As the NHS is outside the scope of the market investigation, the CC should adjust for this effect. If this change is considered in isolation, Ramsay's calculations show that its average ROCE (calculated by the CC) is being inflated by [x] percentage points and by [x] percentage points in 2012 as a result of this change.⁴
- 1.6 More generally, in respect of WACC, Ramsay is concerned that the CC has adopted a methodology which does not produce a fair representation of the Relevant Firms' businesses. In particular, the CC is using unrepresentative data (e.g. based on private hospital groups that are diversified across different markets and different countries) in order to estimate the WACC for a UK stand-alone operator.
- 1.7 Accordingly, the CC needs to reconsider its analysis and adopt a more balanced approach.
- 1.8 Most importantly, the effect of adjusting even just the most obvious errors and omissions (and even where these adjustments are carried out on a prudent basis) is highly material

⁴ Assuming that the average working capital balances over the previous four year period applies in 2012.

to the CC's profitability analysis. These corrections, which are both uncontroversial and need to be made, effectively removes any justification to assert that Ramsay is somehow earning profits above the competitive norm.

- 1.9 For example, simply correcting the analysis for the two errors in the calculations set out at 1.4(a) and (b) above and making a cautious adjustment for the fully depreciated assets reduces Ramsay's ROCE by [X] percentage points to just [X] per cent (i.e. [X] of the WACC range). This adjustment excludes the impact of all the various other omissions in the CC's calculations, e.g. in relation to intangible assets, the MEA value of rent and equipment etc., which need to be taken into account and will reduce Ramsay's ROCE even further.
- 1.10 Overall, Ramsay considers that the data confirms that there is no evidence to support a conclusion that it has earned excessive returns over the five-year period in question. Moreover, the data also confirms that the CC is incorrect to suggest that this analysis supports Theories of Harm 1 and 3. On the contrary, the lack of clear evidence demonstrating that Ramsay is earning profits which are persistently and substantially in excess of their cost of capital shows that Theory of Harm 1 and 3 are without merit.
- 1.11 The remainder of this Annex is structured as follows:
- (a) Section 2 discusses the role of the NHS in growing Ramsay's volumes since it entered the UK market in November 2007;
 - (b) Section 3 discusses the key errors and omissions in the CC's ROCE calculations, and provides calculations that have been reworked by Ramsay; and
 - (c) Section 4 comments on the methodology used by the CC for calculating the cost of capital.

2. GENERAL ISSUES WITH THE METHODOLOGY

The role of the NHS

- 2.1 The CC notes (at paragraph 17 of the working paper) that the profitability of each Relevant Firm has been assessed over the entirety of the firms' activities, meaning that revenues and costs associated with non-private healthcare services are included in the calculations. Given that [X] this approach results in a meaningless measure of profitability in relation to private healthcare services only, which is ultimately the CC's reference market.
- 2.2 In this regard, the Chairman of the inquiry explained at Ramsay's hearing that "*by the terms of our reference the NHS business is not part of what we are doing*".⁵ However, NHS-funded treatment is included within the CC's profitability analysis. This inconsistency on the part of the CC is highly material as it is [X]. Trying to draw parallels between this [X] as against, in contrast, the profitability of the private healthcare sector, is a basic error and wholly misleading.
- 2.3 As previously explained to the CC, upon entering the market in 2007, Ramsay's facilities were operating with [X]. In order to [X].⁶ Chart 1 shows how Ramsay's NHS and privately funded admissions have developed since its entry into the market.

Chart 1: The evolution of Ramsay's NHS and privately funded (insured and self pay) admissions (based on 12-month rolling annual volumes)

[X]

Source: Ramsay Health Care UK Presentation (presented at the CC Hearing on 13 March 2013).

- 2.4 It is noteworthy from the chart that there has actually been [X] both in relative and absolute terms. In 2006, NHS admissions accounted for [X] per cent of Ramsay's business; by 2011/12, NHS admissions had [X] per cent of Ramsay's overall volumes. Accordingly, the CC's ROCE calculations do not shed meaningful light regarding either the trends or absolute levels of the profitability of Ramsay's private treatment operations.
- 2.5 Given the economics of running a hospital (i.e. the large proportion of fixed costs which must be incurred irrespective of the volume of patients treated) it would be implausible to seek to allocate the capital base between private and NHS treatment. Any allocation of this nature would be arbitrary and based on unsupported assumptions.⁷ Moreover, in the absence of the NHS-funded treatment which Ramsay undertakes, the fixed costs of running a hospital would still need to be incurred. [X].
- 2.6 Accordingly, Ramsay fundamentally disagrees with the CC's statement that "*we understand that NHS activity generates a lower margin than privately funded treatment*"⁸ and "*as such, we note that the average ROCE across all activities may understate [profit] earned on the services provided to privately-funded patients*".⁹ As the CC will be aware, a

⁵ Page 44, paragraphs 1 to 3, of the draft transcript of Ramsay's oral hearing of 13 March 2013 as sent to Ramsay on 21 March 2013 ("**Oral Hearing Transcript**").

⁶ The UK public healthcare commissioning has also undergone significant changes in the last two decades. The UK Government has introduced a strategy of patient choice and competition for routine elective care, which has been strengthened and expanded under the Coalition Government.

⁷ In this regard, Ramsay notes that, in the audit market investigation, the CC was unable to undertake a reliable or meaningful assessment of economic profitability for a number of reasons including difficulties in allocating costs between different lines of business. The CC's provisional findings paper states that there were "*difficulties in cost allocation (as firms offered both audit and non-audit services)*" [Emphasis added]. Paragraph 10, Statutory Audit Services For Large Companies Market Inquiry, Provisional Findings Report.

⁸ Paragraph 21.

⁹ Paragraph 22.

comparison of gross margins (which only take account of direct costs) does not provide an assessment of how the fixed costs are ultimately financed, and are therefore misleading for the purposes of assessing the overall profitability of a hospital.¹⁰

- 2.7 Finally, Ramsay is also concerned that by aggregating the ROCE for all the Relevant Firms together, the CC's approach fails to take account of the wide range of different strategies of the different operators. This may ultimately lead the CC to conclude incorrectly that PH operators who run their businesses more efficiently are earning higher profits because of a lack of competition when, in fact, competitive pressures have caused them to "work" their asset base harder (e.g. by doing more NHS work). In addition, it should also be noted that the financing and accounting models differ considerably between operators.¹¹ Unless the differences in operational efficiency and the different financial models of the PH operators are taken into consideration, the CC's ROCE analysis will be misleading.

The investment cycle and the 5-year period for assessment

- 2.8 In its working paper, the CC refers to its market investigation guidelines (in paragraph 25) which explain that profitability at certain points in time may exceed "normal" levels for several reasons, including *"cyclical factors, transitory prices...other marketing initiatives...past innovations or efficiency improvements..."*. The CC goes on to note that it considers the approach of *"...analysing the seven largest firms over a five-year period reflects the overall average level of profitability of the industry rather than reflecting the position of any individual firm or the impact of transitory factors."*
- 2.9 The CC also notes that, as it has not carried out a detailed assessment of profitability prior to 2007 *"[it] recognise[s] that it may be necessary to consider a number of such factors, including past innovation, efficiency and the economic cycle, when interpreting the results of [its] profitability analysis on each of the Relevant Firms"*. In this regard, Ramsay notes that a number of the aforementioned factors are relevant to the interpretation of Ramsay's profitability, particularly the CC's use of 'partial' investment cycles and the efficiency improvements realised by Ramsay (and other operators).
- 2.10 In this regard, fixed assets in the private healthcare industry often have a life span in excess of 10 years, and buildings last much longer. The CC's approach of analysing profitability over a five year period only covers a subset of the life of the fixed assets employed in the industry, and therefore does not capture the full investment cycle. In industries like private healthcare, where significant up-front capital investment costs have been incurred and investment programmes are typically large and periodic, this approach is liable to generate an unreliable picture of profitability (both in terms of the relative profitability of operators across the industry, and the profitability of each operator over time). Accordingly, the CC should be very wary of relying on results of such partial analysis.¹²
- 2.11 The CC should also note that Ramsay has implemented a variety of initiatives which have progressed the business from a situation of [§]. Since acquiring the UK business, Ramsay [§]. In this regard, a five year time period is not adequately long enough to observe the overall impact of these changes. Therefore, any profitability identified by this

¹⁰ As set out in paragraph 2.3 of Ramsay's response to the draft Financial Questionnaire (13 July 2012), Ramsay [§].

¹¹ E.g. Nuffield is run as a charity and therefore does not have the same VAT costs for example, some operators are highly leveraged and some are owned by private equity firms.

¹² For instance, in circumstances where the investment profile is "lumpy", a company with a particular type of asset, for example diagnostic equipment, which is approaching the end of its economic life will have a very different ROCE to a company which has recently completed an investment programme to replace all of its diagnostic equipment, even if the two operators' asset bases are identical in all other respects, earn the same revenue and incur the same operating costs. In this circumstance, the divergence between the companies' ROCE will only reflect the different capital values assigned to these particular assets at a specific point in time, which is completely unrelated to the effectiveness of competition in the market, and the returns each company makes.

analysis is likely to reflect Ramsay's business strategy and management efforts rather than the extent of competition in the market.

- 2.12 Accordingly, Ramsay would urge the CC to be wary of relying on the potentially misleading results of its profitability analysis which only considers a partial investment cycle and does not control for [X] Ramsay has realised.

3. CALCULATION ERRORS IN THE ROCE ASSESSMENT

3.1 The CC's preliminary analysis concludes that:

- (a) the weighted average return across all of the private healthcare providers between January 2007 and June 2012 was 18 per cent. This compares to an average industry WACC of around 9 per cent (i.e. in a range of 7.3 to 10.0 per cent);
- (b) in relation to Ramsay, the CC's analysis shows that Ramsay made an average return of [X] per cent over the same 5 year period, against the same average industry WACC of around 9 per cent; and
- (c) the same analysis records Ramsay's financial performance as [X] in the last 3 years, with its returns [X].

3.2 The CC concludes that this profitability analysis shows that *"the Relevant Firms are, on average, making returns in excess of the cost of capital"*.¹³ The CC also suggests that this finding is consistent with its preliminary conclusions of market power in certain local areas¹⁴ and that it is consistent with some hospital groups having market power in national price negotiations (i.e. that it is consistent with Theories of Harm 1 and 3).¹⁵

3.3 However, Ramsay is concerned that there are some material errors and omissions in the profitability calculations, which significantly overstate Ramsay's ROCE and understates its WACC. These errors and omissions include the following:

- (a) The CC has incorrectly pro-rated the capital value of the Nottingham Woodthorpe hospital in 2008;
- (b) The CC has failed to take into account the depreciation costs in relation to centralised corporate costs;
- (c) Ramsay's ROCE in 2012 is artificially inflated by a transitional change in the way that the NHS is paying for services, which has [X] in Ramsay's business;
- (d) Assets which are fully depreciated in Ramsay's accounts but are still in use, have not been adjusted in the calculations. This means that Ramsay is making returns from assets with a zero book value in the accounts;
- (e) The CC has not assigned any value to intangible assets to Ramsay's business, which is simply implausible in a knowledge-based service industry;
- (f) The CC has not taken account of the MEA value of Ramsay's leases, which is an inconsistent approach compared to its assessment of freehold land and buildings;
- (g) The CC has failed to take account of the MEA value of equipment, furniture and fittings, which would generally be expected to have increased over time;
- (h) The CC's valuation of freehold land incorrectly values Ramsay's Nottingham Woodthorpe hospital at agricultural rates.

3.4 Each of these factors is discussed in turn below.

¹³ Paragraph 4.

¹⁴ Paragraph 71, AIS.

¹⁵ Ibid.

The allocation of the Nottingham Woodthorpe acquisition costs

- 3.5 As previously explained to the CC, Ramsay acquired Nottingham Woodthorpe hospital in March 2008. However, rather than including the full value of the hospital in Ramsay's capital base for 2008, the CC has pro-rated the asset value from the date of acquisition. As Ramsay's 2008 financial year was an 18-month reporting period, this means that the CC has only included 3/18ths of the capital value of the Nottingham Woodthorpe hospital in its ROCE calculations for 2008.¹⁶
- 3.6 This is an incorrect approach and contrary to standard accounting practice. This accounting error results in an underestimation in the capital employed in Ramsay's business in the 2008 financial year and therefore overstates ROCE.
- 3.7 Ramsay has re-worked the CC's calculations and made an adjustment to include the full value of the Nottingham Woodthorpe hospital in the capital employed for the 2008 financial year. This adjustment has the effect of:
- (a) reducing Ramsay's average ROCE over the five year period from [x%]; and
 - (b) reducing Ramsay's ROCE in 2008 by [x%].
- 3.8 The re-worked calculations showing the impact of this adjustment are attached as Appendix 1.

Depreciation of centralised corporate costs

- 3.9 The CC's ROCE calculations have taken Ramsay's centralised corporate costs into consideration, but the CC has failed to make an allowance for the depreciation of those centralised assets. That depreciation effectively relates to all the IT assets that support the business including the data centre, the PCs and equipment, the accounting systems, patient systems etc. The effect of this oversight is that Ramsay's earnings in each year during the reference period are overstated, which has the effect of overstating Ramsay's ROCE.
- 3.10 In the email from Christiane Kent dated 25 March 2012, the CC has specifically asked Ramsay to [x%]. The relevant information is included in Appendix 7. Ramsay has listed each of the various corporate assets that cost more than [x%], with the balance of IT assets shown in total. Of note, the largest expense items were in relation Ramsay's patient administration system, its data centre, and its accounting system, all of which are relevant to the hospitals within the scope of the CC's investigation.
- 3.11 Ramsay also provided a full breakdown of corporate costs in its response of 1 February 2013, which was consistent with the numbers provided in response to Question 8 of the Financial Questionnaire. It was agreed with the CC that [x%] per cent of these annual corporate costs should be allocated to private hospitals based on the proportion of Ramsay's total revenues that are generated by the hospitals within the reference market [x%].¹⁷
- 3.12 Accordingly, the second amendment Ramsay has made to the CC's ROCE calculation is to include [x%] per cent of the corporate depreciation costs in the calculations. This adjustment has the effect of:

¹⁶ As previously explained to the CC, following Ramsay's entry into the UK market in November 2007, the financial year for the reporting of the accounts was adjusted to bring it into line with Ramsay's parent company (i.e. the financial year was adjusted so that it runs from 1 July to 30 June). This means that there was an initial 18 month reporting period from 1 January 2007 to 30 June 2008.

¹⁷ See 25 January 2013 response regarding the allocation of corporate costs [x%].

- (a) further reducing Ramsay's average ROCE over the five year period by [~~3~~] percentage points; and
- (b) reducing Ramsay's annual ROCE values to [~~12~~].

3.13 The re-worked calculations showing the impact of this adjustment in isolation (i.e. excluding the previous adjustment for Nottingham Woodthorpe) are attached as Appendix 2, and a summary table showing the cumulative impact of the changes is set out in Appendix 6.

Fully depreciated assets

3.14 As set out in Ramsay's 20 December 2012 response, Ramsay's capital base includes a significant proportion of fixtures, fittings and equipment which are fully depreciated in its accounts (and therefore have a net book value of zero) but are still in use. These assets provide a contribution to earnings but have no corresponding value in Ramsay's accounts. Ignoring them for the purposes of the calculation of economic profitability will therefore have the effect of significantly overstating ROCE.

3.15 Despite being provided with all the relevant information in relation to these fully depreciated assets (see Ramsay's responses of 20 December 2012 and 11 January 2013), the CC has not made any adjustments to its ROCE calculations. This is also despite the fact that the CC itself acknowledges (at paragraph 52 of the Working Paper) that:

- (a) *"the pattern of depreciation applied may not accurately match the rate at which certain assets actually depreciate in value";*
- (b) *"the period of time over which an asset is depreciated may not reflect its useful economic life";* and
- (c) *"the assets recorded in the fixed asset register may not reflect those being used to provide services to patients".*

3.16 However, the CC's approach fails to reflect economic reality. In particular, it simply adopts the accounting practice whereby these assets were depreciated rapidly in the early years, which means that the asset lives used in the accounts did not match the actual economic reality and value of those assets. It is the latter which is relevant for the purposes of a ROCE assessment which the CC is purporting to carry out and which must reflect the fact these assets are still in use over the period and thus still have an economic value to the business for the purposes of ROCE analysis.

3.17 The CC states in paragraph 53 of the Working Paper that *"we believe that the actual spare capacity may indicate that not all assets are efficiently employed"*, and seems to suggest that this, in some way, provides the justification not to increase the capital employed to include those assets still in use that have been fully depreciated in the accounts (i.e. the CC seems to suggest that as it has not *"sought to reduce the level of capital employed to reflect the efficient utilisation of assets"*, then it does not need to make an adjustment to take account of assets that have been fully depreciated in the accounts but are still in use). Ramsay fundamentally disagrees with the CC's reasoning for four reasons:

- (a) the statement implies that any overestimation of capital employed due to "excess" capacity in the industry will be offset by the underestimation of the capital base as a result of applying no adjustments for the aggregate level of fully depreciated assets in the industry. This is an implausible position to take. The CC's role is not to "horse trade" one factor off against another in the hope that it, in some unquantified way, balances itself out, but to make all the necessary adjustments to ensure that it is carrying out a fair and balanced assessment of ROCE;

- (b) the CC recognises that the nature of private healthcare industry means that assets cannot be worked at 100 per cent capacity utilisation, and instead need to be run with a certain level of spare capacity.¹⁸ This spare capacity is required for a number of reasons, including to be responsive to patients needs; ensure patient treatment is prompt and there are no delays; and, to fit around the consultants work patterns. To achieve a 100 per cent capacity utilisation rate assets such as theatres and equipment would need to be used throughout the day and night which is an unreasonable assumption to make;
- (c) the fact that there is some excess capacity in private hospitals, does not of itself even justify an assumption that there are various assets in the business that are not being used at all (and therefore are not required in the business/will not be replaced when they are fully depreciated). For example, as mentioned above, the utilisation rates of theatres reflect consultants' working patters; the spare capacity in overnight beds ignores the fact that they may be fully utilised during the day (e.g. for day patients); the availability of consultancy rooms reflect the times that doctors want to work, and patients want to be seen, and so on. Accordingly, the link that the CC is attempting to draw between excess capacity in hospitals and assets that are fully depreciated in the accounts but still in use simply does not exist; and
- (d) as previously explained to the CC, Ramsay's business model focuses on [X]. When Ramsay entered the UK there was significant excess capacity in the private hospitals sector, but Ramsay's strategy has been to [X]. The growth in Ramsay's business [X], which further suggests that the CC's position is unrealistic when applied to Ramsay.
- 3.18 In light of the above, Ramsay considers there is no justification for the CC to continue to fail to make the appropriate adjustments for fully depreciated assets in the ROCE calculations. In particular, the argument made by the CC in respect of lack of "efficient utilisation of assets" is unrelated to the error Ramsay has pointed out and is itself speculative and incorrect.
- 3.19 In this regard, Ramsay submitted an extract from its fixed asset register in its response of 11 January 2013. The spreadsheet attached at Annex 3 contained details from the fixed asset register on over 11,600 lines of assets which were fully depreciated in Ramsay's account, but were still in use, as of 30 June 2012. The assets include a mix of fixtures and fittings, medical and diagnostic equipment, IT and management systems and administrative equipment.
- 3.20 For the purpose of determining the impact on Ramsay's ROCE from these fully depreciated assets, Ramsay has assumed, on a cautious basis, that as those assets were still in use up to 30 June 2012 but thereafter had a zero net book value in Ramsay's accounts. This limits the actual economic life of those assets up to 30 June 2012 even though many will continue in use after that date.
- 3.21 Accordingly, this is itself a very cautious approach since the vast majority of these assets are still in use as of today, which means that they are generating and will continue to generate a return for the business even though there is no associated book value of these assets (even on the basis of this adjusted approach). Accordingly, the relevant economic life of these assets is actually longer than has been assumed in this adjustment.
- 3.22 The third adjustment that Ramsay has made has the effect of:
- (a) decreasing Ramsay's average ROCE over the five year period by [X] percentage points; and

¹⁸ Paragraph 53.

(b) increasing Ramsay's ROCE in 2008 and 2009 by [X] percentage points but reducing Ramsay's ROCE in 2010, 2011 and 2012 by [X] percentage points respectively.¹⁹

3.23 The re-worked calculations showing the impact of this adjustment in isolation (i.e. excluding the previous adjustments for Nottingham Woodthorpe and corporate cost depreciation) are attached as Appendix 3, and a summary table showing the cumulative impact of the changes is set out in Appendix 6.

Intangible assets

3.24 At paragraph 11, the CC states that "*[it] has... made adjustments, where appropriate, for certain intangible assets*". Therefore, Ramsay is extremely surprised as to why the CC has not applied any asset value to Ramsay's business for intangible assets, effectively estimating that Ramsay's intangible assets are zero. This is simply not plausible. The healthcare sector is a professional services and knowledge-based industry, and intangible assets will invariably account for a significant proportion of the total asset base.

3.25 Ramsay submitted a detailed response on 11 January 2013, which described the various classes of intangible assets in its business. These include:

- (a) the established operating processes and procedures;
- (b) human capital in the form of an experienced and well trained workforce;
- (c) relationships with GPs, consultants, insurers, the NHS and ultimately patients;
- (d) leadership;
- (e) brand and reputation; and
- (f) IT systems etc.

3.26 The CC has not provided any specific justification as to why these intangible assets should not be taken into account in its ROCE assessment. Ramsay notes that even in the recent local buses inquiry, the CC included a value for intangible assets within its ROCE calculation (to take account of driver training and apprenticeship costs). It is completely implausible to suggest that the intangible assets in a knowledge based service sector such as private healthcare are less than in the local buses sector.

3.27 As the CC will be aware, the market investigation into Statutory Audit Services has just published its Provisional Findings and therefore adds to this precedent. It is important to note that the CC concluded that: "*[it was] not able to reach a conclusion on whether audit firms were making profits above competitive levels or otherwise in this market. This was on account of difficulties in valuing capital employed; the intangible nature of the asset base in this market; difficulties in cost allocation (as firms offered both audit and non-audit services)...*" [emphasis added].²⁰ The CC also notes in its Provisional Findings that "*In the case of large professional service firms, much of the asset base is intangible in the form of clients, reputation, human and intellectual capital, and much of this capital (and other types of costs) is shared with other service lines.*"²¹ Exactly the same reasoning applies in relation to the private healthcare sector, which is unsurprising given that PH is also a knowledge based service sector.

¹⁹ This re-balancing effect reflects the fact there is a lower expense charge for depreciation in the accounts which impacts on the earlier period, but there is an increase in the capital base from extending the useful economic life over a longer period.

²⁰ Paragraph 10, Statutory Audit Services For Large Companies Market Inquiry, Provisional Findings Report.

²¹ Paragraph 7.69, Statutory Audit Services For Large Companies Market Inquiry, Provisional Findings Report.

- 3.28 In contrast, the CC is mis-interpreting the criteria set out in its guidelines in relation to intangible assets in this case, which means that it is applying an inconsistent and unbalanced approach. This is further adding to the upwards bias in the CC's ROCE calculations. In this regard, the CC reiterates its June 2012 market investigations guidelines which state that the CC may consider the inclusion of intangible assets where the following criteria are met:
- (a) it must comprise a cost that has been incurred primarily to obtain earnings in the future;
 - (b) this cost must be additional to costs necessarily incurred at the time in running the business; and
 - (c) it must be identifiable as creating such an asset separate from any arising from the general running of the business.
- 3.29 The CC mis-interprets the third limb of this test. In particular, the CC has rejected:
- (a) staff training and recruitment as an intangible asset on the basis that it *"represents expenditure that is necessarily incurred at the time in running the business, rather than being in addition to it"*;²²
 - (b) the relationships with GPs and consultants as an intangible assets on the basis that *"these relationships do not meet the criteria as assets separate from any arising from the general running of the business"*;²³ and
 - (c) rejected the clinical and administrative processes and know-how on the basis that *"it is not clear that there is an intangible asset of clinical processes separate from the employment of appropriately trained medical directors, matrons and other clinical staff, who are responsible for developing and updating such processes on an ongoing basis."*²⁴
- 3.30 The CC's analysis is circular since all investments, whether in relation to tangible assets or intangible assets, arise to a greater or lesser degree in connection with the general running of the business.
- 3.31 The CC's current approach is also inconsistent with a number of previous inquiries where intangible assets arising in connection with the running of the business have of course been accepted. For example, training of employees (drivers and apprentices) was accepted in the Local Buses inquiry, whilst in the Home Credit inquiry, the CC identified four possible categories of intangible assets:
- (a) an experienced and trained workforce (including staff recruitment costs and both initial and subsequent formal training costs (both in-house and external));
 - (b) costs incurred in successfully recruiting new customers, or successfully gaining new sales to existing customers;
 - (c) knowledge of customers' creditworthiness – representing the costs that a business has incurred in building knowledge of its customers; and
 - (d) IT systems.

²² Paragraph 68.

²³ Paragraph 72.

²⁴ Paragraph 76.

- 3.32 It is far from clear how these categories of intangible assets can be included and/or recognised as material in previous inquiries, including Local Buses, Home Credit and Statutory Audit, on the basis that they are considered to create an asset separate from any arising from the general running of the business, but many of the same categories of intangible assets are not accepted in relation to private healthcare. This seems to be a wholly inconsistent approach, reflecting an incorrect and biased interpretation of the third limb of this test.
- 3.33 If, as Ramsay understands, the rationale behind the third limb of the test above included the need to avoid "double counting" of assets because their value had already been captured elsewhere within the ROCE analysis, Ramsay is confident that the items it has identified do not duplicate costs or other items that have already been taken into account.
- 3.34 For example, in respect of knowhow and processes, Ramsay has clearly explained to the CC why the value inherent within these assets is not in any way reflected in the discrete training budgets or the wage costs of, for example, senior nursing personnel. Safe operating procedures within Ramsay as, for example, captured in its operating protocols, are the product of years of collective learning and improvement developed through the institutional framework and belonging to the business. To the extent these protocols are recorded in databases, the CC should appreciate that these databases will obviously have a proprietary value. To the extent that they are not so recorded, they still form part of the essential operating fabric of the business whereby the value of each individual employee is magnified by the value they generate for the business operating according to safe and efficient procedures.
- 3.35 Furthermore, Ramsay's knowledge of [X] is something that has been developed over time and is within the Ramsay business. This knowledge stems from [X]. This knowledge has proprietary value within the Ramsay business and is an asset providing Ramsay with competitive advantage.
- 3.36 Ramsay also has regard to the email from the CC dated 25 March where it was suggested that:
- [X]
- 3.37 However, this approach is as equally illogical and tending to bias as the misapplication of the guidance noted above. The fact that an intangible asset may be difficult to value does not in and of itself justify excluding its existence altogether from the relevant asset base for the purposes of an economic ROCE calculation, as the CC currently seeks to do. Rather, the question is how best to value or estimate the asset concerned or, if the impact of intangibles is so material, to reconsider whether it is appropriate to pursue or otherwise place weight upon the ROCE calculation performed. The latter approach is entirely consistent with the approach followed in the Statutory Audit market investigation, where the intangible asset base was recognised to be material but incapable of accurate quantification.
- 3.38 Ramsay has provided estimates as to the value of the broader intangible asset base to the CC previously and, again, the unsurprising conclusion in a knowledge based service business dependent upon reputation and processes, is that it is very material indeed.
- 3.39 As set out in Ramsay's response of 20 December 2012, Ramsay's preferred approach to the valuation of intangible assets is to calculate the total value of the business based on discounted future cash flows (i.e. an income valuation methodology). This is a widely recognised approach for valuing businesses and business assets and is one of the most comprehensive appraisal techniques (the intangible asset base is calculated by deducting the tangible capital base from the total valuation of the business). However, the CC has said that it has dismissed this approach due to concerns over "circularity" in the analysis

(i.e. that the valuation of the business may include any future earnings in relation to market power).

- 3.40 Ramsay considers that the CC is significantly overstating this concern. Any additional value arising from the business over and above the tangible asset base is likely to reflect a payment for the knowledge-base, the brand, the reputation etc. and the CC has no basis to "import" an assumption regarding the existence of market power. In any event, whilst the CC has dismissed the discounted cash flow methodology put forward by Ramsay, the cost-based methodology suggested by the CC itself adopts a much more extreme and ultimately unsupportable approach by failing to take any account at all of the value of any intangible assets in the business. This has the inevitable result that the overall asset base is understated by a significant margin.
- 3.41 On the basis of Ramsay's calculations, if a discounted cash flow model is used to value these intangible assets, then this adjustment (on top of the adjustment for Nottingham Woodthorpe, the adjustment for corporate cost depreciation, and the adjustment for fully depreciated assets) further reduces Ramsay's average ROCE by a further [X] percentage points. Clearly, even if the CC assumes that only 20-30 per cent of this value is relevant for calculating intangible assets, it still reduces Ramsay's ROCE by [X] percentage points.
- 3.42 The re-worked calculations showing the impact of this adjustment in isolation are attached as Appendix 4, and a summary table showing the cumulative impact of the changes is set out in Appendix 6.

Leased hospital buildings

- 3.43 The CC (at paragraph 27 of the Working Paper) states that the "*...conceptually appropriate method to estimate the capital employed in an industry is to use the MEA value or DRC of the assets comprising the capital base*". The CC also explains in paragraph 12 of the Working Paper that the CC has made an adjustment to capital employed so that it reflects the modern equivalent asset value (MEA) of those assets required to deliver the service. However, while the CC has sought to estimate the value of freehold land and buildings at their MEA value (i.e. the replacement cost), it has not made an equivalent adjustment to rents and leases, choosing to value these at historic net book values.
- 3.44 Ramsay disagrees with this approach; not only does it not reflect the current market value of the leases and is therefore not economically meaningful, it is internally inconsistent with the CC's approach to valuing the equivalent asset classes of Ramsay's competitors.²⁵ As the majority of Ramsay's property portfolio is leased, this raises serious doubts as to whether meaningful inferences can be drawn from a comparison of the profitability assessment with the other operators.
- 3.45 As previously mentioned, and noted above, all but two of Ramsay's hospitals (Nottingham Woodthorpe and The Lodge) are leased and are accounted for as such in Ramsay's statutory accounts. The majority of these properties are leased from one landlord, Prestbury.²⁶ In May 2007, Capio UK (acquired by Ramsay later that year) renegotiated the lease terms for 20 of its properties owned by Prestbury. At this time, the rent values for each of property [X].
- 3.46 As noted above, due to [X]. Accordingly, the rent costs used in the CC's calculation are not reflective of the current market rate (i.e. the replacement cost) of Ramsay's leases, but instead reveal historic costs of the agreement.
- 3.47 To compute an economically meaningful measure of Ramsay's rental rates for use in the ROCE calculation, the rent for each property would need to be revalued in each year to

²⁵ See paragraphs 44 to 48.

²⁶ See Annex 4 of Ramsay's submission titled "Follow up questions on profitability methodology" (20 December 2012).

reflect the amount which would have been agreed between Ramsay and Prestbury in the face of [§<] (an approach which is confirmed by the CC).²⁷ For example, if [§<].

- 3.48 The CC attempt to justify its decision to include rent costs at their historic level by stating that *"it is not clear whether the cost of the lease would have increased due to higher earnings of the operating company,...or decreased because of the financial crisis and the steep declines in interest rates and asset yields over the period"*.²⁸ The CC's reasoning appears to be flawed for a number of reasons:
- (a) The assertion that rents may have fallen because of the financial crisis and the steep declines in interest rates and asset yields appears to be nothing more than pure speculation. The CC has not provided any evidence to support this assertion;
 - (b) The value of the leases are designed to reflect the [§<] irrespective of whether those leases were re-negotiated with Ramsay or another operator altogether;
 - (c) Ramsay believes that if it was to lease additional sites in the market tomorrow, then [§<] would apply to the lease values;
- 3.49 Ramsay has explained above the reasons why [§<] in the private patient market and Ramsay has provided the CC with clear evidence to establish that fact.

MEA value of Equipment, furniture and fittings

- 3.50 The CC states in paragraph 51 of the Working Paper that it has valued all equipment, furnishing, fixtures and fittings at the net book values indicated in the statutory accounts. However, the net book value is an accounting, rather than economic, measure of an asset value, and may therefore not reflect an asset's true economic value. As previously mentioned, Ramsay is concerned that this approach will generally undervalue the cost of the equipment, furniture and fittings used in its hospitals, and therefore understate the capital employed in its business. This is because the cost of replacing these assets can generally be expected to increase over time (e.g. due to inflation or technological advances).²⁹
- 3.51 In line with the CC's approach of valuing freehold land and buildings, the CC should be seeking to calculate the replacement costs (using MEA valuations) of these assets. This would provide a more realistic valuation of the actual cost of replacing the assets, which are the costs that Ramsay will actually face once the assets have reached the end of their useful economic life. In this regard, Ramsay notes that in the recent market investigation into local bus services in the UK, the CC recognised that buses (within the same category of assets to those in question) needed to be adjusted to the MEA values.³⁰ The CC noted that in order to calculate ROCE *"...we needed to establish an appropriate value for capital employed, recognizing that the historic cost of assets may not be economically meaningful for our purposes. Returns based on the historic cost of assets may result from a combination of changes in asset values due to price changes or technological changes and economic returns generated by the business activities employing those assets. To calculate the economic returns it is necessary to use the MEA value. [emphasis added]"*³¹

²⁷ Paragraph 50: *"Our understanding of the 'replacement cost' of a rental agreement is what would be agreed by a lessor and lessee in each year of the period. This is not necessarily the same as that which was agreed for the life of the lease at the beginning of the period"*.

²⁸ Paragraph 50.

²⁹ See paragraph 3.9 to 3.11 of Ramsay's response titled "Comments on the CC's working paper titled "Profitability analysis of private hospital operators: Planned methodology".

³⁰ Paragraphs 10.17 to 10.23, Local bus services market investigation, Final report.

³¹ Paragraph 10.17, Local bus services market investigation, Final report.

- 3.52 Accordingly, as is widely agreed in the financial valuation literature, it is only appropriate to value assets at historic costs (rather than at MEA value) if, amongst other factors, the assets do not have significant economic value, technological advances are limited and/or any revaluation would be immaterial. This is not the case in relation to the private healthcare sector. At the very least, the CC should revalue these assets in order to take account of the effects of inflation (e.g. using RPI or CPI).

The valuation of freehold land

- 3.53 As set out in Ramsay's 8 February 2013 response³², Ramsay has concerns about certain aspects of the land valuation exercise undertaken by DTZ. Although this is ultimately not a key issue for Ramsay (as it only owns the freehold to the Nottingham Woodthorpe and The Lodge sites), the CC's approach does affect the valuation of the Nottingham Woodthorpe site in particular.
- 3.54 Ramsay is concerned that DTZ has not specifically sought to value the sites on which the hospitals are located (which is the relevant assessment for the purposes of assessing the value of the capital employed in its business), but instead has sought to establish "*the lowest amount that a hypothetical prudent purchaser would pay to acquire a site for an equivalent development in a relevant location*".³³ However, the CC has not explained how these alternative sites have been determined.
- 3.55 In this regard, the Nottingham Woodthorpe site has been classified as agricultural land and valued at [redacted] per acre (towards the lower end of the range for agricultural land values). This translates into a total valuation of [redacted] for the 1.43 acre site. This classification is highly questionable given that the Nottingham Woodthorpe site is located in a residential area of Nottingham, it is connected to the local road system and is well served by public transport links to and from the city centre.
- 3.56 A simple comparison with the estimated land value of The Lodge highlights the implausibility of this approach. DTZ has valued the 1.43 acre site at Nottingham at [redacted] higher than The Lodge's 0.27 acre site (valued at [redacted]). This is despite the fact that the Nottingham site is an established hospital that provides a full range of treatment types, whereas The Lodge only provides a limited range of treatment, mainly for outpatient and daycases. Also, Nottingham Woodthorpe generates around [redacted] times the revenues of The Lodge.³⁴ In terms of location and earnings potential, it is implausible that DTZ has only given the Nottingham site a [redacted] valuation than The Lodge.
- 3.57 In addition, the CC has applied a 15 per cent discount to the gross acreage of all hospital sites between one and 10 acres, even though sites within this range are identified as appropriately sized.³⁵ This reduces the size of the Nottingham Woodthorpe site from its actual size of 1.43 acres to only 1.22 acres. The CC (at paragraph 36) explains that this adjustment is based on the assumption that "*a purchaser would only pay for the proportion of a site that could be developed [under local authority guidelines], which DTZ estimates to be 85 per cent of the gross land area*".³⁶ As the CC is well aware, land is a hedonic good, whose market value is determined by the particular combination of characteristics it possesses. For example, its location, transport links, whether it is rural, suburban or urban, and the availability of open space. The overall market value of a site is determined by the quantity and quality of all these features.

³² Ramsay Health Care UK's comments on DTZ's Draft Report on Land Valuations (8 February 2013).

³³ Paragraph 2.8.

³⁴ For example, annual revenue in 2011/12 was [redacted] at Ramsay's Nottingham hospital compared to gross annual revenue of [redacted] at the Lodge

³⁵ Also see paragraph 31.

³⁶ Paragraph 36. Also see paragraphs 2.24 to 2.27 of "Provision of Land Consultancy Services" (DTZ, 2013) for a more detailed explanation of DTZ's rationale.

- 3.58 Accordingly, the overall market value of a hospital site is determined by the quality and quantity of the "developable" and the so-called "undevelopable" land. Given that the quality and quantity of "undeveloped" land is capitalised into the land valuation, applying this "net-down assumption" incorrectly reduces the acreage, and therefore understates the market value of Nottingham Woodthorpe.
- 3.59 All else equal, the incorrect valuation of the Nottingham Woodthorpe site further results in an underestimate of the capital employed in Ramsay's business, and consequently an overestimation of its ROCE.

Working capital adjustment

- 3.60 It should be noted that the increase in Ramsay's 2012 financial year ROCE the CC has calculated, reflects [x]. This is due to a transitional change in the way Ramsay is being paid by the NHS, which is [x] in 2012.
- 3.61 Accordingly, the CC should make an additional adjustment to take account of this transitional effect, particularly given that NHS-funded treatment is outside the scope of the investigation. One way to do this is to assume that [x] of the previous four years equally applies in 2012. On this basis, Ramsay's calculations show that its average ROCE (calculated by the CC) is being [x] percentage points and by [x] percentage points in 2012 as a result of this change. The workings showing the impact of this adjustment (in isolation) are provided at Appendix 5.
- 3.62 Accordingly, the CC should be extremely cautious of jumping to conclusions in relation to the increase in Ramsay's ROCE in 2012, when this is likely to largely reflect the temporal change in the way it is being paid by the NHS.

Conclusion

- 3.63 The CC needs to reconsider its analysis urgently and adopt a more balanced approach. Most importantly, the effect of adjusting even just the most obvious errors and omissions even where that adjustment is carried out on a prudent basis is highly material to the CC's profitability analysis and, effectively, removes any justification to assert that Ramsay is somehow earning profits above the competitive norm.
- 3.64 For example, simply correcting the analysis for the errors in the calculations in relation to the capital value of the Nottingham Woodthorpe hospital in 2008, taking corporate cost depreciation into account, and making a cautious adjustment for the fully depreciated assets reduces Ramsay's ROCE by [x] percentage points to just [x] per cent (i.e. just [x] of the WACC range). This clearly excludes the impact of all the various other omissions in the CC's calculations, e.g. in relation to intangible assets, the MEA value of rent and equipment etc., which will reduce Ramsay's ROCE even further.
- 3.65 A summary of the cumulative effect of the various adjustments made by Ramsay (e.g. for Nottingham Woodthorpe, corporate cost depreciation, fully depreciated assets and intangibles) is set out on the following page.

Summary of the cumulative impact of the various adjustments made by Ramsay on its ROCE

[X]

4. METHODOLOGY USED FOR CALCULATING COST OF CAPITAL

The use of an average industry wide WACC

- 4.1 At paragraph 89 of the Working Paper, the CC states that "[t]he benchmark for our profitability analysis is the WACC of a hypothetical typical, UK stand-alone private hospital operator of a similar size to the relevant firms." The CC goes on to justify this approach by stating that:

"...it consider[s] that the risk profile of one private hospital operator in the UK does not differ materially from that of another private hospital operator. This does not mean that there will not be some variation in risks across local markets and customer types but that all private hospital businesses are exposed to systematic risks to broadly the same extent. Financing costs and the ability to raise funds should also be similar across all operators based on risk profile. This is unaffected by an individual company's choice of capital structure. Consequently, we have estimated a single WACC for the private healthcare industry."

- 4.2 Ramsay considers there to be a number of problems with this statement.
- 4.3 First, the statement is misleading as it fails to take account of the significant heterogeneity across the industry as regards factors which influence the cost of capital. As noted in Ramsay's response to the CC's cost of capital methodology paper, there are considerable differences between private healthcare operators in terms of the customer groups they serve, their wider business model, their financing model, their geographic coverage (of regions within the UK and overseas) and risk factors.³⁷
- 4.4 Second, as the CC is well aware, a company's risk profile is determined by systematic and company specific risk (i.e. unsystematic risk). The CC's justification of an industry-wide WACC relies on the assumption that operators are "*exposed to systematic risk to broadly the same extent*"³⁸ and therefore have the same risk profile. Not only is this statement factually incorrect (see below), it also understates the contribution (and relative importance) of company-specific risk in determining the risk premium companies must pay when issuing debt or equity (i.e. the cost of capital). Private healthcare operators are diversified across a variety of different markets, different geographical areas with different health systems, which are exposed to different political and economic risks. Private healthcare operators also have different business strategies and financial models. These factors mean companies have different degrees of systematic and company-specific risk resulting in different risk profiles, and therefore different costs of financing.
- 4.5 Third, an industry-wide WACC is likely to be distorted by the operations of a limited subset of PH operators, and therefore does not provide a fair proxy of Ramsay's (or other parties') specific cost of capital. Accordingly, an industry average WACC does not provide a meaningful comparison for assessing whether the individual parties are making profits substantially in excess of their own cost of capital.
- 4.6 It should also be noted that the CC has taken this approach despite the clear evidence set out in Table 1 of Appendix 3, showing the considerable variations in key determinants of a firm's cost of capital (the equity beta, debt-equity ratio and effective tax rate) across a sample of listed private hospital operators. For example, operators' equity betas vary

³⁷ For example, Nuffield is a run as a charity and is not controlled by shareholders; Nuffield's charitable status also means that it qualifies for a number of tax exemptions (as well as relief on capital income and capital gains) meaning that its VAT costs and corporate tax liabilities are different to other operators; and, certain operators have been acquired as investments by private equity firms through leveraged buyouts, and are therefore highly leveraged and more dependent on debt financing.

³⁸ Paragraph 89.

between 0.422 and 1.316, while the effective tax rate varies between 10.9 and 42.1 per cent.³⁹ It is clear from this information that given the material differences in each of the components of the WACC calculation, the CC's approach of calculating an industry-wide WACC is not appropriate.

The use of a single average WACC over a 5-year period

- 4.7 The CC states in paragraph 90 that it has estimated a single or average cost of capital for the whole period and *"does not consider that estimating a separate cost of capital for each year would provide additional useful information for [the] analysis."* As mentioned above, the Relevant Firms' are highly differentiated in terms of business models and financial performance and have been subject to very different trends during the five-year period under consideration, for example in terms of NHS work undertaken, the impact of the financial crisis and changes to the macroeconomic (e.g. different levels of inflation) and political environment in the national markets they operate in.
- 4.8 The use of a single average WACC over a 5-year period means the significant year-on-year variations in cost of capital is effectively "lost" by averaging over the five years (given that averages tend to "smooth" out annual variations in the cost of capital figures). The comparison of a single average WACC to annual estimates of profitability, means that it is impossible for the CC's analysis to differentiate between profits in excess of cost of capital in a given year (i.e. super-normal profits), and annual variations in profit which keep pace with cost of capital (i.e. normal profits).
- 4.9 It should also be noted that the WACC calculations are based on historic data covering the period January 2007 to June 2012, which may not be a reliable indicator of the cost of capital going forwards, particularly given that this period corresponds to the worst financial crisis since the 1930's. The WACC of a business tends to vary over time since most of the inputs necessary to perform the calculation (e.g. the risk-free rate, company beta and cost of debt) follow financial market and macroeconomic fluctuations.⁴⁰ Accordingly, an average WACC over a 5-year period is unlikely to be a representative indicator of the parties' WACC going forwards.

A hypothetical stand-alone UK PH operator

- 4.10 The CC states (at paragraph 83) that to determine whether companies are earning excessive profits due to market power, profits will be compared to *"the cost of capital that would have been faced by a hypothetical stand-alone UK private hospital operator"*.
- 4.11 The CC's approach to estimating the WACC for a stand-alone UK PH operator relies on evidence from diversified firms which have different business operations in different countries.⁴¹ Given that the reference market is focused on the provision of private healthcare services in the UK, and that non-relevant elements of the parties' businesses which do not form part of the reference market cannot be disentangled, it is difficult to see what evidential value a cost of capital calculated on this basis provides. As discussed further below, the diversified nature of the businesses in question should mean that the equity beta is lower than would be the case for a stand-alone UK operator, which will understate WACC.

³⁹ Table 1, Appendix 3.

⁴⁰ In this regard, the credit crisis has resulted in a high level of uncertainty in the estimation of forward looking financial figures (e.g. from the increasing costs of accessing debt financing, including that from stable and reputable institutions; a shortage of credit and lack of "cheap" financing sources; increasing risk aversion amongst loan issuers etc.).

⁴¹ Paragraph 112.

Specific issues with the WACC methodology

Risk free rate

- 4.12 The CC has used the nominal yield on medium- and long-dated (10-year and 20-year) UK gilts from 2007 to 2012 to estimate a UK risk-free rate of between 3.5 and 4.5 per cent.⁴² The CC states (at paragraph 97) that "*[t]he yields on nominal gilts have demonstrated a downwards trend over the period from between 4 and 5 per cent in 2007, to between 1 and 3 per cent in June 2012*" [emphasis added].
- 4.13 Yields on nominal gilts were at incredibly low levels over this period for a number of reasons including: the Bank of England's loose monetary policy through quantitative easing, which has seen it purchase a substantial proportion of all gilt issuance⁴³; investors viewing UK government bonds as a safe haven due to fear of further voluntary and/or involuntary restructuring of European Government debt (or at worst the Euro ceasing to exist in its current form); and, potentially the market's approval of the Coalition Government's austerity programme and commitment to cutting the budget deficit (relative to alternative investment countries).
- 4.14 Accordingly, it is unlikely that medium- and long-dated UK gilt yields over the reference period are representative of these gilt yields in a "normal" environment. The substantial decline in nominal gilt yields over the reference period means that an average over the previous five years is likely to understate the actual risk-free rate going forward, resulting in an underestimation of both the cost of equity and cost of debt, and therefore an underestimation of the WACC.
- 4.15 In this regard, Ramsay would suggest that the CC should carry out a sensitivity analysis of its cost of equity and cost of debt, looking at the impact of a higher risk-free rate on the cost of equity calculation and a higher effective interest rate on its cost of debt.

Equity beta for a stand-alone UK operator

- 4.16 The CC states (at paragraph 106) that it has calculated a beta on the basis of information from "*listed comparable companies*". The CC concludes (at paragraph 114) that "*[t]aking into account our own comparator analysis suggesting a range of 0.20 to 0.74 with an average of 0.47...and the views of the parties suggesting...an average of 0.57, we consider that a range of 0.5 to 0.6 is appropriate for the asset beta in our analysis*". Ramsay is concerned with the CC's approach to estimating the asset beta for a number of reasons:
- (a) As the CC itself notes "*all the firms [used in the comparator analysis] are listed on overseas markets and operate predominantly or wholly outside the UK. The existence of different public and private healthcare systems, as well as varying levels of economic and capital market development may result in firms having systematic risk profiles that are not directly comparable to those of a UK operator*". Therefore, Ramsay questions whether a comparator analysis on the basis of companies which are in fact not comparable to stand-alone UK private healthcare provider can provide any meaningful estimation of the required asset beta.
- (b) Ramsay and HCA have provided asset beta values for their parent companies.⁴⁴ Therefore, the level of both parties' asset betas do not reflect the provision of private healthcare services in the UK, but reflects the systematic risk for their global operations. The CC has not presented any evidence to support their assumption that group-wide betas are good proxies for the beta a UK stand-alone operator of private healthcare services. Ramsay considers that the systematic risk,

⁴² Paragraph 100.

⁴³ "The impact of Quantitative Easing on long maturity gilt yields" (Adrienn Sarandi, 2011).

⁴⁴ Paragraph 112.

and therefore the asset beta, measured across their UK operations alone is likely to be considerably higher than the group-level asset beta. This is because:

- (i) as mentioned in the response to the cost of capital methodology working paper, the systematic risk of the provision of private healthcare in the UK is likely to be significantly higher than in countries which operate a predominantly private healthcare system because NHS treatment is a readily available free alternative.⁴⁵ Therefore, patients will only purchase private medical insurance for private services if they believe when comparing the option private treatment gives them real added value (in terms of quality, range of treatment options and service); and
 - (ii) as noted above, the landscape of healthcare provision in the UK has changed considerably over the last two decades. Key reforms include the introduction (under New Labour) and extension of patient choice (under the Coalition Government), and the introduction of competition for routine elective care (i.e. the "any qualified provider" policy, under the Coalition Government). Both reforms have offered private healthcare operators the opportunity to expand the scope of their NHS activities. This means that Ramsay is exposed to regulatory/political risk (and therefore a higher systemic risk) from any "u-turns" on government policy in relation to the provision of NHS-funded treatment by private providers.⁴⁶
- (c) The analysis fails to account for differences in the large operators in terms of the revenue they obtain from private healthcare treatment. For example, Ramsay generates a lower proportion of its revenues from private healthcare in the UK compared to some of the other operators. However, its beta has been given the same weight as the other Relevant Firms which calculating the average beta.

4.17 The above factors all point to an asset beta of a stand-alone UK operator being significantly higher than that of a group, which is diversified across different markets and different geographic areas. This means that the CC's estimate of the WACC of a stand-alone UK operator is likely to be understated.

Cost of debt for a stand-alone UK operator

4.18 The CC has been unable to identify the cost of debt for a stand-alone UK private hospital operator, instead focussing on the actual cost of debt facing the Relevant Firms.⁴⁷ However, Ramsay considers that the Relevant Firms are likely to be able to access capital at a lower cost than a stand-alone UK private hospital operator (e.g. due to the size and scale of their operations, purchasing economies, and the diversified risks across different public transport markets). In this regard, it is noteworthy that the CC acknowledges that in previous market investigations it has found evidence that small companies may incur a higher cost of debt.

4.19 Accordingly, the use of cost of debt figures for diversified groups is likely to understate the actual cost of debt facing a stand-alone UK operator, which is also likely to result in WACC being understated.

⁴⁵ Paragraph 2.8, Ramsay Health Care UK's response to the CC's working paper titled "Cost of capital: Planned Methodology" (27 November 2012).

⁴⁶ Although the Health & Social Care Bill was passed into legislation, it is not unheard of for incoming government parties to modify recently implemented government healthcare policy. For example, in 1991, the Major Government introduced GP fundholding (the predecessor for the current GP commissioning policy), which was subsequently abolished by New Labour in 1997.

⁴⁷ Paragraph 115.

Gearing for a stand-alone UK operator

- 4.20 The CC's WACC analysis assumes that the UK standalone operator has a gearing of 50 per cent.⁴⁸ However, this level of gearing is significantly above Ramsay's actual level of gearing over the relevant period (set out in Table 9 of the Working Paper). If the level of gearing is decreased to 25.6 **[this figure is already in the public domain (CC's published working paper)]** per cent to reflect Ramsay's gearing in 2011, assuming all of the other CC assumptions remain the same, the upper bound of the WACC increases to [x] per cent (i.e. [x] percentage points higher than the CC's estimate).
- 4.21 Moreover, it should be noted that Ramsay does not consider that the level of gearing for the relevant period reflects its actual target level of gearing, which at [x] per cent would increase the WACC further to [x] per cent (i.e. [x] percentage points higher than the CC's estimates).⁴⁹

The Capital Asset Pricing Model

- 4.22 The Working Paper states (at paragraph 86) that the CC has used the Capital Asset Pricing Model ("**CAPM**") to estimate the cost of equity. As set out in the response to the cost of capital methodology working paper, while Ramsay does not take issue *per se* with the theoretical underpinnings of the model, its applicability to real world scenarios is more questionable due to the set of unrealistic underlying assumptions. The empirical evidence concerning the validity of CAPM models is also mixed at best. The recent volatility in the credit markets provide the clearest indication of the limitations of the model.
- 4.23 Accordingly, due to the limitations of the assumptions underpinning the CAPM model, at the very least the CC should accept that a significant margin of error is likely to exist around the cost of capital figures and therefore, a truly representative "point estimate" cannot be calculated with any certainty. In this regard, Ramsay notes that the CC state (at paragraph 82) that they intend to conduct sensitivity analysis relating to the asset valuation. To ensure the robustness of the estimated WACC to the CC's assumptions (and a UK stand alone operators true financing costs), this sensitivity analysis should also be extended to the cost of capital estimate.

Conclusion

- 4.24 Ramsay is concerned that the CC has adopted a methodology of calculating the WACC which is designed to deliver a low WACC rather than adopting a methodology which produces a fair representation of the Relevant Firms' businesses. In particular, the CC is using unrepresentative data (e.g. based on private hospital groups that are diversified across different markets and different countries) in order to estimate the WACC for a UK stand-alone operator.

⁴⁸ Paragraph 121.

⁴⁹ As set out in the putback of 21 February 2013, Ramsay used a gearing of [x] per cent in its WACC calculations.

Appendix 1 – Adjustment for Nottingham Woodthorpe (in isolation)

[✂]

Appendix 2 – Adjustment for corporate cost depreciation (in isolation)

[✂]

Appendix 3 – Adjustment for fully depreciated assets (in isolation)

[<]

Appendix 4 – Adjustment for Intangible assets (in isolation)

[<]

Appendix 5 – Adjustment for working capital balances in 2012 (in isolation)

[<]

Appendix 6 – the cumulative effect of the adjustments made

[X]

Appendix 7 – Corporate fixed assets

[X]