

NON CONFIDENTIAL VERSION

HCAHospitals

World-Class Healthcare

HCA INTERNATIONAL LIMITED

**Response to Competition Commission's
Notice of possible remedies**

21 October 2013

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1. INTRODUCTION

- 1.1 The Competition Commission ("CC") published on 2 September 2013 its Provisional Findings ("PFs") together with a Notice of possible remedies in its market investigation into private healthcare (the "Remedies Notice"). HCA is responding in this submission to the CC's Remedies Notice. It is to be read in conjunction with HCA's response to the PFs.
- 1.2 HCA vigorously rejects the CC's findings that there are adverse effects on competition ("AECs") in the market for private healthcare in London. The market functions well and is delivering major benefits to consumers through competition on price, quality and innovation. As HCA has set out in its submission responding to the PFs, the CC's findings with regard to London are unfounded and are not supported by the evidence on which the CC seeks to rely. The CC has not demonstrated on a "balance of probabilities" that the market has anti-competitive features. HCA strongly disagrees that the CC has identified AECs which require or justify remedial measures. HCA's response to the CC's Remedies Notice which is set out in this submission is subject to its position that it sees no case for the adoption of remedies.
- 1.3 Without prejudice to this position, HCA nevertheless sets out its views on the CC's remedies proposals on the basis of the CC's AEC findings. This submission is on the hypothetical basis that the AEC findings are correct. As discussed below, even if the CC's findings concerning the private healthcare market were well-founded, there are no grounds to support the CC's proposals in its Remedies Notice. The nature, extent and scale of the AEC which the CC has identified does not indicate that there is sufficiently strong evidence of consumer detriments which justify the measures which the CC is proposing. The CC's proposals are not proportionate and moreover will have significant adverse effects on customers.
- 1.4 HCA is predominantly a London-based provider, and it focuses in this submission on the CC's remedies proposals in relation to HCA's London hospitals. The market for private healthcare in London has important, distinguishing characteristics (including: the presence of major NHS teaching hospitals; large NHS PPUs; investment in tertiary services; higher PMI penetration; substantial historic growth and future growth prospects; and the importance of international patients). The CC has failed to take account of the competitive conditions specifically in London, both in its AEC findings and in its remedies proposals. London is not Bath, Edinburgh, Southampton or Bristol where the CC apparently cites evidence of entry barriers – it is a major, growing tertiary centre with a robust record of entry and expansion. The CC has adopted a "one size fits all" approach to its analysis of private healthcare – making broad generalisations which ignore the very different features of the market in London. This vitiates the CC's analysis of the case for proposed remedies in relation to HCA.
- 1.5 HCA has been given very limited time in which to review and comment on the CC's detailed findings and Remedies Notice, notwithstanding the highly intrusive and extensive nature of the CC's remedies proposals. HCA therefore restricts this response to high-level comments on the proposed remedies and the problems and issues which they would create in the market for private healthcare. HCA intends to supplement these initial comments with further papers and submissions and at its forthcoming hearing.
- 1.6 HCA will submit its response to the PFs following its access to the disclosure room which is to be re-opened following the Tribunal's ruling in *BMI v Competition Commission*. HCA reserves the right to revise or supplement this submission in the light of further data provided in the disclosure room.

2. OVERVIEW AND SUMMARY

2.1 The structure of the submission, and HCA's key arguments, are briefly summarised as follows:

Section 3: legal tests for remedies

2.2 The CC has a duty to ensure that its remedies are proportionate. Under the "double proportionality" principle, it has an even higher burden of proof when proposing radical and intrusive remedies such as divestment. These require a very careful and considered assessment of the effects of remedies and any detriments which they create. A divestiture remedy would be grossly disproportionate.

Section 4: insufficient competition concerns

2.3 Even if the AEC findings are correct, as far as London is concerned the PFs do not describe a market in which there are significant competition problems: there are several other private providers in Central London; the London market is not "static", but growing; NHS PPUs have grown considerably; there has been a record of new entry and expansion; and even the PFs acknowledge that the major PMIs can exercise leverage in negotiations with hospitals providers.

2.4 The only previous case in which the CC has ordered divestiture in a market investigation (*BAA*) was a very different one in which there was "*an almost complete absence of competition*". Even the CC is not suggesting that the provision of private healthcare bears any similarities to the market structure in the *BAA* case.

2.5 The OFT gave unconditional clearance to HCA's acquisition of the St. Martin's hospitals which has created its current portfolio of London hospitals. This clearance fundamentally contradicts the CC's view of the market. The CC is, in effect, seeking to reverse the competition clearance given to HCA to build and expand its business in London.

2.6 In addition, there is no concrete evidence that AECs in the current market are creating any consumer detriments. On the CC's own assessment, a 20% reduction in concentration would at the most give rise to a 3% price reduction for self-pay patients, a figure which itself is highly contentious and subject to a considerable margin of error. In terms of PMI prices, the CC has no evidence that HCA's prices in any way exceed a competitive level, once quality, complexity and costs are appropriately taken into account. Furthermore, the CC has no evidence that any price reductions arising from divestiture would in any event be passed through by PMIs to subscribers and, in all likelihood, they would not.

2.7 Consequently, on the CC's own findings, the PFs do not provide a sufficient foundation for highly draconian divestiture remedies.

Section 5: relevant customer benefits

2.8 HCA's strategy in London is delivering substantial relevant customer benefits which the CC's proposed divestiture remedies would seriously threaten:

- **High quality** – HCA is renowned for the high quality of its hospitals and staff, its clinical resources, and the innovative use of technology, and it regularly outstrips its competitors on a wide range of quality metrics.
- **Greater innovation** – HCA has led the way in bringing new, innovative treatments into its hospitals which have greatly improved the clinical outcomes for seriously ill patients, e.g. in cancer care. In many instances, it has incentivised other providers to follow suit, providing early outcomes data which is available to the market.
- **Greater choice of goods and services** – HCA has introduced into the private sector a wide range of new, highly specialised treatments which were previously only available within the NHS.

2.9 All of these relevant customer benefits would be put at risk by the CC's highly intrusive remedies package.

Section 6: divestiture

2.10 The CC's proposed divestiture remedy is extreme and disproportionate and fails the proportionality test:

- Divestiture would be **ineffective** – unless a purchaser pursues the same strategy as HCA of substantial, ongoing investment in high acuity services, the divestment of [X] would not in fact create a new, high quality competitor in HCA's very specialised clinical services. Even if a purchaser were to maintain the [X] focus on high-quality, tertiary services, it is highly unlikely that there would be a reduction in prices because of the high fixed costs of the business and the requirement for ongoing capital expenditure.
- Divestment has **serious, adverse consequences** – divestment would seriously compromise the high standards of quality, clinical care and innovation. HCA operates its six major hospitals as a well managed network of facilities. Divestment would destroy the synergies which the network currently offers. It would reduce the incentive for continued investment and innovation. It also carries with it substantial asset risks, and the uncertainty over the divestiture process will lead to consultants and staff losses which would do incalculable damage to the business. Patients will suffer through poorer quality and lower standards of healthcare.
- There are **alternative, more proportionate remedies** – there is a wide range of other more proportionate remedies which would facilitate competition and choice, and encourage new entry, with far less harm to consumers.
- The CC's divestiture proposal seems to be driven by its view that a [X] share of supply in private healthcare markets is "too high". This is an arbitrary threshold (which in any event is applied in an inappropriately narrowly defined market) which has no foundation in either law or economics, is irrational, and conflicts with the practice of other competition regulators.

Divestment would be a perverse outcome of a market inquiry, in effect punishing a provider's investment in quality, innovation and efficiency, and moreover would have significant adverse effects on consumers.

Section 7: tying or bundling

Remedy 2(a)

2.11 Hospitals are high fixed-cost businesses and it is legitimate for PMIs and operators to agree discounts and rebates which are dependent on patient volumes. Remedy 2(a) is apparently seeking to protect the PMI's "outside option" to change its network composition. This could be done more effectively by prohibiting express contractual restrictions or arrangements (e.g. exclusivity clauses or targeted pricing clauses) which are aimed at restricting the PMI's ability to change the providers on its network.

Remedy 2(b)

2.12 PMIs have not sought to negotiate terms with individual HCA hospitals, and HCA does not have "one on, all in" clauses in its contracts. However, in framing this remedy the CC will need to be mindful of the consequences of PMIs de-selecting individual hospitals. PMI recognition can be "make or break" for any hospital and the failure to obtain recognition may result in closure and market exits.

Section 8: restrictions on expansion

- 2.13 Hospitals in single or duopoly areas should not be restricted from being able to bid for new PPU opportunities. A blanket prohibition would distort the competitive tendering process and is likely to be unlawful under European law. The OFT already has the power to review PPU transactions on a case-by-case basis and consider whether they have anti-competitive effects under UK/EU competition or merger legislation.

Section 9: consultant incentive schemes

- 2.14 HCA would support a prohibition of schemes which provide benefits which are directly linked to patient referrals (e.g. the consultant "lock-in" provisions found in Circle's contracts). HCA would also support the requirement for any consultant arrangement to be benchmarked against market value.
- 2.15 It is encouraging that the CC recognises that consultant equity schemes are pro-competitive in encouraging new entry. The CC however is wrong to distinguish between equity schemes applying to "new hospitals" and facilities such as individual pieces of diagnostic equipment. Consultant equity is a driver of growth in outpatient and diagnostic facilities, creating new services for the benefit of patients. There are various remedies (e.g. putting in place peer review procedures and increased transparency) which would deal with any perceived risk of over-use of these facilities.

Section 10: consultant quality

- 2.16 HCA fully supports the proposals for increased transparency of consultant performance data.

Section 11: consultant fees

- 2.17 HCA agrees that consultants should be required to be more transparent about their fees. This is easier to provide for in the case of outpatient consultations. It is obviously more difficult in the case of complex, inpatient treatments where there may be unexpected complications and where it is not always possible to discuss fees in advance with the patient.

Section 12: private hospital performance

- 2.18 HCA strongly supports greater transparency of private hospital performance data. It believes that it has led the way in developing information on service quality. Private hospitals should be capable of collecting data similar to that available in the NHS, and supports the initiatives which PHIN has led so far.

3. LEGAL TESTS FOR REMEDIES

- 3.1 HCA submits that the CC's remedies and in particular its divestment proposals, are disproportionate in the light of the CC's AEC findings. The tests to be applied by the CC are briefly summarised as follows.
- 3.2 The CC is required to ensure that any measures which it proposes in a market investigation reference to remedy, mitigate or prevent an AEC meet the relevant statutory tests under the Enterprise Act 2002 ("EA 2002"). The purpose of remedies is to remedy, mitigate or prevent either (i) the AEC, or (ii) any detrimental effects on customers resulting from the AEC (s.134(4), EA 2002).
- 3.3 Under Section 134(6) of the EA 2002, the CC must in particular "*have regard to the need to achieve as comprehensive a solution as is reasonable and practicable*" to the AEC. In addition, under Section 134(7), the CC may in particular "*have regard to the effect of any action on any relevant customer benefits*" of the features of the relevant market giving rise to the alleged AEC.
- 3.4 The CC's approach to these statutory requirements and the factors which it take into account are set out in its revised Guidelines for market investigations (April 2013) ("Guidelines"). These requirements have also been considered extensively by the courts.¹
- 3.5 Any measures which the CC proposes must achieve a "comprehensive" solution and the Guidelines state²: "*The clear preference of the CC is to deal comprehensively with the cause or causes of the AEC, wherever possible, and by this means significantly increase competitive pressures within a reasonable period of time.*"
- 3.6 The Guidelines also state³ that the CC will assess the effectiveness and practicability of remedy options and will "*favour remedies that have a higher likelihood of achieving their intended effect*".
- 3.7 The CC is required to consider the proportionality of any remedy options.⁴ The Guidelines, reflecting the principles developed in the applicable case law, state that proportionality requires that the remedy:
- (i) is **effective** in achieving its legitimate aim;
 - (ii) is **no more onerous** than needed to achieve its aims;
 - (iii) is the **least onerous** if there is a choice between several effective measures;
 - (iv) does not produce **disadvantages** which are disproportionate to the aim.
- 3.8 In considering the proportionality question, the Courts have referred to: "*the balancing exercise between the (achievable) aims of the proposed measure on the one side, and any adverse effects it may produce on the other side.*"⁵
- 3.9 Furthermore, the CC has a higher burden of proof in cases where it seeks to impose more extensive or far reaching remedies such as divestment. In *Tesco*, the CAT referred to the "double proportionality" principle:⁶
- "The more important a particular factor seems likely to be in the overall proportionality assessment, or the more intrusive, uncertain in its effect, or wide-reaching a proposed remedy is likely to prove, the more detailed or deeper the investigation of the factor in question may need to be."*

¹ In particular: *BAA v. CC*; *Barclays and others v. CC*; *Tesco v. CC*

² Guidelines, para 330

³ Guidelines, para 335

⁴ See e.g. *Tesco*, paragraphs 135-138 citing *Federa*, Case C-331/88

⁵ *Tesco*, para 138

⁶ *Tesco*, para 139

The courts will expect the CC to exercise particular care in its analysis of the AEC and of the effects of remedies when proposing intrusive remedies such as divestment.

- 3.10 The CC has a duty to investigate and consider carefully each aspect of the proportionality test and "take reasonable steps" to acquaint itself with the relevant information to enable it to answer each statutory question posed for it.⁷
- 3.11 The CC states in its Guidelines that it will consider the potential effects of remedies "*with particular regard*" to customers. This will include assessing the potential benefits (e.g. lower prices or innovation) and the potential negative effects, including unintended distortions and implementation costs. The CAT noted in *Barclays* that where the CC has proposed far reaching remedies: "*The potential for such a radical remedy to cause disadvantageous side effects calls for vigorous investigation and analysis of its potential adverse consequences.*"⁸ The Tribunal's requirement for "*vigorous investigation and analysis*" is particularly apposite in this case in which the CC is proposing the extreme remedy of divestiture.
- 3.12 The CC will also consider any relevant customer benefits deriving from the existing market structure. Under Section 134(8) of the EA 2002, relevant customer benefits expressly include lower prices, higher quality, greater choice of products or services and greater innovation. The references to quality and innovation are particularly apposite in healthcare markets where patient health and well-being is paramount. The CC must therefore consider the extent to which remedies may harm or extinguish these benefits, and may not impose remedies if these would erode or remove relevant customer benefits.
- 3.13 Under Section 6(1), Human Rights Act 1998, the CC is subject to the duty to act compatibly with rights under the European Convention on Human Rights (the "Convention"). In *BAA*, it was held that Sections 134 and 138 of the EA 2002 should be read and given effect in a way compatible with Convention rights.⁹ Article 1 of the First Protocol to the Convention protects and safeguards property rights. In proposing highly intrusive remedies which interfere with property rights, such as divestment, the CC has a high standard of proof to discharge based on the normal standards of rationality¹⁰ to demonstrate that interference with the fundamental Convention rights is proportionate and justified. This is a particular consideration in the present case, in view of the CC's divestiture proposals.
- 3.14 The EA 2002 thus lays down a statutory framework for a consideration of remedies which requires a clear and unequivocal identification of the alleged AEC and a careful assessment of the objectives and effects of remedies, balancing the effectiveness of the remedies to address the AEC with the detriments which they give rise to.

⁷ *BAA v CC*, CAT judgment of 1 February 2012, para 20(3)

⁸ *Barclays*, para 128

⁹ *BAA v CC*, CAT judgment of 1 February 2012, para 20(2)

¹⁰ *ibid*, para 20(5)

4. INSUFFICIENT COMPETITION CONCERNS

- 4.1 The remedies tabled by the CC are intended to "*remedy, mitigate or prevent*" the AECs. Even if the CC is correct in its analysis of AECs (which, HCA submits, it is not), it has failed to identify sufficiently significant competition problems or concerns, or indeed significant consumer detriments, in the market for private healthcare which justify the remedies which it is proposing, including the highly draconian proposal for divestment.
- 4.2 In *Thomson Holdings*¹¹ it was held that the adverse effects on competition must be identified with "*conspicuous clarity*" in order to provide the requisite basis for recommending remedial measures. The alleged AECs in private healthcare are far from being either conspicuous or clear and do not provide the foundations to justify the remedies proposed in the Remedies Notice. In addition, the CC has failed to identify significant consumer detriments to PMI subscribers or patients.

AEC findings

- 4.3 Although the CC believes that the market is characterised by AECs, HCA notes as follows in the case of London:
- (i) It is apparent from the PFs that on the CC's own analysis the scale, extent and prevalence of any AECs or of any consumer detriment is limited. In particular, although the CC has concerns that the market is concentrated, the PFs recognise a variety of competitive constraints on hospitals. The PFs do not describe a market in which there are clear, pervasive, structural competition problems which require remedial action.
 - (ii) The CC's findings are far from clear-cut and unequivocal and in many instances the PFs acknowledge the uncertainties and contradictions in the evidence on which it relies, e.g. in relation to PMI bargaining power.
 - (iii) The PFs recognise that, in the case of London, the market is not static and is growing and evolving, for example through new entry and growth by PPU's. The CC acknowledges that HCA's competitors in London have expanded and are continuing to invest in new facilities. In this context, the CC has failed to demonstrate that any AECs currently identified by the CC will continue to subsist in the foreseeable future and will require the kind of remedies which the CC is proposing.
- 4.4 HCA highlights in particular a number of aspects of the PFs which acknowledge a range of competitive constraints on HCA and undermine the CC's case for remedies (these issues are further discussed in HCA's response to the PFs):
- (i) HCA is far from being in a monopoly or even duopoly position in London. Notwithstanding the concerns it has about market concentration and HCA's market shares, the CC has acknowledged in its findings the range of other private providers which, to a greater or lesser extent, offer competitive constraints to HCA. These include six other private hospitals groups (BMI; Aspen; St. John's and St. Elizabeth's; Bupa Cromwell, London Clinic; and King Edward VII) operating 9 other hospitals in Central London, all of which have undergone expansion in recent years.
 - (ii) The CC has noted the presence of major PPU's in Central London, such as the Royal Marsden, St. Bartholomew's, Royal Brompton, Chelsea & Westminster; Imperial and King's. Although the CC believes that these currently offer weak competitive constraints, it acknowledges the growth in their revenues, and the fact that the larger PPU's are taking active steps to increase revenues "*by refurbishing their facilities, widening the scope of their services and attracting new consultants and partnering with private operators to further develop activity in this area*".¹² It specifically finds that PPU's are "*gearing up for growth*"¹³ and that London PPU's have been the fastest growing in the UK outpacing PPU's in other parts of the country.

¹¹ *R v Secretary of State ex parte Thomson Holidays*, Court of Appeal judgment

¹² PFs, Appendix 3.1, para 19

¹³ PFs, para 2.29

- (iii) The CC has identified high barriers to entry as one of the features of the market giving rise to AECs. Crucially, however, a critical part of the CC's analysis concerning entry barriers does not apply in the case of London. The CC has provisionally concluded that the static demand for private health services and the lack of significant growth prospects are likely to deter new entrants from making the high capital investment in the facilities. This is described as "*the greatest barrier to entry*".¹⁴ However, as the CC has itself noted, the London market is characterised by higher PMI penetration, the presence of leading NHS hospitals, the availability of a large body of consultants, a larger number of self-pay patients and international patients, and an emphasis on high acuity tertiary care. All of these factors are driving growth in London and the CC has noted that this is encouraging new investment and equipment and facilities in high acuity specialisms such as oncology. Indeed, the CC specifically finds that what is driving growth of London PPU's is "*the size of the potential market as well as demographic factors which drives demand and creates significant opportunities for new entrants*".¹⁵ The London market patently does not therefore face the same entry barriers that may exist in other parts of the country and this in itself substantially undermines the case for the application of remedies affecting HCA's hospitals in London.
- (iv) Furthermore, the CC has not cited any supporting evidence that new entry or expansion has in fact been thwarted or impeded by entry barriers. Quite the contrary, one of the CC's case studies of entry barriers – the London Clinic's new cancer centre – is a sterling example of the successful expansion of a London provider which established a new £80m facility achieving profitability within 2-3 years. The CC has also referred to the entry of a new £90m tertiary hospital, the Kent Institute of Medicine and Surgery ("KIMS"), due to open on 2014, which is targeting tertiary referrals which currently go to London.¹⁶ This investment in a new, full service hospital has occurred in the midst of a recession, showing that investors are prepared to commit funds on new facilities, even in current economic conditions. Both are excellent examples of the successful record of development in London and the CC cites no evidence of operators which have genuinely looked to enter or expand in the London market but have been restricted by entry barriers. In addition to the cases cited by the CC, HCA has referred to numerous other examples of market entry and expansion by independent operators and NHS PPU's, and refers to this further in its response to the PFs.
- (v) HCA also notes the recent submission of Neuterra Healthcare UK Limited to the CC which refers (paragraph 1.2) to its "*potential entrance into the UK private healthcare market*" and its proposals to invest in the UK – yet more evidence of new entry which contradicts the CC's claim of a "static" market.
- (vi) The CC notes that NHS (public) hospitals exert a "*competitive constraint*"¹⁷ on private healthcare providers which needs to be taken into account in the competitive assessment on a case-by-case basis. The CC also notes "*the presence of the UK's main [NHS] teaching hospitals*"¹⁸ in London, which indicates that the competitive constraints from the NHS can be expected to be all the stronger in the London market. It is therefore recognised that NHS hospitals contribute to the competitive pressures on HCA. HCA has previously set out in its submissions the competitive interactions between the NHS and private operators and the effects this has had on HCA's activities.¹⁹
- (vii) The potential for countervailing bargaining power by PMIs is also recognised in the PFs as a further source of competitive constraint:

¹⁴ PFs, para 6.79

¹⁵ PFs, Appendix 3.1, para 9

¹⁶ KIMS' recent submission to the CC makes plain "*its intention to compete with the more expensive Central London hospitals, and generally to increase competition by creating a full service hospital that will represent a local alternative for patients and their families.*"

¹⁷ PFs, para 5.16

¹⁸ PFs, Appendix 6.3, para 26

¹⁹ See e.g. HCA's response to the CC's Issues Statement, Section 7

- The CC accepts the importance of PMI recognition and that "PMIs generally have a relatively strong negotiating position under these circumstances"²⁰ in relation to the recognition of new facilities.
 - The CC finds that de-listing of hospitals may be a credible threat which could give the major PMIs buying power in appropriate circumstances.
 - It is expressly noted in the PFs that PMI fixed fee schedules are capable of distorting competition by preventing patients from going to the consultant (and hence the hospital) of their choice.
 - The use of restricted network products in Central London, which exclude HCA hospitals, is also noted e.g. AXA-PPP's Pathways products and the Aviva "key hospitals" list. According to the PFs, these policies are "growing in attractiveness".²¹ AXA-PPP even acknowledges in its response to HCA's submission that "our networks are central to our competitive ability to negotiate advantageous price terms to the benefit of our customers."²²
 - Similarly, it is recognised that Open Referral products "are becoming more established *and more common*" which may in the future "*have the potential to change the balance of negotiating power*".²³
- (viii) The CC's conclusions on bargaining power are tentative and equivocal, reflecting perhaps the difficulties in forming generalisations applying across the UK as a whole. The PFs note that the evidence does not indicate whether either hospital operators on the one hand, or PMIs on the other, have bargaining power. The CC's finding that HCA, BMI and Spire have market power in negotiations with insurers is in fact tempered by a number of findings concerning the alternative strategies which PMIs use, often successfully, against hospital operators. The PFs note that the PMIs have an important role to play in directing patients to consultants and hospitals and that, with the directional tools available to them: "*PMIs do have scope to take some business away from hospital operators*".²⁴ There clearly are circumstances in which PMIs can exercise outside options to leverage the negotiating position with hospitals. The CC's view that "*the major PMIs and the major hospital operators are dependent upon each other*"²⁵ presents a picture in which neither side necessarily has the upper hand in negotiations and the CC does not argue that this position is any different in London.
- (ix) This is therefore, on the CC's own findings, a market in which:
- HCA is faced with a number of well-established competitors in London.
 - There are major NHS PUs in London (Royal Marsden, Royal Brompton, Imperial, etc.) which have grown their private services considerably, are now behaving more commercially, and are intending to develop their private offering either on their own initiative or in partnership with the private sector to exploit the growth in demand for tertiary care.
 - There are limited barriers to entry in London, and concrete examples of new entry and expansion (even in a depressed economic environment) exploiting the growth opportunities in tertiary services, as the CC's own case study on the London Clinic has evidenced.
 - A concentration of major NHS teaching hospitals in London provides further competitive interaction with HCA's hospitals.
 - The PMI market is itself a highly concentrated market, and the major PMIs exploit a range of alternative strategies in the face of any bargaining power

²⁰ PFs, para 6.175

²¹ PFs, para 6.172

²² AXA-PPP response to HCA submission, para 128

²³ PFs, para 6.179

²⁴ PFs, para 6.189

²⁵ PFs, para 6.169

which, in the CC's view, may be held by hospital operators. The evidence does not conclusively indicate that either side enjoys bargaining power over the other.

4.5 Against this background of a dynamic and growing London market, the CC is not justified in proposing highly intrusive, far-reaching remedies, in particular divestiture, to address the market features it has identified.

OFT clearance

4.6 HCA also draws the CC's attention to the fact that HCA's acquisition of St. Martin's Healthcare Limited in 2000 was investigated and cleared by the OFT. This acquisition, of London Bridge, Lister and Arrazi²⁶ hospitals, has given rise to HCA's current portfolio of its six major facilities in London. The OFT's clearance Decision (Annex 1) notes the wide range of competitive constraints on HCA:

- The OFT finds that NHS PPUs and pay-beds "*will be an effective substitute for many people considering private healthcare*".
- The PMI providers were found to have "*substantial buyer power*".
- The OFT found that "*the data clearly demonstrates that patients travel from Outer London and sometimes even further*" and that "*the market is likely to be at least as wide as all London postcodes*".

4.7 Since the date of this Decision, the market for private healthcare in London has become more, not less, competitive:

- NHS PPUs have expanded considerably and, with the removal of the private income cap, will continue to expand.
- PMIs have become increasingly involved in the patient referral pathway and they are using directional products such as Open Referral policies to direct patients to cheaper providers. Indeed, there has been a particularly prominent example of PMIs forcing a market exit (the former Heart Hospital) by withdrawing recognition,
- There has been a demonstrable record of new entry and expansion in Central London over this timeframe, including BMI's entry into Central London, as well as significant expansion by many of HCA's London competitors (London Clinic, Cromwell, St. John and St. Elizabeth, etc.).
- The London market has expanded considerably, and is continuing to do so.
- HCA has not made any further acquisitions of hospitals in London since this date, but has invested in creating new capacity in tertiary services and helped to grow the market.

The PFs do not indicate whether it is the CC's view that the market is less competitive than at the time of the clearance and, if so, how.

4.8 HCA's last acquisition in London was cleared unconditionally on grounds that it would not significantly affect competition. The CC has failed to demonstrate why it has reached wholly contradictory views. The OFT's clearance Decision, and the conclusions it reached at that time, further undermines the CC's case as to the scale or extent of any competition problems in the London market and its proposal for highly intrusive remedies.

4.9 The OFT's clearance Decision also gives rise to a further point. The OFT's clearance was granted lawfully and was not at the time challenged or appealed. HCA, acting in full reliance on that clearance decision, has made large-scale capital investments totalling approximately [£] in its hospitals over the last decade in order to create high quality facilities and develop

²⁶ Subsequently converted into an outpatient and diagnostic treatment centre, the Devonshire.

and expand its business. If the CC pursues a divestiture remedy, it will in effect be seeking to over-turn, through the mechanism of a market investigation, a clearance decision which was lawfully granted at the time. HCA contends it would be wholly unfair and unlawful, and a breach of HCA's legitimate expectations, for the CC to use its powers to order divestiture of [X] lawfully acquired in reliance on the earlier clearance Decision.

Consumer detriment

- 4.10 Further, the CC has not demonstrated that the alleged AECs give rise to significant consumer detriments which call for the kind of extreme remedies which it is now proposing.
- 4.11 The PFs provide no concrete evidence of actual consumer harm. On the contrary, HCA is consistently viewed as a high quality provider, with high levels of investment and customer satisfaction, which is inconsistent both with an AEC and detriment resulting from it. Third parties (in particular patients) who have provided evidence to this inquiry have not suggested that concentration or barriers to entry have in fact adversely affected patients. The consumer detriment which has been consistently identified by third parties (as witnessed by the large number of letters which the CC has received from disaffected PMI policyholders) relates to PMI managed care practices and the effect these are having on clinical care – issues which the CC has chosen to ignore.
- 4.12 The consumer detriment which the CC ascribes to high concentration of hospital providers is a wholly superficial calculation which purports to reflect the difference between the parties' ROCE and WACC. HCA's response to the PFs addresses this in detail and demonstrates that this alleged gap is based on a wide range of inaccuracies and miscalculations by the CC and is unfounded.
- 4.13 In the PCA, the CC has attempted to evaluate the magnitude of the effect that market concentration has on self-pay prices. However, as HCA points out in its response to the PFs, the PCA concludes that a 20% increase in the weighted average market share of a given hospital is associated with about a 3% price increase for a self-pay treatment. To put it bluntly, the most that the CC believes its intervention may be able to achieve, in reducing market concentration by 20%, is a 3% reduction in these prices. Even if this were to be correct (and HCA strongly disputes this) the CC seriously needs to ask itself whether the intrusive remedies which it is now proposing – the divestiture of [X] - can possibly be justified in view of such a small effect on prices in one part of the market. This very marginal price reduction would need to be weighed against the severe risks (discussed below) to continued investment in innovation and quality of care, and hence patient health and well-being. **In HCA's view, no responsible regulator would regard this as an appropriate trade-off which is in the consumer's interest.**
- 4.14 As far as hospital prices to PMIs are concerned, the CC has failed to consider whether its remedies would in fact have any impact on insurance premiums. It appears from paragraph 7.78 of the PFs that the CC has no idea whether reductions in hospital prices to PMIs would result in lower premiums – indeed, the CC accepts that lower prices may well be *"unsuccessful in reducing premiums"*.²⁷ In its recent letter of 7 September 2013, the CC concedes: *"It nevertheless recognises that the level of such consumer detriment will depend in part on the extent to which any reduction in insured prices would be passed through to consumers. This is an issue which the CC will be considering as part of the remedies phase of its investigation."*²⁸ The OFT also raises this very issue in its submission to the CC (paragraph 16), pointing out that in the absence of positive steps to force the PMIs (through a remedy design) to pass on any benefit of the remedy, consumers would not stand to benefit.

²⁷ PFs, para 7.78

²⁸ Letter from Treasury Solicitors to CAT, para 35

5. RELEVANT CUSTOMER BENEFITS

5.1 In considering remedies, the CC will need to take account of the relevant customer benefits which arise from any features of the market which the CC has identified in its PFs. Consequently, even if the CC is correct in its AEC findings that the market is not well functioning, it needs to recognise the significant customer benefits which the market, and specifically HCA in the London market, is delivering to consumers. If it is the case that the market is characterised by features such as high concentration or barriers to entry (which HCA rejects), the CC needs to take cognisance of the way in which the market positively benefits patients. A number of the proposed remedies would reduce or even eliminate these benefits to the detriment of consumers.

5.2 There are demonstrable customer benefits in the form of:

- higher quality
- greater innovation
- greater choice of products or services.

These are expressly included as relevant customer benefits in section 134(A), EA 2002. These benefits are closely interlinked, e.g. greater innovation drives improvements in quality and clinical outcomes, and contributes to an increased range of clinical treatments and services which are available in the private sector. All of these are manifested in improved patient outcomes. These benefits are particularly evident in London where there is a strong focus on the treatment of high acuity, high complexity conditions and tertiary care.

Higher quality

5.3 HCA has an unparalleled record amongst all the private healthcare operators of providing the best quality of care in the private sector – examples are given below – and has contributed greatly to quality improvements in tertiary care.

5.4 HCA has a strong record of capital investment in its facilities. It has invested a total of [£] over the period 2008-2011, representing [£] of turnover or [£] of net profits. This is higher in comparison to competitors in the UK private healthcare sector. This does not include the substantial sums spent in the form of operating expenses to build high-quality clinical teams and facilities.

5.5 The fruits of this investment, and the benefits which it had delivered to patients, can be seen in the turnaround of the hospitals it acquired in 2001 (the London Bridge and the Lister). A decade ago, these were underperforming facilities. HCA's ownership has transformed these hospitals, the London Bridge in particular, into some of the best and most advanced private hospitals in the world. This has come about through long-term, sustained capital investment in new equipment, new clinical service, intensive care units and cutting-edge technologies. The investment in each of HCA's hospitals is testament to HCA's vision to create world-class tertiary care facilities which can compete internationally.

5.6 The higher quality of HCA's hospitals is demonstrated by:

- advanced clinical pathways (e.g. in cancer care) which ensure that patients receive the best and most advanced proven care in a consistent and measured way;
- the ability to attract and retain the highest calibre consultants;
- depth of resource in terms of clinical staff e.g. HCA is the only hospital operator to employ significant numbers of resident medical officers ("RMOs") and other supporting healthcare professionals such as intensivists and radiologists – e.g. HCA's Wellington Hospital has [£] RMOs in specialised clinical fields where

most private hospitals have just one and HCA has approximately [X] RMOs across its network as a whole;

- its commitment to critical care – it is the only private provider with level 3 ITUs in all its hospitals;
- the use of technology e.g. integrated IT systems which allow the patients' care plans and treatment protocols to be closely co-ordinated and monitored across HCA hospitals;
- HCA's integrated care pathways across all its facilities which involve multi-disciplinary team meetings which bring together representatives from all treatment options to discuss and decide on a patient's treatment plans – e.g. HCA's breast cancer MDT meets weekly to discuss patients across all its hospitals and agree treatment plans;
- innovation with the introduction of new equipment and treatment technologies – this is discussed further below.

5.7 HCA's higher quality offering is measurable and quantifiable as evidenced by its quality record:

- HCA's regular patient experience surveys record very high levels of patient satisfaction with levels of care provided – 99.1% of patients surveyed were satisfied with the overall quality of care, and 99.6% said they were treated with dignity and respect.
- Infection rates – MRSA rates are five times lower than the national average and there were no reported cases of c.difficile in HCA hospitals.
- First class results for cardiac surgery when benchmarked against national and international survival rates, and better cardiac survival rates than the UK average.
- HCA is the largest provider of critical beds in the private sector – the Intensive Care National Audit Research Centre ("ICNARC") study of survival rates in ITUs found HCA to be in the top 10% of hospital operators.
- In cancer care, average waiting times for surgery in HCA is 21 days with a median of 8 days compared to 62 days in the NHS.
- There are excellent quality standards in breast cancer exceeding European standards in four key areas.
- HCA has the first and only private integrated rehabilitation unit in the UK to win UK and international quality accreditations.
- Unplanned transfers out of HCA are fifteen times lower than the national average.
- Unplanned returns to the operating theatre are over ten times lower than the national average.
- HCA achieved a 100% compliance with all CQC clinical outcomes – the only private operator to do so.

5.8 HCA has prepared a report, with the assistance of healthcare consultants Oliver Wyman, on HCA's quality offering, demonstrating through a number of selected case studies specifically how HCA initiatives and innovations have improved clinical outcomes, and how divestiture would adversely impact on quality and patient care. The Quality report is attached in Annex 2. It indicates and quantifies (to the extent that quantification is possible) the patient benefits – in terms of patient satisfaction, better clinical outcomes and even lives saved – derived from HCA's quality of care and innovations. It also demonstrates how these are likely to be adversely affected by a forced divestiture of [X].

- 5.9 As the Quality report indicates, HCA can demonstrate better quality outcomes (e.g. in terms of mortality rates, speed of recovery and patient satisfaction) in these case studies than either other private hospital operators or the NHS and outperforms other operators on a number of quality metrics – for example, HCA achieves 9% better survival rates for breast cancer than the NHS, translating into 29 lives saved per year.
- 5.10 HCA's award-winning Quality 2012 booklet and website (HCAquality.co.uk) publishes key statistics relating to HCA's commitment to clinical quality and its track-record.

Greater innovation

- 5.11 HCA has led the way in the private healthcare sector in bringing new, innovative equipment, technologies and treatments into its hospitals:
- There are numerous examples of capital investment in state-of-the-art equipment e.g. CyberKnife, NanoKnife, de Vinci robotic surgery and the True Beam radiotherapy system (using high-energy x-rays to treat deep-seated tumours in the body) which offer new types of minimally invasive surgical treatments.
 - HCA has introduced new diagnostic systems which include advanced MRI facilities, super low dose CT scanners and digital mammograms for more advanced identification and diagnosis of clinical conditions. HCA's advanced 3T MRI scanners provide for definitive, non-invasive diagnosis of prostate cancer and support cutting-edge research into cancer detection and screening.
 - There are numerous examples of new diagnostic tests e.g. blood tests, genetics, molecular profiling, and vacuum assisted breast biopsies, which significantly reduce the pain and damage of biopsies.
 - HCA has introduced highly sophisticated and advanced care pathways using IT systems such as PatientKeeper, a web-based physician portal to real time patient data and Mosaic, a unique IT system which has revolutionised turnaround times in oncology..
 - HCA's Sarah Cannon Research Institute ("SCRI") has a unique cancer drug trial and development programme which develops new and innovative cancer therapies for seriously ill cancer patients. It is the first, and only, CQC-accredited private research centre in the UK offering clinical trials to NHS and private patients using new investigational drug therapies and is unrivalled anywhere in the UK private sector. This in turn, is incentivising the pharmaceutical industry to bring to market new, clinically-proven drugs against cancer.
- 5.12 Innovation in new technologies and treatments has generated considerable clinical benefits in terms of better quality outcomes for patients:
- It has led to new, minimally invasive procedures avoiding the need for traditional, higher risk surgery (e.g. NanoKnife).
 - CyberKnife provides a case in point. HCA has invested over [£] to build the first CyberKnife in the UK. Previously, some spine patients were having to undergo repeated open surgery to remove the tumour with a knife, with repeat treatments when the tumour re-grew. The CyberKnife has revolutionised this surgery by allowing millimetre accuracy with a beam of radiation to destroy the tumour, with no surgery. This has led to better clinical results and much quicker recovery for the patients. There are now eight such machines in the UK which are helping more patients live.
 - New radiation therapies such as inter-operative radiotherapy ("IORT") allows for more targeted treatments which avoid the need for weeks of conventional outpatient radiotherapy and reduce costs.

- The use of robotic surgery delivers substantial clinical benefits to patients in terms of less pain and discomfort, shorter recovery times, shorter inpatient stays, and a quicker return to normal activities.
- It has introduced highly advanced diagnostic equipment and techniques, e.g. Extremity MRI which uses strong magnetic fields and radio waves to create very high quality computer images of tissues, organs, and structures, improving the detection and diagnosis of clinical conditions.
- These innovations have accelerated the trend away from long inpatient stays to day case or outpatient procedures which enable patients to be discharged more quickly with fewer side effects (and lower costs to the patient or insurer).
- A text-book illustration of how innovation with minimally-invasive procedures is changing the face of healthcare is shown in cardiology. HCA's cardiology admissions [X], almost halving the number of patient days, in part because new outpatient/day care techniques such as angioplasty or TAVI are replacing the need for heart surgery.
- Innovations therefore increase the quality of care and create better clinical outcomes.

HCA provides in Annex 3 examples of new, innovative equipment or procedures which it has introduced in its hospitals and an explanation of the clinical benefits which these offer to patients.

- 5.13 The CC draws attention to HCA's market position and market share in Central London but even if the CC's analysis is correct, this has come about through persistently successful innovation which has established HCA's reputation as a centre of excellence in tertiary care. No other provider in the UK can match HCA's record of innovation and introduction of "firsts" in clinical techniques.
- 5.14 Innovation by HCA has stimulated competition in innovation and quality in the London market. It has incentivised other hospital operators to introduce similar technologies, For example, HCA's Harley Street Clinic introduced the first CyberKnife in 2009, and this was followed by the CyberKnife facility at the London Clinic, and there are now 8 such facilities in the UK. In 2004, the Princess Grace was the first private hospital to invest in the da Vinci robot surgery system, and there are now 20 da Vinci surgery systems within 100 miles of London, including the London Clinic. Competition between hospitals in London is lively and dynamic and has contributed to London's international reputation as a leading centre of tertiary care.
- 5.15 HCA's leadership paves the way for, and facilitates, adoption of these innovations by other hospitals by providing early outcomes data which demonstrates to the market the improvements in quality. This clinical data can be used by other providers to assess the potential of new treatments and technologies. HCA supports its consultants to publish papers and give lectures to disseminate the results of use of new technology.
- 5.16 The benefits of HCA's innovation have also spilled over into the NHS:
- HCA has established a GammaKnife centre in a joint venture with St. Bartholomew's Hospital in 2009.
 - In addition, SCRI has a formal partnership with UCLH (known as UCL Advanced Diagnostics) which has developed state-of-the-art molecular diagnostic tests using highly advanced sequencing technology for the molecular profiling of various types of cancer. These tests are made available to both NHS and private patients for novel anti-cancer therapies.
 - The CyberKnife technology has also been taken up more widely by the NHS, at Mount Vernon, St. Bartholomew's Hospital and the Royal Marsden creating new

standards of care in the NHS and private sector. Innovation by HCA can therefore provide the stimulus and impetus for greater innovation within NHS hospitals.

- 5.17 The HCA Quality report in Annex 2 highlights the improvements in clinical care and outcomes in the case studies it has examined.

Greater choice of goods and services

- 5.18 HCA has also significantly contributed to the creation of new clinical treatments and services within private healthcare, for the first time offering patients a real choice and alternative to the NHS.

- 5.19 Tertiary care was, until relatively recently, provided almost exclusively within the NHS because of the clinical infrastructure and resource which the NHS has to treat high acuity conditions (ITU beds and specialist medical staff). Private treatment in these tertiary specialisms tended to be conducted solely within NHS PPUs. HCA has transformed the landscape of private tertiary care by creating a private alternative to the NHS by investing in private, high acuity facilities which offer highly specialised treatments in areas such as cancer, cardiac treatment and neurosciences.

- 5.20 Over the last decade, HCA has introduced new high-end treatments which were not previously available outside of the NHS:

- HCA is the first and only UK private provider to develop paediatric cardiac services at the Harley Street Clinic with an internationally recognised team of surgeons, cardiologists and paediatric anaesthetists and the only private provider with a comprehensive range of paediatric services.
- It is also the first private hospital with a medical admissions unit which is geared towards the urgent admission of patients with serious complications such as ventricular failure or pneumonia.
- It has developed a dedicated neuro-rehabilitation unit, and the first paediatric neuro-rehabilitation programme in the country.
- It is the first private provider with a facility dedicated to the treatment of breathing disorders.
- HCA is the only private hospital group to offer private maternity and neo-natal services.
- It is currently developing the first private acute stroke unit, with an investment of [£].

- 5.21 Again, HCA's leadership in these areas has often provided the stimulus for other private hospitals to introduce similar clinical specialisms – examples include CyberKnife, NanoKnife, da Vinci robotic surgery systems and Rapid Arc radiotherapy. HCA has therefore created a private market in a wide range of clinical treatments which were not previously available in the private sector.

- 5.22 New, advanced clinical services within HCA also reduce the extent to which patients need to be transferred to the NHS e.g. for critical care. As stated above, HCA has a low rate of unplanned transfers from its hospitals, and lower than other private operators, due to its significant investment in critical care facilities. In 2012, [£].

- 5.23 The CC effectively mistakes success in the market for barriers to entry and the exploitation of market power. To impose such a drastic structural remedy on a successful innovator would not only be unjustified, it would create a very damaging precedent, harming innovation and growth in the UK economy as a whole.

Consumer interest

- 5.24 Consequently, whatever the CC's views may be about the competitiveness of the market, it must recognise that HCA in London has generated major benefits – through increased quality, innovation and a wider range of services – which directly benefit consumers and which vastly outweigh any perceived consumer detriments. The relevant customer benefits in this case translate into better treatments, swifter recovery, and longer lives.

Effects on RCBs

- 5.25 For the reasons discussed below, the CC's divestiture proposals for HCA will erode, and even extinguish, relevant customer benefits by reducing investment and innovation, creating poorer standards, potentially losing specialist service lines, and de-stabilising the hospitals concerned: please refer to section 6 below. Divestment could put lives at risk. **The CC should be under no illusions about the profoundly serious consequences that ill-judged remedies may have on the health and well-being of patients.**

6. REMEDY 1 – DIVESTITURE OF ONE OR MORE HOSPITALS AND/OR OTHER ASSETS IN AREAS WHERE COMPETITIVE CONSTRAINTS ARE INSUFFICIENT

Introduction

- 6.1 HCA sets out its views on Remedy 1, the CC's proposal to order divestiture of [X].
- 6.2 As discussed above, when considering remedies the CC is required to have regard to the need to achieve "as comprehensive a solution as is reasonable and practicable". The factors which the CC is required to take into account in considering remedies which are "reasonable and practicable" are broadly referred to as the proportionality test. In addition, the CC must have regard for the effect of any remedies on any relevant customer benefits.
- 6.3 HCA submits that, having regard to the balancing exercise which the CC is required to conduct, a divestiture remedy in relation to any HCA facility or asset is wholly unreasonable and disproportionate:
- (i) The nature of the AEC findings do not justify such an extreme and intrusive remedy.
 - (ii) Divestiture is unlikely to be effective in achieving the CC's stated aim of creating a further, high-quality competitor to HCA in many of HCA's highly specialised service lines in London.
 - (iii) On the contrary, the divestiture of [X] carries a significant risk of having profound, long-term adverse effects on patients in terms of clinical choice, quality and care. Divestiture could well put lives at risk by adversely impacting on clinical care and customers. The CC is required to take these adverse effects into account, both in its proportionality assessment, in which it must consider any negative effects on outcomes, and also in its assessment of the relevant customer benefits which the market is currently delivering in terms of quality and innovation. Divestiture would lead to significant economic detriments and costs arising from poorer quality and clinical outcomes which vastly outweigh any conceivable benefits.
 - (iv) There are alternative remedies which the CC is proposing or which are available to the CC to address any possible detriment which are far less onerous or intrusive than divestiture.
- 6.4 For these reasons, a divestiture remedy patently fails the proportionality test and would be a wholly unjustifiable remedy. HCA will consider each of these issues in turn.
- 6.5 HCA also comments below on the CC's paper on divestment options (paragraphs 2-27 dealing with HCA). The CC's use of a market share threshold to determine the need for and scale of a divestment package is wholly arbitrary and has no basis in either law or economic theory. In particular, the CC's assertion that in private healthcare markets "*a share of [X] could be too high*" is unfounded.

(1) Lack of justification based on AEC findings

- 6.6 The CC has powers under section 160, EA 2002 (in conjunction with Schedule 8, paragraph 13) to order the divestiture of a business. The forced sale of assets constitutes a significant intervention in a company's property rights. It is an extremely onerous and interventionist remedy which would have a major impact on any business and requires very careful justification. In *BAA*, the CAT has described divestment as a "**seriously intrusive step**" and has stated that the Tribunal "*will naturally expect the CC to have exercised **particular care in its analysis of the problems affecting the public interest and of the remedy it assesses is required***" (emphasis added).²⁹
- 6.7 As stated above, the CC is faced with a particularly high burden of proof before it seeks to impose highly intrusive remedies such as divestment, in the light of the "double

²⁹ *BAA v CC*, CAT judgment of 1 February 2012, para 20(7)

proportionality" principle laid down in *Tesco*. Furthermore, divestment represents a fundamental interference of property rights which are safeguarded under the Convention. There is therefore a particular need for a careful and cautious assessment of the proportionality of the remedy.

- 6.8 There may be exceptional circumstances in which divestment is a proportionate solution to an AEC. In *BAA*, the CC concluded: "*that the market's characteristics which underpin the AECs and detrimental effects would be unlikely to change, absent our remedy, due to the absolute nature of common ownership and particularly high barriers to entry*" (emphasis added).³⁰ The AEC finding in that case was that: "*In the London area there is an almost complete absence of competition and almost total market failure*".³¹ The CC's Guidelines illustrate possible remedy approaches and refer to divestment as a potential remedy (subject to meeting the relevant proportionality tests in each case) where: (i) the market is concentrated and the position of the incumbent is "*protected by high barriers to entry and/or expansion*"; (ii) there is co-ordination between rivals, leading to co-ordinated outcomes; or (iii) there are vertical effects which need to be addressed. The Guidelines state that the objective of divestment is to "*address at source the lack of rivalry resulting from structural features in the market*".³²
- 6.9 None of these factors (even on the CC's own analysis) is present in HCA's case. As discussed in section 4 above, the CC has not put forward a sufficiently strong or compelling AEC finding which would support such an extreme remedy. This is very far from being a case in which (as in *BAA*) there is a "*complete absence of competition and almost total market failure*." Although the CC considers that the market in London is concentrated, it recognises that there are a range of competitive constraints; that the London market has witnessed significant growth and is continuing to grow; and that the major buyers in this market have the ability to exercise alternative options. It specifically concedes that London "*creates significant opportunities for new entrants*".³³ It also acknowledges the potential for future growth and expansion by London PPU's which will increase competitiveness to at least some degree. This is not a case in which there is a fundamental "lack of rivalry" in the market which justifies divestment as the only way to create or foster a new source of competition in London.
- 6.10 In fact, as HCA shows in its response to the PFs, the evidence for competitive constraints is far stronger than the CC considers, but the point made here is that even the PFs describe the factors which demonstrate that the market is functioning competitively.
- 6.11 Given that in Central London the CC finds that there are at least **6 other private providers**, operating **9 other hospitals**, many of whom have grown in recent years, and a further **16 NHS PPU's**, the CC's case for divestiture is unfounded.
- 6.12 The CC is apparently concerned that there are "insufficient" competitive constraints, but does not demonstrate that divestment is a necessary step to unlock further competition in the London market when there are, self-evidently, several other existing competitors to HCA which have the same ability and opportunity as HCA to invest and expand their business, taking advantage of the growth in tertiary services in London. Divestment is therefore grossly disproportionate to the concerns which have been identified, and no reasonable decision-maker would take such extreme measures in the light of the AEC findings.
- 6.13 Furthermore, the CC's view of the market in its remedies proposals is static and not forward-looking. The London market is rapidly evolving. The PFs note (but do not give sufficient weight to) the trends which include:-
- as stated above, the growth and expansion of NHS PPU's following the lifting of the income cap;

³⁰ *BAA*, CC Report, 19 March 2009, para 10.117

³¹ *Ibid*, para 9.1

³² Guidelines, para 373

³³ PFs, Appendix 3.1, para 9

- the growth in outpatient and day care treatments, which is fuelling rapid expansion in outpatient and diagnostic facilities;
- the pace of advances in medical technology creating demand for newer and more innovative treatments;
- PMI "managed care" initiatives and directional policies which are increasingly dictating the treatment pathway of insured patients and imposing cost controls over hospital operators;
- demographic trends in London and the South East which create rising demand for private treatment, particularly in specialist tertiary services;
- the growth in PMI restricted network policies which are becoming increasingly popular with major corporate customers and demonstrate the bargaining power of PMIs;
- the increasing use of menu options by corporate clients which allow individual employees to choose alternative types of cover.

In framing its remedies, the CC fails to take account of the way in which these trends in aggregate are already re-shaping private healthcare in London and increasing the competitive pressures on healthcare providers. It has failed to show why divestiture is required in view of the way in which the market is developing.

- 6.14 HCA refers to and repeats its comments in section 4 with regard to the nature of the CC's findings and the lack of sufficiently significant competition problems or consumer detriments identified in the PFs. The AEC findings fall well short of the standard of proof which would be required to make the case for divestment.

(2) Lack of effectiveness

- 6.15 The CC is required to consider the *effectiveness* of the remedy, specifically the likelihood that it will achieve its intended effect.
- 6.16 The CC has provisionally found that the market is characterised by weak competitive constraints and high entry barriers. Divestment is proposed as a "market-opening" remedy which addresses the alleged lack of rivalry in the market, either by creating a new competitor or by strengthening an existing competitor through disposal of a business. The CC needs to consider very carefully whether divestiture of [§] would in fact be likely to create a new market entrant which would replicate and match HCA's service offerings in complex, high acuity services. HCA submits that there is no evidence that divestment would be likely to lead to this result, and that furthermore there are significant risks that a new owner of the business would not maintain the high level of investment required to sustain the product offering of [§], or [§] focus on highly complex clinical specialisms.
- 6.17 In the PFs, the CC recognises:
- (i) the highly differentiated nature of healthcare provision in Central London; and
 - (ii) HCA's strategy "*focused on high value, high acuity medical specialties, which require heavy expenditure to enter and expand into*" and its willingness "*to make a very significant investment in equipment and facilities*" in tertiary specialisms such as oncology.³⁴
- 6.18 HCA has pursued a strategy in the UK of large-scale investment in its facilities in order to create centres of excellence in tertiary care. In the period 2008-2011, it has invested [§] in new assets, equipment and treatment technologies and annual capital investments represent [§] of turnover and [§] of net profits. This is significantly more than any of its competitors. It has developed and expanded the delivery of private healthcare in many complex clinical fields such as oncology, neurosciences and paediatrics, which were previously the preserve

³⁴ PFs, para 2.15

of the NHS teaching hospitals. It has pioneered new treatment technologies such as CyberKnife, NanoKnife and robotic surgery, and has created a highly advanced clinical infrastructure across its hospitals network which has been fully described in previous submissions.

- 6.19 HCA's commitment to long-term investment to create leading, cutting-edge clinical service lines is demonstrated by the record of investment and expansion at [X] which have developed highly specialist new service lines. Annex 4 summarises the history of investment in [X] and illustrates HCA's turn-around of [X] through creating new, innovative clinical services and high-quality infrastructure, including [X].
- 6.20 Third party evidence to the CC acknowledges HCA's leadership in highly complex clinical specialisms and its reputation for quality:
- The CC refers to the fact that third parties acknowledge "*that HCA has excellent quality hospitals which operated a high level of complexity*" (sic).³⁵
 - In the CC's review of employers' private healthcare schemes, the CC notes that major London corporates "*cited the reputation of [HCA] hospitals for high quality healthcare as being the reason for including them in their schemes.*"³⁶
- 6.21 The CC's concerns with regard to market concentration in London appear to be focused on complex, high acuity specialisms:
- The PFs state that "*HCA's share is particularly high when considering the complex segment of the Central London market*" in areas such as oncology, cardiology, obstetrics and gynaecology.³⁷
 - It is alleged that HCA has a share of over 60% for inpatient admissions in tertiary treatments in Central London.³⁸
 - The CC is particularly concerned with HCA's share of critical care level 3 beds.
- 6.22 The CC must therefore satisfy itself that a purchaser of [X] is *likely* to maintain the same level of investment which will continue to position [X] as [X] which replicate HCA's existing clinical offering.
- 6.23 HCA points out in this regard as follows:
- (i) HCA's record of investment in innovation in high acuity services has been unique. HCA's investment at [X] has completely transformed the hospital over the last 10 years into a world class centre of clinical excellence.
 - (ii) HCA's vision and strategy has been very different from that of some other major providers, including BMI and Spire, which have historically focused on lower acuity clinical procedures and have relied more heavily on NHS provisioning of less complex, more routine procedures which do not require the same level of investment in ITUs and level 3 clinical services. HCA undoubtedly faces significant competition from other providers of tertiary care, but HCA's track record within the various service lines which it offers as a high quality, innovative provider is unmatched within the private sector. This is demonstrated, for example, by the fact that other hospital providers rely to a greater extent than HCA on the back-up provided by the NHS to offer critical care (ITUs, etc.) to patients.
 - (iii) The sheer pace of medical advances in new types of treatment and diagnostic techniques is such that substantial ongoing investment will continue to be necessary to keep [X] at the forefront of medical technology and maintain [X] reputation for clinical quality and excellence.

³⁵ PFs, Appendix 6.10, para 53

³⁶ PFs, Appendix 2.1, para 40

³⁷ PFs, para 6.127

³⁸ *ibid*

- 6.24 It is not apparent to HCA that a purchaser of [X] would pursue the same investment strategy as HCA or manage [X] with HCA's level of skill and diligence. The CC has no control over the long-term vision and strategy of the purchaser of the divested business. No other hospital group has demonstrated the same appetite for sustained capital investment and innovation. There are therefore significant risks that the profile and clinical service offering of [X] would change over time. In that event, the divestment of [X] would have failed to achieve the CC's apparent aim of creating further competition in the range of high acuity, complex specialist services which [X].
- 6.25 Furthermore, [X] a number of clinical service lines which are unique to [X] and which are not replicated in other HCA hospitals. As discussed below, HCA's network strategy allows HCA to develop a different clinical focus in each of its facilities. These services are listed in Annex 4 and include [X]. Divestiture would not in any event create a new competitor for [X].
- 6.26 Moreover, even in a scenario where a purchaser does pursue the same investment strategy and maintains the current level of clinical services and quality within [X], HCA does not consider that divestment is likely to lead to any material reduction in prices:
- HCA's hospitals have substantial fixed costs to provide the infrastructure, resource, equipment and advanced clinical facilities necessary to provide highly complex specialised treatments.
 - There is a high level of medical inflation reflecting increases in property costs, staff costs, consumables, taxes, etc.
 - As HCA demonstrates in its responses to the PFs, the CC has not provided any credible evidence that HCA's prices are significantly higher than comparable London providers. [X].³⁹
 - A purchaser of [X], wishing to maintain the same strategy, would inherit the same cost structure (and would arguably have higher costs due to the purchase price). If it wished to maintain the same level of investment and innovation (pre-requisites to the type of clinical services which HCA is providing), the pricing structure is likely to be comparable to that of HCA.
 - Furthermore, given the synergies discussed below, a new entrant would struggle to replicate the same offering with the same level of quality and efficiency, so it is possible that in some cases prices may even be driven up.
 - BUPA's recent submission to the CC of September 2013 (paragraph 4.100(v)) concedes that a purchaser of "high cost" facilities "will be more restricted in how they can *compete with lower prices while remaining profitable*" and will therefore be "a *weaker competitor*". HCA notes that while its facilities operate at a higher cost than others, this is due to the higher quality it provides, and BUPA misses the point in its submission that competition does take place in terms of quality and innovation.
- 6.27 Accordingly, divestment would create two alternative scenarios, neither of which would be effective in addressing the CC's apparent concerns about concentration and pricing in London:
- (i) The first (and, HCA believes, the more likely scenario) is that a new owner of [X] pursues an alternative strategy which does not maintain the same level of investment and which would change the nature of [X] and [X] clinical services. This would not create an additional effective competitor to HCA in its existing, complex clinical service lines, but would in fact entail a loss of existing capacity and service lines, which in itself may even create upward pressure on prices.

³⁹ [X].

- (ii) The alternative scenario is that a purchaser is found which pursues the same strategy of maintaining high quality, advanced clinical services. With the same cost structure, and the need for continual capital investment to keep at the forefront of medical innovation, there would be little scope to reduce prices to PMIs and self-pay patients and, if anything, some prices could even rise because of the loss of synergies.

In either eventuality, a divestiture remedy would be entirely ineffective in addressing the alleged AECs.

- 6.28 There is no consensus amongst PMIs, all of whom are using this inquiry to promote their own commercial agenda, for divestiture as an effective means of addressing the AEC findings in London. The largest PMIs, predictably, are in favour of divestment but, tellingly, the smaller PMIs do not share their views. HCA urges the CC to closely consider the motivation of PMIs arguing in favour of divestment. They have a clear incentive to maximise their profits by lowering costs. Given a high quality/higher price option and a low quality/low price option, they would always choose the latter. It is no surprise therefore that BUPA and AXA-PPP are in favour of a divestment that presents the real prospect of lowering the quality of care provided to London patients at lower cost.
- 6.29 Furthermore, it is far from being the case that divestment is necessary as a route to market for new entrants. Investors seeking to enter the London market have far easier and potentially less costly ways to develop and expand a presence in London. There are former NHS hospital sites which are currently available for new hospital development. There are also PPU partnering opportunities, particularly in London, which the CC accepts affords a particularly convenient point of entry for new providers. There are also other development sites available on the open market.

(3) Adverse effects and costs

- 6.30 A divestiture remedy would have a highly detrimental impact on the [X] and would adversely affect the high standards of quality, clinical care and innovation [X]. It would reduce competition and choice in London, and lead to poorer clinical outcomes. Divestment would create significant consumer detriments which are wholly disproportionate to its objectives, and erode the customer benefits of high quality and innovation which [X] to patients.
- 6.31 These adverse effects arise from the following:
- (i) [X] significant **quality, clinical and economic benefits and synergies** from being part of HCA's network of London hospitals, the loss of which will significantly weaken [X] ability to compete to provide high quality, high acuity complex treatments to patients.
 - (ii) There is likely to be **reduced investment in innovation and clinical services** [X], which will impact on [X] ability to maintain [X] reputation of high quality, cutting-edge clinical services and reduce competition and choice in tertiary care.
 - (iii) Divestment carries **substantial asset risks** to [X] and there is a strong prospect that the divestment process of itself will disrupt the business and will weaken [X] ability to compete.

- 6.32 These are discussed in more detail as follows.

Quality, clinical and economic benefits and synergies

- 6.33 HCA is the world's largest independent hospital company with 164 hospitals and 106 outpatient centres serving 14 million patients a year. Its core competency and focus is the delivery of high quality healthcare.
- 6.34 HCA operates a single integrated network of high quality, high acuity facilities, with eight different inpatient locations, providing the scale, resources and expertise which maintain these hospitals as leading centres of tertiary care.

- 6.35 HCA's network is unique in that it consists of several facilities, offering highly complex treatments, located within a tight geographical area. This close, geographical juxtaposition of high-quality, high-acuity hospitals allows them to operate as a tightly integrated network, enabling HCA patients and personnel to transfer between network hospitals seamlessly whenever necessary. It also means that HCA's investments in one hospital provide benefits to patients across the entire group of hospitals.
- 6.36 [REDACTED].
- 6.37 HCA's network allows HCA to spread the cost of new technology across all its hospitals. New equipment and clinical procedures for highly specialised treatments are costly and in some cases the patient volumes in any one hospital may not justify the capital investment required. For example, investment in IORT would not be possible without leveraging the use of this system across multiple hospitals, since otherwise there would be too few patient numbers. Similarly, HCA would not have invested in the SCRI UK trials without the network, since otherwise there would be an insufficient volume of patients who could benefit from these trials. Many of the innovations in HCA's hospitals have only been viable, financially and clinically, because these innovations can be utilised across the entire network. The network also allows for a level of sub-specialisation, in which highly specialised treatment units are made available to all the hospitals in the network, e.g. the London Hand and Wrist unit provides a specialist multi-disciplinary service for upper limb conditioning and injuries, drawing from expertise at the Wellington, London Bridge, Lister and Portland hospitals. The HCA Quality report in Annex 2 provides a number of specific case studies of innovative treatments or procedures which would not have happened if the HCA hospitals did not operate as a single integrated network.
- 6.38 HCA's cancer care network provides a particularly good illustration of how higher patient volumes can create network benefits. With [REDACTED] patients treated every year, HCA has the largest private oncology network in the UK. This provides the critical mass enabling HCA to develop highly specialist services, including surgical techniques and diagnostic services, and invest in highly specialised equipment which would not occur in a smaller network. Divestiture would therefore threaten HCA's ability to continue to provide these highly specialised cancer treatments.
- 6.39 HCA's six major London hospitals therefore operate as a single network of facilities which create a centre of excellence in tertiary healthcare services. This allows HCA to develop a different clinical focus and clinical offerings in each of its hospitals. This network strategy allows HCA to co-ordinate and utilise the clinical resources of all its facilities to the benefit of consultants and patients and has been critical in supporting new innovations and investments. The geographical propinquity of the hospitals creates efficiencies by allowing patients to access the facilities across the network. [REDACTED].
- 6.40 The value of networks in healthcare has long been recognised within the NHS. For example, the NHS has created specialist networks in cardiac and stroke services and in cancer care, bringing together NHS teams in different facilities (e.g. the London Cancer Alliance, an integrated cancer system across west and south London) to improve co-ordination, share best practice, allow for different facilities to develop a different clinical focus or sub-speciality and drive clinical improvements. HCA's network serves essentially to replicate the benefits of these NHS networks in private healthcare.
- 6.41 Simplyhealth rightly notes in its recent submission to the CC that an obligation on HCA to divest would "*hamper its ability to continue to provide some of the specialist care services it is able to offer currently through a network of closely interlinked care units.*"
- 6.42 Divestiture would undermine not only [REDACTED], but also the remaining HCA hospitals, all of which benefit from these synergies. The divestment of such a [REDACTED] would similarly weaken the network synergies to HCA's remaining hospitals, and put at risk the high level of clinical care which HCA is currently able to offer. In some cases, it would mean that existing, dedicated specialist centres could no longer be provided because of the fall in patient volumes. There would also be reduced investment in new equipment and services, particularly in highly specialist clinical treatments which require a larger patient base in order to justify. Again, the

HCA Quality report provides a number of specific examples (e.g. the molecular imaging centre for orthopaedic cases) which could well be unviable in a smaller network with lower patient volumes. The CC's divestiture remedy would therefore have a severely detrimental impact both on the remaining HCA hospitals as well as [REDACTED].

- 6.43 The divestment of any one of HCA's hospitals would remove these benefits and synergies which the hospitals derive from participating in HCA's network and would:
- adversely impact on the level of clinical quality and care which the hospitals provide; and
 - potentially reduce the range of treatments which HCA is able to offer.

Reduced investment in innovation and clinical services

6.44 As stated above, HCA has an unparalleled record of investment in its facilities. The scale of capital investment has enabled [REDACTED] to offer new and highly innovative clinical services, improved diagnostic techniques and create the clinical environment necessary to delivery high quality care. HCA has been at the forefront of innovation in the London market.

6.45 HCA's core clinical focus – the treatment of complex high acuity conditions in highly specialised areas such as cancer, cardiology and neurosciences – is one which requires extensive ongoing investment in order to remain competitive in the UK and internationally:

- The NHS is viewed as the preferred environment for serious complex high acuity conditions because of its full back-up of intensive care clinical support. HCA is now offering treatments in areas such as cancer care which, until relatively recently, were only available on the NHS. A private operator seeking to create a private sector alternative must therefore be willing to make substantial investment to innovate and keep abreast of medical advances and maintain a high level of clinical quality.
- HCA's international patients are also an important driver of its business. [REDACTED] of HCA's revenue is derived from overseas patients with highly complex conditions who are able to choose between tertiary centres around the world, including the US, Germany, France and Singapore. HCA received the Queen's award for enterprise In 2007 and 2009 in recognition of its international success. In order to continue to attract this highly mobile group of patients, HCA hospitals must invest heavily to maintain their reputation for medical innovation, quality and excellent clinical outcomes.

6.46 HCA's investment in [REDACTED] over the last few years, and the new equipment and services which this has given rise to, is set out above.

6.47 HCA is committed to further investment in [REDACTED] in the next 12 months or so - which would not go ahead in the event of divestiture:

- [REDACTED].
- [REDACTED].

6.48 As stated above, much of the investment which HCA makes in its hospitals is driven by the fact that new equipment and clinical treatments in highly specialised clinical fields is exploited across HCA's hospitals. The level of investment would therefore be directly impacted by the splitting of the portfolio, which would mean that investment in new specialisms may be unviable.

6.49 However, in addition, for the reasons discussed above, there are significant risks that a purchaser of the business would not in any event seek to pursue the same investment strategy as HCA and maintain the same level of capital spend in new equipment, clinical services and infrastructure or innovate to keep abreast of medical advances in new treatments and techniques. This would mean that [REDACTED] will become less competitive, both

domestically and internationally, in the provision of highly specialised complex tertiary treatments such as oncology or neurosurgery which require large-scale capital investment.

6.50 Indeed, the OFT in its recent submission to the CC (paragraph 12) alludes to this very point when it states that *"the CC would need to ensure that [divestment] did not reduce choice for patients through the purchaser offering a narrower choice of treatments ... and also that service levels were not reduced – e.g. through waiting times for treatment being increased or treatment no longer being offered."*

6.51 The CC would also need to consider the capability and capacity of any purchaser to continue to commit to significant, ongoing capital investment over the next few years, bearing in mind the impact of any gearing to fund a [X] hospital acquisition.

6.52 Reduced investment would have serious implications for clinical quality and care:

- The current clinical infrastructure (high levels of staffing, specialist clinical staff such as RMOs, intensivists and nurses, specialised equipment, level 3 ITUs, theatre capacity, etc.) requires a very high level of investment. This must continue in order to ensure that [X] is able to provide the latest technology in line with evolving medical findings. Lower capital expenditure would adversely affect the quality of care.
- There would be less innovation in terms of new advanced equipment, surgical and diagnostic techniques or clinical services.
- [X] would then be unlikely to attract and retain leading NHS consultants in complex tertiary services. The quality of a hospital and the facilities, its clinical resource and reputation, are key factors in competing for consultants. If the quality of technology drops, consultants will simply take their patients with complex conditions back to the NHS.
- This in turn would significantly weaken [X] profile as [X] of clinical excellence. It would damage the [X] reputation and competitiveness internationally, with the consequence that there may be even fewer incentives and opportunities to invest.

6.53 Thus, far from increasing competition and choice, divestment is more likely to lead to a *reduction* in competition in innovative treatments and technologies for which HCA hospitals are well known, and a *reduction* in quality and worsening of clinical outcomes.

6.54 The divestment of [X], and the impact this would have on its financial position, could also put at risk HCA's wider investment strategy in London:

- [X].
- [X].
- [X].

A divestiture remedy would discourage these types of future investment proposals.

6.55 A divestiture would also more generally have a "chilling" effect on investment in London, and in the UK as a whole. Potential investors, particularly overseas investors, would be justifiably concerned that long-term investment in healthcare could be put at risk through a compulsory divestiture of [X] taken many years to develop. Divestiture would send a signal that successful businesses which innovate and create efficiencies will be punished through the regulatory process – a wholly perverse outcome. The CC's remedies are likely to have the effect of deterring new investment which could significantly weaken London's position as a leading centre of tertiary care. The CC's Guidelines for market investigations recognise these risks in stating: *"In some cases incumbency advantages may result from good commercial decisions made in the past (e.g. to invest in and patent a successful new technology) and*

intervention to overcome these sources of competitive advantage may risk undermining dynamic incentives to invest and innovate."⁴⁰

6.56 The opening statement of the Response to Consultation on Statements and Strategic Priorities that CMA published by BIS states: "*We need our competition regime to create an environment that encourages business to invest in new and better ideas, driving growth and delivering better and cheaper products and services for consumers.*" The PFs, as they relate to HCA, identify a consistent record of high investment and quality that delivers great outcomes for patients and generates further investment opportunities in the public and private sectors. The CC's divestiture proposal would involve a decision that has precisely the opposite effect from that set out by BIS. It would mistake success for the exploitation of market power, and therefore rather than creating an environment where investment is encouraged, it inevitably would deter further investment both in this and other industries throughout the UK economy.

Substantial asset risks

6.57 There are substantial risks that the divestment process in and of itself would seriously damage the [X] and would weaken [X] to compete. This would defeat the very objectives which the CC is seeking to achieve. The CC has a legal duty to take account of the considerable asset risks resulting from divestiture.⁴¹

6.58 HCA has already raised its concerns with the CC that the mere *announcement* that the CC is contemplating the divestiture of [X] would create uncertainties about the future of [X] and would be sufficient to destabilise the consultants, staff and patients and result in a deterioration of the [X]. It is for this reason that HCA has requested that the identity of the [X] is kept strictly confidential. If the CC proceeds with its proposals to order divestiture, once the identity of [X] becomes publicly known, it is very likely that there would be a loss of confidence which would damage [X] irreparably. Consultants have already begun to voice their concerns about the CC's proposals and the impact this could have on their patients.

6.59 Hospitals are entirely dependent on their ability to attract and retain consultants. The consultants are the lynchpin of any private hospital, in terms of delivering inpatient, day case and outpatient services. 85% of GP referrals of PMI-funded patients are to named consultants (not hospitals) and it is therefore the consultants who primarily drive patient volumes to the hospital. The CC's case study on the London Clinic (which describes the competition between HCA and the London Clinic for oncologists at the LOC) acknowledges the importance of having a critical mass of consultants to operate key services.

6.60 As the CC is well aware, consultants are not employees who would simply be transferred together with other staff in any sale process. Consultants are independent (and mobile) practitioners with practising privileges, often at a variety of different hospitals. Unless consultants are willing to maintain their practising privileges, and continue their practices at a hospital, the hospital's business would simply be lost. Several third party submissions have alluded to this, and Nuffield for example concedes in its submission (paragraph 2.9) that if consultants leave "*an acquirer might reasonably expect the attractiveness of any divested facility to decline materially post-acquisition.*"

6.61 The forced disposal of [X] would be unprecedented and cannot be compared with previous hospital transactions, such as BUPA's sale of its hospital portfolio. These transactions involved a change in ownership which had the support of consultants and staff (and, in the case of BUPA, was widely welcomed), to ensure a smooth transition with no disruption to the business. The circumstances here would be very different, involving the forced disposal of [X] giving rise to considerable uncertainty over the future ownership and strategy of [X].

6.62 HCA can cite a recent example in the US which illustrates how future uncertainty about ownership can be destabilising to a hospital business. In 2011, HCA sold the Palmyra Park Hospital ("Palmyra") to the Hospital Authority of Albany-Dougherty County (the "Authority").

⁴⁰ Guidelines, para 58

⁴¹ BAA v CC, para 249

The US Federal Trade Commission ("FTC") temporarily restrained the parties from completing the transaction pending its investigation, and Palmyra was left in a state of limbo for over six months. The delay and uncertainty in this period caused considerable harm to the business. During this time, 60 to 70 employees left the hospital, key members of senior management departed, and also a number of critical medical staff left. The hospital lost a significant percentage of both inpatient and outpatient business - inpatient surgeries declined by approximately one-third. The hospital suspended or deferred capital expenditures for improvements and new services. The Authority was eventually able to complete the transaction following commitments agreed with the FTC, but there was significant damage to the business in this period.⁴²

- 6.63 There is intense competition in London for the top consultants specialising in highly complex, tertiary treatments. The consultants at [X] have numerous alternative facilities in the immediate vicinity of [X] where they are able to practice. There are very low barriers for consultants to switch to alternative facilities, and many of these consultants already have practising privileges at rival hospitals.
- 6.64 It is highly likely that leading consultants at [X] would shift their practice away as a result of the uncertainty over the future of the business. As stated above, the quality and clinical infrastructure which a hospital operator is able to offer are key attractions for consultants. HCA has successfully built a relationship with consultants based on its quality offering and its record of investment and innovation. Most consultants have an NHS post, and HCA has successfully attracted many NHS consultants into private practice by offering the same depth of clinical resource (ITUs, etc.) which these consultants expect in the NHS. The uncertainty over the future ownership of [X], and of the strategy of a future owner, would in effect "blight" [X] and would be extremely destabilising for consultants.
- 6.65 It is likely that other clinical staff – RMOs, intensivists, and nursing staff – would also leave. All of these are highly skilled and sought after and are able to move quickly to alternative facilities.
- 6.66 The loss of consultants and other clinical staff would severely disrupt [X]. It is likely that consultant and other staff departures would snow-ball, running down the business. It would also put at risk the continuity of clinical care for patients currently receiving treatment and break their treatment pathways.
- 6.67 The uncertainties over the sale process would also be very damaging [X].
- 6.68 Under new ownership, [X] would not be covered by HCA's existing PMI contracts. These would need to be re-negotiated. It is not clear what terms of access the PMIs would seek and how long this could take. This in itself could be highly disruptive to the PMI revenues of the hospital.

Implications

- 6.69 Divestment would therefore have the following adverse effects:
- The immediate impact would be to destabilise [X], disrupt the business and lead to the loss of consultants, staff and patients.
 - With the reduction in investment, quality would suffer leading to poorer standards and clinical outcomes.
 - Far from creating an effective competitor, divestment would reduce competition and choice.
 - Divestment would have a "chilling" effect on investment and reduce the willingness of HCA and indeed other operators from committing large-scale investment in the future.

⁴² *Federal Trade Commission v Phoebe Putney Health System, Inc*, US Circuit Court of Appeal for the 11th Circuit

- Ultimately, it would be the patients who suffer through poorer quality and lower standards of healthcare.
- The costs and detriments of divestiture wholly outweigh any possible benefits of remedying AECs.

6.70 In the light of the above, HCA submits that:

- (i) the proposed divestment remedy produces major consumer detriments which are wholly disproportionate to the remedies objectives; and
- (ii) divestment would remove significant consumer benefits which patients currently derive from HCA hospitals, in particular higher quality, innovation and a greater choice of products.

6.71 For these reasons, the divestment remedy fails the statutory tests which the CC must apply.

(4) Alternative remedies

6.72 The proportionality assessment requires the CC to adopt the "least onerous" remedy where there is a choice of alternative measures. It is incumbent on the CC to limit its intervention to the minimum necessary to address any competition concerns. HCA submits that there are a range of alternative proposals which the CC is able to adopt to address its concerns and these are far less onerous and detrimental to the market.

6.73 The CC has itself proposed other measures (remedies 2-7) in its Remedies Notice which seek to address the CC's concerns about market distortions. Although HCA does not consider that the AEC findings justify any remedial measures, it is nevertheless clear that there are alternative proposals to facilitate competition and choice which would be far less intrusive and detrimental than divestiture:

- The CC has proposed behavioural remedies in relation to tying and bundling, the aim of which is "*to prevent BMI, HCA and Spire from using their market power in certain local areas*".⁴³ These directly address the CC's (misconceived) concerns over the use of hospitals' negotiating positions to restrict PMIs from making changes to their networks. On the CC's own analysis, remedies which prevent tying or bundling would protect the ability of PMIs to exercise "outside options", and develop network products with competing hospitals, and facilitate new market entry.
- The CC is also proposing to prohibit certain types of consultant incentive schemes which, the CC finds, restrict competition between hospitals by distorting referral patterns. Again, on the CC's own analysis, the restriction of these schemes would promote competition between hospitals by ensuring that patients can choose hospitals based on either quality or price.
- The Remedies Notice also proposes a package of information remedies which are aimed at tackling the information asymmetries in the market so that consumers can make more informed choices with a view to "*promote competition between private hospitals*".

6.74 The CC has therefore proposed a series of measures which are aimed at limiting market power and fostering greater competition and choice. HCA wholeheartedly welcomes measures which improve the availability of information for patients to make informed decisions on price and quality. Likewise, it welcomes clarification on appropriate and inappropriate relationships with clients. It would accept that the economic costs of these measures are far less onerous or detrimental than divestiture. Furthermore, they do not remove or detract from any relevant customer benefits which the market currently delivers in terms of higher quality innovation and greater choice of products and services. The CC has not shown why these measures would not in themselves address the alleged AECs. The CC

⁴³ Remedies Notice, para 4

cannot therefore demonstrate that divestiture is the "least onerous" of the measures which are available to foster greater competition in the market place.

- 6.75 There are, in addition, alternative remedies which the CC has not put forward but which could also promote competition and would similarly give rise to significantly lower adverse effects or costs:

PMI recognition

- HCA reminds the CC that the genesis of the private healthcare inquiry lay in Circle's much-publicised Complaint that relationships between PMIs and incumbent hospital operators – in Circle's case, BMI – were foreclosing new entrants. This was the core concern which reportedly triggered the OFT's original investigation – a fact which is nowhere apparent in the PFs.
- Although the CC (erroneously) finds that PMI recognition is not a barrier to entry, it is clear from its case studies that PMI recognition is critical to the viability and success of any facility. Remedies relating to PMI conduct in handling admissions into the network would address or remove one of the most significant challenges facing new entrants, and be far more effective than any of the other proposed remedies in facilitating new entry and expansion. In particular, a requirement for PMIs to recognise new entrants – including NHS PPUs – on reasonable terms (for example, based on published average reimbursement rates) would actively encourage further investment in the private healthcare market by removing a key obstacle to new hospital developments. One of the biggest uncertainties and risks for investors is not knowing whether a new development will secure PMI recognition, and an obligation to grant PMI recognition on reasonable terms would drive new competition.

Contractual restrictions

- As HCA has discussed in relation to remedy 2 below, the prohibition of express contractual restrictions between PMIs and hospital operators in relation to the recognition of competitors would be a more effective and proportionate remedy to encourage greater competition.

Prohibit fee-capping of consultants

- The PFs specifically find that PMIs' fee-capping of consultants "*could lead to distortions in competition between consultants and to reduced consumer choice*"⁴⁴, and yet surprisingly it proposes no remedies to address this concern. The lack of any remedies which address PMI issues is reflective of the highly partisan nature of this inquiry. Measures aimed at limiting or prohibiting fee-capping would make an effective contribution to allowing consumers to see the consultant of their choice, thus promoting competition between consultants and hence between hospitals. They would reinforce the behavioural remedies proposed by the CC to remove any restrictions on the ability of patients to choose hospitals on grounds of quality or price, without the PMI dictating how and where the patient is to be treated.

Planning

- The CC suggests (wrongly, in HCA's view) that planning issues may contribute to barriers to entry in London (although the CC provides no specific evidence on this point), but if this is correct the CC could consider proposals to facilitate the planning process in respect of new hospital developments.

NHS property portfolio

- The CC has also failed to consider any remedies which address the dominant role of the NHS in influencing the private sector and the distortions of competition which

⁴⁴ PFs, para 7.70

HCA has highlighted, for example by increasing the time that NHS consultants can commit to private practice.

- The NHS for instance has a large, surplus property portfolio, and the CC could address its (misplaced) concerns about limited site availability in London by ensuring that the NHS disposes of surplus property on an open and transparent basis, specifically inviting bids from private hospital operators, to encourage new entry and expansion in the private healthcare sector. For example, it was recently reported that the NHS is planning a £150 million sale of St, Mary's Hospital buildings, and that "*the hospital's main site in Paddington and the Western Eye Hospital in Marylebone are both up for sale*".⁴⁵ A further example is the Middlesex Hospital which closed in December 2005, and sold to a developer in 2008, for residential re-development. Over the next few years, there are likely to be a spate of NHS hospital closures as NHS services become re-organised in the capital. These sites could easily be utilised by new entrants.

PMIs

- HCA believes that the CC should consider remedies which address the competitive distortions in the PMI market which arise from the market power of BUPA and AXA-PPP and which operate to the detriment of small PMI groups.

Transparency of PMI/PH contracts

- Greater transparency in the terms agreed between PMIs and hospital operators could also facilitate competition. HCA would welcome greater openness by both PMIs and hospital groups in their contractual arrangements. This would also highlight any exclusivity obligations or other clauses which may have foreclosure effects.

Dispute resolution

- HCA would also welcome the introduction of some form of mediation or arbitration to determine contractual disputes between PMIs and hospital operators. It would ultimately be in the interests of patients to have an independent mechanism for the swift resolution of disputes to reduce the risks of hospital de-listings or "out of contract" periods.

New sites

- The CC considers (wrongly) that there is limited site availability in London. HCA strongly disputes this and has provided clear evidence that, at any one time, there are a wide range of properties available to new entrants seeking to build or develop inpatient or outpatient facilities in London. In this regard, HCA would support a remedy requiring land owners or developers of sites suitable for hospital development to advertise these opportunities to healthcare providers. HCA has already referred to this in connection with former NHS sites, but a similar requirement for transparency could extend to all sites suitable for hospital facilities. This would address the CC's concern that HCA has relationships with land owners in Central London which give it a competitive advantage.

(5) CC's divestment options

- 6.76 The CC has provided to the parties a summary of its proposed package of divestiture. Paragraphs 2-37 of the CC's note on divestment options [REDACTED].
- 6.77 The CC's central rationale for selecting [REDACTED] for divestiture is that this would reduce HCA's market share in Central London to below [REDACTED]. The CC asserts as follows (see paragraphs 27, 35-37):

⁴⁵ West End Extra.

- (i) [REDACTED];
- (ii) [REDACTED]; and
- (iii) [REDACTED].

6.78 [REDACTED].

6.79 There are no market share benchmarks or thresholds in competition law or policy to determine whether a business has "too high" a market share and/or the point at which divestiture may be required. Even if the CC believes that it is appropriate to consider a divestiture remedy, the assertion that in the private healthcare market [REDACTED] is unfounded. Market share is only a starting-point in any competition investigation. There is no substitute for a detailed investigation of the market which takes account of all the market dynamics, including the range and strength of competitors, entry barriers, countervailing buyer power, and the pace of growth and technological change.

6.80 The CC refers to the fact that according to DG Comp's Guidelines, [REDACTED] indicates dominance and the Guidelines make no such presumption. In any event, as the CC is well aware, the assessment of whether an undertaking is in a dominant position is merely the first step in the application of Article 102, TFEU/Chapter II, Competition Act which prohibits the abuse, but not the existence, of a dominant position.

6.81 In *Akzo*,⁴⁶ it was held that a market share of 50% (not [REDACTED]) provided evidence of the existence of a dominant position, but only alongside "other factors" which indicated that the undertaking held a position of economic strength. Similarly, in *AstraZeneca*,⁴⁷ the Court reaffirmed that "*the existence of a dominant position derives from a combination of various factors*", and noted the Commission "*did not base its examination exclusively on AstraZeneca's market share, but took care to conduct an in-depth analysis of competitive conditions ...*". [REDACTED] have no legal basis whatsoever.

6.82 Furthermore, in a market that the CC itself acknowledges as differentiated, and where HCA invests significantly, market shares are a very limited tool that can lead to misguided conclusions about market power.

6.83 Guidance from UK and EU competition authorities make it clear that there are no market share benchmarks and that market share is only one factor in assessing market power in competition cases:

- (i) The OFT's Guidelines on the assessment of market power state that market shares alone might not be a reliable guide to market power and that other factors need to be considered, including entry barriers and also successful innovation: "*in a market where undertakings compete to improve the quality of their products, a persistently high market share might indicate persistently successful innovation and so would not necessarily mean that competition is not effective.*"⁴⁸
- (ii) The European Commission's Guidelines on horizontal co-operation similarly state that market share on its own is not definitive and that "*other factors such as the stability of market shares over time, entry barriers and the likelihood of market entry and the countervailing power of buyers/suppliers also have to be considered ... in any event, the Commission interprets market shares in the light of likely market conditions, for instance, if the market is highly dynamic in character and if the market structure is unstable due to innovation or growth.*"⁴⁹
- (iii) The CC's own Guidelines on market investigations also make it clear that there are no market share thresholds and that an assessment of market power requires a

⁴⁶ *Akzo v Commission*, Case 62/86

⁴⁷ *AstraZeneca*, Case T-32/05, paragraphs 239 and 244

⁴⁸ OFT's Assessment of Market Power Guidelines, para 44

⁴⁹ Horizontal Co-operation Guidelines, para 45

careful, in-depth examination of the competitive conditions in the market: "A large market share does not always indicate that competition within the market is weak. It may simply indicate the firm(s) possessing it is capable and relatively efficient, having low cost, an attractive product, or both. Moreover, a firm with a large market share could be vulnerable to entry and expansion which might constrain its market power (see paragraph 175), or face countervailing buyer power (see paragraph 176)."⁵⁰

- 6.84 There is therefore no case law or guidance which supports a benchmark market share of [%].
- 6.85 The CC's Guidelines state, in relation to the scope of a divestiture package: "*In order to achieve a proportionate solution, the CC will seek to identify the smallest such package (or packages) that is likely to be a viable competitor and satisfactorily addresses the AEC.*"⁵¹ The use of an arbitrary market share threshold does not explain how the proposed divestiture package addresses any perceived AECs. The CC's whole approach is disproportionate.
- 6.86 HCA reminds the CC that the OFT investigated and cleared HCA's acquisition of St. Martin's Healthcare Limited, the acquisition of the two hospitals which has created HCA's current portfolio of its six major facilities (see paragraphs 4.6-4.9 above). The OFT expressly noted that the merging parties had a high market share of 62% in neurosurgical services. There was no suggestion by the OFT that a market share exceeding [%] was anti-competitive – indeed, the OFT's decision states that it is "*satisfied that there will be substantial competition to the parties, which will allay any concerns.*"⁵² As stated above, since that acquisition in 2000, the London market has become more, and not less, competitive.
- 6.87 Furthermore, over the last few years, the OFT has cleared several merger transactions involving private hospitals which have given rise to local market shares of [%] or more. In *GHG/Nuffield*, the OFT expressly rejected the application of a market share threshold (the "40/10 rule"), stating: "*... in the context of its statutory duties under the Act and given its extensive evidence of economic evaluation in merger analysis, the OFT generally avoids applying such threshold rules as determination of the competitive impact of a transaction without consideration of empirical evidence ... The OFT therefore has given no substantive weight to this rule and is not minded to do so in future hospital merger cases.*" It has never been proposed by any UK or EU competition regulator that, because of the extent of differentiation in private healthcare, a share of [%] could be "too high".⁵³
- 6.88 It is patently absurd to suggest that private hospital operators should be subject to a market share cap, above which they are not permitted to compete on quality and innovation. HCA has grown its business because of its reputation for quality and clinical excellence. Patients, who have numerous other choices in London, want to go to HCA hospitals for these reasons. In effect, the CC is seeking to penalise HCA for being too successful with its quality offering.
- 6.89 HCA also repeats its criticisms of the CC's approach to market definition and the calculation of market shares (HCA refers to its response to the PFs which comments on this in detail). The CC has not conducted a proper market definition analysis for Central London. It has excluded key competitive constraints, including in particular a significant number of hospitals outside Central London and NHS hospitals. The CC's estimates of HCA's share of admissions and of revenue in Central London are meaningless because they ignore the presence of key competitors in the catchment area from which HCA draws the majority of its patients. Consequently, even if for the sake of argument it was appropriate for the CC to apply a market share threshold to determine if divestiture is justified, it would need to properly calculate market shares taking account of the full range of competitors to HCA in HCA's principal catchment area.

⁵⁰ CC Guidelines, para 190

⁵¹ CC Guidelines, Appendix B, para 10

⁵² OFT clearance Decision of 31 July 2000, para 21

⁵³ OFT, *GHG/Nuffield*, ME/3469/08

- 6.90 The CC rightly notes that HCA hospitals have a broad catchment area and that their catchment areas "overlap substantially". The CC should therefore include all the competitive constraints on HCA in this catchment area in any assessment of market share.
- 6.91 Finally, the CC refers to the fact that its proposed divestment remedy should include the "outpatient [§]" of the target [§]. This also is inexplicable. The CC has on its own admission omitted any assessment of competition in the provision of outpatient facilities. As HCA has consistently submitted to the CC:
- there is strong competition in outpatient and diagnostic services in Central London;
 - barriers to entry are lower and there has in fact been considerable new entry by a whole range of providers including hospital operators, consultant groups and PMIs;
 - with the trend away from inpatient to outpatient treatments, this is a rapidly growing market;
 - HCA's analysis of referral patterns from its outpatient facilities shows that there are only limited referrals to its hospitals;
 - the PFs have not highlighted any competition concerns whatsoever in relation to the provision of outpatient and diagnostic services other than the existence of consultant incentive schemes (which are addressed by remedy 4, as discussed below).
- 6.92 HCA reserves the right to comment further on the divestment options paper which sets out a wholly inadequate reasoning for the CC's divestiture proposals.

7. REMEDY 2 – PREVENTING TYING OR BUNDLING

Introduction

- 7.1 The CC has proposed two variants of a remedy which is designed to "*prevent BMI, HCA and Spire from using their market power in certain areas*". HCA comments generally on both variants and responds to the specific questions posed in the Remedies Notice.

Remedy 2(a)

Views

- 7.2 Remedy 2(a) seeks to impose a restriction on BMI, HCA and Spire from raising prices in response to a PMI's decision to change its hospital network, creating a fall in patient volumes.
- 7.3 HCA's understanding is that the CC is not seeking to restrict or interfere with the ability of a hospital operator to negotiate contract prices with PMIs. The CC has rightly rejected a remedy option (remedy 8) aimed at price controls. It appears from paragraph 42 of the Remedies Notice that this variant of the remedy is directed at situations in which there is an *existing* contract with a PMI, and there are price changes during the term of this contract in response to changes in the composition of a PMI's hospital network.
- 7.4 There are a number of important observations to make with regard to PMI pricing:
- (i) The CC recognises that full service hospitals have higher fixed operating costs which include substantial land, building, equipment and personnel costs.
 - (ii) The CC has also recognised that there are economies of scale in patient volumes, noting for example that some hospital operators have relied on increased volumes of NHS work to help their capacity utilisation. Variations in patient admissions can have a significant impact on the hospital's revenues and profitability.
 - (iii) From HCA's perspective, the volume of PMI referrals and the insurer's plan to grow that business are important factors in the pricing negotiations for both HCA and the PMI.
 - (iv) There are circumstances in which changes to a PMI network may significantly impact on the volume of referrals. The CC has noted the growing prevalence of PMI restricted networks and directional, Open Referral products. For example, Aviva's "key hospital list" network which excludes HCA's hospitals has 26,000 lives in London with a treatment value of £18.9 million, which represents a significant level of business from which HCA is excluded, affecting HCA's pricing proposition.
 - (v) The negotiation over volume "cuts both ways", and PMIs aggressively seek volume discounts and rebates in return for network recognition. The CC has acknowledged in its Annotated Issues Statement that PMIs are not "*unwilling parties to these arrangements, given the discounts that meeting volume thresholds could bring.*"
 - (vi) The volume of patient referrals may be affected by a range of circumstances. These include changes in network composition, but there could also be other factors including the take up of PMI policies.
 - (vii) Competitive prices might have to factor in the risk of lost demand if volume-related prices were prohibited. A blanket prohibition could therefore raise prices.
- 7.5 HCA believes that hospital operators and PMIs should be free to negotiate prices based on volume and that it is legitimate for hospitals to review pricing – either at the beginning or during the term of a contract (e.g. through volume discounts or rebates which are linked to volume targets) – where there are significant changes in volume, however these may be triggered. A remedy which in effect prevented a hospital operator from reviewing prices or discounts in the light of changes in circumstances would be tantamount to a price control. HCA does not believe it would be reasonable or practicable to distinguish between

fluctuations in volume caused by network changes as opposed to falls in volume caused by other factors.

- 7.6 The CC notes in the PFs⁵⁴: "*All the volume discount schemes we have reviewed appear designed to reward the PMI for growing its volume across the whole portfolio of hospitals. We have not found any schemes of the major hospital operators that rewarded a PMI for growing its business at specific sites. By rewarding incremental growth relative to total national volumes in this way, the hospital operator creates an incentive to maximise recognition for a given operator and a disincentive to recognise rival hospitals.*"
- 7.7 In HCA's case, however, fluctuations in patient volumes affect costs across all its hospitals. HCA operates its six major facilities in the same area, Central London. As described above, it runs them as a single, integrated network of hospitals, spreading different clinical focuses and specialisms across the whole group. Thus, a fall in volume at one hospital affects the take-up of services at others. The position may be different in the case of other hospital groups which operate distinct hospitals in different geographical markets.
- 7.8 That said, HCA assumes that the objective of the remedy is to ensure that: (i) the PMI's "outside option" to change its network composition is preserved; and/or (ii) contracts between hospital operators and PMIs do not foreclose new entrants.
- 7.9 These objectives are more likely to be achieved by tackling contractual restrictions which directly relate to and restrict the PMI's power to change its network. Such contractual restrictions or arrangements would potentially cover the following:
- (i) Exclusivity provisions: exclusivity clauses specifically restricting the PMI from changing its network policy for the duration of the contract. An example is AXA-PPP's Corporate Pathways network which is exclusive to BMI (and now includes the London Clinic). These provisions have a far more direct and immediate effect on the PMI's ability to expand and change its network to accommodate new entrants.
 - (ii) Non-recognition clauses: any clauses which require the PMI not to recognise designated competitors. These, similarly, are more likely to restrict the PMI's freedom to choose its providers and are more likely to carry a foreclosure risk.
 - (iii) Targeted pricing clauses: a distinction may be drawn between general pricing review clauses, and price reviews which are expressly triggered because of the PMI's recognition of competitors. Again, this provision, specifically targeted at designated competitors, is more likely to have an exclusionary, foreclosure effect which limits the PMI's options.
- 7.10 Without prejudice to HCA's position that the AEC finding does not support tying or bundling remedies, a remedy focused on prohibiting or limiting contractual restrictions such as exclusivity clauses would avoid the costs and detriments of a blanket prohibition on volume discounts.
- 7.11 It is however questionable whether any cost savings which PMIs achieve through changes in network composition are passed through to subscribers in the form of lower premiums – there is no indication in the PFs that the CC has carried out any analysis of the effects of hospital costs on premiums and the extent to which PMIs are passing on cost savings to their subscribers, with BUPA, AXA-PPP and Aviva all reporting robust performances in their PMI businesses.

Questions

- 7.12 In the light of these comments, HCA responds as follows to the questions in paragraph 44 of the Remedies Notice:

⁵⁴ PFs, para 6.186

(a) Would this remedy be effective? Would hospital operators be able to deter PMIs from removing hospitals from their network or recognising a local rival in ways other than by raising or threatening to raise prices in response?

- 7.13 A remedy which prohibited price changes triggered by changes in volumes would in effect be a form of price control and would not in itself be meaningful or effective. There are clearer and more direct ways in which hospital operators can, and do, prevent PMIs from changing their network and recognising competitors, such as exclusivity clauses or other restrictions which specifically targets the recognition of rival operators. Circle's Complaint to the OFT, which reportedly triggered the market inquiry, was about precisely this issue. HCA believes that a more focused remedy which prohibits or limits these types of contractual restrictions is more likely to be effective and proportionate and it would support such a proposal.

(b) How quickly would this remedy come into effect? Would it be necessary to wait until existing contracts with PMIs had come to an end to implement it or could this process be accelerated, and if so how?

- 7.14 Such a remedy, which prohibits particular types of contractual provisions, is likely to change the basis on which existing contracts are negotiated. The parties must therefore be given a full and fair opportunity, where appropriate, to terminate any existing arrangements or allow current fixed contracts to expire and re-negotiate new contracts.

(c) Is the remedy reasonable? Might a hospital operator have appropriate grounds for seeking a price increase from a PMI in the event that it reduced the amount of business it did with the operator? What economic rationale would there be for a cross-operator (rather than single hospital) volume discount, for example?

- 7.15 A remedy which prevented the parties from reviewing or re-negotiating contract prices in response to changes in volume would not be reasonable or proportionate and would effectively operate as a form of price control. Hospitals are high, fixed-cost businesses and both revenue and profitability are sensitive to fluctuations in demand. PMIs aggressively exploit this by seeking significant volume discounts and rebates in return for volume commitments within their networks. Alternatively, it would incentivise the parties to enter into shorter term contracts to guard against mid-contract changes in network composition, which would increase negotiation costs and potentially increase prices. As discussed above, a more reasonable and proportionate approach would be to prohibit or limit specific types of contractual restrictions which are expressly linked to the recognition of competitors.

(d) Would it be necessary to provide for continuous monitoring of the remedy and/or to establish a mechanism for adjudication in the event of disputes? If it would which would be the most appropriate body to undertake these functions and how should it be funded? What would be the expected costs of monitoring?

- 7.16 The manner of implementation of a remedy in relation to contractual restrictions is a matter for the CC, but a clearly formulated restriction on certain types of contractual provisions having foreclosure effects as discussed above would not necessarily require "continuous monitoring" or "adjudication". A remedy aimed at preventing price changes caused by a fall in volumes would be unworkable.

(e) What other measures would be necessary to prevent circumvention of the objectives of this remedy?

7.17 As stated above, a restriction on volume discounts would not be effective or proportionate. However, restrictions on the type of contractual provisions discussed above could be implemented without difficulty.

Remedy 2(b)

Views

7.18 Remedy 2(b) requires BMI, Spire and HCA to offer and price their hospitals separately and individually to PMIs.

7.19 [§]. However, HCA does not require PMIs to recognise all its hospitals and does not have "one in, all in" restrictions in its PMI contracts.

7.20 The CC would, however, need to consider carefully the implications for hospitals of losing PMI recognition. The OFT's recent submission to the CC (paragraph 17), quite correctly, asks rhetorically "*if there is a danger that either of these remedies would transfer too much power to PMIs given that this sector is concentrated too?*" If BUPA or AXA-PPP de-listed a hospital, this might well lead to a market exit and loss of choice for patients. In addition, as explained above, HCA's position is different to that of BMI and Spire, in that HCA operates its six major hospitals as an integrated network, and recognising some but not all of HCA's hospitals would prevent PMI subscribers from being able to access the full complement of HCA services.

Questions

7.21 HCA's responses to the issues for comment in paragraph 50 of the Remedies Notice are as follows.

(a) Would this remedy be practicable? Would the scale and complexity of negotiating prices on an individual hospital basis be sustainable?

7.22 HCA is able to price its hospitals individually; and it is for PMIs to decide whether they wanted to negotiate terms of access to hospitals on an individual basis. However, as discussed above, HCA operates as a network of facilities in London and there are cost and other benefits in PMIs accessing the whole network of hospitals for their subscribers. As discussed below, there would also be serious consequences for the network if BUPA and AXA-PPP de-listed individual HCA hospitals.

(b) How quickly would this remedy come into effect? Would it be necessary to wait until existing contracts with PMIs had come to an end to implement it or could this process be accelerated, and if so how?

7.23 Hospital operators and PMIs should be given a fair opportunity to adjust to any requirement on these lines following the termination or expiry of any existing contracts. This could obviously involve significant change for any hospitals which are no longer recognised by PMIs within the network. Consultants would need time to relocate their practices, and patients would need to make alternative arrangements. In addition, patients who need to continue to use their local hospital because of continuity of care should be given the opportunity to change insurer if they are able to do so (and as HCA has previously highlighted, many patients cannot do so because of the restrictions on portability).

(c) If practicable, would it be effective? To what extent could reputational risk be relied upon to deter price increases in Single hospital areas?

7.24 There are indeed significant reputational risks for hospitals where there is an "out of contract" dispute with an insurer which acts as a powerful incentive on hospital operators to agree terms with the PMI.

(d) If prices were raised in Single hospital areas how confident could we be that this would lead to new entry and over what time period? Would this depend on the size and attractiveness of the local market concerned, for example the number of PMI subscribers or corporate scheme members in the hospitals' catchment areas?

7.25 HCA refers to its discussion of barriers to entry in its response to the PFs. The London market has seen significant growth, which continues to encourage new entry and expansion. There are a wide variety of competitive constraints on HCA in the London market.

(e) Is it likely that this remedy would have unintended consequences? For instance, would it be likely to lead hospital operators to close hospitals and if they did would this result in consumer detriment?

7.26 HCA can only reiterate that hospitals are high, fixed-cost businesses which are substantially dependent on PMI revenues. PMI recognition can be "make or break" for any hospital and therefore it must always be recognised, in relation to any of these remedies, that if PMIs choose no longer to do business with hospitals, this could make them financially unviable. The market will only function competitively if PMIs recognise facilities and negotiate reasonable terms of access, [X]. The loss of a BUPA or AXA-PPP contract would put most hospitals at risk of closure, and consultants cannot practice privately without access to these patients.

(f) Would hospital operators be able to frustrate the aims of the remedy by entering into arrangements with consultants that would prevent or deter them from practising at an entrant's hospital? Could hospital operators deter or delay PMIs' recognition of an entrant?

7.27 The CC has specifically found that consultant incentive schemes do not constitute barriers to entry, but in any event remedy 4 (discussed below) would address any concerns about hospital operators "tying" consultants to deter new entry. In relation to a hospital operator's ability to deter or delay PMI recognition of new entrants, please see the comments in relation to remedy 2(a) above.

8. REMEDY 3 – RESTRICTIONS ON EXPANSION

Views

- 8.1 This remedy imposes restrictions on hospital operators in Single or Duopoly areas from partnering with NHS Trusts to operate a PPU. Although HCA is not in a Single or Duopoly area, it makes a number of observations about the likely impact that this remedy will have on NHS Trusts and the consequences for PPU developments. HCA does not regard restrictions on PPU partnerships as reasonable or practicable measures.
- 8.2 The expansion of PPUs in recent years (discussed further in HCA's response to the PFs), and the growth of PPU provision which has been triggered by the lifting of the PPU cap on revenue, is a significant development in the market for private healthcare. Although the CC questions the scale of the growth which is likely to take place outside Central London, there is no doubt that many NHS Trusts, particularly in major urban centres, are planning to create or grow their private services, either on their own or in partnership with the private sector, allowing them to utilise private sector experience and expertise in the management and operation of private facilities. This will bring further capacity into the market and increase competition. The CC should welcome and foster this development.
- 8.3 A restriction on providers preventing them from entering into partnerships with NHS Trusts to build new PPU capacity and/or improve existing PPU facilities could seriously restrict the ability of Trusts to seek and develop partnerships with appropriate providers with the right operational skills, experience and expertise and the willingness to invest in these projects. Such a remedy, far from addressing any adverse effects on competition, would create new and unintended market distortions by limiting the number of providers who would be able to bid for these partnering opportunities. HCA understands that the CC followed a similar logic in the statutory audit inquiry, where it decided not to consider mandatory auditor rotation as a suitable remedy, *inter alia*, precisely because it would exogenously reduce the number of potential bidders for an audit client.⁵⁵
- 8.4 NHS Trusts are "contracting authorities" within the meaning of EU procurement law, as implemented by the Public Contracts Regulations 2006 and are required to go out to competitive tender when selecting providers to manage and operate their PPUs. The partnership arrangements will generally involve the procurement of services or a service concession within the meaning of the Regulations. These opportunities are therefore publicly advertised and open to any healthcare provider or investor which wishes to bid. The Trusts as a matter of EU procurement law are required to select providers on the basis of the most economically advantageous tender.
- 8.5 NHS Trusts typically use a range of economic evaluation criteria to assess bids including value for money, management experience and expertise, track record, investment strategy and the deliverability of the project. It is right and proper that NHS Trusts should have the ability to market test the contracts with a wide range of providers in order to select the bidder which best meets the Trust's requirements and provides best value.
- 8.6 EU procurement law prescribes the circumstances in which firms may be excluded from tenders and does not allow NHS Trusts to reject bids on competition grounds. Insofar as the remedy would in effect be introducing new grounds for disqualification or exclusion of bidders, it would be likely to conflict with European law.⁵⁶
- 8.7 The CC's proposed remedy would limit the number of potential bidders for new PPU projects, and thereby subvert the competitive process. It would undermine the very objective

⁵⁵ Provisional Decision on remedies, statutory audit market investigation, 22 July 2013, para 4.59 et seq.

⁵⁶ See e.g. *La Cascina*, Cases C-225/04 and 228/04; see also *Forposta*, Case C-465/11, para 14: "*EU law precludes national rules which provide for the automatic exclusion of an operator from participation in a procedure for the award of a contract or the automatic rejection of tenders, and the application of measures which are disproportionate to the aim pursued.*"

of competitive tender. It could reduce the financial return for the NHS Trusts, impact on the investment into the PPU and hence affect the quality of the facility.

- 8.8 If the CC is concerned that an existing operator in a Single or Duopoly area would reduce competition in the relevant catchment area by partnering with an existing PPU, competition legislation already allows for the authorities to review and prohibit any such transactions on a case-by-case basis. The OFT (and, in due course, the CMA) has the power to investigate merger situations under the Enterprise Act 2002 and determine whether the acquisition of existing facilities creates a substantial lessening of competition. The OFT can also investigate co-operative agreements under the Competition Act 1998 where they do not qualify as a merger situation. Existing competition legislation provides the appropriate framework for the OFT to investigate and decide, on the specific facts of each case, whether a public/private partnership would restrict competition in the local market. Those powers, to investigate PPU partnering on a case-by-case basis could, if necessary, be strengthened. A remedy preventing existing operators from further market growth is therefore unnecessary.
- 8.9 Remedy 3 is, in HCA's view, disproportionate and would create significant detriments to NHS Trusts and, ultimately, to patients.

Questions

- 8.10 HCA now turns to the questions set out in paragraph 44 of the Remedies Notice.
- (a) Would the remedy be effective? In how many and which Single or Duopoly areas is it likely that PPUs will be launched?**
- 8.11 The remedy could have significant adverse effects by limiting the number of bidders for new PPU projects, which could in turn impact on the viability and success of new PPU projects.
- (b) How practicable would it be for other hospital operators to form PPU partnerships in areas where they did not already operate a hospital?**
- 8.12 HCA has welcomed the opportunity to establish a partnership with the Christie NHS Foundation Trust in Manchester to create and develop a new PPU, the Christie Clinic. This has shown that it is possible for HCA to compete for PPU partnerships outside London – and as stated above HCA's view is that competition for these PPU opportunities should be on an open, level playing-field and should not be artificially restricted by excluding incumbent operators. HCA does not consider that there are barriers to entry which restrict hospital operators in other areas from successfully bidding for and winning PPU tenders. Most of the tenders which HCA has participated in have criteria which are weighted towards quality of care, not financial returns.
- (c) Would the remedy give rise to unintended consequences or distortions? Would NHS Trusts suffer because they would be unable to partner with an incumbent hospital operator which could offer a financially more attractive arrangement than an entrant?**
- 8.13 For the reasons set out above, the remedy would give rise to serious market distortions. It will artificially limit the number of providers with which NHS Trusts can engage to explore partnering opportunities. It would negatively affect the Trust's ability to achieve best value and to select the most appropriate partner in terms of management experience, expertise and investment strategy, in a fair competitive process. It is not simply a question of securing the best financial offer – a Trust will usually seek a partner with proven expertise and ability to provide quality of care. The design of the remedy would also need to take account of European law. NHS Trusts are bound to select bidders for service contracts and concessions in accordance with EU procurement law, and are not permitted to exclude bidders, other than on the grounds for disqualification which are set out in the Regulations.

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

- 8.14 In the case where the incumbent is a willing and credible bidder for these projects, the remedy could in these circumstances stifle new PPU development. This would clearly have negative effects on competition, choice and potentially clinical quality. Moreover, a local provider may be able to generate cost savings for the Trust through the synergies from using shared local facilities (e.g. laboratories and administrative functions), resulting in a more competitive pricing proposal.

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

- 8.15 As set out above, the OFT (and in due course the CMA in conjunction with Monitor) already has powers enforce competition and merger legislation in relation to NHS PPU partnering contracts. There is therefore already sufficient oversight of any competition concerns.

9. REMEDY 4 – CONSULTANT INCENTIVE SCHEMES

Views

- 9.1 Following the CC's provisional finding that the existence of consultant incentive schemes gives rise to an AEC, remedy 4 proposes a prohibition of any "*cash or non-cash incentives*", which encourage consultants to refer patients to their hospitals except "*where such ownership results in a reduction in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful*".
- 9.2 The PFs note that private hospital operators offer a variety of schemes which differ in "*nature, value and sophistication*".
- 9.3 It is clear from the evidence in this inquiry that there are a wide range of contractual relationships between hospital operators and consultants, ranging from consulting room licences to equity ownership schemes. It is important that any remedy which restricts "incentives" is clear in scope and creates legal certainty.
- 9.4 HCA sees the case (subject to its comments below) for a prohibition of schemes which provide benefits which are directly linked to patient referrals. The CC refers to "direct" incentives which create short-term, incentive effects by linking the consultants' benefits to the volume or value of business which they bring. HCA believes that it would be possible and practicable to formulate a remedy which addresses restrictions of this nature.
- 9.5 These restrictions would include:
- minimum referral commitments expressed in terms of volume or value of referrals
 - payments or other benefits which are, directly or indirectly, tied to the volume or value of referrals
 - "lock-in" provisions, pursuant to which a consultant must commit to bring a minimum proportion of his/her practice to the hospital (the PFs provide examples of these, e.g. Circle's scheme which requires consultants to "*commit to undertake a given proportion of their work at a Circle hospital*" or Nuffield's previous Practice Privilege Plus scheme which rewarded consultants based on the revenue they generated).
 - arrangements having equivalent effect, e.g. exclusivity requirements in practising privileges which prevent or restrict consultants from practising in rival facilities.
- 9.6 HCA also supports the CC's proposal that any arrangement between the hospital operator and the consultant would not be deemed to constitute an "incentive" if it represented an arm's-length, commercial relationship under which the consultant is being charged a fair market price.
- 9.7 As the CC is aware,⁵⁷ HCA benchmarks its agreement with consultants (including its Consulting Room Licence Agreements, Fully Managed Practice Agreements, and Professional Services Agreements) against an open market value pursuant to its fair market value ("FMV") policy. Under the FMV policy, any payments for services or facilities (to or by the consultant) are determined by reference to an open market consideration, which is established by an independent third party valuation. This ensures that there is no "subsidy" which directly or indirectly acts as an incentive to bring patient referrals. HCA supports applying a similar policy to all other hospital operators.
- 9.8 That said, it should be noted that HCA provides consulting rooms on a rent-free basis to new consultants for the first six months, to help them establish a practice at an HCA hospital. This represents a very low level of subsidy, is not tied to any referral requirements, and is pro-competitive in assisting the consultant with his/her set-up costs. HCA would support a

⁵⁷ See HCA's responses to Section 8 of the CC's market questionnaire

"de minimis" threshold which would allow very limited subsidies of this nature to assist with consultant set-up costs.

- 9.9 The CC's proposals with regard to equity participation raise a number of important issues which require very careful consideration. The CC rightly notes that equity schemes:
- (i) have a lower incentive effect than direct referral schemes because the financial benefit accruing to the consultants is lower and/or less immediate; and
 - (ii) can have pro-competitive effects by encouraging consultants to commit to new facilities and promoting new entry and expansion and hence lowering barriers to entry.
- 9.10 In fact, equity schemes can also be beneficial by encouraging consultants to develop new ideas and ventures (with or without existing hospital operators). For example, London has seen many new facilities which have been set up by consultants, e.g. the Fortius Clinic. Equity schemes therefore play a valuable role in encouraging consultants to innovate and create new services.
- 9.11 However, the binary distinction which the CC appears to draw in the PFs between equity schemes applying to "new hospitals" and equity schemes applying to other facilities such as individual pieces of diagnostic equipment is not meaningful or practicable. The pro-competitive impact of equity schemes which unlock new investment and encourage the delivery of new products and clinical services applies to new clinical units and facilities by an existing hospital operator which would not come to fruition without consultant engagement. In HCA's case, examples include the following:
- (i) The Robotic Radiosurgery LLP is a JV between HCA and consultants to establish and operate the CyberKnife treatment facility at the Harley Street Clinic. This involved major investment of approximately [£]. There were significant risks for HCA as the first private provider to make this investment in a new medical technology. It was integral to the success of the project for the consultants to commit to the development of this unit. [£] The CC's conclusion that "*such commitment strengthens the viability of the business plan and the ability to obtain financing*" is equally applicable to investments of this nature in new, innovative and expensive assets and equipment.
 - (ii) HCA has also established a JV for a number of its new outpatient facilities, e.g. the New Malden Diagnostic Centre which owns an outpatient and diagnostic facility. This required a capital investment of [£] to create consulting rooms with advanced, state-of-the-art MRI, x-ray and ultrasound diagnostic equipment in order to expand outpatient capacity and generate additional competition in this part of South West London and Surrey. Again, consultant commitment and support for the new centre was critical to its growth and development. This has created a new competitor to the local provider, Parkside, and added new choice and access for patients.
- 9.12 The consultants' equity participation in these businesses encourages consultants to be involved in the strategic direction of the new venture and devote their time in developing new services. They are members of the LLP structure and therefore have involvement through quarterly meetings. As part owners rather than merely users, they are also motivated to maximise clinical and quality outcomes. It creates a long-term relationship – equity participation is not a liquid investment which they can cash in at any time. Furthermore, the prospect of equity is often an incentive for consultants to approach the hospital operator with ideas for new services.
- 9.13 In the case of both these projects, the consultants' involvement in these new facilities was a key part of the business case and therefore these are both examples of where equity schemes have pro-competitive benefits in terms of facilitating new investment which outweigh any perceived distortions in referral patterns. Indeed, HCA has already provided specific evidence to the CC that the establishment of new outpatient and diagnostic facilities has not led to any significant changes in the pattern of referrals. It is not meaningful to

distinguish between equity schemes depending on whether the investment is in a new hospital as opposed to a new facility, unit or service within an existing hospital.

- 9.14 In addition, for some new entrants consultant investment may be a necessary pre-condition to unlocking outside funding. KIMS' recent submission to the CC states that Clydesdale Bank required as a condition of its funding of KIMS a cash equity investment from consultants. This could also apply where funding is sought for new outpatient and diagnostic clinics.
- 9.15 The CC expresses concern that equity ownership of facilities involving diagnostic tests and equipment may create "*incentives to conduct unnecessary diagnostic tests or consultations*". Once again, the CC adduces no concrete evidence that equity schemes are tending to encourage unnecessary procedures. However, there are a number of safeguards which would adequately address this perceived risk:
- Hospital operators can put in place peer review procedures to ensure that there is effective clinical governance. As HCA has previously submitted to the CC,⁵⁸ in the case of the CyberKnife centre, all patient referrals are initially screened by a medical director and clinical research fellow, and are then reviewed by a multidisciplinary team ("MDT") based on clinical criteria. The MDT comprises consultant oncologists, neurosurgeons, surgeons and radiologists, a majority of whom are not members of the JV and therefore provide independent clinical judgement on the appropriateness of the treatment. The MDT can and does refuse treatment in appropriate cases [redacted]. This provides the necessary clinical independence and oversight which effectively counter-balances any incentive to carry out unnecessary tests.
 - Any express requirement for consultants to treat patients at a facility could be prohibited as part of the remedy discussed above. As previously indicated, HCA would support any remedy which prohibits hospital operators from adopting equity participation schemes which impose minimum referral requirements or, as in Circle's case, require consultants to undertake a given proportion of their work at the facility.
 - HCA would also support increased transparency of consultant equity participation in the interest of patients, e.g. prominent notices on site or on any documentation (appointment letters, invoices, etc.) which the consultant issues to the patient.
 - It should also be remembered that MRI treatment requires pre-approval from insurers which acts as a further safeguard.
 - There should in any event be provisions in any JV or shareholder agreements which require consultants to exercise independent clinical judgement and act in the best interests of patients – HCA has appropriate provisions in its contracts with consultants.
- 9.16 These would all afford more proportionate ways (than outright prohibition) of addressing the risks identified by the CC. HCA believes that any remedy relating to consultant incentives must be applied on a fair and non-discriminatory basis to all hospital operators. It would be unreasonable and disproportionate for any remedy to apply only to certain operators.
- 9.17 In addition, HCA would point out that the scale of payments typically made to consultants under equity schemes is unlikely to create a significant incentive effect. The average (median) consultant equity investment in HCA's seven JVs is [redacted], and the annual payment is [redacted]. This is not a substantial sum relative to the consultant's total earnings and would not in any event create an incentive to carry out unnecessary tests.
- 9.18 The CC should ensure that any remedy also extends to NHS incentives or restrictions which seek to "tie" NHS consultants to the NHS Trust's PPU. HCA has submitted evidence to the CC about the way in which these can distort the market by restricting NHS consultants from establishing a private practice in competing private hospitals. These incentives are

⁵⁸ See HCA's reply dated 22 February 2013 to AXA-PPP's response to HCA's submission, paragraphs 2.30 and 2.31

sometimes of an indirect nature, e.g. the Trust's offer to extend MDU coverage to the consultant's private practice brought to the PPU, or the provision of free consulting rooms. There are also merit awards and research grants which can be used to incentivise consultants to practise within the PPU.

- 9.19 The CC should also ensure that similar remedies apply to PMI incentives to consultants which have the same propensity to distort referral patterns and influence consultant behaviour. For example, BUPA's Premier Consultant Partnership scheme provides higher reimbursement rates where consultants refer patients for cancer treatment at home, and these incentives will then influence where and how patients are treated. This illustrates how insurers can use consultant incentives to control the way in which care is provided. Furthermore, whereas hospital incentive schemes can (as the CC has acknowledged) create pro-competitive, efficiency benefits in terms of lowering barriers to entry, PMI incentives offer no such benefits or efficiencies and have no such justification. It is disappointing that the PFs do not take account of the distortive effects of PMI incentive schemes. A remedy would not be fair or proportionate if it applied to hospital operators but not to PMIs.
- 9.20 To summarise HCA's position on Remedy 4:
- HCA supports a prohibition of schemes which provide benefits directly linked to patient referrals;
 - payments for consultant services should be benchmarked against fair market value;
 - there is no reason to distinguish between equity schemes for "full services" hospitals and diagnostic services – in both cases, equity schemes promote pro-competitive benefits;
 - the perceived risk of over-use of facilities can be addressed through more proportionate safeguards e.g. MDT reviews and clinical governance programmes;
 - the remedy, whatever form it takes, must apply to all providers (including PMIs) on the same basis.

Questions

- 9.21 HCA turns now to the questions set out in paragraph 63 of the Remedies Notice.
- (a) *Is the remedy practicable? What framework of rules could be used to determine reasonably and practically whether the benefits of an incentive scheme in terms of lowering barriers to entry, outweighed the distortions created? What degree of oversight would be required to monitor compliance and who should fund it and exercise monitoring? How could the "fair market price" test be monitored and enforced and who would be responsible for doing so?***
- 9.22 Any remedy prohibiting or limiting consultant incentive schemes should be clear, have legal certainty and apply on a non-discriminatory basis to all healthcare providers.
- 9.23 As discussed above, it would be practicable to adopt a remedy which (i) prohibits incentives which are directly linked to patient referrals, e.g. incentives incorporating minimum referral commitments; and (ii) requires any arrangements (e.g. the provision of consulting rooms) to be based on a fair market price. HCA does not believe that it would be practicable for a remedy to distinguish between different types of equity schemes. However, any concerns relating to over use of diagnostic services could be addressed by ensuring there are appropriate safeguards, in particular through peer review procedures and enhanced transparency requirements.
- 9.24 Consultants are subject to the professional duties set out in the GMC's guidance on Good Medical Practice, which includes duties to ensure that any financial or commercial interests do not interfere with the consultant's professional duties, The GMC is the appropriate regulator with the powers, skills and experience to regulate doctors, investigate any

breaches of professional practice requirements, and take enforcement action where necessary.

- 9.25 HCA's FMV policy demonstrates that it is practicable for hospital operators to benchmark incentive schemes in line with an open market consideration, based on an independent third party valuation.

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

- 9.26 A remedy of the type indicated above would be reasonable and proportionate. However, a remedy which sought to prohibit consultant equity schemes would not be reasonable and would have detrimental effects, through the loss of innovation and competition, which would wholly outweigh any potential benefits. It would also represent an unwarranted interference with property rights – the rights of consultants to own and operate facilities – which is wholly disproportionate. There are, as discussed above, more proportionate ways to address the risks of over-treatment identified by the CC.

- 9.27 HCA would support a "de minimis" threshold which would allow for hospital operators to provide limited benefits e.g. subsidised consulting rooms for up to six months rent free to assist consultants in setting up their practice at a hospital.

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

- 9.28 It is important that any remedy adopted by the CC is implemented on a non-discriminatory basis and applies to all healthcare providers. It would not be proportionate to restrict the remedy to certain hospital operators only, and exempt other providers. HCA competes with a wide range of other healthcare service providers, including full-service hospitals, specialist clinics, consultant-led outpatient facilities and "niche" suppliers of diagnostic or laboratory services. It should also apply to the NHS, and prohibit any direct or indirect restrictions which NHS Trusts place on consultants to "tie" their private practice to the Trust's own PPU. Whatever remedy is adopted should apply on the same basis to all healthcare service providers, so that all providers compete on a level playing-field. A restriction which did not apply to all providers on the same basis would be discriminatory and unlawful.

- 9.29 As stated above, HCA is disappointed that the CC has failed to take account of PMI incentive schemes such as BUPA's Premier Consultant Partnership scheme. Payments by PMIs which incentivise consultants as to where or how they treat their patients are capable of having the same effects on competition as hospital incentives and offer no countervailing benefits. HCA strongly advocates the prohibition of any PMI incentives which reward consultants financially for recommending cheaper treatments or less expensive hospitals. PMIs are already asserting increasing controls over the patient pathway, directing patients to lower cost providers or requiring lower cost treatment options. PMI incentives to consultants are a further way in which PMIs are distorting treatment pathways and are inimical to the patient's clinical interests.

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

- 9.30 In the US, the Federal Physician Self Referral statute, or "Stark" law (or the "Law"), broadly prohibits a physician from referring patients for "designated health services" ("DHS") payable under Medicare to entities with which the physician has a financial relationship, unless an exception applies.
- 9.31 Notably, the Stark law only prohibits referrals for DHS that are covered by Medicare. It does not regulate privately-funded services paid for by self-funding patients or private insurance companies. Although intended as a "bright-line" rule to simplify conduct in the healthcare marketplace, improve the quality and cost of care, and promote market competition, the Law—with its maze of regulatory definitions, special rules, exceptions, and exceptions to exceptions—has had the opposite effect by increasing transaction costs, limiting innovation, and placing a stranglehold on the implementation of healthcare cost saving models.
- 9.32 The sheer breadth and impracticability of the Law results in virtually every arrangement between healthcare entities and physicians potentially within the ambit of the Law. For example, the definition of the word "referral," central to the Law, requires more than 370 words. The Law's breadth may be illustrated as follows: for Stark law purposes, a physician has a financial relationship with an entity in which the physician has a compensation arrangement → compensation arrangement includes any arrangement between a physician and the entity that involves remuneration → remuneration means any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind. Thus, if an entity provides a physician with anything of value, regardless of how small (e.g., coffee mug, free parking, etc.) the physician and entity have a financial relationship and, in the absence of an exception, the physician may not refer Medicare patients to the entity for DHS. Consequently, there has been a proliferation of exceptions, nearly three dozen and counting, to deal with the Law's myriad of unintended consequences.
- 9.33 Compounding the challenges with the Stark law is a heavily reactive U.S. governmental rulemaking regime that continually issues revised regulations and limited guidance, adding to the complexities and further impeding the workability of the law. It is difficult to see how many of these provisions would apply in the case of the very different structures and practices within the UK private healthcare market. Moreover, it would be challenging to justify the significant governmental infrastructure and support needed to oversee, adapt, interpret, and enforce this type of law and the related increased costs to healthcare entities and physicians under this new regime. In the light of these increased costs, coupled with the negative impact on innovation and a nimble, efficient healthcare marketplace, HCA does not consider the Stark law to be a particularly useful or effective model to apply to UK private healthcare providers.

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

- 9.34 It is unlikely that there would be significant economic costs in implementing the types of remedies which HCA has proposed above, provided these are clearly formulated and applied on a non-discriminatory basis. Hospital operators which include restrictive clauses such as minimum referral requirements would be required to delete these from their contracts.
- 9.35 As stated above, HCA strongly rejects any remedy which seeks to prohibit equity sharing arrangements, which it regards as disproportionate. A remedy prohibiting or limiting equity schemes would be costly in terms of its adverse impact on competition, quality and innovation. Any remedy which required the unwinding of existing equity share arrangements would be wholly unjustified and disproportionate. It is in effect a form of divestiture and an unjustified interference with consultants' property rights. There would be immense practical issues to consider, including how these would be valued, who these stakes could be sold to

and who would seek to purchase them. In many cases, it is likely that this would force the closure of the relevant consultant facility. Competition, choice and patient care would only suffer. This would be a wholly irrational outcome for any competition regulator.

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

9.36 Equity participation has generated significant customer benefits:

- As the CC itself has noted, equity schemes facilitate new entry by ensuring that investors are able to secure a "critical mass" of consultants to commit to the new facility. This has recently been illustrated by the development of the KIMS, a new £85 million private hospital near Maidstone specialising in tertiary services which is due to open in April 2014. A significant number of clinicians have committed to the new hospital, and that this clinician engagement has unlocked funding from the Clydesdale Bank. KIMS' submission states that without consultant equity "*KIMS would never have happened*".
- Similarly, equity participation encourages consultants themselves to devise and set up new ventures in the form of specialist clinics and outpatient facilities – the market has seen a number of clinician-led partnerships, e.g. the Clockhouse Medical Practice which opened in Epsom which is a partnership of 14 local consultants offering day case and outpatient services, and the Fortius Clinic, a specialist outpatient orthopaedic clinic in Central London.
- It allows hospital operators such as HCA to invest in new outpatient facilities to improve outpatient services in different parts of London. These are capital-intensive projects which carry significant risks. Equity investment allows the hospital operator to spread the cost and risk through a sharing of risk and reward with the consultants, and secure the consultants' engagement in developing new services.
- Equity participation also encourages investment in new equipment and technology to improve clinical services within existing hospitals. Again, these may require significant capital investment (as in the case of CyberKnife) and require consultant commitment and backing to justify the investment.

9.37 Equity schemes therefore provide demonstrable customer benefits in terms of higher quality, greater innovation, and greater choice of products and services. They have played a key role, particularly in London, in developing the market for private healthcare. They have significantly contributed to the competitive landscape in London which has seen a plethora of new consultant-backed ventures. As market demand moves away from inpatient services to day care and outpatient provisions, equity schemes have encouraged new growth and competition in outpatient and diagnostic services in particular.

10. REMEDY 5 – CONSULTANT QUALITY

Questions

(a) Is the proposed remedy practicable in all of the nations? Where a consultant practises partly in one nation and partly in another should performance data published in one nation be confined to that relating to performance in that nation?

Yes, the proposed remedy should be practicable in all nations. A consultant's performance data should be published in each nation the consultant works, covering and identifying both his/her publicly and privately funded work. In addition the consultant's UK-wide performance data should also be published, identified by both nation and funding source. The consultants' registration with the GMC is UK wide and his/her overall UK performance data should be transparent and available for both professional and public scrutiny.

(b) Is the proposed list of ten specialities for which performance data will be available on an individual clinician basis appropriate?

Yes, the proposed list of ten specialities should be practicable as a starting point. The list should be expanded over the coming decade to include all medical and surgical specialities. UK-wide speciality registries and audits (covering outcomes for both procedures and diagnoses) should be developed for all specialities. These should be based on ICD 10 or 11 diagnosis coding and OPCS procedure coding. These should be adopted by all providers and commissioners (public and private) in all nations of the UK.

(c) Are the indicators that are currently published for consultants in each of the ten specialities, the way they are presented and the manner of their distribution appropriate? Are they (or some combination thereof) appropriate for other areas of specialty? If not, which indicators would it be appropriate to adopt for each specialty and how should they be presented and distributed?

This question is a matter for the Academy of Medical Royal Colleges (AMRC).

(d) Does the remedy risk giving rise to unintended consequences? Even with standardised mortality rates, might consultant incentives to treat more seriously ill patients be affected?

Sir Bruce Keogh has highlighted the complexity of using and interpreting aggregate measures of mortality such as SHMI and HSMR. The same is true of measures of safety, morbidity and clinical processes. The purpose of such indicators is to identify potential sources of concern. These should be investigated and evaluated promptly and transparently in a clear and consistent framework of local and national/UK accountability.

(e) With what frequency should performance indicators be updated?

Performance indicators should be updated at least annually and ideally every six months. Frequency of updating is not synonymous with the period covered, which should be 12 or 24 months. Periods covered should be consistent UK wide to enable unbiased comparison.

11. REMEDY 6 – CONSULTANT FEES

Questions

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

The remedy is practicable as far as the publication of outpatient fees is concerned (indeed, many consultants already publish their outpatient fees for patients) but would become onerous and cumbersome for day-case and inpatient fees.

It is not yet clear how the Competition Commission envisages the disclosure of fees, for instance:

- does the CC anticipate that consultants would be asked to disclose all possible fees at the beginning of a patient's treatment pathway, or
- does the CC anticipate the fees for the next part of the treatment to be disclosed at the prior appointment?

The "ideal world" solution of providing patients with upfront fees for their entire care pathway at their first appointment is simply not practicable as the care pathway is dynamic, responding at each step to the results of the previous step.

HCA also notes that it is not clear if the CC's proposed remedy aims at forcing consultants to commit to a specific fee level for a certain service. HCA believes that it may be more appropriate for any such fees to be maximum fees or "list prices", i.e. allowing consultants to offer discounts as appropriate. This may also alleviate potential concerns about any softening of competition due to fee transparency among consultants.

HCA does not have information to suggest whether or not outpatient fees vary between different patients. It is, however, likely that fees will vary between first outpatient appointment and subsequent outpatient appointments.

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

For outpatient appointments, this should not pose a problem, but for more complex care it might. This problem is particularly acute for surgeons. In cases where the patient is under general anaesthesia for instance, they will not be able to be kept informed if the consultant is required to carry out procedures not anticipated before the procedure commenced.

An obvious example of this is a patient under general anaesthetic having an angiogram. Should the consultant consider that the best alternative for the patient is to have an angioplasty after performing the angiogram, it is clinical best practice to deliver that care immediately rather than to wake the patient up and then anaesthetise them again, thus putting the patient at greater risk.

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

Yes, it is reasonable to expect consultants to disclose their outpatient consultation fees – this should apply to all consultants.

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

If this was introduced, the furthest point in advance that it would be practicable to give a proposed fee for treatment would be once the patient has been fully diagnosed. Even then, it would need to be a range or guideline as, particularly in surgery, the consultant may encounter unexpected complications. Additionally, the consultant is unlikely to be aware of other costs for instance for the anaesthetist fees or for radiologist fees. It would also add burden to the patient to understand a quite complex situation at a time when they are undergoing health problems.

A more workable alternative which would reduce stress to patients is to ask PMIs to introduce erodible benefits as is done in the Spanish PMI market. PMI customers would be clear of their overall benefit, and could spend up to this limit at their discretion, using the consultants and facilities of their choice (a situation analogous to having a credit card limit that can be spent up to, but will be questioned once the customer meets their limit.)

This solution resolves the issue of shortfalls for PMI companies, allows consultants to act in the patient's clinical best interest, and empowers patients to make their own price/quality trade-offs without the interference of PMI companies that are financially motivated to seek out the cheapest treatment for patients.

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

This kind of remedy would best be overseen by a consumer protection agency or a professional body such as the GMC.

12. REMEDY 7 – INFORMATION ON PRIVATE HOSPITAL PERFORMANCE

Questions

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

The proposed remedy is both desirable and practicable. All private hospitals should be capable of collecting the equivalent of NHS HES data. It would be reasonable to allow 24 months for the full implementation of this remedy, in order to allow all private hospitals the opportunity to put into place systems to collect diagnostic (ICD 10 or 11) information. The same period would also be required to enable all private hospitals to translate to coding procedures using OPCS 4.6, rather than (or in addition to) CCSD. HCA supports and is already committed to collecting ICD 10 diagnostic coding. HCA agrees that, without this data, price/quality measures are misleading. HCA also supports the collection of HES and PROMS data, and its experience in the US is that the market rewards hospitals which are seen by consumers as offering high quality.

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

Private hospitals should also be capable of collecting PROMs data in the same format at the NHS. It would be practical to allow private hospitals 24 months to implement this policy from the time that revised NHS PROMs data standards are published.

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

It should be mandatory for all providers of NHS and privately-funded services to secure detailed information about diagnoses and co-morbidities for all day-cases and inpatients (provided with treatment) and also to record resulting diagnoses in the case of diagnostic investigation. Diagnostic coding for outpatient and A& E attendances should be introduced to privately funded activities (in both private and NHS hospitals - including PPU) to the same timeline mandated for NHS funded outpatient and A&E attendances.

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

The CC should seek a five year voluntary agreement from the Association of Independent Healthcare Organisations (AIHO) that PHIN retains sufficient funding to continue to develop its activities as CQC requires over the coming five years. The OFT should review the adequacy of independent healthcare sector information on quality and safety with CQC after five years. HCA welcomes and fully supports the PHIN initiative. It calls on other hospitals to do so – it is understood that the London Clinic has not as yet committed to PHIN.

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

The CC should consider the likely impact of the information not only on competition, consumer choice and market efficiency but also in terms of its potential impact on reducing avoidable mortality and morbidity. The independent healthcare sector requires time not only to implement PHIN's published development agenda (see <http://www.phin.org.uk/About.aspx>) but also to

build and implement widespread collaboration with a wider range of UK wide/national clinical registries and audits. The sector also needs time to increase the timeliness of data collection, input and analysis (in indeed does the NHS and HSCIC). Major disruption to the structure of, or ownership in, the independent health sector is likely to delay implementation of this agenda – which depends not only on company level structures, systems and strategies but also on widely distributed skills and shared values.