

Non-confidential



HCA INTERNATIONAL LIMITED

**Response to the Competition Commission's Provisional Decision
on Remedies**

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1. INTRODUCTION

- 1.1 HCA submits this response to the Provisional Decision on Remedies ("**PDR**") published by the Competition Commission ("**CC**") on 21 January 2014.
- 1.2 The CC has laid down a very short deadline for submission of responses. HCA has prepared this submission in a very compressed timescale and it reserves its rights to supplement its submission with further comments or evidence at any time.
- 1.3 HCA has already extensively set out its views on the CC's Provisional Findings ("**PFs**") and the CC's Notice of possible remedies ("**Remedies Notice**"), published on 2 September 2013 and 28 August 2013, respectively. HCA's main submissions in response have been: (i) its response to the PFs, dated 11 November 2013, and (ii) its response to the Remedies Notice, dated 21 October 2013. Where appropriate, rather than repeat its comments, HCA refers back to these submissions. It is apparent that there has been little change in the CC's position either in respect of its findings of adverse effects on competition ("**AECs**") or in respect of its proposed remedies package. Where HCA's position on these issues has been previously set out, HCA cross-refers to these submissions.
- 1.4 HCA's position remains that: (i) the CC's AEC findings are unfounded in relation to London; and that (ii) even if correct, these findings would not support a divestiture remedy relating to HCA's hospitals. As in previous submissions, insofar as HCA comments on the CC's remedies, the comments are entirely without prejudice to its views that the CC has erred in provisionally finding AECs as far as London is concerned.

2. OVERVIEW AND SUMMARY

- 2.1 The CC's proposal to order the divestment of two HCA hospitals is grossly unfair, unreasonable and unprecedented. The CC's AEC findings do not support such an extreme remedy involving the expropriation of [X] of HCA's business in the UK¹. Divestment would not even address the CC's perceived concerns about competition and pricing, and would seriously compromise quality of care and patient safety in London. In remedies 3-7, there is much that HCA can support in order to promote greater competition and patient choice. Divestiture, however, is wholly disproportionate and unjustified, and will be vigorously contested by HCA.
- 2.2 The structure of this submission and HCA's key arguments are briefly summarised as follows.

Section 3: procedural failures

- 2.3 The CC has not conducted this inquiry in a fair and objective manner. It has naively accepted, uncritically and without question, the views of the major PMIs, without examining their commercial motives in pressing for divestment. There has been a failure to properly consult and engage with HCA during the formative stages of this inquiry, and the CC case team has disregarded its own "best practice" guidelines in the way in which it has run the investigation. The CC has prejudged the issues and has "closed its mind" to the evidence.

Section 4: AEC findings

- 2.4 The PDR is based on the CC's AEC findings. These are seriously flawed and fail to properly consider:
- the strength and diversity of competition faced by HCA in London and internationally;
 - strong competition in quality and innovation, which has delivered major benefits to consumers and demonstrates that competition is working well in London;
 - the relative ease of entry and expansion in London;
 - market growth, which is driving new investment and further increasing competitive pressures on HCA; and
 - the strong negotiating position of PMIs, which are increasingly using directional products such as restricted network policies in order to contain costs.
- 2.5 The CC's concerns are largely founded on a so-called "pricing" analysis which does not measure prices and is so beset with methodological errors that it is simply not comparing "like with like". 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 taken into account. Furthermore, the CC's own analysis showed that King Edward VII hospital, a central London based hospital operator with a considerably smaller market share than HCA, secured higher or equivalent prices when compared to HCA. On the CC's assessment of self-pay prices (which does not even purport to consider self-pay pricing in London), the CC's analysis suggests that a reduction in the weighted average market share of a hospital by 20 percentage points is associated, at most, with a 3 – 4% price reduction, although even that figure is subject to a considerable margin of error. Indeed, the results lack robustness and it is so flawed that HCA considers that the CC cannot rely on it.

¹ The turnover of the two hospitals for divestment as a proportion of HCA's total UK turnover in 2013.

- 2.6 In 2000, the OFT was so firmly of the view that the market operated competitively that it gave unconditional clearance to HCA for the acquisition of St. Martin's Healthcare Limited, which included the London Bridge Hospital. It is perverse and a breach of HCA's legitimate expectations to reverse the OFT's merger clearance through the mechanism of a market investigation.
- 2.7 Even if the CC's findings were fair and reasonable – which they are not – the competition problems which the CC has identified are not of such a magnitude that they would justify such an extreme remedy, forcing HCA to dispose of over [X] of its UK interests.

Section 5: quality and innovation

- 2.8 The CC's assessment of HCA's quality and innovation record is flawed. It fails to understand how HCA differentiates itself from its competitors by a focus on high-acuity, complex care which drives its investment in new, innovative technologies in tertiary specialisms such as cancer and cardiac care. The CC ignores the evidence of HCA's leadership in introducing innovative treatments ahead of its private sector competitors, and sometimes ahead of the NHS. It is extraordinary that the CC has neither conducted its own analysis, nor apparently sought its own independent clinical advice on these issues. The CC has failed to ask the questions it should have asked as a reasonable and responsible decision-maker carrying out an inquiry into healthcare. It has completely disregarded HCA's evidence about the value and importance of integrated care pathways, and the detrimental effects which divestiture would create in terms of the lower quality of clinical outcomes. These failures fundamentally undermine the CC's assessment of remedies.

Section 6: proportionality of the divestment remedy

- 2.9 The CC has failed to carry out an assessment of the proportionality of divestment, properly weighing-up the effectiveness of the remedy with its very considerable adverse consequences for private healthcare in London:
- there is in fact no credible evidence that divestment would be effective in lowering prices, increasing quality and innovation, or creating a new competitor across the range of HCA's clinical service lines;
 - the purpose of the CC's divestment remedy is to create alternative capacity in the market, however the evidence reveals that sufficient alternative capacity already exists;
 - the CC has not carried out any serious analysis of the extent to which PMIs would in fact pass on any potential price reductions to PMI subscribers, and such an analysis is necessary as PMIs cannot be simply treated as "customers" of hospital operators;
 - the lack of competitiveness in the PMI market and actual market data indicate that patients would not benefit from any price reductions;
 - the CC's assessment of the price benefits of divestiture is based on wholly unreliable evidence, and vastly overstates any supposed impact on price;
 - the CC has underestimated the extent to which losses of economies of scale would increase the costs of the divested hospitals and offset any alleged price reductions;
 - the CC has conducted no proper analysis of the effects which divestiture would have in terms of breaking the network integration which arises from HCA's six hospitals, reducing future investment, innovation and lowering the quality of care; and

- the CC's calculation of the net present value of divestment is based on flawed underlying evidence, is methodologically unsound, and significantly overstated.

Section 7: divestiture package

- 2.10 The CC's approach to selecting the Princess Grace and London Bridge hospitals for divestiture is based on an arbitrary 40% threshold on admissions in London which has no basis in law or economic theory. It is a completely arbitrary market share cap which the CC seeks to impose. **It is unprecedented for any UK or EU competition authority to assert that a market share of 40% or more is "too high"**. This is compounded by the CC adopting an arbitrary geographic market definition for central London. [X]²
- 2.11 It is also not clear why the CC requires divestment specifically of the London Bridge and Princess Grace. These do not constitute the "smallest package" that would create a viable competitor. Even on the CC's flawed logic of imposing a market share cap of 40% by share of revenue, there are alternatives which would reduce HCA's market share in the way the CC is proposing. Given the substantial financial impact of the remedy on HCA's business, HCA should at the very least be given a choice in deciding which assets to dispose of.
- 2.12 The CC's proposed conditions for divestment, for example restricting the type of purchasers and requiring a sale within [X] months, would also seriously affect HCA's ability to secure a fair market value for these businesses.

Section 8: alternative remedies

- 2.13 Even if the CC is correct in its analysis of the market – which it is not – there are *alternative* remedies which would adequately address the alleged AECs. Divestment would not in any event deal with a root cause of the AECs, the barriers to entry, which the CC claims to exist. In remedies 3-7, the CC has tabled a package of measures which would foster even greater competition and patient choice, particularly in London, where there are numerous alternative providers. There are also alternative remedies which the CC has not included, including controls on PMI "managed care" initiatives, which would strengthen the remedies package and help consumers make effective choices.

Remedies 3-7

- 2.14 Without prejudice to HCA's position that the CC has wrongly identified AECs in the private healthcare market, HCA is broadly supportive of the CC's remedies to limit clinician incentives and improve transparency of quality outcomes and fee information. HCA has a few specific comments on the detail of these remedies.

² [X]

3. PROCEDURAL FAILURES

- 3.1 In the course of this inquiry, there have been a number of serious procedural failures by the CC. The CC's conduct and handling of this inquiry is very far from being that of a reasonable and objective decision-maker which has a genuinely open-minded approach to the evidence. The CC has not conducted this inquiry in a fair and even-handed manner or sought to engage meaningfully with HCA about the issues in London.
- 3.2 The CC's assessment of the market has been "complainant-led" and largely shaped by the views of the two main PMIs, namely Bupa and AXA PPP. The PFs and PDR quote extensively from their submissions and the CC's analysis is heavily reliant on their evidence. The CC has not subjected Bupa's and AXA PPP's assertions to any serious or critical examination. The CC naively conflates and confuses the interests of *PMIs* with those of *consumers*: in reality, although PMIs are the major purchasers of private healthcare, their interests are not aligned with those of their subscribers. PMIs are commercially incentivised to reduce costs and maximise profits rather than to promote quality and innovation or good clinical outcomes for their subscribers. The CC's failure to understand this has led it to conduct a very one-sided investigation in which the views of the two PMIs have been largely accepted, while the views of HCA and other hospital operators have been disregarded.
- 3.3 HCA has also raised a number of specific concerns at various points in this inquiry about the CC's procedures and the way it has conducted its investigations. The significant points are summarised as follows.
- 3.4 The CC has failed to follow its established practice of publishing Working Papers at an early stage of the inquiry to allow the parties an opportunity to comment on its analysis at the formative stages of the investigation:
- (i) The CC has a duty to carry out consultations under Section 169 of the Enterprise Act 2002.
 - (ii) The CC has traditionally published Working Papers on aspects of its analysis in order to obtain third party views. The CC's Guidelines specifically state³ "*An additional means of conveying the Inquiry group's developing approach and analysis is to disclose some of the Working Papers, or parts of Working Papers (see paragraph 71), often through publication*". The CC's recommended timetable for the publication of Working Papers is in months 5-9 after the commencement of the inquiry⁴. As the Guidelines indicate, the purpose of the Working Papers is to "*provide a snapshot of the issues, analysis and views*" on which interested parties are invited to comment as the CC's thinking develops.⁵
 - (iii) In the event, the CC published a small number of Working Papers on particular topics, but at a relatively late stage, well into the second year of the inquiry. In HCA's case, the key Working Paper relating to competition in central London⁶ was issued in June 2013, just two months before the PFs and Remedies Notice (and substantially later than the CC's Guidelines recommend). As the courts have pointed out, a consultation must be carried out when views are still at a formative stage so that third party evidence is "*conscientiously taken into account when the ultimate decision is taken*".⁷ In the event, the CC only published its Working Paper after its views on London were already highly developed and its provisional findings were being crystallised. This Working Paper was critical to the case against HCA since it set out the CC's findings in relation to where HCA's hospitals are located. HCA's response to that Working Paper was almost entirely ignored in the CC's analysis of central London in the

³ CC3 – Guidelines for market investigations, para 72(b).

⁴ CC3 – Guidelines for market investigations, para 55.

⁵ CC3 – Guidelines for market investigations, footnote 50.

⁶ Private healthcare in central London: horizontal competitive constraints, 7 June 2013.

⁷ *R v Brent LBC ex p Gunning* (1985) 84 LGR 168.

PFs, despite the fact that HCA had identified substantial flaws in the CC's methodology. By that stage, the CC had already "made up its mind".

- (iv) The CC also inexplicably abandoned publication of a Working Paper on PMI bargaining power which it had previously indicated it would be inviting views on. The CC has never explained the reasons for its volte-face. The Working Paper had obviously been drafted, because HCA was consulted over the confidentiality of some extracts from this document. It is not clear why this document was intentionally held back from the parties during the formative stages of the CC's inquiry.
- (v) The CC published its Annotated Issues Statement ("**AIS**") on 28 February 2013. However, this did not provide the parties with the same level of detailed, in-depth analysis with regard to the CC's developing thinking as the Working Papers traditionally provide in a market inquiry. The AIS is simply a more focused Issues Statement and does not replace the detailed analysis set out in Working Papers. In effect, this meant that HCA was only given an indication of the CC's detailed analysis on key aspects of this case – such as PMI bargaining power – in the PFs, well after the formative stage of its thinking, and at a time when it was less likely to be open to considering third party evidence.

3.5 There have also been serious procedural failings in the CC's handling of the disclosure of evidence in the data room. HCA regrets that it was necessary to commence proceedings against the CC to appeal against its terms of access to material evidence in the inquiry. In its ruling in *BMI v. Competition Commission*, the Competition Appeal Tribunal ("**Tribunal**") found that the CC's procedures were "*fundamentally flawed*", "*not fit for purpose*", and "*in breach of the rules of natural justice*"⁸, and that the CC had failed in its basic duty to provide an opportunity to the parties under investigation to prepare a proper and informed response to the CC's case. The Tribunal's criticisms of the CC's disclosure regime speak for themselves.

3.6 HCA has expressed concerns with respect to the revised disclosure room process adopted by the CC:

- (i) The CC revised its pricing data at a late stage of this inquiry following the discovery of errors in the underlying data set, which had altered its findings.
- (ii) The data presented in the data room did not include the underlying documents or raw data relied upon by the CC as part of its PMI bargaining power and insured price analysis.⁹
- (iii) The number of advisers permitted into the data room was restricted, which limited the HCA's advisory team's ability to assess and evaluate the evidence.
- (iv) The data available in the data room used in the case against HCA could not be discussed with any representative of HCA, and hence HCA's advisory team was prohibited from seeking instructions from HCA. In addition, there was very limited time available for HCA to consider the basket of procedures, once this information had eventually been disclosed. Further, HCA is unable to have sight of the CC's analysis of insured pricing, even though this is pivotal to the CC's case for divestment. In effect, the CC's case for divestiture depends in large part on a comparison of HCA's prices, the results of which are being withheld from HCA, preventing HCA itself from responding in detail to the allegation that it is more expensive than other central London hospitals.
- (v) The requirement to prepare a non-confidential version of the submission whilst also preparing other submissions within the 10 day period was unduly onerous and meant that HCA's advisers had even less time to consider the data.

⁸ *BMI v Competition Commission* [2013] CAT 24, paras 79, 70 and 74, respectively.

⁹ In addition, HCA notes that its advisers were not granted access to the raw underlying data for the CC's first data room exercise (run between 15- 19 April 2013), which focused on the CC's catchment area, LOCI and PCA analyses.

- (vi) The CC rejected a request for HCA's advisers to re-read unredacted versions of their submissions, despite this request being made several months after the completion of the data room process.

- 3.7 The timing of the PDR has allowed little opportunity for the CC to properly consider and take stock of HCA's submissions in response to the CC's PFs and Remedies Notice. The PDR has been issued in a very compressed timescale. The deadline for submissions to the CC's PFs and Remedies Notice closed on 11 November 2013 and HCA's hearing was on 20 November 2013. Allowing for the Christmas break, the CC was therefore allowing a mere six weeks to issue the PDR. It is clear from the "put-back" extracts that the CC has been drafting and preparing its PDR in parallel with the parties' submissions on the PFs and hearings. This would not have provided the CC with the time to properly consider and reflect on the evidence submitted, take appropriate steps to evaluate this evidence by further inquiry, and reach a balanced and considered view on provisional remedies. The CC's own Guidelines require that the CC properly consider the responses to the PFs and Remedies Notice in the period **before** publication of its PDR, not after.¹⁰ As the courts have noted,¹¹ if a consultation only takes place after the authority's work has been done, this will inevitably colour the authority's approach to any representations and make it highly unlikely that the authority will genuinely alter or re-consider its proposals. It is no defence for the CC to argue that it is constrained by the statutory timetable, since its overriding duty is to ensure that it reaches a fair decision based on the evidence available. The delays in the CC's timetable have been entirely of the CC's own making, and cannot be used as an excuse for failing to give proper consideration to the main parties' submissions.
- 3.8 The CC's handling of the remedies phase conflicts with its own recommendations as to best practice. In 2010, a panel of CC members (including Roger Whitcomb who chairs this inquiry) reviewed the CC's approach to remedies in market investigations in the light of the *Tesco* and *Barclays* appeals.¹² They concluded that the CC's process "*tended to "crowd out" time and resources available for consideration of remedies*". The panel recommended that the timescales for reaching the PF stage should be shortened to allow "*equivalent priority and resourcing of work on remedies*". In the private healthcare investigation, the CC has ignored its own recommendations to allow sufficient time to consider and consult on remedies. The PFs were substantially delayed, and as a result the remedies phase has been rushed leaving no time for detailed scrutiny of the CC's remedies proposals. By way of example, the CC issued an information request to HCA on 4 December 2013 asking HCA to quantify the cost of divestment. This is a substantial exercise, for which the CC imposed a derisory deadline of three working days. The CC had simply "run out of time" by that stage. In consequence, its proposals are precipitate, ill thought-out and seriously flawed.
- 3.9 The CC has refused HCA's request for disclosure of the underlying documents on which the CC is relying for its analysis of PMI bargaining power. The CC has disclosed to HCA and/or its advisors its analysis of bargaining power but has not disclosed any of the PMI documents on which the analysis is based. The relative bargaining strength of hospital operators and PMIs forms a significant part of the CC's PFs. HCA has highlighted a number of inconsistencies and discrepancies in the CC's analysis which call into question its conclusions about PMI bargaining power and the disclosure of the underlying documents within the confines of the disclosure room would have allowed HCA's advisers to test the CC's conclusions and develop their submissions that the documentary evidence does not in fact support the CC's assessment. The CC's refusal to grant access to these documents, even on a restricted basis to HCA's advisers is unjustified, unfair and further demonstrates that the CC has little interest in genuinely engaging with the hospital operators on aspects of the evidence.
- 3.10 The CC has also refused the request of HCA's advisers to obtain access to the disclosure room for the purposes of preparing HCA's response to the PDR. This has hampered HCA's

¹⁰ CC3, Guidelines for market investigations, April 2013, pg 17 "*Timescales*".

¹¹ See e.g. *Nichol v Gateshead MBC* (1988) 87 LGR.

¹² Review of the Competition Commission's approach to remedies in market investigations: recommendations and proposed actions, February 2010.

ability to respond to the PDR (in particular in relation to the CC's findings concerning the comparative assessment of HCA's prices) and hence has restricted HCA's rights of defence.

- 3.11 HCA does not therefore consider that the CC has genuinely invited and considered representations from the hospital operators affected. It has not demonstrated a fair and balanced approach to the evidence which HCA has submitted. The CC's whole approach to this inquiry demonstrates that it has pre-judged the issues at a relatively early stage and that it has "closed its mind" to HCA's views on the competitiveness of the market in London and to remedies other than divestment.

4. AEC FINDINGS

- 4.1 The PDR merely repeats the CC's provisional findings relating to the alleged AECs in the market for private healthcare. The CC states that it has not "*at this stage made a final decision regarding the existence and form of any AEC*".¹³ However, its proposed remedies relating to HCA are based on its provisional AEC findings, indicating that the CC's views are unchanged, notwithstanding all the evidence which HCA has submitted following the PFs.
- 4.2 HCA's submissions relating to the AEC findings are set out in detail in its response to the PFs. Its key submissions are briefly highlighted below.
- 4.3 HCA rejects the CC's findings and does not consider that there are AECs in London. However, even if the CC's findings are correct, they do not indicate competition concerns that are sufficiently serious to justify a divestment remedy.

The strength of competitive constraints in London

- 4.4 The evidence available to the CC shows that hospital operators compete inter alia on quality of care, that the market in which HCA competes is **at least** London wide, and that in London hospital operators face competition from a wide range of private hospitals, PPU's, NHS hospitals and international providers. The CC has failed to take account of the strength and diversity of competitive constraints on HCA.
- 4.5 HCA directs the CC to sections 3 – 5 of HCA's response to the PFs, and to HCA's response to the Working Paper "Private healthcare in central London: horizontal competitive constraints".

Failure to consider competition over quality of care

- 4.6 First and foremost, in focusing its attention purely on competition in relation to price, the CC has failed to consider factors, such as:
- how hospitals compete on quality of care;
 - the relevant competitive parameters when hospitals compete on quality of care (e.g. do hospitals compete on outcomes, choice of treatments, staffing, service levels, and so forth);
 - the views of consultants and their role in signalling good quality care to patients;
 - whether the current levels of quality available in London indicate that there are effective competitive constraints;
 - whether a hospital operator's ability to charge higher prices is at all related to how well it competes over quality of care; and
 - whether the evidence available in London indicates to the CC that structural features of London give rise to an adverse effect on competition over quality of care.
- 4.7 With its formal investigative powers, the CC was in an ideal position to assess and consider the above issues, and given that competition on quality of care has a particularly important role for the private healthcare market in London,¹⁴ it should have made this analysis a priority before even contemplating a divestment remedy. The double proportionality principle is directly relevant here: the more wide-reaching and intrusive the remedy (or uncertain the

¹³ Para 2.8 of the PDR.

¹⁴ See section 4 of HCA's response to the PFs.

effect), the more detailed and deeper the CC's investigation should be.¹⁵ The CC's investigation has failed to consider this important aspect of competition.

- 4.8 The CC recognises that HCA's strategy has been to compete with its rivals on quality of care and to do so by focusing on high acuity tertiary care services.¹⁶ HCA has made substantial investments over the last 10 to 12 years totalling [£] to realise its vision of creating centres of excellence in complex care. This has required foresight and indeed investment risk. During this time, HCA's competitors have responded with investments of their own, which HCA has in turn responded to.
- 4.9 The CC does not appear to recognise this competitive interaction as "competition", contrary to its own Guidelines.¹⁷ In the same way that the CC looks at prices as an "indicator" of weak competitive constraints, the CC should consider whether the current levels of investment, innovation and choice of services and quality of care available is an "indicator" of an effective competitive constraint on hospital operators in London.
- 4.10 The CC has not stepped back and observed the cumulative effect of this competitive process. Over time, one would expect to see increasing choice for patients, more complex services offered to patients, and greater adoption of innovative treatments. This is precisely what is observed in London and across the UK.¹⁸ Bupa's own Chief Executive, Stuart Fletcher, observed this trend. He publicly stated, on 1 January 2014, "*We still have medical inflation, but the good news is that cancer treatment is getting much better and there is a lot of innovation*".¹⁹
- 4.11 HCA can justly claim a strong quality record, which attests to the strong level of competition in London. HCA refers the CC to Appendix 2 of its response to the Remedies Notice, section 3 of its response to the PFs, and to section 5 below. HCA can similarly claim that it has embraced a large number of innovative clinical technologies faster than its competitors.²⁰
- 4.12 The CC itself has in part recognised these characteristics:
- *"we concluded that the evidence we had seen indicated that HCA did provide good quality healthcare services, certainly in the three areas on which it submitted case studies",²¹*
 - *"we did accept that HCA had demonstrated that it had been willing and able to adopt innovative techniques. However, in several cases innovative techniques or technologies had been adopted in response to competitors' behaviour",²²*
 - *"there was a reasonable level of evidence that HCA provided good quality and high acuity services and that it had introduced a range of new treatments into the private market in London",²³*
 - *"in central London HCA and its competitors have generally sought to pursue a high-acuity and high-quality strategy",²⁴ and*
 - *"Our case study on The London Clinic's (TLC's) Cancer Centre... illustrates the willingness of some providers, particularly TLC and HCA, to make very*

¹⁵ See *Tesco PLC v Competition Commission* [2009] CAT 6, para 139.

¹⁶ See Appendix 6.3 of the PFs.

¹⁷ CC3, Guidelines for Market Investigations, paras 103 – 106, 127 – 129, and 182 – 184, a.

¹⁸ Even Nuffield, a vocal complainant during the market investigation, observed "*In recent years, Nuffield has seen the prevalence of higher acuity procedures in a private setting increase*" and that *there had been a "shifting composition of procedures"*.

¹⁹ MailOnline, Jan 1, 2014 Wednesday, *City interview: Boss Stuart Fletcher fighting the flab at Bupa*.

²⁰ See section 3 of HCA's response to the PFs.

²¹ Para 2.114 of the PDR.

²² Para 2.115 of the PDR.

²³ Para 2.171 of the PDR

²⁴ Para 2.110 of the PDR.

significant investments in equipment and facilities to try and secure an increased share of certain segments of the healthcare market, particularly oncology".²⁵

- 4.13 Many clinicians have made submissions to the CC outlining their professional and considered view of HCA's hospitals. In response to the CC's PFs and Remedies Notice, consultants pointed to the superior services, hospital infrastructure and clinical support that is available at HCA hospitals.²⁶ This evidence has been ignored by the CC. AXA PPP, a vocal complainant in this market investigation, characterised all of HCA's six hospitals as being known for "*their UK wide and indeed international reputation for excellence, attracting high profile specialists and elite facilities; and coverage of the full range of high-acuity treatments*" and for their "*leading role in introducing technological innovation in the UK*". Even HCA's own competitors have recognised the quality of HCA's hospitals. BMI told the CC that HCA ran "*excellent quality hospitals*".²⁷
- 4.14 The evidence of competition in relation to quality of care and innovation and the CC's own observations concerning HCA's market conduct are simply inconsistent with the CC's provisional view that HCA faces "weak" competitive constraints. The CC has not asked itself what, if not competition, has compelled HCA to engage in such a strategy that would see it reinvest [X] back into its hospital to improve quality and choice for patients. In the PDR, the CC states that it believes, after forcing the divestment of HCA hospitals, "*the new competitive dynamics in London would ensure that patients' needs would be adequately met*".²⁸ How can the CC possibly form any conclusion as to the "new competitive dynamics" when it has not investigated any evidence of the current competitive dynamics in London (or indeed any other geographic market). In short, the CC's divestment remedy is based on a "phantom AEC" as the CC has no idea whether the current market structure in London is already resulting in an optimal or sub-optimal outcome for patients.
- 4.15 Beyond the CC's assessment of local competitive constraints, the CC's failure to consider and compare quality levels between hospital operators in London has significant consequences for the completeness and reliability of other aspects of its PFs:
- Without an assessment of how HCA competes on quality of care with free NHS alternative hospitals, the CC cannot claim to have conducted a reasonable assessment of the competitive role of NHS hospitals.
 - Without an assessment of HCA's quality, the CC cannot reasonably come to a view as to whether HCA's pricing represents "good value for money", i.e. that its pricing reflects higher quality, greater choice or a more complex service offering.
 - Without an assessment of HCA's track record on quality, investment, innovation over time, the CC cannot properly evaluate the extent to which HCA's market share and financial performance are consistent with it having successfully competed in a dynamic market where "quality" is the key competition parameter.

Market definition

- 4.16 The CC has adopted an inconsistent and entirely unreasonable approach to market definition in the case of London.
- 4.17 HCA directs the CC to section 5 of HCA's response to the PFs, which sets out the fundamental flaws in the CC's approach to market definition. The salient points are set out below.
- 4.18 The CC defines the areas between the North and South Circular Roads as the relevant geographic market for HCA's London hospitals.²⁹ There is no justification for using these

²⁵ Para 2.15 of the PFs.

²⁶ See submissions from consultants 19, 34, 35, 37, 38.

²⁷ See para 24 of BMI's hearing summary, 27 March 2013.

²⁸ Para 2.110 of the PDR.

²⁹ Para 5.59 of the PFs and para 2.64 of the PDR.

particular roads; they have no special meaning in the healthcare sector (nor any other sector); no explanation is offered as to why hospitals outside of these roads (even those located 5 minutes outside) are not deemed worthy of any consideration insofar as central London is concerned. For example, one of the country's premier hospitals for cancer treatment, the Parkside Hospital, is based in Wimbledon (located 1.8 miles from the South Circular road, approximately a 5 minute drive) and is completely ignored by the CC.

4.19 In effect, the CC arbitrarily fixes the scope of HCA's geographic market by reference to a road. This is despite the CC stating in its PFs that it is adopting the logit competition index ("**LOCI**") as a market concentration measure specifically because:

"In the healthcare industry, where both patients and hospitals are very heterogeneous, it may be difficult to determine precisely the geographic boundaries of each local market, and thus avoiding a sharp geographic delineation is an appealing aspect of the LOCI measure".

4.20 In central London, the CC abandons LOCI (without any proper reasoning) and adopts a sharp geographic delineation of the market based on two roads.

4.21 The absurdity of such a sharp and arbitrary delineation is best demonstrated by an example. The CC is basing its divestment remedy on a provisional finding that a patient living on Putney Bridge Road (within the South Circular) would never entertain the possibility of visiting Wimbledon (2.4 miles away) to be treated at the Parkside Cancer Centre, even in the event that the quality offering at HCA's hospital based on Harley Street (8.4 miles away) declined. It is irrational and totally unreasonable for the CC to ignore the competitive constraint of a facility that is not only three times closer to the patient, but also offers advanced cancer care services that rival HCA's hospitals.

4.22 The CC can test for itself that any member of Bupa or AXA PPP (among other PMI providers),³⁰ who lives on Putney Bridge Road (in central London) and searches for an approved hospital with "oncology" services would first be directed, by order "relevance" (not even by "distance"), to the Parkside Hospital and the New Victoria Hospital, both of which are outside the South Circular, before any one of HCA's central London hospitals. Yet the CC tells us that these hospitals are not competitive substitutes for HCA's hospitals.

4.23 In addition to abandoning common sense, by adopting such a crude approach to market definition, the CC ignores concrete evidence of patient referrals:

- The CC has not considered how the North / South circular boundary compares to HCA's patient catchment areas. [REDACTED]
- Crucially, the CC has not attempted to consider the proportion of HCA's patients who are resident in central London. It would have shown the CC that:³¹
 - [REDACTED] of HCA's patients travel from within central London – [REDACTED]
 - [REDACTED] of HCA's patients travel from the area between the CC's central London boundary and Greater London – the CC has conducted no examination of the competitive constraints on HCA from hospitals in this area.
 - [REDACTED] of HCA's patients travel from outside Greater London – the CC has conducted no examination of the competitive constraints on HCA for these patients.
 - [REDACTED] of HCA's patients are international patients – the CC has conducted no examination of the competitive constraints on HCA to attract these well-funded and highly mobile international patients.

³⁰ This test was conducted on the Bupa and AXA PPP websites as of 6 February 2014 under their respective hospital search tools.

³¹ [REDACTED]

- The CC has not considered whether its share of supply analysis conflicts with its LOCI patient analysis of HCA hospitals. The CC's LOCI analysis showed that the two divestiture hospitals in fact have a weighted average market share based on admissions of [§]. This is clear-cut evidence of actual patient behaviour which shows that patients in the geographic areas around HCA's hospitals do indeed view rival hospitals as credible alternatives to HCA. This evidence has been completely disregarded by the CC.
- Evidence submitted to the CC by insurers, such as Aviva, shows that HCA's patients are predominantly from areas outside central London. For example, Aviva told the CC that with respect to its top three claimed conditions (as a proportion of hospital spend in London), *"Within the top three claimed conditions, there have been 10 inpatient / day patient stays in London Hospitals. On evaluating these, the home postcodes of the relevant claimants are all except 1 outside of London. Predominantly they are from Surrey, Kent, East Sussex and Hertfordshire. Of these 10 stays, 6 are within the Hospital X and no claimant has a London postcode"*.³²

- 4.24 The CC has not tested the robustness of the North / South Circular cut-off point. For example, assessing what happens to HCA's supposed share of supply / capacity if the CC moves the cut-off point by a mere 2.5 miles (5 minutes drive) or 5 miles (about 10 minutes drive). If the CC is adopting an arbitrary cut-off point, it should have, at the very least, examined a range of cut-off points to examine the sensitivity of its share of supply findings to the exact location of the boundary line.
- 4.25 Submissions from HCA's competitors, such as Aspen (which operates the Parkside Hospital located just outside of the North / South Circular) told the CC that they believe their market is the area within the M25.³³ BMI told the CC: *"BMI's main competitor in London was HCA. As part of its strategy, BMI was targeting increasing numbers of people who might be treated at central London hospitals to be treated at its peripheral London hospitals instead. By means of example, with investment in equipment, BMI had successfully attracted patients to its Clementine Churchill Hospital in Harrow away from HCA's Princess Grace Hospital"*.³⁴ The Churchill Clementine has been ignored by the CC as its falls just outside of the North Circular. The core strategy adopted by the Kent Institute of Medicine and Surgery ("**KIMS**") is expressly stated as being based on competing for patients currently travelling to central London for hospital care.³⁵ The CC has ignored all evidence of hospital operators on the fringes of the North / South Circular competing with hospitals inside the North / South Circular.
- 4.26 The CC has not taken any account of the fact that HCA does not and cannot discriminate, whether on the basis of price or quality of care, between patients inside the North / South Circular and outside these roads. This is a fundamental point because, even if the CC were correct in concluding that there are so-called "captive" patients at central London hospitals (which HCA strongly disputes), these patients are not and cannot be treated in any way differently by HCA to those patients located outside central London. Therefore, patients resident in central London benefit from the competitive constraint posed by hospitals located outside of central London which compete for patients located in these areas.
- 4.27 Contrary to its own market definition guidelines, the CC has not attempted to ask the most fundamental question that must drive any market definition assessment – whether patients utilising central London hospitals would be willing to substitute the hospital in central London for a hospital outside of central London "in response to a small but significant reduction in the value for money of private hospitals in central London", e.g. if HCA's perceived quality of care significantly fell, how would patients and referring clinicians respond.

³² Aviva's response to the Issues Statement, page 53.

³³ See Aspen hearing summary, 26 February 2013, para 7.

³⁴ See BMI hearing summary, 27 March 2013, para 19.

³⁵ <http://www.kims.org.uk/about-kims/about-kims-article/our-mission>

4.28 As for the competitive constraint exerted by the NHS, the CC accepts that the NHS provides a competitive constraint to private healthcare, but in the very market in which major NHS teaching hospitals are most prominent (London), the CC conducts no analysis whatsoever of NHS constraints. This is despite the CC's patient survey evidence showing that 68% of self-pay patients considered having their treatment on the NHS.³⁶ Furthermore, the CC's methodology for examining the preferences of patients and GPs to use NHS services in preference to private hospitals is flawed and ignores evidence put forward by HCA concerning its competitive interaction with the NHS in London.³⁷

Assessment of competitive constraints

4.29 In conducting its assessment of the strength of competitive constraints in central London, the CC relies almost wholly on its assessment of share of supply and capacity. However, each of the CC's three principal assessments of share of supply / capacity is flawed as a result of incomplete or biased data.³⁸

- share of capacity;
- share of admissions; and
- share of revenue.

4.30 The CC's share of supply calculations include:

- admissions and revenue in respect of international patients, but the CC does not at all consider competing overseas providers that impose a competitive constraint on HCA, despite these patients accounting for [X] of HCA's business;
- revenue data for outpatient activity, but the CC has not conducted any assessment of competitive constraints on outpatient activities, nor has it considered the full range of competitors for outpatient services; and
- revenues for service lines in which HCA faces competition from different types of healthcare service providers. For example, the CC includes revenue attributable to fertility services and neuro rehabilitation services, yet the CC has not considered the range of competing providers for these services in London.

4.31 It is unreasonable, and biases HCA's position in this inquiry, to include the revenue and admissions attributable to international patients, outpatients and patients from specific service lines, but not also include reference to the full range of competitors for those patients. The CC's approach is economically unsound and risks artificially inflating HCA's share of supply. The unreasonableness of this approach is exacerbated by the use of these biased shares of supply as the basis for the CC's divestment remedy (discussed further in section 7 below).

4.32 The market share calculations unreasonably omit competitors in London who are outside the North and South Circular. The CC's market share calculations included admissions and revenues from patients who have travelled from locations outside of central London, and therefore who would have had the choice of a number of outer London hospitals.

4.33 Even if one accepts (which HCA does not) that the range of competing hospitals should start and end with the North and South Circular Road, the CC has not even conducted a full and rigorous assessment of the competitors within this narrow geographic area:

- A number of hospitals and NHS PPUs are simply absent from the share of supply tables. The CC claims that admissions information was not available in

³⁶ CC, Patient Questionnaire, B2 (Did you consider having your treatment done on the NHS?).

³⁷ See section 5 of HCA's response to the PFs.

³⁸ The CC is referred to section 5 of HCA's response to the PFs for the list of omissions and errors in the CC's assessment, which have still not been corrected at the time of the CC's PDR.

respect of specific NHS PPUs. Given the time it has had and its formal investigatory powers, the CC should have endeavoured to obtain this data, or at the very least make some effort to calculate an estimate based on capacity. HCA submitted evidence with full references showing that PPU revenue (excluding UCLH) in central London accounted for 22% of total revenues in 2011 / 12, and 25% of revenues in 2012/13. The CC's estimate of 14%, based on an incomplete range of PPUs, does not reflect reality.

- The CC's analysis of share of capacity is flawed as it unreasonably omits PPU capacity data. This is inexplicable because PPU bed numbers are readily available in the public domain and therefore there is no justification for omitting them. **Figure 4.1** below illustrates the extent of the CC's error, which, when corrected, results in HCA's share of capacity moving from [3%]. The corrected share of capacity table shows that HCA's share is only marginally above the CC's 40% threshold. The fact that HCA's share by admissions / revenue is higher than its share by capacity is consistent with the fact that it has a higher quality offering which attracts patients.

Figure 4.1 – HCA's corrected share of capacity in central London based on the CC's market definition³⁹

[3%]

- 4.34 The CC provisionally concludes that NHS PPUs are weak competitors. The basis for this appears to be patient survey evidence, which is demonstrably flawed, and the evidence pertaining to PPUs in London wholly contradicts that assertion.⁴⁰ The CC itself found that patients perceived PPUs in London as offering a higher level of quality than PPUs elsewhere in the UK and that this constituted a special characteristic of the London market.⁴¹

Barriers to entry

- 4.35 The CC finds that economies of scale and high capital costs in a static market constituted the "greatest barrier to entry" for prospective entrants, and these features of the market have provided the CC with the justification for divestiture. However, the CC's own analysis contradicts the existence of these features, insofar as London is concerned.

Market growth

- 4.36 The CC's concerns that static demand for private healthcare is a barrier to entry do not apply in the case of London, which has witnessed year on year growth and continues to expand. As the CC itself has noted, the London market is growing and creating new opportunities for market entry and expansion.
- 4.37 The CC's analysis of market growth is contradictory. In the PDR, the CC acknowledges London's growth prospects. When dismissing the argument by HCA that a new acquirer may be forced to reduce patient choice by ceasing to offer sub-specialisms that are, by their nature, more specialised and attract lower volumes, the CC states: "*Finally, we thought that the growth in the size of the London market would support the provision of specialist services even within an HCA group that held a smaller share of the market*".⁴² However, in the PFs, the CC alleges that "static demand" in the private healthcare market acts as a structural barrier to entry. The CC's approach is entirely contradictory.

Site availability and planning

³⁹ HCA does not consider the above to be a comprehensive account of the London market, but an illustration, using the CC's own data, of the impact of omitting PPUs. Source: Left side - CC's PFs, Table 10, Appendix 6.10. Right side - identical data sourced by the CC, but including mid-2011 PPU bed capacity as set out in Laing's Healthcare Market Review 2011-12 ("PPU dedicated pay beds"). Bed capacity at the Harley Street at UCH PPU, 24 beds, has been attributed to HCA.

⁴⁰ See section 5 of HCA's response to the PFs.

⁴¹ Para 5.59 of the PFs.

⁴² Para 2.119 of the PDR.

- 4.38 Contrary to the PFs, the evidence before the CC further reveals that site availability and planning are *not* barriers to expansion or entry in London.
- 4.39 The CC has made unfounded assertions that limited site availability raises the costs and risks of new market entry into London. HCA has provided the CC with details of numerous sites currently available on the open market in central London, including a number of confirmed NHS sites that are currently or shortly planned to be marketed for sale.
- 4.40 The CC also refers to the issue of planning consent, but the CC has presented no convincing evidence as to the impact of obtaining planning permission on the costs and risks of entry and expansion. Rather, the evidence suggests that there are numerous examples of planning permission for healthcare facilities being granted in the past and that profitable entry and expansion has been achievable.

Record of entry and expansion

- 4.41 There is a strong record of market entry and expansion in London (even in the midst of a recession and one of the worst five year periods in which to study large-scale investment in any sector), including: BMI's entry; the London Clinic's recent expansion in cancer services; and the expansion of numerous other private providers including the Bupa Cromwell, the St. John and St. Elizabeth, Highgate Hospital and the King Edward VII hospital. HCA refers the CC to section 6 of HCA's response to the PFs for further details of these expansions.
- 4.42 There is also concrete evidence of planned new market entry by full-service hospitals in London and the South-East: the London International Hospital is a new 150-bed specialist hospital expected to launch in central London; KIMS will also open in 2014, targeting tertiary referrals into central London; and Spire has recently announced its intention to launch a new flagship hospital in London.⁴³
- 4.43 The CC also, quite correctly, noted that NHS PPUs in London are gearing up for growth. The PFs, however, underestimate the extent to which, with the lifting of the PPU cap on income, PPU expansion is likely to change the competitive landscape in London in the coming years. The revenues of the 12 major PPUs in central London have grown by more than 36% over the last three years and the annual reports of leading NHS Trusts demonstrates that they are embarking on a strategic programme of expansion. Whilst PPUs already exert a strong competitive constraint over HCA there is clear evidence that this will increase. HCA provided detailed evidence (see Appendix 1 to HCA's response to the PFs) on how NHS PPUs are embarking on a strategic programme of expansion – the Royal Marsden for example is targeting revenues of £100 million over the next few years.
- 4.44 The CC must also recognise that its market investigation and the possibility of divestitures will have changed market entry dynamics. The market investigation has created uncertainty (for example, with respect to the legality of hospital consultant relationships) and has presented potential entrants with the possibility of buying an established hospital through a divestiture process. Potential entrants will have understandably wished to wait for the conclusion of the CC's market investigation before deciding to enter the UK market.

⁴³ http://www.propertyweek.com/spire-nurses-london-ambition/5062589_article

PMI recognition

- 4.45 HCA has also noted that, if there is a single factor that holds-up entry in any market, it is assurance of PMI recognition. AXA PPP has itself acknowledged this in the case of London. AXA PPP told the CC: "*AXA PPP had previously considered sponsoring a new entrant to enter the London market. However, it had encountered a number of issues surrounding sponsorship, as the hospital operator would typically seek a guarantee concerning referral volumes, which AXA PPP was not able to give until it was aware that the new entrant was able to attract a sufficient consultant base and the facility would be of the requisite quality*".⁴⁴ There is no reference at all by AXA PPP to London's growth prospects, to site availability, or to planning permission. Put simply, the hold-up was about assurances of PMI volumes and attracting consultants.
- 4.46 Aspen, a hospital operator, told the CC that, as part of its entry and expansion in London, its commercial strategy had been affected by the eight years it took to secure recognition from AXA PPP for its hospital. Aspen further told the CC that it "*had also experienced recognition problems with Bupa*" with its other London facilities.⁴⁵
- 4.47 HCA told the CC that AXA PPP had effectively caused the London Heart Hospital's exit from the market. AXA PPP refused to offer recognition to this advanced hospital facility, without which it lacked financial viability. AXA PPP now complains to the CC about the lack of entry and supply of healthcare in London.

Indicators of market power

Pricing

- 4.48 In terms of prices paid by PMIs, the CC's insured pricing analysis is deeply flawed, does not support the CC's findings, and is unreliable for reasons which have been fully set out in earlier submissions:
- It is not informative of insured prices because the CC has not actually measured "price". There are significant variations in the supposed "price" of individual procedures in the CC's data set, because the CC has failed to control (and even attempt to control) for quality and complexity variations from case-to-case.
 - The CC's refusal to attempt to control for case complexity in its insured price analysis is also inconsistent with its position in the PDR. The CC's remedy design for improving information availability on hospital / consultant performance concedes that "risk-adjusted" data is an important feature of the remedy as it enables "like-for-like" comparisons between episodes.⁴⁶ The level of "risk" is relevant because it directly affects factors such as the length, difficulty or scope of the clinical intervention. The CC has failed to see that these **same factors**, (e.g. length, difficulty and scope of treatment) not only affect outcomes, but also impact on price. This is precisely why it is necessary to use equivalent controls irrespective of whether one is attempting to compare "prices" or "clinical outcomes" between patient episodes.
 - There were also a number of important methodological issues with the CC's analysis, including data flaws, incorrect and incomplete data for key PMIs including Bupa and Cigna, unreliable sample sizes, and a failure of the basket of treatments to adequately represent HCA's range and complexity of treatments and the revenues it derives from insurers.
 - Tests of the statistical significance of the findings cast serious doubts on the CC's assertion that "*prices charged by HCA were significantly higher than those of other operators*", including those of the London Clinic. HCA's episode charges are not statistically significantly higher than the London Clinic's for Bupa patients and for individual treatments (CCSDs). In a large number of

⁴⁴ Summary of AXA PPP's hearing with the CC, 19 March 2013, para 28.

⁴⁵ Aspen hearing summary, 26 February 2013, paras 8 – 9.

⁴⁶ Para 2.458(b) of the PDR.

cases, HCA's charges were not statistically significantly different from the London Clinic's for either AXA PPP or Bupa (and in some cases the London Clinic's charges were statistically significantly higher).

- The CC's findings show that [redacted]⁴⁷
- The significant variation in the value of the indices across hospital operators and over time could not be explained by differences in market concentration, therefore factors that the CC has failed to control for are distorting its findings.

4.49 Given these considerable flaws, the CC's analysis cannot be used to support a finding relating to HCA's higher "prices" compared to the prices of other hospital operators, and certainly cannot be used to demonstrate HCA's relative bargaining position in negotiations with insurers.

PCA

4.50 In terms of self-pay patients, the CC's price concentration analysis ("**PCA**") fails to demonstrate any robust or reliable causal relationship between prices and local market concentration.⁴⁸

- The PCA excluded many of HCA's key competitors because the relevant data was unavailable (55% of invoices were missing in London);
- The relationship between local market concentration and self-pay prices that the CC claimed to have established through the PCA is no longer significant when the episodes of a single operator (Nuffield Health) are excluded;
- The PCA only focused on four treatments (from only three specialties), which are completely unrepresentative of HCA's business; this, among other factors, implies that the PCA has no relevance for HCA;
- There are numerous methodological errors which undermine the CC's attempts to infer a causal relationship between local market concentration and self-pay prices;
- In any event, even with all these flaws, the most the PCA concluded is that a 20% increase in the weighted average market share of a given hospital is associated with about a 3 – 4% price increase for a self-pay treatment – a very low order of magnitude, which cannot support the kind of draconian remedies that the CC is proposing.

4.51 The fact that the CC had to inform HCA several times of changes in the set of HCA's hospitals identified as being of potential concern over the course of the inquiry (including, in the case of the Princess Grace, two months after publishing its PFs) is a strong indication of the high degree of uncertainty and lack of robustness in the CC's analysis. If the CC's analysis was robust, one would not expect to see HCA hospitals "drifting in and out" of the CC's categorisation of "hospitals of potential concern".

Profitability

4.52 There are also serious flaws in the CC's profitability analysis which overestimates HCA's return on capital employed ("**ROCE**"), underestimates the Weighted Average Cost of Capital ("**WACC**").⁴⁹

4.53 To the extent to which the CC finds that HCA has earned profits in excess of the WACC, the CC has failed to take account of the extent to which these derive from its successful track

⁴⁷ [redacted]

⁴⁸ We refer the CC to Appendix 2 of HCA's response to the PFs.

⁴⁹ Appendix 5 of HCA's response to the PFs.

record on investment, innovation and efficiency which make such profits entirely consistent with a successful company operating in a competitive and dynamic market.

- 4.54 HCA strongly disagreed with the CC's calculation of HCA's returns and cost of capital. After adjusting for more appropriate assumptions for HCA's costs and the value of its properties, HCA conservatively estimates its average ROCE for the period 2007-2011 to be in the range of [redacted]. HCA's WACC is in the range of [redacted]. HCA's return is therefore entirely consistent with its cost of capital and does not support a finding of excess profits.

National bargaining analysis

- 4.55 The CC errs in its approach to assessing bargaining power, by overestimating the bargaining position of hospital operators and underestimating the bargaining position of PMIs as well as failing to take account of the alternative strategies which PMIs have used, and are increasingly using, to divert business away from HCA's hospitals.
- 4.56 The CC has also failed to conduct a proper assessment of PMI bargaining power. HCA refers the CC to section 7 of HCA's response to the PFs, which sets out how:
- the CC has overestimated the strategic alternatives available to hospital operators in their negotiations with PMIs;
 - the CC has underestimated the range of strategic alternatives available to PMIs which, in practice, enable them to exercise leverage in their negotiations with hospital operators;
 - the CC's bargaining framework is incorrect from an economic perspective.
- 4.57 The available evidence in fact shows that PMIs have a strong negotiating position in relation to HCA. This includes the successful uptake of PMI restricted networks and directional products (the full impact of which cannot yet be measured, as these products are relatively recent and still rapidly growing). These include Bupa's Open Referral product, Aviva's newly launched Guidewell product and AXA PPP's recently relaunched Care Pathways targeted specifically at utilising alternative capacity in central London. The CC has not considered whether the freedom enjoyed by PMIs to launch products intended to erode HCA's market share is telling of HCA's weak bargaining position. Nor has the CC asked itself why PMIs would launch products intended to divert patients away from HCA's hospitals if they did not credibly believe that sufficient alternative capacity existed in the market.
- 4.58 On HCA's modelling, a delisting of HCA's facilities by Bupa [redacted] and a delisting by AXA PPP, [redacted]⁵⁰ This model, which factors in a reasonable degree of consultant drag, shows that [redacted] Conversely, HCA has submitted clear evidence showing that PMI patients in HCA hospitals can readily be absorbed by competing hospitals in central London in the event of a delisting of some or all of HCA hospitals.

OFT merger clearance

- 4.59 In its response to the Remedies Notice, HCA drew the CC's attention to the fact that HCA's acquisition of St Martin's Healthcare Limited in 2000 was investigated and cleared unconditionally by the OFT. HCA submits as follows:
- (i) The CC's PFs in relation to London are at variance with the OFT's assessment in 2000 that the private healthcare market in London was highly competitive, that the relevant market included outer London hospitals, and that PMIs had substantial buyer power. The CC has failed to explain why its own findings are so fundamentally different and contradictory.
 - (ii) HCA has relied on the OFT's clearance of its acquisition of the London Bridge in 2000 to make significant capital investments to develop and grow the business. It is unfair and perverse for the CC to seek to reverse a competition authority's previous decision, which gave HCA the green light to invest in this facility. It is a breach of

⁵⁰ See section 7 of HCA's response to the PFs.

HCA's legitimate expectations, and an abuse of process, for the CC to seek to use its powers in a market investigation reference to overturn a previous OFT decision without a clear justification.

- 4.60 The CC argues that "*Markets evolve and change over time as does the nature of the analytical tools used by the competition authorities*".⁵¹ As far as the evolution of the market is concerned, HCA challenges the CC to explain how it considers the market to have "evolved" since 2000. As HCA has set out in its response to the Remedies Notice, since 2000 the market for private healthcare has become more, not less, competitive with new market entry and expansion, the expansion of NHS PPU's, and new PMI "Open Referral" policies. The market is less concentrated now than it was in 2000, as new entrants such as BMI have entered the market and competitors such as the London Clinic have expanded. The CC has simply not explained why it believes the market is now significantly less competitive than at the time of the OFT's findings in 2000. In view of the OFT's very clear decision in 2000, the onus is on the CC to explain why it has adopted contrary views.
- 4.61 The CC also contends that there is a "*different analytical approach*" which is taken under "*different legislative frameworks*". However, the OFT and the CC are both competition authorities carrying out an assessment of competition in the market. The same legislative framework (now the Enterprise Act 2002, and, at the time of the OFT's decision, the Fair Trading Act 1973) covers both mergers and, market investigations. Under merger legislation, the OFT considers whether there is a "substantial lessening of competition". In a market investigation, the test is whether there are features of the market which prevent, restrict or distort competition in the supply of goods or services. The OFT and the CC carry out very similar economic assessments of competition by reference to such factors as market definition, market share, barriers to entry, and buyer power. The two regimes share the same objective of ensuring that markets function competitively. Indeed, from April 2014, the functions of the OFT and CC will be combined into a single competition regulator, the Competition and Markets Authority ("**CMA**"). The OFT granted unconditional clearance to HCA for its acquisition of the London Bridge finding that there are "*unlikely to be competition concerns*". CC cannot legitimately argue that, given the very clear OFT finding that the markets operated competitively, and that HCA was faced with a diversity of competition, the CC is entitled to come to diametrically opposite views in its market investigation.
- 4.62 The CC also contends that "*far greater data may be available as well as sufficient time to undertake a more detailed analysis*"⁵² in its investigation. In a mergers case, the OFT receives submissions from the merging parties, takes evidence from third parties, and carries out a detailed assessment to establish whether the merger is likely to create a competition concern. The OFT was clearly of the view in 2000 having carried out this analysis that HCA's acquisition of London Bridge would not give rise to any significant lessening of competition. The CC has covered the same ground as the OFT in considering PPU's, PMIs and the strength of competitors in central London. It is not credible for the CC to argue that because it has access to "greater data" or more time, it is entitled to come to fundamentally different views about the market place.
- 4.63 The CC refers to "*decisions taken several years earlier*".⁵³ HCA repeats the point that, if the CC is arguing that the market has evolved in a way which justifies a very different assessment, it should indicate clearly how and in what way a highly competitive market in 2000 has changed into an uncompetitive market in 2014. There is no explanation of this in the PFs or in the PDR.
- 4.64 A cornerstone of the UK mergers regime is the principle of legal certainty: businesses engaged in mergers and acquisitions need to "know where they stand" in relation to regulatory approvals so that they proceed with investment decisions. An OFT decision approving a merger is final, unless it is judicially reviewed. The CC's use of a market investigation, to order divestiture of an asset which the OFT has permitted HCA to acquire, undermines the principle of legal certainty and creates a dangerous precedent which would

⁵¹ Para 2.93 of the PDR.

⁵² Para 2.93 of the PDR.

⁵³ Para 2.93 of the PDR.

mean in effect that merger decisions are not final and can be revoked in the future at the whim of a competition authority.

- 4.65 The OFT's decision was clear, unambiguous and unqualified. It stated that HCA was entitled to acquire the London Bridge, and that the acquisition would not raise competition concerns. It was so clearly of this view that it saw no need to refer the acquisition to the CC for a more detailed investigation. Neither the CC, nor any third parties, have sought at any stage to appeal against the OFT's decision. HCA relied on this decision, investing substantial funds to develop the hospital and a create world class, high-acuity facility. It is contrary to HCA's legitimate expectations, and an abuse of process, for the CC to seek to use a market investigation reference to overturn the OFT's earlier decision.

5. QUALITY AND INNOVATION

- 5.1 During the course of this inquiry, HCA has submitted a large body of evidence with regard to the role of quality and innovation in the private healthcare market, the importance of quality and innovation in HCA's facilities, the way in which this differentiates HCA's services from that of its competitors, and the level of HCA's investment in new clinical treatments, technologies and more broadly in its hospitals to raise the quality of care provided. There have been serious failures in the CC's approach to these issues. In some cases, the CC has simply ignored submissions on quality and innovation. In other cases, the CC has dismissed evidence without proper inquiry. Many of the CC's comments on quality and innovation in the PDR are just plain wrong.
- 5.2 These issues are of fundamental importance to the CC's assessment of the market and the impact of the proposed remedies:
- HCA's differential service offering is one of the factors which explains pricing differences between HCA and its competitors, and which therefore affects the CC's insured pricing analysis.
 - HCA's high quality and strong record of innovation demonstrates that the market functions competitively and benefits consumers by driving up quality, creating new services and improving clinical outcomes.
 - HCA in particular, and the market more generally, has delivered tangible relevant customer benefits ("**RCBs**") in terms of higher quality, greater innovation and a greater range of services in London.
 - The proposed divestment remedy would endanger the high levels of quality and innovation, both in HCA's remaining hospitals and in the divested hospitals, putting patient care at risk.
- 5.3 HCA's comments on quality and innovation have been set out in detail in previous submissions which are not repeated here:
- The CC's site visit to the Harley Street Clinic, attended by three of the five panel members, in which members and staff were able to see at first hand the standards of clinical excellence which this facility offers.
 - HCA's response to the CC's Issues Statement (see in particular Sections 3 and 16).
 - HCA's response to the CC's market questionnaire, which provides numerous examples of HCA's investment in new equipment and technology.
 - HCA's response to the CC's AIS (see section 3 in particular).
 - HCA's response to the CC's PFs (section 3 in particular deals with the role of quality and innovation in the private healthcare market in London).
 - HCA's response to the CC's Remedies Notice (sections 5 and 6), including the updated quality report in Annex 2 of that response.
 - HCA's supplemental submission following HCA's remedies hearing of 16 December 2013.
 - HCA's paper on the costs of divestment dated 18 December 2013.

5.4 HCA's services are differentiated from those of its central London competitors. It is not merely a question of whether any given HCA hospital is "better" than another hospital in terms of the standard of care delivered. The CC completely misses the point by randomly singling out, for example, the MRSA record of HCA as against that of other providers and using this one specific metric as the defining measure of quality (although, as discussed below, it is one amongst many indicators of quality and HCA can show that it has a better record on MRSA than other providers). The CC fails to grasp the very different nature of HCA's service offering compared to other central London providers which manifests itself in a variety of ways:

- (i) HCA's focus, to a far greater extent than other hospitals, has been on high-acuity, complex cases involving highly specialised clinical conditions. These are the type of services which are generally only treated within the NHS. These often require a very high level of specialisation and sub-specialisation within a given clinical field. These are not services which are widely replicated outside of the NHS.
- (ii) HCA has a deeper, i.e. better resourced clinical infrastructure than any other private provider as a result of years of targeted investment. This includes a larger number of level 3 ITUs and higher levels of staffing with RMOs, intensivists and nurses. This is what attracts consultants to HCA's facilities. Consultants find in HCA's hospitals an environment which replicates, within the private sector, the NHS facilities where most consultants have their primary post (what one consultant called "a mini-NHS"). No other private provider in London offers such an environment with the same levels of clinical support in terms of medical staff, specialist equipment and ancillary services.
- (iii) HCA also has a stronger record of using new, innovative treatments and technologies – numerous examples have previously been given to the CC. HCA has frequently been the first to introduce these technologies in the UK (e.g. CyberKnife, NanoKnife, Da Vinci robotic surgery, and RapidArc radiotherapy). Its record of trialling and using new treatments and diagnostic equipment is stronger than that of its competitors in central London and is to a large extent driven by its strategy of focusing on the more complex specialised treatments, where the pace of advances in medical technology is making a real difference to patient care.
- (iv) HCA caters for a larger proportion of patients with more difficult, complex high-acuity conditions. This means that, for example, its patients are more likely to have pre-existing co-morbidities which complicate the patient's condition and affect his or her treatment. This increases the cost of care and average episode charges – one of HCA's criticisms of the CC's insured pricing analysis is that it has failed to control for these differences in the level of care which is provided in the hospital. HCA has previously provided the CC with worked examples of how the differences in HCA's case-mix and the clinical conditions of patients can significantly impact on costs and make it very difficult to compare provider prices.
- (v) HCA has a substantial international business with [X] of revenue being derived from overseas patients. This is also a point of differentiation from many of its competitors. These tend to be patients with more complex, longer-term conditions who are willing to travel to London for the best clinical care. For example, many of HCA's neuro-rehabilitation patients are from overseas with a longer length of stay. HCA's strategy of focusing on higher acuity care has to a large extent been geared towards meeting the needs of these international patients, who would otherwise travel to major tertiary clinics in other countries such as the US, Germany, or Singapore.

- 5.5 These factors are closely interrelated. HCA's strategy over the last decade has been to consciously focus on specialising in high-acuity, complex conditions and create a private alternative to the NHS (where private provision did not previously exist). This has required high levels of continued investment and innovation to build the clinical specialisms and environment which can cater for these specialisms. In its response to the Remedies Notice, HCA for example showed how the London Bridge was transformed through investment in new services and treatments into a successful tertiary centre with a global reputation for excellence in high-acuity care. HCA is seen, both in the UK and especially in international markets, as a specialist provider of complex care, and this in turn attracts patients with more difficult, complex conditions. This is what sets HCA apart from other central London providers.
- 5.6 Indeed, the CC specifically notes that private healthcare is a "differentiated" market,⁵⁴ and yet the CC fails to carry out any meaningful assessment of the extent to which there is differentiation in the London market. The CC describes the market as "differentiated" but then treats all central London providers as homogeneous.
- 5.7 The CC's approach to assessing clinical quality and innovation in this inquiry has been poor. The CC has lost sight of the fact that it is investigating the provision of **healthcare**, where quality and innovation are of prime relevance to consumer needs. The CC case team has carried out little investigation of the issues, beyond relying on the views of PMIs and competitors, all of whom have a commercial motivation to support a divestment remedy. The CC is obliged to "have regard" to the effect of the remedy on RCBs and to consider any adverse effects on quality and innovation in its proportionality assessment. This requires something more than passive, uncritical acceptance of the views of PMI complaints. The CC could and should have:
- taken specialist advice from appropriately-qualified clinicians on these issues;
 - sought the views of relevant professional regulators and bodies such as Monitor and the Royal Colleges;
 - sought the views of consultants with experience of working at HCA and at other central London hospitals (contact names were previously provided to the CC); and
 - carried out its own comparative assessment of quality in different hospitals by seeking data from other central London providers.
- 5.8 HCA turns to the CC's observations on quality and innovation set out in Appendix 2.1 of the PDR and responds to the CC's specific points.
- Paragraph 108: "It is said, for example, that the average waiting time for surgery for its cancer care patients was 21 days, with a median of 8 days, compared with 62 days in the NHS. We thought that this comparison was not particularly informative since waiting lists for treatment are generally longer for NHS patients than in the private sector and this is a major factor for purchasing private healthcare".***
- 5.9 To put this into context, this is simply one statistic amongst many others which HCA has provided, using whatever information is in the public domain, to evidence HCA's strong record on quality. There are many other indicators which evidence HCA's quality record – see HCA's quality report on its website for numerous other examples, as well as the previous submissions listed above.
- 5.10 HCA fully accepts that benchmarking HCA outcomes against those of other UK private providers is difficult because of the lack of publicly-available information. This is precisely why HCA prepared and submitted to the CC on 19 December 2013 an updated quality report comparing and benchmarking its services against its private sector competitors in six clinical fields. The CC has selected the example of average waiting times – where the only publicly

⁵⁴ Para 30 of Appendix 2.1 of the PDR.

available information relates to the NHS – but where there are private sector comparisons, HCA has shown that it regularly performs strongly relative to its private sector competitors.

- 5.11 HCA would also point out that it has invariably taken the lead within the private sector in publishing its outcome data. If the CC looks at the websites or marketing literature of any other central London private provider, it will not find the same level of detailed clinical outcomes data as on HCA's website. HCA is proud of its quality record and strongly believes that greater transparency is in the interest of patients. HCA's major central London competitors publish far less outcomes data and this in itself is an indicator of the greater importance which HCA places on quality within its facilities. The London Clinic is in fact currently *delaying* the publication of outcomes data to PHIN. The lack of transparency of outcomes and performance data by HCA's competitors is one of the problems which patients face.
- 5.12 The CC observes that waiting times are generally longer for NHS patients and that "*this is a major factor for purchasing private healthcare*". HCA has previously pointed out to the CC that the PMIs are offering cash incentives to their subscribers to elect for NHS treatment rather than claim on their policy, which indicates that PMIs regard NHS treatment as a competitive alternative to private healthcare.
- 5.13 HCA repeats that the CC is able to carry out its own assessment (to take this example, of waiting times) by seeking information from other providers or by talking to consultants who work at rival facilities.

Paragraph 109: "Similarly, HCA compared its five-year survival rates for breast cancer with UK and England averages [...] but, and as was pointed out by AXA PPP, survival rates for breast cancer will be affected by many factors including the age of the patient, their social class and the stage of presentation. [...] did not believe it appropriate to express this performance data in terms of lives saved per year, as HCA has done".

- 5.14 This is a further example of where the CC is wholly reliant on casual views expressed by PMIs rather than carrying out its own inquiries. AXA PPP's view is wrong. Five-year cancer survival rates, both crude and age-standardised, are routinely used by health professionals and academics to make national and international comparisons.⁵⁵ The norm for risk-adjustment in breast cancer, when it is completed, is age-standardisation, not the "many factors" stated above. In fact, Cancer Research UK states that, "*There does not appear to be an association between female breast cancer mortality rates and socio-economic deprivation in the UK. Whilst breast cancer incidence is generally higher in more affluent women, so is breast cancer survival, which together mean deprivation has a minimal effect on mortality rates.*"⁵⁶ Therefore, HCA would contend that crude survival rates are appropriate for comparison, at least on an indicative level.
- 5.15 The statement that it is not "*appropriate to express this performance data in terms of lives*" is confusing. If it is not a hospital group's mission to save lives, then it is unclear what it is. There is no more appropriate measure, particularly given the ongoing push to display data for the public in a way that is tangible and relevant. Saving lives is exactly how Tim Kelsey, the National Director for Patients and Information at NHS England, provides information on the quality improvements due to transparency initiatives: "*In the years since British heart surgeons first published their data, their results have dramatically improved: survival rates for many procedures have increased by a third; **1,000 patients live each year when they might previously have died***".⁵⁷

⁵⁵ The Lancet 2010, Early Online Publication, December 22: Coleman MP, Forman D, Bryant H, et al. Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995-2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data.

⁵⁶ Cancer Research UK, accessed at <http://www.cancerresearchuk.org/cancer-info/cancerstats/types/breast/mortality/> 29 Jan 2014

⁵⁷ <http://www.england.nhs.uk/2013/11/05/tim-kelsey-4/>

Paragraph 110: "HCA compared itself with a broader basket of hospitals as regards infection control. It compared the all England average rate of MRSA infection with its own, saying that its rate was five times lower. We noted, however, that King Edward VII Hospital, a private sector competitor, claims never to have had a case of hospital-acquired MRSA".

- 5.16 HCA provided these statistics because this is an example of where there are comparisons of private sector competitors published on the Public Health England website. It is merely one of numerous indicators of quality, and it is absurd for the CC to pick this out as the sole measure of comparison.
- 5.17 Furthermore, if the CC wishes to focus on infection rates, HCA would point out that it has lower rates of MRSA (and other infections such as C Difficile and MSSA) despite the fact that patient activity is higher, transfers in from other hospitals (including the NHS) are accepted, and length of stay is longer because of higher complexity of treatment. For example, even when comparing HCA against King Edward VII Hospital, the data shows that between 2009 / 2010 and 2012 / 2013, the King Edward VII Hospital had 2.2 cases of MRSA per 100,000 days compared with HCA's 1.4 cases per 100,000 days.
- 5.18 The point that HCA is making in quoting these statistics is twofold:
- (i) There is no "perfect" overall measure for quality, however HCA performs very strongly compared to its private sector competitors across a whole range of different indicators and benchmarks which need to be considered in the round; and
 - (ii) HCA is the only private sector provider which publishes how it performs against a wide range of quality metrics, because of the importance it places on quality. That in itself speaks volumes about the clinical environment which HCA offers relative to that of other central London providers.

Paragraph 111: "Elsewhere, HCA compared itself with other private providers but did not always include its closest competitors. For example, in its case study of breast cancer it compared itself to BMI, Spire and Nuffield but not TLC, which is a closer competitor to HCA, and went onto suggest that one risk to patients of the proposed divestiture would be lack of access to breast MRI, though TLC did offer this".

- 5.19 This is incorrect. HCA submitted to the CC on 19 December 2013 a revised report on its quality offering (Annex 2 of its response to the Remedies Notice) which contained six case studies. These specifically include a comparison with the London Clinic. It is not clear why the CC has ignored this, and it is a further example of evidence being disregarded.
- 5.20 The first case study (section 6 of the report) deals with breast cancer and specifically compares HCA's breast cancer network with London Clinic's offering (see pages 19 and 20). The London Clinic does not offer the same integrated clinical pathways for breast cancer treatment, lacking patient navigators, IORT, integrated pathology and access to leading clinical trials. The case study examines the implications of this, with care being less co-ordinated, more time-consuming and in some cases resulting in sub-optimal treatments. HCA invites the CC case team to read the report. HCA accepts that quality comparisons can be difficult, but would point out that the London Clinic has not joined PHIN, unlike the vast majority of other private providers, and therefore is not making conscious efforts to allow for quality comparisons.

Paragraph 111: "In another comparison it referred to the significant numbers of RMOs that it employed and contrasts this unfavourably with other private hospital operators. However, since HCA owns many more private hospitals with ICU facilities in central London than other operators, we do not find this particularly informative. Further, it was not evident that a suitable acquirer would employ fewer RMOs in the particular circumstances of acquiring HCA's hospitals".

- 5.21 HCA employs significantly more RMOs in each of its hospitals than any other private provider. More than that, many of its RMOs are specialists rather than generalist RMOs. The CC will note that HCA's competitors (e.g. the London Clinic or the Cromwell) have facilities

which are comparable in size with each individual HCA hospital. It is therefore entirely possible to make a "like for like" comparison between individual facilities. When adjusted on a per-admission basis, HCA has twice as many RMOs per admission than the London Clinic. It is an example of where HCA has consciously decided to invest in higher levels of clinical staffing to cater for more complex conditions. [X]

- 5.22 HCA clearly submitted to the CC that the London Clinic (and other rival hospital operators) generally do not "employ" RMOs onsite and instead opt to use on-call RMOs sourced from agencies. The latter is admittedly cheaper, as the RMO is called in defined situations, such as the consultant not being available. However, HCA is committed to employing [X] full-time RMOs to provide "round-the-clock" excellent care to often very sick patients.
- 5.23 It is indeed the case that HCA has more extensive ICU facilities in its hospitals. This, too, is part of HCA's strategy to gear its services towards more complex, high acuity conditions requiring level 3 facilities. HCA is making the simple point that the higher levels of staffing form part of a better resourced clinical infrastructure which other private providers do not provide, and this is how HCA is differentiated from any of its competitors.
- 5.24 It would have been open to any other private provider to pursue the same strategy as HCA over the last 10 years, and develop the same levels of intensive clinical care in their facilities. This is entirely a function of the strategy which a provider wishes to pursue. The fact of the matter is that none of HCA's central London competitors, including the London Clinic, has pursued the same focus or engaged in the same level of investment risk in developing these types of services.

Paragraph 112: "... we also reviewed CQC inspection reports concerning its London hospitals ... CQC reports on TLC, King Edward VII, Sister Agnes and the Royal Marsden PPU were as positive as HCA's".

- 5.25 CQC standards are a basic test of acceptability for hospitals, not a true measure of the degree of quality that hospitals can (and should) provide. Of the 2,424 hospital-based inspections with a registered result listed on the CQC website in the past year, almost 90% have met all standards. There will obviously be significant variations in the quality of care delivered by these hospitals.
- 5.26 The CQC looks at 16 "Essential Standards" – these are the bases of care and imperative for a sound foundation to build a quality programme. There is a large amount of room to grow above these Essential Standards. As evidence, one can look to the recent implementation of the CQC Intelligent Monitoring tool in which the CQC is attempting to improve its processes as it recognises additional factors as being important to quality.
- 5.27 Therefore, the fact that there are other hospitals which meet CQC standards is meaningless. This does not imply that they all offer the same infrastructure or quality of care or meet the same clinical outcomes. To suggest on the basis of CQC audits that the London Clinic, King Edward VII, Cromwell and HCA all offer the same level of quality is incorrect. Perhaps more informative is the fact that HCA is the only private provider group which has never had a major non-compliance identified by the QCQ at any of its hospitals.
- 5.28 Beyond the CQC inspection process, HCA has also pursued accreditations across a wide array of international organisations including:

	HSC	Lister	LBH	PH	PGH	WH
Bupa Cancer Services Network Recognition	✓	✓	✓	✓	✓	✓
Bupa Services Network Recognition		✓				✓
CHKS Risk & Safety	✓	✓	✓	✓	✓	✓
CHKS Leadership & Corporate Management	✓	✓	✓	✓	✓	✓
CHKS Oncology	✓	✓	✓			
CHKS Maternity				✓		
Investors in People			✓			
ISO 9001	✓	✓	✓	✓	✓	
Hospitality Assured	✓	✓	✓		✓	
HFEA Certified		✓				
Human Tissue Authority Certified		✓	✓		✓	✓
Local Supervisory Authority (midwifery) Statutory				✓		
Commission on Accreditation of Rehabilitation Facilities						✓
JACIE			½			
JAG on GI Endoscopy Accreditation		½	½		½	½
Royal College of Perfusion Scientists	½					

5.29 No other private provider can demonstrate the same level of accreditation or meeting the same metrics as HCA. No one provider has been able to claim the same level of quality across as many different areas as HCA.

Paragraph 113: "...but that we did not have sufficient evidence to conclude that its service quality was higher than that offered by close competitors in central London, for example TLC and King Edward VII, that do not have access to the HCA network. However, as we concluded in our Provisional Findings, there is currently very little comparative performance information available on which to assess hospital operators' service quality".

5.30 HCA has submitted six case studies, many of which provide direct comparisons between HCA and its direct competitors in London including the London Clinic. The CC appears to have ignored this evidence.

5.31 The CC is reminded that, in a divestment case, it has a particularly high burden of proof. The Tribunal has called for particularly "*vigorous investigation and analysis*" in cases where the CC is recommending intrusive remedies.⁵⁸

5.32 The differentiation in HCA's facilities is plain to see if the CC carried out the appropriate level of inquiry: the high levels of specialisation in HCA's hospitals; the more challenging, complex cases it receives; the higher levels of intensive care and the supporting infrastructure to service this; and the more widespread use of new, innovative treatments and equipment.

⁵⁸ *Barclays Bank Plc v Competition Commission* [2009] CAT 27, para 128.

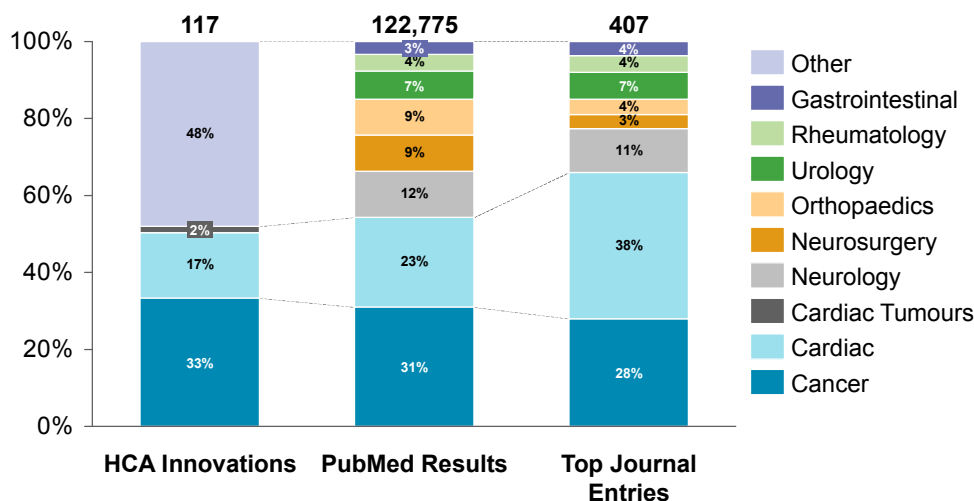
- 5.33 It would also be open to the CC to contact and speak to consultants who have experience of working in the different facilities. HCA has provided the CC with names of consultants who would be very willing to discuss their experiences. The consultants are better qualified than the CC to comment on differences in clinical quality and services. In addition, many consultants have written directly to the CC indicating precisely how divestment would adversely impact on their clinical practices – the CC is able to contact them to understand their concerns in more detail.
- 5.34 HCA agrees that there is only limited performance information which is currently available. However, there is some, and on all the metrics which HCA has provided, HCA outperforms its competitors. The fact that quality is difficult to measure does not absolve the CC of its duty to consider what evidence there is and make an appropriate level of inquiry.

Paragraph 115: "We thought that a large proportion of the innovations cited by HCA were concentrated in cancer care and resembled innovations introduced in leading NHS institutions or concerned drug trials that any hospital can participate in, the trial drugs in question being provided free by the relevant pharmaceutical company".

- 5.35 Many of HCA's innovations are in the field of cancer care. This is a core clinical service for HCA, [✂] It is not clear why the CC dismisses these or considers that these innovations are less relevant to the argument. Innovations such as CyberKnife, NanoKnife, and IORT have delivered substantial benefits in terms of improving clinical outcomes and saving patient lives. As explained in HCA's response to the Remedies Notice, HCA has often been the first to introduce and utilise these innovations, providing the stimulus for other private providers and the NHS to use them.
- 5.36 Some of these innovations have previously been adopted by the NHS. However, even in this case, HCA has typically been the first to introduce these in the private sector – taking the investment risk in these technologies – and stimulating other private hospitals to follow suit. HCA can point to many new clinical treatments and services which it has introduced and which were not previously available outside of the NHS (see paragraph 5.20 of HCA's response to the Remedies Notice). HCA's earlier adoption of these innovations, such as CyberKnife, RapidArc radiotherapy, and Gliolan, have incentivised other private hospitals to introduce similar treatments. HCA has therefore created a private market in these services which was not previously available.
- 5.37 HCA would add that there are also many instances in which it has introduced new, innovative technologies which were not available within the NHS. HCA provided examples in paragraph 5.16 of its response to the Remedies Notice. CyberKnife is a case in point. HCA's Harley Street Clinic introduced the first CyberKnife in 2009. It was subsequently taken up more widely by the NHS at Mount Vernon, Barts and the Royal Marsden.
- 5.38 It is not true that HCA's innovations are overly concentrated in cancer care. Please refer to Annex 3 of HCA's response to the Remedies Notice, which itemised many of these and explained their applications. There are 117 new clinical treatments and processes which HCA has been the first to launch in the UK. Of these, 39 relate to cancer, 20 to cardiac treatment, two to cardiac tumours and 56 to other specialities.
- 5.39 The CC refers to HCA's drug trials. HCA's Sarah Cannon Research Institute ("**SCRI**") has a unique cancer drug trial and development programme. SCRI is a global research organisation focused on conducting clinical trials in oncology and cardiology. Its UK clinical trials unit allows private and NHS patients to participate in clinical trials which are not accessible anywhere else. It is indeed open to patients in other hospitals, and the drugs are provided free by pharmaceutical companies. However, this does not detract from the fact that HCA has invested heavily in creating and developing the SCRI and this is unique within the private sector. As one of the largest clinical research programmes in the world, SCRI is often selected to run trials which would not otherwise come to the UK. As an example, SCRI is running the AZ5363 phase 1B trial for prostate cancer. No other private provider offers this service and no other UK private hospital pursues research and development programmes. It is precisely because HCA has ownership and control over SCRI that it was able to enter into

a cutting-edge collaboration with UCL to provide genetic molecular profiling of cancerous tumours. There is no other central London hospital operator that can claim to be so closely engaged in such collaborative innovation. Although the pharmaceutical company provides the drugs, the SCRI carries out the research and runs the clinical trials. HCA can therefore justly claim that this is a significant innovation within the UK private sector.

5.40 Assessing the balance of trends in innovation over the past decade can be informative. An indicative assessment can be found by performing a broad, unfiltered search on the search engine PubMed and through reviewing top medical journals (the Lancet, the NEJM and the BMJ). This is clearly a rough analysis, but should be indicative of the trends over the past decade in the medical field.⁵⁹ As shown below, HCA's pattern of investment in innovations mirrors those of the market:



Paragraph 115: "Some examples of innovation, for example its adoption of commercially-available software such as Mosaik were difficult to characterise as innovation".

5.41 The CC is confusing "invention" and "innovation". According to the OED definition, to "invent" is to "create or design something that had not existed before"; "be the originator of" while to "innovate" is "to make changes in something established, especially by introducing new methods, ideas or products". In relation to Mosaik, HCA's use of Mosaik is not an "invention" but it clearly is an "innovation".

5.42 Mosaik is a purchased software package, however, the ability to manipulate and use the software is totally dependent on the sophistication and application of the user. LOC has devised the application for Mosaik and provides significant development support to improve upon the existing product, and has been closely involved in its development and customisation. HCA has been recognised by the developers and worked with them to co-produce various editions of the software, acting as a user-developer. LOC was identified as the most sophisticated user among the 3,000+ centres based in the UK and leads the field in improving the established product – which is exactly how innovation is defined.

5.43 LOC's input into the development of the software has led to substantial patient benefits, including:

- live audit capabilities to ensure patient care is top quality;
- integrated use of LOC's defined oncology pathways and protocols;

⁵⁹ Search performed using: Article Title Keywords: new OR novel OR trends OR developments OR advances OR advancements OR innovations OR emerging OR recent and: past 10 years Top Journals include: British Medical Journal, The Lancet and New England Journal of Medicine.

- a truly paper-free environment at LOC, reducing the risk of loss of data; and
- the ability to capture far more data on patient interactions providing all required information to the consultants a patient may see.

This kind of innovation has a large impact for HCA's patients and for patients elsewhere – it has been adapted for use in other situations, it enhances quality for patients and it drives continuous improvement.

- 5.44 The CC has picked out Mosaic, but there are numerous other new techniques or technologies, in and outside of cancer care, within HCA hospitals. Staying with examples of innovative IT systems, HCA provided a list of these in para 6.36(iv) of its response to the Remedies Notice. These include amongst other things the PatientKeeper web-based system which allows consultants to remotely access "real time" patient information, allowing for comprehensive, remote patient monitoring. HCA's introduction of this system won the Laing & Buisson Award for Innovation in 2009 and was described by Forbes Magazine as one of the "*technologies that could change healthcare*".⁶⁰ This is merely one of numerous examples which have been provided to the CC, but on which the CC makes no comment.

Paragraph 115: "We did accept that HCA had demonstrated that it had been willing and able to adopt new techniques or technologies. However, this was in some cases in response to innovations introduced by other private hospitals. ... we therefore thought that the greater rivalry, which we consider will arise from our remedy, will provide a further stimulus to innovation rather than blunt incentives to innovate".

- 5.45 HCA wholeheartedly agrees with the CC's observation that HCA has adopted new techniques or technologies "*in response to innovations introduced by other private hospitals*". This is precisely the point which HCA has been making to the CC since the inception of this inquiry, and this issue goes to the heart of HCA's criticisms of the CC's AEC findings. The CC has thus far focused its attention entirely on price competition and has ignored competition on quality and innovation in its assessment of the London market. HCA considers that there is substantial evidence of lively and dynamic competition in terms of the development of new clinical services, the introduction of new, innovative surgical and diagnostic equipment, and the creation of new care pathways, which has driven up quality and improved clinical outcomes.
- 5.46 HCA also agrees that the competition it faces in the UK and internationally has spurred it to make investments to stay ahead of its competitors. This, too, is a core part of HCA's case. There are numerous examples of HCA developing new technologies and treatments in order to "stay ahead of the game". Equally, there are many instances in which HCA has been the first to develop innovative treatments, which are then adopted by private sector competitors, e.g. HCA's Harley Street Clinic introduced the first CyberKnife in 2009, which was followed by the CyberKnife facility at the London Clinic, and there are now eight such facilities in the UK. HCA strongly believes that there is vigorous competition between hospitals in London over quality and innovation and this has contributed to London's international reputation as a leading centre for tertiary care. While there may be examples of where HCA has responded to innovations by rival hospital operators, the overall evidence (as documented in HCA's response to the PFs), is that HCA has the relatively better track record of investing in innovative care and has been the first to market with several clinical procedures and treatments. The CC has not presented any evidence to the contrary, nor indicates how innovation would be accelerated through divestment.
- 5.47 However, as HCA sets out in **Annex 2**, the CC's inference the change in market structure (i.e. reduction in concentration) arising from the CC's proposed divestment remedy will increase competition, and that this will thereby increase incentives to innovate, is not supported by robust economic evidence. Such a claim must be grounded in relevant economic theory and supported by robust evidence. However, HCA submits that it is not. Indeed, in markets where innovation is important, higher competitive intensity can be associated with a greater level of concentration.

⁶⁰ Farrel, M [2006] *Seven Technologies that could change Healthcare*: www.Forbes.com.

5.48 HCA reminds the CC that it has not in its AEC findings identified any concerns over the level of competition in quality and innovation in London – indeed, it has consistently failed to take any note whatsoever of the way in which the market has evolved through the introduction of new techniques over the last few years. There is no finding of AECs in relation to either quality or innovation. It is therefore wholly irrational for the CC to try to justify a divestment remedy on the basis that this would "provide a further stimulus to innovation". As far as quality and innovation is concerned, there has been no adverse finding which justifies any remedy at all. The CC has never remotely suggested that there is insufficient rivalry in quality and innovation or that the levels of quality and innovation are not what would be expected in a competitive market. There is therefore a fundamental lack of logic in the CC's argument that divestment will provide a further stimulus to innovation.

Paragraph 117: "We consider that HCA's evidence on choice of treatment showed that it had, to a certain extent, widened the range of, in particular, high-acuity treatments available outside the NHS. We noted that other hospitals in central London, however, for example TLC, had adopted a similar strategy".

5.49 This does not do justice to the evidence that HCA has led the way in creating new goods and services in London. The CC has apparently carried out no analysis of the wider breadth of new services which HCA has introduced relative to its rivals.

5.50 Under Section 134(8) of the Enterprise Act 2002, relevant customer benefits expressly include "*greater choice of products or services*". HCA has taken considerable investment risk through a strategy of developing highly specialised, high-acuity treatments which were previously only available within the NHS. HCA has in effect created a private alternative to the NHS in tertiary treatments such as cancer, cardiac and neuro-sciences. There are various examples provided in paragraph 5.20 of HCA's response to the Remedies Notice.

5.51 The success which HCA has had in developing these services has encouraged other private providers, such as the London Clinic, to follow suit and improve their offering. That in itself is evidence of a competitive market at work. However, HCA has invariably demonstrated its leadership in introducing new high-end treatments, which are then subsequently adopted by other private providers.

5.52 The fact also remains that HCA's offering of high-acuity, complex clinical treatments is greater than that of other private providers in London. For example, the London Clinic is larger in size than the London Bridge, but does not offer the same range of complex specialisms including cardiac surgery, the treatment of infectious diseases, rehabilitation medicine or vascular surgery. The Bupa Cromwell is similar in size to the Princess Grace but does not offer a number of complex specialities, including emergency medicine and the treatment of infectious diseases.

5.53 However, even if it is the case that HCA is not unique and that other private providers in London have also to some extent contributed to a greater choice of goods and services, the fact remains that the market as a whole has delivered the RCB of a greater choice of goods and services which the CC needs to take into account in its analysis. The market in London has evolved considerably over the last decade. If the CC compares the range of services offered now with the services offered 10-15 years ago at the time of HCA's acquisition of the St. Martin's Healthcare Limited, there is far greater choice of clinical treatments within the private sector presenting patients with an alternative to the NHS. Annex 4 to HCA's response to the Remedies Notice charts how the London Bridge has expanded its service offering since HCA's acquisition of it in 2000. That is a clear customer benefit which the CC needs to take into account in its assessment of the market. It sits oddly with the CC's concern that there is a competitive failing in the market.

Paragraph 123: "If cited, for example, its nursing ratios, including that it operated a [...] patient/nurse ratio in its paediatric ITU and [...] in cancer, contrasting this with the 1:4 cancer care nurse/patient ratio "observed" at TLC. Since HCA is the only private hospital operator to have a paediatric ITU in central London, we do not find the statement informative and we note that the claimed patient/nurse ratio at TLC is HCA's assessment".

5.54 The CC has not read HCA's evidence. Paragraph 4.103 of Appendix 4 of HCA's response to the PFs compares HCA's nursing ratios (across all of its services) with the London Clinic's nursing ratios (likewise, across the whole hospital). The comparison is not restricted to particular ITUs or service lines. Please read the section in the Appendix, together with footnote 58. The London Clinic figure is not "HCA's assessment", but is taken from the London Clinic's website. This clearly states: "*The nurse to patient ratio is very good with one nurse looking after no more than four patients*", i.e. a 1:4 ratio. Furthermore, the comparison is not at all rendered uninformative by the fact that HCA offers paediatric ITU care, as the proportion of paediatric ITU beds is very small and would not materially affect the overall nurse to patient ratio.

Paragraph 130: "We thought that the unique benefits of the pathways between HCA's facilities had been over-stated since we thought that they applied mainly to cancer treatment, and even then only to a limited range of hospitals and other facilities including the Harley Street Clinic and LOC".

5.55 This is incorrect. HCA has developed integrated care pathways across multiple inpatient and outpatient facilities in relation to cancer care, and in relation to multiple specialities, including cancer. These are described more fully in HCA's quality report. Cancer is indeed an important service line within HCA, and there are well-developed care pathways in cancer care. However, it has also developed similar pathways in other clinical services. The report on quality provides an example in relation to neuro-surgery (section 8), cardiac care (section 10), and orthopaedic care (section 11).

5.56 As previously explained in HCA's quality report, the care pathways within HCA's network create a number of benefits:

- Seamless transfer of patients between hospitals, which enable facilities at individual sites to be accessible to all patients.
- Quality functions can be centrally shared and therefore larger and better equipped, raising the standard and consistency of care.
- Activity can be focussed at certain locations, giving complex activities the "critical mass" needed for specialisation and safety.
- Benchmarking across the network is used to improve quality and drive innovation.

5.57 The CC's observation that HCA's cancer care pathways relate "*only to a limited range of hospitals and other facilities*" is also wrong. For example, HCA provides substantial volumes of lung cancer surgery at the London Bridge. Its patients can then seamlessly transfer their care to LOC for treatment (if that is closer to their home) or they can receive chemotherapy under their LOC protocols at London Bridge – this is particularly beneficial for patients in south London. Additionally, if a patient has fertility concerns due to their chemotherapy treatment, they can be seen at the Lister for consultation and support. All of HCA's hospitals are included in its cancer care pathways.

5.58 The divestment of the London Bridge and Princess Grace would cause considerable disruption to patients, certainly in cancer care but also in other clinical areas. [X] patients seen at the Princess Grace in 2013, [X] were subsequently referred to one of HCA's other hospitals, i.e. [X] **of patients were relying on services elsewhere within HCA's network.** For example, HCA has located the Breast Cancer Institute, its centre of excellence for breast cancer, at the Princess Grace. This clinical centre relies on an infrastructure and expertise drawn from throughout HCA's network. Cutting this centre out of the network and isolating it

from HCA's clinical facilities will weaken it and lower the quality of care in breast cancer currently available to the patients of the Princess Grace and to the patients of HCA's other hospitals.

- 5.59 HCA's report on quality describes very specifically the way in which specialised clinical services are focused at particular facilities, and the way in which HCA patients can access treatment at different facilities depending on how their conditions develop, together with case studies based on real patient experiences. These case studies illustrate the better clinical outcomes which are made possible by treating the different stages of a patient's condition within HCA facilities as opposed to multiple referrals to different hospitals. The CC has not sought to discuss or engage in any way with HCA on these case studies, and the PDR ignores three of them. If the CC questions these case studies, it should indicate why. These are ultimately matters of clinical judgment and it is open to the CC to seek its own medical advice on these issues if it does not accept the views of HCA's clinical team. However, it is unacceptable for the CC to dismiss these as "over-stated" without explaining why.

Paragraph 132: "Even were this not to be possible, consultants could still refer patients to or treat them at the facilities at the Princess Grace hospital, under its new ownership, just as they are currently able to refer patients to, for example, LOC for chemotherapy but TLC for radiotherapy".

- 5.60 The difficulties of consultants outside HCA hospitals from referring patients into HCA facilities have already been discussed above. The CC is grossly underestimating the problems this would create for very sick patients who need urgent treatment.
- 5.61 There are three potential concerns regarding patient referrals. The first is that patients will not be able to benefit from the seamless access to services, such as imaging and diagnostics, that HCA offers across its network. The second is the decrease in the network benefits available to patients, including such best practice as multi-disciplinary partnerships. Finally, the lack of integration and seamless pathways may lead to a decreased likelihood of referral, with consultants wishing to avoid the complication of multiple hospital systems or concerns over decline in quality.
- 5.62 For example, a patient being treated for breast cancer at HCA will receive best in class treatment from HCA's centre of excellence in breast cancer at the Princess Grace, but also potentially chemotherapy treatment through LOC. When she attends these appointments at different facilities, her records will be completely accurate and up to date, with her latest scans and test results immediately available. Her case will be discussed in a multi-disciplinary team meeting with consultants from across HCA's network to determine the best possible treatment and she will be referred into HCA's support programmes provided for all its cancer patients.
- 5.63 Consequently, even if HCA can replicate some of the services at the Princess Grace (on the basis of considerable additional investment), the point remains that patients at the Princess Grace will no longer have the fully-integrated care provided by the network. Similarly, a cardiac patient at the London Bridge would no longer have access to the multi-disciplinary team that brings in expertise from the Wellington or the Lister or access to the rehabilitation facilities at multiple locations. The real patient benefits are due to the integrated nature of the network – they do not exist if a physician must refer to multiple separate hospitals with little or no integration.
- 5.64 As stated above, a fragmentation of pathways runs contrary to what the NHS is currently seeking to achieve in order to improve quality standards. It increases the risk of communication error or delay, and it increases the risk that early warning signs are not identified due to fragmentation. These are genuine concerns about the decline of patient care caused by passing patients among multiple, disjointed providers.

Paragraph 134: "For instance, HCA cited its investment in Intraoperative Radiation Therapy (IORT) which it said would not be possible unless leveraged across several hospitals. However, AXA PPP told us that IORT could be delivered using mobile technology, could be purchased on a per-patient basis and was currently being installed at the, stand-alone, Montefiore hospital in Hove".

5.65 HCA provides IORT through a stationary machine at the Princess Grace. The benefits of IORT are well-known and referred to in HCA's quality report. HCA was the first private hospital to acquire the Intrabeam machine that is in use at the Princess Grace and it has benefited patients across HCA's network since October 2012.

5.66 There are mobile options in the field of IORT that allow transfer between surgical suites and even hospitals, if desired. The mobile technology however has a number of technical limitations. Furthermore, the logistical challenges including storage, transport across London, treatment setup and radiation protection for multiple suites, as identified by the American Association of Physicists in Medicine,⁶¹ convinced HCA to invest in a stationary suite that could be provided to all patients across the network.

5.67 The use of "per-patient" fees by Montefiore Hospital is a financing tool that can make sense for those organisations that are not able to provide sufficient upfront capital to invest in the equipment. Regardless of the owner, a certain volume of patients is required to justify the investment. In this case, Advanced Oncotherapy will be looking to maximise the utilisation of its machine. The argument for a network to provide sufficient volume remains.⁶²

Paragraph 139: "We thought that the network benefits in terms of quality of patient care claimed by HCA were generally over-stated from the patient's perspective since these could be replicated by a consultant referring his or her patient to the most appropriate facilities irrespective of who owned or operated them".

5.68 This is wrong. Network benefits cannot be replicated following divestiture.

5.69 For medical professionals, one of the advantages of using hospitals within the same group is that there is standardisation of patient care, systems, data capture and reporting, information provision for revalidation and flexibility to allow for a truly individualised care for their patients. There is risk inherent in moving patients to hospitals where their full records, history and diagnostic / pathological results are not readily accessible. Fragmentation of the clinical governance system is very likely to result in poorer clinical governance to the detriment of patients.

5.70 As stated above, [§] of cancer patients at the Princess Grace relied on services at other HCA facilities. This would simply not happen if the Princess Grace is sold. It is uncommon for patients to be transferred from one independent hospital to another. Patient records cannot be immediately transferred because of patient confidentiality. Non-network consultants are not linked into the consultant forums and multi-disciplinary teams at HCA hospitals and therefore will be less familiar with the facilities and services which HCA can offer to deal with particular conditions.

5.71 Indeed, the whole of medicine is moving towards models of care based on networks to provide integrated care pathways. This is happening in the NHS as witnessed by the fact that the NHS is currently going through the process of concentrating services into fewer, larger centres of excellence, to create critical mass, drive up quality, and encourage sharing of best practice.

⁶¹ Beddar et al, "Intraoperative radiation therapy using mobile electron linear accelerators: Report of AAPM Radiation Therapy Committee Task Group No. 72", pub 28 April 2006; accessed at: https://www.aapm.org/pubs/reports/RPT_92MPSynopsis.pdf 3 February 2014.

⁶² Advanced Oncotherapy Press Released; accessed at <http://www.londonstockexchange.com/exchange/news/market-news/market-news-detail.html?announcementId=11557258> 3 February 2014.

5.72 HCA has previously provided the CC with an NHS booklet which explains the NHS restructuring in cancer and cardiac services within London: see HCA's email of 18 November 2013 to [X] which enclosed the NHS leaflets on cancer and cardiovascular services. This document explains the need for better integrated pathways by consolidating NHS services in the capital. This highlights many of the points which HCA is making above. See for example page 6:

"Clinicians think they could save more lives if expert teams were seeing a higher volume of patients in large units. Seeing more patients with the same condition would allow dedicated teams to develop and keep improving their skills – especially in areas where surgical techniques change quickly.

Medical advances also mean that clinical teams are specialising in specific types of cardiac surgery. It is not possible for clinicians to develop particular expertise in this field in hospitals seeing a low or average number of patients

Only large centres are able to have specialist surgeons and other staff available 24 / 7

Centralising care would ensure people needing urgent expert help can get it 24 hours a day, 7 days a week. ...

Clinicians think they can help achieve better cardiovascular outcomes if, rather than working separately on two nearby sites, they combine their specialist academic and clinical services on a single campus. This would provide a better environment for sharing best practice, engaging trainees and encouraging high quality research opportunities. It will also help improve outcomes because more patients will be able to take part in clinical trials.

Clinicians recommend developing a single integrated cardiovascular centre at St. Bartholomew's Hospital with the Royal Free Hospital remaining as a second heart attack centre. They believe this would provide the best outcomes for patients.

5.73 HCA draws the CC's attention to these initiatives in the NHS. They provide independent evidence of the benefits of integrated care pathways and the disruption to quality of care which arises from fragmentation. The CC need only contact the NHS directly to take its own evidence on this issue.

5.74 The NHS is pursuing this type of integration across a wide spectrum of tertiary services including cardiac, cancer, and stroke treatments, not only in London but right across the country. Network-based care is the future of healthcare. HCA has created a private system that mirrors the benefits in the NHS, including multi-disciplinary teams, shared services, training and quality systems that are shared across all specialities in the network.

6. PROPORTIONALITY OF THE DIVESTMENT REMEDY

(1) Legal framework

6.1 HCA has set out in its earlier submissions a summary of the relevant legal framework which governs the CC's consideration of remedies and the principles of proportionality which the CC is required to observe in considering remedies: see in particular section 3 of HCA's response to the Remedies Notice. In summary, the proportionality of the remedy requires that the remedy:

- is *effective* in achieving its legitimate aim;
- is *no more onerous* than needed to achieve its aim;
- is the *least onerous* if there is a choice between several effective measures; and
- does not produce *disadvantages* which are disproportionate to the aim.

The proportionality of a remedy means, as Lord Diplock described it, "*in plain English, you must not use a steam hammer to crack a nut, if a nutcracker would do*".⁶³

6.2 The CC has failed to demonstrate how the highly draconian and intrusive remedy of divestiture can be justified as appropriate in HCA's case. It has not correctly considered the proportionality of the remedy or carried out a balancing exercise reflecting the principles developed in the case law. The PDR discloses no reasonable basis for such a remedy.

6.3 Divestment may be an appropriate remedy in certain areas of competition policy. Its use in a market investigation could only be justified in highly exceptional circumstances in which there are substantial competitive failings in the market and divestment is the only feasible way in which the market can be opened to competition.

6.4 In the very different context of merger control, divestiture may in appropriate cases be a logical and appropriate remedy to address the competition problems which a merger has created. In that context, the completion of the merger may have given rise to an immediate, structural change in the market. If the merger is found to create a significant impediment to effective competition, divestment of the acquired business may be the appropriate solution to preserve the status quo ante and re-establish the market structure at its pre-merger level. If a merger has not been consummated, prohibition will be the effective remedy unless there are appropriate behavioural remedies which can be imposed. If the merger has been consummated, divestiture will generally be the appropriate alternative. However, that is a very different application of a divestment remedy which has no analogy with divestiture in a market investigation. In the present case, there has been no act or transaction analogous to a merger situation which has led to an identifiable structural change in the market justifying such a remedy.

6.5 There is a possibility of divestiture in the case of competition law infringements. However, even in this case, divestment is considered an exceptional remedy. The EU Modernisation Regulation, Council Regulation 1 / 2003, makes provision for the European Commission to impose both behavioural and structural remedies for breaches of EU competition law. However, recital 12 notes: "*Structural remedies should only be imposed either where there is no equally effective behavioural remedy or where any equally effective behavioural remedy would be more burdensome for the undertaking concerned than the structural remedy*". They are also subject to a proportionality test. It is notable that even in the case of significant breaches of competition law, a divestment remedy has never been imposed at either UK or EU level.

6.6 HCA reminds the CC that in the private healthcare market investigation there is no allegation of any wrong-doing or any breach of the law by any of the parties subject to the divestment remedy. The CC is not suggesting (and has no grounds to suggest) that the hospital

⁶³ *R v Goldstein* [1983] 1 WRL 151, 155B.

operators are in breach of any provisions of competition law under Chapter I of the Competition Act 1998 / Article 101 of the TFEU or Chapter II of the Competition Act 1998 / Article 102 of the TFEU. This is not a case in which it is being alleged that HCA is engaging in any agreements or practices which prevent, restrict or distort competition. The circumstances for using divestment in cases where there is no allegation of any breach of the law or any wrong-doing would be even harder to justify than in cases involving competition law infringements (which as indicated above, would only justify divestiture in exceptional circumstances).

- 6.7 A market investigation under the Enterprise Act 2002 is aimed at investigating and addressing industry-wide market features rather than single firm conduct. It is concerned *"with something different from particular anti-competitive agreements or abuses of dominant position" and is aimed at "identifying, analysing and, where appropriate, remedying industry-wide or market-wide competition problems which there is no adequate basis for addressing under CA98"*⁶⁴. Under the market investigation regime, a divestiture remedy aimed at a particular operator would therefore be an extremely exceptional tool to remedy a competition problem in the markets for which there would need to be a compelling case.
- 6.8 The only case, possibly the paradigm case, under the market investigation regime in which divestiture has been imposed and upheld by the courts has been *BAA*. This involved a monopoly business where there was *"a complete absence of competition"* and *"almost total market failure"* and demonstrably high barriers to entry which made new entry inconceivable.⁶⁵ Divestment was in that case a market-opening measure to create new entry which otherwise would not have occurred. For the reasons which have been extensively set out in HCA's responses to the PFs and the Remedies Notice, the features of the private healthcare market in London bear no comparison whatsoever with the *BAA* case. In central London alone, HCA competes with six other private providers and 16 NHS PUs and most of these competitors have grown substantially in recent years. The CC cannot therefore justify divestment as being the only way in which competition can be created and fostered. There has been new entry in London, and strong evidence that the market is continuing to grow and attract new operators. This represents a quantum leap from the circumstances which may have justified a divestment remedy in the *BAA* case. The CC has failed to show how the "nuclear option" of divestment can remotely be justified in relation to the private healthcare market in London.
- 6.9 The remedy of divestiture is subject not only to the standard proportionality tests under English law, but also to the European Convention on Human Rights ("**ECHR**"). Divestiture represents a fundamental interference with HCA's property rights. The CC has a duty under Section 6(1) of the Human Rights Act 1998 not to act in a manner incompatible with the ECHR, including Article 1 of the First Protocol which protects and safeguards property rights. The European Court of Human Rights has stated: *"A fair balance must be struck between the demands of the general interest of the community and the requirements of the protection of the individuals' fundamental rights, the search for such a fair balance being inherent in the whole of the Convention. The requisite balance will not be struck where the person concerned bears an individual and excessive burden"*.⁶⁶ There is therefore a very high burden of proof on the CC to justify the forced sale of assets.
- 6.10 The CC is contemplating the forced sale of two hospitals, representing [X] HCA's UK revenue. It is proposing to take away a very substantial part of a business which HCA has built up through years of strategic investment. This is a grossly disproportionate remedy, even if the AEC findings are correct.

⁶⁴ OFT Guidance, "Market Investigation references", para 2.2.

⁶⁵ *BAA Limited v Competition Commission* [2012] CAT 3; para 9.1 of the CC's report on the supply of airport services by BAA.

⁶⁶ *Amato Gauci v. Malta* (2011) 52 ECHR 25.

- 6.11 HCA refers to section 6 of its response to the Remedies Notice, which sets out why the CC's divestiture remedy fails the proportionality test:
- The CC's AEC findings, even if well-founded, do not provide the basis for such an intrusive remedy.
 - Divestiture would not be effective in addressing the alleged AECs.
 - The divestiture of the hospitals would give rise to substantial adverse effects for quality, innovation, and patient care which would outweigh any conceivable benefits which the CC may claim.
 - It would also extinguish RCBs.
 - It is not the least onerous remedy, since there are alternative measures which would address the alleged AECs.
 - The CC's methodology in identifying the hospitals subject to divestiture is flawed, and the CC has not identified the smallest divestment package which would address the alleged AECs.

The CC has not adequately addressed any of these issues. HCA comments as follows on the CC's analysis in the PDR of the proportionality of a divestiture remedy.

(2) Effectiveness of the remedy

- 6.12 HCA has previously set out its reasons why divestiture would not be effective in addressing the CC's alleged AECs (see in particular paragraphs 6.15 – 6.29 of HCA's response to the Remedies Notice):
- (i) Divestment is unlikely to lead to any significant price reductions in central London if (as the CC indicates) a new owner of the hospitals pursues a similar strategy to HCA.
 - (ii) There are significant risks that a new purchaser would not provide the same breadth of high-acuity, complex clinical service lines and therefore divestment would not create an effective competitor to HCA's remaining hospitals in the particular services in which HCA specialises.

There is no considered analysis or robust evidence in the PDR about the likely effectiveness of the remedy in terms of either reducing prices, increasing quality and innovation or creating a new competitor to HCA.

- 6.13 The CC repeats the proposition that divestiture would give rise to a reduction in prices, but there is no evidence that this is likely to happen:
- (i) The CC continues to refer to its belief that HCA's prices are higher relative to its central London competitors, but as previously discussed this is based on a seriously flawed analysis, both of insured prices and of self-pay prices. HCA repeats its criticisms of the CC's assessment of prices which have been fully set out in earlier submissions. These simply cannot be used as the basis for an argument that prices are likely to fall as a result of divestiture – as discussed further in **Annex 2**.
 - (ii) The CC has not carried out any analysis of the extent to which any price reductions would be passed through by PMIs to their subscribers – this is discussed further below.
 - (iii) The CC has underestimated the extent to which divestiture would result in the loss of economies of scale, both for HCA's remaining hospitals and for the divested

hospitals – this is also discussed in subsection (5) below (and in more detail in **Annex 2**).

- (iv) In addition, the CC has carried out no proper analysis of how divestiture would change PMI bargaining power to the extent that PMIs would achieve lower prices from either HCA or the divested hospitals. As HCA has previously shown in responding to the PFs and Remedies Notice, the CC's findings about PMI / hospital negotiating power are very tentatively expressed and do not unequivocally assert that either PMIs or hospitals have the "upper hand" in any negotiations. The CC would need to show how, in the context of these findings, the divestment would significantly improve the bargaining position of PMIs in such a way that they would secure price reductions. The CC merely states that "*PMIs would be in a strong position to drive down both the new owner's or owners' and HCA's prices, since they could credibly switch volume from one to the other and to TLC*".⁶⁷ The CC has not modelled this; it has failed to give this any consideration whatsoever. It is pure assertion, unsupported by any economic evidence that any price reductions would arise.

6.14 As far as the effects on quality are concerned, the CC at least appears to acknowledge the risk that "*the purchasers and/or divesting firms might seek to re-position themselves both vertically, in terms of quality, and horizontally, in terms of the type and range of services they offer were they to judge that this would be more profitable*".⁶⁸ However, the CC concludes that suitable purchasers are likely to have "*the ability and incentive*" to pursue a strategy which does not disadvantage private patients in terms of quality or range of services, and indeed cites benefits from the proposed divestiture in terms of higher quality and increased incentives to innovate.

6.15 The CC makes a number of errors in its assessment:

- (i) The remedy can only be effective if the divested hospital continues to provide the same quality and range of services – if it does not, the divested hospital(s) will no longer be offering a choice to PMIs / consumers and it would not be creating new competition to HCA's remaining hospitals. The CC appears to be accepting that there may well be a "re-positioning" in terms of quality or range of services but this would not "disadvantage" private patients. That, however, is not the point. The issue is whether there will be effective competition in HCA's existing services – in HCA's view, there will not, and the remedy is therefore ineffective in achieving any change in the competitive environment. Can, for example, the CC be confident that the purchaser would offer paediatric intensive care services to rival those of HCA? It cannot, and therefore it cannot say that divestment would create an alternative to HCA in these specialist activities.
- (ii) As discussed above in section 5, the CC has failed to take into consideration HCA's differential service offering which is demonstrated by the much higher levels of specialisation and sub-specialisation which its hospitals offer relative to other competitors in central London. Its belief that a purchaser is "*likely to adopt a similar strategy to HCA*"⁶⁹ is not actually based on any assessment of the breadth and depth of HCA's clinical offering relative to those of other providers.
- (iii) The CC claims that as part of its "*approvals process*" it "*could be reasonably sure that the new owner would have the ability to pursue such as strategy*".⁷⁰ The CC has no power either to *require* a purchaser to provide a particular quality or range of services, or to *ensure* that this is maintained in the foreseeable future.

⁶⁷ Para 85 of Appendix 2.1 of the PDR.

⁶⁸ Para 2.109 of the PDR.

⁶⁹ Para 126 of Appendix 2.1 of the PDR.

⁷⁰ Para 2.117 of the PDR.

- (iv) HCA also notes that one of the CC's divestment conditions is that a purchaser of the divested hospitals should not currently have any hospitals in proximity to these businesses. This condition would appear to rule out any existing central London provider. On that basis, all existing London providers of tertiary services would be excluded from purchasing these hospitals. It is therefore very difficult to see which other potential purchasers could show that they have the experience, expertise and track record to pursue the same strategy as HCA.

6.16 The CC believes that divestment will be effective in improving quality and increasing the incentive to innovate. The basis for this view is simply that divestment increases the number of hospital operators and that this change in market concentration enhances competition to improve quality. Again, the CC's decision making is flawed for the reasons set out in detail in **Annex 2** and summarised below:

- (i) The CC has conducted no assessment of the current level of quality offered in London, and is therefore totally uninformed as to whether there is already an "optimal" level of quality offered to the market based on existing competition. In short, the CC is "shooting blind" with its divestment remedy.

- (ii) The CC has constructed a view that lower market concentration means higher quality without citing any underlying economic theory or any supporting evidence to support this view. The CC assumes a simplistic relationship between market structure and quality, whereas prevailing economic theory and market evidence in fact shows that in markets where investments are important there is no straightforward link between market structure, the strength of competition and, ultimately, quality and innovation.⁷¹ As noted in a 2013 OECD report (to which the CC contributed) on the Role and Measurement of Quality in Competition Analysis, the report noted:

"The relationship between quality and the degree of competition within a market is uncertain and equivocal both in theory and practice, a feature that tends to complicate the task of including quality considerations within any competition analysis. Unlike prices, which generally fall as competition increases, increased competition can either cause quality levels to rise, if firms begin to compete more vigorously in relation to quality attributes, or to fall, if the need to reduce prices leads to a concomitant reduction in quality as production costs are cut. For this reason the relationship between quality and price is also somewhat indeterminate, and dependent upon the particular market forces at issue".⁷²

- (iii) The CC assumes, without any underlying economic theory or supporting evidence, that two smaller hospital operators would have the same ability and incentive to invest in quality and innovation as a single, larger hospital operator.

6.17 HCA reminds the CC again that a number of third parties (other than the main two PMIs, Bupa and AXA PPP, on whom the CC relies for much of its economic analysis) have in their responses to the PFs and Remedies Notice expressed doubts about the extent to which divestment will make any difference to the competitive landscape in London:

- Aviva, in its submission, queries whether there would be any reduction in price: *"Aviva has previously provided evidence that the acquisition of a hospital facility by a hospital operator has resulted in immediate price increases at that facility. We have concerns that if a different operator acquires an HCA facility there is a likelihood it will be taken over as a "going concern", and so continue to be run in the same way with the same staff. It is difficult to see in this situation how, at least for an initial period, there will be much impact on price".⁷³*

⁷¹ See Annex 2.

⁷² OECD, Role and Measurement of Quality in Competition Analysis, 2013, Page 7.

⁷³ Aviva's response to the Remedies Notice, page 4.

- Simplyhealth observes that: "*divestiture would have very few consequences for the existing competitive constraints*" and, like Aviva, queries whether divestiture would not in fact lead to increased prices "*resulting in patients and PMI providers paying more for medical procedures in central London*".⁷⁴
- PruHealth likewise submits that "*It is unlikely that the divestment programme would significantly change the profile of charges incurred*" and believes that "*the status quo of costs charged would merely be replicated by the new purchaser*". PruHealth doubts that divestment "*would benefit the market*".⁷⁵

(3) PMI cost pass-through

Introduction

6.18 HCA strongly rejects the CC's conclusion that the proposed remedies would lead to any price benefits for customers, unless there were to be a significant drop in quality. However, even if there were to be any price reductions from the CC's proposed remedies, HCA strongly disagrees with the provisional conclusions that insured patients would benefit in any meaningful way. There are three main reasons for this:

- First, the CC has not considered the important issue that PMIs cannot be treated as "customers". PMIs' incentives are not aligned with those of patients;
- Second, it is not clear whether and to what extent PMIs would have an incentive to pass these benefits on to final consumers (i.e. large corporate customers, SMEs and individual policyholders) by charging lower premia. The CC needs to explain why PMIs would not just increase their profits; and
- Third, there is evidence showing that PMIs have not passed on cost reductions in the past. Market data already submitted by HCA in its supplemental submission following HCA's remedies hearing shows that PMIs have been able to increase profits and decrease loss ratios over recent years. However, the CC has not taken this into account in considering benefits to patients.

PMIs cannot be treated as "customers" as their incentives are not aligned with those of patients

6.19 HCA submits that the CC cannot draw any meaningful conclusions about the scale of benefits arising from its provisional remedies without analysing the competitive dynamics of the PMI market. As noted above, this includes understanding the interactions between PMIs and patients, and it also requires consideration of the misalignment of PMIs' incentives with patients' interests. After purchasing their private healthcare policy, at the point of requiring treatment policyholders will be keen to obtain high-quality treatments to maximise their clinical outcome in return for their premia. However, it is in the interests of PMIs to reduce the cost of claims as far as possible. As HCA has highlighted to the CC, widening the availability of treatments or the quality of those treatments whilst in the patients' interests does not necessarily align with the PMIs' incentive to reduce claim costs.⁷⁶

6.20 Further, PMIs trade off prices and quality in a different way from the ultimate consumers, namely patients. PMIs may not have the right incentives to promote, or even monitor, the provision of high quality healthcare. The CC raised a very similar issue in relation to monitoring in the context of the ongoing Motor Insurance Market Inquiry, where one of the AECs the CC has provisionally found is the "*(i) lack of effective monitoring by insurers and CMCs of the quality of car repairs; and (ii) significant limitations in consumers' own ability to*

⁷⁴ Simplyhealth's response to the Remedies Notice, pages 1-2.

⁷⁵ PruHealth's response to the Remedies Notice, pages 3-4.

⁷⁶ Paras 1.8 – 1.12 of HCA's supplemental submission following HCA's remedies hearing.

assess the quality of repairs, with the result that cars are too often not repaired to the standard to which consumers are entitled".⁷⁷

- 6.21 This misalignment of PMIs' and patients incentives is fundamentally different from most other industries where there is a clear vertical chain. Insurers are not "customers", but rather producers of a complementary product. In their dealings with the hospital operators, PMIs cannot be trusted to ultimately act in the interest of their clients. As the CC itself knows from other current market investigations, incentives in the insurance market can act against the interest of final consumers. This prevents the CC from simply ascribing any "benefits" it claims will flow from insurers to insured patients. Given these issues, HCA considers that the CC's assessment of the effectiveness and proportionality of its proposed divestiture remedy is flawed. In particular, HCA strongly believes that PMIs would retain any price benefits arising post divestment – if any are realised through the supposed increased competitive constraints on HCA (and BMI in the local areas where its divestitures are proposed) – rather than passing them on to customers. As discussed in more detail in **Annex 2**, this, in turn, undermines the results of the CC's calculation of net present value of divestitures which, as a result, substantially overestimates the benefits to consumers/patients arising from the divestment remedies.

The CC has not undertaken any detailed analysis of pass-through to final consumers or provided sufficient evidence to support its assumptions

- 6.22 The CC notes that *"in the case of insured patients, economic theory indicates that even a monopolist would pass through a proportion of the reduction in cost, with a competitive market resulting in substantially all the benefits being passed to patients".⁷⁸*
- 6.23 Leaving aside any assumptions as to whether the provisional remedies suggested by the CC would result in lower prices (which HCA contends would not be the case), HCA considers that the theoretical assertion made by the CC and its attempt to understand potential pass-through is over-simplistic. As set out above, PMIs cannot be treated as "customers" of private hospital operators, and therefore the theoretical framework used by the CC as set out in the paragraph above (based on a possible range of market configurations going from highly competitive markets to monopoly) to argue that there will be some degree of pass-through is not relevant in this particular case.

Competitive setting, elasticity of demand and curvature of the demand curve affect the degree of pass-through

- 6.24 First, HCA notes that the nature of competition in the PMI market affects the level of pass-through. Academic evidence shows that the higher the degree of competition in an industry, the higher the pass-through rate. Weyl and Fabinger, for instance, surveyed five fundamental principles of tax incidence under perfect competition to successively more general imperfect competitive settings (i.e. monopoly, symmetric imperfect competition and imperfectly competitive models). Their theoretical model shows that the pass-through rate depends on both the competitive setting and the elasticity of demand. The authors also found that under imperfect competition the curvature of demand curve is central to the cost pass-through.⁷⁹
- 6.25 Although the CC itself notes that *"while the extent to which PMIs would pass through lower costs will depend on the level of competition in the insurance market, economic theory suggests that this will range from full to partial depending on the nature of competition in the PMI market"*,⁸⁰ it has still not sought to analyse competition in the PMI market. It seems therefore obvious that the CC must either take a conservative approach in estimating the

⁷⁷ Para 5(b) of the CC's Private Motor Market Insurance Market Inquiry Investigation PFs, December 2013.

⁷⁸ Para 2.75 of the PDR.

⁷⁹ Weyl G. E., Fabinger M., 2013, "Pass-Through as an Economic Tool: Principles of Incidence under Imperfect Competition", Forthcoming in the Journal of Political Economy.

⁸⁰ Para 2.532 of the PDR.

degree of pass through or take a close look at the PMI market in order to assess the magnitude of the pass-through rate.

- 6.26 As suggested in the academic literature, in order to understand the degree of pass-through, the CC should assess competition in the PMI market. This is important to understand the benefits arising from the proposed divestiture remedy and the proportionality of the remedy. The oligopolistic structure of the PMI market, with four major PMI providers (i.e. Bupa, AXA PPP, Aviva and PruHealth) accounting for 87% of the market in 2012 indicates that the degree of pass-through is likely to be low. HCA believes that a thorough assessment of the PMI market is crucial when it comes to understanding the degree of pass-through, and, ultimately, assessing the proportionality of the remedies proposed by the CC.
- 6.27 In the absence of any quantitative or qualitative analysis on the factors influencing the magnitude of the pass-through, HCA believes that the CC should rely on actual evidence of any pass-through. HCA discusses this evidence below.

The CC has insufficient evidence to assert significant pass-through to large corporate customers

- 6.28 In the PDR, the CC considers pass-through for different customer groups. It divided the PMI market into large corporate customers on the one hand and SMEs and individuals on the other.⁸¹ With respect to large corporate customers, the CC has taken as given AXA PPP's assertion that "*the private medical insurance market for large corporate customers is highly transparent, with pricing based on the cost incurred by insurers in the previous period*". This, according to the CC, "*tended to indicate that a significant proportion of the cost reduction would be likely to be passed through in this segment*".⁸²
- 6.29 HCA considers that the CC is correct to consider different groups of policyholders separately as each broad group displays different demand characteristics and negotiate private healthcare policies with PMIs in different ways. The correct framework for considering how prices are agreed between PMIs and corporate customers is a bargaining framework, with corporate customers bargaining over the price they agree to pay and the quality and range of services included in the package. However, the CC has not sought to understand this at all or how the relative bargaining position of corporate and PMIs may affect the degree of pass-through. Instead, it has only relied on the assertion of a single PMI. HCA strongly considers that one piece of anecdotal evidence about transparency of the market is not sufficient to show that a significant proportion of price benefits post divestment are likely to be passed to large corporate customers.
- 6.30 In a bargaining framework, prices depend on the inside and outside options that the PMIs and large corporate customers have when they negotiate the terms of their contracts. This represents a further element of complexity that the CC cannot neglect as it directly impacts on the degree of pass-through, and ultimately the effectiveness and proportionality of the proposed remedies. HCA believes that this issue is particularly relevant in London given the large presence of corporate PMI customers.

The CC has failed to undertake any analysis of pass-through to SMEs and individual policyholders

- 6.31 With regard to SMEs and individuals, the CC simply notes that "*economic theory indicates that at least a proportion of the price benefits resulting from any divestiture remedies would be passed on to policyholders, even if the PMI market were not fully competitive*".⁸³ The CC has not undertaken any analysis of the degree of pass-through to these customer groups of any cost-savings arising from the claimed reduction in hospital prices post-divestiture. Instead, it assumes that these policyholders will benefit to some undefined extent. HCA considers this highly inadequate to support the CC's claimed effectiveness and proportionality of the divestiture remedy. Indeed, the CC's position implies that only a

⁸¹ Para 2.75 of the PDR.

⁸² Ibid.

⁸³ Para 2.76 of the PDR.

proportion of the net present value calculation benefits will be enjoyed by patients and any additional benefits (in HCA's view the majority) will simply be transferred to PMIs.

- 6.32 Furthermore, as noted above, the degree of pass-through depends on the elasticity of demand for PMI cover and the curvature of the demand curve. However, the CC has not sought to understand either of these.
- 6.33 As HCA pointed out in its supplemental submission following HCA's remedies hearing, a feature of PMI provision for individual policyholders is customer lock-in which arises due to medical conditions policyholders develop whilst holding a PMI policy which would not be covered (or only at a prohibitively high cost) if they were to switch to an alternative PMI. These captive PMI policyholders face considerable barriers to switching in response to changes in the value of a PMI's offering. As HCA has already highlighted to the CC in its supplemental submission following HCA's remedies hearing, estimates from the US⁸⁴ suggest that 20% to 66% of the adult population (with a midpoint estimate of 32%)⁸⁵ reported having medical conditions in 2009 that could result in a health insurer denying coverage, requiring higher-than-average premia, or restricting coverage through the use of exclusionary terms. PMIs are able to identify those policyholders with pre-existing medical conditions and set policy premia to exploit their inability to switch. For this potentially large number of locked-in policyholders, PMIs would have no incentive to pass through any reduction in costs arising from divestiture. The CC therefore must exclude this customer base from its analysis of any price benefits flowing from the divestment remedies. In order to do so, the CC should have obtained information from PMIs as to the number of policyholders with pre-existing medical conditions to undertake this analysis.

Market evidence does not support the CC's conclusions on pass-through

- 6.34 As explained above, in the absence of qualitative and quantitative evidence of the degree of pass-through, HCA considers that the CC should rely on actual market evidence. HCA's views that any PMI cost reductions post-divestiture would not be passed on to consumers are supported by evidence of PMI financial performance over recent years. As HCA has highlighted to the CC in its supplemental submission following HCA's remedies hearing, PMIs have been able to extract increases in premia above the increase in claim costs. For instance, Bupa's loss ratios⁸⁶ decreased from 76% to 72.5% between 2009 and 2012 whilst profits before tax increased by 49% and the costs of claims decreased by around 2% (as shown in **Figure 6.1** below).⁸⁷

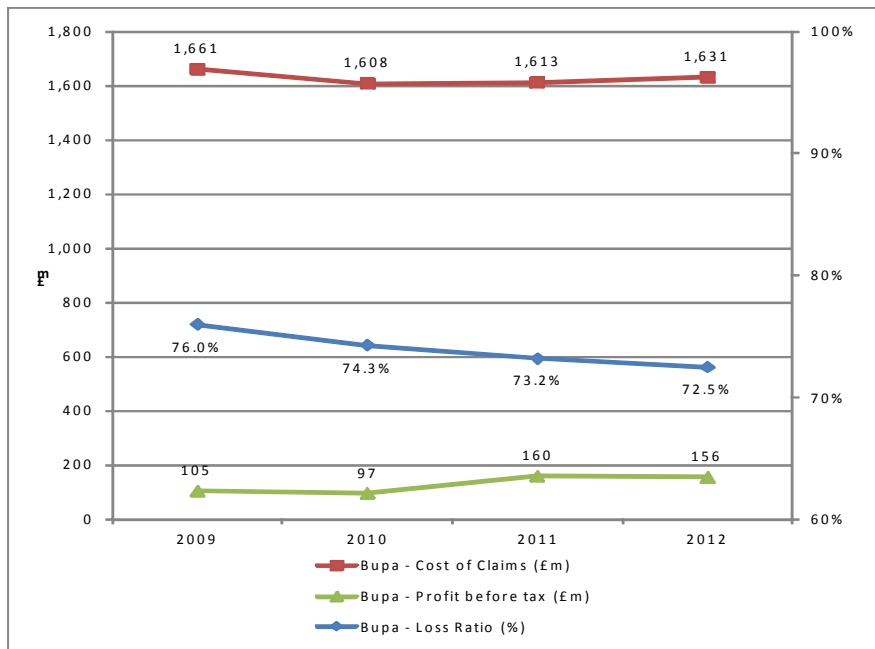
⁸⁴ United States Government Accountability Office, Report to Congressional Requesters, Private Health insurance, March 2012. Available at: <http://www.gao.gov/assets/590/589618.pdf>

⁸⁵ This range depends on the list of conditions used to define pre-existing conditions in each of five US estimates.

⁸⁶ Loss ratios are defined as the cost of claims as a proportion of premium income.

⁸⁷ Paras 1.25 – 1.26 of HCA's supplemental submission following its remedies hearing, December 2013.

Figure 6.1 – Bupa loss ratios and cost of claims over time



Source: HCA analysis of Laing & Buisson data

- 6.35 As the loss ratio has been declining, the evidence above suggests that Bupa has been able to extract increases in premia above the increase in claim costs thus achieving increased profits.⁸⁸ In HCA's views this shows that PMIs have not passed any cost savings on to policyholders in the past which strongly suggests that they would not do so if there were any cost reductions linked to the proposed divestitures. The CC has failed to consider the evidence put forward by both HCA and BMI⁸⁹ and explain why, other than from a theoretical perspective, it would expect to observe a different outcome in the PMI market in the future.
- 6.36 Additionally, the CC has not sought to understand the extent to which a price reduction would affect PMIs' variable costs. HCA has already stressed that PMIs' payments to HCA constitute only a limited proportion of their overall costs of claims and there are numerous policies offered to customers that exclude HCA. The growing trend towards open referral policies and restricted networks also allows PMIs to ensure that their policyholders are not treated at HCA hospitals. Therefore, if there were any price reductions post divestiture of the London Bridge and Princess Grace, this would affect only a limited number of PMI policies and in all likelihood have a minimal impact on a PMI's variable costs.⁹⁰ Whilst HCA does not have sufficient information on PMI's costs to ascertain the precise impact of any reduction of its prices on each PMI's variable costs, it considers that the CC should have obtained the relevant information from PMIs to enable it to undertake this analysis.

(4) Price benefits of divestment

- 6.37 Notwithstanding HCA's submissions concerning the lack of effectiveness of the CC's divestiture remedy, HCA submits that divestments will not generate the price benefits estimated by the CC. In particular, these benefits have been grossly overstated due to a methodology that features a number of fundamental flaws.

⁸⁸ As HCA has presented in its supplemental submission following its remedies hearing, these conclusions hold for AXA PPP as well.

⁸⁹ Para 2.15 of the PDR. The CC stated that BMI argued that the lower prices that PMIs with market power had achieved in the past did not appear to have been passed on in lower premia for customers.

⁹⁰ Para 1.17 of HCA's supplemental submission following its remedies hearing, December 2013.

- 6.38 The submissions summarised below are set out in further detail in **Annex 2**.
- 6.39 HCA and a number of other parties have pointed out serious flaws with both the price concentration analysis ("**PCA**") and insured price analysis ("**IPA**"). It is evident that CC has not engaged with any of the issues raised by HCA and other parties, and has not left itself any time to consult with affected parties.
- 6.40 In particular, the PCA does not have any relevance to London or to HCA: the PCA omitted episodes from a large number of HCA's competitors; it focused on four treatments that are completely unrepresentative of HCA's business; and its results are driven by one operator (Nuffield Health), which is not active in London. As such, the PCA cannot inform in any meaningful way the analysis of price benefits that the CC estimated in the case of the proposed HCA divestments in central London.
- 6.41 In its estimation of the price benefits from the proposed divestment, the CC incorrectly applied results from its analysis of self-pay patient pricing to insured patients, and vice versa. This is totally inconsistent with the CC's assessment in this inquiry of the different nature of competition for self-pay and insured patients.
- 6.42 The PCA analyses only UK inpatients. However, the CC, when estimating the price benefits, also incorrectly applied the results of the PCA to international patients, as well as to day-case patients and outpatients, without any robust justification or supporting evidence. Likewise, it incorrectly applied the results of its IPA to outpatients, without any robust justification or evidence.
- 6.43 Even if one accepted the CC's framework for the assessment of price benefits using the PCA (which HCA does not), once the application to inappropriate groups of patients has been corrected, the estimated price benefits from the proposed HCA divestments are less than £0.98 million per year – **in short, the CC has overestimated these benefits by a factor of nearly 10**.
- 6.44 As for the CC's approach to the estimation of the price benefits of divestments based on the IPA, the CC has not found sufficient evidence to show a robust (i.e. statistically significant) difference in episode charges between HCA and the London Clinic, especially considering that the CC failed to properly control for quality, costs and episode acuity. As a result, the CC has no evidence for it to conclude that price benefits would not actually be nil.
- 6.45 Even if one assumed that the IPA was methodologically sound, the evidence resulting from it cannot be seen as supporting the argument that HCA charges higher prices as a result of its level of market share. Indeed, the IPA shows that prices at the King Edward VII were higher than those prevailing at HCA. Since King Edward VII is a standalone charitable hospital with a considerably smaller market share, this shows that the CC's argument that HCA has market power because of its higher market share is inconsistent with observed market outcomes.

(5) Economies of scale and other costs of divestment

- 6.46 The Guidelines state that the CC will consider economies of scale or scope and the extent to which they translate into lower prices or higher quality, and may therefore constitute an RCB⁹¹. In this section, HCA summarises the evidence on economies of scale and scope in relation to lower costs, and how that translates into lower prices for consumers. The submissions summarised below are set out in detail in **Annex 2**.
- 6.47 HCA provided detailed and considered evidence on the likely losses of economies of scale and scope at HCA's remaining facilities arising from the proposed divestments.⁹² This evidence is informed by its considerable experience and close knowledge of its own business. Despite this, the CC has not properly taken this evidence into account:

⁹¹ CC3 Guidelines for market investigations, para 362.

⁹² HCA's paper on costs of divestment, December 2013.

- The CC simply assumes, without any supporting evidence, that HCA will be able to make greater central cost savings than HCA's own evidence shows.⁹³
- Instead of addressing HCA's submissions, the CC's opts to compare trends in HCA's EBITDA and revenues over time, suggesting that this shows HCA has not realised economies of scale. HCA considers that this analysis is inadequate as the increase in revenue to which the CC refers was driven by growth in patient numbers, which would not be associated with step changes in costs arising from changes in the number of hospitals operated by HCA. Furthermore, HCA considers that EBITDA is not a reliable measure of changes in HCA's costs over time.
- The CC's application of BMI's assumptions on loss of scale economies to HCA's costs is highly inappropriate. It is very unlikely that BMI's centrally provided functions and their associated costs directly mirror HCA's or would provide an "equivalent" model for HCA's business. HCA's operational and hospital network structure, which features six tightly integrated hospitals in London, is markedly different to BMI's, yet the CC has made no allowance for this.
- The CC's argument that economies of scale have not been passed onto consumers, and therefore would not constitute an RCB, hinges solely on its fundamentally flawed IPA.

6.48 The CC has no evidence for its assumption that no costs associated with the loss of economies of scale at the divested hospitals should be factored in to its analysis. The CC has proposed a specific purchaser criteria, however, the economies of scale (from a quality and cost perspective) realised by HCA are significantly driven by the geographic proximity and tightly integrated nature of HCA's hospital network. As there is simply no other equivalent network in existence in London, it is extremely difficult to see how the CC can credibly expect to identify a prospective purchaser, even one with an existing hospital network outside of London or the UK, that is capable of matching the cost and quality benefits generated by HCA's hospital network in London.

6.49 HCA sets out its further analysis on the possibility of reducing central costs following the proposed divestments in **Annex 2**. It is HCA's hope that, on this occasion, the CC decides to fully consider and engage with this evidence.

6.50 **Annex 2** shows that the CC's base case and "downside" case significantly downplays the loss of economies scale. The evidence shows that the proposed divestment will lead to a cost of [§<] in terms of a reduction in HCA's economies of scale and scope, which should be included in the CC's net present value ("**NPV**") calculation. This reflects the realities of HCA's business and the actual extent to which it would be able to scale back central costs following the divestiture of the London Bridge and Princess Grace.

(6) Effect on quality, innovation and patient care

6.51 HCA has set out in section 5 above the CC's failure to properly evaluate quality and innovation in HCA's facilities, the clinical benefits of HCA's integrated care pathways and the adverse consequences flowing from a divestment remedy in terms of clinical outcomes.

6.52 HCA explained its concerns in its response to the Remedies Notice that divestment would harm the benefits and synergies which its network of six closely integrated hospitals has created.⁹⁴ HCA also submitted its updated quality report providing detailed evidence of specifically how divestment would affect the quality of care in six services (breast cancer; prostate cancer; neurosurgery; blood cancer; cardiac care; and orthopaedic care). As HCA explained, these provide examples based on actual patient experiences of how the disruption of integrated care pathways would lead to poorer clinical outcomes for patients, and that there would be similar effects across all its clinical services.

⁹³ Para 2.133 of the PDR.

⁹⁴ Paras 6.30 – 6.71 of HCA's response to the Remedies Notice.

6.53 The quality benefits of HCA's networks have been fully set out and include:

- HCA's ability to offer fully integrated care pathways, which allow for comprehensive diagnosis and treatment of all aspects of a patient's condition depending on the cause of the patient's illness.
- Multidisciplinary teams which bring together leading specialists from different disciplines to provide the highest quality treatment of complex conditions.
- Swift and seamless referral of patients between facilities so that they can access specialist diagnostic and clinical services right across the network.
- Collaborative forums to allow consultants from all of HCA's facilities to discuss best practice, share clinical know-how and come forward with new ideas.
- A highly sophisticated IT infrastructure, not replicated anywhere else in the UK private sector, which provides consultants with up to the minute information on patient records and allows the bedside monitoring of patients.
- Patient volumes which support the business case to invest in highly specialised treatments and equipment which would otherwise not be viable.
- The ability to transfer staff between facilities to support business needs.
- Higher levels of clinical governance because of the ability to share best practice and spread know-how across all facilities.

The impact of divestiture on these network benefits has been carefully described, assessed and where possible quantified.

6.54 There is virtually no reference to or discussion of these issues in the PDR. They do not feature in the CC's consideration of the balancing of the costs and benefits of divestiture. Indeed, as noted above, the CC incorrectly asserts that the divestment will result in improvements in quality and innovation, rather than costs, which it claims make its NPV estimates conservative. As set out in detail in **Annex 2**, HCA strongly submits that this is not the case.

6.55 HCA has also submitted to the CC a table with its assessment of the economic costs which would arise as a result of a divestiture remedy. In this table, HCA identified the adverse impact on quality, innovation and patient outcomes and sought where possible to quantify these. These included:

- The reduction in the range of treatments which would be available to HCA's remaining patients and patients at the divested hospitals.
- Lower levels of investment in new equipment and clinical services in the future, both within HCA's remaining hospitals and in the divested hospitals.
- The disruption to clinical pathways and the impact this would have on patient care and continuity of treatment.
- The loss of clinical know-how and expertise.

HCA pointed out that the CC has an obligation to take into account all consumer detriments whether or not they are capable of quantification. The Tribunal has expressly stated that "*An inability to quantify the benefits of a proposed measure does not justify simply disregarding the issue...while "spurious accuracy" should be avoided, difficulties of precise quantification did not absolve the Commission from conducting the next best assessment*".⁹⁵

⁹⁵ *Tesco Plc v Competition Commission* [2009] CAT 6.

- 6.56 The CC has also ignored all of these consequences. It is not that the CC has considered but wrongly rejected them. The CC has simply not taken any account of these costs and detriments in its analysis.
- 6.57 The only mention in the PDR of any of these issues is in Appendix 2.1, paragraphs 127-132 which deals with the disruption of HCA's care pathways:
- (i) The CC argues that the unique benefits of the pathways between HCA's facilities are over-stated and apply mainly to cancer. This is simply wrong, and has been discussed above (see paragraphs 5.55 to 5.59 above).
 - (ii) The CC alleges that HCA could preserve the RCBs from its care pathways following divestiture by replicating "*the imaging and diagnostic facilities, including breast MRI, elsewhere ...*". This is wrong, and ignores the evidence which HCA has provided. There are a number of unique service lines within the London Bridge and Princess Grace Hospitals which HCA will no longer be able to access (see costs of divestment table, pages 4 and 5). Many of these would require substantial capital investment and, with the reduction in patient volumes, but are unlikely to be economic. For example, the total cost of the London Breast Institute Programme at the London Bridge has been [§<] There would in any event be disruption to the continuity of patient care even if HCA in future developed similar facilities.
 - (iii) The CC also argues that consultants at divested hospitals could continue to refer their patients to HCA's remaining hospitals. This is discussed above (see paragraphs 5.60 to 5.64 above) and is incorrect.
- 6.58 The CC has given wholly inadequate consideration to the adverse effects on quality, innovation and patient care. HCA can only repeat the evidence and submissions which have already been provided to the CC. A failure to consider these issues shows that the CC has not properly considered the proportionality of the remedy.

(7) Net present value of divestiture

- 6.59 In order to assess the proportionality of the divestiture, the CC has estimated the NPV of the proposed divestitures. It uses its assessment of the costs of divestiture and the proposed price benefits and discounts of these over a 20 year time period to reach the conclusion that the divestiture of the London Bridge and Princess Grace, "*does not produce disadvantages that are disproportionate to the aim since the likely price and quality benefits of requiring HCA to divest two of its hospitals exceed the costs substantially*".⁹⁶
- 6.60 HCA disagrees with this assessment. Its detailed analysis of the CC's NPV calculation is set out in **Annex 2** and is summarised briefly below.
- 6.61 HCA considers that the costs and benefits included in the CC's NPV calculations are incorrect. The measure of benefits that the CC includes is overstated. Furthermore, the CC has failed to take into account important costs. In addition, HCA has provided quantified estimates of the loss of investment and economies of scale and scope arising from the CC's proposed divestment, which the CC must take into account in its NPV calculation.
- 6.62 Whilst some other impacts on quality and innovation are not easily measured, as HCA highlighted to the CC in its paper on the costs of divestment,⁹⁷ the CC must take account of all economic or welfare losses, whether or not it is capable of quantification, when assessing the proportionality of its divestment remedy.
- 6.63 HCA also considers that the CC's NPV calculation methodology is flawed. In particular, the CC fails to take into account the impact on competition of its other proposed remedies. The CC itself has suggested that the prohibitions and restrictions on clinician incentive schemes will improve competition on quality and price and that the various information remedies will stimulate competition. This increased competition should arise absent the proposed

⁹⁶ Para 2.173 of the PDR.

⁹⁷ HCA's paper on the costs of divestment, December 2013.

divestitures. HCA also highlighted the prominent plans for future entry and expansion in London, which also render the CC's static approach to its NPV calculation, over a 20 year time horizon, inappropriate.

- 6.64 Setting aside HCA's concerns with the CC's overall methodology, HCA has calculated its own estimate of the NPV of the CC's proposed divestment, using its more accurate measures of quantifiable costs and benefits. HCA finds that the NPV of the proposed divestitures is [REDACTED] over the 20 year time horizon.⁹⁸ HCA notes that the cost estimates underpinning this revised NPV calculation are highly conservative as they do not take into account the negative impact of divestment on quality and innovation, and the chilling effect on investment. In **Annex 2**, HCA presents further scenarios for the revised NPV estimate, showing that even when only parts of the CC's analysis are corrected, the NPV of the proposed HCA divestments is negative.

⁹⁸ This uses the same discount rate that the CC used in its Provisional Decision on Remedies.

7. DIVESTITURE PACKAGE

(1) The CC's methodology in selecting the two hospitals

- 7.1 The CC's Guidelines state that, in deciding on the scope of a divestiture package, the CC will identify the assets which comprise "a viable stand-alone business that can compete successfully on an on-going basis and is of sufficient scale and scope to enable its acquirer to become an effective competitor".⁹⁹ The proportionality test requires that "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".¹⁰⁰ The divestiture remedy should not be more onerous than is absolutely necessary for the divesting party.

Application of 40% market share test

- 7.2 The CC's methodology in selecting the London Bridge and Princess Grace for divestment is seriously flawed. The CC's sole rationale for the divestment of these hospitals is that this would reduce HCA's market share to below 40% of admissions in central London. The CC argues that this is the level necessary to facilitate rivalry "approaching that of a well-functioning market".¹⁰¹ There is no justification whatsoever for the CC to apply a 40% threshold – or indeed any market share threshold – in determining the need for, or the size and scope of, any divestments. This has no basis in law or economic theory.

- 7.3 It is clear from Appendix 2.1 of the PDR that the application of a 40% threshold is the sole criterion which the CC has used in order to identify the relevant hospitals for divestment:

"Our analysis showed that divesting any one of the three hospitals individually would leave HCA with [X] share of revenue. Divesting one of the two larger hospitals plus the Princess Grace would reduce HCA's share of revenue to [X] in the case of London Bridge and [X] in the case of the Wellington".¹⁰²

"The smallest divestiture package that would reduce HCA's share of private healthcare revenue in London to below 40% would comprise the London Bridge and Princess Grace hospitals".¹⁰³

- 7.4 The CC has proceeded on the basis that HCA should be required to divest itself of such assets as are necessary to bring its market share to below 40%. HCA has previously set out its comments concerning the fact that there are no market share benchmarks or thresholds in competition law policy which indicate whether a firm has too much market power, whether a market functions competitively, or whether divestment is an appropriate solution, or to what extent a firm should be required to divest its assets. The CC is referred to HCA's response to the Remedies Notice (paragraphs 6.76 – 6.92), which sets out HCA's submissions on this point. There is no case law, and no competition authority guidelines, which support the CC's proposition that "a share of 40% could be too high"¹⁰⁴ either specifically in private healthcare markets or generally. On the contrary, as HCA has set out in its previous submissions, it is clear from UK and EU competition law cases and from the guidelines issued by UK and EU competition authorities that there are no benchmark or threshold market shares which are indicative of competition concerns in any market.

- 7.5 The recent ruling of the General Court in *Cisco Systems, Inc. and Messagenet SpA v. European Commission* indicates, for example, that a market share which is as high as 80%-90% (i.e. substantially higher than the CC alleges HCA's market share to be) would not necessarily create competition concerns: "... the very high market shares and very high

⁹⁹ CC3 – Guidelines for market investigations, para 9 of Annex B.

¹⁰⁰ CC3 – Guidelines for market investigations, para 10 of Annex B.

¹⁰¹ Para 90 of Appendix 2.1 of the PDR.

¹⁰² Para 29 of Appendix 2.1 of the PDR.

¹⁰³ Para 32 of Appendix 2.1 of the PDR.

¹⁰⁴ Para 30 of Appendix 2.1 of the PDR.

degree of concentration in a narrow market to which the Commission referred merely as a basis for its analysis are not indicative of the degree of market power which enables the new entity to significantly impede effective competition in the internal market".¹⁰⁵ In that case, involving innovative and dynamic technology markets, the company's market share in and of itself did not indicate that it exercises substantial market power.

- 7.6 As HCA has stated in its response to the Remedies Notice, the OFT in its merger clearance decision in *GHG / Nuffield*¹⁰⁶ has expressly rejected the application of a market share threshold (the "40 / 10 rule") in the context of reviewing merger transactions in the private healthcare market.
- 7.7 The CC has therefore misdirected itself that a share of 40% could be "too high". This is an arbitrary threshold which fundamentally departs from previous case law, practise or indeed economic theory. The trend in competition policy has been away from the application of market share thresholds towards an individual, economics-based assessment of market power. The CC's 40% benchmark has no legal or policy justification whatsoever. It is not in the CC's Guidelines, and the CC has never consulted on the introduction of a market share threshold in these cases. No reasonable competition authority could adopt this approach.
- 7.8 The PDR has not acknowledged or responded to HCA's concerns about the use of a 40% market share threshold to justify divestment and determine the size and scope of the divestment package.
- 7.9 The CC's divestiture proposals appear to be entirely based on the views of the two dominant PMIs, namely Bupa and AXA PPP. The PDR acknowledges (see e.g. para 94 of Appendix 2.1) that the CC's proposal is based on the analysis submitted by these two PMIs. The CC relies on a table (see para 35 of Appendix 2.1) showing its analysis of spend in central London. Obviously, the two major PMIs are for commercial reasons pressing for the maximum possible divestiture package, but the CC loses sight of its statutory responsibilities to exercise independent judgement.
- 7.10 By applying an arbitrary threshold of 40%, the CC has failed to identify the "smallest package" that would be a viable, stand-alone competitor and would address the CC's alleged AECs. The CC's analysis is solely driven by its concern to reduce HCA's share of supply to less than 40% rather than by the aim of creating "*a viable stand-alone business that can compete successfully*". The CC has failed to consider whether the divestment of a single hospital would be sufficient to create rivalry in central London. The CC merely states: "*Our analysis showed that divesting any one of the three hospitals individually would leave HCA with [x] share of revenue*".¹⁰⁷ There is no discussion of why the sale of any one of HCA's hospitals, would not provide sufficient opportunity for a new entrant to buy a successful, existing business, develop it in the way it wished, and compete with HCA. AXA PPP describes each of HCA's six hospitals as "elite".¹⁰⁸ The CC places considerable faith in the fact that there are several purchasers who would have the ability, experience and resources to purchase the hospitals and pursue the same strategy as HCA. If so, on this analysis there is no reason why the sale of a single hospital would not suffice to create effective rivalry, particularly bearing in mind that there are already several other well-established competitors to HCA in central London which are financially viable, and have expanded significantly in recent years. The CC's case study of the London Clinic demonstrates that a single hospital can compete effectively with HCA and undergo significant further expansion.

Market definition

- 7.11 If the CC seeks to apply a market share threshold of 40%, it should do so following a proper, robust definition of the market in which HCA competes. HCA's criticisms of the CC's approach to market definition are set out in section 5 of its response to the PFs (in particular, paragraphs 5.54–5.144). The CC's market definition fails to take into account key

¹⁰⁵ *Cisco Systems, Inc. and Messagenet SpA v European Commission* Case T-79 / 12, para 74.

¹⁰⁶ ME / 3468 /08.

¹⁰⁷ Para 29 of Appendix 2.1 of the PDR.

¹⁰⁸ Para 2.8 of AXA PPP's response to the PFs and Remedies Notice.

competitive constraints on HCA, including providers in Greater London, and international providers which compete for HCA's international patients (accounting for [redacted] of its business). If the CC had carried out a proper market definition analysis for HCA's hospitals in central London, taking account of all the competitive constraints on its business, this would show that [redacted] The application of a 40% threshold is flawed, but if there is to be any basis for applying such a benchmark, the CC should at the very least apply it to a correct definition of the market.

Calculation of market share

- 7.12 Furthermore, even if one accepts the principle of applying a 40% threshold to HCA's central London share of revenue, there are on the face of it significant errors and omissions in the CC's calculations. These have been set out in HCA's response to the PFs (see in particular para 5.143). A significant amount of data for competing private hospitals and PPU's is missing. It is extraordinary that, in the context of a two-year market investigation, the CC case team has failed to gather supply data from a significant number of HCA's central London competitors. As a result, the CC's claimed share of supply figures are wholly unreliable and distorted. The level of inquiry which the CC case team has conducted on this issue falls well below the "vigorous investigation and analysis" which the Tribunal requires in a divestment case. The CC has not in fact shown that HCA has a share of supply (by revenue) in excess of 40% in central London.

Share by admission v. revenue

- 7.13 Furthermore, there is no justification for the CC to apply a 40% threshold on the basis of share of **revenue** rather than share of **admissions**. Indeed, the CC accepts: "*It is our provisional view that HCA's share of central London market admissions and / or revenue should be reduced below 40% to enable divestiture to be effective in facilitating rivalry approaching that of a well-functioning market*" (emphasis added).¹⁰⁹
- 7.14 On the CC's own market share calculations, the divestment of [redacted] would reduce HCA's market share by admissions in central London to below 40%. The CC however applies the 40% threshold by reference to revenue rather than admissions. Again, this is a wholly arbitrary approach which the CC fails to explain.
- 7.15 There are major flaws with calculating market share based on revenue rather than admissions or capacity.
- (i) HCA's market share by revenue rather than admissions distorts HCA's market share because it focuses to a greater extent than other providers on more complex, high-acuity cases which require higher-cost treatments (and therefore justifiably higher priced services). As the CC acknowledges,¹¹⁰ a new owner may or may not maintain the same type of high-acuity services which HCA offers, and therefore if the CC insists on calculating share of supply by reference to activity rather than capacity, the number of patient admissions would be a more appropriate measure of market share.
 - (ii) The comparison of HCA's share of supply based on revenue pre- and post-divestiture is illogical from an economic perspective. HCA's revenues **pre-divestiture** would factor in HCA's alleged market power (which HCA strongly refutes exist). **Post-divestiture**, the CC cannot credibly determine what new pricing will be achieved by another hospital operator. Therefore, it is irrational for the CC to use share of revenues as the basis for determining the "smallest divestiture package" capable of reducing HCA's market share to below 40% post-divestiture. Such an approach is meaningless and riddled with uncertainty. It is unsurprising that share of revenues did not form the basis for determining the divestment remedy package in either the *BAA* or *Aggregates* market investigations.

¹⁰⁹ Para 90 of the PDR.

¹¹⁰ Para 126 of the PDR.

Share by capacity

- 7.16 HCA would further argue that if the CC applies a 40% threshold to justify a divestment remedy, this should be calculated on the basis of **bed capacity**. The CC's case for divestment is that there are barriers to entry, inter alia in terms of site availability, which would prevent new entrants from developing new hospitals. The divestment remedy is a market-opening remedy designed to afford a new entrant the opportunity to develop a business within an existing, established hospital. It is up to the new owner to decide on its offering of clinical services, patient case-mix, and consultants. The CC accepts the new owner "*might adopt a different strategy if this is what signals from the newly competitive London market suggested was optimal*".¹¹¹ The divestment remedy should therefore be based purely on the capacity of a given hospital. This would provide a new entrant with the site and infrastructure of a hospital within which it would be able to develop its own strategy.
- 7.17 The use of capacity as the relevant metric for determining the effectiveness of divestiture is confirmed by the CC. At paragraph 85 of Appendix 2.1, the CC writes:
- "Given the high fixed costs inherent in a hospital business, an operator's profitability will be sensitive to volume changes, and we thought that in a more competitive environment the PMIs would be in a strong position to drive down both the new owner's or owners' and HCA's prices since they could credibly switch volume from one to the other and to TLC".*
- 7.18 Therefore, by the CC's own reasoning, the fundamental rationale for divestiture is to ensure that there is sufficient alternative **capacity** for PMIs to switch their volumes between central London hospital operators. Accordingly, the CC should be formulating its divestment remedy solely around the impact on capacity ownership in central London. The CC's remedy cannot control the change in admissions or revenues post-divestiture, it is for the market (in particular, PMIs) to decide where to allocate patient volumes - the only aspect within the control of the CC's divestment remedy is the configuration of capacity ownership within the market.
- 7.19 The CC has set out its calculations of bed capacity in central London. However, as HCA has indicated in its response to the PFs, there are serious, basic errors in this calculation: see paragraphs 5.138-5.143 of HCA's response to the PFs. The most fundamental omission was PPU capacity data. HCA has [§] and on that basis prepared a corrected table of central London bed capacity (see **Annex 1**). This shows that HCA's share of total overnight bed capacity in central London is in fact [§] i.e. HCA's share of capacity in central London is [§] the CC's 40% benchmark. [§]

Inconsistency of approach

- 7.20 It is also clear from the PDR that the CC has not applied this 40% threshold consistently across all the hospital providers. Appendix 2.2 of the PDR deals with divestment remedies outside central London. In relation to the BMI and Spire hospitals, the CC states it is using a "*qualitative approach*",¹¹² involving a catchment area analysis which assesses the competitive constraints in each catchment area. In each area, the CC has assessed the strength and diversity of competition to the relevant BMI or Spire hospital, having regard to such factors as transport links, size of facility, range of services, and capacity. It is not apparent from the CC's analysis that it has applied any market share cap or that the 40% threshold has any significance in any of these areas. The CC has adopted an entirely different approach in central London by applying a 40% threshold rather than by carrying out a detailed economic assessment of the competitive constraints on HCA's hospitals. This has led to HCA being treated in a discriminatory way, imposing a far higher burden of divestments on HCA than on any other hospital provider.

¹¹¹ Para 126 of the PDR.

¹¹² Para 4 of Appendix 2.2 of the PDR.

Selection of hospitals

7.21 Furthermore, even on the basis that the CC is justified in using a market share benchmark of 40%, there is no proper justification for identifying specifically the London Bridge or the Princess Grace hospitals for divestment. This does not constitute the "smallest package" that would create a viable competitor. The CC has not considered whether there is an alternative hospital or hospitals which would reduce HCA's market share to below 40% (of admissions or revenue) and which would create "a rival or rivals to compete with the retained portfolio of HCA hospitals"¹¹³:

- (i) The CC has not differentiated HCA's hospitals on grounds of location: the CC states that "*The overlap of central London hospitals' catchment areas is considerable*" and "*we did not consider that this catchment area data in itself was particularly informative in differentiating the customer base of the three hospitals*".¹¹⁴ Therefore, the CC is not distinguishing between the hospitals on grounds of location.
- (ii) The CC has sought to identify for divestment hospitals with a more general range of services. If so, it is not clear why the CC rules out the divestment of the Lister. It concedes that the Lister is a more general hospital (albeit to a lesser extent than the London Bridge, the Wellington or the Princess Grace). The Lister has a very broad spread of clinical services [§] [§].¹¹⁵ There is therefore no reason to exclude the Lister as an alternative hospital.
- (iii) The CC also distinguishes these hospitals based on patient-mix. [§]
- (iv) It is also difficult to understand why the criterion should be based on PMI revenue rather than self-pay revenue. The CC argues that the effect on rivalry is likely to be "more immediate" for PMIs. It is difficult to see how this could be the case, when one of the CC's divestment conditions is that a new owner can maintain HCA's existing PMI prices for at least 18 months following divestment, meaning that there is no "immediate" cost saving for PMIs if there were to be any price reductions (which HCA asserts would not be the case).
- (v) Furthermore, the CC's methodology is based on a "snapshot" of the hospitals as they currently operate under HCA's ownership, rather than an assessment of what these hospitals would offer to a new owner. [§] If a purchaser bought one or more hospitals, it would not necessarily pursue the same strategy and would have the option to change the clinical focus, service offering or patient-mix of any given facility. The CC recognises this in observing that "*the new owner or owners might adopt a different strategy if this is what signals from the newly competitive London market suggested was optimal*".¹¹⁶ [§] A hospital ultimately provides a platform for consultants to bring their patients and develop their clinical practices. The mix of consultants, services and patients can and will vary over time. There is therefore no reason to mandate specifically which hospitals should be divested, based on HCA's current clinical offering. As noted in its response to the PFs, HCA considers that the CC has underestimated the potential for supply-side substitution both within and across specialties.

7.22 In this context, HCA notes that this is a further instance in which the CC has treated HCA differently from other hospital operators. In relation to a number of BMI disposals, the CC has provided BMI with the choice of which hospitals to divest within a given catchment area. The CC has given no such option to HCA. If the CC believes that divestment is an appropriate remedy, it should at the very least allow HCA the option to decide which of its hospitals it wishes to sell. Again, the CC has adopted a discriminatory approach towards HCA, which creates unnecessary and disproportionate burdens for the company.

¹¹³ Para 93 of Appendix 2.1 of the PDR.

¹¹⁴ Para 22 of Appendix 2.1 of the PDR.

¹¹⁵ Para 13 of Appendix 2.1 of the PDR.

¹¹⁶ Para 126 of Appendix 2.1 of the PDR.

(2) Outpatient facilities

- 7.23 The CC states that the divestment assets "*might include, for example, consulting rooms and diagnostic and testing facilities currently used predominantly by patients of the London Bridge and Princess Grace hospitals*".¹¹⁷ The inclusion of outpatient facilities would not be justified, whether or not they are "predominantly" used by the hospitals' patients.
- 7.24 In the PFs, the CC defines separate markets for inpatient and outpatient care: see para 5.54 of the PFs. It concludes that these are distinct product markets.
- 7.25 The CC's inquiry has focused on the provision of inpatient care within hospitals: see para 6.4 of the PFs. The CC acknowledges that:
- concentration is higher in inpatient care than outpatient care; and
 - barriers to entry and expansion are higher in relation to inpatient care than outpatient care.

HCA has provided evidence that it competes with a very wide range of outpatient and diagnostic facilities right across London and that this is a highly fragmented market: see e.g. its response to question 12.7 of the CC's market questionnaire. There are a very wide range of outpatient facilities which include consultant-run clinics and consulting rooms which provide facilities for consultants to see, diagnose and treat patients in an outpatient setting. The PFs accept that hospitals "*providing inpatient care ... compete with a wider set of providers, including day and outpatient only clinics, in the provision of day patient and/or outpatient care*".¹¹⁸

- 7.26 The CC's shares of supply in central London are based on inpatient and day case admissions [X]. They do not include outpatient treatments. If the CC is proposing to include outpatient facilities at the London Bridge and Princess Grace hospitals, based on its 40% market share threshold, it would need to re-calculate the market shares to include outpatient facilities run by all central London providers. [X]
- 7.27 In other words, the CC cannot, on the one hand, exclude outpatient services in its competitive assessment of the London markets, and on the other hand, include it in its divestment package. The CC has only identified competition concerns in relation to inpatient treatment. The owner of the divested hospitals would be able to establish its own outpatient facilities and these hospitals would compete with a wider range of providers in relation to outpatient treatments.

(3) Divestment Conditions

- 7.28 HCA comments as follows on the CC's proposed conditions for the divestments of the HCA Hospitals.

PMI Contracts

- 7.29 The CC proposes to require that insurers maintain their existing contract terms with the divested hospitals for a period of 18 months from the date of divestiture "*to prevent disruption to patients and to enable the vendors to receive an appropriate market value from the sale by obviating the risk of losing insurer recognition ...*".¹¹⁹
- 7.30 The CC is right to be concerned about the risk that following a change in ownership insurers will not recognise the divested hospitals or will not recognise them on terms which allow the hospitals to maintain the current level of quality and clinical services. This poses a significant risk to the effectiveness of the remedy in creating new competitive constraints on HCA. The CC explicitly acknowledges this risk by requiring a roll-over of the existing contractual terms. Following this 18 month period, there are no assurances that PMIs will agree terms with the

¹¹⁷ Para 96 of the PDR.

¹¹⁸ Para 5.48 of the PFs.

¹¹⁹ Para 2.89 (c) of the PDR.

new owners of the London Bridge or Princess Grace, and if they do not, these hospitals will not be viable and will be forced to exit the market. Alternatively, if the PMIs agree terms it may be on a very different basis which would force the hospitals to re-position their strategy away from complex, high-acuity cases. The CC will at most have secured 18 months of continuity, but there are significant risks about what would happen to these hospitals after that interim period.

- 7.31 It is also clear from the 18 month hold over period that the CC is not in any event envisaging that prices and terms will change in the immediate future. Even if one accepts the CC's flawed conclusions about the price benefits of divestment, on the CC's timetable PMIs and consumers would not see any price changes for several years.
- 7.32 The CC's base case scenario seems to be the prospect of relatively small price reductions several years in the future. This needs to be weighed against all the risks to quality, innovation and patient care which have been set out in HCA's submissions. Any reasonable decision-maker would see that, carrying out this balancing of costs and benefits, divestment is a wholly disproportionate measure.

Purchasers

- 7.33 The CC states that "*existing UK hospital operators with facilities in close proximity to the divestiture facilities are unlikely to be considered suitable purchasers*".¹²⁰
- 7.34 Since the CC considers that there is a central London "market" this condition would apparently rule out any central London provider (private providers or PPU's). Given that the CC seeks a purchase by a provider with "*expertise and experience in operating hospitals of a level of acuity services and specialism appropriate to the hospitals being divested*",¹²¹ its decision to exclude any other central London provider is wholly lacking in logic. The only other providers who would have any previous expertise or experience in the UK in running private facilities in tertiary specialisms such as oncology are in central London. There are no other UK-based providers which have a track record of operating high-acuity hospitals; the only potential candidates would be overseas hospital groups.
- 7.35 This condition would be wholly disproportionate and would seriously restrict the number of potential bidders for the two hospitals. It would directly impact on HCA's ability to secure a fair market price in any disposal of the hospitals. It contravenes the principle of proportionality by forcing HCA to sell its hospitals at an under-value. It also creates an even stronger probability that the remedy would not secure the continuity of high quality, high-acuity services within these hospitals.

Divestiture period

- 7.36 The CC's proposed period of [X] months is too short and does not allow a reasonable amount of time for:
- the marketing of these facilities through a formal tender process;
 - discussions and negotiations with potential purchasers;
 - the purchaser's due diligence of the hospital;
 - negotiating and putting in place transitional arrangements to ensure continuity of services; and
 - the purchaser's ability to secure relevant approvals (e.g. CQC registration) for a change in ownership.
- 7.37 The CC points out that Nuffield sold nine of its hospitals to BMI within six months. However, the sale of the HCA hospitals would create more complex issues because of a need to

¹²⁰ Para 2.85 (d) of the PDR.

¹²¹ Para 2.85 (d) of the PDR.

separate assets which are currently integrated within a tightly-knit group of facilities in a single geographical area. This would require more time to achieve.

- 7.38 HCA submits that the divestiture period should be [X] months, and that a shorter period would adversely affect its ability to secure a fair market value for the assets.

8. ALTERNATIVE REMEDIES

- 8.1 The CC has failed to give proper consideration to remedies which provide alternatives to divestment. The PDR does not demonstrate that divestment is the least onerous remedy which would address the alleged AECs in the private healthcare market.
- 8.2 In considering the proportionality of a remedy, the CC is required to consider whether there is a choice of alternative remedies and, if so, whether divestiture is the least onerous solution to the competition problems which the CC has identified:
- (i) The CC's Guidelines indicate that the CC's approach to remedies is "*an iterative process*" which involves looking at "*a potentially wide range of remedy options [which] are progressively narrowed down until a solution has been found that enables the CC to meet its statutory duties*".¹²²
 - (ii) The courts have stated that the proportionality principle requires the CC to adopt the least onerous measure: "*When there is a choice between several appropriate measures recourse must be had for the least onerous ...*".¹²³
 - (iii) Furthermore, the Tribunal in *Barclays* states that this puts an obligation on the CC to consider alternative remedies which, even if not as effective as the CC's preferred remedy, will nonetheless mitigate the AEC without being unreasonable, impracticable or disproportionate.¹²⁴ In other words, even if the CC does not regard alternative remedies as being as effective as "the nuclear option" (or Lord Diplock's "steam hammer") of divestment, in view of the highly intrusive nature of divestment, and its high costs and adverse consequences for consumers, it must consider whether there are other remedies which would mitigate, even if they do not wholly remove, the alleged AECs. This forms part of the balancing exercise which the CC is required to undertake. It is a duty which weighs particularly heavily on the CC in a divestment case because of the highly penal nature of the remedy.
- 8.3 The CC has proposed a range of remedies other than divestiture, each of which it believes will address the alleged lack of competition in the private healthcare market.

Remedy 3

- 8.4 Remedy 3 (restriction on expansion) in particular is a market-opening remedy which directly addresses the alleged structural features of high barriers to entry and weak competitive constraints. The CC notes that this remedy "*therefore increased local rivalry by facilitating entry to the local area or market expansion of a smaller existing operator, through a partnership with the NHS Trust to operate the PPU*".¹²⁵ The remedy will have a particular impact in London, compared to the rest of the UK, since PPU expansion is likely to happen more quickly in London. The CC has noted in its PFs: "*In general, London-based PPUs, which are broadly larger and have historically dominated the NHS private healthcare revenue stream, are positioning themselves to take advantage of the lifting of the cap more quickly than those outside London, by, for example, investing in additional capacity, refurbishing their existing facilities, and specialising in the provision of privately-funded healthcare services, such as cancer services*".¹²⁶ The CC specifically finds that PPUs are "gearing up for growth" and that London PPUs have been the fastest growing in the UK, outpacing PPUs in other parts of the country. HCA has submitted strong evidence that future expansion plans by London-based PPUs, including the Royal Marsden, Barts, Royal Brompton, Chelsea & Westminster, Imperial and Kings. Many of these PPUs are looking to set up partnerships with existing private sector operators, in order to tap into investment

¹²² CC3 – Guidelines for market investigations, para 381.

¹²³ *The Queen v Minister for Agriculture, Fisheries and Food and Secretary of State for Health exp Fedesa and others*, Case C-331 / 88, para 13.

¹²⁴ *Barclays Bank Plc v Competition Commission* [2009] CAT 27, para 120.

¹²⁵ Para 2.182 of the PDR.

¹²⁶ Para 9 of Appendix 3.1 of the PFs.

capital and operational expertise. The London market represents a particularly significant opportunity for private investors, and the CC's market-opening remedy will have a stronger impact in London.

Remedy 4

- 8.5 Remedy 4 (clinician incentives) is also aimed at enhancing competition between hospital operators. The CC considers that incentive schemes have the potential to distort competition between hospitals for referrals and that the remedy will ensure that competition is carried out on quality and price rather than on the value of inducements. It also noted that, although incentive schemes are not a barrier to entry as such, access to consultants is a key consideration for new entrants. Remedy 4 will have the effect of removing the incentives or restrictions which interfere with consultant referral patterns in central London. The CC specifically noted in the AIS that incentive schemes are more common in London, and so it follows that the remedy will have more marked pro-competitive benefits there.¹²⁷ Indeed, the CC fully acknowledges in its PDR that even though the divestment remedy will not "*reduce HCA's share of oncology significantly*",¹²⁸ remedy 4 may be "*effective in promoting competition in cancer treatment in central London*".¹²⁹

Remedies 5-7

- 8.6 Remedies 5-7 (information on consultant and hospital performance) constitute a package of measures which remove information asymmetries in this market. The CC justifies these remedies (and HCA agrees) on the grounds that they help patients exercise "*meaningful choices*" and "*allow PMIs to stimulate competition between healthcare providers on the value they offer with benefits in terms of improvements and quality and reductions in price for patients*".¹³⁰ It is seen as a pro-competitive measure, which will encourage patients to shop around both for hospitals and consultants. Given the fact that the market in London offers the widest range of different hospital providers in close proximity to each other, and indeed the largest pool of consultants, these information remedies can be expected to have the strongest impact in London by encouraging consumers to choose alternative providers.

Effectiveness

- 8.7 The CC has therefore tabled a package of remedies in addition to divestiture which, on the evidence before it, are likely (on the CC's own analysis) to have marked pro-competitive effects in London. These address both structural and conduct features giving rise to the alleged AECs. The CC is confident that these are effective and proportionate remedies which will open up the market and benefit competition. HCA therefore fails to see any justification for divestment in addition to these other remedies.
- 8.8 The CC argues that it does not "*consider that any of our proposed remedies would in isolation address the AECs comprehensively*".¹³¹ However, it fails to consider the interaction of remedies 3, 4, 5-7 in combination and how these would address the alleged AECs. All of these alternative remedies are said to "*increase rivalry*" in the market for private healthcare. The CC does not justify why the hugely intrusive remedy of divestment is required in addition to these proposals to resolve its concerns.
- 8.9 HCA also reiterates that, as stated above, even if the CC believes that remedies 3-7 are not in aggregate as effective as divestment, it is nevertheless required to consider whether remedies 3-7 mitigate, even if they do not entirely remove, the alleged AECs (*Barclays*). In other words, the very fact that divestment is such an extreme and penal measure – which in this case carries significant risks to quality and patient care – requires the CC to accept alternative remedies which may be less effective but which go some way towards addressing, if not entirely eliminating, the AECs. In a market investigation, the CC is required

¹²⁷ Para 131 of the AIS.

¹²⁸ Para 92 of Appendix 2.1 of the PDR.

¹²⁹ Para 92 of Appendix 2.1 of the PDR.

¹³⁰ Para 2.482 of the PDR.

¹³¹ Para 4.6 of the PDR.

to consider whether the market is "well-functioning", not "perfectly functioning".¹³² The question therefore is whether remedies 3-7 would ensure a market that functions well. The CC's own assessment of these remedies demonstrates that they would achieve that objective.

- 8.10 Furthermore, the CC accepts that remedies 3-7 will facilitate competition in Single or Duopoly areas where divestiture would not be an effective remedy. The CC states: "*We addressed our competitive concerns in such areas by adopting much less intrusive remedies than those potentially available, such as price control, aimed at increasing rivalry by lowering entry barriers and increasing transparency*".¹³³ The CC therefore accepts that in areas where a hospital provider has a **monopoly** or **duopoly** position, remedies 3-7 will have the effect of facilitating competition. It is difficult to understand why these "much less intrusive" remedies would not be equally (if not more) effective in areas where a hospital provider does not have a monopoly or duopoly, but in fact is exposed to competition and where patients and PMIs have competitive alternatives which would be fostered even further by remedies relating to the lowering of entry barriers and improvements in transparency.

PMI remedies

- 8.11 There has been a failure by the CC to consider remedies aimed at addressing competitive distortions created by PMI conduct: see paragraphs 6.72-6.75 of HCA's response to the Remedies Notice. There is a range of measures which the CC could implement to address these issues which (in combination with remedies 3-7) would facilitate more competition in the markets:
- (i) PMI recognition is a pre-requisite to the viability and success of any hospital facility. There is clear evidence that the withdrawal of PMI recognition by a major PMI would make a hospital unviable. In the case of the London Heart Hospital, the de-recognition of the facility has led to a market exit in central London. The CC has failed to consider remedies relating to PMI recognition e.g. an obligation to handle network admissions on fair and reasonable terms, arbitration procedures to resolve disputes, reasonable notice periods on termination of recognition, or even the requirement to recognise new entrants on reasonable terms. The CC implicitly recognises the importance of PMI recognition to competition between private hospitals in its divestiture remedy when it requires PMIs to maintain existing terms with the London Bridge and Princess Grace hospitals for a minimum period of 18 months.
 - (ii) The CC has failed to pay heed to the fact that the weight of third party views in this inquiry has been on the distortion of competition caused by PMI "managed care" practises. The overwhelming majority of consultants¹³⁴ and patients who have submitted evidence to the CC have complained about the extent to which PMIs are restricting patients' choice of consultants and hospitals as a result of:
 - the arbitrary de-listing of consultants without due process;
 - the re-directing of patients away from the consultants in hospitals of their choice to cheaper, less qualified alternative providers;
 - substantial cuts in PMI rates to consultants to uneconomic levels, disincentivising consultants from continuing in private practise and compromising quality of care;
 - the restrictions on PMI policies which prevents subscribers from going to the providers of their choice;
 - the increasing interference of PMIs in clinical and treatment pathways which restrict how patients should be treated; and

¹³² CC3 – Guidelines for market investigations, para 30.

¹³³ Para 4.39 of the PDR.

¹³⁴ As at 31 January 2014, the CC had published over 250 submissions which it had received from consultants. Virtually all of these submissions raised complaints about the impact of PMI "managed care" initiatives and the implications for competition and patient choice.

- the fee-capping of consultants which prohibits patients from being treated by consultants who charge more than the PMI reimbursement rate even though the patient is willing to pay the excess through a "opt-up" fee.

There has been a chorus of concern by third parties about these issues. Consultants and patients have provided real, concrete examples and case studies to the CC demonstrating how these practices are limiting competition and choice, lowering the quality of care, and often putting patient's health at risk. The CC has failed to acknowledge let alone consider and address any of these concerns or investigate how these are restricting competition between hospital operators. The consumer detriment flowing from these practices has been entirely ignored.

- (iii) The only PMI "managed care" initiative which the CC has taken the trouble to consider is the fee-capping of consultants. In PFs, the CC has specifically concluded that fee-capping "*could lead to distortions of competition between consultants and to reduce consumer choice*".¹³⁵ Yet the CC has proposed no remedies to address this concern and turns a blind eye to these anti-competitive practices.
- (iv) HCA considers that the CC's remedies package should include a consideration of remedies which address these issues. These would facilitate competition between hospital providers by tackling the restrictions which fetter the patient's ability to choose which consultants, and hence which hospital, to go to for treatment. Remedies of this nature – which are being called for by the overwhelming majority of consultants and patients who have submitted evidence to this inquiry – would be far more effective and proportionate in stimulating rivalry between hospitals in London, where the brunt of PMI managed care initiatives is being felt.
- (v) In its response to the Remedies Notice, HCA proposed an alternative remedy which would address the issue of foreclosure of new entrants through contractual restrictions in PMI / hospital contracts. The original OFT inquiry into the private healthcare market was in part triggered by Circle's much-publicised Complaint that relationships between PMIs and incumbent hospital operators were foreclosing new entrants. The CC has been provided with concrete evidence of exclusive contracts, e.g. AXA PPP's Corporate Pathways network which is exclusive to BMI and the London Clinic in London. In discussing remedy 2, the CC has rejected any prohibition of these types of contractual restrictions, citing in particular the fact that such a remedy would require an adjudication or dispute resolution process. The CC's reasons for dismissing this remedy are not convincing. It would be relatively straightforward to devise a prohibition of contractual restrictions which restrict the PMI's right to appoint competing hospitals onto its network. There is no reason why this should require adjudication, since it could be left to any parties affected by these restrictions to take civil action to enforce the remedy.

Barriers to entry

- 8.12 The CC's Guidelines state that the CC aims to "*deal comprehensively with the **cause or causes of the AEC***".¹³⁶ If there are, as the CC argues, structural barriers to entry and expansion which give rise to AECs, divestment in itself does not provide an effective remedy to those barriers. Divestment does not deal with the root causes of those structural barriers which (if the CC is correct in its analysis) would continue to impede new entrants into the London market.
- 8.13 The CC has failed to consider alternative remedies which would address its concerns about barriers to entry. HCA has indicated in its response to the Remedies Notice that there are alternative measures which would facilitate new entry. For example, if the CC maintains its view that there is limited availability of property sites for new entrants (which HCA strongly rejects), there are measures which it could take to facilitate site availability, either by freeing-up NHS surplus property or ensuring that private sector opportunities are advertised to

¹³⁵ Para 7.70 of the PDR.

¹³⁶ CC3 Guidelines for market investigations, para 330.

healthcare providers. Similarly, if the CC believes that the planning process is a barrier, it can consider appropriate changes to facilitate the planning process in respect of hospital developments. These are more effective and proportionate ways of dealing with the root causes of any alleged entry barriers. There has been no attempt to give these any consideration. The CC's approach to remedies has not in any sense been "iterative". It has started and ended with divestment and has ignored alternative ways of addressing the AEC findings.

OFT report

- 8.14 HCA notes in addition that the OFT's original report in the private healthcare market study which led to the reference to the CC has suggested various remedies which the CC might wish to consider. The OFT stated that it is not for the OFT to determine which remedies would or would not be appropriate but it had nevertheless (bearing in mind that the OFT had spent over a year examining the market) "*developed a detailed understanding of the type of remedies that could be appropriate*".¹³⁷ There was no suggestion in the OFT's report that divestment might be an appropriate solution. In particular, the OFT proposed measures which could reduce barriers to entry, some of which now form part of the CC's remedies 3-7. Following its own review of this market, the OFT did not consider that divestment could be "on the table". This reinforces how perverse the CC's divestment proposal is.

¹³⁷ Para 10.29 of the OFT's report in the private healthcare market study.

9. REMEDY 3 – RESTRICTIONS ON EXPANSION

- 9.1 HCA notes the CC's proposals for Remedy 3 that all PPU partnerships should be subject to mandatory pre-notification to the OFT/CMA and assessed under a competition test.
- 9.2 HCA looks forward to further details of the CC's proposals, including the procedures for pre-notification, the competition test to be applied by the OFT/CMA and procedures to be followed by the OFT/CMA in assessing these transactions.
- 9.3 HCA strongly supports a "safe harbour" provision as suggested in para 2.250 of the PDR. This would improve the efficiency of the remedy and minimise the cost and burden on NHS Trusts and prospective bidders. NHS Trusts can often be constrained by the lack of resources to engage specialist legal and economic input. Therefore, the "safe harbour" criteria should be easy to interpret and apply based on publicly available information. HCA would support a "safe harbour" provision based on the 25% share of supply test. This could be determined based on a fixed geographic area, e.g. based on drive time isochrones or ONS geographic boundaries.
- 9.4 HCA will comment further once the CC has published further details of its proposals.

10. REMEDY 4 – CLINICIAN INCENTIVES

- 10.1 HCA's principal comment in relation to remedy 4 is that it should have general application to all healthcare providers. It should not, as the CC suggests in para 2.375 of the PDR, be confined to arrangements between hospital providers and consultants. This would discriminate against hospital providers such as HCA and moreover would not fully address the competitive distortions which the CC has identified in its AEC findings.
- 10.2 The CC finds that: (i) incentives can "*affect consultants' referral decisions*"; and (ii) incentives "*lead to excessive diagnostic tests or consultations*".¹³⁸ If the CC wishes to address these AECs, it should apply the remedy to all healthcare providers.
- 10.3 There is no logic in excluding consultant-owned facilities. If there is a risk of distortions in referral patterns, or of excessive testing or consultations, this risk must apply whether a facility is owned by a hospital operator or by a group of consultants. If the CC applies the remedy only to hospital operators, it will be creating a new competitive distortion in that hospitals will be restricted in the financial terms which they can offer to consultants, whereas consultant-owned facilities would be under no such restrictions.
- 10.4 Similarly, the remedy should extend to insurers to cover any incentive arrangements which they agree with consultants. If a PMI pays a consultant to treat a patient in a particular way or in a particular location, this has the same potential to distort the consultant's referral decision (i.e. lead to inappropriate treatment decisions). This has precisely the same effect as incentive schemes offered by hospital operators. Insurers are becoming increasingly important in determining patient care pathways, and therefore should be subject to the same restrictions.
- 10.5 HCA agrees with the principle of a de minimis threshold covering the provision of general facilities (tea, coffee, stationery, etc.). These are facilities which are offered in any workplace and would not affect a doctor's referral decision. It should suffice for the hospital to make a general statement on its website that it provides facilities of this nature to its consultants.
- 10.6 In para 2.379 of the PDR, the CC recommends disclosure on the hospital's website of the market value of each service. The precise market value of facilities, e.g. consulting rooms, is competitive information. HCA would suggest that the principle of transparency would be satisfied by a statement that the value of the service exceeds the threshold.
- 10.7 The CC proposed in para 2.380 of the PDR that where a hospital engages a clinician to provide services, e.g. as medical director, the hospital should disclose the payments made. This information would normally be regarded as confidential. Again, HCA believes that there would be sufficient transparency for patients if they are aware of the fact that there is a service contract under which the consultant is remunerated. There is no reason to disclose the specific value of the remuneration.
- 10.8 HCA has previously commented on the pro-competitive nature of equity schemes and how they can encourage new entry and expansion by encouraging and creating new clinical services and ventures: see section 9 of HCA's response to the Remedies Notice. However, if the CC intends to limit the equity stake of individual clinicians, the cap should be raised to at least 5%. A cap of 5% would be too small to influence a consultant's referral decisions or commissioning behaviour. In corporate transactions, 5% is often seen as the threshold for non-material shareholdings, e.g. in the context of non-compete covenants.
- 10.9 HCA fully supports the principle that equity schemes should not have any direct incentive effects by requiring clinicians to bring a designated volume of business or refer minimum numbers of patients to the facility. However, in drafting this condition, the CC should note that hospitals can legitimately require their consultants to perform a minimum number of procedures in the theatre for the purposes of a quality audit and clinical outcomes review.

¹³⁸ Para 2.280 of the PDR.

This ensures that the hospital maintains the minimum quality levels. This condition is purely designed to ensure that the hospital's clinical governance criteria are met and not in any way aimed at ensuring that referrals are diverted away from other facilities. Consequently, in designing the remedy, hospitals should be allowed to require consultants to perform the basic minimum number of procedures where this is clearly linked to quality audits.

11. REMEDIES 5 AND 7 – INFORMATION ON HOSPITAL AND CONSULTANT PERFORMANCE

Overview

11.1 HCA strongly supports the proposed remedies 5 and 7, which are encompassed within a single measure. Overall, HCA strongly supports:

- A single remedy that addresses the lack of publicly available data on both consultant and hospital quality by requiring private hospital operators to provide information in an appropriate format to a suitable information organisation so that meaningful performance measures can be derived and made available to the public;
- The information requirements proposed by the CC;
- The proposed characteristics, role, membership and governance of the proposed information organisation; and
- The selection of PHIN as the proposed information organisation.

Single remedy

11.2 HCA agrees that the same datasets can be used to provide both facets of a patient episode. There are two distinct yet related dimensions of a single patient experience: the consultant and the hospital. It is more efficient, effective and useful if all aspects of a patient's experience of private healthcare are recorded in a single, integrated database. This will make it easier to analyse the interaction between the consultant and hospital dimensions and derive a range of performance measures for: (i) the consultant; (ii) the hospital; and (iii) the consultant in that hospital. The results will enable patients to make informed, better choices about which consultant to see and in which hospital to see him / her.

11.3 Such an approach will also make it easier to build up profiles of each hospital as a whole entity (including information from the Health and Social Care Information Centre ("**HSCIC**"), Public Health England ("**PHE**") and national clinical audits and registries) and profiles of each consultant's practice as a whole, both specifically within particular facilities and generally across his / her work in both the private and public healthcare markets.

11.4 The CC has proposed that the remedy will apply only to those private hospital operators with a UK turnover of £5 million or more.¹³⁹ HCA believes that there should be no turnover threshold and the remedy should apply to all operators (including NHS PPUs and, although outside the scope of this market investigation, elective cosmetic surgery providers) licensed by the CQC to provide privately funded hospital outpatient, day-case and inpatient treatments in the UK. This is not only on grounds of equal treatment, but also in expanding the pool of operators required to submit information to the maximum extent possible it would encourage competition by allowing data from smaller operators to be compared against that of larger operators and build a comprehensive profile of the market.

Information Requirements

11.5 HCA supports the collection and derivation of the proposed performance measures set out in para 2.465 (a) to (g) and (i) of the PDR.

11.6 In relation to procedure specific measures of improvement in health outcomes,¹⁴⁰ HCA strongly supports the collection and derivation of this performance measure in principle, but asks the CC to consult further with PHIN on increasing the number of procedures for which this measure would be available and identifying the most appropriate measures.

11.7 In addition, HCA recommends that the information organisation is required:

¹³⁹ Para 2.465 of the PDR.

¹⁴⁰ Para 2.465 (h) of the PDR.

- to collect from private hospital operators, or receive from HSCIC, information on hospitals transfers (including between private hospitals and between private and NHS hospitals); and
- to collect from private hospital operators, and / or where appropriate receive from HSCIC or national clinical audits and registries, information on patient mortality rates whilst in hospital, within 30 days of discharge, and on the basis of diagnosis, treatment and speciality.

Patients, GPs, consultants and hospitals would all benefit from the mandated publication of this key outcome measure. The NHS and national audits and registries are moving in this direction. The challenge is to ensure an appropriate case-mix adjustment (hence the importance of diagnostic coding). GPs and well-informed patients are surely interested in understanding this most cardinal of outcomes – not only to compare consultants but also to understand the order of magnitude of risk associated with procedures.

- 11.8 HCA strongly supports the CC's proposed data and timing requirements set out in para 2.466 of the PDR but has some suggestions to improve the quality of data.
- 11.9 In relation to patient identifiers,¹⁴¹ overseas patients ordinarily resident in the EEA should also be required to provide their European Health Insurance Card ("**EHIC**") numbers. Other overseas patients should be required to provide other traceable (and ideally unique and lifetime) personal identifiers.
- 11.10 HCA agrees with the CC that the diagnostic coding system should be to an internationally recognised standard¹⁴² (e.g. ICD 10, and then 11 when it is introduced in 2015). HCA believes the standard adopted should be synchronised as far as possible with the standard adopted at any time by NHS England. [§] Diagnostic codes are a prerequisite for case-mix adjusted measurements because they enable the outcomes of patients with identical, proximate or different diagnoses (receiving identical or different treatments) to be compared and contrasted and therefore enable both clinicians and patients to understand better what works best (or not).
- 11.11 HCA would find it useful if the CC could set out more fully its intentions regarding suitable data security provisions for the raw data.¹⁴³ HCA supports making the raw data fully available to all relevant interested parties. HCA infers from this proposal that the CC requires full transparency of activity volumes from hospital operators from April 2017 at the latest. It would be helpful if the CC could first confirm whether full transparency is its intention and secondly specify in more detail what it means by "suitable data security provisions". For example, is the CC referring just to the attribution of pseudonyms to patient identifiers or to other potential requirements, e.g. limitations on viewing and downloading the data? Does the CC expect the information organisation to make the raw data available free of charge or at an additional cost, even to those interested parties paying subscription fees?
- 11.12 HCA strongly supports the CC's proposals and timings regarding procedure coding.¹⁴⁴ HCA supports the movement from CCSD to OPCS coding by April 2019. Ways will need to be found to ensure that new and emerging treatments will be coded accurately in a timely manner as part of an evolving system, but this is a matter than can be addressed well before the deadline. Furthermore, the categories of "unspecified" or "other" treatments currently in the OPCS coding system will need to be reviewed and either deleted or re-designated more accurately as not only do these vague titles hinder the collection of quality information but there is a risk that the funder could be under- or overcharged for these treatments.
- 11.13 HCA strongly supports the CC's proposal that the CMA reviews this remedy.¹⁴⁵ However, HCA recommends the review happens five years after the publication of the CC's final

¹⁴¹ Para 2.466 (b) of the PDR.

¹⁴² Para 2.466 (c) and footnote 229 of the PDR.

¹⁴³ Para 2.466 (f) of the PDR.

¹⁴⁴ Para 2.467 of the PDR.

¹⁴⁵ Para 2.469 of the PDR.

report, which could be between April 2019 or at the latest April 2020, not five years after implementation of the remedy, which could be as late as April 2022. A review date of April 2019 or April 2020 could be aligned usefully with the end of the information organisation's five year plan and mandate and any review of that plan and mandate. The review should look at the quantity and quality of the information provided, the promotion of the resource amongst healthcare professionals and patients, feedback on the resource, what additional information patients would value.

Information Organisation

- 11.14 HCA strongly supports the need for the information organisation to be independent and have all the characteristics, attributes and processes set out in paragraphs 2.470, 2.471 and 2.473 of the PDR.
- 11.15 HCA strongly supports the CC's proposal that the CMA nominates two of the non-executive members to the management board of the information organisation.¹⁴⁶ Moreover, HCA submits (for the avoidance of doubt) that the independent chair and the original board members should be approved also by the CMA. HCA supports the recommendation that the chair should nominate new board members.¹⁴⁷
- 11.16 The CC invited submissions on issues that might be reserved to the CMA-nominated board members of the information organisation.¹⁴⁸ HCA recommends that the following issues should be reserved as such:
- The five year plan and initial budget;
 - Annual reports;
 - Annual budgets and subscription rates; and
 - New board members.

The CC should require that the issues above must be supported by both the independent chair and at least one of the two CMA-nominated non-executive board members as well as an overall majority of board members. The CC should also require that the two CMA-nominated board members are responsible for nominating any new chair for the approval of both the whole board, and then the CMA.

- 11.17 Similarly the chair should be given the authority to write to the CMA at any time recommending a change in information policy regarding the private healthcare market, if that recommendation enjoys the support of both CMA-nominated non-executive board members (as well as support from the chair and any other board members). The board of the information organisation must have the opportunity to consider and comment on any such recommendation at one board meeting, at least, before the chair writes to the CMA.
- 11.18 HCA recommends that the subscription fees for hospital operators (both private and NHS PPU) and PMIs should be set in direct proportion to the number / volume of publicly and privately funded episodes / cases of inpatient treatments reported by member organisations to PHIN in the previous calendar year. This should reflect volumes of inpatient activity conducted by private hospital operators in the UK and volumes of UK activity funded by PMIs.
- 11.19 HCA recommends that voting rights at general meetings of the information organisation should be in direct proportion to subscriptions paid. Although this would give the private hospital operators a modest majority of voting rights, HCA considers this would be justified on two grounds:
- The private hospital operators will bear the responsibilities of generating the datasets and providing them to the information organisation and of managing the consultant information; and

¹⁴⁶ Para 2.471 of the PDR.

¹⁴⁷ Para 2.472 of the PDR.

¹⁴⁸ Para 2.471 of the PDR.

- The market for private healthcare services is wider than the market for private medical insurance because the former reflects insured, self-pay and overseas patients.
- 11.20 HCA believes that the proposed powers to be vested in the independent chair and two CMA-nominated non-executive board members of the information organisation would provide sufficient safeguards against the private hospital operators gaining any unfair advantage over the PMIs in relation to the operation of the information organisation.
- 11.21 HCA strongly supports the CC's view that the Private Healthcare Information Network ("**PHIN**") demonstrates already many of the characteristics, attributes and processes of the proposed information organisation.¹⁴⁹ HCA believes that, with the benefit of the requirements in the proposed remedy, PHIN is highly capable of addressing the shortcomings in the availability of information publicly in a timely and effective manner. Not only does HCA strongly consider PHIN is highly suitable to become the information organisation but believes that PHIN is the best, and possibly the only, existing organisation capable of delivering the information requirements proposed in the remedy to the required timeline and within a budget of £2 million a year.¹⁵⁰ HCA supports the CC's view that an upper budget of £2 million funding per year should be sufficient for the proposed information organisation to deliver on its proposed responsibilities. That is however dependent on the provision of all the required information from all private hospital operators in a timely, complete and accurate manner. It is also dependent on the provision of similarly timely, complete and accurate information from a variety of public organisations, including HSCIC, PHE and national clinical audits and registries.
- 11.22 HCA believes that the CC's estimate of the total costs of delivering the proposed remedy is in the correct order of magnitude.¹⁵¹

Conclusion on the single remedy

- 11.23 HCA believes that the proposed single remedy, as modified in accordance with HCA's comments above, would be the least onerous necessary to secure adequate, consistent and transparent supply-side information on the quality and safety of private healthcare services.
- 11.24 HCA strongly supports this remedy because it is a dynamic, behavioural remedy that will better inform patients, and incidentally their advisors, about the quality of services available and it has the potential to raise the standards of hospital operators and consultants. HCA believes that this remedy has the power to transform the private healthcare market over the next five years. In April 2017, consumers will be able to see survival rates at Hospital A and compare them with Hospital B. At this point, competition will be further facilitated by further assisting consumers to make informed decisions about their treatment pathways and stimulating hospital operators and consultants to improve their profiles both absolutely and relatively to their competitors. To achieve its objective, the CC and CMA must ensure that PHIN has the resources to ensure that the information is promoted to the public effectively, for example, through search engine optimisation as well as the formal channel of PMIs' letters. HCA believes that this information remedy should be given the opportunity over a four year period to take effect before the CC or the CMA finalises or implements any static, structural divestment remedies.

¹⁴⁹ Para 2.474 of the PDR.

¹⁵⁰ As set out in para 2.485 of the PDR.

¹⁵¹ As set out in para 2.488 of the PDR.

12. REMEDY 6 – CONSULTANT FEE INFORMATION

- 12.1 HCA recognises that a lack of consistent and comparable information on consultants' fees may remain to an extent a feature of the market. Therefore, HCA would be prepared to support a measure requiring consultants, as a condition of granting practicing privileges, to provide fee information to patients using standard letter templates provided by the hospital and obliging the hospital operators to ensure that consultants complied with this requirement.¹⁵²
- 12.2 HCA is willing to accept and support the proposed remedy 6 (as modified in the PDR), despite the fact that the remedy will be onerous for hospital operators of all scales and sizes, because HCA agrees that consultants should provide greater information about their fees to patients. The remedy would be particularly onerous to HCA given the high acuity of its patients and the fact that, even after full diagnosis, the risk of complications in high acuity cases would require multiple treatment pathways to be described and priced for patients. There will be additional costs incurred not only in setting up the system of template letters but also in monitoring continually the consultants' compliance with the obligations.
- 12.3 Furthermore, it is not clear who would bear the financial risk if there turned out to be a shortfall between the fees quoted and the fees actually incurred, particularly where the treatment pathway is not clear and straightforward at the time of providing the information. Additionally, the PDR does not state whether or not there would be any penalty imposed on the hospital operators if consultants do not provide the necessary information when required. HCA asks the CC to clarify these points.
- 12.4 HCA supports the proposed protocol for the operation of this remedy.¹⁵³ In particular, HCA supports the distinction between information provided at the time of confirming initial or subsequent outpatient consultation appointments and the information to be provided at the point of recommending or confirming treatment. As currently designed, the remedy would require consultants to set out differently the fee quotes depending on whether the patient is insured or self-pay. It would be helpful to know whether the "package price" for self-pay patients needs to be broken down into its constituent fees in the same way as for insured patients.
- 12.5 HCA accepts the recommendation that consultants practicing privately should submit information on both their consultation fees and standard procedure fees to the information organisation by December 2016 for publication alongside information on consultant performance and that the fee information should cover all procedures (usually or routinely) undertaken by the consultant in his or her private practice.¹⁵⁴ However, this requirement should not prohibit consultants in an emergency from undertaking appropriate unplanned procedures beyond the scope of their standard procedures.

¹⁵² As set out in paras 2.522 and 2.525 – 2.528 of the PDR.

¹⁵³ Paras 2.523 and 2.524 of the PDR.

¹⁵⁴ Para 2.529 of the PDR.