

Submission supplementing HCA's remedies hearing

1. Shares of revenue or admissions are an inappropriate basis upon which to design a divestiture remedy

1.1 HCA reiterates a point it has raised in its response to the PDR and at its hearing concerning the CC's reliance on market shares based on revenue or admissions rather than capacity.

1.2 Even if the CC is correct in its approach of applying an arbitrary 40% market share cap for the design of its divestiture remedy, HCA considers that share of *revenue* or *admissions* is an inappropriate measure for the CC to use:

- *It conflicts with the CC's economic rationale for divestiture:* The CC's concern is that PMIs believe HCA has too much bargaining power. The CC's stated aim is to ensure that there is sufficient alternative capacity for PMIs to switch patients away from HCA hospitals. The CC believes its divestment remedy would be effective because "*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.*"¹ Accordingly, it is the measurement of share of capacity pre- and post-divestiture that is relevant to the "effectiveness" of the remedy, as this is what determines a PMI's ability to switch volume away from HCA hospitals. Designing a divestiture remedy around HCA's share of revenues is inconsistent with the CC's underlying rationale for divestiture.
- *It punishes an efficient provider that is preferred by patients:* A hospital operator that competes more successfully, for example on quality or choice of services, will attract a higher proportion of patients for a given level of capacity in the market compared to an inefficient or lower quality hospital operator. As the CC itself recognises, HCA is a high quality provider. It has successfully attracted patients by developing high-quality facilities, with its focus on high acuity, more complex cases and new, innovative treatments. Its share of patient revenue or admissions is merely reflective of that success. Measuring share of revenues or of patient admissions to design a divestiture remedy penalises the efficiency of successful hospital operators and conflicts with the revealed preference of patients.
- *It is distorted by quality/case mix differentials:* Average revenue per patient is substantially influenced by the type, quality and complexity of services provided. As the CC acknowledges, private healthcare is a vertically and horizontally differentiated market. It follows that HCA's share of revenue is biased by systematic differences in the complexity and quality of its services, and in the mix of complexities across individual patients receiving apparently similar treatments. Indeed, in its analysis of insured prices, the CC recognised the significant impact that differences in cost, for example because of higher acuity or more complex treatments, will have on revenue per admission².
- *It is affected by service profile which may change:* The CC can mandate the sale of hospital capacity, but it cannot simply assume that, post-divestiture, HCA's hospitals and the divested hospitals will attract the same consultants, offer the same range of services

¹ Appendix 2.1, PDR, para 85

² Appendix 6.12, PFs, para 20.

at the same level of quality and to the same mix of patients as before divestment. The CC itself recognises that the service profile may be reconfigured post-divestiture.³ It is only HCA's share of hospital capacity that the CC can effectively claim to change with its divestiture remedy.

- *It is excessive if the CC is correct in its provisional view that a breakup would reduce prices:* If the CC maintains its view that HCA possesses market power and prices its services significantly above its competitors, and if it argues that the divestment would result in lower prices relative to competitor hospitals, it must also believe that, post-divestiture, HCA's share of revenues will reflect the loss of such alleged market power – thereby lowering HCA's share of revenue even further. As a result, the CC would be incorrect to assert that the divestiture of Princess Grace and London Bridge Hospital is the smallest divestiture package capable of lowering HCA share of revenues to below 40%.
- *It is biased upwards by an inconsistently narrow geographic market definition.* In its analysis of every other local private healthcare market in the UK, the CC uses a market definition that would give a market share of half what it calculates for HCA in London. In this case, the CC has adopted a wholly arbitrary definition of the market by reference to the area within the North/South Circular. This does not take account of the competitive constraints on HCA's business outside this area - from which [3<] of its patients are drawn. It is simply not tenable for the CC to exclude from its geographical market definition competitors, such as the Parkside cancer facility, on the grounds that they are located beyond the North/South Circular.

1.3 HCA would also make the general point that, where products or services are differentiated, either horizontally or vertically, market shares are a bad proxy for competitive constraints. The CC and OFT merger assessment guidelines note that:

*"an over-reliance on concentration measures to indicate changes in market power, in particular where products are differentiated, has been termed the 'binary fallacy': the assumption that all firms in the market exercise competitive constraints upon one another in proportion to their market shares, but that firms outside the market exercise no constraint at all."*⁴

1.4 Thus, any market share threshold is inappropriate in a market such as private healthcare, which the CC has agreed is differentiated. Indeed, this is recognised by the OFT which has stated that even as a filter in the first phase of a merger inquiry, indicators such as IPR, UPP or GUPPI, which take into account product differentiation and closeness of competition, provide a much better proxy than market shares⁵. In the context of insured patients, the ability of PMIs to exclude HCA for some of its insurance products also needs taking into account. Given this, HCA fails to understand how, in the context of an in-depth and almost two year long market investigation into private healthcare provision, the CC can maintain that market shares are an appropriate tool on which to base conclusions about both the strength of competition and the benefits of a divestment remedy.

1.5 As HCA indicated at its hearing:

³ Appendix 2.1, PDR, para 126.

⁴ Footnote 63, OFT 1254/CC2 Merger Assessment Guideline

⁵ Slides 2 – 3, http://www.of.gov.uk/shared_of/mergers_ea02/publications/Fletcher-Walters-UPP_up_and1.pdf

- HCA's share of bed capacity in Central London is [§<].
- This does not justify any divestment, but in any event the CC's methodology [§<].
- If the CC were to pursue a divestment remedy, it should allow HCA the choice as to which hospital to divest, since there are alternative hospitals which satisfy the CC's criteria of offering a wide breadth of services and significant levels of PMI revenue.

2. Entry/expansion

2.1 During the hearing, Mr. Whiticar queried why other hospital operators had not made use of available sites in London. It was not clear which period of time Mr Whiticar was referring to, but the question wrongly implies that hospital operators have not taken advantage of available sites to either enter or expand in London. In fact, there have been several such occurrences.

2.2 HCA has submitted evidence of the following developments over the last 10 years:

- Aspen acquired the **Highgate Hospital** (2003): Following Aspen's substantial investment in the hospital, it has seen significant expansion and now boasts three operating theatres, 34 beds, 11 outpatient consulting rooms and an advanced diagnostic suite.
- **Aspen Parkside Cancer Centre** (2003): Aspen developed a new standalone facility at 49 Parkside, Wimbledon, to significantly expand its oncology services. The newly developed facility offers dedicated cancer treatment including radiotherapy and chemotherapy that complement the services available at the main hospital site.
- **Hospital of St John and St Elizabeth** (2007): the re-development of Brampton House to significantly expand the hospital's capacity. The re-development has enabled the relocation of outpatient and diagnostic capacity in the main hospital site, freeing up space for greater inpatient activity.
- Bupa acquired the **Cromwell Hospital** (2008): Following Bupa's acquisition of the central London based hospital; it commenced a large-scale refurbishment and reconstruction programme in 2012 leading to an expansion of services.⁶
- **London Clinic Cancer Centre** (2009): The London Clinic has redeveloped a new cancer centre at 22 Devonshire Place. The development included 47 new inpatient rooms, state-of-the-art treatment technologies and new diagnostic facilities.
- **BMI Fitzroy Square Hospital** (2009): BMI acquired the central London based, 17 bedded hospital facility to expand its portfolio of London hospitals. BMI opened a new gynaecological wing of the Fitzroy Hospital in 2011, offering a comprehensive range of services for women's health.
- **BMI City Medical** (2009): BMI developed a new outpatient and diagnostic facility in the City of London.

⁶ Annex A, Appendix 6.3, Provisional Findings, para 1.

- **BMI Weymouth Hospital** (2010): BMI, together with the Phoenix Hospital Group, developed a new hospital in central London, featuring 17 inpatient rooms and 4 operating theatres as well as additional consulting / diagnostic facilities at 9 Harley Street.
- **HCA's Platinum Medical Centre** (2010): HCA developed a new healthcare facility spanning seven floors and including 4 day surgery theatres, a 12 bedded day surgery unit and 10 bedded chemotherapy ward.
- **Hospital of St John and St Elizabeth** (2011): The hospital developed a new "urgent care centre" which competes with a similar service first offered privately by HCA. In 2011, the hospital also invested in expanding its imaging department.
- Aspen expanded its **Parkside Hospital** through the development of the "Parkside Hospital at Putney" facility (2012).
- Aspen expanded its **Highgate Hospital** (2013): Aspen constructed a new diagnostic centre to upgrade the services available at its hospital. Floor plans and construction pictures are available on the Aspen website.
- **King Edward VII Hospital** (ongoing): The re-development of two sites, Mackintosh House and Agnes Keyser House. This will provide the hospital with a total area of 100,000 square feet (a substantial increase from 66,000 square foot).
- **C&C Alpha Group** acquired a central London site for a new private hospital development (the former NHS Ravenscourt Park Hospital). The site will be used for the development of the new London International Hospital, a 150 bedded state of the art hospital focusing on complex tertiary specialties.

2.3 The above list (which does not include PPU, NHS hospital, or independent outpatient developments)⁷ shows that there is strong evidence of entry and expansion by hospital groups in London, and that this has occurred through a combination of acquisitions and site development.

2.4 In addition, during the hearing HCA provided to the CC an array of marketing materials of sites that are currently available and would be highly suitable for re-development as healthcare facilities. HCA has recently signed a lease of space at the Shard for a new outpatient and diagnostic facility – the same opportunity would be available to any other hospital operator (there is still significant surplus space available in this development). Just this week, another development opportunity has been presented to HCA at [X]. This would be 20% larger than the London Bridge Hospital's main site. The new building could be readily used for a healthcare facility, and HCA does not consider that it would be difficult to obtain planning consent. It is simply one further example (amongst very many others) of a site which is available now to any potential new entrant.

2.5 The above trend should also be seen in the context of the OFT/CC's market inquiry. The CC's investigation will have affected entry/expansion decisions in the market, for example, by creating legal uncertainty about the legitimacy of consultant / hospital equity partnerships (a market entry strategy) and opened up the possibility of forced hospital sales. A rational

⁷ We refer the CC to, by way of example, section 5 of HCA's response to the Issues Statement and section 6 (and Annex 1) of its response to the PFs.

investor would naturally wait for the conclusion of the CC's inquiry before deciding to enter London.⁸

3. Hospital Capacity – central London

3.1 During the hearing, Mr Witcomb suggested that hospital capacity had been falling. There was no reference to the underlying data to support this view, or whether this was a reference to a national or regional trend. However, a review of the inpatient capacity of central London providers tells a different story. Since the CC's data in 2011, there appears to have been a significant increase in hospital capacity (see the table below, which shows overnight bed capacity for the central London independent hospitals identified by the CC). Furthermore, evidence submitted to the CC showed that PPUs in London are gearing up for large-scale expansion of their private patient services.⁹

Table: Hospital capacity– central London (independent hospitals only)

Independent hospital operators in central London	Overnight bed capacity measured by CC (2011)	Overnight bed capacity today (2014)¹⁰
TLC	170	285 ¹¹
King Edward VII	60	58 ¹²
Hospital of St Johns and Elizabeth	49	155 ¹³
Bupa (Cromwell)	118	128 ¹⁴
BMI	153	183 ¹⁵
Aspen (Highgate only)	28	34 ¹⁶
Total	578 beds	843 beds

3.2 These figures show that the bed capacity offered by private providers in central London has increased by 46% in the space of just three years. This figure excludes PPUs, and including PPU bed capacity would show even higher levels of growth.

3.3 They also indicate that the CC's analysis is already out of date and does not reflect current market conditions.

⁸ If, notwithstanding the evidence before it, the CC maintains its view that site availability is the major barrier to entry in London, this should be another reason why ownership of **hospital capacity** is at the core of the CC's competition concerns, and hence share of capacity is the relevant metric for the design of its divestiture remedy.

⁹ See Annex 1 of HCA's response to the PFs.

¹⁰ These capacity figures were sourced from hospital operator websites as at 19 February 2014.

¹¹ <http://www.thelondonclinic.co.uk/about-us/about-the-london-clinic>.

¹² http://www.kingedwardvii.co.uk/patient_rooms.cfm. This hospital however is in the process of a significant expansion through the re-development of a further 66,000 square feet adjacent to its existing site: see HCA's email to the CC of 18 November 2014.

¹³ <http://www.hje.org.uk/index.php/About-HJE/accommodation-a-facilities.html>

¹⁴ https://www.bupa.com/media/61583/218397_cromwell_hospital_fact_sheet.pdf. We note that the CC states that the Bupa Cromwell now has 131 beds (see para 3.38, Provisional Findings).

¹⁵ <http://www.bmihealthcare.co.uk>.

¹⁶ <http://www.highgatehospital.co.uk/our-hospital/about-us/>.

4. The competitive constraints on HCA and network benefits

- 4.1 During the hearing, Mr. Witcomb appeared to be suggesting an irreconcilable tension between (i) HCA's arguments concerning the quality and innovation advantages which it yields from operating a network of tightly integrated hospitals and (ii) HCA's arguments concerning the effectiveness of competition from hospital operators in London which do not run a number of hospitals as a network (Mr. Witcomb's question: "*Which line are you running?*"). HCA sees no such tension.
- 4.2 The CC also questioned whether HCA could claim that it operates in a broad market, while at the same time claiming that it is a high quality operator, and that its quality is significantly higher than other providers. In fact, this position is perfectly consistent, as explained below.
- 4.3 HCA submits that the relevant market should be defined broadly, both in terms of the product and geographic dimensions. This is consistent with the market being characterised by significant vertical differentiation across private healthcare providers.
- 4.4 As the CC has itself stated, the provision of private healthcare in London is differentiated¹⁷. This differentiation takes a number of forms – private healthcare providers can be differentiated, for example, by the quality of care offered, the level of acuity that is catered for, the type of specialties, sub-specialties and individual treatments that are provided, and the geographic location of facilities.
- 4.5 Differences in providers' strategies in relation to investment in the quality of treatments, the quality of patient experience and whether cutting edge innovative treatments are offered, imply that private healthcare providers are vertically differentiated, whereby different providers offer different levels of quality to patients. Therefore, in the context of private healthcare provision, HCA competes with its rivals by investing to ensure it is ahead of its competitors, offering higher quality, specialist, innovative treatments. This is perfectly consistent with HCA operating within a broad product and geographic market, alongside lower quality and lower cost providers, with competition between this range of providers driving vertical as well as horizontal differentiation.¹⁸ The fact that HCA operates in a broad geographic and product market is confirmed by the ability of PMIs to use non-HCA facilities located inside and outside of central London as well as by HCA's record of investment in response to improvements by other private hospitals and the NHS.
- 4.6 It is the very fact that the market is competitive that provides the competitive pressure and incentive for HCA to continually strive to differentiate its offering, invest in high-quality services, and innovate. HCA's strategy and focus on the development of tertiary services is very much a product of the competitive market in London.
- 4.7 HCA submits that it is incorrect that there is any tension between the quality and innovation advantages HCA yields from operating a network of tightly integrated hospitals and the effectiveness of competing hospital operators in London who do not run a number of hospitals as a network. HCA considers that the CC's assertion that there may be such a tension points to an argument often called the "**efficiency offence**" which suggests that an

¹⁷ Paragraph 6.135 of the CC's Provisional Findings.

¹⁸ This is a feature of numerous markets. See, for example, Sutton (1991, 1997). The economic theory of such markets is well established. See, for example, Gabszewicz and Thisse (1980), Shaked and Sutton (1983), Tirole (1988). Note that lower quality products in vertically differentiated markets must have lower prices if they are to survive in the market. Matching the price of products which have lower quality and lower costs might be seen as predatory.

inefficient or lower quality *competitor* needs protecting. As European Competition Commissioners and previous Chairmen of the Competition Commission have said in the past, "*the role of competition policy is to protect competition, not competitors*".^{19,20,21} Having a larger scale allows HCA to invest in certain niche procedures and technologies and sub-specialisms that would not be sustainable at a smaller scale. However, that is only one of the types of investment that lead to a private healthcare provider's offering being more or less appealing to customers. Therefore, hospital operators of a much smaller scale can still provide a substantial competitive constraint on HCA.

5. Insurer's incentives in regards to quality and innovation

- 5.1 There was some discussion at the hearing about the extent to which the interests and incentives of *PMIs* are not aligned with those of *consumers*. Given the questions raised at the hearing, HCA reiterates the points it has made in previous submissions that *PMIs* do not (as the CC appears to be suggesting) "represent" the interests of their subscribers and that the motives and incentives of *PMIs* in seeking divestiture have to be examined very closely.
- 5.2 In its PDR, the CC provisionally concluded that its divestment remedy would lead to benefits in terms of lower prices and increased quality and innovation. The CC argued that price benefits would be enjoyed directly by the customer, defining customers as "*self-pay patients, insurers and insured patients*" (emphasis added) and that "*any quality or innovation benefits would accrue directly to the patients treated at these facilities*"²². These quotes demonstrate that the CC considers that *PMIs* can be treated as customers of private healthcare facilities, and that any improvements in quality or innovation at private healthcare facilities will be passed on by *PMI* providers directly to patients.
- 5.3 In its response to the PDR, HCA outlined why the CC's arguments, as summarised above, are misleading and why the CC cannot assume that any increases in quality or innovation would be passed on to patients, without analysing *PMIs*' incentives²³. *PMIs* provide insurance, and once a policy is sold the *PMIs*' interests are different from those of insured patients.
- 5.4 For *PMIs*, there is a trade-off between cost and quality:
- (i) Granted, *PMIs* have an incentive to increase revenue by selling more policies at a higher premium. To that end, recognising higher quality or more innovative

¹⁹ Neelie Kroes, "Preliminary Thoughts on Policy Review of Article 82", Speech at the Fordham Corporate Law Institute, New York, Sep. 23, 2005 at http://europa.eu/rapid/press-release_SPEECH-05-537_en.htm, last visited 25 February 2014.

²⁰ Derek Morris said that, "Government, in the shape of the MMC, holds the ring, intervening to protect not individual companies but the process of competition", <http://www.timeshighereducation.co.uk/features/just-a-regulator-type-of-guy/105902.article>, last visited 25 February 2014.

²¹ US DOJ said that, "[t]he Supreme Court has underscored this basic principle repeatedly over the past several decades. In 1984, it observed in *Copperweld* that the type of "robust competition" encouraged by the Sherman Act could very well lead to injury to individual competitors.⁵⁸ Accordingly, the Court stated that, without more (i.e., injury to competition), mere injury to a competitor is not in itself unlawful under the Act.⁵⁹ In so stating, the Court cited its 1977 decision in *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.* for the proposition that the antitrust laws "were enacted for 'the protection of competition, not competitors.'" , http://www.justice.gov/atr/public/reports/236681_chapter1.pdf, last visited 25 February 2014.

²² Paragraph 2.73 of the PDR.

²³ Paragraphs 6.19 – 6.21 of HCA's response to the PDR.

services/facilities might in principle allow PMIs to sell more, or charge more for, PMI policies to maximize revenue.

- (ii) On the other hand, PMIs are incentivised to minimise costs in order to maximise profits, Costs are obviously minimised by reducing the magnitude and volume of claims, and therefore PMIs have no incentive to pursue recognition strategies that would increase the quality or range of healthcare services available under the policies and encourage more claims.

5.5 In practice, that trade-off will (from the PMI's perspective) favour cost reduction over quality. Any increased revenue PMIs are able to achieve from offering higher quality care as part of their policies is unlikely to outweigh the increased costs to PMIs. This is because at the point of purchasing a private healthcare insurance policy, customers are not in immediate need of healthcare services and so are more likely to consider simple metrics such as price and availability of some nearby hospitals than consider details of the quality of treatments covered within a particular specialty, how innovative particular treatments are, or the range of sub-specialties offered. This would suggest that PMI recognition of highly specialised, innovative, high quality care is unlikely to generate significant extra policy sales or allow PMIs to charge much higher prices. In this context, given that the potential costs in terms of additional policy claims are likely to outweigh any benefits, PMIs are incentivised to minimise the cost of claims through offering lower quality (and so lower cost) treatments and facilities to the patient and limiting the availability of privately provided, high acuity, complex care.

5.6 This trade-off, of course, is not aligned with policyholders' interests at the point at which they require private healthcare services. When seeking treatment, and so making a claim, patients want the best possible healthcare. At this point they will be better informed about the specifics of their care requirements, seek more information from their GPs and consultants and place significant weight on the quality and specialisation of particular treatments offered as part of their PMI policy. The quality of care, and depth of specialisation is therefore likely to significantly increase the likelihood of a policyholder making a claim on its healthcare insurance policy, rather than using the NHS, and making a claim for higher quality, innovative private treatment. Therefore, PMI recognition of highly specialised, innovative, high quality care is likely to increase the claims costs the PMI faces thereby undermining any incentive to offer it.

5.7 Therefore, the CC cannot rely on PMIs having incentives in line with insured patients and PMIs cannot be considered as customers by the CC, in the same way, for example, that the CC might consider a retailer of a manufacturer's products as the manufacturer's customer. A retailer has no incentive to restrict purchase of a manufacturer's products or minimise the usage of its own stores. In other words, a retailer does not face the same trade-off as an insurance provider when considering whether to offer increased quality and innovation to its customers – a retailer's incentive to pass on improvements in a manufacturer's quality is far more straightforward than those of PMIs. The nature of an insurance product is that insurance providers' incentives are not aligned with their customers, as recognised by the CC in other contexts²⁴.

²⁴ In the private motor insurance inquiry the CC provisionally concluded that an AEC existed arising from a misalignment of insurers and customers' incentives, see for example paragraph 5(b) of the CC's Private Motor Market Insurance Market Inquiry Investigation Provisional Findings, December 2013.

- 5.8 The CC's analysis in the PDR, and its treatment of PMIs as customers of healthcare providers, essentially ignores one side of the trade-off faced by PMIs. In assuming that increases in quality and innovation will accrue directly to insured patients²⁵, the CC ignores PMIs' incentives to reduce their claims costs, by restricting access to high quality, innovative treatments or to particular facilities. In reality, these incentives will impact on barriers to entry in private healthcare provision and PMIs' recognition of different procedures. PMIs' reluctance to recognise new facilities is an important restriction on private healthcare providers' ability to expand, and the CC should analyse this issue rather than focussing on site availability which HCA has shown is not a problem in London. This is discussed in more detail in section 6 below.
- 5.9 Instead of relying on incorrect assumptions and a partial analysis of competition in the provision of private healthcare, therefore, the CC must analyse PMIs' incentives in detail to understand the functioning of competition, whether there is an AEC (including, in particular, in relation to barriers to entry) and the impact of its remedies on the quality of care that patients will receive. Similarly, PMIs' incentives must be borne in mind by the CC when assessing the reliability of PMIs' submissions, particularly in relation to a high quality and highly innovative provider such as HCA.
- 5.10 HCA has, during the course of this inquiry, provided the CC with many instances in which PMIs have been resistant to HCA's innovations in new facilities or treatments: see for example HCA's reply to AXA PPP's submission dated 22 February 2013; see also the various examples of [§<]. HCA's strategy has been to offer tertiary care previously available only within the NHS. This is often unwelcome to PMIs, because it increases the incidence of claims, and PMIs have responded for example by offering financial incentives to patients to stay within the NHS (again, this has been previously evidenced to the CC in earlier submissions). However, HCA has thereby created new services within the private sector, increased patient choice, and hence competition, to the benefit of consumers.

6. Insurer recognition is a relevant barrier to entry

- 6.1 During the hearing, there was discussion regarding PMI recognition of hospital facilities representing a barrier to entry / expansion. The panel's former position on this issue, which we assume is unchanged, was to query why a PMI would pose a barrier to entry / expansion in central London when it might be desirable to introduce greater rivalry in London. HCA set out in section 5 above one reason why PMIs have an incentive not to recognise a new hospital: more limited access to hospitals and complex treatments reduces expected claims costs. This is not the only reason why PMI recognition can be a barrier to entry.
- 6.2 In the remainder of this section, HCA sets out the evidence presented to the CC of PMI conduct, which clearly demonstrates that insurer recognition has been pivotal in affecting commercial entry / expansion decisions in London.
- 6.3 Aspen told the CC that as part of its entry strategy for the London market (which it said was the area **within the M25**),²⁶ following its acquisition of the Highgate Hospital in 2003, it took Aspen from **2003 until 2011** to achieve recognition from AXA PPP. Eventually recognition was granted, but only because "*Aspen had to agree to grant significant discounts to tariff compared with existing facilities in the same Greater London geography*".

²⁵ Paragraph 2.73 of the PDR.

²⁶ Aspen hearing summary, para. 7.

- 6.4 Aspen also told the CC that it "*had also experienced recognition problems with Bupa back in the early 2000s. Bupa had two products, its network and non-network products, and back in 2003 Bupa would not grant Holly House Hospital network recognition. The same thing happened at Parkside, and again Aspen had to agree significant discounts with Bupa in order to gain recognition*". Aspen has therefore been very clear in its evidence to the CC that PMI recognition has been its main barrier to entry and expansion in central London and that the PMIs have used their leverage to extract significant discounts.
- 6.5 AXA PPP told the CC²⁷ that it "*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.*" In short, the hospital operator's decision not to proceed with sponsored entry was because of **uncertainty over PMI volumes** over any other factor. This is unsurprising given the highly concentrated PMI market, where the failure to obtain recognition can make or break a hospital.
- 6.6 The CC's Annotated Issues Statement has also provided other examples of where PMI non-recognition of new hospitals has been an impediment to new entry/expansion (see in particular AIS, Appendix E, paras. 36-45):
- The CC noted: "*We saw in our Bath case study that AXA PPP's refusal to recognise the new Circle hospital in Bath for day-care and inpatient treatment caused Circle significant difficulties*" (para. 40).
 - AXA PPP excluded Nuffield's Leeds hospital from AXA PPP's main acute hospital network, causing it financial difficulties (para. 43).
 - AXA PPP's refusal to recognise the Edinburgh Clinic "*prevented its expansion into areas of treatment requiring day-care or inpatient care*" (para. 44).
- Of course the CC rightly goes on to note (para. 45) that in the cases where entry/expansion had taken place "*We did not, however, find PMI recognition to be a problem*" – the logical conclusion to be drawn.
- 6.7 HCA also informed the CC that AXA PPP's decision not to recognise the then new, state-of-the-art, London Heart Hospital resulted in the eventual exit of the hospital from the private sector. This is a clear illustration of the power of a single insurer to dictate the fate of a hospital. As an aside, the hospital site is currently being marketed for sale, and could be used by any prospective hospital operator to launch a new hospital in central London. To be clear, the only example of a market exit of a hospital in central London has been caused by a PMI's decision to withdraw recognition.
- 6.8 Spire has also stated to the CC: "*Uncertainty about what PMI recognition would look like adds significant risk to purchasing in London.*"²⁸
- 6.9 The evidence reveals that insurer recognition has been a material issue that has influenced entry/expansion decisions in London. PMIs have a pivotal role in determining the extent to which there is new entry and expansion in central London. If they genuinely wish to see even

²⁷ AXA PPP hearing summary, 19 March 2013, para. 28

²⁸ Spire hearing summary, 19 November 2013, para. 17

greater competition and choice, they themselves have the means to promote and sponsor new entry and expansion. They have not consistently done so in the past. Given that the dominant purchasers in this market – the purchasers which the CC believes it needs to "protect" – have the means and ability to facilitate new entry and expansion, there is no case for a divestment remedy as a market-opening measure.