

Private Healthcare Remittal: Submission of AXA PPP

Introduction

AXA PPP welcomes the opportunity to make further submissions to the CMA in connection with this remittal.

This submission contains AXA PPP's observations on the CMA's Insured Price Analysis ("IPA") working paper of 11 June 2015 (the "Working Paper") in the context of the CMA's other evidence. AXA PPP also has a number of comments to make in response to the submissions by HCA that were published on the CMA's website on 19 and 30 June 2015, which will be relevant to the CMA's further competitive assessment. AXA PPP notes that many of HCA's submissions relate to issues that were considered in depth by the CMA during the course of the market investigation, and addressed by the CMA in its Final Report of 2 April 2014 (the "Report"). AXA PPP's focus in this submission is therefore on developments since the Report which may be relevant to the remittal. For completeness, AXA PPP's position with respect to certain arguments that have been repeated by HCA is also summarised. AXA PPP also refers the CMA to its previous submissions on these issues.¹

This submission contains confidential information, the disclosure of which may adversely affect AXA PPP's legitimate commercial interests. A non-confidential version will be supplied separately as requested by the CMA.

A. Insured Pricing Analysis

1 Key findings

AXA PPP does not intend to comment in detail on the revised IPA. However, it notes the CMA's conclusion in the Working Paper that the results of its updated analysis are "comparable with both the DRR [the Data Room Report prepared by KPMG on behalf of HCA] and the [Report] result",² and that further revisions and sensitivity tests also generate results finding that HCA charges higher prices than The London Clinic ("TLC").

While AXA PPP does not have sight of the actual results, these findings are consistent with AXA PPP's own experience of dealing with HCA and other providers in Central London, which has been described at length in AXA PPP's previous submissions to the CMA. In particular, the evidence included in AXA PPP's submission of 6 May 2015 confirmed that HCA continues to charge higher prices and command more significant price increases than TLC (as well as other providers), as evidenced by its index of charges of the central London providers against the national average for 2014, which is provided again below for convenience.

¹ See in particular AXA PPP's Response to Issues Statement (22 July 2012); Response to Annotated Issues Statement (4 April 2013); Submissions on Provisional findings report (20 September 2013); letter dated 20 December 2013; response to Provisional decision on remedies (7 February 2014); initial remittal submission (9 March 2015); and remittal submission (6 May 2015).

² Para 6 of the Working Paper.

Central London provider	Index of charges against national average (2014)
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]

AXA PPP submits that whatever allegations that HCA might level against the IPA, as evidence it should not be viewed in isolation, and whatever the precise results, its directional weight points to higher prices, and should be interpreted in light of the corroborative experience of PMIs such as AXA PPP.

2 Quality differences

AXA PPP notes the CMA's reference (in footnote 21 of the Working Paper) to arguments made by HCA that it "provides higher quality care and treats more complex patients than TLC, which are issues that could potentially affect HCA's costs". AXA PPP understands that the CMA intends to consider whether there are any significant differences between HCA and TLC, for example any quality differences, as part of its overall competitive assessment in its forthcoming provisional findings. AXA PPP notes that the CMA considered this issue in the Report, and stated that the evidence available to it, including HCA's specific examples, did not lead it to conclude that HCA's quality was materially higher than that of close competitors in central London, for example TLC, St John's and St Elizabeth's and King Edward VII.

In AXA PPP's view, it remains the case that there are no quantifiable differences in medical quality between, in particular, HCA and TLC to justify material price differences between them.

AXA PPP's perception, and its experience of PMI customer perceptions, is that TLC in no way has a reputation for being "lower quality" or treating a simpler mix of cases than HCA: both have comparable reputations for being high-quality providers of high acuity hospital services. Nor is there anything in the CMA's Report to suggest TLC is lower-quality. We believe that the appropriate starting point, therefore, is neutral, that is to make no assumption in HCA's favour that it is higher quality or treats more complex patient needs. As such, in the absence of reliable evidence from HCA and/or TLC that establishes a quantifiable difference notwithstanding comparable reputations, no weight can be given to unsubstantiated claims from HCA that its higher quality drives higher costs and explains HCA's higher prices than TLC.³

³ As AXA PPP noted in its letter to the CC of 20 December 2013, the selection of a small number of particular examples does not constitute reliable evidence. The potential for unreliability is well recognised, for example, in the way in which hospital performance tables are used, whereby apparent recorded underperformance is not taken as proof of actual underperformance but rather as an identification of outliers exhibiting prima facie poor performance in order to initiate a deeper investigation of the particular circumstances and causes, to establish whether there is actual underperformance.

AXA PPP also observed in its submission of 6 May 2015 that some quality data previously published by HCA (mortality data on the Society of Cardiothoracic Surgeons' website) is no longer available. The inference from this development cannot be that HCA believes it has evidence supporting its superior quality.

3 IPA in conjunction with other evidence

Significance of the IPA results

The fact that on further revision the CMA has again found statistically significant price differences in its bilateral IPA comparison between HCA and its closest competitor, TLC, is particularly striking. As the CMA has recognised in the Report in the context of assessing other evidence on price differences between competitors,⁴ one would expect “shadow pricing” by price followers of price leaders – in this case by TLC (and other rivals) of HCA -- which would diminish or even mask entirely the size of any price difference. Indeed, even if there were only a very modest or no price difference, AXA PPP's view is that the IPA is a one-way test.

Stepping back from the technical detail, therefore, AXA PPP believes it is important not to lose sight of the fact that even if the IPA had found that TLC charges virtually the same as HCA, such a result would not show HCA has no market power and is not setting prices substantially above the competitive level, as it cannot simply be assumed that TLC's prices are at the competitive level. The IPA results are therefore all the more powerful in showing price differences notwithstanding the possibility that the benchmark (TLC's prices) could itself be inflated if TLC takes advantage to price in the shadow of HCA's higher prices (which would be a rational course of action for the closest competitor of a dominant rival). As noted above, the index of charges of the central London providers against the national average for 2014 indicates that while *all* central London providers are charging above the national average (which may in part reflect common higher London costs), AXA PPP considers that there is no reason to assume that TLC prices in particular ([>]) reflect the price that would prevail in a competitive London market absent the AEC features that permit HCA's market power.

IPA evidence in conjunction with the CMA's profitability evidence

Whilst positive evidence of higher prices from the IPA supports the view that HCA has market power, and accords with the experience of AXA PPP, AXA PPP considers that it should not be viewed in isolation as it reinforces the already “important indicator” (Report, para. 6.441) of market power in the guise of the CMA's extensive profitability analysis that concluded HCA earned returns “substantially and persistently above its cost of capital” (Report, para. 6.491). In particular, the CMA determined in its Report that:

- (i) HCA was one of three hospital groups that together earned 52% of privately funded healthcare services relevant profits⁵; with the concentration of HCA operations in central London compared to the other two groups well known;
- (ii) HCA has persistently made profits in excess of its costs of capital;⁶ and

⁴ In assessing evidentiary weight, the CMA recognised the dampening effect that shadow pricing may have of price differences in its assessment of price differences between independent anaesthetists and anaesthetist groups, in that the former may follow the pricing of the latter (cf. Report at para 7.29).

⁵ Report, §69

⁶ Report, §6.467

- (iii) its assessment of consumer detriment arising from the three largest hospital groups including those of HCA were significant at around 10% of revenues based on excess returns versus an expected market ROCE of 10%.⁷

Profitability, as noted by CMA guidance (CC3, para. 112), is a fuller analysis than simply looking at prices/ costs and cannot be explained away by arguments of higher costs due to location or allegedly superior quality.

As to superior quality, it should also be noted that even if - contrary to the evidence - it were proven that HCA had higher quality than TLC, to an extent that "justifies" the observed price gap, this would not explain away high profitability, as opposed to higher prices than TLC. Thus, whilst a quality product may cost more to produce, and hence would understandably sell at a higher price, the cost of that extra quality is subtracted from the extra revenue generated by that quality when measuring profit. Thus if the price gap due to higher quality reflects the cost gap due to higher quality, profitability will not rise.

Thus, given that the CMA has evidence not just of higher HCA prices but of sustained high HCA profitability, the quality-gap argument, in any case unsubstantiated, cannot be considered as a justification of HCA's position. Accordingly, the CMA's profitability evidence (whose validity remains wholly untarnished by HCA's appeal) and the IPA complement one another, and the latter, as a one-way test and notwithstanding any shadow pricing effects, makes an already compelling AEC case even more powerful. As previously noted in AXA PPP's submission of 9 March 2015, the finding of excess profitability is in and of itself sufficient to support the CMA's analysis of market features (weak competitive constraints on HCA and high barriers to entry and expansion) establishing an overall insured AEC.

B. Further HCA Submissions

AXA PPP has considered HCA's further submissions of 19 and 30 June 2015, and has a number of observations in respect of these submissions.

1 HCA's market position

In its submission HCA argues that its share of capacity in London has fallen as a result of the expansion of other hospital providers.

According to AXA PPP's data, however, HCA's share of admissions and share of revenue in central London have remained consistent (at [40-50%] of its spend for 2012, 2013 and 2014 and a [40-50%] share of all patients treated) which reflects the fact that HCA itself continues to expand.

AXA PPP notes that HCA also makes little reference to its market shares in key specialties, notably oncology and cardiology, which as described in AXA PPP's previous submissions (and acknowledged in the CMA's Report) are of critical importance to PMI customers, especially corporates in the central London area including the City, as well as Canary Wharf. AXA PPP notes that HCA's share of admissions and revenue in relation to these key specialties has also remained consistently high over the past three years, as demonstrated in the table below.

⁷ Report, §§70 -71

HCA's Market Share of the Central London Market			
(Inpatient, Day Case and Outpatient)			
	2012	2013	2014
<i>By revenue</i>			
Claims Paid	[X]	[X]	[X]
Oncology Spend	[X]	[X]	[X]
Cardiology Spend	[X]	[X]	[X]
<i>By admissions</i>			
Patients Treated	[X]	[X]	[X]
Oncology Patients	[X]	[X]	[X]
Cardiology Patients	[X]	[X]	[X]

Source: AXA PPP internal claims data

2 Developments in Central London

HCA argues that since the CMA's Report there have been a number of developments which had a positive impact on the barriers to entry and competition in Central London. AXA PPP acknowledges that there have been some developments, but notes that to a large extent those put forward by HCA are either (i) historical; (ii) speculative; or (iii) specialist outpatient facilities that will not represent a material constraint on HCA's full service (and expanding) inpatient facilities. By way of example:

Historical developments already considered in the Report

- HCA makes frequent reference to TLC's cancer centre. As the CMA is aware, this centre opened in 2009 following many years of development and was fully taken into account by the CMA in reaching its AEC finding in the Report. As such this is not a recent post-Report development in the context of this remittal. On the contrary, HCA has proved that it has been able very effectively to retain its market share of admissions and spend (in the oncology market in particular) notwithstanding the presence of TLC.

Speculative developments

- While King Edward VII has secured funding to develop a further site the timescales for completing this site remain unclear.
- HCA makes reference to Spire's stated desire to develop high acuity, broad range services in London. However, AXA PPP's understanding is that these plans remain aspirational and long term. As noted in AXA PPP's submission of 6 May 2015 and in Spire's own presentation attached as an appendix to HCA's submission, it appears that Spire's original plan of developing a single hospital of significant size has been set aside in favour of a more modest facility across two sites, which may "potentially" open in 2018. AXA PPP is not aware of any further concrete developments in Spire's plan since Spire's presentation in August last year.

- HCA repeatedly refers to the proposed London International development. As the CMA is aware, the owners of this site have had apparent plans to develop this site for many years. As yet development has not commenced.

Outpatient developments

- HCA cites the example of London Claremont which it claims shows 'how competitive this market is becoming'. As a matter of fact, however, London Claremont is a small outpatient facility in Harley Street which cannot constrain inpatient services provided at any of HCA's hospitals.
- HCA refers to the intention of Optegra to develop a new eye clinic in London, which is both speculative and insignificant in terms of being a very minor specialty. Such a clinic would not be able to compete with HCA hospitals in any meaningful way.
- HCA also mentions the expansion of Fortius, an outpatient orthopaedic provider, with only one outpatient facility currently in London and plans to open a second at the end of 2015. Fortius (and other minor outpatient facilities) will similarly have no competitive impact on HCA's portfolio of multi-specialty, high acuity facilities.

HCA's expansion in inpatient and key specialities

AXA PPP notes that HCA makes very little reference to its own development activities since the Report. In particular, HCA almost completely omits any reference to its successful acquisition of the management contracts for private patient units ("PPUs") at Guy's and St Thomas' Hospital and St George's Hospital, which are in addition to its existing management of the PPU at UCL. As highlighted in AXA PPP's submission of 6 May 2015:

- The contract to manage the PPU at Guy's and St Thomas' NHS trust (and related agreements) has already allowed HCA a significant expansion of its oncology services, notably the opening of The London Radiotherapy Centre. These services will be further expanded with the planned cancer centre scheduled to open next year.
- AXA PPP understands that the contract to develop a PPU at St George's hospital has also been awarded to HCA. The plans for this unit have not been publicly disclosed but are likely to include a full range of specialties with a focus on the existing specialisms in the trust including cardiothoracic, obstetrics, paediatrics and neurology services, thereby further strengthening HCA's market position. AXA PPP notes that the CMA has as yet taken no formal action pursuant to either the Private Healthcare Market Investigation Order or the Enterprise Act 2002 with respect to this PPU.

AXA PPP also notes that HCA has substantially increased its outpatient capacity as a result of the additional space it has secured at the Shard, which in turn has enabled HCA to expand its inpatient capacity at the London Bridge Hospital.⁸ HCA has also recently

⁸ As noted in AXA PPP's letter of 20 December 2013, in its Planning Statement (para 6.18 of the Planning Application 13/AP/3322) HCA stated that "[BGL Partners report] has confirmed that there is no suitable space available within the [London Borough of Southwark] area which have a C2 Use Class [healthcare facility] and therefore the search has had to assess the conversion of alternative uses, including B1 [offices] space within this location." Subsequently, HCA secured additional space for approximately 100 consulting rooms at the Shard which can accommodate up to 800 patients per day (see (<http://www.ft.com/cms/s/0/943945ce-4864-11e3-a3ef-00144feabdc0.html#axzz3gPxEv6Z7>)).

opened a large full service diagnostic suite in the vicinity of Harley Street, the Harley Street Diagnostic Centre.

In addition, AXA PPP also understands that HCA plans to develop and expand The Portland Hospital which will add to its obstetrics and gynaecological footprint in London. HCA is believed to have acquired a site next to the existing Portland site separated by a narrow road which it intends to connect to the main hospital by building a bridge between the two premises. This will broadly double the capacity at the Portland hospital.

In overall terms, therefore, HCA's own development activities have had (and are likely to continue to have) a much greater impact on the Central London market (and in particular on relevant specialties) than those of third parties. While such expansion is to be welcomed, given the growth in demand, consistent with the CMA's assessment of the importance of market share as a gauge to HCA's must-have status, it remains the case that PMIs cannot credibly threaten to delist or switch away sufficiently from HCA because the collective capabilities (i.e., "spare capacity" in the widest sense of consultants, equipment and facilities) of rivals are not a credible alternative not only in terms of absorption of demand but critically also (or in any event) as a result of corporate customer preferences for HCA facilities to which PMIs must align their offer.

3 Competition by the NHS

AXA PPP notes HCA's arguments that the NHS will be investing in highly specialist services in London, such as radiotherapy services via the introduction of Proton Therapy services at UCL (and the Christie) and cardiac services, which will act as a competitive constraint on HCA.

This argument is of little relevance to the CMA's analysis. AXA PPP agrees with the CMA's previous findings that the NHS does not compete directly with the private medical providers. Customers who have private medical insurance will in the main choose to be treated in the private medical market (both in private facilities and in NHS facilities as a private patient). Few will opt, even though they have the right to do so, to be treated in an NHS facility as an NHS patient. While the activities of the NHS may inform private healthcare providers as to which new services and technologies they may need to develop to ensure that they continue to operate commercially competitive services, they do not directly constrain HCA.

4 Outer London providers

AXA PPP notes HCA's repeated attempts to argue that outer London hospitals are competitors to their inner London facilities. As AXA PPP has observed a number of times in the past, customers living in Central London would not and do not travel to outer London facilities to receive treatment (and are thus a captive patient base). Nor will corporates or their professional staff be willing to pay PMI premiums and yet have to travel outside of London around or during the working day, so this argument remains not pertinent in relation to the critical London corporate client base of PMIs. By contrast, many customers who live outside Central London will consistently travel into London to receive treatment, for example because:

- (i) It suits them to have consultations and investigations proximate to their workplace;

- (ii) Once a relationship with a specialist has been established they are unlikely to want to change specialist in order to have further treatment outside of central London; and
- (iii) They have a perception that treatment in central London is superior ('higher quality') than treatment in outer London due to the "Harley Street" effect.

Customer preferences and practices in this respect have not changed materially since the Report.

5 Barriers to entry and expansion

5.1 Planning policy

AXA PPP notes HCA's further submission published on 30 June 2015 in relation to proposed changes in property planning policy by Westminster City Council. HCA's main argument appears to be that the Westminster City Council's proposed new protections of social and community facilities and conversion of office properties to residential use will reduce the barriers to entry and expansion for hospital development in central London, and that such proposals 'will require the CMA to reconsider its findings on site availability and planning obstacles in central London'.

AXA PPP makes the following points:

- (i) Future policy change is clearly not evidence of actual market change – the effect is not known; and therefore there is no evidence to support HCA's stated view that 'the reforms are expected to generate a number of potential sites attainable by hospital operators at a reasonable market value'.
- (ii) The policy changes relate to the Westminster area only; while this area is important as it includes the Harley St area, it includes neither the City of London nor any of the other eleven⁹ inner London boroughs.
- (iii) As AXA PPP has submitted previously, hospital premises often have specific requirements. This is particularly the case for radiotherapy facilities given the nature and size of the equipment involved, which is often sited underground or in a separate, purpose built facility. It should be noted that the new Westminster City Council planning policies also include recent adoption of restrictions on excavations for basement development affecting/adjacent to residential properties.

5.2 Ability to attract consultants

Regardless of changes in planning policy, AXA PPP remains of the view that assembling a site for a major new hospital in Central London is difficult, and that even if a site can be identified the process of development is typically lengthy and extremely costly. In addition, the simultaneous need, to attract and retain a sufficient number of consultants represents a significant barrier to entry. If a provider does not have significant support from consultants both at the time the premises are acquired and when bringing patient referrals to their facility once opened, it is unlikely to succeed.

The importance of consultants is also illustrated by the CMA's case study of expansion in London, namely TLC's building of a new cancer centre. Quite apart from the large capital

⁹ See <http://www.londoncouncils.gov.uk/node/1938> (inner London boroughs)

outlay and the time that it took to find and obtain planning permission in respect of a suitable site, the other problem that TLC reported encountering in relation to its cancer centre related to the availability of appropriate specialist consultants:¹⁰

“TLC told us that it had encountered difficulties in retaining key oncologists. It had had a cooperation agreement with the London Oncology Clinic (LOC) but this expired and the LOC was acquired by HCA. TLC told us that it had been necessary to offer a small number of consultants large financial incentives to retain their practice at TLC. [...]

We found that while TLC had been successful in expanding in central London it had encountered difficulties and delays in doing so, the main ones being identifying, acquiring and obtaining permissions for a suitable site and retaining and attracting oncologists to practise at its clinic. As a result, [confidential].”

As the TLC case study illustrates, to be able to open a private hospital in London of any significant size, it is necessary to procure both access to a suitable site, with the necessary planning permissions, and the relevant personnel (which includes both nursing and administrative staff and, importantly, reputable clinical and surgical consultants in the relevant speciality/ies). The prospective entrant should not be viewed as needing to tackle a series of individual challenges one after the other, but as overcoming several mutually reinforcing barriers *at the same time*. As such, the entrant’s problem of coordination (persuading consultants who may be being tempted by HCA while also persuading landlords/planning authorities) makes the task of overcoming entry barriers as a whole substantially greater than the sum of its parts when each is simply looked at in isolation, and helps explain the limited record of entry and expansion to date.

AXA PPP has previously noted that HCA has been very successful in attracting and retaining specialists, enhanced by some of its strategic acquisitions such as Leaders in Oncology. It is unclear whether other providers would be successful in attracting consultants away from HCA. AXA PPP does not consider that the implementation of the Private Healthcare Market Investigation Order has reduced this barrier to entry to any material extent.

6 PMI practices

6.1 Increase in Open Referrals

HCA’s statements in respect of PMI practices are largely repetitive of arguments made (and considered by the CMA) during the market investigation, in relation to which AXA PPP made detailed submissions. AXA PPP does not propose to repeat its previous submissions in significant detail, but in summary:

- (i) AXA PPP has consistently argued that HCA has a significant proportion of must have facilities in Central London and cannot have a compelling proposition with corporate customers without HCA hospitals, especially in cancer care and other high acuity services.
- (ii) As noted in its submission of 6 May 2015, AXA PPP retains limited ability to direct patients away from HCA facilities to any material extent. In particular, the take-up of AXA PPP’s Healthcare Pathway product has been low among corporate customers

¹⁰ Report, §§6.31-33.

(who in many cases have continued to demand access to HCA's must have facilities) and policy numbers remain static.

- (iii) The percentage of open referrals to total referrals continues to be low; in 2014 this amounted to 8% of referrals that resulted in hospital treatment in central London . Further, of this 8%, around [redacted] were in any event referred to HCA (a larger proportion than any other provider).

AXA PPP also notes HCA's reference to the extent to which Bupa's open referral has been taken up. Bupa is clearly best placed to address HCA's statements in this respect, but AXA PPP notes that this comment was made some time ago and has not been recently repeated. Furthermore, as noted above it remains the case for all PMI providers that redirection in more complex specialties (notably oncology and cardiology) is more difficult given the limited number of alternative facilities, thus enabling HCA to maintain its dominant position even in relation to open referral products. AXA PPP notes that HCA does not claim a fall in its share of Bupa claims.

6.2 PMI bargaining power

HCA also repeats its previous arguments that insurers can easily remove their facilities from their network, referring to BUPA's temporary removal of certain BMI facilities outside central London from hospital lists, and to AXA PPP's development of an Oral Surgery network as evidence of insurers bargaining power. Both of these issues were considered by the CMA in its Report, and there have been no material developments since the Report to alter the CMA's conclusions with respect to PMIs.

AXA PPP has previously provided a lengthy explanation that it is not true that it is 'easy' and effective to remove facilities from a network, for the following reasons:

- (i) In the short term insurers face the fact that providers such as HCA will increase the prices charged to insurers to 'rack' rates. AXA PPP faced such a scenario in a dispute with HCA in 2009 when threatened with increased prices of at least 50%; and
- (ii) Insurers cannot move patients away from facilities in the short term without causing significant patient detriment.

HCA also suggests that insurers can delist particular facilities (but retain others). This is not the case. As AXA PPP has demonstrated in its previous submissions HCA negotiates with respect to its entire portfolio of facilities as opposed to individual negotiations for separate facilities, and AXA PPP's experience is that HCA threatens significant price increases for facilities that continue to be recognised in the event that other facilities are excluded. In addition, in reality it is difficult to delist hospitals entirely, especially given HCA's high acuity facilities, as there will always be a need to permit access to excluded facilities on a case by case basis, based on medical necessity. In this circumstance HCA would reserve the right to charge punitive rack rates for such patients.

Finally, HCA argues that insurers have the ability to exclude new HCA facilities in development and drive down prices. Again, this does not accord with AXA PPP's experience. As set out in AXA PPP's submission of 6 May 2015, the agreed uplift in HCA's 2014 contract [redacted].

C. Conclusion

In summary, the conclusions in the Working Paper as to the results of the updated IPA analysis are consistent with AXA PPP's own experience of dealing with HCA and TLC (as well as with HCA's other smaller competitors). AXA PPP also remains of the view that there are no quantifiable differences in medical quality which would justify materially higher prices between HCA and TLC.

As noted above, the IPA should be viewed as complementary to – and a reinforcement of – the CMA's profitability analysis of the Report, which remains a compelling and untarnished quantitative indicator of market power, in conjunction with the qualitative AEC market features identified by the CMA. In particular, the CMA's analysis in this regard is not susceptible to distortion as a result of (i) TLC pricing in HCA's shadow (which would tend to depress price differences, and makes the IPA results more striking); and/or (ii) alleged or real quality or patient mix differences between TLC and HCA.

AXA PPP also observes that HCA's submissions of 19 and 30 June have overstated developments in central London whilst failing to address (or explain) its own expansion activities since the publication of the Report. In fact, at least on AXA PPP data, HCA's market shares have remained persistently stable and always above 45% (ranging up to 61%) of revenue when looked at overall or in key specialties (oncology or cardiology) in each year of the 2012-14 period.

In AXA PPP's view, therefore, there have been no material developments since the Report that would reasonably justify a departure from the CMA's previous AEC finding. AXA PPP would be happy to discuss these submissions with the CMA and assist further.