

Private healthcare remittal

Notice of possible remedies

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Introduction

1. On 4 April 2012, the Office of Fair Trading (OFT) made a market investigation reference to the Competition Commission (CC) under sections 131 and 133 of the Enterprise Act 2002 (the Act) regarding the supply or acquisition of privately-funded healthcare services in the UK.
2. On 1 April 2014 the remaining functions of the CC in relation to the reference were transferred to the Competition and Markets Authority (CMA), under Schedule 5 to the Enterprise and Regulatory Reform Act 2013 and the Schedule to the Enterprise and Regulatory Reform Act 2013 (Commencement No. 6, Transitional Provisions and Savings) Order 2014 (the Order).
3. Accordingly the final report dated 2 April 2014 (the Final Report) was published by the CMA in exercise of its functions under section 136(1) of the Act. In the Final Report, the CMA found that certain structural features of the markets for the supply or acquisition of privately-funded healthcare services were leading to adverse effects on competition (AECs) in respect of insured patients in central London and in respect of self-pay patients across the UK. We decided that a package of remedies, including divestiture of one or two of the hospitals owned by HCA International Limited (HCA) in central London, would form as comprehensive a solution as is reasonable and practicable to the AECs and/or the detrimental effects on customers arising from the AECs.
4. As a result of the decisions reached by the CMA in the Final Report, HCA applied on 30 May 2014 to the Competition Appeal Tribunal (the CAT) for a review under section 179 of the Act.
5. During the proceedings before the CAT, HCA's external economic advisers identified certain errors in the CMA's insured pricing analysis (the IPA). In light of these errors, the CMA considered that the appropriate course of action was for the matters to be remitted back to the CMA for it to review the IPA and re-consult with interested parties.
6. Accordingly, on 12 January 2015, the CAT ordered that the following decisions, as contained in the Final Report, should be quashed and remitted back to the CMA for reconsideration:
 - (a) the CMA's finding of an AEC in the markets for the provision of hospital services in respect of insured patients in central London; and
 - (b) the CMA's divestiture remedy, by which HCA was required to divest itself of one or two of its hospitals in central London, as described in paragraphs 11.132, 13.1(a) and 13.48 of the Final Report.

Remittal provisional decision

7. Since launching the remittal on 25 February 2015, the CMA has been re-considering, among other things, the IPA.
8. In our provisional findings report, we provisionally concluded that there are two structural features in the markets for the provision of privately-funded healthcare services by private hospital operators in central London which lead to an AEC:
 - (a) high concentration, with HCA having a large market share; and
 - (b) high barriers to entry and expansion, arising [primarily] from high sunk costs and long lead times, [the latter being exacerbated by limited site availability and planning constraints].
9. In combination, these features result in weak competitive constraints on HCA in the provision of privately-funded hospital services for insured patients in central London (the insured AEC).
10. We also provisionally concluded that the insured AEC is leading to customer detriment in the form of higher prices being charged by HCA than we would expect to find in a well-functioning market.
11. In the light of this updated provisional finding, we are now considering what, if any, remedies are required to address the insured AEC, together with the separate AEC we found in the Final Report in respect of self-pay patients (the self-pay AEC), in central London.

Criteria for consideration of remedies

12. When deciding whether any remedial action should be taken and, if so, which action should be taken, the CMA will consider (a) how comprehensively the possible remedy options – individually or as a package – address the AECs and/or the resulting detrimental effects on customers, and (b) whether they are reasonable and practicable.¹
13. The CMA will assess the extent to which different remedy options are likely to be practicable and effective in achieving their aims, including whether they are practicable and when they are likely to have effect.² The CMA will generally look to implement remedies that prevent an AEC by addressing its underlying

¹ *Guidelines for market investigations: Their role, procedures, assessment and remedies (CC3)*, paragraph 330.

² *CC3*, paragraphs 327 & 330.

causes, or by introducing ongoing measures that can be put in place for the duration of the AEC. The CMA will tend to favour remedies that can be expected to show results within a relatively short period of time. In line with our revised guidelines,³ the CMA will also consider whether or not to limit the duration of individual remedies by including sunset provisions in their design. This approach might be appropriate if, for example, the relevant competitive dynamics of a market are likely to change materially over the next few years or the measure in question is intended to have a transitional impact, while other longer-term measures take effect.⁴

14. The CMA will be guided by the principle of proportionality in ensuring that it acts reasonably in making decisions about which remedies to impose. The CMA will therefore assess the extent to which different remedy options are proportionate, and in particular it will be guided by whether a remedy option:
 - (a) is effective in achieving its legitimate aim;
 - (b) is no more onerous than needed to achieve its aim;
 - (c) is the least onerous if there is a choice between several effective measures; and
 - (d) does not produce disadvantages which are disproportionate to the aim.⁵
15. The CMA may also have regard to the effects of any remedial action on any relevant customer benefits (RCBs) arising from a feature or features of the market giving rise to the AEC or AECs. We set out our proposed approach to analysing RCBs in paragraphs 57 to 64 of this Notice.
16. In the event that the CMA reaches a final decision that there is an AEC, the circumstances in which it will decide not to take any remedial action are likely to be rare but might include situations in which no practicable remedy is available, where the cost of each practicable remedy option is disproportionate to the extent that the remedy option resolves the AEC, or where RCBs accruing from the market features are large in relation to the AEC and would be lost as a consequence of any appropriate remedy.⁶

³ *Market studies and market investigations: Supplemental guidance on the CMA's approach (CMA3)* (revised September 2015), paragraphs 4.14–4.25.

⁴ *CMA3*, paragraphs 4.14–4.25.

⁵ *CC3*, paragraphs 335–337.

⁶ *CC3*, paragraphs 355–369.

Possible remedies on which views are sought

17. In this Notice we describe remedy options that we have considered in addressing the insured AEC, together with the self-pay AEC in central London, and/or their detrimental effect on customers. This includes remedies considered in our original inquiry, as well as certain new remedies. We describe each of these remedy options in turn, explaining the feature(s) they are meant to address and how they are intended to work in practice. We invite views on specific issues that we raise in this Notice as well as any other issues that the parties to the investigation and other interested parties would like to put to us.
18. We have drawn on the work undertaken in relation to remedies in our original inquiry. However, we will reach a new decision on remedies, having regard to our findings during this remittal and any new submissions and evidence received.
19. We have distinguished in this Notice between those remedies which we are minded to consider (because we currently believe they have the potential to be practicable and effective) and those which we are not minded to consider. In reaching this view we have had regard to the analysis of the effectiveness of a number of possible remedies set out in the Final Report. At this stage we are only proposing to consider further those remedies in the first category but we will consider further the remedies in the second category and other proposals if parties are able to provide relevant evidence and reasoning as to why these alternatives would be practicable and effective. We will also be giving careful consideration to the proportionality of possible remedies, in the light of the further analysis conducted during this remittal.
20. We first set out, in paragraphs 21 to 36, those remedies which we currently believe may be practicable and effective and which we are minded to consider further. We invite views on the effectiveness and proportionality of these measures and on the most appropriate means of specifying and implementing them. We then set out in paragraphs 37 to 56, those remedies which we are not currently minded to consider further, although we also invite views on these.

Remedy options that we are minded to consider

21. We set out below possible remedies to address the insured AEC, together with the self-pay AEC in central London, and/or the customer detriment that these AEC give rise to.

Remedy 1 – Divestiture of one or more hospitals and/or other assets owned or operated by HCA in central London

22. The aim of divestiture in market investigations is generally to address competition problems arising from structural features of the market. This may be done either by creating a new source of competition through disposal of a business or assets to a new market participant, or by strengthening an existing source or sources of competition through disposal of a business or assets to an existing market participant that is independent of the divesting party (or parties).

How the remedy would work

23. The AECs arise from HCA's large market share, combined with barriers to entry and expansion, in central London. HCA owns six hospitals⁷ and other facilities which between them account for around half of all admissions to acute private hospitals in central London. HCA's closest rival in central London, The London Clinic, has a share of admissions of 12.1%.⁸ The remainder is made up of BMI, Bupa Cromwell, other private hospitals and private patient units (PPUs).⁹
24. The remedy would require HCA to divest a hospital or hospitals and other assets (the divestiture package) to a suitable purchaser or purchasers sufficient to impose a competitive constraint on HCA's remaining hospitals in central London. In considering the scope of the divestiture package that would be practicable and effective in addressing the AECs we would take account of the range of services provided by each of HCA's hospitals, their customer base, the volume of their admissions and their turnover. Our proposed approach to analysing the effectiveness of divestiture package options is as set out in the Final Report.¹⁰ In particular, we identified the following factors as being salient in assessing the effectiveness of a potential divestiture package:
- (a) In line with our analysis underpinning the AEC findings, the appropriate product market definition is according to medical specialty and the appropriate geographic market definition is central London with weak constraints from outside central London.

⁷ HCA's central London hospitals comprise: the Wellington, the London Bridge, the Lister, the Portland, the Princess Grace and the Harley Street Clinic.

⁸ For all hospitals, we analysed data from 2011, only for admissions in the 16 specialties and oncology that form the focus of our competitive assessment.

⁹ Table 4.2 of the competitive constraints section of the provisional findings.

¹⁰ [Private healthcare market investigation: Final report](#), paragraphs 11.68–11.72.

- (b) The insurers and hospital operators negotiate a price across a ‘bundle’ of treatments, with hospital operators seeking to increase treatment prices for the remaining services in response to insurers’ attempts to reduce the number of treatments for which they recognise a given hospital operator.
 - (c) The combination of a specialty-level product market, and prices that are negotiated jointly across a full range of services, suggested that a strong market position in one or a small number of specialties would allow a private hospital operator to exert market power.
 - (d) High barriers to entry and expansion in central London were a feature of the market giving rise to the AECs.
25. In the Final Report,¹¹ we identified that the following divestiture options would be practicable and effective in addressing the competition concerns in central London:
- (a) either the Wellington Hospital (including the Platinum Medical Centre); or
 - (b) both the London Bridge Hospital and the Princess Grace Hospital (excluding associated facilities, such as 30 Devonshire Street, 47 Nottingham Place and HCA’s facility in the Shard).
26. Absent new evidence to the contrary, our current view is that these alternative divestiture options would be practicable and effective. However, we invite parties to provide submissions on the likely effectiveness of these divestiture packages.
27. We will also give very careful consideration to the proportionality of any divestiture remedy. We would welcome submissions as to whether other divestiture packages are now available that would be similarly practicable and effective, but less intrusive than the above divestitures. We would also welcome submissions as to the likely costs and benefits of any divestiture remedies we may find to be practicable and effective, having regard to current market conditions and, among other things, to our reconsideration of the IPA.

Issues for comment 1

28. We set out below a series of questions regarding the divestiture remedy proposed in central London. We invite responses to the following questions:

¹¹ Final Report, paragraphs 11.125–11.132.

- (a) Would a divestiture remedy address the insured AEC and self-pay AEC in central London effectively and comprehensively?**
- (b) Would a divestiture package comprising either the Wellington Hospital or London Bridge Hospital and Princess Grace Hospital, effectively constrain HCA in terms of the range of specialisms offered and the capacity of the hospitals (ie theatres, beds, ICU, etc)?**
- (c) Are there suitable purchasers available with the appropriate expertise, commitment and financial resources to operate and develop the divestiture business as an effective competitor without creating further competition concerns?**
- (d) Would any other, divestiture package be similarly effective? Should alternative HCA assets be considered for divestiture?**
- (e) Would divestiture of an HCA hospital or hospitals and/or other assets confer market power on the acquirer? In what circumstances might this risk arise? Are there hospitals or other assets whose divestiture would be particularly likely to give rise to this risk?**
- (f) How long should HCA be given to effect the sale of the divestiture package? In relatively straightforward divestiture cases a maximum period of six months is appropriate. Is that sufficient in this case?**
- (g) What are the relevant costs and benefits that we should take into account in considering the proportionality of the divestiture options? ¹² How could we go about quantifying these?**

Remedy 2 – Require HCA to give competitors access to its hospital facilities to compete

29. This remedy would seek to increase the competitive constraint on HCA by requiring the firm to allow other private hospital operators to rent space in its facilities in order to compete. This might be an effective alternative to divestiture, if significant new entry is expected within a certain time frame, as the remedy could be time-limited.

¹² [Final Report](#), paragraphs 13.36–13.47.

How the remedy would work

30. As in the case of divestiture, this remedy would seek either to create a new source of competition, or to strengthen an existing source of competition by increasing the quantity of non-HCA controlled private hospital capacity in central London. HCA would be required to allow another hospital operator to rent out a whole hospital building for a given period of time, together with its equipment.
31. The rental price could be determined through the market (ie let other hospital operators bid for the space).

Issues for comment 2

32. We invite responses to the following questions:
 - (a) **Would the remedy be practicable and effective in remedying the insured and self-pay AECs?**
 - (b) **Would existing competitors and/or new entrants be interested in renting hospital facilities for a limited period of time? If so, how long should HCA be required to rent out its facilities to another operator?**
 - (c) **Would the remedy give rise to unintended consequences or distortions?**
 - (d) **Are there other remedies that would be as practicable and effective in remedying the AECs that would be less costly or intrusive?**
 - (e) **Is this remedy a potential (effective and proportionate) alternative to full divestiture? Are the effects of this remedy similar to those of remedy 1?**
 - (f) **What provisions would need to be put in place for the monitoring and enforcement of this remedy and which body should be responsible?**
 - (g) **Should HCA be allowed to move staff, administrative functions and equipment, etc out of the hospital building that it rents out? Or should HCA be required to allow staff to transfer to new operator?**
 - (h) **What hospital/facilities should be rented out by HCA?**

Remedy 3 – Restrictions on HCA’s further expansion in central London

33. We have provisionally found that there are substantial barriers to entry and expansion in the private hospital markets in central London, arising from the limited availability of suitable sites for private hospitals, as well as long lead times to build new facilities, high sunk costs and the existence of planning constraints.
34. This remedy would seek to facilitate entry by competitors in the central London markets by preventing HCA from expanding its private hospital portfolio within central London via the acquisition of new sites for use as hospitals and/or clinics.¹³

How the remedy would work

35. This remedy would seek to lower the barriers to entry and expansion arising as a result of limited site availability for operators other than HCA by preventing HCA from acquiring further suitable hospital sites in central London. We consider that, as a result of its market position, HCA may be able to pay more for new sites as by avoiding new entry, it protects its existing sites from greater competition, and therefore the sites are worth more to HCA than a new entrant. In contrast, the price that a competitor would be able to pay for a site will be limited by the level of profits that it can expect to earn from operating that site.

Issues for comment 3

36. We invite responses to the following questions:
 - (a) **Would the remedy be effective in facilitating entry by new competitors and/or expansion by existing (non-HCA) operators in central London? Would it remedy the AECs in a timely manner?**
 - (b) **In order for this remedy to be practicable and effective, which healthcare activities should be covered? For example, should HCA be prevented from expanding its portfolio of secondary and tertiary healthcare activities only, or should the restriction also apply to primary healthcare activities, eg GP surgeries? Should HCA be prevented from expanding its outpatient and/or inpatient services?**

¹³ We have already implemented a remedy following the Final Report that addresses barriers to entry by restricting a private hospital operator facing weak competitive constraints in a local area from acquiring the right to manage a local PPU in the same local area. [Final Report](#), Section 11: Remedy measures that we are taking forward, paragraphs 11.245–11.337.

- (c) **Should this remedy be time-limited? If so, for how long should the remedy apply? Should its removal be contingent on changes in the market, eg large-scale entry?**
- (d) **Would the remedy give rise to unintended consequences or distortions?**
- (e) **Would customer detriment arise if the incumbent was prevented from expanding within central London but no entrant appeared?**
- (f) **Is there any risk that HCA could circumvent this remedy?**
- (g) **What provisions would need to be put in place for the monitoring and enforcement of this remedy and which body should be responsible?**
- (h) **What are the relevant costs and benefits that we should take into account in considering the proportionality of this remedy? How could we go about quantifying these?**

Remedy options that we are not minded to consider

37. We set out below those remedies which we currently believe are not likely to be practicable and effective and which, therefore, we are not currently minded to explore further.

Remedy 4 – ‘Light-touch’ price control

38. A price control would set the maximum prices that could be charged at hospitals which we consider have market power.
39. We considered the option of imposing a price control in the Final Report¹⁴ but came to the view that:
- (a) it would be very difficult and costly to set it up in this market (whether in the form of a reference tariff or by comparison to charges levied by similar hospitals);
 - (b) it may be vulnerable to circumvention, in that hospitals subject to such a cap would be incentivised to reduce the quality of the service they provide;

¹⁴ [Final Report](#), paragraphs 12.63–12.68.

- (c) it may generate distortion risks over time by discouraging innovation and the introduction of new and better treatments and procedures; and
 - (d) it would also discourage new entry into an area subject to a capping regime, unless the potential new entrant could be certain that the fact of its entry would result in the removal of price caps in that area.
40. In the context of the remittal, we have considered whether a 'light-touch' price control could be effective and/or less onerous than a standard price control at addressing the AECs. A 'light-touch' price control could take the form of a requirement for HCA to reduce its prices by a set percentage from existing contract levels for a period of time. We found that this option might avoid the issue raised at sub-bullet (a) above but not the issues raised at sub-bullets (b), (c) and (d).
41. Moreover, a 'light-touch' price control would only be feasible on a short-term basis (ie for a period of a few years) otherwise the risk of distortion becomes more significant. The time-limited nature of a light-touch price control might be attractive if we believed that the market was going to become more competitive over time, due to the entry or expansion of other private hospital operators.
42. Our current view is that this remedy might be effective in mitigating any price detriment to customers arising from HCA's market power. However, we do not believe that it would address the underlying causes of the AEC or remedy any detriment taking the form of lower quality or less innovation in the market.
43. On balance we are of the view that a price control would not be an appropriate remedy. However, we invite views on this.

Remedy 5 – Preventing tying and bundling

44. In our Final Report,¹⁵ we considered whether a remedy that imposed restrictions on the behaviour of private hospital operators in their negotiations with insurers could be effective in preventing them from exercising market power. In our previous Remedies Notice dated 28 August 2013 we consulted on two potential versions of this remedy:
- (a) The first version sought to prevent private hospital operators with market power from raising their prices across their whole hospital portfolio if a

¹⁵ [Final Report](#), paragraphs 12.22–12.62.

PMI changed its network policy such that patient volumes to the hospital operator concerned were likely to fall.

(b) A second version sought to require private hospital operators with market power to offer and price their hospitals separately.¹⁶

45. In our Final Report,¹⁷ we concluded that neither of these versions of the remedy was likely to be effective in remedying the AEC.
46. As part of the remittal process, we have reconsidered these potential remedies and whether they might be practicable and effective. As previously, we still believe that this type of remedy would not address the source of HCA's market power but rather could only mitigate the firm's ability to use this power to achieve prices above the competitive level. We continue to be concerned that any attempt to control the terms on which insurers and HCA contract would be incomplete as a means of preventing the exercise of market power – and, therefore, be ineffective – and could give rise to significant additional costs and distortions in the market.
47. On balance, therefore, we are of the view that this type of remedy is unlikely to be effective. However, we invite views on this.

Remedy 6 – Facilitate site availability in central London

48. During this remittal, we have considered whether a remedy that would help make more sites available in central London for private hospital use could be practicable and effective in addressing the AECs. We have considered two potential versions of this remedy:
- (a) recommendation to NHS trusts/Department of Health to sell surplus buildings for medical uses to private hospital operators; or
- (b) recommendation to the government to change planning regulations to facilitate entry/expansion by non-HCA hospital operators into central London.
49. The aim of the first version of this remedy would be to ensure that NHS sites that are no longer required by NHS trusts and are, therefore, being sold, are made available to private hospitals rather than used for other purposes (eg converted for residential use). In effect, the remedy would recommend that the NHS marketed such sites to private hospital operators first and, only if

¹⁶ [Notice of possible remedies](#).

¹⁷ [Final Report](#), paragraphs 12.22–12.62.

there was no interest at a reasonable price, would the NHS then seek to market the sites more broadly, including for conversion to residential use.

50. However, we have several concerns with this remedy. In the first instance, we noted that the likelihood of this recommendation being followed and hence the effectiveness of the remedy is highly uncertain. This remedy could only be implemented via a recommendation to NHS trusts, rather than by means of an order or undertakings. Given that the latter need to prioritise their own financial viability, we believe that they would seek to sell unwanted sites for the greatest potential value and would be unlikely, therefore, to give priority to private hospitals when marketing their surplus land and buildings.
51. Second, we observed that this remedy does not address the long lead times for new hospitals to enter the central London market, although buildings previously used as hospitals should be quicker to redevelop than other building sites. Therefore, this is unlikely to offer a timely solution to remedying the AECs.
52. We would also need to consider ways in which we could prevent HCA from purchasing these sites (if it can pay more for them than its competitors due to its strong market position), otherwise the remedy would be ineffective in increasing the competitive constraint on HCA.
53. The aim of the second version of this remedy would be to ensure that planning restrictions in central London are relaxed/changed in order to give priority to non-HCA hospitals being built. In order to be effective, we would have to recommend to the government that private hospital use was given preference over other uses in planning decisions.
54. The effectiveness of this remedy is uncertain given that it will take a very long time to remedy the AECs. This remedy does not address the long lead times required for new hospitals to enter, in addition to the fact that any changes to planning legislation or guidance are also likely to take a reasonably long time.
55. Furthermore, it is unclear whether the government would be prepared to change planning laws to facilitate entry of private hospital operators.
56. On balance we are of the view that neither the first version nor the second version of this remedy would be appropriate. However, we invite views on this.

Relevant customer benefits

57. As explained in paragraphs 14 and 15 above, in deciding which remedies to impose, the CMA may in particular have regard to the effect of any action on any RCBs of the feature or features of the market concerned.¹⁸
58. RCBs are limited to benefits to relevant customers in the form of:
- (a) lower prices, higher quality or greater choice of goods and services in any market in the UK (whether or not the market to which the feature or features concerned relate); or
 - (b) greater innovation in relation to such goods and services.
59. The Act¹⁹ provides that a benefit is only an RCB if the CMA believes that:
- (a) the benefit has accrued as a result (whether wholly or partly) of the features concerned or may be expected to accrue within a reasonable period of time as a result (whether wholly or partly) of that feature or those features; and
 - (b) the benefit was or is unlikely to accrue without the feature or features concerned.
60. The CMA is minded to consider RCBs and invites submissions from interested parties on this matter. In considering potential RCBs, the CMA will need to ascertain that the market feature (or features) with which it has been concerned results, or is likely to result, in lower prices, higher quality, wider choice or greater innovation, and that such benefits are unlikely to arise in the absence of the market feature or features concerned. RCBs may include benefits to customers in the market in which the CMA has found an AEC and to customers in other markets within the UK.
61. If the CMA is satisfied that there are RCBs deriving from a market feature that has resulted in an AEC, the CMA will consider whether to modify the remedy that it might otherwise have imposed or recommended. When deciding whether to modify a remedy, the CMA will consider a number of factors including the size and nature of the expected benefit and how long the benefit is to be sustained. The CMA will also consider the different impacts of the features on different customers.

¹⁸ CC3, paragraphs 355–369.

¹⁹ Section 134(7).

62. It is possible that the benefits are of such significance compared with the effects of the market feature(s) on competition that the CMA will decide that no remedy is called for. This might occur if no remedies can be identified that are able to preserve the RCBs while remedying or mitigating the AEC and/or the customer detriment.
63. Alternatively, the CMA, as a result of identifying RCBs, may choose a different remedy, for example a behavioural rather than a structural remedy. In this case, the CMA will have to weigh the disadvantage of a less comprehensive solution to the competition problem against the preservation of the benefits that result from the feature concerned.²⁰
64. In the Final Report, the CMA considered whether RCBs, as defined by the Act, were present and, if so, whether and to what extent we should modify our remedy package in order to preserve them. Having taken into account submissions from HCA and other interested parties, we concluded that we did not need to vary our remedy package in order to preserve any RCBs.²¹

Next steps

65. The parties to this investigation and any other interested persons are requested to provide any views in writing, including any suggestions for additional or alternative remedies that they wish the CMA to consider, by 3 December 2015 either by email to Private-Healthcare@cma.gsi.gov.uk or in writing to:

Lara Stoimenova
Competition and Markets Authority
Victoria House
Southampton Row
London
WC1B 4AD

²⁰ CC3, paragraphs 355–369.

²¹ Final Report, paragraphs 13.32–13.49 and Appendix 11.1, paragraphs 67–71.