



# **Private healthcare market investigation**

## **Response to Provisional Findings and Notice of Possible Remedies**

**Bupa**

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# 1. EXECUTIVE SUMMARY

- 1.1 Bupa welcomes the opportunity to engage on remedies to address effectively the substantial competition concerns provisionally identified by the Competition and Markets Authority (“CMA”) in the Central London private hospital market.
- 1.2 This submission sets out Bupa’s comments on the Notice of Possible Remedies (“NPR”) published by the CMA on 10 November 2015. It also comments briefly on the Provisional Findings (“PFs”) and how these affect the design of the appropriate remedies package.
- 1.3 We look forward to discussing the contents of this submission further with the CMA at the proposed remedies hearing on 16 December 2015, and are of course willing to provide any additional evidence the CMA requires to deliver a comprehensive and effective remedies package to address the competition concerns in Central London.
- 1.4 Please note that this submission contains commercially sensitive information and should not be published in this confidential format.

## *Comments on the Provisional Findings*

- 1.5 Bupa welcomes the PFs published on 10 November 2015. We agree that there is clear evidence of Adverse Effects on Competition (“AECs”) for self-pay and insured patients in the Central London private hospital market caused by:
  - i. The highly concentrated market, which is dominated by Hospital Corporation of America (“HCA”); and,
  - ii. The high barriers to entry and expansion that prevent any meaningful constraint being exercised on HCA.
- 1.6 The weak level of competition in Central London has resulted in substantial customer detriment:
  - i. The CMA found in its Final Report of April 2014 that HCA was earning significant and sustained excess profits during the period 2007 to 2011, despite the recession. These excess profits indicate that HCA’s prices are too high.
  - ii. Given the importance of Central London to the entire private insurance market, and corporate customers in particular, the high prices will have had detrimental knock-on effects on customers across the UK<sup>1</sup>. Hundreds of thousands of customers have been priced out of the insured market in the last decade.

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<sup>1</sup> A well-functioning Central London market is of critical and growing importance to the performance of the private healthcare sector across the UK. Central London accounted for [X] of total Bupa claims spend in 2014, up from a level of [X] in 2011. Greater London (Central London and Outer London combined) accounted [X] of Bupa’s claims spend in 2014. The region has a substantial effect on premium inflation not only for personal and corporate customers in Central London but also on customers across the UK.

- iii. Insurers have been restricted from bringing innovative lower cost products to customers in Central London due to HCA's dominant negotiating position.

1.7 However, while Bupa agrees strongly with the CMA's broad conclusions in the PFs, we raise the following concerns:

- i. The CMA's analysis on market shares and concentration in the PFs (and previously the Final Report of April 2014) relies primarily on revenue and admissions data from 2011. HCA has grown substantially since 2011. Our experience is that HCA now controls even higher shares of revenue in strategically important specialisms (such as Oncology and Cardiology) and in aggregate across specialisms. Bupa's 2014 hospital spend in Central London shows:
  - a. HCA's aggregate revenue share was [X] in 2014 (and [X] for in-patient spend)<sup>2</sup>, up from [X] in 2012;
  - b. HCA's revenue share was 40% or more in [X] key specialisms, and over 50% [X] specialisms.
  - c. In each of the three largest specialisms by spend – [X] (together accounting for [X] of Bupa's spend with HCA in Central London) – HCA's share is [X]
  - d. Looking only at in-patient spend, HCA had an aggregate share of [X] and had shares of over 50% in [X] key specialisms.

HCA also has a series of expansion projects in progress that will make it even stronger in the next few years<sup>3</sup>. There is a significant risk, therefore, that the PFs underestimate HCA's dominance at a specialism level and the strength it gains from dominating so many specialisms in combination.

- ii. The CMA's analysis in the PFs focusses on 17 specialisms – the 16 'common' specialisms offered by 80% or more of the private hospitals in the UK and Oncology. However, as Bupa has noted before<sup>4</sup>, there are important specialisms in Central London outside these 17 – specialisms which HCA dominates and which the CMA should consider in its competitive assessment and remedies design. Examples of HCA's 2014 revenue shares in key specialisms not included in the CMA's 17 are: [X]
- iii. The CMA has proved that HCA earned substantial excess profits between 2007 and 2011. However, HCA has seen rapid revenue growth since 2011, meaning customer detriment appears likely to be even higher now. As we have requested previously, the

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<sup>2</sup> Even using a much wider Greater London market definition (the area of Central and Outer London combined), HCA had a revenue share of [X] in 2014 and was dominant shares in a number of specialisms.

<sup>3</sup> Please also note that HCA now controls [X] spending in its local market in Manchester through The Christie Clinic. The Christie accounted for [X] million of Bupa's spend in 2014 making it the [X] facility in HCA's portfolio (much larger than the Lister Hospital or Leaders in Oncology Care in Central London) despite HCA having opened The Christie only in September 2010. Its control of The Christie strengthens the bargaining position of the HCA group as a whole including strengthening its bargaining power in Central London. For an insurer, a contract dispute could now undermine the insurer's coverage in Central London and in Manchester simultaneously.

<sup>4</sup> See our Response to the Annotated Issues Statement (April 2013) and our Response to the Provisional Findings (September 2013).

CMA should have updated its profitability analysis to reveal the full extent of this detriment (and so to accurately consider the proportionality of remedies).

- iv. The CMA appears to have softened its conclusions on the pricing differential found in the Insured Price Analysis (“IPA”), provisionally finding that HCA is more expensive than The London Clinic (TLC), but no longer concluding on the size of the differential. Bupa emphasises that:
    - a. There is no objective evidence to show more complex patients are steered towards HCA rather than TLC. Bupa sees no evidence in the market to support the view that patients, doctors and insurers direct more complex cases to HCA ahead of TLC in a systematic way.
    - b. The number of pathology tests recorded on invoices is not a reliable indicator of patient complexity as it is affected by billing arrangements insurers have with individual hospital operators. Indeed, HCA bargaining strength has allowed it to charge separately for more tests and drugs than TLC. So, perversely, an outcome of its bargaining power may be misrepresented here as a defence for its pricing. [X<]
    - c. The differential in pricing may have grown since 2011, as demonstrated by the high annual price increases HCA has negotiated into its contract with Bupa, the cumulative effect of which was illustrated in Figure 2 of our May 2015 submission.
    - d. In the absence of any other objective and robust evidence, it is Bupa’s view that HCA remains able to charge higher prices than its rivals simply because it faces insufficient competitive constraints.
- 1.8 Bupa reaffirms its observations in the response to the IPA working paper: the CMA has found HCA to have higher prices than TLC, but evidence of a significant price differential between HCA and TLC is not essential to a finding of an AEC in Central London. The high levels of excess profits of HCA in the market must be given appropriate weight in any assessment of competitive conditions in Central London and provides clear evidence that prices are too high.

### **Comments on Possible Remedies Options**

- 1.9 Bupa believes strongly that HCA divesting a package of hospitals is the only effective way to address the AECs in Central London.
- 1.10 Divestments offer a clear cut and timely solution, introducing real and immediate rivalry into the market, without the need for costly ongoing monitoring and the risk of circumvention. Competition in the market will not improve without the CMA’s urgent intervention.
- 1.11 The remedies package should be designed with a forward-looking view. It should account for market concentration, HCA size and customer detriment today – these are very high and as described above potentially underestimated by the analyses based on the 2011 data in the PFs. It should also take into account the further planned expansion HCA already has in motion.
- 1.12 We agree strongly with the CMA’s view (in paragraph 24 of the NPR) that “[t]he 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 specialities would allow a private hospital operator to exert market power”. The effectiveness of a remedy therefore relies on its ability to introduce meaningful competition at the specialism level.

- 1.13 It is reasonable and proportionate to take this once in a generation opportunity to place the private healthcare market in Central London on a more sustainable footing.

### Remedy Option 1: HCA divests one or more hospitals

- 1.14 The CMA sets out two possible divestment packages in the NPR.
- 1.15 The CMA considers that HCA could divest:
- A. The London Bridge and The Princess Grace (excluding associated facilities, such as 30 Devonshire Street, 47 Nottingham Place and HCA's facility at the Shard); **OR**
  - B. The Wellington Hospital (including the Platinum Centre).
- 1.16 Bupa agrees that these two remedy options would be practicable, but we do not believe that either would be sufficient as proposed.
- 1.17 The CMA needs to expand the scope of the divestment package in order to address effectively HCA's dominance (particularly at the specialism level). We propose below a variation on the packages proposed that would be effective, practicable and proportionate.
- 1.18 Bupa believes that HCA divesting the London Bridge Hospital is a necessary and fundamental element to any effective remedies package. The London Bridge Hospital is critically important to corporate customers and if it remains in HCA's control will continue to confer 'must have' status on all of the remaining facilities in the HCA group. Insurers would have increased countervailing bargaining power in respect of the London Bridge Hospital if it were a standalone facility. Further, if HCA is allowed to retain its facility at the Shard and the PPU at Guy's and St Thomas, there would be some increased options for customers (both insurers and individual consumers) in the local area and rivalry between the facilities may grow over time.
- 1.19 Divesting only the Wellington Hospital is in Bupa's view entirely insufficient. We present 2014 data to show that if HCA divested only the Wellington, it would retain a [X] aggregate share by revenue in the Central London market (almost [X] larger than any rival), with shares of over 40% in [X] key specialisms – see **Error! Reference source not found.** in Section 2. In particular, HCA would continue to dominate Oncology with a share of [X] of revenue. HCA would also retain the London Bridge Hospital in this scenario which it could, in negotiations with insurers, continue to tie together with its other large hospitals – the Portland, the Harley Street Clinic, Princess Grace and The Christies Clinic in Manchester – meaning that as a group [X]
- 1.20 The CMA's other proposed package – the London Bridge Hospital and the Princess Grace Hospital – performs better than the Wellington Hospital only option, but would also not be fully effective in addressing the AECs. HCA would retain a [X] aggregate revenue share in the Central London market, which is high in this differentiated market and in view of the fact that HCA is well advanced in bringing further capacity on line (and given its strength in Manchester). It would maintain shares of 40% or over [X] key specialisms. Critically, HCA would retain dominant shares in the strategically important specialisms of [X]. The effectiveness of the package could be improved by the inclusion of HCA's interests in the Leaders in Oncology business into the package to address the high Oncology shares, but this would still not address remaining concerns in Cardiology.
- 1.21 So Bupa believes neither of the CMA's possible remedy options would be fully effective as currently designed.

- 1.22 The CMA should, therefore, examine the expanded packages of:
- i. Package A:
    - a. The London Bridge Hospital (sold to one acquirer); **AND**
    - b. The Harley Street Clinic (sold to a separate acquirer); **AND**
    - c. The main primary care and outpatient facilities that feed these two facilities (e.g. the Roodlane GP practice); **AND**
    - d. Behavioural undertakings on HCA.
  - ii. Package B:
    - a. The London Bridge Hospital (sold to one acquirer); **AND**
    - b. The Wellington Hospital (sold to a separate acquirer); **AND**
    - c. Additional Oncology services in Central London; **AND**
    - d. The main primary care and outpatient facilities that feed these two facilities (e.g. the Roodlane GP practice); **AND**
    - e. Behavioural undertakings on HCA.
- 1.23 We explain in Section 2 why the expanded divestment packages would be effective and proportionate. Critically, they address concentration concerns in the most important specialisms (particularly [X]). In both cases, HCA would remain overwhelmingly the largest group in Central London with further expansion in progress (and with its ability to now leverage into the Central London market its [X] presence in Manchester).
- 1.24 We expect there will also be sufficient acquirer interest for the London Bridge Hospital and the Harley Street Clinic / The Wellington Hospital to be sold to different acquirers, which will introduce two new fascia into the Central London hospital market, successfully reducing market concentration and fostering competition.
- 1.25 We also explain the behavioural undertakings which include: obligations on HCA to remove existing restrictive contractual clauses that could jeopardise the success of the newly-divested facilities; and, options for insurers to renegotiate pricing with the HCA group. In line with the CMA's guidance, we also consider it important that the CMA considers in particular the appointment of a hold-separate manager to oversee the management of the remedy package prior to divestment, in order to preserve the competitiveness of the package.
- 1.26 HCA should be given six months to effect the divestments, with a divestiture trustee appointed if necessary after that period.

## **Remedy Option 2: Third parties rent HCA facilities**

- 1.27 The CMA proposes in its NPR that Remedy Option 2 could address the insured and self-pay AECs by requiring HCA to give HCA's competitors access to its hospital facilities. This would

involve HCA allowing another hospital operator to rent out a whole hospital building for a given period of time, together with its equipment, at a market rent.

- 1.28 The CMA should not pursue Remedy Option 2 further, since it is not sufficient or effective to address either the insured AEC or the self-pay AEC. This is because:
- a. Third party entry within any timeframe is wholly uncertain and thus it is not clear on what basis a time-limited remedy is appropriate.
  - b. While Bupa considers that a long-term rental of HCA facilities may be capable of replicating some of the effects of a full divestment. This is not what Bupa understands the CMA to be proposing in Remedy Option 2. In any event, the proposed rental model is wholly unproven as a business model between competing private healthcare operators in the industry and would by its nature undermine incentives to compete. Notably, HCA as landlord would have opportunities to obtain insight into, and influence over, the operational strategy of a horizontal competitor (e.g. what specialisms they are focussing on and how they run the service). HCA would also be able to influence the commercial viability of the service for example through ground rents and service charges. There are also concerns that the landlord-tenant relationship would create a new point of contact and therefore increase the risk of information exchange between horizontal competitors.
  - c. The ability and incentives of a competitor to compete with HCA would be reduced further under a short-term (potentially uncertain) lease arrangement, even if the rental package covered all necessary assets, equipment and personnel in addition to the facility itself. Similarly, it is likely that HCA's incentives to compete with the leased facility would be undermined in circumstances where the facility reverted into HCA's full operational control after a short-term period (since it would not be in HCA's interest to re-take possession of a facility which had been suffering significant competition from a significantly larger rival). Moreover, it is not clear that consultants would themselves consider it attractive to work at a facility only for the short-term, with no guarantee that the tenant operator would remain in the central London market once the lease terminated.
  - d. The remedy as a whole would also require significant monitoring and enforcement by an appropriate body.
- 1.29 Given the significant customer detriment in this case, and the complexities noted above, we do not believe Remedy Option 2 would be reasonable, practicable or effective.

### **Remedy Option 3: HCA restricted from acquiring additional facilities**

- 1.30 The CMA proposes to restrict HCA from acquiring additional sites for facilities, which will lower entry barriers for rivals as HCA can often outbid rivals for sites. This remedy on its own would be entirely ineffective in addressing the existing AECs and it should only be considered as a possible adjunct to the divestment package explained above.
- 1.31 Acquiring a site is not the only barrier to entry rivals face, so there would be no guarantee that this would encourage significant new entry within in a timely period. This remedy would make only a marginal improvement. There is also significant risk that HCA could circumvent the remedy as we explain in the submission.

1.32 Bupa, therefore, does not consider that this remedy is appropriate for the CMA to take forward on a standalone basis, although as explained in Section 4 below, it has some merit as an accompaniment to a full divestment remedy.

### **Other Remedy Options considered and Relevant Customer Benefits (RCBs)**

1.33 Bupa believes that only divestment offers the clear cut, effective, and timely solution that the market and customers so urgently need.

1.34 Therefore, we agree that the CMA should not consider further the options:

- i. *Remedy Option 4 “Light-touch price control”*. The CMA recognised in the Final Report that price control is extremely complex to design and administer, and that there are circumvention risks. In Bupa’s view, there would be a high risk of circumvention by HCA – e.g. it may be encouraged to distort patient referral pathways or to over-treat to grow revenues in the constraint of fixed unit prices. This remedy option would not address the underlying causes of the AECs.
- ii. *Remedy Option 5 “Preventing tying and bundling”*. As we have explained before in the original market investigation, this remedy would not be effective as it is too open to circumvention<sup>5</sup>. This remedy option would not address the underlying causes of the AECs.
- iii. *Remedy Option 6 “Facilitate site availability in Central London”*. It seems highly speculative to assume that recommendations to NHS trusts to sell more assets in London (or to constrain to whom these sites could be sold) or to the Government to change the planning regime would deliver positive improvements within a reasonable period of time. We expect NHS trusts would be very uneasy to have the value of their sites reduced by obligations to market them first or only to private hospital operators (rather than a wider set of commercial developers), particularly in the current environment of financial stress on the NHS. A change to the planning regime could require significant public consultation and take several years. Therefore, credible and constraining entry on HCA would be speculative and, were it to appear at all, could take many years.

1.35 Bupa sees no evidence of RCBs stemming from HCA’s dominant size, the market concentration, or the entry barriers that mitigate the need for remedies and a comprehensive divestment package in particular.

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<sup>5</sup> See our response to the Remedies Notice (September 2013).

## 2. REMEDY 1 – Divestiture of one or more hospitals and/or other assets owned or operated by HCA in central London

### Introduction

- 2.1 The AECs in Central London are caused by structural features that have persisted, and are highly likely to persist, for a long time. There is a clear case for a structural remedy in Central London.
- 2.2 In Bupa's view:
- i. Requiring HCA to divest a package of facilities is the **only** way to remedy the AECs in Central London effectively.
  - ii. The divestments must create effective competition at a specialism level, not just at an aggregate level. HCA derives significant strength from dominance in high value, strategically important specialisms such as Oncology and Cardiology.
  - iii. The two possible divestment options proposed by the CMA in the NPR will not be sufficient in addressing and remedying the AECs. Their scope must be expanded to provide an effective basis for competition and in light of HCA's rapid expansion.
  - iv. It is necessary, reasonable and proportionate to consider expanded divestment packages that will more likely be effective in creating competition within the many specialisms HCA currently dominates. These packages would include the London Bridge Hospital and the Harley Street Clinic or The Wellington Hospital, in each case together with necessary additional assets (e.g. the Roodlane GP practice).
  - v. The London Bridge Hospital and The Harley Street Clinic/ The Wellington should each be sold to different acquirers which would introduce two new, large-scale players into the Central London market.
  - vi. The divestments should be made within a period of six months, failing which a divestiture trustee should be appointed.
  - vii. The divestment package should be supported by short-term behavioural undertakings on HCA (explained below).
- 2.3 This section explains how we reach this view, and is structured as follows:
- i. Part A summarises relevant context for the divestment package;
  - ii. Part B explains HCA's dominance at a specialism level and shows how remedy options seek to address these;
  - iii. Part C responds to the set of questions asked by the CMA about Remedy Option 1 in the NPR.

## PART A: RELEVANT CONTEXT FOR DIVESTMENT

- 2.4 Bupa strongly agrees with the CMA's salient factors for assessing potential divestiture packages in paragraph 24 of the NPR:
- i. The appropriate product market definition is according to medical specialty and the appropriate geographic market definition is Central London.
  - ii. 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; and
  - iii. *"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 specialities would allow a private hospital operator to exert market power"* (emphasis added, NPR paragraph 24(c)). This is Bupa's experience.
- 2.5 We emphasise also that there is a high degree of product and geographic differentiation even within specialism and within Central London. Within a specialism there are different levels of complexity of treatment, often requiring different equipment and services. [§<]. The market is therefore not undifferentiated. In undifferentiated markets competition authorities have tended to look at market shares above 40% as an indicator of market power concerns. Given the level of differentiation in private healthcare in Central London, we consider lower thresholds are more appropriate.<sup>6</sup>
- 2.6 The differentiation also means that Bupa strongly believes that revenue (value) market shares are more meaningful to the divestment discussion than shares based on patient admissions (volume)<sup>7</sup>. Patient admissions are not like-for-like across specialities or within them. For example, the spend on the average Oncology patient far exceeds the spend on an average Rheumatology patient. Revenue shares better reflect this differentiation between and within specialisms. Negotiations between insurers and hospital groups also focus primarily on revenues.

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<sup>6</sup> In the Competition Commission's investigation of the proposed joint venture between Anglo American PLC and Lafarge S.A., the Competition Commission used a lower 33% threshold because of the degree of product and geographic differentiation in that case.

<sup>7</sup> The Competition Commission Market Investigation Guidelines note: "In most contexts, the CC uses actual or projected revenues in the market as the bases for measurement [of shares]. They are the best 'real world' measure and are particularly pertinent when products differ in quality" (Annex A, p87). We note also the CMA's Final Report (footnote 372): "We note that shares based on revenues are relevant whenever there is vertical product differentiation, which is what HCA claims, ie that its quality is higher than that of its central London rivals ... Given that we did not find evidence of substantial quality differentiation in central London, we note moreover that our finding that HCA charges higher prices may itself be an indication of the lack of spare capacity at HCA's close competitors, and that this is captured in our shares of revenue".

2.7 The PFs set out clear evidence of the factors and outcomes of the AECs for self-pay and insured patients in Central London. Some key market features relevant to the consideration of divestment remedies are:

- i. **HCA dominates in specialisms and in aggregate:** In 2014 HCA accounted for [X] of Bupa's total hospital spend in Central London (it is over [X] larger than its next largest rival, TLC) and [X] of our spend in Central London on *in-patient* hospital activity in 2014. It has dominant market shares in [X] of specialisms. It has particularly high shares in strategically important specialisms such as Oncology [X] and Cardiology [X] – as we show in **Error! Reference source not found.** later in this section. These high value specialisms are acutely important to private medical insurance customers and are growing rapidly given demographic and health trends in the UK<sup>8</sup>.
- ii. **HCA's strength continues to increase rapidly. Error! Reference source not found.** below illustrates HCA's dramatic growth trajectory and how it now dwarfs all other Central London operators. Bupa's experience is that HCA's share of spend has grown appreciably in aggregate and in specialisms since the CMA's analysis in the Final Report of April 2014 (which relied primarily on 2011 data)<sup>9</sup>. As noted in paragraph 1.7(ii) above, we are concerned that the PFs underestimate HCA's strength by focussing only on the revenues and admissions across 17 specialisms. There are high spend specialisms present in Central London outside these 17 and the CMA's analysis must take HCA's dominance in these into account. There are also a series of HCA expansions planned and in progress that will augment HCA's size even further when they come on line in the short-to-medium term<sup>10</sup>. We are concerned that the PFs underestimate HCA's current and growing strength.  
  
[X]
- iii. **There is little evidence of credible and constraining new entry on the horizon**<sup>11</sup>. New entry has not materialised for many years despite the attractiveness of the Central London market relative to the rest of the country. The difficulty of large-scale entry is evidenced by the feedback from The Cleveland Clinic, VPS and Spire (as recognised by the CMA). Further, HCA's dominant position means it is able to negotiate contractual clauses into agreements with insurers [X] that protect its existing patient flows and could frustrate successful entry.
- iv. **There is a clear price effect to this market power.** For self-pay patients, the CMA established a statistically significant relationship between market concentration and

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<sup>8</sup> For example, research conducted by Bupa in 2011 projected that the costs of cancer diagnosis and treatment in the UK will increase by over 60% in real terms by 2021 affecting NHS and private providers. See "*Cancer Diagnosis and Treatment: a 2021 projection*".

<sup>9</sup> The CMA used 2013 LaingBuisson data on total hospital revenues and admissions in Table 4.1 of the PFs. However, when the CMA looks at shares at a specialism level (which the critical level to consider as noted by the CMA in paragraph 24 of the NPR) it relies only on 2011 data. This 2011 data will, in our view, significantly underestimate HCA's current revenue shares at a specialism level.

<sup>10</sup> See Section 2 of our May 2015 response to the Invitation to Comment for a list of HCA's planned expansion projects already in progress or announced publicly. As noted in Footnote 3, HCA's rapid expansion in Manchester through The Christie Clinic must also be considered when evaluating its bargaining strength.

<sup>11</sup> A new entrant would need to achieve sufficient scale, scope and track record before it offers a credible alternative for insurers and can act as any real constraint on HCA. Small scale or niche entry is of little benefit. HCA has, for example, repeatedly pointed towards the 'entry' of the London International hospital, but this has never actually materialised.

prices. For insured patients in Central London, the features of the market have allowed significant and sustained excess profits to persist, which underscores that prices are too high. Bupa believes HCA's profitability may have increased further since 2011 and that its pricing has diverged from other providers<sup>12</sup>. The CMA's IPA analysis has also concluded that HCA is significantly more expensive than TLC.

- v. **Significant sustained and growing customer detriment.** HCA's high excess profits can be used to infer the extent to which customers are over-charged<sup>13</sup>. But this captures only part of the harm caused. HCA's strength also means customers receive fewer innovative products from insurers (due to, for example, the contractual constraints imposed by HCA which have restricted the development of lower cost networks). Hundreds of thousands of customers have also had to down-grade or entirely give up their private insurance cover due to rapidly rising premium inflation, which is driven in part by the cost inflation in Central London.

2.8 There is a clear and substantial harm being caused to customers by HCA's high market shares, and barriers to entry and expansion for rivals mean that the situation will not be resolved without CMA intervention. Indeed, the evidence points towards growing harm to customers. Therefore, a structural remedy is necessary, reasonable and proportionate.

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<sup>12</sup> In Bupa's May 2015 submission we showed that (i) [redacted] (see Table 3 and Figure 2 of that submission), and (ii) LaingBuisson data on the market shows that HCA has grown revenues much faster than other hospital operators in Central London.

<sup>13</sup> We infer HCA's excess profits are very large from page A6(13)-31 of the Final Report of April 2014, which showed that the largest seven hospital operators in the UK had a weighted average ROCE of almost 10 percentage points above the midpoint of the WACC range. We expect HCA was pulling up this weighted average.

## **PART B: HCA DOMINANCE IN SPECIALISMS AND IN AGGREGATE**

- 2.9 In the analysis that follows we use our claims spend data for Central London for the calendar year of 2014. We note:
- i. This is a more up-to-date picture of HCA's strength than the market share evidence in the CMA's Final Report which, for the specialism shares, was based on 2011 data.
  - ii. This includes the broader range of specialisms that are relevant to Central London and so provides a more comprehensive picture of HCA's strength than in the 17 covered by the CMA's analysis. **Error! Reference source not found.** in the Annex to this submission shows that key specialisms in Central London are outside (and in many cases more important than) the 17 used in the PFs.
  - iii. This includes all hospital operators to which we pay claims in Central London, including smaller facilities (like small, niche PPUs) which in reality place little competitive constraint on HCA because they are too small and fragmented to offer a viable alternative to insurers.
  - iv. Bupa's spend is likely to be broadly representative of other insurers' experience, but smaller insurers may face even higher prices from HCA relative to other hospital operators (and so higher HCA shares).
- 2.10 In 2014, Bupa claims spend with HCA in Central London was just over [X], which is [X] of Bupa's total hospital claims spend in the market<sup>14</sup>. HCA has a dominant share at the aggregate level in this (highly differentiated) market.
- 2.11 HCA's share is growing rapidly. In 2012, for example, our spend with HCA in Central London was [X], which was a [X] share. As noted above, HCA's further planned expansions (both within and outside Central London) will make it even larger.
- 2.12 **Error! Reference source not found.** below shows how Bupa's 2014 total spend with HCA in Central London splits across specialisms. HCA's share of Bupa's total hospital spend in Central London within a specialism is reflected by the height of the column; the quantum of Bupa's spend with HCA is represented by the width of the respective column. Key observations include:
- i. In [X] key specialisms shown HCA occupies a share of over 40%<sup>15</sup> of Bupa's spend in Central London.
  - ii. The 10 largest specialisms by quantum of spend account for [X] of Bupa's spend with HCA in Central London (as illustrated by the vertical dotted line)<sup>16</sup>. [X]

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<sup>14</sup> HCA also has facilities outside Central London – e.g. The Christie Clinic in Manchester – which are not included here. Bupa's total spend with HCA nationally in 2014 was [X] million. The Christie Clinic now occupies a [X] spend in the Manchester area.

<sup>15</sup> As noted earlier, a lower threshold (e.g. 33%) may be more appropriate given the high degree of differentiation in the market.

<sup>16</sup> These 10 most important specialisms by quantum of hospital spend in Central London in 2014 are: Oncology; Trauma & Orthopaedic surgery; Cardiology; General surgery; Gastroenterology; Haematology; Obstetrics & Gynaecology; Cardiothoracic

- iii. HCA's shares for the [X]
- iv. In the three largest specialisms [X] These three specialisms account for around [X] of Bupa's spend with HCA.
- v. Spend on [X] exceeds the total spend on all other specialisms outside the top 10. This illustrates how influential the large strategically important specialisms are to a hospital group's bargaining strength.

[X]

2.13 **Error! Reference source not found.** in the Annex shows a version of the above chart focussing only on in-patient hospital spend in Central London. HCA had a [X] revenue share of Bupa's in-patient hospital spend in Central London in 2014.. [X] Therefore, the dominance and concentration concerns are even more pronounced on an in-patient only basis.

2.14 Within the HCA portfolio of hospitals, the London Bridge Hospital, the Wellington Hospital, and the Harley Street Clinic are the most substantial facilities in terms of spend. Together they account for [X] of Bupa's total spend with HCA in Central London. **Error! Reference source not found.** shows how Bupa's 2014 spend splits between HCA's facilities.

[X]

2.15 [X] The importance of the [X] to corporate customers can be seen in the breakdown of Bupa's corporate claims by HCA facility in **Error! Reference source not found.** This shows:

[X]

[X]

2.16 It is also important to note that HCA is opening additional capacity in the London Bridge area, further strengthening its position. HCA opened a radiotherapy centre for private patients on the Guy's and St Thomas Hospital campus in October 2014. Construction has also begun on a new £100 million NHS and private patient cancer centre at Guy's and St Thomas Hospital next to London Bridge. We understand that HCA will be building a private cancer hospital on four of the 12 floors of the new building<sup>17</sup>. Finally, HCA will be opening facilities on three floors of The Shard.

2.17 Moreover, HCA is able to exercise and maintain its market power through the control of downstream referral channels. The Roodlane and Blossoms GP practices – both of which are owned by HCA – are particularly important referral channels for corporates into the London Bridge Hospital. These private GP practices have a large number of sites in the City and have onsite occupational health facilities within many of the large corporates.

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surgery; Urology; and, Clinical Radiology. It should be noted that these reflect a relatively high level of aggregation by specialism – within certain sub-specialisms, particularly high-complexity treatments, HCA's market shares are much higher.  
<sup>17</sup> See news release at: <http://www.hcahospitals.co.uk/press-releases/britains-newest-radiotherapy-centre-opens-at-guys-hospital-campus-in-london/> (accessed 26 April 2015)

## Considering divestment packages

- 2.18 The divestment package therefore needs to address HCA's strength at the specialism level (particularly the largest specialisms in terms of spend), create sufficient rivalry within specialisms, and reduce HCA's ability to tie its facilities together in negotiations.
- 2.19 **Error! Reference source not found.** illustrates how HCA's share of Bupa's hospital spend in Central London in 2014 would change in different divestment remedy scenarios, assuming all else equal. The table is arranged as follows:
- i. Specialisms are arranged in descending order of total Bupa spend with HCA in Central London in 2014.
  - ii. Column A shows the share of Bupa's hospital spend within Central London controlled by HCA in each specialism – the more darkly shaded the block the higher the share. For example, HCA accounts for [X] of Bupa's Cardiology spend with hospitals in Central London.
  - iii. Columns B to F show the number of percentage points key individual facilities contribute to HCA's overall share. The London Bridge, for example, is shown in column B and it contributes [X] percentage points to the HCA's Central London share of [X] in Cardiology (or, expressed differently, if the London Bridge Hospital was a standalone facility it would have on its own a [X] share in the Central London market in Cardiology).
  - iv. Column G shows the combined share HCA derives from owning the London Bridge Hospital, the Wellington Hospital and the Harley Street Clinic (i.e. what it would retain if it sold all other facilities);
  - v. Columns H to J show HCA's remaining market shares after the hospitals listed at the top of each column are divested, assuming all else equal.

[~~8~~]

2.20 We now focus and elaborate on four possible remedy scenarios.

### **Column H: Divest the Wellington Only**

- 2.21 Divesting only the Wellington would be ineffective in addressing the AEC at the specialism level and in aggregate.
- 2.22 In aggregate, across all specialisms, HCA's revenue share of Central London spend could remain at around [X]. It would continue to be several orders of magnitude larger than other rival operators (with further expansion plans in progress).
- 2.23 In [X] specialisms shown in **Error! Reference source not found.**, HCA could remain above 40% of Bupa's spend, with particularly high concerns in the three highest value specialisms. [X].
- 2.24 **Error! Reference source not found.** shows the post-divestment HCA position graphically. The vast majority of Bupa's spend with HCA would be in specialisms that HCA continues to dominate.
- 2.25 Further, as HCA would continue to control the London Bridge, the remaining group of HCA-owned hospitals would continue to be extremely difficult to negotiate against or to exclude from an insurer network given HCA's ability to tie its portfolio of hospitals together.
- 2.26 Therefore, Bupa believes this option will be ineffective.

[X]

### **Column I: Divest The London Bridge Hospital and the Princess Grace Hospital, based on 2014 claims spend**

- 2.27 Divesting the London Bridge and the Princess Grace performs better than the "Wellington only" divestment package at addressing the AEC.
- 2.28 HCA's aggregate share could reduce to [X] (which is still high in this differentiated market) with further expansion in progress. However, it is the strength it maintains at a specialism level that is the key concern, as shown in Figure 7 below:
- i. HCA would retain a share of over 40% in [X] specialisms by value.
  - ii. HCA would retain a share of over 40% in [X] specialisms shown in **Error! Reference source not found.**
  - iii. [X] is a particular concern given the importance of this specialism and the fact that HCA will soon bring additional [X] services on-line.
- 2.29 As recognised by the CMA (and noted in paragraph 2.3iii above): *"a strong market position in one or a small number of specialities would allow a private hospital operator to exert market power"*. Bupa considers this remedy option to be ineffective as currently designed – HCA will retain market power.
- 2.30 Further, there are, several additional risks to the effectiveness of the remedy:

- i. The effectiveness of the remedy would be weakened if The London Bridge Hospital and the Princess Grace Hospital were sold to the same acquirer. The new acquirer would be able to tie recognition of the Princess Grace to the essential London Bridge. The new acquirer would also have a market share of nearly [redacted].
- ii. Bupa has significant concerns that the Princess Grace would be an ineffective competitor in the market on a standalone basis. Bupa understands the economics of the Princess Grace to be weaker – it has little room for expansion; is spread across several floors; and it is an outlier in its ratio of operating theatres to beds. The CMA will be better placed than ourselves to access from HCA the operating cost ratios of this facility, but we understand it to be a 'higher running cost' facility than average. It would, therefore, have weaker ability to compete in the market post divestment and to lower prices for customers overall.
- iii. Bupa has significant concerns that HCA's control of primary care and outpatient facilities near The City – e.g. Roodlane – could see patient flows being directed away from the new rivals towards HCA's retained facilities. This would frustrate the effectiveness of the divestments.

2.31 On the basis of the above, were the CMA to pursue further this remedy, it would need at a minimum to re-design the package as:

- i. HCA to divest the London Bridge and the Princess Grace, but have these sold to different acquirers; **AND**
- ii. HCA to divest further Oncology services. Bupa would recommend the standalone business of Leaders in Oncology; **AND**
- iii. HCA to divest the primary care and outpatient facilities that feed these facilities e.g. the Roodlane GP practices

. [redacted]

### **Column J: Divest the London Bridge Hospital and the Harley Street Clinic**

2.32 If both the London Bridge Hospital and the Harley Street Clinic are divested, HCA's total market share could fall comparably to around [redacted] in aggregate. HCA would remain several orders of magnitude larger than any other rival in Central London (with further expansion still to come on-line), but Bupa considers this remedy more effective than the two above because:

- i. This package more effectively reduces HCA's high market shares in [redacted]. The specialisms where it maintains its very high market shares would be lower value specialisms – see Figure 8 below.
- ii. While the London Bridge Hospital and the Harley Street Clinic could not be sold to the same acquirer, when sold to different acquirers the remedy would create two new, scale players in Central London with strong brands, locations and speciality mix. The Harley

Street Clinic is far better placed to compete against the Wellington Hospital and TLC than the Princess Grace.

- iii. Overall market concentration will be reduced substantially, meaning concerns that HCA's pipeline of expansion will quickly create a new AEC would be reduced.

2.33 However, to be effective, the package would need to include the primary care and outpatient facilities that feed these two hospitals e.g. the Roodlane.

[§<]

### **Column K: Divest the London Bridge Hospital and the Wellington Hospital**

2.34 If both the London Bridge Hospital and the Wellington Hospital are divested, HCA's overall market share would remain [§<] in aggregate. As a group, HCA would remain very much larger than any other operator in London (and it would maintain its strength outside of London e.g. The Christie Clinic in Manchester).

2.35 The London Bridge and the Wellington would need to be sold to separate acquirers, which would introduce two new fascia into the market of sufficient scale and scope of specialisms to be credible competitors.

2.36 This option is the most effective in addressing HCA's overall size and reducing its overall number of specialisms in which it can exert market power – see Figure 9 below.

2.37 However, HCA would still maintain very high shares in [§<] Oncology meaning that the divestment of further Oncology services would be required (e.g. Leaders in Oncology).

2.38 To be effective, the package would need to include the primary care and outpatient facilities that feed these two hospitals e.g. the Roodlane. With these included, Bupa would welcome this remedy as effective and proportionate.

[§<]

## **PART C: CONSULTATION QUESTION RESPONSES**

### ***Question (a): Would a divestiture remedy address the insured AEC and self-pay AEC in central London effectively and comprehensively?***

2.39 Bupa believes that HCA divesting a package of hospitals is essential to addressing the AECs in Central London. This would introduce more rivalry and choice for patients and insurers in a clear cut and rapid way.

2.40 However, we emphasise that to remedy the AEC effectively, the divestment package must:

- i. Introduce sufficient rivalry at the specialism level – particularly the strategically important specialisms (the highest value and complexity specialisms)<sup>18</sup>.
- ii. Be based on current market characteristics with a forward-looking view rather than on 2011 market shares given that HCA has since grown substantially (and has a series of further expansion initiatives well advanced).
- iii. Involve assessment of the operating cost ratios and profitability of each of the divested facilities by the CMA to understand the ability of an acquirer to compete effectively with HCA using that divested facility. It is Bupa's understanding, for example, that the Lister and the Princess Grace are 'higher running cost' facilities due to their configuration and so the new owner would be more restricted in how it could compete post divestment.

2.41 To be effective, the divestment package would need to be supported by undertakings from HCA:

- i. Restrictions should be placed on who can buy the facilities – see paragraph 2.46 below.
- ii. HCA should be required to remove any contractual clauses in existing contracts with insurers that restrict that insurer's ability to guide volume away from HCA or to launch new products and networks without HCA. If these clauses remain, HCA will remain protected from the new rivalry created by the divestments. There is no guarantee that insurers will be able to negotiate these clauses out of future contracts fairly or without exchanging other significant concessions.
- iii. We have assumed that insurers would be given the opportunity to negotiate terms with the divested facilities. However, to maximise consumer benefits insurers must also be given the option (but not the obligation) to renegotiate existing contracts and prices with HCA. It would be inappropriate to allow HCA to retain, for the full terms of the existing contracts, the higher prices that it negotiated while in its dominant position.

2.42 We also consider it important that, in line with the CMA's guidance, a hold-separate manager is appointed immediately to avoid HCA using the period until divestment to redirect key staff (e.g. consultants), assets (medical equipment) and patient activity from the divested hospital to its retained facilities in Central London. HCA must not be allowed to devalue the competitive position of the divested facilities.

***Question (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 (i.e. theatres, beds, ICU, etc.)?***

2.43 No, as illustrated in paragraphs 2.21 to 2.30 above, Bupa does not believe that either of the CMA's two proposed divestment remedies options would be sufficient. In both cases HCA would retain very high market shares across a range of high value specialisms.

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<sup>18</sup> The CMA should focus on revenue market shares rather than patient admissions market shares to better capture the high value and complexity nature of certain specialisms. Examining only admissions data will incorrectly rank the importance of facilities. To illustrate, [X] is one of HCA's largest facilities by admissions (according to Bupa's member data) but is a very small facility in value terms.

2.44 We, therefore, propose more effective packages in paragraphs 2.31 and 2.37. The divestment package would need to be supported by the behavioural undertakings set out in paragraph 2.41 above.

***Question (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?***

2.45 Yes, Bupa expects that there will be significant interest from parties to acquire the divested assets. These are likely to include international healthcare operators (US, Middle Eastern and European) and private equity. We note also that the CMA has already discussed the possibility of entry into Central London with The Cleveland Clinic and VPS. Once the remedies are implemented, these or comparable parties are likely to engage in the market.

2.46 However, Bupa considers it that certain restrictions should be placed on the identity of purchasers, as some purchasers would create new competition concerns:

- i. The London Clinic should not be allowed to acquire a divested facility as this will mean the Central London market remains very concentrated with TLC potentially occupying dominant shares in certain specialisms.
- ii. The large national hospital groups – BMI and Spire – should not be allowed to buy the London Bridge Hospital (although they may be able to acquire other elements of the package). If one of these already large national groups with significant bargaining power against insurers were to acquire this essential facility it could use it to reinforce the group's existing strength against insurers and to leverage the London Bridge's power and pricing across the full group<sup>19</sup>.
- iii. Bupa believes the divested facilities should be sold to at least two separate acquirers. This would notably increase the number of rival fascia in Central London. Further, selling all divested hospitals to a single acquirer may simply transfer market power in some specialisms to the new owner.
- iv. In principle, Bupa would not object to another insurer purchasing a hospital as there can be significant efficiencies from the vertical-integration of funder and provider. However, if an insurer were to buy the London Bridge Hospital, which is essential to serving many large corporate accounts, that insurer could gain significant advantage over other insurers for the national business of these corporate accounts (e.g. if it raised prices at London Bridge while giving itself preferential terms). Therefore, it would need to make access available access to other insurers on fair and reasonable terms.

***Question (d): Would any other, divestiture package be similarly effective? Should alternative HCA assets be considered for divestiture?***

2.47 Yes, alternative HCA assets should be considered as the CMA's two current proposed options would not be sufficient to address the AEC in aggregate or at the specialism level. Particular concerns arise in the strategically important specialisms and in light of HCA's further expansion plans coming on-line.

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<sup>19</sup> In the Final Report, the CMA found BMI and Spire to already be earning excessive profits.

2.48 In paragraphs 2.31 to 2.38 we set out further remedies options that would be more effective than the two proposed by the CMA.

2.49 In Bupa's view, the necessary and effective divestment packages should be either:

i. Package A:

- i. The London Bridge (sold to one acquirer); **AND**
- ii. The Harley Street Clinic (sold to a separate acquirer); **AND**
- iii. The main primary care and outpatient facilities that feed these two facilities (e.g. the Roodlane GP practice); **AND**
- iv. Behavioural undertakings on HCA.

ii. Package B:

- i. The London Bridge (sold to one acquirer); **AND**
- ii. The Wellington Hospital (sold to a separate acquirer); **AND**
- iii. Additional Oncology services in Central London; **AND**
- iv. The main primary care and outpatient facilities that feed these two facilities (e.g. the Roodlane GP practice); **AND**
- v. Behavioural undertakings on HCA.

2.50 Both of the above two packages would be proportionate and practicable.

***Question (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?***

2.51 If all hospitals in the divestment package were sold to the same purchaser, then there is a risk that this new provider would have market power in key specialisms. Bupa, therefore, believes the hospitals should be sold to different purchasers.

2.52 Given the importance of the London Bridge Hospital to corporate insurance customers (because of its location, size and specialism mix) it would retain some market power even outside of HCA's hands. However, were it a standalone facility, insurers would have far greater opportunity to negotiate effectively with it. For example, it would be much easier for insurers to launch and communicate policies to corporate customers that offered "all hospitals in Central London except one (the London Bridge)" or with the London Bridge as a top-up feature paid for separately. If HCA is successful in establishing its planned facilities in the London Bridge area, the London Bridge Hospital will also face increasing competition over time.

2.53 Further, in separate hands The London Bridge Hospital will become a strong competitor to HCA's other facilities in the Harley Street area, which will significantly improve rivalry across Central London.

**Question (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?**

- 2.54 A six month time limit is sufficient. If HCA is unable to reach a deal within this period a divestiture trustee should be appointed to make the sale within three months.
- 2.55 It is unfair to consumers for there to be a significant (further) delay before the remedies take effect.

**Question (g): What are the relevant costs and benefits that we should take into account in considering the proportionality of the divestiture options? How could we go about quantifying these?**

### **Relevant benefits**

- 2.56 Customer detriment from the AECs for self-pay and insured patients is significant, sustained and growing.
- 2.57 Using a similar approach to that applied by the Competition Commission in the Aggregates inquiry, the CMA can calculate the differential between HCA's average ROCE and the mid-point of its WACC range as an input into calculating the direct financial detriment for customers.
- 2.58 The extent of HCA's differential between ROCE and WACC has not been published by the CMA, but Bupa expects it to be very large<sup>20</sup> and potentially to have grown since 2011.
- 2.59 Customers have been over-paying in each year and will continue to do so without decisive action by the CMA. Therefore, a proxy for the benefit from an appropriate remedies package could be estimated by a present value of the future over-payments that would occur without the proposed remedies package. A societal discount rate of around 3.5% could be applied in this discounting of future savings.
- 2.60 We emphasise that this approach would yield conservative estimates of the benefits because it does not capture the indirect costs that customers face due to HCA's market power – including:
- i. The upward pressure on all hospital prices in Central London (and weaker pressure on efficiency) that result from the high level of concentration in the market.
  - ii. The cost to customers of not having innovative, lower-cost PMI network products available in Central London.

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<sup>20</sup> We infer it is very large from page A6(13)-31 of the Final Report of April 2014, which showed that the largest seven hospital operators in the UK had a weighted average ROCE of almost 10 percentage points above WACC. We expect HCA was pulling up this weighted average.

- iii. The cost to customers outside Central London who receive no or more limited PMI cover because of the effects of high healthcare costs in Central London on their employers' benefits choices.

2.61 An alternative approach would be to use the IPA and self-pay pricing analyses to infer how much prices could fall if HCA were to price in line with its next closest rival.

**Relevant costs**

2.62 We agree that there may be some offsetting costs, both one-off and ongoing, caused by the remedies. However, we expect these to be small in absolute terms and when balanced against the possible savings to customers.

2.63 In particular, we note that in the Provisional Decision on Remedies in January 2014, the Competition Commission identified the one-off and ongoing costs for HCA of divesting the London Bridge and the Princess Grace Hospital. These were one-off costs of between £12 million and £14 million and (potential) ongoing costs from reduced economies of scale.

**Figure 1: Competition Commission estimates of divestment costs**

One-off costs		Ongoing loss of economies of scale	
Transaction costs £m	Other one-off costs (reorganization costs) £m	Base case £ per year	Downside case £m per year
£5m	£7-9m	0	£5m

Source: Table 4 of Provisional Decision on Remedies, January 2014

2.64 On the basis of these numbers, we infer that the total costs of this divestment package could be:

- i. Under £15 million in present value terms in the Base Case; and
- ii. Under £70 million in present value terms in an extreme Downside Case, using an assumed HCA cost of capital of around 9% and the extreme assumption that these ongoing costs run into perpetuity.

**Proportionality**

2.65 Even in an extreme downside case, the costs per year for HCA would very likely be under 2% of HCA's current revenues and would more likely (in the base case) be much lower.

2.66 The savings to customers from addressing the AECs would very significantly outweigh these costs. Assuming patient volumes were unchanged, treatment costs would have to soften by less than 1% in the Central London hospital market on account of the remedies for the customer benefits to outweigh HCA's costs.

2.67 Therefore, in Bupa's view, it is reasonable and proportionate for the CMA to pursue an expanded divestment package that will assure customers of effective competition in Central London today and in future (and in light of the threat that HCA's continued rapid expansion could rebuild its dominant position).

2.68 Our expanded packages of (i) the London Bridge Hospital and the Harley Street Clinic or (ii) the London Bridge Hospital and the Wellington Hospital, would both be proportional and are far more likely to be effective than those currently proposed in the NPR.

### 3. REMEDY 2 – Require HCA to give competitors access to its hospital facilities to compete

#### Introduction

- 3.1 The CMA proposes in its NPR that one standalone remedy to address the insured and self-pay AECs would be to require HCA to give HCA's competitors access to its hospital facilities ("Remedy Option 2"). This would involve HCA allowing another hospital operator to rent out a whole hospital building for a given period of time, together with its equipment, at a market rent.
- 3.2 The CMA explains that the hypothesis, on which it invites views, is that this remedy:
- i. *"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"; and*
  - ii. *"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"<sup>21</sup>.*
- 3.3 In Bupa's view, Remedy Option 2 would not achieve these objectives, and is not sufficient to address either the insured AEC or the self-pay AEC. This is because:
- i. Third party entry within any timeframe is wholly uncertain and thus it is not clear on what basis a time-limited remedy is appropriate.
  - ii. While Bupa considers that a long-term rental of HCA facilities may be capable of replicating some of the effects of a full divestment. This is not what Bupa understands the CMA to be proposing in Remedy Option 2. In any event, the proposed rental model is wholly unproven as a business model between competing private healthcare operators in the industry and would by its nature undermine incentives to compete. Notably, HCA as landlord would have opportunities to obtain insight into, and influence over, the operational strategy of a horizontal competitor (e.g. what specialisms they are focussing on and how they run the service). HCA would also be able to influence the commercial viability of the service for example through ground rents and service charges. There are also concerns that the landlord-tenant relationship would create a new point of contact and therefore increase the risk of information exchange between horizontal competitors.
  - iii. The ability and incentives of a competitor to compete with HCA would be reduced further under a short-term (and potentially uncertain duration) lease arrangement, even if the rental package covered all necessary assets, equipment and personnel in addition to the facility itself. Similarly, it is likely that HCA's incentives to compete with the leased facility would be undermined in circumstances where the facility reverted into HCA's full operational control after a short-term period (since it would not be in HCA's interest to re-take possession of a facility which had been suffering significant competition from a significantly larger rival). Moreover, it is not clear that high quality staff (nurses and consultants) would themselves consider it attractive to work at a facility only for the short-

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<sup>21</sup> NPR, paragraphs 29-30.

term, with no guarantee that the tenant operator would remain in the Central London market once the lease terminated.

- iv. The remedy as a whole would require significant monitoring and enforcement by an appropriate body.

3.4 In Bupa's view, and as outlined in Section 2 above, divestiture of HCA facilities remains (as the CMA has already concluded in its Final Report) the most appropriate and proportionate means of addressing the AECs identified in Central London.

3.5 Each of these points is considered in further detail below.

### Third party entry is uncertain

3.6 The CMA's hypothesis is that Remedy 2 "*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*"<sup>22</sup>.

3.7 The CMA's guidance on the design of remedies in the context of market investigations is clear that the circumstances in which a remedy for a specified, limited duration may be appropriate include where the CMA considers that "*an AEC and/or its detrimental effects would not endure beyond a particular date or event*", or where a particular element of a remedy package is "*intended to be a temporary arrangement to deliver improvements in the short term, while other longer-term measures take effect*", or where the proposed remedy "*is expected to become obsolete over time*" (e.g. because of "*prospective changes in technology, policy or regulatory frameworks, consume behaviour or other aspects of the competitive environment*")<sup>23</sup>.

3.8 In the context of market investigations, explicitly time-limited remedies appear to have been used only in one case by the CMA or its predecessors. In *Veterinary Medicines*, the Competition Commission (as it then was) required veterinarians to provide prescriptions at no additional charge for a period of three years. The CC in that case found that by the end of the three year period, there would *inter alia* be "*a reasonable prospect that competition from pharmacies would be sufficiently established*" for the identified AEC to cease (and thus for the remedy to become redundant), although the CC also recognised that there was uncertainty as to when exactly sufficient competition would be established and therefore recommended on-going monitoring of the situation following that period<sup>24</sup>.

3.9 Bupa's understanding is that Remedy Option 2 is envisaged as a standalone remedy and not as an interim measure pending other remedies taking effect. Accordingly, the CMA would need to be confident either that Remedy Option 2 would become obsolete because of macro, market-wide changes in the market (which Bupa considers are wholly unanticipated and which are not in any way considered in the PFs), or that sufficiently significant new entry would occur

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<sup>22</sup> NPR, paragraph 29.

<sup>23</sup> CC3, paragraph 339.

<sup>24</sup> See paragraph 173 of *A Report on the Supply within the United Kingdom of Prescription-only Veterinary Medicines* (2003). There have also been a number of time-limited remedies imposed in the context of merger reviews. For example, in *Reckitt Benckiser / KY Brand* (2015), the CMA imposed an eight year licence of the KY brand to a third party. Notably, a shorter licence period was rejected because "*a short-term licence will not be sufficient to allow the licensee to establish or strengthen its own position as an effective competitor*" (paragraph 12.33 of the Report). In *Draeger Medical / Air Shields* (2004), the CC sought behavioural remedies for a three year period while accompanying structural remedies took effect. In *Coloplast / SSL* (2002), a price control remedy was required for a period equivalent to that of a distribution agreement for the relevant product (and thus the remedy lapsed at the same time as the distribution agreement).

within a reasonable time frame such that the insured and self-pay AECs would dissipate and that as a result Remedy Option 2 would become obsolete.

- 3.10 Significant new entry is however implausible given that, as the PFs make clear, there is unlikely to be entry into Central London on a sufficient scale to exert a material competitive constraint on HCA in the near future (and even over the longer-term the CMA is uncertain as to likelihood of entry)<sup>25</sup>. The PFs highlight in particular that, in order to represent a sufficient constraint, any entry would need to be in the form of large full-service hospitals (capable of competing with, and constraining HCA, across the many specialisms HCA currently dominates).
- 3.11 Bupa considers that the CMA is correct to conclude in the PFs that such entry is extremely challenging and unlikely. In particular we consider it unlikely that either VPS Healthcare or the Cleveland Clinic - the entry of both of which is discussed in the PFs - will provide the necessary competitive constraint in the near term and we agree with the PFs' observation that *"it is not clear that either of [VPS Healthcare or the Cleveland Clinic] has secured a suitable site for development"*<sup>26</sup>:
- i. In respect of VPS Healthcare, the PFs conclude that *"it is uncertain whether VPS will be able to enter the market"*<sup>27</sup>. Bupa agrees with this and notes that, in any event, if VPS Healthcare were to enter the market via its site in Ravenscourt Park in West London, its location would be significantly less attractive to corporate customers than any of HCA's facilities and would not therefore pose a material competitive constraint on HCA's facilities<sup>28</sup>.
  - ii. The PFs note that the Cleveland Clinic itself considers that *"it was currently at too early a stage to discuss its plans in detail"* and that therefore *"we [the CMA] consider that this potential entry remains uncertain at the current time"*<sup>29</sup>. We note that the Cleveland Clinic has recently announced it has signed a long-term lease for (non-hospital) property in Central London, but the public statements make clear it still needs to gain planning permission<sup>30</sup>. Bupa agrees with the PFs' further observation that, in circumstances where the requisite planning permission has not yet been sought (as is the case for the Cleveland Clinic), there can be no basis for considering entry – or the form of that entry – as anything other than uncertain. Bupa notes in this respect that the CMA explicitly concluded in the Final Report that planning regulations themselves – in particular as these relate to changes of use – constitute barriers to entry and expansion in Central London<sup>31</sup>; therefore, even if the Cleveland Clinic has acquired a property, the need to secure the relevant planning permission (in addition to the long lead-times associated with any subsequent development) still presents a very significant hurdle to entry. In this respect, Bupa notes that The London Clinic required several years to open its Cancer Centre even after acquiring a suitable site.

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<sup>25</sup> PFs, paragraph 5.69.

<sup>26</sup> Ibid.

<sup>27</sup> PFs, paragraph 5.68(f).

<sup>28</sup> PFs, paragraphs 5.68(f) and 5.65.

<sup>29</sup> PFs, paragraph 5.68(f).

<sup>30</sup> Press release in October 2015:

[http://www.cleveland.com/healthfit/index.ssf/2015/10/cleveland\\_clinic\\_to\\_open\\_health\\_care\\_facility\\_in\\_pricey\\_central\\_london.html](http://www.cleveland.com/healthfit/index.ssf/2015/10/cleveland_clinic_to_open_health_care_facility_in_pricey_central_london.html)

<sup>31</sup> Final Report, paragraphs 6.105 – 6.106.

- iii. The PFs conclude that VPS Healthcare and the Cleveland Clinic would only be able to exert a material competitive constraint on HCA due to their "*combined size*"<sup>32</sup>. It follows that the entry of only one of these entities (which for the reasons given above and in the PFs is itself highly uncertain) would not be sufficient to exert a material constraint on HCA<sup>33</sup>.

3.12 In Bupa's view, therefore, there is no credible evidence of significant entry into Central London such that there is a reasonable prospect of entry within a certain timeframe or that the use of a temporary time-limited remedy could be justified.

### **The proposed rental model is wholly unproven and would undermine incentives to compete**

3.13 Subject to the significant caveats in paragraphs 3.14 to 3.19 below, Bupa considers that in principle it is possible for a private hospital operator to compete effectively in Central London either by renting an appropriate facility on a long-term basis, or through the outright ownership of a facility. In both these scenarios, the tenant operator would have the incentive to invest in the facilities, build the necessary consultant relationships, build its reputation and develop itself as an effective competitor over the long-term. Such a long-term arrangement would specifically be effective in circumstances where it also included all necessary assets, equipment and services that would be required for those facilities to compete across key specialisms, including those in which HCA has particular market power such as oncology and cardiology.

3.14 However, Bupa notes that:

- i. Remedy Option 2 proposes the use of a rental model that is wholly unproven as between competing private hospital operators in the private healthcare industry, either in Central London or in the rest of the UK; and
- ii. Remedy Option 2 necessarily envisages a lease arrangement between competitors. Such an arrangement (whether short-term or long-term) suffers from significant structural shortcomings that undermine in particular the incentives of the tenant to compete effectively and cannot be regarded as equivalent to a standard lease arrangement.

3.15 While Bupa is aware that some hospital operators do rent out their facilities, or parts of their facilities, to third party health professionals (such as consultant consortiums and other clinics) it considers that such examples are not equivalent to the proposed arrangement in Remedy Option 2, since they are effectively rental agreements either between different levels of the market (e.g. hospital operator-consultant) or differentiated product offerings in which the operator landlord does not compete with the tenant (e.g. hospital operator-clinic). Such arrangements are clearly distinguishable from those proposed in Remedy Option 2, under which HCA would be renting its facilities to a direct horizontal competitor. Bupa is unaware of any hospital operators renting facilities or other space directly from other private hospital operators during the normal course of business.

3.16 Bupa also notes that some NHS trusts also rent out PPU's to third parties. However, such rentals are equally distinguishable from the arrangements proposed under Remedy Option 2 -

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<sup>32</sup> PFs, paragraphs 5.69 and footnote 317.

<sup>33</sup> Bupa notes that it also is highly uncertain that Spire will enter into Central London in the foreseeable future, despite HCA's assertion otherwise – as the PFs note, any entry by Spire would take "*several years*" and it is not even in negotiations to acquire sites (or has in fact acquired any sites) in Central London (PFs, paragraphs 5.40 and 5.34).

notably, NHS trusts are not horizontal competitors with the operators to which they rent PPUs. Moreover, the incentives behind the rental of PPUs are by their nature peculiar to the NHS. For example: (i) third party operators have expertise in the provision of private healthcare, which the NHS itself lacks; (ii) the NHS is typically capital-constrained and therefore looks to raise funds through the rental of PPUs to third parties necessary to the develop the service as part of the agreement with a third part, and; (iii) PPUs are often run on the basis of a profit share between the relevant NHS trust and the third party operator.

3.17 Bupa is not aware of any examples of rental arrangements in respect of which the tenant operator is able to compete successfully with the landlord. In the UK an example of which Bupa is aware in which a hospital operator rents hospitals from a third party property company is that of BMI, in which case the leases are for a long-term [X] period. Specifically, Bupa understands that the BMI operating company rents its facilities from a related entity controlled by a consortium of financial counterparties (that have no direct participation in the provision of healthcare and which own BMI's physical assets), through a long-term lease of 20 years. Bupa's understanding is that while BMI rents the hospital buildings from this entity, the responsibility for equipping and maintaining the facilities falls to BMI, with the rent for the site effectively set at a level that allows the financial counterparties to service the debt interest payments owed to the consortium of financial counterparties. The impetus for BMI renting from this third party entity is clearly wholly fact-specific and provides no useful precedent for the lease arrangement proposed in Remedy Option 2.

3.18 The lack of relevant precedent for the proposed lease arrangement emphasises the structural shortcomings to which such an arrangement gives rise. In particular, Bupa is concerned that under any lease arrangement (whether long- or short-term):

- i. HCA would have a comprehensive working knowledge of the costs associated with the relevant facility (since it is currently operated by and under the control of HCA), meaning that for the term of the lease HCA would have a clear understanding of a significant part of a competitor's cost base<sup>34</sup>.
- ii. HCA would have opportunities to gain visibility into the tenant operator's future operating strategy. In particular, any material improvements or other reconfigurations to the facility that the tenant operator considered necessary in order to compete effectively would likely need to be approved by HCA as landlord under the terms of the lease agreement. Such an approval would grant HCA oversight of (and ability to influence) a competitor's future strategy, as the CC (as it then was) has previously recognised in analogous situations<sup>35</sup>. In particular in a highly concentrated market, such a degree of insight into a competitor's current and future operations by an entity with significant market power such as HCA is

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<sup>34</sup> Bupa does not consider that the costs of the same hospital when operated by HCA and by a third party operator would be materially different, unless the third party were able to re-engineer the service model to be more efficient (which Bupa considers unlikely). In particular, the majority of any hospital's costs are represented by nurses, which costs will be fairly fixed regardless of owner.

<sup>35</sup> Notably, exactly the same concerns were raised by the CC (as it then was) in the merger review of Tesco's acquisition of a Co-operative Group store in Slough (2007). In that case, the CC considered as a possible remedy the lease by Tesco of a store to a third party competitor. The CC noted in respect of this proposal that "*even if we were to approve the initial terms of the lease, there would be scope for Tesco to exert influence, for example, in considering applications by the tenant to make changes to the leased store. There is also the possibility that the requirement to notify the landlord of changes to the store would give Tesco a competitive advantage. In addition, the need for the tenant to maintain a good relationship with Tesco as its landlord may undermine the incentive to compete*" (paragraph 8.25). The CC's observations in that case are directly applicable to Remedy Option 2 and clearly illustrate the prima facie concerns that arise in remedies of this kind.

wholly undesirable and prima facie unlikely to improve the competitive structure of the market.

- 3.19 Given the lack of any relevant precedent and the fact that the structural nature of a lease arrangement between horizontal competitors has the potential to undermine competition, Bupa therefore considers that the proposed lease arrangement would be prima facie unattractive for an operator. Bupa emphasises that the structural concerns with the lease arrangement are only exacerbated by the highly concentrated nature of the Central London, in which HCA (the proposed landlord) has significant market power.

**An operator's ability to compete successfully with HCA is further undermined by the short-term nature of the proposed remedy**

- 3.20 In addition to the lack of relevant precedent and the structural concerns with lease arrangements between horizontal competitors, Bupa is particularly concerned that the short-term nature (and potentially uncertain duration) of the proposed remedy will further prevent a tenant operator from being able, or having the incentive, to compete with HCA:
- i. As noted above, material improvements or reconfigurations to the leased facility would need to be approved by HCA as landlord. In addition to the issues of transparency, a tenant may not consider it worthwhile even to request such changes (which may involve significant sunk costs) in circumstances where the lease is only guaranteed for a short-term or an uncertain period, since there would be no guarantee that the tenant could recoup the investment before the lease term expired. The tenant's incentives to develop the business though investment would therefore be significantly diminished under a short-term lease.
  - ii. Similarly, Bupa notes that various crucial pieces of medical equipment (e.g. imaging, theatre and medical plant equipment) typically have a ten year (or longer) life span. For such equipment, it is wholly unclear that a tenant operator would be willing to invest in it in order to develop the competitiveness of a facility that is only available for a portion of this period, since following the rental term the operator would be forced to find an alternative location for the equipment or risk losing any return on its investment. Compared to a scenario where the operator owns a facility outright and thus can be assured of being able to make full use of the equipment (and thus guarantee the maximum possible return on its investment), the proposed lease arrangement therefore reduces the tenant operator's ability and incentive to develop its competitiveness.
  - iii. Even if the rented facility were made available with all of its existing staff, in the case of a short-term (or otherwise time-limited) tenancy Bupa's view is that consultants will be less willing to be persuaded to move to the tenant operator since the consultant would only be practising at the facility for a limited (potentially uncertain) period. Even if the consultants are already practising at the facility (as operated by HCA), it is unclear to Bupa that these consultants have more of an incentive to remain at the rented facility (since the tenant will only be able to offer work for the term of the lease) rather than move to another HCA facility which would guarantee work over the long-term<sup>36</sup>. As a result, it is unclear that a

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<sup>36</sup> Bupa notes that the tenant could of course offer better terms to these consultants in order to retain them at the leased facility. However, the consequence of this would be that the tenant operator's costs would rise, meaning that it would potentially be less competitive in the market as compared with HCA.

tenant operator would be able to attract or retain sufficient consultants (or other necessary medical staff) in order to be able to compete effectively<sup>37</sup>.

- iv. A tenant would need to be confident that it could attract sufficient business from PMIs in order to make the rented facility viable. However, given that the facility will only be available to the tenant for a short-term (and potentially uncertain) period, insurers are likely to be wary of committing significant patient volumes to the facility. Moreover, contractual restrictions in Bupa's current contract with HCA prevent Bupa from directing patients away from HCA on the basis of price - it would therefore be very difficult for Bupa to direct patients to the new facility even if it offered better pricing than HCA<sup>38</sup>. HCA may have similar clauses in its contracts with other insurers, the net effect of which would be to hamper the tenant operator's ability to gain sufficient insurer business at the rented facility.
- v. Even if the relevant HCA facilities are rented on the basis of being a 'going concern' (i.e., containing all relevant staff and assets - see further below), there remains the risk that the tenant operator would simply be interested in running the hospital on an 'as is' basis rather than developing it as a competitor to the remaining HCA facilities. The clear risk in this circumstance is that the tenant operator would be prepared to accept a margin above the rental costs (and any necessary maintenance costs) rather than competing hard with HCA, in particular given that the lease will be for a relatively short period which will reduce incentives to develop the facility as a credible competitor to HCA (as explained above). Remedy Option 2 could therefore have little or no impact on the market in terms of creating or strengthening competition to HCA (and thus lowering prices for consumers).
- vi. In addition to a significant undermining of the tenant's incentives to compete with HCA, a short-term lease may also undermine HCA's incentives to compete with the tenant. This would be because HCA would not be willing to run-down the tenant operator's business by competing fiercely with it since, after a short-term period, HCA would be receiving that business back. This can be contrasted with a situation in which HCA and a third party operator compete on a wholly free-standing basis; here, both HCA and the competitor have every incentive to compete effectively against each other.

3.21 The short-term nature of the proposed remedy there has a very significant effect on the ability and incentives of both the tenant and HCA to compete against each other, and Bupa is not convinced that a remedy in this form can be effective to address the AECs that have been identified. Given these concerns, therefore, it would be all the more important, if this remedy were to be pursued, to ensure that the lease package contains all the necessary staff, assets and equipment needed for the operator to compete immediately with HCA; in Bupa's view, simply leasing a facility to a third party would not be sufficient to grant that third party the necessary access to the London market to compete effectively with HCA, in particular in

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<sup>37</sup> In this respect, Bupa notes that it is crucial that in order to be competitive immediately, an operator needs to have in place appropriate referral pathways and consultant relationships. The CMA recognises this in the PFs when it notes that it is "*likely that when a hospital is new to market [which an HCA hospital leased by a tenant operator would, in effect, be], it would also take time to get its referral pathways in place and therefore to compete effectively*" (paragraph 5.22). Bupa estimates that in the case of a new hospital it would take up to three years for a new hospital to establish the necessary patient administration systems, consultant relationships and referral patterns for the hospital to reach a steady-state occupancy level and thus to be an effective competitor. Bupa's view is therefore that, under a short-term lease arrangement which does not also encompass all the existing and necessary staff, the tenant operator would not have sufficient time to establish the necessary referral relationships in each of the relevant specialisms before the lease expires.

<sup>38</sup> See paragraph 3.4 of our May 2015 response to the Invitation to Comment.

respect of key specialisms in which HCA holds particular market power such as Oncology and Cardiology.

- 3.22 In this respect, the PFs note that "*capacity is related to multiple dimensions (not only the utilisation and availability of day and overnight beds, but also operating theatres, intensive care facilities, and other specialist facilities)*"<sup>39</sup>. It follows that the ability to compete effectively requires sufficient access to each of these dimensions - for example, the ability to compete effectively in Oncology would require not only access to beds but also "*the availability of theatre slots and radiotherapy services*" since in respect of this specialism such availability is "*more likely to be the constraining factor*"<sup>40</sup>.
- 3.23 The CMA indicates at paragraph 30 of the NPR that it envisages that equipment would be included in the scope of Remedy Option 2, but the NPR is silent on the precise scope of the facilities and associated assets, equipment and personnel that would be included. It is therefore unclear to Bupa whether Remedy Option 2 would ensure that all these elements would be available to the operator under the remedy, particularly for key specialisms<sup>41</sup>. This is particularly a concern in the context of a short-term remedy given that a tenant would need immediate access to all necessary assets, equipment and services required to operate the hospital effectively.
- 3.24 In this respect, the PFs recognise the significant loss of investment (effectively, a sunk cost) that would be incurred by an unsuccessful entrant in respect of equipment purchased for a new facility which is then on-sold second-hand<sup>42</sup>. If an operator leasing from HCA for a time-limited period was required to purchase additional equipment in order to compete viably with HCA, it would face the same sunk costs in respect of this equipment (which would most be magnified since there will be less time to recoup the investment before the lease runs out). The clear risk arising out of Remedy Option 2 is therefore that where the whole range of equipment and other assets is not immediately available to the tenant operator as part of a wider rental package, that operator will not only need to source these assets at considerable cost but will also not see a sufficient return on those costs to recoup its investment<sup>43</sup>. Even in circumstances where the lease includes the equipment currently in the facility, it is unclear to Bupa that this equipment would necessarily allow the tenant to compete viably and competitively e.g. it is unclear whether all of the equipment would be strictly necessary for the tenant to operate the facility (in which case it would simply represent an additional and unnecessary cost), or whether the equipment would be of the requisite standard and quality. As a result, Bupa considers that any inventory of equipment within the facility would need to be carefully verified.

### **Significant on-going monitoring and compliance would be necessary**

- 3.25 Remedy Option 2 envisages a time-limited lease arrangement between HCA and a third party hospital operator, which would end once significant new entry has materialised in Central

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<sup>39</sup> PFs, paragraph 4.47.

<sup>40</sup> PFs, paragraph 4.21(b).

<sup>41</sup> It is also unclear exactly how such a package would, in practical terms, be effected – for example, would the staff working at the facility transfer to the tenant operator for the term of the lease or would the incoming operator have to staff the facility itself? If the former would the staff transfer permanently or would they merely be seconded (and therefore remain under HCA's ultimate responsibility)?

<sup>42</sup> PFs, paragraph 5.15.

<sup>43</sup> It would therefore be wholly inappropriate for HCA to move staff, equipment or other assets out of a facility prior to offering it for lease.

London. In Bupa's view, such an arrangement would require significant on-going monitoring. In particular:

- i. The CMA proposes that "*the rental price could be determined through the market (i.e. let other hospital operators bid for the space)*"<sup>44</sup>. Bupa considers that assessing the market price of the relevant facility as well as any additional assets, personnel and equipment would be challenging: as noted above, there is no precedent for this type of arrangement in the industry. The pricing would need to be verified as fair by an appropriate third party, as would the terms of the lease arrangement<sup>45</sup>.
- ii. Moreover, an unintended consequence of multiple operators bidding for the facility is that, in the event of a particularly high rental price being agreed, not only would this benefit HCA through increased rental proceeds (in addition to the increased freehold value of the underlying property) but it will also make it easier for HCA to undercut the tenant operator by competing aggressively on pricing. The perverse outcome of such a situation could be that the tenant operator is further unable to compete effectively with HCA and prices in Central London remain at current levels (since the tenant would need to keep its prices high in order to cover the rental costs).
- iii. The ongoing commercial relationship between HCA and the tenant operator would need to be closely monitored. Any decisions by HCA to refuse requests from the tenant operator to (for example) reconfigure or otherwise improve the leased facility would need to be verified as justifiable by the third party monitor. Since HCA will have little incentive to agree to these changes, it may be necessary for a third party to assess not only the reasonableness of the request by the tenant but also, once HCA has responded to the request, the reasonableness of that response.
- iv. An assessment of whether sufficiently significant entry had occurred in Central London for the lease arrangement to fall away would also need to be made. As Remedy Option 2 explains, the proposed lease arrangement would effectively become redundant once "*significant new entry*" has occurred in Central London. The question therefore arises as to what such entry comprises and in what circumstances the remedy will fall away - it will no doubt be the case that during the term of the lease, submissions will be made by HCA (and possibly others) arguing that the operations of particular private healthcare entities in Central London represent (either singly or together) sufficiently significant new entry to justify a waiving of Remedy Option 2.

3.26 It is also not clear who would take on this role, which is likely to involve ongoing active monitoring of the arrangements. Bupa notes that access remedies, of which Remedy Option 2 is essentially an example, are typically implemented in industries which are already highly regulated - such as the utilities, telecommunications and transport industries. These industries already contain the appropriate oversight mechanisms and regulatory structure to allow for complex access remedies and related proposals to be implemented and monitored efficiently. As the CMA recognised in the Final Report, the same is not true of the private healthcare industry which has no overarching regulatory body or structure - Monitor is concerned with the operation of the NHS, while other bodies such as the CQC are concerned only with relatively

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<sup>44</sup> NPR, paragraph 31.

<sup>45</sup> Alternatively, in circumstances where the market price is merely considered to be equivalent to the highest bid (as the CMA appears to envisage), Bupa's view is that HCA should be obliged to rent the facility at that price.

specific aspects of the private healthcare (in respect of CQC, the standard and quality of care)<sup>46</sup>.

- 3.27 CMA guidance is clear that "*elaborate monitoring and compliance programmes*" reduce the effectiveness of a remedy. Such monitoring and / or compliance oversight clearly increases the implementation costs of a remedy, in particular when compared to structural remedies - indeed, as the CMA notes, "*in remedying competition problems arising from high concentration structural remedies may be expected to increase competitive constraints on the behaviour of firms in the market within a short timescale and without requiring ongoing detailed monitoring by the CMA and/or any other body such as the sector regulator (emphasis added)*"<sup>47</sup>.

### **Conclusion on Remedy Option 2**

- 3.28 Overall, therefore, Bupa is extremely doubtful that any credible operator would find the lease arrangement attractive or that such an arrangement would create a real, standalone competitor able to compete actively and creatively against HCA. This is particularly the case if the intention is that this remedy would operate only for a limited period pending further entry, potentially by third parties. There is, for the reasons set out above, no certainty as to when this new entry might occur but if the effect of such entry is that the remedy falls away then the lessee would presumably at that point be required to find alternative premises or cease to operate. It seems very unlikely that an operator that is offered a lease on such an uncertain basis will have commercial incentives to invest in or grow the business.
- 3.29 As a result, and given that the competition problem that the CMA has identified in this case relates to high concentration and there is no real prospect of the position changing in the foreseeable future, divestiture should be considered as the only appropriate remedy model.

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<sup>46</sup> The CMA noted in the Final Report that "*there is at present no private healthcare industry regulator*" (paragraph 12.67). This observation was made in respect of the rejected price control remedy, in relation to which the CMA considered that a regulator would need to be created. The CMA rejected price control as a remedy partly on the basis that the cost of setting up and administering such a regime would be considerable. Bupa considers that similar concerns arise in respect of Remedy Option 2.

<sup>47</sup> CC3, paragraph 387.

## CONSULTATION QUESTION RESPONSES

### **Question (a): Would the remedy be practicable and effective in remedying the insured and self-pay AECs?**

3.30 No, for the reasons given in paragraph 3.1 to 3.29 above. In particular:

- i. Third party entry within any timeframe is wholly uncertain.
- ii. The proposed remedy model - which is based on rental - is wholly unproven as a business model between private healthcare operators in the industry and, particularly if implemented on a short-term basis, would undermine incentives to compete.
- iii. The ability of a competitor to constrain HCA does not depend simply on access to a facility in Central London, as the CMA has already recognised. The lease arrangement would need to cover a range of additional assets, equipment and personnel in addition to the HCA facility itself and, even then, it is not clear that a tenant operator would have the ability or incentive to compete effectively with HCA.
- iv. The remedy as a whole would require significant monitoring and enforcement by an appropriate body.

3.31 In Bupa's view, divestiture of HCA facilities remains (as the CMA has already concluded in its Final Report) the most practicable and effective means of addressing the AECs identified in Central London.

### **Question (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?**

3.32 There is no relevant precedent for the proposed lease arrangement between private hospital operators in the industry, and indeed hospital rentals of any kind by operators is rare. It is therefore highly unlikely that existing competitors or new entrants would in principle be interested in renting from HCA - see in particular paragraphs 3.13 to 3.19 above.

3.33 Moreover, renting a facility from HCA (in particular for a short-term period) would seriously undermine the incentives of the tenant to compete with HCA - see paragraphs 3.20 to 3.23.

### **Question (c): Would the remedy give rise to unintended consequences or distortions?**

3.34 Yes. In particular:

- i. The rental relationship between HCA and the tenant would grant HCA as landlord the possibility of insight into the tenant's cost structure and commercial strategy. This is particularly undesirable in Central London, which is a highly concentrated market in which HCA has significant market power.
- ii. There is a risk that bidding for the HCA facility will simply result in the eventual tenant being required to maintain high prices in order to cover the rental costs. High rental costs would also assist HCA by granting it the possibility of more easily undercutting the tenant's pricing.

- iii. There is a risk that prospective tenants will be content simply to run the rented facility on an 'as is' basis (particularly if rented only for a short-term period), rather than competing hard with HCA.

***Question (d): Are there other remedies that would be as practicable and effective in remedying the AECs that would be less costly or intrusive?***

- 3.35 For the reasons given above, Remedy Option 2 would be neither practicable nor effective in remedying the AECs. Moreover, the remedy would require significant monitoring and enforcement (see paragraphs 3.25 to above).
- 3.36 Bupa's view remains that the only practicable, proportionate and effective remedy is divestiture - see further Section 2 above.

***Question (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?***

- 3.37 Remedy Option 2 is in no way a potential alternative to full divestiture, because on any analysis there are significant flaws with any proposal whereby one competitor leases a facility from another - see paragraphs 3.13 to 3.19 above.
- 3.38 Moreover, if a short-term lease is envisaged in anticipation of significant new entry into Central London, the efficacy of the proposal is further undermined. In particular, there is no evidence of such entry within a certain timeframe (see paragraphs 3.6 to 3.12), and the short-term nature of the lease arrangement would itself undermine the tenant's (and HCA's) incentives to compete - see paragraphs 3.20 to 3.24.

***Question (f): What provisions would need to be put in place for the monitoring and enforcement of this remedy and which body should be responsible?***

- 3.39 Very significant ongoing monitoring and enforcement would be required which, notwithstanding the other defects of Remedy Option 2, further undermine the remedy's appropriateness and efficacy - see further paragraphs 3.25 to 3.29 above.

***Question (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 a new operator?***

- 3.40 Given the very significant period required by a new operator to establish the necessary consultant relationships and referral pathways, it would be very important that no staff were removed from the facilities. Similarly, given the time taken to equip hospitals with the necessary equipment and assets, the basic principle should be that no administrative functions, equipment or assets should be removed from the facilities. See further paragraphs 3.21 to 3.24 above.
- 3.41 In any event, given that the proposed lease arrangement is to be time-limited, Bupa considers that even if the facilities are leased with the necessary staff and associated assets, the tenant operator will still lack the incentive and ability to compete effectively with HCA – as explained above.

***Question (h): What hospitals / facilities should be rented out by HCA?***

- 3.42 For the reasons given above, Bupa does not consider that Remedy Option 2 is appropriate or could be effective and practicable. Were the CMA to consider this remedy further, however, the

size of the leased package would need to be wider than the divestiture package proposed by Bupa in Section 2 above. This is principally because, as outlined in paragraphs 3.1 to 3.29 above, the tenant will have weaker incentives to compete with HCA than where it owns the competing facility outright (as would be the case under a divestiture remedy). In order to compensate for these weaker incentives, the tenant would therefore require more facilities for the remedy to have a chance of having a similar effect to the divestment alternative.

- 3.43 Bupa would consider it important that the package only contained the larger hospital sites in which the tenant could readily reconfigure the operations as it saw fit. Since there will be little or no incentive for the tenant to significantly invest in new equipment or facilities or the short-term (potentially uncertain) term of the lease, the package therefore needs to include sites with all necessary facilities, services and equipment already installed. Similarly, it would be important that the facilities were able to offer these services and equipment across all the key specialisms in which HCA has particular market power.

## 4. REMEDY 3 – RESTRICTIONS ON HCA’S FURTHER EXPANSION IN CENTRAL LONDON

### *Introduction*

- 4.1 In Remedy Option 3 the CMA proposes to restrict HCA from acquiring further suitable hospital and/or clinic sites in Central London. The CMA suggests that this may help to lower entry barriers for other hospital operators seeking to acquire suitable sites. Suitable sites are in scarce supply and HCA is currently in a position to outbid other operators for sites, as in acquiring a site it enjoys the additional benefit of also protecting its existing market power.
- 4.2 Bupa notes first that this remedy would be entirely ineffective on a standalone basis in addressing the existing AECs caused by HCA’s large market share and the customer detriment that exists currently. The divestment remedies discussed in Section 2 above are necessary, effective and proportionate to address the existing harm effectively. Remedy Option 3 will not achieve the necessary change on its own and so, if the CMA were to consider this remedy further, it should only do so as an adjunct to the package of divestments set out in Section 2 above.
- 4.3 Bupa recognises that Remedy Option 3 may assist in preventing the existing AECs from getting worse over time: it may partially restrict HCA’s further growth (although there is a high risk it could be circumvented, as we explain below) and it could potentially offer some more opportunity for rivals to grow in the market if appropriate new sites emerge. However, on its own, it will be ineffective in materially changing the existing competitive dynamics in Central London.

### **CONSULTATION QUESTION RESPONSES**

***Question (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?***

- 4.4 The remedy would improve the odds of a new competitor entering (as HCA would be taken out of the bidding), but we expect the impact on the actual flow of entry and expansion to be small. Entry will continue to be constrained by the scarcity of suitably located sites coming on to the market, the high sunk costs of acquiring and configuring the hospital, and other relevant entry barriers (e.g. entrenched consultant referral patterns and restrictive contractual clauses). The London Clinic, for example took several years to open its new Cancer Centre even following the acquisition a suitable site.
- 4.5 Further, there remains a significant risk that HCA could circumvent the remedy – see examples in paragraph 4.16 below.
- 4.6 Therefore, Bupa does not believe that this remedy would be effective on a standalone basis in remedying the AEC. It would not do so fully or in a timely manner. It would provide at best only partial protection against future harm through HCA (even after divestments) continuing to build

its presence in central London. This remedy option would therefore only have some merit if combined with the divestment remedies proposed in Section 2.

**Question (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?**

- 4.7 Bupa does not believe this remedy would be effective on a standalone basis. If, however, the CMA pursues this remedy, it must apply to all forms of healthcare activities – primary, secondary, tertiary in both outpatient and inpatient settings.
- 4.8 Bupa has previously expressed significant concern about HCA entering primary healthcare through the acquisition of private GP practices (e.g. Roodlane) and the effects this may have on referral patterns and also on barriers to entry and expansion for rivals. If the objective of this remedy option is to lower entry barriers, then primary healthcare activity must be included in the coverage of the remedy.
- 4.9 Outpatient activity should also be covered to restrict HCA’s ability to circumvent the remedy. If HCA is allowed to purchase outpatient facilities, it may seek to shift outpatient activities out of its large hospital sites (which currently each offer a mix of outpatient and inpatient services on site) so as to free up capacity in these facilities to further expand inpatient services. HCA would, therefore, continue to grow significantly within its existing inpatient facility footprint and would still be able to outbid rivals for outpatient facilities given it would be growing its market power.

**Question (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, e.g. large-scale entry?**

- 4.10 Bupa does not believe this remedy would be effective on a standalone basis. If, however, if the CMA goes forward with Remedy Option 3 no specific time limit should be put in place. Past experience shows that entry into Central London could take many years to occur. Rather, the CMA should agree to re-examine hospital competition in the Central London market in 10 years’ time. This would give the opportunity for Remedy Option 3 to be re-assessed and potentially changed at that point.
- 4.11 Further, it is unnecessary to make the duration of the remedy contingent on specified events at the *ex-ante* point of drafting the Order. HCA would already have the legal option available to ask the CMA to re-evaluate the appropriateness of the Order if there were a material change of circumstance in the market<sup>48</sup>. Seeking to speculate on and to spell out specified ‘triggers’ at this stage is, therefore, unnecessary and indeed may limit the CMA’s options in future. There is significant risk also in ambiguity on how these triggers may be drafted.

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<sup>48</sup> Section 162 of the Enterprise Act 2002

- 4.12 The CMA gives the example of ‘large scale entry’ leading to the remedy being removed – however to specify this fully, one would need to define (amongst other things):
- i. What ‘large’ is and on what basis it is measured;
  - ii. How it would apply to relevant key specialisms, and inpatient versus outpatient/day-case – large scale entry in single niche specialism would have little impact on competition; and
  - iii. When this entry is deemed to have taken place e.g. when contracts are signed, when doors open, or at the point that the entrant has demonstrated successful track record in providing competitive constraint (and if so, on what basis that success should be defined).
- 4.13 Bupa is strongly of the view that, in the interests of customers, the remedy should only be removed when there is sound evidence of effective competition having returned to the market. This will require investigation by the CMA to determine what is in the best interests of customers. Seeking to embed speculative trigger events now, ex ante, is therefore only likely to harm customer interests.

***Question (d): Would the remedy give rise to unintended consequences or distortions?***

- 4.14 Bupa considers that there is a risk of unintended consequences; for example, if HCA seeks to circumvent the remedy through increasing the range of partnerships (and so not full acquisition of sites) it has across the market – see paragraph 4.16 below.

***Question (e): Would customer detriment arise if the incumbent was prevented from expanding within central London but no entrant appeared?***

- 4.15 Bupa considers that the risk of customer detriment from the remedy is low, particularly when weighed against the detriment existing in the counterfactual in which HCA is able to continue to extend its strength.

***Question (f): Is there any risk that HCA could circumvent this remedy?***

- 4.16 Yes there is a high risk that HCA could circumvent the remedy. Examples may include:
- i. Using partnerships and joint ventures to avoid formally acquiring a site, as HCA has done in relation to PUs<sup>49</sup>.
  - ii. Expanding the floor-space of its existing site portfolio e.g. building additional floors on top of or beneath the facility.
  - iii. If outpatient services are not covered by the remedy, acquiring new outpatient sites and moving existing outpatient services out of the large hospitals to free up capacity in these inpatient facilities.

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<sup>49</sup> See, for example, HCA lease of the premises from Guy’s and St Thomas’ NHS Foundation Trust which was structured to avoid being a relevant merger situation, ME/5641/12, Available at: <https://assets.digital.cabinet-office.gov.uk/media/555de2e4ed915d7ae2000037/HCA.pdf>

- iv. Acquiring further facilities just outside central London to act as an overflow for the larger inpatient facilities within Central London.

***Question (g): What provisions would need to be put in place for the monitoring and enforcement of this remedy and which body should be responsible?***

- 4.17 Remedy Option 3 would require ongoing monitoring particularly given the high risks of circumvention. In Bupa's view, the CMA would be best placed to monitor the remedy. HCA should be required to prepare an annual report for the CMA or an appointed monitoring trustee to demonstrate its compliance with the spirit of the remedy.

***Question (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?***

- 4.18 Bupa considers that the benefits from this remedy are likely to be relatively low given that acquiring a site is not the only barrier that new operators face; circumvention risks are high; and, effective entry would still likely take many years (meaning any future benefits should be time-discounted into to present value terms).
- 4.19 Remedy Option 3 would not be effective as a standalone remedy. We could see it of benefit only as an adjunct to the divestment remedies in Section 2 to prevent HCA from rapidly rebuilding its dominant position.

## Annex A: Supporting Data

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