PRIVATE HEALTHCARE REMITTAL
PROVISIONAL FINDINGS AND NOTICE OF POSSIBLE REMEDIES
RESPONSE OF AXA PPP

1 Introduction and Executive Summary

AXA PPP welcomes the opportunity to respond to the CMA's Provisional Findings ("PFs") and Notice of Possible Remedies ("Notice") in this matter. This submission includes our response to both documents.

AXA PPP does not intend to repeat its views on the areas where it is in agreement with the CMA and has already stated its position clearly in its previous submissions. This response is therefore focused on the main issues and evidence that we believe have not previously been disclosed to AXA PPP or dealt with in AXA PPP's submissions, and on a small number of areas where AXA PPP's views differ from those set out in the PFs and Notice.

AXA PPP agrees with most of the CMA's conclusions, which are broadly consistent with our experience of the market in central London. AXA PPP's views (which are set out in more detail in the response below) may be summarised as follows:

- HCA continues to benefit from significant market power, which is likely to increase as HCA continues to expand its presence in central London. Whatever the precise mechanism used to measure HCA's market share, the simple fact remains that AXA PPP is dependent on HCA as a "must have" provider across a range of key specialties. AXA PPP remains in no doubt that HCA charges higher prices than other providers.
- AXA PPP therefore agrees with the CMA's provisional finding that high concentration as a result of HCA's market share in central London, together with high barriers to entry and expansion, represent an adverse effect on competition ("AEC") for insured patients.
- AXA PPP continues to have particular concerns with respect to HCA's strength in oncology services, which continues to grow. Barriers to entry remain particularly high for radiotherapy services.
- AXA PPP agrees that barriers to entry in central London remain high. In addition to difficulties in identifying sites and lengthy development times, the simultaneous need to attract and retain a sufficient number of consultants willing to move their work from existing hospitals and to establish the clinical reputation of the new facility across the range of key specialties, including oncology, represent significant barriers to entry.
- AXA PPP notes the possibility that one or more other providers may enter the central London market. However we do not believe there is firm evidence that any such entry would provide sufficient remedy in the near term. It seems clear that entry by new entrants such as VPS or the Cleveland Clinic, who may have secured sites, have still to face the considerable barriers referred to above.
- Critically, therefore, such potential entrants could not be offered to corporate clients of PMIs as a credible alternative in lieu of the HCA network. Without this, such a

new entrant does not represent a credible new 'outside option' that PMIs could leverage in negotiations with HCA and thereby counteract the AEC i.e. to constrain HCA to such an extent that PMIs such as AXA PPP would no longer be dependent on HCA as a contracting partner.

- AXA PPP does not believe that complex patients are disproportionately directed towards HCA rather than TLC. In our view HCA's assertions are not supported by the available data, which indicates that if anything TLC may be treating more complex patients than HCA.
- Nor is pathology a suitable proxy for patient complexity. AXA PPP remains concerned that pathology is an area prone to billing abuse. We provide some further evidence on this topic in the response below.
- It is entirely reasonable for the CMA to continue to rely on the profitability analysis presented in the Final Report. To the best of AXA PPP's belief HCA's profitability remains high, and it is striking that HCA does not appear to have made submissions to suggest that its profitability levels have changed or should otherwise be reassessed.
- The only effective remedy to address the identified AEC and remove AXA PPP's dependence on HCA involves divestiture of certain HCA facilities. Preventing future expansion by HCA would do nothing to address the current AEC which has been in place for some time. Similarly a remedy involving the lease of an HCA facility would not be effective, as neither HCA nor the tenant of the facility would have strong incentives to invest during the term of the lease.
- In order to create an effective competitor to HCA and TLC, and remove the AEC, it is essential that the divestment package enables the purchaser to provide a full offering, such that HCA is no longer an unavoidable contracting partner. In particular, the divestment package must include sufficient facilities to enable a full oncology offering, given the importance of this specialty for customers, HCA's particular strength in this area and the particular barriers that exist for radiotherapy facilities.
- In AXA PPP's view the most effective, yet proportionate, divestment package would consist of the London Bridge hospital (including the outpatient facilities at the Shard), the recently opened London Radiotherapy Centre, and the Princess Grace hospital. HCA would continue to benefit from a leading position due to its range of other facilities and further expansion plans.

AXA PPP looks forward to discussing these issues further with the CMA in its forthcoming hearing.

2 HCA's market power

2.1 HCA remains "must have"

AXA PPP agrees with the CMA's previous finding that central London is a highly concentrated market in which HCA has a strong position across all specialties and an even stronger position when considering the most common specialties and the more complex segments of the market (which are those which customers expect to be covered by a PMI policy). This position has not changed: HCA continues to benefit from a very strong

position which is likely to increase as HCA continues to expand its presence in central London, and its position is particularly strong in relation to certain key specialties, notably oncology and cardiology.

AXA PPP does not propose to comment in detail on the approach to defining the market, measuring market share and assessing competitive constraints taken in the PFs, or on the various arguments that HCA has put forward in disagreement with the CMA which, in our view, have been thoroughly addressed by the CMA in the PFs. As the CMA is aware from our extensive previous submissions on these issues, whatever the precise mechanism used to measure HCA's market share, the simple fact remains that AXA PPP remains dependent on HCA as a "must have" provider across a range of key specialties.

2.2 Oncology

AXA PPP continues to have particular concerns with respect to HCA's strength in oncology services.

On the supply side, as AXA PPP has previously described, oncology is one of the more complex medical specialties and is the one with the highest share of admissions in central London. It is of disproportionate commercial significance to private hospital providers because most cancer patients present to other specialists, who refer the patients in question to oncologists for treatment together, as part of a cancer multidisciplinary team. Cancer treatments, which typically last for a relatively long period of time, are therefore associated with ongoing treatments across other specialties. In consequence, the revenue associated with cancer treatments is much higher than the share of admissions and revenues in oncology alone.

On the demand side, cancer is the priority health insurance issue for consumers and corporate customers: as noted by HCA's Cancer Strategy document, 76% of people ranked it as their foremost health concern, and 91% gave cancer as their main reason for taking out PMI. It follows that, for the customers of a PMI such as AXA PPP, oncology is a vital part of their private health insurance packages[1].

HCA facilities account for almost [✂]% of AXA PPP's oncology spend in central London for the twelve months from July 2014 – June 2015, with TLC (the second largest provider) accounting for [✂]%, and Bupa Cromwell [✂]%. HCA therefore remains an unavoidable contract partner in the central London market for oncology services, and its dominant position in this market continues to grow. An overview of its presence follows below:

- The Wellington Hospital offers a wide range of cancer services, including diagnostic services, medical treatment and surgical care (supported by high dependency and intensive care facilities if required). Its diagnostic imaging services include access to MRI scans, a low dose PET-CT, CT, ultrasound and a same day mammography service. The Wellington Hospital does not offer radiotherapy, which is available at the Harley Street Clinic.
- The Harley Street Clinic has an extensive cancer service, from "state-of-the-art equipment and facilities to leading drug development and treatment options"[2]. These include cancer diagnostics, chemotherapy, radiotherapy and cancer support services. The Clinic also houses the Cyberknife centre.

[1] Final Report, Appendix 6.2, paragraph 60.

[2] http://theharleystreetclinic.com/cancer/

- The oncology offering at the London Bridge Hospital (which has historically not provided a full range of cancer services) has been strengthened with the opening of the London Radiotherapy Clinic, a purpose built centre which offers comprehensive and sophisticated radiotherapy planning and treatment on one site (leased from Guys and St Thomas' hospital). The clinic offers direct access to the London Bridge Hospital (described as its "sister site") for in-patient and day case facilities if needed by radiotherapy patients.
- HCA continues to own Leaders in Oncology Care ("LOC"), a specialist cancer treatment centre set up by four leading consultants in 2005 which now includes over 80 consultants. LOC provides treatment to patients across five LOC treatment centres, which provide consultations and day case cancer treatment which including chemotherapy, hormone therapy, immunotherapy and supportive care, which represents a significant proportion of AXA PPP's oncology spend (see section 6.1 below). In addition, LOC accounts for a significant proportion of oncology referrals in London, which are primarily directed to other HCA facilities.
- HCA continues to pursue acquisitions in the cancer treatment area. An example is that in July 2013 HCA acquired 80% of The Prostate Centre which describes itself as "a state-of-the-art private clinic dedicated to the diagnosis and management of all prostate problems and urological cancers"[3]. It is based in central London and has 12 specialists, physicians and radiologists.
- HCA will also control the Guys and St Thomas' PPU, described by HCA as "a hub for South East London, providing specialist cancer services, training, development and research, and allowing to provide better cancer treatments and improved outcomes for patients". The centre will be a single site for both cancer diagnosis and ongoing cancer treatment, and is due to open in Autumn 2016[4].

As set out further in response to the Notice (at section 6) below, the inclusion of appropriate oncology facilities in any divestiture package is essential in order to remedy the AEC effectively.

3 Barriers to entry and expansion

3.1 Overview

AXA PPP agrees with the CMA's findings that barriers to entry in central London are high. We have previously emphasised the fact that assembling a site for a major new hospital in central London is difficult, and that even if a site can be identified the process of development is typically lengthy and extremely costly. In addition, the simultaneous need to establish a clinical reputation and to attract (and retain) a sufficient number of consultants willing to move their work from existing hospitals represents a significant barrier to entry.

When considering the prospects and likely impact of potential entry, therefore, it is necessary for the CMA to consider the following factors:

[3] http://www.theprostatecentre.com/

[4] http://www.guysandstthomas.nhs.uk/our-services/cancer/cancer-centre/cancer-centre.aspx

- Whether the proposed entry or expansion is on a scale sufficient to counteract the AEC (i.e. will HCA be constrained to a sufficient extent that it is no longer an unavoidable contracting partner);
- Whether the proposed entry or expansion will provide services across the various specialties necessary to counteract the AEC;
- Whether the proposed entry will be able to attract a sufficient number of consultants across the various specialties.
- Whether the operator has a sufficiently strong brand to satisfy the demands of PMI corporate customers.
- How long it will take to establish a sufficiently strong clinical reputation (bearing in mind that, for example, it will by definition take a number of years to build a critical mass of 5 year survival rates for a cancer facility).

Against this backdrop, we have a number of observations on the evidence considered by the CMA in recent months, which are set out below.

3.2 Spire

AXA PPP notes Spire's views[5] that while it is interested in exploring opportunities to enter central London, it is not currently in negotiation on any sites, contrary to HCA's suggestion during the remittal. This is consistent with AXA PPP's own understanding of the status of Spire's consideration.

Even if it could be said that entry by Spire was likely given its stated interest, there is no indication that such entry would be timely or sufficient – without further detail of the size of facility that it will ultimately develop, nor the services that it will offer – to constrain HCA in the future.

3.3 NHS sites

AXA PPP notes the CMA's further finding that evidence provided by NHS hospitals (which HCA submitted were likely to dispose of possible sites) was mixed and in certain respects contradicted HCA's submissions. Again, this is consistent with AXA PPP's own evidence. AXA PPP also notes Spire's view that the precise scope and timing of any opportunity to acquire an NHS site is very unclear.

3.4 The Cleveland Clinic

AXA PPP notes the CMA's observation that the Cleveland Clinic, a US-based provider of private healthcare services, has recently acquired an office building in Grosvenor Place, which it may look to convert to hospital use. The CMA adds, though, "we note that it is not yet clear whether the Cleveland Clinic will be able to use the building it has acquired for hospital purposes and that this route to entry has not been taken by any of the other operators looking to enter the central London market."

AXA PPP is not familiar with the Cleveland Clinic, which has no current presence in the UK. The Cleveland Clinic has not approached us to discuss any potential facility in central London or elsewhere. As the CMA notes, the acquisition of office premises is very recent, no application for planning permission has yet been made, and there is no certainty that

[5] PFs paragraph 5.34.

the Cleveland Clinic will in fact be able to use the building it has acquired for hospital purposes, with the Cleveland Clinic itself informing the CMA that it is too early to discuss its plans in any detail.

Even if the building is ultimately converted for hospital use, the timeframe for such conversion is entirely unclear, as is the range of specialties that the Cleveland Clinic would propose to offer. To AXA PPP's knowledge the Cleveland Clinic's only other venture outside North America to date concerns a multi-specialty hospital in Abu Dhabi (in partnership with Mubadala Development Company) which opened earlier this year, seven years after an initial ground breaking ceremony[6] and two years later than originally anticipated.

Equally there is no guarantee that the facility developed would be sufficient in terms of size and services offered to constrain HCA to a sufficient extent in the future. AXA PPP notes the CMA's comment (at PFs footnote 317) that together the site at Grosvenor Place and the former Ravenscourt Park hospital site would accommodate around 300 beds, which suggests that the site at Grosvenor Place would – if planning permission were granted – accommodate around 150 beds, which is similar in size (in terms of number of beds) to the London Bridge (148 beds)[7] or the Princess Grace (128 beds)[8], but significantly smaller than the Wellington (266 beds)[9].

In addition to the time taken to secure planning permission and develop the physical premises, it would also be necessary for the Cleveland Clinic to attract suitable consultants and build a sufficient reputation before it is likely to constrain HCA to any material constraint. AXA PPP anticipates that it would take some time to persuade corporate customers that Cleveland Clinic, which has no established brand or clinical reputation in the UK, would represent an effective alternative to HCA.

3.5 VPS

Similarly there is no certainty that VPS will ultimately enter the market. As AXA PPP has noted in previous submissions and discussions with the CMA, discussions about a potential development on the Ravenscourt Park hospital site have continued for many years without any sign of firm entry to date. AXA PPP notes the CMA's conclusion that it remains uncertain whether VPS will be able to enter the market (notwithstanding its apparent desire to do so).

The comments above with respect to the Cleveland Clinic therefore also hold true for VPS: the likelihood of entry and the timeframe for potential entry is unclear, and the size of the hospital (which previously accommodated 150 beds) would be similar in size (in terms of number of beds) to the London Bridge (148 beds) or the Princess Grace (128 beds), but significantly smaller than the Wellington (266 beds).

While AXA PPP notes VPS' proposal to develop a proton beam accelerator at the site, we remain sceptical that this would be a viable proposition given the limited number of patients who are likely to benefit from such specialist treatment, and the NHS's plans to provide such facilities elsewhere in London and the UK. The location of the Ravenscourt Park hospital to the West of London is also unlikely to provide a material constraint on HCA's

[6] http://www.almaryahisland.ae/en/media-centre/fact-sheets/cleveland-clinic

[7] http://www.hcahospitals.co.uk/our-hospitals/find-a-hospital-or-outpatient-centre/london-bridge-hospital/

[8] http://www.hcahospitals.co.uk/our-hospitals/find-a-hospital-or-outpatient-centre/the-princess-grace-hospital/

[9] http://www.thewellingtonhospital.com/about-us/the-wellington-hospital/

strong position in the City, which is of particular importance to corporate customers. It is therefore doubtful that entry by VPS, even if it were to occur, would remove AXA PPP's dependence on HCA.

3.6 Entry cannot therefore be relied upon to address the AEC

Ultimately the critical question for the CMA in this context is whether prospective entry will be sufficient to eliminate AXA PPP's dependence on HCA as a "must have" provider in central London. The mere fact of physical premises is clearly not enough (and even then, it is not currently clear whether the premises identified by VPS or the Cleveland Clinic are in fact viable).

Given the above, the likelihood of effective entry, within a reasonable timeframe, that is of a sufficient scale (in terms of size, range of specialties, consultants and reputation) to represent a realistic alternative to corporate customers and remove AXA PPP's dependence on HCA is highly doubtful on the basis of the evidence before the CMA (including direct evidence from the potential entrants themselves) and, in AXA PPP's view, cannot be relied upon to address the AEC provisionally identified by the CMA. As discussed further in Section 6.2 below, nor can the prospect of such entry justify a weaker remedy than outright divestiture.

4 Insured prices

4.1 HCA pricing

AXA PPP has consistently maintained throughout the course of the market investigation and this remittal process that HCA charges higher prices than other providers, notwithstanding the general economic environment and the regulatory scrutiny under which it is currently operating. AXA PPP has provided a range of evidence, outside the parameters of the IPA, in support of this statement, including:

- [✂][10].
- [✂][11].
- [✂][12].

AXA PPP continues to maintain, therefore, that as evidence the IPA should not be viewed in isolation but should be interpreted in light of the corroborative experience of PMIs such as AXA PPP.

AXA PPP would also repeat its view that, even if the IPA had found no difference in price between HCA and TLC (which would not be consistent with AXA PPP's own experience), it cannot simply be assumed that [✂][13].

4.2 Patient complexity

AXA PPP notes HCA's continued argument that any difference in price between HCA and TLC is due to the fact that HCA treats more complex patients than TLC. This does not

[10] See AXA PPP submission of 6 May 2015.

[11] See AXA PPP response to CMA questions of 12 August 2015, submitted on 26 August 2015.

[12] See AXA PPP response to CMA questions of 12 August 2015, submitted on 26 August 2015.

[13] See AXA PPP submission of 24 July 2015.

accord with AXA PPP's own experience. Our further response to HCA's submissions on this issue is set out below.

As previously stated, AXA PPP does not believe that more complex patients are disproportionately directed towards HCA rather than TLC. AXA PPP notes that HCA continues to assert that it incurs higher costs as a result of increased complexity. AXA PPP remains of the view that this assertion is not supported by the available evidence.

American Society of Anesthesiologist (ASA) scores

AXA PPP has considered HCA's claim (summarised at PFs paragraph 8.44) that the ASA score is on average higher at HCA than the London Clinic. By way of background, ASA is a classification system adopted by the American Society of Anesthesiologists which anaesthetists use to make an assessment of patients before operations. It has six categories, namely:

1. Normal healthy patient
2. A patient with mild systemic disease
3. A patient with severe systemic disease
4. A patient with severe systemic disease that is a constant threat to life
5. A moribund patient who is not expected to survive without the operation
6. A declared brain dead patient whose organs are being removed for donor purposes

HCA reports an average ASA figure of 1.7 to 2.0 for their hospitals and compare this to an average 1.6 for TLC. Whilst we have not seen the details of this calculation, it would appear that they have taken an average of ASA categories. As ASA categories are ordinal data, this would not be a suitable approach, and results in a meaningless figure (which in any case does not show a meaningful difference between HCA and TLC).

AXA PPP previously commented on data gathered by the National Joint Registry (NJR) showing percentages of people more likely to have problems before or after surgery at TLC and HCA. These percentages, for people more likely to have problems, are given in the NJR data as those categorized as ASA 3+. The relevant figures for the hospitals are shown in tables 1 and 2 below.

Hip Replacement

Table 1

	ASA 3+ (April 2003- March 2015)	**Number of Hip Replacements (April 2012 – March 2015)**
London Clinic	10%	408
London Bridge	12%	181
The Wellington Hospital	4%	127
Princess Grace Hospital	3%	953
The Lister Hospital	25%	68

Table 1 shows that of the HCA hospitals, the London Bridge hospital has a slightly higher percentage of patients with an ASA score of 3+ and the Lister Hospital a much higher percentage, whereas the other two hospitals have a considerably (around two thirds) lower percentage than TLC. The HCA hospital with by far the largest volume of hip replacements, The Princess Grace, is also the one with the lowest percentage of people with an ASA score of 3+.

As the ASA scores and volumes are taken from different time periods, using these two sets of figures to create a weighted average can only give an approximate figure. However doing this gives a combined HCA figure of 5.4% for patients with an ASA score of 3+ which is approximately half that of TLC.

Knee Replacement

Table 2

	ASA 3+(April 2003- March 2015)	**Number of Knee Replacements (April 2012 – March 2015)**
London Clinic	14%	151
London Bridge	14%	209
The Wellington Hospital	2%	227
Princess Grace Hospital	10%	315
The Lister Hospital	21%	25

For patients having knee replacements, only the Lister hospital had a greater percentage of people representing a greater risk (ASA 3+) than TLC. The Lister is also, by far, the hospital performing the least number of these operations. The London Bridge hospital has the same percentage of higher risk patients as TLC. The Princess Grace has a lower percentage of riskier patients and The Wellington Hospital a very small percentage. Combining the figures for the HCA hospitals, with the same caveat as the hip replacement

figures presented above, gives an overall figure of 9.1% for patients with an ASA figure of 3+ at HCA compared to the 14% at TLC.

In summary, use of ASA scores actually shows HCA hospitals taken together to be dealing with less complex cases than TLC, contrary to HCA's assertion.

Pathology is not a proxy for patient complexity

AXA PPP remains of the strong view that pathology charges in invoice data are not a good basis for comparing and controlling for differences in patient complexity between HCA and TLC.

Background

As previously discussed with the CMA, AXA PPP regards the extra lines of billing from HCA as a measure of HCA's ability to generate extra income and profit, rather than an indicator of complexity.

Pathology tests are by their nature, discretionary and of low harm impact to patients. Almost all common tests can be ordered from two vials of blood (one vial of clotted blood for plasma assays and one vial containing EDTA to prevent clotting for whole blood assays). Once the two vials have been drawn there is no further patient detriment in ordering additional tests – the amount of blood required is the same.

The combination of the high degree of discretion, the low patient harm and the significant profits available (as noted below, HCA tests are billed at up to [✂] times the cost to the NHS of performing the test) means that pathology is an area prone to billing abuse. As the CMA is aware, [✂].

In our original submissions to the CC during the market investigation, AXA PPP highlighted that one of the incentive schemes operated by HCA involved [✂].

[✂].

Hip and knee replacement data

As discussed above, the available NJR data in relation to hip and knee replacements (described in Tables 1 and 2 above) rejects the hypothesis that HCA sees more complex patients for hip and knee replacements. Whilst, as described above, AXA PPP considers that pathology billing does not represent a proxy for complexity, we have out of interest considered pathology billing for joint replacement. AXA PPP has analysed the number of pathology line items for these procedures at HCA and TLC over the period [✂].

Table 1 above indicates that combining the figures for HCA hospitals gives an overall figure of 5.4% for patients with an ASA score of 3+ which is approximately half of that for TLC, thus indicating (on the basis of HCA's logic) that in fact TLC is treating more complex patients. To the extent that pathology is a reliable indicator of complexity therefore, it would be reasonable (again, on the basis of HCA's own logic) to expect that TLC would have higher number of pathology line items for these procedures. However, as set out in Table 3 below, available data for hip replacements indicates fewer pathology line items at TLC than HCA for these cases.

Table 3

Procedure	Provider	Total No of Stays	Average No of Pathology Lines Billed	Average Pathology Benefit Claimed
W3712 (Primary total hip replacement)	HCA	[✂]	[✂]	[✂]
	TLC	[✂]	[✂]	[✂]

Similarly Table 2 above indicates that combining the figures for the HCA hospitals gives an overall figure of 9.1% for patients with an ASA figure of 3+ at HCA compared to the 14% at TLC. However, Table 4 again indicates that the average number of pathology lines for the relevant procedures is lower in TLC that HCA.

Table 4

Procedure	Provider	Total No of Stays	Average No of Pathology Lines Billed	Average Pathology Benefit Claimed
W4200 (Complex primary total knee replacement)	HCA	[✂]	[✂]	[✂]
	London Clinic	[✂]	[✂]	[✂]
W4210 (Total prosthetic replacement of knee joint)	HCA	[✂]	[✂]	[✂]
	London Clinic	[✂]	[✂]	[✂]
W5200 (Unicompartmental knee replacement)	HCA	[✂]	[✂]	[✂]
	London Clinic	[✂]	[✂]	[✂]

Procedures driving the price difference

AXA PPP's views in connection with the particular procedures that appeared to be driving the price difference within the IPA were set out in its submission of 25 September 2015.

5 Profitability

AXA PPP supports the CMA's provisional re-adoption of its finding in the Final Report that HCA made returns substantially and persistently in excess of the cost of capital, and that this suggests that HCA is charging prices that are higher than would be expected in a competitive market.

As AXA PPP has previously stated, profitability levels remain a compelling indicator of market power and a finding of excess profitability is more than sufficient to support the analysis of market features establishing an AEC. The approach of the CMA in the Final Report and the PFs is in this respect wholly consistent with CC3 which describes profitability as a "fuller analysis" than simply looking at prices or prices and cost. In

particular, any difference in “quality” or “complexity” as HCA alleges would not explain high profitability.

It is striking that HCA has not made any further submissions on this issue during the course of the remittal (beyond continuing to express general disagreement with the CMA’s original finding) that would provide any indication that its profitability levels have changed or should otherwise be reassessed. To the best of AXA PPP’s belief HCA’s profitability remains high. In AXA PPP’s view, therefore, it is entirely reasonable for the CMA to continue to rely on the profitability analysis presented in the Final Report.

6 Remedies

AXA PPP continues to believe that divestment is the only remedy which will resolve the current lack of competition in central London. As discussed further in section 6.1 below, AXA PPP remains concerned that the divestment packages proposed by the CMA do not contain all of the components required to create a credible third competitor in central London, in particular with respect to cancer services.

In AXA PPP's view, the CMA's alternative proposed remedies (Remedy 2 and Remedy 3) will not be effective in addressing the current AEC that the CMA has identified, nor would they be practicable for the reasons described in sections 6.2 and 6.3 below.

AXA PPP agrees that proposed remedies 4-6 contained in the Notice are unlikely to be effective and practicable. We have no further submissions to make on those remedies at this time.

6.1 Possible remedy 1: Divestiture

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

(b) **Would a divestiture package comprising either the Wellington Hospital or London Bridge Hospital and Princess Grace Hospital, effectively constrain HCA in terms of the range of specialisms offered and the capacity of the hospitals (ie theatres, beds, ICU, etc)?**

(c) **Are there suitable purchasers available with the appropriate expertise, commitment and financial resources to operate and develop the divestiture business as an effective competitor without creating further competition concerns?**

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

(e) **Would divestiture of an HCA hospital or hospitals and/or other assets confer market power on the acquirer? In what circumstances might this risk arise? Are there hospitals or other assets whose divestiture would be particularly likely to give rise to this risk?**

(f) **How long should HCA be given to effect the sale of the divestiture package? In relatively straightforward divestiture cases a maximum period of six months is appropriate. Is that sufficient in this case?**

(g) **What are the relevant costs and benefits that we should take into account in considering the proportionality of the divestiture options?[14] How could we go about quantifying these?**

AXA PPP believes that a divestiture remedy would address the insured AEC in central London. As AXA PPP has previously set out, an effective remedy to address the AEC in this case should result in the hospitals in central London being owned by three different operators, each of which has a credible proposition for customers across the full range of specialties (given that, as the CMA recognises in the Notice of Possible Remedies (at paragraph 24), one of the salient factors in assessing the effectiveness of a potential divestiture paragraph is the fact that "the combination of a specialty-level product market,

[14] Final Report, paragraphs 13.36 – 13.47.

and prices that are negotiated jointly across a full range of services, suggested that a strong market position in one or a small number of specialties would allow a private hospital operator to exert market power").

If there are three such groups, then any one of these providers could in principle be excluded from an insurer proposition, because a credible package would continue to be possible by combining the other two providers and no single provider would be "must have".

In AXA PPP's view, the essential components of a credible proposition in central London are as follows:

- A significant flagship hospital in central London
- Harley Street provision
- Coverage for a full range of specialties.
- High acuity cover
- A full cancer service including radiotherapy.

In AXA PPP's view, in order to meet the above requirements HCA should be required to divest the London Bridge (including the London Radiotherapy Centre and the outpatient facilities at the Shard) and the Princess Grace. The only alternative package that would comprise all of the necessary elements would be the divestiture of the Wellington and the Harley Street Clinic.

This package would broadly provide the acquirer with the necessary components identified above. Neither hospital should be acquired by the London Clinic, but instead should be acquired by an independent provider to ensure that each of the resulting providers in central London are suitably constrained by the others. Given the passage of time since the Final Report, AXA PPP considers that this remedy should be implemented as soon as practicable. In order for the remedy to be successful, it is essential that employees (including management teams) and consultant relationships are included in the divestiture to enable continuity of provision without any disruption to patient care.

London Bridge, London Radiotherapy Clinic and the Princess Grace would represent an effective yet proportionate solution

In AXA PPP's view, a divestiture package involving the London Bridge hospital, London Radiotherapy Clinic and Princess Grace hospital would represent a comprehensive and effective, yet proportionate, solution, as it provides the purchaser with each of the key elements required to compete with HCA, without depriving HCA of its ability to continue to compete across the range of specialties. As the table below indicates, this package would represent just under [✂]% of AXA PPP's total spend ([✂]) in central London, leaving HCA with almost [✂]% of total spend.

Total spend with HCA Hospitals and other HCA Facilities in Central London

	July 2014 - June 2015	
Hospital	**Hospital Benefit Paid**	**Proportion AXA PPP total spend in Inner London**
London Bridge Hospital	[✂]	[✂]
Wellington Hospital	[✂]	[✂]
Harley Street Clinic	[✂]	[✂]
Princess Grace Hospital	[✂]	[✂]
Leaders in Oncology Care	[✂]	[✂]
Lister Hospital	[✂]	[✂]
Portland Hospital	[✂]	[✂]
Harley Street @UCLH	[✂]	[✂]
London Radiotherapy Centre	[✂]	[✂]
Other HCA facilities	[✂]	[✂]
Total Spend across HCA facilities	[✂]	[✂]

Addressing the oncology market

In the Final Report, the CMA observed that even following divestiture of either (i) the Wellington or (ii) London Bridge and the Princess Grace, HCA would retain a relatively high market share in oncology.

While neither the PFs nor the Notice consider this issue in any detail, it remains true today. HCA's oncology share remains significantly larger than that of its closest rival, TLC, and its position has strengthened further with the opening of the London Radiotherapy Centre (marketed as a "sister site" to the London Bridge hospital) and will continue to grow when the PPU at Guys and St Thomas is opened in 2016. Unless HCA divests sufficient oncology facilities, therefore, this significant market power will continue, and HCA will have the continued ability to [✂].

As demonstrated by the table below, the London Bridge, LRC and Princess Grace facilities together represent around [✂]% of AXA PPP's oncology spend from July 2014 to June 2015, [✂]). HCA would remain the largest oncology provider (accounting for [✂]% of spend) and retain its most important facilities (Harley Street Clinic and LOC) in addition to a range of other facilities where it continues to expand (including the Guys and St Thomas PPU).

Oncology spend with HCA Hospitals and other HCA Facilities in Central London[15]

Hospital/Facility Name	Hospital Benefit Paid	% Total Oncology spend (across all providers)
Harley Street Clinic (including Cyberknife)	[✂]	[✂]
Leaders in Oncology Care (LOC)	[✂]	[✂]
London Bridge Hospital	[✂]	[✂]
Princess Grace	[✂]	[✂]
Harley Street @ UCLH	[✂]	[✂]
The Wellington Hospital	[✂]	[✂]
London Radiotherapy Centre	[✂]	[✂]
Other HCA facilities	[✂]	[✂]
Total Oncology Spend across HCA facilities	[✂]	[✂]

As noted previously, neither the Wellington/PMC nor London Bridge/Princess Grace currently provides radiotherapy facilities, which are essential to a full cancer offering.

In order to provide an effective competitive constraint to HCA, therefore, at least one of these divestment hospitals would have to install radiotherapy facilities. However, barriers to entry are particularly high for such facilities. A linear accelerator (which is a necessary piece of equipment for any fully functional cancer unit) cannot simply be installed in an existing hospital room as the considerable radiation it produces needs to be contained. This requires a specially-designed vault or bunker with walls, floor and ceiling of lead and concrete of up to 3 metres thick. Such vaults or bunkers can weigh around 1,000 tons and represent a major challenge in an existing building, which is why they are often sited underground or in a separate, purpose-built facility. This requires a suitable site to be found, with planning permission and other regulatory approvals to be obtained, as well as the necessary building works being completed, which is time consuming and costly (see, for example, the 3½-year and £90 million construction process for TLC's new adjacent cancer centre premises, the overall timeline for which was six years).

There is therefore no certainty that the acquirer of the London Bridge hospital (or the Wellington hospital in the alternative) in its current format would be able to develop a comprehensive cancer offering within a short timeframe (as the CMA previously suggested), which would necessarily include (a) attracting sufficient consultants; (b) acquiring suitable equipment, including radiotherapy equipment; and (c) adapting the acquired facilities to house such equipment.

As a result, it is essential that [✂]. In AXA PPP's view the inclusion of LRC therefore will be of significant importance to the purchaser of the London Bridge (which would otherwise not be able to provide a radiotherapy service) but will not impact HCA's existing offering (as the LRC, having opened very recently, currently constitutes a very small share of the

[15] Note that, similar to the total spend figures provided above, these shares have been calculated on a prudent basis, as they include [✂].

oncology market (at least as far as AXA PPP's spend is concerned)) or the development of the Guys and St Thomas PPU which will be separately located from LRC and London Bridge Hospital.

Guys and St Thomas PPU

As the CMA is aware, AXA PPP was not supportive of HCA's successful bid to run the PPU at Guys and St Thomas Hospital and previously argued that HCA should be required to divest this contract. Without prejudice to its previous submissions on this topic, [✂].

If required HCA could obtain access to the NHS radiotherapy facilities at Guys and St Thomas, in addition to its existing facilities at Harley Street Clinic, and thus also continue to offer a comprehensive oncology offering to patients (in competition with the divested facilities) which will continue to expand once the PPU opens next year.

Inclusion of the Shard is required given capacity constraints at London Bridge

In AXA PPP's view the divestment of London Bridge should also include the outpatient facilities at the Shard, which are marketed as part of the London Bridge offering.

As the CMA notes, the case officer's report on HCA's planning application for these facilities was clear and unequivocal that HCA had been granted planning permission in the Shard for reasons that were exceptional (notably its operation of the nearby London Bridge hospital and links with the GST trust) which justified the granting of the permission on a "personal" basis to HCA. AXA PPP also submitted evidence in December 2013 in which HCA stated that there was no suitable space within the London Borough of Southwark area which had a C2 [healthcare facility] class, which led HCA to assess the conversion of alternative uses.

There is therefore no guarantee that planning permission will be readily available for alternative outpatient facilities in the area. Without these outpatient facilities the London Bridge hospital is capacity constrained, and it will be difficult for the acquirer to invest in and improve the facility in competition with HCA without the excess capacity that the Shard provides. There would also remain a risk that [✂].

Leaders in Oncology Care ("LOC")

AXA PPP has previously expressed concern over HCA's ownership of LOC. As noted in section 2.2 and in the tables above, the treatment provided in LOC's own treatment centres represents a significant proportion (almost [✂]%) of AXA PPP's spend. In addition, LOC accounts for a significant proportion of onward referrals in central London, which are primarily directed to other HCA facilities.

AXA PPP has previously argued that LOC should be independent of any features that might or do influence referral patterns and the decisions that consultants make on treatment on behalf of patients. AXA PPP remains concerned that LOC may be influenced to use HCA facilities for additional services including diagnostic tests, the provision of drugs and treatment.

AXA PPP's strong preference remains that LOC should be run independently of HCA and without the consultants who use it having a financial interest. Absent such a remedy, AXA PPP welcomed the CMA's clarification in its Defence in AXA PPP v CMA[16] that the Private

[16] CMA Defence, paragraphs 70 – 75.

Healthcare Market Investigation Order 2014 applies to LOC in the same way as other facilities, and would encourage the CMA to keep [✂].

The Wellington alone is not an effective remedy

In AXA PPP's view, divestment of the Wellington hospital alone is not a sufficient remedy, as the acquirer would, critically, lack radiotherapy facilities. Such a divestiture would account for only [✂]% of AXA PPP's total spend in central London, and only [✂]% of AXA PPP's oncology spend in central London. HCA would therefore retain a significant share and in all likelihood would continue to be a "must have" provider.

An alternative package to the divestiture of London Bridge, LRC and the Princess Grace, therefore, would have to include the Harley Street Clinic (i.e. HCA's alternative radiotherapy facilities) in order to be an effective remedy. In terms of oncology spend this would represent a more significant divestiture for HCA, and would be a less effective option than the London Bridge package as HCA would retain its dominant position with respect to the hub in the South East of central London, which is of particular importance to corporate customers located in the City and Canary Wharf.

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

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

(b) **Would existing competitors and/or new entrants be interested in renting hospital facilities for a limited period of time? If so, how long should HCA be required to rent out its facilities to another operator?**

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

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

(e) **Is this remedy a potential (effective and proportionate) alternative to full divestiture? Are the effects of this remedy similar to those of remedy 1?**

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

(g) **Should HCA be allowed to move staff, administrative functions and equipment, etc out of the hospital building that it rents out? Or should HCA be required to allow staff to transfer to new operator?**

(h) **What hospital/facilities should be rented out by HCA?**

AXA PPP notes the CMA's suggestion that this type of remedy 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.

However, the entry analysis in the differentiated markets of individual medical specialties cannot be premised on a homogeneous market in which bed capacity is the only measure and scale is the only issue. In this case there is no current expectation of significant new entry of a sufficient scale, but even if there were, this would not capture the issue of quality and reputation – in terms of consultants, equipment and proven reputation built over time,

notably in cancer treatment – to "countervail against" an AEC[17] and remove the dependence of PMIs such as AXA PPP's on HCA.

In other words, such an entrant would not, in any meaningful time horizon, represent a new 'outside option' in lieu of HCA that is a "critical determinant of countervailing buyer power"[18] so as to enable AXA PPP credibly to offer PMI packages to corporate clients that *include* the new provider *but exclude* HCA. As such, any new entry, even if its timeliness, likelihood and scale were not in question -- which they clearly are -- it would not equip PMIs such as AXA PPP with a new and credible threat of excluding HCA in negotiations with it. This entry would therefore fail to alleviate HCA's "must have" status and accordingly fail to counteract the provisional AEC defined by the CMA.

These considerations based on the principles set out in CC3 are reinforced given the parallel that may appropriately be drawn with the position of the CMA in its Merger Assessment Guidelines, when considering whether potential entry or expansion might be sufficient to prevent a substantial lessening of competition arising in a merger context. In particular, the CMA will typically consider in this context whether such entry or expansion would be

- likely;
- timely - in this respect the CMA indicates that, while a case by case analysis is required, it may consider entry or expansion within less than two years as timely, which would be unlikely in the case of a new private hospital; and
- sufficient to defeat any attempt by the merged firm to exploit any lessening of competition - the guidance notes that small scale entry by a producer of differentiated goods may be insufficient, as the niche product may not necessarily compete strongly with other products in the overall market, and so may not constrain incumbents effectively.

In AXA PPP's view the same criteria should be used when considering whether potential entry is sufficient to justify a "temporary" remedy rather than a structural divestment remedy. As described in section 3 above, these criteria are clearly not satisfied in the case of either the Cleveland Clinic or VPS (and, given the anticipated size of these facilities, *both* would need to enter in order to provide scale of a similar size to the proposed divestiture packages, leaving aside the remaining concerns about their ability to offer a full range of specialties, attract consultants and establish a suitable reputation), nor has any other likely, timely and sufficient entry to constrain HCA to a sufficient degree been identified. The AEC is therefore not likely to be "short-lived" or "swift enough" (to use the terminology of CC3[19]) but instead is likely to remain in place for a very long duration, if not permanently, raising concerns as to effectiveness and removing any proportionality arguments that might be made in its favour.

In any event, whatever the ultimate duration of such an arrangement, AXA PPP does not consider that the proposed Remedy 2 would be practicable or effective in remedying the insured AECs in the intervening period. In particular, this proposed remedy suffers from two inherent flaws.

[17] CC3, paragraph 205.

[18] CC3, paragraph 176.

[19] CC3 paragraphs 338 and 175.

- First, HCA itself would be less inclined to invest in and seek to expand its business elsewhere in central London in competition with the rented facility (compared to if it were to divest that facility), as this would undermine the value of the leased asset that may revert in time.
- Second, the "tenant" of the selected facility would have no incentive to invest in or expand the facility given that it would only be occupying the facility for a relatively short period.

These reduced investment incentives would likely relate to at least the following:

(a) investment in facilities and capital equipment which may be impossible for the tenant to extract at the end of the term.

(b) consultant relationships, as to the extent that these are facility specific they would revert to HCA at the end of the term.

(c) investments in branding and marketing which would be dampened by the prospect of the hospital reverting to HCA.

More generally all market participants would be likely to take into account the prospects of the facility reverting to HCA when considering their own strategy, which may deter expansion by rivals. By way of comparison, it is difficult to envisage that – in the event that Gatwick airport had been leased to an alternative tenant by BAA rather than sold – both Gatwick and Heathrow would be competing to expand their capacity to the same degree as they are currently under (permanent) separate ownership.

In addition to these concerns, the remedy would require ongoing monitoring which would be burdensome for the CMA (or any other body that is appointed for this purpose).

AXA PPP does not therefore consider that this remedy would be an effective alternative to divestiture, and is not aware of such a remedy having been considered an effective solution in any comparable case involving a market of this nature in the UK.

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

(a) **Would the remedy be effective in facilitating entry by new competitors and/or expansion by existing (non-HCA) operators in central London? Would it remedy the AECs in a timely manner?**

(b) **In order for this remedy to be practicable and effective, which healthcare activities should be covered? For example, should HCA be prevented from expanding its portfolio of secondary and tertiary healthcare activities only, or should the restriction also apply to primary healthcare activities, eg GP surgeries? Should HCA be prevented from expanding its outpatient and/or inpatient services?**

(c) **Should this remedy be time-limited? If so, for how long should the remedy apply? Should its removal be contingent on changes in the market, eg large-scale entry?**

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

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

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

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

(h) **What are the relevant costs and benefits that we should take into account in considering the proportionality of this remedy? How could we go about quantifying these?**

AXA PPP does not consider that the proposed Remedy 3 would be practicable or offer even a remote prospect of effectively remedying the insured AECs. In particular, the proposed Remedy does nothing to address the current AECs that have been identified by the CMA, and which have been in effect in central London to the detriment of customers for some time.

Furthermore, as noted above, it is not clear when, if ever, such a remedy would begin to address the identified AECs given that there is no certainty as to the timing or nature of entry by another provider. The proposed remedy could also be challenging to implement, given the potential for loopholes (for example if HCA were to engage in joint ventures or expand via agents or nominee companies) and costly to monitor and enforce, in particular with respect to the expansion of existing facilities.

As stated above, therefore, divestiture is the only remedy which would effectively address the identified AECs.