

## Spire Healthcare response to Provisional Findings and Notice of Possible Remedies

### **HCA Remittal – Provisional Remedies consultation questions**

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

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

Our comments are based on our experience in seeking a London site in the last couple of years.

Yes, a divestiture remedy is essential to addressing these issues in the short-term due to the long lead time and material commercial investment involved in establishing a new hospital. There is no other way to have a short term impact on the market.

The success of the remedy is however dependent upon the divested assets being bought by a hospital operator that is able to ensure from the start that the assets are strong competitors in the London market. This seems likely to reduce the potential acquirers to the main UK private hospital operators with experience of high acuity procedures.

Secondly the divestiture package should include any associated outpatient diagnostic and treatment centres such as 31 and 120 Old Broad Street and Canary Wharf [X] In general we believe that satellite diagnostic centres are a positive thing in a competitive market as they bring care closer to the patient and increase choice and finally for providers they can increase the speed and reduce the cost of entry to the market. [X]

Thirdly, the package should include the divestiture of other primary care practices such as GP practices owned by HCA that primarily refer to the divested asset. [X]

An alternative, more preferable solution is to prevent private operators in central London owning GP practices in their catchment areas, other than any based in their hospitals. This should include requiring existing ones to be divested. [X]

- (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)?

Yes, particularly when subject to the caveats in the answer to paragraph (a) of Remedy1 above.

- (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?

Yes, but this is probably only the larger UK private hospital operators who have all the mechanisms, skills, efficient operations and relationships with insurers in places to operate the hospital as a strong competitor from day one.

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

No. The disposal of the Wellington (including the Platinum Medical Centre) or both the London Bridge and Princess Grace are key to opening the market up. No other combination would be as effective.

- (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?

We do not believe so.

- (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?

Yes, 6 months should be sufficient in this circumstance.

- (g) What are the relevant costs and benefits that we should take into account in considering the proportionality of the divestiture options? <sup>12</sup> How could we go about quantifying these?

No comment

**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?

This is not a practicable or effective remedy and is not a viable alternative to divestment. It would not be attractive to a hospital operator to rent a HCA facility on any basis other than a long term lease given the required investment of time and money in making the facility work. It would not be viable for a hospital operator to invest a facility which will be handed back to its main competitor at the end of a short to mid-term lease. There would also be various legal issues to be resolved, including TUPE and branding. For example, would HCA staff TUPE over to the tenant and then TUPE back to HCA at the end of the term? In any event, whether staff were TUPED or not, it would be difficult to recruit and obtain the loyalty of staff and consultants as they would know the operator would only be in the building for a short period. There would be no guarantee that any business built up over the lease period could be transferred to a new site once the lease expired. The new operator would need to build its own brand at the site, and again, would just be handing that goodwill back to HCA at the end of term. The tenant would be unlikely to make any significant investment in improving and growing the facility when the business is time limited. It would be very difficult for the new operator to obtain and maintain consultant and patient confidence with a short term business, particularly in the face of very strong competition from HCA. Even if such a remedy was workable for a hospital operator, the additional protections outlined in paragraph (a) for Remedy 1 above would also need to be put in place in order for the remedy to be effective.

- (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?

No, because of the reasons stated above.

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

It would not be effective and therefore would not achieve the aims of the CMA.

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

No, Spire does not believe there is a practicable and effective alternative to full divestiture.

- (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?

No, Spire does not believe there is a practicable and effective alternative to full divestiture.

However, in addition to the divestment remedy, Spire would welcome support from the CMA in terms of encouragement to planners for conversion to private hospital use - to the extent that this can be achieved. [X] Clearly the proposal would have to be reasonable – Spire would not expect any proposal to be approved if it was unreasonable but an encouragement for private hospitals would be beneficial.

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

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

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

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

(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?

It is not clear whether this remedy is proposed as an alternative to divestment. This remedy would be a very effective remedy in addition to divestment, in order to prevent HCA's continued expansion whilst other operators establish new facilities and slowly increase market share until eventually, the market will hopefully become well-functioning.  
[X]

(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?

It should be applied to all activities [X]

(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?

Spire believes removal should be contingent on changes in the market, i.e. the emergence of a well-functioning market.

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

Spire does not believe so.

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

Spire does not believe so. Spire believes that there is substantial spare capacity in Central London.

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

This is a risk unless the remedy is tightly and comprehensively drafted as regards the structure of ownership etc.

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

The CMA would be an appropriate body.

(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?

There would be minimal cost in implementing this remedy.