

HCA INTERNATIONAL LIMITED

**RESPONSE TO THE CMA'S PROVISIONAL FINDINGS AND NOTICE OF
POSSIBLE REMEDIES**

HCA INTERNATIONAL LIMITED

RESPONSE TO THE CMA'S PROVISIONAL FINDINGS

1. INTRODUCTION

- 1.1 HCA sets out in this submission its response to the CMA's Provisional Findings ("PFs").¹ It is submitting a separate response to the CMA's Notice of possible remedies.
- 1.2 HCA vigorously rejects the CMA's provisional findings that there are adverse effects on competition ("AECs") in central London in respect of either insured or self-pay patients. The CMA has not established to the requisite standard of proof (on a balance of probabilities) that high concentration and barriers to entry and expansion result in weak competitive constraints. All the evidence points to the fact that the market in central London is highly competitive and is attracting considerable new investment, and that competition is driving quality and innovation, and increasing the healthcare choices for consumers.
- 1.3 It is extremely disappointing that the CMA has largely repeated the findings in its Final Report and has failed to engage with the evidence which HCA has provided during the Remittal Inquiry. In the recent litigation, the Tribunal stated that the CMA had an obligation to conduct a "*genuine and effective*" reconsideration of the issues. It is however apparent from the PFs that the CMA has approached this remittal with the preconceptions it formed in the earlier inquiry and with the objective of "defending" its earlier decision. It has singularly failed to carry out a fresh and impartial reconsideration of its findings.
- 1.4 In particular:
- The CMA's revised AEC finding largely rests on its view that HCA has a high market share in central London. Even if this is the case (it is in fact based on a highly flawed measurement of share of supply), this in itself would not be a sufficient basis for concluding that there are weak competitive constraints.
 - The CMA has carried out a very poor assessment of competition in the market, largely relying on the number of times in which competitors are mentioned in HCA's internal business cases. It has not carried out a proper evaluation of the strength and capability of competitors, and in particular has ignored the strong growth of NHS PPU's (Royal Marsden, Royal Brompton etc.) in recent years and the investments they are making for further expansion.
 - The CMA's finding that high sunk costs and long lead times create barriers to entry is unjustified and ignores the fact that the market in central London is expanding and that following the upturn in the economy there is increasing investment in new inpatient, day case and outpatient facilities.
 - Indeed, the CMA acknowledges the potential for "large scale entry" over the next five years – Barts, VPS, the Cleveland Clinic, Spire – which wholly undermines its case for saying that there are barriers to entry and expansion which deter new investment.
 - The CMA has not properly evaluated the bargaining power of PMIs. It has overstated the harm which PMIs would suffer if they de-listed HCA hospitals, and it has understated the negotiating leverage which PMIs have in their use of "managed care" strategies such as Open referral and service line tenders.

¹ Unless otherwise specified, all references to "PFs" refer to the CMA's Provisional Findings published in November 2015.

Furthermore, it is irrational for the CMA to conclude that PMI bargaining power can be ignored in its competitive assessment on the grounds that it does not "completely" offset any market power held by hospital operators. That is the wrong test for the CMA to apply.

- Further, the CMA cannot support an AEC finding resulting from high market shares given that there is sufficient capacity (whether measured in terms of beds, ☒) which allows PMIs to switch all their patients to non-HCA hospitals. It has not provided any evidence of any other capacity constraints.
- The CMA continues to rely on the IPA to allege that HCA charges higher prices than TLC. The pricing data which the CMA used for its analysis is now four to eight years old. At most, that analysis shows that there are just ☒ (out of around ☒) procedures which account for the majority of any price difference. However, the CMA's methodology is so flawed that even the CMA recognises that it can no longer conclude what price difference there is between HCA and TLC, even in these ☒ procedures, because of the difficulties in carrying out "like-for-like" comparisons.
- Furthermore, the CMA has still provided no evidence whatsoever which demonstrates that there is any causal link between concentration and pricing in this market. The Tribunal noted that it was for the CMA to demonstrate that high concentration was driving higher prices, and the CMA has failed to do so. The analysis of the available spare capacity in central London is wholly inconsistent with any such link.
- The CMA states that there is no evidence that HCA offers materially higher quality than its competitors, and yet the reason which PMIs gave as to why they consider HCA hospitals as "must have" hospitals is that their policyholders regard HCA as having a better reputation for quality and clinical excellence. To the extent that the CMA believes that HCA has any leverage in negotiations with PMIs, this is clearly because of its high quality which attracts PMI policyholders, and the views of PMIs confirm this.
- Furthermore, it is irrational for the CMA to conclude that competition over quality/range is working well, but that competition over price is dysfunctional. The same competitive disciplines that are driving competition on quality/range are also driving price competition. This is clearly a sign of competition working well in this market.
- Since even the CMA recognises that the IPA no longer supports a finding of higher pricing, the CMA seeks to shift the emphasis onto its profitability analysis, and now argues that HCA's high profitability is indicative of higher pricing. However, there are serious errors in the CMA's profitability analysis which substantially overstate HCA's returns. It also provides no basis for linking profitability with any alleged AECs. In fact the PFs reveal that TLC, which is used as the pricing comparator, actually has higher margins than HCA.
- The self-pay AEC is based on a PCA which is also flawed. The CMA has at no stage carried out an assessment of self-pay prices specifically in central London and is merely extrapolating from UK-wide prices. The CMA has also erred in concluding that nothing in the Remittal Inquiry materially affected the CMA's reasoning in support of the self-pay AEC finding. Some of the flaws identified

during the remittal in relation to the IPA also invalidate the CMA's assessment of self-pay prices and local market concentration.

- Finally, the CMA's conclusions with regard to central London are wholly inconsistent with its previous conclusions relating to non-London operators (BMI, Spire, Nuffield and Ramsay). The CMA made no AEC findings whatsoever outside central London notwithstanding the fact that there is even higher concentration and greater barriers to entry in local markets outside central London. It cannot therefore justify an AEC finding for central London, where the market is significantly more fragmented and where there is far more evidence of new entry and expansion. The CMA has also applied a different methodology in evaluating competitive constraints in London and non-London markets and this unlawfully discriminates against HCA.

1.5 The structure of HCA's submission follows the structure of the PFs:

- **Section 2** – Competitive assessment of private hospital operators in central London
- **Section 3** – Barriers to entry and expansion in central London
- **Section 4** – Bargaining
- **Section 5** – Quality and range
- **Section 6** – Empirical analysis on insured prices
- **Section 7** – Profitability
- **Section 8** – Self-pay patients analysis and AEC
- **Section 9** – Inconsistencies in the CMA's London and non-London findings
- **Section 10** – Conclusions.

2. COMPETITIVE ASSESSMENT OF PRIVATE HOSPITAL OPERATORS IN CENTRAL LONDON

Key points

The CMA's conclusion that HCA is subject to weak competitive constraints is based on a thoroughly flawed analysis of the market:

- The CMA's central concern is with HCA's market share, which it regards as "*too high*", and wrongly assumes that having a high share of supply in and of itself gives rise to weak competitive constraints.
- Private healthcare is a highly differentiated market, and a provider's absolute share of supply by admissions or revenue rather than capacity is not a reliable indicator of its market power.
- There is no considered assessment of the strengths and capabilities of competitors, including private providers, PPUs, day case/outpatient providers, and Greater London hospitals, and the way in which competitors are developing and expanding their services.
- In particular, the CMA has underestimated the competition which HCA faces from NHS PPUs, which have grown by over 20% since 2011/2012 and which are targeting significant growth over the next few years.
- The CMA's economic assessment of the market boils down to precisely how many times competitors are mentioned in HCA's internal business cases. The CMA is of course entitled to review internal business cases to gain insights into the functioning of a market, but it cannot rely solely on these and must consider these in combination with all the other evidence relating to competitive constraints – a simple "name check" of competitors is completely inadequate.
- The CMA continues to question whether there is sufficient capacity for PMIs to switch, despite HCA's analysis of the IPA showing that there is more than enough bed capacity, and without providing any evidence that there are any other capacity constraints in the market. In fact, the PMIs have now conceded that the real barrier to switching is not that rival hospitals are capacity constrained, but that policyholders prefer to use HCA on grounds of its reputation for quality.

CMA's reliance on shares of admissions and revenue

2.1 HCA reiterates that the CMA's assessment of competitive constraints is based largely on estimated shares of supply by admission and by revenue. It is not merely "one" factor, but the primary factor in the CMA's analysis:

- The CMA's revised AEC finding states that it is HCA's "**large market share**", together with barriers to entry, which gives rise to the AEC for both insured and self-pay patients. This shift in the way in which the AEC is formulated – referring to HCA's high market share rather than weak competitive constraints – is very telling and reveals the real nature of the CMA's concerns. In the revised finding weak competitive constraints are merely assumed to follow from HCA's large market share without proper analysis.

- The CMA's assessment of competitive constraints in the Final Report is wholly pre-occupied with estimated shares of supply: see paragraphs 6.204-6.211, and the CMA's finding that *"On the basis of our share of supply analysis described above, we found central London to be 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"* (paragraph 6.211, Final Report).
- The PFs similarly focus almost entirely on central London shares of supply: *"We remain of the view that HCA has a **high share of supply** by total admissions in many specialties, and that **HCA's share is particularly high** when considering the potentially more complex segments of the central London market such as oncology and cardiology"* (paragraph 4.53, PFs).
- The CMA's original consideration of the divestiture remedy is based on its view that *"A 40% threshold could be **too high** in the circumstances of a differentiated market"* (paragraph 11.109, Final Report).
- The divestiture options discussed in section 11 of the Final Report were aimed at addressing what the CMA perceives to be a "market share problem", i.e. HCA's alleged high share of supply, and the need to *"**release shares of supply within key specialisms to competitors to enable PMIs in particular to offer policies without HCA**"* (paragraph 11.73, Final Report).

2.2 The CMA is fixated on HCA's market share and wrongly assumes that a high market share in and of itself indicates market power. However, as the CMA's own guidance on the assessment of market power notes: *"In a market where undertakings compete to improve the quality of their products, a persistently high market share might indicate persistently successful innovation and so would not necessarily mean that competition is not effective".*²

2.3 Similarly, in a recent speech, the Chief Executive of the CMA warned against making any assumptions that high concentration is an indication of market power: *"I should also stress that we recognise there is no straightforward relationship between concentration and competition. Our analysis of competition is much more subtle than this. In the recent past we have cleared a number of mergers that resulted in significant increases in concentration because we thought that the market arrangements implied that this higher concentration would not translate into market power. So you can be reassured that **we are not obsessed about concentration, and we are not embarking on a new crusade against big firms.**"*³ The CMA, however, is indeed "obsessed" about concentration in private healthcare and has put it at the core of its AEC findings.

2.4 In HCA's view, market share in the provision of private healthcare cannot be seen as causing a lack of competitive constraints – rather, market shares are an outcome of the competitive process. When firms can invest to improve the quality and range of services leading to high fixed costs, it is the very intensity of price competition that can lead to higher market shares. The CMA has conducted no analysis to understand what would be the efficient or competitive market structure arising in a market characterised by the sorts of fixed or sunk costs it identifies. Without having done that, it is not clear to HCA how the CMA

² OFT 415, December 2004, "Assessment of market power", paragraph 4.4.

³ "CMA: How we intend to use market investigations to extend the frontiers of competition", Alex Chisholm, 9 September 2014.

can conclude that its market share is “high” and that this causes a lack of effective competitive constraints on HCA.

2.5 Furthermore, HCA reiterates that the CMA's reliance on shares by admission and revenue rather than capacity are misleading and the PFs fail to address HCA's comments on this issue:

- A hospital operator such as HCA which is more successful in competing on quality and innovation will inevitably attract a higher proportion of patients. Its share of admissions or revenue will not reflect its market power. Indeed, during the Remittal Inquiry AXA-PPP has openly acknowledged that the only barrier to switching the patients away from HCA hospitals to alternative providers is the fact that *"Only a small subset of its clients would be prepared to submit to redirection because of HCA's reputation"* for high quality (paragraph 26, summary of AXA-PPP's hearing).
- Share of revenue is distorted by differences in quality and case-mix. The CMA acknowledged in the Final Report that *"HCA has a relatively strong focus on high acuity care and that it has been the leader in introducing a range of treatments/diagnostic techniques"* (paragraph 6.411, Final Report). HCA's focus on high-complexity clinical treatments which drive higher revenue will inevitably distort its share of revenue compared to competing providers.

2.6 The CMA asserts that *"share in revenue could take account of any vertical product differentiation that may exist due to the high quality and stronger reputation of central London hospitals relative to outer London hospitals"* (paragraph 4.25, PFs). However, this fails to answer HCA's point that HCA's share of revenue is likely to be higher than that of central London competitors because of differences in type, quality and complexity of services. HCA's business is geared towards high-acuity, tertiary care to a greater extent than its competitors, and this will be reflected in its share of revenue.

2.7 It is HCA's share of total capacity which is a more appropriate measure of its market position. As discussed below, the relevant consideration is the capacity available to PMIs in rival hospitals to switch away from HCA. HCA's share of capacity in central London is approximately 41%, and there is more than enough capacity in non-HCA hospitals for PMIs to redirect all their policyholders away from HCA. That does not support the CMA's view that HCA's share is "too high" or that it is subject to weak competitive constraints.

Central London shares exclude relevant competitors and include irrelevant specialities

2.8 The CMA acknowledges that it had previously failed to include in its shares of supply in the Final Report a number of NHS PPUs and that their inclusion reduces HCA's share of supply by 30%. This is a significant reduction in HCA's share of capacity, admission and revenue, and demonstrates that the CMA has significantly underestimated the position of PPU competitors in central London.

2.9 The CMA's comment that HCA's share of revenue is *"still high at 50%"* (paragraph 4.29, PFs) demonstrates that the CMA is wholly pre-occupied with market share, and has failed to consider the nature of competition, the growth of these NHS PPUs, and their expansion plans over the next few years.

2.10 HCA also notes that the CMA relies on 2013 LaingBuisson data which is now over two years old. It is highly surprising that in this Remittal Inquiry over the last year the CMA has not sought updated market information from providers in central London so that it could base its assessment on 2015 data. This is likely to show that PPUs have grown even further and account for an even higher share in today's market.

2.11 The CMA also errs in stating that *"including the revenue and capacity of specialist PPUs (such as Royal Marsden, Great Ormond Street Hospital, Moorfields Eye Hospital, and RNOH) in our shares is likely to overstate the competitive constraints they place on HCA, given that they are only effective competitors for a limited subset of HCA's specialties."* (paragraph 4.29, PFs):

- The referral pathway typically involves a GP referral (or, increasingly, a PMI referral) of the patient to a specialist within a hospital, and therefore it is the hospital's strengths within a given speciality which dictates whether it is an effective competitor for patients for a particular treatment.
- The CMA has concluded that each speciality constitutes a separate product market, and has therefore broken down shares of admissions and revenues by speciality. A specialist PPU is obviously an effective competitor within its own specialism, and therefore there is no reason to exclude that PPU from the market shares for that specialism, or to regard it as a less effective competitor.
- Specialist PPUs cited by the CMA are renowned nationally and internationally within their clinical field – Royal Marsden (for cancer), Great Ormond Street (for paediatric services), Moorfields (for ophthalmology) and RNOH (for orthopaedic conditions). They are formidable competitors for the clinical treatments they provide. The Royal Marsden, for example, is the leading cancer clinic in the UK and boasts the highest revenue per bed of all private central London hospitals. HCA has recently provided details of the significant investments made by the Royal Marsden to enhance its cancer services within its PPU.⁴
- AXA-PPP acknowledged that there were 11 PPUs in central London (including specialist PPUs such as Royal Marsden and Royal Brompton) which were *"significant competitors in the central London "elite" market"* (Appendix 6.10, Annex A, paragraph 10, Final Report).

2.12 Furthermore, the CMA has not addressed HCA's criticism that its *aggregated* shares of supply include service lines in which HCA faces competition from a wider set of competitors than those considered by the CMA, including HCA's fertility/IVF activities and HCA's neuro-rehabilitation services at the Wellington.⁵

Central London shares exclude non-inpatient providers

2.13 In responding to HCA's argument that the CMA's competitive assessment has failed to include outpatient and day case providers which compete with HCA, the CMA states that non-inpatient providers represent only a small share of the market and would *"only cause HCA's share of total revenue to fall by x percentage points aggregated across all specialties"* (paragraph 4.39, PFs). HCA notes that on this basis the CMA estimates that HCA has x%, not 50%, of total revenue in central London.

⁴ Nabarro email of 22 July 2015.

⁵ HCA's submission on structural AECs, 1 May 2015, paragraph 4.126.

- 2.14 However, it is misleading simply to consider a share of non-inpatient providers of total revenue. As HCA has previously noted,⁶ there are particular specialisms in which outpatient and day case services play a more significant role: in orthopaedics, 30% of HCA's revenue derives from outpatient and day case episodes, and HCA competes directly with significant day case providers, such as Fortius Group. In oncology, 30% of HCA's revenue is from outpatient and day case services. It is necessary then to look at non-inpatient shares by individual specialism, not merely by total revenue.
- 2.15 Furthermore, there has been significant recent entry and expansion by new day case clinics indicating that day case (and outpatient) providers are becoming a more significant part of the competitive landscape in central London:
- The London Claremont Clinic near Harley Street opened in 2014 with over 35 member consultants.
 - Advanced Oncotherapy PLC is launching a new proton therapy centre on Harley Street opening in 2016/17.
 - Nuada Medical Group has been expanding and recently launched a new neurology unit.
 - Optegra is opening a new eye clinic nearby Harley Street.
 - Fortius Group is in the process of establishing a new orthopaedic clinic in the City.
- 2.16 HCA further notes that according to Table 4.5 of the PFs, outpatient providers represent a significant proportion of PMI spend – 30% in the case of Bupa and 30% in the case of AXA-PPP.
- 2.17 Furthermore, day case and outpatient providers all expand the potential outside options available to PMIs to switch patients away from HCA for day case and outpatient procedures. The trend from inpatient to day case/outpatient treatment settings improves those options by enabling PMIs to steer patients to a wider set of providers in future. The CMA acknowledges this in paragraph 4.47 of the PFs when it states that "*overnight beds is likely to become a less important constraint and measure of capacity in hospitals.*" Hence, the capacity available in day case and outpatient clinics should be included in the CMA's competitive assessment.
- HCA's criticisms of the CMA's calculations for shares of capacity in private hospitals including PPUs in central London***
- 2.18 As HCA has previously pointed out,⁷ the CMA has failed to include the CCL3 capacity of NHS PPUs in its market share estimates. The CMA argues that "*It is not always possible to compare independent hospitals with NHS PPUs on a like-for-like basis, as patients in the PPU would have access to the NHS hospital's general facilities ...*" (paragraph 4.43, PFs). The mere fact that CCL3 beds are provided in the NHS hospital rather than within the PPU building is not a legitimate reason to exclude them. A patient in a PPU who requires intensive care would use the CCL3 beds within the NHS hospital to which the PPU is attached, i.e. the PPU is able to provide that patient with CCL3 care. Indeed, PPUs actively market themselves as being able to offer the strength and depth of resource of a large NHS

⁶ HCA's submission on structural AECs, 1 May 2015, paragraph 4.103.

⁷ *Ibid*, paragraph 4.128.

hospital. The CMA could easily obtain from NHS Trusts estimated average occupancy rates of PPU patients in NHS ITUs, as an indication of the capacity which is typically available. This would provide a direct like-for-like comparison between PPUs and independent hospitals.

- 2.19 The CMA accepts that HCA's share of consulting rooms is significantly reduced if one includes consulting rooms available at non-inpatient facilities. However, even the revised market share estimate of 30% is likely to be an overestimate. In addition to the consulting rooms listed in LaingBuisson's Directory of independent medical/surgical hospitals and clinics, there are numerous consulting rooms in which consultants see, diagnose and advise patients – as HCA has previously indicated⁸, a "Google" search using the term "London consulting rooms" produces a very wide range of medical consulting rooms in central London, and similarly the Bupa consulting and facilities finder search tool lists an extensive number of consulting rooms and clinics.

Spare capacity in central London

- 2.20 The CMA noted in its Final Report that its finding that HCA charged higher prices than competitors "*may itself be an indication of the lack of spare capacity at HCA's close competitors*" (paragraph 11.107, Final Report).

- 2.21 Moreover, the CMA recognised that because insured prices are subject to bilateral 'bargaining' between hospital operators and PMIs, a lack of spare capacity is a key assumption in concluding that PMIs are unable to get competitive outcomes from negotiations with HCA:

"Considering [an insurer], its outside options in a negotiation with a hospital operator are given by the hospitals to which the [insurer] can switch its customer base in each local area in case of no agreement with the hospital operator (i.e. full delisting)" (paragraph 6.238, Final Report).

- 2.22 In the Data Room that opened in June 2015, HCA's economic advisors, KPMG LLP, conducted an analysis to test whether there was sufficient spare bed capacity in central London for insurers to direct their patients away from HCA.⁹

- 2.23 The results of this analysis on spare bed capacity showed that all insurers could have collectively found sufficient spare bed capacity at central London private healthcare facilities other than HCA for all their inpatients at HCA, on any given day in 2011. This level of spare bed capacity is far greater than the amount that would be needed to give an individual insurer a credible threat to switch the totality of its patients. In the PFs the CMA did not dispute the results of this analysis. It did, however, respond that it does not accept that "*the availability of beds at non-HCA facilities is by itself a good indicator of effective spare capacity in central London*" (paragraph 4.46, PFs).

- 2.24 The availability of beds is the prime determinant of the capacity available at a hospital. HCA referred to this in its hearing as "*the key pinchpoint when we are looking at our hospitals*".¹⁰ Indeed, the CMA also regards bed capacity as the principal factor for any new entrant. In concluding that site availability is a barrier to entry in central London, the CMA specifically referred to the need for a new entrant to establish a large enough site to accommodate

⁸ HCA response to CMA information request, 7 July 2015.

⁹ Analysis of spare inpatient capacity in central London, 24 July 2015.

¹⁰ Transcript of hearing on 13 August 2015, page 40, lines 23-24.

sufficient space for beds. For example, the CMA noted that *"The Ravenscourt Park Hospital site represented the minimum size (around 190,000 square feet) sufficient to provide the necessary 150 beds for a viable hospital ..."* (paragraph 6.73, Final Report). Similarly, in the PFs the CMA consistently refers to the need for new entrants to acquire a large site in order to provide for sufficiently large bed capacity.

2.25 However, even if the CMA now considers that there are other indicators of capacity, there is no evidence, and the CMA does not appear to suggest that there is any evidence, that there are capacity constraints which would prevent PMIs from directing patients to non-HCA facilities. On the contrary, the CMA has previously concluded in the Final Report that there is significant excess capacity in the sector:

- The CMA recognised in paragraphs 5.29 and 5.30 of the Final Report that there is substantial spare capacity in the private healthcare sector which is likely to incentivise supply-side substitution.
- In paragraph 4.8 of the original Provisional Findings in 2013, the CMA referred to under-utilisation of capacity and at paragraph 7.5(d) noted that consultants have no difficulty accessing hospital facilities.
- The CMA clearly stated in paragraph 6.187 of the Final Report: *"Our approach to capacity constraints is that unless we have specific evidence that a rival is capacity-constrained, if we see evidence to suggest it is a close competitor, we assume it has capacity to support a de-listing by an insurer of the focal hospital. This is consistent with ... data we have seen on excess capacity."* The CMA has therefore acknowledged that there is a presumption that competitors are able to absorb patients from rival operators.
- HCA consultants are continually targeted by rival hospitals to bring their patients and they are not encountering any capacity constraints which affect their ability to refer patient at short notice to other central London hospitals.

2.26 The CMA refers to other "dimensions" of capacity, namely day-patient beds, operating theatres, intensive care facilities and consultants. KPMG has prepared an updated analysis of spare capacity in central London ("Second Spare Capacity Report") which is being submitted together with this submission which measures the extent of available capacity by reference to other factors.

2.27 ✂.

2.28 ✂.

2.29 ✂.

2.30 ✂.

2.31 The CMA has also referred to *"the days and times at which consultants are available and willing to practise and when patients are willing to be seen"* (paragraph 4.47, PFs). However, there is no evidence which suggests that consultant availability is a constraining factor:

- In view of the presence of the major NHS teaching and research hospitals in central London, there is a large body of consultants who are available and seek to treat private patients. The LaingBuisson Report *"Private acute medical care in central*

London" ("LaingBuisson Report")¹¹ notes that there are over 3,000 consultants who have a private practice in central London. There is a far greater concentration of consultants in central London than in any other local healthcare market.

- The CMA has not identified any barrier to entry with regard to the provision of consultants within hospitals. Indeed, the CMA specifically noted in the Final Report that *"We felt that there was no shortage of consultants, in aggregate, from our case studies and other evidence ..."* (paragraph 6.124, Final Report).
- None of the case studies cited by the CMA, including TLC's new cancer centre, has indicated that a shortage of consultants has affected the ability of operators to expand or launch new clinical services.
- In any event, consultants can, and do, readily switch their practice from one facility to another (many have multiple practising privileges), and if PMIs were to direct their patients to non-HCA facilities, consultants would in any event switch their practices to ensure that they do not suffer any loss of revenue.

2.32 Furthermore, as the CMA itself accepts, the capacity available in the market has increased since the reference period of the IPA (2007-2011) because of the expansion of PPU's (paragraph 4.80, PFs). Consequently, the extent of non-HCA capacity is now even greater than that indicated by the IPA.

2.33 The data in the IPA shows that there is sufficient capacity even in the most extreme scenario that all PMIs seek to redirect all their policyholders away from HCA. In practice, a more likely scenario in the event of a dispute would be that a PMI seeks to redirect a proportion of its business to alternative hospitals.

2.34 The PMIs even concede that there is sufficient capacity for switching to take place. AXA-PPP submitted to the CMA at its hearing: *"Regarding spare capacity, AXA-PPP stated that there may theoretically be sufficient capacity in relation to available beds and operating theatre hours among other hospital operators which might mean it would conceivably be able to redirect its business in a mathematical sense."*¹²

2.35 The PMIs appear to be raising a wholly new point that *"even if there was sufficient spare bed capacity, it did not necessary translate into an effective competitive constraint on HCA, especially if that spare capacity was located in facilities which were unattractively located for PMIs' customers or which did not offer a comparable level of quality or range of treatments."*

2.36 The suggestion that spare capacity is *"located in facilities which were unattractively located"* can be dismissed. HCA's spare capacity analysis relates to hospitals only in central London. The CMA has already concluded that the relevant market for the purposes of its competitive assessment is central London and that the precise location within central London does not have any significance. For example, the CMA specifically noted that *"location within central London was not a relevant factor to take into account in designing an effective divestiture remedy"* (paragraph 11.99, Final Report).

¹¹ Section 3.1.5, page 24.

¹² Summary of hearing with AXA-PPP on 12 August 2015, paragraph 26.

- 2.37 AXA-PPP observed that, while one important factor is available capacity (which, it conceded was "*available ... in a mathematical sense*"), "*the second important factor was reputation*".¹³ AXA-PPP stated that policyholders "*saw HCA as a 'high technology hospital [which] treated more complex patients and got better outcomes*".¹⁴ In other words, AXA-PPP accepts that the only constraint on redirecting patients away from HCA is the reputation and quality of HCA hospitals. This means that the PMIs are not suggesting that there is any structural barrier to switching, and that its policyholders wish to go HCA hospitals because of the higher quality environment which HCA offers. This is precisely the point which HCA has advanced throughout this inquiry. HCA has built a reputation for quality as a result of continuous investment in providing high quality care and its capability to treat high-acuity, complex patients. There can be no case for a divestiture remedy where HCA's position arises from the fact that it enjoys a quality differential to other operators.
- 2.38 HCA has demonstrated that there is more than enough capacity, based on ⌘, for PMIs to redirect all of their patients to rival hospitals. If the CMA believes that there are capacity constraints which prevent or impede switching, it should provide the evidence for this and allow HCA to consider it and respond. The burden of proof is on the CMA to provide any concrete evidence of capacity constraints. This is important, because the CMA's case for a divestment remedy is that it would "*release shares of supply within key specialisms to competitors*" (paragraph 11.73, Final Report) so that "*non-HCA hospitals are able to absorb insurers' volumes currently treated at HCA hospitals across the full range of specialities*" (paragraph 11.107, Final Report). Thus far, the CMA has presented no evidence to suggest that non-HCA hospitals do not already have that ability.

Updating shares of supply

- 2.39 HCA has shown that many of its competitors have grown in the last few years, indicating both that new capacity has come on stream and that the market in central London as a whole is growing.
- 2.40 The CMA's response is that this has made little difference in HCA's share of supply based on the LaingBuisson data. This is, in fact, incorrect:
- HCA's share of central London bed capacity has declined from 46.5% in 2011 to 41.4% currently.
 - HCA's share of central London revenue has declined from ⌘% in 2011 to 50.4% (based on 2013 data).
- 2.41 There is no logic to the CMA's exclusion of the seven NHS Trusts with PPUs in central London from the share of supply estimates. Each of these competes with HCA and therefore should be included in the market share estimates.
- 2.42 The CMA's preoccupation with HCA's absolute share of supply relative to that of its competitors ignores the significant growth which has taken, and is taking, place in central London. The LaingBuisson data shows that there has been an increase in non-HCA capacity in the following hospitals since 2011:

¹³ *Ibid.*

¹⁴ *Ibid.*, paragraph 13.

Capacity growth	Beds	
	2011	Current
Cromwell	118	128
London Independent	58	61
Royal Brompton	31	47
Royal Marsden	21	46
London Clinic	170	183
Aspen	28	43

Source: LaingBuisson Report; figures for Aspen sourced from Final Report and Aspen's website.

- 2.43 There has also been significant revenue growth by most of HCA's central London competitors:

Revenue growth 2011-2013	(£ million)	
	2011	2013
Bupa Cromwell	✂	94
TLC	✂	137
St John & St Elizabeth	✂	46
King Edward VII	✂	20
Royal Marsden	✂	67.8
Great Ormond Street	✂	41.9
Imperial	✂	34.3
Royal Brompton	✂	33.6
UCL	✂	21.6
Moorfields	✂	21.3
Royal Free	✂	20.4

Source: Final Report and LaingBuisson Report.

- 2.44 The revenue figures in the LaingBuisson Report are based on 2013 data. The data for 2015 is likely to show continued growth by many of these competitors. As noted above, it is highly surprising that during this 12-month remittal process, the CMA has not sought to update its share of revenue estimates based on current rather than historic market data.
- 2.45 HCA has also pointed out that there is likely to be growth in the admissions/revenues relating to individual specialisms. For example, the LaingBuisson Report indicates that HCA currently

accounts for just 8% of orthopaedic operations in central London, based on data on the volume of operations submitted to the National Joint Registry up to early 2014.¹⁵ The LaingBuisson Report also indicates the strength which HCA's competitors have in individual clinical service lines (showing the number of consultants at each facility specialising in individual treatments).¹⁶

- 2.46 With regard to Greater London market share, HCA notes that including the four hospitals which the CMA disregarded in its assessment would reduce HCA's share of Greater London beds to 8%. The question of whether Greater London hospitals are an effective constraint on central London providers is considered below.
- 2.47 In paragraph 4.52 of the PFs, the CMA cites HCA's plans to expand various facilities. However, it cannot be concluded from this that HCA's share of capacity "*will grow in the near future*". HCA has provided many examples of both new entry and expansion plans by its competitors, including the expansion of capacity by independent providers and the rapid growth of PPUs. Indeed, in recent years PPU growth has outstripped that of independent competitors. There is therefore no basis to conclude that HCA's share of capacity (which in fact has declined since 2011) will grow in the future relative to that of its competitors.

HCA's criticisms of the CMA's use of evidence from business cases

- 2.48 The CMA argues that it does not accept that it has placed "*unduly heavy reliance*" on HCA's business cases in its competitive assessment and that the review of business cases was only "*one aspect of the evidence we considered*" (paragraph 4.60, PFs). However, a reading of paragraph 6.204-6.208 of the Final Report shows that the CMA's analysis of the competitive constraints of independent competitors, PPUs, Greater London providers, and international competitors was based almost entirely on a tendentious reading of highly selective extracts from a small number of business cases.
- 2.49 This remains the case in the PFs: paragraphs 4.60-4.145 of the PFs demonstrate that the CMA's assessment as to the strength of competition from other providers is wholly dependent on whether they feature as competitors in HCA's business cases, or to the extent to which they do so. There is no other consideration whatsoever. 8.
- 2.50 The CMA notes that a number of HCA business cases post-date the OFT's market inquiry and CC investigation and states that it is "*mindful of the potential for the context of HCA's business cases to be affected by the OFT/CC scrutiny during the latter part of the period*" (paragraph 4.61, PFs). The CMA appears to be suggesting that HCA deliberately prepared these business cases in a way which would emphasize the competition it faced, and HCA vigorously rejects this. 8. If the business cases had been prepared for the purpose of submitting them to the OFT/CC as evidence of competitive constraints, they would have been drawn to the OFT/CC's attention, and they were not. Furthermore, there has been no change in the style, format or content of business cases before and after the launch of the OFT/CC market investigation.

¹⁵ LaingBuisson Report, Appendix 1.

¹⁶ *Ibid.*

- 2.51 The CMA claims that the business cases only refer to PPUs "*within particular specialisms such as paediatrics and oncology*" (paragraph 4.72, PFs). The CMA's analysis of HCA's cases mentioning PPU competitors mainly relies on ☒ cases cited in paragraphs 4.66 to 4.70.¹⁷ Out of these cases, ☒ relate to ☒services and ☒ relates to ☒.¹⁸ The others refer to a wider range of specialties than the CMA suggests, including ☒.¹⁹ It is unsurprising these business cases would only be referring to competitors in the "*particular*" specialisms relevant to them. Moreover, many of HCA's largest investments (requiring a formal business case) over the last few years have been in ☒ and the business cases for those investments relate to these clinical specialties. It is absurd for the CMA to conclude from this that HCA does not face competitive constraints in other clinical specialties merely because there are fewer business cases in those specialisms.
- 2.52 The CMA also argues, based on a few selected extracts from the business cases, that HCA regards PPUs as offering an "*inferior service*" (paragraph 4.67, PFs) because of capacity constraints. It relies on comments in a very small number of business cases to this effect. HCA points out as follows:
- Those business cases either pre-date the lifting of the PPU revenue cap in 2012, which has paved the way for significant investment and expansion in PPUs, or were written shortly thereafter before the change in law had noticeable effect. ☒. The CMA's analysis is purely backward looking and does not reflect market developments since 2011/2012.
 - The very fact that HCA saw an opportunity to invest in and build a service which would rival that offered by PPUs in those specialisms demonstrates the competitive nature of the market, and how PPUs have spurred HCA to create new clinical service lines. This is a clear illustration of the competitive process at work. It is perverse for the CMA to interpret these business cases as evidence of a lack of effective competition in the market.
 - HCA has already dealt with the claim that NHS PPUs are capacity-constrained because NHS hospitals prioritise NHS over private patients. While this may have been an issue in the past, there is no evidence that PPU patients are currently encountering any difficulty in getting access to NHS critical care facilities. HCA is not aware of any instances in which PPU patients are being turned away from NHS critical care units because of a lack of capacity. On the contrary, PPUs are now aggressively marketing themselves as offering the full back-up of a large NHS hospital, which is combined with the convenience of a dedicated private wing. Further, NHS Trusts are very keen to diversify into private services in order to off-set the cuts in NHS budgets, and they have resolved any capacity problems which may previously have existed.
 - The CMA uses business case ☒to claim that "*some NHS hospitals are capacity constrained and have considered closing their PPUs in order to achieve their waiting list performance targets*". This is wrong. ☒.
- 2.53 In any event, there are numerous references to the fact that PPUs are a serious competitive threat to HCA:

¹⁷ Cases ☒.

¹⁸ Cases ☒.

¹⁹ See cases ☒, for example.

- As the CMA admits, a significant number of business cases ✂.²⁰
- HCA is also well aware of PPUs' "✂"²¹
- As the CMA concedes, a number of cases recognise ✂.²²

2.54 It is deeply disappointing to see that a large portion of the CMA's analysis of competitive constraints in the PFs consists of a numerical count of the precise number of times a competitor is mentioned in the business cases. For example, in relation to NHS competitors (discussed below) the CMA quibbles that these are mentioned ✂, not ✂ times. This is hardly an adequate basis on which to assess the strengths of competitive constraints.

2.55 HCA also reiterates that the business cases were prepared for very limited purposes and therefore the CMA cannot base its competitive assessment merely on the business cases:

- These were drafted for the purposes of ✂. They provide a financial evaluation of the proposal and focus on the financial returns anticipated from the investments. One would not expect such a document to contain a detailed forensic analysis of the relevant markets. They are, in effect, ✂, and they are written from that point of view.
- There would be no reason for a business case to comment on the range of competitors. Competition is a daily reality for the business which is well understood by management. It is not required to be spelled out to the management team in every business case.

2.56 HCA has similar concerns regarding the CMA's comments about independent competitors. The CMA states (paragraph 4.73, PFs) that TLC and Bupa are the main competitors because they are mentioned both more frequently and in more detail. However, there are numerous mentions of other competitors to many of the business cases and it is simply not true that TLC and Bupa Cromwell are the only competitors which HCA is worried about:

- The CMA notes that other than ✂.²³
- Collectively, ✂.²⁴ ✂.²⁵ ✂.²⁶ and ✂.²⁷
- ✂.²⁸

2.57 Moreover, even if the CMA were justified in relying on HCA's internal papers to assess the strength of competitors, it is not clear why the CMA only refers to business cases for investment, and no other internal papers such as strategy documents which also evidence the competitiveness of the market.

²⁰ Cases ✂.

²¹ Case ✂.

²² Cases ✂.

²³ Cases ✂.

²⁴ Cases ✂.

²⁵ Case ✂.

²⁶ Case ✂.

²⁷ Case ✂.

²⁸ Cases ✂.

Parties' views during this remittal on competitive constraints from private hospitals (including PPUs) in central London

2.58 The CMA acknowledges that PPUs have grown by 20% in the period 2011-2013. It nevertheless disregards PPUs as a competitive constraint on the grounds that PPU growth *"has been broadly in line with the overall growth in the private healthcare market in central London over the same period"* (paragraph 4.80, PFs). However, this ignores a number of factors:

- In the Final Report, the CMA noted that the lifting of the cap *"created increased potential for additional revenue streams"* (paragraph 24, Appendix 3.1, Final Report) but that *"the extent of PPU expansion remains uncertain"* (paragraph 6.242, Final Report). The LaingBuisson data bears out, not only that PPU expansion has been sustained, but also that it has been significant. That there has been 20% growth in just two years demonstrates that PPUs have become a significant competitive force. It is irrational to conclude that a sector of the market which has grown by 20% in two years is not a competitive constraint.
- PPUs have brought, and are increasingly bringing, new capacity into the market. PPUs now account for 25% of inpatient beds, compared to 8% in 2011. This increases even further the capacity available to PMIs to switch to non-HCA providers and therefore increases the competitive constraints on HCA.
- The CMA cited a number of reasons in the Final Report why PPU growth may be tempered in future (paragraph 20, Appendix 3.1, Final Report). In fact, none of these factors has impacted on PPUs, most of which have published ambitious plans to expand private provision over the next few years. The CMA's "uncertainty" over PPU growth which the CMA expressed in its Final Report (and which the CMA repeats in the PFs) has been shown to be unfounded.
- Also, the CMA has itself expressed the view that PPUs are likely to grow, and this finding forms the basis for the PPU remedy, which allows the CMA to investigate all new PPU partnering proposals. It is inconsistent for the CMA to argue that a PPU remedy is required unless it also believes that PPU growth is likely and will create new partnering opportunities.
- Therefore, the fact that PPU growth is *"broadly in line with the overall growth"* in the market is not a reason to conclude that PPUs are not a significant, and growing, competitive constraint.

2.59 The CMA argues that it is *"unnecessary for us to examine or conclude on the extent to which PPUs enjoy competitive advantages due to their status as NHS entities"* because *"we expect the effect of these advantages to manifest in market outcomes (such as shares of supply)..."* (paragraph 4.81, PFs). This is wrong. The strategic advantages which a competitor enjoys strengthens its capability and must be taken into account in the CMA's assessment of the market. As PPUs invest and expand their services, these competitive advantages are becoming more important. The OFT specifically noted in its Private Healthcare Market study in April 2012 that PPUs have competitive advantages which should be taken into account in any partnering arrangements.²⁹

²⁹ Private Healthcare Market Study, April 2012, OFT, paragraphs 9.8-9.12.

- 2.60 The CMA acknowledges that PMIs consider PPUs to be effective substitutes in terms of clinical outcomes but alleges that *"patients may not fully share these views"*. The only basis for that view about patients is the CMA patient survey, and the CMA acknowledges HCA's criticism about the way in which the relevant question about PPUs was framed. This does not provide sufficient evidential support for the CMA's view.
- 2.61 The CMA states that it has *"seen no evidence that PMIs are able to divert significant numbers of patients"* to PPUs (paragraph 4.87, PFs). Bupa has in fact contradicted this, saying at its recent hearing that there was *"sufficient capacity in relation to available beds ... in private patient units ..."* (paragraph 21, Summary of Bupa hearing on 12 August 2015).
- 2.62 The CMA states that *"We have already responded, in the Final Report, to HCA's arguments on the cost advantage that its central London rivals might have due to their charity status, such as corporation tax relief, business rate relief and VAT savings"* (paragraph 4.85, PFs). This is not the case. In the Remittal Inquiry HCA noted that several of its central London competitors including TLC, Hospital of St John and St Elizabeth, and King Edward VII enjoy various cost savings due to their charitable status.³⁰ In submitting this evidence, HCA explained to the CMA that the CMA was wrong to conclude that *"only marginal costs (as opposed to fixed costs) should be relevant for pricing decisions"* (paragraph 6.364, Final Report). In its submission, HCA drew on a range of academic papers to explain that where prices are determined in a bargaining framework, as is the case in private healthcare for insured prices, these prices will account for fixed costs; and additionally that in an industry with relatively high fixed costs (such as private healthcare), investment in quality and innovation can contribute to a firm's fixed costs and can realistically only be undertaken if the investing firm is able to earn an adequate return. The CMA fails to address these issues in the PFs.
- 2.63 The CMA states that it ignored *"the extent to which the Cromwell enjoys competitive advantages due to its vertical integration with Bupa"* because this would *"manifest in market outcomes such as shares of supply ..."* (paragraph 4.86, PFs). HCA responds as follows:
- This statement is incorrect as a matter of economics. The CMA appears to be saying that it can use the level of market shares as an indicator of the degree to which aspects of Bupa's strategy confer a competitive advantage. It is hard to see on what basis the CMA feels it can draw this conclusion as this would only be possible with a very sophisticated analysis. The reason why this conclusion is unsupported (and in fact contrary to evidence) is that the various hospital operators are not all the same. There are differences in their reputation, levels of investment, timing of investments, scale and scope economies that all contribute to a given market outcome. The assessment the CMA needs to make is to consider whether market shares indicate a lack of competition or instead the reward for effective competition. To rule out other firms' competitive advantages on the basis of existing market shares amounts to assuming the conclusion of the analysis.
 - This is at odds with the CMA's Guidelines for market investigations which note the importance of examining the impact of vertical relationships. The Guidelines state that where a firm has significant market power in one or more markets along the

³⁰ HCA submission of 1 May 2015, paragraph 4.60. HCA has also previously submitted evidence which estimated the significant value of the tax subsidies to these hospitals (the CASS Research Report of May 2013); furthermore the CMA has recognised that as charities they may benefit from a lower cost of capital. See Final Report, Appendix 6.14, paragraph 67.

supply chain, there is a risk of foreclosure of rivals: see paragraphs 273-278 of the CMA Guidelines for market investigations (CC3 (revised)).

- Bupa has a position of market dominance in PMI, and the CMA accepts that HCA *"is likely to be severely impacted in the event of a full de-listing by either Bupa or AXA-PPP"* (paragraph 6.29, PFs). The CMA also accepts that the Bupa Cromwell is one of HCA's "main competitors" (paragraph 4.75, PFs). Bupa's ownership of the Cromwell therefore gives it significant advantages in central London.
- Bupa's vertical integration with the Cromwell is also highly relevant to the issue of bargaining power, and increases Bupa's outside options in any negotiations with HCA. The CMA's own evidence referred to the fact that the Cromwell would benefit from the direction of Bupa's Open referrals and that this in turn would *"allow it to attract new consultant users"* (paragraph 2, Annex A, Appendix 6.2, Final Report).

2.64 The CMA also makes the wholly unfounded assertion in paragraph 4.88 of the PFs that *"consultants do not view PPUs as close substitutes for private hospitals"* in respect of their preferences as to where they base their practice. HCA refutes this:

- The CMA refers to the OFT survey of 2011, but this found that the majority of consultants surveyed (54%) considered that PPUs were a substitute to private hospitals in terms of their own practice. The CMA is therefore basing its assertions on the views of a minority of consultants in the sample.
- The survey was nationwide, and not London-specific. The CMA has noted that the top 10 PPUs are all located in London and account for the majority of NHS private patient revenue, and that London PPUs are a more potent competitive force. The CMA cannot therefore rely on a national survey which included areas where PPUs are a weaker competitive constraint. Indeed, the OFT specifically noted that PPUs with the highest annual revenues (i.e. in London) and which have stronger and growing demand from domestic and international patients are a more powerful competitive constraint: see paragraph 4.30 of the OFT Report "Private Healthcare Market Study".
- In its hearing with the CMA, Aviva pointed out that it was aware of specialists *"recommending that patients use the PPU because of the intensive facilities available at certain NHS hospitals."*³¹
- ✂ of HCA's consultants also have practising privileges at NHS PPUs (other than HCA administered PPUs) and base their practice there. HCA believes ✂ are likely to have admission rights at PPUs.

Competition from non-inpatient facilities in central London

2.65 HCA has addressed the CMA's comments concerning shares of supply of non-inpatient providers above.

2.66 The CMA's statement in paragraph 4.93 of the PFs that *"consultants prefer to operate from a single inpatient facility"* is wrong and is contradicted by the fact that there is a very wide range of day case and outpatient clinics which have been successfully established in central London, often owned and managed by consultants, e.g. Fortius Clinic, Nuada, and Queen

³¹ Summary of hearing with Aviva held on 13 February 2013, paragraph 32.

Anne Street Medical Centre. Consultants typically have an equity interest in these clinics, which incentivises them to split their practice and carry out day case and outpatient consultants in these clinics. HCA has provided the CMA with an extensive list of day case and outpatient clinics (see response to Information Request of 7 July 2015). There are also numerous new entrants including Optegra and the London Claremont Clinic. The consultants carrying out day case/outpatients consultations in these clinics will typically carry out inpatient treatments in central London hospitals.

- 2.67 A recent article in HealthInvestor (attached in **Annex 1**) concerning Fortius Group describes how expansion is being driven by the rapid growth in the number of consultants, which started as 12 and is expected to reach 60 by the end of the year. Its consultant equity model has successfully attracted many leading orthopaedic consultants.
- 2.68 Large numbers of consultants also work at HCA's various outpatient centres. For example, 102 consultants practise at The Wellington Outpatient & Diagnostic Centre, 68 at Chelsea Outpatient Centre (280 King's Road) and 50 at 31 Old Broad Street.
- 2.69 The CMA asserts that because HCA's business cases only mention imaging and diagnostic providers, there is no evidence that other non-inpatient providers provide a competitive constraint. Once again, the business cases cited by the CMA relate to new investments in imaging and diagnostic equipment and therefore obviously focused on the competitors in this area: that cannot be used as an argument that HCA disregards the competitive constraints from other day case/outpatient providers. In any event, there are business cases which refer where relevant to other types of competitors and services:
- ✂.
 - ✂.
 - ✂.
- 2.70 Furthermore, as HCA has submitted, there are minimal barriers to entry for day case and outpatient providers and there has been significant investment in new clinics, particularly by consultant groups.

Competitive constraints from the NHS

- 2.71 There are at least ✂ business cases which clearly refer to the NHS as a provider of publicly funded healthcare services.³² HCA considers it is misleading of the CMA to claim that there are only "✂" (paragraph 4.112, PFs). ✂:
- ✂.
 - ✂.
 - ✂.
- 2.72 The NHS does therefore provide a competitive constraint in terms of the range and quality of services provided in HCA's hospitals.
- 2.73 The CMA dismisses certain business cases referring to NHS competition on the grounds that these merely "✂". As HCA has previously submitted, this in itself acts as a competitive

³² Cases ✂.

discipline which provides further incentives for HCA to invest to maintain and improve quality and to develop new and innovative clinical services for the purposes of attracting patients who would otherwise go to the NHS. ✂. The very purpose of creating "new demand" for private hospital services is to attract these patients.

- 2.74 The CMA notes that the cash benefits provided by PMIs to steer patients to the NHS represents a small proportion of PMI spend. However, it is a further tool which is available to the PMIs (alongside other "directional" policies) to direct patients away from HCA, and this needs to be taken into account in the analysis of bargaining power. The CMA states that the cash incentive is "sizeable", but from the PMIs' perspective it is likely to represent a relatively small proportion of the total cost payable, particularly in the case of high-value and long-term cancer treatments.

Competitive constraints from private hospitals and PPUs outside central London

- 2.75 The CMA argues in paragraph 4.124 of the PFs that the very fact that patients living in outer London travel into central London suggests that outer London hospitals are not effective substitutes. The CMA is in effect asserting that because at any given time some consumers purchase from supplier "A" rather than supplier "B", A and B ipso facto are not substitutes, which is absurd.
- 2.76 HCA would remind the CMA of the test for substitutability in its Guidelines for market investigations: *"The hypothetical monopolist test (HMT) is a tool which can be used to identify effective substitutes and to check that the market is not defined too narrowly. The principle behind it rests on defining a market as a product, or collection of products, a sole supplier of which could hypothetically impose a small but significant non-transitory increase in price (sometimes referred to as the SSNIP test). The test can help to identify the constraints that would prevent a hypothetical monopolist from exercising market power. In practice, it may often be used, not quantitatively, but as a conceptual framework"*.³³
- 2.77 HCA has repeatedly criticised the CMA for failing to consider and test how existing patterns of usage would change in response to a small but significant alteration in the value of a hospital's offering.
- 2.78 The CMA also argues that the fact that central London patients do not go to outer London hospitals shows that these hospitals do not constrain HCA in central London. Again, the CMA has not in fact tested this on normal substitutability principles. Even if that is correct, it is still the case that outer London hospitals constrain HCA in competing for outer London patients, and that constraint benefits all HCA patients, since HCA does not discriminate between patients in and outside central London.
- 2.79 The CMA has not disputed that the response to small but significant changes in the relative value for money of private healthcare providers inside and outside of central London is an important factor in determining the competition between these two geographic areas. However, in response to this point, in paragraphs 4.126-4.127 of the PFs the CMA states that it has not tested how patterns of usage inside and outside of central London would change in response to a change in relative value for money because it was difficult to test this in its survey and difficult to interpret how changes in usage patterns would affect PMIs' choices. This is not a sufficient basis for disregarding this important issue, and certainly no

³³ CMA Guidelines for market investigations (CC3 (revised)), paragraph 138.

basis whatsoever for concluding that private healthcare providers outside of central London exert a weak competitive constraint.

- 2.80 As a result, the CMA's market share figures, which include HCA's admissions/ revenue from patients located outside of central London but exclude all providers outside of central London, are inappropriate and not a reliable basis for forming any conclusions on the strength of competitive constraints.
- 2.81 The CMA repeats the proposition that central London hospitals are more convenient to outer London commuters who travel into central London for work, and states that once a patient has seen a consultant in central London, any follow-up treatment will also be in central London. The CMA's only evidence of this is the fact that ☒ was unsuccessful in using consulting rooms in central London to attract patients to its outer London hospitals. ☒, it should be noted, ☒ and its lack of success with its outpatient rooms is likely to be for an entirely different reason. HCA notes that ☒ does consider that patients who use central London consulting rooms will use outer London hospitals for surgery. Similarly, Bupa has specifically stated that "*Our members prefer to see a consultant close to their home address*".³⁴
- 2.82 HCA repeats that ☒% of its patients are resident outside central London, and these patients all have local choices. Many such residents obviously do use local private hospitals – several of these hospitals are successful and are expanding. To a very large number of patients, they clearly are effective substitutes.
- 2.83 HCA also repeats its general criticisms of the CMA's heavy reliance on its business cases. In any event, the business cases do refer to outer London competitors for both inpatient and outpatient facilities, for instance:
- ☒.
 - ☒.
 - ☒.
- 2.84 In its conclusions on market definition, the CMA accepts that Greater London hospitals compete with HCA hospitals for "*the marginal self-pay patient who needs relatively straightforward treatment and lives in Greater London, particularly if central London hospitals are unable to discriminate between patients based on where they live*" (paragraph 3.32, PFs). It does therefore appear that the CMA now at least acknowledges the competitive constraints from Greater London hospitals in respect of self-pay patients.
- 2.85 The CMA argues that the same does not apply in respect of insured patients because "*each PMI needs to be able to offer local hospital cover [in central London] ... for a substantial number of policyholders in the area*" (paragraph 3.32, PFs). However, this misses the point:
- Greater London hospitals provide not only self-pay patients but also insured patients with alternative local choices for what the CMA refers to as "*straightforward treatment*". HCA must therefore ensure that the quality and range of its services are sufficient to attract PMI patients who otherwise have alternative local hospitals.

³⁴ Bupa's Open referral Q&A leaflet: see HCA's submission on structural AECs, 1 May 2015, paragraph 4.90(ii).

- Furthermore, as HCA has previously submitted, PMIs have been increasingly using directional products and policies, such as Open referral or "guided" referral at the pre-authorisation stage, to divert patients away from central London to Greater London hospitals. The LaingBuisson Report specifically noted "*PMI drives to place more routine work at out of central London hospitals*".³⁵ Bupa's Open referral strategy was expressly designed to facilitate this trend.
- The PMIs have also developed lower cost restrictive networks which offer PMI patients outer London hospitals as an alternative to central London hospitals.

Thus outer London hospitals exercise competitive constraints on HCA for both self-pay and insured patients.

Competitive constraints from international competitors

- 2.86 The CMA concedes that HCA does compete with international providers for overseas patients in respect of quality and range (paragraphs 4.143 and 4.144, PFs). As HCA has previously submitted, this competition benefits HCA's domestic and international patients by improving quality and clinical outcomes for all patients. International competition is therefore a further competitive constraint on the business at least in respect of quality.
- 2.87 The CMA states that "*this is mainly in relation to a couple of specialties*". This is wrong. Again, the CMA bases this statement on the fact that there are some business cases for investments in ✂ and ✂ which mention overseas competitors in these fields, but that does not mean that overseas competition is restricted to these services. HCA competes with international providers across the full range of specialisms. It draws particularly significant numbers of overseas patients in the following areas:

³⁵ LaingBuisson Report, page 14.

- There are also competitive constraints from other Greater London providers and international competitors.
- Outpatient and day case providers are becoming more significant as the market moves away from inpatient provision.
- Most of HCA's direct competitors are growing in both capacity and revenue.
- All of HCA's competitors in central London have competitive advantages which HCA does not enjoy.

2.91 The CMA has therefore failed to carry out a credible assessment of competition in central London.

3. BARRIERS TO ENTRY AND EXPANSION IN CENTRAL LONDON

Key points

- The CMA has revised its finding to state that the main barrier to entry and expansion is high sunk costs and long lead times. However, these factors in themselves do not constrain new entry and expansion in the market which, the CMA accepts, is growing and encouraging new investment.
- The CMA has resiled from its previous view that site availability is a barrier to entry, and now states that site availability "exacerbates" barriers to entry. In fact, the CMA's own analysis shows that a significant number of NHS sites will become available to the market over the next two to five years, and the Cleveland Clinic's recent acquisition of 33 Grosvenor Place demonstrates that large commercial sites are also available.
- Similarly, the CMA has retreated from its previous view that the planning regime is a barrier to entry and now states that planning constraints are a "contributing factor" increasing barriers to entry. However, the only evidence which the CMA can cite relates to the use swap regime which, at most, only affects the acquisition of residential property within the Harley Street special policy area.
- There has already been significant expansion in the market by existing providers (including TLC, HCA, King Edward VII and Aspen) and in the next few years there will be further new entry by Barts PPU, Spire, the Cleveland Clinic and VPS. This pipeline of new hospital developments demonstrates that sunk costs and long lead times are not, in fact, deterring new entry and expansion.

High sunk costs and long lead times

- 3.1 HCA is concerned that the CMA has not appropriately assessed the importance or magnitude of sunk costs in the context of private healthcare provision in central London.
- 3.2 HCA notes that the CMA agrees in paragraph 5.20 of the PFs that the extent to which sunk costs act as a barrier to entry or expansion depends on the size of those costs. The CMA concludes that the sunk costs that it considers are required for entry into private healthcare provision in central London are likely to be "high".
- 3.3 However, it is not the absolute size of any sunk costs which is important in considering whether sunk costs constitute a barrier to entry, but rather the relative size of any sunk costs set against the market size and the likely profit that would be achieved upon entry. Market growth, for example, reduces the likelihood that sunk costs would constitute a barrier to entry and expansion, since in a growing market it is more likely that demand will be sufficient to allow firms to recover sunk costs, as HCA has previously stated.³⁶

³⁶ HCA's submission on structural AECs, 1 May 2015, paragraphs 3.5-3.22; see also Professor Bruce Lyons' Expert Review, 13 February 2014, paragraph 59.

- 3.4 The CMA, however, has done no analysis of the magnitude or importance of sunk costs relative to the size of the market or the likely profit that might be achieved upon entry. Without such analysis, it is unclear what basis the CMA has for concluding that the evidence suggests that sunk costs are likely to be “high” or that they constitute a barrier to entry

Availability of suitable sites

- 3.5 The CMA concedes that some NHS sites will become available to new entrants. It states that, based on the information provided by NHS Trusts, the evidence is “mixed”, but it is clear from the evidence presented in paragraph 5.35 of the PFs that a number of large, substantial sites will be sold on the open market and will be available for new hospital developments:

- ✂.
- ✂.
- ✂.
- ✂.

- 3.6 Thus, even on the CMA's own analysis:

- ✂.
- ✂.
- ✂.

- 3.7 This shows that, over a five year time frame, on the CMA's own analysis a total of at least ✂ square feet of NHS hospital sites will be available to new entrants. This does not include the other sites mentioned by HCA (✂) in respect of which the CMA has not received a response from the NHS Trusts. These sites already have planning consent for C2 use as hospitals. There is therefore a substantial volume of property which will become available which is suitable for hospital development.

- 3.8 The CMA notes that the reorganisation of NHS Trust estates “*has the potential to ease constraints on the availability of suitable sites for entry/expansion by private hospital operators over the next five to six years*” but argues that this time frame is too long to “*constrain HCA in the near future*” (paragraph 5.44, PFs). This does not in fact reflect the CMA's own findings. As stated above, the CMA has verified that in the next ✂ alone there will be ✂ substantial sites which will become available to new entrants. ✂

- 3.9 The CMA raises a new and unfounded objection that the fact that the NHS is disposing of these sites to build new hospitals raises “*questions about the cost effectiveness of converting these old buildings into modern hospitals*” (footnote 293, PFs):

- As HCA has previously explained, the NHS is reconfiguring clinical services within London in order to concentrate NHS facilities within a smaller number of locations, not because of any problems with existing buildings. This is being driven by a strategy of creating integrated, specialist centres of excellence. For example, an NHS leaflet explaining the need for the restructuring of cardiovascular services at Barts explains: “*Current services are not always meeting recommended standards. Specialist teams are spread across too many hospitals so they are not always*

serving the recommended population size or carrying out the recommended number of procedures ... clinicians have told us that we should combine specialist cardiovascular services currently provided at the Heart Hospital, the London Chest Hospital, and St Bartholomew's to create an integrated cardiovascular centre".³⁷

- VPS has acquired the Ravenscourt Park Hospital site, which was previously the NHS Royal Masonic Hospital, and has been closed for a number of years. This is a clear indication that former NHS sites are suitable for reconversion.
- The London Heart Hospital previously housed a state-of-the-art private cardiac facility before it was acquired by UCLH in 2001. It can therefore readily be converted back for private use.

3.10 In relation to the examples of expansion in paragraph 5.38 of the PFs, while these may not be relevant to the specific issue of site availability (because these examples involve redevelopment on the operator's existing site), they all nevertheless indicate the ease with which existing operators are growing and launching new services, for example the Bupa Cromwell's expansion of its oncology offering, and BMI Independent's new ITU facilities. None of these operators has encountered any significant barriers to expansion.

3.11 The CMA argues that HCA has exaggerated the extent to which Aspen's Highgate Hospital has expanded, but this is incorrect:

- It is not true to say that "*The main element of the expansion at Highgate Hospital is the new imaging/diagnostic suite together with the refurbishment of the hospital's facilities*" (paragraph 5.38, PFs). The Hospital's website³⁸ states that the expansion also involves further inpatient rooms, outpatient rooms, a new high-dependency unit, a new operating theatre and a minor operating suite.
- The expansion programme has increased the Hospital's bed capacity by over 53% from 28 (as reported in table 11.4, Final Report) to 43. This is a substantial expansion for any hospital. The CMA cannot simply dismiss this as being marginal.

3.12 In any event, there are examples of operators expanding by acquiring new sites:

- King Edward VII is undertaking a large site expansion, creating an additional 40,000 square feet of hospital space in the Harley Street area. As HCA has previously submitted, it did not encounter any difficulty in acquiring a neighbouring site adjacent to the existing hospital to allow for expansion, which is expected to increase capacity by one-third.³⁹
- HCA has itself expanded the Portland Hospital with the addition of floors 2-6 Argosy House. Whilst the CMA argues that this is "*relatively small scale expansion*" (paragraph 5.39, PFs), given that the Portland has an existing internal area of

³⁷ "Improving specialist cancer and cardiovascular services", NHS England: leaflet attached to HCA's submission on site availability in and around Harley Street.

³⁸ www.highgatehospital.co.uk: The Hospital's press release of 31 July 2013 states – "*The hospital is currently undergoing a £13 million extensive redevelopment and expansion programme which when completed in December 2013 will include 43 patient rooms (all en suite), a High Dependency Unit, four fully-equipped operating theatres, a state-of-the-art Endoscopy Suite, Physiotherapy Suite, 15 outpatient rooms, and a private GP service.*"

³⁹ See HCA's submission "Site availability in and around Harley Street", paragraph 6: Howard de Walden has worked with the King Edward VII Hospital to create further space of 101,000 square feet in the Harley Street area.

square feet, the new premises add around % extra capacity which again is a significant level of expansion for any hospital. This is sufficient to allow for .

- 3.13 The CMA states at paragraph 5.40 of the PFs that Spire's entry is not imminent. HCA points out that Spire publicly announced in its 2014 half-year results that two central London sites are *"in early stages of planning"* and *"potentially opening in 2018"*. This is Spire's own publicly stated position.
- 3.14 Furthermore, may well have a narrower range of property options because of " " (paragraph 5.34, PFs). It does not follow from this that other new entrants, which for example are prepared to acquire leasehold properties or to refurbish e.g. existing NHS hospital buildings would face the same difficulties of locating a suitable site.
- 3.15 The CMA acknowledges that PPU partnerships provide a further means of entry into central London. It notes that Barts is currently going through a tender process for a new PPU, but claims that this is *"unlikely to provide a means of entry of sufficient scale ... to provide a significant competitive constraint on HCA"* (paragraph 5.41, PFs). This is wrong for a number of reasons:
- The CMA states that it will be largely providing cardiovascular services. However, it is important to note that the Trust's OJEU tender notice invited candidates to bring forward appropriate solutions for any clinical services, and therefore it was open to bidders to specify which services they wished to develop. If a new PPU is to focus on cardiovascular services, it will be because the successful bidder's business case sees the opportunities in this clinical field.
 - In the Final Report, the CMA alleged that HCA had over % share of supply in cardiology (paragraph 6.208, Final Report) and in considering divestment options it specifically referred to the need to free up shares of supply in cardiology. The launch of the new Barts PPU will obviously affect the CMA's assessment of competitive conditions in cardiology.
 - The new PPU will obviously be a competitive constraint to HCA in relation to the particular services which it offers, and given that Barts is a leading tertiary centre for cardiac treatment, the new PPU will be a strong competitor in this field.
 - The size of the site (78,000 square feet) is as large, if not larger, than some of HCA's hospitals. . The size of the site is sufficient to create a viable, profitable and effective competitor in the market.
- 3.16 The CMA refers to the *"scarcity"* of PPU contracts (paragraph 5.41, PFs) but given the very large number of NHS teaching and research hospitals these contacts are far more numerous in London than in other parts of the country. As previously indicated, virtually all NHS Trusts in London are keen to build and expand their private patient capability. Some (such as Royal Marsden) have done so using their own resources but many (e.g. UCLH) have looked to partner with private hospital operators to create new PPUs. There is no reason why this trend should not continue. St. George's and RNOH, just outside central London, are both in the process of establishing PPU partnerships and it is highly likely that other Trusts will continue to do so. PPU contracts in London cannot be described as *"scarce"*.
- 3.17 The CMA notes that Class C2 planning permission has been given for a large private hospital development (125,798 square feet) at Earls Court, but argues there is no

"commitment to use the site for private hospital use" (paragraph 5.42, PFs). This misses the point. HCA referred to the Earls Court site as evidence that planning consents are being granted for large scale hospital developments and that the planning regime is not a barrier to entry. This site is therefore available for new entrants with the benefit of C2 planning consent. Indeed, HCA understand that Spire's name has recently been linked to this site, and no doubt this is one of the sites which Spire is actively considering.

3.18 The CMA notes the availability of commercial sites for new entrants but asserts that the examples provided by HCA were "*significantly smaller than the size of building that certain potential entrants*" require. This is not true:

- HCA provided details, for example, ✂. ⁴⁰
- Howard de Walden has also submitted details to the CMA of commercial sites in excess of 120,000 square feet. ⁴¹
- Furthermore, 25 out of the 57 commercial property sites listed in the updated McKinsey Report are over 120,000 square feet.
- HCA has therefore provided numerous examples of large commercial sites in excess of 120,000 square feet.

3.19 The Cleveland Clinic's recent acquisition of 33 Grosvenor Place, Mayfair is the most recent example of the availability of commercial sites for hospital development. The building provides 192,000 square feet of space. The CMA argues that "*It is not yet clear whether the Cleveland Clinic will be able to use the building it has acquired for hospital purposes*" (paragraph 5.44, PFs) but HCA notes as follows:

- Cleveland Clinic is a major US healthcare operator. It is solely in the business of providing private healthcare and has no other activities. It would not have made such a substantial investment (£250 million) in this site unless it was proposing to launch a new healthcare facility. Furthermore, its chief of International Business Development has stated that it intends to offer health care services from the site. ⁴²
- ✂.

Planning policy

3.20 The CMA continues to assert that the use swap system in the Harley Street Special Policy Area is a constraint on new entrants in that locality. HCA has previously explained why this is not a material barrier to entry, but the CMA has not addressed any of HCA's points:

- New entrants can satisfy planning requirements by either converting part of the development to return a proportion for residential use or alternatively by buying additional space and converting this for residential use. Howard de Walden has indicated that it has worked with other healthcare providers in this way.

⁴⁰ HCA's submission supplementing remedies hearing, 28 February 2014, paragraph 2.4.

⁴¹ HCA's submission on site availability in and around Harley Street, paragraph 4.

⁴² "Dr. Marc Harrison, the Clinic's chief of International Business Development, will lead the planning process for the London project. He said in a statement that the hospital is examining ways to tailor its care to the needs of that city. "We are pleased to have acquired 33 Grosvenor Place and are excited to explore the opportunity to offer health care services that complement the current local health care market." http://www.cleveland.com/healthfit/index.ssf/2015/10/cleveland_clinic_to_open_health_care_facility_in_pricey_central_london.html

- A use swap is not a mandatory requirement, and planning authorities consider other compensatory provisions e.g. payment of a fee to compensate for the reduction of residential space.
- The use swap system only applies to residential property, and does not affect the acquisition of commercial buildings.
- As the CMA now concedes, it only applies to the Harley Street Special Policy Area and does not affect any other part of central London.

3.21 The CMA has not presented any other evidence that the planning regime constrains new hospital development. HCA has cited substantial evidence that C2 planning consents have been granted on numerous occasions for new NHS and private hospital sites.⁴³

3.22 It follows that even if the CMA disregards all of HCA's points regarding use swaps, the CMA's findings can be put no higher than that the planning regime is a potential barrier to entry in respect of the conversion of residential property for hospital use within the Harley Street Special Policy Area. This does not form a reasonable basis for the CMA's conclusion in paragraph 5.57 of the PFs that planning constraints generally "increase" the barriers to entry facing hospital operators.

3.23 The CMA asserts that the planning permission granted to HCA for the Shard "*would not have been forthcoming for another healthcare/medical facility's operator*" (paragraph 5.55, PFs). This is wrong. HCA has sought the expert opinion of its planning consultants, Rolfe Judd Planning ("Rolfe Judd"), who advised HCA in relation to this planning application. A copy of Rolfe Judd's opinion is attached in **Annex 2**. This states:

- The use of "personal planning conditions" is in fact discouraged in central government planning guidance to local authorities and therefore is not common.
- ✂.
- ✂.
- ✂ therefore rejects the CMA's unfounded assertion that such permission would not have been forthcoming for another healthcare/medical facility's operator.

3.24 The CMA also asserts that Westminster City Council's ("WCC") "*interim approach of halting office to residential conversions is not of direct relevance to hospital operators since the aim is specifically to protect office use, rather than other social and community uses*" (paragraph 5.56, PFs). This issue is also addressed in Rolfe Judd's opinion. Again, the CMA's comment is wrong. As Rolfe Judd notes, WCC's interim approach is designed to halt office to residential conversions, but not conversions from office to alternative commercial use. Rolfe Judd notes: "✂".

Recent and potential future new entry

3.25 In response to the evidence which HCA has submitted of new entry and expansion in central London, the CMA has grouped the evidence into six categories.

Category 1

⁴³ See e.g. HCA's submission on structural AECs, 1 May 2015, paragraphs 3.54-3.58, and 3.67.

3.26 The CMA argues that the examples of expansion merely involve *"upgrades, refurbishments, or minor extensions to existing facilities ... rather than the development of significant new capacity"* (paragraph 5.68(a), PFs). As stated above, this is incorrect. The Bupa Cromwell, TLC and Aspen have all increased both bed capacity and revenues since 2011 and have expanded their service offerings. Other providers, including the Hospital of St. John and St Elizabeth, and BMI have also launched new services. Several NHS PPU's (including the Royal Marsden and Chelsea and Westminster) have similarly grown their capacity and revenues. There have been no significant barriers to this growth. It is a misinterpretation of the evidence to dismiss these examples as merely minor upgrades, refurbishments or extensions.

3.27 Indeed, TLC is continuing to grow and a recent article (attached in **Annex 3**) notes that TLC has secured £65 million funding from HSBC to expand its facilities: *"including provision of new and improved theatre capacity, intensive care and radiology facilities [which] will allow the London Clinic to continue to provide cutting edge healthcare to a higher number of patients, many of whom come from around the world to seek treatment."* Again, a £65 million capital expenditure programme which creates new capacity cannot be dismissed as "minor".

Category 2

3.28 Contrary to the CMA's assertion, HCA has not provided any examples of expansion that are merely as a result of a change of ownership. Nuada has expanded by launching new clinical services not merely by acquiring existing business: its recent press release states *"The move into 19 Harley Street follows **Nuada's successful entry into providing surgical services in gynaecology, urology and spine which began in January 2015** and builds upon its strong base in the imaging and diagnosis of prostate cancer"*.⁴⁴ This growth has come through the recruitment of new consultants. HCA also referred to the fact that Nuada is also believed to have leased space within BMI's Weymouth Hospital to provide inpatient treatments, and this is relevant to showing how outpatients/day case providers are increasingly a source of new entry into the provision of inpatient care.

Category 3

3.29 Likewise, HCA has not provided any examples of *"NHS hospitals expanding their capacity to treat NHS patients"* (paragraph 5.68(c), PFs). Again, the CMA has misinterpreted HCA's submissions. All the evidence relating to NHS expansion and growth relates only to PPUs in respect of private patients. HCA referred to the fact that planning consent has been given to certain NHS hospitals (Barts, UCLH, and Chelsea and Westminster) but this was in the context of showing that there is no barrier to the granting of planning consent for either NHS or private hospital developments.

Category 4

3.30 The CMA's assertions (paragraph 5.68(d), PFs) about new specialist clinics which have recently entered the market are also unfounded:

- Fortius Group's new orthopaedic facility, Optegra's new eye clinic, the Harley Street Eye Clinic, and Advanced Oncotherapy, have all announced new facilities within a space of just 18 months since the date of the Final Report. This reflects the rapid pace of change in the sector. This growth will undoubtedly continue and further specialist clinics will continue to enter the market.

⁴⁴ HCA's submission on investment and expansion, 24 August 2015, paragraphs 3.3-3.4 and Exhibit 5.

- Specialist providers are key competitors for the particular services they provide. Fortius Group, for example, is a leading orthopaedics provider with 50 consultants (more orthopaedic consultants than at any other central London hospital including any HCA hospital). They are a significant competitive constraint in the fields in which they operate.
- The establishment of the Harley Street Eye Clinic is a case study which illustrates how easy it is for new specialist clinics to start up (even in Harley Street) and commence activity in a short time frame. The article in Independent Practitioner, which HCA recently submitted to the CMA,⁴⁵ described precisely how straightforward it was for this new entrant to find premises, recruit staff and launch business within approximately one year.
- A recent article in HealthInvestor about the new Optegra eye hospital (attached in **Annex 4**) similarly demonstrates ease of entry. The new hospital was formed by converting two adjacent houses in Queen Anne Street, off Harley Street to create an 11-bed facility with ophthalmic theatres over six floors.
- The CMA continually repeats its assertion that there are difficulties in acquiring sites, but the evidence shows otherwise. Fortius Group, Advanced Oncotherapy, Optegra, and the Harley Street Eye Clinic have all found suitable new sites in and around Harley Street, and secured the necessary planning consents without any difficulty. In addition, Howard de Walden has previously provided evidence of developing a new building at 11 Harley Street for Isokinetics, an Italian sports injury clinic.⁴⁶ The CMA states that another new entrant, Proton Partners International, has not yet identified a suitable site in central London but it has only just publicly announced its intention to launch a new business and there is no indication that it is encountering any difficulty in identifying suitable sites.

Category 5

- 3.31 The CMA notes that the new Barts PPU represents "mid-sized" new entry in 2017. As stated above, the new PPU is expected to be a significant new competitor in the fields in which it specialises. HCA notes the CMA's comments that King's has put on hold its plans for a new PPU, but the fact remains that this may well be an option which King's seeks to explore in the future. In addition, the LaingBuisson Report notes that King's has "*plans to move the existing private patients to a new wing and increase the capacity from 21 to 38 beds in the summer of 2015*".⁴⁷

Category 6

- 3.32 The CMA notes that VPS and the Cleveland Clinic have announced plans to enter the market but that these were at an early stage and therefore "*uncertain at the current time*" (paragraph 5.68(f), PFs). Both VPS and the Cleveland Clinic are substantial, well-resourced and experienced healthcare operators. They have both committed large scale investment in central London. The only issue for the CMA appears to be the time frame in which they do so.

⁴⁵ Nabarro letter to CMA dated 12 October 2015.

⁴⁶ HCA's submission on site availability in and around Harley Street, paragraph 4.

⁴⁷ LaingBuisson Report, page 122.

- 3.33 As far as VPS is concerned, it has publicly stated that it intends to open a new hospital on the Ravenscourt Park site in 2017.⁴⁸ This is realistic, since there are existing hospital buildings which only require refurbishment and fitting-out. The CMA refers to ✂ but the CMA does not explain why ✂ would necessarily interfere with VPS's proposed launch date. In any event, ✂ and therefore the CMA cannot reasonably conclude that *"it is uncertain whether VPS will be able to enter the market"*.
- 3.34 As far as the Cleveland Clinic is concerned, the site has already been acquired. The CMA notes that the Cleveland Clinic has not yet announced precise plans for the site or obtained planning consent, but there is no evidence that this would take any more than two to three years to re-develop the site and establish a new hospital.
- 3.35 HCA understands that ✂.
- 3.36 Further, HCA would point out that it is in the commercial interests of new entrants such as the Cleveland Clinic and Spire to delay any announcements as to their precise plans until the conclusion of the CMA's decision in this market inquiry.
- 3.37 The CMA argues that there has been no large scale entry in central London in the last decade and that this is *"consistent"* with the existence of barriers to entry (paragraph 5.69, PFs). However, it does not follow that it is barriers to entry (as opposed to other factors) which have deterred new entry within this period. There has been a severe economic downturn in recent years. The CMA has cited in the Final Report a number of cases where operators faced difficulty in launching or expanding facilities, but in all of these cases the operators had financial difficulties caused by the lack of financing. With the improvement in the economy, access to capital is easing and there is now considerable investor appetite for new projects. There is no evidence that the lack of large-scale entry has been due to structural barriers to entry rather than access to finance.
- 3.38 The CMA is also wrong to say there has been only one example of significant expansion, that of TLC's cancer centre. King Edward VII is currently undergoing a 30% increase in its capacity. HCA has also expanded its existing hospitals and outpatient/diagnostic centres by acquiring new sites. Aspen has increased bed capacity at the Highgate Hospital by 53%. In addition, as shown by Table 1 above, the Cromwell, Royal Brompton and Royal Marsden have all increased capacity since 2011.
- 3.39 In any event, it is apparent from the evidence before the CMA that over the next few years there will be significant new entry and expansion in central London:
- Barts' new PPU will commence in 2017
 - Spire has indicated potentially two new hospitals opening in central London in 2018
 - on the CMA's own analysis, there will be at least ✂ available to new entrants in 2016/2017 and at least ✂ available by 2019/2020
 - VPS is keen to enter central London and has stated that it intends to launch a new hospital in 2017
 - Cleveland Clinic has also made a major investment and has acquired a site which would support a 150-bed hospital

⁴⁸ VPS press release dated 28 July 2015, attached to Nabarro's letter to CMA dated 29 July 2015.

- a number of smaller specialist clinics are emerging in fields such as orthopaedics, ophthalmology, and cancer treatment
 - PPU's have expanded and are continuing to expand and have published ambitious growth targets for the next few years.
- 3.40 This represents an impressive pipeline of new entry and expansion. It contrasts starkly with the CMA's findings of a flat and static healthcare market outside central London. It undermines the CMA's finding that there are barriers to entry and expansion and that there is any need for remedial measures.
- 3.41 The CMA argues that new entry may occur over "*a longer time frame, for example the next five years*". However, even if this is correct, the CMA is still obliged to take this new entry into consideration both in assessing whether there is an AEC and in formulating any remedy:
- The CMA's Guidelines for market investigations state that the CMA will consider "*the likelihood of entry within a time scale that would bear on the incentives and decisions of the existing firms in the market*".⁴⁹ Bearing in mind the cycle of PMI/hospital contracts which are typically re-negotiated every three years, it is highly likely that the next round of negotiations with PMIs will take place in a market which is seeing further new capacity being developed.
 - The CMA should also be mindful of the likely date of implementation of any divestment remedy which, following appeal procedures and any divestiture period, is unlikely to be realised until 2019/2020 at the earliest by which time, even on the CMA's own analysis, further large-scale entry will have taken place.
 - The CMA has sought to project the costs and benefits of a divestiture remedy over a 20-year period. It is therefore bound to take into account likely entry and expansion into the market over a five year, or even longer, time frame, and not merely short-term entry.

Conclusion

- 3.42 HCA has submitted to the CMA throughout this inquiry that central London has the most robust record of new entry and expansion of any local healthcare market in the UK. Developments over the last 18 months have borne this out.
- 3.43 In the light of announcements of new entry by Barts, Spire, VPS and the Cleveland Clinic – not to mention the host of smaller specialist clinics which are also emerging – the CMA cannot credibly maintain that there are significant barriers to entry and expansion which are deterring new market entrants.

⁴⁹ CMA Guidelines for market investigations (CC3 (revised)), paragraph 230.

4. QUALITATIVE ASSESSMENT OF BARGAINING STRENGTH

Key points

The CMA's qualitative assessment of bargaining strength suffers from serious shortcomings, in particular:

- The CMA's bargaining framework is substantially incomplete and, as a result of a misguided application of economic theory, the CMA is unable to determine reliably the relative bargaining strength held by PMIs and hospital operators, the extent to which the bargaining surplus is shared between parties, and, crucially, the impact of any change in market concentration on bargaining outcomes.
- The CMA cannot reasonably discount PMI bargaining power merely because it considers that it does not "completely" prevent the exercise of any market power by hospital providers. That is not a legitimate approach to the assessment of bargaining power.
- The CMA has not considered the extent to which HCA's bargaining power is attributable to factors other than local market concentration (e.g. its reputation for better quality and range), and the important consequences such other factors have for its AEC findings and remedy proposals.
- On closer examination of PMI evidence, the relative harm that PMIs purport they would suffer as a result of de-listing one or more of HCA's hospitals has been vastly overstated and, when comparing the relative strength of outside options, the strength of HCA's outside option pales by comparison to that held by a major PMI.
- Open referral has grown at a relatively rapid rate since its inception and has become "normalised" in the market through its significant uptake to date and through the marketing efforts of PMIs. Guided referral offers a new mechanism for PMIs to steer policyholders toward 'preferred' healthcare providers using means that go well beyond those adopted in open referral.
- Recent developments have shown that the PMI market is becoming increasingly concentrated, which narrows even further the outside options of hospital operators.

Bargaining economic framework

- 4.1 Each party's outside option and the way in which the 'bargaining surplus' is shared (the "sharing rule") are the two key determinants of bargaining outcomes, where such outcomes include price and non-price factors affecting PMIs and patients.
- 4.2 A proper assessment of each party's outside option and the sharing rule is critical in informing any conclusions about bargaining outcomes. This includes conclusions about any link between these outcomes and their postulated drivers, including market shares or local market concentration.
- 4.3 Whilst the CMA appears to recognise that consideration of outside options and the sharing rule is important for determining bargaining outcomes (paragraph 6.11, PFs), its assessment of how they do so suffers from serious shortcomings. As a result, the CMA is unable to form any reliable conclusion as to the impact of market concentration on bargaining outcomes through their impact on outside options or the sharing rule. By extension, the CMA is also

unable to form any reliable conclusion as to the impact of any remedy that seeks to redistribute bargaining power from HCA to the PMIs.

4.4 The shortcomings of the CMA's approach fall into three categories:

- (a) The CMA has not assessed the outside options of PMIs and hospital operators jointly;
- (b) The CMA has not formed an accurate understanding of the sharing rule; and
- (c) The CMA has not considered what a shift in bargaining power towards PMIs will imply for patients.

The CMA has not assessed both parties' outside options jointly

4.5 The CMA states that "*HCA argued that we focused our analysis on the outside options of PMIs, despite acknowledging that the bargaining outcome would depend on both hospital operators' and PMIs' outside options*" (paragraph 6.6(a), PFs).

4.6 This is a mischaracterisation of HCA's submission. While the CMA did refer to hospital operators' outside options in its Final Report, crucially, it failed to *weigh* the strength of HCA's outside option directly against the strength of the outside options available to PMIs. That is, to assess HCA's bargaining strength **relative** to the PMIs'. Without doing so, the CMA cannot form a reliable view of what bargaining outcomes will be.⁵⁰

4.7 It is only after weighing up the respective strength of each party's outside option, side-by-side, that it is clear to any reasonable observer that the bargaining strength of insurers, such as Bupa and AXA-PPP, vastly outweighs HCA's. While we address this issue in further detail below, put simply, in the case of a de-listing by Bupa, Bupa projected it would incur a relatively small financial loss of between £~~10~~),⁵¹ in HCA's case (where Bupa represented around £~~10~~, or ~~10~~%, of HCA's PMI revenues in 2014), the result would be ~~10~~. When comparing the relative bargaining strength of HCA and PMIs, the inescapable conclusion is that the strength of HCA's outside option pales by comparison to that of a major insurer.

The sharing rule

4.8 As noted in a previous submission by HCA's economic advisers, KPMG,⁵² the sharing rule is the **key** parameter for determining how the relative balance of bargaining parties' outside options translates into the overall bargaining outcome. The sharing rule is of particular importance when both sides have much to lose from a breakdown (as the CMA provisionally concludes in the case of bargaining between private healthcare operators and PMIs), since the surplus to be shared between the parties would be large, and hence different values of the sharing rule could lead to substantially different bargaining outcomes.

4.9 The CMA therefore must have an accurate understanding of the sharing rule if it is credibly to conclude on the relationship between outside options and bargaining outcomes. Specifically, the submission by KPMG showed that:⁵³

⁵⁰ See HCA submission of 1 May 2015, paragraphs 5.12-5.14 for a discussion of the importance of considering both parties' outside options when assessing bargaining outcomes

⁵¹ Final Report, Appendix 6.10, Annex A, Figure 2.

⁵² The CMA's Assessment of Negotiations Between Hospital Operators and PMIs and the Economics of Bargaining, KPMG LLP, 8 May 2015, paragraph 20.

⁵³ *Ibid.*

- (a) bargaining outcomes depend not only on the outside options of both parties but also on the sharing rule,⁵⁴ and that to evaluate the current balance of bargaining power and what bargaining outcomes would be, they must be considered collectively;
- (b) the sharing rule is also the key factor determining the **impact** of a change in either party's outside option on the bargaining outcome;
- (c) the fact that a wide range of sharing rules have been estimated in the empirical academic literature across different industries means the CMA cannot simply presume the value that the sharing rule might take; and
- (d) because several factors that determine outside options can be reasonably expected also to affect the sharing rule, and because PMIs' outside options appear to be considerably more valuable than HCA's outside options, the sharing rule is likely to be **heavily tilted** in favour of PMIs.

4.10 The CMA acknowledges, however, that it has been unable to evaluate the sharing rule (which it refers to as "relative bargaining strength") between HCA and the PMIs:

"based on our review of submissions and internal documentary evidence, we did not draw any precise conclusions on the extent of parties' relative bargaining strengths and the way that they share the surplus. Our analysis [...] did not enable us to determine how their respective bargaining strength affects the bargaining outcome" (paragraph 6.9, PFs).

4.11 The fact that the CMA has been unable to evaluate the sharing rule means that it cannot credibly draw any conclusions about the relationship between outside options (and by extension, supposed determinants of outside options such as market shares) and bargaining outcomes.

4.12 Despite conceding that its analysis "*did not enable [it] to determine how [HCA's and the PMIs'] respective bargaining strength affects the bargaining outcome*", the CMA proceeds by considering only whether: (i) the sharing rule is such that HCA would have no bargaining power and the PMIs would therefore be able to extract all of the bargaining surplus – which the CMA describes in this case as the PMIs having "countervailing power" (paragraph 6.76, PFs) – or (ii) the sharing rule is "extreme" in the sense that hospital operators earn "a very small share" of the bargaining surplus.

4.13 At paragraph 6.73 of the PFs, for example, the CMA notes:

- *"We considered that both parties to the negotiations are extracting **a share** of the surplus and therefore the provider retains some market power in the negotiations."*
- *"Therefore, we consider that HCA is likely to still be able to extract **a share** of the bargaining surplus in negotiations with Aviva and VitalityHealth."*

4.14 And at paragraph 6.77 the CMA concludes that "*an **extreme** sharing rule [...] is [not] a plausible description of negotiations in the central London private healthcare market*" (paragraph, 6.77, PFs).

⁵⁴ Note that in the academic literature the "sharing rule" is sometimes referred to as each party's "bargaining weight".

- 4.15 While the CMA does not seem to be clear or consistent in its use of the term countervailing power in the PFs,⁵⁵ the CMA is in any case applying an unreasonable standard against which to gauge HCA's bargaining strength. Based on these findings from the PFs, the suggestion by the CMA is that if HCA manages to extract any share at all from its bargaining with PMIs, there can be no basis for asserting that HCA is subject to sufficiently strong "countervailing" bargaining power.
- 4.16 Contrary to the CMA's misplaced belief, buyer power is not binary. There can be varying degrees of it. As noted in the CMA's Guidance on NHS hospital mergers,⁵⁶ a customer has countervailing buyer power "*when it has the negotiating strength to limit a provider's ability to raise prices or lower quality*".⁵⁷ This is an important point for the CMA to grasp as it is also relevant as to the effect any remedy proposal would have on the market.
- 4.17 Moreover, given the CMA's observation that "*typically [in a bilateral bargaining context], an agreement is reached if both parties receive some financial benefit above and beyond the value of their outside options*" (paragraph 6.4, PFs), the CMA would presumably draw a similar conclusion about the supply-side of every market characterised by bilateral bargaining, if applying the same standard. It is therefore hard to see how the CMA would **ever** conclude that countervailing power exists in bilateral negotiations.
- 4.18 In any case, the CMA's considerations are not relevant for the purpose of its analysis, since even if HCA were able to earn some amount of the bargaining surplus, the sharing rule may **still** be heavily tilted in favour of the PMIs, and (in conjunction with the PMIs' relatively valuable outside options) the balance of bargaining power overall may still lie heavily with the PMIs. To determine the extent to which this is the case, the CMA must form an understanding of the sharing rule over and above simply whether it is "extreme" or not.
- 4.19 In response to HCA's contention that, given the wide range of sharing rules that have been estimated in the empirical academic literature, the CMA cannot simply presume the value, or range of values, of the sharing rule, the CMA stated that in its view the "*wide range of estimated bargaining strengths that HCA cited from the academic literature reflects the difficulties and uncertainties around estimating bargaining strengths rather than the prevalence of extreme sharing rules*" (paragraph 6.10, PFs).
- 4.20 Whilst the empirical estimation of sharing rules will of course be subject to uncertainty, as is true of any statistical analysis, the CMA has provided no actual evidence in support of its claim that the confidence intervals of estimated sharing rules presented by HCA reflected "*the difficulties and uncertainties around estimating bargaining strengths rather than the prevalence of extreme sharing rules*" (paragraph 6.10, PFs).
- 4.21 In fact, a review of the results of one of the healthcare-specific studies cited by KPMG relating to the healthcare industry shows that the CMA's interpretation is incorrect in this case. In Grennan (2013) and Grennan (2014),⁵⁸ the range of sharing rules reflects a range of

⁵⁵ The CMA refers to countervailing buyer power variously as "[*that*] which is sufficient to offset the exercise of market power by HCA" (paragraph 30); "[*that*] which completely prevents the exercise of market power by hospital providers" (paragraph 6.78) and "*buyer power which prevents the exercise of market power*".

⁵⁶ CMA guidance on the review of NHS mergers (CMA29), paragraph 6.79.

⁵⁷ Also see CC2 (revised), "*an individual customer may be able to use its negotiating strength to limit the ability of a merged firm to raise prices. Authorities refer to this as countervailing buyer power.*" Merger Assessment Guidelines, paragraph 5.9.1.

⁵⁸ See Grennan, M., 2013, Price discrimination and bargaining: Empirical evidence from medical devices, American Economic Review 103, 145-177; and Grennan, M., 2014, Bargaining ability and competitive advantage: Empirical evidence from medical devices, Management Science 60, 3011-3025.

sharing rule estimates covering 96 buyers (hospitals), and multiple sellers of 11 different medical products⁵⁹ over a 3.5 year period, and not simply a confidence interval around a single estimated sharing rule. In fact, the average sharing rule as reported in Grennan (2013) is 0.33 (from the perspective of the seller), meaning that the buyer on average captures 67% of the bargaining surplus, and this is estimated with a very low margin of error.⁶⁰ This shows that in spite of the wide range of individual sharing rules, the average overall sharing rule is in this case substantially tilted towards buyers, a result that can be stated with a fairly high degree of statistical confidence.

- 4.22 Furthermore, the CMA, in focusing only on whether the results cited provide evidence that there is a 'prevalence' of extreme sharing rules, misses the point. HCA presented this evidence in support of its view that the CMA cannot simply presume that sharing rules do or do not take particular values, **in particular** because estimates of seemingly "extreme" sharing rules are not rare, and importantly, it is not only "extreme" values of the sharing rule that would have significant implications for the CMA's analysis.
- 4.23 The conclusions in paragraphs 6.44, 6.56, 6.61 and 6.70 of the PFs,⁶¹ as well as the CMA's additional points about the uptake of restricted network policies and open referral policies, all relate to the CMA's assessment of how strategies available to PMIs affect their outside options in negotiations with HCA, and the conclusion in paragraph 6.33 of the PFs relates to an evaluation of **PMIs'** outside options in the case of a full delisting. While the relative balance of **both** parties' outside options may reveal information about the likely value of the sharing rule, a simple assessment of only PMIs' outside options cannot.

Implications of a change in bargaining power

- 4.24 The relative bargaining strength of hospital operators and PMIs manifests itself in a range of outcomes that are directly or indirectly influenced by the parameters over which both parties negotiate. Specifically, negotiations between PMIs and hospital operators determine:
- (a) The price paid by PMIs for services to insured patients;
 - (b) The range of services offered (through the ability of PMIs to recognise or otherwise facilities and individual treatments); and
 - (c) The quality of services provided insofar as the returns earned on previous investments in developing high quality services are affected.
- 4.25 HCA has previously submitted that in this case it is particularly important for the CMA to consider the incentives that PMIs have to exercise their bargaining power in a way that is in the interest of patients, and that there is evidence that PMIs do not share the same incentives as patients.
- 4.26 While the CMA determined in the Final Report that PMIs are relevant "customers" of private hospital operators (paragraph 11.160, Final Report), HCA notes that in his recent dissenting judgement in the Tribunal's recent judgment in *Federation of Independent Practitioner*

⁵⁹ These are all types of 'coronary stent'.

⁶⁰ Grennan (2013) shows that the standard error of the mean bargaining weight (0.04) is eight times smaller than the mean (0.33). Note that as standard errors are simulated, confidence intervals cannot be inferred.

⁶¹ Respectively, "PMIs will also be severely impacted by full delisting, as they would incur costs of sending patients to alternative hospitals" (paragraph 6.33) "the presence of restricted networks does not necessarily strengthen PMIs' bargaining strength" (paragraph 6.44), "service line tenders can but do not necessarily improve the PMIs' outside options against HCA" (paragraph 6.56), "PMIs are able to withhold recognition for new facilities" (paragraph 6.61), and "PMIs are, in principle, able to use open referrals to direct patients away from HCA and this has potentially improved PMIs' outside options to some extent" (paragraph 6.70).

Organisations ("FIPO") v CMA, 29 April 2015, Mr Dermot Glynn stated that PMIs' significant bargaining power over consultants may give rise to an AEC due to the misalignment of PMIs' and patients' incentives, and that PMIs should not be considered as relevant "customers":⁶²

- *"The 2002 Act requires the CMA to take account of adverse effects on innovation when considering whether action should be taken to remedy, mitigate or prevent any detrimental effect on consumers resulting from the AEC" ... "In the present case, the consumers are patients, not intermediaries such as PMIs or employers"*
- *"it is [...] obvious that PMIs also have other incentives, and that these may sometimes conflict [with those of employers and policyholders]. This is why [...] PMIs sometimes steer patients towards fee-assured or fee-capped consultants and sometimes threaten to de-list consultants on purely financial grounds. It is also why they sometimes steer patients towards low-cost medical solutions. In concluding that "[i]nsurers increasingly determine not only fee levels but also which consultants a patient may see", the CMA suggests that it expects this trend to continue [...]"*
- *"PMIs have significant buying power in relation to consultants and are also in a strong position in relation to individual policy-holders. It was not reasonable of the CMA to expect that the fundamental conflicts of interest affecting PMIs would not give rise to an AEC"*

4.27 This is consistent with HCA's previous submissions to the CMA on PMIs' interests. As HCA has shown, PMIs' incentives primarily relate to minimising their total cost of claims as far as possible, whereas it is in the patients' interest, at the point of requiring treatment, to receive prompt and high-quality treatments to maximise their clinical outcome. PMIs can minimise their costs by steering patients towards lower-quality hospitals through guided referral policies, and by other means of interfering in the patient pathway. For example by steering patients towards fee-capped consultants, as noted by Mr Glynn in *FIPO v CMA* (see paragraph 4.26). They can also achieve it by not recognising new innovative treatments such as those only available at the NHS, such that at the point of requiring any of those treatments, patients would use the NHS.⁶³ Crucially, in all these cases, the PMIs can lower their costs and increase their profits by reducing the range and quality of services available to their policyholders.

4.28 The CMA's view that it is in the patients' interest to move bargaining power to favour the PMIs is not based on evidence and is misguided. In light of the fact that PMIs' and patients' incentives are not aligned, the CMA must consider what the long-term implications for current and future patients of such a distribution of bargaining power would be for innovation, investment and product choice. This would require both an analysis of the channels through which bargaining power affects incentives to invest and of the different possibilities and capabilities that PMIs and hospitals have to materially affect product choice and innovation through their investments. The CMA has provided no arguments or evidence that would suggest that dynamic efficiency would be improved by enhancing the bargaining power of PMIs relative to HCA.

⁶² *FIPO v CMA* [2015] CAT 8, 29 April 2015, paragraphs 76, 91 and 94.

⁶³ See, for example, Response to the CC's Provisional Decision on Remedies, paragraph 6.19-6.21; HCA's response to the CC's notice of possible remedies, paragraph 6.28; HCA's supplemental submission following HCA's remedies hearing, paragraphs 1.8-1.12.

- 4.29 For example, various papers in the academic literature on bargaining have focused on the negative role of the exercise of buyer power on supplier's incentives to invest and innovate.⁶⁴ These have shown that in the context of bilateral bargaining, an all-else-equal increase in the buyer's relative bargaining power can have the immediate effect of reducing the seller's incentives to invest and innovate.
- 4.30 The CMA would not, therefore, be justified in concluding that any change in the relative bargaining power in favour of PMIs would definitively be in the interest of patients. Furthermore, in line with the dissenting judgement from the FIPO CAT appeal, the CMA should not treat the evidence provided by PMIs as it would evidence from "customers" in a different market. It must recognise that PMIs have interests to pursue that are not aligned with those of patients and subject their evidence to a sufficient level of scrutiny.


Determinants of bargaining power

- 4.31 The CMA states that the "*competitive position of hospitals at the local level*" is an important factor that both PMIs and hospital operators take into consideration in their negotiations over insured prices (paragraph 6.25, PFs), and that "no party has submitted any new evidence or argument indicating otherwise, so we provisionally readopt this finding".
- 4.32 When assessing "local competitive conditions", the CMA principally relies on the role of "local concentration". The CMA refers to the following finding in the Final Report (paragraph 6.5, PFs):
- "the availability of other hospitals to which the PMI can divert its customers in each local area in case of a full de-listing is an important determinant of PMIs' outside options. PMIs' outside options will depend on the hospital operator's average local concentration across its portfolio of hospitals. If average local concentration is higher, it will be more difficult for a PMI to find substitutable hospitals in local areas, which will weaken a PMI's outside options. This gives rise to a positive relationship between average local concentration and insured prices, other things being equal."*
- 4.33 The CMA is incorrect that HCA has not submitted any new evidence or argument in respect of its finding about the role of local competitive conditions. During the course of this remittal, HCA has noted that prices will reflect local market concentration only "*where HCA's market share is the result of its hospitals attracting patients mainly as a result of the weak competitive constraints in their location*";⁶⁵ and HCA has submitted evidence from its economic advisers that shows that there is sufficient spare capacity in central London for each and every insurer to divert all of their policyholders in any given day to other private hospitals.
- 4.34 The CMA, almost as an aside, refers to footnote 397 of its Final Report:

⁶⁴ This argument is formalized, for instance, in Battigalli et al. (2006) and, more recently, in Inderst et al. (2015). Other papers in the literature derive a more nuanced picture, such as Chen (2014), where the impact of a change in buyer power through various channels can increase or decrease welfare by affecting available choice as well as efficiency enhancing process innovation. While much of the literature is framed in terms of the interaction between retailers and their suppliers, the applicability is clearly wider. For instance, Peters (2000) shows in an empirical analysis how increased buyer power increased the possibility to appropriate rents from innovations, and negatively affects suppliers' incentives to innovate.

⁶⁵ A Submission on the Analysis of Insured Prices, KPMG, 1 May 2015, paragraph 62.

"We also stated that PMIs' outside options will not only reflect local concentration, but are more generally related to their ability to divert policyholders under the terms of the policy away from the delisted hospital."

- 4.35 It is this latter statement by the CMA which exposes a **major omission** in the PFs. The existence of factors other than local concentration and barriers to entry which influence the PMI's *"ability to divert policyholders under the terms of the policy away from the delisted hospital"* is of crucial importance to both the existence of an AEC and the CMA's remedy proposals, yet the CMA fails to deal with this 'elephant in the room'.
- 4.36 The fact that there is sufficient spare capacity for any insurer to transfer all of its policyholders to non-HCA hospitals in central London  in conjunction with both the CMA's previous conclusion that location within central London is not relevant for an assessment of the effectiveness of a divestment remedy (paragraph 11.99, Final Report) and with the fact that all major PMIs have policies that exclude HCA hospitals, makes clear that patients of any individual PMI do indeed have the ability to divert away from HCA. If this is not largely observed, this is not related to the location of HCA's hospitals. The key question is whether PMIs have the incentive to restrict their policyholders from accessing HCA hospitals. This will depend on a number of factors that are likely to be unrelated to HCA's overall share of supply in central London.
- 4.37 One such factor highlighted in PMI submissions is HCA's quality and reputation as perceived by PMI corporate customers. For example, AXA-PPP submitted the following to the CMA:
- "Regarding spare capacity, AXA-PPP stated that there may theoretically be sufficient capacity in relation to available beds and operating theatre hours among other hospital operators which might mean it would conceivably be able to redirect its business [away from HCA] in a mathematical sense. However, even if that was the case, only a small subset of its clients would be prepared to submit to redirection because of HCA's **reputation**. In terms of factors constraining insurers' ability to de-list or switch away from HCA, capacity – even if it was more broadly defined as including consultants, equipment, facilities and beds – was only one factor, but the second important factor was **reputation**."*
- 4.38 This point was expanded upon by AXA-PPP in their written submissions to the CMA:
- "PMIs cannot credibly threaten to de-list or switch away sufficiently from HCA because the collective capabilities (i.e., "spare capacity" in the widest sense of consultants, equipment and facilities) of rivals are not a credible alternative not only in terms of absorption of demand but **critically also (or in any event) as a result of corporate customer preferences for HCA facilities to which PMIs must align their offer.**"*
- 4.39 The issue of quality and reputation is also relevant to the PMIs' insistence that HCA operates "must have" hospitals. The CMA refers to this assertion several times in the PFs,⁶⁶ but at no point explains what is meant by "must have". In the Final Report the CMA noted that *"there is no clear definition of a 'must-have' hospital and [PMIs'] views will reflect individual strategic considerations"* (paragraph 6.173, Final Report) and *"insurers do not necessarily characterize hospitals in the same way: what may be a 'must-have' hospital for one insurer*

⁶⁶ For example, in relation to the HPA joint venture, the CMA states "we consider that it is likely that HCA would still retain some degree of bargaining strength, as HCA would still benefit from all the features that make its hospitals 'must-have' in the view of both Bupa and AXA-PPP" (paragraph 6.73, PFs).

will not necessarily be regarded as a 'must-have' hospital for another insurer" (paragraph 6.297, Final Report). However this ambiguity is not referred to by the CMA in the PFs.

- 4.40 The evidence available to the CMA (covering spare capacity and perceived quality) points to in the fact that, if HCA's hospitals are "must have", this is due to HCA's high perceived quality, rather than to HCA's share of supply or the location of its hospitals in central London. The CMA has itself stated "*We [the CMA] recognize that the reputation of a business, either a group or a local hospital, may be developed over time by providing high-quality products or services*".⁶⁷
- 4.41 For example in the Final Report the CMA notes that AXA-PPP "defined the 'must have' private hospitals as comprising those healthcare facilities offering the strongest professional reputation for a broad range of treatments and those which we believe are a 'must have' for our large corporate clients".⁶⁸ It is not clear that PMIs' corporate customers consider hospitals "must have" on the basis of the share of supply of the hospital operator; instead, HCA's superior reputation and quality appear to be more plausible alternatives.
- 4.42 There have been other references to HCA's reputation for high quality care.⁶⁹ Indeed, it is in relation to this very issue, that HCA's bargaining strength is primarily dependent on HCA's reputation for a high quality, innovative service among PMI customers, that HCA made the following submission to the CMA:

"✂ If we do not give their customers great customer service and give them fantastic healthcare and so on, then we do not have any leverage in that negotiation ✂, the idea that one side has all the power I think completely misses the point. That is not the way it works."

- 4.43 The above submission is cited by the CMA at paragraph 6.14 of the PFs and, while we welcome its inclusion, it is disappointing to see that the CMA has misunderstood the point that HCA was making.
- 4.44 If HCA's negotiating strength is in fact attributable to factors other than market concentration and barriers to entry, specifically, because HCA has successfully built and maintained its reputation for high quality and complex care, this is the result of a pro-competitive process of competition, and signals competition delivering excellent outcomes for patients. That being the case, this would not provide support for the CMA's AEC finding, which instead attributes HCA's bargaining strength to market concentration and barriers to entry. Such a finding would similarly affect whether any remedy (and the type of remedy) that would be effective in the market. Specifically, if the 'issue' in the market is not the lack of spare capacity available for PMIs to switch to, then divestiture cannot and should not be the solution.

Hospital operator outside options - full de-listing

- 4.45 The CMA has readopted its earlier findings from the Final Report that "*hospital operators appear most unlikely to be able to replace any lost business rapidly and would be severely impacted by a major delisting*" (paragraph 6.26, PFs). The CMA added that the resulting loss

⁶⁷ Final Report, Appendix 6.13, paragraph 77.

⁶⁸ *Ibid.*, Appendix 6.10, Annex A, paragraph 42.

⁶⁹ For example, HCA's competitor, BMI, refer to HCA as having excellent quality hospitals that operated a high level of complexity (Final Report, Appendix 6.10, paragraph 53). AXA-PPP referred to all six of HCA's hospitals as being "elite" hospital facilities, "*elite hospitals being those that provided the strongest professional reputation for a broad range of treatments*" (Final Report, Appendix 6.10, Annex A, paragraph 42).

of consultants, following the delisting, is "*a major issue and a real risk*".⁷⁰ Separately, the CMA has remarked that a full de-listing would result in the "*destruction*" of HCA's business (albeit also to the relevant PMIs' business).⁷¹

- 4.46 To be clear, HCA's PMI revenues have been and remain absolutely critical to the viability of HCA's business. In 2014, they accounted for 80% of HCA's revenues.⁷²
- 4.47 Bupa alone accounted for around £100m of HCA's revenues in 2014 (over 80% of PMI revenues and 80% of total revenues),⁷³ while AXA-PPP accounted for over £100m of HCA's revenues (approximately 80% of PMI revenues and 80% of total revenues) and this increases by a further £100m once Simplyhealth revenues are included.
- 4.48 In addition to the direct financial loss of revenue from de-recognition by the PMI, the subsequent loss of consultants (via the 'consultant drag' effect) practising at HCA's facilities would multiply this loss. HCA previously submitted to the CMA, a de-listing by either BUPA or AXA-PPP would cause irreplaceable and unsustainably large losses to HCA, and almost certainly result in business failure:
- A BUPA de-listing would lead to HCA losing 80% of its total revenues (80% of its revenues through direct loss of recognition, and a further 80% of its revenue as a result of the consultant drag effect). Based on 2014 turnover figures, this would represent a loss of 80% £100m.
 - An AXA-PPP de-listing would cause HCA to lose 80% of its total revenues (80% of revenue through direct loss of recognition, and a further 80% of revenue due to the consultant drag effect). Based on 2014 figures, this would represent a loss of around £100m. Again, these figures did not include Simplyhealth revenues.
- 4.49 PMI market consolidation has further weakened HCA's outside option. For example in the case of Aviva / VitalityHealth (now represented by the 'Healthcare Purchase Alliance'), the combined healthcare purchaser would account for over £100m of HCA's revenues (80% of HCA's PMI revenues, based on 2014 figures). Once the loss of consultants via the consultant drag effect is also taken account of, the extent of the losses would similarly be multiplied.
- 4.50 Therefore, in the case of a de-listing by any one of the major insurers, 80% which far outweighs the financial impact on any PMI. HCA disagrees with the CMA's finding that the scale of the impact is in any way "similar" to the impact of a HCA de-listing on a PMI (paragraph 6.33, PFs).
- 4.51 Furthermore, the level of harm to HCA would be far in excess of the "substantial damage" inflicted on BMI following Bupa's de-listing of 37 hospitals in 2011/12.⁷⁴ In the case of the BMI delisting, BUPA de-listed just over half of BMI's hospitals. In the case of a de-listing of HCA's six central London hospitals alone,⁷⁵ this would represent 80% of HCA's **total UK revenues** (2014).

⁷⁰ *Ibid.*

⁷¹ Transcript of hearing on 13 August 2015, The Panel Chairman, page 33, line 7.

⁷² Financial information provided to the CMA in HCA's response to CMA questionnaire, 26 August 2015, Annex 2.

⁷³ Revenues based on 2014 figures.

⁷⁴ Final Report, paragraph 6.332.

⁷⁵ This percentage only takes into account revenues generated in the hospital itself. It does not therefore take account of the further loss of revenues to nearby outpatient and diagnostic facilities.

4.52 The stark inequality of bargaining power between hospital operators and PMIs was confirmed by *PMIs themselves* in their submissions to CMA:

- (i) WPA informed the CMA that it "*believed there were advantages to (PMI) scale and there was a potential risk that the two larger insurers could be in a position where they could dictate terms with consultants and hospitals.*"⁷⁶
- (ii) Simplyhealth raised its concerns regarding major insurers de-recognizing hospitals. Simplyhealth informed the CMA that: "*In the event that a hospital was delisted by a major insurer, the concern was that this could impact the long-term sustainability of that hospital or hospital group.*"⁷⁷

PMI outside options

4.53 Before addressing each of the outside options considered by the CMA, HCA makes two overarching points which relate to the CMA's assessment:

- (i) As noted above, the CMA's assessment of "PMIs' outside options" has not distinguished between those determinants of outside options that may give HCA bargaining power because of its higher quality, range of services and reputation on the one hand, and those that may give HCA bargaining power because of its local market concentration on the other. This has important consequences for its findings. For example, the purported 'limited uptake' by PMI customers of hospital networks excluding HCA could equally indicate that PMIs' customers are **choosing** to use HCA's hospitals because of the perceived quality, breadth of services and brand reputation.
- (ii) The CMA refers in its summation of PMI outside options (e.g. paragraphs 6.30 and 6.47, PFs) to contractual clauses that HCA and PMIs have negotiated that stipulate a different price for different volumes. In short, this amounts to PMIs paying higher prices for lower volumes. The CMA uses this to suggest that HCA has bargaining power, since insurers would have to pay a higher unit price for their remaining patients. The CMA is aware that in a high-fixed cost business such as hospital operation, volume discounts can be an efficient way of allocating fixed costs across patient volumes, meaning that pricing will be cost-reflective and HCA passes on volume-based savings where they are available.

Full de-listing

4.54 In respect of the PMI's outside option of a full hospital delisting, the CMA has readopted its findings from the Final Report:

"We therefore provisionally readopt our finding in paragraph 6.316 of the Final Report that PMIs will also be severely impacted by full delisting, as they would incur costs of sending patients to alternative hospitals. They would be likely to have to pay higher prices to the delisted hospital operator due to reduced discounts. They could also lose future sales due to reputational damage" (paragraph 6.33, PFs).

4.55 The CMA characterised the harm to PMIs in implementing a hospital de-listing as follows:

- patient disruption

⁷⁶ WPA hearing summary, 6 February 2013, paragraph 23.

⁷⁷ Simplyhealth hearing summary, 1 February 2013, paragraph 46.

- loss of tariff discounts
- loss of future sales due to reputational effects, in particular, corporate customers.

4.56 However, when examining the above factors closely, it is evident that the level of supposed harm has been overstated by PMIs, and, in any event, is considerably smaller than the harm that would be inflicted on HCA following a delisting.

Patient disruption

4.57 While the CMA provisionally found that PMIs would incur costs of sending patients to alternative hospitals, the CMA did not account for the fact that PMI contract negotiations will commence well in advance of the contract expiry date. Generally, such discussions are initiated ☒ prior to expiry.

4.58 In the case of Bupa's de-listing of BMI hospitals, Bupa announced its decision to de-list 12 hospitals two months before the contract end date, before deciding to add an additional 25 hospitals one month before contract expiry.⁷⁸ In HCA's case, an insurer may decide to make such an announcement even sooner.

4.59 In addition to this pre-termination period, a PMI contract can include ☒. For example, ☒ with HCA contains the following provision:

"☒"⁷⁹

4.60 ☒.⁸⁰ That is, the contract is automatically extended for a further 9 months for AXA to manage its network transition.

4.61 For the avoidance of doubt, this was not a one-off provision for 2011. ☒".⁸¹

4.62 Therefore, ☒ would each have a significant period of time, before and after the official contract end date, to begin the process of phasing out network recognition of one or more HCA hospitals.

4.63 It is also very important to bear in mind that, ☒ HCA would have no incentive to cause disruption to patients undergoing treatment at HCA's facilities. It would not be in HCA's interests to cause disruption to patients' treatment pathways as this could have extremely serious repercussions for HCA, who provides care to, often, very sick patients. Any hospital operator faced with such circumstances would be compelled to continue providing care until a patient's treatment pathway had been safely concluded.

Loss of tariff discounts

4.64 For the same reasons set out above, it is misleading to suggest that PMIs face the immediate prospect of a price increase (or loss of discount) for patients undergoing or about to undergo treatment at HCA's hospitals.

4.65 During the contract termination notice period, HCA would be contractually bound to continue treating insured patients at the agreed rates. As noted above, this can provide the PMI with a significant period of time to manage its transition to de-listing one or more HCA hospitals.

⁷⁸ Final Report, Appendix 6.11, paragraphs 83 - 85.

⁷⁹ HCA / Bupa 2013 contract (main agreement), clause 5.4, submitted to CMA by email on 30 July 2013.

⁸⁰ HCA / AXA-PPP 2010 Agreement, clause 8.2.2. See HCA's response to CC First Day Letter.

⁸¹ *Ibid.*

4.66 During that time, Bupa can begin its process of directing new claims to alternative hospital facilities. ✂:

"✂."82

4.67 ✂.

4.68 ✂⁸³

4.69 ✂.

4.70 ✂.

4.71 ✂. Internal PMI documentary evidence relied upon by the CMA in its Final Report demonstrated that even the major PMIs (with larger cohorts of insured patients) were confident of being able to redirect a substantial proportion of their policyholders away from HCA hospital facilities. In the case of AXA-PPP, it believed it could re-direct ✂. BUPA projected that it could redirect up to ✂ to alternative providers.⁸⁴

4.72 It is now apparent that these PMI internal projections understate the extent to which patients could be redirected to alternative hospital facilities. KPMG's spare capacity analysis from the CMA's data room, which had the benefit of market-wide admissions and spare bed capacity data showed that ✂ could move all of their patients to rival hospital facilities located in central London alone. That is, without even taking account of the substantial spare capacity available in Greater London which, in the case of many patients, would be closer to their homes. With the benefit of this new information, HCA expects PMIs to be further emboldened in future negotiations with HCA.

4.73 In any event, notwithstanding such spare capacity findings, ✂. Specifically, Bupa projected a ✂ loss of between ✂ following a de-listing and ✂ if it could redirect a greater proportion of its patients than its estimate.⁸⁵ Given the overall breadth of Bupa's overall UK business, such an amount could be easily absorbed. AXA-PPP would have a ✂ number of patients to redirect than Bupa, so its ✂ would be expected to be ✂ still.⁸⁶

Lose future sales of policies due to reputational damage

4.74 The CMA accepted PMI views that they would suffer reputational damage and a future loss of sales as a result of a HCA delisting.

4.75 First, the extent of any loss in sales volumes would be significantly mitigated by:

- (i) A significant part of a PMIs customer base being captive. As noted by insurer, WPA, "... *private customers with identified existing medical conditions on their policy may find it difficult to switch insurer. Another insurer may well be unwilling to include pre-existing conditions in a new policy*".⁸⁷ This 'lock-in effect' would feature more

⁸² HCA / Bupa 2013 contract (main agreement), clause 3.4, submitted to CMA by email on 30 July 2013.

⁸³ AXA-PPP, 2010 Agreement, 8.2.2. Submitted to CMA in response to First Day Letter.

⁸⁴ Final Report, Appendix 6.10, Annex A, paragraphs 54 – 59 and Figure 2.

⁸⁵ Final Report, Appendix 6.10, Annex A, see Figure 2.

⁸⁶ AXA's own projection (Final Report, Appendix 6.10, Annex A, paragraph 56) is wildly unrealistic, especially when compared to Bupa's projections. HCA made a number of criticisms about AXA's model, see HCA's response to the original Provisional Findings, paragraphs 7.32 – 7.35.

⁸⁷ WPA hearing summary, 6 February 2013, paragraph 13.

prominently with respect to insurers such Bupa, AXA-PPP and Aviva/VitalityHealth, as they represent a much larger proportion of policyholders.

- (ii) As to the importance of HCA coverage to corporate clients, the CMA's survey evidence indicated a more mixed picture than is made out by PMIs, with a number of large firms in London willing to consider coverage without HCA hospitals, e.g. *"Some very large corporations [X] told [the CMA] that it was not important to provide their staff access to the HCA hospitals".*⁸⁸
- (iii) There would be a degree of switching inertia by PMI customers, which would be exacerbated by the PMI's ability to engage with brokers and customers and directly influence perceptions of HCA and the London market. PMIs such as Bupa, AXA-PPP and Aviva have considerable PR machinery at their disposal and have excellent relations with important sales intermediaries. Bupa's PR management of the BMI de-listing provides ample evidence of its strengths in this respect.

4.76 Secondly, as noted above (see '*Determinants of bargaining power*') the CMA must carefully consider the reasons **why** a small core of corporate PMI customers hold a strong preference for HCA's hospitals. For example, evidence from corporate customers indicated that the *"reputation of [HCA] hospitals for high-quality healthcare [was] the reason for including them in their schemes."*⁸⁹ If corporate customers are reluctant to switch because HCA is perceived to offer high quality care, such evidence does not strictly support the CMA's AEC findings or remedy proposals, and is also entirely consistent with the outcome of a competitive process based on quality and range.

4.77 Other than HCA's reputation for higher quality, the only other factor referred to by the CMA's was corporate customers' 'location' preferences.⁹⁰ This point was raised predominantly in relation to the London Bridge Hospital: *"The location of the London Bridge Hospital, in particular, made it possible for employees of City firms to minimize their absence from the office when attending medical appointments."*⁹¹ Indeed, X internal documents only referred to the London Bridge Hospital as being valued for its X.⁹² These findings are highly relevant as:

- (i) The reason the London Bridge Hospital's location is valued is its proximity to employers' offices in the City, as staff can return to work after attending the hospital. However, this "convenience factor" relates to **outpatient and diagnostic services**, where an employee might feasibly return to work after their procedure or consultation. In the case of an admission for inpatient or day-case treatment, the far greater likelihood is that the patient would return home. Therefore, in the event of a de-listing of the London Bridge Hospital, a PMI would only require substitute coverage for outpatient and diagnostic care in close proximity to the City. As the CMA is aware, outpatient and diagnostic care is subject to greater and more varied competitive constraints and the entry and expansion barriers identified by the CMA do not apply.
- (ii) When X delisted BMI hospitals, it retained coverage for a select number of BMI hospitals for strategic reasons. Nothing prevents X from adopting a similar

⁸⁸ Final Report, Appendix 2.1, paragraph 38.

⁸⁹ Final Report, Appendix 2.1, paragraph 40. The CMA also noted (without specifying the proportion) that *"Others, for example, [X], however, told us that since no appropriate quality measures were available it was impossible to draw value-for-money conclusions."*

⁹⁰ Final Report, Appendix 2.1.

⁹¹ Final Report, Appendix 2.1, paragraph 39.

⁹² Final Report, Appendix 6.10, Annex A, paragraph 44 and Figure 1.

negotiating position with respect to the London Bridge Hospital (which accounted for 10% of HCA expenditure).⁹³ Furthermore, the impact on HCA would still be equally destructive for a hospital should HCA de-list any of HCA's six hospitals. In short, the PMI outside option can be exercised as a partial delisting whereby a subset of HCA's central London hospitals are delisted, substantially mitigating any purported harm to PMIs.

4.78 Thirdly, notwithstanding the above, based on market evidence, the follow-on financial impact on PMIs has been vastly overstated. It is telling that, following Bupa's de-listing of BMI hospitals, Bupa reported a growth in profits of **over 120%** the next year.⁹⁴ BMI is the UK's largest hospital operator with a presence across numerous locations around the country, including solus coverage in some local areas. In the case of de-listing HCA, the effect would be, according to PMI evidence, confined to a relatively small core of City-based corporate customers in London,⁹⁵ where there is in fact sufficient alternative hospital and outpatient capacity.

4.79 If anything, the outcome of its negotiations with BMI emboldened Bupa and it has used such dealings to create an image of a PMI aggressively 'taking on' hospital operators in order to *increase* future sales. For example, Bupa trumpeted the outcome of its negotiations with Spire. Bupa reported: *"In November, we signed a ground-breaking long-term agreement with Spire Healthcare on prices... until 2021"*,⁹⁶ and added: *"We intend to work with other hospital providers in a similar way"*. It was reported at the time that *'Bupa is demanding fees cut of up to 15 per cent from private hospitals like Spire. Spire said a reduction in pricing terms could have a **significant adverse effect** on the group's revenues or profit derived from BUPA-funded patients' if it could not secure the similar terms."*⁹⁷

Restricted networks

4.80 The CMA provisionally readopts its findings from the Final Report, specifically, the CMA does *"not consider that the presence of restricted networks necessarily strengthens PMIs' bargaining power against HCA"* and that such networks have not *"significantly improved"* the PMIs' outside options (paragraph 6.44, PFs). The apparent basis for the CMA's conclusion is that there has been *"limited uptake of such policies"*.

4.81 First, the level of uptake, when seen in context, is material:

- (i) AXA-PPP reported considerable growth in subscriber numbers for its Corporate Pathways Product within a relatively short period of time (since the product was re-launched in October 2012).
- (ii) The 10% of Aviva users are on Aviva's main restricted network, the Key List, which excludes all six of HCA's hospital facilities. On this point, the CMA suggests 10%. However, this is incorrect, the 10%.
- (iii) VitalityHealth submitted to the CMA that it *"had offered products to corporates in London that did not include HCA, and that over the past year it had worked relatively*

⁹³ See Final Report, Appendix 6.10, Annex A, Figure 1.

⁹⁴ Bupa reported in its 2013 H1 results that its UK 'underlying profits' had increased by 124% year-on year. See Bupa, Half Year Statement for the six months ended 30 June 2013, pages 8 and 9. HCA is conscious that this figure refers to the whole of Bupa's UK business, but in the same presentation

Bupa made clear that its health insurance profits had also increased over the previous year.

⁹⁵ Final Report, Appendix 2.1, paragraphs 30 – 41.

⁹⁶ <http://www.bupa.com/media/1053294/preliminary-announcement-fy-2014.pdf>

⁹⁷ City A.M. article *"Spire Healthcare lays out price range amid BUPA contract talks"*, 8 July 2014; refer to <http://www.cityam.com/1404782168/spire-healthcare-lays-out-price-range-amid-bupa-contract-talks>

well".⁹⁸ It further noted that it had "*reduced HCA's share of its London spend by [X] per cent by encouraging the use of other facilities.*"⁹⁹

- (iv) The CMA's analysis of employer healthcare schemes demonstrated that major corporates in central London have taken up restricted network policies. The CMA's survey of companies contradicts its finding that there is only limited take-up of these policies. While some investment banks wanted access to HCA hospitals "*not all investment banks took this view*".¹⁰⁰

- 4.82 Secondly, a number of these restricted networks were re-configured during the course of the last market investigation.¹⁰¹ In that time, they have experienced significant growth in subscriber numbers.¹⁰² Therefore, the CMA must take into account the 'direction of travel' as well as the current subscriber levels for such networks.
- 4.83 Thirdly, the **existence** of these products means that it is possible for a PMI to launch and credibly market hospital coverage in London without HCA's six hospitals. It is highly unlikely that PMIs would launch and market a 'defunct' product to their customers. In that sense, it is factually incorrect to describe HCA as "a must-have" hospital, particularly given the X of Aviva policyholders are on a network that excludes HCA. The level of uptake of such networks cannot therefore be attributed strictly to a lack of non-HCA capacity or specialty coverage. To the extent that other factors, such as HCA's service and reputation for quality, has influenced demand for the restricted networks, this does not provide support the CMA's AEC findings (see '*Determinants of bargaining power*' above).
- 4.84 Fourthly, the CMA is wrong to consider the significance of each PMI initiative in isolation. It is when all PMI practices (e.g. restricted networks, service line tenders, open/guided referral products and other directional initiatives such as NHS cash benefits), are **considered together** that the CMA can properly take stock of PMI bargaining power. In that regard, the creation of restricted networks is less relevant given prevalence of open and guided referral practices which achieve the same effect but with far less transparency.

Service Line Tenders

- 4.85 The CMA provisionally concludes that "*service line tenders can but do not necessarily improve PMIs' outside options against HCA*" (paragraph 6.56, PFs). On the basis of new evidence, HCA notes that this is a different finding to that in the CMA's Final Report where the CMA stated that it did "*not consider that such strategies materially improve the PMIs' outside options*" (paragraph 6.325, Final Report). However, the CMA still underestimates the corresponding improvement to PMI bargaining power, particularly when seen together with other PMI market developments.
- 4.86 The CMA reports that X were made by Bupa and correctly concludes that service line tenders ("SLTs") can improve PMI outside options to a significant extent. However, the CMA points to a clause in Bupa's contract with HCA, which it believes shows that "X.
- 4.87 This is a mischaracterisation of the clause in question.

⁹⁸ Final Report, Appendix 6.11, paragraph 170.

⁹⁹ *Ibid.*

¹⁰⁰ Final Report, Appendix 2.1 (*Companies with staff in London*).

¹⁰¹ See HCA's response to AIS, paragraphs 5.69 – 5.80, and HCA's response to the original Provisional Findings, paragraph 7.21.

¹⁰² See, for example, HCA's response to original Provisional Findings, paragraphs 7.15 – 7.16.

- 4.88 ✂.
- 4.89 ✂.
- 4.90 ✂.
- 4.91 ✂.
- 4.92 Whilst the CMA dismisses the materiality of the total savings generated by AXA-PPP's SLTs, it does not take account of the **future potential** to generate savings. SLTs already account for ✂ of Bupa's overall expenditure, which is a significant amount when considering the sums involved, and there is no reason why AXA-PPP cannot replicate this.
- 4.93 The overall trend clearly shows that such SLTs are increasing in prevalence and scope. For example, Bupa announced the launch of a new hospital outpatient physiotherapy network from January 2016 ✂ Furthermore, HCA understands that Bupa is in the planning stages of launching an oncology SLT, which would have a further, dramatic impact on the private healthcare market.
- 4.94 Therefore, there is significant potential for greater savings through adoption of Bupa's aggressive SLT strategy.
- 4.95 The CMA underplays the future significance of SLTs by concluding: "*the extent to which service-line tenders might improve PMIs' outside options depends on the extent to which they successfully restrict patients to preferred providers. This in turn (along with the level of savings achieved via the service-line tender) is affected by the other factors determining bargaining outcomes*" (paragraph 6.54, PFs).
- 4.96 However, the CMA will have recognised that SLTs first arise in respect of high volume procedures (and, so far, mostly in relation to outpatient procedures) that account for a significant proportion of PMI expenditure. Outpatient activity also accounts for a large proportion of hospital revenues, ✂.
- 4.97 As the CMA is aware, there are even greater competitive constraints in outpatient and diagnostic service lines and the barriers to entry identified by the CMA in respect of inpatient hospital services simply do not apply. Therefore, the potential for PMIs to continue expanding the scope of SLTs is considerable, and any supposed obstacles PMIs face in respect of inpatient care are irrelevant to the future potential of SLTs.
- 4.98 ✂:
- ✂.
 - ✂.
 - ✂.

Strategic recognition of new facilities

- 4.99 Whilst HCA welcomes the CMA's finding that PMIs are able to withhold recognition in respect of new facilities, it disagrees with the CMA's conclusion that this does not in any way alter the CMA's conclusions on PMI outside options against HCA.
- 4.100 Firstly, the CMA fails to acknowledge that the ✂. ¹⁰³
- 4.101 Secondly, this ✂. Even on the basis of the CMA's flawed IPA, these tariff demands from ✂ are wildly excessive.
- 4.102 Thirdly, the CMA has not addressed HCA's submission that it is logically inconsistent that a hospital operator with supposed market power, such as HCA, would be able to ride roughshod over PMIs in respect of pricing negotiations, but be at the mercy of the same PMI in respect of facility recognition. Either HCA has unilateral market power or it does not. The ability of PMIs to withhold recognition of HCA facilities strongly indicates it does not.
- 4.103 Fourthly, the ability to withhold recognition is a powerful weapon and, in the long run, it effectively shapes the market structure. HCA has previously submitted that AXA-PPP's withdrawal of recognition for the then privately-owned Heart Hospital foreshadowed its exit from the market. The pattern is set to repeat itself. HCA notes that Bupa has announced to the market that it will only recognise **one** proton therapy centre in the market.¹⁰⁴ The obvious rationale is that it can, in the short-run, secure a larger discount by agreeing to concentrate volumes with one provider. However, the long-run effect is that it limits future capacity development in the market. It is precisely because of these sorts of 'short-termist' practices, which halt the rate of innovation in private healthcare, that HCA previously recommended a remedy requiring PMIs to automatically recognise new facilities for a set period.

Open referral, guided referral (e.g. Fast Track Appointments), and incentives to use NHS

- 4.104 On the basis of new evidence, the CMA provisional conclusion has been amended to: *"PMIs are, in principle able to use open referrals to direct patients away from HCA and this has potentially improved PMIs' outside options to some extent"* (paragraph 6.70, PFs).
- 4.105 However, the CMA adds *"taking into account the overall limited uptake of open referral policies, and the fact that HCA still receives a sizeable proportion of open referrals, we consider that the impact of open referrals on PMIs' outside options is nevertheless relatively limited"*.

Uptake of open referral

- 4.106 As to the CMA's comments concerning the limited uptake of open referral, we note that ✂ of Bupa's policyholders in the UK were on open referral policies (paragraph 6.68, PFs). Given that open referral was launched for corporate clients in 2011 that is a rapid rate of uptake. In short, ✂ policyholders are now on open referral and potentially subject to redirection away from HCA's facilities. We note that the proportion of Bupa policyholders in central or Greater London is not provided. However, as Bupa has previously stated that eight

¹⁰³ See cover email to CC dated 30 July 2013, enclosing HCA / Bupa agreement (2013).

¹⁰⁴ See HealthInvestor - Article: *'The waiting game'*, 3 November 2015, which refers to the following comments made by Bupa's new head of health funding: *"Bupa is only likely to contract with one proton beam therapy provider and given Bupa is the UK's biggest PMI provider, that could be a fatal blow to the providers who lose out"* (attached in **Annex 5**).

out of every ten corporate policy renewals has been on an open referral basis,¹⁰⁵ it would be expected to be equally material.

- 4.107 In the case of AXA-PPP, it has re-launched its open referral product after Bupa, and within a short time-frame had rapidly grown its open referral subscriber base.¹⁰⁶ However, AXA-PPP has the same potential as Bupa to grow its open referral subscriber level.
- 4.108 The Healthcare Purchasing Alliance (representing Aviva and VitalityHealth) recently informed HCA that open referral currently represents 30% of all referrals but that this figure is fast growing, with a projected estimate of 40% referrals being on an open/guided basis within 3 years.
- 4.109 Therefore, there has been growth in open referral given the short-time frame since its relatively recent inception, to the point where open referral is now a well-established feature of the market. The rate of growth may have slowed, as reported by Bupa, however, there is a still an upward trend that the CMA must take account of.
- 4.110 The CMA has also not fully appreciated the potential impact of PMI 'guided referrals' which take place across **both** open referral and non-open referral PMI policies. This initiative supplants the normal GP referral pathway since it is Bupa (not the GP) which makes the referral to the provider of its choice. In that sense, guided referral goes beyond the realm of open referral. For example, HCA understands that PMIs have used tactics such as exploiting fears over the possibility of top-up fees, and offering to take care of any hospital appointment administration, in order to appropriate control over where the patient is treated.
- 4.111 There is enormous scope for guided referral practices, such as PMI managed pathways, and the trend suggests this will be exploited by PMIs in respect of high volume services which can significantly impact hospital revenues.
- 4.112 For example, BUPA has developed a special pathway for musculoskeletal services, under which patients are initially directed to BUPA health centres and approved physiotherapists, and once in the BUPA controlled pathway, only referred to designated healthcare providers.
- 4.113 AXA-PPP similarly launched its own Musculoskeletal Health Pathway, which removes the GP referral from the pathway and exerts control over the facility at which a patient is provided treatment.
- 4.114 HCA provided the CMA with a letter sent by AXA-PPP to consultants in respect of its Fast Track Appointments service.¹⁰⁷ The letter noted "*Fast Track Appointments is proving popular with our members and is used in an increasing number of situations*". The letter confirmed that the service is available to all AXA's members and added "*We currently help our members to find specialists in around 15% of all referrals. We expect this to **rise to 30% by the end of next year and ultimately to over 50%***". This is clear confirmation of the extent to which AXA-PPP believes it can steer its policyholders to preferred providers and therefore its ability to systematically redirect policyholders away from HCA facilities.
- 4.115 HCA also recently drew the CMA's attention to a new initiative which Bupa has announced, concerning the launch of a self-referral pathway for breast and bowel cancer.¹⁰⁸ Bupa

¹⁰⁵ Bupa hearing summary, 20 March 2013, paragraph 70.

¹⁰⁶ HCA's response to the original Provisional Findings, paragraphs 7.15 – 7.16.

¹⁰⁷ Letter to CMA dated 28 October 2015, 'HCA / PMI bargaining power – further developments'.

¹⁰⁸ Letter to CMA dated 22 October 2015, 'HCA / PMI bargaining power – further developments'.

subscribers with symptoms of breast or bowel cancer are encouraged to contact Bupa for assessment by a "nurse-led self-referral team" which will then "*quickly refer the customer directly to the right specialist for tests ...*". In the case of potential bowel cancer patients, this enables Bupa to steer patients away from HCA's endoscopy facilities to, for example, TLC or the Bupa Cromwell. HCA informed the CMA that it is no coincidence that Dr Charles Lowdell, the consultant oncologist, is quoted in Bupa's press release in relation to this initiative. Dr Lowdell practises at TLC and the Bupa Cromwell.

- 4.116 Guided referral can be used in conjunction with other PMI initiatives such as SLTs. HCA informed the CMA that BUPA had written to it earlier this year to announce its intention to establish a specialist network of chemotherapy providers.¹⁰⁹ A network provides the ideal basis for a PMI to also establish a guided referral service which directs demand to the lower cost providers on the network. This is another reason why the potential impact of PMI initiatives should be considered together rather than in isolation.

Impact of Open referral

- 4.117 HCA notes that the PMIs have also downplayed the impact, to date, of open and guided referral in their submissions to the CMA.
- 4.118 Firstly, it is noteworthy that the rhetoric outside of the market investigation is quite different to submissions to CMA.
- 4.119 For example, Bupa reported that: "*In 2014, BUPA Health Funding corporate customers experienced some of the **lowest premium increases on record. Because of our success in healthcare cost containment, we were able to reduce or hold premiums level for over half our renewing corporate customers.** We continue to lead reform of the UK private healthcare market through our on-going drive to reduce healthcare costs, including those charged by private hospitals...*".
- 4.120 These remarks do not in any way corroborate PMI claims that strategies such as open and guided referral have had a 'limited impact' in the market.
- 4.121 In any event, the CMA has attempted to measure the impact of open referral on HCA by comparing HCA's share of total spend in Greater London compared to HCA's share of open/guided referral spend in Greater London. A significant disparity between the two figures would provide evidence of systematic redirection of demand away from HCA's hospital facilities.
- 4.122 HCA requests that the CMA perform the same calculation in respect of central London spend, as it is HCA's strong belief that PMIs also use open referral to re-direct claims **within** central London to other healthcare providers.
- 4.123 In any case, for AXA-PPP, there is a ⌘ disparity between the two percentages (paragraph 6.69, PFs), which the CMA correctly recognises shows that AXA is able to use open referral to move patients away from HCA.
- 4.124 For Bupa, however, the CMA refers to the fact that HCA receives ⌘ of Bupa's total spend in Greater London, but only ⌘ of Bupa's Open/guided referral spend. ⌘. It is surprising that the CMA considers the figures ⌘ and ⌘ to be "similar" when considering the CMA's other findings in this market investigation.

¹⁰⁹ HCA's submission on structural AECs, 1 May 2015, paragraph 5.48.

- 4.125 The fact is Bupa has ✂. In that regard, HCA submitted evidence to the CMA which indicated that a core rationale for launching open referral was specifically to divert demand away from providers such as HCA.¹¹⁰ Furthermore, contrary to Bupa's submissions, there are no contractual restrictions preventing the operation of its open referral policies. ✂.

Other recent developments

Aviva / Vitality

- 4.126 The CMA reports, as a recent development, that *"Aviva and VitalityHealth (formerly known as PruHealth), the third and fourth largest PMIs with shares of revenue of ✂% and ✂% respectively, that they are creating a new joint purchasing arrangement that will establish a joint venture (known as HPA) to negotiate with private hospital providers for the procurement of hospital services on their joint behalf"* (paragraph 6.71, PFs).
- 4.127 The CMA's provisional finding is that *"✂this development is likely to change the relative balance of negotiations in favour of Aviva and VitalityHealth, by weakening HCA's outside options (relative to a situation in which HCA could negotiate independently with Aviva and VitalityHealth)"* (paragraph 6.73, PFs).
- 4.128 However, the CMA notes that *"HCA is likely to still be able to extract a share of the bargaining surplus in negotiations with Aviva and VitalityHealth"* (paragraph 6.73, PFs) and therefore this market development is dismissed. The suggestion is that if HCA manages to extract 'any share whatsoever' from its bargaining with PMIs, there can be no basis for asserting that HCA is subject to strong bargaining power. As noted above (see *Bargaining economic framework*), the CMA is applying an incorrect standard. The suggestion that the mere extraction of a part of the surplus is a sign of market power is simply wrong.
- 4.129 This further consolidation by PMIs is a material development that will increase the level of PMI negotiating strength and further limit HCA's own bargaining power.
- 4.130 It is also consistent with the overall trend in the market which has witnessed greater exertion of bargaining power by PMIs. Indeed, Bupa's new Head of Health Funding noted that, notwithstanding HCA's challenge of the divestiture remedy before the Tribunal, he was *"quietly optimistic"*, noting that *"[Bupa have] done deals with two or three of the majors that are much better, we've still got one or two to go,"* he says. *"We're determined on this point and we're 100% lined up as a global organisation on this."*¹¹¹

¹¹⁰ *Ibid.*, paragraph 4.86 (second bullet).

¹¹¹ HealthInvestor - Article: *'The waiting game'*, 3 November 2015 (attached in **Annex 5**).

5. QUALITY AND RANGE

Key points

- The CMA has not undertaken a considered assessment of clinical quality and therefore is not in a position to conclude that there is no material quality differential between HCA and other hospitals in central London.
- In fact, all the evidence before the CMA points to HCA's higher quality offering. Even if the CMA does not regard the differential as "material", the question it fails to consider is whether these quality differentials are capable of explaining any pricing differentials in the IPA.
- The CMA accepts that HCA offers a broader range of treatments. However, it wrongly argues that HCA's offering of higher complexity treatments, together with a more extensive clinical infrastructure, does not create higher costs for the business as a whole which will be reflected in higher prices.
- The PMIs themselves have confirmed that the reason they regard HCA as a "must have" provider is precisely because of its reputation for quality.
- Importantly, the CMA has (rightly) concluded that there is sufficient competition over quality and range in central London and that this has produced innovations which have worked well for consumers. The CMA fails to explain why the same competitive constraints which drive investments in quality and range do not also drive price competition. There is a glaring inconsistency between the CMA's findings on competition over quality/range and competition over price.

Differences in quality between hospital operators

Lack of objectively comparable measures

- 5.1 The CMA maintains its view in the Final Report that *"There is still a lack of objectively comparable measures of clinical quality"* and that this *"makes quality difficult to assess"* (paragraphs 7.13 and 7.27, PFs). The CMA previously argued that *"This has greatly limited our ability to compare the various hospital operators"* (paragraph 6.412, Final Report).
- 5.2 However, the CMA has not taken any steps, either in the original market inquiry or in the subsequent Remittal Inquiry, to seek relevant quality data from hospital operators, clinicians or relevant clinical bodies. The CMA could have sought advice from independent clinical experts to conduct an objective assessment of the comparative quality offering at different central London hospitals. It could also have consulted with GPs and consultants to establish their views on differences in quality.
- 5.3 This investigation commenced in 2012. It beggars belief that at no point over the last four years has the CMA sought any clinical input with regard to establishing the extent of clinical quality at HCA's hospitals, particularly given the pivotal role of quality in healthcare.

Assessment of evidence during original market investigation

- 5.4 In any event, the CMA has not properly taken account of the evidence before it which indicates HCA's higher quality offering.
- 5.5 For example, the CMA noted that HCA employs more RMOs and CNSs than TLC, but simply dismissed this as "*unsurprising given that it has more ITUs than TLC*" (paragraph 6.417(b), Final Report). However, the fact that HCA has more RMOs and CNSs in fact has nothing to do with having more ITUs – RMOs operate across a wide range of clinical specialties (not just critical care) and CNSs support the treatment of cancer patients. That HCA has more such staff reflects the fact that its clinical environment is geared to a higher quality of patient care across the business as a whole.¹¹²
- 5.6 The CMA also dismissed the fact that HCA has a higher nurse-to-patient ratio than TLC on the spurious grounds that HCA was basing this comparison on a statement on TLC's website. However, the CMA was in a position to verify from TLC whether HCA's comment is correct. Either it neglected to do so, or it did but could not find any contradictory evidence. Again, the fact that HCA has a higher nurse-to-patient ratio reflects its investment in a greater level of patient care across all its specialisms.
- 5.7 HCA submitted a detailed quality report with six case studies highlighting the specific features of its hospital network which underpin its high quality healthcare offering. These case studies compare HCA's offering with that of TLC in the six clinical fields. The CMA has not properly engaged with any of this evidence:
- The six case studies provided very specific comparisons between the facilities of HCA and other providers, including TLC, in these clinical fields, and explained why these would lead to better outcomes. There is very little discussion of these in the Final Report and there is little reason given as to why the CMA has dismissed this evidence.
 - The CMA asserted that the examples provided by HCA "*applied mainly to cancer treatment*" (paragraph 57, Appendix 11.1, Final Report). Certainly, HCA provided case studies explaining the benefits of its clinical pathways for breast cancer, blood cancer, and prostate cancer. However, it also submitted case studies for neurosurgery, orthopaedic care and cardiac care and therefore the assertion is incorrect.
 - The CMA pointed out that HCA was unable to benchmark its quality outcomes against private sector (rather than NHS) outcomes. HCA fully accepts that there is limited publicly available data which compares private sector providers. However, in each case study it provided specific reasons why HCA's facilities (and the use, for example, of multidisciplinary teams, innovative equipment, etc.) would be more likely to achieve better clinical outcomes. There has been no consideration of this by the CMA – it simply asserts the evidence available "*did not lead us to conclude that HCA's quality was appreciably higher than that of close competitors in central London.*" (Appendix 11.1, paragraph 39, Final Report).

¹¹² The number of resident medical officers and nurses in a private hospital was identified as an indicator of clinical quality in the CQC report, *How safe are NHS patients in private hospitals? Learning from the Care Quality Commission*, Centre for Health and Public Interest, November 2015.

5.8 The CMA has also dismissed the considerable evidence submitted by consultants which attested to the higher quality environment within HCA facilities which attracted them to practise there:

- The letters submitted by HCA consultants provided very specific explanations of why the clinical infrastructure within HCA's hospitals provided benefits in the treatment of patients within the consultant's specialism.
- The letters were written by a wide range of different consultants representing numerous different clinical fields.
- The CMA recognises that "*The letters were generally consistent with the arguments contained in HCA's submissions to us, stressing in particular the benefits to patients of the HCA "network" structure.*" (Appendix 11.1, paragraph 30, Final Report). There is no explanation as to why evidence produced by so many leading consultants has been ignored in the CMA's assessment of quality.
- In addition, there is nothing to suggest that the CMA has sought its own evidence from clinicians and the CMA has previously confirmed that it has never at any point sought input by clinicians or from specialist bodies such as Monitor or the Royal Colleges.

5.9 HCA has also made extensive submissions which highlighted the differences in the services offered by HCA and TLC, and again the CMA has simply not engaged with any of this evidence:

- **IT infrastructure:** HCA provided numerous examples of IT systems and software that it makes available to hospital staff, nurses and consultants to improve the speed and quality of care at its hospitals.¹¹³ The CMA has not sought to identify whether comparative software technology is available at other hospitals and the corresponding benefits this provides.
- **Methods of working:** HCA operates its multi-disciplinary teams in specialties such as neurosurgery on a 'proactive basis', that is, such sessions draw upon the expertise of clinicians from different fields in order to inform treatment decisions **prior** to the delivery of care. In comparison, TLC's MDT programme is retrospective only, in that MDT sessions are held **after** patient episodes as part of a 'lessons learned' approach. Prospective MDTs that review each patient's progress at multiple stages of their treatment pathway are widely regarded by bodies such as NICE and the Royal Colleges as being the recommended practice for patients.¹¹⁴
- **Integrated hospital network:** HCA's network integration supports central investments in quality programmes and infrastructure, which benefit all hospitals. Seamless patient movement between hospitals ensures that patients can transfer to the most appropriate location for their care, and investments in one location benefit patients across the whole network. Best practices from across the network can be formalised and spread to drive continuous quality improvement in all hospitals.

¹¹³ Response to Notice of Possible Remedies, paragraph 6.369(iv).

¹¹⁴ For example, Royal College of Surgeons, National Peer Review Programme "Manual for Cancer Services: Breast Cancer Measures", April 2013.

- **Accreditation:** HCA has obtained recognised quality accreditations from an array of independent organisations.¹¹⁵ To HCA's knowledge, no other private hospital operator possesses the same breadth of accreditation as HCA. For example, two HCA endoscopy units are JAGS accredited (specifically, at the Wellington Hospital and the London Bridge Hospital), whilst TLC's endoscopy unit is no longer JAG accredited. This is particularly significant in view of the fact ✂. A further example would be ICNARC in relation to the quality of intensive care facilities at HCA's hospitals.¹¹⁶ These accreditation bodies should be able to provide evidence concerning the quality of HCA's facilities compared to other healthcare operators.

5.10 The CMA's finding that there are no material quality differentials between HCA and other central London hospitals is also inconsistent with the evidence provided by PMIs:

- AXA-PPP submitted that it used HCA's hospitals as "must have" hospitals because its policyholders *"have a desire to achieve the **"best" access for themselves**"* and it defined "must have" private hospitals *"as comprising those healthcare facilities offering the **strongest professional reputation** ..."* (Appendix 6.10, Annex A, paragraph 42, Final Report). This is a very clear acknowledgement that it is HCA's reputation as having the **"best"** hospitals with **"the strongest professional reputation"** which requires AXA-PPP to include HCA hospitals in its policies.
- AXA-PPP made the same point at its recent hearing with the CMA, when it asserted that the only constraint on redirecting patients away from HCA is the reputation of HCA's hospitals for quality, complexity, etc.

Measurement of quality is critical to improving quality

- 5.11 HCA's high-quality service to patients is also indicated by the fact that HCA collects, monitors and publishes more data on its quality and performance than any rival private hospital operator in London, including TLC.
- 5.12 HCA is proud of its offering and believes that greater transparency is in the interest of patients. HCA's major central London competitors publish far less outcomes data and this in itself is an indicator of the greater importance which HCA places on quality.
- 5.13 Even if the CMA took the simple step of reviewing the websites or publicly available literature of any other central London private provider, it will not find the same level of clinical outcomes data as on HCA's website.¹¹⁷
- 5.14 By way of analogy, the NHS Outcomes Framework sets out the outcomes and indicators used to hold the NHS Commissioning Board to account for improvements in health outcomes. The development of this framework focuses on how services are improving patient outcomes. HCA adopts several such measures to monitor to achieve a similar goal. Without rigorous measurement and monitoring, a hospital operator cannot credibly seek to improve clinical quality.
- 5.15 Furthermore, HCA supports more national studies, audits, registries and databases than any other private operator, and allows open reporting of its outcomes on third party websites and in professional publications.

¹¹⁵ See examples provided at paragraph 5.28 of HCA's response to PDR.

¹¹⁶ Intensive Care National Audit & Research Centre (ICNARC).

¹¹⁷ <http://www.hcahospitals.co.uk/about-hca/quality-standards/our-quality-promise/>

- 5.16 More recently, HCA has made considerable investments in the capture, validation and analysis of data relating to clinical outcomes. Specifically, ✂.
- 5.17 ✂. This coding exercise can therefore be undertaken with respect to historic data. The CMA could take the reasonable step of requiring TLC and other hospital operators to do the same in order to provide a risk-adjusted clinical outcomes data set. This would, in effect, be a "trial run" of the information remedy that needs to be implemented.
- 5.18 HCA's investment in measuring and monitoring quality is carried out for more than just regulatory purposes. It helps to identify opportunities for improvement. Without such commitment to quality measurement, it is difficult to see how rival operators can meaningfully improve quality, and, furthermore, it is unlikely that HCA would go to such lengths if it not did believe that monitoring quality more effectively led to an increased number of better clinical outcomes for patients.

Extent of quality differential

- 5.19 There is a further point regarding the extent of any quality differential between HCA and TLC, and its impact on any alleged price differences in the IPA.
- 5.20 The CMA stated that in its view the evidence does not indicate that HCA's quality is "*materially*" higher than that of TLC (paragraph 7.13, PFs) or "*substantially*" better than expected (paragraph 7.14, PFs). It is not clear what criteria the CMA is using to assess the "materiality" of quality differences between HCA and TLC and what factors it considers would establish a "substantial" difference.
- 5.21 However, the relevant question for the CMA is not whether the quality differential is "material" or "substantial" (however that is to be measured) but whether any quality differential is capable of explaining the price differences in the IPA. The extent of any alleged price difference in the IPA is relatively small and therefore it is entirely conceivable that even non-substantial quality differentials are capable of explaining or contributing to differences in price. The CMA has failed to ask itself the question whether the quality differentials which are observable are capable of having an impact on HCA's prices.

Evidence of differences in range

The relationship between range and quality

- 5.22 The CMA found that HCA did offer a wider range of services than TLC (paragraph 6.416, Final Report), and that HCA has been a leader in introducing a range of treatments/diagnostic techniques (paragraph 6.411, Final Report). However, the CMA believed that examples in which HCA has a wider range of treatments or procedures is not evidence that HCA provides higher quality of care than TLC.
- 5.23 The CMA's distinction between range and 'quality' is erroneous. Having a wider range of treatments or diagnostic tools at a clinician's disposal *can* improve quality, for example, by increasing the likelihood of a successful clinical outcome, improving the speed and accuracy of diagnosis or increasing the rate of recovery. It can similarly improve the patient's healthcare experience, for example, by minimising the risk of patient requiring a transfer out to the NHS.

- 5.24 In the field of cancer care, a wider range of treatment modalities for a patient with cancer could mean that a clinician is able to **choose** the optimum treatment modality for each specific patient, having regard to the type and progression of their disease.
- 5.25 For example, HCA offers both Gamma Knife and CyberKnife to patients, whereas TLC only offers Cyberknife. There may be circumstances in which it is more appropriate to use Gamma Knife rather than CyberKnife. Patients being treated at TLC would not have this option available to them. Similarly, having access to a wider range of diagnostic tools could mean that the *optimum* method for detecting and treating a particular type of illness is available to a clinician.
- 5.26 Further examples include:
- TLC did not previously offer 3T MRI scanning. 3T MRI scanning represents an advanced form of imaging that provides the highest resolution for clinical diagnosis. There could be circumstances in which a clinician believes that producing a 3T MRI scan is more appropriate, e.g. in order to examine an area of the patient's body in greater detail.
 - TLC does not offer cancer patients 'brachytherapy', whereas HCA does. It is believed that this is because due to insufficient patient volumes in previous years. Again, brachytherapy may represent the most optimum treatment modality for certain groups of cancer patients.
 - TLC does not possess an integrated molecular genetic profiling lab for its cancer patient. In contrast, HCA has entered into a joint venture with UCLH in setting up a molecular profiling laboratory which can identify the most appropriate form of cancer treatment based on the genetic profile of the patient, and this service is integrated into HCA's patient pathway.
 - HCA offers patients the Macmillan Cancer information centre, a place where patients affected by cancer and their family can obtain information and guidance about the illness as well as lifestyle advice on the management of their condition. HCA understands that TLC previously operated such a centre but has since been closed. HCA also offers complimentary therapy, play therapists, patient/family groups, fathers groups and other such support without any cost to the patients.

Differences in range attributable to size of hospital network

- 5.27 The CMA found that any difference in service range between HCA and TLC is likely to be explained to some extent by the different in the size of their hospital portfolios and that both HCA and TLC have expanded their ranges in recent years (paragraph 7.19, PFs).
- 5.28 The correlation between HCA's hospital network size and the range of its treatments is a statement of the obvious, and is precisely the point that HCA is been attempting to make to the CMA. HCA's comparatively larger hospital network **enables** it to create centres of excellence and expertise at the different hospital sites, which combines to create a single hospital network with a superior depth, range, expertise and infrastructure than its competitors.
- 5.29 Indeed, the CMA's acceptance of an association between the 'size of HCA's portfolio' and the range of services it offers relates directly to the one of the relevant customer benefits of

HCA's existing structure. Should the CMA seek to reduce HCA's network size, according to the CMA's **own findings**, one would expect a diminution in range (as there would be two smaller portfolios, rather than a single large portfolio).

Relationship between range and average costs

- 5.30 The CMA states that it does not accept HCA's arguments that a broader range of high complexity treatments means that it has a higher cost base since it *"would expect any services where HCA's cost base is higher to be reflected in the prices of those treatments that only HCA provides rather than those treatments where it competes directly with TLC"* (paragraph 7.20, PFs). However, this is wrong for a number of reasons.
- 5.31 This is factually inaccurate, since HCA's broader range of services and deeper clinical infrastructure supports all of its treatments, including those treatments in the common basket. For example, the high number of ITUs and critical care facilities (which the CMA considers is relevant to range) increases HCA's costs across the board.
- 5.32 Furthermore, the CMA's observation does not reflect the way in which hospital operators and PMIs carry out hospital pricing negotiations. As the CMA is aware, there is no treatment-by-treatment price negotiation. Prices are negotiated without reference to individual treatments and across a broader spectrum of services.
- 5.33 Moreover, the CMA accepts that there could be a level of cross-subsidisation but that *"any cross-subsidisation is likely to be limited"* (paragraph 7.20, PFs). The CMA does not define what it means by a "significant" level of cross-subsidisation. Again, given the relatively small alleged price differences in the IPA, even relatively low levels of cross-subsidisation would have a bearing on any pricing differentials.

Competition on quality and range

- 5.34 The CMA's own Guidelines make clear that: *"Prices and costs are not the sole indicators of the level of competition in the market. Poor quality, lack of innovation, or limited product ranges are prominent along other indicators of weak competition in the market ... In several past market investigations, such analysis has spotlighted various negative non-price factors as important indicators of weak competition"*.¹¹⁸
- 5.35 It is important to note that the CMA has concluded that there is effective competition of both quality and range in central London: *"Overall, our view is that the evidence provided by HCA (see paragraphs 6.390-6.411) show that over the past years various hospital operators in central London, including HCA and TLC, have expanded the range of treatments provided (including complex treatments) and have incurred investments to expand and/or improve the product offer at their hospitals (for example through the adoption of new equipment or hospital expansions and refurbishments). These decisions were sometimes accompanied by a view of attracting consultants"* (paragraph 6.407, Final Report).
- 5.36 The CMA has noted in the Final Report that there is a process of competitive rivalry in central London which has encouraged investment in quality and range:
- The CMA stated that HCA's investments set out in its business cases *"are frequently accompanied by a consideration of its private competitors in central London ..."*

¹¹⁸ CMA Guidelines for market investigations (CC3 (revised)), paragraph 127.

These investments are sometimes offensive and sometimes defensive in nature" (paragraph 6.406(a), Final Report).

- It also observed that *"over the past years various hospital operators in central London, including HCA and TLC, have expanded the range of treatments provided (including complex treatments) and have incurred investments to expand and/or improve the product offer at their hospitals (for example, through the adoption of new equipment or hospital expansion, or refurbishment)"* (paragraph 6.407, Final Report).
- The CMA also acknowledged that when HCA had introduced new treatments or diagnostic techniques, *"competitors had been relatively quick to follow suit and that, similarly, HCA had responded to other competitors' investments"* (paragraph 6.411, Final Report).

- 5.37 The CMA has therefore concluded on the issue of quality and range: *"We also found that, notwithstanding the weak competitive constraints and barriers to entry and expansion, there is a degree of competition over both quality and range in many local areas, including central London."* (Paragraph 6.440, Final Report).
- 5.38 The CMA however argues that the fact that there is sufficient competition on quality/range does not mean that there is sufficient competition on price. The CMA asserts that this is because insured patients are *"less sensitive to the price of treatments"* (paragraph 7.24, PFs). The CMA's reasoning however lacks coherence.
- 5.39 First, it would appear from this that the CMA at least accepts that the same competitive constraints apply in the case of self-pay patients, who are sensitive to both quality and price. That being the case, it is difficult to understand how the CMA can sustain its self-pay AEC.
- 5.40 Second, the CMA expressly acknowledges that rival hospitals in central London are investing in quality and in new services and that this creates a competitive constraint on HCA which incentivises HCA to improve its own quality and range of services. The finding in the Final Report indicates that there is a process of competitive rivalry between hospitals in central London which results in new products and services. This competitive dynamic is evident in HCA's own business cases. The CMA provides no logical explanation why the same rivalry, which drives investments in quality and range, would not also constrain HCA's prices with PMIs.
- 5.41 Third, the CMA falls back on the argument that *"the range of alternatives available to PMIs in London ... is much narrower than those facing individual patients and consultants"* (paragraph 7.25, PFs). This is nowhere explained. The very same hospitals in central London which compete with HCA on quality and range (including independent providers such as TLC and the Bupa Cromwell and the numerous PPU's) also compete with HCA on price. The CMA cannot logically argue that there is one set of competitors for quality, and a completely different set of competitors for price.
- 5.42 Consequently, in view of the CMA's very clear findings that competition on quality and range is working well for consumers, it cannot reasonably maintain its finding that there is insufficient price competition.

6. EMPIRICAL ANALYSIS ON INSURED PRICES

Key points

- The IPA presented in the CMA's provisional findings is flawed. It does not meet the standard set out by the CAT and cannot be relied upon to reach an AEC finding in relation to insured prices.
- The CMA cannot reasonably conclude that there is any price difference between HCA and TLC on a like-for-like basis, and it cannot conclude that any price difference is driven by HCA's market share.
- The CMA cannot reach this conclusion because:
 - the IPA does not conduct a comparison on a like-for-like basis as further demonstrated by the results of the KPMG Report on HCA Patient Comorbidities ("Comorbidities Report");
 - the IPA's results are not statistically reliable;
 - the IPA's analysis is not representative or informative of HCA's overall pricing; and
 - the evidence and views overwhelmingly point to market shares not enabling HCA to charge higher prices. This is confirmed by KPMG's new analysis of spare capacity and by the views of Bupa and AXA PPP.

Introduction

- 6.1 In the PFs the CMA presents its current assessment of the IPA. While the CMA's position has changed in some important ways, the CMA continues to rely on its IPA to reach a conclusion that HCA charges higher prices than TLC.
- 6.2 The CAT set a number of clear tests for the review of the IPA, and the evidence shows these tests are clearly failed by the IPA. Therefore, on the basis of the evidence that both HCA and its advisers have put forward during the appeal process and the Remittal Inquiry, and the additional evidence set out in the KPMG December 2015 Data Room Report ("PFs DRR"), the Second Spare Capacity Report and the Comorbidities Report, it would be unreasonable for the CMA to continue to rely on the IPA results to support its insured AEC findings, let alone use it as an input to support any remedy (especially a divestment remedy) or quantify any price benefits thereof.
- 6.3 HCA also notes that the IPA relied on data from the period from 2007 to 2011, which, by the time the Remittal Inquiry ends, will be about five to nine years old. This in itself casts serious doubts on the extent to which the CMA can rely on the IPA for its findings or in the assessment of the effectiveness of any remedies it may seek to impose, particularly given the number of changes in the competitive conditions in the supply of private healthcare (set out in section 2 of this response).
- 6.4 In the rest of this section, HCA first summarises the key issues flagged by the CAT as important for the review of the IPA, and then considers the evidence and the CMA's position in relation to each of these issues.

The key issues identified by the CAT

- 6.5 During the appeal process that led to the Remittal Inquiry, the CAT set out a number of the key requirements that an analytical comparison between the insured prices charged by different hospital operators would need to meet in order for the results of that analytical comparison to be relied upon.

Prices need to be compared on a like-for-like basis

- 6.6 The CAT concluded that the price comparison must be conducted on a like-for-like basis for any estimated price difference to be considered meaningful. In particular, the CAT stated that *“it will be important in the context of the present case to be able to examine carefully the basis for the CMA’s conclusion that [...] - in constructing the IPA - prices have been correctly measured and comparisons have been performed on a suitable like-for-like basis”*.¹¹⁹

Price differences need to be statistically reliable

- 6.7 The CAT ruled that the IPA must be sufficiently precise and statistically reliable. In discussing the importance of the R^2 the CAT stated that *“If the robustness of the CMA’s parameter estimates can be sufficiently undermined by reference to these points, that would mean that a key part of the statistical reassurance one may have that it is safe to rely on the parameter estimates could be removed and the IPA could not properly be relied upon as a basis for any insured AEC decision or as a basis for any divestment decision. If HCA is successful in getting to this point, there is a very real prospect (to put it no higher) that no insured AEC decision or finding could be made and also a real prospect, therefore, that no new divestment decision should be made.”*¹²⁰ And it went on to state that *“[t]he potentially material impact of the R^2 point and the statistical error point has been accepted by the CMA”*.¹²¹

A price difference needs to be representative

- 6.8 As for the representativeness of the price comparison, HCA notes that the CMA itself acknowledged the importance of it. In particular, it concluded that *“[w]hile a particular hospital operator may have a lower price for one treatment, this may be offset by a higher price for a different treatment. This means that comparing the price of too small a number of treatments may lead to distorted results as the hospital operator may have higher or lower prices elsewhere.”*¹²² The CMA also noted that *“[...] because negotiations between a PMI and a hospital operator focus on all of a PMI’s expenditure, we thought it was more appropriate to compare prices over as wide a range of treatments as possible.”*¹²³

The relationship between price and market shares needs to be causal

- 6.9 The CAT stated that any relationship between local market concentration and the level of prices must be found to be causal. In particular, the CAT concluded that *“it will be important in the context of the present case to be able to examine carefully the basis for the CMA’s conclusion that the relationship between market share and prices is causal”*.¹²⁴

- 6.10 The rest of this section considers the evidence for each of these issues in turn.

Prices are not compared on a like-for-like basis

- 6.11 According to the CMA, the IPA continues to show that, on average, HCA charges higher prices than TLC across the set of treatments that both hospital operators provide (paragraph 6(a), PFs).¹²⁵ Importantly, however, the CMA acknowledges that its position has changed

¹¹⁹ HCA v CMA [2014] CAT 11, paragraph 37.

¹²⁰ HCA v CMA [2014] CAT 23, paragraph 12.

¹²¹ Ibid., paragraph 13.

¹²² CMA original PFs, Appendix 6.12, paragraph 4.

¹²³ Final Report, Appendix 6.12, footnote 16.

¹²⁴ HCA v CMA [2014] CAT 11, paragraph 37.

¹²⁵ In the Final Report, the CMA concluded that TLC is HCA’s closest competitor (see paragraph 6.218) and the only hospital it has been compared against in the context of the IPA. However, as noted in section 2 HCA is

since the Final Report, as it can no longer conclude on the exact size of the price differential between HCA and TLC (paragraph 39, PFs).

- 6.12 The CMA explains that it cannot rule out the possibility that patient complexity is contributing to the price differences it observes (paragraph 39, PFs), and it goes on to conclude that differences in patient complexity are unlikely to be the major driver of the price differences it finds in the revised IPA (paragraph 39, PFs).
- 6.13 This position is internally inconsistent, as it is unclear how the CMA can come to the view that there is any, let alone significant, price difference on a like-for-like basis, while having no way of quantifying this.
- 6.14 Leaving this aside, there is no evidence of a price difference on a like-for-like basis. In the IPA WP DRR, HCA highlighted the low explanatory power of the CMA's analysis (low R^2 , discussed next) which pointed to additional factors being "left out" of the model,¹²⁶ and had shown that better controlling for patient complexity led to the price difference essentially disappearing.¹²⁷
- 6.15 In reviewing this evidence the CMA considered two questions (paragraph 8.26, PFs):
- "(a) Are there plausible mechanisms through which more complex patients are disproportionately directed towards HCA rather than TLC?*
- (b) Is the number of pathology charges in the invoice data a good basis for comparing and controlling for differences in patient complexity between HCA and TLC?"*
- 6.16 In relation to the first question, HCA put forward a number of arguments and evidence to show that HCA does treat more complex patients than TLC. The IPA WP DRR presented the results of line item data analysis which is consistent with the mechanism whereby more complex patients would be directed to HCA instead of TLC.¹²⁸ In addition, HCA submitted further evidence on the range and type of services provided to its patients that would result in HCA treating more complex patients than TLC (paragraphs 8.31-8.37, PFs). The CMA also considered views of third parties. In particular the CMA referred to the views from AXA PPP who acknowledged the greater range and complexity of HCA's treatments, but commented that it did not consider there would be "material differences" between HCA and TLC in terms of patients' complexity (paragraphs 8.38 – 8.41, PFs).
- 6.17 The views and evidence submitted by these third parties are entirely irrelevant to the point considered. First, it seems odd for there to be no connection between the greater range and acuity of HCA's treatment (that AXA PPP and others concede) and the complexity of patients it treats: why would a hospital operator incur the cost to invest in costly services if these did not attract patients that needed a different type of care?
- 6.18 Second, it is not clear on what basis AXA PPP and others could comment on the "materiality" of any difference in patients' needs (or complexity) for the IPA. The only sense in which differences in complexity are "material" for the IPA is if they translate in a difference in costs that accounts for the difference in price. The kind of evidence that AXA PPP and others cite is extremely high level and therefore is unable to determine, at a granular level, if differences in patient complexity more than offset any difference in price estimated by the IPA. In other words, there could be differences in the level of complexity that completely change the IPA (as HCA maintains there clearly are) and at the same time are not being picked up at the level at which third parties have commented. Finally, it is doubtful that AXA PPP or others were commenting on material differences in complexity with this test in mind and certainly this is not the way in which their view is set out in the PFs. Furthermore AXA

constrained by many other private hospital providers (within and outside central London, including international providers) and the NHS. In addition, as discussed in section 2, TLC is not the right benchmark to be compared against due to TLC's charitable status.

¹²⁶ IPA WP DRR, 24 July 2015, paragraph 3.10.

¹²⁷ IPA WP DRR, 24 July 2015, paragraphs 5.6 and 5.7. For the full results of the analysis, please see Annex 5 of the IPA WP DRR, 24 July 2015.

¹²⁸ IPA WP DRR, 24 July 2015, Section 4.3.

PPP and TLC have not reviewed the data room so could not have gained an insight into what level of complexity differentials could be considered “material” to the IPA.

- 6.19 In considering this evidence the CMA stated that: *“it is clear that HCA provides some services that TLC does not, in particular cardiology, which may lead it to attract patients with more co-morbidities for non-cardiology-related treatments. However, without any evidence on the share of HCA patients where this issue may be relevant, we cannot conclude on the extent to which this is leading to greater patient complexity at HCA to an extent that would invalidate our comparison of HCA and TLC prices across the range of treatments in the common basket”* (paragraph 8.48, PFs). The CMA further stated that *“the extent to which this mechanism is likely to lead to greater patient complexity within ‘common basket’ treatments is far from clear. The evidence that HCA has provided in relation to this mechanism is limited”* (paragraph 8.49, PFs).
- 6.20 For these reasons the CMA found that *“the limited evidence that HCA submitted did not lead us to consider that these mechanisms would result in a systematic and material difference in the complexity of HCA and TLC patients within the same treatments. As such (and for the reasons set below), we cannot be confident of the extent to which the KPMG analysis is really capturing differences in patient complexity”* (paragraph 8.53, PFs).
- 6.21 HCA reminds the CMA that it needs to demonstrate on a balance of probabilities that it is comparing prices on a “like-for-like basis”; the CMA cannot make broad, unfounded assertions and then require HCA to prove the contrary.¹²⁹ This issue, regarding whether the IPA captures differences in patient complexity, is one of the many areas in which the CMA is seeking to reverse the burden of proof. The CMA has a responsibility to ensure that its analysis is robust, collecting evidence where appropriate.
- 6.22 This notwithstanding, HCA’s economic advisers, KPMG, investigated this issue and produced a Comorbidities Report. The analysis shows that:
- (i) HCA treats many patients with complex comorbidities. The patients with ☒ represent ☒% of patients in the CMA’s common basket procedures and ☒% of patients in the top-☒ CCSDs that have the greatest contribution to the price differential;
 - (ii) ☒;
 - (iii) failing to properly control for these comorbidities in an analysis such as the IPA would lead to biased results;¹³⁰
 - (iv) furthermore, it is likely that, ☒ and any estimate of the effect on the IPA based on such an analysis of only HCA patients is highly likely to be an underestimate.¹³¹
- 6.23 These results clearly address the CMA’s questions. First, it shows that there is a ☒ of patients receiving the common basket procedures that display ☒. This addresses the CMA’s concern that this issue may not be material. Second, ☒, thereby showing that the patient pathway that HCA argued is in place is in operation. Third, these patients are ☒ to treat and lead to differences in episode charges, which is consistent with the line item analysis presented in the IPA WP DRR. Finally, when properly accounting for these comorbidities in an analysis of insured prices, the estimated price difference changes substantially, showing that the exclusion of them from the CMA’s IPA biases its results.

¹²⁹ CMA Guidelines for market investigations (CC3 (revised)), paragraph 319.

¹³⁰ Comorbidities Report, section 3.6.

¹³¹ It is also likely to be an underestimate due to the broad range of services attracting patients with other comorbidities. As KPMG has previously shown, HCA performs a number of highly complex procedures that TLC does not, and it is likely that these procedures may have the effect of attracting patients with other comorbidities. Due to the time available for this response, and the CMA’s focus in the PFs on ☒, HCA has focused on ☒ for this submission.

- 6.24 On the line items analysis, the CMA did not consider that the number of line items, such as pathology charges, is likely to be a reliable proxy for patient complexity due to potential differences in billing practices between insurers and hospital operators.
- 6.25 KPMG tested these issues in the PFs data room. KPMG's analysis relied on two facts highlighted in the PFs. The first is that the billing practices undermining the analysis were raised in connection with episodes which included packages (paragraph 8.64 part (a), PFs). The second is that Bupa mentioned that for its inpatient episodes, both HCA and TLC were contractually able to bill all items on a line-by-line basis (with no partial packages) (footnote 506, PFs). As these episodes are not affected by the CMA's concerns relating to different contractual provisions, KPMG re-ran the modified IPA that used the count of pathology charges for:
- (i) all episodes without packaged prices; and
 - (ii) all of Bupa's inpatient episodes.
- 6.26 ✂.
- 6.27 These findings further demonstrate why the CMA must carefully scrutinise, in the same manner it does in respect of HCA's submissions, remarks made by PMIs, rather than simply accept them at face value.

Price differences are not statistically reliable

- 6.28 The CAT has clearly highlighted the importance of correctly assessing the statistical robustness of any IPA produced by the CMA. With regard to the R^2 measure, the CAT has ruled *"It should be emphasised that this does not mean that the R^2 point and the statistical error point do not have a material impact on the validity of the IPA. If the robustness of the CMA's parameter estimates can be sufficiently undermined by reference to these points, that would mean that a key part of the statistical reassurance one may have that it is safe to rely on the parameter estimates could be removed and the IPA could not properly be relied upon as a basis for any insured AEC decision or as a basis for any divestment decision."*¹³²
- 6.29 As HCA has previously submitted when estimating price levels and deriving price differences from them, it is important to make sure all explanatory variables that can influence the level of prices are correctly accounted for. The CMA's R^2 measure, once correcting for the errors highlighted in the CAT DRR, shows that the CMA's model fails to do this.
- 6.30 The CMA sets out the view that its model needs to only explain a modicum of price variation in order to be considered statistically valid, stating *"[i]f the correct R-squared figures were so low that it appeared as if the regression model did nothing to explain the variation in prices then this could call into question these regressions and the 'representative patient' approach that we use to calculate the price indices and the resulting price differences between HCA and TLC"* (paragraph 8.113, PFs).
- 6.31 HCA notes that the CMA has itself accepted that the R^2 measure must provide sufficient confidence that the IPA was effectively controlling for relevant patient characteristics. At HCA's recent hearing, the Inquiry Chairman stated robustly that this point was so obvious that the CMA took this as axiomatic – and yet the CMA is now willing to rely on results which do not provide sufficient assurance that age, gender and length of stay are controlling for price variations.
- 6.32 Further, HCA has already adduced expert evidence to the Tribunal that the results on which the CMA is now seeking to rely are not sufficient to provide sufficient confidence that it is capturing all the factors which explain treatment prices. Professor Waterson noted in his Expert Report to the Tribunal when commenting on the CMA's errors in its original IPA: *"The overall impact is that rather than "a large majority of regression results having an adjusted R^2 that is above 80%", making this correction shows, according to the KPMG analysis set out in Table 9, that only a minority passes this criterion. Because the statements on accuracy of*

¹³² CAT Ruling, 23 December 2014 , paragraph 12.

*explanation are wrong, the reader of the appendix gains a false impression of the extent to which the three patient-related factors in the regressions are accurately capturing the true treatment prices. This is important because these results then feed into later processes in calculating the price charged by particular operators to particular PMIs. [...] In my view, given the results following correction of this error, **it would have been appropriate and reasonable for the CMA to seek additional explanatory variables within the data in order to achieve a higher average degree of explanation of treatment prices, prior to testing overall differences across operators.***¹³³

- 6.33 The R² statistics presented by the CMA continue to show that the three explanatory variables used by the CMA, namely age, gender and length of stay, do not explain enough of the variation in insured prices. As such, the CMA cannot be confident that its insured-price comparison has been conducted on a like-for-like basis, and therefore that any systematic differences in patient or episode complexity have been properly accounted for.
- 6.34 The analysis of the expected prediction error, which the CMA has refused to engage with properly (Appendix D, paragraph 6, PFs), casts further doubts on the level of confidence that the CMA can place on the IPA results.
- 6.35 Although different from the analysis of statistical significance, the analysis of the expected prediction error provides further evidence of the fact that there are important determinants of episode price that the CMA's IPA has not accounted for.

Price differences are not representative

- 6.36 The CMA appears to consider that its common basket approach to assessing price differences between HCA and TLC is sufficiently representative to be reliable. Furthermore, they state that a comparison based on the common basket treatments may underestimate any price differences.
- 6.37 This contrasts with the CMA's original position as set out above in paragraph 6.8 where the CMA emphasised the importance that a sample should be representative in order for the analysis to be reliable.
- 6.38 HCA's view is that the approach is flawed because the sample of procedures used in the IPA does not provide enough of a basis for an informative assessment of relative prices, even ignoring all broader issues with the methodology. There are two main reasons why the sample used by the CMA (the "common basket") is problematic.
- 6.39 The first is that the common basket is small relative to the number of treatments HCA and TLC provide,¹³⁴ which risks (though does not imply) it being unrepresentative of HCA's and TLC's offering as a whole.
- 6.40 Evidence submitted previously shows that the treatments in the common basket are not representative of HCA's or TLC's business, or of treatments outside the common basket. For example, treatments inside the common basket are less complex than those outside.¹³⁵
- 6.41 Within this 'bad' sample, ⌘CCSDs drive the vast majority of the weighted average price difference. These ⌘ CCSDs are not representative of HCA's business (as previously shown),¹³⁶ and hence the risk that the price difference cannot be informative of pricing levels outside the common basket is significantly amplified.
- 6.42 The CMA states that, even if the treatments in the common basket are not representative, this does not undermine its analysis, as operators face less competition over the treatments outside the common basket and therefore, if anything, such treatments are likely to display higher price differences. In this sense, the CMA claims its analysis is conservative (paragraph 8.100, PFs).

¹³³ CAT Expert Report, 7 October 2014, paragraph 24.

¹³⁴ CAT DRR, Annex 7, paragraph 3.

¹³⁵ CAT DRR, Annex 7, paragraphs 5-7.

¹³⁶ IPA WP DRR, 24 July 2015, paragraph 5.8.

- 6.43 This position is not founded on any analysis of competition for treatments outside the common basket. HCA has already explained that the whole approach to measuring competitive constraints by considering competitors at a given point in time is inappropriate in a market where competition translates in a continuous stream of new treatments being introduced to market.
- 6.44 However, even if this was not an issue, KPMG has shown in the PFs DRR that ✂.
- 6.45 This clearly demonstrates that the idea that HCA faces less competition outside the common basket is completely unfounded and contrary to available evidence. It is also worth noting that these are also additional reasons why comments by Bupa¹³⁷ relating to the supposed “superdominance” of HCA and TLC outside the common basket are also entirely unfounded.
- 6.46 Finally, the CMA has incorrectly excluded multiple-CCSD episodes because it believed that multiple-CCSD episodes may not be comparable across operators due to differences in billing practices (paragraph 8.64 part (a), PFs) and Healthcode stating that they are only “to a limited degree accepted by insurers (Appendix E, paragraph 11, PFs).
- 6.47 Analysis in the PFs DRR shows that ✂.¹³⁸ In light of this, it is not rational for the CMA to conclude that “*our overall estimated price differences between HCA and TLC are robust to the inclusion of multiple-CCSD episodes*” (paragraph 8.135, PFs).
- 6.48 The fact that the inclusion of more data significantly changes the results of the IPA testifies both to the lack of representativeness of the analysis and to the general lack of robustness of the CMA’s IPA.

There is no causal relationship between HCA’s prices and its market share

- 6.49 For all the reasons set out above, the IPA cannot be seen to provide any evidence of a price differential between HCA and TLC on a like-for-like basis. However, even if one were to conclude that there was a price difference, the evidence overwhelmingly shows that this cannot be due to HCA’s local market share.
- 6.50 HCA has submitted numerous pieces of evidence over the course of the inquiry showing that the relationship between insured prices and market shares cannot be a causal one. Importantly, HCA has provided evidence of the variation in estimated price differences in the CMA’s IPA across years and insurers, while HCA’s market share has remained stable across time.¹³⁹ This variation is confirmed in the PFs results and puts the existence of a causal relationship between market shares and prices into serious doubt if it does not rule it out altogether.
- 6.51 In addition to the evidence already submitted before the remittal, KPMG analysed spare inpatient bed capacity and found that there is plenty of spare capacity in central London.
- 6.52 The importance of spare capacity in the context of bargaining between HCA and the PMIs is recognised by the CMA in the Final Report:
- “PMIs’ outside options will not only reflect local concentration, but are more generally related to their ability to divert policyholders under the terms of the policy away from the delisted hospital.”¹⁴⁰*
- 6.53 As noted in section 4, in a bargaining context, the existence of sufficient spare capacity for PMIs to divert their demand to other hospital operators is economically inconsistent with any theory of negotiated prices arising from market shares. This is because there is no clear link between HCA’s market share and PMIs’ outside options in the presence of such spare capacity.

¹³⁷ Bupa’s Response on the IPA WP, paragraph 2.6.

¹³⁸ PFs DRR, paragraph 4.25.

¹³⁹ A Submission on the Analysis of Insured Prices, paragraphs 81-83 and Table 6.

¹⁴⁰ Final Report, footnote 397.

- 6.54 However, even aside from these theoretical arguments, evidence of spare capacity fundamentally undermines the CMA's position set out in the Final Report.
- 6.55 In the PFs, the CMA has set out views from third parties commenting on the spare capacity analysis and has observed that "[c]apacity 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)" (paragraph 4.47, PFs).
- 6.56 KPMG tested a number of these other aspects of spare capacity in the data room, and its analysis confirms (and extends) the results obtained in the previous data room: namely that ✂.
- 6.57 This of course demonstrates as completely unfounded any contention that HCA's market share somehow enables it to charge higher prices.
- 6.58 To the extent that HCA has any bargaining power, this is due to its quality and reputation. These are entirely pro-competitive factors. Importantly, the views expressed both by HCA, and now also by third parties, are in agreement on this point.
- 6.59 HCA notes in section 4 that any bargaining power it may have with PMIs must relate to its quality, rather than its market share, and that the evidence put forward by PMIs in relation to HCA being "must have" relates to HCA's quality and reputation, rather than a lack of spare capacity elsewhere. It is in relation to this very issue that HCA made the following submission to the CMA:
- "✂If we do not give their customers great customer service and give them fantastic healthcare and so on, then we do not have any leverage in that negotiation.... ✂ the idea that one side has all the power I think completely misses the point. That is not the way it works."**¹⁴¹
- 6.60 This appears also to be consistent with the view of AXA, which, in its hearing with the CMA of 12 August 2015, acknowledged that customer preference is the critical consideration for whether to redirect business away from HCA, as opposed to a lack of spare capacity:
- "Regarding spare capacity, AXA PPP stated that there may theoretically be sufficient capacity in relation to available beds and operating theatre hours among other hospital operators which might mean it would conceivably be able to redirect its business [away from HCA] in a mathematical sense. However, even if that was the case, only a small subset of its clients would be prepared to submit to redirection because of HCA's reputation".**¹⁴²
- 6.61 This invalidates an AEC based on market shares and of course undermines the effectiveness of any remedy that was linked to HCA's market share.

¹⁴¹ Transcript of hearing on 13 August 2015, pages 31-32.

¹⁴² Summary of hearing with AXA PPP on 12 August 2015, paragraph 26.

7. PROFITABILITY

Key points

- The CMA has shifted the emphasis away from the IPA and onto the profitability assessment to support its insured AEC finding, which reflects the CMA's acceptance that the IPA is seriously flawed and cannot be relied on.
- However, the CMA's profitability analysis is based on inadequate and outdated assumptions (particularly in relation to hospital property valuations in central London), and the CMA can place no weight on these results.
- As acknowledged by the CMA guidelines, a profitability analysis should only be used in the context of an overall assessment of the market, and cannot be relied upon in isolation to provide conclusive evidence about the competitive nature of the market. Instead it must be linked to other solid evidence and market features, which the CMA does not have.
- It is important for the CMA to exercise care when interpreting the results of its profitability analysis and considering how much weight to give to a profitability analysis as part of a wider evidence base. The CMA has not reflected this in the use of its profitability results as support for its AEC finding.

Introduction

- 7.1 In the PFs, the CMA seeks to place greater reliance than previously on its assessment of HCA's profitability. The CMA concludes that *"HCA earned returns substantially and persistently in excess of the cost of capital"* and argues that this demonstrates that *"the price of healthcare services may be high in relation to the costs incurred by HCA in providing these services and thus higher than we would expect in a competitive market"* (paragraph 11.38, PFs).
- 7.2 In the Final Report, the CMA found that BMI, HCA and Spire *"have during the period under review, been earning substantially and persistently in excess of the cost of capital"* (paragraph 6.474, Final Report). However, the CMA did not allege in the Final Report that higher profitability gave rise to AECs for insured or self-pay patients either within or outside central London:
- The CMA relied solely on the IPA to support its finding that in central London *"local substitutability plays a role in determining insured price outcomes and provides an indication of the magnitude of the relationship between local concentration and insured prices"* (paragraph 6.488, Final Report).
 - The CMA's case in the recent judicial review proceedings before the Tribunal was put precisely in these terms, that the CMA's empirical analysis of the IPA formed the basis for the insured AEC finding in central London: *"That finding, based on the*

empirical analysis, was then considered in conjunction with other evidence identified by the CMA, namely the qualitative evidence of insured price negotiations and the outcome of the PCA (Final Report, paragraph 6.377-6.378). The CMA concluded that, notwithstanding the limitations of its empirical analysis, overall for central London the results of the empirical analysis all support the hypothesis that local substitutability plays a role in determining pricing outcomes and provides an indication of the magnitude of the relationship between local concentration and insured prices (Final Report, paragraph 6.381)".¹⁴³

- The Tribunal also found that the IPA was "**absolutely critical** as the basis of the CMA's findings of relevant AECs and thus for its decision to impose the divestment remedy".¹⁴⁴
- The CMA concluded that notwithstanding that BMI and Spire also "*made returns that are substantially and persistently in excess of the cost of capital*" there was "*insufficient evidence in the IPA that local concentration outside central London, combined with barriers to entry and expansion, was leading to higher insured prices across the range of treatments outside central London*" (paragraphs 6.493-6.494, Final Report).

7.3 The CMA now recognises, following HCA's extensive criticisms of the IPA, that the IPA is seriously flawed and is incapable of supporting a finding that HCA's market share in central London leads to higher prices. It therefore now seeks to shift the emphasis away from the IPA and onto its profitability assessment to justify its finding of an AEC in support of insured patients. This shift in the CMA's reasoning reflects the weaknesses in the CMA's case and its acceptance that the IPA can no longer be relied on.

7.4 In this regard, the CMA is, once again, uncritically adopting the views of Bupa and AXA-PPP who have both urged the CMA to recognise that the IPA cannot in and of itself support the insured AEC finding:

- AXA-PPP argued that while "*the IPA was treated by the CMA in the litigation as a "critical part" of the reasoning supporting the original insured AEC decision ... we do not believe that it is necessary for any revised, corrected or "new" IPA to form a critical part of the reasoning for any new insured AEC decision ...*".¹⁴⁵
- Likewise, Bupa argued that "*the IPA is only one aspect of the evidence contributing towards the CMA's assessment of competitive conditions in central London and we would be concerned if it were to assume a disproportionate significance in the CMA's reconsideration of these issues*".¹⁴⁶

7.5 The CMA is therefore praying in aid its profitability analysis in order to shore up its finding of an AEC in respect of insured patients. However, for the reasons set out below, the CMA cannot rely on the profitability assessment, any more than on the IPA, to support its AEC finding.

7.6 The CMA asserts that it "*did not receive any submissions, from HCA or other parties, providing new evidence or arguments that either challenged the robustness of the original*

¹⁴³ CMA's Amended Defence, paragraph 78.

¹⁴⁴ *HCA v CMA & Ors* [2014] CAT 11, 25 July 2014, paragraph 31.

¹⁴⁵ AXA-PPP's letter to the CMA dated 9 March 2015.

¹⁴⁶ Bupa's letter to the CMA dated 9 March 2015.

profitability analysis, or suggested that HCA's profitability had declined since 2011" (paragraph 11.39, PFs). However, HCA would point out as follows:

- The CMA repeatedly stated that the remittal was confined to its "*reconsideration of the IPA*" and at no point did it invite submissions relating to profitability on the basis that it could no longer rely solely on the IPA.
- The CMA also expressly requested HCA and other interested parties "*to not simply repeat points made in the original market investigation and to focus instead on (relevant) new points not previously raised or on evidence which points to changes in the market since the original market investigation*".¹⁴⁷
- HCA has previously made extensive submissions with regard to the CMA's profitability analysis which have not been addressed either in the Final Report, or in the PFs. Furthermore, the CMA has not reviewed the profitability analysis in the light of any material changes since 2011.

7.7 The remainder of this section covers the following:

- Substantial developments since 2011 which the CMA needs to consider;
- Concerns with the CMA's evidence on profitability in the PFs;
- Flaws in the CMA's interpretation of and reliance upon its profitability analysis of HCA; and
- The uncorrected errors in the CMA's profitability analysis from 2011.

Substantial developments since 2011

7.8 In the PFs the CMA relies on the profitability analysis it conducted in 2013 in relation to the period 2007 to 2011. This is the same analysis that the CMA relied on in its Final Report.

7.9 The CMA's profitability analysis is based on estimates of HCA's return on capital employed ("ROCE"), which is compared to an industry-wide cost of capital metric. The CMA's ROCE analysis uses an adjusted EBIT¹⁴⁸ figure as the numerator for estimating ROCE, with adjusted capital employed being the denominator. The adjustments to capital employed made by the CMA, in order to achieve an economically meaningful estimate of operating assets, are necessarily subjective. The views of HCA and the CMA on these adjustments are highly divergent, particularly in relation to defining the appropriate alternative use for HCA's hospital properties. The central London property market has seen considerable growth since the CMA conducted its profitability analysis, and this should be properly accounted for, as reflecting the appropriate asset values is a crucial part of any ROCE analysis.

7.10 In this section we discuss the CMA's most recent views on alternative use, which are inconsistent with the underlying assumptions of the 2011 profitability analysis, and material changes in circumstances since 2011, both of which raise questions about the validity of the profitability analysis.

¹⁴⁷ CMA's letter to Nabarro dated 13 April 2015.

¹⁴⁸ Earnings before interest and tax.

The CMA's current views on alternative use are inconsistent with the results of its profitability analysis

- 7.11 HCA's position is that, when considering possible alternative uses for the purpose of valuing property, the most likely alternative use of its properties would be residential.¹⁴⁹ In the context of the profitability analysis, the CMA dismissed HCA's arguments and held the view that the alternative use would be commercial. This was on the basis that a change of use to residential was not viable, given planning permission and costly social housing requirements.¹⁵⁰
- 7.12 However, in the recent provisional notice of remedies the CMA believed that the sale of NHS properties is likely to be to residential developers.¹⁵¹ This clearly implies that the appropriate valuation for HCA's assets is one that assumes residential as the alternative use.
- 7.13 The CMA cannot place weight on a profitability analysis which relies on property valuation assumptions which are inconsistent with its current view of the market. The CMA cannot logically argue that, for the purposes of its profitability assessment, the relevant benchmark is commercial use, whereas for the purposes of its assessment of barriers to entry, the relevant benchmark is sale to residential developers. The CMA's analysis should reflect its current view and it should acknowledge that the valuations it relies on for the profitability analysis are based on an outdated assumption of alternative use, substantially underestimating HCA's capital base and therefore overstating the estimate of HCA's ROCE.

Property valuations

- 7.14 In conducting its profitability analysis, the CMA used a report prepared by Altus Edwin Hill ("AEH") to value HCA's land and buildings, which assumed that the alternative use would be commercial offices.¹⁵²
- 7.15 HCA strongly believes that the land and buildings should be valued with reference to the alternative use that has the highest value, in this case residential property, as this represents the true opportunity cost of such buildings being used as hospitals. HCA submitted a KPMG valuation which assumed that the most appropriate alternative use for HCA's properties would be residential, an assumption the CMA did not to adopt in its original analysis but that it now seems to consider appropriate. For a discussion of the property assumptions in the 2011 PFs please refer to paragraph 7.45 below.
- 7.16 There have been a number of material changes in the property market since the previous profitability analysis was conducted by the CMA, which significantly limit the weight which can be placed on the underlying property valuations used by the CMA and any results derived using those values. Indeed these changes point clearly to the original analysis underestimating the value of HCA's assets and hence overestimating its profitability.
- 7.17 These changes have included an increase in residential conversions and recent examples where planning permission has been granted for conversion of hospitals to residential developments in central London. In August 2015, the London Chest Hospital (Tower Hamlets) was sold to Circle Housing for approximately £49.6m for residential conversion.¹⁵³

¹⁴⁹ HCA's response to the original Provisional Findings, Appendix 5, paragraph 5.41.

¹⁵⁰ Final Report, Appendix 6.13, paragraph 116.

¹⁵¹ Notice of Possible Remedies, paragraph 49.

¹⁵² Final Report, Appendix 6.13, paragraph 100.

¹⁵³ <http://www.bartshealth.nhs.uk/media/press-releases/2015/october/profits-of-former-hospital-sale-to-benefit-patients/>

Circle has partnered with developer Crest Nicholson to redevelop this site and will apply for planning permission in 2016.¹⁵⁴ In 2014, St Bernard's Hospital (Ealing) sold disused land and buildings to property developers Catalyst and Westcombe.¹⁵⁵ There has also been a significant improvement in political desire for greater stocks of residential housing, which has been reflected in a more benign attitude towards residential conversions. For example, from May 2013 the UK government changed planning rules to allow office to residential conversions without the need for planning permission and also without the requirement to contribute any affordable housing costs to local authorities (the scheme is now expected to be made permanent).¹⁵⁶

- 7.18 The evidence above shows that there is now further support for HCA's position that the most likely alternative use of HCA's hospital properties is ✂. We also note that residential and commercial prices have increased significantly since the CMA conducted its profitability analysis in 2013. This means that the CMA cannot rely on the results of its profitability analysis which are based on outdated assumptions on alternative use and market values.

The CMA's justifications for a five year time period is inconsistent with its assessment of remedies

- 7.19 The CMA relies on profitability analysis as supporting evidence for its AEC finding, which covers a five year time period.
- 7.20 Part of the CMA's justifications for using this time period is the investment lead time of two or three years for many of the assets used by private healthcare providers the three year duration of the PMI contracts and the relatively short period during which hospital operators incur lower returns while starting up.¹⁵⁷
- 7.21 This position is at odds with HCA's view that the proposed five year period does not reflect the full life cycle of the major assets in the industry, and is insufficient to see competition play out in the market, by taking into account the investment lifecycles and time that it takes for the market to respond to changes.¹⁵⁸
- 7.22 While the CMA rejects the use of a longer time period for the purposes of assessing HCA's profitability, the CMA uses a 20-year time period for its remedy cost-benefit model in the Final Report.¹⁵⁹ HCA believes that it is not consistent for the CMA to use a five year time period for profitability analysis, and a 20-year time period for the remedies assessment.¹⁶⁰
- 7.23 The CMA's own evidence and arguments suggests that a five year time period is not appropriate for the market in question, and certainly not a sufficiently long period to reflect the large scale and associated risk of investments made by hospital operators,¹⁶¹ which again raises serious questions over the validity of the CMA's profitability analysis as reliable supporting evidence for its AEC finding.

¹⁵⁴ <http://newsroom.circle.org.uk/joint-venture-to-bring-new-homes-at-landmark-site/>

¹⁵⁵ <http://www.wlmht.nhs.uk/about-wlmht/redevelopment/st-bernards-redevelopment/land-sales/>

¹⁵⁶ <https://www.gov.uk/government/news/thousands-more-homes-to-be-developed-in-planning-shake-up> and Section 4.12: <http://researchbriefings.files.parliament.uk/documents/SN06418/SN06418.pdf>

¹⁵⁷ Final Report, Appendix 6.13, paragraph 24.

¹⁵⁸ Final Report, Appendix 6.13, paragraph 23 and HCA's response to the original Provisional Findings, Appendix 5, paragraph 5.297.

¹⁵⁹ Final Report, paragraph 11.228 (e).

¹⁶⁰ *Ibid.*, paragraph 11.230.

¹⁶¹ CMA Guidelines for market investigations (CC3 (revised)) note that "where large and risky investments have been made, the [CMA] would expect to see a normal level of profitability restored over a relatively long timescale" (paragraph 121).

The CMA adopts an inconsistent position on the importance of hospital brand

- 7.24 In the Final Report, the CMA does not assign any value to HCA's brand when estimating the capital employed, drawing on the results of a survey by Nuffield Health which found that patients did not exhibit significant awareness of hospital brand¹⁶². However, this survey is patient focussed. Therefore the omission of brand on this basis, omits the large brand asset associated with GP's and consultant's awareness of HCA's brand, and the associated quality. The CMA appears to recognise the importance of brand in the PFs noting:

*"... some **private hospitals** and PPU's [in central London] which are **perceived** by patients as offering a higher quality of care"* (paragraph 3.24(a)(iv), PFs).

- 7.25 HCA believes that perception of quality is precisely what a brand should signal. Therefore, the CMA's comments above suggest that its thinking on the importance of brand has evolved since the 2011 analysis. This implies that HCA's asset base was underestimated (specifically in relation to intangible assets) in the CMA's profitability analysis, which therefore cannot be relied upon since it is likely to overestimate HCA's ROCE.
- 7.26 For a discussion of the intangible assumptions in the 2011 PFs please refer to paragraph 7.51 below.

CMA's new comments on profitability

- 7.27 In the PFs, the CMA presents two charts showing revenue and EBITDAR margins¹⁶³ by firm in central London (Figures 9.1 and 9.2, PFs) to support its conclusion that *"HCA's profitability, as measured by its return on capital employed, may have increased"* since the profitability analysis was conducted (paragraph 9.7, PFs).
- 7.28 This data does not support the CMA's findings in relation to profitability, nor does it support the CMA's use of profitability analysis to support its AEC finding because:

- **There is no apparent trend in margins:** There appears to be no trend in profitability over the period, with year-on-year fluctuations and differences between firms.
- **HCA has lower margins than TLC:** The CMA uses the chart to corroborate the view that HCA's profits are high, yet one of the five comparators shown in the chart has persistently higher margins than HCA. In fact, it is TLC, the hospital operator used as the pricing comparator by the CMA in the IPA analysis¹⁶⁴.
- **Growth in revenue doesn't provide any indication of profitability:** HCA considers that it is normal to observe revenue growth in a growing market, and that growth in revenue cannot be used to assess whether economic profits are too high, let alone any adverse effect on competition. In fact this simply testifies that the central London market is dynamic, and provides increasing opportunities for all participants to expand and enter. The recent expansion of all players (particularly the PPUs), and the ongoing and planned entry of large additional hospitals are consistent with a growing market.

Capital has not been considered: The CMA cannot conclude on how ROCE has changed since 2011, without considering what has happened to the capital employed

¹⁶² Final report, Appendix 6.13, paragraph 27 and footnote 27.

¹⁶³ Earnings before interest, tax, depreciation, amortisation and rent.

¹⁶⁴ Note TLC has a higher margin, even before tax, which given its charitable status it is largely exempt from.

in that time. There have clearly been substantial changes in circumstances affecting the capital base (specifically to increase it), not least the changes to the property market in central London, which the CMA has not taken into account.

- 7.29 It is therefore HCA's view that the CMA has provided no credible new evidence on profitability in the PFs. The new evidence presented by the CMA cannot be used to corroborate the results of the CMA's profitability analysis.

The CMA's margin chart shows the CMA has understated HCA's capital employed

- 7.30 What *can* be concluded from the CMA's chart of margins by provider is that the CMA's assessment of what a fair return is for HCA is unreasonably low.
- 7.31 Given a particular asset base, an estimate of the cost of capital can be used to estimate an implied 'fair' profit margin for the firm being assessed. In other words what does the operating profit (being the numerator of the ROCE) figure need to be, in order for the ROCE to equal the cost of capital.
- 7.32 Using the CMA's own estimates of capital employed and cost of capital in its profitability analysis, the average implied fair EBITDAR margin for HCA is approximately 8% (2007 to 2011).¹⁶⁵ This is 8% than the margin achieved by both TLC and BUPA Cromwell in Figure 9.2, which are in excess of 8%.¹⁶⁶ In other words, any private healthcare operator in central London requires a certain level of profit margin in order to generate a reasonable return from the substantial capital base needed. The minimum required profit margin is likely to be significantly higher in central London, where property prices are high, than in other parts of the UK, which is borne out by Figure 9.2.
- 7.33 HCA drew the CMA's attention to the low implied margin in the CMA's calculations, in the context of the substantially understated asset base, in its response to the 2011 PFs.¹⁶⁷ However, the CMA did not address this issue in the Final Report.
- 7.34 The unrealistically low implied margin should be interpreted as a signal that the CMA's estimates of HCA's capital employed and the industry cost of capital, are materially understated.

Interpretation of and reliance upon profitability analysis

- 7.35 Notwithstanding HCA's reservations with the details of the CMA's methodology for its profitability analysis and its results, HCA disagrees with the CMA's interpretation of the results. HCA considers that the CMA should recognise that there is inherent uncertainty in the analysis and that, as a single firm measure, a healthy performance of HCA can and should be seen as an indication of its efficiency, good management and reward for successful investment.

¹⁶⁵ To approximate the implied EBITDAR margin, HCA took the CMA's estimate of HCA's capital employed and multiplied this out by the CMA's mid-point cost of capital for the industry (both from the Final Report), to get the EBIT implied by the CMA. HCA then calculated the ratio of this implied EBIT and the EBIT used in CMA's ROCE for HCA (again from the Final Report) to get the CMA's margin understatement ratio. This was then applied to the EBITDAR margins for HCA presented by the CMA in figure 9.2.

¹⁶⁶ While we have not modelled the implied EBITDAR for the non-HCA hospitals, based on the CMA's actual capital employed figures, the need for significant property assets when running a private hospital in central London would suggest a similar implied fair EBITDAR margin for these hospitals.

¹⁶⁷ HCA's response to the original Provisional Findings, Appendix 5, paragraph 5.142.

- 7.36 Further, it is HCA's strong view that to significantly rely on a single firm profitability analysis to reach an AEC finding is misleading and carries a risk of punishing success. Where profitability analysis is used for this purpose, this should be on the basis of a market wide assessment and alongside supporting evidence, neither of which the CMA has done.

HCA's profitability is a measure of success

- 7.37 HCA is a successful private hospital operator and its profitability is simply reflective of that success. Following its entry into the UK market and expansion in London, HCA has invested heavily to develop an offering that no private hospital operator was providing at the time. This focuses on high acuity treatments. HCA has continued to innovate and invest in new technologies and other factors (such as its highly trained staff), to build the high quality offering on which its strong brand is founded.

Using profitability as evidence will have unintended consequences

- 7.38 Profitability is an important signal for investment and entry decisions. Consequently, the use of profitability evidence needs to be afforded great care, particularly where firm level (rather than industry level) measures are used.
- 7.39 An interpretation of high profitability as evidence to support a serious intervention in the market will be counter-productive, by dampening the very incentives that make markets work well.
- 7.40 For a discussion of how HCA's performance is linked to success, and the consequences of placing undue weight on profitability analysis as evidence, please refer to HCA's response to the CMA's provisional decision on remedies¹⁶⁸,

Profitability analysis should be market wide

- 7.41 The CMA cannot rely on the profitability analysis of one player; an assessment of profitability should be based on a market wide analysis. However, in the PFs, it appears that the CMA is using its assessment of HCA's profitability alone as support for its AEC finding.
- 7.42 The need for a market wide assessment of profitability is clearly set out by the CMA in its own market investigation guidelines, however the CMA has not conducted this analysis for the central London market, and instead has based its assessment on the figures for HCA in isolation.

Uncorrected errors in the CMA's 2011 profitability analysis

- 7.43 In this section we set out material concerns raised by HCA in its response to the CMA's profitability analysis that were not addressed by the CMA in the Final Report. The material flaws with the CMA's profitability analysis mean that the CMA's estimate of HCA's profitability is overstated and highly uncertain.
- 7.44 The concerns set out by HCA still hold and HCA continues to believe that the CMA's profitability analysis is not robust, and cannot be relied upon, as support for the CMA's AEC finding.

¹⁶⁸ See sections titled 'Interference with incentives to invest and innovate, by preventing a firm forced to divest from realising fair market value (FMV) for its assets' and 'HCA has undertaken a large number of risky investments since entering the central London market'.

Property valuations

- 7.45 As explained in paragraph 7.11 above, in the context of the profitability analysis, the CMA did not accept HCA's arguments that the most likely alternative use for HCA's property would be residential. This was on the basis that:
- 7.46 "...it was logically inconsistent to maintain that (a) it is relatively straightforward to gain planning permission *for change of use to residential*, (b) *there is a significant difference between commercial and residential property values* and (c) *a new entrant would have to compete with residential developers rather than commercial developers to obtain a site*".¹⁶⁹
- 7.47 The CMA's rationale for the above appears to be that if planning permission for a change of use to residential was easy to gain, then the logical result would be that commercial price increases would be similar to those of residential, as a developer would simply change the use of the property before sale. It is HCA's view that this was largely a result of a time lag in the market, following which commercial prices would increase at rates which are closer to the increase of residential prices. Recent evidence shows that the difference between residential and commercial prices has now largely diminished, which supports HCA's view (and for the period 2007 to 2011 the CMA's base case ROCE, using the AEH commercial valuation was 3% compared to 3% using the KPMG residential valuation).¹⁷⁰
- 7.48 HCA considers that the CMA's conclusions detailed in paragraph 7.46 above did not fully address HCA's evidence in its response to the original Provisional Findings in 2013. HCA summarises the evidence it provided to support the "residential use" assumption below:
- **Planning permission:** KPMG submitted valuations for HCA based on residential use, along with recent planning decisions where hospital to residential conversions had been permitted in central London. For example, in February 2012, WCC gave planning permission for 300 new homes where The Middlesex Hospital was previously located.¹⁷¹ Furthermore, HCA hospitals are located in highly sought after locations and for each HCA hospital, "...*there is significant unmet demand for residential housing in the surrounding area*."¹⁷²
 - **Social housing costs:** HCA undertook a sensitivity analysis on the value of HCA's hospital assets, assuming maximum affordable housing and section 106 costs.¹⁷³ This analysis reduced the overall property valuation by £30 (£3% of the total valuation). Whilst this would be the maximum cost, and is therefore likely to overstate the actual cost, the property values were still substantially higher than the AEH valuations used by the CMA.¹⁷⁴
- 7.49 Recent evidence, summarised in paragraphs 7.14 to 7.18 above, shows that HCA's views on the conversion of hospital sites to residential property have been borne out. Further, since the profitability analysis was performed, the CMA has changed its position on the likely alternative use of central London hospital sites. This is evidenced in the provisional remedies notice, where the CMA states that NHS sites are likely to be converted to residential use following sale.¹⁷⁵

¹⁶⁹ CMA, Final report, Appendix 6.13, paragraph 116.

¹⁷⁰ HCA's response to the original Provisional Findings, Appendix 5, Figure A5.2.

¹⁷¹ *Ibid.*, Appendix 5, paragraph 5.50.

¹⁷² *Ibid.*, Appendix 5, paragraph 5.55.

¹⁷³ *Ibid.*, Appendix 5, paragraph 5.70.

¹⁷⁴ *Ibid.*

¹⁷⁵ Notice of Possible Remedies, paragraph 49.

7.50 It is therefore unreasonable for the CMA to rely on its commercial use assumption and the corresponding valuations of HCA's assets, which serve to materially overstate HCA's ROCE.

Understated intangibles

7.51 The CMA has not assigned any value to a number of key intangible assets, which HCA has developed over time, including:

- brand and reputation: the perceived quality of HCA's hospitals and treatments has been built up through service excellence over many years, and is clearly shown by the willingness of overseas patients to choose HCA hospitals over a myriad of international choices;
- highly trained specialist staff;
- relationships with consultants and GPs; and
- relationships with customers.

7.52 The CMA dismisses the above on the basis that such assets did not meet its recognition criteria, primarily on the basis that the costs incurred in developing these intangible assets are not additional to costs necessarily incurred in running the business, nor did they serve to create an asset which is separate from any asset arising from the general running of the business.¹⁷⁶

7.53 It is clear that by eliminating these assets in their entirety, the CMA substantially underestimates the capital employed by HCA when conducting its profitability analysis, and therefore overstates ROCE.

7.54 HCA's implied fair margin analysis, described in paragraphs 7.30 to 7.34 above, shows that the CMA has substantially underestimated HCA's capital employed. The exclusion of intangible assets created by the business through investments over many years is one of the primary explanations for this.

7.55 Further, the CMA's position on brand perception appears to have changed since the Final Report.¹⁷⁷ This is one of the most important assets held by HCA (as the loss of such a hard-earned reputation and brand value would be catastrophic for business) - and excluding it in its entirety from the capital base will serve to materially overstate the ROCE.

Overseas patient profitability

7.56 HCA has provided the CMA with a model which allocates costs, revenues and assets between UK and overseas patients, in order to estimate the ROCE for different types of patients. The CMA has dismissed this model on the basis that HCA's approach allocated a disproportionate quantity of costs to UK patients, ✂.

¹⁷⁶ Final Report, Appendix 6.13, paragraphs 69 to 82. Note for reputation or brand the CMA did not capitalise the asset purely on the basis that the costs incurred in developing the brand were not additional to costs necessarily incurred running the business i.e. the criteria of being a separate asset was not discussed.

¹⁷⁷ See paragraph 7.24 above.

- 7.57 However, even after correcting this assumption, the difference in ROCE between UK and overseas patients is still large, with the blended average ROCE for overseas patients being $\times\%$ compared to UK patients, with a ROCE of $\times\%$.¹⁷⁸
- 7.58 HCA agrees that overseas patients on average stay at one of HCA's hospitals for longer than a UK patient. Most of these patients travel significant distances for their treatment and are therefore likely to stay for an extra period of time, either side of the normal treatment window, for practicality purposes.
- 7.59 Further, certain treatment types typically used by overseas patients may be lower cost, including rehabilitation being included during an inpatient stay, rather than on an outpatient basis for a UK patient. \times .
- 7.60 Given that the CMA has provided no evidence that the cost per day for overseas patients is higher and further that there are good reasons why the cost per day could be lower this should not be reflected in a further adjustment of the figures, which indicate that overseas patients have approximately $\times\%$ higher ROCE than UK patients.
- 7.61 HCA clearly faces substantial competition from the global private healthcare market for overseas patients. These overseas patients are focussed on quality, and enjoy a lot of choice when deciding where to go for treatment as there are a wide range of operators available to them. The substantially higher ROCE for overseas patients therefore demonstrates that:
- The CMA's analysis does not focus on the UK market and therefore cannot provide reliable information on its competitiveness;
 - The profitability figures for HCA's combined UK offering are both: inherently imprecise and very likely highly overstated, particularly if they are to be used as an indicator of market power in the UK market, and the CMA has done no analysis of the international market.
 - The CMA needs to clearly explain why the application of an ROCE methodology to the overseas market, which is clearly competitive and in which HCA has a relatively low market share, results in apparently excess profits. Without being able to rationalise this finding, the CMA cannot rely on its finding of excess profitability for HCA's UK operations as support for its AEC finding.
 - HCA provides exceptional, world leading quality, which patients with substantial choice are willing to specifically travel to the UK for. This quality underpins the HCA brand and further supports HCA's view that omitting HCA's brand from the capital base serves to substantially understate ROCE.
 - HCA earns a fair rate of return on UK patients.

Time period of analysis

¹⁷⁸ Note: these ROCE figures are calculated using the same assumptions that HCA used to arrive at the blended ROCE of $\times\%$, see for example HCA's response to the original Provisional Findings, Appendix 5, Figure A5.1.

- 7.62 The CMA performs its profitability analysis over a five year time period using data for 2007-2011. HCA fundamentally disagrees with the CMA's approach here and sets out the reasons for this below.
- 7.63 The CMA believes that there were significant changes in the structure of the industry between 2006 and 2008, such as the temporary exit of Bupa, which rendered the financial data from this period inappropriate for inclusion in the profitability analysis.¹⁷⁹ This is a perplexing rationale from the CMA, considering that competitive markets are rarely in equilibrium. Competitive markets will experience changes in firm and market wide profitability, impacting entry and exit decisions, which in turn influences firm and market wide profitability. It therefore remains HCA's view that an analysis that captures a sufficient period of time to allow competitive forces to play out would necessarily have to include a period of change.
- 7.64 The CMA also stated that there were practical difficulties in interpreting the results of the analysis against a background of significant changes in the market structure over time, and in obtaining data over a longer period.¹⁸⁰ However, HCA had financial data available for a ten year period up to 2011¹⁸¹ and indeed presented this to the CMA.
- 7.65 The CMA's final justification for a five year time period of analysis was the investment lead time of two or three years for many of the assets employed by the private healthcare providers (property and medical technologies/equipment), the three year duration of the PMI contracts and the relatively short period during which they incur lower returns while starting up. In the CMA's view, this means that a five-year period is sufficiently long for the competitive dynamics of the industry to play out.¹⁸² However, it is clear that the major assets in this industry i.e. property and medical equipment/technologies, have much longer lifecycles than five years and indeed the CMA has provided no evidence to the contrary.¹⁸³ Further, the CMA itself recognises the long lifecycle of the industry in its remedy cost benefit analysis, where it assesses the impact of the proposed remedy over a 20-year period (see paragraph 7.22 above).
- 7.66 It is HCA's view that the longest time period that can practically be analysed should be used for an assessment of profitability, so that as much of the economic cycle as possible is captured. The CMA itself held this view in the recent Payday lending investigation, where it "...used as a full a time period as practical by updating the analysis to include data up to 30/06/14."¹⁸⁴
- 7.67 In continuing to rely on a five year period of analysis, the CMA's analysis is inconsistent with the approach it has taken in other areas of analysis and other investigations. The CMA has also not provided any evidence to support short asset lifecycles in the industry, which HCA considers to be incorrect. Conducting profitability analysis over such a short period of time serves to give a misrepresentative and in this case overestimated view of profitability.

Working Capital

¹⁷⁹ Final Report, Appendix 6.13, paragraphs 19-21.

¹⁸⁰ *Ibid.*

¹⁸¹ HCA's response to the original Provisional Findings, Appendix 5, paragraph 5.296 and Figure A5.14.

¹⁸² Final Report, Appendix 6.13, paragraph 24.

¹⁸³ *Ibid.*, Appendix 6.13, paragraph 23.

¹⁸⁴ CMA, Payday Lending Final Report, paragraph 4.125. This resulted in a seven year time period from 2008 to 2014.

- 7.68 The CMA uses the average level of (net) working capital during the year in its profitability assessment¹⁸⁵ and does not include any operational cash balances held by providers.¹⁸⁶ This is on the basis that whether a firm holds an operating cash balance or uses an overdraft is a financing choice.¹⁸⁷
- 7.69 However, the CMA does not address HCA's argument that cash is important to a business, in order to demonstrate its "financial robustness", for example in negotiations with PMIs.
- 7.70 In the response to PFs, HCA cited the example of Bupa using BMI's poor cash position as leverage during contract negotiations.¹⁸⁸ In HCA's view, this example demonstrates that the decision to use operating cash rather than an overdraft is not purely a financing decision, but is in fact operational, and could contribute to the success of business critical negotiations.
- 7.71 HCA believes that the CMA's lack of consideration of the impact of operating cash on business negotiations is unreasonable, and has resulted in an unsupported assumption within its profitability analysis which overstates HCA's profitability.

Leased assets

- 7.72 HCA leases a ✂ of its property assets. In its response to the 2011 PFs, HCA argued that these should be capitalised and taken into account in any assessment of capital employed, as the accounting treatment is subjective and arbitrary and the results of the ROCE analysis between providers will vary substantially, depending on the financing arrangements.¹⁸⁹
- 7.73 The CMA disagreed with HCA and simply followed the accounting treatment for leased assets, the weaknesses of which are widely acknowledged by the International Accounting Standards Board and academics.¹⁹⁰ The CMA's justification for this was:
- 7.74 *"...We thought that the extent of this distortion and its direction, i.e. whether the exclusion of leased properties from the capital base increased or decreased returns, would depend on the level of rent relative to the cost of acquiring the building. In some cases, the ROCE could be increased by renting buildings rather than acquiring them, whilst in others the ROCE would be reduced".*¹⁹¹
- 7.75 HCA fundamentally disagrees with this statement. Stripping out five years of rent from the profit figure will increase ROCE. However, adding in the current property value will push up the capital base considerably, decreasing ROCE. The large increase in the capital figure will offset the slight increase in profit. In other words purchasing rather than renting, in the current market, will almost always reduce ROCE, especially over such a short period of time.¹⁹²

¹⁸⁵ Final Report, Appendix 6.13, paragraph 131.

¹⁸⁶ *Ibid.*, Appendix 6.13, paragraph 133.

¹⁸⁷ *Ibid.*

¹⁸⁸ Final Report, Appendix 6.11, paragraph 255 and HCA's response to the original Provisional Findings, Appendix 5, paragraph 5.151.

¹⁸⁹ HCA's response to the original Provisional Findings, Appendix 5, paragraphs 5.99 to 5.117.

¹⁹⁰ *Ibid.*, Appendix 5, paragraphs 5.103 to 5.111.

¹⁹¹ Final Report, Appendix 6.17, paragraph 66.

¹⁹² By way of example, assume that an entity requires 1 square foot of property, this is leased for £60, yields on the market are 10%, profit before rent costs are £100 and other non-property assets are £100. The impact on ROCE, over a five year period for an entity that rents this 1 square foot of space is simply a reduction in profit of £60 per annum. The impact on ROCE, over a five year period for an entity that owns this 1 square foot of space is to add £600 to the asset base (£60/10%) per annum. The ROCE for the entity that rents is 40%, whereas the entity that owns the property has a ROCE of 14%. Further, for the ROCE's to be equivalent the yield has to increase to 40%, which is clearly unrealistic.

Freehold improvements and refurbishments

- 7.76 The CMA does not include HCA's freehold improvements and refurbishments in capital employed, on the basis that:
- 7.77 *"We have not, however, capitalized HCA's freehold improvements and refurbishments in addition to the KPMG building value as we reasoned that this was equal to approximately half the potential affordable housing liability that KPMG had not reflected in its valuation and, therefore, already represented a very conservative assumption from the point of view of our analysis."*¹⁹³
- 7.78 In HCA's view, the CMA's arguments are incorrect. The exclusion of social housing costs in the KPMG valuation is a separate assumption, which recent evidence on social housing requirements (described in paragraph 7.17 above) proves was entirely reasonable. The CMA cannot disregard a selection of tangible assets from HCA's capital base, simply because it takes a different view on another assumption elsewhere.

Cost of capital

- 7.79 HCA raised a number of concerns on the CMA's cost of capital calculation, in its response to the 2011 PFs. Many of these have either simply not been addressed or been incorrectly addressed by the CMA. HCA summarises these issues below:
- **Beta sampling frequency:** In the context of other ongoing cases, the CMA has acknowledged the limitations of using betas, which are estimated on the basis of daily data: *"We have estimated these [betas] on both a monthly and a quarterly basis. This approach follows the research findings of Gilbert et al. which show that monthly and quarterly betas are generally more reliable than those estimated on the basis of high frequency data, i.e. daily or weekly betas"* (CMA, Energy Market Investigation).¹⁹⁴ The limitations of using high frequency data are also widely recognised in theory and academic literature and this was highlighted by HCA in its previous submissions to the CMA.¹⁹⁵ Despite this, the CMA continued to use betas sampled on a daily basis. HCA's analysis suggests that if the CMA had correctly used monthly betas, the cost of capital would be materially higher.¹⁹⁶
 - **Inappropriateness of South African and Indian markets for beta proxies:** HCA provided clear evidence to the CMA that the South African and Indian markets are not suitable proxies for beta estimates, as neither the CAPM nor the efficient market hypothesis hold for these two markets.¹⁹⁷ The CMA has not addressed these points, and indeed placed equal weight on each of the beta proxies identified (including US comparators). The CMA has also made no adjustment for the different country risks in emerging markets. Removing or at least placing less weight on these less relevant proxies would serve to make the cost of capital estimate more robust.
 - **Bloomberg betas used are statistically unreliable:** As noted by HCA previously, the betas used by the CMA are based on underlying data that exhibits a high level of

¹⁹³ Final Report, Appendix 6.17, paragraph 58.

¹⁹⁴ CMA Provisional Findings to Energy Market investigation, Appendix 10.4.

¹⁹⁵ HCA's response to the original Provisional Findings, Appendix 5, paragraph 5.245.

¹⁹⁶ With implied equity betas using the CMA's own comparators and equal weighting approach moving from 086.-1.20 to c.1.6.

¹⁹⁷ HCA's response to the original Provisional Findings, Appendix 5, paragraphs 5.211 to 5.216.

noise and is therefore statistically unreliable.¹⁹⁸ The CMA does not comment on statistical reliability of the beta data in its analysis or interpretation of the outturn betas.

- **Measuring inflation:** HCA identified that the CMA did not treat inflation in a manner that is consistent with precedent, set by the CMA itself in many other cases.¹⁹⁹ Further, the CMA has not addressed an inflation error in its equity risk premium calculation.²⁰⁰ This is due to errors in the CMA's methodology in relation to the interchange between nominal and real rates. These errors not only impact the CMA's risk free rate estimate but the entire cost of capital calculation, with the net effect of decreasing the cost of capital and therefore overestimating profitability.
- **Cost of debt:** When estimating the cost of debt the CMA used data from credit rating agencies that are not internationally recognised, such as 'Thai rating and Information Service Co.'²⁰¹ and from this, the CMA concludes that South African and Indian providers have higher credit ratings than US providers. The conclusion that South African and Indian providers are safer counterparties to lend money to than listed US firms is clearly incorrect and makes the CMA's analysis of cost of debt unreliable.
- **Gearing structure for adjusting beta:** The CMA observes country-specific equity betas, which need to be adjusted to strip out the impacts of the proxy firms' gearing structure, in order to derive the asset betas. However, the CMA uses the UK industry gearing structure, rather than firm specific gearing, to arrive at asset beta. This is internally inconsistent. Country-specific equity betas should be de-g geared using country-specific gearing levels, in order to estimate country-specific asset betas. Mixing country-specific equity betas with UK-specific gearing is an oversight the CMA must address.

7.80 The errors and inconsistencies in the CMA's cost of capital calculation demonstrate that the CMA's profitability analysis is highly unreliable undermining the CMA's ability to place any reliance upon its profitability analysis.

¹⁹⁸ HCA's response to the original Provisional Findings, Appendix 5, paragraph 5.224.

¹⁹⁹ HCA's response to the original Provisional Findings, Appendix 5, paragraph 5.155 and Final Report, Appendix 6.14, paragraphs 17 – 18.

²⁰⁰ *Ibid.*

²⁰¹ Final Report, Appendix 6.14, Table 8.

8. SELF-PAY PATIENTS ANALYSIS AND AEC

Key points

The CMA has incorrectly assessed the evidence before it during the Remittal Inquiry and the analysis of the self-pay patients AEC in the Final Report is flawed. In particular:

- The CMA's self-pay analysis (in particular, the price-concentration analysis, or PCA) is undermined by some of the same flaws that affect the IPA. Specifically, HCA's advisors' analysis of the raw data underlying the CMA's IPA showed that when episode complexity was better controlled for, the results of the IPA substantially changed. The CMA failed to correctly examine the implication of this for its analysis of self-pay patients.
- The PCA is not relevant to central London or HCA's self-pay business, and the CMA relied on a flawed analysis of qualitative evidence to extrapolate the UK-wide relationship it found between local concentration and self-pay prices in the PCA to central London.
- More generally, the PCA is not robust. First, just as the IPA, the PCA has failed to appropriately control for complexity and construct a comparable analysis. Second, the PCA cannot be used to identify a causal relationship between local market concentration and self-pay prices.
- The CMA's reasoning on quality and range to insured patients undermines the self-pay patients AEC, particularly as the CMA accepted that self-pay patients are likely to be more price-sensitive than insured patients on average and may typically have more alternatives available to them than insured patients.
- There have been a number of material changes in the provision of privately funded healthcare services to self-pay patients in central London since the publication of the Final Report (which relied on data from 2009 to mid-2012 in the PCA), including the rapid growth of PPUs in central London and new and innovative self-pay pricing mechanisms introduced by HCA. The CMA either ignored or mischaracterised the implications of these as part of the competitive assessment it carried out in PFs.
- The CMA's assessment of competitive constraints is flawed, and this undermines the self-pay AEC.

Introduction

- 8.1 In the original private healthcare market inquiry, the CMA identified features that in its view gave rise to AECs in the supply of hospital services, which led to higher prices for inpatient and some day-case and outpatient hospital services to self-pay patients at private hospitals in local markets, including central London (paragraph 10.5, Final Report).
- 8.2 The CAT stated that if, during the consultation on the IPA through the Remittal Inquiry, something emerged that had ramifications for the self-pay AEC, the CMA would need to consider these and the implications for the overall reasoning in the Final Report.²⁰²
- 8.3 The CAT also stated that it is important to carefully examine whether the relationship between market share and insured prices was causal.²⁰³
- 8.4 In the PFs, the CMA notes that although the self-pay AEC decision was not quashed by the CAT, the CMA's findings on self-pay patients remain a relevant issue as they formed part of the basis for the divestment decision which was quashed by the CAT (paragraph 10.7, PFs).
- 8.5 As set out in PFs, the CMA chooses to examine two aspects in this regard. First, the CMA considers three sources of potential competitive constraints on HCA (non-inpatient providers, PPU's and the NHS). The CMA concludes that these may impact on competition for self-pay patients to a greater extent than for insured patients. However, the CMA also concludes that the competitive constraints that these are likely to impose on HCA are weak (paragraphs 10.9 and 10.40, PFs).
- 8.6 Second, the CMA examines some of HCA's criticisms of the IPA, insofar as they may apply to the CMA's analysis of self-pay patients. The CMA concludes that it can rule out the hypothesis that its observed relationship between self-pay prices and local concentration may be driven by differences in episode complexity (paragraphs 10.9 and 10.41, PFs).
- 8.7 HCA sets out next why it believes that the CMA failed to correctly examine the evidence before it, thus incorrectly confirming its finding of an AEC in relation to self-pay patients. Specifically, the remainder of this section considers in turn:
- some of the flaws identified in relation to the IPA that also invalidate the CMA's assessment of self-pay prices and local market concentration;
 - the CMA's inappropriate extrapolation of the results of the UK-wide relationship it found between local market concentration and self-pay prices to central London;
 - other factors implying a lack of robustness in the CMA's assessment of the relationship between local market concentration and self-pay prices;
 - the inconsistency between the CMA's reasoning on quality and range and the finding of an AEC in relation to self-pay patients;
 - a number of the material changes in the provision of privately funded healthcare services to self-pay patients in central London since the publication of the Final Report (which relied on data from 2009 to mid-2012 in the PCA); and

²⁰² *HCA v CMA* [2014] CAT 23, paragraph 60.

²⁰³ *HCA v CMA* [2014] CAT 11, paragraph 37.

- the flaws in the CMA's assessment of competitive constraints which undermine the self-pay patients AEC.

- 8.8 HCA notes that the CMA states: *"In relation to the PCA, we do not consider that patient complexity within the relevant treatments across different local markets is likely to be systematically correlated with local concentration to an extent that would call into question our results. **Even if we were to put less weight on the accuracy and robustness of the PCA, we would, in any case, provisionally conclude that the other evidence, such as barriers to entry, internal documents, market shares, and parties' views, indicates that local self-pay prices are likely to be driven by weak competition in some local markets including central London**"* (paragraph 10.41, PFs).
- 8.9 HCA strongly disagrees that barriers to entry, internal documents and market shares indicate that self-pay prices are likely to be driven by weak competition in central London, and let alone that evidence on these would be sufficient for an AEC finding for self-pay patients. HCA sets out the reasons for this in section 2 (competitive assessment of private hospital operators in central London) and section 3 (barriers to entry and expansion in central London) above.
- 8.10 Notwithstanding all of HCA's concerns about the PCA and about the CMA's assessment of the provision of private healthcare services to self-pay patients, and even assuming that the PCA was a robust piece of evidence (which HCA disagrees with), HCA notes that the economic significance of the effect of local market share on self-pay prices estimated by the PCA is minimal. Specifically, a 20 percentage points reduction in (weighted average) local market share would only lead to a 3.4% reduction in self-pay prices (paragraph 11.65, Final Report). This implies that even a (ineffective and disproportionate, in HCA's view) divestment remedy such as that imposed in the original market inquiry would have only led, even according to the CMA, to a base case scenario of price benefits to self-pay patients from the divestment of the ~~XX~~ of only £~~XX~~ per year (Table 2, Appendix 11.2, Final Report).

The flaws in the IPA undermine the PCA for self-pay patients

- 8.11 The CMA's empirical analysis of insured prices set out in the IPA WP published during the Remittal Inquiry sought to compare insured prices across hospital operators on a like-for-like basis (paragraphs 30-31, IPA WP).
- 8.12 However, scrutiny of this analysis during the Remittal Inquiry showed that the factors the CMA had controlled for were likely to be insufficient to ensure that comparisons of insured prices across private hospital operators were truly made on a like-for-like basis.
- 8.13 Specifically, analysis by HCA's advisors of the raw data underlying the CMA's IPA (disclosed following HCA's appeal to the CAT after the publication of the Final Report), highlighted the significant differences in both patient and treatment mix at HCA relative to TLC, the hospital operator the CMA used as a comparator, even once accounting for the factors (patient age, gender and length of stay) that the CMA's analysis already included (paragraphs 4.20-4.33, KPMG Data Room Report of 24 July 2015).
- 8.14 The ability to use information available in the raw data (that is, including the individual items that an insured patient received and his or her insurer was charged for as part of an episode) was instrumental to (i) the assessment of whether the comparison between HCA and TLC was on a like-for-like basis and (ii) the actual results of the analysis.

- 8.15 Indeed, following the evidence put forward by HCA's advisers, which relied on an analysis of the raw data containing information on the items received by an insured patient as part of an episode, the CMA itself notes in its PFs that it is no longer in a position to rule out that any differences in insured prices between HCA and TLC are not driven by differences in episode complexity (paragraph 39, PFs).
- 8.16 The CMA noted that granular data with details on the specific items (for example, procedures, treatments, tests) that a self-pay patient actually received was not available, or in any event would not be comparable, across hospital operators in the case of self-pay patients (differently from insured patients) (footnote 5, Appendix 6.9, Final Report). As such, the CMA cannot test whether similar considerations as those that led it to change its findings on the analysis of insured pricing could also be relevant for its analysis of self-pay prices. The CMA thus relies on a speculative theoretical argument to dismiss the possibility that differences in patient complexity may affect the PCA results (paragraphs 10.32-10.39, PFs). HCA responds to this argument in paragraphs 8.39-8.50 below.
- 8.17 Finally, HCA notes that its external advisers were never provided with the raw data used by the CMA for the PCA. They were only provided with "clean data", that is, after the CMA had made a number of changes to the datasets received from the five hospital operators whose data was analysed in the PCA. Given that HCA's advisers identified numerous errors in the CMA's data cleaning process when examining the raw data for insured patients following the publication of the Final Report,²⁰⁴ HCA is concerned that the PCA may have been affected by similar errors.

The CMA has inappropriately extrapolated the results from the UK-wide analysis of the relationship between local market concentration and self-pay prices to central London

- 8.18 Notwithstanding HCA's concerns around the PCA's inability to control for complexity in a robust way, or to identify a causal relationship between local market shares and self-pay prices, as set out below in [paragraphs 8.39-8.50 and 8.51-8.62 respectively] below, HCA submits that the PCA is simply not relevant to central London or to HCA's business.
- 8.19 In the Final Report, the CMA concluded that the PCA, together with its qualitative review of evidence on private hospital operators' pricing strategies, identified a relationship between prices and local market concentration that applied to all hospital operators included in the analysis, including HCA (paragraph 6.266, Final Report).
- 8.20 HCA, however, argues that PCA is not representative of central London or HCA's self-pay business and that the CMA erred in concluding that any relationship between local market concentration and self-pay prices that it identified in the PCA also held for HCA or for central London.
- 8.21 The CMA applied the results of the PCA to all areas of the UK, including central London, based on a qualitative assessment of private hospital operators' pricing strategies. This is in stark contrast to the approach taken in the IPA whereby the CMA estimated separate models for operators inside and outside of central London in order to attempt to better control for differences in the competitive landscape and quality and range of healthcare provision. Paragraphs 8.68-8.79 below set out a number of changes in circumstances that render the qualitative assessment used to extrapolate the results unreliable.

²⁰⁴ See KPMG Data Room Report of 24 July 2015; and CMA, IPA Working Paper, Appendix A.

8.22 Next, HCA explains why even setting aside these changes of circumstances, the CMA's own evidence shows that the CMA is incorrect to assume that its PCA results apply in central London. Specifically, HCA sets out in more detail some important differences between private healthcare provision in central London and the rest of the UK and the implications of these for the conclusions the CMA drew from the PCA set out in the Final Report.

(1) Differences in hospital quality inside and outside central London

8.23 HCA considers that providers located outside of central London are close competitors to it. However, the CMA noted that there are important differences in competitive conditions and that central London is characterised by the strong reputation of some private hospital operators and PPUs, which are perceived by patients as offering a higher quality of care than private hospitals and PPUs elsewhere in the UK (paragraph 3.33, PFs). As discussed in paragraphs [8.52-8.58], quality of care is likely to be a key determinant of both a private hospital operator's self-pay prices and its local market share (or, in this case, its LOCI). A full assessment of quality is important in interpreting any evidence on the relationship between local market share or concentration, and self-pay prices.

8.24 As a result, if the CMA believes that there are systematic differences between the level of quality inside central London compared to the level of quality outside, it is incorrect to simply assume that any relationship identified on average, across the country between LOCI and self-pay prices applies equally in central London.

(2) Difference in the competitive landscape inside and outside central London

8.25 The CMA excluded from its measurement of LOCI (and from its PCA more generally) the vast majority of self-pay data from inside of central London, including PPUs (paragraphs 17-18, Appendix 6.9, Final Report).

8.26 Self-pay invoices used in the PCA analysis were in fact collected from only five providers, namely BMI, HCA, Nuffield, Ramsay and Spire. These providers accounted for less than half (38%) of self-pay invoice data in central London; 38% of self-pay invoices in central London were thus excluded from the analysis. No data was collected in relation to self-pay episodes from the majority of HCA's central London competitors, including TLC, Bupa Cromwell Hospital, King Edward VII, Aspen, the St. John and St. Elizabeth or any of the London-based PPUs.

8.27 It is important to note that PPUs have a greater presence in central London than elsewhere in the UK, and London PPUs are also typically larger than PPUs outside of it (paragraph 14, Appendix 6.10, Final Report), so their exclusion in central London is likely to have an even more significant effect than their exclusion outside of central London.

8.28 Overall, therefore, the large amount of missing data for central London as well as the failure to include PPUs, also implies that the LOCI measure of local market concentration for central London hospitals is unreliable. The CMA also specifically acknowledges this concern, stating that *"the LOCI measure may be less accurate for hospitals in certain regions [...] such as London"* (paragraph 19, Appendix 6.9, Final Report). This further undermines the CMA's conclusion that the results it obtains for its PCA can be reliably applied to central London (or HCA) specifically.

(3) Difference in treatment mix

- 8.29 The PCA set out in the Final Report was based on four focal treatments selected by the CMA based on their frequency in the self-pay invoice data; they represented the four most common treatments in the data across all operators (see Final Report, paragraph 6.260). However, there are substantial differences in the mix of treatments provided by HCA, compared to those provided by other private hospital operators. This is highlighted by examining the importance of the four focal treatments used by the CMA in its PCA to HCA's self-pay business. While these four focal treatments were the most common treatments on average across private hospital operators, they accounted for only approximately 3% of HCA's self-pay inpatient episodes and 3% of HCA's UK self-pay inpatient revenues between 2009 and 2012.²⁰⁵ As the CMA itself noted, the focal treatments were only provided at four of HCA's hospitals in central London (footnote 85, Appendix 6.9, Final Report). In other words, the PCA does not evaluate over 3% of HCA's self-pay revenue, and completely excludes self-pay pricing information from two of HCA's hospitals.^{206,207}
- 8.30 As a result, the CMA cannot conclude that any relationship between LOCI and self-pay prices identified using its PCA is representative of HCA's prices.

(4) Difference in patient mix episode complexity

- 8.31 There are differences in the characteristics of patients in central London compared to the rest of the UK, as noted by the CMA (paragraph 21, Appendix 6.10, Final Report). The CMA itself also stated that *"the strong reputation of central London hospitals, in particular for complex, high-acuity services, contributes to some patients' willingness to travel longer distances to access central London hospitals"* (paragraph 6.225, Final Report).
- 8.32 Paragraphs 8.39-8.50 below set out that the failure in the PCA to properly account for differences in episode complexity implies that the PCA cannot compare prices on a like-for-like basis. Furthermore, the existence of likely differences in patient characteristics in central London (compared to the rest of the UK), over and above the factors controlled for in the PCA, undermines the CMA's conclusion that any relationship it identified on average, across local markets and across operators, can be extrapolated specifically to central London.

(5) Conclusions on the extrapolation of the PCA to central London

- 8.33 Given the number of differences between central London and the rest of the UK, some of which were highlighted by the CMA itself in its geographic market definition (paragraph 5.59, Final Report), it is imperative that the CMA fully tests whether any relationship it identified across the UK held inside central London for HCA specifically.²⁰⁸ However, the available data

²⁰⁵ HCA's response to the original Provisional Findings, Annex 2, paragraph 2.95.

²⁰⁶ The CMA noted that such four treatments were nevertheless among HCA's top 7 treatments (Final Report, Appendix 6.9, footnote 16). 3%. The CMA's results that indicate that the treatments are in the top 7 are after its data cleaning process. HCA's advisers could not replicate the CMA's analysis to check this, as the CMA provided insufficient detail on how it cleaned (or processed) the raw data. But the prevalence of the focal treatments after the data cleaning is not informative, as it does not demonstrate the overall importance of the treatments to HCA's actual UK inpatient self-pay business.

²⁰⁷ Even under the sensitivity analysis where the CMA included an additional 50 treatments, the number of HCA episodes that included one of these treatments was less than 600, for the whole period of the analysis. See, CMA, Final Report, Appendix 6.9, Annex A, Table 3.

²⁰⁸ The CMA attempted to assess the robustness of the PCA to the exclusion of a large number of competitors in London, by running an analysis in which it excluded the London data from the PCA. The results of this analysis *"were robust to such exclusions"* (Final Report, Appendix 6.9, footnote 10). This is both unsurprising and completely uninformative as to whether the general, UK-wide results of the PCA held equally for London or central London. The reason the PCA results were robust to the exclusion of London data was that, as the CMA

sample for HCA was too small²⁰⁹ to enable the CMA to estimate a price-concentration relationship for HCA specifically.²¹⁰ Instead, the CMA then relied on a flawed analysis of qualitative evidence to extrapolate the UK-wide relationship it found between local concentration and self-pay prices to central London.²¹¹

- 8.34 This approach is in stark contrast to the CMA's approach in the IPA.²¹² Indeed, the results and the conclusions the CMA drew from the IPA for central London and for the rest of the UK were different. While HCA is strongly of the view that the results in London, similarly to the rest of the UK, do not identify a relationship between market shares and prices, the CMA seems to consider that this is the case. This would indicate, on the basis of the CMA's own analysis, a different relationship between insured prices and local concentration in these areas. The CMA has not provided any evidence as to why the rationale used to conduct separate analyses for central London and the rest of the UK does not apply to self-pay patients.

The assessment of the relationship between local market concentration and self-pay prices is not robust

- 8.35 In the Final Report the CMA concluded that the PCA, alongside its qualitative review of evidence on private hospital operators' pricing strategies, showed that:

- there was a causal relationship between local concentration and self-pay prices (paragraph 6.274, Final Report); and
- an additional competitor (fascia) would be expected to reduce self-pay prices by between 3% (going from 1 to 2 competing fascia) and 9% (going from 0 to 1 competing fascia), on average (paragraph 6.264, Final Report).

- 8.36 This section summarises some of the key theoretical and empirical flaws in the PCA analysis and the CMA's interpretation of the qualitative evidence, which invalidate the conclusions set out above:

- First, there are weaknesses in the way in which the CMA has implemented the PCA. Particularly in light of recent evidence from the IPA, the CMA cannot reliably

itself recognised, "London accounts for a relatively small proportion of our sample of self-pay invoices" (Final Report, Appendix 6.9, footnote 8), or "*around 7 per cent*" (Final Report, Appendix 6.9, paragraph 18). Given this small percentage of observations, it was highly unlikely that the data pertaining to London could be driving the overall results for the UK market, and therefore the exclusion of this data would not be expected to materially affect the results.

²⁰⁹ The PCA was in fact conducted on the four focal treatments, meaning it relied on just 248 observations from HCA (HCA's response to the original Provisional Findings, Annex 2, paragraph 2.95). When the CMA included an additional 50 treatments, there were only 598 out of 21,406 observations, or fewer than 2.8% of episodes. See, Final Report, Appendix 6.9, Annex A, Table 3.

²¹⁰ Final Report, footnote 384. Of the total relevant episodes after cleaning collected from HCA, the great majority (72%) were excluded from the PCA on the basis that they related to "*irregular episodes*" (Final Report, Appendix 6.9, Annex A, Table A3). The other hospital operators considered in the PCA had between 2% to 10% of their invoices excluded. The fact that so many of HCA's episodes have atypical specialties or are uncommon treatments within the data provides further evidence that HCA is seeing a different patient mix than other hospital operators.

²¹¹ The CMA described the nature of its qualitative evidence in Annex B to Appendix 6.9 of its Final Report. That evidence appeared to consist of some internal documents relating to the way in which hospital operators monitor competitor behaviour and the extent to which they may set prices according to local competitive conditions. The CMA, however, was unable to point to any firm evidence of HCA monitoring its competitors' prices in a similar fashion to the other operators (Final Report, Appendix 6.9, Annex B, paragraphs 5 and 16).

²¹² Notably, in the context of the IPA, the CMA decided to conduct separate analyses for central London and the rest of the UK to control for (i) any material quality differences between hospital operators, on average, across their portfolios of hospitals, in these two areas (Final Report, paragraph 6.363) and (ii) any differences in costs (e.g. labour costs) between these areas (Final Report, paragraph 6.365).

conclude that the PCA appropriately controls for patient or episode characteristics, including complexity, and as a result cannot rely on the PCA as providing robust evidence of a link between local concentration and self-pay prices.

- Second, the PCA does not establish a causal relationship between local concentration and self-pay prices.

8.37 Together, these flaws fundamentally undermine (i) the CMA's reliance on the PCA, (ii) the AEC finding in relation to self-pay patients, (iii) the use of the PCA results to support for the existence of an analogous relationship between local concentration and prices for insured patients, and finally (iv) any estimates of price effects arising from any divestment remedy.

8.38 As set out below, the arguments put forward by the CMA in the Final Report or in the PFs either ignore the above criticisms, or do not adequately address them.

The PCA has weaknesses which undermine its validity

8.39 In the PFs of the Remittal Inquiry, the CMA considers whether the criticism put forward by HCA in relation to the analysis of insured prices that the CMA's analysis did not adequately control for differences in patient complexity may also apply to the CMA's analysis of self-pay prices (that is, to the PCA) (paragraphs 10.25 and 10.27, PFs).

8.40 Specifically, the CMA considers two questions (paragraph 10.32, PFs):

- whether the PCA adequately controlled for differences in patient complexity, and
- whether there was a plausible reason why one might expect its observed relationship between self-pay prices and local market concentration to be affected by patient complexity.

8.41 On the first point, the CMA notes that the PCA also included variables seeking to measure a hospital's average direct cost and whether a hospital had CCL3 beds, and the CMA believes that this means that the PCA may be more effective (than the IPA) at capturing potential differences in patient complexity (paragraphs 10.34-10.35, PFs). The CMA also points to the effects of age, gender and length of stay being, generally, statistically significant thus suggesting that these patient characteristics are controlling for factors that may drive differences in costs (and thus prices) between operators and are therefore "*likely to be effectively controlling for differences in patient complexity*" (paragraph 10.36, PFs).

8.42 On this point, HCA notes that the possibility that the PCA may be more effective at capturing differences in patient complexity than the IPA (which HCA in any event questions) does not say anything about the robustness of the PCA. The IPA cannot be taken as a benchmark of an analysis that adequately controls for patient complexity, given its limitations (see HCA's discussion in section 6).

8.43 As for the statistical significance of factors such as gender, age and length of stay, this says little about other potential drivers of patient or episode complexity being omitted from the analysis. A review of the CMA's analysis of insured prices found that data on the individual treatments received by patients for a given episode showed that, even after taking into account the patient's age, gender and length of stay, there remained substantial differences in the number and nature of treatments performed by different hospital operators (paragraphs 1.5 and 4.25-4.33, KPMG Data Room Report of 24 July 2015). The CMA itself acknowledges that it is not able to rely on these patients' characteristics to ensure a like-for-like comparison (paragraph 39, PFs).

- 8.44 Given these results and the CMA's own views, the CMA would therefore need to carefully assess the implications of these results for the PCA in order to ensure its robustness, including whether the self-pay episodes considered in the PCA were being compared on a like-for-like basis.
- 8.45 On the second point, the CMA explains that the relationship between local market concentration and self-pay prices may in principle be overstated as a result of failing to suitably control for patient complexity if there was *"a mechanism whereby highly-concentrated local markets display high prices and high patient complexity within the treatments that are being compared across hospitals"* (paragraph 10.38, PFs). The CMA postulates that one possible such mechanism may involve:
- (a) *A high-quality hospital attracts high-complexity patients within the relevant treatments [...] from other local markets.*
 - (b) *This leads to high concentration in that local market and also to higher prices at the leading hospital.*
 - (c) *This leads to surrounding local markets having lower patient complexity for these treatments, as the more complex patients are attracted to the increasingly concentrated market.*
 - (d) *The local market with the high-quality provider then has higher concentration, while the surrounding local markets display lower concentration, relative to the increasingly concentrated market, but have lower-complexity patients and, so, lower prices"* (paragraph 10.38, PFs, footnotes omitted).
- 8.46 The CMA rules out this mechanism on the basis that it has not received evidence pointing to a pattern *"whereby more complex patients travel outside their local market in such a way that drives high concentration (and high prices) in some local markets and results in low complexity, low concentration and low prices in others for specific treatments"* (paragraph 10.39, PFs).
- 8.47 In this regard, HCA notes that the CMA only suggests one possible mechanism whereby failing to control for patient complexity may lead to an overstatement of the relationship between local market concentration and self-pay prices. And even under that possible mechanism that the CMA set out, the CMA postulates some assumptions that seem inconsistent with the approach followed by the CMA in the PCA. One of the two measures of local market concentration used in the CMA's approach was LOCI, which the CMA stated is appealing because it does not rely on establishing geographic market boundaries of each local market, and thus avoids a sharp geographic delineation (paragraph 16, Appendix 6.4, Final Report). So it is unclear what the CMA means with *"[hospitals attracting patients] from other local markets"*, where the geographic dimension of the relevant market was actually left undefined in the context of the PCA (with LOCI as the measure of local market concentration).
- 8.48 Further, while HCA is conscious that the PCA was performed with data on hospitals from the whole of the UK (that is, not just from the London area), the possible mechanism set out by the CMA actually appears to be *consistent* with the CMA's own evidence on travel patterns of patients that attend London hospitals. The CMA states that *"the strong reputation of central London hospitals, in particular for complex, high-acuity services, contributes to some patients' willingness to travel longer distances to access central London hospitals"*

(paragraph 6.225, Final Report). This, combined with the CMA's conclusion that HCA has a high share of supply in central London (see paragraph 11.6, PFs), is completely at odds with the CMA dismissing the mechanism it postulated on the basis that it had not received evidence pointing to a pattern "whereby more complex patients travel outside their local market in such a way that drives high concentration (and high prices) in some local markets and results in low complexity, low concentration and low prices in others" (paragraph 10.39, PFs). In fact the evidence available to the CMA is entirely consistent with this pattern existing throughout the UK, wherever there may be differences in quality of provision across contiguous geographical areas (or even markets).

8.49 For these reasons HCA submits that the CMA failed to properly consider the implications of the evidence that emerged during the consultation on the IPA and that the CMA unreasonably confirmed its earlier findings on the PCA.

8.50 More generally, as set out in paragraphs 8.11-8.16 above, the results of the IPA and the inability to conclude on the extent to which the CMA's price comparison was like-for-like (even after controlling for age, gender and length of stay) mean that similar issues are very likely to apply to the PCA.²¹³

The PCA does not establish a causal link between concentration and prices

8.51 By using the PCA, the CMA sought to measure whether there was a statistical relationship between local market concentration and self-pay prices (for inpatient treatments). The CMA concluded that the correlation that it identified in the PCA could be interpreted as evidence of a causal relationship (paragraph 6.274, Final Report).

8.52 However it is well understood in economics that such a correlation need not be causal, and can indeed be spurious in industries where investments to improve quality are important.²¹⁴ In this context, a positive correlation between prices and concentration or market share could arise because greater investment in better quality lead to higher costs (and therefore to higher prices) and at the same time lead to attracting more patients (and hence to a greater market share).

8.53 The provision of private healthcare is characterised by extensive non-price competition – in particular, competition over the quality and range of treatments offered.²¹⁵ In order to

²¹³ The IPA consultation process showed (with regard to insured prices) the importance of close examination of the raw data. This is because such data is likely to be informative of the actual items that a patient received and thus likely to be informative of the episode complexity and costs. As set out in paragraph 8.16 above, the CMA noted that granular data with details on the specific items that a self-pay patient actually received was not available, or in any event would not be comparable, across hospital operators in the case of self-pay patients (Final Report, Appendix 6.9, footnote 5). (For the avoidance of doubt, HCA's external advisers were never in a position to examine the original self-pay datasets the CMA received from the hospital operators and therefore could not corroborate this directly. See, for example, page 1 of the HCA Data Room Report of 19 April 2013). The CMA, therefore, cannot test whether similar considerations on the inability to control for potential differences in episode complexity (and cost) as those that led it to change its findings on the analysis of insured pricing could also be relevant for its analysis of self-pay prices.

²¹⁴ See, for example, KPMG's submission on the analysis of insured prices of 1 May 2015, paragraphs 9 and 61, and also Demsetz, H. (1973) "Industry Structure, Market Rivalry, and Public Policy" *The Journal of Law and Economics* pp 1-3.

²¹⁵ See, for example, KPMG's submission on the analysis of insured prices, paragraphs 6, 10 and 17, and also Hsia, R. Y., Antwi, Y. A., and Weber, E. (2014) "Analysis of variation in charges and prices paid for vaginal and caesarean section births: a cross-sectional study", *BMJ Open*; Gautam, G., Nevo, A., and Town, A. (2015) "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry" *American Economic Review* 105(1): 172-203; Gaynor, M. and Vogt, W. (2003) "Competition among Hospitals" *Rand Journal of Economics*; Haas-Wilson, D. and Garmon, C. (2011) "Hospital Mergers and Competitive Effects: Two Retrospective Analyses" *Int. J. of the Economics of Business* 18(1): 17-32; Dranove, D., Shanley, M. and White, W. (1993) "Price and

successfully compete on quality and range, private hospital operators need to make investments. Hospital operators that make such investments also incur costs, which increase prices. The CMA did recognise the existence of competition over both quality and range in central London (paragraph 36, Final Report) and that competition in private healthcare provision is characterised by hospital operators “positioning” themselves in terms of quality, range and price (paragraph 6.384, Final Report).

- 8.54 A higher quality private hospital provider, however, is also likely to have a higher market share insofar as patients value quality and the provider’s offering is competitive among both price and non-price aspects. As a result, firms that offer higher quality care can in general be expected to charge higher prices and also have a larger market share. This does not describe a causal relationship between higher prices and market share – instead, the relationship is caused by a third factor, namely the (costly) provision of higher quality care. This view is also shared by the CMA’s Chief Economic Adviser, who in a well-known textbook stated that *“it is quite possible that the leading firm in a market has the best product and so charges the highest prices”*.²¹⁶
- 8.55 For the PCA to be able to demonstrate the existence of a causal relationship between local market concentration and self-pay prices, the CMA would therefore need to ensure that the analysis is conducted on a comparable (or like-for-like) basis, something that the CMA itself accepted in its Final Report (paragraph 27, Appendix 6.9, Final Report). This was also noted by the CAT (paragraph 37, CAT Ruling of 25 July 2014). There are at least two dimensions in which this is relevant. First, comparisons need to be on a like-for-like basis to ensure that potential differences between episodes (for example due to differences in patient characteristics, or episode complexity) are accounted for. This was further discussed in paragraphs 8.39-8.50 above. Second, even if differences in patient characteristics and episode complexity were correctly accounted for, there is still the possibility that patients with the same characteristics and associated with the same degree of episode complexity may receive a different level of quality of healthcare depending on the hospital where they get treated. Such differences, as set out in paragraph 8.54 above, may drive both differences in prices and in market shares.²¹⁷
- 8.56 A preference of patients for quality may constitute an example of an “unobserved demand factor”,²¹⁸ and the CMA itself acknowledged that it was possible that its PCA did not account for all unobserved demand factors (paragraph 65, Appendix 6.9, Final Report). However, it also concluded that such factors would be negatively correlated with local concentration.²¹⁹ This is because, according to the CMA, areas characterised by high demand (and therefore

Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition” *Journal of Law and Economics* 36: 179-204; Keeler, E., Melnick, G. and Zwanziger, J. (1999) “The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior” *Journal of Health Economics* 18: 69-86; Melnick, G., Zwanziger, J., Bamezai, A. and Pattison, R. (1992) “The Effects of Market Structure and Bargaining Position on Hospital Prices” *Journal of Health Economics* 11: 217-233.

²¹⁶ S Bishop and M Walker, “The Economics of EC Competition Law: Concepts, Application and Measurement”, Sweet and Maxwell, 2010, paragraph 14-019.

²¹⁷ In a leading textbook, the CMA’s Chief Economic Adviser agreed with this general principle: *“price concentration studies come with a health warning: unless carried out with great care, they can easily give a misleading result. This is particularly the case if there are underlying factors that drive both price and concentration or market share, such as market size or quality”*. S Bishop and M Walker, “The Economics of EC Competition Law: Concepts, Application and Measurement”, Sweet and Maxwell, 2010, paragraph 14-027.

²¹⁸ See, for example, Ho, K. and Pakes A. (2014) “Hospital Choices, Hospital Prices, and Financial Incentives to Physicians” *American Economic Review* 104(12): 3841-3884.

²¹⁹ HCA notes that in Appendix 6.9 the CMA referred to a positive correlation between the unobserved demand factors and LOCI. But since the CMA interpreted LOCI as one minus a hospital’s weighted market share, one may infer that the CMA posited a negative correlation between unobserved demand factors and local concentration.

strong unobserved demand factors) may attract entry and expansion and thus lead to lower levels of concentration. Therefore, omitting those factors from the PCA would underestimate the “true” relationship between local market concentration and self-pay prices (paragraph 62, Appendix 6.9, Final Report).

- 8.57 HCA believes this argument is fundamentally at odds with the CMA’s findings that the private healthcare market is characterised by barriers to entry and expansion (paragraph 10.3, Final Report). In addition, traditional economic literature suggests that failing to control for unobserved demand factors, including differences in quality, is likely to overestimate, rather than underestimate, the relationship between market concentration and prices.²²⁰
- 8.58 As a result, the PCA – which cannot accurately measure differences in quality across different private hospital operators and, therefore, is unlikely to compare different episodes at different hospitals while fully accounting for potential quality differentials – cannot be relied upon to establish a causal relationship between local market concentration and self-pay prices. In other words, it cannot simply be assumed that any statistical relationship identified between local market concentration and self-pay prices is evidence of an ability for private hospital operators facing fewer local competitors (or facing competitors with a lower local market share) to charge higher prices; instead, any such statistical relationship may be driven by the failure to properly account for the impact of quality.
- 8.59 The failure to identify a robust causal relationship between local market concentration and self-pay prices has three implications.
- 8.60 First, the CMA cannot rely on the PCA as evidence of an AEC finding linked to local market concentration.
- 8.61 Second, the CMA cannot use the PCA results to support the existence of an analogous relationship between local concentration and prices for insured patients.
- 8.62 Third, the CMA cannot rely on the results of the PCA to accurately determine the impact of any change in local market concentration (for example, following a divestment remedy) on self-pay prices. Without being able to isolate a causal relationship between self-pay prices and local market concentration, rather than simply identifying a statistical correlation, the CMA cannot make predictions²²¹ about the impact of an exogenous change in local concentration (for example through a divestment remedy) on self-pay prices.

²²⁰ See, for example: Akerberg, Daniel, C. Lanier Benkard, Steven Berry, and Ariel Pakes. "Econometric tools for analysing market outcomes." *Handbook of econometrics* 6 (2007): 4171-4276. Berry, Steven, James Levinsohn, and Ariel Pakes. "Automobile prices in market equilibrium." *Econometrica: Journal of the Econometric Society* (1995): 841-890. Berry, Steven, James Levinsohn, and Ariel Pakes. "Differentiated Products Demand Systems from a Combination of Micro and Macro Data: The New Car Market." *Journal of Political Economy* 112, no. 1 (2004): 68-105.

²²¹ HCA also notes that the CMA used a so-called “reduced-form approach” in the PCA, as opposed to a “structural approach”. While a “structural approach” is more involved and more data-intensive than a “reduced-form approach”, there are limitations from the implications that one can draw from the latter. This is because a “reduced-form approach” uses in the analyses variables that are themselves the outcomes of a competitive process (in the PCA, these would be for example prices and local market shares or local concentration) rather than undertaking an analysis from first principles (that is, mainly, using as some of the key inputs of the analysis costs and patient preferences). For a discussion of the relative merits of reduced-form and structural approaches see Davis and Garcés (2010). The CMA has itself explained in its Final Report in Appendix 6.9 that there could be a bias in the OLS estimates due to “*endogeneity*” arising through “*omitted variables*” (Final Report, Appendix 6.9, paragraph 52). These concerns can be particularly serious if competition takes place in several dimensions, including non-price ones, such as quality and product range. A structural approach is recognised to be more appropriate to mitigate these concerns and, if carried out robustly, to produce predictions that are reliable.

The CMA's findings on quality and range undermine the self-pay AEC

- 8.63 HCA argued that it was inconsistent for the CMA to find a degree of competition over both quality and range in central London, but a lack of effective competition and an AEC with respect to prices (paragraph 4.8, HCA submission of 1 May 2015).
- 8.64 The CMA disagrees with HCA (paragraphs 7.23-7.26, PFs). Focusing on the insured segment of the market, the CMA reasons that individual insured patients (that is, personal policyholders as opposed to policyholders who are insured via their employers), when deciding where to get treated, have a much wider set of options available to them than insurers do when negotiating with hospital operators. Since individual insured patients, at the point of deciding where to get treated, are likely to mainly care about quality and range, this might drive hospitals to have stronger incentives to improve quality and range. By contrast, the CMA argues, insured prices are determined through negotiations between hospital operators and insurers, and insurers have fewer options available to them than individual patients. Therefore, according to the CMA, *"while there is a degree of competition over both quality and range in central London, hospital operators may not face strong incentives to compete on price, particularly insured prices"* (paragraphs 7.23-7.26, PFs).
- 8.65 Notwithstanding HCA's disagreement with this conclusion by the CMA with respect to the insured price AEC (as set out in section 6), HCA submits that the CMA's reasoning in relation to the implications for self-pay patients is also flawed.
- 8.66 This is because self-pay patients have at least as many options open to them (including the NHS) as individual insured patients when deciding where to get treated. Self-pay patients are also more likely to care about price than insured patients (which the CMA itself recognised in part (a), paragraph 10, PFs) - in addition to caring about quality and range - and therefore put further pressure on the hospital operators' pricing decisions.
- 8.67 Therefore, given the CMA identifies no issue with quality and range offered to patients, because hospitals are constrained by the wider range of options available to individual insured patients, it is inconsistent for the CMA to find a self-pay AEC at all, whether with regard to quality/range (which the CMA – correctly, in HCA's view – does not) or with regard to prices.

There have been material changes in circumstances since the CMA's Final Report

- 8.68 The PCA set out in the Final Report relied on self-pay data from 2009 to mid-2012 (paragraph 8, Appendix 6.9, Final Report), which by the end of the Remittal Inquiry will be between about 4 to 7 years old. However, since the publication of the Final Report, there have been a number of material changes in the provision of privately funded healthcare services to self-pay patients in central London, and these affect the extent to which (if any) the CMA can reasonably conclude it can rely on this data for its self-pay findings.
- 8.69 These changes include the rapid growth of PPU's in central London, which pose an effective competitive constraint on a number of aspects of HCA's patient offering, including its prices to self-pay patients. HCA sets out the evidence in this regard in section 2 of this submission.
- 8.70 Further, HCA has changed the way in which it sets self-pay prices and, in response to market demand, is introducing a number of innovative package pricing products for self-pay patients. This is in and of itself a material change in circumstances. Further, this represents extra evidence that HCA faces competitive constraints and continues to respond to them and

to innovate, including with respect to commercial practices. In addition, this has implications for the CMA's interpretation of the PCA results and of the qualitative evidence (that is, hospital operators' internal documents and responses to the CMA's market questionnaires in the original inquiry) that the CMA used to complement its findings from the PCA. HCA next sets out the nature of these implications.

- 8.71 The PCA was conducted using data on self-pay invoices across the UK. According to the CMA, the PCA allowed it to identify a relationship between local market concentration and self-pay prices. Any such relationship identified through the PCA would be an average one, across local markets throughout the UK.
- 8.72 As set out in paragraphs 8.18-8.34 above, the CMA was unable to assess whether this average relationship between local market concentration and self-pay prices held in central London specifically. Unlike for the other four private hospital operators included in the PCA (BMI, Nuffield, Ramsay and Spire) the CMA was unable to perform a version of the PCA specifically for HCA (or for central London). The CMA was therefore not in a position to confirm whether its quantitative results from the PCA also applied to HCA or to central London, which constituted only a relatively small proportion of the dataset considered as acknowledged by the CMA (footnote 8, Appendix 6.9, Final Report).
- 8.73 Instead, as set out in Final Report, the CMA relied on a qualitative assessment of private hospital operators' pricing behaviour. Specifically, in the Final Report, the CMA concluded that its review of the qualitative evidence on self-pay pricing showed no differences in the pricing behaviour between hospital operators (paragraph 4, Annex B, Appendix 6.9, Final Report). Specifically, the CMA concluded:
- that it considered the *“behaviour of the five main hospital operators to be broadly comparable”* (paragraph 4, Annex B, Appendix 6.9, Final Report);
 - that while it could *“not identify any specific internal documents that illustrate how HCA hospitals monitor competitor prices”* (paragraph 16, Annex B, Appendix 6.9, Final Report), it was able to draw its conclusions based on what *“hospital operators have told us about their behaviour in general terms [...]”*, (footnote 9, Annex B, Appendix 6.9, Final Report); and
 - that *“the available evidence also showed that it is also common across the industry for self-pay price setting to be delegated to individual hospitals. In cases where pricing strategies are developed at the group level, individual hospitals are given autonomy to adjust the prices to some degree”* (paragraph 6, Annex B, Appendix 6.9, Final Report).
- 8.74 HCA submitted evidence during the original inquiry showing that ✂ (paragraph 20.5, HCA, Response to Market Questionnaire).
- 8.75 ✂.
- 8.76 These recent developments have at least two implications.
- 8.77 First, they represent further evidence that HCA faces a number of competitive constraints and that it continues to respond to these and to innovate as a result of these, even in relation to its commercial practices. ✂.

- 8.78 More generally, HCA's innovative pricing changes need to be accounted for in any review of the qualitative evidence on the prices received by self-pay patients in central London, and, ultimately, in order for the CMA to draw any reliable conclusions about the existence of an AEC in relation to self-pay patients in central London.
- 8.79 Second, the result of these changes to HCA's pricing strategy is that the CMA's qualitative assessment of private hospital operators' pricing strategies set out in the Final Report and summarised above cannot still be valid in relation to HCA. As a result, it would be incorrect for the CMA to keep relying on its qualitative assessment to support its quantitative assessment of the relationship between local market concentration and self-pay prices and extrapolate the results of the UK-wide relationship it found to central London. HCA therefore submits that the CMA has an even weaker basis to rely on the PCA results for its self-pay AEC finding in central London than was the case at the time of the Final Report.

The flaws in the CMA's assessment of competitive constraints undermine the self-pay patients AEC

- 8.80 As discussed in paragraph 8.5 above, in the Remittal Inquiry the CMA considered whether the competitive constraints on HCA arising from non-inpatient providers, PPU's and the NHS had materially changed since the publication of the Final Report.
- 8.81 HCA sets out in section 2 of this submission why it believes that the CMA's competitive assessment was flawed. In particular, HCA sets out its concerns over the CMA's assessment of the competitive constraints arising from non-inpatient providers in paragraphs 2.65-2.70, from PPU's in paragraphs 2.58-2.64 and from the NHS in paragraphs 2.71-2.74.
- 8.82 The CMA's flawed assessment of such competitive constraints casts severe doubts not only on the insured AEC, but also on the self-pay AEC.
- 8.83 Further, the CMA acknowledges that central London hospitals (therefore including HCA's) may be constrained by hospitals located in Greater London for marginal self-pay patients (paragraph 3.32, PFs). Notwithstanding HCA's position that this finding is also relevant to insured patients (see section 2 of this submission), this is a further reason why the self-pay AEC cannot be supported.

9. INCONSISTENCIES BETWEEN THE CMA'S LONDON AND NON-LONDON ANALYSIS

Key points

- The CMA made no insured AEC finding outside central London, even though there are even higher levels of concentration and higher barriers to entry in non-London markets.
- It is therefore irrational for the CMA to conclude that there is an AEC in central London which is a more competitive and dynamic market, witnessing higher levels of new entry and expansion, than any other local healthcare market in the UK.
- Further, the CMA has discriminated against HCA in breach of its public law duties of fairness and equal treatment.
- The CMA has applied different tests and standards in considering whether there is an insured AEC in and outside central London, without objective justification.
- Moreover, the CMA has conducted a wholly different analysis, using a different methodology, of HCA's prices compared to that for non-London operators; the same analysis applied to HCA in the Remittal Inquiry would in fact have produced different results in the case of non-London operators from those set out in the Final Report.

9.1 There are fundamental discrepancies between the CMA's findings relating to central London and non-London operators. The CMA's provisional finding that there is an AEC in respect of insured patients within central London is wholly at odds with its conclusion in the Final Report that there is no AEC for insured patients outside central London. The contrast between the CMA's findings in and outside central London in relation to insured patients further demonstrates that there is no reasonable foundation for the PFs.

9.2 The CMA concludes in the PFs that (i) high concentration and (ii) barriers to entry and expansion create weak competitive constraints on HCA in central London. However, the CMA found the same features of high concentration and barriers to entry and expansion, and hence weak competitive constraints, in markets outside central London and it also found that these features applied to an even greater extent. It is irrational for the CMA to conclude that the same features create AECs for insured patients in central London, but not outside central London.

9.3 The CMA found that there were several areas of high concentration outside central London:

- It identified 140 "*hospitals of potential concern*" outside central London owned by BMI, Spire, Nuffield and Ramsay. Of these, 70 were identified in the CMA's local catchment area analysis as being "*insufficiently constrained*" i.e. subject to weak competitive constraints.
- All 70 hospitals which were found to be "*insufficiently constrained*" are either subject to no competitors, or fewer competitors, compared to HCA's hospitals in central London which compete with six private providers and 16 PPUs.

- A significant number of the 70 *"insufficiently constrained"* hospitals are either solus hospitals (the only hospital in the relevant area) or duopoly hospitals (only one of two hospitals in the relevant area).
 - Consequently, the markets outside central London are characterised by higher levels of concentration and higher market shares than within central London.
- 9.4 Consequently, the CMA's finding of weak competitive constraints applies, and applies to an even greater extent, to markets outside central London.
- 9.5 The CMA also found that there are significant barriers to entry outside central London:
- The CMA stated that *"In all local areas, including in central London, a combination of high sunk costs and long lead times associated with setting up a private hospital together constitute a significant barrier to entry and expansion"* (paragraph 6.143, Final Report).
 - The CMA argued that this was *"particularly evident where there was over-capacity in the local market where demand was small, flat or contracting"* (paragraph 6.143, Final Report).
 - It also noted that *"generally demand was relatively limited and/or not growing"* outside central London and that *"in many local areas there was not currently, nor was there the prospect of in the near future, sufficient private patient revenue to sustain two private hospitals profitably and that this would, particularly when combined with the high sunk costs concerned, be a strong deterrent to entry."* (paragraph 6.56, Final Report).
 - This is in contrast to the position in central London, which the CMA accepts *"has been growing such that a lack of growth does not create a barrier to entry"* (paragraph 5.12, PFs).
 - Hence, the barriers to entry and expansion in non-London markets are *"particularly evident"* because demand is low or static in these markets.
- 9.6 Again, therefore, the CMA's finding of barriers to entry and expansion applies, and applies to an even greater extent, in markets outside central London.
- 9.7 Consequently, the features of the market which the CMA considers gives rise to an AEC are even greater in markets outside central London. If there is not sufficient evidence to support an AEC finding outside central London, there can be no justification for such a finding in relation to central London.
- 9.8 It is no answer to say that the CMA found that the IPA in central London shows that HCA charges higher prices than its closest competitor in central London, whereas the CMA found that the IPA outside central London provided mixed results which were insufficient to support such a finding:
- The CMA's insured AEC finding is based on the same features that are alleged to exist in and outside London, namely high concentration and barriers to entry. The IPA is relevant only insofar as the CMA alleges that the AEC leads to consumer detriment in the form of higher prices and insofar as the CMA seeks to quantify that

detriment. The CMA cannot therefore justify making an insured AEC finding in central London when it has made no such finding outside central London.

- The CMA concluded that there was an AEC in respect of self-pay patients outside central London and that *"private hospitals in more concentrated areas charge higher self-pay inpatient prices than hospitals in less concentrated local areas"* (paragraph 6.483, Final Report). It specifically noted that *"the finding of a significant positive relationship between local concentration and prices in the self-pay segment provides some support for the existence of an analogous relationship between local concentration and prices in the PMI segment"* (paragraph 6.376, Final Report). It nevertheless made no insured AEC finding outside London.
- The CMA's assessment of PMI bargaining power outside central London noted that the strength of a PMI's bargaining position depends on the availability of alternative facilities in the relevant local area and that *"the availability of substitutable rival hospitals, as provided by local concentration, is thus a determinant of prices for similar reasons in the self-pay segment as in the PMI segment"* (paragraph 6.374, Final Report).
- In any event, as set out in section 6, the IPA in central London does not permit the CMA to make a finding that higher concentration in central London causes or leads to higher insured prices and the CMA accepts that it can no longer conclude on the extent of any alleged price difference, and is no longer able to quantify the extent of any consumer detriment, if any.

9.9 Similarly, it is no answer to say that the insured AEC finding is supported by the fact that the CMA's profitability assessment allegedly demonstrates that HCA *"has made returns that are substantially and persistently in excess of its cost capital"*. The CMA found that both BMI and Spire *"have been earning returns substantially and persistently in excess of the cost of capital"* (paragraph 6.474, Final Report) and that this also suggested *"that the price of private healthcare services may be high in relation to the costs incurred by hospital operators in providing these services, and thus higher than we would expect to find in a competitive market"* (paragraph 6.476, Final Report). Consequently, the CMA makes substantially similar findings with regard to HCA, BMI and Spire, but there was nevertheless no insured AEC finding outside central London. The CMA cannot logically argue that high profitability outside central London is not indicative of an AEC, whereas high profitability within central London is.

9.10 There are significant differences between central London and other non-London markets, which indicate that the CMA has seriously erred in finding that there is an AEC in central London:

- There are far more competing fasciae in central London than in any other market. HCA competes with six private providers and 16 NHS PPUs.
- While many of the non-London markets have solus or duopoly hospitals, that is far from the case in central London where HCA represents no more than 41% of the available bed capacity.
- London is a growing market which has seen 20% growth in the period 2011-2013, unlike other parts of the country which have seen no or little growth.

- London has also seen capacity expansion in the last few years and there is a pipeline of further new entry and expansion.
 - The top 10 NHS Trusts with PPU are based in London adding to the competitive landscape, and the CMA has acknowledged that PPUs are a more potent competitive force in London than in other parts of the country.
- 9.11 The CMA has a duty under public law to treat HCA fairly and even-handedly in the conduct of its investigation, and not to discriminate unlawfully against HCA. This requires the CMA not to treat parties which are in a comparable position differently unless such difference in treatment can be objectively justified.
- 9.12 As Lord Sumption held in *Bank Mellat v HM Treasury (no. 2)* [2013] 3 WLR 179 (Supreme Court) ("*Bank Mellat*") the non-discrimination obligation arises both as part of the common law duty of public authorities to act rationally and also in circumstances where a public authority is subject to a duty to act proportionately: "*A measure may respond to a real problem but nevertheless be irrational or disproportionate by reason of its being discriminatory in some respect that is incapable of objective justification*" (at paragraph 25):
- (i) A difference of treatment that cannot be objectively justified is unlikely to have a rational basis because "*treating like cases alike and unlike cases differently is a general axiom of rational behaviour*": *Matadeen v Pointu* [1999] 1 AC 98 (PC), per Lord Hoffmann at p.109.
 - (ii) Non-discrimination is also an aspect of proportionality. This is because a public authority will not be able to justify as necessary or proportionate any action interfering with the rights of a party in one case where it does not also seek to take such action in other cases which, on an objective analysis, are not properly distinguishable. See *Bank Mellat* at paragraph 25; and further, *Coventry v Lawrence* [2015] 1 WLR 3485 (Supreme Court), per Lord Clarke at paragraph 132, approving Lord Sumption's reasoning.
- 9.13 In reaching its insured AEC finding in central London, the CMA has discriminated against HCA in breach of its public law obligations for the reasons set out above:
- HCA's position is comparable to that of other private healthcare providers outside London from the perspective of the private healthcare market investigation. Indeed, HCA operates in a more competitive market than other private healthcare operators.
 - The CMA has reached wholly different conclusions as to whether there is an insured AEC, notwithstanding that it made the same findings of weak competitive constraints and high barriers to entry within and outside central London.
 - The CMA has also applied a different standard of analysis in respect of HCA and non-London operators.
 - There is no objective justification for the CMA's difference of approach in relation to London and non-London operators.
- 9.14 The CMA has also discriminated against HCA in that it has applied a different analysis of insured prices, on the basis of a different methodology, in and outside central London. The CMA concludes in the PFs that based on the results of the IPA, the AEC in central London

"is leading to consumer detriment in the form of higher prices being charged by HCA" (Summary, paragraph 6, PFs).

- 9.15 There are however significant differences in the IPA carried out in and outside central London, as set out next:
- 9.16 In the Final Report, the CMA's IPA relied on an analysis based on "price indices" and was applied to both London and non-London operators. In the Remittal Inquiry, the CMA extensively modified the original analysis (including to take into account of the errors identified during the CAT appeal) and also relied on an entirely new analysis based on a "pooled regression". This pooled regression analysis was only applied to HCA and TLC. The CMA therefore never performed any of the analysis on which it is basing its conclusions on HCA in the PFs, on any non-London operators.
- 9.17 HCA's economic advisers, KPMG, in the PFs Data Room, tested whether applying these analyses to non-London operators could bring different results. They followed the same methodology as the CMA did for HCA and TLC in the pooled regression, but they applied it to non-London operators.²²²
- 9.18 This analysis by KPMG found that BMI's prices are ~~✂~~ that the CMA used in its analysis of insured prices outside of central London. Specifically, as shown in Annex 6 to the DRR, the insured prices charged by these ~~✂~~.²²³
- 9.19 As explained in various submissions, HCA does not believe this analysis is robust and the CMA should not rely on it. However, if the CMA did rely on it, it should also consider that the same type of statistical finding that contributed to the CMA's conclusion that there was an AEC in central London with respect to insured patients in HCA's case applies to ~~✂~~ outside of central London. To reach a different finding in London compared to out of London would amount to clear discrimination.
- 9.20 In the light of the above, the CMA's insured AEC finding against HCA is also vitiated by the fact that it has made no insured AEC finding against operators outside central London. No rational competition authority could have reached such divergent views in relation to the London and non-London analyses. Furthermore, the CMA has unlawfully discriminated against HCA in its assessment of HCA's position in central London.

²²² KPMG was not allowed sufficient time in the data room to conduct further analyses, including on the price indices model.

²²³ ~~✂~~.

10. CONCLUSIONS

- 10.1 The CMA has failed to establish, to the requisite standard of proof, that there are AECs for either insured or self-pay patients in central London.
- 10.2 The CMA has not properly considered the evidence which HCA has submitted. Its whole approach during this remittal has been to "defend" its original decision at all cost rather than to accept that its original findings were wrong.
- 10.3 A fair, objective and rational competition authority could not have reached these conclusions, and HCA vigorously contests the CMA's provisional findings.

ANNEXES

No	Annex
1	HealthInvestor article 'Fortius favours the brave', 3 November 2015
2	Expert opinion of Rolfe Judd, 23 November 2015
3	Private Healthcare UK article 'World-renowned UK hospital improves facilities with HSBC support', 4 November 2015
4	HealthInvestor article 'Optegra launches new Harley Street hospital', 6 November 2015
5	HealthInvestor article: 'The waiting game', 3 November 2015

HCA INTERNATIONAL LIMITED

RESPONSE TO THE CMA'S NOTICE OF POSSIBLE REMEDIES

1. INTRODUCTION

- 1.1 HCA sets out in this submission its response to the CMA's Notice of Possible Remedies. It has submitted a separate response to the CMA's Provisional Findings (PFs).
- 1.2 HCA rejects the CMA's provisional finding that high concentration and barriers to entry and expansion result in weak competitive constraints on HCA in the provision of private healthcare services to either insured or self-pay customers (see HCA's Response to the PFs). This submission is therefore subject to HCA's stated position that there is no case for further remedial intervention by the CMA.
- 1.3 Without prejudice to this position, HCA sets out in this submission its views on the CMA's remedy proposals. In particular, that:
 - The CMA is required to consider the effectiveness and practicability of each remedy proposal, and ensure that any adopted remedy is proportionate. The CMA should also have regard to the effect of any action on any relevant customer benefits. The CMA must exercise particular care in its assessment of remedy proposals, particularly when proposing remedies such as divestiture which are extremely intrusive, costly and uncertain in effect.
 - A divestiture remedy would not be effective in lowering prices as HCA's prices are competitive on a like-for-like basis. Further, the IPA provides no evidence of a 'causal' link between market share and price (as opposed to other drivers of price such as quality), so there is no basis upon which to assert that a reduction in HCA's market share will result in lower prices. In any event, even if the remedy did result in lower prices to PMIs, these would be unlikely to be passed on to policyholders to a material degree and would come at the risk of harming range, quality and innovation in a sector where such non-price outcomes are critical.
 - Notwithstanding the lack of effectiveness, a divestiture remedy would be considerably more onerous than needed to achieve the CMA's aim. There is sufficient spare capacity across several metrics, the existing market structure boasts effective outcomes for consumers in respect of quality and range, the conditions for entry are ideal (new entry / expansion is expected over the next three years), and PMIs are already demonstrating their ability to exercise significant bargaining power.
 - Given that any perceived adverse effect on competition (AEC) would be short-lived, the fact that it would take several years for any impact on prices to take effect, a divestiture remedy does not represent a timely or practicable solution.
 - A divestiture remedy would give rise to serious and long-lasting economic costs that go beyond the substantial costs, disruption and asset risk creating by the divestiture process itself, such as the loss of relevant customer benefits from HCA's network of hospitals relating to range, innovation and quality as well as longer-term adverse effects on the incentives to invest.
 - In sum, a divestment remedy cannot be justified, it would not be effective in lowering prices (for a given level of quality and range), and the CMA has no basis for

asserting it would be proportionate in the light of the costs and risk of serious adverse effects on HCA, the divested hospitals and the market as a whole.

1.4 However, assuming hypothetically that the CMA's findings are correct, there are more effective and less onerous (relative to divestment) alternative remedies available to the CMA that would address the AEC findings provided they are designed and implemented proportionately. The remedies which would potentially satisfy the CMA's intended aim include:

- **Remedy 3:** This remedy would restrict HCA's further expansion in central London. While still a highly intrusive interference in HCA's business, such a remedy would address the issue identified by the CMA relating to site availability for new entrants. However, it would need to be designed so that it is limited in time and no wider in scope than is necessary to address the alleged AECs.
- **Remedy 6:** This remedy comprises two measures to address the issues of site availability, (i) a recommendation to NHS Trusts/Department of Health to sell surplus buildings to private hospital operators, and (ii) a recommendation to government to amend planning regulations to facilitate further private hospital development. Either remedy would be an effective and proportionate means of addressing the alleged AECs. The CMA's concerns about their effectiveness are misplaced and premature at this stage of the investigation.
- **Remedy 4:** This remedy would impose short-term tariff uplift caps on HCA. While HCA does not accept there is any basis for such a remedy, it would nonetheless represent a less intrusive (and more timely) solution than divestment given the short-lived nature of any AECs.
- **Remedy 2:** This remedy would require other hospital operators to rent hospital facilities from HCA for a limited period of time. This remedy gives rise to similar considerations regarding effectiveness, proportionality and adverse effects to those raised in relation to divestiture. Whilst a remedy requiring HCA to lease space to a new entrant for a short period of time (as opposed to outright disposal) may be potentially less intrusive than divestment, HCA cannot comment definitively without a clearer understanding of the nature and scope of the CMA's proposal.

1.5 The structure of HCA's submission is as follows:

- **Section 2** – Legal framework
- **Section 3** – Divestiture remedies
- **Section 4** – Other remedies

2. LEGAL FRAMEWORK

- 2.1 The CMA is required to ensure that any measures which it proposes in a market investigation reference to remedy, mitigate or prevent an AEC meet the relevant statutory tests under the Enterprise Act 2002 ("EA 2002").
- 2.2 The purpose of remedies is to remedy, mitigate or prevent either (i) the AEC, or (ii) any detrimental effects on customers resulting from the AEC (s.134(4), EA 2002).
- 2.3 Under Section 134(6) of the EA 2002, the CMA must in particular "*have regard to the need to achieve as comprehensive a solution as is reasonable and practicable*" to the AEC. In addition, under Section 134(7), the CMA may in particular "*have regard to the effect of any action on any relevant customer benefits*" of the features of the relevant market giving rise to the alleged AEC.
- 2.4 The CMA's approach to these statutory requirements and the factors which it takes into account are set out in its revised Guidelines for market investigations (CC3 revised, April 2013), as supplemented by Market Studies and Market Investigations: Supplemental guidance on the CMA's approach (CMA 3, January 2014 (revised September 2015)) (together, the "Guidelines"). These requirements have also been considered extensively by the courts.¹
- 2.5 Any measures which the CMA proposes must achieve a "comprehensive" solution and the Guidelines state: "*The clear preference of the [CMA] is to deal comprehensively with the cause or causes of the AEC, wherever possible, and by this means significantly increase competitive pressures within a reasonable period of time*".²
- 2.6 The Guidelines state that the CMA will assess the effectiveness and practicability of remedy options and will "*favour remedies that have a higher likelihood of achieving their intended effect*".³
- 2.7 The Guidelines confirm a key factor in determining this is the consideration of the timescale over which a remedy is likely to have effect. In doing so, the CMA will, among other things, select a remedy which can be "*sustained for as long as the AEC is expected to endure*". Notwithstanding the CMA's preference "*to favour remedies that can be expected to show results within a relatively short time*", the CMA is also clear that "*where an AEC is expected to be short-lived (for example, because a specific future event is expected to bring it to an end) and the timescale for implementation of a particular remedy option would extend significantly into this period, the CMA will consider whether an alternative measure would be more appropriate*".⁴ Further, in deciding whether to specify a finite duration, the CMA may include sunset provisions into a remedy as part of their design, which will generally take effect "*by reference to a particular date or a clearly defined future event*".⁵

¹ In particular: *BAA v CC*, [2012] CAT 3; *Barclays and others v CC* [2009] CAT 27; *Tesco v. CC* [2009] CAT 6.

² Guidelines, CC3 revised, paragraph 330.

³ *Ibid.*, paragraph 335.

⁴ Guidelines, CMA 3, paragraph 4.18.

⁵ *Ibid.*, paragraph 4.19.

- 2.8 The CMA is also required to consider the proportionality of any remedy options.⁶ The Guidelines, reflecting the principles developed in the applicable case law, state that proportionality requires that the remedy:
- (i) is **effective** in achieving its legitimate aim;
 - (ii) is **no more onerous** than needed to achieve its aims;
 - (iii) is the **least onerous** if there is a choice between several effective measures;
 - (iv) does not produce **disadvantages** which are disproportionate to the aim.
- 2.9 In considering the proportionality question, the courts have referred to: "*the balancing exercise between the (achievable) aims of the proposed measure on the one side, and any adverse effects it may produce on the other side.*"⁷
- 2.10 The CMA has a duty to investigate and consider carefully each aspect of the proportionality test and "*take reasonable steps*" to acquaint itself with the relevant information to enable it to answer each statutory question posed for it.⁸
- 2.11 Furthermore, the CMA has a higher burden of proof in cases where it seeks to impose more extensive or far reaching remedies such as divestment. In *Tesco*, the CAT referred to the "double proportionality" principle:⁹
- "The more important a particular factor seems likely to be in the overall proportionality assessment, or the more intrusive, uncertain in its effect, or wide-reaching a proposed remedy is likely to prove, the more detailed or deeper the investigation of the factor in question may need to be. Ultimately the Commission must do what is necessary to put itself into a position properly to decide the statutory questions."*
- 2.12 The courts will expect the CMA to exercise particular care in its analysis of the AEC and of the effects of remedies when proposing remedies such as divestment, which the CAT described as being "*a seriously intrusive step*".¹⁰ The CMA itself has described divestiture as representing "*a very significant intervention in property rights*" and that, in the context of market investigations, divestiture takes on an elevated level of intrusiveness compared to divestiture remedies under the mergers regime.¹¹
- 2.13 The CMA states in its Guidelines that it will consider the potential effects of remedies "*with particular regard*" to customers. This will include assessing the potential benefits (e.g. lower prices or innovation) and the potential negative effects, including unintended distortions and implementation costs. The CAT noted in *Barclays* that where the CMA has proposed far reaching remedies: "*The potential for such a radical remedy to cause disadvantageous side effects called for vigorous investigation and analysis of its potential adverse consequences.*"¹² The Tribunal's requirement for "*vigorous investigation and analysis*" is particularly apposite in this case in which the CMA is proposing the extreme remedy of divestiture.

⁶ See e.g. *Tesco v. CC* [2009] CAT, paragraphs 135-138 citing *Federa*, Case C-331/88.

⁷ *Tesco v. CC* [2009] CAT, paragraph 138.

⁸ *BAA v CC*, [2012] CAT 3, paragraph 20(3).

⁹ *Tesco v. CC* [2009] CAT, paragraph 139.

¹⁰ *BAA v CC*, [2012] CAT 3, paragraph 20(7).

¹¹ *Groceries*, Original Market Investigation Report, paragraph 11.265 and footnote 1.

¹² *Barclays v CC* [2009] CAT 27, paragraph 128.

- 2.14 The CMA must further consider any relevant customer benefits deriving from the existing market structure. Under Section 134(8) of the EA 2002, relevant customer benefits expressly include lower prices, higher quality, greater choice of products or services and greater innovation. The references to quality and innovation are particularly apposite in healthcare markets where patient health and well-being is paramount. The CMA must therefore consider the extent to which remedies may harm or extinguish these benefits, and may not impose remedies if these would erode or remove relevant customer benefits.
- 2.15 Under Section 6(1), Human Rights Act 1998, the CMA is subject to the duty to act compatibly with rights under the European Convention on Human Rights (the "Convention"). In *BAA*, it was held that Sections 134 and 138 of the EA 2002 should be read and given effect in a way compatible with Convention rights.¹³ Article 1 of the First Protocol to the Convention protects and safeguards property rights. In proposing highly intrusive remedies which interfere with property rights, such as divestment, the CMA has a high standard of proof to discharge based on the normal standards of rationality¹⁴ to demonstrate that interference with the fundamental Convention rights is proportionate and justified. This is a particular consideration in the present case, in view of the CMA's divestiture proposals.
- 2.16 The EA 2002 thus lays down a statutory framework for a consideration of remedies which requires a clear and unequivocal identification of the alleged AEC and a careful assessment of the objectives and effects of remedies, balancing the effectiveness of the remedies to address the AEC with the detriments which they give rise to.

¹³ *BAA v CC*, [2012] CAT 3, CAT judgment of 1 February 2012, paragraph 20(2).

¹⁴ *Ibid*, paragraph 20(5).

3. DIVESTITURE REMEDIES

Summary

- 3.1 In this section HCA sets out its views on Remedy 1, the CMA's proposal to order divestment of one or more HCA hospitals.
- 3.2 The CMA states that it is minded to consider this remedy because it believes it has the potential to be practicable and effective in addressing the insured and self-pay AECs in central London that it has provisionally found and/or the customer detriment these AECs lead to (paragraphs 19 and 21, Notice of Possible Remedies)
- 3.3 As noted above, HCA strongly disagrees with the CMA's provisional finding that there is an AEC in central London, with regards to either insured or self-pay customers. HCA sets out its reasoning for this disagreement in its response to the PFs.
- 3.4 Notwithstanding this position, HCA sets out its views on why the divestment remedies being considered by the CMA would not be effective, given the CMA's provisional finding of an AEC, and in any event would be disproportionate.
- 3.5 Based on the evidence before it, the CMA cannot reasonably conclude that a divestment of one or more of HCA's hospitals would be effective. The evidence in fact shows that none of the necessary conditions for a divestment remedy in the private healthcare market to be effective are met.
- 3.6 Specifically, the evidence indicates that HCA's insured prices are competitive when considered on a like-for-like basis. However, even if HCA had the ability to charge prices above competitive levels, the evidence on spare capacity (across a number of measures) in central London suggests that any such ability would not be due to HCA's local market share. As a result, the evidence suggests a divestment would not significantly change the bargaining power of HCA relative to PMIs, and would not lead to lower prices to PMIs. Finally, a divestment would not lead to lower prices to policyholders or better non-price outcomes, such as better quality and range.
- 3.7 Similarly, a divestment remedy cannot be expected to lead to lower prices to self-pay patients in central London, as no causal relationship exists between local market share and self-pay prices which is robust and relevant to central London or to HCA.
- 3.8 In fact, a forced divestment of one or more HCA hospitals would cause a range of economic costs to HCA, to patients and to other potential investors. A divestment remedy would interfere with incentives to invest and innovate, by preventing a firm forced to divest from realising fair market value (FMV) for its assets. It would also impose a number of one-off costs of divestment to HCA and to the purchaser(s) of the divested asset(s). Furthermore, it would result in the loss of a range of relevant customer benefits (RCBs) both at HCA's remaining hospitals and at the divested hospital(s).
- 3.9 In sum, a divestment remedy imposed on HCA would be both ineffective and disproportionate.
- 3.10 This section proceeds by setting out HCA's position on why a divestment remedy:
- would not be not effective;

- would be more onerous than needed to achieve the CMA's stated aim;
- would not be the least onerous; and
- would produce disadvantages which are disproportionate to the aim.

(1) A divestment remedy will not be effective

- 3.11 HCA submits that a divestment remedy will not lead to a reduction in prices for a given level of quality and range. This is because:
- it will not lead to lower prices to PMIs for a given level of quality and range of private healthcare services
 - even assuming that divestment led to lower prices to PMIs (which HCA strongly contests), such lower prices would be unlikely to lead to lower prices to policyholders.
- 3.12 As to non-price elements of the private healthcare offer, a divestment remedy is highly unlikely to lead to better outcomes to customers in the form of better quality and range of private healthcare services, either at HCA's remaining hospitals or at the divested hospital(s). On the contrary, it is likely to lead to worse outcomes by increasing costs of delivering services and reducing the incentive and ability for private hospital operators to invest. The CMA itself recognises in its discussion of a potential price cap remedy that lower prices may lead to reduced levels of investment and innovation and thus lower quality and narrower range of private healthcare services (Notice of Possible Remedies, paragraph 39 (c)).
- 3.13 The CMA and the CAT have previously recognised that there are essentially four necessary conditions, all of which have to be met for a divestment remedy to be effective. Specifically, in the case of a divestment remedy imposed on HCA it would have to be the case that:
- (i) HCA's insured prices are not competitive (when considered on a like-for-like basis);
 - (ii) HCA's ability to charge prices above competitive levels is due to its local market share;
 - (iii) A divestment would lead to significantly lower prices to PMIs for a given level of quality and range;
 - (iv) A divestment would lead to better outcomes for policyholders, either in the form of lower prices for a given level of quality and range and/or better non-price outcomes such as better quality and range.
- 3.14 While it would be sufficient that any one of these conditions is not met for a divestment remedy to be ineffective, in the remainder of this section, HCA sets out the reasons why the evidence before the CMA shows that actually none of these conditions is met and therefore no divestment remedy could be considered effective. Each condition is considered in turn.
- 3.15 HCA concludes this section with a brief discussion of why the CMA's analysis of self-pay prices cannot be relied upon to determine whether a divestment in central London would lead to reduced prices to self-pay patients.
- 3.16 Finally, HCA notes that two prominent PMIs, Simplyhealth and (then) PruHealth, submitted that they would not expect a divestment to lead to lower prices. This would suggest that

some of the PMIs themselves questioned the effectiveness of the CMA's potential divestment remedy.¹⁵

(i) HCA's insured prices are competitive on a like-for-like basis

3.17 To determine whether HCA's insured prices are competitive, the CMA has set out to test, by means of an insured pricing analysis ("IPA"), whether HCA's insured prices differed from the insured prices of the hospital operator which the CMA considered to be HCA's closest competitor, TLC. The CMA adopted this approach in the Final Report on the Private Healthcare Market Investigation of 2 April 2014 (the "Final Report"), in the Remittal Inquiry Insured Price Analysis Working Paper of 11 June 2015 ("IPA WP"), and continues to adopt it in the PFs.

3.18 In this section, HCA first sets out why the absence of a price differential with TLC implies that HCA charges competitive prices, contrary to arguments made by AXA PPP and Bupa in response to the IPA. HCA then sets out why the IPA, when properly accounting for differences in patient and episode mix between HCA and TLC, points to there being no price difference on a like-for-like basis. Finally, it explains how HCA's lack of bargaining power with PMIs confirms the fact that HCA's prices are competitive.

Absence of a price difference between HCA and TLC implies that HCA charges competitive prices

3.19 AXA PPP and Bupa responded to the IPA WP and suggested that even if the revised IPA identified a small or even no difference in HCA's and TLC's insured prices, this could not constitute proof of HCA's prices being at competitive levels, either (i) because TLC might be "pricing in the shadow" of HCA's supposedly above-competitive prices, or (ii) because both operators might be "super-dominant" in their own right, with both charging above-competitive prices.¹⁶

3.20 HCA has already explained that AXA PPP's and Bupa's arguments are flawed in its response to these submissions:

- First, HCA noted that these two reasons are internally inconsistent in the way they explain the source of TLC's supposed market power, and both cannot be true. The first reason suggests that TLC's prices are constrained by HCA's prices (with TLC setting supposed above-competitive prices only in response to HCA's own supposed above-competitive prices), whereas the second implies TLC's prices are not constrained by HCA's prices (with TLC setting prices with little or no regard to HCA's prices).¹⁷
- Second, there is no evidence to support the theory that TLC is "pricing in the shadow" of HCA, or to support the idea that HCA or TLC being "super-dominant", and both are implausible in this case. "Pricing in the shadow" is implausible given

¹⁵ "Simplyhealth submits that, in respect of central London, divestiture would have very few consequences for the existing competitive constraints; HCA would simply be replaced by a different provider, with the consequence that there would be no material changes"; "PruHealth did not necessarily believe that the sale of one or more of HCA's hospitals would exert downward pressure on prices and in all likelihood a new entrant would charge the same as HCA." See Simplyhealth response to original Notice of Possible Remedies, 20 September 2013, and PruHealth hearing summary, 30 September 2013, paragraph 10, respectively.

¹⁶ AXA PPP's Response to the IPA WP, page 3; and Bupa's Response to the IPA WP, paragraph 2.12-2.15.

¹⁷ A submission on responses to the IPA Working Paper by AXA PPP and Bupa, HCA, paragraph 2.4.

the secret nature of contract negotiations, and in any case would imply the existence of tacit coordination between private hospital operators and of excessive profits being earned by TLC – hypotheses that the CMA has not considered or explicitly ruled out, respectively. Furthermore, Bupa's references to "super dominance" are implausible given the evidence that the PMIs have strong bargaining power, even by the CMA's assessment (see section 4 of HCA's response to the PFs). In fact, HCA and TLC having a degree of differentiation between their service propositions is consistent with the market providing strong competitive pressures to invest and innovate and delivering a broad range of services and patient choice.¹⁸

- 3.21 The CMA makes no reference to these arguments in the PFs and for the reasons above it cannot reasonably consider them in any assessment of the effectiveness of a divestment remedy.

The IPA does not show any insured price difference between HCA and TLC on a like-for-like basis

- 3.22 During HCA's appeal of the CMA's decisions in the original private healthcare inquiry, the CAT noted that it is important "*to be able to examine carefully [...] whether – in constructing the IPA – prices have been correctly measured and the comparison has been performed on a suitable like-for-like basis*".¹⁹ The CMA also recognises that for any comparison of prices across HCA and TLC to be meaningful, it must be done on a like-for-like basis.²⁰
- 3.23 In its IPA WP, of June 2015 the CMA presented the results of a revised IPA. The CMA concluded that HCA's insured prices were ⌘ higher than TLC's.²¹
- 3.24 In response to the IPA WP, following analysis conducted in a Data Room, HCA's economic advisers submitted a Data Room Report ("IPA WP DRR").²² In the IPA WP DRR, HCA's economic advisers showed that there were a number of flaws in the analysis presented in the IPA WP, which meant the price comparisons were not conducted on a like-for-like basis.²³
- 3.25 One of the ways in which HCA's economic advisers modified the analysis in the IPA WP to enable a better comparison was to more adequately control for episode complexity, by accounting for the number of units of different invoice items (such as pathology tests) each patient had received. Such modified analysis showed that there is no difference between HCA's and TLC's insured prices.
- 3.26 The CMA presents a further revised IPA in the PFs. On the basis of this analysis, the CMA provisionally concluded that HCA's insured prices were on average ⌘ higher than TLC's between 2007 and 2011 (paragraph 8.149, PFs).
- 3.27 While HCA continues to have strong reservations about the IPA (for the reasons set out in section 6 of HCA's Response to the PFs), HCA notes that, importantly, the CMA provisionally concludes in the PFs that "*HCA's reasons why it attracts more complex patients*

¹⁸ A submission on responses to the IPA Working Paper by AXA PPP and Bupa, HCA, paragraph 2.30.

¹⁹ *HCA v CMA* [2014] CAT 11, paragraph 37.

²⁰ See, for example, PFs, paragraph 8.148.

²¹ IPA WP, paragraph 31.

²² KPMG Data Room Report, 24 July 2015.

²³ IPA WP DRR, paragraph 1.4.

than TLC are plausible" (paragraph 8.150, PFs) and that the CMA *"cannot rule out the possibility that our IPA analysis may not fully account for differences in patient complexity between HCA and TLC"* (paragraph 39, PFs). Furthermore, the CMA *"can no longer conclude on the size of [the] price difference between HCA and TLC"* (paragraph 39, PFs).

3.28 The CMA's provisional conclusions clearly demonstrate that it cannot reasonably rule out the possibility that there is no difference between HCA and TLC's prices on a like-for-like basis.

3.29 Further analysis conducted by HCA's economic advisers, KPMG,²⁴ ✂. These results are consistent with the line item analysis presented by KPMG in the IPA WP DRR²⁵ which showed that ✂.

3.30 In sum, the IPA fails to demonstrate that HCA's prices are not competitive on a like-for-like basis.

HCA does not have significant bargaining power with PMIs, confirming that HCA's prices are competitive

3.31 As discussed in section 4 of HCA's response to the PFs, the evidence of bargaining between HCA and PMIs is consistent with HCA's prices being competitive on a like-for-like basis. Specifically, HCA does not have significant bargaining power with PMIs.

3.32 Where two parties negotiate over prices or other outcomes, the key determinants of each party's bargaining power, and hence of the bargaining outcome, are (i) each party's outside option and (ii) the way in which the 'bargaining surplus' is shared (the "sharing rule").

3.33 As HCA has pointed out, in its review of bargaining outcomes, the CMA's assessment of how these factors affect bargaining power and bargaining outcomes suffers from serious shortcomings. These include:

- (a) the CMA has not assessed the outside options of PMIs and hospital operators jointly; and
- (b) the CMA has not formed an accurate understanding of the sharing rule.

3.34 As a result, the CMA is unable to form any reliable conclusion as to either the present distribution of bargaining power between HCA and the PMIs, or the impact of market concentration on bargaining outcomes.

3.35 In any case, the CMA appears to have set out only to consider whether the sharing rule is such that HCA earns a very small or zero share of the bargaining surplus. However as noted in section 4 of HCA's response to the PFs, even if HCA were able to earn some amount of the bargaining surplus, the sharing rule may still be heavily tilted in favour of the PMIs, and (in conjunction with the PMIs' relatively valuable outside options) the balance of bargaining power overall may still lie heavily with the PMIs.

3.36 HCA has indeed provided substantial evidence during the Remittal Inquiry which points to the PMIs' outside options being substantially more valuable than HCA's outside options, and that the sharing rule is likely significantly skewed in PMIs' favour.²⁶

²⁴ Report on HCA Patient Comorbidities, KPMG, 4 December 2015.

²⁵ See IPA WP DRR, section 4.4.

²⁶ See The CMA's Assessment of Negotiations Between Hospital Operators and PMIs and the Economics of Bargaining, KPMG, 8 May 2015.

3.37 For these reasons the CMA cannot reasonably conclude that HCA has significant bargaining power with PMIs.

(ii) There is no evidence that HCA's local market share has any bearing on its ability to negotiate higher prices with the PMIs

3.38 As set out above, HCA submits that the evidence is consistent with it charging competitive prices. In particular, HCA maintains that its prices are not higher than TLC's on a like-for-like basis, and that it does not have significant bargaining power with PMIs.

3.39 However, to the extent that HCA has some bargaining power vis-à-vis the PMIs, one would need to determine what the drivers of this are; in other words, what would "cause" a given level of HCA's prices.

3.40 The CAT has explicitly recognised the importance of assessing causality. In particular, it concluded that:

"[i]n our opinion, there is force in the points [...], that it will be important in the context of the present case to be able to examine carefully the basis for the CMA's conclusions that the relationship between market share and prices is causal [...]".²⁷

3.41 As discussed in section 6 of HCA's response to the PFs, the IPA provides no evidence for a causal relationship between market share and prices. Further, the CMA has not appropriately assessed other evidence on causality, or whether other factors, such as differences in costs or quality might better explain any estimated price difference.

3.42 On this point, HCA also notes that it was the inability of the CMA to find a robust relationship between local concentration and insured prices outside of central London that led to the CMA changing its view in the Final Report (relative to the PFs in the original private healthcare inquiry) and concluding that there was no insured AEC outside of central London.²⁸ See section 9 of HCA's response to the PFs.

3.43 HCA discusses below the evidence concerning the likely drivers of any difference in insured prices between HCA and TLC.

HCA's local market share cannot be a significant driver of differences in insured prices

3.44 The CMA provisionally concludes that weak competitive constraints (resulting from high concentration and HCA's large market share, and high barriers to entry and expansion) *"are likely to be the most important factor in HCA's higher prices"*. (paragraph 11.37 and 11.40-41, PFs)

3.45 The CMA has not, however, presented any reliable evidence that there is a causal relationship between concentration or HCA's market share and insured prices.

3.46 In section 4 of HCA's response to the PFs, HCA explains that HCA's share of supply (or local market concentration) could only be a driver of PMIs' outside options in negotiations with HCA if PMIs were constrained in their ability to divert their patients away from HCA hospitals. HCA has previously submitted to the CMA that there was sufficient spare capacity in central

²⁷ *HCA v CC* [2014] CAT 11, paragraph 37.

²⁸ Final Report, paragraph 13.38.

London for PMIs to divert all of their inpatient customers to alternative, non-HCA, central London hospital operators.²⁹

- 3.47 In response to this evidence, the CMA concludes that *"the necessary level of spare capacity to facilitate switching by PMIs cannot be a matter of precise calculation"* (paragraph 4.47, PFs), and that *"the availability of beds at non-HCA facilities is [not] by itself a good indicator of effective spare capacity in central London"* (paragraph 4.46, PFs), since capacity is related to *"multiple dimensions"*, including operating theatres, intensive care facilities, other specialist facilities and the days and times at which consultants are available and willing to practise (paragraph 4.47, PFs).
- 3.48 The CMA does not present in the PFs its own analysis of what would constitute sufficient spare capacity to constrain HCA's prices. However, as noted in section 2 of HCA's response to the PFs, even if the CMA considers that there are other indicators of capacity, there is no evidence that there are capacity constraints which would prevent PMIs from directing patients to non-HCA facilities.
- 3.49 In fact, an updated analysis of spare capacity in central London prepared by HCA's economic advisers, KPMG (the "Second Spare Capacity Report") shows that there is sufficient spare capacity, based on ✂, for PMIs to redirect all of their patients to non-HCA hospitals in central London. The CMA cannot therefore assert that there are any capacity constraints whatsoever in relation to ✂. In section 2 of HCA's response to the PFs, HCA also highlights that there is no evidence which suggests that consultant availability is a constraining factor for the PMIs' ability to redirect patients.
- 3.50 Furthermore, in its assessment of bargaining, the CMA presents evidence and statements from AXA PPP and Bupa relating to the ability of PMIs to switch away from HCA, including references to HCA's hospitals being "must have". As set out in section 4 of HCA's response to the PFs, the evidence set out by the CMA does not support any conclusion that PMIs' outside options are driven by HCA's share of supply, or by a lack of spare capacity in central London. If anything, as discussed below, it supports a conclusion that PMIs' outside options are impacted by HCA's reputation and higher quality. HCA also notes that to the extent that individual HCA hospitals are considered "must have" (as AXA PPP has contended),³⁰ it is not clear how a divestment would improve PMIs' outside options in negotiations with any new operator(s), or lead to lower insured prices, as the PMIs may still consider the divested hospital(s) to be "must have".
- 3.51 The CMA's own analysis of causality is flawed, as also demonstrated by a number of additional considerations:
- While the IPA cannot provide evidence of a causal link, the high degree of variation in insured prices estimated by the CMA – across time and PMIs – is inconsistent with the CMA's view that insured prices are driven by shares of supply, which remained stable over the period of the CMA's analysis.³¹

²⁹ Analysis of spare inpatient capacity in central London, KPMG, 24 July 2015, paragraph 1.7.

³⁰ AXA PPP noted that six of the seven hospitals it identified as "must have" in central London were the six hospitals operated by HCA. See Final Report, Appendix 6.10, Annex A, paragraph 42.

³¹ See, for example, October 2014 Data Room Report, Table 12; and Appendix 8; A Submission on the Analysis of Insured Prices, KPMG, 1 May 2015, paragraphs 81-83 and Table 6; A submission on responses to the IPA Working Paper by AXA PPP and Bupa, HCA, paragraph 2.16.

- Despite the CMA reaching the same conclusions with regard to barriers to entry and expansion and weak competitive constraints outside of central London, the CMA did not find any causal link between concentration and prices outside central London. The CMA has provided no evidence as to why this should be the case for central London, particularly given the evidence pointing to large amounts of spare capacity.
- As HCA has previously submitted,³² the CMA's framework for assessing the link between market shares and prices is outdated. Antitrust authorities have been moving away from a heavy reliance on market shares and concentration measures because they, and the academic literature, acknowledge that high market shares can be consistent with intense competition, and that efficient firms selling products with attractive characteristics tend to grow as consumers choose their products. Simple correlations between market share and margins frequently, therefore, do not imply causation.³³

Differences in quality, range and reputation are a more likely driver of any differences in insured prices

- 3.52 While the CMA's assessment of the PMIs' outside options shows that PMIs' outside options are highly unlikely to be driven by HCA's share of supply, or by a lack of spare capacity in central London, it does, however, reveal that differences in perceived quality, range and reputation between HCA and other private healthcare operators may explain any differences in bargaining power between HCA and other central London hospital operators, and hence in insured prices (to the extent that such a difference was established on a like-for-like basis). At the same time, differences in quality, range and reputation may be a key driver of HCA's market share, a point that the CMA fails to acknowledge.
- 3.53 As noted in section 2 HCA's response to the PFs, AXA PPP and Bupa have stated that to the extent that they face restrictions in diverting patients away from HCA, these in practice relate to HCA's higher perceived quality and range. Specifically, AXA PPP has noted that *"there may theoretically be sufficient capacity in relation to available beds and operating theatre hours among other hospital operators which might mean it would conceivably be able to redirect its business in a mathematical sense. However, even if that was the case, only a small subset of its clients would be prepared to submit to redirection because of HCA's reputation"*.³⁴ The CMA also cites the "widespread views" among PMIs that HCA has a number of "must have" hospitals (paragraph 6.31, PFs); in the Final Report it noted that AXA PPP defines "must have" private hospitals as *"those healthcare facilities offering the strongest professional reputation for a broad range of treatments and those which we believe are a 'must have' for our large corporate clients"*.³⁵ These statements suggest that any bargaining power enjoyed by HCA would be due to its higher perceived quality and superior reputation.
- 3.54 The CMA further reported that both AXA PPP and Bupa submitted that spare capacity would not act as an effective competitive constraint as many patients have an unrestricted choice of hospitals in their policy networks (paragraph 4.21(b), PFs). Because AXA PPP's and

³² See A Submission on the Analysis of Insured Prices, KPMG, 1 May 2015, paragraphs 58-64.

³³ See also S Bishop and M Walker, "The Economics of EC Competition Law: Concepts, Application and Measurement", Sweet and Maxwell, 2010, paragraph 14-027.

³⁴ Summary of hearing with AXA PPP Healthcare Limited on 12 August 2015 paragraph 26.

³⁵ Final Report, Appendix 6.10, Annex A, paragraph 42.

Bupa's customers are able to purchase restricted network or guided referral products, this shows that – rather than local market shares or concentration – a key factor limiting AXA PPP's and Bupa's ability to divert patients away from HCA is that their customers have a preference for HCA.

Legitimate cost differences between HCA and TLC may also explain any insured price difference, to the extent that one is established on a like-for-like basis

- 3.55 The IPA did not control for any cost differences between HCA and TLC. The CMA claimed it did control for costs, but it only controlled for cost differences between central London and the rest of the UK.³⁶ As such, the CMA's hypothesis that TLC's insured prices are a valid benchmark for HCA's insured prices requires that HCA and TLC face a similar cost base.
- 3.56 As a charity, TLC receives significant benefits in terms of tax exemptions, including exemption from corporation tax, business rate reliefs and VAT reliefs, as well as benefitting from a lower cost of capital.³⁷
- 3.57 However, in the Final Report, the CMA concluded that *"only marginal costs (as opposed to fixed costs) should be relevant for pricing decisions"*³⁸ and that *"[s]ince corporation tax is applied to net profits and business rates are fixed costs, [the CMA] would not expect either of these to be relevant for pricing. Regarding VAT, [the CMA] considered the likely impact that this may have and found it to be small. Taking these two points into consideration, [the CMA] therefore did not consider charity status to have a material impact on the price comparisons"*.³⁹
- 3.58 During the Remittal Inquiry, HCA noted that the CMA had erred in its assessment of the impact of TLC's charity status in its analysis of insured price differences. Specifically, HCA explained that the CMA was wrong to disregard the effect on insured prices of potential differences in fixed costs between hospital operators.⁴⁰
- 3.59 HCA drew on a range of academic papers to explain that:
- where prices are determined in a bargaining framework, as is the case in private healthcare for insured prices, these prices will account for fixed costs;⁴¹ and
 - in an industry with relatively high fixed costs and relatively low marginal (or variable) costs, the potential to earn a positive margin acts as a powerful incentive for firms to compete for consumers, for example by investing in quality and innovation, as each consumer brings a contribution to fixed costs. This investment can itself contribute to the fixed costs that a firm has to shoulder and can

³⁶ The CMA states in the Final Report that it conducted its IPA separately for central London and the rest of the UK because this *"allowed for the analysis to control for potential differences, such as treatment/patient mix and marginal costs, between the operators active in central London and those active across the rest of the UK"*. Final Report, paragraph 6.338.

³⁷ This was recognised by the CMA: *"[t]he basis of our estimate of the WACC in this analysis is that which would apply to a hypothetical stand-alone UK operator which was liable to the prevailing rates of corporation tax as a commercial entity. This may mean that our pre-tax WACC estimate is above that which would be appropriate for a charity"*. Final Report, Appendix 6.14, paragraph 67.

³⁸ Final Report, paragraph 6.364.

³⁹ Final Report, paragraph 6.367.

⁴⁰ HCA's submission on structural AECs, 1 May 2015, paragraph 4.64.

⁴¹ HCA's submission on structural AECs, 1 May 2015, paragraph 4.67. This will apply in particular to investments that may be contingent on the bargaining outcome: see also Raskovich (2003), *"Pivotal Buyers and Bargaining Position"*, The Journal of Industrial Economics, Volume 51, Issue 4, pages 405-426.

realistically only be undertaken if a return is earned on it. This again implies that a hospital operator must take its fixed costs into account when setting prices. A simplistic model linking pricing decisions only to marginal costs is therefore not only at odds with economic theory under the correct framework but is also contrary to basic commercial reality.⁴²

- 3.60 HCA's economic advisers also noted that since HCA's mix of treatments appears generally to be more complex than TLC's, HCA would likely have higher operating and investment costs than TLC, especially if (as is likely) the difference in cost base and additional treatments are apportioned across all of HCA's treatment prices.⁴³
- 3.61 HCA further pointed out that TLC has acknowledged that its charitable status is one of the reasons it believes it is able to charge lower prices than HCA.⁴⁴
- 3.62 The CMA stated in the PFs that "[w]e have already responded, in the Final Report, to HCA's arguments on the cost advantage that its central London rivals might have due to their charity status" (paragraph 4.85, PFs).
- 3.63 However, the CMA did not respond to HCA's points on the relevance of fixed costs anywhere in the PFs.
- 3.64 In sum, the CMA is incorrect in stating that *"only marginal costs (as opposed to fixed costs) should be relevant for pricing decisions"*. For the IPA results to be meaningful, the CMA must properly consider legitimate differences in HCA's and TLC's (fixed and marginal) costs, including corporation tax, business rates, VAT and cost of capital. Without such an exercise, the CMA is not in a position to rule out that an important driver of any insured price difference between HCA and TLC is (as mentioned by TLC) the difference in their cost bases.

(iii) A divestment would not lead to significantly lower prices to PMIs for a given level of quality and range

- 3.65 As discussed in section (ii) above, the evidence points to there being no material link between the PMIs' outside options in negotiations with HCA and HCA's market share or local market concentration. The results on spare capacity set out in the Second Spare Capacity Report are clear evidence of this. Furthermore, as mentioned in section (ii) above, the view of the PMIs is that spare capacity is not a driver of whether a hospital is "must have" or not, rather it is patient choice arising from HCA's high quality and reputation. This view of the market is also inconsistent with a divestment having any effect on prices to PMIs for a given level of quality and range.
- 3.66 There is therefore no evidence that any divestment remedy would have a material impact on the PMIs' ability to negotiate lower prices with HCA.
- 3.67 Moreover, even if the CMA considered that a divestment would lead to an improvement in the PMIs' outside options, as set out above, any impact of this on the bargaining outcomes would depend on the "sharing rule". Since this is likely tilted in favour of the PMIs, any hypothetical change in the PMIs' outside option would likely be of a small order of

⁴² HCA's submission on structural AECs, 1 May 2015, paragraph 4.68.

⁴³ A Submission on the Analysis of Insured Prices, KPMG, 1 May 2015, paragraph 72-73.

⁴⁴ Summary of hearing with The London Clinic held on 27 February 2013, paragraph 6.

magnitude. In any event, given the CMA has not assessed this, it is not in a position to exclude that even if there was a hypothetical change in the value of the PMI's outside options, this would lead to a material change in the bargained outcome.

- 3.68 Further, HCA reiterates below that a divestment remedy is likely to increase costs for private healthcare providers (for example due to a loss in scale and scope economies). This would in turn generate an upward pressure on prices charged to PMIs following a divestment, as opposed to lower prices to PMIs.
- 3.69 In sum, a divestment would not lead to lower prices to PMIs, and may well increase prices in so far as costs will increase.

(iv) A divestment would not lead to better outcomes for policyholders

- 3.70 HCA next sets out why a divestment would not lead to better outcomes for policyholders.
- 3.71 First, HCA sets out how even if a divestment led to lower prices to PMIs (which HCA disagrees with), this would not lead to a reduction in premiums charged to policyholders for a given level of quality and range.
- 3.72 Second, HCA sets out how a divestment would not lead to better non-price outcomes for policyholders.

A divestment would not lead to lower prices to policyholders

- 3.73 Even if a divestment led to lower prices to PMIs (which HCA disagrees with), these would not lead to a reduction in premiums charged to policyholders.
- 3.74 In this market, the issue of pass-through to final consumers is an important one, as HCA sets out next. In this context the CMA needs to take account of the fact that even if the divestment resulted in lower prices to PMIs, these would be unlikely to be passed through to policyholders to any material degree.

The CMA must consider whether lower prices to PMIs would be passed through to policyholders

- 3.75 In the Final Report, the CMA concluded that its responsibility in designing and implementing remedies as part of a market investigation is, *inter alia*, to remedy, mitigate or prevent any detrimental impact on customers, and that in its view, *"as funders of private healthcare, insurers are customers of HCA and [the CMA considers] that it is appropriate to treat them as such"*.⁴⁵
- 3.76 The CMA's decision to treat PMIs as relevant "customers" from the perspective of designing and implementing remedies is however not justified as a matter of economics. That PMIs cannot simply be treated as customers is explained clearly in the dissenting view by one member of the panel, Dermot Glynn, in the Tribunal's recent judgment in *Federation of Independent Practitioner Organisations ("FIPO") v CMA*.⁴⁶

⁴⁵ *FIPO v CMA* [2015] CAT 8, paragraph 76.

⁴⁶ *FIPO v CMA* [2015] CAT 8. Although the Tribunal's majority decision was that Mr Glynn's judgment *"involves a departure from the rationality approach"* in a judicial review and involves an analysis which *"goes into the merits of the case beyond what is appropriate for the Tribunal on a challenge under section 179 of the 2002 Act"*, his comments are nevertheless important in the context of the present Remittal Inquiry, in which the CMA has an obligation to reconsider the merits of its AEC findings.

- 3.77 Mr Glynn explained that in his view the CMA should design any measures to remedy AECs with regard to the impact on consumers, and that PMIs should not be considered consumers in this case. Mr Glynn explained that this is due to the divergent incentives between PMIs and policyholders:

*"The 2002 Act requires the CMA to take account of adverse effects on innovation when considering whether action should be taken to remedy, mitigate or prevent any detrimental effect on consumers resulting from the AEC"*⁴⁷

*"In the present case, the consumers are patients, not intermediaries such as PMIs or employers".*⁴⁸

*"it is [...] obvious that PMIs also have other incentives, and that these may sometimes conflict [with the incentives of employers and policyholders]. This is why [...] PMIs sometimes steer patients towards fee-assured or fee-capped consultants and sometimes threaten to de-list consultants on purely financial grounds. It is also why they sometimes steer patients towards low-cost medical solutions".*⁴⁹

- 3.78 HCA has previously submitted evidence to the CMA that PMIs' incentives are not necessarily aligned with those of patients.⁵⁰ PMIs' incentives primarily relate to minimising their total cost of claims, whereas it is in patients' interests, at the point of requiring treatment, to receive high-quality treatments to maximise their clinical outcome. Analogously to the case of consultants discussed by Mr Glynn, PMIs can achieve this outcome by steering patients towards lower-quality hospitals through guided referral policies. They can also achieve it by not recognising new innovative treatments such as those only available at the NHS, so that at the point of requiring any of those treatments, patients would use the NHS.

- 3.79 Treating PMIs as consumers is also inconsistent with the CMA's report on private motor insurance. In its final report on that investigation, the CMA considered the issue of pass-through at length. For example, the CMA considered pass-through in respect of its evaluation of the effectiveness of multiple remedies in respect of its first theory of harm (relating to the separation of cost liability and cost control in relation to non-fault claims).⁵¹

It is highly unlikely that even if the divestment resulted in lower prices to PMIs, these would be passed through to policyholders

- 3.80 Even if divestment were to lead to lower prices to PMIs (which as discussed above would be highly unlikely to occur), there is no evidence that these price reductions would be passed on to policyholders.

- 3.81 As HCA set out in its response to the CMA's Provisional Decision on Remedies in the original private healthcare inquiry, the extent of pass-through will depend on a number of factors including the elasticity of demand for private medical insurance, the curvature of the demand function for this product, the degree of competition between PMIs and the

⁴⁷ *FIPO v CMA* [2015] CAT 8, paragraph 80.

⁴⁸ *FIPO v CMA* [2015] CAT 8, paragraph 76.

⁴⁹ *FIPO v CMA* [2015] CAT 8, paragraph 91.

⁵⁰ See, for example, Response to the CC's Provisional Decision on Remedies, paragraph 6.19-6.21; HCA's response to the CC's notice of possible remedies, paragraph 6.28; HCA's supplemental submission following HCA's remedies hearing, paragraphs 1.8-1.12.

⁵¹ See, for example, the CMA's consideration of Remedy 1C (measures to control the cost of providing replacement vehicles to non-fault claimants), Private motor insurance market investigation, Final Report paragraph 10.74.

proportion of customers holding a policy who would not be covered (or only at a prohibitively high cost) if they were to switch to an alternative PMI (that is, those that are "locked in" a given policy or with a given PMI).⁵²

3.82 In the Final Report, the CMA made the following points about the likely pass-through of insured price reductions.

- First, the CMA stated that according to economic theory, *"even a monopolist would pass through a proportion of the reduction in cost, with a competitive market resulting in substantially all the benefit being passed to patients"*;⁵³
- Second, in respect of PMI sales to large corporate customers, the CMA noted statements by Bupa and AXA PPP that this market was transparent, with sophisticated buyers, and that *"evidence provided by Bupa on the relative loss ratios across corporate and other insurance policies supported the contention that the corporate market was relatively competitive"*.⁵⁴ The CMA concluded that this evidence suggested that *"a significant proportion of the cost reduction would be likely to be passed through in this segment"*.⁵⁵
- Third, in respect of private medical insurance sales to SME businesses and individual policyholders, the CMA concluded that *"[l]oss ratios over the period appeared to us to be reasonably stable across all three insurers. The combined ratios were also relatively stable across the period and very similar across the three largest insurers"*, and that *"the level of the combined ratio did not suggest that the insurers were making large margins on their PMI products"*. The CMA concluded that this evidence suggested that *"this was consistent with a market in which there would be a high level of pass-through of a reduction in costs"*.⁵⁶
- Fourth, in response to HCA's observation that any price reductions arising from divestment may affect only a limited number of PMI policies,⁵⁷ the CMA stated: *"[w]e did not consider this argument to be relevant to the question of pass-through, which logically examines what proportion of the cost savings are passed to consumers, not [...] what proportion of consumers benefit from the reduction"*.⁵⁸

3.83 The CMA concluded that *"it was reasonable to take into account the full reduction in prices when assessing the proportionality of our divestiture remedy"*.⁵⁹ In its assessment of the NPV of the divestment remedy, the CMA thus assumed a 100% rate of pass-through, occurring immediately following the divestment.

3.84 HCA contends that the CMA did not carry out a reasonable assessment of the issue of pass-through, and therefore reached a wrong conclusion on it, for at least six reasons.

3.85 First, the CMA ignored the complex relationship between prices agreed by PMI with a private hospital operator and premiums charged to policyholders. Insurers do not buy and resell

⁵² HCA's Response to the CC's Provisional Decision on Remedies, paragraphs 6.24-6.26.

⁵³ Final Report, paragraph 11.166.

⁵⁴ *Ibid.*, paragraph 11.167.

⁵⁵ *Ibid.*, paragraph 11.167.

⁵⁶ *Ibid.*, paragraph 11.170.

⁵⁷ HCA's Response to the CC's Provisional Decision on Remedies, paragraph 6.36.

⁵⁸ Final Report, paragraph 11.171.

⁵⁹ Final Report, paragraphs 11.170 and 11.171.

private healthcare treatments, like a retailer sells branded goods. Rather, PMIs agree a number of parameters with private healthcare providers (including prices for treatments that would be charged *if* a PMI patient received one); and they sell an insurance policy. The link between hospital charges and policy prices therefore is not a simple one that can be characterised in terms of simple "inputs" and "outputs".⁶⁰ In some cases, as discussed in paragraph 3.229 below, lower costs are only achieved through limiting the range of treatments received and/or their quality. Ignoring this relationship implies that the CMA does not consider the possibility of the value of policies to patients actually worsening if further bargaining power is transferred to the PMIs and generally prevents the CMA from reaching any reliable conclusions on pass-through.

- 3.86 Second, the CMA did not attempt to estimate the factors relevant to an economic assessment of whether PMIs would pass through cost savings, including the elasticity of demand and supply, the curvature of the demand function and the degree of competition in the supply of private medical insurance. The CMA did not, for example, appear to take into account the fact that the PMI market is highly concentrated, with four major providers (i.e. Bupa, AXA PPP, Aviva and Vitality) collectively having an 87% share of supply in 2012,⁶¹ despite economic theory predicting that the degree of pass-through may be relatively low in concentrated markets.⁶² Instead the CMA has simply relied on evidence relating to PMIs' loss ratios, concluding that *"the level of the combined [loss] ratio [...] was consistent with a market in which there would be a high level of pass-through"*, even though *"it would not be possible to conclude from this information whether a reduction in costs would be passed to patients or not"*.⁶³ The CMA cannot reasonably form a view on pass-through based on such an approach.
- 3.87 Third, even if the CMA concluded that some PMIs had some incentive to pass on cost savings to policyholders, it is not clear that they would have the incentive to pass on cost savings to *existing* policyholders (particularly those with pre-existing conditions), as opposed to new customers,. If insurers had an incentive and were able to lower premiums to new customers only, it may in any event take a considerable time for these lower premiums to be enjoyed by a significant proportion of policyholders, and this would have to be taken into account in the CMA's net present value calculation of the net benefits of any divestment remedy it may impose.
- 3.88 Fourth, the CMA failed to properly assess how PMIs and large corporate customers are likely to bargain over prices. To the extent that the sharing rule is tilted in PMIs' favour, there could be very little change in prices to these customers if PMIs' costs fall. In any case, if the contractual relationship between hospital operators and PMIs is sophisticated enough, so that PMIs and hospital operators are able to use fixed fees and means other than the treatment charge to "split the surplus", any changes in bargaining should not result in any changes in treatment prices and therefore it is not clear that there would be any pass-through at all.

⁶⁰ For example, any changes in agreed prices for a given treatment with a given private healthcare provider may not lead to any changes in actual costs to PMIs, if the PMI does not send its policyholders for that treatment at that private healthcare provider.

⁶¹ See Final Report, paragraph 3.80.

⁶² Cost pass-through: theory, measurement, and potential policy implications - A Report prepared for the Office of Fair Trading [CMA]; RBB Economics, February 2014, page 7.

⁶³ Final Report, paragraph 11.170.

3.89 Fifth, with respect to SME businesses and individual policyholders, the CMA was not justified in stating that because *"the level of the combined [loss] ratio did not suggest that the insurers were making large margins on their PMI products [w]e thought that this was consistent with a market in which there would be a high level of pass-through of a reduction in costs"*.⁶⁴

- Although industries where suppliers earn lower margins might in general be expected to have a greater degree of pass-through than industries where suppliers earn higher margins, the CMA still cannot reasonably infer from this information that there will be a high level of pass-through in this case. As noted in a paper prepared for the CMA, even in a perfectly competitive market (which the private medical insurance market clearly is not), *"the extent of industry-wide cost pass-through [...] depends on the elasticity of demand relative to supply"*.⁶⁵ The CMA does not, however, appear to have estimated the elasticity of demand or supply for private medical insurance.
- Further, the CMA does not appear to have considered the point, raised by HCA,⁶⁶ that PMIs would have no incentive to pass through any reduction in costs to the large proportion of customers who are "locked in" (as described above).

3.90 Finally, the CMA's conclusion that different cost impacts on different PMIs is *"[not] relevant to the question of pass-through"* is not justified:

- In its final report on the private motor insurance market investigation, the CMA takes the very different – and more reasonable – stance that *"a change in marginal cost that affects all firms in a competitive market with inelastic demand will tend to be passed through into prices. However, it is less clear that this is the case for a change in marginal cost that affects only a small proportion of firms. In imperfectly competitive markets, the extent of the impact on price of cost changes affecting only some of the firms in the market depends on the specific characteristics of the market and the change in costs"*.⁶⁷
- The CMA has made no attempt to assess the impact on pass-through if different PMIs achieved different price reductions (as would be predicted, for example by the IPA, which finds price differences that are highly variable across different PMIs).

3.91 If the CMA were minded to confirm its divestment decision, it would reasonably have to undertake a thorough analysis of the implication for the value of private medical insurance policies of any changes in the bargained outcomes between PMIs and hospitals, in order to assess whether the proposed divestment would be effective to address the purported AEC identified by the CMA.

A divestment would not lead to better non-price outcomes, such as better quality and range

⁶⁴ Final Report, paragraph 11.170.

⁶⁵ Cost pass-through: theory, measurement, and potential policy implications - A Report prepared for the Office of Fair Trading [CMA]; RBB Economics, February 2014, p4.

⁶⁶ HCA's Response to the CC's Provisional Decision on Remedies, paragraph 6.33.

⁶⁷ Private motor insurance market investigation Final Report, paragraph 6.68

- 3.92 HCA next sets out the reasons why a divestment is highly unlikely to lead to better non-price outcomes to patients, such as better quality and range, and it is in fact likely to reduce them.
- 3.93 Specifically, first, HCA summarises the CMA's arguments supporting its view that divestment would lead to non-price benefits. Second, HCA sets out the reasons why the CMA's arguments are flawed. Third, HCA sets out further reasons why a divestment would not lead to better non-price outcomes, with reference to the evidence available and to standard economic theory.

The CMA's arguments

- 3.94 In the Final Report, the CMA concluded that divestiture would likely lead, over time, to "substantial" advantages to customers arising from "greater rivalry on quality and innovation".⁶⁸ However the CMA did not quantify any non-price benefits in its calculation of the net present value of the proposed divestment remedy, as it felt that they were not *"amenable to reliable quantification"*.⁶⁹
- 3.95 In support of its conclusion that a divestment would lead to improved non-price outcomes, the CMA first noted that depending on specific industry features, greater competition might incentivise or disincentivise firms to invest. The CMA referred to the former case (where greater competition incentivises firms to invest) as the "escape competition effect", and it referred to the latter case (where greater competition disincentivises firms to invest) as the "profit extraction effect". In the CMA's words, the "escape competition effect" occurs where *"by giving firms a competitive advantage, in terms of either margins or market share or both, competition stimulates investment"*, and the "profit extraction effect" occurs where *"by undermining firms' ability to extract profits, competition discourages investment"*.⁷⁰
- 3.96 The CMA concluded that in the supply of private healthcare services in central London, *"the 'escape-competition effect' dominates and there is a positive relationship between competition and investment"*.⁷¹
- 3.97 The CMA further referred to four examples of "local rivalry" stimulating competition over quality and range as evidence of competition driving investment.⁷²

Reasons why the CMA's arguments are flawed

- 3.98 The CMA was not justified in stating that a divestment could lead to an improvement in non-price outcomes, for the following reasons:
- 3.99 First, the CMA has, by its own admission, conducted no assessment of the current level of quality in central London and is therefore in no position to determine whether the optimal level of quality is currently being offered, or the likely impact on investment of its proposed

⁶⁸ Final Report, paragraph 11.225.

⁶⁹ *Ibid.*, paragraph 11.225.

⁷⁰ *Ibid.*, paragraph 6.420.

⁷¹ Final Report, paragraph 6.422. The CMA stated that this was because private healthcare is not an R&D-intensive, innovation-driven market where the size and the risk associated with investments in innovation are substantial and where "if market power was not protected (eg by means of patents), rivals would be able to adopt the technology and compete with the innovator without facing the associated R&D costs that the innovator faced, and the innovator would not be able to recoup its investment costs. This would undermine incentives to innovate in the first place" (Final Report, paragraph 6.420).

⁷² Final Report, paragraphs 11.223-11.225.

divestment remedy. Additionally, the CMA has not identified any detriment in the form of reduced quality and range or innovation (see section 5 of HCA's response to PFs).⁷³

- 3.100 Second, the approach taken by the CMA in determining whether competition incentivises or disincentivises investment is simplistic and does not reflect the complexity of the link between competition and investment or how the competitive process works in this case. The CMA appears to use "competition" simply to mean a greater number of players in the market, or lower market shares. This is not warranted in markets where investing to differentiate is important. Indeed, HCA notes that the "escape competition effect", which the CMA concludes characterises private healthcare in central London, predicts that high market shares (and high investment) of some firms can be the outcome of the competitive process. The CMA also states that "*shares in revenues could take account of any vertical product differentiation that may exist due to the higher quality and stronger reputation of central London hospitals relative to outer London hospitals*" (PFs, paragraph 4.25).
- 3.101 This position is consistent with HCA's view of the market where market shares reflect success and is inconsistent with an approach that sees market shares as the root cause of a competition problem that can be addressed by divestment. The CMA in other words is inconsistent in its description of the market; conducts no assessment of the extent to which market shares reflect quality and investment (despite acknowledging that they do, according to the "escape competition effect" and the relationship between market shares and quality that the CMA describes); and therefore presents no credible argument why in this context a divestment would increase competition and incentives to invest. In fact, as noted at paragraphs 3.134-3.158 below, it would instead likely chill incentives to invest by interfering with the competitive process.
- 3.102 Third, if instead the intensity of competition is seen through the lens of the bargaining power exercised by PMIs, there is also no clear cut relationship between the bargaining power of PMIs and incentives to invest (this is discussed further at paragraph 3.106 below).

Further reasons why a divestment would not lead to better non-price outcomes

- 3.103 There are instead several reasons to expect that investments will decrease, and quality and range with it, following a divestment.
- 3.104 First, given HCA is one of the top investors, and the highest investor relative to its revenue of all the national private hospital operators, it is entirely possible that an acquirer may follow a strategy of investing less. To the extent that the new purchaser does not have the same strategy or appetite for investment and innovation as HCA, or the same ability to deliver quality outcomes as HCA, there will be a direct impact in terms of lower quality or range to the detriment of patients.
- 3.105 Second, as discussed at paragraphs 3.134-3.158 below, a forced divestment of an HCA hospital will have a chilling effect on investments. HCA entered the market where hardly any private operators offered high acuity treatments. It took great commercial risks by investing heavily in low value assets to take business that was previously done by the flagship NHS hospitals in London. A number of other private hospital operators have followed in HCA's wake and developed effectively new markets and services in private provision. A divestment will amount to forcing the original investor to selling not whether, when and to whom it

⁷³ HCA's Response to CC's Provisional Decision on Remedies, paragraph 6.16.

chooses to do so. But instead to whom and when the CMA deems appropriate. This could not have been anticipated at the time of investment and will necessarily send a negative signal to, and reduce investment by, current players and perspective investors in the private healthcare market and beyond.

- 3.106 Third, as mentioned above and as noted in section 4 of HCA's response to the PFs, the academic economic literature on bargaining power has shown that increasing buyers' bargaining power can have a detrimental effect on suppliers' incentives to invest and innovate. The CC recognised the potential for buyer power to decrease incentives to innovate in the Groceries Inquiry.⁷⁴ In that case the CC was concerned about the undue transfer of risk up the supply chain. In the context of private healthcare the PMIs already have the ability to transfer substantial risks onto hospital operators. Indeed HCA has already pointed to instances where the lack of advance recognition of facilities or services has restricted expansion and innovation in the industry.⁷⁵ A further transfer of bargaining power favouring the PMIs must carry an even greater risk that investments will be stifled. The CMA, having in the past found this to be a competition problem, needs to at the very least conduct a full assessment of whether this is likely in the present case before drawing any conclusions on the magnitude of the decrease in investments.
- 3.107 Although HCA contends that a divestment remedy would have no such impact on bargaining power (for a given level of quality and range), if the CMA believes it would, and should the CMA propose a divestment remedy, a shift in bargaining power in favour of the PMIs could lead to weaker incentives to invest.
- 3.108 In fact, since providing greater quality and range increases the cost of serving the policies sold by the PMIs, a decrease in quality and range could be profit maximising for them. This was pointed out by HCA in its previous response to the CC's Notice of possible remedies⁷⁶ and is consistent with the view expressed by Mr Glynn in relation to the misalignment of PMIs' and customers' interests (see paragraph 3.76-3.78 above). The fact that PMIs could benefit from lower quality and range would suggest that they may well have an incentive to exercise their bargaining power in a way that decreases investment in private healthcare.
- 3.109 Fourth, as set out at paragraphs 3.183-3.240 below, a divestment is likely to lead to a loss of RCBs, which includes a reduction in investment and innovation along with a loss of other RCBs, such as a reduction in network benefits and integrated patient care. This would in turn imply a *reduction* in quality and range of private healthcare services.
- 3.110 In sum, the CMA cannot reasonably conclude that any divestment remedy would lead to better non-price outcomes. In fact, it is likely to lead to worse non-price outcomes.

The CMA's analysis of self-pay prices cannot be relied upon to determine whether a divestment in central London would lead to reduced prices to self-pay patients

- 3.111 In section 8 of HCA's response to the PFs, HCA comments on why the analysis on which the self-pay AEC was based was flawed. Further, in section 2 of HCA's response to the PFs, HCA notes how the CMA's competitive assessment was flawed.

⁷⁴ The supply of groceries in the UK: market investigation, CC, 2008, paragraph 36.

⁷⁵ See, for example, Supplemental submission following HCA's remedies hearing, December 2013, paragraph 1.10. See also, HCA's response to the Market Questionnaire, paragraph 33.28: "✂". Examples are provided from paragraphs 33.29 – 33.37.

⁷⁶ HCA's Response to the CC's Notice of possible remedies, paragraph 6.28.

- 3.112 The implication of these flaws for the CMA's analysis is that the CMA is not in a position to draw a causal link between local market share and self-pay prices, particularly in central London.
- 3.113 Therefore the CMA is not in a position to argue that a divestment remedy would be effective in lowering self-pay prices in central London: there is no robust evidence showing that reducing HCA's market share would drive a reduction of self-pay prices in central London.

(2) A divestiture remedy is more onerous than needed to achieve the CMA's stated aim

- 3.114 Notwithstanding the fundamental problems relating to the 'effectiveness' of a divestment remedy, such a remedy would be substantially more onerous than needed to achieve the CMA's aim.
- 3.115 The CMA has stated "*the key factor in determining the effectiveness of the divestiture remedy would be ensuring that non-HCA hospitals are able to absorb insurers' volumes currently treated at HCA hospitals across the full range of specialties*".⁷⁷

Sufficient spare capacity in central London

- 3.116 HCA's share of capacity in central London has been re-calculated by the CMA and this resulted in a significant fall in HCA's share of capacity from 46.5% (in the Final Report) to 41.4% (in the revised PFs), therefore there is considerably more non-HCA capacity in central London than the CMA had initially believed (specifically, more than the size of HCA's Lister Hospital).
- 3.117 In any event, as noted above it has been determined that, of this non-HCA capacity, based on actual PMI admissions data there is enough spare capacity in central London for PMIs to redirect all of their policyholders away from HCA to other central London operators, and that this level of spare capacity extends ✂. Moreover the spare capacity relating to ✂.

Competitive market outcomes

- 3.118 The CMA's own findings point to the market in central London being competitive, with such competition driving quality, range and innovation, thereby increasing healthcare choices for consumers.⁷⁸
- 3.119 Unlike the CMA's previous divestiture decision in the BAA market inquiry, where evidence of underinvestment, poor quality facilities and a lack of ambition in development was identified,⁷⁹ the CMA has reached positive findings in respect of quality and range in central London. For example, the CMA has found (among other findings)⁸⁰ that "*HCA... has been the leader in introducing a range of treatments/diagnostic techniques*"⁸¹ and that in central London there are "*a significant number of private hospitals and PPUs, with a widespread offer of complex treatments or specialties*" with a "*strong reputation [held by] some private hospitals and PPUs which are perceived by patients as offering a higher quality of care than private hospitals and PPUs elsewhere in the UK.*"⁸²

⁷⁷ Final Report, paragraph 11.107.

⁷⁸ See section 5 of HCA's response to the PFs.

⁷⁹ See Guidelines, CC3 revised, paragraph 129.

⁸⁰ See section 5 of HCA's response to the PFs.

⁸¹ Final Report, paragraph 6.411. Indeed, on 30 November HCA became the first hospital operator to acquire the ✂

⁸² Final Report, paragraph 5.59.

3.120 Quality and range are, as the CMA puts it, "**important indicators**" of the extent of competition in a market.⁸³ As a result, the CMA's AEC relates solely to price rather than important outcomes for patients, for which the existing market structure is demonstrating a well-functioning market.

Ideal conditions for entry

3.121 The conditions are ripe for private healthcare entry and expansion in central London. For example:⁸⁴

- With the improvements in the economy, access to capital is easing and there is now considerable investor appetite⁸⁵ for new hospital projects involving entry, expansion and upgrade.
- The CMA is aware of numerous suitable sites for potential hospital development that are available now and coming onto the market in the near future.⁸⁶ However, we note that the CMA has expressed concerns that HCA may be in a position to outbid rival hospital operators to acquire such sites.
- Westminster City Council has announced changes to its planning regime that represent a significant shift in policy which will both directly and indirectly assist the introduction of new healthcare uses in this central part of London.

3.122 Indeed, there is expected to be large scale entry and expansion in central London over the next two to five years:⁸⁷

- VPS has publicly confirmed that it intends to open a new hospital on the Ravenscourt Park site in 2017.
- Barts' new PPU development is set to commence in 2017.
- Cleveland Clinic's development of a recently acquired site which would be suitable for a large, 150-bed hospital.
- Spire publicly announced in its 2014 half-year results that two central London sites are "*in early stages of planning*" and "*potentially opening in 2018*".
- Other central London PPUs are continuing to expand and have published ambitious growth targets for the next few years.

PMIs successfully leveraging bargaining power

3.123 HCA has previously described the array of developments in the PMI market that have enabled PMIs to leverage even greater levels of bargaining power in their negotiations with hospital operators, all in the absence of a divestiture remedy.⁸⁸ We note, for example, that in

⁸³ Guidelines, CC3 revised, paragraph 127.

⁸⁴ See section 3 of HCA's response to the PFs.

⁸⁵ See HCA submission "Material developments since April 2014", '*there is a strong appetite for investment, as evidenced for example by the fact that Mediclinic has invested £430 million in Spire, and Genesis, the Australian specialist radiation therapy, has invested over £100 million to buy Cancer Partners UK*'.

⁸⁶ See section 3 of HCA's response to the PFs.

⁸⁷ See section 3 of HCA's response to the PFs; and the PFs, paragraph 5.69.

⁸⁸ See section 4 of HCA's response to the PFs.

2014, Bupa's "corporate customers experienced some of the lowest premium increases on record" and attributed this directly to its "success in healthcare cost containment".⁸⁹

3.124 In light of the above factors, any further remedial intervention (that is, over and above the remedies already implemented)⁹⁰ by the CMA can be described in the following terms:

- It need only relate to a short term period, i.e. the next three years.
- The purported need to exclude HCA from competing for new sites for inpatient hospital development.
- Given the seriously intrusive nature of divestiture⁹¹ and the likely timescale for implementing of any divestiture remedy, divestment is far too onerous to achieve the CMA's aims.

3.125 Without taking into account HCA's stayed appeal before the Tribunal (and any further litigation that may ensue), it would take a period of **six months** to agree the terms of any undertakings or order relating to the sale of hospitals, there would then likely follow a ⌘, after which HCA's existing prices to PMIs would be rolled over for the new operator for a further **18 months**. That is, any price benefits that might be conceivably yielded would take around ⌘ to have any bearing on the market. However, this period of implementation is precisely the period in which the remedy is required to be effective.

3.126 Furthermore during this period of implementation, the hospitals being sold would be subject to considerable uncertainty and risk of harm, notwithstanding the risk of adverse consequences that arise from the subsequent disintegration of HCA's hospital network and the longer-term adverse consequences of divestiture set out in this submission.⁹²

3.127 In short, even after accepting the CMA's case for remedial intervention, imposing a divestiture remedy would be akin to the CMA using a 'sledgehammer to crack a nut' (and missing) when there are far more proportionate and effective alternative remedies at its disposal.

(3) A divestment remedy is not the least onerous remedy

3.128 A divestment remedy would not be the least onerous remedy capable of meeting the CMA's stated aims. HCA has put forward alternatives to divestment in Section 5 below which would be less onerous yet effectively address the alleged AECs identified by the CMA.

(4) The proposed divestment remedy produces disadvantages which are disproportionate to the aim

3.129 As discussed sub-section (1) above, there is no evidence that a divestment remedy would be effective. Specifically, there is no basis for the CMA to reasonably conclude that a divestment remedy would bring any benefits to patients, either in the form of lower prices, or in the form of non-price benefits such as greater quality and range.

⁸⁹ *Ibid.*

⁹⁰ The Private Healthcare Market Investigation Order 2014, which largely came into force on 2 April 2015.

⁹¹ See section (4) below, in particular paragraph 3.140

⁹² See paragraphs 3.175-3.180 below.

- 3.130 On the other hand, and as HCA has previously submitted,⁹³ there is evidence that shows that a divestment remedy would be likely to bring about a wide range of significant economic costs and risks to HCA, and have a detrimental impact on patient outcomes.
- 3.131 As a result, based on the evidence available, HCA submits that a divestment remedy would be disproportionate.
- 3.132 In this section, HCA sets out three categories of economic costs that the proposed divestment remedy would bring about:
- (i) the interference with incentives to invest and innovate, by preventing a firm forced to divest from realising fair market value (FMV) for its assets;
 - (ii) costs of divestment to HCA and to the purchaser(s) of the divested asset(s); and
 - (iii) the loss of relevant customer benefits (RCBs).
- 3.133 Each of these categories of costs is discussed in greater detail below.

(i) Interference with incentives to invest and innovate, by preventing a firm forced to divest from realising fair market value (FMV) for its assets

- 3.134 During the course of the original private healthcare inquiry, HCA submitted that imposing a forced divestment of assets on a company that has been successful in the marketplace thanks to a risky strategy to invest and to innovate is likely to have a chilling effect on incentives to invest in the industry where it operates and potentially in other industries too.⁹⁴ This effect is likely to be stronger, the more important investment and innovation are as part of the competitive process in an industry.
- 3.135 This view was shared by Professor Bruce Lyons in his expert review of the CMA's economic evidence used to justify the CMA's proposed divestment remedy in the original inquiry:

"Actions taken by a competition authority against firms to remedy high prices can have serious side effects if they are seen to penalise success. First, they undermine the investment incentives for firms with high market shares. Second, they undermine the investment incentives for new entrants. Third, they create legal uncertainty over what is and is not a permissible unilateral pricing policy; which may result in, for example, inflexible pricing. Importantly, actions taken in one market will have consequences that chill competition in all markets in which another successful firm achieves a large market share – not just in the market under consideration".⁹⁵

⁹³ See for example HCA's response to the CC's Notice of Possible Remedies, Section 6; HCA's Response to the CC's Provisional Decision on Remedies, Sections 6(5) and 6(6) and Annex 2; HCA's submission on the Costs of divestment, 18 December 2013.

⁹⁴ HCA's response to the CC's Notice of Possible Remedies, paragraphs 6.55-6.56. See also HCA's Response to the CC's Provisional Decision on Remedies, Annex 2, paragraphs 1.90-1.100.

⁹⁵ Expert Review: 'Major Weaknesses and Mistakes in the Economic Evidence Used to Justify the Proposed Break-Up of the HCA Private Hospital Network in central London', Professor Bruce Lyons, 13 February 2014, paragraph 80.

- 3.136 HCA also submitted that by being forced to divest it will likely not be in a position to realise the fair market value (FMV) of its assets. This is one mechanism through which a chilling effect takes place.⁹⁶
- 3.137 Estimates of the FMV of an asset (for example, a hospital) will vary depending on subjective market views and on the characteristics and preferences of the owner of the asset. An important consideration in this context is whether the original investor is adequately compensated for the risk incurred in investing in the asset. If a firm is not adequately compensated for the risk associated with the original investment (and any subsequent investments), this sends a strong message to potential investors about the balance between risk and reward associated with investments in the sector.
- 3.138 The investor's view of the risk-reward profile of the operating asset will take into account that owner's ability to manage and operate the asset effectively. Therefore, where the owner of such an asset is better at managing that asset than a potential buyer, the value of the asset to the current owner may well be higher than the value to a potential buyer. Absent a forced divestment, the original investor is likely to be willing to hold on to those assets under such circumstances. In this case, a forced divestment would not return the FMV of the asset.
- 3.139 This view is shared by the CMA's Chief Executive, who, in a public speech that also covered the role of divestments in market investigations, noted that:
- "the firm should be indifferent between holding this asset and selling it at a fair price. In this context, the only reason why it may incur a loss is if its previous valuation incorporated the effect of market power, and the divestment reduces this market power... Now, I am conscious that this is a somewhat theoretical argument, and I will highlight some of the complications...In general, we would expect market structures to evolve organically to maximise efficiency. Firms experiment continuously to achieve the most efficient scale and the most efficient split between functions that are internalized and functions that are externalized. So by mandating divestments, we potentially disrupt that process of experimentation; and we potentially lose the resulting efficiencies. I am perfectly conscious of these risks, and as a rule I would expect divestments to remain relatively rare."*⁹⁷
- 3.140 HCA agrees that a forced divestment of its hospitals disrupts a process of 'experimentation' that it has been undertaking since its entry into the private healthcare market in 1996 and subsequent expansion in 2001, and may lead to a loss in efficiencies. A divestment remedy is a seriously intrusive form of intervention, and a competition authority should be very wary of considering such a remedy, especially in circumstances – such as in the present case – where a firm has become successful as a direct result of its investments (including acquisitions in central London cleared by the OFT), its innovative activity and the quality of the services it provides. This is even more so in markets where, as the CMA concludes applies to private healthcare in central London, the "escape competition effect" dominates. As the CMA acknowledges, in such cases investment, which is driven by competition, "[gives] firms a competitive advantage, in terms of either margins or market share or both".⁹⁸ Intervention in these circumstances would amount to an "efficiency offence", that is, penalising the success of a company that performs better than its competitors. The message

⁹⁶ HCA's Response to the CC's Provisional Decision on Remedies, Annex 2, paragraph 1.96.1.96.

⁹⁷ <https://www.gov.uk/government/speeches/cma-how-we-intend-to-use-market-investigations-to-extend-the-frontiers-of-competition>

⁹⁸ Final Report, paragraph 6.420.

to investors and firms of a forced divestment would be that if they become "too successful" as a result of pro-competitive 'experimentation', they may not be in a position to keep their assets, or to dispose of them when they want or how they want.

3.141 HCA next sets out in more detail why a forced divestment can interfere with a company's incentive to invest and to innovate, by preventing it from realising the FMV of its assets, and in particular why this would apply in the case of a forced divestment of one or more of HCA's hospitals. Specifically, HCA sets out:

- two of the key conditions that are required for firms to be willing to undertake risky investments: the 'fair bet principle' and the ability to achieve FMV of a firm's assets;
- a summary of the range of investment and innovation that HCA has undertaken over time and the level of risk that it has been exposed to in doing so; and
- some of the key reasons why the CMA's assessment is flawed.

3.142 Finally, HCA sets out why the CMA's assessment of these issues in the Final Report was flawed.

Two key conditions for firms to be willing to undertake risky investments: the 'fair bet principle' and the ability to achieve FMV

3.143 HCA sets out below two key conditions for firms to be willing to undertake risky investments: the 'fair bet principle' and the ability to achieve FMV.

The 'fair bet principle'

3.144 For firms to be incentivised to undertake risky investments, they must be able to earn a return that sufficiently compensates them for the risk taken on. This principle, known as the 'fair bet principle', is well understood by regulators,⁹⁹ and requires the ability for firms to enjoy returns associated with upside scenarios, to compensate for the downside risk associated with individual investments.

3.145 A key component of the fair bet principle is also the ability of a firm to achieve FMV for assets it sells – including if this FMV is higher than may originally have been expected as a result of the firm enjoying higher profits having benefitted for example from higher than expected demand. HCA next discusses the importance of a firm being able to achieve FMV for its assets.

The ability to achieve FMV

3.146 If a firm needs to sell assets or, as in this case, is forced to, a key component of being able to earn fair return (and therefore of the fair bet principle holding) is that it should be able to earn what it considers to be a FMV. Clearly, if a firm does not expect to be able to achieve FMV for assets it may sell, the fair bet principle does not hold and this will have a negative impact on incentives to invest.

⁹⁹The 'fair bet principle' was recognised, for example by the communications regulator Ofcom in its recent cost orientation review: "in order to ensure that an investment is a fair bet, [a] firm should be allowed to enjoy some of the upside risk when demand turns out to be high (i.e. allow returns higher than the cost of capital) to balance the fact that the firm will earn returns below the cost of capital if demand turns out to be low. This issue is particularly important where there is significant uncertainty around demand (or other factors that affect returns)". See Cost Orientation Review, Ofcom, paragraph 2.39

3.147 In assessing the proportionality of a divestiture remedy, the CMA is required to consider whether the divestiture assets can be sold at FMV. The Tribunal has stated that a divestiture remedy is only capable of being proportionate if *"the company has an appropriate opportunity to realise a fair market price for that business"*.¹⁰⁰

3.148 In assessing the ability of HCA to achieve FMV, the CMA must consider several factors:

- The first and most immediate reason why a forced sale will not deliver FMV is that the choice of whether to sell or not is removed by construction. This simple fact, coupled with the fact that prospective buyers know that there is ultimately a need for HCA to sell, imply that HCA's bargaining position is reduced.
- The second is the restriction in the identity of purchasers. As the CMA places restrictions on who might purchase the assets, this also limits the value that can be realised for two reasons. First, it simply reduces the number of buyers which can depress the realised value. Second, it may eliminate some buyers who may have a higher valuation than those who are allowed to bid. To the extent that operators currently present in London are limited in their ability to purchase, this also eliminates those potential buyers who may be better placed to exploit the economies of scale, scope and broader synergies.¹⁰¹ Third, it would likely depress the value for the site by restricting the use of the site to a private hospital use. The CMA writes in relation to remedy 6(a) that *"[t]his remedy could only be implemented via a recommendation to NHS trusts, rather than by means of an order or undertakings. Given that the latter need to prioritise their own financial viability, we believe that they would seek to sell unwanted sites for the greatest potential value and would be unlikely, therefore, to give priority to private hospitals when marketing their surplus land and buildings."*¹⁰² The CMA's observation implies that if the class of buyers for a hospital building is limited to just private hospital operators, the greatest potential value for the site would be unlikely to be yielded.
- The third is that the buyer who has the greater ability to exploit the synergies of these assets with others in its possession, is the current owner: HCA. The most direct way in which a forced sale prevents HCA from achieving FMV is signalling to the buyers that HCA's most valuable alternative to selling the assets (retaining ownership of them, as they are more valuable to HCA than to any buyer) is eliminated. Lowering the value of HCA's outside option in this way could lower the price it is able to achieve for the assets to significantly below their FMV. This, of course, happens without any consideration for any alleged market power held by HCA, which as shown by the spare capacity analysis is not related to market shares.

¹⁰⁰ See HCA's submission on FMV, submitted to the CMA by email on 18 March 2014, paragraph 1; and *BAA v CC*, [2012] CAT 3, paragraph 76.

¹⁰¹ The CMA previously concluded, for example, that in the case of its divestment decision following the original investigation, the purchase of the divested assets by *"larger commercial operators with a presence in central London [...] could give rise to fresh competition concerns. In these circumstances, the CMA might conclude that the operators concerned were not suitable purchasers"* (Final Report, paragraph 11.151). This clearly has the potential to restrict the most efficient operator(s) of the divested assets from bidding.

¹⁰² Notice of Possible Remedies, paragraph 50.

- There are plenty of entirely pro-competitive reasons why HCA will have a higher valuation than prospective buyers. These include its reputation with consultants, GPs and patients for running high quality hospitals; the management and operational systems already in place; the specific skills of management in maximising value from hospital assets in the London market; the ability to conduct different types of investments and introduce innovations because of the range of services offered across the network and the scale of patient numbers treated. The fact that HCA is recognised internationally as one of the top hospital operators in the world is a clear sign that these effects will be significant.
- The fourth is that the timing of the sale is not of the vendor's choice. Specifically, at the time of conducting investments and acquiring assets HCA, like any other firm, would have been comfortable that it was going to be able to choose to sell at a time of its choosing, including whether macroeconomic and local conditions are such that the value of the assets is maximised. For example, having to sell assets in the London market at a time where there are many other site options for entrants, makes the value of the assets likely to be less than it would otherwise be. Similarly, HCA may think that in the future the value of the assets will be potentially higher because of better macroeconomic conditions. A forced sale eliminates this choice and potentially reduces the value of the assets in a way that the CMA has not considered.
- Finally, in order for there to be a significant chilling effect on investment, the question is not just whether there are measurable differences in the value that the seller should expect or not (although these are important and the CMA should conduct a thorough analysis to investigate them). The important thing is that a seller should have the ability to conduct this evaluation.
- Removing this ability, even if that is done – as in some cases the CMA may believe – for reasons that benefit competition, will always have a consequence in terms of reducing incentives to invest. This is why divestment, as a remedy tool should be used very sparingly, as highlighted by the CMA's Chief Executive. And this is also why any assessment of proportionality should not examine "whether" there would be a chilling effect, but only "how much" of a chilling effect should be expected.

HCA has undertaken a large number of risky investments since starting its activities in central London

- 3.149 As HCA has submitted to the CMA on several occasions, HCA has made a large number of high-value investments since entering the central London market, to realise its vision of creating centres of excellence in tertiary care to provide a private alternative to the NHS.¹⁰³
- 3.150 The CMA has indeed acknowledged that HCA *"has a relatively strong focus on high-acuity care and that it has been the leader in introducing a range of treatments/diagnostic techniques"*.¹⁰⁴

¹⁰³ See, for example HCA's response to the CC's Provisional Findings, paragraphs 2.8, 3.31-3.35, and Table 3.1; HCA's response to the Issues Statement, 3.14 – 3.20; HCA's response to Market Questionnaire, questions 9, 67 and 68; and HCA International Quality report 'Quality, innovation and clinical outcomes in HCA hospitals', December 2013.

¹⁰⁴ Final Report, paragraph 6.411.

- 3.151 By investing in the way it has done, HCA has therefore behaved as a commercial enterprise relying on the 'fair bet principle' since its acquisition of the London Bridge Hospital and Lister Hospital was cleared by the OFT in 2001. However, as HCA sets out next, the proposed divestment remedy would curtail its ability to reap some of the benefits of its successful investments, thus breaking the 'fair bet principle' and making HCA unable to realise the FMV of its assets.

The CMA's reasoning in the Final Report is flawed

- 3.152 In the Final Report, the CMA dismissed HCA's argument on its assets being sold below FMV. In particular, the CMA concluded that *"the 'fair market value' of an asset must be judged at the point at which it is sold provided that the disposal process is conducted in a way that does not prevent HCA from achieving FMV, and it is not appropriate to take into account, as a cost of the remedy, the possibility that at another time, the fair market value of the assets may be higher than at the point of sale"*.¹⁰⁵ As such, the CMA decided not to account for the costs associated with a sale at below FMV.¹⁰⁶
- 3.153 HCA disagrees with the CMA's conclusions for the following reasons.
- 3.154 First, as discussed at paragraph 3.148 above, HCA cannot see how the value of an asset at the time of divestment could be the "fair market value" for that asset, if such a value is depressed due to the way the divestment process is designed or due to the bidders not having the ability to manage that asset as efficiently as the seller.
- 3.155 Second, the CMA, when citing the six month time period taken by Nuffield when it sold nine of its hospitals to BMI in 2008, failed to have regard to the very different nature of HCA's facilities, the significantly higher net asset value of HCA's hospitals and the complexities which arise from trying to split out a hospital or hospitals from a closely-integrated group, which would make this a far more intricate and complex transaction than Nuffield's sale of nine regional hospitals to BMI. While the CMA acknowledged that HCA has previously raised this issue,¹⁰⁷ the CMA stated simply that *"almost all of the same issues would need to have been addressed by Nuffield [in that case]"*,¹⁰⁸ and continued to point to this example when justifying a six month time period in the Final Report.¹⁰⁹ The CMA did not set out why it disagreed with HCA that these transactions would not be comparable, and cannot reasonably conclude on the necessary timescale for investment based on that example.
- 3.156 Third, in the Final Report, the CMA further dismissed concerns regarding the adverse effects that such intrusive divestment remedies can have on investment simply by stating that *"any reader of our report will be aware of the fact that our decision to require divestiture is taken following an in-depth and lengthy investigation which led to our finding that in this particular market there is an AEC and that the structural remedy based on the circumstances of the case is appropriate"*.¹¹⁰
- 3.157 HCA submits that this statement contained no coherent reasoning or analysis, and that it failed to address the points raised by HCA on the likely chilling effect on investment of a

¹⁰⁵ *Ibid.*, paragraph 11.213.

¹⁰⁶ *Ibid.*, paragraph 11.215.

¹⁰⁷ *Ibid.*, paragraph 11.23.

¹⁰⁸ *Ibid.*, paragraph 11.182.

¹⁰⁹ Final Report, paragraph 11.183

¹¹⁰ *Ibid.*, paragraph 11.198.

divestment remedy. Specifically, the fact that the CMA found an AEC in this case and that on the basis of that AEC considered the appropriate remedy was a divestment, is precisely the reason why a chilling effect will result. The reliance by the CMA on market shares in its evidentiary basis, even in the context of the incumbent firm being a large investor and a high quality provider, and the consideration of divestments even in the presence of spare capacity, are precisely the reasons why any further consideration of a divestment remedy will necessarily lead to a chilling effect.

- 3.158 In the Final Report, the CMA referred to HCA's submission that "*absent a forced divestiture, HCA is free to consider its exit strategy unconstrained, and to optimally select the time and manner of and potential exit*".¹¹¹ The CMA rejected the submission that divestiture under these conditions would be below fair value on the basis that fair value for these purposes means "*fair market value at the time at which the divestiture took place*".¹¹²
- 3.159 However, this response does not engage with or address HCA's concern as to the *manner* (rather than the timing) of divestiture. In particular, the CMA failed to weigh the cost to HCA of being required to divest its hospitals as hospitals rather than as sites for residential real estate, despite the CMA itself having placed weight, in the context of assessing barriers to entry, on the observations that disposal of property for housing purposes may be more attractive for vendors of hospitals than disposal of hospitals as hospitals;¹¹³ and that certain potential sites for new entry or expansion were liable to be used for residential development instead.¹¹⁴ As noted above, the CMA notes this possibility again in the Notice of Possible Remedies (paragraph 50). Without conducting any assessment of the cost to HCA of being required to divest its property in a particular manner and for a particular purpose, the CMA was not in a position to judge that divestment would be for FMV.

(ii) Costs of divestment to HCA and to the purchaser(s) of the divested asset(s)

- 3.160 In addition to the inability to achieve FMV, a divestment would likely generate a number of economic costs to HCA, including:
- transaction costs;
 - asset risk caused by the divestment process; and
 - reputational damage.

- 3.161 Each category of economic costs is discussed in turn next.

Transaction costs

- 3.162 HCA would likely incur a number of one-off costs following a divestment which would need to be taken into account by the CMA in its assessment of proportionality. HCA next discusses in turn the different categories of transaction costs it would be likely to incur.

Professional adviser and legal costs

¹¹¹ *Ibid.*, paragraph 11.188.

¹¹² *Ibid.*, paragraph 11.213.

¹¹³ *Ibid.*, paragraph 6.75.

¹¹⁴ *Ibid.*, paragraph 6.82.

3.163 In the original private healthcare market inquiry, HCA provided estimates of the professional adviser and legal costs it anticipated it would incur due to the divestiture and which it believes are relevant for the CMA's proportionality assessment. As HCA submitted to the CMA, these comprise:

- M&A Corporate Finance costs;
- Financial, tax, IT and pensions due diligence costs;
- Clinical/commercial/quality/governance diligence costs;
- Tax structuring costs;
- Property valuations costs;
- Political adviser costs; and
- Legal fees.

3.164 These were estimated for two scenarios, depending on whether the two proposed hospitals would be sold to a single or to two separate buyers.¹¹⁵

3.165 In its Final Report, the CMA concluded that it would be conservative to use the upper end of the range of fees estimated by HCA in its NPV calculation.¹¹⁶ These costs are likely to have increased since, so would have to be re-assessed.

Monitoring trustee costs

3.166 HCA submitted that it would be required to appoint a monitoring trustee to oversee the divestiture process and compliance with divestiture commitments, the cost of which would need to be considered by the CMA.¹¹⁷

3.167 In its Final Report, the CMA concluded that it would be appropriate to be conservative and to use the upper end of the range of costs estimated by HCA in its NPV calculation.¹¹⁸ These costs are likely to have increased since, so would have to be re-assessed.

Redundancy and reorganisation costs

3.168 Following a divestment, HCA would have to reorganise a number of centrally provided services. In doing so HCA would likely incur financial costs as well as potentially considerable opportunity costs relating to management time. As HCA has previously informed the CMA,¹¹⁹ such costs include the cost of packages to staff made redundant, costs associated with the redesign of central services, costs of communication with affected staff, costs of effecting changes in the IT system and processes currently in place like staffing and patient movements, and costs associated with changes to CQC and other registrations.

3.169 In its Final Report, the CMA stated that HCA did not provide an estimate of the costs associated with redundancy and reorganisation of its business that would be faced as a

¹¹⁵ HCA's Response to CC's Provisional Decision on Remedies, Annex 2, paragraphs 1.134-1.135.

¹¹⁶ Final Report, paragraph 11.211.

¹¹⁷ HCA's Response to CC's Provisional Decision on Remedies, Annex 2, paragraph 1.136.

¹¹⁸ Final Report, paragraph 11.211.

¹¹⁹ HCA's submission on the Cost of Divestment, 18 December 2013, paragraphs 5.3-5.4.

direct result of the divestiture remedy but that HCA had *"agreed with the estimate proposed by the [CMA] in the provisional decision on remedies"*.¹²⁰ These costs are likely to have increased since, so would have to be re-assessed.

Other costs incurred by HCA

3.170 In addition to the costs outlined above, HCA would likely incur a number of other costs following a forced divestment decision in relation to:

- opportunity costs of the time spent by its internal legal and executive team for example in contract renegotiations with PMIs, developing new strategies and processes for the smaller network, communicating changes to staff, consultants, doctors, patients across the entire HCA network;
- costs of updating marketing collateral;
- costs of addressing conveyancing considerations affecting HCA's properties; and
- costs involved in obtaining lender consent.

3.171 HCA notes that in the Final Report the CMA did not consider these costs in its NPV calculation.

Transaction costs of the purchaser of the hospital(s)

3.172 HCA has previously submitted¹²¹ that any purchaser of the divested hospital(s) would likely incur significant one off costs, including:

- development or integration costs of services previously provided to the divested hospitals at HCA group level
- staffing costs associated with Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) transfers
- costs associated with Care Quality Commission (CQC) registration
- costs associated with acquiring additional Registrations, including Specialist Clinical Accreditations
- costs associated with establishing Quality control processes
- costs associated with obtaining Key Services Accreditation
- costs associated with acquiring PMI recognition

3.173 In addition, a purchaser would likely incur considerable legal and professional adviser fees (relating to the same categories as listed in paragraph 3.163 above),¹²² costs associated with service transition, such as mitigating the disruption to maintaining records of patient care, and costs incurred in relation to retaining consultants during the transition period.¹²³

¹²⁰ Final Report, paragraph 11.212.

¹²¹ HCA's Submission on the Cost of Divestment, 18 December 2013, paragraphs 5.7-5.9.

¹²² HCA's Submission on the Cost of Divestment, 18 December 2013, paragraph 5.9.

¹²³ HCA's Submission on the Cost of Divestment, 18 December 2013, paragraph 5.10.

- 3.174 In its Final Report, the CMA concluded that it would be conservative to use the upper end of the range of transaction costs estimated by HCA in its NPV calculation.¹²⁴ These costs would now have likely have increased so would have to be reviewed.

Asset risk caused by divestment process

- 3.175 As previously submitted by HCA,¹²⁵ the CMA's divestiture consultation and remedy creates a high degree of uncertainty about the future of the hospitals. The problem is particularly acute with respect to consultants, whom hospital operators need to attract and retain in order to be successful.
- 3.176 Consultants practising at HCA hospitals have numerous alternative facilities in their immediate vicinity; there are very low barriers for them to switch to alternative facilities and many of these consultants already have practising privileges at competing hospital networks.
- 3.177 Uncertainty about the prospective ownership, management and investment in the hospital is likely to result in a number of consultants deciding to move their practice to alternative facilities.
- 3.178 Furthermore, as noted at paragraph 3.206 below, ✂
- 3.179 In the Final Report, the CMA stated that "*a monitoring trustee [would] mitigate asset risk at the hospitals to be sold*".¹²⁶ The CMA stated that the monitoring trustee would "*monitor HCA's compliance with the undertakings or order [...] which imposes a duty on HCA to maintain the business being divested in good order and not to undermine its competitive position [and which would] require a commitment from HCA not to encourage or induce consultants or key nursing or technical staff currently practising or employed at the divested hospital(s) to move their practise (or employment) to the group's retained facilities*".¹²⁷
- 3.180 Such a requirement would not, even if HCA's compliance with it was monitored by a monitoring trustee, sufficiently mitigate asset risk at the hospital(s) to be divested. The asset risk associated with consultants switching to alternative facilities has arisen not because of any "encouragement" or "inducement" on the part of HCA. Rather, it has arisen due to the uncertainty surrounding the future of the hospital(s) the CMA is considering forcing HCA to divest. The CMA was therefore wrong in not accounting for asset risk in its assessment of proportionality in the Final Report.

Reputational damage

- 3.181 As HCA has previously noted, both HCA and a new purchaser would also likely suffer reputational damage arising from the erosion of HCA's network synergies:¹²⁸
- At HCA's remaining hospitals, a divestment risks creating uncertainty among consultants, clinical staff and patients. This can have significant adverse consequences on the reputation of the remaining hospitals. The diminution of HCA's private care offering is also expected to diminish HCA's reputation and

¹²⁴ Final Report, paragraph 11.211.

¹²⁵ HCA's response to original Notice of Possible Remedies, from paragraph 6.57.

¹²⁶ Final Report, paragraph 13.19.

¹²⁷ *Ibid.*, paragraphs 11.181(a)-11.181(b).

¹²⁸ HCA's Submission on the Cost of Divestment, 18 December 2013, Table 2.

profile in the UK and overseas, impairing its ability to attract patients from overseas and compete with hospitals in the US, Germany, Singapore and elsewhere.

- At the divested hospitals, there is also the risk of a reduction in brand value, as these hospitals, when divested from the broader network, may have 'less to lose' in terms of reputation and indeed a different strategy may be pursued by the acquirer(s) which does not focus to the same extent on quality. The new owner may not focus on attracting higher-acuity patients and so may not have the same motivation to invest in new treatments, technologies and quality.

3.182 The CMA did not consider the cost of reputational damage to HCA or to the new purchaser(s) in its assessment of proportionality in the Final Report. The CMA must fully account for this cost category in any future such assessment.

(iii) Loss of RCBs

3.183 During the course of the original inquiry, HCA argued that the CMA's proposed divestment remedy would result in a loss of relevant customer benefits (RCBs). These comprise:¹²⁹

- loss of scale economies;
- loss of network benefits and synergies;
- reduction in the level of investment at the divested and HCA's remaining hospitals;
- reduction in quality both at the divested and HCA's remaining hospitals; and
- reduction in range of goods and services.

3.184 Each is discussed in turn below, before HCA turns to a discussion of additional costs relating to the adverse effects of disruption to patients following a divestment.

Loss of scale economies

3.185 During the original private healthcare inquiry, HCA argued that the divestment package envisioned by the CMA would have a detrimental impact on the efficiency of its remaining business due to a disruption of integrated pathways and a loss of economies of scale and scope.¹³⁰

3.186 As HCA noted, HCA's central costs, over which economies of scale and scope are realised, primarily relate to group level fixed operating costs, such as the costs of the head office and other buildings, IT costs and the head office staff that provide Group functions. HCA provided the CMA with a detailed estimate of the value of scale and scope economies that would be lost as a result of the proposed divestment, based on a series of fixed and common costs incurred.¹³¹ HCA further noted that a change in economies of scale would significantly affect HCA's ability to undertake large investments. In this context, HCA submitted evidence of previous investments that would not have been commercially viable were its scale reduced to the extent envisaged by the CMA's proposed divestment, such as investments

¹²⁹ HCA's Response to the CC's Provisional Decision on Remedies, Annex 2, paragraphs 1.68-1.133.

¹³⁰ HCA's Response to the CC's Provisional Decision on Remedies, Annex 2, paragraph 1.95.

¹³¹ HCA's Response to the CC's Provisional Decision on Remedies, Annex 2, paragraphs 1.108 -1.119 and Annex 2, Appendix 2.

into treatments that require a minimum number of episodes to be performed each year from a clinical perspective.¹³²

- 3.187 HCA noted that since the acquirer of the hospitals would also require the centralised services described above, the acquirer may also incur costs associated with the loss of economies of scale and scope,¹³³ including the costs of replicating central services previously provided by HCA, the costs of setting up or procuring laboratory services, and the cost of employing extra staff to replace the "bank staff" that HCA employs.¹³⁴
- 3.188 In response to the CMA's previous provisional decision not to include any loss of economies of scale in its calculation of detriment, HCA submitted an extensive reasoning as to why the CMA's analysis was flawed, as discussed below.
- 3.189 In the Final Report, the CMA disagreed with HCA's submissions, and concluded that it would be inappropriate to include any loss of economies of scale in the "base case" estimate of the net present value calculation of the divestiture remedy.¹³⁵ The CMA's reasoning is set out next, along with HCA's response to each of the points made by the CMA, in turn.
- 3.190 First, the CMA's response did not address many of the points raised by HCA in respect of flaws in the CMA's provisional decision not to include any loss of economies of scale in its 'base case'. These flaws included that:
- The CMA had incorrectly relied on evidence on HCA's financial performance ✂ to infer that HCA does not benefit from economies of scale. HCA submitted that this was an invalid test, since HCA had not acquired any hospitals over this period (and thus could not have benefitted from the economies of scale relevant to the proposed divestment remedy – that is, relating specifically to the makeup of its network).¹³⁶ HCA further submitted that the CMA was wrong in principle to rely on ✂,¹³⁷ and
 - The CMA had provided no evidence in saying that it "*expect[s] that HCA would in fact be able to make much more significant cost savings following a reorganization of its operations*",¹³⁸ which contradicted substantially the evidence submitted by HCA to the CMA.
- 3.191 In evaluating the costs of any divestment remedy in future, the CMA must reasonably engage also with the evidence put forward by HCA on economies of scale at the group level and must not rely on the analysis in its original provisional findings, which HCA has shown to be inadequate.
- 3.192 Second, the CMA rejected HCA's argument that economies of scale at the hospital network level may lead to a relevant customer benefit, on the grounds that the IPA set out in the Final Report showed that consumers face higher (rather than lower) prices from HCA (compared

¹³² HCA's submission on the Costs of divestment, 18 December 2013, Table 1. Table 1, HCA's submission on the costs of divestment, 18 December 2013.

¹³³ HCA's submission on the Costs of divestment, 18 December 2013, Table 5.

¹³⁴ Bank staff are ✂.

¹³⁵ Final Report, paragraph 11.208.

¹³⁶ HCA's Response to the CC's Provisional Decision on Remedies, Annex 2 paragraph 1.123.

¹³⁷ HCA noted, for example, that central costs that are apportioned out to individual sites – which are included in HCA's calculations of economies of scale – only ✂. See HCA's Response to the CC's Provisional Decision on Remedies, Annex 2, paragraph 1.124.

¹³⁸ HCA's Response to the CC's Provisional Decision on Remedies, paragraph 2.135.

to TLC).¹³⁹ The CMA concluded that *"to the extent that HCA did benefit from economies of scope or scale, it was not passing these on to its customers and, therefore, they did not qualify as an RCB"*, and that *"the loss of any such benefits would already be reflected in our quantification of the price benefits of divestiture using the results of the IPA since this analysis compared HCA's prices with those of a significantly smaller operator, TLC, which would not enjoy the same economies of scope"*.¹⁴⁰

- 3.193 HCA submits that the CMA erred in the implications it drew from the IPA for its assessment of RCBs. As set out in section 6 of HCA's response to the PFs, the IPA cannot identify a robust insured price difference between HCA and TLC on a like-for-like basis, so the CMA's premise for its argument is flawed. In any event, the CMA excluded the possibility that even if HCA were to charge higher insured prices than TLC, this could be consistent with HCA benefitting from scale economies and passing those cost benefits on to consumers in the form of lower prices (for a given quality of care and patient complexity / patient mix), to a larger extent than if HCA was operating at a smaller scale. Further, as discussed at paragraphs 3.55-3.64 above, TLC enjoys significant cost advantages that in its own view enable it to price competitively. The CMA has not considered these cost differences in its IPA and the overall price difference (whatever it may be) will naturally reflect the underlying costs of providing services, including any economies of scale enjoyed by HCA. Without a full review of all costs, and an accurate measurement of price differences, the CMA is simply not in a position to draw any conclusions on what price levels imply for HCA's or TLC's underlying costs.
- 3.194 Third, the CMA considered that if there were significant economies of scale or scope at the group level in the provision of private healthcare services, it would expect that a suitable purchaser of HCA's hospitals (which may include national or international groups) would be able to recreate as part of their own business any scale or scope economies lost by HCA; and that for this to happen, such a purchaser would not have to be London-based, as many of the staff costs listed by HCA related to functions that could be performed outside of London or the UK.¹⁴¹
- 3.195 The CMA's observation that the purchasers would be able to recreate any scale or scope economy lost by HCA is speculative, particularly as the identity of the potential bidders was and is still highly uncertain and subject to competition criteria.¹⁴²

Loss of network benefits and synergies

- 3.196 In the original inquiry HCA argued that its network strategy creates significant benefits and synergies which have played an important role in building the success of its hospitals (for example, integrated patient pathways, clinical governance/oversight, clinical know-how, IT infrastructure, GP/Consultant liaison, operational/management expertise, education and training, cross-hospital transfer of staff, common services, reputational and brand integrity).¹⁴³ HCA noted that these synergies can lead to improvements in care and greater innovation. For example, HCA's integrated patient pathways can lead to facilities at individual sites being accessible to all patients; better-equipped quality functions leading to a

¹³⁹ Final Report, paragraph 11.206.

¹⁴⁰ *Ibid.*, paragraph 11.206.

¹⁴¹ Final Report, paragraph 11.207

¹⁴² To the extent that the buyer is less efficient at managing the divested assets than HCA, this will also likely lead to HCA not achieving FMV for the assets. See paragraphs 3.137-3.138 above.

¹⁴³ HCA's Response to the CC's Notice of Possible Remedies, paragraph 6.36.

higher standard and consistency of care; complex activities achieving the critical mass needed for specialisation and safety; and better benchmarking to improve quality and drive innovation.¹⁴⁴

- 3.197 In respect of the benefits from having integrated patient pathways, HCA submitted a report,¹⁴⁵ prepared with the assistance of healthcare consultants Oliver Wyman, which demonstrated through a number of specific case studies how HCA initiatives and innovations have improved clinical outcomes, and why the proposed divestment remedy would reduce HCA's ability to provide integrated care to its patients across its network, especially in clinical services such as cancer care, neuro-surgery, cardiac care and orthopaedic care.¹⁴⁶ HCA further noted that there is a wealth of evidence on the importance of integrated patient pathways.¹⁴⁷ HCA notes that in addition to the decrease in quality of services, a loss of integration is likely to be associated with other costs related to the increased time of transfers of patients and records, duplication of administration and the risks of information lapses.¹⁴⁸
- 3.198 Additionally, HCA noted that a divestment would lead to several potential concerns in relation to patient referrals, including that patients will not be able to benefit from the seamless access to services such as imaging and diagnostics that HCA offers across its network; that there would be a decrease in the network benefits available to patients including such best practice as multi-disciplinary partnerships; and that the lack of integration and seamless pathways may lead to a decreased likelihood of consultants from outside HCA hospitals referring patients into HCA facilities, with consultants wishing to avoid the complication of multiple hospital systems or concerns over decline in quality.¹⁴⁹ HCA submitted that network benefits could not simply be *"replaced by a consultant referring his or her patient to the most appropriate facilities irrespective of who owned or operated them"*, as the CMA had stated.¹⁵⁰ In particular, HCA noted that patients would suffer because medical professionals would lose standardisation of patient care, systems, data capture and reporting, information provision for revalidation and flexibility to allow for a truly individualised care.¹⁵¹
- 3.199 These issues apply equally, if not more so, in the case of the divested hospital(s) as an acquirer would be less likely to be able to replicate HCA's integrated patient pathways and would likely incur costs in relation of the design of the same at the divested facilities.
- 3.200 The importance of these features is evidenced by the fact that the NHS is currently going through the process of concentrating services into fewer, larger centres of excellence, to create critical mass, drive up quality, and encourage sharing of best practice.¹⁵²

¹⁴⁴ HCA's Response to the CC's Provisional Decision on Remedies, paragraph 5.56.

¹⁴⁵ HCA's Response to the CC's Notice of Possible Remedies, HCA Quality Report, Annex 2..

¹⁴⁶ HCA's Response to the CC's Provisional Decision on Remedies, Annex 2, paragraphs 1.76-1.78.

¹⁴⁷ As HCA noted in its submission on the costs of divestment of 18 December 2013, a useful summary of integrated care and a number of studies considering its benefits has been published by the King's Fund and the Nuffield Trust, see

<http://www.nuffieldtrust.org.uk/sites/files/nuffield/evidence-base-for-integrated-care-251011.pdf>.

¹⁴⁸ HCA's submission on the costs of divestment, 18 December 2013, Table 1.

¹⁴⁹ HCA's Response to the CC's Provisional Decision on Remedies, paragraphs 5.61-5.64.

¹⁵⁰ Provisional Decision on Remedies, paragraph 5.67.

¹⁵¹ HCA's Response to the CC's Provisional Decision on Remedies, paragraph 5.69.

¹⁵² *Ibid.*, paragraph 5.71.

- 3.201 In the Final Report, the CMA disagreed with HCA's arguments. HCA submits that the CMA erred in doing so.
- 3.202 First, the CMA concluded that the examples provided by HCA about the benefits of an integrated care pathway "*applied mainly to cancer treatment, and even then only to a limited range of hospitals and other facilities including the Harley Street Clinic and LOC*".¹⁵³ The CMA concluded that the fact that TLC offered an integrated cancer service at its new centre indicated that such a care pathway can be created by an operator with a smaller scale than HCA,¹⁵⁴ and that its proposed divestments would not fundamentally affect HCA's cancer treatment pathway or pathways (and that to the extent that it would be disrupted the effects could be mitigated).¹⁵⁵
- 3.203 The CMA does not appear to have considered HCA's detailed submission in response to the PDR in the original inquiry on the benefits of an integrated care pathway; instead, in the Final Report, the CMA simply reiterated points from its PDR. In HCA's response to the PDR,¹⁵⁶ HCA noted that the Quality report submitted alongside the response to the Notice of Possible Remedies provided several examples of the benefits of an integrated care pathway relating to non-cancer care, including neuro-surgery (section 8), cardiac care (section 10), and orthopaedic care (section 11); and that cancer care pathway benefits also extended to both the London Bridge hospital and the Lister hospital. The CMA's conclusion that the examples given by HCA "*applied mainly to cancer treatment, and even then only to a limited range of hospitals and other facilities including the Harley Street Clinic and LOC*" ¹⁵⁷ is thus inconsistent with the facts.
- 3.204 Second, the CMA concluded that consultants would still be able to refer patients to the divested hospital(s) if they were the hospital best able to treat the patient¹⁵⁸. The CMA disagreed that there were any RCBs associated with a patient being treated only at a single hospital group.¹⁵⁹ This demonstrates a disappointing lack of understanding of the benefits of 'integrated' healthcare networks.¹⁶⁰ Network integration, among other things, allows seamless patient and data movement between hospitals ensures that patients can transfer to the most appropriate location for their care. The transfer of confidential patient data from one privately owned facility to another can often cause delay (and potentially error) in treatment and diagnosis, therefore having instant, up-to-date access to accurate patient data across the network is a real benefit to patients and clinicians.

Reduction in the level of investment and innovation

- 3.205 In the original inquiry HCA argued that the divestment remedy would result in severe negative impacts on investment and innovation both for the divested hospitals and HCA's remaining hospitals.

¹⁵³ Final Report, Annex 11.1, paragraph 57.

¹⁵⁴ *Ibid.*, paragraph 11.196.

¹⁵⁵ *Ibid.*, Annex 11.1, paragraph 57.

¹⁵⁶ HCA's Response to the CC's Provisional Decision on Remedies, Annex 2, paragraphs 1.76-1.78 and Final Report, Appendix 11.1, paragraphs 16-23.

¹⁵⁷ Final Report, Appendix 2.1, paragraph 130.

¹⁵⁸ Final Report, paragraph 11.196.

¹⁵⁹ Final Report, Annex 11.1, paragraph 59.

¹⁶⁰ See HCA International Quality report 'Quality, innovation and clinical outcomes in HCA hospitals', December 2013.

- 3.206 With respect to the divestment remedy proposed by the CMA at the time, HCA noted that there was a real risk that the new owners of the divested hospitals may not invest and innovate to the same degree as HCA,¹⁶¹ in part because it may not pursue the same strategy of attracting international patients, and as such, competing on innovation and quality with elite hospitals from around the world. HCA also noted that its levels of investment have been higher than other national private healthcare providers.¹⁶² ✂.
- 3.207 HCA also noted that following divestment, it ✂.¹⁶³
- 3.208 In the Final Report, the CMA disagreed with HCA's arguments. HCA submits that the CMA was wrong in doing so.
- 3.209 First, the CMA concluded that while HCA was an innovative operator, adopting a range of new technologies, *"other, smaller operators, tended to innovate to a similar extent and, in some cases, adopted new technologies prior to HCA"*.¹⁶⁴ The CMA concluded that a large proportion of the innovations cited by HCA as examples of innovative services at its hospitals were concentrated in cancer care and resembled innovations introduced in leading NHS institutions or concerned drug trials that any hospital can participate in, and that others may not be characterised as innovations.¹⁶⁵ Further, the CMA noted that HCA had made a sizeable number of investments in direct response to competitors' investments (meaning greater competition would stimulate investment),¹⁶⁶ and that many such innovations could be made by hospitals not part of a network.¹⁶⁷
- 3.210 It is incorrect to say that other operators innovate to a similar extent. First, the CMA has conducted no analysis to base its conclusion on. Second, as it is clear from the evidence, HCA is the largest investor in the market among all the national hospital operators. It invests more than others relative to its revenue. Third, HCA has presented a large list of instances where HCA was first to market (in many cases ahead of the NHS). There is no comparable evidence from any other firms in the market. Finally, the international reputation of HCA as a world class provider and its ability to attract international patients speaks for itself in terms of it having a market leading ability to introduce new treatments and provide top quality care. It is therefore unlikely that any buyer would be in a position to replicate HCA's investment track record.
- 3.211 Second, the CMA concluded that HCA's competitors with a smaller patient base have a proven track record of investing in high-quality and high-acuity services, both within and outside central London. As such, the CMA concluded that HCA's ability to innovate would not be impaired as a result of the divestment, as it would be *"very unlikely to reduce either HCA or the divestiture package below [the] minimum scale [required to make investments commercially viable]"*.¹⁶⁸
- 3.212 The CMA missed the point here and adopted the wrong standard. The issue is not whether an operator would "continue to invest" or whether a buyer with a smaller patient base would invest in high acuity services. The question is whether they would do so *to a similar extent as*

¹⁶¹ HCA's Response to the CC's Provisional Decision on Remedies, Annex 2, paragraph 1.69-72

¹⁶² *Ibid.*, Annex 2, paragraph 1.81-1.84

¹⁶³ *Ibid.*, Annex 2, paragraph 1.85-1.89.

¹⁶⁴ Final Report, paragraph 11.192

¹⁶⁵ Final Report, Appendix 11.1, paragraphs 41-42.

¹⁶⁶ *Ibid.*, Appendix 11.1, paragraph 43.

¹⁶⁷ *Ibid.*, Appendix 11.1, paragraph 44.

¹⁶⁸ *Ibid.*, paragraph 11.197.

HCA. If there was a risk they did not, there would be a loss in RCBs, which the CMA would have to take into account in its assessment of a possible divestment remedy. The reasons set out above show that so far the CMA has not conducted any robust analysis in this regard. The CMA is therefore in no position to conclude that a buyer would invest to a similar extent, in fact the evidence available to the CMA suggests that, conversely, a new operator would not likely invest to the same extent as HCA, which would have a detrimental impact on patient outcomes.

- 3.213 There are three further points that HCA notes with regards to the likely loss in RCBs in the form of a reduction in investment and innovation.
- 3.214 First, as set out in paragraphs 3.134 - 3.158 above, a divestment would likely lead to a chilling effect on investment and innovation, which would in turn lead to a likely loss of RCBs regardless of the other reasons set out in the preceding and following paragraphs.
- 3.215 Second, to the extent that the CMA considers that a divestment will increase the PMIs' bargaining power vis-à-vis HCA (and vis-à-vis the purchaser of its assets), it will need to quantify the likely reduction in investment and new treatments being introduced that would flow from that change, and the impact on patients. As explained above, PMIs may benefit from reduced range and lower quality of treatment, and have historically resisted investment in new innovative treatments. The CMA has not considered this point and would need to investigate this issue fully in order to be able to come to a conclusion on the likely effects of a divestment on the overall level of investment in the market.
- 3.216 Finally, HCA notes that a reduction in the level of investment will naturally translate into lower quality of care and a smaller range of treatments being offered. This is considered next.

Reduction in quality

- 3.217 In the original inquiry HCA submitted extensive evidence on the likely reductions in quality that would arise as a result of the divestment remedy.¹⁶⁹
- 3.218 At its remaining hospitals, HCA reiterated that the loss of clinical know-how and expertise, disruption to integrated pathways and a reduction in clinical outcomes and continuity of treatment arising from the loss of network benefits (as discussed at paragraphs 3.196-3.204 above) would lead to a reduction in the quality HCA is able to offer patients.¹⁷⁰ For instance, the removal of skilled clinicians from its network resulting in loss of clinical know how and expertise lowers HCA's ability to initiate and foster high quality research and development of improved health care services.
- 3.219 At the divested hospitals (by reference to the London Bridge and the Princess Grace hospitals), HCA noted that a similar negative impact from the loss of network benefits would arise. This may be, for instance, due to a loss of access to the clinical expertise of consultants, trained nurses and radiologists from across HCA's network as well as fewer opportunities for within-network benchmarking, quality monitoring, audit programmes and

¹⁶⁹ See HCA's Response to the CC's Provisional decision on Remedies, section 6(6) and Annex 2, paragraphs 1.68-1.78; HCA's Submission on the Costs of Divestment, 18 December 2013, Table 1; and HCA's Response to the CC's Notice of Possible Remedies, paragraphs 6.33-6.43.

¹⁷⁰ HCA's Response to the CC's Provisional decision on Remedies, Annex 2, paragraph 1.74-1.78.

collaboration across hospitals.¹⁷¹ For example, unlike HCA, the divested hospital's clinician's multi-disciplinary meetings (MDM) will not be able to pool together expertise from across HCA's network to audit quality of care, conduct peer reviews and input proactively into treatment plans. HCA also noted that a new owner may not pursue the same strategy of high-quality, high-acuity care that HCA has pursued,¹⁷² which would have a detrimental impact on patient outcomes.

- 3.220 Further, HCA argued there was a risk that following a change in ownership PMIs will not recognise the divested hospitals on terms which allow the hospitals to maintain the current level of quality and clinical services. HCA noted that under the new ownership, HCA's existing contracts with PMIs would need to be re-negotiated, and the PMIs may take advantage of this to extract terms that achieve a quality-cost combination that is misaligned with patient preferences.¹⁷³ This could also potentially lead to worse patient outcomes.
- 3.221 In the Final Report, the CMA disagreed with HCA's arguments. HCA contends that the CMA erred in doing so.
- 3.222 First, the CMA stated that it did not believe that HCA's quality was appreciably higher than that of close competitors in central London.¹⁷⁴
- 3.223 HCA disagrees with the CMA's reasoning and sets out its views and evidence on this issue in section 5 of its response to the PFs.
- 3.224 Second, the CMA dismissed HCA's argument that the remedy would be ineffective if the new owner(s) sought to reposition vertically (in terms of quality). The CMA concluded that it was "likely" that any acquirer of the divested hospital(s) would have the incentives to pursue a high-acuity, high-quality strategy; it also noted that the objective of the remedies was to stimulate new competitive dynamics in central London that would ensure that patients' needs would be met, regardless of whether the new entrant would follow the same strategy as HCA.¹⁷⁵
- 3.225 As set out in section 5 of HCA's response to the PFs, the CMA has no reasoned basis on which to draw a conclusion that quality will not reduce as a result of its divestiture remedy, because it has declined to conduct any robust analysis of quality in the private healthcare market.
- 3.226 HCA has already noted the extensive evidence on the relationship between volumes of treatment and patient outcomes. It is well known in the healthcare literature that hospital operators that treat higher volumes of patients with certain conditions have better health outcomes for those patients, including through learning-by-doing. This is known as the "volume-outcomes effect". Thus, to the extent HCA is providing higher volumes of certain treatments, patients receiving those treatments at HCA may have better outcomes.¹⁷⁶ The

¹⁷¹ HCA previously provided estimates of these costs in relation Princess Grace and the London Bridge Hospital. See HCA's Submission on the Costs of Divestment, 18 December 2013, Table 1.

¹⁷² HCA's Response to the CC's Provisional decision on Remedies, Annex 2, paragraph 1.69.

¹⁷³ See HCA's Response to the CC's Notice of possible remedies, paragraph 6.28; HCA's Response to the CC's Provisional decision on Remedies, Annex 2, paragraphs 1.69-1.73.

¹⁷⁴ Final Report, paragraph 11.192 and Appendix 11.1, paragraph 39.

¹⁷⁵ *Ibid.*, paragraph 11.194.

¹⁷⁶ As HCA's economic advisers have previously submitted (see 'A Submission on the Analysis of Insured Prices', KPMG, 1 May 2005, footnote 25), there is a very large literature on the volume-outcome relationship in medicine. Some of the papers from the literature include, Birkmeyer, J. D., Siewers, A. E., Finlayson, E. V. A., Stukel, T. A., Lucas, F. L., Batista, I., Gilbert Welch, H., and Wennberg, D. E. (2002) "Hospital Volume and Surgical Mortality in

CMA must consider the impact on patient outcomes that would result from a loss of patients at HCA.

Reduction in the range of treatments available

- 3.227 In the original private healthcare inquiry, HCA argued that the divestment remedy may have an adverse effect on the range of treatments that it would be able to offer to its patients and that would be available in the market.¹⁷⁷
- 3.228 HCA noted that a lack of patient access to a number of treatments at HCA's remaining hospitals after a divestiture would result in severe disruptions to the patient pathway, would limit patient choice and would have an adverse impact on clinical outcomes. HCA noted that treatments at the remaining hospitals would also be affected as a result of a reduction in the size of the network.¹⁷⁸
- 3.229 HCA further noted¹⁷⁹ that there would likely be an adverse effect on the range of treatments available at the divested hospitals, either because the acquirer of these hospitals may not have the ability or incentive to pursue HCA's strategy of focusing on high acuity healthcare services (which HCA believes is likely), or, in any case, because a new operator would likely incur costs resulting from the lack of access to HCA's remaining facilities which the divested hospitals could earlier draw on. This could mean that patients at the divested hospital(s) are no longer able to access these services in private facilities and will have to turn to the NHS, thereby harming patient choice (and potentially outcomes).
- 3.230 HCA submitted that there are also likely to be adverse effects on the levels of future investment and range of clinical services across HCA's remaining hospitals due to a reduced network and smaller patient volumes, as well as at the divested hospitals.¹⁸⁰
- 3.231 In the Final Report, the CMA disagreed with HCA's arguments as follows.
- 3.232 First, the CMA dismissed HCA's argument that the remedy would be ineffective if the new owner(s) sought to reposition horizontally (in terms of types and range of services offered). As with its assessment of quality, the CMA noted that the objective of the remedies was to stimulate new competitive dynamics in central London that would ensure that patients' needs would be met, regardless of whether the new entrant would follow the same high-quality strategy as HCA.¹⁸¹

the United States, *New England Journal of Medicine* 346: 1128-1137; Silber, J. H., Rosenbaum, P. R., Brachet, T. J., Ross, R. N., Bressler, L. J., Even-Shoshan, O., Lorch, S. A., and Volpp, K. G. (2010) "The Hospital Compare Mortality Model and the Volume–Outcome Relationship" *Health Services Research* 45: 1148-1167; Dimick, J. B., Staiger, D. O., Baser, O., and Birkmeyer, J. D. (2009) "Composite measures for predicting surgical mortality in the hospital" *Health Affairs* 28(4): 1189-98; Halm, E. A., Lee, C., and Chassin, M. R. (2002) "Is volume related to outcome in health care? A systematic review and methodologic critique of the literature" *Annals of Internal Medicine* 137(6): 511-520; Gaynor, M., Seider, H., and Vogt, W. B. (2005) "The volume-outcome effect, scale economies, and learning-by- doing" *American Economic Review Papers and Proceedings* 243-247; Gowrisankaran, G., Ho, V., and Town, R. J. (2006) "Causality, learning and forgetting in surgery" Working Paper, University of Arizona, Rice University, University of Pennsylvania, http://www.u.arizona.edu/~gowrisan/pdf_papers/learn_forget_surgery.pdf.

¹⁷⁷ HCA's Response to the CC's Notice of potential Remedies, paragraph 6.43.

¹⁷⁸ HCA has previously provided examples of treatments that may be affected by a divestment of the London Bridge and Princess Grace hospitals, and estimates of the costs associated with the loss of these treatments. See HCA's Submission on the Costs of divestment, 18 December 2013, Table 1.

¹⁷⁹ HCA's Submission on the Costs of Divestment, 18 December 2013, Table 1.

¹⁸⁰ HCA has provided examples and the associated costs in the context of a divestment of Princess Grace and the London Bridge Hospital. See HCA's Submission on the Costs of Divestment, 18 December 2013, Table 1.

¹⁸¹ Final Report, paragraph 11.194.

- 3.233 The CMA, however, failed to acknowledge the importance of the relationship between the size of HCA's hospital network and the range of treatments it offers.
- 3.234 At paragraph 7.19 of the PFs, the CMA finds that any difference in service range between HCA and TLC is likely to be explained to some extent by the difference in the size of their hospital portfolios. Indeed, this is the point HCA has been making. HCA's comparatively larger hospital network enables it to create centres of excellence and expertise at the different hospital sites, which combines to create a single hospital network with a superior depth, range, expertise and infrastructure than its competitors. The CMA's acceptance of an association between the 'size of HCA's portfolio' and its range of services directly supports one of the RCBs from HCA's existing structure. Should the CMA seek to reduce HCA's network size, according to the CMA's own findings, it should expect a diminution in range (as there would likely be two smaller hospital portfolios, rather than a single larger portfolio).
- 3.235 Second, although the CMA acknowledged that HCA had widened the range of high-acuity treatments available outside the NHS, it concluded that other hospitals in central London such as TLC had adopted a similar strategy.¹⁸² On this basis that the *"divestiture remedy would be unlikely to result in a reduction in the [...] range of healthcare services in central London"*.¹⁸³
- 3.236 But the mere fact that TLC has broadened its range of services is irrelevant. The fact is, HCA's integrated hospital network offers a relatively larger range and depth of treatments than TLC, which operates one hospital.
- 3.237 HCA also notes that the CMA's conclusion is at odds with that of one of the smaller PMIs. In its response to the CMA's notice of possible remedies in the original inquiry, Simplyhealth noted that *"the potential obligation on HCA to divest some of its hospitals may hamper its ability to continue to provide some of the specialist care services it is able to offer currently through a network of closely interlinked care units"*.¹⁸⁴
- 3.238 Finally, HCA notes that very similar arguments to those set out at paragraphs 3.217-3.226 equally apply to the CMA's flawed assessment of the likely impact of divestiture on the range of healthcare provided.

Disruption to patients

- 3.239 In the *Groceries* Market Investigation, the CMA noted the following concerning possible supermarket divestiture remedies:

"We also believe that there is a significant difference between store divestitures and the other remedies we decided to pursue in relation to highly-concentrated local markets. Whilst our other remedies will ensure that grocery retailers have the opportunity to enter a market to establish a new competing grocery store in the future, store divestitures involve the transfer of ownership of an existing, trading store. In our view, such a transfer could have a disruptive effect on consumers in the short term. Those customers who have chosen to shop at the divested store and who are familiar with that store will either find their store operated by

¹⁸² Final Report, paragraph 11.200.

¹⁸³ *Ibid.*, paragraph 11.201.

¹⁸⁴ Simplyhealth's Response to the CC's Notice of Possible Remedies, 20 Sept 2013, page 2.

*another retailer or will have to find an alternative store to continue shopping with the same retailer".*¹⁸⁵

- 3.240 The CMA was willing to take account of the short-run inconvenience to grocery shoppers in the context of grocery store divestitures, but does not consider the adverse effect of 'patient disruption' in the context of hospital divestitures. On that note, the CMA accepts that a new operator can and may decide to reconfigure services and adopt a different healthcare strategy to HCA.¹⁸⁶ The CMA must therefore accept there would be a similar (and potentially harmful) disruption to patients in a hospital setting, whether this be in the way of a change to hospital functions and procedures, the service range, disruption caused by changes to IT systems or other central support capabilities. The CMA's requirement to rollover PMI contracts would not mitigate such patient disruption.

¹⁸⁵ The supply of groceries in the UK market investigation, Competition Commission, 2008, paragraph 11.266

¹⁸⁶ Final Report, Appendix 11.1, paragraph 70.

4. OTHER REMEDIES

4.1 The CMA has proposed a number of alternative remedies to address the alleged AECs and has invited comments on these. Without prejudice to HCA's view that there is no basis for the CMA's AEC findings, and therefore no basis for any proposed remedies, HCA comments as follows.

4.2 The CMA's proposals in any event demonstrate that there are alternative measures which allow for a more effective and proportionate means of addressing the CMA's AEC findings. Where there is a choice between effective measures, the CMA is bound to adopt the least onerous measure.

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

4.3 In remedy 3, the CMA has proposed a restriction on HCA's further expansion in central London *"by preventing HCA from expanding its private hospital portfolio within central London via the acquisition of new sites for use as hospitals and/or clinics"* (paragraph 34, Notice on possible remedies).

4.4 The CMA states that this remedy specifically addresses the finding that there is limited site availability and that HCA *"may be able to pay more for new sites in order to prevent new entry"* (paragraph 35, Notice of possible remedies). The CMA has also previously asserted that HCA has incumbency advantages in obtaining new sites.¹⁸⁷

4.5 HCA reiterates the points made in its response to the PFs concerning site availability:

- The CMA has greatly exaggerated the difficulty which a new entrant faces in requiring suitable sites for hospital development.
- There is, at any one time, a pipeline of commercial sites on the open market and a significant proportion of these are large sites (in excess of 120,000 square feet) which the CMA considers necessary for large scale new entry.
- The CMA also acknowledges that there are a significant number of large NHS sites which will come onto the market in the next few years and will be available for large-scale hospital development.
- VPS and the Cleveland Clinic have both shown that they have been able to acquire suitable sites for large-scale hospital development.

4.6 HCA also vigorously refutes the observation that HCA *"pays more"* for new sites to exclude new entrants. The CMA cites no evidence for this assertion. In every case in which HCA has acquired new sites, it has used the site to create new facilities or expand services, as in the case of Argosy House. HCA has not bid for or acquired sites for the purposes of excluding new entrants. As HCA has previously submitted to the CMA, there are numerous site opportunities which HCA has not pursued.¹⁸⁸

¹⁸⁷ Final Report, paragraphs 6.61-6.106.

¹⁸⁸ See Exhibit 1(c) provided to the CMA at HCA's hearing of 18.12.14 which listed *"20 sites which have been brought to us in the last six years"*.

- 4.7 However, hypothetically if the CMA's findings were correct, HCA accepts that remedy 3 would in principle be an effective and proportionate way of addressing the issue of site availability in order to facilitate new entry and increase even further non-HCA capacity. It is also less intrusive than either remedy 1 or 2.
- 4.8 HCA stresses that remedy 3 would be a significant and highly intrusive interference with HCA's rights to acquire and develop future sites to allow for the expansion of its business. It would restrict HCA's ability to build and operate new hospital facilities, launch new services, and expand its existing offering for a given period. The proportionality of this remedy would depend on its scope, and the CMA would need to ensure that it is no wider than strictly necessary to address its concern that there is a lack of suitable sites for new hospital developments.
- 4.9 The CMA's competitive assessment has "*focused largely on hospitals providing inpatient care*" (paragraph 3.19(a), PFs), and the CMA has noted that "*concentration is relatively higher in the provision of inpatient care than in the provision of day patient and outpatient care.*" (paragraph 6.4, Final Report). The CMA has not made any adverse findings, either in relation to site availability or more generally, with regard to either outpatient/day care services, or to primary care (GP) services. HCA has provided numerous examples of new entrants which have launched new outpatient/day case clinics (e.g. Optegra, Fortius, Advanced Oncotherapy, etc.). Accordingly, the remedy would need to be restricted to sites for inpatient activities only. A remedy which prevented HCA from acquiring sites for stand-alone day case or outpatient clinics would be wider than necessary to address the alleged AECs.
- 4.10 The remedy would also need to be limited to the period necessary to facilitate new entry and expansion in central London, and in this regard the CMA has noted as follows:
- The CMA acknowledges that VPS and Spire are keen to enter the market by 2017/2018, but the CMA expresses uncertainty (wrongly, in HCA's view) over whether they have acquired appropriate sites.
 - The CMA has also noted that a number of new NHS sites will become available by 2016, and further sites will become available by 2019/2020.
 - Barts' new PPU will be operational in 2017, and the Cleveland Clinic also has plans to enter the market.
 - The CMA accepts the potential for large-scale entry into the central London market over the next five years.
- 4.11 In the light of the above, the remedy should be limited in time, and HCA submits that a period of three years would be sufficient on the basis that (i) this would safeguard the availability of sites to investors seeking to enter the market within this time frame; and (ii) there will be further new capacity brought onto the market by this period which will have further increased in competitive constraints on HCA.
- 4.12 Further, the remedy should allow HCA to acquire and develop sites which competitors do not wish to acquire. The CMA alleges that the purpose of the remedy is that HCA should not be allowed to "out-bid" rival operators for new sites. This could be achieved, for example, by preventing HCA from bidding for or acquiring sites unless they have first been made

available to other hospital operators for a given period (say, six months) and no bids, or no bids at the relevant market price, have been received in this period.

- 4.13 Without prejudice to its position with regard to the CMA's AEC findings, HCA is prepared to consider and comment further on the effectiveness and proportionality of the remedy if the CMA pursues this proposal as an alternative to divestment.

Remedy 6 – facilitate site availability in central London

- 4.14 The CMA has proposed an alternative remedy 6 which also addresses the issue of site availability.
- 4.15 Either version of this remedy would also potentially be an effective and proportionate measure to deal with the CMA's concern about the availability of new sites in central London, and merits further consideration as an alternative to divestment.
- 4.16 The CMA states that the first version of this remedy – a recommendation to NHS Trusts/Department of Health to sell surplus buildings to private hospital operators – is unlikely to be followed because NHS Trusts would be incentivised to sell sites for higher value to other (presumably residential) users. However, as HCA has pointed out, there are current and anticipated changes to the planning regime which promote commercial over residential usage of sites which would make it more difficult for residential developers to out-bid private hospital operators. Indeed, HCA specifically proposed this remedy during the original inquiry.¹⁸⁹
- 4.17 As HCA has submitted to the CMA, there is a substantial amount of NHS surplus property which will be coming onto the market over the next few years. HCA understands that the DoH/NHS is in the process of setting-up an entity to manage the disposal of sites across the NHS. A remedy which encouraged NHS Trusts to dispose of sites specifically to private hospital operators is therefore likely to be highly effective because of the volume of property which has been earmarked for sale.
- 4.18 These sites have existing hospital buildings with C2 planning consent. Examples are the Heart Hospital site and the Royal Masonic Hospital on the Ravenscourt Park site. It is very easy for new entrants to refurbish these buildings and re-open them as private hospitals. It is therefore incorrect to suggest that there will be a long lead time in using these sites for new hospital development.
- 4.19 The CMA also states that the second version of this remedy – a recommendation to the Government to change planning regulations – is uncertain and does not address the long lead times required for new hospitals to enter. HCA's response to this is as follows:
- If the CMA believes that there are planning constraints which exacerbate barriers to entry, this recommendation would seek to address the issue at source i.e. by removing the alleged hurdles for new entrants.
 - It is not clear why the CMA believes that the Government may not be prepared to change planning laws – this is surely a matter for the CMA to discuss with the Government, including the potential time frame for any such changes.

¹⁸⁹ HCA's response to the CC's Notice of possible remedies, 21 October 2013, page 34.

- The CMA has previously introduced such a remedy in the Groceries inquiry and therefore there is a precedent for this type of remedy in a market investigation reference.¹⁹⁰

Remedy 4 – "light touch" price control

- 4.20 HCA notes the CMA's comments with regard to a price cap.
- 4.21 While HCA does not accept that there is any reasonable basis for imposing price controls, this remedy would also be a less intrusive measure than either remedy 1 or 2 and HCA would be prepared to give it further consideration depending on its scope.
- 4.22 As the CMA has noted in the Final Report, the CMA's justification for a divestment remedy was based on the price impact of divestiture on PMI and not self-pay prices. In respect of non-London operators, the CMA found an AEC only with regard to self-pay and not insured patients. The CMA concluded in relation to BMI that the cost of divestment would substantially outweigh any benefits for self-pay prices and hence could not be justified. On this reasoning, any price caps proposed as an alternative to divestment should apply to PMI prices alone.
- 4.23 As the CMA has noted in the Final Report, PMI prices are generally negotiated on "*the overall bundle of a hospital operator's services (i.e. the associated revenue), with relatively little focus on the price of individual treatments.*" (paragraph 6.276, Final Report). The CMA also observed that "*Rather than negotiating over the price of individual treatments, parties will generally negotiate at renewal over a single percentage increase in prices across all treatments.*" (paragraph 6.292, Final Report).
- 4.24 It would therefore be practicable to impose controls on the percentage increase in HCA's PMI contract prices for a given period of time. This could for example be done by reference to various indices based on medical inflation.
- 4.25 ☒ which account for a large proportion of the average weighted price difference between HCA and TLC. HCA submits that any price controls should logically be confined to these specific procedures☒ HCA notes that the NHS operates different tariffs for these procedures depending on whether the relevant NHS provider is ☒-accredited and a similar tariff-based approach could be adopted for private hospitals.¹⁹¹
- 4.26 The CMA states that a price control carries the risk that:
- hospitals would be incentivised to reduce the quality of the service they provide;
 - it may discourage innovation and the introduction of new and better treatments and procedures.
- 4.27 However, as noted above, the very same risks arise in relation to the CMA's proposed divestment remedy. There is no logical reason why these risks would be any greater in the case of a price control than in the case of divestment. Accordingly, the CMA cannot logically discount the possibility of price controls, as an alternative to divestment, on the basis that there is a possibility that they could reduce quality or innovation. As stated above, the CMA

¹⁹⁰ The supply of groceries in the UK market investigation, CC, 30 April 2008.

¹⁹¹ See Nabarro letter of 16 October 2015 to CMA.

is bound to adopt the remedy which is least onerous for HCA where there is a choice of remedies.

- 4.28 Furthermore, a short-term price cap would be more likely to limit any potential risks to quality and innovation for the duration of the cap, whereas a divestment remedy produces adverse effects for quality and innovation over the longer term. In addition, for the reasons set out above, a divestment remedy creates worse effects than a price cap for quality and innovation because of the disruption to HCA's network of hospitals and clinical pathways.
- 4.29 Curiously, the CMA states that this remedy would not address "*any detriment taking the form of lower quality or less innovation in the market*", but the CMA has concluded that there is sufficient competition over quality / range and innovation, and the CMA has not make any findings that there is a lack of quality or innovation in the market.
- 4.30 For the reasons set out above, based on the strong prospects for new entry and the creation of new capacity over the next few years, any price cap should be strictly limited in time, and HCA submits that a period of three years will be sufficient.

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

- 4.31 The CMA has proposed a remedy which appears to be aimed at providing competitors with access to HCA's hospital facilities for a limited period of time. The CMA states this would require HCA "*to allow other private hospital operators to rent space in its facilities in order to compete.*"
- 4.32 Any remedy which requires HCA to cease its existing business activities and dispose of assets to third parties is a form of divestment and, as such, is subject to similar considerations regarding effectiveness and proportionality which have been discussed above in relation to remedy 1. That said, a remedy which requires HCA to lease space to new entrants for a short period of time, as opposed to an outright disposal of a business in perpetuity, would potentially be a less intrusive measure than a permanent divestment of the business.
- 4.33 It is difficult for HCA to comment on the effectiveness and proportionality of the remedy without a clearer understanding of the CMA's proposals, in particular:
- i. HCA assumes that, if the CMA's concern is that new entrants lack suitable sites the remedy would require a "bare" lease of space at a market rental. However HCA would wish to understand this further.
 - ii. The CMA indicates that HCA would need to rent out "*a whole hospital building*". Since the remedy is aimed at addressing an alleged lack of sites, it is HCA's position that any of its facilities would provide sufficient alternative capacity for a new entrant. Again, HCA would wish to understand the CMA's proposals in this regard before commenting in more detail.
 - iii. As indicated above, given the prospects for new market entry, this remedy would need to be limited in time, and HCA submits that a period of three years would be sufficient.

- 4.34 This remedy would give rise to a number of practical considerations and HCA is prepared to comment further on these if the CMA is minded to pursue this option as an alternative to remedy 1.

Other proposals

- 4.35 HCA had proposed a number of alternative remedies in its response to the CC's Notice of possible remedies in the original inquiry but these were ignored without comment by the CMA. If the CMA considers that remedies are necessary, it needs to apply its mind to the full range of alternative measures which would be a more proportionate means of addressing any specific concerns. In the original inquiry, it has completely failed to do so.
- 4.36 In particular, both Aviva and PruHealth have indicated their support for a remedy which provided greater information to PMIs about hospital operators' costs as opposed to a divestment remedy:
- At its hearing, Aviva *"proposed an alternative remedy to the CC, which involved requiring some form of open-book accounting by hospital operators to justify the costs procedures. ... it suggested that hospital operators move to an open-book accounting process, rather than simply informing PMIs that the cost of a procedure would increase by a certain percentage without any details. ... being able to understand hospital operators' costs would mean that hospital operators would need to become more competitive and consider their expenses in approaching price increases with PMIs."* (Summary of hearing with Aviva on 24 October 2013, paragraph 32).
 - VitalityHealth (then PruHealth) also stated that it *"required a level of data which enabled it to make comparisons between providers in order to judge their cost effectiveness. ... if the proper data was provided then PruHealth could set up condition-specific networks that would enable it to direct patients to the most cost effective, highly valued consultant or hospital. ... If information was more readily available PruHealth would be in a position to compare, challenge and defend the tariffs with particular hospital groups as a whole, as opposed to a hospital-by-hospital basis."* (Summary of hearing with PruHealth on 30 September 2013, paragraphs 3 and 19). Indeed, PruHealth specifically stated at the hearing that divestment was not likely to be an effective remedy.
- 4.37 A consistent feature of this inquiry is the CMA's blind acceptance of the views of Bupa and AXA PPP in favour of divestment. The CMA has wholly ignored the fact that smaller PMIs do not share their views that divestment would be an effective remedy.¹⁹²
- 4.38 HCA would be willing to consider a remedy aimed at contractually providing PMIs with greater information about costs in the event that they have any specific queries or concerns about pricing.
- 4.39 HCA reiterates that the CMA has a clear duty to ensure that it considers carefully all potential remedies and chooses the one which is the least onerous. Thus far, it has failed to engage with HCA in examining alternative solutions which would remedy any alleged problems in the market place.

¹⁹² See paragraph 3.16 above.