

## Private Healthcare Remittal Provisional Decision on Remedies: Response of AXA PPP

### 1 Introduction and executive summary

AXA PPP is surprised by the CMA's Provisional Decision on Remedies (PDR), which it considers to be flawed in a number of material respects.

As the CMA recognises, HCA's market power in central London continues to result in an adverse effect on competition (AEC). This is consistent with AXA PPP's extensive submissions, corroborated by those of other parties, over a four year period. AXA PPP experiences this as commercial reality on an ongoing basis, and has provided clear evidence to the CMA that HCA is charging substantially higher prices than other providers, which cannot be justified on quality or "complexity" grounds.<sup>1</sup> The PDR does not suggest that additional evidence has been received which would contradict AXA PPP's experience.

Notwithstanding the above, the clear consumer detriment that results from HCA's excessive pricing, and the CMA's statutory obligation "in particular to have regard to the need to achieve as comprehensive a solution as is reasonable and practicable to the adverse effect on competition"<sup>2</sup>, the CMA has provisionally decided not to proceed with a divestiture remedy to address this AEC. It appears from the PDR that this change of view rests predominantly on the prospect of a new facility being approved and developed by Cleveland Clinic (CC), a new entrant which has no experience of the UK market. The PDR presupposes that CC will succeed in an entry strategy (that BMI, Spire, Nuffield, Ramsay et al have not attempted) such that the central London market will self-correct, in a manner sufficiently swift, certain, and comprehensive in scope that it would replicate the benefits of a structural remedy in good time, rendering that remedy of at best transitional benefit, and therefore disproportionate.

AXA PPP's strong view is that the CMA's provisional conclusion remains correct on diagnosis (AEC) but is fundamentally flawed as to the cure (remedy), and that the reliance placed by the PDR on new entry does not provide a rational basis for a decision to take no action to cure the identified AEC. In particular:

- The CMA fails to take proper account of its own finding that the combination of specialty-led product markets and prices that are negotiated jointly across a full range of hospital services means that retained HCA market power in a single important specialty, notably oncology, results in retained HCA market power across hospital services as a whole. There is no evidence whatsoever that CC will provide a full oncology offering over any reasonable timeframe. [3<]
- Even leaving aside this fundamental concern, a high level review of the NPV analysis, which is the driver of the CMA's provisional conclusion that the divestiture remedy proposed in its Notice of Possible Remedies ("the Remedy")<sup>3</sup> would be disproportionate, reveals a number of material flaws in approach. Some of the

<sup>1</sup> See, e.g. AXA PPP submission of 24 July 2015, page 2; AXA PPP submission of 5 August 2015, page 4; AXA PPP submission of 25 September 2015; AXA PPP Response to Provisional Findings and Notice of Possible Remedies (4 December 2015), Section 4.2; Transcript of Hearing on 16 December 2016, page 26; and AXA PPP Letter of 21 January 2016, page 2.

<sup>2</sup> Enterprise Act 2002, section 134(6).

<sup>3</sup> i.e. the divestiture of either (a) The Wellington Hospital; or (b) the London Bridge Hospital and Princess Grace Hospital.

issues identified are likely to be sufficient in and of themselves to generate a positive NPV once corrected; in other cases a combination of a (usually small) number of points will lead to the same result. In summary, AXA PPP considers it almost inconceivable that a balanced judgement would not lead to a significantly positive overall NPV, thereby demonstrating that the Remedy is proportionate (see section 3 below).

- As the CMA itself notes, the other remedies implemented by way of the Private Healthcare Market Investigation Order 2014 (“the Order”) were not designed to address the market power concerns identified by the CMA, and are not sufficient on their own to do so. AXA PPP continues to have a number of misgivings about the effectiveness of these remedies in any event (see section 4 below).

In short, AXA PPP strongly believe that the PDR is flawed, and cannot be relied upon to reach a view that the Remedy would be disproportionate. Divestment of suitable facilities (including oncology capabilities) is the only means of addressing the AEC that persists, and is entirely proportionate to that AEC. The CMA must act now, or PMIs will continue to have no choice but to contract with HCA, and consumers will continue to suffer the effects of HCA’s excessive prices, with no prospect of such detriment being addressed in the medium to long term, let alone the short term. Failure to do so would not be a rational response given the weight of evidence before the CMA.

AXA PPP requests a meeting with the CMA to discuss these issues further.

## **2 Entry by CC will not provide an effective constraint unless and until a full oncology offering is provided**

According to the PDR, CC is expected (together with other existing operators in central London) to “effectively constrain HCA by early 2022”.<sup>4</sup> As discussed at the hearing in December 2015, AXA PPP is unfamiliar with CC and has not had any direct discussions with CC to date about its potential entry. AXA PPP also remains of the view that a facility in Grosvenor Place is unlikely to provide a material constraint on the London Bridge hospital, particularly with respect to corporate customers located in the City and Canary Wharf.

In any event, in AXA PPP’s view the CMA’s provisional decision as to the constraint that CC is likely to impose on HCA is fundamentally misguided, as the PDR fails to take proper account:

- On the demand side, of the critical role of cancer treatment in end-user demand for PMI. As set out in previous submissions<sup>5</sup> and discussed at AXA PPP’s hearing in December 2015, the provision of cancer treatment is a core requirement for PMI customers;
- On the supply side, of the fact that effective treatment typically involves a range of different services and specialists, and customers have strong preferences and expectations for holistic “team-based” treatment offerings.<sup>6</sup> By way of further example, the most common tumours are breast, lung, prostate and bowel. All of these may require surgical treatment – but it is essential for such treatment to be

<sup>4</sup> PDR paragraph 19.

<sup>5</sup> See e.g. AXA PPP response to First Day Letter of 9 March 2015.

<sup>6</sup> Transcript of Hearing of 16 December 2015, page 7.

discussed in a multidisciplinary team meeting which involves an oncologist, pathologist and radiologist as well as the surgeon to determine what the best plan of management should be;

- Of the pivotal nature of HCA's market power at critical specialty level, particularly oncology (and cardiology), which the CMA has consistently recognised; and
- Of the CMA's own consistent findings that the "combination of a specialty-level product market [i.e., oncology], and prices that are negotiated jointly across a full range of [hospital] services" means that retained HCA market power in oncology results in retained HCA market power across hospital services as a whole.<sup>7</sup>

As discussed previously, the logical consequence of these factors is that CC (or any other entrant) would represent a credible alternative to HCA no earlier than the date at which it has operational radiotherapy facilities comparable to HCA, together with all other "surgical" and "medical" aspects of the holistic treatment of cancer. In reality, [§<].

As noted in the PDR, CC currently plans only to offer surgical oncology services in its facility at 33 Grosvenor Place.<sup>8</sup> This is a very surprising statement, as surgery for cancer should not be conducted as an isolated service. Whilst many cancers do present to surgeons in the first instance, the management of cancers requires discussion across disciplines and the ability to select and offer the best treatment or combinations of treatment. This is usually a combination of surgery, and/or radiotherapy and/or chemotherapy. Customers are not going to choose to go to a provider knowing that it offers only part of a treatment package over an alternative provider who can offer a full range of treatments.<sup>9</sup> AXA PPP notes that CC appears not to have a strong track record in the provision of oncology services in its existing facilities in the US, according to the data cited by the CMA.<sup>10</sup>

The only evidence that the CMA provides in support of a suggestion that medical oncology services may be provided at some point in the future is a statement from CC that "it would adapt its services to serve the market".<sup>11</sup> This is extremely vague (with no indication as to the time at which CC would assess its performance or consider such "adaptation", let alone how long it would take for services and facilities to then be adapted and established), and demonstrates a surprising lack of engagement and understanding on the part of the CMA as to the importance of oncology as a holistic offering, and the particular barriers to entry faced by providers wishing to develop services in this area. In particular, no indication is provided that such "adaptation" would, or would be likely to, include medical oncology services (and if so, within what timeframe). The CMA suggests that expansion of existing facilities to include the adaptation of buildings to accommodate radiotherapy facilities would take less time than the development of TLC's cancer centre<sup>12</sup>, but no evidence (or corroboration from CC, or TLC) is provided in support of this assertion, and it is not clear to AXA PPP where such facilities would be sited (given the particular infrastructure

<sup>7</sup> Notice of Possible Remedies, paragraph 24(c).

<sup>8</sup> PDR paragraph 1.30.

<sup>9</sup> See e.g. Final Report Appendix 6.3 for a summary of TLC's and HCA's acknowledgement of the importance of a comprehensive cancer offering.

<sup>10</sup> PDR paragraph 1.27.

<sup>11</sup> PDR paragraph 1.31.

<sup>12</sup> PDR paragraph 1.75.

requirements described a number of times in AXA PPP's previous submissions<sup>13</sup>, which would be likely to create additional delay and complexity from a planning and development perspective), or when they would be developed. Nor are assurances provided as to CC's ability to procure the necessary staff to provide such services, which may be particularly difficult in relation to oncology given lengthy treatment episodes (see section 3.3 below) and efforts by HCA to retain consultants (see section 4.2 below).

Consequently, it is irrational to suppose that HCA prices will fall assuming CC does eventually enter the market (let alone in anticipation of such entry), when it is common ground that CC lacks concrete plans for a comprehensive oncology offering. There is no rational basis whatsoever for concluding that entry by CC (or any other provider) in the provision of a full range of oncology services, which is essential to address the AEC identified by the CMA, will be likely, timely and sufficient.

[<]

AXA PPP also completely disagrees with the CMA's provisional conclusion that "it would be disproportionate to require HCA to divest an additional radiotherapy facility in order to bring forward the full impact of the remedy [if the CMA's divestment remedy were implemented] by a year or two". No evidence is offered in support of the assertion that such a facility could be developed at the Wellington or at London Bridge Hospital (or elsewhere in proximity to these facilities) in "a year or two". As noted above and previously, development of a radiotherapy facility involves specific infrastructure requirements which often result in complex planning and development processes.

### 3 The CMA's NPV analysis is flawed

Underpinning the provisional conclusion in the PDR is the CMA's net present value (NPV) analysis, which purports to show that the NPV from the Remedy is negative.<sup>14</sup>

Even leaving aside AXA PPP's fundamental concern that there is no basis on which to conclude that CC will provide an effective constraint in oncology (set out in section 2 above), AXA PPP considers that the NPV analysis cannot be relied upon by the CMA to justify a decision that divestiture would be disproportionate.

According to the PDR, the CMA has performed its NPV analysis using a number of different assumptions as to: (a) the time horizon over which the Remedy is expected to have an effect / entry by CC is expected to take place (with analysis performed for three, five, seven and ten years) ("Time Frame"), (b) the price benefit of the Remedy (modelled on the basis of a 3% or 6% benefit) ("Price Benefit"), and (c) the loss of scale economies ranging from a highest estimate "downside case", to a mid-range base case, to an assumption of zero loss of economies of scale "upside case". This analysis has resulted in a provisional conclusion that "[on] a number of plausible assumptions, the [NPV] of the divestment is negative or only marginally positive. Taking account also of the significant uncertainty over the elements of the NPV calculation, we could not form an expectation that the benefits of a divestiture remedy would outweigh the costs."<sup>15</sup>

<sup>13</sup> AXA PPP submission of 9 March 2015, page 2; and AXA PPP response to IPA working paper, dated 24 July, paragraph 5.1(iii).

<sup>14</sup> See PDR Appendix and in particular PDR Table 2.1 / PDR Appendix Table 8 "NPV of Divestiture", as corrected by the "Correction to the net present value analysis" issued on 6 April 2016.

<sup>15</sup> PDR, paragraph 2.58.

Due to confidentiality restrictions, AXA PPP and its economic advisers have not had full sight of the CMA's NPV analysis. This submission is therefore based on the non-confidential version of the PDR (as corrected). However, even on the basis of the non-confidential version, it is apparent that this analysis is deficient, and biased against finding a positive NPV in numerous ways.

Assumptions, explicit or implicit, on four dimensions underpin the NPV analysis:

- (i) The **Probability** of CC Entry;
- (ii) The **Price Benefit** of the Remedy (pending entry);
- (iii) The **Time Frame** of the Price Benefit (until entry occurs); and
- (iv) The **Costs and Efficiency Losses** of the Remedy.

Essentially, the specific set of assumptions on these four dimensions that corresponds most closely to the CMA's thinking is:

- (i) Entry by CC is 100% certain;
- (ii) the Price Benefit of the Remedy is only 3%;
- (iii) the Time Frame of the Price Benefit is only five years (the gap between when the Remedy would begin to take effect in 2017 and when CC would provide an "effective constraint" in 2022); and
- (iv) there are significant scale economy losses associated with the Remedy.

The combination of these four specific assumptions on the four dimensions shows, in Revised Table 2.1, that the divestment has an NPV of -£18.453 million. If the CMA adopted the downside case on loss of scale economies, the NPV would be even more negative at -£38.770 million.

However, Revised Table 2.1 also shows that there are specific assumptions under which the NPV has a significant positive NPV. For example if the Time Frame is seven years rather than five years, and the Price Benefit is 6% rather than 3%, the NPV is +£37.515 million on the base case on scale economies and +£87.654 million when considering the upside case on scale economies.

In AXA PPP's view, therefore, the critical question is whether the outcomes generating negative NPVs are in fact "plausible" and whether, if so, they represent a significant (probability-weighted) fraction of the likely outcomes. In AXA PPP's view, the assumptions relied upon by the CMA to generate a negative NPV are not sufficiently supported by evidence, as discussed further below, and are not therefore "plausible" but unreasonably optimistic, and cannot be relied upon to justify a finding that the Remedy would be disproportionate. In AXA PPP's view, a more "plausible" (yet still optimistic) estimate (taking the different assumptions applied by the CMA, and again leaving aside AXA PPP's fundamental concern described in section 2 above) would assume a Time Frame of at least seven years (but in reality likely longer, as discussed in section 3.3 below), a Price Benefit of 6%, and loss of scale economies no greater than the base case. This generates a positive NPV of at least £37.515 million, and the range of plausible values of the NPV extends to beyond the £136.094 million reported in Revised Table 2.1.

Set out below are nine factors that, in AXA PPP's view, the CMA has failed to take into proper consideration.

### 3.1 Certainty of entry

**Factor 1: the CMA assumes that entry by CC is 100% certain**

This factor is not explicitly considered by the CMA. The NPV analysis assumes that CC will enter with complete certainty i.e. 100% probability. AXA PPP believes there must be some uncertainty about whether this entry will happen (given that CC does not yet have planning permission), and even if the entry were extremely likely, such that the expectation is that it will occur, this expectation cannot logically assume a 100% likelihood, as opposed to (say) an 80% likelihood. In weighing its proportionality calculation, the CMA, having identified an AEC, must attach some weight to the (say) 20% probability that the entry on which it is relying may not happen at all). By contrast the Remedy, if adopted, could be assumed to be certain.

### 3.2 Price benefit of Remedy

**Factor 2: The evidence from all sources points to an expectation of a Price Benefit of at least 6%, not 3%**

The CMA's provisional conclusion that the NPV is negative or only marginally positive rests on an assumption that the Price Benefit resulting from the Remedy would be only 3%. In particular, the CMA states that analysis based on its own base case, and alternative analysis presented by HCA's advisers, KPMG "indicates that HCA's prices to UK patients (in 2015) exceeded the level where it would have earned its WACC by between 3.1% and 10.7%. As explained ... we have placed more weight on the KPMG 2 scenarios, which gives a range between 3.1% and 6.2%".<sup>16</sup>

The CMA has exercised its discretion to rely for the purposes of its analysis on calculations submitted by HCA's advisers of 3.1% to 6.2%, ignoring its own estimated range of 7.5% to 10.7%. But the CMA offers no reasonable grounds for placing greater reliance on the very bottom of the range provided (with the 3.0% Price Benefit that is relied upon in the NPV analysis actually falling even below the 3.1% at the bottom of the range presented by KPMG).

In AXA PPP's view this is unreasonably biased towards finding a negative NPV, and a more reasonable (yet still conservative) approach would be to consider one of the following approaches:

- (i) take the mid point of the KPMG range (4.65%)
- (ii) take the lower bound of the CMA estimate (7.5%).
- (iii) take the midpoint of (i) and (ii) above (6.075%)
- (iv) take the upper bound of the KPMG range (6.2%)
- (v) take the average of (i) – (iv) (6.1%)

In short, a number of alternative, reasonable, approaches indicate that a number around 6% is the better estimate of the Price Benefit, which is within the range submitted by HCA itself as one its own estimates of the excess return on capital. It should also be noted that these methodologies exclude the very significant property capital gains from the calculation, and are thus likely to be conservative on any basis.

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<sup>16</sup> PDR Appendix, paragraph 24.

**Factor 3: The revenue base to which the Price Benefit applies is artificially narrow because it excludes outpatient revenues**

The CMA notes that competition in outpatient activities may *already* be adequately competitive. Thus, in the CMA's view, the benefit of the Remedy will be felt primarily in in-patient and day-case procedures, and its analysis appears (on the basis of the non-confidential version) to exclude revenues from outpatient procedures.

If this is indeed the approach taken by the CMA, then AXA PPP is concerned that the CMA has made a serious analytical mistake. To give a conceptual example, consider two activities A and B whose cost is each £50. Suppose that A is overpriced by £5 (which is 10% of £50) and B is competitively priced. Then the overcharge is £5 in absolute terms: 10% of A, but 5% of the entire basket of A+B. A refund of a 5% overcharge where this has been computed over the entire basket (including the competitive element) has to be applied to the entire basket. Applied to this case, this will increase the revenue base to which the Price Benefit is applied, increasing the NPV of the Remedy.

**Factor 4: The private healthcare market in central London is growing and this scales up the revenues to which the Price Benefit should be applied.**

The private healthcare market in central London can be expected to grow over time. AXA PPP regards it as uncontroversial to assume that the London market will grow in real terms by at least 2% per annum over the next decade, and notes that there are various more optimistic views as to expected growth levels. This will increase the size of the market to which the Price Benefit will apply, increasing the NPV of the Remedy.

**Factor 5: The CMA appears to have applied the Price Benefit of the Remedy only to the (pre-divestment) HCA assets, as opposed to the market as a whole**

The CMA appears to have applied its assumed Price Benefit only to the remaining HCA assets and the divested HCA assets, but not to the remainder of the market. This is wholly irrational, and contradicts the very concept of a market. Since HCA's share of the central London market is a little below 50%, the CMA has applied the Price Benefit to less than half the market.

**Factor 6: The CMA has not given any weight to the qualitative benefits of additional competition in the period before CC entry**

Competition occurs on multiple dimensions, not just price. In other cases, and in general, the CMA attributes significant weight to non-price dimensions of competition.

While the PDR recognises additional benefits (for example in terms of quality or range) would be likely to result from the Remedy<sup>17</sup> it considers that they will be corrected by the entry of CC. However, this approach fails to take account of the Time Frame before CC enters. In the years when the Remedy is operative before CC has entered, these qualitative benefits would therefore be realised, and may be significant. While recognising the difficulties in quantification, the CMA should, in AXA PPP's view, at least acknowledge that this is a material factor, and that any quantitative estimates of the NPV are therefore likely to be understated given this dimension.

### 3.3 Time-frame of the Remedy

**Factor 7: Relying on a five year Time Frame is unreasonably optimistic**

<sup>17</sup> PDR paragraph 2.55.

The CMA assumes that CC will, with certainty, build and open a hospital in Central London, and that - once up and running - this will cure the AEC. The Price Benefit of the Remedy therefore, according to the CMA, only applies from implementation until the AEC is "solved" by CC entry in 2022. In the CMA's view, CC will take around three years to open its doors, and then a further two years to get to the point where it is actively competing for business, sufficient to constrain HCA.

AXA PPP considers that the CMA has seriously misjudged the likely speed of entry by CC to the point where CC (in combination with existing non-HCA facilities) would allow PMIs to cease to be dependent on HCA.

At the outset AXA PPP observes that the questions of:

*(Q1) when will CC achieve utilisation consistent with viability?; and*

*(Q2) when will CC (in conjunction with other non-HCA facilities) provide a viable alternative such that PMIs are no longer dependent on HCA?*

are quite distinct questions, and that the answer to Q2 is almost certainly materially longer than the answer to Q1. In particular, the CMA's view that CC will be established two years after opening is, in AXA PPP's view, an optimistic answer to Q1 but a wholly unrealistic answer to Q2, which is the relevant question in terms of whether CC entry will solve the AEC.

AXA PPP considers that there are at least four separate milestones that would have to be achieved in order for CC to become (with other facilities) a viable alternative to HCA. Moreover three of these four milestones cannot be implemented in parallel, as but must be undertaken sequentially.

The four milestones are:

*(M1) The time required to apply for and secure planning permission and develop the facility*

The CMA assumes that it will take CC around three years to apply for and secure planning permission (including for radiotherapy facilities) on the scale envisaged; to build out and convert the new facility, including the radiology facilities, install all medical equipment, hire medical staff, obtain insurer recognition, and secure CQC approval.

However, if - as is necessary if CC is to cure the AEC - CC were to include radiotherapy and oncology provision, the time for planning permission and building is likely to be longer than the process for a facility which cannot do so. As such assuming M1 = 3 years is, in AXA PPP's view, an optimistic answer (even leaving aside the fact that, on the basis of the evidence before the CMA, CC appears to have no plans at present to include radiotherapy facilities in its plans). To the best of AXA PPP's knowledge, CC has not yet applied for planning permission, despite representing to the CMA that it intended to do so during March 2016. The likely timescale for entry presented in the PDR is therefore already delayed. There is also no certainty as to the size or format of the resulting facility, which may be heavily influenced by the planning process; nor is there any certainty as to the timing of the grant of planning permission (if planning permission is indeed granted<sup>18</sup>) once the application is made.

*(M2) The time required to build reputation to attract consultants and patients*

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<sup>18</sup> AXA PPP notes CC's statement that it would seek an alternative site in the event that planning permission is not granted, which suggests that there is at least a possibility that planning permission will not be forthcoming.

CC does not currently have significant name-recognition or brand name in the London market, either in absolute terms or certainly comparatively to the marquee central London hospitals, including those contemplated in the CMA's original Remedy. [REDACTED].<sup>19</sup>

As a result, AXA PPP does not believe that any significant proportion and number of established private consultants currently operating at HCA would contemplate moving their practice (if at all) until after CC is built, has secured recognition from the major insurers BUPA and AXA PPP, attracted a strong professional staff, attracted at least some other consultants of high-standing, has developed name recognition amongst potential patients; and established itself as a high-quality hospital for a number of years. The consultant recruitment issue is likely to be particularly difficult in oncology given the nature of the patient journey and the length of treatment episodes, and the links between HCA and LOC.<sup>20</sup>

It should further be noted that issues of consultant-recruitment, patient acceptance, quality and reputation are in varying degrees intertwined resulting in "chicken and egg" problems. These complexities can only create greater risk of delay.

Accordingly, AXA PPP believes that it will be a number of years after opening before CC starts to develop the required momentum, and the notion that it will be fully established as a replacement for HCA two years after cutting the ribbon is fanciful. The CMA offers little reasoning in support of its view, which it acknowledges could be susceptible to delay.<sup>21</sup> [REDACTED].<sup>22</sup> Hence the time to achieve this second milestone implies M2 = [REDACTED] (at a minimum).

*(M3) The time required for patient referral patterns to alter*

Even when a consultant has moved their practice to CC, this does not mean that their existing stock of patients will move across instantly. It is generally regarded as difficult to move patients between hospitals, without good medical reason, within treatment episodes. And whereas episode length for routine procedures is comparatively short (e.g. three months), for oncology, episode length is frequently more than two years. During this lag, the legacy cohort of patients already being treated at HCA will tend to remain at HCA, and PMIs will still be dependent on HCA. CC will therefore be primarily competing for new patients.

AXA PPP considers that, [REDACTED]. Hence the time to achieve the third milestone M3 = [REDACTED] (at a minimum).

*(M4) The time required for corporate customers to consider a "non-HCA" policy to be a fully acceptable option*

As consultants move to HCA and patients follow, AXA PPP will over time be able to market CC as an alternative to HCA, and begin to write HCA out of corporate contracts. [REDACTED]. Hence the time to achieve this fourth milestone M4 = [REDACTED] (at a minimum).

*The overall likely period for CC to become fully established and sufficient to replace HCA*

<sup>19</sup> [REDACTED]

<sup>20</sup> See e.g. Transcript of Hearing of 16 December 2015, page 12. While the PDR states that CC has engaged medical advisers to assist in its development plans, it does not appear that CC has engaged consultants or other medical staff to treat patients. In order for CC to represent an effective constraint on HCA, it will be necessary for at least some HCA consultants to agree to practice at CC, as recruiting consultants from elsewhere will do little to impact referral patterns. This is particularly the case for oncology, given the strong links between LOC and HCA.

<sup>21</sup> PDR, paragraph 1.82

<sup>22</sup> [REDACTED]

The total time (T) for CC to reach a strength where the majority of major corporate buyers regard it as a satisfactory replacement for HCA depends on whether the various milestones have to be undertaken sequentially, or whether they can be solved concurrently.

Of the four stages described above, AXA PPP considers that M1, M2 and M3 can only happen sequentially yielding a total time of T = [X]. However AXA PPP considers that M4 can start when the hospital opens (at Year 3 if the schedule holds) and can happen broadly in parallel with (rather than sequential to) the shifting of consultants (M2) and patient numbers (M3). Thus the total time T is the three year build followed by max (M2+M3; M4).

Accordingly, after opening, there are two necessary parallel paths, each of which is likely to be of at least [X] years duration until CC will be in a position to displace HCA. Hence AXA PPP considers that optimistically CC could be established as a significant competitor to replace HCA in no sooner than [X] years (assuming no delay for developing radiotherapy facilities, and no delay to the other steps).

It is possible that CC may itself be viable before this point by taking on whatever business it can attract. But this is the answer to Q1 (i.e. the first of the two questions set out at the beginning of this section). What is needed is for CC to develop the sort of business that can replace HCA, including premier level oncology services, and in this the tight timetable assumed by the CMA is wholly unrealistic.

This analysis further assumes that HCA is entirely passive and non-strategic in allowing CC to build out its business [X].

As such AXA PPP considers that the estimate of [X] years above is conservative. [X]

To summarise, the CMA assumes that CC entry will be the most significant driver to neutralise the AEC within five years of divestment. AXA PPP considers the CMA's view on the speed with which CC could constrain AEC to be irrationally optimistic. AXA PPP's view is that a timeframe of at least [X] years is the lowest in which CC could be in a position to displace HCA, and even that on highly optimistic assumptions (including an assumption that CC will develop oncology facilities in the short term, which as noted in section 2 above does not appear to be the case on the evidence before the CMA).

### 3.4 Costs and efficiency losses

AXA PPP notes that the CMA has made provision for some losses of economies of scale as a result of HCA being required to divest a significant proportion of its central London operations. The CMA also makes provision for transaction and reorganisation costs of implementing the Remedy (amounting to around £16 million). AXA PPP considers that the scale economies, on the one hand, and transaction / reorganisation costs, on the other, are fundamentally different.

#### ***Factor 8: Transaction costs will not affect forward looking pricing***

Whereas scale economies, if they cannot be regained, may impact on pricing on a forward looking basis, and hence impact consumers, the transaction / reorganisation costs are one-off fixed and sunk costs that will not affect forward-looking pricing. The argument that the costs of implementing a remedy will influence future market prices would be no different to arguing that the costs that HCA (or indeed any other party) has incurred in professional fees during the CMA's current investigation will affect future pricing. They are merely a loss of producer surplus from a firm that has enjoyed – over a sustained period of

time - returns significantly above the cost of capital (even excluding capital gains), and whose market position constitutes an AEC. Therefore to accord significant weight to these in determining the outcome of the investigation is, in AXA PPP's view, misguided.

**Factor 9: Lost scale economies are over stated**

With respect to lost scale economies, AXA PPP considers that the CMA has afforded too much respect to HCA's claims, for a number of reasons:

- To the extent that some of the overheads relate to the administration of the divested facilities, HCA could voluntarily offer to include these with the divested assets.
- HCA's business (in central London, the UK more generally and elsewhere) continues to expand, and it is therefore likely that resources could be re-applied within the business in a short period of time.
- The Remedy itself will result in a reduction of market prices, and may therefore be expected to lead to a corresponding increase in demand (over and above the exogenous market growth trend).
- To the extent that scale economies are important, this will likely have an impact on the identity of the bidder(s) for the divested assets. In particular, organisations that believe that adding the divested assets to their existing portfolios, whether in the UK or worldwide, will, other things equal, be likely to have a competitive advantage in any divestment auction, which would be expected to counteract any deemed effect that reduces the Price Benefit of the Remedy.

AXA PPP therefore considers that there are no grounds for relying on the "downside case" set out in the CMA's analysis, and that the base case is also likely to be conservative in the circumstances.

### 3.5 Conclusion on the NPV Analysis

According to the CMA, taking account of the "significant uncertainty over the elements of our NPV calculation, we could not form an expectation that the benefits of a divestiture remedy would outweigh its costs." The CMA adds that it is "mindful of the fact that we can no longer place as much reliance on other aspects of our evidence base as at the time of the Final Report. In particular ... our revised IPA no longer allows us to conclude on the size of the price difference..."<sup>23</sup>

As set out in AXA PPP's response to the CMA's provisional findings, and discussed further during the hearing on 16 December 2015, in AXA PPP's view the CMA's hesitation in this respect is unfounded. AXA PPP has provided a range of evidence as to the extent of the price gap between HCA and TLC, and has provided further evidence showing that price differences cannot be explained by reference to quality and / or "complexity" differences.<sup>24</sup> AXA PPP has not seen further evidence from HCA or the CMA to dispute its submissions, and in its view the CMA is perfectly able to rely on the weight of evidence before it.

<sup>23</sup> PDR paragraph 2.58.

<sup>24</sup> See, e.g. AXA PPP submission of 24 July 2015, page 2; AXA PPP submission of 5 August 2015, page 4; AXA PPP submission of 25 September 2015; AXA PPP Response to Provisional Findings and Notice of Possible Remedies (4 December 2015), Section 4.2; Transcript of Hearing on 16 December 2016, page 26; and AXA PPP Letter of 21 January 2016, page 2.

Indeed, AXA PPP believes that the CMA has fundamentally misunderstood the impact of uncertainty in this case. As discussed above, in AXA PPP's view the prospect of CC constraining prices materially before 2022 is [~~low~~] - the probability of it taking longer is very likely and the benefits of the Remedy become very large as that timeframe extends. The uncertainties are therefore highly asymmetric and overall clearly point in favour of forming an expectation that the benefits of the Remedy would outweigh its costs, not against.

In summary, therefore, the analysis above suggests that on the probability of entry, the Price Benefit of the Remedy, and the Time Frame of the Price Benefit, the CMA has made erroneous assumptions that bias it towards an extreme outcome. AXA PPP believes that all of its critiques of the CMA's NPV approach are compelling, and accordingly that appropriate adjustment must, on any reasoned and reasonable analysis, be made to the CMA's NPV analysis.

Of the numerous points AXA PPP raises, some of these are likely to be sufficient on their own to generate a positive NPV (compared to the base case on lost scale economies, a 3% Price Benefit, and a five year Time Frame which is accorded significant weight by the CMA); in other cases a combination of a (usually small) number of these points will lead to the same result. But even if the CMA were to take issue with some (or even many) of these points, AXA PPP considers that it is almost inconceivable that a balanced judgement would not lead to a significantly positive overall NPV, thereby demonstrating that the Remedy is proportionate.

As for the CMA's overall NPV conclusion to the contrary, AXA PPP's view is that:

- the CMA's analysis on a variety of individual issues is either wrong, or at best (highly) optimistic as to aspects of CC entry, and (highly) pessimistic as to aspects of the Remedy, which are issues on the merits for the CMA to consider before reaching a final decision; and
- taken in aggregate, the combination, in essence, of: (i) cumulative optimism on CC's entry impact and (ii) cumulative pessimism on the Remedy means that the PDR's proportionality analysis has passed the point at which its overall conclusion is reasonable and sustainable.<sup>25</sup>

#### **4 Other remedies are insufficient to address concerns**

AXA PPP has consistently supported the remedies implemented by way of the Private Healthcare Market Investigation Order 2014. However, as the CMA acknowledges, these remedies were not (with the exception of the PPU remedy) aimed at addressing the market power of private hospital operators, and are ill equipped to address the CMA's continuing concerns. Furthermore, AXA PPP continues to have concerns about the effectiveness of the remedies contained in the Order, as described further below.

##### **4.1 PPU remedy**

As the CMA will recall, AXA PPP repeatedly requested that the CMA give further consideration to the procedural framework to be applied to the PPU remedy, and in particular emphasised the importance of enabling third parties to comment on any CMA

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<sup>25</sup> This is independent of the fundamental critique in Section 2 relating to oncology, which AXA PPP considers renders the entire approach of the PDR unreasonable, irrespective of the details of the NPV analysis.

investigation prior to a final decision by the CMA (as is standard practice in merger cases). These recommendations were not adopted.

In AXA PPP's view, the single case to date under this remedy<sup>26</sup> highlighted the shortcomings of the CMA's procedure. No information was provided to the public, nor to interested parties, prior to the publication of the decision. The CMA therefore appears to have relied entirely on the submissions of the parties involved, without providing any opportunity for any other interested party to comment. AXA PPP remains concerned that this failure to consult may compromise the proper investigation of any future cases, and would urge the CMA once more to consider adopting a more transparent procedure, which would be consistent with the CMA's overall transparency objectives.

[X]

#### 4.2 Incentives remedy

AXA PPP remains concerned that the incentives remedy is vulnerable to circumvention.

[X]

AXA PPP also notes that paragraph 1.76 of the PDR states that

“... in our Final Order, we put in place a remedy to prohibit a range of clinician incentives, which could distort clinicians' motivations to refer patients to the best hospital facility for their needs. As discussed in the Final Report, we consider that, in addition to its intended purpose, this remedy should also limit the ability of HCA to prevent competitors from attracting and retaining consultants in order to compete across a full range of services”.

However, this statement appears to be at odds with the comment at 1.54 of the PDR that:

“HCA told us that it had approached consultants with a view to implementing an employment model to retain their services”.

[X]

#### 4.3 Information remedy

AXA PPP notes that the publication of data to support the information remedy will not start to be implemented until next year. It remains to be seen how effective the remedy will be in addressing customer information asymmetry and aiding decision-making. AXA PPP believes that this remedy is unlikely, however, to have a significant impact on HCA's market power in central London.

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<sup>26</sup> PPU/001/15 Private patient unit arrangements between HCA International Limited and University Hospital of South Manchester NHS Foundation Trust.