



N A B A R R O

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Competition & Markets Authority
Victoria House
Southampton Row
London
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13 April 2016

Our ref: BQ/CKM/CKM/H2700-37

Dear Ms Moore

HCA – Private healthcare market investigation remittal - PDR

We enclose HCA's response to the CMA's Provisional Decision on Remedies ("PDR") of 22 March 2016.

HCA welcomes the CMA's provisional decision not to impose any further remedies in addition to those which have already taken effect under the Private Healthcare Market Investigation Order 2014. The CMA has correctly concluded that the benefits of a divestment remedy could not be expected to outweigh its costs and that therefore divestment would be a disproportionate remedy. HCA welcomes and supports the CMA's view that it is not justified in seeking the divestment of any of HCA's hospitals.

HCA however has a number of comments on the CMA's analysis, and focuses its response on five specific aspects:

(i) **The CMA is not justified in making any AEC finding with regard to central London**

HCA maintains its view that there is no basis for an AEC finding in relation to either insured or self-pay patients. This is now even clearer in view of the fact that: (i) the CMA acknowledges that it can no longer rely on the IPA to conclude that HCA's prices are higher than TLC's, and (ii) the CMA now accepts that there is significant new entry and expansion underway. There is therefore no longer any evidence that there are structural features of this market which restrict competition. In this light, the correct and proper outcome of this remittal would be a finding that there are no structural AECs in central London.

(ii) **The CMA correctly concludes that Cleveland Clinic will shortly be entering the market, but it does not place sufficient weight on all the evidence of new entry and expansion in central London**

New entrants include Barts PPU, Spire, VPS, a new hospital in Wigmore Street, as well as numerous specialty clinics such as Fortius, Nuada and Optegra. In addition, a number of existing operators (including TLC, King Edward VII, and several NHS PPUs) are in the process of expanding their facilities. New entry and expansion is expected to add over 600 inpatient beds, representing around 35% of current inpatient capacity, in the next three to five years. This is a substantial change in the market which will significantly increase the competitive constraints on HCA. It also demonstrates that there are no significant structural barriers which deter either new entrants from establishing new facilities or existing operators from expanding their hospitals. It is striking that just in the last 12-15 months of this remittal

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inquiry, there have been four announcements of new hospital entry and it is highly likely that there will be others in future.

(iii) **The CMA cannot rely on its profitability analysis as an alternative to the IPA to support an AEC finding**

HCA welcomes the CMA's revisions to its profitability analysis to take into account more appropriately the value of its property portfolio, as well as the CMA's decision to assess profitability of UK patients separate from international patients. However, there are still a number of flaws in the CMA's profitability analysis, such as the failure to take account of HCA's leased property portfolio and to account for the value of HCA's brand, which means the CMA overstates HCA's economic profit. While HCA welcomes the CMA's recognition that its estimates of benefits from a divestment remedy are uncertain, because they are based on a profitability analysis that requires substantial judgement and assumption, HCA is concerned that the CMA continues to place too much weight on this evidence. The CMA cannot adequately support its assumption that its estimate of HCA's economic profit (which in any case is overstated) is the result of a lack of competition, and is incorrect to use this estimate to quantify the benefits of a potential divestment remedy.

(iv) **The CMA is wrong to suggest in its assessment of the divestment remedy that divestment could in principle be an "effective" remedy**

In the recent litigation, the Tribunal emphasised that the CMA would need to demonstrate that HCA's prices are higher than those of its competitors on a like-for-like basis, and that there is a causal link between HCA's prices and its share of supply. The CMA has not been able to substantiate either of these propositions. It points to no evidence to show that the divestment of any of HCA's hospitals would lead to lower insured prices for any given level of quality and range of clinical services. On the contrary, HCA's analysis of spare capacity provides firm evidence that there is already sufficient capacity available to PMIs to offer products which exclude HCA hospitals. In that light, the CMA cannot claim that a divestment remedy is necessary to lower prices by the creation of alternative capacity. The CMA even accepts that HCA's spare capacity analysis is "informative", and the CMA does not cite any specific evidence to demonstrate that capacity is constrained.

(v) **The CMA is absolutely right to conclude that divestment would be a disproportionate remedy, and it has in fact grossly underestimated the costs and adverse consequences of a divestment remedy in its assessment of the NPV**

The costs which would arise from divestment are substantially higher than those estimated by the CMA. In this remittal inquiry, HCA has undertaken an extensive and detailed analysis of the one-off costs and the loss of economies of scale which would flow from a divestment of the hospitals identified by the CMA. HCA is submitting updated estimates which show that these costs significantly exceed those which the CMA has used in its calculations. Furthermore, the CMA has made a number of further significant errors in its NPV model, in particular in its calculation of HCA's relevant revenues and in the period over which losses of economies of scale are likely to arise. The CMA claimed in its press release accompanying the PDR that its decision was "*finely balanced*", but an NPV based on the correct figures puts beyond doubt that the costs of divestment would far exceed any alleged benefits on any reasonable assumptions used by the CMA. The NPV is negative under any plausible assumptions regarding new entry, price benefits or the costs of divestment.



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In the final stages of the original private healthcare market inquiry in 2014, the CMA withdrew its insured AEC finding in respect of non-London operators, because it recognised that the weight of evidence, and specifically the CMA's analysis of prices in the IPA, could not support its original views. HCA urges the CMA similarly to recognise that there is no evidentiary basis for an AEC finding in central London. It would be unreasonable and discriminatory for the CMA to maintain its insured AEC finding in central London, notwithstanding the fact that there are lower levels of concentration and lower barriers to entry in central London than in many other private healthcare markets in the UK.

HCA trusts that its comments will be given careful consideration by members of the Inquiry Group and that these will be reflected in the Group's Final Report which concludes this remittal.

HCA's response addresses the CMA's position as it is set out in the PDR. HCA would expect to be properly consulted in the event that there is any significant change to the CMA's position in its consideration of remedies.

HCA's submission is confidential and includes information which falls within confidentiality ring 1. We will prepare and submit in due course a non-confidential version.

If HCA can be of any further assistance to you or your colleagues, please do not hesitate to let us know.

Yours sincerely

Cyrus Mehta
Partner
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**HCA'S RESPONSE TO THE
CMA'S PROVISIONAL DECISION ON REMEDIES**

13 April 2016

1. INTRODUCTION

- 1.1 HCA submits its response to the CMA's Provisional Decision on Remedies ("PDR") dated 22 March 2016.
- 1.2 HCA has already submitted detailed responses, both to the CMA's Provisional Findings ("PFs") and to the CMA's Notice of Possible Remedies ("Remedies Notice") of November 2015. HCA does not propose to repeat points it has already extensively set out, either in relation to the CMA's findings on adverse effects on competition ("AEC"), or to its proposals for remedies. Where appropriate, HCA cross-refers to its earlier submissions.
- 1.3 HCA has prepared this submission within the short period which the CMA has laid down for responses to its consultation. HCA reserves its rights to supplement its submission with further comments or evidence.
- 1.4 The structure of HCA's submission is as follows:
- **Section 2** – Summary
 - **Section 3** – AEC findings
 - **Section 4** – New entrants
 - **Section 5** – The CMA's updated profitability analysis
 - **Section 6** – Divestment is not an effective remedy
 - **Section 7** – Divestment is not a proportionate remedy
- 1.5 The following annexes also form part of this submission:
- **Annex 1** – One-off costs of divestment
 - **Annex 2** – EV to EBIDTA analysis
 - **Annex 3** – Losses of economies of scale
 - **Annex 4** – Losses of investment and quality

2. SUMMARY

- 2.1 HCA welcomes the CMA's provisional decision that divestment is not a proportionate remedy. As HCA has consistently argued throughout the CMA's investigation, the divestment of one or more of its hospitals would be an extremely intrusive and damaging measure. A divestment would create substantial and long-lasting economic costs, and would give rise to serious risks to innovation, quality and clinical care. HCA wholeheartedly agrees that the costs of divestment, in terms of, *inter alia*, transaction costs, reorganisation costs and losses of economies of scale, would outweigh any alleged benefits. Indeed, as discussed below, the CMA has significantly overstated the benefits and significantly underestimated the costs of divestment, thereby overstating the net present value ("NPV") of a divestment remedy.
- 2.2 HCA also strongly supports the CMA's provisional decision that there is no case for any remedies other than those which have already been imposed in the Private Healthcare Market Investigation Order 2014 and which the CMA expected would each deliver increased competition in their own right.¹
- 2.3 HCA however comments as follows on five specific aspects of the PDR.

(i) Lack of AECs

- 2.4 The CMA bases the PDR on its provisional AEC finding in its PFs, while noting that it has not made a final decision regarding the existence or form of any AEC and/or any resulting customer detriment. HCA maintains its view that there is no basis for any structural AEC findings in relation to either insured or self-pay patients in central London. On the CMA's own analysis, there is now no case for an AEC finding:
- The CMA accepts in the PDR that it cannot determine with any degree of confidence either (i) that HCA's prices are higher than TLC's on a like-for-like basis or (ii) that HCA's prices are linked to its share of supply. Since the allegation of higher pricing was central to the CMA's AEC finding, that finding can no longer be sustained.
 - The CMA acknowledges in the PDR that there will be further significant new entry into central London over the next three to five years. On current figures, the market is set to expand by at least one-third. The CMA can therefore no longer assert that there are high barriers to entry and expansion which deter new investment.

(ii) New entry

HCA agrees with the CMA's findings concerning the Cleveland Clinic's imminent entry into the market. However, there are a number of other new entrants in central London including

¹ Final Report, paragraph 11.231.

the Barts PPU, VPS, a new hospital in Wigmore Street, and numerous specialty clinics such as Optegra, as well as potential new entry by Spire. The PDR notes the evidence of this expected entry but places limited weight on it. All of these developments are highly relevant and should be taken into account in assessing the competitive dynamics of the market over the next three to five years. As stated above, new entry/expansion on this scale demonstrates that there are no significant factors which deter investors from establishing and expanding hospital facilities. It also shows that HCA is subject to increasingly strong competitive constraints in central London from both actual entry and the threat of entry.

(iii) The CMA's updated profitability analysis

2.5 The CMA has updated its profitability assessment for the purpose of quantifying the benefits of a divestment remedy.

2.6 HCA welcomes the CMA's decision to update HCA's ROCE by adjusting HCA's property valuations and by allocating HCA's ROCE to UK and international patients separately. HCA also welcomes the CMA's recognition of the inherent uncertainty surrounding the assumptions behind any profitability analysis, and therefore the need for caution when considering any estimates of benefits based on this analysis.

2.7 However, HCA is still concerned that too much weight is being placed on profitability analysis in support of the CMA's AEC finding and in quantifying the benefits of a potential divestment remedy. Specifically:

- The CMA has not linked economic profits with a lack of competition. Profitability also reflects efficiency and a reward for investment, which are important in a well-functioning market.
- The CMA recognises problems with using profitability evidence in other cases. The CMA's approach in the remittal inquiry is in contrast to the CMA's recent PDR in its energy market investigation, which put more weight on pricing, rather than profitability, analysis.
- The CMA's reliance on its estimate of HCA's economic profitability in the PDR is inconsistent with other parts of its analysis and evidence base, including the fact that HCA has lower profit margins than TLC, yet the CMA does not find that TLC earns excess profits.

2.8 Additionally, there remain some flaws and errors in the CMA's updated profitability analysis, which cause the CMA to significantly overstate HCA's economic profits. These include:

- Errors in the updated ROCE analysis, specifically the exclusion of HCA's leased properties (contrary to the new IFRS 16 leases standard) and a failure to assign value to some of HCA's key intangible assets.

- Incorrect treatment of the WACC calculation, including incorrect beta sampling frequency, problems with proxy betas and errors in the CMA's treatment of inflation.

(iv) Divestment is not an effective remedy

2.9 HCA strongly disagrees with the CMA's view that divestment would be an *effective* remedy even if the provisional AEC findings in the PFs were justified:

- There is no evidence whatsoever that a divestment of any hospital would lead to a reduction in prices for any given level of quality or range of services.
- As the CMA now acknowledges, the IPA does not provide a sufficient basis for the CMA to conclude that there is any price difference between HCA and TLC on a like-for-like basis and/or that any price differences are as a result of HCA's share of supply.
- The CMA seeks to rely on its profitability analysis to assess the price/revenue impact of a divestment. However, for the reasons set out above, the CMA's profitability analysis shows no link between HCA's level of economic profits or prices and HCA's market share. In addition, the CMA's analysis of HCA's economic profitability remains flawed. The CMA cannot therefore reasonably conclude from its profitability assessment that divestment would lead to a reduction in prices for any given level of quality or range of services.
- The CMA has shown no causal link between HCA's prices and its share of supply. Despite this, the CMA reiterates that the purpose of a divestment remedy is to create "*incremental non-HCA capacity [which] would make it easier for PMIs to offer credible products which did not rely on including HCA facilities*" (paragraph 2.5, PDR). The CMA notes that HCA has provided evidence that there is already sufficient spare capacity in central London but the CMA states that there are "*conflicting pieces of evidence*" which create "*some uncertainty about whether this represents convincing evidence of suitable spare capacity that would allow the insurers to move entirely away from HCA if they so wished*" (paragraph 2.34, PDR). However, the CMA has not found any evidence to suggest that PMIs are unable to switch their subscribers to alternative providers on grounds of a lack of available capacity. Furthermore, recent submissions by the PMIs do not suggest that there is a lack of spare capacity in London but instead show that PMI policyholders desire the ability to be treated at HCA's hospitals because of its reputation for higher quality care.

(v) Divestment is not a proportionate remedy

2.10 HCA welcomes the view of the CMA that divestment is not a proportionate remedy, and agrees with the decision not to impose an intrusive and costly remedy. However, in HCA's

view, the case against divestment is even stronger than presented by the CMA, and the CMA overstates the NPV of a divestment remedy in four ways.

2.11 First, **the CMA's NPV model contains material calculation errors which overstate the NPV of a divestment remedy**. The CMA's estimation of the benefits and costs of divestment contain calculation errors that, when corrected, strengthen the conclusion that under a range of plausible scenarios the NPV of divestment is negative. HCA notes that:

- The CMA's NPV calculations are based on a material overstatement of HCA's 2015 UK self-pay and insured inpatient and day-case revenues, due to an apparent error in its calculations.
- The CMA is inconsistent in its application of the loss of economies of scale.

2.12 Fixing only these errors leads to NPVs that are negative in the CMA's base and downsides cases for the 5 year scenario, with both a 3% and a 6% revenue reduction, the scenarios on which the CMA places most weight (paragraphs 2.52 and 2.53, PDR); it also substantially reduces the NPV in all scenarios.

2.13 Second, **the CMA does not take into account the impact of further litigation on the date at which divestment would occur**. A conservative estimate would be that a divestment would be delayed by at least 12 months, commensurately shortening the period over which any benefits would be realised before expected entry.

2.14 Third, **the CMA overstates the benefits of a divestment remedy**. HCA notes that:

- The CMA has no evidence linking a divestment to any improvements in market outcomes.
- The CMA overstates HCA's economic profitability, which is used by the CMA to quantify the benefits of a divestment remedy.
- The CMA disregards the future impact of the information remedy imposed following the original inquiry.
- The CMA inappropriately puts weight on NPV scenarios yielding benefits beyond 5 years.

2.15 Fourth, **the CMA underestimates the costs of a divestment remedy**. HCA welcomes the CMA's recognition that there will be substantial transaction costs, reorganisation costs and losses of economies of scale resulting from a divestment. However, HCA notes that the CMA has not updated its estimates of these costs from the original inquiry, instead applying (with some modifications) its estimates from the Final Report. Consistent with HCA's submissions, the costs in a number of the categories considered by the CMA have increased:

- The CMA excludes or underestimates a number of one-off costs that would result from a divestment in its NPV calculations.
- The CMA underestimates the losses of economies of scale that would result from a divestment in its NPV calculations.
- When updating only the losses of economies of scale that the CMA accepts to reflect HCA's actual common costs in 2015, and making no further adjustments, there are higher economies of scale losses in the CMA's NPV model.
- The CMA incorrectly excludes losses of investment at the divested hospitals and at HCA.

2.16 It is clear from the results of the NPV assessment that, under no range of plausible assumptions regarding entry, price benefits, or the costs of divestment, is the NPV of a potential divestment remedy positive. Therefore any of the proposed divestment packages would be grossly disproportionate and would be wholly unjustified.

3. AEC FINDINGS

- 3.1 The CMA notes in the PDR (paragraph 1.13) that it has not made a final decision regarding the existence and/or form of any AEC and/or resulting customer detriment. However, the CMA's discussion of remedies in the PDR is based on the provisional AEC findings in the PFs of November 2015. The CMA states that the PDR considers what remedies should be imposed "*to address the AECs as set out in the PFs*" (paragraph 1.14, PDR).
- 3.2 HCA has made extensive submissions and has also submitted considerable evidence in response to the PFs.² It is not clear from the PDR whether, and to what extent, the CMA has considered and taken account of these in considering remedy options.
- 3.3 HCA strongly believes there is no basis for the CMA's view that there are structural features of the market which lead to an AEC for insured and/or self-pay patients in central London, and hence no basis for any remedies. There are no AECs that require or justify any remedy measures.
- 3.4 HCA's views on the AEC findings in respect of both insured and self-pay patients have been extensively set out in previous submissions, and are briefly reiterated as follows:

(i) ***Central London is highly competitive***

- The CMA makes heavy reliance for its AEC finding on HCA's high market share, despite HCA's share of bed capacity being just 41% and substantially lower now than previously identified by the CMA.³ In any event, an alleged high market share is not in and of itself sufficient for a finding of weak competitive constraints, as HCA's market share is consistent with it competing successfully in a competitive market.
- HCA faces substantial competition *inter alia* from numerous independent providers, NHS PPU's, specialist day case and outpatient clinics, hospital providers outside central London, and overseas providers. Such competition is only enhanced by the implementation of the CMA Private Healthcare Market Investigation Order 2014.⁴
- There has been strong growth in the market of around 8% per annum since 2006.⁵ Many of HCA's competitors have also significantly grown revenue. NHS PPU's have grown by over 20% since 2011/12 (and now account for 25% of

² HCA's response to PFs dated 4 December 2015, and subsequent correspondence with CMA.

³ HCA's response to PFs, paragraph 2.40.

⁴ Final Report, 11.231.

⁵ HCA's response to PFs, paragraph 2.58.

beds in central London) and have published ambitious growth targets over the next few years.⁶

(ii) ***There are no major barriers to entry***

- There continues to be significant new entry and expansion in central London. The purported barriers identified by the CMA – high sunk costs and long lead times, land availability and the planning regime – have not in fact deterred new investment in this market.
- At numerous stages of this market investigation, HCA has pinpointed a number of potential hospital development sites that would be available in the open market, some of which would not require change of use planning permission or a significant refit.⁷
- There have been notable planning policy developments in Westminster which would assist developers in introducing new private healthcare premises.⁸
- In the PDR, the CMA expressly recognises that there is imminent new entry by the Cleveland Clinic, VPS, Barts PPU, and a new hospital on Wigmore Street (paragraphs 1.25 – 1.47, PDR), and there are likely to be other entrants into the market too.
- The CMA has rightly acknowledged that entry by Cleveland Clinic is likely to occur within five years and that this represents a substantial new entrant in London. Such planned entry should lead the CMA to reconsider its original view that large-scale new entry in central London is unlikely.
- As discussed below, it is likely that there will be at least one-third new non-HCA capacity over the next five years. It is clear that none of the alleged barriers identified by the CMA have deterred any of these operators from making significant investments in establishing new hospital facilities. In the light of this evidence, the CMA cannot logically maintain its position that there are structural barriers to entry and expansion which adversely affect competition.

(iii) ***HCA faces strong bargaining power from the insurers***

- As a result of recent consolidation in the PMI industry, there are now just three significant PMIs (Bupa, AXA PPP and Aviva/VitalityHealth, the joint purchasing group).
- HCA has demonstrated that there is sufficient available capacity in central London (however that may be measured) to allow PMIs to switch all their patients away from HCA if they wish to do so. This view is corroborated by PMI

⁶ *Ibid.*

⁷ For example, see paragraphs 3.5 – 3.9 of HCA's response to PFs.

⁸ HCA's response to PFs, 3.24.

submissions indicating that the ability to move their policyholders is not constrained by a lack of alternative hospital capacity.

- The PMIs, the principal buyers in this market, exercise strong negotiating power over private hospitals, particularly given the recent consolidation in the PMI market. This is driven, in part, by HCA's reliance on their revenues to cover the significant fixed costs of its business. The PMIs have reinforced their position in recent years by developing and exploiting "managed care" strategies such as open referral, service line tenders and restricted networks.

(iv) ***There is no evidence that HCA charges higher prices than its competitors***

- The Tribunal previously emphasised 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, and that issues regarding whether - in constructing the IPA - prices have been correctly measured and comparisons have been performed on a suitable like-for-like basis"*.⁹
- The CMA now recognises that that the IPA provides no evidence that either (i) there is any price difference between HCA and TLC when prices are compared on a like-for-like basis, or (ii) there is any causal link between concentration and pricing in this market, therefore neither evidentiary component highlighted by the Tribunal is satisfied.
- The PCA, which provides the basis for the self-pay AEC, is similarly flawed and provides no grounds for linking HCA's self-pay prices and its share of supply.
- The CMA now seeks to rely on its profitability analysis to support its view that HCA's prices are higher than the competitive level. Even this is expressed very tentatively in that the CMA considers that increased competition *"might"* reduce prices towards the lower end of the range of the CMA's assumptions. However, as discussed in Section 5 below, there is no basis whatsoever for linking HCA's profitability with pricing above the 'competitive level' or any alleged AECs, and a careful examination of causality is again notably absent from the CMA's findings.
- Throughout this inquiry, the CMA's allegation of HCA's "higher prices" has been central to its AEC finding. However, the CMA cannot rely either on the IPA or on its profitability assessment to determine with any confidence either whether there is a difference compared with TLC's prices or what the price difference is. The only logical consequence is for the CMA to recognise that there is no longer any basis for its AEC findings in central London.

⁹ *HCA v CMA*, [2014] CAT 11, paragraph 37.

(v) ***There is vigorous competition over quality/range***

- The CMA has recognised that there is sufficient competition in central London over quality and range of clinical services. However, the CMA has still not explained why it believes the same competitive disciplines that are driving competition on quality/range are not also driving price competition. There is no reason to believe that while competition over quality/range is satisfactory, competition over price is not.

(vi) ***Central London is far more competitive than markets outside London, where the CMA has made no insured AEC finding.***

- The CMA cannot conceivably justify making an AEC finding in relation to insured patients in central London when it has made no such findings in markets outside central London which (on its own analysis) are characterised by higher levels of concentration and greater barriers to entry.

3.5 In summary:

- HCA competes in a highly competitive market with seven other independent hospital operators and 11 NHS PPU operators, and central London has the highest number of competing fasciae of any areas in the UK.
- There is no evidence that HCA's prices are higher than its competitors when compared on a like-for-like basis, let alone as a result of its share of supply.
- The market is rapidly growing as a result of increased demand for tertiary services, and many of HCA's competitors have expanded.
- There is substantial new entry underway in the next five years, as the Cleveland Clinic, VPS, and Barts, amongst others, are establishing new facilities.
- PMIs, unlike HCA, have credible "outside options" if they wish to move their subscribers to non-HCA hospitals and there is sufficient alternative capacity available to them to do so.
- The market has delivered, and is continuing to deliver, innovation, high quality and an increasing range of clinical services.

3.6 These are all signs of a competitive, dynamic and well-functioning market. There is no evidence whatsoever that the market operates to the detriment of consumers.

3.7 In the press release accompanying the PDR, the CMA states "*We still believe the market requires more competition*". It is not clear what finding in the PFs or PDR supports the view that the market "requires" more competition. There are 19 private hospital operators in central London, many of them have grown in recent years, and are continuing to grow, and

there is more than sufficient alternative capacity available if PMIs wish to switch. The CMA's own price analysis provides no evidence that HCA's prices are any higher than those of its competitors. The CMA has also acknowledged that there is sufficient competition between central London operators over the quality and range of clinical services. There is in any event "more competition" underway, with the market set to expand by at least a third. The CMA expresses no such view that markets outside central London "require" more competition, even though many localities have a monopoly or duopoly provider and are characterised by even higher barriers to entry.

- 3.8 In the light of the above, the CMA cannot reasonably conclude that there are any AECs in central London in respect of either insured or self-pay patients. In the final stages of its original inquiry in 2014, the CMA acknowledged that the IPA provided no evidence of any systematic price differences between operators for insured patients outside central London, and the CMA accordingly withdrew its proposed insured AEC finding in relation to non-London operators. It follows that the correct and proper outcome of this remittal is for the CMA similarly to conclude there are no structural AECs in central London for either insured or self-pay patients.

4. NEW ENTRANTS

4.1 The CMA correctly concludes (paragraph 1.85, PDR) that "*large scale entry seems likely to take place by early 2020, with such entry being likely (in combination with other non-HCA hospitals) to result in an effective competitive constraint on HCA*". HCA has consistently argued that investors are being increasingly attracted to central London and that the growth in tertiary services creates significant new investment opportunities which encourages new entry and expansion.

4.2 The CMA rightly acknowledges the imminent entry of the Cleveland Clinic and the significant impact this will have (and is already having) in central London. However, there is significant new entry and expansion by a wide range of other operators which is also contributing to the competitive landscape in central London. The CMA does not take sufficient account of the combined effect of all these new entrants in re-shaping the market in central London.

4.3 HCA comments as follows on the CMA's views in the PDR regarding new entrants.

Cleveland Clinic

4.4 HCA agrees that "*Cleveland Clinic is a credible potential entrant, with a well thought-out strategy to enter the central London market and with firm and relatively well advanced plans*" (paragraph 1.59, PDR).

4.5 As HCA has pointed out, the Cleveland Clinic has already engaged [redacted] to launch its new hospital and is actively marketing itself to consultants. It is offering to employ consultants to deliver services, and this employment model is gaining interest with consultants.

4.6 HCA agrees that it is highly likely that Cleveland Clinic will obtain planning consent to develop 33 Grosvenor Place as a hospital. Cleveland Clinic is likely to have already undertaken confidential, pre-application discussions with the City Council, given the levels of investment proposed.

4.7 HCA agrees that a period of three and a half years would be more than adequate to complete the hospital, even allowing for a delay in planning consent. Having regard to its own experience in carrying out fit-outs in its buildings, HCA believes that three to three and a half years would be reasonably achievable. 33 Grosvenor Place is a completely renovated modern building. It will only require internal refitting and reconfiguration for use as a hospital, and this will not necessitate substantial construction or civil engineering works. It is therefore reasonable to assume that the hospital will open up by late 2019/early 2020 at the latest.

4.8 The CMA states (paragraph 1.75, PDR) that Cleveland Clinic intends to provide surgical oncology, but not medical oncology, although it would adapt its services to serve the market. HCA agrees with the CMA that Cleveland Clinic would in any event easily and rapidly be

able to expand to provide the full range of oncology services. HCA has itself commenced new oncology services at its hospitals within a period of 12 - 18 months:

- [X].
- [X].
- [X].

4.9 As the CMA rightly notes, a new entrant will have a competitive impact even prior to opening a new hospital. 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. Cleveland Clinic will, as is usual, be negotiating its own PMI contracts and soliciting interest among consultants well in advance of opening.¹⁰ [X]. Furthermore, such entry will take place in the context of increasing consolidation in the PMI market, for example, following AXA PPP's acquisitions of SimplyHealth and Universal Providence, Aviva's joint venture with VitalityHealth, and Bupa's acquisition of Benenden.

4.10 Cleveland Clinic's entry in central London is further evidence that there are no significant barriers to entry or expansion:

- (i) Cleveland Clinic has reportedly paid a consideration of £250 million for the purchase of the site. The CMA notes that "*Cleveland Clinic has invested a considerable amount of time and money in developing its strategy, and laying the ground work, for entry in central London*" (paragraph 1.29, PDR). The CMA has previously asserted that the combination of high sunk costs and long lead times of setting up a new hospital is a barrier to entry, but there is no sign that these factors have deterred or discouraged Cleveland Clinic from committing substantial funds and resources to opening a new facility in central London.
- (ii) The Cleveland Clinic has acquired a large, prime central London site of 191,000 square feet, suitable for a hospital of 215 beds. This demonstrates that there are suitable sites available for large-scale new entry. It is consistent with all the evidence which HCA has previously provided about the availability of large properties which are suitable for hospital developments.
- (iii) As the CMA correctly observes, it is "*reasonably likely*" that Cleveland Clinic will obtain C2 planning consent for its conversion of this site for hospital use, and therefore it is incorrect for the CMA to allege in the PFs that planning constraints are "*a factor*" of any significance in increasing barriers to entry.

¹⁰ In paragraph 5.21 of the PFs, the CMA noted that "*some insurers were now agreeing to recognise new facilities opened by hospital operators in central London, prior to such facilities being opened (or even under consideration)*".

VPS

- 4.11 The CMA considers (paragraph 1.66, PDR) that entry by VPS is "*uncertain*" and therefore it has "*not placed significant weight on this prospective entry in assessing the effectiveness and/or proportionality of our remedies*". In HCA's view, there is clear evidence that VPS is committed to redeveloping the Ravenscourt Park Hospital within a short timeframe.
- 4.12 VPS publicly announced its plans to open a new facility on this site in 2017, and it has also confirmed to the CMA that it has "*planned to enter the central London market via the redevelopment of the Ravenscourt Park Hospital*" (paragraph 1.65, PDR). The CMA correctly notes that VPS is a large hospital group with a proven track record of building and operating large scale hospitals.
- 4.13 The CMA states that VPS is in "*active discussions*" (paragraph 1.39, PDR) with CCAG over the lease of the site, [§].
- 4.14 The CMA states that if VPS were unable to acquire this site, it would have to search for an alternative "*which could take a significant period of time*" (paragraph 1.66, PDR). However, as HCA has demonstrated in previous submissions, there are at any one time several alternative commercial sites which are available for large scale hospital projects.¹¹ The CMA refers to Spire's search for a site, but for the reasons discussed below this is not indicative of the time it would take to find a suitable site. It is clear that VPS has the commitment, funds and resources to enter the market and even if the current negotiations were unsuccessful, it would in due course be able to identify an alternative property.
- 4.15 The alleged "*uncertainty*" expressed by the CMA relates solely to [§]. As the CMA correctly concludes, once agreement is reached entry would be rapid and VPS itself has stated that it intends to open in 2018:
- the building is already configured as a hospital and only requires some refurbishment;
 - C2 planning permission is already in place.
- 4.16 Furthermore, even if VPS were to decide not to proceed with this site, the Ravenscourt Park Hospital would remain available to any other operators wishing to enter the market. It forms a large site with existing hospital buildings which can readily and quickly be put into operation as a private hospital.

¹¹ By way of example, see HCA's submission on the CMA's findings on structural AECs, 1 May 2015, Annex 1, McKinsey Report, *Assessing the availability of London estate for potential new entrants* (27 March 2015); HCA's response to the PFs, paragraph 3.18; HCA's response to the original PFs, paragraph 6.71 and Exhibit 3 (Altus Edwin Hill, statement on property availability); HCA's submission, *Site availability in and around Harley Street*, 18 November 2013; and HCA remedies hearing presentation, 18 February 2014, slide 7.

4.17 The CMA states that the hospital's "*location in Hammersmith might make it less attractive to corporate customers, for example those located in Canary Wharf*" (paragraph 1.80, PDR). There is no basis for this view:

- The CMA has previously found that there is a high degree of geographic overlap in the catchment areas of all of HCA's central London hospitals. [§<]. Since VPS's new hospital intends to specialise in high-acuity, tertiary services such as cancer and brain surgery, amongst other treatments, it would similarly expect to have a broad catchment area into the City including Canary Wharf and beyond.
- There is no evidence to suggest that corporate City-based customers would not be treated in hospitals in other parts of central London, including HCA's Wellington Hospital in north west London and Bupa's Cromwell Hospital in south west London.
- Furthermore, there are a number of major NHS hospitals in the vicinity of this site, namely Charing Cross Hospital, Hammersmith Hospital (Imperial), and Chelsea and Westminster, and others, including St. Mary's and the Royal Marsden, within easy commuting distance. There is therefore a large body of NHS consultants in west London for which Ravenscourt Park would be a highly convenient location for their private practice, which will include a significant number of private, City-based patients.

4.18 VPS is a further case study of how a new operator is readily able to enter the market:

- Again, it shows that sunk costs and long lead times are no deterrent to an investor such as VPA who sees significant growth opportunities in tertiary services in central London.
- Site availability was no barrier – CCAG bought this former NHS site for the purposes of a new private hospital development.
- As with all previous NHS sites, there has been no need to secure a fresh C2 planning consent.

Spire

- 4.19 The CMA finds that Spire is a potential entrant but that *"the likelihood of finding a suitable site and the time frame over which such entry may take place remains uncertain"* (paragraph 1.68, PDR). In HCA's view, the CMA is wrong to conclude that *"The probability of Spire entering the market in the foreseeable future (i.e. the next five years) is low."*
- 4.20 Spire has publicly stated that it has two central London sites *"in early stages of planning"*.¹² It has also indicated that its recent acquisition of St. Bartholomew's Hospital in Cheam *"is part of our strategy to extend Spire's coverage in and around London"*. [§<].
- 4.21 As HCA has previously noted, it is in Spire's commercial interest to delay any announcement as to its precise plans until the conclusion of the CMA's decision in this market inquiry. Spire has pressed for a divestment option, and the CMA needs to be alive to the issue of "regulatory gaming" by third parties. Spire would benefit commercially from a divestment remedy (by weakening HCA as a competitor and through the opportunity to acquire successful hospitals below their full market value) and the CMA should not therefore uncritically accept Spire's assertions about its alleged difficulties in finding an appropriate site.
- 4.22 [§<].
- 4.23 [§<]. It is difficult to reconcile this evidence with the CMA's view that there is a "low probability" of Spire entering the market within this time-frame.

Barts PPU

- 4.24 HCA agrees that the new Barts PPU on the St. Bartholomew's site will be a new entrant within the next three years. HCA notes that Nuffield Health has now been named as preferred provider to design, build, fund and run the PPU.¹³
- 4.25 The CMA states (paragraph 1.83, PDR) that it will be insufficient *"to constrain HCA effectively across a range of specialties given its narrow focus"*. However, the new facility will nevertheless represent an important competitive constraint in the clinical services which it offers:
- The CMA has concluded that each clinical specialty constitutes a separate product market, and has therefore broken down shares of admissions and revenues by specialty. A specialist PPU is obviously an effective competitor within its own

¹² See Spire's half year results for 2014, <https://investors.spirehealthcare.com/media/1084/spire-2014-half-year-results-presentation.pdf>. In Spire's Annual Report, 2014, it is noted that one of Spire's four strategy "pillars" is to *"develop new sites and services, targeting identified growth areas such as radiotherapy and cancer care, but also orthopaedics, cardiac and general surgery, and acquiring or building new hospitals in areas where Spire is underrepresented, including London"*.

¹³ <http://www.healthinvestor.co.uk/ShowArticle.aspx?ID=4764>; <http://www.bartshealth.nhs.uk/media/latest-news/2016/april/preferred-provider-of-private-patients-unit-announced/>

specialism, and therefore there is no reason to regard that PPU as any less of a competitive constraint for the services it offers.

- The CMA also observes (paragraph 2.27, PDR) that this is a "*specialty-led product market*" and that "*a strong position in one or a small number of specialties would allow a private hospital operator to exert market power*".
- AXA PPP has expressly acknowledged in its submissions that major specialist PPUs such as the Royal Marsden and the Royal Brompton are "*significant competitors in the central London "elite" market*".¹⁴ In this case, it is understood that Nuffield will invest up to £45 million into the 78,000 square foot facility which will feature its own intensive care unit.¹⁵
- The new PPU is expected to specialise in cardiac care, but it has also been reported that it will offer orthopaedics and general surgery services too.¹⁶ Therefore it is by no means narrowly focused on a single specialty. Furthermore, once the PPU is operational, it will be relatively easy for the new hospital to diversify into other low and high-acuity services.
- In any event, in the Final Report (paragraph 6.208(d)) the CMA alleged that HCA has over 60% share of supply in cardiology and in considering divestment options it specifically referred to the need to free-up shares of supply in cardiology. The launch of a new Barts PPU obviously affects the CMA's assessment of competitive conditions at least in cardiovascular services. PMIs will now have an additional, alternative cardiac hospital to which they can re-direct their subscribers requiring cardiac treatment. A specialist hospital of this nature will therefore be an equally effective competitor to HCA for cardiac/cardiovascular services.
- HCA would also point out that the size of this site (78,000 square feet) is as large, if not larger, than some of HCA's hospitals.

4.26 As stated above, the proposed partner for this project is Nuffield and this project demonstrates that PPU partnerships offer a further means for new operators to enter the market in central London.

Wigmore Street Hospital

4.27 HCA notes the CMA's comments (paragraphs 1.47 and 1.83, PDR) concerning plans for a new hospital on Wigmore Street specialising in spinal and neurological services.

4.28 As in the case of Barts PPU, the new hospital will provide a competitive constraint to HCA in spinal and neurological services. Precisely the same comments apply *mutatis mutandis* in

¹⁴ Final Report, Appendix 6.10, Annex A, paragraph 10.

¹⁵ <http://www.healthinvestor.co.uk/ShowArticle.aspx?ID=4764>

¹⁶ <http://www.standard.co.uk/news/health/sherlock-shrine-set-for-new-life-as-private-heart-hospital-a3219996.html>

respect of the provision of spinal and neurological services. Again, once the hospital is operational, the operator would also relatively quickly be able to launch additional services if it wished to do so.

4.29 The plans by this operator provide further evidence that there are no major barriers to entry and expansion in central London:

- It is a further example of new entry in and around Harley Street and demonstrates that (contrary to the CMA's views in the Final Report and PFs) it is possible for new entrants to find suitable sites in this area.
- The expected time to launch the facility is only 15 months from the grant of planning permission.
- Once again, neither sunk costs nor lead times have deterred this operator from its proposals for new entry.

Specialist clinics

4.30 HCA has also provided evidence of new/recent entry for expansion by specialist day case and outpatient clinics, including:

- Fortius Group's new orthopaedic facility
- The London Claremont Clinic near Harley Street
- Optegra's new eye clinic
- Nuada Medical Group
- The Harley Street Eye Clinic
- Advanced Oncotherapy.

4.31 The CMA states (paragraph 1.46, PDR) that these are "*very small relative to the market ... and highly specialised*". However, as HCA has previously submitted, these new specialist clinics are part of a broader competitive trend which has seen the emergence of new, smaller-scale, specialised providers. As the recent article in Healthcare Market News reported, these clinics are developing entire patient pathways which offer an alternative to an inpatient hospital setting: "*So far, the challenge to the existing general hospital is small but the trend towards day surgery means that for a lot of specialties you don't need a full service hospital. It won't change the market overnight, but the emergence of these operators could*

*continue to chip away at the incumbent market and in five years or so we could see more smaller providers delivering high-acuity care in the less capital intensive specialties."*¹⁷

4.32 The emergence of these specialist providers must be viewed in the context of the fact that the trend in demand is away from inpatient towards day care and outpatient treatments. These specialist providers are therefore emerging and expanding in a sector which is becoming an increasingly important part of the way in which private healthcare services will be delivered in the future. They improve the PMIs' outside options by enabling them to steer subscribers to a wide set of providers, thus increasing the competitive constraints in the market place.

Expansion

4.33 The CMA also needs to include in its assessment of new capacity the planned expansion by existing central London providers:

- King Edward VII is undertaking a large site expansion, creating an additional 40,000 square feet of hospital space in the Harley Street area. This will increase the hospital's capacity from 60 to 80 beds by 2018. The hospital has recently stated: *"We will also be creating two further theatres as well as expanding one of the existing ones. That will give us five theatres in all. There are also plans to develop a day case unit, a new physiotherapy department and a full IVF facility."*¹⁸
- TLC is undergoing a major further £75 million expansion and plans to open 16 new beds in 2016.¹⁹
- LaingBuisson recently reported that the Hospital of St John & St Elizabeth is planning to add a further 10 beds in a new medical ward.²⁰
- Several other hospital operators (the Bupa Cromwell, the Royal Brompton, Royal Marsden, London Clinic and Aspen) have reported a significant increase in capacity since 2011. Aspen, for example, has increased capacity by over 50% in this period.²¹
- HCA has also presented evidence regarding the expansion plans of other NHS Trusts in central London in relation to their PPU's, including the Royal Marsden and Royal Brompton.²²

¹⁷ Healthcare Market News, December 2015/January 2016 (see Nabarro letter to CMA dated 14 December 2015), <https://www.laingbuisson.co.uk/MediaCentre/PressReleases/PrivateAcuteMedicalCareinCentralLondon2ed.aspx>

¹⁸ Interview with KEVII's Chief Executive, Andrew Robertson, Healthcare Market News, December 2015/January 2016.

¹⁹ LaingBuisson, Central London Report 2016, page 134.

²⁰ LaingBuisson, Central London Report 2016, page 125.

²¹ LaingBuisson, Central London Report 2016.

²² See, for example, HCA's submission on the CMA's findings on structural AECs, 1 May 2015, paragraph 4.50; and Nabarro email to CMA dated 22 July 2015.

Total new capacity

4.34 In the light of the above, the total likely (non-HCA) inpatient capacity which is coming on stream in central London by 2021/2022 is at least 600 beds:

	<u>Beds</u>
Cleveland Clinic	215
Spire	150
VPS	150
Barts PPU	26
Wigmore St. Hospital	25-50 ²³
King Edward VII	20
TLC	16
St John & St. Elizabeth	<u>10</u>
Total	<u>600+</u>

This represents approximately 35% of current inpatient bed capacity in central London (estimated at 1,691 by LaingBuisson).²⁴ This is equivalent to over three new hospitals each of TLC's size. Even if one were to exclude Spire on the basis that its entry is "uncertain", this still leaves 450+ new beds, or 26% of current capacity.

4.35 This figure excludes:

- the increase in capacity which has already taken place (e.g. by TLC, Bupa Cromwell, Aspen) since 2011/2012 (the data relied on by the CMA in its Final Report);
- further planned expansion by other NHS PPUs, such as Royal Marsden and Royal Brompton, which have announced plans to create new capacity over the next three to five years;
- new entry and expansion by specialist day case and outpatient clinics (Optegra, Nuada, Fortius, etc.).

4.36 The CMA's approach to divestment has been to consider how much spare capacity is required in order to release shares of supply to allow PMIs to switch to non-HCA hospitals. As discussed below, HCA believes that it has shown convincingly that there is already sufficient available capacity to allow for this. Nevertheless, given that this is the CMA's approach, it would need to take into account all the new capacity which is coming onto the market over the next five years. On any analysis, a one-third increase in competitor capacity in any market over a five-year period would be seen as representing a substantial change which significantly increases the competitive constraints on all central London operators.

²³ Bed capacity not yet known, but a site of 65,000 square feet would be expected to allow for a mid-sized hospital with this range of beds.

²⁴ LaingBuisson, Central London Report 2016, page 25.

- 4.37 Furthermore, HCA would note that, over the next few years, there are highly likely to be further new entrants other than those referred to in the PDR. It is striking that, just in the last **12 - 15** months in which this remittal inquiry has taken place, there have been four announcements of new hospital projects (Cleveland Clinic, VPS, Barts PPU and Wigmore Street Hospital), not including Spire. The CMA should not assume that these will be the only new hospital entrants, and it is highly likely that others will follow.
- 4.38 In the original inquiry, the CMA noted that there had been "*no examples of new hospital openings in central London and few instances of expansion*" (paragraph 6.89, Final Report), and the CMA assumed that this was as a result of structural barriers to entry. However, as HCA consistently explained during the inquiry, the CMA was looking at a period in which there had been a severe economic downturn which had affected investors' access to capital and risk appetite. Indeed, where the CMA cited specific examples of operators facing difficulties in launching or expanding facilities, it was clear that these difficulties were due to problems in obtaining financing rather than to any structural barriers to entry. In fact, as economic conditions have improved, and access to capital has eased, investors are now keen to fund substantial new build hospital projects. Developments since the CMA's Final Report in 2014 have borne this out.
- 4.39 Consequently, both in relation to its assessment of AECs, and in its consideration of remedies, the CMA would need to consider not only the Cleveland Clinic, VPS, Barts PPU and the new Wigmore Street Hospital, and indeed Spire, but also other new entrants which are likely to enter the market over the next few years. It is undeniable, from the evidence over the last 12 - 15 months, that there is growing momentum in the market as investors see the opportunities for growth in tertiary services. As the CMA itself has acknowledged, there are also an increasing number of surplus NHS buildings coming onto the market which would provide investors with appropriate sites which already have C2 planning consent. This will contribute to the competitive pressures in central London.

5. THE CMA'S UPDATED PROFITABILITY ANALYSIS

(i) Introduction

5.1 In the original inquiry, the CMA conducted an analysis of HCA's profitability, in which it estimated HCA's Return on Capital Employed ("ROCE") and compared this to an estimate of the Weighted Average Cost of Capital ("WACC").²⁵ In the PFs, the CMA stated that:

"In relation to prices we found there was a price difference between HCA and TLC and that HCA had persistent and sustained excess profits, which taken together indicate that prices are above the competitive level that we would expect to find in a well-functioning market. This leads us to conclude that there is customer detriment arising from the AEC we have identified."²⁶

5.2 HCA responded to the CMA's reliance on profitability as part of its response to the PFs. Subsequent to that, HCA also submitted a report it had commissioned by Professors Gregory and Lyons on the use of profitability analysis in the remittal inquiry. In the PDR the CMA has not commented on the points made by HCA or by Professors Gregory and Lyons in relation to its use of profitability analysis in the PFs, noting that it will take into account such submissions in its final report of the remittal inquiry.²⁷

5.3 In the PDR, however, the CMA has updated its assessment of HCA's profitability and has used this analysis to quantify the impact on prices of the increase in competition that the CMA expects to arise as a result of a divestment remedy.²⁸ Implicit in the CMA's use of profitability analysis to quantify the benefits of divestment, is an assumption that the results of the CMA's profitability is relevant evidence to identify a lack of effective competition.

5.4 HCA sets out in Section 6 that the CMA's divestment remedy would not be an effective remedy.

5.5 In this section, HCA sets out its comments on the CMA's use of its analysis of HCA's profitability. In particular, this section sets out HCA's views on the CMA's reliance on profitability analysis both to support an AEC finding and to quantify consumer benefits from a potential divestment remedy. In addition, this section comments on the CMA's analysis of HCA's profitability and shows that the CMA continues to overestimate HCA's ROCE in relation to the WACC.

²⁵ Original PDR, January 2014, paragraph 2.41.

²⁶ PFs, paragraph 11.42.

²⁷ *Ibid*, paragraph 1.16.

²⁸ PDR, paragraph 2.42-2.43.

(ii) The CMA should not use profitability evidence to quantify benefits from a proposed divestment remedy

5.6 As set out above, HCA commissioned and submitted to the CMA an expert opinion by Professors Alan Gregory and Bruce Lyons on the CMA's profitability analysis (as set out in the PFs). That submission highlighted that competition authorities should be very cautious in determining that any particular level of profit is "excessive" due to the inherent uncertainty surrounding this type of analysis.²⁹

5.7 In seeking to use the results of its profitability analysis to quantify the benefits of a potential divestment remedy, the CMA recognised the uncertainty surrounding its profitability analysis (PDR, paragraph 2.54):

"There is accordingly significant uncertainty over the likely level of price benefits that would result from a divestiture. In light of this uncertainty and the range of NPVs [...] our current view is that divestiture is not a proportionate remedy as we could not form an expectation that the benefits of the remedy would outweigh the costs."

5.8 HCA welcomes the CMA's recognition of the inherent uncertainty surrounding profitability analysis, and the CMA's caution in putting weight on these results as part of its NPV analysis of a potential divestment remedy.

5.9 However, in HCA's view, the CMA is continuing to put too much weight on its estimates of excess profit. Professors Gregory and Lyons noted that the CMA has not assessed whether HCA's profitability is the result of efficiency and a reward for investment risk, rather than the result of a lack of effective competition.³⁰ Without such an assessment, using profitability analysis as a central piece of evidence to support an AEC finding and as the basis for quantifying the benefits of a potential divestment remedy is unsound.³¹

5.10 In the rest of this section HCA briefly summarises its concerns on the CMA's use of profitability analysis to support a provisional AEC finding and to quantify the benefits of a potential divestment remedy.

No link between high estimated profitability and a lack of effective competition

5.11 As set out by Professors Gregory and Lyons, it is entirely to be expected that at least some firms in a well-functioning, competitive market will make profits in excess of the WACC, for a number of reasons.³² It is therefore important to understand why certain company returns may be above an industry WACC, before such estimates are automatically associated with a lack of competition (and used to quantify the benefits from potential remedies).

²⁹ A submission on the CMA's analysis of profitability, dated 20 January 2016, paragraph 1.5.

³⁰ A submission on the CMA's analysis of profitability, dated 20 January 2016, paragraph 1.5.

³¹ *Ibid*, paragraphs 5.17 – 5.19.

³² *Ibid*, paragraph 1.5.

5.12 Professors Gregory and Lyons set out in detail why relatively high levels of profit, in particular for an individual firm, are consistent with (and central to) well-functioning and competitive markets. Professors Gregory and Lyons also noted that there are reasons to expect estimates of HCA's returns to be consistent with a competitive central London private healthcare market. To summarise:

- Some firms may earn higher profits as a reward for superior efficiency.³³ In the case of HCA, it has vast experience delivering private healthcare through activities in the USA, which it applies to its Central London Hospitals in order to drive efficiency.³⁴
- Higher profits are also required to encourage risky investment, such that in a well-functioning competitive market it would be expected that some firms would earn relatively high levels of profit for periods of time, as a reward for risky investment that has paid off (the "fair bet principle").³⁵ HCA has undertaken substantial risks in investing in its facilities, as set out by HCA in previous submissions.³⁶ The riskiness of these investments is also evidenced by examples of failed entry / investment, in part as a result of lack of PMI recognition.³⁷
- Higher profits may also be required to bring forward investment, to compensate firms for the opportunity cost of giving up the option to wait for new information about the likely returns from the investment ("option theory of investment").³⁸

5.13 Therefore, if profitability analysis is to be used as part of an AEC finding, robust evidence is required to link higher profits to a lack of effective competition, and to rule out these other, pro-competitive explanations for some firms having higher profitability. Similarly, robust evidence of such a link is also essential if profitability analysis is to be used to quantify the benefits of a potential remedy to address an AEC – otherwise, there is no foundation for the view that profitability can be expected to decline as a result of supposed increases in competition from a particular remedy.

5.14 In the PDR the CMA has not recognised these issues. The CMA's use of profitability as a result risks promoting inefficiency and reducing incentives to invest, if successful businesses infer that high measured profitability is a regulatory risk (a "profitability offence").³⁹

³³ *Ibid*, paragraph 3.16.

³⁴ *Ibid*, paragraph 5.9.

³⁵ Overview of HCA's submissions, 19 June 2015, paragraphs 4.9-4.11.

³⁶ HCA response to Remedies Notice, paragraphs 3.149 - 3.151.

³⁷ *Ibid*, paragraph 5.9.

³⁸ *Ibid*, paragraphs 3.20 – 3.21.

³⁹ *Ibid*, paragraph 3.22.

CMA recognises problems with using profitability evidence in other cases

- 5.15 The expert opinion by Professors Gregory and Lyons set out that in a large number of previous market investigations, profitability analysis did not form part of the CMA's evidence base and that at least until 2014 high profitability alone was not sufficient to find an AEC.⁴⁰
- 5.16 In the remittal inquiry, by contrast, the CMA appears to rely heavily on its profitability analysis to support its AEC finding and to quantify the potential benefits of a potential divestment remedy. The CMA notes (PDR, paragraph 2.41) that:
- “Our revised IPA no longer allows us to conclude on the size of [the price difference between HCA and The London Clinic] that is due to weak competitive constraints, as we cannot be sufficiently certain that we have adequately controlled for any differences in patient complexity between HCA and TLC.”*
- 5.17 In the absence of evidence on pricing, the CMA relies on its profitability analysis to quantify the benefits of a potential divestment remedy.
- 5.18 This approach is in contrast to the CMA's approach in the recent PDR in its market investigation into the supply and acquisition of energy in Great Britain (“energy market investigation”).
- 5.19 In the energy market investigation, the CMA was seeking to quantify the consumer detriment associated with its provisional AEC finding, which it used to measure the benefits from its (provisionally) proposed remedies. In order to do this, the CMA used two methodologies: first, a ‘direct approach’, being a comparison of prices of the larger suppliers with those of two smaller suppliers, chosen as a ‘competitive benchmark’; second, an ‘indirect approach’, using the results of its profitability analysis (alongside an analysis of cost inefficiency).
- 5.20 In discussing the relative merits of these two approaches, the CMA in the energy investigation noted that it favoured its first, direct methodology, the comparison of average prices, rather than its indirect methodology relying on its profitability assessment. The CMA argued that this was because prices are ultimately what matter to consumers, rather than a supplier's level of profitability or cost efficiency.⁴¹
- 5.21 In the remittal inquiry, if the CMA were to follow the same approach and put more weight on its pricing analysis, the logical conclusion would be that there is a lack of evidence of any consumer detriment in the private healthcare market in central London. Instead, however, the CMA uses its profitability analysis to quantify consumer detriment despite this lack of evidence from the IPA.

⁴⁰ *Ibid*, paragraph 3.26.

⁴¹ Provisional Decision on Remedies, energy market investigation, paragraph 56.

5.22 HCA submits that this is inappropriate, particularly given that, as set out above, the CMA has not analysed the causes of HCA's profitability and not taken into account the fact that these are likely to be the result of its investment record and superior efficiency.

5.23 In fact, in the energy market investigation, the CMA found that the detriment estimated by comparing prices to a competitive benchmark is larger than its estimate of economic profits. The CMA concluded, as a result, that firms' costs were inefficient (supported by an analysis of firms' costs and an estimate of cost inefficiency), and that this also contributed to prices being above a competitive benchmark.⁴² In the remittal inquiry, however, the CMA has provided no evidence that prices are above a competitive level, nor that HCA is inefficient. This would imply that any economic profit earned by HCA is a result of its efficiency.

Relying on profitability analysis is inconsistent with other parts of the CMA's evidence and analysis

5.24 The CMA's use of profitability analysis to support a provisional AEC finding and to quantify the benefits of a potential divestment remedy is inconsistent with other parts of the CMA's evidence base and analysis.

5.25 First, the CMA estimates that [§<]. This undermines the CMA's argument that higher profitability is driven by a lack of effective competition, and therefore undermines the CMA's use of profitability analysis to support its AEC finding and to quantify the benefits of a potential divestment remedy.⁴³

5.26 Second, as HCA has noted in previous submissions, HCA has lower EBITDAR⁴⁴ margins than TLC⁴⁵, yet the CMA does not find that TLC earns excess profits (despite TLC having, if anything, a lower cost base due to its tax status). This suggests that any estimate that HCA's ROCE is above its WACC is the result of HCA more efficiently utilising capital, rather than the result of its prices being higher than those of TLC. This therefore supports HCA's view that its profitability is a result of its superior efficiency, and undermines the CMA's suggestion that economic profit is a result of a lack of effective competition.

(iii) CMA has overestimated the difference between ROCE and WACC

5.27 In the PDR, the CMA has updated aspects of its ROCE analysis from the original inquiry, adjusting for new information received during the remittal. Specifically the CMA has:

- Extended its ROCE analysis to cover the period from 2012 to 2015 (where previously the CMA had sought to measure HCA's profitability only for the period

⁴² *Ibid*, paragraph 147.

⁴³ *Ibid*, paragraphs 5.13 – 5.14.

⁴⁴ Earnings before interest, tax, depreciation, amortisation and rent.

⁴⁵ HCA response to PFs, paragraph 7.28.

2007 – 2011). This included updating estimates of capital employed, including the value of HCA's properties.⁴⁶

- Allocated overhead costs and capital to different customer types, in order to try to estimate the relative profitability of HCA's UK (self-pay and insured) and overseas patients.⁴⁷

5.28 The CMA's updated analysis gives estimates of the level of economic profits (i.e. the amount by which operating profit exceeds the expected return on capital) earned by HCA on UK patients of between 3.1% and 10.7% of revenues.⁴⁸

5.29 The CMA has sought to use this analysis to estimate the impact of increased competition on prices, which it argued would be brought about by a potential divestment remedy. The CMA considered that the impact on prices from a divestment remedy was likely to be towards the lower end of its range of economic profits (as a percentage of revenue). This was based on its review of the asset valuations included in its range of estimates. Therefore, in its analysis of the proportionality of a divestment remedy, the CMA uses the assumption that the potential benefit would be that "*revenues would decline by between 3% and 6%*" (PDR, paragraph 2.43).

5.30 While HCA welcomes the CMA's updates to its previous profitability analysis, there remain some flaws and errors, which cause the CMA to significantly overstate HCA's economic profits. These include:

- errors and omissions in the updated ROCE analysis resulting in an overstated ROCE estimate; and
- incorrect treatment of the WACC calculation, including incorrect beta sampling frequency, problems of proxy betas and errors in the CMA's treatment of inflation.

The CMA has overestimated HCA's ROCE

5.31 The CMA has made a number of errors and omissions in its updated ROCE analysis for the PDR report. This results in an overstated ROCE estimate. These errors include:

- flawed treatment of HCA's leased properties, resulting in a significant understatement of HCA's capital employed;
- the inclusion of outdated and inappropriate Altus Edwin Hill ("AEH") property valuations as a base case; and

⁴⁶ PDR, paragraph 2.42.

⁴⁷ *Ibid*, paragraph 2.42.

⁴⁸ *Ibid*, paragraph 2.43.

- failure to assign value to HCA's key intangible assets which significantly undervalues HCA's capital employed and therefore overestimates the CMA's ROCE estimate.

5.32 HCA discusses each of these in turn in the following paragraphs.

The CMA's treatment of HCA's leased properties is flawed

5.33 Current accounting standards require that the value of leased property is not reflected on a firm's balance sheet, and therefore this implies that such leased property value would not be included in ROCE analysis. Therefore, the method of financing that a firm chooses (i.e. whether it chooses to rent or buy its assets) has a significant impact on a firm's ROCE under this approach.

5.34 Professors Gregory and Lyons, however, set out that the rent versus buy strategy of firms should be controlled for when estimating ROCE for the purposes of profitability analysis in a market investigation – or in other words that whether a firm chooses to rent or buy assets should not cause large swings in the ROCE.⁴⁹ Elsewhere in its analysis, the CMA appears to agree that the rent versus buy strategy of firms should be controlled for when comparing profitability.⁵⁰ For consistency, in its profitability analysis, the CMA should seek to avoid penalising firms which have a strategy of renting rather than owning assets.

5.35 This is also consistent with the updated accounting treatment of leased assets (IFRS 16) which will become mandatory for all firms in coming years. Under previous accounting standards, leases were classified as either finance leases and reported on the balance sheet, or as operating leases which were off balance sheet. The new IFRS 16 leases standard treats all leases in a similar way by capitalising them onto the balance sheet.

5.36 The CMA, however, has excluded [redacted] from its capital employed estimate. [redacted],⁵¹ which means that, under current accounting rules the value of these properties is not reflected on the balance sheet (and therefore not included in the CMA's capital employed calculation). This implies that the CMA's estimate of HCA's ROCE is significantly lower than the estimate that would be implied if the CMA took into account leased property valuations.

5.37 Note that HCA's current level of revenue and profitability (and any future forecasts of the same) is based on the current portfolio of assets held by HCA, [redacted]. The CMA's NPV analysis necessarily assumes that HCA's current profit levels will continue going forwards, which will require the full portfolio of assets currently in use. For this to be the case, it must be assumed that HCA continues to renew these leases at least for the period of the NPV analysis in question, and perhaps into perpetuity if the CMA wishes to look beyond a finite

⁴⁹ A submission on the CMA's analysis of profitability, dated 20 January 2016, paragraph 4.18.

⁵⁰ A submission on the CMA's analysis of profitability, dated 20 January 2016, paragraph 4.18.

⁵¹ [redacted]. For further details, see for example HCA's response to CMA's post-remittal request for information on profitability, dated 20 January 2016, page 11.

time period. When leases are capitalised into perpetuity, HCA's average ROCE over the period 2007-2015 [§<].

5.38 In the CMA's analysis of the NPV of a divestiture remedy, costs and benefits have been projected over a three, five, seven and ten-year period. If the CMA wished to truly reflect the assets required by HCA to continue to generate the current level of revenues and profits, it must value these leased assets, using a lease termination date that is at least in line with the time period used in the NPV models. This does not avoid the issue described in paragraph 4.34 above, of penalising firms based on lease/buy strategy but is the minimum assumption needed if profitability is to be used in assessing benefits. If leases are capitalised to the lease terms of three, five, seven or ten years (the time periods suggest by the CMA for projecting the costs and benefits of divestment)⁵² this has the effect of [§<].

5.39 The capitalisation of leases will not affect the CMA's estimate of WACC as rating agencies have already adjusted for lease capitalisation and therefore the cost of capital will not be affected. For example, in June 2015, Moody's reviewed and updated its methodology regarding its financial statement adjustments for off balance sheet leases.⁵³ As a result of this, the adjustments now used in Moody's methodology are more closely aligned with the revised lease capitalisation accounting standard, IFRS 16.

Some of the CMA's property valuations continue to be an underestimate

5.40 The CMA has updated its valuations of HCA's property assets since the Final Report, using two different approaches as follows:

- The Altus Edwin Hills (AEH) property valuation forms the starting point for the CMA's 'base case' valuation for its ROCE analysis. This approach values HCA's owned buildings on the basis of their replacement cost and HCA's land on a residual basis and then adjusts for depreciation based on Valuation Office Agency reports. This approach assumes that HCA's properties would be used as commercial buildings.
- The second approach is to use KPMG's 2013 property valuation report which values HCA's owned properties on the basis of a residential alternative use and applies the Land Registry price index to capture the updated property values.

5.41 In the PDR, the CMA uses both valuation approaches to arrive at a final valuation, although it notes that it places more weight placed on the KPMG valuation.⁵⁴ HCA believes that the AEH valuation should be discounted as the underlying alternative use assumption is unrealistic, and therefore that the CMA should place weight only on the KPMG valuation. As HCA has noted in previous submissions to the CMA, rationally a firm would choose an

⁵² PDR appendix on profitability and net present value analysis, paragraph 39.

⁵³ https://www.moody.com/research/Moodys-updates-its-global-methodology-for-financial-statement-adjustments--PR_327853

⁵⁴ PDR appendix on profitability and net present value analysis, paragraph 16.

alternative use that maximises the value.⁵⁵ Although the difference between Central London residential and commercial property prices has slightly decreased, Central London residential property prices remain significantly higher than commercial values.

5.42 Additionally, as noted by the CMA in the PDR it has become increasingly easy and more common for developers to convert properties to residential use due to updated planning permission regulations and the political desire to create more residential housing in Central London. Therefore, HCA would argue that the CMA should place less weight on the AEH property valuation as this assumes commercial use and therefore undervalues HCA's asset base.

5.43 Whilst HCA welcomes the CMA's use of the property values included in the KPMG 2013 report, appropriately inflated upwards, the CMA should note that this report did not include [redacted].⁵⁶ [redacted] which has the effect of further undervaluing HCA's asset base.

The CMA has not valued HCA's intangible assets

5.44 The CMA has failed to assign a value to HCA's intangible assets, notably its reputation and the value of HCA's individual hospital brands. These assets are key to HCA's ability to attract customers in a competitive marketplace. For example, HCA is very successful in attracting overseas patients, therefore providing a good indication of its strong reputation.

5.45 As discussed in the submission by Professors Gregory and Lyons, the CMA and PMIs have made a number of statements which emphasise the importance of HCA's reputation for high quality. Notably, the CMA stated in the PFs that:

"...some private hospital and PUs [in central London] which are perceived by patients as offering a higher quality of care"⁵⁷

5.46 Failing to value these assets results in the CMA underestimating HCA's capital, despite repeated mentions in the PFs, by the CMA and PMIs, acknowledging HCA's superior reputation.

5.47 One approach that the CMA may wish to explore is a royalty-based approach to evidence the value of HCA's reputation and hospital brands. Where a brand name is used under licence, a royalty tends to be payable, which is based on the value of that brand. Using these royalty payments, it is possible to estimate the asset value of proxy hospital brands. To the extent that UK hospital providers have used such agreements, the CMA may be able to estimate a range of appropriate royalty rates,⁵⁸ which can be used to estimate the value of the brand.

⁵⁵ A submission on the CMA's analysis of profitability, dated 20 January 2016, paragraph 4.15.

⁵⁶ [redacted].

⁵⁷ PFs, paragraph 3.24 (a)(iv).

⁵⁸ [redacted].

The CMA has underestimated WACC

- 5.48 In addition to the CMA's overstatement of HCA's ROCE, the CMA has also underestimated the industry WACC, as noted by Professors Gregory and Lyons.⁵⁹ This underestimate is the result of a number of errors in the CMA's methodology, including incorrect beta sampling frequency, problems with beta proxies and errors in the treatment of inflation. Each of these points are discussed separately below.

Incorrect beta sampling frequency

- 5.49 The CMA has used the same methodology in the PDR for calculating WACC as was used in the Final Report in the original inquiry. This involved using betas which are sampled on a daily basis. It has been shown in academic literature that low frequency estimates (i.e. using quarterly or monthly data) are preferred as they do not under-estimate beta.⁶⁰
- 5.50 If the CMA was to use more appropriate monthly data, the cost of capital would be materially increased with an even greater increase if quarterly data were to be used. In the energy market investigation, the CMA has acknowledged that betas should be calculated on a monthly or quarterly basis as this is more reliable than daily beta estimates.⁶¹ Therefore, the CMA should replicate this with the private healthcare market investigation.

Inappropriate beta proxies

- 5.51 The WACC calculated by the CMA has been underestimated due to the inappropriateness of the CMA's beta proxies. As discussed by Professors Gregory and Lyons,⁶² in the Final Report in the original inquiry the CMA used various different countries as proxies for beta, some of which carry a substantial risk premium. In ignoring the underlying market riskiness associated with these beta proxies, the CMA has underestimated the cost of equity capital for these proxies.
- 5.52 The CMA must also take into account the different markets that it has used for its beta proxies, and acknowledge that the frictionless market assumption underlying the CAPM does not hold in reality. As previously noted by HCA, the CMA uses Bloomberg as the source of its beta estimates and has made no attempt to check for statistical significance of beta estimates. This results in the CMA using beta proxies which should be disregarded and have the effect of reducing the cost of equity capital.⁶³

Errors in the CMA's treatment of inflation

- 5.53 The CMA has made errors in its treatment of inflation. Within its calculation of WACC, the CMA used the assumption that investors' return requirements are driven by expected

⁵⁹ A submission on the CMA's analysis of profitability, dated 20 January 2016, paragraph 4.28 to 4.43.

⁶⁰ A submission on the CMA's analysis of profitability, dated 20 January 2016, paragraph 4.29.

⁶¹ CMA Provisional Findings to the energy market investigation, Appendix 10.4, paragraph 46.

⁶² A submission on the CMA's analysis of profitability, dated 20 January 2016, paragraph 4.33.

⁶³ *Ibid*, paragraphs 4.34 and 4.44.

inflation. However, the CMA should use actual inflation rates, as this influences the outcomes that are observed in the financial statements.⁶⁴ This impacts the expected returns on the market and the equity risk premium. Failure to use actual inflation implies that the CMA's estimate of WACC is too low.

Overall impact of correcting for the CMA's errors in its WACC estimate

- 5.54 Correcting for the errors in the inappropriateness of the CMA's beta proxies and incorrect inflation, WACC will increase by approximately 4.3% for the period 2007-2011.⁶⁵

⁶⁴ *Ibid*, paragraph 4.36.

⁶⁵ *Ibid*, paragraph 4.43.

6. DIVESTMENT IS NOT AN EFFECTIVE REMEDY

6.1 The CMA considers (paragraph 2.33, PDR) "*that a divestment remedy is likely to be effective in reducing prices by increasing the competitive constraints on HCA.*" Although the CMA rightly concludes that divestment is not proportionate, HCA strongly disagrees that divestment could in any event be considered an effective remedy in the circumstances of this case.

6.2 For the reasons which have previously been set out in HCA's response to the Notice of Remedies,⁶⁶ HCA considers that there is no evidence that the divestment of any of HCA's hospitals would lead to lower insured prices for a given level of quality and range of private healthcare services:

- First, there is no evidence that HCA's insured prices are higher than its nearest competitor, TLC, when considered on a like-for-like basis.
- Second, the CMA has not established any causal link between HCA's prices and its share of supply in central London.

6.3 In any event, even if divestment hypothetically were to lead to lower prices to PMIs, there is no evidence that it would result in lower prices to policyholders.

Existence of a price difference

6.4 The effectiveness of the CMA's divestiture remedy depends on whether there is credible evidence of a price difference between HCA and TLC once their respective prices are compared on a like-for-like basis.

6.5 The CMA has previously sought to rely on its IPA to conclude that HCA charges higher prices than TLC. During the course of this remittal, HCA has provided extensive evidence, which need not be repeated here, to show that the IPA fails to demonstrate that HCA's prices are higher than TLC's, on a like-for-like basis. Furthermore, following the publication of PFs, HCA has submitted further, compelling evidence to show that once patient complexity is properly controlled for, there is no longer any price difference between HCA's and TLC's insured prices, including in particular:

- (i) the Data Room Report of 4 December 2015 which demonstrated that [redacted] and substantially increases the value of the adjusted R²;
- (ii) the report on HCA patient comorbidities of 4 December 2015 which, analysing HCA's ICD-10 data, demonstrated that [redacted], and that therefore any analysis of pricing that

⁶⁶ HCA's response to the Remedies Notice, paragraphs 3.11 – 3.113.

does not correctly account for comorbidities will not be comparing prices on a "like-for-like" basis;

(iii) a submission on patient and episode complexity of 22 December 2015 which summarised how the line item analysis and the comorbidities analysis demonstrate [redacted] which affect the "like-for-like" comparisons between HCA and TLC;

(iv) a further submission on complexity dated 8 March 2016 which, on the basis of further analysis of HCA ICD-10 data, showed that [redacted].

6.6 The CMA states in the PDR (paragraph 2.41): "*Our revised IPA no longer allows us to conclude on the size of this price difference that is due to weak competitive constraints, as we cannot be sufficiently certain that we have adequately controlled any differences in patient complexity between HCA and TLC.*"

6.7 HCA welcomes the CMA's acknowledgment in the PDR that it can no longer rely on the IPA either: (i) to conclude with any confidence that there is a price difference between HCA and TLC once all relevant factors, including differences in patient complexity, have been fully taken into account; and (ii) to determine the size and extent of any price difference that may exist.

6.8 It follows from this that the CMA can derive no support from the IPA to demonstrate that there is a price difference between HCA and TLC once their respective prices are compared on a like-for-like basis, and/or that any price difference is as a result of HCA's share of supply, which would be a necessary pre-condition for a finding that divestment would have the effect of reducing HCA's prices.

Causal link between market share and price

6.9 The existence of a causal link is fundamental to the CMA's AEC finding, as previously highlighted by the Tribunal.⁶⁷ The evidentiary burden is on the CMA to show that the price difference identified between HCA and TLC is caused by a lack of non-HCA hospital capacity in central London and that the solution is therefore divestment of HCA capacity.

6.10 The CMA provisionally concluded 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*" (paragraphs 11.37 and 11.40-41, PFs). This finding is reiterated in the PDR (at paragraph 2.32).

6.11 However, there is no evidence for such a conclusion:

(i) The IPA itself is not evidence of a causal relationship between HCA's market share and its prices. In that regard, a simple plotting of market shares and price levels for two hospital operators does not represent firm evidence of causality. A high market

⁶⁷ *HCA v CMA* [2014] CAT 11, paragraph 37.

share can equally be consistent with an efficient firm selling a relatively more attractive product in a competitive market. (As stated above, PMIs now concede that the reason why its subscribers wish to go to HCA hospitals is because they are perceived as having higher quality and a stronger reputation for clinical excellence).

- (ii) There is compelling evidence showing that PMIs do not face any material capacity constraints (that could be remedied by divestment) which prevent them redirecting their patients to non-HCA facilities,⁶⁸ including statements by the largest PMIs that there is theoretically enough spare capacity in the market. Therefore, it is questionable what impact a re-allocation of hospital capacity from HCA to other operators would have on prices.
- (iii) The CMA stated that the planned entry by Cleveland Clinic is inconsistent with there being sufficient spare capacity in central London. This is not correct. The Cleveland Clinic could, and likely does, expect to earn market share by providing a better quality of service and attracting consultants and patients because of this. Therefore, no inconsistency arises.
- (iv) The CMA did not find any causal link between concentration and prices outside central London (where high concentration and barriers to entry were similarly identified) and no reasoning has been provided to explain why a causal link would therefore appear in the central London market, particularly given the presence of substantial spare capacity.
- (v) The CMA has published evidence showing that HCA's margins have been comparable to those of TLC (a relatively smaller hospital operator),⁶⁹ casting further doubt on the existence of a causal link between HCA's market share and its ability to charge relatively higher prices that are unreflective of its costs.
- (vi) The fact that the CMA's IPA shows a high degree of variation in estimated insured prices, across time and PMIs, is inconsistent with the view that insured prices are being driven by market concentration, which has remained stable over the period of the CMA's analysis.⁷⁰
- (vii) There is strong evidence that HCA does not hold significant bargaining power over PMIs and, given the CMA's incomplete analysis of bargaining between PMIs and hospital operators,⁷¹ the CMA is not in a position to assess what the likely impact of a change in market concentration would be on bargaining outcomes such as price.

⁶⁸ Updated analysis of spare capacity in central London, 4 December 2015.

⁶⁹ PFs, paragraph 9.5 and figure 9.2.

⁷⁰ 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.

⁷¹ HCA's response to PFs, section 6.

6.12 In light of the above, the CMA cannot reasonably assert that, on the balance of probabilities, it is HCA's market share in central London that is the cause (or indeed the "*most important factor*") of any estimated price difference between HCA and TLC, particularly when there is reason to believe that other explanations relating to cost, reputation and/or quality could provide a better explanation. The Tribunal indicated that there would need to be "*careful examination*" of any alleged relationship between prices and market shares.⁷² In the PDR, the CMA resorts to mere assertion that weak competitive constraints are "*likely*" to give rise to higher prices. The CMA does not substantiate this assertion with any evidence whatsoever and it would not bear scrutiny.

6.13 Furthermore, as detailed in Section 7 below, a divestment remedy would be likely to increase costs (for example due to a loss in scale and scope economies) and result in the loss of relevant customer benefits, which would generate upward pressure on prices charged to PMIs among other consumer harm.

Pass through to policyholders

6.14 In the PDR, the CMA states that "*HCA has not provided any further reasoning or evidence that gives us reason to revise our conclusions that the large majority of any price reductions would be passed through to patients*" (paragraph 2.33). However, HCA has in fact submitted further reasoning to the CMA that should give it cause to reconsider its views on PMI pass through:⁷³

- (i) The CMA's starting point of treating PMIs as "customers" is at odds with its statutory duty to consider "consumers" of private healthcare (i.e. the patients). HCA pointed to new evidence in the Tribunal's judgment in *Federation of Independent Practitioner Organisations*⁷⁴ where it was noted by Mr Dermot Glynn that the CMA should design measures to remedy AECs with regard to the impact on "consumers", and that PMIs should not be considered consumers due to the possibility of divergent incentives between PMIs and policyholders.⁷⁵
- (ii) As noted in an independent paper commissioned by the OFT shortly after the original provisional decision on remedies, even in a perfectly competitive market, "*the extent of industry-wide cost pass-through [...] depends on the elasticity of demand relative to supply*".⁷⁶ Given the importance of considering such factors, the CMA has still not explained why it cannot practicably consider pass through as part of a coherent economic framework. This omission is particularly relevant given the CMA's overreliance on evidence relating to PMI loss ratio trends and its own admission that

⁷² *HCA v CMA* [2014] CAT 11, paragraph 37.

⁷³ HCA's response to PFs, paragraph 3.73 – 3.91.

⁷⁴ *FIPO v CMA* [2015] CAT 8.

⁷⁵ *Ibid*, *FIPO v CMA* [2015] CAT 8, paragraphs 76, 80 and 91.

⁷⁶ Cost pass-through: theory, measurement, and potential policy implications - A Report prepared for the Office of Fair Trading [CMA]; RBB Economics, February 2014, p4.

"it would not be possible to conclude from this information whether a reduction in costs would be passed to patients or not".⁷⁷

- (iii) The CMA did not consider HCA's point that PMIs have a limited incentive to pass on cost savings to *existing* policyholders (particularly those with pre-existing conditions and who are perhaps "locked in") as opposed to its new customers. HCA noted that it may also take considerable time for these lower premiums to be enjoyed by a significant proportion of policyholders.
- (iv) The CMA's limited pass through assessment also ignored the complex relationship between prices agreed by PMI with a private hospital operator and premiums charged to policyholders. For example, the impact of a lower price for a group of treatments would not necessarily translate into lower claims costs for a PMI (and therefore lower premiums) because a PMI's policyholders may not be eligible (or choose not to) receive these treatments from the relevant hospitals.

6.15 In any event, we note that the CMA's finding was that only a *"large majority"* of the purported price benefits would be passed on by PMIs to policyholders, i.e. some element will not be passed on (PDR, paragraph 2.33). This is another reason for the CMA to apply caution to any figures yielded by the CMA's NPV analysis.

Reliance on profitability analysis to demonstrate effectiveness

6.16 It is now apparent from the PDR that, in the light of the CMA's inability to determine from the IPA the extent of any price difference between HCA and TLC, the CMA seeks to rely instead on its profitability analysis to show that its divestment remedy would be effective in reducing prices.

6.17 The CMA notes *"...our revised IPA no longer allows us to conclude on the size of this price difference that is due to weak competitive constraints"* (PDR, paragraph 2.41) and *"[t]herefore, in order to assess the potential impact of a divestiture remedy, we have developed our profitability analysis"*.

6.18 However, the whole purpose of the IPA was to compare HCA's prices with those of TLC. In circumstances in which the CMA has conducted a pricing comparison, which does not reveal any significant price difference once all relevant factors are accounted for, it cannot justifiably ignore that pricing analysis and instead rely on a profitability analysis, a more indirect measure which is subject to even greater confounding factors, to support its assertion that HCA's prices are above the competitive level.

6.19 Furthermore, as set out in Section 5 above, given the shortcomings in the CMA's profitability findings, this analysis does not give the CMA a reasonable basis upon which to conclude a price difference exists let alone the magnitude of any price difference. Nor does it provide

⁷⁷ Final Report 11.170

any basis upon which to conclude that divestiture would **cause** the relevant price/revenue impact the CMA assumes would occur. In short, it takes the CMA no further than the IPA in demonstrating that divestiture would be effective. Rather, the fact that TLC's profit margins are broadly equivalent to HCA's suggests that HCA's prices are not likely to be above the competitive level.

Availability of spare capacity

- 6.20 The CMA states in the PDR (paragraph 2.6, PDR) that "*the rationale for imposing a divestment is that by creating incremental non-HCA capacity, this remedy would make it easier for PMIs to offer credible products which did not rely on including HCA facilities.*" This is the same justification that was advanced in the Final Report – that divestment would "free-up" shares of supply and allow PMIs to switch their subscribers away from HCA.⁷⁸ Similarly, the CMA refers to the effect of new entry (paragraph 1.73, PDR) "*in terms of increasing the availability of non-HCA capacity in the central London market.*"
- 6.21 During the remittal inquiry, HCA has submitted substantial evidence that there is already spare capacity in central London hospitals for all insurers to shift their patients to non-HCA hospitals:
- KPMG's first Report,⁷⁹ based on its analysis of data in the Data Room, demonstrated that all insurers could have collectively found sufficient spare bed capacity in central London private healthcare facilities other than HCA for all their inpatients at HCA on any given day in 2011.
 - KPMG's second Report⁸⁰ on spare capacity carried out further analysis based on other "dimensions" of capacity, [§<].
- 6.22 This demonstrates that there is already sufficient alternative capacity available to PMIs to switch away from HCA. It undermines the CMA's view that a divestment remedy is needed to create alternative capacity or that divestment would be necessary or effective in reducing prices by improving PMIs' outside options.
- 6.23 Indeed, in the Final Report, the CMA had previously concluded that there is significant available capacity in the private healthcare sector. The CMA expressly stated in paragraph 6.187 of the Final Report that it would assume that PMIs could switch to alternative providers "*unless we have specific evidence that a rival is capacity-constrained.*"
- 6.24 Furthermore, even the PMIs themselves now accept that there is sufficient alternative capacity available in central London:

⁷⁸ See e.g. paragraph 11.73, Final Report.

⁷⁹ Analysis of spare inpatient capacity in central London, 24 July 2015.

⁸⁰ Updated analysis of spare capacity in central London, 4 December 2015.

- Neither Bupa nor AXA PPP any longer seek to argue that they are unable to switch their patients away from HCA facilities on grounds of HCA's alleged share of supply or a lack of alternative capacity within HCA's competitors.⁸¹
- Bupa and AXA PPP have not challenged or contested the evidence which HCA has put forward, or submitted any alternative explanation as to why HCA's share of supply prevents PMIs from using alternative hospitals, and hence why HCA's share of supply is required to be reduced through a divestment remedy.
- In fact, Bupa and AXA PPP now concede there is no need to introduce additional, non-HCA capacity into the market. AXA PPP expressly noted that it does not "*consider that there was an immediate need for additional capacity in the central London market from the perspective of PMIs.*"⁸²
- It is very clear from the submissions of both Bupa and AXA PPP that in their view it is not high concentration or HCA's alleged share of supply, but rather HCA's reputation for quality and complexity, which is driving subscribers to choose HCA hospitals. This has been very clearly expressed in AXA PPP's response to the PFs in which it asserts that HCA's "must have" status is "*largely a matter of brand*"⁸³ and that new capacity "*would not capture the issue of quality and reputation – in terms of consultants, equipment and proven reputation over time*".⁸⁴

6.25 In the PDR, the CMA states that while the KPMG analysis of the existence of spare capacity in central London "*presents some evidence*" of sufficient spare capacity which is "*informative*" (paragraph 2.34), the CMA refers in paragraph 2.35 to "*a number of conflicting pieces of evidence*".

6.26 However, none of the points raised by the CMA in paragraphs 2.35(a) - (d) of the PDR challenge or contradict the results of the KPMG analysis. These are dealt with in turn.

Consultant availability

6.27 First, the CMA argues that while the analysis shows that there is sufficient capacity measured by reference to [§<] "*it did not answer our point that the existence and extent of spare capacity would also be substantially determined by the days and times at which consultants were available and willing to practise, and when patients were willing to be seen*" (PDR, paragraph 2.35(a)). HCA's response to this is as follows:

- HCA has in fact already addressed this point in its response to the PFs.⁸⁵ There is no evidence which suggests that the lack of consultant availability on any particular

⁸¹ See e.g. HCA's observations on third party hearing summaries dated 9 February 2016, paragraphs 7-11.

⁸² AXA PPP Summary of hearing of December 2015, paragraph 10.

⁸³ AXA PPP Summary of hearing, paragraph 7.

⁸⁴ AXA PPP Response to PFs and Notice of remedies, 7 December 2015, p.18.

⁸⁵ HCA's Response to PFs, paragraph 2.31.

days or times is a constraining factor. There is a high concentration of consultants in central London (more so than in any other local market in the UK) and the CMA has itself noted that there is no shortage of consultants which acts as a barrier to new entry or expansion.

- [3<]. It is very often consultants themselves who approach HCA with ideas about expanding or enhancing the level of clinical services within its hospitals. [3<].⁸⁶
- [3<].
- Furthermore, the CMA has not in fact put forward any evidence to suggest that "*the days and times at which consultants were available*" constrain an operator wishing to launch new services. The burden of proof is on the CMA to provide at least some concrete evidence of capacity constraints. No such evidence has been put forward.

PMI views

6.28 Second, the CMA argues that the KPMG findings are not consistent with the insurers' views on spare capacity. However, this is not the case based on the PMIs' most recent submissions:

- As stated above, the PMIs are no longer asserting that it is HCA's share of supply which is preventing them from switching to alternative providers. They are not contesting the KPMG evidence of the availability of alternative capacity in the market place.
- Bupa and AXA PPP are now clearly arguing that the only constraint on re-directing patients away from HCA is the reputation of HCA hospitals, which the CMA recognised is "*developed over time by providing high-quality products or services*".⁸⁷ They are not alleging that PMIs cannot switch because of structural barriers, which divestment would need to address. They concede that subscribers wish to use HCA hospitals because of the strength of HCA's reputation, not because there is any lack of alternative facilities. In that case, a divestment remedy which is designed to free up alternative, non-HCA capacity would not serve any purpose in terms of allowing for switching to take place.
- In any event, even if PMIs were to argue that there is a lack of sufficient capacity in central London (which they are not), they have a commercial interest in seeking divestment and therefore their views cannot be accepted without critical examination. Any views alleging a lack of spare capacity would need to be backed up by concrete evidence. Thus far, no such evidence has been forthcoming.

⁸⁶ For example, see Business case 8, 13, 21, 37, 43, 44, 50, 51, 64, 72, 78, 81, 83, 85, and 93.

⁸⁷ Final Report, Appendix 6.13, paragraph 77.

Waiting times

6.29 Third, the CMA states that the KPMG results were not consistent "*with some instances of internal documents indicating a lack of spare capacity*" (PDR, paragraph 2.35(c)). The CMA also argues that hospitals need to keep a degree of spare capacity in order to minimise waiting times. However, HCA points out as follows:

- The CMA does not state which internal documents, and for which providers, indicate a lack of spare capacity. If it is relying on these, it should refer expressly to them and disclose them within the confidentiality ring so that this evidence can be reviewed and addressed. HCA does not believe there is any evidence of a general lack of capacity in the market. Furthermore, the growth which other (non-HCA) hospitals have achieved in both revenues and admissions in recent years does not point to any capacity constraints on growth.
- As far as the need for hospitals to keep a degree of spare capacity is concerned, HCA would point out that the KPMG analysis shows that there is more than sufficient capacity even [redacted]. The more likely eventuality as a consequence of negotiations breaking down with a particular PMI, is for that PMI to seek to divert a proportion of its patients to alternative hospitals. That is sufficient for the PMI to exercise bargaining power over HCA. The very fact that there [redacted], even taking into account the fact that hospitals need to maintain a degree of spare capacity to minimise waiting times.

New entry

- 6.30 Fourth, the CMA argues that new entry over the next few years is inconsistent with KPMG's finding that there is sufficient capacity for PMIs to switch. However, there is no such inconsistency. As the CMA has previously noted,⁸⁸ "*The increasing cost and sophistication of medical technology used to diagnose, monitor and treat patients has been identified as a major opportunity by certain hospital groups.*" It notes the "*willingness of some providers, particularly TLC and HCA, to make very significant investments in equipment and facilities to try and secure an increased share of certain segments of the healthcare market, particularly oncology.*" Expectations of further growth in demand can facilitate market entry. The market has shown year-on-year revenue growth of 8% for the last ten years, as growth in demand, particularly for high-acuity treatment, is encouraging new providers to invest in facilities and services. New entrants such as Cleveland Clinic and VPS have identified significant growth opportunities in tertiary services for the foreseeable future. This makes London an attractive market for new entrants to come into the market with innovative, high-quality services which meet the growth in market demand.
- 6.31 Thus, KPMG's analysis of spare capacity provides compelling evidence that there is already sufficient capacity available to allow PMIs to develop products which exclude HCA hospitals. In this light, there can be no justification for a divestment remedy, the purpose of which is to create alternative, non-HCA capacity.

Smallest effective divestment package

- 6.32 The CMA states in paragraph 2.38 of the PDR that the divestment package which it originally proposed in 2014 – either (i) the London Bridge and Princess Grace Hospitals; or (ii) the Wellington Hospital and Platinum Medical Centre – represents "*the smallest effective divestment package that would be effective*".
- 6.33 Given that the CMA no longer intends to propose a divestment remedy, and that such a remedy would be disproportionate, there is no reason to consider hypothetically what the smallest divestment package would be. However, for completeness, HCA would point out that the CMA provides no reasoning or evidence to support the above assertion and that it would appear to be based entirely on the CMA's analysis in the Final Report:
- The CMA's original methodology in identifying the divestment package was seriously flawed: HCA refers to its previous submissions on this issue (see in particular section 7 of HCA's response to the CC's PDR of 21 January 2014).
 - The CMA would in any event need to take account of the KPMG spare capacity analysis which has been presented during this remittal. Even though the CMA expresses some "*uncertainty*" about this analysis, it recognises (paragraph 2.34,

⁸⁸ Final Report, paragraph 2.15.

PDR) that this analysis "*presents some evidence that, based on a set of assumptions around utilisation of beds, operating theatres, ICU beds and about the availability of specific specialities, there was sufficient spare capacity across a range of non-HCA private hospitals and PPU's in Central London*" and that this analysis is "*clearly informative*". The CMA would therefore at a minimum need to revise its assumptions about the level of shares of supply which would need to be released through a divestment remedy in the light of the analysis of spare capacity which has been provided. As discussed above, the spare capacity analysis demonstrates that there is already sufficient available capacity for PMIs to switch all their subscribers to non-HCA hospitals.

7. DIVESTMENT IS NOT A PROPORTIONATE REMEDY

(i) Introduction and summary

7.1 The CMA assesses the proportionality of a divestment remedy by reference to two analyses. First, the CMA presents an NPV calculation based on estimates of the benefits and costs that the CMA believes are “*quantifiable*” (paragraph 2.39, PDR). Second, the CMA presents a qualitative assessment of the likely impacts on those factors that it has not quantified, namely quality and range of services.

7.2 The CMA’s NPV calculation is based on the following assumptions:

- Price benefits: Based on the results of its profitability analysis, the CMA assumes that a divestment would result in HCA’s revenues from UK self-pay and insured inpatient and day-case patients declining (through a price reduction) by between 3% and 6% (paragraph 2.43, PDR). The CMA assumes that prices at the divested hospital(s) and HCA’s remaining hospitals would be renegotiated gradually over three years following divestment, and therefore that any price benefits from divestment would be realised partially in the second year following divestment, and fully from the third year (paragraph 2.49(b), PDR).
- Costs of divestment: The CMA assumes that a divestment would lead both to one-off costs to HCA and the new operator(s), and to (ongoing) losses of economies of scale. The CMA estimates that the one-off costs would amount to £[<], based on £[<] of transaction costs (incurred in year one following a divestment) and £8 million of reorganisation costs (incurred across years one and two). The CMA further assumes that the ongoing loss of economies of scale would amount to £8.2 million, £[<] and £0 million, in its “base”, “downside” and “upside” cases, respectively.
- The period of time that elapses prior to entry on a sufficient scale to effectively constrain HCA: The CMA assumes that absent divestment, there would be sufficient entry after a certain time such that the price benefits would fall to zero. The CMA considers a range of scenarios of between three and ten years, placing most weight on a five year period. The CMA also assumes that the losses of economies of scale would cease at the same time as entry.
- The discount rate: The CMA applies a 3.5% discount rate, in line with the HM Treasury Green Book approach (paragraph 2.49(c), PDR).

- 7.3 Depending on the assumptions applied, the CMA reports NPVs of divestment of between £-45.2 million and £136.1 million, as shown in Revised Table 2.1 of the PDR.⁸⁹
- 7.4 The CMA notes that “*whether the overall impact of divestiture is positive or negative depends on the assumptions that are made around the potential losses of economies of scale, the likely price benefits and the time period over which divestiture has an incremental effect*”, and acknowledges that there is “*material uncertainty around each of [these] factors*” (paragraph 2.51, PDR). The CMA concludes that, since “*on a number of plausible combinations of assumptions, the NPV is negative*” (paragraph 2.51, PDR), it “*could not form an expectation that the benefits of the remedy would outweigh the costs*” (paragraph 2.54, PDR).
- 7.5 In its qualitative assessment, the CMA considers that “*a divestiture could...stimulate...investment... [but] that the expected entry of Cleveland Clinic meant that any such (incremental) quality and/or innovation benefits were likely to be short-lived*” (paragraph 2.55, PDR). The CMA accordingly reports that it places no weight on non-price benefits in its assessment of proportionality.⁹⁰
- 7.6 HCA agrees with the CMA that its NPV calculations are subject to material uncertainty and that it is correct to treat the results with caution, particularly due to the highly intrusive nature of divestment. Furthermore, HCA welcomes the CMA’s view that divestment is not a proportionate remedy based on the scenarios to which the CMA attaches the most weight.
- 7.7 However, in HCA’s view, the case against divestment is even stronger than presented by the CMA, as the CMA overstates the NPV of a divestment remedy in four ways:
- **First, the CMA’s NPV calculations contain material calculation errors which overstate the NPV of a divestment remedy.** The CMA’s calculations of the benefits and costs of divestment contain errors that, when corrected, strengthen the conclusion that under a range of plausible scenarios the NPV of divestment is negative. HCA notes that:
 - (i) The CMA’s NPV calculations are based on a material overstatement of HCA’s 2015 UK self-pay and insured inpatient and day-case revenues, due to an apparent error in its calculations.⁹¹ This error alone leads the CMA to overstate the NPV by [3%] in the 3, 5, 7 and 10 year scenarios respectively, when assuming a 3% price benefit.⁹²

⁸⁹ Unless otherwise noted, all NPV figures relating to the CMA’s analysis are from the revised PDR released by the CMA on 6 April 2016.

⁹⁰ PDR, paragraph 2.55.

⁹¹ Rather than using the disaggregated revenues that HCA provided the CMA, the CMA attempts to approximate these revenues based on a mathematical calculation that has the effect of overstating revenues by [3%].

⁹² This is true regardless of whether the base, downside or upside case is considered. Each error is twice the noted size with a 6% price benefit.

- (ii) The CMA commits an error in how it models losses of economies of scale. Whilst the CMA notes that the 3, 5, 7 and 10 year periods modelled relate to the time period that elapses prior to sufficient entry, its NPV calculations assume that, not only would there be no price benefits but there would also be no losses of economies of scale after this time. This means that when the CMA calculates the costs of divestment in the 10 year case, it assumes that losses of economies of scale would persist for 10 years, but in the 3 year case, that losses of economies of scale would persist only for 3 years. This is incorrect, as the loss of economies of scale at HCA following a divestment is unrelated to the timescale of new entry. This error alone⁹³ leads the CMA to overstate the NPV by up to £[<] (3 year scenario, downside case).
- (iii) Fixing only these two errors leads to NPVs that are negative in the CMA's base and downside cases for the 5 year scenario, with both a 3% and a 6% price benefit – the scenarios on which the CMA places most weight (paragraphs 2.52 and 2.53, PDR) – and substantially reduces the NPV in all scenarios. All NPV calculations reported in the rest of this section correct for these errors.
- Second, **the CMA does not take into account the impact of further litigation on the date at which divestment would occur.** A conservative estimate would be that divestment is delayed by at least 12 months, commensurately shortening the period over which any benefits would be realised before expected entry. Under the 3% revenue scenario, this error leads the CMA to overstate the NPV by £[<] in the base case, £[<] in the downside case, and £[<] in the upside case, with a 3% price benefit.
 - Third, **the CMA overstates the benefits of a divestment remedy.** As noted in Sections 5 and 6, the CMA has no evidence, either from its IPA or from its profitability analysis that a divestment would lead to a reduction in prices. Notwithstanding this observation, HCA notes that:

(i) The CMA overstates HCA's economic profitability, which is used by the CMA to quantify the benefits of a divestment remedy. HCA shows in Section 5 that the CMA's estimate of HCA's ROCE is overstated, due to its failure to appropriately take account of HCA's leased property, and its failure to value HCA's intangible assets. HCA also shows in Section 5 that the CMA's estimate of WACC is significantly overstated. Even correcting for only the CMA's failure to take into account leased assets reduces the CMA's estimate of HCA's ROCE (and by extension its estimate of benefits) by approximately [<].

⁹³ That is, not having corrected for the CMA's revenue error described above.

- (ii) The CMA disregards the future impact of other remedies imposed following the original inquiry. In particular, in the original inquiry, the CMA assumed that the information remedy, which requires hospital operators to publish information about their performance from 1 September 2016, would reduce HCA's prices even absent a divestment remedy. The benefits that the CMA expects to arise from this remedy have not yet been realised, but the CMA has omitted this impact in its latest NPV analysis.
 - (iii) The CMA's evidence on Cleveland Clinic's entry plans suggests that the CMA should put most weight on the scenario that assumes the effects of entry will materialise after 3 years, and that the CMA should not put significant weight on scenarios that assume the impact of entry occurs only after 7 or 10 years.
- Fourth, **the CMA underestimates the costs of a divestment remedy.** HCA welcomes the CMA's recognition that there will be substantial transaction costs, reorganisation costs and losses of economies of scale resulting from a divestment. However, HCA notes that the CMA has not updated its estimates of these costs from the original inquiry, instead applying (with some modifications) its estimates from the Final Report. Consistent with HCA's submissions, the costs in a number of the categories considered by the CMA have increased:⁹⁴
 - (i) The CMA excludes or underestimates a number of one-off costs that would result from a divestment in its NPV calculations. Updating these costs leads to one-off costs of between £[>]and £[>], versus the CMA's estimate of £[>].⁹⁵
 - (ii) The CMA underestimates the losses of economies of scale that would result from a divestment in its NPV calculations. Updating these estimates, based on HCA's current expectations of costs that could and could not be scaled back and HCA's 2015 common costs, leads to losses of economies of scale of £[>]and £[>]per annum following a divestment of the London Bridge and Princess Grace Hospitals, and the Wellington Hospital together with the PMC, respectively. The CMA's outdated estimates of losses of economies of scale are considerably lower, at £8.2 million (base case), £[>] (downside case) and £0 million (upside case).

⁹⁴ HCA indicated to the CMA in its response to the Remedies Notice, that it was likely that [>]. Given the limited time to respond to the Remedies Notice, HCA did not submit revised estimates of costs. In the intervening period, HCA has undertaken a thorough exercise to update these costs.

⁹⁵ The CMA assumes that [>] of these costs are incurred in the first year following divestment, and [>] are incurred in the second year. Whilst HCA believes that the CMA overstates the proportion of costs that would be incurred after the first year, to be conservative HCA follows a similar approach in its NPV calculations.

- (iii) Even updating only the losses of economies of scale that the CMA accepts in its base case to reflect HCA's 2015 common costs, and making no further adjustments, leads to costs of [§<].⁹⁶
- (iv) The CMA incorrectly excludes losses of investment at the divested hospitals and at HCA. [§<].

7.8 Once the material calculation errors described above are corrected, accounting for the overstatement in benefits and updating the costs of divestiture to reflect HCA's 2015 costs yields NPV estimates that are negative under all scenarios.⁹⁷ Specifically:

- **Updating the CMA's NPV (for the CMA's base and downside cases):** Using the CMA's assumptions about economies of scale, but updating only to account for HCA's 2015 rather than 2011 cost data, leads to NPVs of between £[§<] and £[§<] in the base case, and between £[§<] and £[§<] in the downside case;
- **HCA base case:** Updating the CMA's NPV model to capture the impact of the information remedy, and HCA's updated estimates of one-off costs and losses of economies of scale leads to NPVs of between £[§<] and £[§<];
- **HCA base case correcting for the impact of litigation on the timing of a divestment remedy:** Adding a further correction to the HCA base case, to take account of the fact that the divestment would be delayed by at least 12 months due to ongoing litigation, would lead to NPVs of between £[§<] and £[§<];
- **HCA base case correcting for the impact of litigation, plus including the impact of a reduction in investment:** Adding a further correction to the previous scenario, to include HCA's quantification of the [§<].

7.9 It is clear from the results of the NPV that, under no range of plausible assumptions regarding entry, price benefits, or the costs of divestment, is the NPV of a potential divestment remedy positive. Therefore requiring divestment under any of the proposed divestment packages would be grossly disproportionate.

7.10 In the rest of this section HCA explains:

- the material calculation errors in the CMA's NPV model and presents the resulting NPVs when correcting these errors;
- the CMA's failure to take into account the impact of ongoing litigation;
- why the CMA has overestimated the benefits of divestment;

⁹⁶ Note that the CMA's calculation is based on a divestment of the London Bridge and Princess Grace Hospitals only.

⁹⁷ In light of HCA's views on the CMA's estimated price benefits, only the CMA's 3% price benefit assumption is presented.

- why the CMA has underestimated the quantifiable costs of divestment;
- HCA's revised NPV calculations; and
- the negative impact of divestment on the quality and range of services in central London.

(ii) Errors in the CMA's NPV calculations

7.11 HCA has reviewed the spreadsheet provided by the CMA on 6 April 2016 ("the CMA's NPV spreadsheet model").⁹⁸ In the course of its review, HCA has identified two errors in the CMA's NPV calculations:

- First, the CMA's calculations materially overstate price benefits due to an error in the CMA's calculation of HCA's revenues.
- Second, the CMA's calculations reflect inconsistent assumptions relating to the time period over which there will be losses of economies of scale.

7.12 HCA discusses each error in turn below, before explaining the implications of correcting for these errors on the CMA's NPV calculations.

The CMA's calculations materially overstate price benefits due to an error in its calculation of HCA's revenues

7.13 In the course of its review of the CMA's NPV spreadsheet model, HCA uncovered an error that causes the CMA's calculations of price benefits to be materially overstated in each of its scenarios.

7.14 The CMA calculates price benefits at each of HCA's inpatient facilities separately,⁹⁹ by multiplying 2015 UK inpatient and day-case revenues for self-pay and insured patients at that facility by 3% and 6%, respectively.

7.15 However, the CMA incorrectly calculates the revenue base (2015 UK inpatient and day-case revenues for self-pay and insured patients) in each case. Based on information available to the CMA (and contained in the CMA's NPV spreadsheet model), the correct revenue base would be the sum of HCA's 2015 inpatient and day-case revenues for self-pay and insured patients at each facility. Instead, the CMA calculates HCA's self-pay and insured revenue at each facility by multiplying the total inpatient and day-case revenues at each HCA facility by the proportion of all revenues at that facility that were self-pay or insured – a proportion that was calculated across revenues from inpatients, day-case patients and outpatients. Had the CMA included only the proportion of revenues from inpatients and day-case patients that

⁹⁸ See "NEW_160406 Copy of HCA NPV Analysis.xlsx".

⁹⁹ Although in the Harley Street Clinic's calculation the CMA includes HCA's revenues from its other central London facilities.

were self-pay or insured in its calculations, rather than the proportion of revenues from all patients, it would have calculated the correct¹⁰⁰ revenue base. Instead, the CMA's error leads it to [X<]

The CMA's calculations reflect inconsistent assumptions relating to the time period over which there will be losses of economies of scale

- 7.16 The CMA notes that its NPV calculation approach “*assumes that the incremental impact of the divestment would reduce to zero once new entry...exerts an effective competitive constraint on HCA since... [this entry would] have the effect of reducing prices to the competitive level*” (paragraph 2.45, PDR). The CMA reflects this assumption in its NPV model by calculating the sum of the present value of the price benefits and costs over, respectively, a 3, 5, 7 and 10 year period.
- 7.17 The CMA's approach implies, however, that in the case that there is sufficient entry after 10 years, the losses of economies of scale (which represent the only ongoing cost in the NPV model beyond year two) are modelled for ten years. However in the case that there is sufficient entry after three years, the losses of economies of scale are only modelled for three years.
- 7.18 In other words, as well as assuming that the benefits of divestment end once new entry occurs, the CMA assumes that the losses of economies of scale also cease to apply at that point. This assumption is incorrect (and the CMA gives no reasons or evidence to support it). HCA notes that in the original inquiry, the CMA assumed (in its downside case) that losses of economies of scale would persist for 20 years, considerably longer than the 3, 5, 7 or 10 years assumed in the PDR.

The impact of correcting for these errors on the CMA's NPV calculations

- 7.19 Table 1 shows the impact of correcting for the two errors discussed above on the CMA's NPV calculations. To be conservative, HCA presents results where it applies economies of scale losses only over 10 years (rather than the 20 years used by the CMA in the original inquiry).¹⁰¹

¹⁰⁰ The CMA gives no indication in the PDR as to why it would use outpatient revenues in this calculation. Indeed, the CMA states “*We have applied this price reduction to UK self-pay and insured revenues from inpatient and day-case treatments*” and “*We have assumed that divestiture would have no impact on the prices charged by HCA for outpatient treatments*” (paragraph 2.44, PDR).

¹⁰¹ HCA notes that in the original investigation, the CMA included a downside case in its NPV calculations that modelled losses of economies of scale over a 20 year period.

Table 1: NPV of divestment correcting for the CMA's errors (£000)

	3% price benefit			
Loss of economies of scale	Year 3	Year 5	Year 7	Year 10
£[redacted]- downside case	[redacted]	[redacted]	[redacted]	[redacted]
£8.2 million – base case	[redacted]	[redacted]	[redacted]	[redacted]
£0 million – upside case	[redacted]	[redacted]	[redacted]	[redacted]
	6% price benefit			
Loss of economies of scale	Year 3	Year 5	Year 7	Year 10
£[redacted]- downside case	[redacted]	[redacted]	[redacted]	[redacted]
£8.2 million – base case	[redacted]	[redacted]	[redacted]	[redacted]
£0 million – upside case	[redacted]	[redacted]	[redacted]	[redacted]

7.20 As shown in Table 1, correcting for these errors in the CMA's NPV calculations gives substantially lower NPVs than the CMA reports in the PDR, revealing that the CMA overstates the NPV of divestment by up to £[redacted] (3 year scenario, 6% price benefits, downside case). Notably, as well as being negative in all the base case and downside case scenarios with a 3% price reduction, the NPVs are now also negative in all of the 5 year base case and downside case scenarios on which the CMA places most weight.¹⁰²

7.21 In the remainder of this section, all NPVs reported by HCA correct for these errors.

(iii) The CMA's calculations do not account for the impact of further litigation delaying a divestment decision

7.22 A number of grounds of appeal in *HCA v CMA* have been stayed by the Tribunal, including in relation to the divestiture of HCA's hospitals.¹⁰³ It remains HCA's view that divestment is an extreme, unjustified and grossly disproportionate remedy, and therefore, should a fresh decision be made requiring HCA to divest its hospitals, such litigation would be recommenced. This litigation is highly likely to postpone the implementation date of any divestment remedy at least by 12 months, i.e. to September 2018, and this is without regard to the possibility of further appeals. The CMA has itself recognised that challenges to remedies are likely to delay the period in which any potential benefits to consumers may arise.¹⁰⁴

¹⁰² "We considered that most weight should be placed on the base case and downside scenarios (with less emphasis given to the upside scenario)" (paragraph 2.53, PDR); "We have placed most weight on the '5 year scenarios'" (paragraph 2.52, PDR).

¹⁰³ *HCA v CMA*, [2014] CAT 23, paragraph 62.

¹⁰⁴ Presentation *UK Markets Regime*, Alex Chisholm, CEO, Competition and Markets Authority, December 2015, slide 10.

7.23 A delay of at least 12 months due to litigation would result in a commensurate delay to both the costs and benefits of divestment, but there is no reason to suggest it would delay the entry decisions of the Cleveland Clinic or other potential entrants. Reflecting this delay in the CMA's NPV model would thus result in a shortening of the period in which price benefits are realised by at least one year.¹⁰⁵

(iv) Benefits of divestment

7.24 In its NPV calculations, the CMA assumes that a divestment will lead to a reduction in HCA's revenues from UK self-pay and insured inpatients and day-case patients of between 3% and 6%, which the CMA assumes will emerge through a reduction in HCA's prices to these patients. This estimated revenue reduction corresponds to the lower end of the CMA's estimate of HCA's economic profit as a proportion of revenues from UK patients (paragraph 2.43, PDR).

7.25 The CMA further assumes that:

- price benefits from divestment would be realised partially in the second year following divestment, and fully from the third year, as prices at the divested hospital(s) and HCA's remaining hospitals would be renegotiated gradually over a period of three years (paragraph 2.49(b), PDR); and
- price benefits would persist until such time as there is "*entry on a sufficient scale to effectively constrain HCA*" (paragraph 2.51, PDR). The CMA notes that its "*provisional view is that entry by Cleveland Clinic (primarily) is likely, together with other non-HCA hospitals, to act as an effective competitive constraint on HCA by early 2022*" (paragraph 2.52, PDR), meaning that it places most weight on price benefits persisting until 5 years following divestment. The CMA also considers the impact of price benefits persisting until 3, 7 and 10 years following divestment, due to the "*uncertainties around the timing of such entry and the speed and extent to which it will exert a competitive constraint*" (paragraph 2.46, PDR).

7.26 The CMA also notes that a divestment remedy could lead to non-price benefits, but places no weight on these in its assessment of proportionality.¹⁰⁶

7.27 As noted in Section 6, the CMA has no evidence that divestment of one or more hospitals is an effective remedy and therefore no evidence that it will lead to any reduction in HCA's prices. As such, a divestment remedy for HCA is not proportionate under any circumstances. Setting this aside, however, and without prejudice to this overall view, HCA explains below that:

¹⁰⁵ The costs and benefits of divestment would also be discounted by an additional year, dampening their present value.

¹⁰⁶ "*We have not placed weight on... non-price benefits in our assessment of proportionality*" (paragraph 2.55, PDR).

- the CMA's estimate of HCA's economic profit, used to quantify price benefits of divestment, is overstated;
- other remedies imposed following the original inquiry would dampen any price benefits attributable to a divestment remedy;
- the CMA should place little or no weight on scenarios that assume a price benefit would persist for more than 5 years; and
- a divestment will lead to no non-price benefits.

7.28 The remainder of this section deals with each of these in turn.

The CMA overstates price benefits due to errors and inconsistencies in its profitability analysis

7.29 HCA set out in Section 5 that the CMA overstates HCA's economic profitability in the following ways:

- The CMA excludes HCA's [x<]leased property portfolio from its capital employed estimate, contrary to other parts of its analysis, and contrary to the new IFRS 16 leases standard.
- The CMA does not take into account any value relating to HCA's intangible assets, such as its brand. This is inconsistent with the importance of brand as recognised by market participants (including the PMIs).
- The CMA understates HCA's WACC as a result of a number of methodological flaws.

7.30 These errors are material and imply that the CMA's overstatement of the benefits from a divestment remedy is substantial. For example, even correcting only for the CMA's incorrect treatment of HCA's leased property assets has the effect of reducing the CMA's current ROCE calculation by [x<] percentage points for the 3, 5, 7 and 10 year NPV scenarios respectively.

7.31 The CMA notes that its estimates of price reductions following a divestment remedy are based on a number of judgements and assumptions, and that therefore "*there is significant uncertainty over the likely level of price benefits that would result from a divestiture*" (paragraph 2.54, PDR). HCA welcomes this view, and agrees that the CMA's estimates of price benefits, based in large part on the results of its profitability analysis, are subject to substantial uncertainty.

7.32 However, HCA is concerned that, in using an estimated price benefit of between 3 and 6% for its NPV assessment, the CMA does not treat its analysis of price benefits with appropriate caution in light of this uncertainty.

7.33 HCA shows above that there are a number of flaws in the CMA's methodology which imply that the CMA's estimate of price benefits from divestment are in fact overstated. Even making a conservative assumption to correct only one of these flaws – the failure to take into account HCA's leased property portfolio in line with the latest accounting standards – implies that the CMA's estimated price benefits following a divestment remedy should be reduced by [X].

7.34 In HCA's view, given the number of flaws and uncertainties that remain in the CMA's analysis, the CMA cannot put weight on any price reductions arising out of its divestment remedy. In light of this, in the following sections, HCA presents results only in relation to the CMA's 3% scenario for price benefits from divestment, though notes that it considers even this to be a substantial overestimate.

The information remedy imposed following the original inquiry would dampen any price benefits attributable to a divestment remedy

7.35 In the original inquiry, the CMA imposed three remedies to address AECs that it identified, including a combination of measures to improve the public availability of information on consultant fees and information on the performance of consultants and private hospitals (together, the "information remedy").¹⁰⁷

7.36 In the Final Report, the CMA assessed the extent to which this remedy would impact on prices and concluded that this impact could and should be quantified.

7.37 In the Final Report, the CMA concluded that "*the (price) impact of our information remedy and our divestiture remedies would have effect via the same mechanism of increasing competition in the market*".¹⁰⁸ The CMA accordingly "*took into account the likely impact of our information remedies on the level of prices charged by HCA's central London hospitals and deducted this from our estimate of the NPV of the divestiture remedy*",¹⁰⁹ by assuming that the impact of the remedy would reduce HCA's revenues (via a reduction in prices) by around 1%.¹¹⁰

7.38 In the PDR, the CMA does not account for the potential benefits stemming from the introduction of the information remedy.

¹⁰⁷ The other two remedies were measures to ensure that arrangements between NHS trusts and private hospital operators to operate or manage a PPU will be capable of review by the CMA (the "PPU remedy") and a restriction or ban on certain benefits and incentive schemes provided by private hospital operators to clinicians (the "clinician incentives remedy"). The CMA did not attempt to quantify the benefits from either of these two remedies.

¹⁰⁸ Final Report, paragraph 11.228(d).

¹⁰⁹ Final Report, paragraph 11.228(d).

¹¹⁰ Final Report, paragraph 11.234.

7.39 If the CMA is to assume that a divestment remedy would lead to price benefits, it must use only the incremental benefits, net of the impact of the information remedy, in its NPV calculations. Since hospital operators are not obliged to comply with the CMA's Final Order¹¹¹ until 1 September 2016,¹¹² and in line with the CMA's previous assumption that the information remedy would begin to have a price impact in 2018, in HCA's view nothing has changed between the publication of the Final Report and the publication of the PDR that would alter when and to what extent the information remedy would impact on prices.¹¹³

7.40 The 1% figure used in the Final Report was based on [X].

The CMA should place little or no weight on scenarios that assume a price benefit would persist for more than five years

7.41 As noted in Section 6, HCA does not agree that a divestment would lead to any benefits in the form of lower prices to consumers. Therefore in HCA's view, any new entry, for example by the Cleveland Clinic, would not lead to lower prices to insurers or consumers.

7.42 Even setting this aside, the CMA recognises that Cleveland Clinic's own business plans indicate that it expects to earn significant revenues in central London in both [X] and [X] and therefore that it could exert a significant constraint on HCA by that point (paragraph 1.82, PDR). This suggests that the CMA's estimated price benefits can be expected to materialise before five years, and therefore that the CMA's three year scenario is likely to be the most plausible. At a minimum, HCA submits that based on this evidence, the CMA should not put significant weight on scenarios that assume the impact of entry occurs only after 7 or 10 years.

A divestment would not lead to non-price benefits

7.43 HCA welcomes the CMA's provisional decision to place no weight on non-price benefits in its proportionality assessment.

7.44 HCA strongly disagrees, however, with the CMA's provisional conclusion that "*an increase in rivalry resulting from a divestiture remedy could be expected to increase competition on quality and range (not just on price) and an improvement in the quality of hospital services over time*" (paragraph 2.55, PDR).

7.45 In its response to the Remedies Notice,¹¹⁴ HCA set out a number of reasons why a divestment would not lead to better non-price outcomes for patients, including that: a new operator would be likely to follow a strategy of investing less than HCA; a forced divestment

¹¹¹ Private Healthcare Market Investigation Order 2014, CMA, 1 October 2014.

¹¹² HCA notes that some of its competitors in central London, for example TLC (see 'Summary of hearing with The London Clinic on 15 December 2015', CMA, January 2016) has not yet begun to report this information.

¹¹³ Whilst the CMA no longer relies on the IPA to estimate the price benefits of divestment, the CMA continues to assume that a divestment would result in price benefits to consumers due to increased competitive pressure on HCA, as it did in the Final Report.

¹¹⁴ HCA's response to the Remedies Notice, paragraphs 3.92-3.110

would have a chilling effect on investment; and any increase in PMIs' bargaining power could reduce incentives for HCA and other healthcare operators to invest, and could lead to PMIs attempting to reduce quality and range. HCA further noted that a divestment is likely to lead to a loss of RCBs relating to quality, range and investment. Several of these issues are discussed in more detail in the discussion of costs of divestment below.

7.46 The CMA does not adequately respond to the points made by HCA in the Remedies Notice, and must reassess its provisional conclusion that a divestment remedy could improve non-price outcomes. In fact, as HCA notes below, the CMA must instead account for a loss of RCBs relating to non-price outcomes in its assessment of the costs of divestment.

(v) Costs of divestment

7.47 The CMA includes in its NPV model three categories of economic costs arising from a divestment:

- Transaction costs: The CMA includes as transaction costs the costs incurred by both seller and buyer(s) to obtain legal and professional advice relating to the divestment process. The CMA estimates that in the first year following divestment, there would be £[<] of transaction costs, comprising £[<] to HCA and £[<] to the purchaser(s).¹¹⁵
- Reorganisation costs: The CMA defines these as the costs incurred by the seller *“to reduce the central business functions to reflect the smaller size of the business”* (paragraph 35, Appendix to the PDR). The CMA estimates that HCA would incur £4 million of redundancy and reorganisation costs in each of the first two years following divestment.
- Loss of economies of scale: these comprise the losses to customers resulting from the higher prices that HCA would have to charge to recover its central costs over a smaller number of hospitals post-divestment. The CMA estimates that these losses would amount to £8.2m (base case), £[<] (downside case) and £0m (upside case) (paragraph 39(b), PDR).

7.48 In each category, the CMA bases its cost estimates on the estimates it included in the Final Report. These costs were themselves based on only a divestment of the London Bridge and the Princess Grace Hospitals; the CMA did not take into account the potential costs of a divestment of the Wellington Hospital together with the PMC. In its response to the Remedies Notice, HCA noted that these costs are likely to have risen since they were previously estimated, and that they would need to be re-assessed.¹¹⁶ Whilst the CMA acknowledges HCA's argument, it has not attempted to update its cost assessment.

¹¹⁵ [<]

¹¹⁶ See, for example, HCA's response to the Remedies Notice, paragraphs 3.165, 3.167 and 3.169.

7.49 HCA has re-assessed the costs relating to a number of these categories, and sets out its estimates of these costs in Table 2 below.

Table 2: HCA's estimates of the costs of a divestment remedy (£000)

Cost categories included in the CMA's NPV model	London Bridge + Princess Grace (single buyer)	London Bridge + Princess Grace (two buyers)	Wellington + PMC
One-off costs			
Transaction costs	[]	[]	[]
Reorganisation costs	[]	[]	[]
Monitoring trustee costs	[]	[]	[]
Loss of investment (year 1)	[]	[]	[]
Ongoing costs			
Losses of economies of scale	[]	[]	[]
Losses of economies of scale: adopting CMA base case assumptions	[]	[]	[]
Losses of economies of scale: adopting CMA downside case assumptions	[]	[]	[]
Loss of investment (year 2 onwards)	[]	[]	[]

7.50 Given the limited time available to respond to the PDR, HCA has not been able to quantify a number of other costs of a divestment remedy, including the losses of relevant customer benefits (RCBs) other than economies of scale, such as a loss of quality and range of services, and asset risk at the divested hospital(s). If the CMA is unable to quantify these costs for inclusion in the NPV model, HCA submits that the CMA must treat its quantification of the costs of divestment as an underestimate, and that the NPVs based on these costs are therefore overstated.

7.51 In the rest of this section, HCA sets out more detail on the estimates of the costs of divestment in each of the categories in Table 2.

Transaction costs

7.52 Transaction costs, as defined by the CMA, include the costs incurred by both the seller and buyer(s) to obtain legal and professional advice relating to the divestment process. The CMA assumes that a divestment would lead to transaction costs of £[], incurred by both HCA (£[]) and the purchaser(s) (£[])¹¹⁷ during the first year following divestment.

¹¹⁷ In its NPV model, the CMA applies the [].

- 7.53 The CMA’s estimate of transaction costs associated with a divestment remedy is based on estimates submitted by HCA in the original inquiry. In the Final Report, the CMA adopted the upper estimate of the transaction costs submitted by HCA (£[redacted]).¹¹⁸ In the PDR, the CMA excludes certain categories of costs, arguing that they are double-counted or that they would not arise, and takes the mid-point of the estimates submitted by HCA for the other cost categories (paragraph 33, PDR).
- 7.54 In its response to the Remedies Notice, HCA noted that the costs it submitted in the original inquiry are likely to have increased and would need to be reassessed.
- 7.55 HCA has [redacted], and its legal counsel, Nabarro, to identify and estimate the magnitude of the different transaction costs that would result from a divestment of the London Bridge and the Princess Grace Hospitals, and the Wellington Hospital together with the PMC. HCA notes [redacted] and Nabarro have extensive experience in advising clients in sales processes (including in healthcare transactions) and business restructuring, and are well placed to estimate these costs. The assumptions and methodology underpinning the calculations of transaction costs are explained in Annex 1.
- 7.56 [redacted] Nabarro’s estimates of these costs are set out in Table 3 and Table 4. HCA notes that some of the costs included in Table 3 and Table 4 differ from the cost estimates submitted in the original inquiry. This is due to HCA having been able, in the additional time available in the remittal investigation, [redacted] to consider these costs in more detail than was possible during the original investigation.

Table 3: Estimated transaction costs to HCA (£000)

7.57	London Bridge + Princess Grace (single buyer)	London Bridge + Princess Grace (two buyers)	Wellington + PMC
Corporate finance M&A advice fees	[redacted]	[redacted]	[redacted]
Due diligence fees: financial, tax, IT, pensions	[redacted]	[redacted]	[redacted]
Due diligence fees: clinical, commercial, quality, governance	[redacted]	[redacted]	[redacted]
Legal fees	[redacted]	[redacted]	[redacted]
Tax structuring advice fees	[redacted]	[redacted]	[redacted]
Total transaction costs to HCA	[redacted]	[redacted]	[redacted]

¹¹⁸ Final Report, paragraph 11.214

Table 4: Estimated transaction costs to the purchaser(s) of the divested hospital(s) (£000)

7.58	London Bridge + Princess Grace (single buyer)	London Bridge + Princess Grace (two buyers)	Wellington + PMC
Corporate finance M&A advice fees	[<]	[<]	[<]
Debt arrangement fees	[<]	[<]	[<]
Due diligence fees: financial, tax, IT, pensions	[<]	[<]	[<]
Due diligence fees: clinical, commercial, quality, governance	[<]	[<]	[<]
Legal fees	[<]	[<]	[<]
Tax structuring advice fees	[<]	[<]	[<]
Political adviser fees	[<]	[<]	[<]
Total transaction costs to the purchaser(s)¹¹⁹	[<]	[<]	[<]

7.59 In respect of the categories of costs put forward by HCA and accepted by the CMA in the original inquiry, but that the CMA now excludes, HCA notes the following:

- The CMA does not include in the PDR due diligence fees incurred by the seller in its NPV calculations, as in its view “*due diligence fees are only incurred by the buyer*” (paragraph 33(d), Appendix to PDR). [<], HCA would incur due diligence advisory fees relating, for example, to the preparation of access to a large amount of data to prospective buyers, including possibly through a series of deal/data rooms, and the potential preparation of a series of due diligence reports on financial and non-financial matters relating to the divested hospital(s). The CMA must therefore include the seller’s due diligence cost estimate in its NPV model.
- The CMA does not include political adviser fees in its NPV calculations, as in its view “[*neither*] vendor [*nor*] purchaser would need to incur such costs” (paragraph 33(c), Appendix to PDR). [<], HCA would not be expected to pay for a political adviser, however each buyer would be expected to incur costs of around £[<] on such a service. The CMA must therefore include the political adviser cost estimate in its NPV model.
- The CMA contends that tax structuring fees “*would be covered by the legal ... fees*” (paragraph 33(e), Appendix to PDR), and it therefore excludes HCA’s previous estimate of this cost from its NPV calculations. [<], the estimates of tax

¹¹⁹ Total transaction costs for scenarios with two buyers are the sum of the costs of each buyer.

structuring fees and legal fees reported in Table 3 and Table 4 above are independent and the legal fees do not contain any advice relating to tax structuring. The CMA must therefore include the tax structuring cost estimate in its NPV model.

- The CMA contends that property valuation fees “*would be covered by the ... M&A fees*” (paragraph 33(e), Appendix to PDR), and it therefore excludes HCA’s previous estimate of this cost from its NPV calculations. As noted in Annex 1, [redacted] and therefore Table 4 does not include a separate category for property valuation fees.
- Table 4 reports one cost item [redacted] for which HCA did not submit an estimate in the original inquiry, and that the CMA does not consider in the PDR: debt arrangement fees to the purchaser(s). As noted in Annex 1, any buyer would likely need to raise debt to cover its purchase, and would incur costs of arranging this debt that would not be incurred absent a divestment. The CMA must include this cost category in its NPV calculation.

Reorganisation costs

7.60 Reorganisation costs, as defined by the CMA, are the costs incurred by the seller “*to reduce the central business functions to reflect the smaller size of the business*” (paragraph 35, Appendix to the PDR). The CMA assumes that a divestment would lead to reorganisation costs of £8 million, incurred by HCA during the first two years following divestment (£4 million in each year).

7.61 The CMA’s calculation of reorganisation costs is based on the midpoint of its estimate of these costs during the original inquiry (£7-9 million). That estimate was based on the CMA’s estimates of the costs that BMI would have incurred were it to have been ordered to divest seven hospitals, scaled by the ratio of HCA’s to BMI’s central costs. The details behind the CMA’s assessment of BMI’s likely reorganisation costs have not been disclosed to HCA.

7.62 In the time available, and given the considerable uncertainty around the extent of reorganisation that HCA would need to undertake, HCA has not been able to quantify the precise reorganisation costs it would incur following a divestment.

7.63 HCA notes, however, that these costs may be substantial. For example:¹²⁰

- [redacted].¹²¹
- HCA also notes that there would likely be substantial costs to the purchaser(s) before they could begin to run the hospitals on a standalone basis. For example, a new entrant not already operating private hospitals in the UK (such as an

¹²⁰ See Annex 1 for further details

¹²¹ [redacted].

international operator) might have to purchase EPR and other clinical systems. Such systems typically cost upwards of £5 million.¹²²

- [redacted].¹²³
- [redacted].^{124 125}

7.64 For these reasons, the CMA's estimate of £8 million appears to be towards the lower end of potential costs that any operator would incur for a restructuring on the scale implied by the CMA's potential divestment package.

7.65 Additionally, there are a number of reasons why an estimate, based on the CMA's expectation of what BMI's reorganisation costs would have been, might underestimate HCA's potential reorganisation costs:

- First, HCA's hospital network is closely integrated, and may be more so than BMI's network. HCA has provided the CMA with a large volume of evidence during the original and remittal inquiries relating to HCA's integrated patient pathways, integrated IT infrastructure, shared clinical know-how and operational expertise, common services and other network synergies that benefit its patients and allow for a higher quality of care.¹²⁶ Were HCA to have to divest the London Bridge and Princess Grace Hospitals, or the Wellington together with the PMC, it would likely wish to attempt to replicate – to the extent possible – these synergies across its remaining network. Although HCA contends that for a number of these benefits replicating them to the full extent would not be possible (representing a loss to patients), and attempts to even partially replicate these benefits would likely give rise to significant costs.
- Second, the hospitals that the CC had provisionally decided to order BMI to divest were not similar to the divestment packages contemplated by the CMA for HCA. Each of the proposed divestment packages for HCA accounts for a considerably higher proportion of HCA's total capacity than the proportion of BMI's total capacity accounted for by the divestment packages that the CC had provisionally proposed for BMI. Each of the three HCA hospitals has over 100 inpatient beds (the Wellington together with the PMC has more than 200), and either divestment package would account for more than 30% of HCA's inpatient bed capacity. By contrast, the largest hospital that BMI would have had to divest (assuming it would have selected the smallest hospital from each option) would have had only 47 inpatient beds, and had it selected the largest hospital from each option, a

¹²² See, for example, <http://www.digitalhealth.net/news/29466/clatterbridge-signs-up-for-meditech>.

¹²³ [redacted].

¹²⁴ [redacted].

¹²⁵ [redacted].

¹²⁶ See for example, HCA's Response to the CC's Remedies Notice, paragraph 6.36.

divestment would have accounted for only 16% of BMI's total inpatient bed capacity. It seems highly likely that HCA would face potentially substantially higher costs of reorganising its business as a result of the proposed divestment than would BMI, since the proposed divestment represents a much more substantial proportion of HCA's overall UK business.

- Third, it is in any case unclear that the CMA's estimates of BMI's reorganisation costs were valid. These costs were estimated by the CC only for the purpose of its PDR in the original inquiry, and the CMA noted in the Final Report that BMI had, in its response to that document "*set out a number of additional costs ... which it argued should be taken into account*", but which the CMA concluded "*it was not necessary to come to a view on ... [given] divestiture was no longer a proportionate remedy*".¹²⁷ HCA notes that the CMA arrived at a higher estimate of several of HCA's cost items, including transaction costs, in the Final Report versus the Provisional Decision on Remedies in the original inquiry, and it is therefore plausible that the £7 - 9 million provisional estimate for BMI was an underestimate.

7.66 Based on the discussion above, HCA has, on a conservative basis, used the CMA's £8 million estimate of reorganisation costs in the assessment of the proportionality of the NPV, though it considers that this is likely to be an underestimate of these costs.

Monitoring trustee costs

7.67 In the Final Report, the CMA noted that HCA would be required to appoint a monitoring trustee approved by the CMA, "*to monitor the divestiture process and compliance with the Undertakings or Order on the CMA's behalf*".¹²⁸ The CMA also acknowledged that the cost to HCA of appointing a monitoring trustee was a relevant cost of divestment, and included it in its NPV model.¹²⁹

7.68 In the PDR, the CMA omits the cost of a monitoring trustee in its updated NPV model. The CMA does not explain why it does so.

7.69 HCA has asked [§<] to estimate the costs that HCA would face in appointing a monitoring trustee. Whilst the terms of such an appointment are no longer clear as the CMA has provisionally decided not to pursue a divestment remedy, [§<] has assumed for the purpose of this exercise that the requirement would be in line with what the CMA previously set out in the Final Report. [§<] estimates are set out in Table 5 below. The assumptions and methodology underlying these calculations are explained in Annex 1.

¹²⁷ Final Report, paragraph 12.15.

¹²⁸ Final Report, paragraphs 13.1(a)(ii).

¹²⁹ Final Report, paragraph 11.211.

Table 5: Estimated monitoring trustee costs (£000)

	London Bridge + Princess Grace (single buyer)	London Bridge + Princess Grace (two buyers)	Wellington + PMC
Monitoring trustee fees	[REDACTED]	[REDACTED]	[REDACTED]

Losses of economies of scale

7.70 In the PDR, the CMA recognises that a divestment would result in losses of scale economies. In order to account for such losses in its NPV calculation, the CMA reviewed the cost estimates that HCA put forward during the original inquiry and concluded that, in certain areas, common costs could be reduced further than HCA had assumed (paragraph 2.47 and Table 6, PDR).

7.71 During the original inquiry, HCA submitted that if it were to divest the London Bridge and Princess Grace, it would incur costs of £[REDACTED] per annum due to a loss of scale economies. This estimate was based on 2011 cost data and comprised the following cost categories:¹³⁰

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

7.72 The CMA states that it carefully considered HCA's assumptions and estimates above, and presents the following adjustments:

- some further rationalisation could be achieved for central cost functions where HCA employs large teams, under the assumption that any excess staff would either be transferred to the purchaser(s) of the divested hospitals or made redundant;
- 50% of costs associated with HCA Laboratories could be recovered by scaling back their operation; and
- the costs of running SCRI UK are fully variable and could be scaled back in full in case of divestiture (Table 5, Appendix to the PDR).

7.73 As such, the CMA concludes that a more reasonable estimate of such losses would be around £8.2 million per annum (paragraph 2.47 and Table 6, PDR). Nevertheless, the CMA notes that its assessment involved a number of assumptions over which there is some uncertainty. As such, it considers the results to be indicative rather than precise estimates of the likely loss of economies of scale (paragraph 29, Appendix to the PDR).

¹³⁰ HCA's response to the CC's PDR, Annex 2, Table 8.

- 7.74 The CMA presents three scenarios in its NPV model:
- a base case, where the CMA assumes that HCA would incur losses of economies of scale of £8.2m per year;
 - a downside case, where the CMA assumes that HCA would incur a loss of economies of scale of £[<], in line with HCA's own estimate of its loss of economies of scale based on 2011 costs; and
 - an upside case, where the CMA assumes that HCA would incur no loss of economies of scale as it would be able to reorganise its operations to reduce central and other overhead costs proportionately to what is divested (paragraph 2.47, PDR).
- 7.75 HCA welcomes the CMA's conclusion that "*HCA was likely to suffer some losses of economies of scale as the result of being required to divest a significant proportion of its central London hospitals*" (paragraph 2.53, PDR). In particular, HCA welcomes the CMA's conclusion that "*the upside scenario assumption of zero loss of economies of scale is likely to overstate the NPV of the divestiture remedy*" (paragraph 2.53, PDR). In light of this finding, it is clear that the CMA should place no weight on its NPV upside case.
- 7.76 Nevertheless, HCA believes that the CMA's base case assumptions¹³¹ on the cost savings that HCA would make following a divestment are arbitrary and the CMA has not set out how it expects HCA to achieve them.
- 7.77 Furthermore, the CMA's estimates of economies of scale losses are based on HCA's common costs from 2011, and the assumptions about the extent to which HCA could make cost savings underlying the CMA's estimates are also now outdated. As HCA has previously noted to the CMA,¹³² HCA's common costs have increased since 2011, due to it having [<]. Relying on central costs from 2011, and assumptions from the original inquiry, therefore, provides an incorrect view of the likely economies of scale losses that HCA would incur following a divestment. It is also inconsistent with the CMA's reliance on the 2015 revenue base to assess benefits from divestment.
- 7.78 The CMA replied to HCA stating that further evidence from HCA would be welcome as part of its response to the PDR, and would be considered before the CMA made its final decision and published this in the Final Report.¹³³
- 7.79 HCA welcomes the CMA's willingness to accept new cost estimates and has therefore undertaken an extensive exercise to precisely quantify both the increases in HCA's central

¹³¹ It is important to note that the assumptions on economies of scale losses and potential rationalisation are not fully detailed in the PDR and therefore, HCA has had to rely on the high level economies of scale losses provided by the CMA in Table 6, Appendix to the PDR.

¹³² Nabarro letter to Lesley Moore dated 15 March 2016

¹³³ CMA letter to HCA from Lesley Moore, dated 16 March 2016.

and group costs that have occurred since 2011, as well as the expected losses of economies of scale that would result from a divestment remedy.

- 7.80 This costly and time-consuming exercise, which due to the limited time available during the original inquiry, was considerably more thorough than the corresponding exercise undertaken during the original inquiry, included input from each member of HCA's executive team as well as the non-executive heads of each of HCA's departments. For each department, a detailed review of the function and head count of the department along with a bottom up review of how the workload of the department would change following a divestment was undertaken.¹³⁴ For a number of departments, [redacted].¹³⁵ Full details of this analysis are set out in Annex 3.
- 7.81 Table 6 shows the results of these analyses. HCA estimates that the likely loss of economies of scale it would incur at its remaining hospitals would range from [redacted] depending on whether it were to divest the Wellington Hospital together with the PMC or the London Bridge and the Princess Grace Hospitals.

Table 6: Estimated losses of economies of scale (£000)

7.82 Cost category	London Bridge + Princess Grace	Wellington + PMC
Recharged central costs	[redacted]	[redacted]
Group costs	[redacted]	[redacted]
HCA Laboratories	[redacted]	[redacted]
SCRI UK	[redacted]	[redacted]
Total	[redacted]	[redacted]

- 7.83 In addition to the costs set out in Table 6, HCA expects to incur losses of purchasing economies of scale relating to centrally procured services (e.g. pharmaceutical companies, providers of clinical products, utility companies, etc.).¹³⁶ These losses have not been included, and therefore the figures presented in Table 6 represent an underestimate of the losses of economies of scale that HCA would incur as a result of a divestment remedy.

Replication of CMA's economies of scale

- 7.84 In HCA's view, the figures presented in the previous paragraphs represent the best estimates of the economies of scale losses that would arise from a divestment remedy, and are extensively evidenced in Annex 3. However, HCA has also considered the CMA's own base case and downside case assumptions, and revised these to at least take into account

¹³⁴ HCA notes that the estimates of economies of scale losses in 2011 did not apply to a potential divestment package that included the Wellington and PMC, as this was only proposed by the CMA in the Final Report. As such, HCA has updated its cost assessment to cover both divestment packages.

¹³⁵ This exercise has revealed that [redacted].

¹³⁶ [redacted].

the latest HCA data on common costs. Specifically, HCA has applied the CMA's own base case and downside case assumptions about the proportion of costs that HCA could save following a divestment to HCA's 2015 common costs and, using the 2011 recharge percentage, has allocated common costs to the divested hospitals. This produces estimates of losses of economies of scale to HCA, as a result of divesting both the London Bridge and Princess Grace Hospitals, of approximately [redacted] under the CMA's own base case and downside case assumptions, respectively. In other words, even using the CMA's own methodology and changing only the underlying data used (i.e., updating 2011 to 2015 data) produces materially larger estimates of the economies of scale that HCA would incur as a result of divestment than the CMA assumes in the PDR. Table 7 shows the updated economies of scale losses for the CMA's base and downside cases.

Table 7: Estimated losses of economies of scale: Updating the CMA's base case and downside case (£000)

7.85 Cost category	CMA downside case	CMA base case	CMA downside case, updated to 2015 costs	CMA base case, updated to 2015 costs
Recharged central costs	[redacted]	[redacted]	[redacted]	[redacted]
Group costs	[redacted]	[redacted]	[redacted]	[redacted]
HCA Laboratories	[redacted]	[redacted]	[redacted]	[redacted]
SCRI UK	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]

Losses of investment

- 7.86 In its response to the Remedies Notice, HCA noted that a divestment remedy would result in severe negative impacts on investment and innovation both for the divested hospitals and HCA's remaining hospitals.¹³⁷
- 7.87 The CMA does not include estimates of any such negative impacts as part of its cost estimates in its NPV calculations.
- 7.88 HCA has estimated the potential reduction in investment following a divestment of either of the divestment packages, and sets these out in Table 8.

Table 8: Estimated loss of investment (£000)

Loss of investment	London Bridge + Princess Grace	Wellington + PMC
[redacted]		
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]		

¹³⁷ See HCA's response to the Remedies Notice, paragraphs 3.205-3.216.

Loss of investment	London Bridge + Princess Grace	Wellington + PMC
[X]	[X]	[X]
[X]		
[X]	[X]	[X]
[X]	[X]	[X]

7.89 In the following paragraphs, HCA provides more detail on the types of investment which are likely to be impacted by a divestment remedy, which form the basis of the estimates set out in Table 8.

Immediate loss of investment at the divested hospitals

7.90 [X].

7.91 As HCA has noted to the CMA on a number of occasions, including in its response to the Remedies Notice,¹³⁸ in HCA's view it is likely that a new operator would pursue a strategy of investing less than HCA. As such, HCA views it as plausible that the new operator may not undertake the investments that are on hold.

Ongoing loss of investment at the divested hospitals and at HCA's remaining hospitals

7.92 In relation to potential investment at the divested hospitals and HCA's remaining hospitals, HCA has conducted a quantitative assessment of how its investment levels since 2011 have compared with nine of its national and international competitors for which data are readily available. The results of this analysis, which is set out in Annex 4, show that HCA invested around [X] of its revenues between 2011 and 2014, compared with an average of 6.2% for its competitors.¹³⁹

7.93 Based on the indicative assumption that a new operator would invest the same proportion of its revenue as the average of these nine operators, and that investment at HCA's remaining hospitals would also fall to this proportion, HCA estimates that there would be an ongoing loss of investment of [X] per annum following a divestment. Details on the assumptions and calculations underlying these figures are set out in Annex 4.

Loss of investment in the wider economy

7.94 As noted in its response to the Remedies Notice,¹⁴⁰ HCA considers that a divestment remedy would likely chill investment incentives and lead to a loss of investment in the healthcare sector and in the wider economy. Whilst it is not possible to quantify the likely impact on such investment, HCA notes that a reduction in investment in the UK economy by

¹³⁸ HCA's response to the Remedies Notice, paragraph 3.206.

¹³⁹ HCA notes that such an analysis is likely to underestimate the loss of investment following a divestment. HCA has expended a considerable amount of money on the CAT appeal and remittal inquiry that it may have put towards investment. [X].

¹⁴⁰ HCA's response to the Remedies Notice, paragraphs 3.134-3.158.

even a very small proportion (below 0.005%) would result in a negative NPV in every one of the scenarios considered by the CMA in Table 2.1.¹⁴¹

(vi) HCA's NPV calculations

- 7.95 In this section, HCA sets out revised calculations to illustrate the impact on the CMA's NPV estimates of some of its concerns with the CMA's methodology and assumptions that it has discussed in this section.
- 7.96 As set out in Sections 5 and 6, divestment would not be an effective remedy, and further, the CMA has no evidence either from its IPA or from its profitability analysis that a divestment would lead to any reduction in prices. As a result, in HCA's view the CMA is incorrect to conduct an NPV assessment where any positive price benefits are attributed to a divestment remedy.
- 7.97 Even setting aside this concern, HCA has shown that the CMA's estimates of potential price benefits are materially overstated. As a result, HCA presents results only in relation to the CMA's 3% scenario for price benefits from divestment, though HCA considers even this to be a substantial overestimate.
- 7.98 HCA has assessed the NPV of divestment under a range of assumptions.¹⁴²

Updating the CMA's NPV estimate for HCA's 2015 costs

- 7.99 As set out above, the CMA's NPV analysis is based on HCA's 2011 cost data. HCA has applied the CMA's own base case and downside case assumptions about the proportion of costs that HCA could save following a divestment to HCA's 2015 central costs and, using the 2011 recharge percentage, has allocated common costs to the divested hospitals (on a conservative basis).
- 7.100 Table 9 below shows the results of updating the CMA's base and downside case NPVs with HCA's 2015 central and group costs. Updating the CMA's base case results in NPVs of [£<]; updating the CMA's downside case results in NPVs of between [£<].

¹⁴¹ See Quarterly National Accounts time series dataset, Office of National Statistics. HCA has calculated this figure using 2015 Total Gross Fixed Capital Formation (current prices, seasonally adjusted), and assuming a 10 year impact.

¹⁴² All scenarios correct for the errors in the CMA's methodology set out in paragraphs 7.11-7.21 above.

Table 9: Updating the PDR NPVs to reflect HCA's 2015 central and group costs (£000)

Scenario	3% price benefit			
	Year 3	Year 5	Year 7	Year 10
Updating CMA base case	[<]	[<]	[<]	[<]
Updating CMA downside case	[<]	[<]	[<]	[<]

HCA's alternative NPV estimates

7.101 HCA sets out alternative NPV estimates based on the discussion above about the flaws in the CMA's approach. Specifically, HCA sets out the following alternative NPV estimates:¹⁴³

- **HCA base case:** modifying the CMA's NPV model to capture the HCA's updated estimates of losses of economies of scale, and one-off costs. This leads to NPVs of between [<];
- **HCA base case correcting for the impact of litigation on the timing of a divestment remedy:** as per the previous scenario, plus correcting for the CMA's failure to take into account the impact of litigation on the timing of a divestment remedy. This leads to an NPV of between [<].
- **HCA base case correcting for the timing of litigation, plus including the impact of a reduction in investment:** As per the previous scenario, plus taking into account the impact of a reduction in investment that would likely arise as a result of a divestment remedy. This leads to an NPV of between [<].

7.102 To reflect the uncertainty surrounding the proposed divestment packages, as well as the number of potential purchasers, HCA has calculated NPVs separately for the potential divestment of: the Wellington Hospital together with the PMC, the London Bridge and the Princess Grace Hospitals to a single purchaser, and the London Bridge and the Princess Grace Hospitals to two purchasers.

Table 10: NPVs of divesting the London Bridge and Princess Grace Hospitals to a single purchaser (£000)

Loss of economies of scale	3% price benefit			
	Year 3	Year 5	Year 7	Year 10
HCA base	[<]	[<]	[<]	[<]
HCA base, plus impact of litigation	[<]	[<]	[<]	[<]
HCA base, plus impact	[<]	[<]	[<]	[<]

¹⁴³ As noted in Footnote 97, In light of HCA's views on the CMA's estimated price benefits, only the CMA's 3% price benefit assumption is presented.

	3% price benefit			
Loss of economies of scale	Year 3	Year 5	Year 7	Year 10
of litigation and impact of loss of investment				

Table 11: NPVs of divesting the London Bridge and Princess Grace Hospitals to two purchasers (£000)

	3% price benefit			
Loss of economies of scale	Year 3	Year 5	Year 7	Year 10
HCA base	[]	[]	[]	[]
HCA base, plus impact of litigation	[]	[]	[]	[]
HCA base, plus impact of litigation and impact of loss of investment	[]	[]	[]	[]

Table 12: NPVs of divesting the Wellington Hospital (to a single purchaser) (£000)

	3% price benefit			
Loss of economies of scale	Year 3	Year 5	Year 7	Year 10
HCA base	[]	[]	[]	[]
As above, plus impact of litigation	[]	[]	[]	[]
As above, plus impact of loss of investment	[]	[]	[]	[]

7.103 Overall, it is clear from Table 10, Table 11 and Table 12 that, under all plausible assumptions regarding entry, price benefits, or the costs of divestment the NPV of a divestment remedy is negative. Therefore, divestiture of any HCA’s hospitals would be grossly disproportionate and wholly unjustified.

7.104 HCA submits that, in fact, the last of the three scenarios presented in Table 10, Table 11 and Table 12 are the most appropriate, since it takes into account the impact of a divestment remedy on investment, which is an important cost of divestment that should be recognised. In the Final Report, the CMA did not include economic costs relating to a loss of investment in its NPV model, stating that “*investment is more likely to increase rather than decrease in response to additional competition*”.¹⁴⁴ In the PDR, the CMA considers that HCA did not “*provide any new or additional argumentation or evidence*” during the remittal inquiry to give it reason to revise its conclusion that “*no such costs were likely to arise as the result of a divestiture remedy*” (paragraph 2.48, PDR).

¹⁴⁴ Final Report, paragraph 11.215.

7.105 In its response to the Remedies Notice, HCA set out detailed reasons why the CMA's original reasoning was flawed, and explained in detail why a reduction in investment would be expected. HCA noted that:

- Imposing a forced divestment on a company, like HCA, that has been successful in the marketplace due to it following a risky investment and innovation strategy, would lead to a chilling effect on incentives to invest and innovate in the industry in which it operates, and potentially also in other industries.¹⁴⁵
- There are clear reasons to believe that the divestment of the London Bridge and Princess Grace Hospitals would lead to a reduction in investment at the divested hospitals, and also at HCA's remaining hospitals.¹⁴⁶
- HCA invests more than its competitors relative to its revenue (as set out in paragraph 7.92), and there is no evidence that other operators have invested or innovated to a similar extent;¹⁴⁷

7.106 The CMA is therefore incorrect to state that HCA did not “provide any new or additional argumentation or evidence” (paragraph 2.48, PDR) during the remittal investigation, and does not explain why the information provided by HCA in its response to the Remedies Notice does not give it reason to revise its conclusion. On the contrary, HCA has provided a large amount of additional argumentation and evidence during the remittal inquiry, which the CMA appears to disregard.

(vii) Other impacts from divestment

7.107 While appropriately taking into account only the quantifiable costs of divestiture, as set out above, leads to a negative NPV under any plausible set of assumptions, there are a number of other non-quantifiable but negative impacts from divestiture that must be accounted for in the CMA's assessment of proportionality. In particular, reductions in quality and range, and asset risk are likely as a result of a divestment remedy. The NPV estimates set out above, therefore, are based on underestimates of the costs of divestiture and overstate the NPV. In this section, HCA describes the evidence it has previously submitted on losses of quality and range and presents new evidence on this matter regarding SCRI UK. HCA finally discusses the potential asset risk from a divestment.

Loss of network benefits and synergies and reduction in quality and range

7.108 In its response to the Remedies Notice, HCA noted that a divestment remedy would result in severe negative impacts on network benefits and synergies at HCA's hospitals, and lead to a

¹⁴⁵ One such reason would be that HCA may not be able to realise fair market value (FMV) for its assets. HCA set out a number of reasons why this would be the case.

¹⁴⁶ HCA's response to the Remedies Notice, paragraphs 3.205-3.206 and 3.212.

¹⁴⁷ HCA's response to the Remedies Notice, paragraphs 3.205-3.206.

reduction in quality and range of services, both at the divested hospital(s) and HCA's remaining hospitals.¹⁴⁸

7.109 In the original inquiry, HCA provided a large volume of evidence relating to why a divestment remedy would lead to a loss of quality and range. HCA noted, for example, that:

- A divestment remedy would put at risk the significant benefits and synergies created by HCA's network strategy (at both HCA's remaining hospitals and the divested hospital(s)), which have played an important role in building the success of its hospitals and which can lead to improvements in care and greater innovation.¹⁴⁹
- Quality at HCA's remaining hospitals and the divested hospital(s) may be adversely affected by a loss of access to clinical know-how and expertise of consultants, trained nurses and radiologists from across HCA's network, and fewer opportunities for within-network benchmarking, quality monitoring, audit programmes and collaboration across hospitals.¹⁵⁰
- A new owner may also not pursue the same strategy of high-quality, high-acuity care that HCA has pursued, which would have a detrimental impact on patient outcomes.¹⁵¹
- PMIs might not recognise the divested hospitals on terms which allow the hospitals to maintain the current level of quality and clinical services, and might take advantage of contract renegotiations with HCA to extract terms that achieve a quality-cost combination that is misaligned with patient preferences.¹⁵²
- A divestment would put some services at HCA's remaining hospitals and the divested hospital(s) at risk, due in part to a reduced network and lower patient volumes adversely affecting future investment and reducing the range of clinical services. This could mean that patients at the divested hospital(s) are no longer able to access these services in private facilities, thereby harming patient choice.¹⁵³

7.110 In the Final Report, the CMA did not include economic costs relating to a loss of quality and range in its proportionality assessment, stating that in its view, "*there was no evidence to*

¹⁴⁸ HCA's response to the Remedies Notice, paragraphs 3.196-3.204; 3.217-3.238.

¹⁴⁹ See, for example, HCA's Response to the CC's Remedies Notice, Annex 2; HCA's submission on the costs of divestment, 18 December 2013, Table 1; and HCA's response to the CC's Provisional Decision on Remedies, paragraphs 5.61-5.69 and Annex 2 paragraphs 1.76-1.78.

¹⁵⁰ See, for example, HCA's Response to the CC's Remedies Notice, paragraph 6.36; and HCA's Response to the CC's Provisional Decision on Remedies, paragraph 5.56.

¹⁵¹ See, for example, HCA's Response to the CC's Remedies Notice, Annex 2, paragraphs 1.69-1.72.

¹⁵² See HCA's Response to the CC's Remedies Notice, paragraph 6.28; and HCA's Response to the CC's Provisional decision on Remedies, Annex 2, paragraphs 1.69-1.73.

¹⁵³ See HCA's Submission on the Costs of divestment, 18 December 2013, Table 1.

suggest a reduction in the quality or range of treatments as a result of our divestiture remedy".¹⁵⁴

7.111 In the PDR, the CMA considers that HCA did not "*provide any new or additional argumentation or evidence*" during the remittal inquiry to give it reason to revise its conclusion that "*no such costs were likely to arise as the result of a divestiture remedy*" (paragraph 2.48, PDR). In the remittal inquiry HCA has, however, set out detailed reasons why the CMA's original reasoning was flawed, and explained in detail why a reduction in quality and range would be expected. For example, HCA noted that:

- There is extensive evidence in the healthcare literature that hospital operators that treat higher volumes of patients with certain conditions have better health outcomes for those patients, known as the "volume-outcomes effect". To the extent that HCA is providing higher volumes of certain treatments, patients receiving those treatments at HCA may have better outcomes, and a divestment remedy that reduces the size of HCA's network may thus adversely affect patient outcomes.¹⁵⁵
- The CMA's conclusions that HCA's quality was not appreciably higher than that of close competitors in central London, and that it was "*likely*" that any acquirer of the divested hospital(s) would have the incentives to pursue a high-acuity, high-quality strategy, were flawed.¹⁵⁶
- The CMA's conclusion that the examples provided by HCA about the benefits of an integrated care pathway "*applied mainly to cancer treatment, and that its proposed divestments would not fundamentally affect HCA's cancer treatment pathway or pathways*" was flawed.¹⁵⁷
- The CMA's conclusion that consultants would still be able to refer patients to the divested hospital(s) if they were the hospital best able to treat the patient, and thus that there are no RCBs associated with a patient being treated only at a single hospital group, was flawed.¹⁵⁸

7.112 In Annex 4, HCA presents new evidence on the innovative services provided by the SCRI, and describes how the benefits that this organisation brings, not only to patients, but to PMIs and pharmaceutical companies as well, would be reduced in the event of a divestment.

7.113 The CMA is therefore incorrect to state that HCA did not "*provide any new or additional argumentation or evidence*" (paragraph 2.48, PDR) during the remittal investigation, and the CMA must engage with the points raised by HCA in its assessment of the proportionality of a divestment remedy.

¹⁵⁴ Final Report, paragraph 11.215.

¹⁵⁵ See, for example, 'A Submission on the Analysis of Insured Prices', KPMG, 1 May 2015, footnote 25.

¹⁵⁶ See HCA's response to PFs, Section 5 and HCA's Response to the Remedies Notice, paragraph 3.203.

¹⁵⁷ HCA's Response to the Remedies Notice, paragraph 3.203.

¹⁵⁸ HCA's Response to the Remedies Notice, paragraph 3.204.

Asset risk and reputational damage

- 7.114 In its response to the Remedies Notice, HCA noted that a divestment remedy would result in asset risk and reputational damage at the divested hospital(s).
- 7.115 The CMA does not engage with the issue of asset risk and reputational damage in the PDR, and does not include any such costs in its proportionality assessment.
- 7.116 In its response to the Remedies Notice, HCA noted that a divestment remedy would:¹⁵⁹
- create a high degree of uncertainty about the future of the hospitals, especially with respect to consultants, whom hospital operators need to attract and retain in order to be successful;
 - [redacted]; and
 - result in a reduction in the brand value of the divested hospitals.
- 7.117 HCA also noted that the appointment of a monitoring trustee would not sufficiently mitigate asset risk at the hospital(s) to be divested, as the asset risk associated with consultants switching to alternative facilities would arise not because of any encouragement or inducement on the part of HCA, but rather because of the uncertainty surrounding the future of the hospital(s).¹⁶⁰
- 7.118 The CMA must engage with the points raised by HCA in its assessment of the proportionality of a divestment remedy.
- 7.119 While the precise costs of loss of quality and range and asset risk are difficult to quantify, they are costs that must be taken into account in the NPV. Any NPV that fails to take these costs into account understates the costs of divestiture, and therefore is overstated.

(viii) Conclusions

- 7.120 As set out in this section, HCA agrees with the CMA that its NPV calculations are subject to material uncertainty and that it is correct to treat the results with caution, particularly due to the highly intrusive nature of divestment. Furthermore, HCA welcomes the view of the CMA that divestment is not a proportionate remedy based on the scenarios to which the CMA attaches the most weight.
- 7.121 However, in HCA's view, the case against divestment is even stronger than presented by the CMA, and the CMA overstates the NPV of a divestment remedy. In this section, HCA has shown that, under all plausible assumptions regarding entry, price benefits, or the costs of

¹⁵⁹ HCA's response to the Remedies Notice, paragraphs 3.175-3.177 and 3.181.

¹⁶⁰ HCA's response to the Remedies Notice, paragraphs 3.180.

divestment the NPV of a divestment remedy is negative. Therefore divestiture of any HCA's hospitals would be grossly disproportionate and is wholly unjustified.

8. CONCLUSIONS

HCA therefore submits as follows:

- There is no evidence that the market is characterised by either weak competitive constraints or high barriers to entry and expansion. There is therefore no basis for an AEC finding in relation to either insured or self-pay patients.
- The CMA's AEC findings were based on the allegation that HCA charges higher prices than its competitors. The CMA acknowledges that it can no longer rely on the IPA for any such finding. The CMA's profitability analysis similarly does not provide any evidence of price differences linked to high concentration.
- In any event, even if the CMA believes there is any justification for its AEC findings, there is no case for a divestment remedy affecting HCA's hospitals.
- Divestment would not be effective in reducing prices for any given level of quality or clinical services.
- HCA agrees with the CMA's conclusion that divestment would be a disproportionate remedy. In fact, the CMA has significantly understated the costs and adverse consequences of divestment which would far outweigh any conceivable benefits that could arise.
- HCA does not believe there is any case for remedies, and given the CMA's clear findings relating to divestment, it does not propose to comment on any alternative remedy options.