

THE LONDON CLINIC
COMPETITION AND MARKETS AUTHORITY PRIVATE HEALTHCARE REMITTAL
RESPONSE TO THE PROVISIONAL DECISION ON REMEDIES ("PDR")

Introduction and Summary

1. This Response to the PDR is submitted on behalf of The London Clinic (the "Clinic") which strongly disagrees with the CMA's provisional decision stated at paragraph 19 PDR Summary that *"although a divestiture remedy would be effective in addressing the AEC in central London, it would not be proportionate."*
2. The Clinic considers that this provisional conclusion is not reasonable because it is not objectively justified by the evidence currently available to the CMA. Accordingly, the Clinic urges the CMA to reconsider its analysis and, in its Final Report, to require HCA to divest hospitals in central London.
3. This Response begins by summarising the AECs to be remedied and the CMA's statutory duty in considering remedies. There follows a detailed analysis of the evidence relating to potential entry by Cleveland Clinic as this new evidence is fundamental to the conclusions reached in the PDR. We explain why the CMA's provisional conclusions as to the likelihood, timeliness and impact of entry by Cleveland Clinic are not objectively justified by the evidence currently available.
4. Next we explain why, even if entry by Cleveland Clinic were to occur on the basis foreseen by the CMA (which the Clinic disputes), a divestment remedy would nevertheless still be a proportionate remedy in the circumstances.
5. Finally, the Clinic repeats submissions made previously to the effect that a divestment remedy would need to address oncology in order to be effective.

AECs to be remedied

6. In its Provisional Findings dated 10 November 2015 ("PF"), the CMA provisionally concluded that *"two structural features in the markets for the provision of privately funded healthcare services to insured patients in central London were, in combination, leading to an AEC (the insured AEC):*

High concentration, with HCA having a large market share; and

High barriers to entry and expansion, arising primarily from high sunk costs and long lead times, the latter being exacerbated by limited site availability and planning constraints" (PDR paragraph 1.7).

7. The CMA also provisionally concluded that *"In combination, these features resulted in weak competitive constraints on HCA in the provision of privately funded healthcare serves for insured patients in central London"* (PDR, paragraph 1.8) and that *"the AEC was leading to consumer detriment in the form of higher prices being charged by HCA than we would expect in a well-functioning market"* (PDR, paragraph 1.9).
8. The market for private healthcare in central London is substantial (the UK market was worth an estimated £6.71bn in 2012, Final Report paragraph 2.12) and accordingly the consumer detriment resulting from the identified AEC is significant on any analysis.

The CMA's Statutory Duty

9. Where the CMA decides that there is an AEC, it has a statutory duty under section 134(4) of the Enterprise Act 2002 ("EA02") to decide:

"Whether action should be taken by [the CMA] ... for the purpose of remedying, mitigating or preventing the adverse effect on competition concerned or any detrimental effect on customers so far as it has resulted from, or may be expected to result from, the adverse effect on competition;

Whether it should recommend the taking of action by others for the purpose of remedying, mitigating or preventing the adverse effect on competition concerned or any detrimental effect on customers so far as it has resulted from, or may be expected to result from, the adverse effect on competition; and

In either case, if action should be taken, what action should be taken and what is to be remedied, mitigated or prevented".

10. The EA02 requires the CMA, in considering these questions *"in particular to have regard to the need to achieve as comprehensive a solution as is reasonable and practicable to the adverse effect on competition and any detrimental effects on customers so far as resulting from the adverse effect on competition"* (EA02, section 134(6)).

11. Relevant Guidelines (CC3) specifically address possible remedy outcomes at Paragraph 354, which reads:

"In reaching a decision on what remedial action to take, the CC will seek a comprehensive solution to the AEC and resulting customer detriment. In so doing, it will have regard to the need for the solution to be both reasonable and practicable. A consequence of balancing these considerations is that there may be circumstances where the CC judges, for example on the basis of considerations of proportionality, that it should not pursue an effective remedy option that is potentially available to it. There may also be rare cases where having found an AEC, the CC chooses not to take any remedial action, for example:

(a) *where there are no practicable remedy options available to the CC, including any possible recommendations to others;*

(b) *where the cost of each practicable remedy option is disproportionate compared with the extent that the remedy option resolves the AEC. This might be the case, for example, if the market in which the AEC was found was small in relation to the costs of each practicable remedy option and/or if it was only practicable to mitigate some of the negative consequences of an AEC and the costs of doing so were prohibitively high;*

(c) *where RCBs accruing from the market features are both large in relation to the AEC and would be lost as a consequence of any practicable remedy (see Paragraphs 355-359)."*

12. The Clinic considers that this Remittal is not one of the "rare" cases where the CMA might reasonably choose not to take any remedial action at all. The CMA has found an AEC in a large, strategically important market which serves both UK consumers and attracts considerable custom from overseas. Furthermore the CMA has provisionally identified a practicable and effective remedy – divestment of hospitals by HCA. All the stakeholders submitting evidence in response to the CMA's Notice of Possible Remedies, except HCA, considered that divestment was essential and would be effective (PDR, paragraph 2.7 AXA PPP "told us it continued to believe that divestment was the only remedy which would resolve the current lack of competition in central London"; paragraph 2.10, Bupa submitted "that requiring HCA to divest a package of hospitals was the only effective way to address the AEC's in central London"; paragraph 2.24, Spire "told us that a divestiture remedy was essential to addressing the competition issues in central London").
13. None of the examples listed in the CC3 Guidelines is relevant. The proportionality of the divestment remedy is discussed in detail below but it should be emphasised that the AEC in this case relates to the whole market for private healthcare in central London and a divestment remedy would be capable of addressing all the negative consequences of the AEC. In summary, a failure to remedy the identified AEC would be a breach of the CMA's statutory duty and would lead to significant consumer detriment in the form of higher prices being imposed by HCA than would occur in a well-functioning market.
14. The next section addresses the evidence on the prospects of large scale entry into the central London market by Cleveland Clinic.

Evidence on new entry by Cleveland Clinic

15. The evidence on potential large scale entry by Cleveland Clinic is pivotal to the outcome of the Remittal. The CMA's provisional decision that it would be disproportionate to address the AEC hinges on the likelihood of entry by Cleveland Clinic since the CMA does not attach significant weight to the prospect of entry by other players. (PDR Summary, paragraph 11).
16. The key evidence on potential entry by Cleveland Clinic is very recent. In the PF (Paragraph 5.70) which was published in November 2015, the CMA provisionally found that "There are

*substantial barriers to entry and expansion in Central London. Our review of the evidence indicates that the principle barriers to entry in Central London arise as a result of a combination of high sunk costs and long lead times, with the latter factor exacerbated by the limited availability of suitable sites and planning constraints. We consider that these barriers have contributed to the lack of substantial entry into the market over the last 10 years, and the limited examples of expansion, in spite of the attractiveness of the Central London market to private hospital providers. Moreover, our provisional conclusion is that there is unlikely to be entry or expansion of a private hospital operator of sufficient scale to constrain HCA in the near future. However, as set out in Paragraph 5.69, we consider that over a longer time frame, for example the next 5 years, there **may** be large-scale entry into the Central London market". [emphasis added]*

17. The PF also recites (Paragraph 5.68(f)) that: *"The Cleveland Clinic indicated that it was currently at too early a stage to discuss its plans in detail. However, we noted that the article detailing its purchase of 33 Grosvenor Place indicated that it was still considering how to use the site and had not yet sought permission from either the freeholder of the site or the local planning authorities to convert the building from office to hospital use. As a result, we consider that this potential entry remains uncertain at the current time"*.
18. The CMA's provisional thinking as set out in the PDR appears to have developed considerably since the date of the PF. At Paragraph 10 of the PDR Summary, the CMA notes that: *"Our provisional view is that Cleveland Clinic is likely to enter the market with a new hospital by early 2020, offering over 200 beds, a broad range of specialisms and an owner with a strong reputation for quality"*.
19. The Clinic understands that the change of position by the CMA follows an informal meeting with the Cleveland Clinic (details of which are unpublished) and review of information and documents provided by the Cleveland Clinic to the CMA, some of which are briefly described in the PDR. The information disclosed in the PDR is limited, evolving and untested. In the Clinic's submission, the evidence available to the CMA at present is insufficient for the CMA to form a reasonable belief that entry by Cleveland Clinic would constrain HCA within a reasonable timeframe. In particular, the Clinic considers that the CMA's provisional conclusion in relation to Cleveland Clinic is flawed:
 - The CMA has placed undue weight on uncertain and evolving plans of Cleveland Clinic which may not come to fruition.
 - The CMA has placed insufficient weight on evidence that there has been no large scale entry into central London in the previous 10 years, as detailed in the Final Report.
 - The CMA has underestimated the structural and strategic barriers to entry which it had identified in the Final Report as they would apply to potential entry by Cleveland Clinic.

- The CMA has attached insufficient weight to the views of third parties including customers, other potential entrants and The Clinic itself.

Undue weight placed on Cleveland Clinic's Plans

20. The CMA characterises the position of the Cleveland Clinic, as follows: "*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*". It is difficult for the Clinic to comment on the confidential plans of the Cleveland Clinic but an objective assessment of the evidence described in the PDR would not reasonably lead to this conclusion.
21. Whilst Cleveland Clinic is a credible potential entrant, it is apparent that its plans for entry are not fully formed and are fluid:
- In November 2015, the Cleveland Clinic was reportedly not even in a position to discuss its plans in detail. A mere four months later, the CMA characterised those plans as "*firm and relatively well advanced*." The Clinic has not seen the plans and accordingly cannot comment on the reasons for this changed view. But this seems a remarkably rapid evolution in Cleveland Clinic's thinking and the CMA's analysis. It begs the question whether the CMA has subjected the plans to appropriate scrutiny and testing.
 - In particular, [REDACTED]. The Clinic encourages the CMA to discuss this with the Cleveland Clinic and conduct a more thorough due diligence exercise on the Cleveland Clinic's plans.
 - As noted above, Cleveland Clinic previously indicated that it planned to apply for planning permission in relation to 33 Grosvenor Place in March 2016. It has not done so at the date of this Response. This is evidence of the changing factual matrix and the uncertainty of Cleveland Clinic's plans and the planning process. It casts doubt on the reasonableness of the CMA's assessment of the timeliness of entry which uses as a start-date an event that has not come to pass.
 - Cleveland Clinic's own evidence to the CMA contemplates alternative sites to 33 Grosvenor Place (PDR, paragraph 1.59 and footnote 28) indicating that Cleveland Clinic itself is not certain that it will choose to proceed with construction of a hospital on this site. The CMA has not analysed in detail the prospects of any other specific site and so if there is any doubt as to the suitability of 33 Grosvenor Place as a new hospital site (e.g. for planning reasons), then the CMA's provisional findings on entry are unsafe.
 - The PDR (at paragraph 1.32) reports that Cleveland Clinic's own evidence is that it is working with advisers to develop its strategy for the central London market. This evidence suggests that the thinking of Cleveland Clinic is evolving and at

an early stage. It is inconsistent with the CMA's characterisation of a "*firm and relatively well advanced plan*". Whilst it may be the case that the plan is relatively well advanced compared to the position in November last year (when Cleveland Clinic had no plan it could discuss in detail), that does not mean that it is sufficiently certain for the CMA to assume it is likely to be implemented in its current form (or at all).

- The PDR also notes that Cleveland Clinic or its advisers have had "*preliminary informal discussions*" with Bupa and an interview with Aviva and AXA PPP. Whilst these are sensible, preliminary steps by a potential entrant they are not evidence of a firm and well-advanced plan. Indeed the PDR describes the purpose of the interviews conducted by BCG as to "*refine perspective on market attractiveness, entry scenarios, [and] operating model*". Again, such discussions suggest an evolving plan the details of which remain to be finalised. Indeed, as noted below, the current plan of Cleveland Clinic does not involve the development of an oncology capability, a specialty which AXA PPP and Bupa consider as being under-served and necessary for successful entry against HCA. This fact also suggests that the plans of Cleveland Clinic are at early stage and may evolve. The Clinic also considers that this fact suggests that the information regarding the size of the Cleveland Clinic's offering (over 200 beds) may also be inaccurate. Without oncology, 200 beds would be unnecessary, since a hospital in central London without oncology would be likely to focus on day patients and out patients, for whom overnight beds are not required.

22. In light of the above uncertainties in the plans of Cleveland Clinic, it would be unsafe to attach weight to specific details of them. The conclusions in the PDR currently place undue weight on plans which are subject to change and apparently untested by the CMA.

Insufficient weight attached to the views of third parties

23. The Clinic has been operating in the private healthcare market in central London for many years. PMIs such as AXA PPP and Bupa are leading customers for private healthcare in central London. They are highly credible and experienced operators which understand the market dynamics precisely.
24. In contrast, Cleveland Clinic does not currently operate in the central London market and is by its own admission developing its plans. Inevitably plans change to adapt to market realities and customer needs.
25. Accordingly, it would be inappropriate to discount or attach less weight to the observations of seasoned market operators in favour of untested and early stage plans of a potential new entrant.

26. Similarly, it is essential that the CMA reflects on the evidence gathered for the Final Report and during the Remittal from other potential or failed entrants, including other experienced operators. This is discussed in the next section.

Insufficient weight placed on evidence of absence of entry in the last decade

27. The Final Report contains a detailed analysis of entry and expansion into the private healthcare analysis since the mid-2000s (paragraphs 6.10 et seq.)
28. The evidence in Cleveland Clinic's plans must be viewed critically in the context of the CMA's own analysis of lack of entry in the previous decade. That analysis identified no new entry into central London even close to the scale reportedly contemplated by Cleveland Clinic. The only potentially relevant case study cited in the Final Report relates to expansion by an existing operator, the Clinic, through construction of the Cancer Centre.
29. The CMA stated that *"We found that while TLC had been successful in expanding in central London it had encountered difficulties and delays in doing so, the main ones being identifying, acquiring and obtaining planning permissions for a suitable site and retaining and attracting oncologists to practise at the Clinic."*
30. There are very good reasons why, despite the apparent attractiveness of the healthcare market in central London, no attempted entry has been successful in the last decade. As the CMA rightly identifies, the absence of any meaningful entry into central London in the last decade reflects the significant barriers to entry to the market. These barriers persist (as the CMA has rightly concluded) and will apply equally to potential entry by Cleveland Clinic, as discussed in the next section.

Underestimation of structural and strategic barriers to entry

31. The Final Report contained an assessment of barriers to entry and expansion at paragraphs 6.42 et seq. These were identified by the CMA as:
- costs of entry
 - healthcare regulation
 - site availability
 - planning regulations
 - strategic barriers, being PMI recognition and clinician incentives.
32. Specifically in relation to the Cleveland Clinic, the key barriers, in the submission of the Clinic, are planning regulations and strategic barriers and both are discussed below.

33. The CMA itself identified the principal uncertainty regarding the entry as the ability to obtain planning permission to convert 33 Grosvenor Place into a hospital. The basis of the CMA's analysis of this crucial issue appears to be limited to evidence from Cleveland Clinic and Westminster City Council ("WCC") (PDR, paragraph 1.60). The CMA did not, it appears, have reference to any expert evidence on the issue.
34. It is not clear from the PDR if a planning application has been finalised or whether the CMA had reviewed such an application. The CMA conceded that there is uncertainty in relation to the planning application but nevertheless appears to have accepted at face value that the planning application would be submitted in March 2016 and permission granted through the course of 2016 (PDR, paragraph 1.61).
35. This assumption by the CMA is not supported by the evidence. First, as at the date of this submission no application appears to have been made.
36. Second, even if a planning application were to be made, the CMA has no reasonable basis for the timing projections in the PDR for receipt of planning permission. The evidence from WCC appears to relate to generic statements about general issues such as "parking, traffic and servicing". Whereas, the Clinic's evidence is that any planning permission would need to have considered a range of specific issues such as the exact design of the interior and location of equipment including MRI scanners. The Clinic has previously advised the CMA of the complexities of this planning process for the internal siting of these machines. The CMA does not appear to have taken expert evidence or even subjected the projections of Cleveland Clinic to any meaningful scrutiny.
37. Relevant evidence does exist, however, in the form of the Cancer Centre which took around 6 years to construct and involved detailed and time consuming planning issues. The CMA stated that Cleveland Clinic would not face the same planning constraints as The Cancer Centre because it is not located in the Harley Street area (PDR, paragraph 1,63). Yet that is not a basis to discount planning hurdles in its assessment of potential entry by Cleveland Clinic. Merely because the specific hurdles are not the same does not mean that significant hurdles do not exist. It is simply premature to form such a conclusion when no planning application has been made and indeed, it would appear that the CMA may not even have seen any final application much less taken any expert view of the prospects for or timing of that specific planning application.
38. Accordingly, the CMA's current view (expressed at paragraph 1.64, PDR) that "*if planning permission is applied for in March and granted within around six months, it is likely that Cleveland Clinic's London hospital will open in late 2019 to early 2020*" is meaningless as the assumptions on which it rests are flawed and lack any specific evidential support.
39. The other key entry barriers that Cleveland Clinic would face as a potential entrant are the strategic barriers represented by the need to obtain PMI support and clinician recruitment. The Clinic considers that, in principle, Cleveland Clinic is a highly credible organisation but

that this alone does not translate into PMI acceptance in the central London market. Were Cleveland Clinic to construct a London hospital, the recognition of that hospital would depend on a range of factors, including availability of the right specialties and consultants at the time of opening (which even on the wildly optimistic predictions of the CMA would not be before end 2019.) The evidence before the CMA from Cleveland Clinic suggests that it is working with a number of medical consultants to develop its strategy for the central London market. In other words, it has not finalised its strategy and there is no basis on which to conclude whether any final strategy would be attractive to PMIs (or their corporate or individual customers).

40. The evidence from PMIs to the CMA is, however, clear. AXA PPP stated "*a new entrant would need to offer key specialties (and in particular oncology)...in order to amount to an alternative offering that would be acceptable to 'the vast majority of customers' in London.*" (PDR, paragraph 1.48)
41. Bupa stated that "*Cleveland Clinic would need to provide the full range of [...] services in order to be an effective competitor to HCA.*" (PDR, paragraph 1.53)
42. Despite oncology being a pre-condition for acceptance it would appear from the PDR that Cleveland Clinic does not currently intend to offer oncology. Whilst the CMA noted that Cleveland Clinic would "*adapt its services to serve the market*", the absence of oncology in its offering would be a fundamental omission undermining the credibility of Cleveland Clinic in the eyes of its customers. The PDR glosses over this at paragraph 1.75 noting that Cleveland Clinic could add oncology at a later date. This is unconvincing as it is pure conjecture on the part of the CMA that Cleveland Clinic would do so. There is no analysis or evidence whether it would be possible or attractive to include oncology services at a hospital to be constructed at 33 Grosvenor Place. Even if one conjectures that oncology capability may be added subsequently, there is no evidence that it would be available in the near future. The CMA identifies The Cancer Centre as a relevant example of expansion by an existing operator into oncology but wrongly states that it took three and a half years to develop. As noted elsewhere in the PDR the Cancer Centre took six years to develop, with the construction phase alone being three and a half years.
43. In relation to recruitment of clinicians, there is no proper analysis of the significance of this as a barrier to entry. The Clinic understands that Cleveland Clinic operates a model of direct employment of consultants in the US, not previously seen in the UK. Such a model is therefore untested and it simply would not work for the vast majority of consultants who wish to continue to conduct NHS work.
44. In addition, the Clinic considers that the Cleveland Clinic would be faced with having to encourage and attract consultants to such a degree that they would be prepared to break the relationships they have in place at the hospitals at which they currently practice. This is because it would not be likely that a consultant would simply add practicing privileges at

the Cleveland Clinic to their existing hospitals as they would be spread too thinly across central London.

45. The evidence from third parties is again clear. The CMA notes that "*Bupa submitted that Cleveland Clinic would find it difficult to 'prise away' consultants from HCA. Similarly, TLC remained of the view that the difficulty of attracting and retaining consultants was a barrier to entry.*" (PDR, paragraph 1.76). AXA PPP also identified "*the need to attract and retain (simultaneously) a sufficient number of consultants who were willing to move their work from existing hospitals to a new facility*" as a barrier to entry. (PDR, paragraph 1.48)
46. The Clinic considers that notwithstanding the terms of the Final Order, clinician incentives offered by HCA and the difficulty in attracting consultants remain an important barrier to entry and expansion in the central London market which could reasonably be expected to impede or deter entry by Cleveland Clinic.
47. In conclusion, the PDR is flawed because it does not contain a specific analysis of planning regulations, PMI acceptance and clinician recruitment as potentially significant barriers to entry by Cleveland Clinic. The Clinic recognises that an important reason for this omission is that the Cleveland Clinic plans are only now emerging and are evolving. At present, it may be the case that there is not yet specific evidence for the CMA to analyse. In these circumstances, the appropriate course for the CMA is to form its best view on the likelihood and timeliness of entry based on the evidence before it. But that does not mean that if no specific evidence is available on a point, the CMA should make unjustified assumptions or form premature conclusions. If insufficient evidence exists for the CMA to form a reasonable view justified by the facts on a key point such as the likelihood of planning permission being granted, the appropriate course would be for the CMA to conclude that it cannot safely form a view on the timeliness and likelihood of entry. This is particularly important here as the implications of the findings on entry in the PDR contribute to a provisional decision not to remedy an AEC in a large and strategically important market.

Potential entry by Cleveland Clinic would not be effective to address the AEC

48. For the reasons explained above, the Clinic considers it is premature to draw any firm conclusions about whether Cleveland Clinic will enter, the scope of the services it may offer or when it will start operating. This section explains why, even if one accepts at face value the current scope of planned entry by Cleveland Clinic as described in the PDR, such entry would not be effective to address the AEC.
49. There are two main reasons why the hypothesised entry would be ineffective. First, HCA holds a dominant position in oncology and its sub specialties in central London, whereas Cleveland Clinic's plans as described in the PDR expressly exclude oncology. Second, entry by Cleveland Clinic, even on the most optimistic timetable would not occur until 2020 and by the CMA's reckoning it would not exert an effective constraint until 2022.

50. In relation to oncology, the evidence of key customers, Bupa and AXA PPP, described above is that in order to be effective to constrain HCA, Cleveland Clinic must offer the full range of services, including oncology. The Clinic strongly agrees with AXA PPP and Bupa. Entry by Cleveland Clinic would not address oncology, a key speciality, meaning that it would not be effective to constrain HCA.
51. As to timing of entry, the view of AXA PPP is summarised at PDR, paragraph 1.49: "...even if Cleveland Clinic or VPS were to enter and provide a full offering (including oncology), it would be unlikely to materially change the position within central London (and HCA's 'must-have' status) within a decade."
52. The Clinic's view is that it is likely to take up to ten years for Cleveland Clinic to open, if it opened at all. If oncology were added at a later date (as hypothesised in the PDR), that would not be for 15 or 20 years.
53. In summary, the CMA has provisionally concluded that, absent a remedy, the AEC and HCA's market power would be largely unconstrained until 2022 which is the earliest date by which the CMA considers that entry by Cleveland Clinic could become an effective constraint. The AEC in oncology would not be addressed at all by entry of Cleveland Clinic. In the view of the Clinic, the delay before potential entry of Cleveland Clinic could have an effect would be longer, at least 10 years. On any analysis, entry by Cleveland Clinic cannot be described as effective to remedy the AEC.

Divestment would not be disproportionate

54. In this section we examine the assessment of proportionality of the divestment remedy and analysis set out at PDR paragraphs 2.39 to 2.60, as revised by the Correction published by the CMA on 6 April 2016. We explain why on an objective assessment of the evidence the CMA should conclude that divestment would be proportionate even taking into account the prospects of potential entry by Cleveland Clinic.

55. It is important to recall the CMA's conclusions on proportionality at paragraphs 13.36 et seq of the Final Report. In particular, the conclusions at paragraph 13.44 Final Report identify the net present value of divestment:

"We estimate that the quantifiable benefits (i.e. price benefits) to customers likely to arise from the divestiture remedies would be in the range of £30 million to £44 million per year and the annual costs to be between £0 and £[] million. We estimated that the net present value of our divestiture remedies was, therefore, approximately £298 million over a 20-year period¹. In addition, we considered that there were likely to be other benefits in terms of quality and range that could be significant over time but could not be readily quantified".

56. The Clinic considers that on an objective assessment of the evidence before the CMA, divestment should still be considered as a proportionate remedy on the basis set out in the

¹ This figure refers to our base case estimate. Our downside case indicates an NPV of approximately £117 million, while our upside case indicates an NPV of approximately £474 million.

Final Report. In other words, it would not be appropriate to take into account potential entry by Cleveland Clinic in the proportionality assessment because the prospect is too remote and uncertain. To do so would be inconsistent with the CMA's standard approach to consideration of entry in market and merger inquiries which requires entry to be likely, timely and effective in the circumstances of the case.

57. Even if the CMA considers it appropriate to consider entry by Cleveland Clinic, the approach adopted in the PDR and the Correction is flawed because it includes assumptions that are not justified on the facts.

Consideration of entry by Cleveland Clinic as part of a proportionality analysis

58. The CMA's provisional conclusions on the likelihood and effect of potential entry by Cleveland Clinic are summarised at PDR, paragraph 1.85:

"On this basis we provisionally conclude 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 (comparable to that of the divestment we proposed in the Final Report) by early 2022. That is to say, we provisionally conclude that, on balance, new entry is likely to be effective in addressing the AECs and that, while there is some uncertainty about timing, this is likely to occur by early 2022."

59. By any measure, this is a tentative conclusion, as is apparent from the CMA's language: "seems likely", "on balance" and "while there is some uncertainty about timing".

60. The Clinic also notes the dissenting opinion of one Group member, summarised at PDR paragraph 1.86:

"One of the Group members did not agree with this provisional conclusion and considered that new entry, even if it were to take place within the timescales set out above, which that Group Member felt was not certain, was unlikely to be an effective competitive constraint on HCA such as to remedy the AEC (in contrast to the divestment we proposed in the Final Report)."

61. In short, the provisional conclusions on entry are expressed tentatively by the majority and dissented from by one Group member. This is perhaps not surprising as the facts are uncertain and the CMA's analysis is evolving to reflect new evidence. In November 2015, the CMA reached a provisional conclusion that Cleveland Clinic "may" enter whereas in the PDR (from March 2016) the CMA concludes that Cleveland Clinic would be "likely" to enter. In the Clinic's submission, the CMA's analysis should continue to evolve in response to new evidence since the date of the PDR, in particular that no planning application has been submitted in respect of 33 Grosvenor Place and that Cleveland Clinic is only now starting to talk to potential partners, suggesting that its plans are still at a preliminary stage. Both facts call into question the likelihood and timing of entry.

62. The CMA's stated methodology for considering potential entry more generally in its market and mergers investigations would also suggest that it would not be appropriate in this case to take entry into account in the proportionality analysis. In order to attach weight to evidence of entry, the CMA generally requires such entry to be timely, likely and effective². If there is insufficient evidence on any of these criteria then potential entry cannot be considered in assessing whether there is an AEC in market investigations or a substantial lessening of competition in merger inquiries. The rationale for this approach is sound. In conducting a prospective analysis, it is particularly important that the analysis is rooted in fact and based on compelling and consistent evidence. Otherwise, it is no more than speculation. This approach was followed in the current inquiry both in the Final Report and in the PF on remittal. In the PF the CMA did not attach weight to potential entry of Cleveland Clinic because it could not satisfy itself that the requirements for likely entry in a short period were met (PF paragraph 5.68(f) and 5.69).
63. By contrast, the assessment of proportionality in the PDR appears to assume entry by Cleveland Clinic that would fully address the AEC (or at least have equal effect as the proposed divestment remedy) as the counterfactual to divestment. The Clinic recognises the challenges facing the CMA in trying to take account of this very recent market development but considers that on the evidence in this case, entry is such an uncertain and distant prospect that it cannot be considered in this way.
64. Alternatively, if the CMA were to take account of the prospect of entry then it should reduce the weight it attaches to the effect of entry by Cleveland Clinic to reflect the material uncertainties that exist as to likelihood, timeliness, scale and scope of such entry. At present, the NPV analysis only adjusts for timeliness.
65. The following sections discuss the specific assumptions used in the NPV analysis and explain why, even if it is minded to consider entry in its proportionality analysis, the CMA's methodology is flawed.

Assumptions as to timing of entry by Cleveland Clinic

66. The CMA's provisional view is set out in PDR paragraph 2.52, as follows:
- "As set out in Paragraph 1.85, our provisional view is that entry by Cleveland Clinic (primarily) is likely, together with other non-HCA hospitals, to act as an effective constraint on HCA by early 2022 which corresponds to Year 5 in our NPV analysis. For this reason, we have placed most weight on the '5 year' scenarios in Table 2.1".*
67. Table 2.1 contemplates NPV analysis on the basis of four periods: years 3, 5, 7 and 10. In the submission of the Clinic, the column relating to year 3 is clearly irrelevant as there is no reliable evidence that Cleveland Clinic would have entered and constrained HCA by

² CC3 – Guidelines for market investigations, paragraph 175 and 205; CC2- Merger assessment guidelines, paragraph 2.8

2019/20. It is irrational to include that column and indeed risks introducing framing bias into the review of the NPV as it may imply that 5 years is somehow a "mid-range" period.

68. In fact, a 5 year period is not realistic on the evidence before the CMA. The provisional conclusion in paragraph 1.85 is founded on false assumptions as to the progress of the planning process. First, it assumes that a planning application is submitted on 33 Grosvenor Place by March 2016 which, as far as the Clinic is aware, has not occurred. Second, it assumes that planning permission would be received in the latter part of 2016 which is wildly optimistic and directly contradicted by the evidence of the planning process for development of the Clinic's Cancer Centre.
69. The evidence from the Clinic and AXA PPP that even if Cleveland Clinic were to enter, no constraint would be imposed (if at all) for 10 years or more (see paragraphs 51-53 above) also suggests that 5 years is too short a period reasonably to be taken into account. For these reasons, the Clinic submits that a more reasonable framework for assessment would be an "upside" of 7 years, a "base case" of 10 years and a "downside" of 13 years.

Assumptions as to economies of scale

70. The Clinic considers that the assumptions in the NPV analysis on economies of scale that might be lost as a result of the divestment used are unsound. It is useful to recall the findings reached by the CMA in the Final Report, paragraph 11.208:

"On this basis we have concluded that it will be inappropriate to include any loss of economies of scale in our 'base case' estimate of the NPV of our divestiture remedy. However, we have included the full cost of economies of scale put forward by HCA (£ [] million per year) in our 'downside case'. We consider this to be a highly conservative approach".

71. In the PDR, the CMA takes a different view. Its NPV analysis assumes three scenarios: £[]million downside case; £8.2million base case; and £0million upside case. At paragraph 10 of the Correction the CMA states:

"In terms of the estimated loss of economies of scale, we considered that most weight should be placed on the base case scenario and downside scenarios (with less emphasis given to the upside scenario). While our review of HCA's submissions indicated that the £[]million estimate was likely to overstate the actual losses, we thought 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 operations. Therefore, we consider that the upside scenario assumption of zero loss of economies of scale is likely to overstate the NPV of the divestiture remedy."

72. The difference in the CMA's own estimation of loss of economies of scale between zero in the Final report and £8.2million in the PDR is not explained in the PDR. In the Clinic's submission, more weight should be attached to the CMA's analysis in the Final Report which

is clearly reasoned than the unsubstantiated view expressed at paragraph 10 of the Correction and in the PDR generally. Accordingly, the Clinic considers that the relevant loss of economies of scale should be estimated as zero.

73. One point on which the CMA is consistent between the Final Report and the PDR is that HCA's estimate overstates the potential loss of economies. In the Final Report the CMA states that "*We consider this to be a highly conservative approach*". Consequently, it is irrational in the PDR to attach more weight to HCA's estimate than to the CMA's own analysis.

74. Accordingly, the Clinic submits that more weight should be attached to the two base cases calculated by the CMA being £8.2million in the PDR and zero in the Final Report.

Importance of non-price benefits of divestment

75. In the Final report, the CMA considered that "*there were likely to be other benefits in terms of quality and range that could be significant over time but could not be readily quantified.*" Whilst, it is difficult to quantify such benefits and so include in the NPV calculation, having identified such benefits the CMA should still reflect these in the overall analysis particularly given the size and importance of the private healthcare market in central London.

Conclusions on the NPV analysis

76. Paragraph 8 of the Correction summarises the problem facing the CMA in conducting an NPV analysis:

"The NPV analysis indicates 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 (i.e. the period of time that elapses prior to entry on a sufficient scale to effectively constrain HCA). We note that there is material uncertainty around each of these factors; however, on a number of plausible combinations of assumptions, the NPV is negative."

77. For the reasons given above, the uncertainties are in fact so material that it would be unreasonable for the CMA to take entry by Cleveland Clinic into account at all in the proportionality analysis.

78. Even if the CMA does use entry by Cleveland Clinic as a counterfactual in its proportionality assessment, the calculation as it currently stands is flawed. Some of the combinations of outcomes that result in a negative NPV in the analysis are implausible for the reasons given above, in particular the unrealistic assumptions of entry constraining HCA in 3 or 5 years. If these were to be disregarded, and time periods started at 7 and 10 years, as proposed above by the Clinic, then the picture changes fundamentally and would present a positive scenario in 8 of the 12 combinations.

79. The range of the 8 positive outcomes is £10million - £136million. The range of the 4 negative outcomes is £(45million) - £(8million). The top end of the negative ranges is based on the "downside" case of HCA's calculation of lost economies of scale which the CMA has twice dismissed (in the PF and the PDR). Using the CMA base case estimate for lost economies of scale in the Final Report the outcome is positive. Using the PDR base case estimate, the outcome is marginally negative £(14million) and £(8million).
80. In other words, 10 out of the 12 combinations that the Clinic considers plausible are positive. This is without even considering non-price benefits or making any probability weighting or discount as to the impact of entry based on material doubt as to likelihood, scope and scale of entry. If appropriate adjustments are made, the analysis would be likely to be positive. On balance the weight of evidence would point to a positive outcome even if the proportionality analysis uses a counterfactual of entry by Cleveland Clinic.

A divestment remedy would need to address oncology in order to be effective

81. The Clinic repeats its submissions made in its response to the PF regarding the composition of the divestment package.

Eversheds LLP

3 May 2016