



Private Healthcare Remittal

Response to Supplemental Provisional Decision on Remedies

Bupa

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Non-confidential version

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1. Executive Summary

- 1.1 This submission sets out Bupa's response to the Competition and Markets Authority's ("CMA") Supplemental Provisional Decision on Remedies ("SPDR") published on 7 July 2016, following on from the CMA's publication of its initial Provisional Decision on Remedies ("PDR") on 6 April 2016. The submission contains commercially sensitive information that should not be published without Bupa's prior permission.
- 1.2 Bupa does not consider that the evidence presented by the CMA in any way supports its overall provisional conclusion that there are no remedies that address, even partially, the Adverse Effects on Competition ("AECs") for self-pay and insured patients that the CMA provisionally continues to find.
- 1.3 More specifically:
- i. The evidence on possible future entry in the London market, which was already limited, has become even weaker and more uncertain. The CMA now considers that there is no more than a "*strong prospect*" of entry by the Cleveland Clinic "*within the next 5 to 10 years*", and accepts the Cleveland Clinic would not be offering medical oncology (a specialism in which HCA is super-dominant) for "*years or decades*". The CMA now points to evidence of entry by a few small niche players, previously rejected as insufficient to constrain HCA, in order to reach an extremely tentative conclusion that such entry "*if it occurs, could also result in downward pressure on HCA's prices, in particular if such entry occurs across a wide range of specialisms*."¹ However, there is no material new evidence or reasoning to support this change of position since the PDR (see paragraphs 2.7 *et seq.* below).
 - ii. The CMA has not provided any reasoning to explain its departure from its previous conclusions on the operation of market power. The PDR had previously provisionally concluded that a strong market position in one specialism (such as oncology) allows a provider to leverage that position across its entire product offering, and thereby exert market power.² For the reasons given by Bupa in its response to the PDR and previously, there is in fact compelling evidence to show that HCA's ability to maintain a particularly strong position in strategically important specialisms (such as oncology) has a disproportionate effect on its overall market power (see paragraphs 2.21 *et seq.* below).
 - iii. The CMA continues to give no consideration to the fact that HCA will continue to strengthen its market position in Central London over the next 5 to 10 years, such that any putative entrants (whether the Cleveland Clinic or others) would be competing against a significantly larger entity with dominant shares in all the crucial specialisms. Over the past five years, HCA has grown its Central London claims revenues from Bupa by [X]. There is no reason to expect that HCA's growth will slow (indeed, with HCA's further expansion projects in progress and coming on-line and its dominance in Oncology, its growth is likely to accelerate). Further, HCA will be able to cement its power, as there is evidence it does already, with restrictive contractual clauses with insurers and embedded relationships with consultants (see paragraphs 2.26 *et seq.* below). The absence of any assessment of the impact of the growing strength of HCA, and its ability to frustrate the growth of rivals, is a glaring hole in the CMA's assessment of the effectiveness of entry in 5 to 10 years as a constraint on HCA.

¹ Para 33 SPDR. Emphasis added.

² PDR, paragraph 2.21.

- iv. The CMA is wrong to use “fully effective entry” as its “Central Case” in its NPV analysis. There is insufficient evidence on the timing or form on entry to support the assumption that the effect of such entry would be fully effective in reducing HCA's prices to the competitive level. Indeed, the CMA acknowledges “*material uncertainties regarding both the timing and effectiveness of future entry*” and that “[a]fter careful consideration of the new evidence available to the CMA, we consider that the likelihood and timing of entry of Cleveland Clinic is more uncertain than it was at the time of the PDR and we can no longer assume that it will (together with other non-HCA hospitals) be fully effective in addressing the AEC”.³ The CMA does not have evidence to support a 100% price reduction as either plausible or likely, particularly where there is in fact clear evidence to the contrary such as the absence of any evidence of effective entry into Oncology (a specialism that on its own already accounts for [X] of claims revenue). This wholly undermines the assumption of “fully effective” entry in its “Central Case” – the CMA must revise all of its NPV tables that rely on this ungrounded assumption.

The CMA’s own analysis shows that when partially effective entry is assumed – with a 50% price reduction impact – divestment of the Wellington hospital would be proportionate even when HCA’s economies of scale losses are included. Given that a 100% price effect from any putative entry is implausible on the evidence, therefore, it is Bupa’s view that divestment is clearly proportionate when the appropriate price effects of entry are taken into account. Bupa’s analysis on this point is summarised in paragraphs 1.8 – 1.19 below, and explained in detail in section 3 below and the Confidential Annex.

- v. Bupa continues to have concerns about other aspects of the NPV analysis as set out in the SPDR. The CMA is, for example, incorrect to use the social cost of capital to discount HCA’s economies of scale losses, as this overcompensates HCA and does not reflect the cost to society, and correcting this materially impacts the NPV results. Correcting for the errors explained in section 3 and taking into account the more plausible price effect of any entry (as outlined above) would mean that the benefits of a divestment of HCA hospitals significantly outweigh the costs of such a remedy in all relevant scenarios (see section 3 and Confidential Annex A).

1.4 The CMA's legal obligation is to achieve as comprehensive a solution to the AECs as is reasonable and practicable. Against that background, and given the CMA's provisional conclusions on the proportionality of a divestment remedy, it is difficult to understand why the CMA has not given a more detailed consideration to possible alternative remedies in the SPDR. Bupa notes in this respect that the SPDR states that the CMA typically looks for remedies that prevent an AEC by extinguishing its causes and can be expected to show results in a short time.⁴ While this position is unobjectionable, it does not imply that where the CMA cannot identify any remedies that fulfil these criteria, it need not impose any remedies at all. The need to consider alternative remedies is particularly important in light of the CMA's revised findings not only that entry is unlikely to take place for 5 to 10 years (with one Group member believing there will be no meaningful entry over 20 years), but also that there is no currently foreseen entry in Oncology. Bupa has already identified a number of potential alternative remedies in response to the PDR that do not appear to have been given any consideration. These are summarised in section 4.

1.5 Throughout the five years of investigation by the competition authorities, Bupa has been consistent on the urgency and importance of intervention by the CMA (and before it the OFT and

³ SPDR Appendix, paragraph 49.

⁴ SPDR, paragraph 7.

Competition Commission).⁵ This is the only way to give customers better value for money in private healthcare in Central London. Every major report published by the authorities during the inquiry has identified significant competition problems in Central London. The PDR itself makes clear that HCA has enjoyed nine consecutive years of substantial excess profits. The SPDR continues to recognise the AECs in Central London and concludes that entry by the Cleveland Clinic and other far smaller entities - if it takes place - will now not happen for a longer period than initially thought, with material uncertainties as to the effects of such entry on HCA's pricing.

- 1.6 We therefore find it unjustifiable that the CMA should, on the basis of the increasingly speculative and uncertain effects of possible entry, and a flawed NPV calculation, maintain its provisional decision to take no action. The effect of this provisional conclusion on remedies, if upheld, will be that these AECs (and all associated significant customer detriment) will continue in full. Indeed, given that the SPDR considers that constraining entry will now not take place for considerably longer than the CMA envisaged in the PDR customers would face hundreds of millions of pounds of detriment over this future period.
- 1.7 We ask the CMA to revisit its analysis and look forward to engaging further with the CMA on this matter.

Confidential Annex Summary

- 1.8 [REDACTED]

⁵ During the same five years, HCA has grown its central London revenue share [REDACTED]

2. The effectiveness of entry to constrain HCA

- 2.1 The conclusions of the SPDR rest critically on the CMA's view that there is a "*strong prospect of a combination of large-scale entry by Cleveland Clinic and entry by other large and / or smaller and more specialised providers, which can be expected to exert a competitive constraint on HCA*".⁶
- 2.2 For a number of reasons this entry analysis does not appear to be supported by the available evidence or fully reasoned.
- 2.3 First, the evidence in the SPDR on possible future entry in the Central London market is weaker and more uncertain than in the PDR:
- i. The SPDR provisionally concludes that the Cleveland Clinic will now enter the market later than previously anticipated (5 – 10 years) and that it will not provide any medical oncology services. The evidence on the Cleveland Clinic's ability to constrain HCA once (if) it has entered is also weak and does not appear to have been fully considered in the SPDR.
 - ii. The SPDR makes a number of un-evidenced and inconsistent statements regarding the prospect of entry by entities other than the Cleveland Clinic. The SPDR does not provide any view as to when the CMA expects other providers will enter the market (merely noting that "*it is not possible for us to predict the scale or timing of this with any degree of certainty*").⁷
- 2.4 Second, the SPDR departs, without providing any reasoning, from its previous findings on the operation of market power. Previously, the CMA had provisionally concluded that a strong market position in one specialism allows a provider to leverage that position across its entire product offering. The SPDR now asserts that despite HCA maintaining its position in oncology it will be subject to an increased level of putative competition in other specialisms that will materially reduce HCA's overall bargaining position. Bupa does not consider this revised view to be sufficiently reasoned, or correct – in fact, HCA's must-have position in oncology means that it can exert market power across its portfolio and the putative entry identified in the SPDR will not reduce HCA's bargaining position materially.
- 2.5 Third, the CMA continues to give no consideration to how HCA will grow its market position in Central London in the coming years. The failure to undertake any such detailed analysis means that the CMA cannot reach a sufficiently reasoned or robust conclusion that potential entrants would be able to constrain HCA sufficiently at the point of entry. The CMA also fails to consider the evidence that HCA can, and already does, frustrate the growth of rival providers.
- 2.6 These points are considered in more detail below.

⁶ SPDR, paragraph 34.

⁷ SPDR, paragraphs 29 and 32.

The evidence on entry is more weak and uncertain

- 2.7 Bupa notes the CMA’s recognition of the increased uncertainty regarding the Cleveland Clinic’s entry into Central London. Nonetheless, the SPDR concludes that “*there is still the strong prospect of entry by the Cleveland Clinic within the next five to ten years*”.⁸ However, even on the evidence presented in the SPDR, there is significant uncertainty as to whether the Cleveland Clinic will enter in this timeframe. In particular, Bupa notes that the SPDR itself recognises that:
- i. Commercial discussions with the Grosvenor Estate continue but the Estate is unable to offer “*any indication of timing or certainty of reaching an acceptable agreement*”. Such an indication clearly suggests that the prospects of entry – let alone the timing – remain uncertain.
 - ii. The planning application for the Grosvenor site has not been submitted and “*does not appear imminent*”. The fact that this crucial step in the development process is not yet complete introduces a further degree of uncertainty.
 - iii. The “*UK’s recent decision to leave the European Union may result in further delays to major investment decisions*”. It is not clear from the SPDR that – as requested by Bupa – the CMA has tested the effect of the Brexit vote on the Cleveland Clinic’s plans, including as regards the timing of its possible entry.
- 2.8 Bupa notes that the Cleveland Clinic also made clear to the CMA at its hearing⁹ that its entry plans were complicated and contingent on a number of important assumptions:
- i. The Cleveland Clinic explained that “*it was a complicated entry to the market*” requiring several steps and consents and that the Cleveland Clinic had “*not yet ... obtained any of the necessary consents from the Grosvenor Estate*”.
 - ii. The Cleveland Clinic noted that the negotiation with landlord was “*a particularly complex negotiation*” in part because “*there had not been any major, significant private hospital entry into the central London market over the last 30 years*”, and that negotiations with certain protected tenants in the building had not yet been finalised.¹⁰ This reflects the position of the Grosvenor Estate – mentioned above – and underlines the lack of certainty that agreement can be reached between the parties.
 - iii. The Grosvenor Square site is in a conservation area which would increase the amount of scrutiny and consultation necessary before the Cleveland Clinic could commence refurbishments.
 - iv. The Cleveland Clinic raised concerns that a key planning assumption for its business case for entry had changed when the CMA’s PDR suggested that no action would be taken against HCA: “*Cleveland Clinic also said that a key planning assumption that had changed was that HCA would be restrained in the marketplace from its growth appetite of protecting its market share (ie that the CMA would impose a divestment remedy and/or constraints on further HCA expansion). Cleveland Clinic said that it expected HCA to aggressively expand over the period during which it would be establishing itself in the market*”.
- 2.9 Given the above, Bupa’s view is that the CMA has not evidenced its view that there is a “*strong prospect*” of entry by the Cleveland Clinic in 5 to 10 years. In particular material entry in the early part of that period seems extremely unlikely in light of the finding in the SPDR that the CMA can

⁸ SPDR, paragraph 29.

⁹ Cleveland Clinic hearing summary, April 2016.

¹⁰ Ibid, paragraph 7, emphasis added.

no longer conclude that the Cleveland Clinic would constrain HCA across a range of specialisms from 2022 i.e. around 5 years from now. Indeed, the evidence on file suggests that the timing of entry is wholly uncertain.

2.10 The Cleveland Clinic’s hearing with the CMA provides further evidence that the Cleveland Clinic itself remains highly uncertain about the impact of its potential entry. For example, the hearing summary states that:

- i. The Cleveland Clinic “*planned to provide some 200 beds (100 to start with) and that it would not be providing the full range of services. As such, its effectiveness as a counterbalance (to HCA) would be limited. Cleveland Clinic said that, looking ahead to 2022-2024 when it had entered the market and ramped up its services, it would be smaller than The London Clinic*”;
- ii. The Cleveland Clinic “*expected that HCA would expand aggressively during this period of time, and that Cleveland Clinic would be a relatively small player*”;
- iii. The Cleveland Clinic “*would be worried about others [HCA] having the ability (based on their size and scale) to make it difficult to compete in the marketplace*”; and,
- iv. The Cleveland Clinic was “*concerned that its competitors would try to put models in place that would align physicians, particularly those looking for access to ITU beds, with their own facilities. This would make it difficult to develop relationships with those physicians and also restrict the patient flow*”.

2.11 On the basis of the above, it seems clear that the Cleveland Clinic does not expect to be able to constrain HCA effectively, and is also concerned that HCA will be able to deploy defensive measures to frustrate its entry and protect HCA’s market position.

2.12 Likewise, the SPDR does not provide any evidence that the Cleveland Clinic would be able to exert a competitive constraint on HCA once (if) it enters. Bupa has already explained in its PDR response why the assumption that Cleveland Clinic could constrain HCA by 2022 is flawed.¹¹ These flaws remain and are not repeated in detail here, but include: the Cleveland Clinic’s small size relative to a very much larger HCA; the Cleveland Clinic’s untested business model in the UK; the absence of effective constraints in Oncology; and, HCA’s ability to frustrate the effectiveness of the Cleveland Clinic’s entry through defensive measures.

2.13 Bupa has additional specific concerns relating to the SPDR’s assumption that the Cleveland Clinic could be expected to place “*significant downward pressure*” on HCA’s prices following entry and the treatment of our previous submissions on this point:¹²

- i. [REDACTED]
- ii. [REDACTED].¹³
- iii. [REDACTED]
- iv. [REDACTED]

¹¹ See Bupa’s PDR response, paragraph 2.9 *et seq.*

¹² SPDR, paragraph 29.

¹³ [REDACTED]

- 2.14 There is no evidence in the SPDR that the CMA has assessed our evidence or conducted any modelling of its own to support its assertion that the Cleveland Clinic (even with other smaller entrants) would be able to fully reset the market back to competitive levels.
- 2.15 As regards entry by other entities, the SPDR appears to attach considerable weight to a number of un-evidenced statements regarding the prospect of entry. Notably, the SPDR states that “*it is not possible for us to predict the scale or timing of this with any degree of certainty*”, yet still goes on to provisionally conclude that there is a “*strong prospect*” of such entry, “*which can [with the Cleveland Clinic] be expected to exert a competitive constraint on HCA*”. These two statements are simply inconsistent.
- 2.16 More generally, there is no material new evidence presented in the SPDR to justify the departure from the CMA’s previous position in the PDR that “*we do not attach significant weight to the prospect of entry by others [i.e. other than the Cleveland Clinic], given the greater uncertainty over their entry or, in some cases, the more limited range of services likely to be provided to them*”:
- i. The only new pieces of evidence in the SPDR relating to such entry is the submission by the Schon Klinik of a planning application, and an announcement by Nuffield that it is a preferred bidder for the St Barts PPU, neither of which materially increase the prospects of effective entry.¹⁴ Both are small players focussing on a narrow set of specialisms.
 - ii. The examples of entry that are cited by the CMA would not be of sufficient scale to constrain HCA materially, either in those specialisms or at an overall level. For example, the CMA cites Optegra, a specialist ophthalmology provider, as one of its three examples of entry since 2014, but fails to mention that ophthalmology is a tiny fraction of the HCA portfolio ([redacted]), and so this entry has almost no impact on HCA’s market power (even if Optegra entirely replaced HCA in this specialism).
 - iii. It is not sufficient when seeking to establish the likelihood of effective entry to rely on an “*increased interest [in entering the central London market]*” along with “*an expected continued growth in demand*”. Absent evidence showing that these expressions of interest have crystallised into concrete entry plans, such elements on their own cannot establish the likelihood of entry. There have been for many years expressions of interest in entering the Central London market, none of which have transpired into material entry given the barriers to entry and expansion that the CMA has previously identified.
- 2.17 Although the SPDR acknowledges that “*each instance of possible entry is insufficiently certain or insufficiently broad in scope to be effective in addressing the AEC*”, it considers this possible entry “*as a whole, not just individually*”, on which basis the SPDR concludes that entry in aggregate – if it occurs – could constrain HCA.¹⁵ Such a characterisation is simply implausible and not one that the CMA can reasonably reach on the facts it presents.
- 2.18 HCA already dominates the Central London market [redacted]. Entrants would need to form substantial and effective constraints across all of these specialisms to address fully the AEC. There is no evidence in the SPDR that this type of entry is plausible in the relevant period.

Figure 1: [redacted]

- 2.19 Given the lack of evidence and reasoning in the SPDR, the CMA’s statement that “*entry by other potential new entrants, if it occurs, could also result in downward pressure on HCA’s prices, in particular if such entry is across a wide range of specialties*” is simply an unsubstantiated truism. The SPDR wholly fails to establish in factual, evidential terms that there is any strong likelihood

¹⁴ SPDR, footnote 14.

¹⁵ SPDR, paragraph 31.

of entry by these entities, or that such entry could constrain HCA.

2.20 We therefore agree fully with the one Group member who found that “*significant new entry is unlikely in the next ten years and in any event is not likely to be an effective constraint on HCA such as to address the AEC*”.¹⁶

The SPDR does not justify the CMA’s new position on market power

2.21 The SPDR states that “*we do not accept the argument that maintaining a strong market position in one specialty (eg oncology) means that increased competition in others will have no effect on HCA’s overall prices*”.¹⁷ The SPDR also notes that “*even if there are some specialties where HCA retains a strong position (eg in oncology), greater competition in other services will reduce its overall bargaining position*”.¹⁸

2.22 This represents a significant, and unexplained, change of position as compared to the CMA’s previous provisional conclusion in the PDR, in which the CMA stated that “*the combination of a specialty-level product market, and products which are negotiated jointly across a full range of services, suggested that a strong market position in one or a small number of specialisms would allow a private hospital operator to exert market power*”.

2.23 The CMAs reasoning in this respect appears to rest on an assumption that HCA’s market power and overall bargaining position will decrease if it is subject to an increased level of putative competition in some specialisms, even if it retains its market position in others (in particular, oncology).

2.24 This reasoning is not supported by the evidence available to the CMA, given that:

- i. It ignores the disproportionate strategic importance of Oncology as a specialism. Figure 1 above demonstrates that Oncology [X].¹⁹ Regardless of whether there is materially increased competition in other specialties in the future (which Bupa doubts), HCA will therefore retain a strong overall bargaining position [X]. Absent clear evidence of effective future entry in oncology that would be sufficient to constrain HCA effectively in this specialism (as to which, see below), HCA will therefore remain capable of leveraging its [X] across other specialisms, and the CMA provides no evidence in the SPDR to demonstrate otherwise.
- ii. As explained above, the entrants identified by the CMA are all small scale and none of the putative entrants identified in the SPDR will be offering credible oncology services. Notably, the SPDR now recognises that the Cleveland Clinic will not offer medical oncology “*for ‘years or decades’, if at all*”.²⁰ It is simply implausible to suggest that these entrants will be in any position to constrain HCA’s negotiating power in relation to oncology by virtue of their position – individually or collectively – in other specialisms [X].

2.25 Given the above, the SPDR does not provide sufficient – or any – compelling reasoning for its new position on market power. In fact, as Bupa and others have previously submitted, [X]. This is even more the case given that, as explained below, HCA is expected to increase significantly in size and bargaining position over the next 5-10 years.

¹⁶ SPDR, paragraph 76.

¹⁷ SPDR, paragraph 51.

¹⁸ SPDR, paragraph 51.

¹⁹ See for example Bupa’s response to the PDR, paragraph 2.33 *et seq.*

²⁰ SPDR, paragraph 27.

The CMA continues to give no consideration to the evolution of HCA's position in the Central London market

- 2.26 The SPDR gives no consideration to HCA's trajectory of growth and expansion in Central London in the period until putative entry arises. Like the PDR, the SPDR also provides no analysis of how HCA may frustrate the success of any entrants e.g. through contractual clauses with insurers, embedded relationships with key clinicians, or influence over primary care referrals.
- 2.27 HCA is growing much faster than any other provider in Central London.
- 2.28 Over the last five years Bupa's claims spend with hospitals in Central London [REDACTED]. The compound average growth rate (CAGR) across our Central London spend was [REDACTED].

Figure 2: [REDACTED]

- 2.29 [REDACTED].
- 2.30 HCA is growing much faster than [REDACTED].
- 2.31 The CMA presents no evidence that this rate of growth will slow. Indeed, the CMA is aware that HCA has a series of further expansions in progress (e.g. the Shard, Guys' and St Thomas', and the Portland).
- 2.32 Therefore, HCA will be very much larger, and its dominance more entrenched (exactly as the Cleveland Clinic predicts), if any entry from the Cleveland Clinic or other smaller niche players does arise in 5 to 10 years' time.
- 2.33 We submitted evidence projecting HCA's market share over the next decade if no divestment is ordered and HCA maintains the conservative aggregate growth of [REDACTED] per annum.²¹ As shown in Figure 3 HCA's aggregate share in Central London is on track to [REDACTED] by 2022. Its share will be even higher in key specialisms and will grow by more than [REDACTED]. The SPDR contains no meaningful analysis of this growth trajectory or whether it is realistic to believe that the putative entry (by Cleveland Clinic and others) would be sufficient to address the AEC.

Figure 3: [REDACTED]

- 2.34 Finally, as set out in our previous submissions,²² there is evidence that HCA is already able to frustrate the growth of rival providers. The SPDR, however, contains no mention of this or analysis of HCA's ability (and, as it gets larger, increasing ability) to use these means to frustrate the impact of rivals. As examples:
- i. We have shown the CMA the restrictive contractual clauses that HCA imposes on us that: [REDACTED];²³
 - ii. We have explained to the CMA case studies where HCA's strength has directly impacted outcomes for consumers negatively – e.g. [REDACTED];²⁴

²¹ [REDACTED]

²² See, for example, Bupa PDR response, paragraph 2.53.

²³ Bupa PDR response, paragraph 4.36 *et seq.*

²⁴ See Bupa's response to the CMA's follow-up questions on Bupa's response to the PDR.

- iii. The CMA has received evidence from other insurers about how HCA has sought to defend its market position and revenues through contractual clauses. The CMA's case study on the opening of The London Clinic's Cancer Centre, for example, explains:

“48. AXA PPP told us that HCA had sought contractual arrangements which would have had the effect of 'locking out' new provision in London and that HCA wanted AXA PPP to 'guarantee not to recognize' the new cancer facilities being developed by TLC. AXA PPP submitted email exchanges between HCA's then Commercial Director and AXA PPP's Head of Provider Management in 2006 in which, on 13 October, HCA set out how it saw the goals of the two parties: 'We [HCA] are looking to have new facilities recognized and have network integrity within central London in tertiary services, and you [AXA PPP] are looking for an ability to offer wider access to your members.' AXA PPP told us that 'network integrity' referred to a situation in which AXA PPP should not add further radiotherapy facilities to its current network in London.

*49. HCA told us that in the negotiations with AXA PPP which led to the revised 2010 contract there was discussion of a pricing formula based on whether AXA PPP was proposing to recognize TLC's newly opened Cancer Centre and the impact that this would have on the volume of cancer referrals to HCA hospitals. HCA told us that its position reflected its concern that the forecast volume of patients through its radio-therapy facilities, in which it had invested very heavily, might be impacted. As the economics of capital-intensive facilities such as these are very sensitive to volume, additional radiotherapy capacity could therefore undermine their profitability”;*²⁵

- iv. Other hospital operators – such as The Cleveland Clinic²⁶ and Spire²⁷ – have explicitly raised concerns to the CMA about HCA's ability to restrict their growth; and,
- v. We have shown how HCA is locking in key revenue-earning consultants with equity relationships.²⁸

2.35 The SPDR contains no assessment of how HCA could, and does, employ measures to protect its market share and revenue envelope. In the face of the evidence, the CMA simply assumes in its Central Case that entry will be “fully effective” against (the very much larger) HCA. This is unreasonable.

²⁵ CMA Final Report, page A6(3)-10.

²⁶ The Cleveland Clinic Hearing Summary, April 2016.

²⁷ Spire response to PDR, April 2016, where it notes that the CMA has “*inexplicably chosen to ignore relevant evidence*” on HCA's restrictive contractual clauses.

²⁸ See Bupa's response to the CMA's follow-up questions on Bupa's response to the PDR.

3. The Proportionality Assessment

- 3.1 The SPDR updates the Net Present Value analysis the CMA uses in assessing the proportionality of the CMA’s two proposed divestment packages – the divestment of (a) the Wellington Hospital; or (b) The London Bridge Hospital and The Princess Grace.
- 3.2 The CMA has revised its NPV analysis since the PDR. In essence, the SPDR explains that:
- i. The CMA Group continues to provisionally find that either of its two divestment packages would be effective in addressing the AEC.
 - ii. However, due to updated cost estimates from HCA, the CMA now finds that the divestment of the Wellington would result in substantially lower costs for HCA. The CMA therefore focusses its NPV analysis on the divestment of the Wellington as it considers that HCA would be more likely to choose this package.
 - iii. The CMA updates its NPV analysis for some (but not all) of the issues raised by parties in response to the PDR. The most substantive changes are:
 - a. The CMA accepts that entry will take longer, so now shows NPVs at 5 years, 7 years, 10 years and 20 years.
 - b. The CMA’s central case assumes “fully effective entry” (which as we explain below and in section 2 cannot be supported by the evidence). However, the CMA now also shows a more realistic “sensitivity case” where entry is only “partially effective” (a 50% impact on prices), and this shows the divestment to be proportionate.
 - c. The CMA includes HCA’s (now higher) economies of scale losses for the full 20 years of assessment in its “central” and “downside” cases. This vastly increases the estimated cost of divestment (which as we explain below is incorrect).²⁹
 - d. The CMA includes a real market growth rate of 3.5% per annum to reflect the fact that the market will grow over the period.³⁰
- 3.3 We have significant concerns with the CMA proportionality assessment in the SPDR. We highlight six key concerns below – as Points A to F.
- 3.4 Divestment is clearly proportionate when these concerns are addressed.

²⁹ The “upside” case does not include economies of scale losses – and the divestment packages are clearly proportionate across all permutations of this scenario.

³⁰ We agree with the CMA’s decision to include this market growth rate and that the rate of increase should be at least 3.5% per annum, particularly given the market growth rates reported by LaingBuisson and the very rapid trajectory of growth in HCA revenues. Additionally, we note that [X].

A) The CMA’s central case of ‘fully effective entry’ and a 100% reduction in prices is unsupported by evidence and must be changed

3.5 As explained in section 2 above:

- i. The CMA now faces much higher uncertainty about the timing and form of any entry into the Central London market – indeed the CMA acknowledges “*material uncertainties regarding both the timing and effectiveness of future entry*”³¹ and that “[a]fter careful consideration of the new evidence available to the CMA, we consider that the likelihood and timing of entry of Cleveland Clinic is more uncertain than it was at the time of the PDR and *we can no longer assume that it will (together with other non-HCA hospitals) be fully effective in addressing the AEC*”;³²
- ii. HCA will likely be much larger and more powerful when any putative entry occurs, and so better able to defend its position against any entry (as it has done before). As noted in Section 2, the CMA has not acknowledged in the SPDR the negative impact that HCA’s continued growth and market power will have on the effectiveness of any entry; and,
- iii. There is no evidence presented by the CMA of credible constraining entry in Oncology, [REDACTED] and continues to grow rapidly.

3.6 It follows from the above that:

- i. The impact that entry could have on reducing HCA’s prices down to the competitive level could in theory range from 0% to 100%. The CMA does not on the facts of this case have sufficient evidence to assume the extreme bound of 100%. Yet the CMA makes fully effective entry its Central Case, which is plainly wrong as it is not supported by evidence and is inconsistent with the CMA’s statement above that “*we can no longer assume ... [entry to] be fully effective in addressing the AEC*”. **Therefore, all of the CMA’s NPV scenarios in the SPDR that rely on this central assumption of fully effective entry must be dismissed.**
- ii. **A lower ‘partially effective entry’ must become the central case.** Given the likely growth of HCA over the next decade, the current evidence on entry available to the CMA, and HCA’s history of restricting the impact of competitors, it is our view that only a small impact on prices could be reasonably justified given HCA’s market position at the point putative entry occurs. **A 25% impact is a more reasonable assumption.**
- iii. The lack of any evidence of constraining entry in Oncology, [REDACTED], means that **a 75% impact on prices would appear to be the absolute maximum upper bound scenario that the CMA could optimistically assume from entry.** Even this would rely on fully constraining entry in [REDACTED] and HCA not actively defending its position through leveraging its market power or foreclosure tactics, two points which the evidence available to the CMA do not support.
- iv. **The CMA should place little weight on the “Year 5” estimates in its NPV tables.** Year 5 (2022) entered into the CMA’s thinking at the PDR stage where it had increased confidence on the entry of Cleveland Clinic and this was seen as the earliest point at which the Cleveland Clinic could constrain HCA. The new evidence from the Cleveland Clinic recognises that its entry and ramp up is on a much delayed timetable. The CMA also has not received any substantive new evidence on other competitors since the PDR to change

³¹ SPDR, paragraph 34. Emphasis added.

³² SPDR, paragraph 49. Emphasis added.

its view on the likelihood of large-scale entry by other providers before 2022. Therefore, a material constraint on HCA by Year 5 now appears too optimistic.

- 3.7 On the basis of this evidence, it is unjustifiable for the CMA to assume “fully effective entry” with a 100% reduction on HCA’s prices to competitive levels in its “Central Case”. **Fully effective entry is simply not supported by the facts (and the CMA acknowledges that it can no longer assume this), and cannot be the “central” case.**
- 3.8 The CMA’s “sensitivity case” of a 50% reduction in prices appears more realistic, although we still believe too optimistic. As noted in section 2, HCA is on track to have a share of [X] of the Central London market by 2022 and has a series of further expansions to come on line before this. Given HCA’s likely scale, the must-have positions it would still maintain in many key specialisms, its contractual protections in place with insurers, and its influence over key clinicians, [X] even if entry by Cleveland Clinic and others occurs. **We would, therefore, recommend a 25% impact as the more reasonable Central Case.**
- 3.9 We show the NPV scenarios of 25%, 50%, and 75% impact on prices in the Confidential Annex (see Table 3, Table 4, and Table 5). **In each scenario, divestment of the Wellington is shown to be proportionate** based on the expected value of the divestment even with the CMA’s best estimate of HCA’s economies of scale losses included (and before further corrections to the NPV analysis, detailed below, are included).

B) Using the social cost of capital to discount HCA’s economies of scale losses is incorrect

- 3.10 We explain in Point C below why the CMA is incorrect to include HCA’s alleged losses of economies of scale in the way it has in the NPV.
- 3.11 However, if economies of scale losses are included in the NPV, their quantum must first be discounted at HCA’s own cost of capital (9.0% to 10.0%) not the social cost of capital (3.5%). **Using the social cost of capital to estimate the present value of divestment costs over-compensates HCA, and so overstates the costs of the remedy to society.**
- 3.12 This makes a significant difference to the estimated costs of the divestment and the proportionality assessment across all scenarios. We show in the Confidential Annex (paragraph A.18 and Table 6) that **using the social cost of capital overstates the costs of the divestment by over 50%.**
- 3.13 We ask the CMA to consider two issues:
- i. The CMA includes the economies of scale losses because it believes they will impact HCA’s future pricing. If HCA’s costs rise by £x million per annum, the CMA considers that this would change HCA’s future profitability and so decrease the price reduction that HCA could afford and so be expected to result from the divestment. The CMA should therefore consider: *“How much would society (government) need to give HCA now in a lump sum to make HCA indifferent in its future pricing decisions – i.e. to compensate HCA fully for the alleged increased stream of costs?”* This would be the true cost of the remedy to society – in effect, the investment that society would need to make in the private company to release the full benefits of the divestment remedy. The lump sum that would leave HCA indifferent (fully compensated from its shareholders’ perspective) would be HCA’s increased per annum costs discounted at HCA’s own cost of capital. Given this amount of money today,

HCA's future decision making on price would be unchanged (HCA's managers and shareholders would be fully compensated for the increased costs they would face).

- ii. HCA will itself treat the (alleged) increased costs from the divestment no differently to other costs in its business. The losses in economies of scale costs will not be 'ring-fenced' and so enter into HCA's pricing decisions in a different way.³³ So the best estimate of how the costs will over time affect HCA's pricing will be given by the opportunity cost of this money within its business – the opportunity cost given by HCA's own cost of capital.
- 3.14 The appropriate way to enter the economies of scale losses into the NPV, therefore, is to first discount them at HCA's discount rate to get the lump sum society would need to, in effect, invest (the cost to society) to release the full benefit. Second, the CMA could spread that lump sum amount across the 20 years as an annuity using the social cost of capital. In this way, both the benefits and costs of the divestment would be reflected from the point of view of society (and using the social cost of capital in line with the Green Book) but HCA as a private company would not be overcompensated.³⁴
- 3.15 We show in the Confidential Annex the very material impact first using HCA's cost of capital, instead of the social cost of capital, has on the total cost of the divestment. This improves the proportionality of the divestment in all scenarios.
- 3.16 In Table 6 of the Confidential Annex we combine Point A and Point B and show that the divestment of the Wellington is clearly proportionate on both the central and downside case of for HCA's economies of scale losses.

C) The CMA's treatment of economies of scale losses

- 3.17 The SPDR explains that:
- i. The CMA now includes HCA's economies of scale losses for the full 20 years of assessment (and does not assume they taper off);
 - ii. HCA argued that its estimated per annum economies of scale losses have increased. The amounts now included by the CMA is significantly higher than at the PDR stage; and,
 - iii. The CMA does not consider the economies of scale losses to be Relevant Customer Benefits, but includes them in the NPV because it believes that these losses will reduce the amount that HCA can reduce prices after the divestment while continuing to earn *at least* profits in line with cost of capital.
- 3.18 We continue to have significant concerns with how the CMA includes these (alleged) economies of scale losses in the NPV. While we welcome the CMA's confirmation that they are not RCBs, as set out in our PDR response, this was not the only reason why the CMA should not include them in the way it has.

³³ Government often implements initiatives that change the future cost profiles for businesses (for example, the London Living Wage will likely cause HCA's costs to rise). However, HCA would not discount these increased costs, due to Government intervention, differently to other increased costs in its business (e.g. due to exchange rate movements). There is no reason for HCA to treat the divestment costs differently to other costs in its future price formation.

³⁴ The Green Book notes the State Aid risk created if private companies are over-compensated through public resources. The CMA's current treatment of discounting HCA's costs in effect over-compensates HCA by exaggerating the amount that "a market economy investor" would need to give HCA to fully compensate its managers and shareholders for these alleged increased costs.

- 3.19 First, there is good reason to believe that the economies of scale losses will be inflated precisely because of the AEC. We note:
- i. The AEC means that HCA's cost base in Central London has not been exposed to effective downward pressure from competition (for example [REDACTED]). So HCA's entire cost base is likely to be inflated relative to that which would arise were HCA facing well-functioning competition and insurers could exercise choice and drive efficiency.
 - ii. A very substantial component of the alleged economies of scale losses related to the contributions the HCA UK business would make to HCA Global's costs for its US Headquarters. However, as we explained in our PDR response, the AEC itself (through its effect on revenues, profits and price elasticity) will likely have resulted in HCA UK being required to make a higher contribution to HCA Global's costs than it would have done in the absence of the AEC.
- 3.20 It is perverse to use these AEC-inflated costs to counterbalance the proportionality of a remedy to the AEC. We see no evidence in the SPDR that the CMA has assessed the efficiency of HCA's costs (see further below) or the allocation rules used for HCA Group costs.
- 3.21 Second, the CMA acknowledges that other Central London hospitals – standalone facilities that are much, much smaller than HCA (and so without the benefit of HCA's alleged economies of scale) – are able to survive effectively in the market at prices significantly below HCA. The IPA, for example, showed that TLC had prices much lower than HCA (and still covered its cost of capital) and market evidence shows that hospital operators operate and are willing to enter Central London at prices very much lower than those of HCA (please see Annex B).³⁵
- 3.22 Yet when the CMA includes HCA's economies of scale losses and protects HCA by assuming that HCA should continue to make at least its cost of capital after divestment (which may be an inefficient outcome if HCA is itself inefficient), the CMA arrives at the conclusion that the price reduction range HCA can afford post divestment is "*low*" and "*the range includes zero*".³⁶
- 3.23 **This should immediately trigger alarm bells for the CMA.** It suggests that HCA is so inefficient compared to other smaller hospital operators that following the divestment it could not cover its cost of capital even if it retained its much higher prices (e.g. gave zero or minimal price reductions) and still remained more than three times larger than any other operator. It is perverse to protect a substantially less efficient firm from well-functioning competition because it unable to survive on a level playing field with smaller, efficient firms willing to charge lower prices.
- 3.24 Third, **other hospital providers could replicate these economies of scale after the divestment**, which would reduce the social cost of the divestment. The CMA specifically acknowledges this in the SPDR:
- "... it is not clear that these scale economy losses are a net loss. If the buyer of the divested assets is an established operator, then it may benefit from economies of scale and replicate some or all of the potential losses that HCA may incur ... Under this scenario, our view is that any scale economies lost to HCA should not be included in the NPV calculation (since these would not limit customers' price benefits)."³⁷*
- 3.25 We believe it is extremely likely that potential acquirers of the divested hospital(s) – such as large hospital groups like Spire, Nuffield or Ramsey – could replicate some or all of the alleged

³⁵ Cleveland Clinic has suggested to the CMA that it will enter at prices below HCA. [REDACTED].

³⁶ SPDR, paragraph 20.

³⁷ SPDR Appendix, paragraph 22, emphasis added.

economies of scale losses (and that they would pass these through to customers in lower prices, which HCA does not).

- 3.26 We also disagree with the CMA's assessment that other hospitals in the market would not lower their prices in the more competitive market created post divestment, and so achieve increased volumes and economies of scale of their own. If HCA's market power is addressed, Bupa would seek to introduce more competition across providers in the market to reward efficient providers. As examples, [redacted]. These tools would encourage all providers to focus more on efficiency, as efficiency would be rewarded in increased volumes.
- 3.27 We show in Table 7 of the Confidential Annex the very substantial impact on NPVs that arise if the CMA assumes that rival hospitals (collectively) are able to replicate just a quarter or a half of HCA's alleged economies of scale losses.
- 3.28 Fourth, we continue to believe that the economies of scale losses should taper off relatively quickly. All the cost items claimed by HCA are operational costs that could be scaled over time – i.e. will be variable and avoidable costs over time – particularly if they were inefficiently incurred in the first place.

D) The CMA can bring insurer benefits forward in time

- 3.29 We welcome the CMA's amendment to its modelling to allow divestment benefits to arise immediately and in full for self-pay benefits (rather than with an 18 month delay).
- 3.30 However, we continue to believe that **the CMA is being unnecessarily and erroneously conservative** in assuming that zero price benefits will arise for insured patients for 18 months following the divestment.
- 3.1 Indeed, we see no reason why the CMA should tolerate a period before which insured prices adjust. This simply protects hospital producer surplus at the expense of consumers.
- 3.2 Speaking as the UK's largest insurer (and on behalf of over 1.5 million customers), we would be **highly motivated** to put in place new contracts and pricing that improve outcomes for customers **as quickly as possible**. Our customers would expect us to take action and, with divestment taking place only in 2017, we would have plenty of time to put in place all necessary ground work:
- i. We can give the prospective acquirer of the divested assets forward guidance on the likely range of prices we will seek. We already do this when a new entrant wants to open a hospital. So contracts with new prices and terms could be in place **from day one** of the divested hospital 'opening'. **These price benefits could arise in full and immediately for insured customers.**
 - ii. Insurers and HCA could also negotiate new pricing terms **in advance of divestment** or immediately thereafter. The CMA could direct HCA and insurers to commit to complete negotiations within a specific time-frame (say 6 months). This again could ensure that benefits flow through to insured customers more quickly.
- 3.3 It would seem a reasonable and proportionate action by the CMA to mandate that insurers and hospitals need to come to revised terms more quickly given that this would bring about **tens of millions of pounds** of extra benefit to insured customers. There would be no real barrier to implementation.

- 3.4 The CMA's decision to maintain this assumption of an 18 month delay before any insured patient benefits arise is unnecessary and will harm customers, when customers themselves are saying they would be willing and indeed keen to act more quickly. It is possible and proportionate for the CMA to mandate HCA, the new entrant(s), and the insurers to come to new pricing arrangements **much more quickly**.
- 3.5 In the Confidential Annex we show the impact of bringing forward the insurer price benefits by one year, rather than the current approach of delaying them for a full 18 months. **This has a material impact on all NPVs.**

E) HCA's profitability continues to be underestimated

- 3.31 The SPDR continues to underestimate materially the likely price effect of the divestment by using the most conservative estimate of HCA's excess profitability (the scenario referred to as "KPMG 2"). **Focussing only on KPMG 2 favours HCA substantially.** It makes the divestment remedy appear less proportionate. We put this point to the CMA in our PDR response and fail to see any meaningful consideration of the points raised in the single paragraph response the CMA gives it in the SPDR (paragraph 50 of the SPDR Appendix).
- 3.32 To summarise briefly our points:
- i. The PDR modelled HCA's profitability over a nine year period (which included the financial crisis) under three scenarios:
 - a. **Base Case** – Property is revalued by Altus Edwin Hall on the basis of commercial property alternative use.
 - b. **KPMG 1** – Property is revalued by KPMG on the basis of residential property alternative use (increasing Capital Employed) and capital gains are recognised in the P&L.
 - c. **KPMG 2** – Property is revalued by KPMG on the basis of residential property alternative use (increasing Capital Employed) but capital gains are not recognised in the P&L.
 - ii. The analysis showed that on any of the three scenarios HCA had earned hundreds of millions of pounds in excess profits over the nine years.³⁸
 - iii. The CMA, however, focused only on the KPMG 2 scenario in its NPV modelling. The KPMG 2 scenario is **by far** the most conservative estimate of HCA's economic profits. The estimated excess profits in KPMG 2 is under half of the excess profits in the KPMG 1 scenario, for example. As KPMG 2 is the lowest profitability scenario, it also leads to the lowest estimated benefit from the divestment. KPMG 2 gives the lowest price reduction range by some distance, and its price reduction range does not overlap with those of the Base Case or KPMG 1 scenarios.

³⁸ Customer detriment as measured by the excess profits is very large, and in fact would be substantially underestimated by these figures. For example, the producer surplus will not capture the welfare losses from people excluded from the market by the higher prices or the losses of innovation in the market.

- iv. The CMA's own analysis in the PDR suggested it was wrong to focus exclusively on KPMG 2. In the PDR, the CMA was clear that the estimated value of HCA's properties would lie somewhere between the KPMG valuation³⁹ and that of Altus Edwin Hill (in the Base Case):

"12. we noted (a) the price differentials between residential and commercial property have not disappeared (to date) and we would expect such convergence in prices to take a number of years to be realised (if at all); and (b) several of HCA's properties were located within the Westminster Central Activity Zone, which is currently exempt from the new planning development rights This indicates that the value of HCA's buildings is likely to be somewhere between the Aldus Edwin Hill and KPMG valuations.

16. The evidence that we collected indicated that the value of HCA's land and buildings was likely to be between the Altus Edwin Hill and the KPMG valuations. C&W's report, together with the information on the purchase price of 33 Grosvenor Place, suggested that a value approximately midway between these two points may be the most appropriate. However, when taking into account the potential costs of converting a building to hospital use, this suggested that more weight [but not all weight] should be placed on the KPMG valuation." (emphasis added)

It follows that some weight should be attached to the Base Case, and the CMA should at a minimum place more weight on price reductions towards the upper end of the KPMG 2 range – which would align more closely to price reductions in the Base Case range (even after removing capital gains) – than on the 3% lower bound, which is an extreme point.

- v. For the reasons set out in our PDR response (see paragraphs 3.32 – 3.42 of that submission), the CMA is also incorrect in fully excluding capital gains as the trajectory of property prices in central London is such that a reasonable expectation could be formed of continued capital appreciation over a 5-10 year period.

3.33 The SPDR continues to use KPMG 2 only. In paragraph 50 of the SPDR, the CMA explains its reasons as:

- i. *"We still consider the opportunity cost to HCA of operating a private hospital is given by the highest value alternative use of the HCA assets."* We do not dispute this approach, but note, as the CMA itself explained above, that the value of the HCA assets are not yet, and may never be, at the value of the residential property alternative use.⁴⁰ So relying exclusively on KPMG 2 is incorrect on the CMA's own facts; and,
- ii. *"[W]e explained that the capital gains on those assets should be excluded for the purposes of an economic profitability assessment as part of a competition review as HCA should not expect such windfall gains to be repeated in the future"*. We note (as we did in the PDR) that HCA enjoyed these gains repeatedly over the nine years and that there is no market evidence cited by the CMA to suggest property prices in central London will not continue to rise over the next 5 to 10 years. So we find it strange that the CMA should so definitively assert that *"HCA should not expect"* such gains in future and dismiss them in full.

3.34 Our concern remains, therefore, that the CMA chooses to focus exclusively on the most conservative estimate of HCA profitability and so minimises the likely benefit from the divestment. **These assumptions are at odds with the CMA's own evidence and unsupported by market**

³⁹ We note, and the CMA is clearly aware, that KPMG is HCA's economics advisor in the CMA inquiry. This raises concerns about the independence of this valuation.

⁴⁰ One could also expect substantial costs re-purposing a hospital to residential use, suggesting a discount should be factored in to the valuation.

evidence. At a minimum this should mean that the CMA places more weight on the upper end of the price reduction range than at the bottom end (3%).

F) Inconsistencies remain in the CMA's modelling

3.35 We set out in the Confidential Annex some further concerns about the NPV modelling that we believe have the effect of understating the benefit of the price divestment.

Modelling of annual growth

3.36 The CMA's formula applying the annual growth rate of 3.5% is incorrect in its treatment of the early years of price benefits. This has a compounding effect across the 20 years, resulting in the value of aggregate price benefits being understated.

Numerical inconsistencies on revenues

3.37 We welcome in the SPDR the CMA's correction of the treatment of outpatient revenues. However, as noted previously in the PDR response, we believe that there continue to be numerical inconsistencies between sheets of the CMA's modelling on the scale of HCA's revenues that affect the scale of price benefit that the CMA should factor into its proportionality assessment.

4. Alternative remedy options

- 4.1 The CMA provisionally concludes in the SPDR that a divestment remedy would be disproportionate. In the PDR, the CMA has separately provisionally found that, in light of the anticipated timing of entry, no other remedies would be either effective or proportionate.
- 4.2 The effect of these provisional findings, if maintained, would be that the CMA will take no action to address the specific AECs that it has identified in relation to the London market on the basis of a potential – but highly uncertain – prospect of further entry over a 5-20 year time horizon. This would on any basis be an extraordinary result. It is clear that the evidence that the CMA is relying on does not – and is not considered by the CMA to – reach the standard of timely, likely and sufficient entry that would be necessary to avoid the need for a finding of an AEC, and yet the end result that the CMA is currently proposing is in practical terms exactly the same as if it had reached this conclusion.
- 4.3 The credibility of this conclusion is therefore questionable and should be questioned by the CMA. Against this background, and moreover given the CMA's statutory duty to achieve as comprehensive solutions to the AECs as is reasonable and practicable, the CMA, if it intends to maintain its position on the main divestment remedies that have been proposed, will need to conduct a thorough review of the extent to which there may be alternative remedies to ensure that the identified AECs are addressed to the extent possible. Even remedies that are only partially effective in resolving the AECs must be considered, as this would be a superior outcome for consumers than the CMA deciding to take no action.
- 4.4 The PDR did not contain more than a high-level assessment of some alternative options. The SPDR contains no assessment of alternative remedies, including the remedies we set out in our PDR response.
- 4.5 Bupa firmly believes divestment is still effective and proportionate. Sections 2 and 3 explained why the CMA's own evidence justifies the proportionality of divestment of, at least, the Wellington hospital together with the Platinum Medical Centre. However, if the CMA chooses not to order a divestment then in order to discharge its statutory duty to find as comprehensive a solution to the AEC as is reasonable and practicable, it must consider in more detail the scope for further remedies including the scope to amplify or strengthen existing remedies. The need for this is even stronger given that the evidence in the SPDR now suggests that the significant customer detriment will likely be experienced for longer if the CMA takes no action.
- 4.6 As noted, Bupa has already made submissions in its PDR response on the form such remedies could take (see section 4 of that submission). A summary of these remedies is outlined below.

A narrower divestment package

- 4.7 If the CMA's decision turns on the scale of divestment costs on HCA (although, to be clear, we believe that the treatment of these is currently incorrect in the NPV), then the CMA should consider smaller scale divestments that may only be partially effective, but improve outcomes for customer.
- 4.8 Two narrower packages that the CMA should consider are:
 - i. Divest the London Bridge Hospital to reduce HCA's control over the Corporate market segment (given its critical location for The City and Canary Wharf);

- ii. Divest (a) Leaders in Oncology Care (The London Oncology Clinic) or The Harley Street Clinic and (b) The London Radiotherapy Centre to address HCA's control over Oncology (see section 2 above for further detail on the importance of addressing HCA's market position in Oncology).⁴¹

A price control and arbitrator

- 4.9 In circumstances where a divestment is rejected as disproportionate, the CMA should undertake more detailed consideration of a price control on HCA than it appears so far to have carried out, before it can reasonably conclude that no such remedy is feasible.⁴²
- 4.10 The scale of customer detriment that will arise over the next 5 to 10 years if no divestments are ordered will be very substantial – several hundred millions of pounds even on the most conservative of the CMA's profitability estimates for HCA. A price control is, therefore, highly likely to be proportionate and, even if only partially effective, a price control will be better for customers than the CMA taking no action.
- 4.11 Bupa accepts that there may be challenges to overcome in managing a light-touch control, but given the huge detriment to customers that will result if no action is taken, it is necessary to consider this price control option as a safeguard for customers (even if such a safeguard only partially addresses the AECs that the CMA has provisionally identified). We set out in our PDR response our suggestions for how a price control remedy could be designed that would at least be partially effective, would be proportionate, and would clearly be better for customers than no action.
- 4.12 We also consider that there is value for customers in an arbitrator that can monitor the conduct of HCA (until its dominance is addressed by entry) and can quickly handle contentious matters between insurers and HCA during contractual negotiations and disputes.

Stronger constraints on HCA's relationships with consultants

- 4.13 A significant risk to the successful entry of the Cleveland Clinic and others into the Central London market is the significant control that HCA can exert over consultants (and private GPs).
- 4.14 HCA has a number of avenues to increase the 'stickiness' of consultants, many of which are not covered by the CMA's existing Final Order on the clinician incentives remedy. For example, we have provided evidence to the CMA of HCA's use of equity relationships to lock in the highest-value consultants.⁴³
- 4.15 The CMA should consider amending and expanding the scope of the clinicians incentives remedy as it applies to HCA such that:
 - i. All HCA's financial relationships with consultants and GPs are published in detail and can be scrutinised publicly. Total payments to individual clinicians should be published each quarter. This will allow the cumulative effect of these relationships to be understood and monitored.

⁴¹ See paragraphs 4.7 *et seq.* of Bupa's response to the PDR.

⁴² See paragraphs 4.20 *et seq.* of Bupa's response to the PDR.

⁴³ See Bupa's response to the CMA's supplemental questions on Bupa's PDR response.

- ii. HCA should be banned from forming equity-holding relationships with clinicians. All existing equity-holding relationships should be unwound.⁴⁴

Removal of all restrictive contractual clauses with insurers

- 4.16 HCA is in a position to impose contractual clauses on insurers that limit the insurer's ability to deliver value for money in the market. These clauses have an anti-competitive effect as they foreclose opportunities for other hospital providers. Insurers do not have the bargaining power to remove these clauses on their own (or without conceding further significant price rises).
- 4.17 HCA uses these clauses already and there is a significant risk that it will do so more often if the CMA does not address the AEC directly.
- 4.18 If the CMA does not address HCA's market dominance directly, the CMA should immediately order HCA to remove all existing clauses that have or could have actual or potential foreclosure effects.⁴⁵

⁴⁴ See paragraphs 4.32 *et seq.* of Bupa's response to the PDR, and Bupa's response to the CMA's supplemental questions on Bupa's PDR response.

⁴⁵ See paragraphs 4.36 *et seq.* of Bupa's response to the PDR.

Annex A: Confidential Annex

A.1 [REDACTED]

Annex B: Comparison of hospital pricing in the market

- B.1 The CMA conducted its IPA analysis between HCA and The London Clinic on total episode costs for a basket of surgical procedures over the period 2007 to 2011. This showed that HCA was substantially more expensive than The London Clinic on the comparable basket even after the CMA had undertaken all case-mix adjustment feasible on the Healthcode data. The difference was large and statistically significant.
- B.2 Our experience is that pricing between HCA and The London Clinic has [REDACTED] since 2011, [REDACTED].
- B.3 As the CMA knows, Bupa calculates an ‘affordability index’ to compare pricing between hospital groups. This focusses on the surgical activity where there is a common coding structure between hospital groups (CCSD coding). We note that there is not the same level of rigor on case-mix adjustment as was undertaken by the CMA in its IPA, but that these relative benchmarks are instructive and are used as a basis in our negotiations with hospital providers.
- B.4 The results of a recent Affordability analysis across the largest hospital groups are presented in Table 9.

Table 9: [REDACTED]

- B.5 The table shows that:
- i. [REDACTED]
 - ii. [REDACTED]
 - iii. [REDACTED]
 - iv. [REDACTED]