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Our ref: BQ/CKM/H2700/00037

Dear Ms Moore

HCA - Supplemental Provisional Decision on Remedies

Introduction

1. We are responding on HCA's behalf to the CMA's Supplemental Provisional Decision on Remedies ("SPDR") dated 7 July 2016.

2. HCA welcomes and supports the CMA's confirmation in the SPDR that it remains of the view that the divestment of HCA assets is not a proportionate remedy. Neither Bupa nor AXA PPP has presented any further evidence in response to the Provisional Decision on Remedies ("PDR") of 22 March 2016 which would justify the imposition of any additional remedies in relation to central London. As the CMA correctly observes, divestiture would be "*a seriously intrusive step*",[1] and there is no basis whatsoever for the CMA to adopt such a draconian and discriminatory remedy on the basis of the available evidence.

3. HCA does not propose to repeat the extensive submissions which it has previously made, including its Response to the PDR and its Observations on the third party responses to the PDR. However, while the CMA is wholly correct to conclude that there is no case for any additional remedies (other than those which have already been imposed by the Private Healthcare Market Investigation Order 2014), HCA briefly reiterates a number of general points with regard to the CMA's analysis in the SPDR.

There is no basis for an AEC finding

4. As HCA has maintained throughout this remittal, the CMA has not demonstrated to the requisite evidentiary standard that there are any structural adverse effects on competition

[1] SPDR, para 64.

("AECs") in relation to either insured or self-pay patients in central London. The SPDR proceeds on the assumption that there are AECs. The CMA cannot reasonably sustain its provisional findings of structural AECs, and therefore there is no basis for the consideration of any remedies. There are no significant barriers to full and effective competition in central London which would justify any further remedial action.

5. The CMA's own findings in this remittal investigation undermine its previous views that there are structural AECs in central London.

New entry

6. First, the CMA now correctly accepts in the SPDR that "*there is a strong prospect of new entry*"[2] in central London by large-scale hospital operators, such as Cleveland Clinic, VPS and Spire, and by specialised operators, such as Schön Klinik, Barts PPU and Optegra. The CMA rightly recognises that there is growing interest by investors as a result of continued growth in demand for private healthcare services, and that new operators are expected to enter the market. It is therefore incumbent on the CMA to reverse its earlier view in the Provisional Findings that there are substantial barriers to entry, in the form of high sunk costs, lack of site availability, and planning constraints, which inhibit or prevent new entry. The CMA cannot logically argue that there are structural barriers which deter entry, when there is clear evidence that large- and small-scale operators are in the process of establishing new facilities. HCA has demonstrated that investors are prepared to commit significant funds in new hospital projects; are securing large sites for new facilities; and are successfully navigating their way through the planning regime. Furthermore, the CMA's own NPV considers entry and market growth when assessing the proportionality of divestment. The logical conclusion to be drawn from this is that structural barriers are not deterring either new entry or expansion.

IPA

7. Secondly, the CMA has acknowledged in this remittal that it can no longer rely on its insured price analysis ("IPA") to conclude that there is any systematic price difference between HCA and its competitors in central London. The CMA accepts in the SPDR that the IPA "*no longer allows us to conclude on the size of the price difference that is due to weak competitive constraints on HCA, as we cannot be sufficiently certain that we have adequately controlled any differences in patient complexity between HCA and TLC*".[3] In the CMA's Final Report of April 2014, the IPA was the cornerstone of the CMA's finding that there were structural AECs for insured patients in central London. The CMA relied on the IPA to demonstrate that weak competitive constraints and barriers to entry gave rise to higher prices for insured patients within central London. Since the CMA now accepts that the IPA does not provide sufficient evidence of a causal link between HCA's share of supply and HCA's prices for insured patients (a clear requirement set by the Tribunal[4]), there is no basis for its finding of structural AECs in relation to insured patients.

[2] SPDR, para 35.
[3] SPDR, para 65.
[4] Tribunal judgment (application for disclosure) in *HCA v CMA*, 25 July 2014, paragraph 37

Profitability

8. Thirdly, the CMA's profitability analysis similarly does not demonstrate that HCA's prices exceed the competitive level. HCA has pointed out that there are numerous flaws in the CMA's profitability analysis.[5] In any event, the CMA itself acknowledges in the SPDR that its finding of HCA's higher profitability may reflect economies of scale and other efficiencies. Therefore, the CMA's findings on profitability do not provide sufficient evidence of a causal link between HCA's market position and its prices,[6] again falling short of the clear standard required by the CAT for finding a structural AEC with regard to prices (insured or self-pay).

Availability of spare capacity

9. Fourthly, the CMA also accepts that there is evidence of spare capacity in central London, particularly in relation to the availability of beds and theatre capacity.[7] The evidence of spare capacity is relevant, both to the findings concerning structural AECs, and to the effectiveness of a divestment remedy. The CMA argued in the Final Report that there are capacity constraints which inhibit the bargaining power of PMIs by preventing them from switching subscribers away from HCA hospitals to competing facilities in central London. This was a factor in the CMA's "*hypothesis that local substitutability plays a role in determining insured price outcomes*".[8] The CMA can therefore no longer conclude in support of the AEC findings that there is a lack of spare capacity or that there is a causal relationship between HCA's share of supply and its insured prices. In the presence of sufficient spare capacity, any real or perceived difficulty the PMIs have in diverting patients away from HCA cannot be attributed to a lack of alternative capacity. In fact, as HCA has previously submitted,[9] and consistent with submissions from the PMIs,[10] the ability of any PMI to divert patients away from HCA is driven by HCA's reputation for its quality of care, which is entirely consistent with a competitive market. At the very least, the CMA is required to reconsider its conclusions about PMI bargaining power in the light of the evidence of spare capacity which HCA has put forward.

London / non-London operators

10. Furthermore, the CMA cannot credibly maintain the position that there is an AEC in relation to insured patients within, but not outside, central London. On the CMA's own analysis in the Final Report of April 2014, there are higher levels of concentration outside central London (since many local markets are characterised by monopoly or duopoly hospitals); and there are greater barriers to entry (since the CMA has found that many local markets outside central London are characterised by nil or low growth in demand which discourages new investment). The PMIs have not sought to challenge the CMA's findings that there are no insured AECs in markets outside central London, and they have therefore accepted this finding as reasonable

[5] See e.g. Submission on the CMA's analysis of profitability, Professors Alan Gregory and Bruce Lyons, 20 January 2016.
[6] SPDR, para 67.
[7] SPDR, para 71.
[8] See e.g. Final Report, paras 6.324-6.329.
[9] HCA, Response to PDR, paras. 2.19 and 6.24
[10] See, for example, AXA, Response to remittal PFs, page 6

and lawful. It would be irrational for the CMA to maintain its insured AEC finding in central London in these circumstances.

11. In addition, for the reasons set out in HCA's previous submission,[11] the CMA would unlawfully discriminate against HCA if the CMA maintains an insured AEC finding against HCA, even though it accepts that the IPA cannot be relied on, in circumstances in which the CMA has made no insured AEC finding against other hospital operators (Spire, BMI, Nuffield and Ramsay) on the grounds that the IPA does not support such a finding. The Court of Appeal has recently reaffirmed in *Gallaher & Somerfield v CMA*[12] that under the public law principle of equal treatment, the CMA has a duty to treat all parties under investigation on a fair and comparable basis. There must be objective justification for any difference in treatment. There is no such justification in this case.

Conclusion on AECs

12. In the recent judicial review proceedings, the Tribunal quashed the CMA's divestment remedy and required the CMA to carry out a "*genuine and effective reconsideration*" of its AEC findings, without any preconceptions arising from its original inquiry.[13] The CMA should not therefore be seeking to "defend" its earlier analysis, but rather to carry out a fresh assessment of the market.

13. The Tribunal noted that "*the IPA was absolutely critical as the basis for the CMA's findings or relevant AEC*s" and that HCA's criticisms of the IPA were "*centre stage*" in the proceedings.[14] The Tribunal concluded that if the robustness of the IPA were undermined, it "*could not properly be relied upon as a basis for any insured AEC decision*".[15]

14. The Tribunal also pointed out that, while the self-pay AEC decision had not been quashed, the CMA would need to give "*careful consideration*" to the flaws in the IPA in the context of the self-pay AEC and "*the implications it may have for the overall reasoning in the Final Report.*"[16]

15. In the light of the above, the CMA should draw the necessary consequences from its own findings and accept that there is no longer a sufficient evidentiary basis for its finding of structural AECs, in relation to either insured or self-pay patients in central London.

There is sufficient spare capacity in central London

16. In the SPDR, the CMA expresses "uncertainty" about the level of spare capacity in central London. It accepts that there is evidence of spare capacity on some dimensions (beds and theatres) but not on others. The CMA asserts that there are "*some constraints on overall*

[11] HCA's Response to the PFs, paras 9.12 et seq.
[12] *Gallaher Group & Somerfield v CMA* [2016] EWCA Civ 719.
[13] Tribunal judgement, 23 December 2014, para 89.
[14] Tribunal judgement (application for disclosure), 25 July 2014, para 31
[15] Tribunal judgement, 23 December 2014, para 12.
[16] Ibid, para 60.

effective capacity" although it accepts that the uncertainty "*feeds into how confident we can be about the likely price impact of any divestment remedy*".[17]

17. HCA has provided considerable evidence of spare capacity in central London in the two KPMG reports on spare capacity. HCA welcomes the CMA's acceptance that there is evidence of spare capacity in respect of beds and theatres. However, HCA fails to understand how the CMA can justify its assertion that there are "*some constraints on overall effective capacity*".[18] HCA has repeatedly challenged the CMA to disclose the evidence for capacity constraints, and the CMA has failed to do so.

18. The CMA argues that HCA's analysis did not consider "*the availability of consultants and their teams, nor other specialist staff and equipment, or the times when patients are willing to be seen.*"[19] This is incorrect. HCA expressly dealt with each of these issues in its Response to the PDR (see in particular paragraphs 6.27-6.29) to demonstrate that, on the basis of all the available evidence, none of these factors is in fact prohibiting the ability of competing providers in central London to offer private healthcare services to insured or self-pay patients. In fact the CMA's own consultant survey shows that that 44% of consultants in Greater London have time available and would like to do more private work[20] suggesting that PMIs would have little difficulty in finding consultants to treat their patients if they were to move them from HCA's facilities.

19. The CMA asserts in the SPDR that the views and actions of parties and internal documents (which have not thus far been disclosed) "suggest" that there is a lack of effective capacity "*for example theatre capacity at peak times and available ITU beds*"[21]. However, KPMG's second report on spare capacity has demonstrated that, based on the data available, there is more than enough capacity for PMIs to re-direct all their patients to rival ✂. The hard data does not support the "suggestion" of a lack of effective capacity. In the light of this evidence, the CMA needs to explain why it continues to believe that competitors are capacity constrained in relation to these factors.

20. Further, even if consultants or other specialist staff or equipment were not available at the time when patients are willing to be seen, it is wholly unclear how a divestment (that is shifting hospital facilities between hospital operators) could be effective in addressing any such lack of availability.

21. HCA would also remind the CMA that the PMIs are no longer seeking to demonstrate that there is insufficient spare capacity which prevents them from switching subscribers away from HCA facilities. In addition, Spire has confirmed to the CMA its view that there is sufficient spare capacity in central London.[22]

[17] SPDR, para 71.
[18] Ibid.
[19] Ibid.
[20] An Assessment of the Private Healthcare Market – Consultants Survey. Question B4.
[21] SPDR, para 71.
[22] Spire's response to the PFs, and Notice of possible remedies – consultation question 3(c).

22. Moreover, if the CMA continues to believe that there are some constraints on capacity, it has a duty to adduce the evidence for this. The burden of proof is on the CMA. It is not sufficient for the CMA to make unfounded assertions about capacity constraints, and then require HCA to disprove them.

23. The CMA is right to conclude that, given the existence of spare capacity in central London, it cannot be at all confident about the likely price impact of divestment. However, in view of the data analysis which HCA has put forward, the evidence for the availability of spare capacity in central London is much clearer and more conclusive than the CMA concedes in the SPDR.

Cleveland Clinic's entry into central London

24. The CMA states that it can no longer conclude that Cleveland Clinic will enter the market by 2019/2020, although it nevertheless accepts that there is a strong prospect that Cleveland Clinic will launch its new hospital within the next five to ten years.

25. There is clear evidence that Cleveland Clinic is actively pursuing its plans for its new facility in central London, and in HCA's view there is every expectation that it is likely to start treating patients by 2020:

- Cleveland Clinic has completed its acquisition of the premises.
- It has engaged a highly experienced team, which includes ✂ who are experienced in running private hospitals.
- ✂.
- It is also actively marketing to consultants.
- ✂.
- It has commenced discussions with PMIs.

These are all strongly indicative of Cleveland Clinic's intention and strategy to commence operations imminently.

26. The CMA refers to the fact that Cleveland Clinic has not as yet submitted a planning application ✂. However, given that Cleveland Clinic has acquired the relevant site, none of these are matters which would necessarily result in any significant delay. It is clear that Cleveland Clinic is progressing its plans to launch the new hospital in parallel with its planning application, and therefore even if its planning application is not submitted until later this year or next year, it is still likely that it would be in a position to launch its services by 2020.

27. ✂.

28. ✂. Even allowing for some slippage in the timetable because of the planning process, this would suggest that opening by 2019/2020 is eminently achievable.

29. HCA sees no reason for the CMA to change its original assessment that Cleveland Clinic is likely to constrain HCA by 2022 at the latest. In any event, based on its progress to date, there is every expectation that Cleveland Clinic would be able to commence operations well within a five year timeframe.

There is no evidence that divestment would be an effective or proportionate remedy

30. The CMA's Guidelines require that a remedy should be both effective in achieving its aim and proportionate.[23]

Effectiveness

31. In the PDR, the CMA provisionally indicated that divestment could be an "effective" remedy in reducing prices by increasing the competitive constraints on HCA.[24] As HCA has consistently argued, there is no evidence that the divestment of any of HCA's hospitals would lead to lower insured prices for a given level of quality and range of private healthcare services. HCA refers to its Response to the PDR.[25]

32. The Tribunal has noted that the effectiveness of a remedy is a material consideration in its own right and requires careful assessment.[26]

33. As the CMA itself recognises in the SPDR, there are considerable uncertainties over the price impact of divestiture:

- As noted above, the CMA accepts that the IPA does not provide sufficient evidence of a causal link between HCA's share of supply and HCA's prices for insured patients. Accordingly, the CMA no longer seeks to rely on the IPA to demonstrate that divestment would lead to lower prices.

- The CMA also recognises that "*there is mixed evidence on the extent of spare capacity in the central London market*", which leads to a number of uncertainties on *"how confident [the CMA] can be about the likely price impact of any divestment remedy"* and this could *"also mean that a divestiture remedy is not fully effective"*.[27]

- Furthermore, the CMA has erred in *"expect[ing] a divestiture to increase the competitive market constraints on HCA, as it provides PMIs with an additional hospital operator (or an existing operator with additional hospitals) with whom they can agree a contract."*[28] In a bargaining context, as acknowledged by the CMA, what matters is the outside option of the negotiating parties, i.e. the value of the next best alternative to reaching an agreement with the other party. The addition of another hospital operator with whom to negotiate is in itself irrelevant without it improving the PMIs'

[23] CC3 (revised) Guidelines for market investigations, paras 334-341.
[24] PDR, para 2.57.
[25] HCA's Response to the PDR, section 6.
[26] *Tesco v CC* [2009] CAT 6, para 165.
[27] SPDR, para 71
[28] SPDR, para 68

outside option. The CMA has not shown a link between an additional hospital operator and the bargaining strength of the PMIs, and indeed the evidence on spare capacity shows that no such link exists.

- The CMA also states *"the size of [the relationship between a reduction in prices to PMIs and growth in demand by final customers] will depend on the extent to which a divestiture is successful in lowering prices and the price elasticity of demand, which, for insured patients, depends on the extent to which lower prices are passed on to final customers and on the extent to which this increases demand for PMI"*. [29] The CMA correctly recognises that even if there were to be any benefits from divestment, the extent of any benefits from divestment depends on the degree to which the PMIs would pass on any price reduction. HCA has made submissions setting out reasons why one may expect such degree of pass-through to be low.[30] This means that not only is the SPDR NPV highly likely to overstate the price benefits from a divestment (and therefore underestimate the degree by which the divestment remedy is disproportionate), but crucially, the CMA cannot be confident that a divestment remedy would even be effective at reducing prices to *"final customers"* (i.e. insured patients).

- The CMA states that its profitability analysis provides evidence that HCA has earned supernormal profits. HCA considers that the CMA's profitability analysis is highly flawed. In any event, however, the CMA accepts that HCA's profitability may reflect efficiencies (and not necessarily a lack of effective competition) and that it does not necessarily follow "*that HCA's prices post-divestment would fall all the way to the point where its returns were equal to its WACC.*"[31]

- The CMA also correctly notes that the profitability analysis is *"an imperfect measurement of market power*" and cannot be relied on in itself to justify a divestiture.[32]

34. As HCA has previously pointed out, the fact that TLC's profit margins are broadly equivalent to HCA's suggests that HCA's prices are not likely to be above the competitive level.

35. The CMA will also recall that smaller PMIs (other than Bupa and AXA PPP) have previously submitted to the CMA that in their view a divestment would not lead to lower insured prices, and Aviva had expressed the concern that it could in fact lead to increased prices "*resulting in patients and PMI providers paying more for medical procedures in central London.*"[33]

[29] SPDR, Appendix, para 28
[30] See, for example, HCA's Response to the Remittal PFs, paragraphs 3.73 – 3.91 and HCA's Response to the Remittal PDR, paragraphs 6.14 – 6.15.
[31] SPDR, para 68.
[32] SPDR, fn 44.
[33] Aviva's response to the Remedies Notice on the original inquiry, page 4; see generally HCA's Response to the original PDR, para 6.17.

36. There is also no evidence to suggest that divestment would be effective in improving either quality or innovation. The CMA has repeated in the SPDR that "*while we have not identified detriment in the form of a lack of quality and/or innovation in the market, we continue to believe that divestiture would be likely to bring benefits of this form.*"[34] However, it has not at any stage, either in the original inquiry or in this remittal, provided any evidence whatsoever to support the assertion that divestment would lead to benefits in quality and innovation. The CMA has previously accepted in the Final Report that there is effective competition over quality and innovation in central London, which has delivered benefits to consumers. There is no basis for the CMA's view that a divestment would generate further improvements in quality and innovation, or that "*such benefits are likely to be significant.*"[35] On the contrary, HCA has provided evidence which highlights the risks that a divestment would create for quality and innovation at HCA hospitals.[36]

37. It is clear that the CMA can no longer state with any degree of confidence whatsoever that divestment would lead to lower prices (or increased quality) or what the price impact (if any) of a divestiture would be, and therefore cannot conclude that divestiture would be an effective remedy at all.

Proportionality

38. In the SPDR, the CMA updated its NPV analysis in response to submissions from various parties and confirmed its conclusion from the PDR that a divestment remedy would not be proportionate.[37] HCA wholeheartedly agrees with this conclusion, as the evidence clearly shows that the costs of a divestment remedy overwhelmingly outweigh any potential benefits.

39. HCA has reviewed the CMA's updated NPV and has identified errors relating to the CMA's estimation of economies of scale losses as well as at least four methodological errors, with respect to the treatment of:

- Weighted average cost of capital ("WACC")
- Outpatient revenues
- Effect of new entry
- Growth of HCA revenues

40. Addressing these methodological errors causes the NPV of divestment to reduce, making a divestment remedy even more disproportionate than the CMA has determined in the SPDR. We enclose Annex 2 to this letter which discusses these points in more detail.

[34] SPDR, para 72.
[35] SPDR, para 72
[36] See, for example, HCA's Response to the Remittal PFs, paragraphs 3.92 – 3.110 and 3.205 – 3.238; and HCA's Response to the Remittal PDR, paragraphs 7.43 – 7.46 and 7.108 – 7.113.
[37] Supplemental PDR in the Remittal Inquiry, paragraph 75.

41. It follows from the above that the CMA must conclude that, even if *ex hypothesi* there were structural AECs in central London, divestment would be neither an effective nor a proportionate remedy to address them.

Conclusion

42. The CMA has indicated that it expects to issue its Final Report next month, in August 2016. HCA very much hopes that the CMA can now bring this inquiry to a swift conclusion. The CMA's investigation is now in its fifth year, and has imposed substantial costs and burdens on HCA, and no doubt on other parties, as well as sustaining the regulatory uncertainties for investors in central London. It is time that the private healthcare industry is allowed to move on. The Private Healthcare Market Investigation Order 2014 has made some positive changes, in particular in curbing consultant incentive schemes and in providing for clinical output data to be made available to patients, and HCA supports these reforms. HCA agrees that there is no justification for the CMA to impose any further remedies, and trusts that this inquiry will be brought to a close as soon as reasonably possible.

Yours sincerely

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ANNEX: COMMENTS ON NPV ANALYSIS IN THE SPDR

Introduction

1. HCA contests the CMA's finding of an AEC in central London, and it also contests the CMA's view in the original PDR that a divestment remedy could be effective in remedying such an AEC. Without prejudice to HCA's position on both these issues, HCA comments as follows on the CMA's updated net present value analysis of a divestment remedy in the SPDR ("SPDR NPV").[1]

2. The CMA concludes from the SPDR NPV that a divestment remedy would be disproportionate.[2] HCA fully agrees with this conclusion.

3. In reviewing the SPDR NPV, HCA disagrees with the CMA's estimation of the size of the economies of scale losses and has identified a number of methodological errors which, when corrected for, make the NPV of divestment even more disproportionate. This Annex reviews each in turn.

Economies of scale

4. HCA agrees with the CMA that HCA's loss of scale of economies flowing from a divestment remedy should count as an economic cost and should therefore be included in the NPV analysis.[3] However, HCA notes that in the NPV the CMA has modified the levels of the loss of scale economies estimated by HCA and its reasons for doing so are flawed.

5. HCA submits that the CMA should have used in the NPV the actual estimate for the loss of scale economies put forward by HCA, as these estimates are the most accurate available. HCA undertook a detailed and thorough review of its business, interviewed all major department heads, and considered clinical and commercial requirements when developing the estimates. In making modifications to those estimates, the CMA has made assumptions that run against commercial reality For example, the CMA has assumed that ✂.

[1] HCA notes that the CMA only reported the NPV from a divestment of The Wellington Hospital, and not of London Bridge Hospital and The Princess Grace Hospital. The CMA justified this by stating that this would be *"the least costly and least intrusive package"* (SPDR, Appendix, para 29). According to the CMA a divestment of London Bridge Hospital and of The Princess Grace Hospital would be even more disproportionate than one of The Wellington Hospital by virtue of having higher economies of scale losses. All arguments set out in this Annex hold equally for a divestment of The Wellington Hospital or London Bridge Hospital and The Princess Grace Hospital.
[2] SPDR, para 75.
[3] SPDR, para 48.

6. The CMA, having provided no reasonable basis for its alternative approach, should therefore adopt as its base case the economies of scale losses estimated by HCA. Under all plausible scenarios, when using these economies of scale losses, the NPV of divestment is negative.

Methodological errors

7. The CMA has implemented a number of changes to the NPV as presented in the SPDR. According to the CMA, this is due to the CMA having taken into account a number of the arguments made by the parties in response to the PDR. Following a review of the SPDR NPV, HCA has identified a number of modifications to the NPV which are flawed.

8. In particular, the CMA has erred in:

- ignoring the serious errors highlighted by HCA in the calculation of WACC and adopting a WACC range of 9 to 10%;
- including outpatient revenues in the calculation of price benefits;
- including a scenario where only 50% of the price benefits of new entry are realised; and:
- applying a growth rate to HCA's domestic revenues without considering the source of such revenue growth or the costs associated with it.

9. HCA now deals with each of these errors in turn.

The CMA erred in adopting a WACC range of 9 to 10%

10. In the Final Report to the original inquiry, the CMA used a WACC estimate of 10% as the benchmark to estimate customer detriment.[4] The CMA did not update the WACC in the remittal PFs ("PFs"). However, following the remittal PDR and the CMA's decision to use profitability analysis to quantify potential benefits of a divestiture remedy, the CMA updated its profitability analysis and published its Assessment of the cost of capital working paper (the "WACC paper") to update the WACC analysis. In the WACC paper, the CMA estimated a WACC range of 7.6% to 10.5%[5] and continued to use a benchmark WACC of 10% to quantify customer detriment.[6]

11. HCA made a number of submissions (prior to the WACC paper) which commented on the CMA's methodology related to the measurement of WACC.[7] However, in the WACC paper, the CMA either did not acknowledge or inadequately addressed many of the issues that HCA had raised in these submissions.

[4] Final Report, Appendix 6.14, para 20.
[5] WACC paper, 22 April 2016, para 6.
[6] WACC paper, 22 April 2016, para 8.
[7] These submissions include: HCA's Response to the Provisional Findings, HCA's Response to the Remittal Provisional Findings, HCA's Response to the post-remittal PDR and an independent submission on the CMA's analysis of profitability in the Private Healthcare Market Investigational Remittal Inquiry, by Professors Alan Gregory and Bruce Lyons.

12. Therefore, in response to the WACC paper, HCA submitted a paper to the CMA (the "WACC Response"),[8] prepared with expert input from Professor Alan Gregory, which addressed the errors and methodological flaws in the CMA's analysis set out in the WACC paper, including new and existing errors that had been raised by HCA but not addressed by the CMA. Specifically, HCA identified three errors in the CMA analysis, which if corrected, would lead to a material impact on the calculation of WACC.[9] HCA also identified a number of other shortcomings in the CMA's methodology for measuring WACC.

13. Bupa also responded to the WACC paper with a short submission. Bupa argued that the CMA did not present evidence for why it believed a WACC of 10% is appropriate as the point estimate. Bupa therefore argued that the WACC is *"…more likely…"* to be around the mid-point (9%).[10]

14. In the SPDR, the CMA recognises Bupa's argument and instead of using a point estimate of 10% (towards the upper end of the CMA's WACC range), as in both the WACC paper and the Final Report, it changes the benchmark used to estimate the customer detriment from 10% to a range of 9% to 10%.[11] Notwithstanding HCA's concerns with the CMA's WACC calculation itself, HCA considers that reliance on the CMA's mid-point estimate may not properly reflect the asymmetrical nature of the upside and downside costs of miscalculating WACC. In HCA's view, it is likely that the downside risk of underinvestment outweighs the potential upside of lower prices to consumers.[12] The CMA should consider this risk asymmetry before placing reliance on its mid-point estimate.

15. As a result of the CMA's use of its mid-point WACC estimate, in the SPDR NPV, the CMA considers scenarios with higher price benefits (✂) than in the PDR NPV (✂), thus inflating the estimated NPV from divestment.

16. By contrast, in the SPDR, the CMA recognises only one[13] of the points raised by HCA and totally disregards the majority of HCA's comments as set out in response to the WACC paper, claiming that these points were not new and that the CMA had already dealt with those arguments by HCA in the WACC paper.[14] This is incorrect.

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[8] HCA's response to the CMA's assessment of the cost of capital, 9 May 2016.
[9] The WACC Response, para 1.3.
[10] Bupa's response to the WACC paper, May 2016, para 2.4.
[11] SPDR, NPV appendix, para 67.
[12] This potential asymmetry has been recognised by the Competition Commission ("CC") and has been accounted for in other cases. See for example, a discussion of the risk asymmetry when estimating WACC in paragraph 150, Appendix F to the Heathrow Gatwick Cost of Capital, 3 October 2007
[13] This is in relation to updating firm leverage data. The CMA stated it amended its calculations accordingly. The CMA stated the effect on the overall beta estimates was negligible. However, this is not clear; and the fact that the CMA made this error in the first place shows that the CMA had made a fundamental error of principle.
[14] SPDR, NPV appendix, para 69.

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17. Table 1 below lists all the arguments put forward by HCA on WACC-related issues in HCA's response to the WACC Working Paper, which have not been addressed by the CMA at any stage, either in the original inquiry or in the remittal inquiry.

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Table 1: Errors and other concerns and shortcomings in the WACC analysis previously submitted by HCA and the CMA's responses

	HCA argument	CMA response
Errors in the CMA WACC analysis	Firm leverage (gearing) is measured incorrectly for the purposes of unlevering betas	*Addressed in the SPDR*
	The CMA has wrongly relied upon statistically insignificant beta estimates	*Inadequately addressed*
	The impact of inflation on the equity risk premium is incorrectly calculated	*Ignored*
Other concerns and shortcomings with the CMA's methodology	Too much weight is put upon certain estimates of the equity market return that are not representative of the time period being analysed for the Remittal Inquiry	*Inadequately addressed*
	The asset beta is understated due to selection of inappropriate overseas proxies	*Inadequately addressed*
	Cost of debt is understated through use of assumptions which do not reflect the market rates which applied during the relevant period of the Remittal Inquiry	*Ignored*

Source: HCA; CMA, Remittal PDR and SPDR

18. HCA maintains that the joint impact of the issues discussed in HCA's response to the WACC paper is material and that a WACC analysis that fails to correctly account for them is flawed. Correcting for these errors and methodological flaws has a material impact on the CMA's WACC estimate, resulting in an adjusted WACC range of 10.3% to 11.7%, with a mid-point of 11.0%.

19. As a result of these errors, the CMA has overestimated its estimates of HCA's excess profits and therefore has overstated the NPV of a divestment remedy.

The inclusion of outpatient revenues in the calculation of price benefits

20. In the PDR NPV, the CMA only applied price benefits from divestment to inpatient and day-case patient revenues, but not to outpatient revenues.

21. In response to the PDR, Bupa argued that since the CMA's assessment of profitability, and of "excess profits", related to inpatients, day-case patients and outpatients, the price benefits of divestment should be applied across the revenues from all these patient types, that is, including outpatients.[15]

22. In the SPDR NPV, the CMA accepts Bupa's arguments and thus applies the estimated price benefits of divestment to HCA's outpatient revenues as well, thus increasing the NPV of divestment (all else equal).

[15] Bupa's Response to Remittal PDR, paras 3.21-3.31.

23. ✂ the CMA's inclusion of outpatient revenues in the calculation of price benefits from divestment is flawed.

24. The CMA accepted that its competitive assessment in the Final Report *"focussed on private hospitals and PPUs providing inpatient care"* since *"concentration is relatively higher in the provision of inpatient care than in the provision of day-patient and outpatient care"*.[16] While it noted that *"certain"* day case and outpatient treatments *"are likely to be subject to similar competitive conditions"*[17] it has not conducted any detailed analysis which would allow it to conclude that there are AECs applying generally to outpatient services or indeed that there is any relationship whatsoever between concentration (which the CMA has expressly stated is lower in outpatient services[18]) and outpatient prices. This relationship would be required to support the presumption that a divestment would lead to a direct reduction in outpatient prices and thus to benefits to outpatients.

25. Nor can the CMA assume that any reduction in inpatient or day-case prices due to divestment (which HCA strongly rejects) would indirectly lead to a reduction in outpatient prices. Indeed, the CMA recognised in the remittal PDR that its assessment of competitive constraints between different treatment modalities could not support an assumption that HCA's outpatient prices would fall as a result of divestment.[19]

The fact that the CMA's profitability analysis included outpatients is simply a function of how a profitability analysis is performed. The CMA however recognises that profitability may be driven by HCA's scale economies and efficiencies.[20] In this context, and without a link between divestment and prices, there is simply no basis for the inclusion of outpatient revenues in the NPV calculations. Therefore including these revenues necessarily biases the CMA's calculations by overstating the NPV of a divestment. Specifically, by including HCA's outpatient revenues, the SPDR NPV overstates the NPV of divestment by between ✂ and ✂ relative to NPV scenarios that exclude these revenues.[21]

[16] Final Report, para 6.4.
[17] Final Report, para 6.4.
[18] *Ibid.*
[19] Remittal PDR, para 2.44.
[20] SPDR, para 67.
[21] This is in the case of a divestment of The Wellington Hospital in the CMA's central scenario, with fully effective entry, considering the 5, 7, 10 and 20 years scenarios and all price benefit scenarios between the ✂ to ✂ range considered by the CMA, and maintaining all the other assumptions in the SPDR NPV.

Non-confidential version

26. Table 2 shows the results of the CMA's central NPV scenario, excluding outpatient revenues.

Non-confidential version

Table 2: NPV of divestiture, Central estimate (fully effective entry), excluding outpatient revenues, £m

✂

Source: Analysis based on SPDR NPV, replicating Table 6 in the SPDR but excluding outpatient revenues from the estimation of price benefits.

The use of a scenario where only 50% of the price benefits of new entry are realised

27. In the SPDR NPV, the CMA considers a set of scenarios where it assumes that new entry would not be fully effective and that, absent a divestment, prices on entry would only be expected to fall by 50% of the impact that a divestment would have. For example, if the CMA assumes that divestment would lead to a ✂% decrease in prices, then entry would only be assumed to have a ✂% impact on HCA's prices. This effectively reduces the benefits from entry and increases the relative benefits from divestment.

28. These scenarios undermine the very causal relationship that the CMA is relying on to support the effectiveness of divestment. If the entry of a credible competitor, which would serve to reduce HCA's market share, does not have the result of lowering HCA's prices, then it calls into question whether there is any causal relationship between market share and price.

29. The CMA cannot have it both ways:

- either the CMA believes that there is a robust causal relationship between market concentration and prices and profits, and therefore a divestment remedy or new entry could be effective in exerting downward pressure on prices and profits; or
- the CMA is hesitant about the robustness of this relationship, and therefore the effectiveness of a divestment remedy would be called into question.

30. If the CMA deems a divestment remedy to be effective, then it can place no weight on scenarios where new entry is only partially effective. The CMA itself has correctly noted that, looking at the wide range of new entrants into the market, and assessing this evidence of new entry collectively, new entry will exert significant downward pressure on HCA's prices.[22] It is therefore not clear what basis there is for this sensitivity analysis.

31. Removing these scenarios with partially effective entry from the SPDR NPV shows that for the vast majority of plausible scenarios the NPV of divestment is negative.

The application of a growth rate to future HCA's revenues

32. In the PDR NPV, the CMA applied price benefits from divestment to the expected stream of future HCA's revenues using HCA's 2015 actual revenues as a proxy for such a stream.

33. In response to the PDR, Bupa argued that due to the recent growth in the private healthcare market in central London, the CMA should apply a growth rate to HCA's revenues in the

[22] SPDR, para 51.

NPV.[23] Applying this growth rate causes the price benefits from divestment to increase over time as HCA's revenue base would increase over the twenty year NPV time period.

34. In the SPDR, the CMA accepts Bupa's arguments and applies a 3.5% real growth rate to HCA's revenues.

35. HCA submits that the CMA's application of a growth rate to HCA's revenue is flawed and inconsistent with the CMA's own reasoning underpinning an AEC finding.

36. ✂.

37. Further, as the CMA's assessment of potential benefits from a divestment is based on an assessment of HCA's excess profitability, it is unrealistic, and therefore flawed, to apply a growth rate to HCA's revenues going forward, but not to consider likely changes to its cost base associated with providing services to those patients.

38. In sum, the CMA has erred in applying a growth rate to HCA's revenues in the NPV, which has resulted in the CMA overstating the NPV of a divestment remedy.

Conclusion

39. For the reasons set out above, when the benefits and costs of a proposed divestment remedy are appropriately accounted for, under all plausible scenarios the NPV of divestment is negative, and a divestment remedy is disproportionate.

[23] Bupa's Response to the Remittal PDR, paras 3.48-3.51.