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THE LONDON CLINIC

COMPETITION AND MARKETS AUTHORITY PRIVATE HEALTHCARE REMITTAL

RESPONSE TO THE SUPPLEMENTAL PROVISIONAL DECISION ON REMEDIES ("SPDR")

Introduction and Summary

1. This Response to the SPDR is submitted on behalf of The London Clinic (the "Clinic") which strongly disagrees with the CMA's provisional decision stated at paragraph 16 SPDR that divestiture of one or more of HCA's hospitals and/or other facilities in central London (Remedy 1 in the Provisional Decision on Remedies ("PDR")) would not be proportionate.

2. The CMA describes in the SPDR how it has considered new evidence "about the likelihood, timing and scope of new entry in the central London market" (SPDR, paragraph 14) and "comments made in response to the PDR about our NPV analysis" (SPDR, paragraph 15). As a result of this evidence the CMA has substantially revised its detailed analysis but its provisional conclusion that divestiture is not proportionate still rests on the prospect of potential entry by the Cleveland Clinic.

3. This provisional conclusion is however not supported by the evidence available to the CMA. It is clear from the SPDR that the evidence from the Cleveland Clinic itself is that new entry into the central London market is not likely, and would not be timely enough or of sufficient scale to be an effective constraint on HCA. The CMA has received this evidence directly from the Cleveland Clinic, but has irrationally failed properly to take it into account.

4. It is also clear that the CMA has failed in its statutory duty to consider appropriate remedial action, in particular in its assessment of proportionality of the divestment remedy under consideration. Instead of forming a view on the facts as to whether this is one of the "rare" cases where it should take no remedial action despite identifying an effective remedy to an AEC, the CMA has ducked the question. It has instead listed a range of alternative approaches within its NPV analysis which yield wildly divergent outcomes, (-£157m to +£500m NPV in the "central estimate") without reaching a conclusion on which scenario is the most plausible.

5. The Clinic shares the view of the dissenting group member that new entry is unlikely in the next ten years and in any event is not likely to be an effective constraint on HCA and there therefore the most plausible scenarios are those which assume no effective entry within 20 years.

6. Accordingly, the Clinic urges the CMA to reconsider its analysis and, in its Final Report, to require HCA to divest hospitals in central London. This is the only way effectively to resolve the identified AECs.

7. Alternatively, if the CMA continues to consider that Remedy 1 is not a proportionate remedy, it is incumbent on the CMA to discharge its statutory duty by properly considering and selecting alternative remedies to address the identified AEC. This could include a more limited divestment package.

8. This Response begins by briefly summarising the AECs to be remedied and the CMA's statutory duty in considering remedies. This is followed by an analysis of potential entry and explains why the CMA's provisional conclusions as to the likelihood, timeliness and impact of entry are not objectively justified by the evidence. Next, we briefly consider the assessment of proportionality and the NPV analysis.

AECs to be remedied and the CMA's statutory duty

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

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

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

12. The CMA also provisionally concluded that *"In combination, these features resulted in weak competitive constraints on HCA in the provision of privately funded healthcare serves for insured patients in central London"* (PDR, paragraph 1.8) and that *"the AEC was leading to consumer detriment in the form of higher prices being charged by HCA than we would expect in a well-functioning market"* (PDR, paragraph 1.9).

13. The market for private healthcare in central London is substantial (the UK market was worth an estimated £6.71bn in 2012, Final Report paragraph 2.12) and accordingly the consumer detriment resulting from the identified AEC is significant on any analysis.

14. Where the CMA decides that there is an AEC, it has a statutory duty under section 134(4) of the Enterprise Act 2002 ("EA02") to consider whether any remedial action should be taken and if so, what that action should be.

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

16. Relevant Guidelines (CC3) set out the principles of proportionality that the CMA must apply when considering remedies and at paragraph 354 sets out the circumstances where, having identified an AEC, the CMA may choose not to take any remedial action, describing these circumstances as "rare".

17. The Clinic repeats its submissions made in response to the PDR that this Remittal is clearly not one of the "rare" cases where the CMA might reasonably choose not to take any remedial action at all. The relevant market is not one which is "small in relation to the costs of each practicable remedy option" and this is not a case where it is "only practicable to mitigate some of the negative consequences of an AEC", as described in CC3 paragraph 354.

18. The CMA has found an AEC in a large, strategically important market which serves both UK consumers and attracts considerable custom from overseas. Furthermore the CMA has provisionally identified a practicable and effective remedy – divestment of hospitals by HCA- which would be capable of addressing all the negative consequences of the AEC. A failure to remedy the identified AEC by imposing the identified divestment remedy would be a breach of the CMA's statutory duty and would lead to significant consumer detriment in the form of higher prices being imposed by HCA than would occur in a well-functioning market.

19. The CMA has reached the provisional conclusion that the divestment remedy would not be proportionate, in that it has been "unable to form an expectation that the benefits of such a remedy in addressing the AEC would outweigh its costs" (SPDR paragraph 75). To reach this conclusion, the CMA used the NPV model to compare potential benefits against the cost of divestiture. The potential gains from the divestiture were reduced by the impact of potential new entry.

20. The assessment of the likelihood and impact of new entry is therefore key to the CMA's provisional conclusion. Where the CMA considers potential entry in its market and merger

investigations, relevant guidelines[1] indicate that the CMA requires such entry to be likely, timely and sufficient to prevent the SLC or AEC, in order to be taken into account. If there is insufficient evidence on any of these criteria, then the potential entry cannot be taken into account. In this case, it is clear that the CMA does not have sufficient evidence before it to conclude that entry by any of the hospital operators it identifies meets all three of these criteria. Paragraphs 24 to 39 address the evidence on the prospects of entry into the central London market in more detail.

21. However, if the CMA remains of the view that the identified divestment remedy is not proportionate, the CMA must then properly consider alternative remedy packages to fulfil its statutory duty. CC3 paragraph 333 notes that "while generally preferring to address the causes of the AEC, the CC will consider introducing measures which mitigate the harm to customers created by competition problems, for example if other measures are not available"; paragraph 381 states that "the identification of the Group's preferred remedy is an iterative process in which a potentially wide range of remedy options are progressively narrowed down until a solution has been found that enables the CC to meet its statutory duties".

22. If the CMA considers that the divestment package proposed of the London Bridge and Princess Grace hospitals or Wellington Hospital and Platinum Medical Centre would produce too many diseconomies of scale to be proportionate, the CMA must then consider whether any alternative, smaller divestment packages, comprising fewer than two fully standalone private hospital facilities would be suitable, for example LOC (Leaders in Oncology Care), perhaps with the Princess Grace, which is one of the smaller hospitals in the HCA group in central London.

23. Including the LOC in the divestment package would also allow the CMA to address HCA's position in oncology which has been identified by all the stakeholders in the remittal investigation as the main source of HCA's market power. The Clinic notes in particular, Bupa's comments in its hearing that HCA continues to have a "stranglehold" in oncology[2] and that "HCA used its dominance in specialisms like oncology to leverage across all of its operations in other specialisms in terms of negotiating power, with the result that it is able to extract higher prices."[3]

Evidence on potential entry into the central London market

24. In the Provisional Findings ("PF") published in November 2015, the CMA provisionally found that "*There are substantial barriers to entry and expansion in central London…We consider that these barriers have contributed to the lack of substantial entry into the market over the last 10 years , and the limited examples of expansion, in spite of the attractiveness of the central London market to private hospital operators. Moreover, our provisional conclusion is that there is unlikely to be entry or expansion of a private hospital operator of sufficient scale to constrain HCA in the near future*…" (PF, paragraph 5.70)

25. The PF also notes that *"The Cleveland Clinic indicated that it was currently at too early a stage to discuss its plans in detail. However, we noted that the article detailing its purchase of 33 Grosvenor Place indicated that it was still considering how to use the site and had not yet sought permission from either the freeholder of the site or the local planning authorities to convert the building from office to hospital use. As a result, we consider that this potential entry remains uncertain at the current time"* (PF, paragraph 5.68(f)).

26. At the time of publication of the PDR in March 2016, notwithstanding that the Cleveland Clinic still had not yet sought permission from either the freeholder of the site or the local planning authorities to convert 33 Grosvenor Place from office to hospital use (i.e. in terms of practical steps taken, the Cleveland Clinic was still in exactly the same position as it had

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1 CC3 –Guidelines for market investigations, paragraph 175 and 205; CC2- merger assessment guidelines, section 5.8

2 Bupa hearing of 17 May 2016, paragraph 4

3 Bupa hearing of 17 May 2016, paragraph 10

been at the time of the PF), the CMA found that Cleveland Clinic was "*likely to enter the market with a new hospital by early 2020*" (PDR Summary, paragraph 10).

27. At the time of publication of the SPDR in July 2016, the position of the Cleveland Clinic has not advanced, in that it still has not applied for planning permission or obtained permission from the freeholder for the change of use, and may be considered to have materially worsened. The CMA itself notes that the application for planning permission "*does not appear imminent*" (SPDR, paragraph 26) and the Cleveland Clinic told the CMA that it has [✂] (SPDR, paragraph 26). On the basis of new evidence received from the Cleveland Clinic by way of a hearing on 15 April 2016, the CMA has revised its view again, provisionally concluding now that there is "*the strong prospect of entry by Cleveland Clinic within the next five to ten years*" (SPDR, paragraph 29).

28. The key new evidence that the CMA received from the Cleveland Clinic in the hearing is that:

- [✂]. Cleveland Clinic could not offer the CMA any indication of timing or even certainty of reaching an acceptable agreement;
- one of its "key planning assumptions" was that HCA would be restrained in the market by the imposition by the CMA of a divestment remedy; and
- even if it were to enter, its effectiveness as a counterbalance to HCA would be limited, in that it would not provide a full range of services, it would be smaller than the London Clinic and it expects that HCA would expand aggressively.

29. On the basis of this new evidence, it is simply not credible for the CMA to conclude that the Cleveland Clinic is likely to enter, or that entry would be timely or effective in constraining HCA.

30. A "strong prospect" of entry is clearly of a lower order of possibility than "likely to enter". The CMA has therefore revised its estimation of the possibility of entry downwards, referring to "if and when" Cleveland Clinic enters (SPDR paragraph 73), from a more than 50% chance to less than 50%. This downward trend means that entry by the Cleveland Clinic must now be considered unlikely.

31. In terms of timeliness, the CMA's Merger Assessment Guidelines refer to entry or expansion within "less than two years" as timely[4]. The CMA's Market Investigations Guidelines refer to entry being "in the near future ... swift"[5] and "within a short time"[6] to countervail against a prospective AEC decision. Entry within five to ten years does not meet this criteria, even if that timescale was supported by the evidence, which it is not. Cleveland Clinic's own evidence indicates real uncertainty over its timing, describing the steps which it needs to take before a planning application can even be submitted and acknowledging that the process is complex and will require public consultation[7]. The Clinic repeats its submissions on the complexity of entry and expansion and its view that entry by the Cleveland Clinic is likely to take at least ten years, if it happens at all.

32. Even if entry does take place, the evidence submitted by the Cleveland Clinic indicates that it will not be sufficient to constrain HCA, noting that it will be smaller than the London Clinic. The CMA notes that "we can no longer conclude that the Cleveland Clinic entry… will be sufficient (in terms of the range of specialisms offered) to constrain HCA fully" (SPDR paragraph 28).

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4 CC2 paragraph 5.8.11

5 CC3 paragraph 175

6 CC3 paragraph 205

7 Summary of hearing with Cleveland Clinic on 15 April 2016, paragraph 10

33. The CMA must therefore revert to its position in the PF that this potential entry remains uncertain at the present time, and it should not be accorded any further weight in the CMA's assessment.

34. The CMA notes in the SPDR that at the time of the PDR "we did not place much weight on the possibility of entry by hospital operators other than the Cleveland Clinic" (SPDR, paragraph 31), but has now chosen, for reasons not explained, to consider other sources of possible entry "more broadly" (SPDR paragraph 30) .

35. The CMA goes on to say that "we remain of the view that, individually, each instance of possible entry is insufficiently certain or insufficiently broad in scope to be effective in addressing the AEC, we also consider that it is important to view the likelihood and impact of possible new entry as a whole, not just individually" (SPDR, paragraph 31).

36. The concept of entry "as a whole" rather than on an individual basis is unsustainable, since each hospital operator makes an independent decision whether to enter the market and when. It is not the case that the existence of a number of possible, but unlikely entrants, or timely but ineffective entrants, somehow operates to constrain an existing operator in the same way as one likely, timely and effective entrant. The CMA having failed to find a single example of new entry which is sufficiently likely, timely and effective to constrain HCA cannot rely on several examples of new entry which meet some but not all of these criteria.

37. The CMA goes on to identify possible large scale entry by VPS and Spire, but notes that these operators "have yet to acquire suitable properties" (SPDR, paragraph 32). They are therefore even further away from likely entry than the Cleveland Clinic. The evidence available to the CMA about the plans of VPS and Spire is wholly insufficient for the CMA to form a reasonable belief that entry by either of these operators is likely or sufficiently timely or effective to constrain HCA.

38. The CMA also considers small scale specialist entry such as that by Schon Klinik. But entry by these operators, even if more likely than large scale entry, would clearly be insufficient to constrain HCA. The CMA puts forward the view that "even if the new entry is not across all specialities, our view is that entry in some specialities is likely to increase the competitive constraints on HCA overall" (SPDR, paragraph 51). But the CMA contradicts itself on this point, noting that "a strong market position in one or a small number of specialities would allow HCA to exert market power which is likely to be spread across the prices it charges for different services"… but "we do not accept the argument that maintaining a strong market position in one speciality (e.g. oncology) means that increased competition in others will have no effect on HCA's overall prices" (SPDR, paragraph 51).

39. The Clinic strongly agrees with the CMA's first statement that HCA's strong market position in one speciality allows it to exert market power across others. This means that small scale specialist entry, even if likely or timely, will in no way be effective in constraining HCA.

Assessment of proportionality and the NPV analysis

40. As the CMA is aware, the Clinic is a single site, charitable organisation. The Clinic simply does not have the resources to invest in engaging specialist accountancy or economic advisors to conduct a detailed review of the CMA's NPV analysis of the divestment remedy. Whilst the CMA must consider all relevant evidence and possible scenarios, the CMA should not abdicate its responsibility by failing properly to conclude which of the potential scenarios are the most plausible.

41. The Clinic wholly disagrees with the CMA's provisional conclusion that the divestment would not be proportionate and makes the following limited points:

42. The CMA's approach to reflecting the new evidence on entry in assessing proportionality has simply been to include scenarios where entry takes place in year 5, 7 or 10 following divestiture and to allow for "fully effective" and "partially effective" entry. The CMA has also included a scenario where there is no effective entry over a 20 year period following divestiture. This remains the most likely scenario in the Clinic's view. The Cleveland Clinic has stated categorically that it is not intending to provide oncology services on entry, and

it would not offer these services for years or decades, if at all; and that it would be "extraordinarily difficult" to provide radiation therapy on site. Entry by the Cleveland Clinic could therefore not be considered to be "fully effective". No smaller scale entry by a specialist operator will be effective in constraining HCA. This means that there is no evidence to support a conclusion that "fully effective" entry is likely at all. The CMA must conclude that only the "partially effective" entry scenarios are plausible, and that the timeframe for entry must be further than 5 years away.

43. The CMA's conclusion that "any loss of economies of scale should be modelled on a constant basis over the 20 year period, rather than tapering off" (SPDR Appendix paragraph 21) is not supportable. The idea that HCA would be unable to recover lost economies of scale even over a 20 year period is not credible.

Conclusions

44. In order for the CMA to accord weight to the prospect of new entry in its analysis, that new entry must be likely, timely and sufficient to effectively constrain HCA. The evidence must be particularly strong where the CMA proposes to take no remedial action to address an identified AEC, a situation which the relevant guidelines describe as "rare".

45. The evidence before the CMA simply does not support the conclusion that entry by the Cleveland Clinic or any other hospital operator meets these three criteria.

46. The CMA must therefore conclude that the most plausible of the numerous scenarios it has modelled in its NPV analysis are those where entry either does not take place at all or only takes place in year 10; and that it is not "fully effective". On all these scenarios, the NPV of the divestment is positive.

47. Accordingly, the Clinic urges the CMA to reconsider its analysis and, in its Final Report, to require HCA to divest hospitals in central London. This is the only way effectively to resolve the identified AECs and for the CMA to fulfil its statutory duty.

48. In the alternative, if the CMA continues to believe that the proposed divestment package produces too many diseconomies of scale to be proportionate it must properly consider and select alternative remedies to address the identified AEC, in order properly to fulfil its statutory duty. The Clinic believes a smaller divestment package, including the LOC and perhaps the Princess Grace could be a suitable remedy which would also have the benefit of dealing with HCA's "stranglehold" in oncology.

Eversheds LLP

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