

Private healthcare remittal

Summary of final report

5 September 2016

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The Competition and Markets Authority has excluded from this published version of the report information which the inquiry group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [✂]. Some numbers have been replaced by a range. These are shown in square brackets. Non-sensitive wording is also indicated in square brackets.

Summary

1. This document summarises our findings in relation to:
 - (a) whether there are any features that are preventing, restricting or distorting competition (referred to as an ‘adverse effect on competition’ (AEC)) in the markets for the provision of privately-funded healthcare services in central London, and, if so,
 - (b) whether any action should be taken to remedy, mitigate or prevent the identified AEC(s) and/or any customer detriment arising from the AEC(s).

Background to this remittal

2. On 2 April 2014 the Competition and Markets Authority (CMA) published its final report on the Private Healthcare Market Investigation¹ (the Final Report).
3. After publication of our Final Report, HCA challenged the CMA’s self-pay and insured AEC decisions and the divestment decision at the Competition Appeal Tribunal (CAT) on a number of different grounds. AXA PPP also appealed, among other things, the divestment decision.
4. During the litigation, HCA’s economic advisers, KPMG, identified, among other things, two coding errors in our insured pricing analysis (the IPA) which in its view impacted the robustness of the estimated price difference between HCA and its closest competitor, The London Clinic (TLC).
5. In light of these two errors, the CMA considered that the appropriate course was for the matter to be remitted to it in order for the CMA to review the IPA and re-consult with interested parties. Consequently, on 12 January 2015, the CAT ordered that the insured AEC decision and the divestment decision be quashed and remitted to the CMA for reconsideration.

Our approach to the remittal

6. In determining our approach to the remittal we were guided by the CAT’s Ruling of 23 December 2014 (Ruling) where the CAT stated that:

¹ [Private healthcare market investigation: Final report](#), 2 April 2014.

- (a) our task is to ‘consult on the IPA and then re-determine the questions whether any new insured AEC decision should be made and whether any new divestment decision should be made’;²
- (b) the quashing of the insured AEC and divestment decisions ‘will leave all other parts of the Final Report, including all the reasoning in it and the other decisions regarding various other AECs on foot...’, but the CMA ‘will have to consider what impact the new information and representations it receives in relation to the IPA has upon the existing statements of reasoning contained in the Final Report with respect to those decisions’; and
- (c) ‘If in the course of further consultation on the IPA anything emerges which [...] does have an indirect knock-on effect on the reasoning in relation to the self-pay AEC decision, the CMA will need to give careful consideration to that question and the implications it may have for the overall reasoning in the Final Report.’³

7. With the CAT’s Ruling in mind:

- (a) we have reviewed and re-consulted on the IPA;
- (b) in relation to the other analysis and evidence that supported the insured AEC decision, we have considered whether to readopt the findings set out in our Final Report, taking into account all relevant arguments and evidence put to us by parties, both in relation to our reasoning in the Final Report and in relation to any changes in the market since the publication of our Final Report; and
- (c) we have considered whether there are any knock-on consequences for our reasoning in relation to the self-pay AEC decision.

8. We have relied upon the data on which the analysis in the Final Report was based, although we did update certain data where we considered it appropriate to do so (for example, in carrying out our profitability analysis, as explained in paragraph 12).

² AXA PP Healthcare Limited v Competition and Markets Authority and others, Ruling of 23 December 2014, [2014] CAT 23, (the Ruling), at paragraph 56(b).

³ Ruling, at paragraph 60.

Overview of changes since the Final Report

9. A summary of our detailed assessment can be found below. However, to put this in context, it is helpful to understand how and why our thinking has changed since the Final Report.
10. In the Final Report, we placed significant reliance on the IPA both in support of our AEC finding in relation to the insured private healthcare markets in central London, and in assessing the proportionality of the proposed divestiture remedy.
11. We carried out the IPA for central London to estimate the extent of any price difference between HCA and TLC. In order to ensure that we were comparing like with like, we controlled for a number of factors. As explained above, errors found in the IPA presented in the Final Report were the basis for the remittal to the CMA. Having amended the IPA to correct these errors, and considered in detail the additional submissions and evidence received from parties during the remittal, we find that we can no longer use the IPA to conclude on the size of the price difference between HCA and TLC, as we cannot be sufficiently confident that we have adequately controlled for any differences in patient complexity, and hence are comparing like with like.
12. As a result, although we still find that there is an AEC in the insured private healthcare market in central London, we can no longer use the IPA either to estimate the size of the customer detriment caused by the AEC, or the potential impact of a divestiture remedy on prices. Instead, we have had to rely more heavily on our profitability analysis to estimate both customer detriment and the potential impact of divestiture on prices. We have had to make a number of assumptions both in carrying out our profitability analysis and in using it to estimate the detriment arising to insured and self-pay patients. We consider that the number and the nature of these assumptions reduces the reliance that we can place on the detriment estimates in this case. This is discussed in more detail in paragraphs 40 to 48 and 70 to 75.
13. In addition to the reduced reliance that we can now place on the IPA, further analysis undertaken and evidence received during the remittal have also cast some doubt on the extent of capacity constraints in the central London market. The assessment of capacity is complex. Our view is that, overall, there are some constraints on effective capacity, although analysis undertaken during the remittal suggests there may be spare capacity in some measures, such as number of beds available and intensive care unit (ICU) capacity.

14. The combination of these factors has made it less certain what the likely impact of any divestment would be in terms of reduced prices. As explained further below, this makes it difficult for us to conclude with any degree of confidence that a divestment remedy would be proportionate, as we are not in a position reliably to quantify the benefit of the divestment.
15. To add to this, the position on likely future new entry has also evolved since the Final Report. At the time of the Final Report, there had been no entry of scale and virtually no entry of any size in London for over ten years. During the remittal, Cleveland Clinic announced its plans to open a large new private hospital at a site in central London (although since this announcement, Cleveland Clinic has experienced delays which mean that its planning application has yet to be submitted, and hence the likelihood and timing of entry is increasingly uncertain). There has also been entry by a small number of specialist operators and plans for entry by others. While the precise timing, scope and impact of future new entry is uncertain, our view is that there is a real prospect of new entry within the medium term (by which we mean, in this context, the next 7 to 12 years) which would have a significant impact on the scale of customer detriment arising from the AEC. This prospect of entry is one of a number of factors bearing on our assessment of the proportionality of the divestment remedy.

Our analytical framework

16. When revisiting our competitive assessment for privately-funded healthcare services in central London we conducted detailed analysis around two high-level questions:
 - (a) whether there are any structural features in this market that could give rise to an AEC; and
 - (b) what are the AECs (if any) arising from these structural features.
17. We first defined the relevant product and geographic markets, which provided us with a framework, in terms of the set of specialties and relevant (private) healthcare providers on which our subsequent analysis has largely focused. We then reassessed the market features which characterise privately-funded healthcare services in central London, based on an analysis of local competitive constraints, barriers to entry and expansion and the framework for bargaining (between hospital operators and private medical insurers (PMIs)). Finally, we reconsidered market outcomes for privately-funded healthcare services in central London based on an analysis of non-price outcomes (quality and range), insured prices (including our revised IPA) and profitability.

Figure 1: The specific issues that we considered as part of our competitive assessment of privately-funded healthcare services in central London



18. We provide a brief summary of our key conclusions on market structure and market outcomes below.

Market structure

Market definition

19. We readopt our conclusions in relation to product and geographic market definition as set out in our Final Report. We find:
- (a) Distinct product markets in the provision of hospital services for individual specialties and, for each individual specialty, separate markets for inpatient, day-patient and outpatient services.
 - (b) The area covering the private hospitals and private patient units (PPUs) in central London is a separate geographic market.
20. Our competitive assessment has focused on private hospitals, including PPUs, in central London across 16 key specialties and oncology. We have also taken into account competitive constraints exerted by specialist and non-inpatient providers in central London, by private hospitals and PPUs outside central London and by the NHS on a case-by-case basis.

Competitive constraints

21. We find that the market for privately-funded healthcare services to insured patients in central London remains highly concentrated as HCA continues to have high shares of supply relative to other hospital providers (around 50% share of total revenue and admissions, compared with just over 10% for the next largest competitor) across many of the 16 key specialties, plus oncology, on which our competitive assessment has focused.
22. We recognise that there has been some growth in PPUs in central London since the Final Report. However, this has been broadly in line with overall growth in private healthcare in central London, and PPUs continue to have a small share of admissions in the markets for privately-funded healthcare services. HCA's internal documents suggested that it views some PPUs as a potential source of competitive constraint, and we judged that a small number of PPUs appear capable of imposing a competitive constraint on HCA, in particular specialist PPUs, such as those at the Royal Marsden and Great Ormond Street. On the whole, however, our view is that the constraints imposed by PPUs in aggregate remain weak at present. We also find that non-inpatient providers (both outpatient only and providers of day-case and outpatient facilities) in aggregate are currently a weak constraint on HCA. Non-inpatient facilities have a small share of Bupa's and AXA PPP's admissions and a small share of their revenues. In addition, the evidence suggests that although non-inpatient providers compete with HCA for a narrow set of services, primarily imaging and diagnostic procedures, HCA itself maintains a strong position in this area.
23. Despite some changes in the market, in our view HCA continues to face weak competitive constraints both from other central London hospital providers/PPUs and from providers outside central London, and we remain of the view that NHS services are not a close substitute for private patient services provided by HCA. We also do not believe that competition from international providers constrains the prices HCA charges to UK customers due to its ability to price discriminate, as evidenced by the fact that self-pay prices on its UK websites are 'For UK Residents Only'.
24. In summary, we readopt our conclusion from the Final Report and find that HCA currently faces weak competitive constraints in the market for the provision of privately-funded hospital services for insured patients in central London. However, as set out in paragraph 13 above, we note that there is now some mixed evidence on the extent of spare capacity in the central London market. We take this into account in assessing the nature and extent of the competitive constraints on HCA and the expected effectiveness and proportionality of any remedy.

Barriers to entry and expansion

25. In spite of the attractiveness of the growing privately-funded healthcare services market in central London, there has been no substantial entry, and only limited expansion, by private hospital operators over the last ten years (or more).
26. Our review of the evidence indicates that high sunk costs and long lead times, exacerbated by the limited availability of suitable sites and planning constraints, remain the principal barriers to entry in central London.
27. We noted that the reorganisation of many NHS trusts' estates has the potential to ease constraints on the availability of suitable sites. However, our view is that this is highly unlikely to take place in a sufficiently timely manner to facilitate the new entry of private hospital operators that could constrain HCA in the near future (by which we mean, in this context, the next two years).
28. During the remittal, we received evidence of actual entry by a small number of specialist providers, as well as increased interest in entry/expansion in the central London market and evidence of expected continued growth in demand within central London. Although we recognise that there have been recent setbacks for some of the planned new entrants, we believe that there is still a greater prospect of new entry in the future, compared with that which existed at the time of the Final Report – of both larger hospital operators and smaller, more specialised entrants. However, it is not possible to predict precisely the timing or impact of any such entry.
29. Given the lead times in establishing a hospital, we would be aware of any new entry likely to take place in the near future (that is, within two years). Although we know of some planned new entry in this time frame, eg the Schön Klinik and the Nuffield PPU at Barts, we do not believe these new entrants would impose a sufficient constraint on HCA to address the AEC on their own.
30. As discussed further below, our view is that there is a real prospect of new entry which would result in an increased competitive constraint on HCA, and therefore downward pressures on HCA's prices over the medium term. This is relevant to our assessment of the proportionality of potential remedies. However, for the purpose of assessing whether there is an AEC, we have not seen any evidence to suggest that the threat of such entry has placed any significant constraint on HCA to date, or will do so in the near future. We therefore do not consider that the prospect of large-scale, smaller or

specialist new entry in the medium term undermines our finding that there is an AEC.

31. We therefore readopt our conclusion from the Final Report that significant barriers to entry and expansion exist.

Bargaining

32. As we noted in our Final Report, with regard to insured patients, prices of treatments are set in national bilateral negotiations between hospital operators and PMIs, which typically focus on the price of the overall bundle of services/treatments.
33. In relation to central London, we continue to find that HCA and the PMIs are dependent on each other and have some power in the bargaining relationship, ie neither side are 'price-takers'. We do not agree with HCA's argument, put to us during the remittal, that an extreme 'sharing rule', in which HCA receives a very small share of the bargaining surplus, is a plausible description of its negotiations with PMIs in the privately-funded healthcare services market in central London. The evidence put to us suggests that PMIs are not able to negotiate on a 'take-it-or leave it' basis with HCA given the PMIs' views that their own customers consider HCA hospitals in central London to be a 'must have'.
34. We have also considered the extent to which PMIs can use alternative products or contracting strategies to increase their outside options (eg through the use of restricted networks, service-line tenders and open referrals). We have found that, although there has been some growth in their use by PMIs, they have not materially improved PMIs' outside options with respect to HCA.
35. Therefore we readopt our conclusion from the Final Report that while PMIs have some bargaining power, they do not have countervailing buyer power which is sufficient to offset the exercise of market power by HCA.

Market outcomes

36. Outcomes of the competitive process in a market can provide evidence about how a market functions, the extent of competition, whether there is an AEC and, if so, the extent of any resulting customer detriment.

Quality and range

37. In relation to quality, we continue to find that there is no evidence of material quality differences between HCA and TLC, although we note there is a lack of comparable data across the common range of treatments that both hospital operators provide.
38. Similarly in relation to product range, while we recognise that HCA offers a wider range of treatments than TLC (eg HCA offers cardiology while TLC does not), we consider that both operators nonetheless offer a broad range of treatments.
39. On this basis we readopt our conclusions in the Final Report that there is a degree of competition over both quality and range in central London.

Insured prices

40. As part of the original market investigation, we conducted an empirical analysis of insured prices for inpatient and day-case treatments for the period from 2007 to 2011, using a methodology that controls for a number of differences between hospital operators in relation to treatment and patient mix (such as patient gender, length of stay and age) – this is what we generally refer to as the IPA, which was the key focus of the litigation and the subsequent remittal. At a high level, the IPA for central London aimed to identify whether there was a price difference between HCA and its closest competitor, TLC.
41. As explained in paragraph 4 above, there were some errors in the analysis presented in our Final Report which we have corrected during the remittal. We have also undertaken a significant amount of additional work during the remittal, in particular in response to detailed comments from parties on the revised IPA Working Paper published during the remittal. HCA submitted a number of new submissions and evidence which suggested that: our IPA did not fully account for differences in patient complexity between HCA and TLC; that HCA, in its view, attracted more complex patients than TLC; and that when this was taken into account, there was no statistically significant price difference between HCA and TLC.
42. We have produced estimates of price differences between HCA and TLC for 36 insurer-year pairs which show that, for many insurers in many of the years covered by our analysis, HCA charged higher prices than TLC. Looking at the overall average price difference across all insurers and all years also indicates that HCA's prices were higher than TLC's, and that this difference was statistically significant.

43. There are four main drivers that could plausibly explain a price difference between HCA and TLC: different treatment mix; different patient complexity; quality differences; and weak competitive constraints on HCA. The first three reasons would be consistent with a competitive market, whereas the fourth reason would suggest a competition problem.
44. Differences in treatment mix are explicitly controlled for in the IPA, which only compares treatments that HCA and TLC both provide.
45. On patient complexity, the IPA includes a number of variables (patient age, sex and length of stay) that attempt to control for this, but HCA has argued that the analysis does not do this effectively. The reasons given by HCA as to why it attracts more complex patients than TLC (for the same treatments) are plausible, although there are difficulties in quantifying the effect of this, given limitations in the data available. While other parties did not consider that HCA treated more complex patients than TLC for the same treatments, we cannot rule out the possibility that differences in patient complexity are not fully controlled for in the IPA. As a result, we cannot be confident that the IPA is comparing like with like in terms of patient complexity.
46. We then considered quality as a possible reason for the price difference. We did not find any evidence of material quality differences between HCA and TLC, and therefore in our view this is unlikely to explain the price difference.
47. In contrast, there is a substantial body of evidence and analysis indicating that HCA has a strong position in central London and faces weak competitive constraints (see our findings above). Our finding from the IPA that there is a price difference between HCA and TLC is consistent with that evidence.
48. We therefore still conclude that weak competitive constraints are leading to HCA charging higher insured prices than TLC. However, unlike at the time of our Final Report, we can no longer conclude on the size of this price difference between HCA and TLC, as we cannot be sufficiently confident that the IPA adequately controls for any differences in patient complexity, and hence compares like with like.

Profitability

49. Both in the Final Report and in our updated analysis in the remittal, we found that HCA earned returns substantially and persistently in excess of the cost of capital. Our finding of excess profitability suggests that the price of privately-funded healthcare services may be high in relation to the costs incurred by HCA in providing those services, and thus higher than we would expect in a well-functioning market. Therefore, we readopt our conclusions

in the Final Report that HCA made returns that were substantially and persistently in excess of the cost of capital and that this, together with the evidence concerning market share and barriers to entry, suggests that HCA is charging prices that are higher than would be expected in a well-functioning market.

Our findings on the AEC(s)

Insured AEC

50. We conclude that the following two structural features in the markets for the provision of privately-funded healthcare services to insured patients in central London are, in combination, leading to an AEC:
- (a) high concentration, with HCA having a large market share; and
 - (b) 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.
51. In combination, these features result in weak competitive constraints on HCA in the provision of privately-funded healthcare services for insured patients in central London.
52. We also conclude that the AEC is leading to customer detriment in the form of higher prices being charged by HCA than we would expect in a well-functioning market. As explained in paragraphs 47 to 49 above, this conclusion is supported by the profitability analysis which demonstrates that HCA has made returns that are substantially and persistently in excess of its cost of capital, and is consistent with the revised IPA.
53. We note that some of the evidence in support of the AEC is now less certain than at the time of the Final Report, and that we are no longer able to conclude on the extent of the customer detriment arising from the AEC. We have taken this into account in assessing the effectiveness and proportionality of potential remedies. However, we remain of the view that there is an AEC.

Self-pay AEC in central London

54. As explained in paragraph 6 above, the self-pay AEC decision has not been quashed by the CAT. However, as instructed by the CAT and given that we previously based our divestment decision on both the insured AEC decision and the self-pay AEC decision, we have also considered whether any of the

analysis undertaken during the remittal in relation to the insured AEC decision could have a material impact on the reasoning in support of the self-pay AEC decision insofar as it relates to the central London market.

55. We conclude that nothing that has emerged during the remittal has a material impact on the reasoning in support of the self-pay AEC decision insofar as it relates to the central London market.

Remedies

56. Having concluded that there are AECs in insured and self-pay private healthcare services in central London, we considered what, if any, additional remedies were required to address these AECs (these remedies would be in addition to those set out in the Final Report, and already implemented by the Private Healthcare Market Investigation Order 2014).
57. In our Notice of Possible Remedies (Remittal Remedies Notice) published in November 2015, we outlined six remedies which we were considering, and invited comments. The parties subsequently suggested further remedies and/or variations to the remedies that we had proposed. We considered each potential remedy, taking account of our consideration of the evidence we have received in written responses to our Remedies Notice, response hearings with parties to this investigation, and their further submissions of evidence.

Framework used

58. We assessed the extent to which the different remedy options are likely to be effective in achieving their aims, including whether they are practicable and when they would be likely to have an effect.
59. We also assessed the extent to which the different remedy options are proportionate, and in particular whether a remedy option:
- (a) is effective in achieving its legitimate aim;
 - (b) is no more onerous than needed to achieve its aim;
 - (c) is the least onerous if there is a choice between several effective measures; and
 - (d) does not produce disadvantages which are disproportionate to the aim.
60. In making our assessment of proportionality of the divestment remedy, we were mindful of the following comments made previously by the CAT:

- (a) 'The greater the interference with [European Convention on Human Rights (ECHR)] rights, the more robust and reliable the evidential basis relied upon to justify that interference may be required to be.' (HCA International Limited v CMA [2014] CAT 11, paragraph 36); and
- (b) 'where the CC has taken such a seriously intrusive steps as to order a company to divest itself of a major business asset ..., the [CAT] will naturally expect the CC to have exercised particular care in its analysis of the problem....and of the remedy it assesses is required.' (BAA v CC [2012] CAT 3, paragraph 20(7))

Divestiture remedy

61. We considered which hospitals HCA would need to divest in order to remedy, mitigate or prevent the AEC or customer detriment arising from the AEC.
62. Our view remains that divestiture of either the Wellington Hospital together with the Platinum Medical Centre, or the London Bridge Hospital together with the Princess Grace Hospital, would be of sufficient scale and provide a sufficiently broad range of specialisms to be capable of creating a new competitor which would be likely to exert a material constraint on HCA. As a result, we are of the view that a divestiture remedy is likely to be effective in remedying or at least mitigating the AEC we have identified and thereby would reduce prices.
63. We considered whether additional oncology services should be included in the divestiture packages, as suggested by some of the parties, since neither of the potential divestiture packages offered radiotherapy treatments. However, we observed that there are already a number of other private hospital operators offering radiotherapy treatments in central London, such that it was not clear that additional non-HCA radiotherapy facilities were required for effective competition in central London. Nonetheless, we do recognise that a divestment (or new entry) without a full range of oncology services may not be a fully effective constraint on HCA in the short term, although it would still have an impact on prices. However, we reasoned that a purchaser of a divested hospital could install the required facilities to compete across the full range of oncology services within a few years (if there was an economic case for doing so). Given the existing non-HCA radiotherapy capacity in the market and the time frame over which a purchaser of the divestiture package could develop radiotherapy, our view is that it would be disproportionate to require HCA to divest additional radiotherapy facilities.

64. We then assessed the proportionality of the proposed divestiture remedy. In order to be satisfied, after careful consideration, that such a remedy is proportionate, we would need to be satisfied that the benefits of the remedy are expected to outweigh the costs.
65. To assist us in making this assessment, we conducted an analysis of the net present value (NPV) of the proposed divestiture, which sought to quantify the costs and benefits of divestiture, taking into account a range of plausible scenarios. We compared the costs and benefits of divestiture against a counterfactual situation in which there was no remedy. In coming to a view on the appropriate counterfactual situation against which to assess the costs and benefits of a divestiture remedy, we considered how the market was expected to develop over the next 20 years, particularly with respect to new entry.
66. Our view is that there is a real prospect of new entry within the medium term (ie within 7 to 12 years from now, which is 5 to 10 years post divestment assuming it will take two years for divestiture to be completed). Given uncertainties about when new entry will occur, which have increased since the Remittal Provisional Decision on Remedies, we have included different scenarios based on new entry taking place in year 5, 7 or 10 following divestiture (which represents 7, 9 or 12 years from now).
67. The impact which new entry would have on prices would necessarily depend on the nature and scale of that entry. We note that the most likely new large-scale entrant is Cleveland Clinic. Although Cleveland Clinic intends to provide a wide range of specialties, it has also confirmed that it does not intend to provide medical oncology on site for many years if at all. We note that the PMIs have told us that additional non-HCA oncology services are essential to constrain HCA, and we recognise that a new entrant providing PMIs with a credible alternative in oncology would be likely to be a more effective constraint on HCA than one which did not. However, our view is that increasing competition in other specialties will result in lower prices overall, even if HCA retains a strong position in one or a small number of specialisms. As we discussed earlier in paragraph 63 when considering divestiture packages, we consider that even without medical oncology, if Cleveland Clinic enters the market it is likely to exert significant downward pressure on HCA's prices.
68. We have not sought to model exact entry scenarios, as we consider this would be spuriously precise given the uncertainties described above. Instead we have modelled variations within three plausible scenarios: (a) a scenario in which entry removes 75% of the excess profits estimated from our profitability analysis; (b) a scenario in which entry removes 100% of the

excess profits; and (c) a scenario in which entry removes 50% of the excess profits. We recognise that none of the potential entrants in relation to whom we have specific evidence would be likely (by themselves) to have the impact reflected by the top end of this range. However, we consider that large-scale entry by a single player, most likely Cleveland Clinic, or a combination of entrants, would be likely to remove a significant proportion of the excess profits.

69. Next, we sought to assess the likely impact of divestiture on HCA's prices, ie the expected benefit of a divestiture remedy. One of the difficulties in conducting this analysis during the remittal was that we could no longer rely on the IPA to estimate the likely impact on prices that could be expected to result from a divestiture remedy. Therefore, we have had to rely much more heavily on our profitability analysis in the remittal in order to assess the extent to which HCA's prices exceed the competitive level (recognising the large number of assumptions required to identify excess profits by customer type, ie UK, overseas and NHS patients).
70. We used our profitability analysis to estimate the extent to which the prices charged by HCA exceeded the level at which HCA would have earned a 'normal' return on capital employed and therefore, the level of detriment. This, in turn, indicates the maximum extent to which prices might be expected to fall if HCA's market power were to be reduced, for example by a divestiture remedy, and gives a range of between 3.0% and 7.5% of revenues. However, there are a number of reasons we would not expect divestiture to result in prices falling by as much as 3.0% to 7.5% (ie to the level where HCA earns no more than its weighted average cost of capital (WACC)).
71. In a bargaining context, where prices are determined through bilateral negotiations between multiple hospital operators and multiple insurers, we would expect a divestiture to increase the competitive constraints on HCA, as it provides insurers with an additional hospital operator (or an existing operator with additional hospitals) with whom they can agree a contract. As such, we would expect insured prices to fall following divestiture, even if the extent of the decrease may vary for different hospital operators and PMIs. However, given that these negotiations lead to different hospital operators charging different prices to different insurers, it has not been possible to model the process of price setting in this market in a way that leads to predictions of how much average prices could be expected to change in response to additional competition (be it a divestiture or new entry).

72. As a large operator, HCA is likely to benefit from economies of scale not realised by smaller competitors. Some of HCA's excess profits may reflect these sorts of efficiencies.
73. Post divestment, therefore, HCA's unit costs would increase, as a consequence of any such loss of economies of scale, reducing the scope for it to cut prices while still making normal returns. Our best estimate is that, due to this loss of economies of scale, the potential decrease in prices as a consequence of divestment is at least two percentage points less than HCA's excess profits might otherwise imply.
74. In addition, we note that: (a) the mixed evidence on spare capacity has increased uncertainty over the likely impact of a divestment remedy on HCA's prices; and (b) we expect the information remedies imposed following the Final Report to have some impact on prices, irrespective of whether there is a divestiture.
75. Taking the above into account, we therefore believe the realistic range of price impact due to divestment to be substantially lower than the 3.0% to 7.5% range estimated by the profitability analysis.
76. The potential impact of the economies of scale which HCA would lose as a result of the divestiture are taken into account directly in our NPV analysis by adjusting the price benefits of the divestment. However, given the other factors set out in paragraphs 74 and 75 above, the results of the NPV analysis should be treated as an upper bound of the NPV of divestiture.
77. We also note that the range of estimated price impacts is far lower than the price impact that we had assumed when we ordered divestment in the Final Report.
78. What the NPV analysis shows is that under a range of different scenarios, reflecting different plausible assumptions about the price impact of divestiture and the timing and effectiveness of new entry, the NPV of divestiture ranges from –£[200–300] million to £[700–800] million.
79. We believe it is unlikely that there will be no new entry at all within 20 years following divestiture, or that there will be new entry which has no impact on prices. However, even disregarding the prospect of new entry entirely, we would still need to expect that divestment would lead to a reduction in prices, albeit only a small reduction, in order for the benefits of a divestment to outweigh the costs. There are various reasons why we cannot be confident that this would be the case. In particular, if the extent to which HCA's profits exceed its WACC is at the lower end of our range (3%), there is a real risk that the divestiture would have no impact on prices, once lost economies of

scale and the impact of the existing information remedy are taken into account. Even if we were to assume that HCA's profits are higher than this, for the reasons set out above there are uncertainties about how much prices will fall as a result of the divestiture.

80. In light of our NPV analysis, and giving due consideration to the uncertainties as to the price impact of divestiture and the prospect of new entry in the market within 20 years of the divestiture, we were unable to form an expectation that the benefits of a divestiture remedy in addressing the AEC would outweigh its costs. We were also mindful of the comments of the CAT regarding the intrusiveness of divestiture and the need for particular care before making such an order (see paragraph 60). We therefore conclude that the proposed divestiture package for HCA does not meet our criteria for a proportionate remedy.
81. The inquiry remittal group (the Group) is not unanimous in this decision, with two of the five group members (Anthony Morris and Jeremy Peat) dissenting.
82. The dissenting members consider 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 (in contrast to the divestiture remedy). They believe that in the majority of the most plausible scenarios, the price benefits of divestiture would outweigh the costs significantly, and divestiture would therefore be both fully effective and proportionate.
83. Having concluded that our proposed divestiture package was disproportionate we also considered narrower divestiture packages (either London Bridge on its own, or one or more oncology centres) put forward by one party, which it considered would partially mitigate the AEC. However, we concluded that we could not form an expectation that the benefits of these remedies would outweigh the costs.

Other remedies

84. We noted submissions from parties that even if divestiture was not considered proportionate, we should still look at other ways of reducing HCA's market power pending any effective new entry. We therefore looked in detail at a range of other potential remedies. In particular, given the prospect of future entry and the possible time-limited nature of the AEC, we considered a 'light touch' price control measure which at the time of the Remittal Remedies Notice we had not been minded to consider further.
85. The remedies we considered were:

- requiring HCA to give competitors access to its hospital facility in order to compete;
- placing restrictions on HCA's further expansion in central London;
- a price control on HCA;
- preventing tying and bundling, including the removal of all restrictive contractual clauses with insurers;
- measures to enhance the availability of sites for private hospitals in central London; and
- imposing stronger constraints on HCA's relationships with consultants.

86. However, we conclude that all would be ineffective in addressing the identified AEC.

Our decision on remedies

87. We have therefore concluded that there are no additional remedies that would be both effective and proportionate in addressing the features in the private healthcare market in central London that we have identified, beyond those that we imposed in the Private Healthcare Market Investigation Order 2014 ('Final Order'). This was a majority decision of the Group.