

# Private healthcare remittal

Provisional decision on remedies

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The Competition and Markets Authority has excluded from this published version of the provisional decision on remedies 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 [✂].

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## Summary

1. This document presents our provisional decision on what additional remedies (if any) to adopt to address the adverse effects on competition (AECs) and resulting customer detriment that we have provisionally found during the remittal of the private healthcare market investigation. The provisional decision on remedies and its accompanying appendix provide a basis for further consultation. We invite views in writing on this provisional decision on remedies by **5pm on 13 April 2016**.
2. In reaching this provisional decision on remedies, we have taken into account the expected impact of the remedies that have already been imposed on the private healthcare market by the Competition and Markets Authority (CMA), including measures to:
  - (a) allow the CMA to undertake a competition review of new private patient unit (PPU) arrangements;
  - (b) prohibit certain types of incentive schemes operated by private hospitals which reward referring clinicians for treating patients at particular facilities; and
  - (c) require the publication of performance information on private healthcare facilities and consultants.

### Background to the remittal

3. The market investigation regarding the supply or acquisition of privately funded healthcare services in the UK was referred to the Competition Commission (CC) by the Office of Fair Trading (OFT) in April 2012. The CMA, to which the relevant functions of the CC were transferred, published its Final Report in April 2014 (Final Report). The CMA found that certain structural features in the market were leading to AECs in respect of insured patients in central London and in respect of self-pay patients across the UK, and announced a package of remedies including divestiture of one or two of the hospitals owned by HCA International Ltd (HCA).
4. HCA applied in May 2014 to the Competition Appeal Tribunal (the CAT) for a review of certain aspects of the Final Report. During the proceedings, errors were identified in the CMA's insured pricing analysis (IPA). The CMA asked for the matters to be remitted back to the CMA for it to review the IPA and re-consult with interested parties. Consequently, in January 2015 the CAT ordered that the following decisions, as contained in the Final Report, should be quashed and remitted to the CMA for reconsideration:

- (a) the CMA's finding of an AEC in the markets for the provision of hospital services in respect of insured patients in central London; and
- (b) the CMA's divestiture remedy, by which HCA was required to divest itself of one or two of its hospitals in central London.

### **AECs to be remedied**

5. In November 2015 we provisionally concluded that 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 and weak competitive constraints on HCA:
  - (a) high concentration, with HCA having a large market share; and
  - (b) high barriers to entry and expansion.
6. Although the self-pay AEC decision was not quashed by the CAT, we also considered whether any of the analysis undertaken during the remittal had a material effect on the reasoning in relation to the self-pay AEC decision. We provisionally concluded that competitive constraints on HCA in this market are generally weak, and that nothing that has emerged during the remittal has a material impact on the reasoning in support of the self-pay AEC decision.
7. We therefore considered what, if any, additional remedies are required to address the insured AEC, together with the separate AEC we found in the Final Report in respect of self-pay patients in central London, and published a Notice of Possible Remedies (the Remedies Notice) with the remittal provisional findings (PFs) in November 2015. These remedies would be in addition to those already ordered after the Final Report, and which have been implemented.
8. We have not, at this stage, made a final decision regarding the existence and form of any AEC and/or resulting customer detriment as a result of the remittal. Our provisional decision on remedies (PDR) therefore considers remedies that address the AECs as set out in our PFs. Our final decision on any AECs, and appropriate remedies, will take into account all evidence received and submissions made including the responses to our PFs and PDR.

### **Recent market developments and provisional conclusions on new entry/ expansion**

9. In the Final Report, we concluded that there were high barriers to entry to the central London market, illustrated by the lack of large-scale entry or substantial change in the structure of the market over the last ten years,

despite the attractiveness of the growing privately funded healthcare services market in central London. Since the publication of the PFs, we have received additional evidence that there is likely to be future large-scale entry by one or more private hospital operators in central London.

10. Based on the evidence currently available to us, our provisional view is that Cleveland Clinic is likely to enter the market with a new hospital by early 2020, offering over 200 beds, a broad range of specialisms and an owner with a strong reputation for quality in the USA. We expect that Cleveland Clinic will, together with the other existing operators in central London, effectively constrain HCA by early 2022, recognising that there is some uncertainty over this time frame.
11. We also note evidence of other potential entrants into the central London market of varying scale, scope and likelihood. Although these entries, if they occurred, could add to the constraint on HCA, we do not attach significant weight to the prospect of entry by others, given the greater uncertainty over their entry or, in some cases, the more limited range of services likely to be provided by them.
12. Our provisional view is therefore that the expected duration of competition concerns in the market for the provision of private healthcare services in central London has significantly reduced since the publication of the Final Report of the original investigation. This has been taken into account in our assessment of the proportionality of the remedies considered in the remittal. This provisional decision was reached by a majority of four to one.

### **Assessment of potential remedies**

13. This PDR considers 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***

14. 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 are likely to have effect.
15. When deciding which remedies to propose, we also assessed the extent to which 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.

### ***Divestment remedy***

16. We considered which hospitals HCA would need to divest in order to remedy the AEC, recognising the likelihood of new entry in the London market which is a new development since the publication of the Final Report.
17. Our provisional view is 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 remedy the AEC, and would therefore be an effective remedy, as we discussed in the Final Report.
18. However, we provisionally conclude that this proposed divestiture package for HCA is not a proportionate remedy. Given the expected entry of Cleveland Clinic within three years of the proposed divestment (assumed to take place in 2017), and our expectation that this, together with existing non-HCA private hospitals in central London, would provide an effective competitive constraint on HCA within two years of opening (ie by early 2022), we found that the benefits of divestment in addressing the AEC are likely to be short-lived. On a number of plausible combinations of assumptions, including our base case assumptions, the net present value (NPV) of the divestment remedy is negative or only marginally positive. Taking account also of the significant uncertainty over the elements of our NPV calculation, we could not form an expectation that the benefits of a divestiture remedy would outweigh its costs.
19. Given the lack of certainty that the benefits will outweigh the costs, we provisionally conclude that, although a divestiture remedy would be effective in addressing the AEC in central London, it would not be proportionate. We recognise that this is a finely balanced decision, and note that the inquiry remittal group (the Group) was not unanimous in this decision.

### ***Price control remedy***

20. Our current view is that a light-touch price control is unlikely to be an effective means of mitigating the detriment to customers due to uncertainty over the extent to which HCA's prices exceed the competitive level, which means that

there is a significant risk of either leaving some detriment unaddressed or forcing prices below the competitive level, and the potential for circumvention of the remedy by HCA. This meant that we could not be sure that a price cap would even address the detriment specified in the headline price reduction.

21. Our provisional conclusion is that a light-touch price control remedy does not meet our criteria for effectiveness.

### ***Other remedies***

22. We also considered several other potential remedies, as described in the Remedies Notice. However, we provisionally conclude that none would be effective in addressing the provisionally identified AEC.

### **Provisional decision on remedies**

23. We have therefore provisionally concluded that there are no additional remedies that would be both effective and proportionate in addressing the features 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.
24. The Group will consider responses to this PDR and further developments in the market, particularly concerning the likelihood of significant new entry into the central London market, before making a final decision on remedies.

## Provisional decision on remedies

### 1. Introduction

- 1.1 On 4 April 2012, the OFT made a market investigation reference to the CC regarding the supply or acquisition of privately funded healthcare services in the UK.
- 1.2 On 1 April 2014 the remaining functions of the CC in relation to the reference were transferred to the CMA.
- 1.3 The Final Report was published by the CMA on 2 April 2014. In the Final Report, the CMA found that certain structural features of the markets for the supply or acquisition of privately funded healthcare services were leading to AECs in respect of insured patients in central London and in respect of self-pay patients across the UK. The CMA decided that a package of remedies, including divestiture of one or two of the hospitals owned by HCA in central London, would form as comprehensive a solution as was reasonable and practicable to the AECs and/or the detrimental effects on customers arising from the AECs.
- 1.4 HCA applied on 30 May 2014 to the CAT for a review of certain aspects of the CMA's Final Report.
- 1.5 During the proceedings before the CAT, HCA's external economic advisers identified certain errors in the CMA's insured pricing analysis (the IPA). In light of these errors, the CMA considered that the appropriate course of action was for the matters to be remitted back to the CMA for it to review the IPA and re-consult with interested parties.
- 1.6 Accordingly, on 12 January 2015 the CAT ordered that the following decisions, as contained in the Final Report, should be quashed and remitted to the CMA for reconsideration:
  - (a) the CMA's finding of an AEC in the markets for the provision of hospital services in respect of insured patients in central London; and
  - (b) the CMA's divestiture remedy, by which HCA was required to divest itself of one or two of its hospitals in central London, as described in paragraphs 11.132, 13.1(a) and 13.48 of the Final Report.
- 1.7 On 10 November 2015, after re-consulting on the IPA and considering further arguments and evidence put to us by the parties, we provisionally concluded that the following 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):

- (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.

- 1.8 In combination, these features resulted in weak competitive constraints on HCA in the provision of privately funded healthcare services for insured patients in central London.
- 1.9 We also provisionally concluded that the AEC was leading to customer detriment in the form of higher prices being charged by HCA than we would expect in a well-functioning market.
- 1.10 The self-pay AEC decision was not quashed by the CAT. However, we have considered whether any of the analysis undertaken during the remittal in relation to the insured AEC decision had a material effect on the reasoning in relation to the self-pay AEC decision. The evidence suggests that self-pay prices are driven by weak competition in local markets, including central London. We have also provisionally concluded that competitive constraints on HCA in this market are generally weak. Therefore, we have provisionally concluded that nothing that has emerged during the remittal has a material impact on the reasoning in support of the self-pay AEC decision.
- 1.11 In the light of these updated PFs, we are now considering what, if any, remedies are required to address the insured AEC, together with the separate AEC we found in the Final Report in respect of self-pay patients (the self-pay AEC), in central London.
- 1.12 We published a Remedies Notice with the PFs on 10 November 2015. This set out a number of measures that we considered could address the AECs and the resulting detrimental effects and invited comments from all interested parties. We received a number of responses to our Remedies Notice and have held several response hearings and meetings with relevant parties. Non-confidential versions of such responses and summaries of response hearings held can be found on our website.<sup>1</sup> In addition, since the publication of our PFs, we have issued a number of information requests and received various submissions from parties in relation to a range of topics, including HCA's

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<sup>1</sup> [Private healthcare market investigation case page](#).

financial performance and various firms' plans for entry into the central London market. This evidence is referred to, as appropriate, in this document.

- 1.13 Having given careful consideration to all of the evidence we have gathered to date, including the submissions received in response to the Remedies Notice, and in the response hearings, this document sets out our PDR and serves as a basis for further consultation. We have not, at this stage, made a final decision regarding the existence and/or form of any AEC and/or resulting customer detriment.
- 1.14 The PDR therefore considers what remedies (if any) should be imposed to address the AECs as set out in our PFs. In reaching this provisional decision on remedies, we have taken into account the expected impact of the remedies that have already been imposed on the private healthcare market in the UK, as set out in our Final Order,<sup>2</sup> including measures to:
- (a) allow the CMA to undertake a competition review of (new) PPU arrangements, other than those that give rise to a relevant merger situation (which are already covered by the merger control rules);
  - (b) prohibit certain types of incentive schemes operated by private hospitals which reward referring clinicians (directly or indirectly) for treating patients at particular facilities; and
  - (c) require the publication of performance information on private healthcare facilities and consultants.<sup>3</sup>
- 1.15 Although we consider that these existing remedies will improve competition within the private healthcare market in central London, we do not consider that they will fully address the insured AEC or self-pay AEC or the resulting customer detriment. Indeed, with the exception of the PPU review remedy, the existing remedies were not specifically aimed at addressing the market power of private hospital operators but rather at addressing information asymmetries between patients and private healthcare providers (both hospital and consultants) and the detriment arising from such asymmetries. In the case of the PPU remedy, we expect that this should facilitate new entry in local markets around the UK, including in central London, increasing competitive constraints on incumbent hospitals. However, as set out in the Final Report (11.232) the level of constraint from PPUs tends to be limited where they specialise in a narrow range of medical services. We note that several central

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<sup>2</sup> [Private Healthcare Market Investigation Order 2014](#).

<sup>3</sup> The CMA's Final Order also requires the publication of information on consultant fees. However, this clause has not been brought into effect, pending the outcome of an appeal against this remedy by FIPO.

London PPUs have taken this approach, including the Barts PPU (see paragraphs 1.41 and 1.42).

- 1.16 Our final decision on any AEC, and appropriate remedies, will take into account all of the evidence received and submissions made, including the responses to our PFs and PDR.
- 1.17 This document begins by setting out the framework we have used for consideration of remedies. Prior to discussing the remedies that we have considered, we set out our assessment of the potential impact of current market developments, particularly the potential entry into the market by Cleveland Clinic and other private hospital operators. We then provide a detailed discussion of the remedies that we have considered to address the features that we have provisionally identified. These include:
- (a) divestiture of one or more of the hospitals owned by HCA in central London (Remedy 1);
  - (b) requiring HCA to give competitors access to its hospital facilities to compete (Remedy 2);
  - (c) placing restrictions on HCA's further expansion in central London (Remedy 3);
  - (d) a 'light-touch' price control (Remedy 4);
  - (e) preventing tying and bundling (Remedy 5);
  - (f) and measures to facilitate site availability in central London (Remedy 6).

For each of these remedies we discuss how it could address the AEC and set out the views of parties. We then assess questions around the design and implementation of these remedies, before assessing and concluding on their effectiveness and proportionality. In their responses to the Remedies Notice, parties<sup>4</sup> did not propose that we consider any alternative remedies to those set out in the notice.

### ***Framework for the assessment of remedies***

- 1.18 When deciding whether any remedial action should be taken and, if so, which action should be taken, the CMA will consider how comprehensively the

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<sup>4</sup> 'Parties' refers to all businesses which have made submissions as part of the market investigation, including private hospital operators, private medical insurers (PMIs), consultants, patients, and or representatives of the same.

possible remedy options – individually or as a package – address the AECs and/or the resulting detrimental effects on customers, and whether they are reasonable and practicable.<sup>5</sup>

- 1.19 The CMA will assess the extent to which different remedy options are likely to be effective in achieving their aims, including whether they are practicable and when they are likely to have effect.<sup>6</sup> In particular, a remedy must be capable of effective implementation, monitoring and enforcement. The effectiveness of any remedy may be reduced if elaborate monitoring and compliance programmes are required. The CMA will generally look to implement remedies that prevent an AEC by addressing its underlying causes, or by introducing ongoing measures that can be put in place for the duration of the AEC. The CMA will tend to favour remedies that can be expected to show results within a relatively short period of time. In line with our revised guidelines<sup>7</sup> and EU case law, the CMA will also consider whether or not to limit the duration of individual remedies by including sunset provisions in their design. This approach might be appropriate if, for example, the relevant competitive dynamics of a market are likely to change materially over the next few years or the measure in question is intended to have a transitional impact, while other longer-term measures take effect.<sup>8</sup>
- 1.20 The CMA will be guided by the principle of proportionality in ensuring that it acts reasonably in making decisions about which remedies to impose. The CMA will therefore assess the extent to which different remedy options are proportionate, and in particular it will be guided by 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.<sup>9</sup>
- 1.21 In reaching a judgement on whether to implement a particular remedy, the CMA considers its potential effects on those persons most likely to be affected by it, generally customers and the businesses subject to the remedies. The CMA seeks to quantify the costs and benefits associated with a remedy where

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<sup>5</sup> *Guidelines for market investigations: Their role, procedures, assessment and remedies (CC3)*, paragraph 330.

<sup>6</sup> *CC3*, paragraphs 327 & 330.

<sup>7</sup> *Market studies and market investigations: Supplemental guidance on the CMA's approach (CMA3)*, paragraphs 4.14–4.25.

<sup>8</sup> *CMA3*, paragraphs 4.14–4.25.

<sup>9</sup> *CC3*, paragraphs 335–337.

it is reasonably practicable to do so, taking into account any relevant customer benefits (RCBs) arising from the adverse features of the market concerned.

- 1.22 In the event that the CMA reaches a final decision that there is an AEC, the circumstances in which it will decide not to take any remedial action are likely to be rare but might include situations in which no practicable remedy is available, where the cost of each practicable remedy option is disproportionate to the extent that the remedy option resolves the AEC, or where RCBs accruing from the market features are large in relation to the AEC and would be lost as a consequence of any appropriate remedy.<sup>10</sup>

### ***Key market developments: assessment of future entry***

- 1.23 As set out in our PFs, in spite of the attractiveness of the growing privately funded healthcare services market in central London, there has been no large-scale entry or substantial change in the structure of the market over the last ten years or more, and only limited incremental expansion/changes in ownership.<sup>11</sup> However, during the remittal, we have received evidence that there may be future large-scale entry by one or more private hospital operators in central London.
- 1.24 In this section, we discuss the evidence that we have gathered to date in relation to new entry into the central London market and our assessment of the likelihood, timing and foreseeable impact of such entry. This assessment is relevant to the provisional conclusions that we have reached in this PDR.

#### *Large-scale entry*

##### *Cleveland Clinic*

- 1.25 In late 2015, Cleveland Clinic, a US-based, not-for-profit<sup>12</sup> private healthcare provider, acquired a long-term lease of a 191,000 sq ft site at 33 Grosvenor Place in Belgravia, central London for £[redacted] million. Cleveland Clinic intends to convert 33 Grosvenor Place, which is currently used as office space, for use as a private hospital. The expected capacity of the new facility would be around 215 beds, of which approximately 40 would be intensive care beds.

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<sup>10</sup> CC3, paragraphs 355–369.

<sup>11</sup> PFs (10 November 2015), paragraph 23.

<sup>12</sup> Cleveland Clinic is a non-profit multi-specialty academic medical centre that integrates clinical and hospital care with research and education, according to its website.

- 1.26 Cleveland Clinic is a well-established hospital operator with 15 hospitals, 11 of which are located in Ohio, with the remaining four in Florida, Nevada, Canada and Abu Dhabi. The only existing hospital outside North America is in Abu Dhabi, which is a multi-specialty hospital with 364 beds and was opened to the public in May 2015. Cleveland Clinic has more than 1,400 beds on its main campus in Ohio and 4,450 beds worldwide. For the year ended December 31, 2014, Cleveland Clinic reported a \$467.5 million operating profit on \$6.7 billion in revenue. In 2014, it reported 5.9 million outpatient visits and employed over 3,000 physicians and scientists.<sup>13</sup>
- 1.27 According to the U.S. News & World Report's Best Hospital Rankings, in the USA, Cleveland Clinic is ranked number one in Cardiology and Heart surgery, number two in Gastroenterology and GI surgery, as well as Nephrology, Rheumatology and Urology and number three in Diabetes and Endocrinology, Gynaecology, Orthopaedics and Pulmonology. Cleveland Clinic is ranked in the top 10 hospitals in the USA across its other specialties, with the exception of oncology and paediatric specialties.<sup>14</sup>
- 1.28 Cleveland Clinic told us that it had had a long-standing interest in entering the central London market (since 2001) but had previously been unable to identify a suitable location. It had started to pursue entry actively (once again) in 2014.
- 1.29 In order to verify Cleveland Clinic's plans, we asked for, and were provided with, a number of supporting documents, including internal business plans which have been approved by its board. A meeting was held with the management of Cleveland Clinic. The evidence demonstrates that Cleveland Clinic had invested a considerable amount of time and money in developing its strategy, and laying the groundwork, for entering central London. We have set out below details of Cleveland Clinic's plans, including the services it intended to offer at its new hospital; its proposed customer base and pricing; the discussions it has had with consultants and PMIs; its financing arrangements; and progress with converting the site at Grosvenor Place.
- 1.30 Cleveland Clinic planned to offer a range of tertiary treatments, including cardiology, vascular, orthopaedics, urology, nephrology, neurology, plastics and dermatology. Cleveland Clinic told us that it did not currently have plans

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<sup>13</sup> [Cleveland Clinic Facts and Figures](#).

<sup>14</sup> [US News and World Report – Health, Rankings](#). U.S. News & World Report publishes a 'Best Hospitals Rankings'. According to its website, U.S. News & World Report 'sifted through data for nearly 5,000 hospitals and results from surveys of more than 140,000 physicians to rank the best centres in 16 adult specialties from cancer to urology. Death rates, patient safety and hospital reputation were a few of the many factors [it] considered.'

to offer medical oncology, although it would offer surgical oncology, but that it would adapt its services to serve the market.

- 1.31 Cleveland Clinic hired Boston Consulting Group (BCG) and PricewaterhouseCoopers to advise it on the commercial aspects of its entry, including advice on the current (approximate) level of healthcare prices in central London. On the basis of the advice received, Cleveland Clinic has developed detailed business plans setting out its strategy for entering the private healthcare market in central London, through the acquisition of the site in Grosvenor Place. These were approved by its board; however, Cleveland Clinic indicated that these business plans may evolve as it learned more about the market. [REDACTED]
- 1.32 Cleveland Clinic told us that it had already retained the services of a number of (medical) consultants in an advisory capacity and that it was working with them to develop its strategy for the central London market. Cleveland Clinic also informed us that it had held some preliminary informal discussions with [REDACTED]. According to its internal documents, BCG also conducted interviews with senior executives of [REDACTED] and [REDACTED] to 'refine perspective on market attractiveness, entry scenarios, [and] operating model'. BCG reported that [REDACTED] and [REDACTED] were supportive of new entry, that they viewed cardiology and oncology as underserved specialties, and that a 'Central zone 1 location was important for convenience' for corporate PMI customers.
- 1.33 Cleveland Clinic's business plan indicated that it would seek to attract customers from among UK insured, UK self-pay and overseas patients. Cleveland Clinic's board paper dated 24 September 2015 showed the value of the private healthcare market in London to be [REDACTED]. [REDACTED]
- 1.34 Cleveland Clinic told us that it had engaged Moody's in discussions regarding its financing strategy for entry into the central London market. Cleveland Clinic was Aa2 rated by Moody's and AA- by S&P. The acquisition of 33 Grosvenor Place was completed in part through [REDACTED]. The company told us that it had significant cash flows from its other operations that could be used to finance the works, the investment and its entry into central London.
- 1.35 Cleveland Clinic's plans for the site depended on obtaining planning permission to convert the building. Cleveland Clinic believed that it would take three years from the grant of planning permission until it would be able to treat its first patient. [REDACTED]

1.36 The application for planning permission for the conversion of 33 Grosvenor Place from office use to hospital use was due to be submitted in March 2016<sup>15</sup> and, subject to approval, Cleveland Clinic envisaged that refurbishment works would begin during 2016. Cleveland Clinic had already employed a number of advisers to help with the planning process, including architects, planning advisers, stakeholder engagement consultants, development managers, highway and servicing consultants, legal counsel and communication consultants to advise on its planning application.

#### VPS

1.37 In July 2015, VPS announced plans to enter the central London market via the purchase of the (currently disused) Ravenscourt Park hospital.<sup>16</sup> VPS managed 16 fully operational hospitals across the UAE, Oman and India, as well as pharmaceutical manufacturing, a pharmacy retail chain, and primary, secondary and tertiary care clinics. The group's capacity was over 1,100 beds and it served approximately 3 million patients a year and employed over 750 physicians.<sup>17</sup>

1.38 In a press release dated July 2015, VPS stated that Ravenscourt Park hospital was expected to have capacity of 150 beds.<sup>18</sup> During the summer of 2015, VPS told us that it planned to open the refurbished hospital in 2017. Its plan for the site was as a full-service, tertiary hospital. VPS told us that it would be the first private hospital in the UK to offer proton beam therapy, a kind of radiotherapy, used in cancer treatment.

1.39 C&C Alpha Group (CCAG), the current owner of the tenant company for Ravenscourt Park hospital, told us that it was in active discussions with VPS and Imperial College NHS Trust over a revised Share Purchase Agreement for the company holding the lease of Ravenscourt Park Hospital, [REDACTED]. [REDACTED]

1.40 CCAG told us that the planning permission for the site had been secured, as shown by a copy of its Certificate of Lawfulness of Use or Development submitted to us.

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<sup>15</sup> As of the date of publication of this report, we understand that Cleveland Clinic has not yet submitted its planning application to Westminster City Council.

<sup>16</sup> Article in *The National* (27 July 2015): '[VPS Healthcare to invest £105 million on new London cancer care hospital](#)'. The Ravenscourt Park Hospital is located in Hammersmith. It was leased by the NHS between 2002 and 2006, and used to treat NHS patients. BBC news article (29 August 2006): '[Hospital closes after four years](#)'. The site was acquired by C&C Alpha in 2007, which intended to refurbish the site and open it as a private hospital (the London International Hospital). See [Final Report](#), paragraph 6.73. However, C&C Alpha is now in discussions regarding the sale of the site to VPS.

<sup>17</sup> [VPS corporate brochure](#).

<sup>18</sup> Article in *The National*, op cit. The Ravenscourt Park hospital has around 185,000 sq ft of space.

### *PPU entry*

- 1.41 In the Final Report, we noted that Barts Health NHS Trust was tendering for a partner to operate a new PPU from its site in east London. Preferred bidder status was awarded by Barts Health NHS Trust in 2015 following a competitive dialogue procurement that began in 2014, and discussions to conclude a contract are ongoing. The preferred bidder is a new entrant to the London PPU market and will be investing, developing, managing and operating the PPU facility located on the St Bartholomew's Hospital site in West Smithfield with a floor area of approximately 78,000 sq ft. The expected capacity is in the region of three theatres, 26 beds, a full diagnostic suite and outpatient services. Barts Health indicated that the facility was expected to focus largely, although not exclusively, on cardiovascular treatments.
- 1.42 The PPU is currently expected to open in 2018.

### *Spire*

- 1.43 During our original investigation, Spire Healthcare (Spire) told us that it was searching for a suitable site in central London in which to open a hospital.<sup>19</sup>  
[✂]
- 1.44 [✂]
- 1.45 [✂] This contract runs until March 2021.<sup>20</sup>

### *Entry/expansion by others*

- 1.46 We are aware of other firms that have opened (or have firm plans to open) specialist private healthcare facilities in central London. In our PFs,<sup>21</sup> we observed that these facilities were very small relative to the market (offering a handful of inpatient beds or day-case only facilities) and highly specialised, for example Fortius Clinic, Advanced Oncotherapy, the Harley Street Eye Clinic and Optegra.
- 1.47 During February 2016, Howard de Walden Estates<sup>22</sup> told us that a large European hospital group intended to open a private hospital in central London (on Wigmore Street, in close proximity to Harley Street). The hospital would be 65,000 sq ft., and would specialise in spinal treatments and neurology. Howard de Walden Estates told us that the new entrant was attracted to

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<sup>19</sup> Final Report, paragraphs 3.10–3.14.

<sup>20</sup> PFs, paragraph 5.21.

<sup>21</sup> PFs, paragraph 5.68.

<sup>22</sup> The Howard de Walden Estate owns and manages a large property portfolio in Marylebone.

central London due to the market's attractiveness to overseas patients. However, the new entrant plans to attract UK insured and self-pay patients as well. The hospital is expected to take 15 months to establish from the grant of the planning permission. The application for planning permission was due to be submitted in late March 2016.<sup>23</sup>

### *Views of parties on future entry*

#### *AXA PPP*

- 1.48 AXA PPP told us that it was aware of the possibility that one or more providers may enter the central London market. However, it said that it did not believe that there was firm evidence that any such entry would provide 'sufficient remedy' to the AEC in the near term. In AXA PPP's view, a new entrant would have to offer key specialties (and in particular, oncology) which 'lie at the core of demand for corporate private healthcare insurance' in order to amount to an alternative offering that would be acceptable to 'the vast majority of corporate customers' in London. AXA PPP also noted that potential new entrants, such as VPS or Cleveland Clinic, still faced considerable barriers to entry, including lengthy development times, the need to attract and retain (simultaneously) a sufficient number of consultants who were willing to move their work from existing hospitals to a new facility, and the need to establish the clinical reputation of a new facility across the range of key specialties, including oncology.<sup>24</sup>
- 1.49 In relation to Cleveland Clinic, AXA PPP said that the time frame for its building conversion was unclear, as was the range of specialties that Cleveland Clinic would propose to offer. AXA PPP also noted that it would take time to persuade corporate customers that Cleveland Clinic would represent an effective alternative to HCA.<sup>25</sup> In AXA PPP's view, even if Cleveland Clinic or VPS were to enter and provide a full offering (including oncology), it would be unlikely to materially change the position within central London (and HCA's 'must-have' status) within a decade.
- 1.50 AXA PPP submitted that there was no certainty that VPS would enter the market. In addition, AXA PPP said that the Ravenscourt Park hospital was unlikely to provide a material constraint on HCA given its location in west

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<sup>23</sup> As of the date of publication of this report, this planning application does not yet appear to have been submitted to Westminster City Council.

<sup>24</sup> AXA PPP response to Remedies Notice on 4 December 2015, p1, first section.

<sup>25</sup> AXA PPP response to Remedies Notice on 4 December 2015, p5, section 3.4.

London compared with HCA's hospitals which were more central and closer to the City.<sup>26</sup>

### *Bupa*

- 1.51 Bupa told us that there was little evidence of credible and constraining new entry on the horizon. Bupa noted that new entry had not materialised for many years despite the attractiveness of the central London market relative to the rest of the country. It also told us that HCA's strong market position meant that it was able to negotiate contractual clauses into agreements with insurers that protected its existing patient flows and could frustrate successful entry.<sup>27</sup>
- 1.52 Bupa also said that it considered it unlikely that either VPS or Cleveland Clinic would provide the necessary competitive constraint on HCA in the near term.
- 1.53 Bupa told us that Cleveland Clinic would find it difficult to 'prise doctors away' from HCA. In Bupa's opinion, HCA 'have built up a stranglehold' around consultants and 'continue to reinforce that in some specialities', such as oncology. In Bupa's view, Cleveland Clinic would need to provide the full range of [redacted] services in order to be an effective competitor to HCA.

### *HCA*

- 1.54 HCA told us that Cleveland Clinic 'have an incredible reputation in healthcare' and that it was one of the largest and best-funded healthcare groups in the world. HCA made the point that the Cleveland Clinic facilities were 'some of the finest' and that, in earlier conversations with consultants it had communicated its strategy to doctors [redacted]. HCA told us that Cleveland Clinic was already attracting consultants practising at HCA. HCA told us that it had approached consultants with a view to implementing an employment model to retain their services.
- 1.55 HCA also told us that Cleveland Clinic was actively progressing its plans for a new hospital at 33 Grosvenor Place and that it had engaged former HCA hospital staff, [redacted].
- 1.56 In relation to private medical insurance policies, HCA told us that it had already seen products that excluded HCA and [redacted].

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<sup>26</sup> AXA PPP response to Remedies Notice on 4 December 2015, p6, section 3.5.

<sup>27</sup> Bupa response to Remedies Notice on 3 December 2015, p14, paragraph 2.7.

### *The London Clinic*

- 1.57 In The London Clinic's (TLC's) view, historical evidence of actual entry should carry the most weight in an assessment of the constraint posed by new market entry, and there had not been any large-scale entry into the central London private hospital market in the last decade. On Cleveland Clinic in particular, TLC's view was that it was likely to take up to ten years for Cleveland Clinic to open, if it opened at all. TLC believed that it was simply not possible for Cleveland Clinic to open by 2018, as suggested by some earlier estimates, due to difficulties in obtaining planning permission and construction (particularly around the installation of MRI scanners and radiotherapy equipment), potentially lengthy negotiations with PMIs, and difficulties in attracting consultants.

### *Our assessment of the likelihood and timing of entry/expansion*

- 1.58 For each of the potential entrants mentioned above, we considered both the likelihood of them entering the central London market and the timescale within which they could be expected to do so.

### *Cleveland Clinic*

- 1.59 We have carefully considered the evidence provided by Cleveland Clinic. In light of this evidence, we are satisfied that Cleveland Clinic is a credible potential entrant, with a well thought out strategy to enter the central London market and with firm and relatively well-advanced plans. We observe that Cleveland Clinic is a large private healthcare group with significant experience in operating high-acuity healthcare facilities. It has recent experience of developing new private healthcare facilities outside the USA, having opened a 4.5 million sq ft hospital in Abu Dhabi in May 2015. Cleveland Clinic has acquired a large (191,000 sq ft) building in central London and its board has approved its plan to redevelop that building as a hospital. In addition, Cleveland Clinic told us that it had sufficient funding in place to undertake the investment required to develop the hospital. Cleveland Clinic has undertaken extensive preparatory work in order to facilitate its entry, including employing various business, medical and planning advisers. Cleveland Clinic also told us that it was likely to seek an alternative site for entry if planning permission was not granted for the current site.<sup>28</sup>

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<sup>28</sup> Cleveland Clinic has also commissioned a detailed report from Cushman & Wakefield on various available buildings and sites in central London which would satisfy their requirements.

- 1.60 We consider that the principal uncertainty regarding the entry of Cleveland Clinic relates to its ability to obtain planning permission to convert 33 Grosvenor Place into a hospital. We collected a range of evidence to inform our assessment of the likelihood of Cleveland Clinic obtaining planning permission. Cleveland Clinic told us that it was in preliminary discussions with Westminster City Council (WCC). WCC told us that it would expect most applications for major works to take around 16 weeks from formal application to a committee determination. However, where there were concerns around the viability of the site for the use proposed – and WCC told us that there often were – this could be 20 weeks instead of 16. WCC also told us that it tried to pre-empt any issues relating to section 106 (a legal agreement to secure the necessary planning obligations from the development) by negotiating with the parties in tandem with the application itself. Particular issues that tended to arise in such cases were the parking, traffic and servicing which were significantly different from the current office use, ie drop-off of patients, employees’ – including consultants – dedicated parking, and private ambulances. The WCC planning portal indicated that 33 Grosvenor Place is not a listed building and the conversion to ‘medical use’ was an allowable ‘change of use’ within the Westminster area.<sup>29</sup>
- 1.61 On the basis of the evidence above, we consider that although there is uncertainty in relation to its planning application, if the planning application is submitted in March 2016, as indicated by Cleveland Clinic, it is reasonably likely that it will obtain planning permission to convert 33 Grosvenor Place from office to medical use over the course of 2016.
- 1.62 We next considered the likely timescale for entry by Cleveland Clinic into the central London market. As noted above, Cleveland Clinic’s plans envisaged opening its new hospital approximately three years after obtaining planning permission. In order to assist us in our assessment of the timing of likely entry, we looked at previous entries in the UK market and by Cleveland Clinic elsewhere:
- (a) We noted that in 2003, TLC began the process of planning and financing the Cancer Centre project and acquired the premises in which to house it. The Cancer Centre admitted its first patients in December 2009. TLC indicated that it had taken around three and a half years to find a suitable site and to obtain the necessary permissions, with construction of the Cancer Centre taking a similar amount of time. TLC highlighted that obtaining planning entailed negotiating a complex Town Planning Class

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<sup>29</sup> [Planning Portal – Change of use.](#)

use swap for the, then residential, 23 Devonshire Place (located near Harley Street in Marylebone) which, had it not been accomplished, would have required work on the Cancer Centre to cease.<sup>30</sup> It had cost £90 million to build and equip.<sup>31</sup>

(b) Cleveland Clinic Abu Dhabi, the group's only hospital outside North America, is the result of a partnership agreement signed in 2006 between Mubadala Development Company and Cleveland Clinic. The hospital was officially inaugurated in December 2015, although it admitted its first patient in May 2015. Cleveland Clinic told us that the hospital took longer than expected to build (around seven years in total). However, this was due in part to the global financial crisis.

1.63 We noted that Cleveland Clinic has already acquired 33 Grosvenor Place and that this building was located outside the Harley Street Special Policy Area<sup>32</sup> such that it would not face the same issues of use swaps as TLC did with its Cancer Centre. On this basis, we considered that the relevant comparison in terms of timing was with the period of time required to construct the Cancer Centre, ie around three and a half years (from the date that planning permission was obtained). In relation to Cleveland Clinic's Abu Dhabi hospital, we noted that this project was much larger than its proposed London facility, at 4.5 million sq ft, compared with just under 200,000 sq ft. Therefore, while the latter was built on a greenfield site and took around seven years, we reasoned that a significantly smaller facility could be built in a shorter time period.<sup>33</sup>

1.64 In light of the evidence discussed above, our current view is that, if planning permission is applied for in March and granted within around six months, it is likely that Cleveland Clinic's London hospital will open in late 2019 to early 2020, ie around three and a half years from the date of obtaining planning permission. We note that this is a slightly longer time frame for conversion of the building than envisaged by Cleveland Clinic (of three years). However, we recognise that there could be delays in either obtaining planning permission, or in converting the site (due to unforeseen circumstances).

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<sup>30</sup> The use swap involved the assembly of a package of premises to provide additional residential accommodation at 11 Devonshire Place, 4 Marylebone Mews, 59 Wimpole St and 92 New Cavendish Street to replace some of that lost at 23 Devonshire Place. Subsequently the remaining residential accommodation was created, at 50 Hallam Street.

<sup>31</sup> See [Final Report](#), paragraph 6.29 and Appendix 6.3. It took TLC around three and a half years to acquire a suitable site and to obtain planning permission.

<sup>32</sup> [WCC document on SPAs](#).

<sup>33</sup> It has 364 (expandable to 490) beds (see [Cleveland Clinic website](#)).

## VPS

- 1.65 We contacted both VPS and CCAG to understand their plans for the central London market. VPS told us that while it did have plans to enter the central London market via the redevelopment of the Ravenscourt Park hospital, it could not provide further information at this point in time. From our discussions with CCAG, we understand that [REDACTED].
- 1.66 While there appeared to be an incentive on both sides (VPS and CCAG) to come to some agreement in regards to Ravenscourt Park, given the limited information we have been able to collect from VPS<sup>34</sup> regarding its entry plans [REDACTED], we consider it uncertain whether VPS will be successful in acquiring the Ravenscourt Park hospital.<sup>35</sup> If VPS were unable to acquire this site, we noted that it would have to start a search for another site, which could take a significant period of time.<sup>36</sup> On the basis of this evidence, therefore, our provisional conclusion is that entry by VPS is uncertain. As a result, we have not placed significant weight on this prospective entry in assessing the effectiveness and/or proportionality of our remedies.
- 1.67 However, as noted in paragraphs 1.37 to 1.40 above, VPS is a large private hospital group with a proven track record of building and operating large-scale hospitals. If agreement were reached, entry could be relatively rapid as planning permission is already in place and the building is already configured as a hospital (although it will require refurbishment). Therefore, while we consider the likelihood of entry to be uncertain, we consider that if VPS did acquire the site, entry could take place as early as 2019.

## *Spire and others*

- 1.68 Spire had been looking to enter the central London market for a number of years and [REDACTED]. In light of the evidence provided by Spire, it was clear that it was still interested in entering the central London market, but the likelihood of finding a suitable site and the time frame over which such entry may take place remain uncertain. On this basis, we have provisionally concluded that the probability of Spire entering the market in the foreseeable future (ie the next five years) is low. As a result, we have not placed significant weight on

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<sup>34</sup> We have not received any information on VPS's financing or building plans.

<sup>35</sup> The hospital site used to be an NHS general hospital but closed down in 2006 and has been closed ever since. In 2012 the building started to be redeveloped by CCAG to house the London International Hospital, which was going to specialise in cancer and diseases of the heart and brain. However, due to difficulties securing funding, CCAG have abandoned its plans and have been seeking to sell the site to VPS.

<sup>36</sup> In this context, we noted the extended period of time [REDACTED].

this prospective entry in assessing the effectiveness and/or proportionality of our remedies.

- 1.69 As discussed in paragraphs 1.41, 1.46 and 1.47, there are several other potential entrants to the central London market. In the case of the Barts PPU, we considered that [X] is very likely to enter the central London market in 2018 on this site, with a specialised cardiovascular facility. To date, we have limited evidence from other parties looking to enter into the central London market. The information that we have on the large European group (mentioned above in paragraph 1.47) is very limited and was provided by a third party, rather than the hospital operator itself. This indicated that it would have to apply for planning permission before it could convert the building.

#### *Competitive impact of entry and expansion*

- 1.70 We next considered the extent and likely timing of any competitive constraint on HCA from entry by Cleveland Clinic, VPS, the Barts PPU and/or the potential new hospital in Wigmore Street.
- 1.71 In the Final Report, we took into account two main factors in assessing the extent to which a divestiture remedy would result in an effective competitive constraint on HCA: (i) the size and scale of HCA's hospitals in terms of admissions, revenues and capacity (in terms of beds, theatres, consulting rooms and ICU facilities); and (ii) the range of medical specialisms offered.<sup>37</sup> We concluded that the divestiture of either the Wellington Hospital (including the Platinum Medical Centre), or the London Bridge Hospital and the Princess Grace Hospital, would be sufficient to exert an effective competitive constraint on HCA since these hospitals, together with other non-HCA hospitals, would be of a sufficient scale and provide a sufficiently broad range of specialisms to remedy the AECs identified.<sup>38</sup>
- 1.72 In the Final Report we concluded that although the proposed divestiture packages left HCA with a large share of supply in oncology, obstetrics and gynaecology, the rival or rivals acquiring these hospitals would have the ability

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<sup>37</sup> [Final Report](#), paragraph 11.70. We also considered the customers served by HCA's hospitals, including their geographic location and whether they were self-pay, insured or overseas patients. We observed that there were already several non-HCA hospitals located in and around Harley Street, such that additional non-HCA capacity was not required in this area. In the case of the London Bridge Hospital, we noted that it was the only hospital in that location, such that divesting it to another operator would not address any competitive advantage derived from its location but would only transfer that advantage to the purchaser. Our review of the catchment areas of HCA's hospitals demonstrated a high level of geographical overlap, which supported our conclusion that any of HCA's hospitals could compete effectively for patients across the central London market and beyond. Therefore, we determined that location within central London was not a relevant factor to take into account in designing an effective divestiture remedy. [Final Report](#), paragraph 11.99.

<sup>38</sup> [Final Report](#), paragraph 11.126.

to begin providing or expanding their provision of services within those specialisms.<sup>39</sup>

- 1.73 In assessing the likely competitive impact of potential entrants, we considered that these same factors (range of medical specialisms and capacity) were relevant. We noted that entry by Cleveland Clinic would result in a significant increase in private hospital capacity in central London, with the new facility expected to provide around 215 beds, around 40 of which would be ICU beds.<sup>40</sup> This compared with around 226 beds and 20 ICU beds at the Wellington Hospital and around 225 beds (and 12 ICU beds) at the London Bridge and Princess Grace hospitals (combined).<sup>41</sup> This indicated that entry by Cleveland Clinic would have a similar effect in terms of increasing the availability of non-HCA capacity in the central London market as either of the divestiture packages set out in our Final Report.<sup>42</sup>
- 1.74 Next, we considered the range of specialisms that Cleveland Clinic planned to offer. As set out in paragraph 1.30, Cleveland Clinic planned to provide a broad range of tertiary medical services from 33 Grosvenor Place, including cardiology, orthopaedics, urology, vascular and neurology treatments. As a result, we would expect it to provide a general competitive constraint on HCA.
- 1.75 We considered whether the fact that Cleveland Clinic was not currently planning to provide medical oncology or radiotherapy would reduce the extent to which it could constrain HCA, particularly in light of the emphasis placed on a competitor needing to provide the full range of oncology services in the submissions from some PMIs. In the Final Report we concluded that it would be possible for a hospital operator to adapt a hospital's service offering to incorporate new treatments and specialisms, for example by attracting consultants in different specialisms, hiring new specialist staff, or acquiring new equipment, but that this process would be likely to take time, and it would require sufficient spare capacity to facilitate such an expansion of the service offering. We considered that TLC's development of the Cancer Centre (which took three and a half years) provided a relevant example in this context. Our current view is that this development was similar to the construction of a new hospital and that an expansion by an existing operator of the range of services offered, including adapting buildings to accommodate radiotherapy facilities, would take less time than this.<sup>43</sup>

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<sup>39</sup> Final Report, paragraph 11.142.

<sup>40</sup> This is equivalent to around 15% of total central London overnight bed capacity (see Final Report, Table 11.4).

<sup>41</sup> Wellington, London Bridge and Princess Grace figures are quoted as at the time of the Final Report.

<sup>42</sup> Although the impact on market shares in terms of revenues and/or admissions would differ.

<sup>43</sup> As set out in paragraph 1.30, Cleveland Clinic indicated that it would adapt its services to serve the market.

- 1.76 Bupa submitted that Cleveland Clinic would find it difficult to ‘prise away’ consultants from HCA. Similarly, TLC remained of the view that the difficulty of attracting and retaining consultants was a barrier to entry. As set out in the Final Report, we did not find there to be any barriers to entry in relation to the ability to attract consultants to practise at a hospital.<sup>44</sup> However, in our Final Order, we put in place a remedy to prohibit a range of clinician incentives, which could distort clinicians’ motivations to refer patients to the best hospital facility for their needs. As discussed in the Final Report, we consider that, in addition to its intended purpose, this remedy should also limit the ability of HCA to prevent competitors from attracting and retaining consultants in order to compete across a full range of services.<sup>45</sup> The CMA has the power to take action to enforce the terms of the Final Order if they are not being complied with.
- 1.77 In the case of VPS, we noted that the business currently planned to operate a 150-bed hospital from the Ravenscourt Park site, although it is unclear how many ICU beds, theatres and consulting rooms it might have. While this would be a large facility, it would create around 30% less incremental non-HCA capacity than either of the divestiture packages set out in our Final Report. In terms of the range of services offered, VPS provided us with very limited evidence. It told us that the facility would provide a full range of services, with a particular focus on oncology treatments, including proton beam therapy. As explained in paragraph 1.66, the limited evidence and ongoing uncertainty over its entry means that we have not placed significant weight on VPS in coming to our provisional decision on remedies.
- 1.78 In regard to location within central London, in its submission Bupa told us that the London Bridge area was of particular importance to corporate insurance customers.<sup>46</sup> Furthermore, Bupa believed that if VPS Healthcare were to enter the market via its site at Ravenscourt Park in west London, its location would be significantly less attractive to corporate customers than any of HCA’s facilities and would not therefore pose a material competitive constraint on HCA’s facilities.<sup>47</sup> Similarly, AXA PPP told us that the location of Ravenscourt Park hospital was unlikely to provide material constraint on HCA’s strong position near the City, which, in AXA PPP’s view, was of particular importance to corporate customers.<sup>48</sup>

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<sup>44</sup> Final Report, paragraphs 6.138–6.141.

<sup>45</sup> Final Report, paragraph 11.141.

<sup>46</sup> Bupa response to Remedies Notice, p22, paragraph 2.52.

<sup>47</sup> Bupa response to Remedies Notice, p28, paragraph 3.11.

<sup>48</sup> AXA PPP response to Remedies Notice, p7, section 3.5.

- 1.79 We noted both Bupa's and AXA PPP's views on the importance of location. In the case of Cleveland Clinic, we observed that its site at 33 Grosvenor Place is in a central location. As a result, we consider that this hospital would be attractive and easily accessible to corporate customers across central London. As set out in the Final Report, our review of the catchment areas of HCA's hospitals demonstrated a high level of geographical overlap. This evidence supported our conclusion in the Final Report that any of HCA's hospitals, several of which are located in Marylebone and St John's Wood, could compete effectively for patients across the central London market and beyond.<sup>49</sup> Based on this same evidence, we have no reason to doubt that a hospital in Grosvenor Place could compete equally effectively.
- 1.80 In the case of VPS, we observed that its location in Hammersmith might make it less attractive to certain corporate customers, for example, those located in Canary Wharf. However, we noted that it could be expected to be attractive to customers in west and central London and thereby exert a constraint on HCA. Moreover, over time we might expect the hospital to develop a broad catchment area in the way that HCA's hospitals have done.
- 1.81 Therefore, our provisional conclusion is that the entry of Cleveland Clinic would be likely significantly to increase the level of competitive constraint on HCA given its size, range of services and central location, while the entry of VPS would have a significant but somewhat lesser effect in increasing the competitive constraints on HCA, although such entry was more uncertain than that of Cleveland Clinic.
- 1.82 In terms of the timing of the impact of any competitive constraint, we note that a new entrant could have an impact on prices even prior to opening, in particular where contracts with PMIs are renegotiated after it has become clear entry could happen, although it is not possible to predict the scale or timing of this with any degree of certainty. However, we recognise that the extent of any constraint would be likely to increase over time as a new entrant establishes referral pathways and a reputation in the market. In this respect, [X] and, as discussed in paragraph 30, its central location should help it in attracting patients and consultants. More importantly, as set out in paragraph 1.27, above, Cleveland Clinic has a strong reputation for quality and innovation in the USA, which is likely to help it in establishing a reputation in the central London market, initially among consultants, but also among insurers, patients and corporate clients of the PMIs. On this basis, although it is not possible to identify reliably the precise timing of when a competitive constraint will emerge, we consider that Cleveland Clinic is likely to exert such

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<sup>49</sup> Final Report, paragraph 11.99.

a competitive constraint (in combination with other non-HCA hospitals) within two years of it opening its inpatient facility, ie by the beginning of 2022, assuming that the facility opens in late 2019/early 2020. We note that Cleveland Clinic's own business plans indicate that it expects to earn significant revenues in central London in both [redacted] and [redacted]. This suggests that Cleveland Clinic could impose a constraint on HCA before early 2022, although we recognise the possibility of delay to these timescales.

- 1.83 In the case of the Barts PPU, we note that this is likely to create additional competition in cardiovascular services within the next three years, ie by mid-2019, assuming that the facility takes a year to establish itself.<sup>50</sup> However, by itself, the additional competitive constraint imposed by this PPU (alongside the existing competitors in the central London market) would be insufficient to constrain HCA effectively across a range of specialties given its narrow focus. The same also applies to the potential new hospital on Wigmore Street, which, if it opens, is intended to be a specialised spinal and neurological facility. While, in theory, a large number of clinics opening across a full range of specialties could, eventually, be expected to constrain HCA, we have provisionally concluded that the scale of entry/expansion by specialist providers is insufficient to have a material impact on competitive dynamics in the foreseeable future.

*Our provisional conclusion of the likelihood of future entry/expansion*

- 1.84 Based on the evidence available to us at present, we provisionally conclude the following regarding market entry into central London:
- (a) Cleveland Clinic intends to build a new hospital with 215-bed capacity in 33 Grosvenor Place, which will offer a broad range of specialisms. The group has a clear business plan, which envisages opening the hospital by late 2019/early 2020, subject to planning permission being applied for and expeditiously granted. Cleveland Clinic has already taken a number of steps to put these plans into motion. [redacted]. On the basis of the evidence presented, our provisional view is that the Cleveland Clinic entry is likely to occur. We consider that this entry is likely to take place within the next four years and to be sufficient (large size and broad range of specialisms) to constrain HCA by early 2022, ie within a period of around five to six years from now.
  - (b) Barts selected a preferred bidder for its PPU contract in 2015 and we understand that the PPU is expected to open in 2018. The PPU's capacity

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<sup>50</sup> This shorter time frame reflects the fact that both [redacted].

is approximately 26 beds and it will focus mainly, but not exclusively, on cardiovascular treatments. On the basis of the evidence gathered, our provisional view is that the entry is very likely to take place and is also timely (within two years), but insufficient in terms of size and specialism to constrain HCA effectively on its own, although we expect that it will add incrementally to the constraint on HCA.

(c) VPS is currently negotiating its acquisition of Ravenscourt Park hospital from CCAG. On the basis of the evidence gathered, our provisional view is that although the likelihood and timeliness of entry (potentially 2019) are difficult to assess, [✂], if entry were to take place, it could be sufficient in scale (150 beds across a broad range of services, including proton beam therapy) to constrain HCA in the future, in combination with other potential entrants.

(d) In regard to Spire and other entrants, we consider that these potential new entries are either too uncertain to take into account in our assessment or are unlikely due to their specialised nature to exercise a sufficient constraint on HCA.

1.85 On this basis, we provisionally conclude that large-scale entry seems likely to take place by early 2020, with such entry being likely (in combination with other non-HCA hospitals) to result in an effective competitive constraint on HCA (comparable to that of the divestment we proposed in the Final Report) by early 2022. That is to say, we provisionally conclude that, on balance, new entry is likely to be effective in addressing the AECs and that, while there is some uncertainty about timing, this is likely to occur by early 2022.

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

## **2. Remedy measures that we have considered during the remittal**

- 2.1 In the Remedies Notice, we set out three remedies that we were minded to consider and three remedies that we were not minded to consider. The former comprised:
- (a) Remedy 1 – divestiture of one or more of HCA’s hospitals and/or other facilities in central London;
  - (b) Remedy 2 – require HCA to give competitors access to its hospital facilities to compete; and
  - (c) Remedy 3 – restrictions on further expansion by HCA in central London.
- 2.2 The remedies that we were not minded to consider further comprised:
- (a) Remedy 4 – a ‘light-touch’ price control;
  - (b) Remedy 5 – preventing tying and bundling; and
  - (c) Remedy 6 – measures to facilitate site availability in central London.
- 2.3 In the following section, we set out our consideration of the potential design, effectiveness and proportionality of each of these remedies in turn.

### ***Remedy 1 (divestiture remedy)***

#### *Aim of remedy*

- 2.4 The aim of divestiture in market investigations is generally to address competition problems arising from structural features of the market. This may be done either by creating a new source of competition through disposal of a business or assets to a new market participant, or by strengthening an existing source or sources of competition through disposal of a business or assets to an existing market participant that is independent of the divesting party (or parties).
- 2.5 The remedy would require HCA to divest a hospital or hospitals and other assets (the divestiture package) to a suitable purchaser or purchasers sufficient to impose a competitive constraint on HCA’s remaining hospitals in central London. The rationale for imposing a divestment is that by creating incremental non-HCA capacity, this remedy would make it easier for PMIs to offer credible products which did not rely on including HCA facilities. As a result, the competitive constraint on HCA would be increased with the result that prices for insured and self-pay patients would fall.

2.6 In the Remedies Notice, we asked parties for their views on whether a divestiture remedy would address the insured AEC and self-pay AEC in central London effectively and comprehensively, and whether a divestiture package, comprising either the Wellington Hospital or the London Bridge Hospital and Princess Grace Hospital, would effectively constrain HCA in terms of the range of specialisms offered and the capacity of the hospitals (ie theatres, beds, ICU, etc).

#### *Views of parties*

##### *PMIs*

- *AXA PPP*

2.7 AXA PPP told us that it continued to believe that divestment was the only remedy which would resolve the current lack of competition in central London. However, AXA PPP also said that it remained concerned that the divestment packages proposed by the CMA did not contain all of the components required to create a credible third competitor in central London, in particular with respect to oncology. AXA PPP stated that the essential components of a credible proposition in central London were:

(a) a significant flagship hospital in central London;

(b) Harley Street provision;

(c) coverage for a full range of specialties;

(d) high-acuity cover; and

(e) a full cancer service, including radiotherapy.<sup>51</sup>

2.8 AXA PPP told us that HCA should be required to divest the London Bridge Hospital (including the London Radiotherapy Centre and the outpatient facilities at the Shard) and the Princess Grace Hospital. The only alternative package that would comprise all of the necessary elements would be the divestiture of the Wellington Hospital and the Harley Street Clinic.

2.9 AXA PPP also told us that neither hospital should be acquired by TLC but instead should be acquired by an independent provider to ensure that each

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<sup>51</sup> AXA PPP response to Remedies Notice, p14, section 6.

provider in central London was suitably constrained by others, and that the divestiture remedy should be implemented as soon as possible.<sup>52</sup>

- *Bupa*

- 2.10 Bupa submitted that requiring HCA to divest a package of hospitals was the only effective way to address the AECs in central London.<sup>53</sup> Bupa said that divestments offered a clear-cut and timely solution, introducing real and immediate rivalry into the market, without the need for costly ongoing monitoring and the risk of circumvention. Bupa indicated that competition in the market would not improve without the CMA's intervention.<sup>54</sup>
- 2.11 Bupa told us that the remedies package should be designed with a forward-looking view. It should account for market concentration, HCA size and current customer detriment which Bupa stated was very high and potentially underestimated by the analyses based on the 2011 data in the PFs. Bupa said that it should also take into account the further planned expansion HCA already had in motion.<sup>55</sup>
- 2.12 Bupa told us that either of the two divestiture packages set out in the Remedies Notice would be practicable, but it did not believe that either would be sufficient as proposed.<sup>56</sup>
- 2.13 Bupa told us that the scope of the divestment package should be expanded in order to address effectively HCA's 'dominance' (particularly at the specialism level).<sup>57</sup> Bupa proposed the following packages instead:
- (a) Package A:
- (i) the London Bridge Hospital (sold to one acquirer);
  - (ii) the Harley Street Clinic (sold to a separate acquirer);
  - (iii) the main primary care and outpatient facilities that fed these two facilities (eg the Roodlane GP practice); and

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<sup>52</sup> AXA PPP response to Remedies Notice, p15, section 6.1.

<sup>53</sup> Bupa response to Remedies Notice, p5, paragraph 1.9.

<sup>54</sup> Bupa response to Remedies Notice, p5, paragraph 1.10.

<sup>55</sup> Bupa response to Remedies Notice, p5, paragraph 1.11. This expansion includes HCA's lease on three floors at the Shard, its radiotherapy centre for private patients on the Guy's Hospital campus, as well as the new NHS and private patient cancer centre at Guy's Hospital, a new advanced screening outpatient clinic on Devonshire Street, and HCA's expansion of the Portland Hospital into an adjacent building, with the aim of doubling the paediatric activity at the hospital. Bupa submission to the CMA, May 2015, paragraph 2.20.

<sup>56</sup> Bupa response to Remedies Notice, p6, paragraph 1.16.

<sup>57</sup> Bupa noted that its alternative proposed divestiture packages would address HCA's market power in particularly important specialisms, such as cardiology and oncology. Bupa response to Remedies Notice, p6, paragraph 1.23.

(iv) behavioural undertakings on HCA in relation to its contracts with insurers (see paragraph 2.14 below).

(b) Package B:

(i) the London Bridge Hospital (sold to one acquirer);

(ii) the Wellington Hospital (sold to a separate acquirer);

(iii) additional Oncology services in central London;

(iv) the main primary care and outpatient facilities that fed these two facilities (eg the Roodlane GP practice); and

(v) behavioural undertakings on HCA in relation to its contracts with insurers (see paragraph 2.14 below).

2.14 In Bupa's view behavioural undertakings should include obligations on HCA to remove [✂] restrictive contractual clauses with insurers that could jeopardise the success of the newly divested facilities, and options for insurers to renegotiate pricing with the HCA group.

2.15 Bupa believed that HCA divesting the London Bridge Hospital was a necessary and fundamental element to any effective remedies package as it was critically important to corporate customers. As a result, Bupa told us that, if it remained in HCA's control, it would continue to confer 'must have' status on all of the remaining facilities in the HCA group. Bupa submitted that insurers would have increased countervailing bargaining power in respect of the London Bridge Hospital if it were a stand-alone facility. Furthermore, if HCA were allowed to retain its facility at the Shard and the PPU at Guy's and St Thomas', there would be some increased options for customers (both insurers and individual consumers) in the local area and rivalry between the facilities may grow over time.<sup>58</sup>

#### *Hospital operators*

- *HCA*

2.16 HCA told us that it strongly disagreed with the CMA's provisional finding that there was an AEC in central London, with regard to either insured or self-pay customers. HCA stated that the divestment remedies being considered by the CMA would not be effective for a number of reasons, given the basis of the

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<sup>58</sup> Bupa response to Remedies Notice, p6, paragraphs 1.17 & 1.18.

CMA's PFs, and that a divestiture remedy would be disproportionate. This included, among other things, the lack of evidence of a price differential with TLC on a like-for-like basis, and the evidence that there were no alternative capacity constraints in central London. This, in HCA's view, showed that there was no basis for asserting that divestment would lead to any price benefits.<sup>59</sup>

- 2.17 HCA told us that a forced divestment of one or more of its hospitals would cause a range of economic and other costs to HCA, to patients and to other potential investors. HCA stated that a divestment remedy would interfere with incentives to invest and innovate. Furthermore, HCA submitted that divestiture would result in the loss of a range of RCBs both at HCA's remaining hospitals and at the divested hospital(s) and would also impose a number of one-off costs of divestment to HCA and to the purchaser(s) of the divested asset(s).<sup>60</sup>
- 2.18 HCA told us that a divestment remedy would not be effective, would be more onerous than needed to achieve the CMA's stated aim, would not be the least onerous alternative and would produce disadvantages which were disproportionate to the aim.<sup>61</sup> In particular, HCA stated that the evidence from the CMA's revised IPA showed that its insured prices were comparable to those of TLC when compared on a like-for-like basis (in particular when differences in patient complexity were more fully controlled for), such that divestiture was unlikely to result in a decrease in its prices. In addition, HCA submitted analysis, carried out by KPMG, relating to the availability of spare capacity in central London. Based on data for 2011, this analysis, in HCA's view, indicated that there was sufficient spare capacity across a range of non-HCA private hospitals and PPU's – in terms of inpatient and [ ] – to accommodate insurers' patients being treated at HCA. In other words, there was sufficient non-HCA capacity in central London in order to allow insurers to move all of this activity from HCA to other providers and to delist HCA if they so wished.
- 2.19 HCA noted that PMIs such as AXA PPP and Bupa had themselves accepted that there was sufficient spare capacity in the market to direct their patients away from HCA facilities. HCA noted that even if all PPU's were excluded from the spare capacity analysis, there was still sufficient capacity for: (i) every insurer to move all its patients away from HCA on any day; (ii) both Bupa and AXA PPP to move all their patients on any day.
- 2.20 Even if divestiture were effective in terms of reducing prices to PMIs, HCA argued that such reductions would be unlikely to be passed to policyholders.

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<sup>59</sup> HCA response to Remedies Notice, p6, paragraphs 3.3 & 3.4.

<sup>60</sup> HCA response to Remedies Notice, p6, paragraphs 3.8 & 3.9.

<sup>61</sup> HCA response to Remedies Notice, p6, paragraph 3.10.

HCA also told us that, irrespective of any effect on prices, a divestment remedy was highly unlikely to lead to better outcomes for customers in the form of better quality and range of private healthcare services, either at HCA's remaining hospitals or at the divested hospital(s). On the contrary, HCA told us that it was likely to lead to worse outcomes by (i) increasing costs of delivering services and reducing the incentive and ability for private hospital operators to invest; (ii) the loss of RCBs from HCA's network of hospitals relating to range of services innovation and quality; and (iii) subject the hospitals concerned to considerable asset risk during the divestiture process. Therefore, the remedy would not lower prices for a given level of quality and range of private healthcare services.<sup>62</sup>

- *TLC*

2.21 TLC told us that it considered that divestment of hospitals (and other assets) by HCA would in principle be a practical, effective and proportionate remedy.

2.22 However, TLC said that it remained concerned that the specific divestiture package identified by the CMA would not effectively and comprehensively address the AEC or constrain HCA as it would not deal with HCA's very high market shares in certain sub-specialties.

2.23 TLC said that, in the field of oncology, HCA's market power was 'entrenched by its super-dominant position in relation to certain sub-specialties: chemotherapy and radiotherapy'. Therefore, TLC told us that for the divestiture remedy to be effective in respect of oncology in central London, the divestment package must include Leaders in Oncology Care (LOC) and the NHS PPU's operated by HCA in central London in addition to the Wellington Hospital or the London Bridge Hospital and the Princess Grace Hospital.<sup>63</sup>

- *Spire*

2.24 Spire told us that a divestiture remedy was essential to addressing the competition issues in central London in the short term due to the long lead time and material commercial investment involved in establishing a new hospital.

2.25 Spire submitted that the success of the remedy was dependent upon the divested assets being bought by a hospital operator that was able to ensure from the start that the assets were strong competitors in the London market. Spire believed that the divestiture package should include any associated

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<sup>62</sup> HCA response to Remedies Notice, p6, paragraphs 3.11 & 3.12.

<sup>63</sup> The London Clinic response to Remedies Notice, p2.

outpatient diagnostic and treatment centres such as Old Broad Street and Canary Wharf. In Spire's view, the package should include the divestiture of other primary care practices such as GP practices owned by HCA that primarily referred to the divested asset(s).<sup>64</sup>

- 2.26 In regard to the remedy's effectiveness, Spire said that the disposal of the Wellington Hospital (including the Platinum Medical Centre) or both the London Bridge Hospital and Princess Grace Hospital were key to opening the market up. No other combination would be as effective.<sup>65</sup>

### *Design issues and effectiveness assessment*

2.27 Our proposed approach to analysing the effectiveness of divestiture package options is as set out in the Final Report.<sup>66</sup> In considering the scope of the divestiture package that would be effective in addressing the AECs, we have taken account of: the range of services provided by each of HCA's hospitals; their customer bases; and the size and scale of HCA's hospitals in terms of the volume of their admissions, their turnover and capacity. In addition, we identified the following factors as being salient in assessing the effectiveness of a potential divestiture package:

- (a) In line with our analysis underpinning the AEC findings, the appropriate product market definition is according to medical specialty and the appropriate geographic market definition is central London with weak constraints from outside central London.
- (b) The insurers and hospital operators negotiate a price across a 'bundle' of treatments, with hospital operators seeking to increase treatment prices for the remaining services in response to insurers' attempts to reduce the number of treatments for which they recognise a given hospital operator.
- (c) The combination of a specialty-level product market, and prices which are negotiated jointly across a full range of services, suggested that a strong market position in one or a small number of specialties would allow a private hospital operator to exert market power.
- (d) High barriers to entry and expansion in central London were a feature of the market giving rise to the AECs.<sup>67</sup>

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<sup>64</sup> [Spire Healthcare response to Remedies Notice](#), p1.

<sup>65</sup> [Spire Healthcare response to Remedies Notice](#), p2.

<sup>66</sup> [Final Report](#), paragraphs 11.68–11.72.

<sup>67</sup> [Final Report](#), paragraph 11.68.

- 2.28 As we set out in the Final Report, in considering the scope of the divestiture package we took account first of the range of specialties each of HCA's hospitals provided. Our reasoning was that divesting a highly specialised hospital would not, certainly in the short term, enable the new owner to compete effectively with the retained hospitals operated by HCA. We therefore sought to identify hospital assets which provided a broad range of services and identified the London Bridge, the Wellington, the Princess Grace, and (to a lesser extent) the Lister hospitals as falling into this category.<sup>68</sup>
- 2.29 Next, we considered the scale or size of HCA's hospitals in terms of shares of admissions, revenues and capacity. We noted that there were several potential measures of capacity, including overnight beds, operating theatres, consulting rooms and ICU beds, and that the interpretation and the collection of capacity data had presented certain problems.<sup>69</sup>
- 2.30 We concluded that the divestiture of either the Lister or the Princess Grace on their own would create insufficient incremental non-HCA supply to effectively constrain HCA, but that requiring HCA to divest either the London Bridge and Princess Grace hospitals, or the Wellington hospital (together with the Platinum Medical Centre) would create an effective constraint on HCA, thereby addressing the AEC.<sup>70</sup>
- 2.31 We concluded that it was not necessary for the effectiveness of the divestiture remedy to require HCA to divest additional outpatient or diagnostic facilities.<sup>71</sup>
- 2.32 In the context of the remittal, we have considered the various submissions that we have received on the potential effectiveness of the divestiture packages set out in the Final Report. First, we considered HCA's argument that the revised IPA showed that there was no difference between its prices and those of TLC, when compared on a like-for-like basis. As set out in our PFs, we have provisionally found that HCA charged higher insured prices than TLC, although we also found that our revised IPA no longer allowed us to conclude on the size of this price difference that is due to weak competitive constraints, as we could not be sufficiently certain that we had adequately controlled for any differences in patient complexity between HCA and TLC.<sup>72</sup> However, we found that, taking into account all of the evidence, weak competitive constraints on HCA were likely to be the most important factor in

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<sup>68</sup> Final Report, paragraphs 11.72–11.75.

<sup>69</sup> Final Report, paragraph 11.79.

<sup>70</sup> Final Report, paragraphs 11.112–11.124. Either of these divestiture packages was considered to be sufficient to create an effective competitive constraint on HCA in combination with other non-HCA hospitals in central London.

<sup>71</sup> Final Report, paragraphs 11.133–11.136.

<sup>72</sup> PFs, paragraphs 8.149 & 8.150.

this price difference.<sup>73</sup> This finding is consistent with the results of our profitability analysis, which show that HCA has made returns that are substantially and persistently in excess of its cost of capital, and, therefore, suggest that HCA's prices are likely to be above the competitive level. As a result, we consider that a divestiture remedy is likely to be effective in reducing prices by increasing the competitive constraint on HCA.

2.33 We noted HCA's argument that the benefit of any price reductions would not be passed through to patients. However, these arguments were addressed in the Final Report<sup>74</sup> and HCA has not provided any further reasoning or evidence that gives us reason to revise our conclusions that the large majority of any price reductions would be passed through to patients.

2.34 We reviewed KPMG's analysis of the existence of spare capacity in central London and considered this alongside other evidence on the existence of spare capacity in central London. We noted in the Final Report that we were 'not able to obtain robust data on spare capacity'<sup>75</sup> and in the PFs that calculating relevant levels of spare capacity 'cannot be a matter of precise calculation'.<sup>76</sup> KPMG's analysis presents some evidence that, based on a set of assumptions around utilisation of beds, operating theatres, ICU beds and about the availability of specific specialties, there was sufficient spare capacity across a range of non-HCA private hospitals and PPUs in central London based on capacity data and Healthcode invoice data for 2011. While this analysis is clearly informative, there remains some uncertainty about whether this represents convincing evidence of the existence of suitable spare capacity that would allow the insurers to move activity away from HCA if they so wished.

2.35 In particular, this evidence must be balanced against a number of conflicting pieces of evidence.

(a) First, while the updated KPMG analysis sought to take account of the points we had made in the PFs on theatre capacity, intensive care facilities and differences across specialties, it did not answer our point that the existence and extent of spare capacity would also be 'substantially determined by the days and times at which consultants were available and willing to practise, and when patients were willing to be seen',<sup>77</sup> which

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<sup>73</sup> PFs, paragraphs 11.25–11.37.

<sup>74</sup> Final Report, paragraphs 11.157–11.172.

<sup>75</sup> Final Report, paragraph 11.107.

<sup>76</sup> PFs, paragraph 4.47.

<sup>77</sup> PFs, paragraph 4.47.

was an issue that had also been raised in hospital operators' internal documents where they considered the need for capacity expansions.

- (b) Second, the KPMG findings were not consistent with the insurers' views on spare capacity nor with their actions. We noted PMIs' and TLC's views that PMIs faced difficulties 'when trying to find alternative capacity to absorb their demand were they to delist HCA'.<sup>78</sup> We noted that Bupa, in particular, 'did not expect to be able to delist HCA'.<sup>79</sup> Both AXA PPP's and Bupa's internal documents (and also HCA's internal documents) noted the difficulties they would face in delisting HCA.<sup>80</sup>
- (c) Third, it was not clear that the KPMG results were consistent with hospital providers' own views and actions, with some instances of internal documents indicating a lack of spare capacity which was not consistent with KPMG's results. In addition, private operators, much more so than NHS hospitals, were likely to require a degree of spare capacity in order to minimise waiting times, as well as to facilitate consultant and patient preferences.
- (d) Fourth, Cleveland Clinic's current entry plans, as well as those of VPS and of other smaller or more specialised providers, did not appear to be consistent with the finding that there was an abundance of spare capacity in the central London market.

2.36 We also considered AXA PPP's and Bupa's arguments that a divestiture package would need to include additional oncology services in order to be effective. As set out in the Final Report, both potential divestiture packages currently provided some oncology services and already had groups of specialist (oncology) consultants practising at these facilities.<sup>81</sup> However, neither of the potential divestiture packages offered radiotherapy treatments. We considered, therefore, how long it would take the purchaser(s) of one of these packages to develop such services. The most recent example of a central London hospital operator developing these services was that of TLC's Cancer Centre. The construction of the Cancer Centre, which included radiotherapy equipment, took around three and a half years. However, we

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<sup>78</sup> Final Report, paragraph 6.216.

<sup>79</sup> Final Report, paragraph 6.318.

<sup>80</sup> Final Report, Appendix 6.11, paragraphs 32–35, 50–53, 58–61 and 122–124.

<sup>81</sup> In the Final Report, we concluded that, on balance, we had insufficient evidence that consultant incentive schemes constituted a barrier to entry or expansion. Further, because we had other competition concerns as regards such arrangements, we adopted measures to restrict or prohibit them. Therefore, we concluded that a rival to HCA would not be prevented from expanding its services in these specialisms because of difficulties in attracting or retaining consultants (paragraph 11.141). While AXA PPP, Bupa and TLC have suggested that such schemes may create a barrier to entry, we have not received any evidence or argumentation during the remittal that gives us reason to change our conclusion on this point.

noted that this was for construction of the whole site. We reasoned that for an existing hospital operator to install radiotherapy facilities (only) and the associated infrastructure, would take substantially less time, although the exact period would depend on the existing configuration of the site.<sup>82</sup> While this potential delay in the speed with which the purchaser of a divestiture package could compete across the full range of oncology services could reduce the effectiveness of the remedy, our current view is that it would be disproportionate to require HCA to divest an additional radiotherapy facility in order to bring forward the full impact of the remedy by a year or two. We note that the remedy could be expected to be at least partially effective prior to a purchaser offering a full range of oncology treatments.

- 2.37 While Spire, AXA PPP and Bupa also suggested that HCA should be required to divest some of its primary care practices, we noted that we have not found vertical integration between HCA's hospitals and GP practices to give rise to an AEC (for example, the ability to foreclose rivals). Therefore, we have provisionally concluded that including such assets in the divestiture packages would not serve to enhance their effectiveness.
- 2.38 On this basis, we remain of the view that a divestiture package comprising the London Bridge and Princess Grace hospitals or a package of the Wellington Hospital together with the Platinum Medical Centre would be effective in addressing the AEC (and that these represent the smallest effective divestiture package that would be effective).

#### *Proportionality assessment*

- 2.39 In order to assess the proportionality of our divestiture package, we have taken into account both the quantifiable costs and benefits of divestiture and the potential impact on the quality and range of services offered in central London. In the case of the former, we have quantified the costs and benefits and carried out an NPV calculation (set out in more detail in the Appendix), whereas, in the case of the latter, we have conducted a qualitative assessment.
- 2.40 In coming to a range of estimates of the likely impact of the divestment, we have made an assessment of the price, and hence, revenue impact of any divestment, the relevant time period over which any impact would be expected to last, and the extent of any loss of scale economies and

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<sup>82</sup> Within this same time period, we would expect such an operator to be able to attract suitable consultants and specialist staff to provide radiotherapy treatments.

transaction costs that should be balanced against any price benefits in the market. These considerations are set out in detail in the Appendix.

### *Price benefits*

- 2.41 During our original investigation, we carried out a profitability analysis for the period 2007 to 2011. We used this analysis to obtain an estimate of the customer detriment arising from HCA's (and other private hospital operators') market power. In contrast, we used our insured pricing analysis and our price concentration analysis results to estimate the likely impact on prices that could be expected to result from the increased competition in the market brought about by a divestiture remedy.<sup>83</sup> As set out in the PFs, while we found that HCA charges higher insured prices than TLC, our revised IPA no longer allows us to conclude on the size of this price difference that is due to weak competitive constraints, as we cannot be sufficiently certain that we have adequately controlled for any differences in patient complexity between HCA and TLC.<sup>84</sup>
- 2.42 Therefore, in order to assess the potential impact of a divestiture remedy, we have developed our profitability analysis in a number of respects. First, we have updated the analysis to cover the period up to 2015 (inclusive) in order to ensure that we have current estimates of the economic profits made by HCA.<sup>85</sup> Second, we have sought to identify the relative profitability of HCA's UK (self-pay and insured) and overseas customers, through an allocation of overhead costs and capital between customer types.
- 2.43 This analysis gave us a range of estimates of the level of economic profits<sup>86</sup> earned on UK patients of between 3.1% and 10.7% of revenues. However, on the basis of our review of the appropriateness of asset values contained in our various ROCE scenarios (see the Appendix), we consider it reasonable to assume that increased competition might have a price impact towards the

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<sup>83</sup> [Final Report](#), Appendix 11.2: Quantifying the Price Benefits of Divestitures.

<sup>84</sup> [PFs](#), paragraphs 11.25–11.37.

<sup>85</sup> As set out in the [PFs](#), section 9, we provisionally concluded that there was no evidence of a material change in HCA's profitability since 2011. We noted Bupa's submissions that HCA's profitability may have increased since 2011. However, an increase in profitability would not have altered our finding (that HCA was making profits that were substantially and persistently in excess of the cost of capital). Therefore, we determined that it was not necessary to update our profitability analysis for the purposes of assessing whether or not there is an AEC in the central London market. However, when considering the potential impact of remedies, we considered that an increase in HCA's profitability could have an impact on our assessment of the proportionality of any remedies. Therefore, for these purposes, we have updated this analysis (and the accompanying weighted average cost of capital (WACC) calculation).

<sup>86</sup> Economic profits are profits in excess of the WACC, which we have estimated to be around 10%. See [Final Report](#), Appendix 6.14.

lower end of this range. Hence, our cost-benefit analysis has been conducted using the assumption that revenues would decline by between 3 and 6%.

- 2.44 We have applied this price reduction to UK self-pay and insured revenues from inpatient and day-case treatments. We have assumed that divestiture would have no impact on the prices charged by HCA for outpatient treatments. This approach is based on our assessment of the level of competitive constraint across the different treatment modalities as set out in our PFs.<sup>87</sup>

#### *Impact of divestiture assuming entry takes place*

- 2.45 Our approach assumes that the incremental impact of the divestment would reduce to zero once new entry (together with other non-HCA hospitals) exerts an effective competitive constraint on HCA since, for the reasons set out above, we consider that entry will address the AEC and would, therefore, have the effect of reducing prices to the competitive level.
- 2.46 As set out in paragraph 1.85, we consider it likely that large-scale entry will take place in late 2019 or early 2020 and that it will result in an effective constraint on HCA by early 2022. We recognise that there are uncertainties around the timing of such entry and the speed and extent to which it will exert a competitive constraint. Therefore, we have considered a range of scenarios (of between three and ten years after divestiture) in terms of the period of time over which a divestiture remedy has effect.

#### *Costs of divestiture*

- 2.47 In our NPV analysis, we have taken into account three potential costs of divestiture. First, we considered the potential transaction costs associated with a divestiture. During the original investigation, HCA provided a total estimate of transaction costs of between £[redacted] million and £[redacted] million. We reviewed these cost estimates (see the Appendix) and have provisionally concluded that £[redacted] represents a reasonable level of transaction costs (for vendor and purchaser combined) to factor into our assessment. Second, we have also made the assumption that HCA would face one-off reorganisation costs of around £8 million in order to reconfigure its business following a divestiture. Finally, we considered the potential loss of economies of scale. During the original investigation, HCA provided us with an estimate of the potential loss of economies of scale of £[redacted] million (annually) as the result of

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<sup>87</sup> PFs, paragraph 4.40. We noted that non-inpatient providers may exert some constraint on hospital operators within the outpatient segment, although we also noted that HCA owned a sizeable share of the non-inpatient facilities within central London. We consider that this approach may be somewhat conservative, with some, albeit a reduced price effect in the outpatient segment.

being required to divest one or more of its central London hospitals. As discussed in the Appendix, we reviewed this estimate and have provisionally concluded that a more reasonable estimate of such losses would be around £8.2 million per year. However, we note that there is uncertainty over the extent of any economies of scale. Therefore, we have considered scenarios in which HCA suffers a loss of economies of scale of £0, £8.2 million and £[X] million, with £8.2 million as the base case and the upper and lower estimates representing sensitivities.<sup>88</sup> The lower end of this range is based on the assumption that HCA could reorganise its operations to reduce central and other overhead costs proportionately, avoiding any loss of economies of scale following a divestiture. The upper end of the range is based on HCA's own estimate of its loss of economies of scale.

- 2.48 We noted HCA's submissions that a divestiture remedy would result in a number of additional costs, including interference with incentives to invest and innovate by preventing a firm that is forced to divest from realising a fair market value for its assets, and the loss of RCBs in the form of (loss of) network benefits and synergies; reduction in the level of investment at the divested and HCA's remaining hospitals; reduction in quality both at the divested and HCA's remaining hospitals; and reduction in range of goods and services offered. We considered these submissions in detail in the Final Report<sup>89</sup> and concluded that no such costs were likely to arise as the result of a divestiture remedy. We do not consider that HCA has provided any new or additional argumentation or evidence that gives us reason to revise this conclusion.

#### *Net present value of divestiture*

- 2.49 In estimating the NPV of a divestiture remedy, we have brought together our estimates of the benefits and costs and made the following assumptions:
- (a) The transaction costs would be incurred at the point of making the divestiture (ie during the first year), while the reorganisation costs would be incurred equally across the first two years.
  - (b) The price benefits of divestiture are realised partially in the second year (50%) and fully from the third year onwards. This reflects the assumption that prices at both the divested hospital(s) and HCA's remaining hospitals

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<sup>88</sup> These three cases are set out as the base case, upside case and downside case, respectively, in our tables of results.

<sup>89</sup> [Final Report](#), paragraphs 11.189–11.201.

would be renegotiated gradually over the three years following divestiture as agreements with the insurers came up for renewal.

- (c) We have used a discount rate of 3.5%, in line with the HM Treasury Green Book approach.

2.50 The results of our analysis are set out in Table 2.1, below. This shows that the impact of divestiture in the base case is negative under either price reduction scenario over a three-year period. The impact of divestiture is negative (–£1.5 million) under the 3% price reduction and positive but small (£6.4 million) under the 6% price reduction scenario over a five-year period. Over a seven- or ten-year period, the impact of divestiture is positive under either a 3% or a 6% price reduction in the base case scenario.

**Table 2.1: NPV of divestiture**

NPV estimate	UK self pay & insured sensitivities			
	Year 3 (2019/20)	Year 5 (2021/22)	Year 7 (2023/24)	Year 10 (2025/26)
	3.0%			
Loss of economies of scale				
£[ ] million – downside case	(28,345)	(21,858)	(15,802)	(7,465)
£8.2 million – base case	(15,737)	(1,540)	11,713	29,960
£0 million – upside case	7,236	35,483	61,853	98,156
	6.0%			
£[ ] million – downside case	(24,804)	(13,884)	(3,690)	10,344
£8.2 million – base case	(12,196)	6,434	23,825	47,768
£0 million – upside case	10,777	43,457	73,964	115,965

Source: CMA analysis.

Note: The dates set out in the table assume that divestiture takes place within nine months of the date of our Final Order, ie by September 2017.

2.51 The NPV analysis indicates that whether the overall impact of divestiture is positive or negative depends on the assumptions that are made around the potential losses of economies of scale, the likely price benefits and the time period over which divestiture has an incremental effect (ie the period of time that elapses prior to entry on a sufficient scale to effectively constrain HCA). We note that there is material uncertainty around each of these factors; however, on a number of plausible combinations of assumptions, the NPV is negative.

2.52 As set out in paragraph 1.85, our provisional view is that entry by Cleveland Clinic (primarily)<sup>90</sup> is likely, together with other non-HCA hospitals, to act as an effective competitive constraint on HCA by early 2022, which corresponds to year 5 in our NPV analysis. For this reason, we have placed most weight on the ‘5 year’ scenarios in Table 2.1.

<sup>90</sup> Entry by smaller operators, such as [ ] via the Barts PPU, is also likely to have an incremental effect in terms of constraining HCA.

- 2.53 In terms of the estimated loss of economies of scale, we considered that most weight should be placed on the base case and downside scenarios (with less emphasis given to the upside scenario). While our review of HCA's submissions indicated that the £[X] million estimate was likely to overstate the actual losses, we thought that HCA was likely to suffer some losses of economies of scale as the result of being required to divest a significant proportion of its central London operations. Therefore, we consider that the upside scenario assumption of zero loss of economies of scale is likely to overstate the NPV of the divestiture remedy.
- 2.54 We also note that our assumptions are, in some respects, based on analyses which contain further assumptions. For instance, the estimated price reductions are based in material part on our profitability assessment. In that context, our analysis of returns by patient type (UK and overseas) required a number of judgements and assumptions. There is accordingly significant uncertainty over the likely level of price benefits that would result from a divestiture. In light of this uncertainty and the range of NPVs – from –£21.9 million to £43.5 million (five-year period) – our current view is that divestiture is not a proportionate remedy as we could not form an expectation that the benefits of the remedy would outweigh the costs.
- 2.55 Finally, we considered whether a divestiture remedy could be expected to give rise to any non-price benefits that we should take into account. While we have not identified detriment in the form of a lack of quality and/or innovation in the market, in the Final Report, we concluded that an increase in rivalry resulting from a divestiture remedy could be expected to increase competition on quality and range (not just on price) and an improvement in the quality of hospital services over time.<sup>91</sup> While we still consider that a divestiture could stimulate such investment, we noted that the expected entry of Cleveland Clinic meant that any such (incremental) quality and/or innovation benefits were likely to be short-lived. On this basis, we have not placed weight on such non-price benefits in our assessment of proportionality.

#### *Provisional conclusion on divestiture remedy*

- 2.56 We considered which hospitals HCA would need to divest in order to remedy the AEC. Our assessment took account of broadly the same factors that we had considered in the Final Report. However, we recognised the likelihood of new entry in the central London market, which has changed significantly since the Final Report.

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<sup>91</sup> Final Report, paragraph 11.225. PFs, paragraph 7.3.

- 2.57 Our provisional view is that a 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 a sufficient scale and provide a sufficiently broad range of specialisms to remedy the AEC. Therefore, we provisionally conclude that a divestiture remedy would be effective in addressing the AEC.
- 2.58 In relation to the proportionality of divestiture, we found that an effective divestiture package (as discussed above) would create costs in the short term (in terms of one-off transaction and reorganisation costs and the ongoing costs to HCA in the form of a loss of economies of scale). Given the expected entry of Cleveland Clinic within three years of the proposed divestment (assumed to take place in mid-2017) and our expectation that this would provide an effective competitive constraint, together with other non-HCA hospitals, on HCA within two years of opening (ie by early 2022), we found that the benefits of divestment in addressing the AEC are likely to be short-lived. On a number of plausible combinations of assumptions, including our base case assumptions, the NPV of the divestment remedy is negative or only marginally positive. Taking account also of the significant uncertainty over the elements of our NPV calculation, we could not form an expectation that the benefits of a divestiture remedy would outweigh its costs. In reaching this provisional assessment, we were mindful of the fact that we can no longer place as much reliance on other aspects of our evidence base as at the time of the Final Report. In particular, as set out in the PFs and noted in paragraph 2.41, our revised IPA no longer allows us to conclude on the size of the price difference that is due to weak competitive constraints.
- 2.59 We provisionally conclude, therefore, that our proposed divestiture package for HCA does not meet our criteria for a proportionate remedy. While the remedy would be effective in achieving its legitimate aim, ie the increase in competition in the market for privately funded healthcare services in central London, and the divestiture packages, as set out in paragraph 2.6, represent the least onerous effective remedy, we could not form an expectation that the benefits of such a remedy would outweigh its costs.
- 2.60 As noted in paragraph 1.86, one of the Group members did not consider that new entry is likely to be an effective constraint on HCA (in contrast to the divested hospitals). On that basis, the Group member concerned considered that the benefits of the divestiture remedy should be calculated over a longer period and, in contrast to the majority of the Group, provisionally concluded that a divestiture remedy would be both effective and proportionate.

## **Remedy 2 (access remedy)**

### *Aim of remedy*

2.61 As in the case of divestiture, this remedy would seek either to create a new source of competition, or to strengthen an existing source of competition, by increasing the quantity of non-HCA controlled private hospital capacity in central London. HCA would be required to allow another hospital operator to rent one or more of its hospitals (including all the relevant plant and equipment) for a given period of time, for example, until new entry into central London had, in combination with existing non-HCA hospitals, created an effective competitive constraint on HCA.<sup>92</sup> In effect, this remedy would serve as a time-limited ‘divestiture’ of certain HCA facilities, and we have considered it in the context of our view that the AEC in central London is likely to be limited in time to around five to six years, given the prospect of new entry by Cleveland Clinic.

### *Views of parties*

#### *PMIs*

- *AXA PPP*

2.62 AXA PPP told us that a new entrant via this remedy would not represent a new ‘outside option’ in lieu of HCA. AXA PPP would not credibly be able to offer PMI packages to corporate clients that included the new provider (on an HCA-leased site) but excluded HCA. AXA PPP told us that this remedy would fail to alleviate HCA’s ‘must have’ status and would fail to counteract our provisional AEC.<sup>93</sup>

2.63 AXA PPP also said that, in its view, HCA would be less inclined to invest and seek to expand its business elsewhere in central London in competition with the rented facility, as this would undermine the value of the leased asset that may revert in time. Second, AXA PPP believed that the ‘tenant’ of the selected facility would have no incentive to invest in or expand the facility given that it would only be occupying it for a relatively short period.

2.64 AXA PPP told us that it did not consider that this remedy would be an effective alternative to divestiture, and was not aware of such a remedy

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<sup>92</sup> We note that this additional competitive constraint from entry would have to have an effect separate from the constraint arising from the operator of HCA’s leased assets.

<sup>93</sup> [AXA PPP response to Remedies Notice](#), p20, section 6.2.

having been considered an effective solution in any comparable case involving a market of this nature in the UK.<sup>94</sup>

- *Bupa*

- 2.65 Bupa told us that this remedy would not achieve its objectives, and was not sufficient to address either the provisional insured AEC or the self-pay AEC.<sup>95</sup> Bupa said that third party entry within any time frame was uncertain and it was not clear on what basis a time-limited remedy was appropriate.
- 2.66 Bupa considered that the proposed rental model was wholly unproven as a business model between competing private healthcare operators in the industry and would by its nature undermine incentives to compete. Bupa told us that in its view, HCA would be able to influence the commercial viability of the service, for example through ground rents and service charges. There are also concerns that the landlord-tenant relationship would create a new point of contact and therefore increase the risk of information exchange between horizontal competitors.<sup>96</sup>
- 2.67 Bupa believed that the ability and incentives of a competitor to compete with HCA would be reduced further under a short-term (and potentially uncertain duration) lease arrangement, even if the rental package covered all necessary assets, equipment and personnel in addition to the facility itself. Similarly, it was likely that HCA's incentives to compete with the leased facility would be undermined in circumstances where the facility reverted into HCA's full operational control after a short-term period (since it would not be in HCA's interest to retake possession of a facility which had been suffering significant competition from a significantly larger rival). Moreover, Bupa said that it was not clear that high-quality staff (nurses) or consultants would themselves consider it attractive to work at a facility only for the short term, with no guarantee that the tenant operator would remain in the central London market once the lease terminated.<sup>97</sup>
- 2.68 Bupa also said that the remedy as a whole would require significant monitoring and enforcement by an appropriate body.
- 2.69 Bupa said that it was extremely doubtful that any credible operator would find the lease arrangement attractive or that such an arrangement would create a

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<sup>94</sup> AXA PPP response to Remedies Notice, p20, section 6.2.

<sup>95</sup> Bupa response to Remedies Notice, p34, paragraph 3.3.

<sup>96</sup> Bupa response to Remedies Notice, p34, paragraph 3.3.

<sup>97</sup> Bupa response to Remedies Notice, p34, paragraph 3.3.

real, stand-alone competitor able to compete actively and creatively with HCA.<sup>98</sup>

### *Hospital operators*

- *HCA*

2.70 HCA told us that any remedy which required HCA to cease its existing business activities and dispose of assets to third parties was a form of divestment and, as such, was subject to similar considerations regarding effectiveness and proportionality which it had discussed in relation to Remedy 1. However, HCA also said that a remedy which required HCA to lease space to new entrants for a short period of time, as opposed to an outright disposal of a business in perpetuity, would potentially be a less intrusive measure than a permanent divestment of the business.<sup>99</sup>

2.71 HCA said that this remedy would need to be limited in time and that a period of three years would be sufficient. However, HCA also said that this remedy would give rise to a number of practical considerations.<sup>100</sup>

- *TLC*

2.72 TLC told us that the access remedy would not be practicable or effective in remedying the insured and self-pay AECs. TLC said that the success of any central London hospital depended on developing long-term relationships with consultants and it would simply not be credible to enter the market or expand on a time-limited basis.

2.73 TLC also said that the minimum period that would be required in order to make the access remedy in any way practical would be 25 years. Any short- or medium-term rental would not correspond with hospital investment cycles and the operator would have weak incentives to re-invest in the rented hospital facilities and complex clinical equipment so as to keep them updated and attractive. In that context, TLC considered the divestment remedy to be a significantly more practical, effective and comprehensive remedy to change the competitive conditions in the central London market.

2.74 Furthermore, TLC submitted that it did not consider that a rental agreement would somehow act as a stepping stone to entry by a competitor seeking to

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<sup>98</sup> Bupa response to Remedies Notice, p43, paragraph 3.28.

<sup>99</sup> HCA response to Remedies Notice, p52, paragraphs 4.32–4.34.

<sup>100</sup> HCA response to Remedies Notice, p52, paragraphs 4.32–4.34.

develop a new hospital on a different site, as it might not be attractive to enter on a leased site, for a limited period of time, invest in that site and in growing goodwill associated with that site, and then re-locate.<sup>101</sup>

- *Spire*

2.75 Spire told us that an access remedy was not a practicable or effective remedy and was not a viable alternative to divestment. Spire said that it would not be attractive to a hospital operator to rent an HCA facility on any basis other than a long-term lease given the required investment of time and money in making the facility work. It would not be viable for a hospital operator to invest in a facility which would be handed back to its main competitor at the end of a short- to medium-term lease.

2.76 Spire said that there would be no guarantee that any business built up over the lease period could be transferred to a new site once the lease expired. The new operator would need to build its own brand at the site, and would just be handing that goodwill back to HCA at the end of term. Spire said that in its view the tenant would be unlikely to make any significant investment in improving and growing the facility when the business was time-limited.<sup>102</sup>

#### *Our assessment of access remedy*

2.77 This remedy would require a hospital operator to lease, rather than buy outright, a hospital site for a limited (and potentially short) period of time in order to address the AEC for the period over which it is expected to persist.

2.78 We reasoned that this remedy may be effective in providing a short-term constraint on HCA, ie for as long as it was in place, provided that the package of assets that was leased to a competitor was of a sufficient scale and scope. In this respect, we considered that the package would need to be the same as that identified as an effective divestiture package (either the Wellington Hospital, or the London Bridge and Princess Grace Hospitals), ie offer a broad range of specialisms and contain substantial capacity (in terms of beds, theatres, consulting rooms and ICU facilities) with which to compete. However, we thought that the effectiveness of this remedy was likely to be reduced by its short-term nature. For example, it might be difficult for a new operator to retain existing highly trained staff and consultants at a facility given the likely disruption resulting from two changes of control in a five-year

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<sup>101</sup> [The London Clinic response to Remedies Notice](#), p3.

<sup>102</sup> [Spire Healthcare response to Remedies Notice](#), p3, first paragraph.

period.<sup>103</sup> Without such staff, an operator could not compete effectively with HCA over the relevant period. Similarly, we thought that these disruptions may make the leased facilities less attractive to patients, further reducing the effectiveness of the remedy in terms of addressing HCA's market power.

- 2.79 We considered the concerns expressed by a number of the parties, that new entrants would not be interested in taking on a facility for a short-term period. We thought that, at a sufficiently low rent, entrants were likely to be interested in operating such facilities. However, we agree that a new operator would be unlikely to make any significant investments in improving and growing a facility which would revert to its original owner (HCA) at the end of the short-term lease. Therefore, this would limit the effectiveness of the constraint over the relevant period.
- 2.80 Overall, our provisional conclusion is that while this remedy would be likely to increase the competitive constraint on HCA, its short-term nature and the associated disruption mean that it would be unlikely to be effective.
- 2.81 In addition to our concerns over the effectiveness of this remedy, we observed that it was likely to create significant costs for both HCA and patients. For example, we considered that the transaction costs associated with agreeing leases on HCA's assets were likely to be similar to those associated with divestiture, as were any loss of economies of scale. In addition, we were concerned that the disruption of transferring facilities back and forth in a limited time period would cause inconvenience for patients and could affect the quality of care provided. We noted that such costs would be significantly higher under this type of short-term leasing agreement than for a divestiture remedy (due to the two changes of control and due to the temporary nature of the remedy, which we thought would be more likely to encourage staff and consultants to seek alternative arrangements). On this basis, while this remedy might be preferred by HCA (to divestiture), we considered that the remedy was not in fact less onerous than divestiture and the benefits were likely to be lower. Given our assessment of the proportionality of divestiture, it follows that the costs of this remedy are also likely to exceed the benefits.
- 2.82 In summary, we provisionally conclude that this remedy would be unlikely to be effective in addressing the features giving rise to an AEC in central London and that it was also not proportionate to its aim.

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<sup>103</sup> These changes would occur as the new entrant took over the facilities from HCA and then, at the end of the period, transferred the back to HCA control.

### ***Remedy 3 (preventing further expansion remedy)***

#### *Aim of remedy*

- 2.83 We have provisionally found that there are barriers to entry and expansion in the private hospital markets in central London, arising from the limited availability of suitable sites for private hospitals, as well as long lead times to build new facilities, high sunk costs and the existence of planning constraints.
- 2.84 This remedy would seek to facilitate entry by competitors in the central London markets by preventing HCA from expanding its private hospital portfolio within central London via the acquisition of new sites for use as hospitals and/or clinics.<sup>104</sup>
- 2.85 This remedy would seek to lower the barriers to entry and expansion arising as a result of limited site availability for operators other than HCA by preventing HCA from acquiring further suitable hospital sites in central London. Our hypothesis is that HCA may be able to pay more for new sites than its potential competitors as, by avoiding new entry, it protects its existing sites from greater competition and maintains its position of strength in central London. In contrast, the price that a competitor would be able to pay for a site would be limited by the level of profits that it can expect to earn from operating that site in competition with HCA's portfolio of hospitals.

#### *Views of parties*

##### *PMIs*

- *AXA PPP*

- 2.86 AXA PPP told us that it did not consider that the proposed Remedy 3 would be practicable or offer any prospect of effectively remedying the current AECs. AXA PPP also said that the remedy could be challenging to implement given the potential for circumvention (ie HCA could engage in joint ventures or expand via agents or nominee companies) and costly to monitor and enforce, in particular with respect to the expansion of existing facilities.<sup>105</sup>

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<sup>104</sup> We have already implemented a remedy following the Final Report that addresses barriers to entry by restricting a private hospital operator facing weak competitive constraints in a local area from acquiring the right to manage a local PPU in the same local area. [Final Report](#), paragraphs 11.245–11.337 ('Remedy measures that we are taking forward').

<sup>105</sup> [AXA PPP response to Remedies Notice](#), p22, section 6.3.

- *Bupa*

- 2.87 Bupa said that this remedy would be entirely ineffective on a stand-alone basis in addressing the existing AECs caused by HCA's large market share and the customer detriment that existed currently. Bupa also said that if the CMA were to consider this remedy further, it should only do so as an adjunct to the package of divestments.<sup>106</sup>
- 2.88 Bupa considered that Remedy 3 may assist in preventing the existing AECs from getting worse over time, since it may partially restrict HCA's further growth (although there was a high risk it could be circumvented) and it could potentially offer some more opportunity for rivals to grow in the market if appropriate new sites emerged. However, on its own, Bupa told us that it would be ineffective in materially changing the existing competitive dynamics in central London.<sup>107</sup>

#### *Hospital operators*

- *HCA*

- 2.89 In its submission, HCA contested the suggestion that it 'pays more' for new sites to exclude new entrants. HCA said that, in every case in which it had acquired new sites, it had used the site to create new facilities or expand services, as in the case of Argosy House. HCA has not bid for or acquired sites for the purposes of excluding new entrants and stated that, at any given point in time, there were numerous sites available for private hospital development.<sup>108</sup>
- 2.90 HCA stressed that Remedy 3 would be a significant and highly intrusive interference with HCA's rights to acquire and develop future sites to allow for the expansion of its business. However, HCA said that it would be less intrusive than either Remedy 1 or 2.<sup>109</sup>
- 2.91 HCA also told us that, if it were implemented, the remedy should be limited in time, and submitted that a period of three years would be sufficient on the basis that this would safeguard the availability of sites to investors seeking to enter the market within this time frame and there would be further new capacity brought onto the market by the end of this period which would have

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<sup>106</sup> [Bupa response to Remedies Notice](#), p47, paragraph 4.2.

<sup>107</sup> [Bupa response to Remedies Notice](#), p47, paragraph 4.3.

<sup>108</sup> [HCA response to Remedies Notice](#), p48, paragraph 4.6. Argosy House is a building adjacent to HCA's Portland Hospital that HCA has converted for use as a private healthcare facility.

<sup>109</sup> [HCA response to Remedies Notice](#), p48, paragraphs 4.7 & 4.8.

further increased the competitive constraints on HCA. HCA said that the remedy, if it were implemented, should only be in relation to inpatient and day-case facilities. HCA also said that the remedy should allow HCA to acquire and develop sites which competitors did not wish to acquire.<sup>110</sup>

- *TLC*

2.92 TLC told us that it was supportive of this remedy and considered that it would in principle be effective in facilitating new entry and/or expansion by non-HCA operators in central London. TLC said that acquisition should not be limited to the purchase of sites or hospital facilities but also to the acquisition of parts of the referral process.<sup>111</sup>

- *Spire*

2.93 Spire told us that this remedy would be very effective in addition to divestment, in order to prevent HCA's continued expansion while other operators established new facilities and slowly increased market share until, eventually, the market would become well-functioning.<sup>112</sup>

#### *Our assessment of expansion remedy*

2.94 As set out in paragraph 2.85, this remedy would potentially be effective if we considered that HCA would otherwise deter, delay or prevent entry by its competitors by out-bidding them to acquire the limited number of suitable sites in central London for use as private hospitals. We observed that HCA has expanded its operations in recent years, for example acquiring and developing the Platinum Medical Centre, (additional floors in) Argosy House and the Shard, among other sites. However, the evidence indicates that each of these expansions has taken place in response to a clear business need for the additional space to develop HCA's healthcare offering. We have not received any evidence of HCA acquiring (or seeking to acquire) sites that its competitors were also looking to buy. Nor have we seen any evidence that HCA has sought to obtain significant spare capacity, which it might use to deter entry.

2.95 We also considered the potential entry plans of Cleveland Clinic, VPS and Spire. Cleveland Clinic had acquired an office building, which it proposed to convert to hospital use. VPS was looking to purchase the Ravenscourt Park hospital site from CCAG. HCA had not sought to acquire either of these sites.

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<sup>110</sup> HCA response to Remedies Notice, p49, paragraphs 4.11 & 4.12.

<sup>111</sup> The London Clinic response to Remedies Notice, p3.

<sup>112</sup> Spire Healthcare response to Remedies Notice, p4, first paragraph.

Evidence provided to us by Cleveland Clinic suggested that the difficulties that it faced in identifying and securing a suitable site were largely the result of a combination of the specific requirements of a private hospital (in terms of location and building configuration) and significant competition from alternative uses, which were generally better understood by developers (eg office or residential use). The evidence did not suggest that competition from HCA was a relevant factor.

2.96 On this basis, we conclude that a remedy preventing HCA from expanding further in central London is unlikely to be effective in facilitating or accelerating entry/expansion in the central London market by other private hospital operators.

2.97 Therefore, we do not propose to implement a remedy preventing HCA from expanding further in central London.

#### ***Remedy 4 ('light-touch' price control)***

2.98 In the Remedies Notice, we categorised a 'light-touch' price control as a remedy that we were not minded to consider further. However, given the developments in terms of likely future entry and the consequent time-limited nature of the AEC, we reasoned that this type of remedy merited further consideration. Therefore, in this section, we set out our detailed assessment of the likely effectiveness and proportionality of this remedy.

#### *Aim of remedy*

2.99 The aim of a price control remedy would be to mitigate the customer detriment arising from the features that we have provisionally identified. It would do this by setting the maximum prices that could be charged by HCA to insurers for its central London hospitals for the period of time over which the AEC was expected to persist (see paragraphs 1.24 to 1.86).

2.100 We considered the option of imposing a price control in the Final Report<sup>113</sup> but came to the view that:

- (a) it would be very difficult and costly to set it up in this market (whether in the form of a reference tariff or by comparison to charges levied by similar hospitals);

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<sup>113</sup> [Final Report](#), paragraphs 12.63–12.68.

- (b) it may be vulnerable to circumvention, in that hospitals subject to such a cap would be incentivised to reduce the quality of the service they provide;
- (c) it may generate distortion risks over time by discouraging innovation and the introduction of new and better treatments and procedures; and
- (d) it would also discourage new entry into an area subject to a capping regime, unless the potential new entrant could be certain that the fact of its entry would result in the removal of price caps in that area.

2.101 In the context of the remittal, we have considered whether a 'light-touch' price control could be effective and/or less onerous than a standard price control in addressing the AECs. A 'light-touch' price control could take the form of a requirement for HCA to reduce its prices by a set percentage from existing contract levels for a period of time, whereas a 'standard' price control would entail the setting of prices based on a bottom-up assessment of the costs of providing various medical treatments. The former would be significantly less complex to implement.

2.102 In the Remedies Notice, we asked parties for their views on the effectiveness of this remedy assuming that it took the form of a requirement for HCA to reduce its prices by a set percentage from existing contract levels for a period of time, ie a one-off reduction in prices rather than a redetermination of the price of each service offered. Their views are summarised below.

#### *Views of parties*

##### *PMIs*

- *AXA PPP*

2.103 AXA PPP told us that it did not consider that a price control mechanism would be effective because HCA would have the ability to circumvent any controls that were put over it.

- *Bupa*

2.104 In Bupa's view, there would be a high risk of circumvention by HCA. For example, it may be encouraged to distort patient referral pathways or to over-treat to grow revenues in the constraint of fixed unit prices. In addition, Bupa

noted that this remedy option would not address the underlying causes of the AECs.<sup>114</sup>

### *Hospital operators*

- *HCA*

2.105 HCA told us that it did not accept that there was any reasonable basis in the CMA's findings for imposing price controls. However, it believed that this remedy would be a less intrusive measure than either Remedies 1 (the divestment remedy) or 2 (the access remedy).<sup>115</sup>

2.106 HCA also said that, if the CMA were to impose this remedy, it would be practicable to impose controls on the percentage increase in HCA's PMI contract prices for a given period of time. HCA thought that this could be done, for example, by reference to various indices based on medical inflation.

2.107 HCA also told us that a short-term price cap would be more likely to limit any potential risks to quality and innovation for the duration of the cap, whereas a divestment remedy would produce adverse effects for quality, range and innovation over the longer term and disrupt HCA's network of hospitals and clinical pathways.

2.108 HCA stated that based on the strong prospects for new entry and the creation of new capacity over the next few years, any price cap should be strictly limited in time, and HCA submitted that a period of three years would be sufficient.<sup>116</sup>

- *TLC*

2.109 TLC submitted that it would not support a price control and was of the view that the CMA should not take this remedy forward.<sup>117</sup>

### *Our assessment*

#### *Price control options and considerations*

2.110 Having reached the provisional conclusion that a divestiture remedy would not be proportionate, we examined the feasibility and proportionality of a short-

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<sup>114</sup> [Bupa response to Remedies Notice](#), p9, paragraphs 1.34 (i).

<sup>115</sup> [HCA response to Remedies Notice](#), p51, paragraphs 4.21.

<sup>116</sup> [HCA response to Remedies Notice](#), p51 & 52, paragraphs 4.24 & 4.28–4.30.

<sup>117</sup> [The London Clinic response to Remedies Notice](#), p3.

term price control remedy carefully (ie a price control to mitigate the detriment to customers arising from higher prices prior to a new entrant exerting an effective competitive constraint on HCA). We considered three potential approaches to a price control:

- (a) Option 1: a cost-plus or 'bottom-up' approach, ie a price control based on an analysis of costs, plus a margin to allow HCA a reasonable return on capital;
- (b) Option 2: using the NHS tariff schedules, as set by Monitor as a benchmark (potentially with some adjustments); and
- (c) Option 3: using the existing tariff schedules negotiated between HCA and the PMIs and then making adjustments.

- *Option 1: Cost-plus/bottom-up*

2.111 This approach is, in principle, the least distortionary means of controlling outcomes as prices would take into account all the relevant costs of production, as well as the need for HCA to earn a reasonable return on the capital it employed in providing private healthcare services. However, we observed that setting such a price cap would be highly complex in practice due to the large number of different treatments and the shared cost base used to provide them.<sup>118</sup>

2.112 A large proportion of the costs incurred in providing private healthcare services are 'joint' or shared across treatments, for example, in 2015 around [X]% of HCA's cost base was made up by direct cost of sales, which may (broadly) be apportioned to specific treatments, while the remaining [X]% (approximately) was made up of overhead and capital costs, which were shared across all treatments.<sup>119</sup> This meant that decisions over the allocation of costs would drive prices to a large extent. We noted that there were significant risks associated with making inappropriate allocations, including discouraging HCA from offering those healthcare services which it judged to be under-remunerated. This could result in reduced choices for patients and/or less competition in the market for certain healthcare services.

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<sup>118</sup> We note that evidence of the approach to negotiations between the private hospital operators and the insurers shows that the industry (itself) does not take this approach to setting prices.

<sup>119</sup> These percentages are based on direct costs of £[X] million (as of 2015) and total costs of between £[X] million and £[X] million, comprising approximately £[X] million of P&L costs and a capital charge of between £[X] million and £[X] million. The capital charge is based on a WACC of 10% and the range of capital employed estimates contained in the 'base case' and 'KPMG 2' scenarios (see the Appendix). We note that even among direct costs, there may be certain categories – such as the costs of employing nursing staff – that can be difficult to attribute to a specific treatment.

2.113 We noted that the complexity of setting a price control for all treatments on this basis was significant and would, therefore, be both time-consuming and costly. As the CMA does not have the available resources to design and implement this type of price control, we would need to set up an independent body to undertake this work. We reasoned that setting up such a body would take at least six months from the date of the final report, and possibly significantly longer given the need to attract suitably qualified staff. Once set up, we thought that it would take at least a year to undertake the analysis required to set (and to consult on) the level of prices by treatment type. Given the contentious nature of these decisions, further time may be required to resolve disputes over the levels chosen. As a result, our current view is that it is likely that a price control set in this way could not be implemented in a timely manner, making this version of a price cap remedy ineffective in addressing the (time-limited) AEC. Therefore, we have not considered this version of a price cap remedy further.

- *Option 2: using NHS tariffs*

2.114 We have also considered using NHS tariff schedules as the basis of a price control for HCA. This approach would allow us to ‘piggy-back’ on the detailed work done by Monitor in this area, ie approximating a cost-plus price control without the resource requirements and associated costs. However, we have found a number of differences between the NHS and private healthcare sector which creates a risk that the NHS tariffs are inappropriate. We identify some of these risks below:

- (a) The NHS provided a different mix of treatments, including a range of services, such as A&E, that private hospitals did not offer.
- (b) The NHS operated a different ‘business model’, for example it could operate at higher capacity since patients were not given the same level of discretion over when to be treated and were not accommodated in individual rooms.
- (c) The NHS tariffs reflected a variety of factors that may not be relevant to the private sector, for example encouraging certain types of treatments or treatment modalities, and/or reflecting the budgetary constraints of the NHS.<sup>120</sup>

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<sup>120</sup> For example, we understand that the NHS tariffs may seek to encourage NHS hospitals to treat patients on a day-case rather than inpatient basis, rather than purely reflecting the cost differentials associated with each modality of treatment.

- (d) National NHS tariffs set by Monitor were indicative, each trust negotiated its annual budget with its respective Clinical Commissioning Group (CCG), therefore actual tariffs charged varied across the country.<sup>121</sup>
- (e) Monitor may allow CCGs and hospital providers to agree prices below the NHS tariffs once volume goes above a pre-agreed level, incentivising NHS trusts to manage activity within pre-agreed levels.<sup>122</sup>

2.115 These differences meant that the tariff schedules set by Monitor were likely to be inappropriate along two dimensions. First, the level of the tariffs was likely to be too low, since as set out in (b), the NHS could make more intensive use of its asset base and offer a more 'basic' service to patients. Second, the relative level of treatment prices may not reflect pure cost differences but other factors, which were not relevant to the private sector. In light of these considerations, we provisionally conclude that using Monitor's tariffs is not appropriate since it risks introducing material distortions into the pricing schedules that may have unintended consequences on the market, including discouraging the provision of certain services.

- *Option 3: using existing tariffs*

2.116 Our proposal under Option 3 is for a 'light-touch' price control where we use existing pricing schedules as negotiated between PMIs and HCA and apply a percentage decrease to these tariffs. We would then allow these tariffs to increase with inflation each year. The price control would be 'sunsetting' after a period of time.

2.117 This approach has the advantage of using price schedules that have been negotiated in the private sector by HCA and therefore reflect the range and mix of treatments provided. We noted that this option would be significantly less resource intensive than a cost-plus approach and, therefore, was more likely to be feasible. In order to put this remedy into effect, it would be necessary to:

- (a) identify the price decrease that would mitigate the customer detriment as fully as possible, while allowing HCA to cover its costs and to earn a rate of return consistent with its cost of capital;

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<sup>121</sup> Under the terms of the Health & Social Care Act 2012, NHS England has a duty to specify those healthcare services for which it thinks a national price should be used, and Monitor has the duty to set that price. There is also provision for setting rules governing not only how nationally set pricing will work, but also how local price-setting must operate.

<sup>122</sup> [NHS payment system](#).

- (b) identify the level of cost inflation faced by HCA over the period of the price control to ensure that prices tracked costs over the period; and
- (c) design a mechanism to monitor and enforce the remedy over its lifetime to prevent circumvention and arbitrate disputes between HCA and the insurers.

#### *Design issues and assessment of effectiveness*

- 2.118 As set out in the Appendix, we used our updated profitability analysis to identify the extent to which HCA's prices may be above the competitive level. This analysis indicates that for HCA to make a ROCE in line with its WACC, its prices to UK patients would need to be between 3.1% and 10.7% lower than they have been in recent years. This is a broad range and, as set out in the Appendix, the best estimate within this range depends on the assumptions made regarding both the value of HCA's capital assets (particularly buildings) and the allocation of (common and joint) costs between UK and overseas patients.
- 2.119 While our best estimate of the extent of 'excess' pricing is between 3 and 6% (see paragraph 2.43), we note that there is a material level of uncertainty about the appropriate level of adjustment to tariffs to mitigate the customer detriment. As a result, there is a significant risk of getting the percentage decrease in tariffs wrong, which could have substantial adverse unintended consequences. For example, if the price decrease imposed were too small, then the remedy would be only partially effective as it would not address the customer detriment in full, although such a remedy would still reduce the (price) detriment suffered by customers. In contrast, if the price decrease were too high this would force HCA into an economic loss (on its efficiently incurred costs), making the remedy disproportionate to its aim. Given the uncertainty over our estimates of the extent to which HCA's prices have exceeded the competitive level, we considered that any imposed price reduction should be towards the lower end of the 3% to 6% range we identified. This was on the basis that the costs of imposing an excessive price reduction (the potential withdrawal of HCA from providing some or all private medical treatments and/or potential reductions in the quality of services provided) were likely to exceed the costs of prices which were (in this scenario, slightly) above the competitive level. However, that approach would also create a greater risk that the remedy would not be effective in mitigating the customer detriment.
- 2.120 Next, we considered which measure of inflation would best capture likely changes in HCA's cost base over the period of a price cap. We noted HCA's suggestion of using medical inflation. The only such measure of inflation we

found was Monitor's inflation estimates.<sup>123</sup> We noted, however, that these may not be fully reflective of private operators' costs because of the different negotiating power of the NHS and the different mix of inputs required and treatments offered by the NHS, among other considerations. Therefore, our current view is that it would be most appropriate to use the higher of Monitor's inflation estimates and CPI as a measure of inflation to up-rate HCA's prices in the years following the imposition of the x% price decrease. However, to the extent that this approach provided an inaccurate measure of actual inflation in the provision of private medical services, it could result in a cap that either became less effective over time, or which became tighter, potentially forcing HCA's prices below the competitive level.

- 2.121 Finally, we noted that we would need a process for arbitrating disputes between the insurers and HCA. In addition, we would need a mechanism to prevent circumvention of any price cap. For example, the introduction of new and/or revised treatments would necessitate the setting of new prices. As this remedy does not address HCA's underlying market power, an independent arbiter would need to determine any such 'new' prices, otherwise HCA may be able to set them above the competitive level.
- 2.122 Therefore, an adjudicator body would be required. The adjudicator would need to be an independent body and would require staff of a number and level of expertise to allow it to carry out its arbitration function effectively. This would create potentially material additional costs for the industry. The CMA would not be in a position to undertake such a role due to the lack of available resources for these purposes.
- 2.123 We considered that a price cap of this form could be implemented in a reasonably timely manner, ie within six months of the date of our final report, due to the simplicity of the structure.
- 2.124 However, we thought there was a significant risk that HCA would be able to circumvent the remedy and to continue exercising its market power. We noted that capping the 'line item' prices charged by HCA to its customers would not necessarily be effective in capping the total bill. For example, HCA could alter its billing practices to recover any revenue 'lost' as the result of a price control. We thought that it would be difficult for an arbitrator to manage disputes over invoices, given the potential volume of such disagreements (between insurers and HCA) and the complexity of adjudicating individual cases. In addition, we noted that HCA might circumvent the remedy through the introduction of new services or the adaptation of existing ones. This would create a need to set

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<sup>123</sup> [Monitor inflation assumptions.](#)

'new prices' for which there would be no reference tariff. In this context, we thought HCA could continue to exercise its market power.

2.125 Finally, given the time-limited nature of this remedy, we were concerned that it may be difficult for an adjudicator to attract and retain suitably qualified staff to manage the volume of disputes and that this had the potential to reduce the effectiveness of the remedy.

*Provisional conclusion on 'light-touch' price control remedy*

2.126 Our current view is that a light-touch price control is unlikely to be an effective means of mitigating the detriment to customers due to uncertainty over the extent to which HCA's prices exceed the competitive level, which means that there is a significant risk of either leaving some detriment unaddressed or forcing prices below the competitive level, and the potential for circumvention of the remedy by HCA. This meant that we could not be sure that a price cap would even address the detriment specified in the headline price reduction. Therefore, our provisional conclusion is that a light-touch price control remedy does not meet our criteria for an effective remedy.

***Remedy 5 (constraints on private medical insurer/private healthcare provider contract terms ('tying and bundling'))***

*Aim of remedy*

2.127 In our Final Report,<sup>124</sup> we considered whether a remedy that imposed restrictions on the behaviour of private hospital operators in their negotiations with insurers could be effective in preventing them from exercising market power. In our previous Remedies Notice dated 28 August 2013 we consulted on two potential versions of this remedy:

- (a) The first version sought to prevent private hospital operators with market power from raising their prices across their whole hospital portfolio if a PMI changed its network policy such that patient volumes to the hospital operator concerned were likely to fall.
- (b) A second version sought to require private hospital operators with market power to offer and price their hospitals separately.<sup>125</sup>

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<sup>124</sup> Final Report, paragraphs 12.22–12.62.

<sup>125</sup> CC Notice of possible remedies (28 August 2013).

2.128 In our Final Report,<sup>126</sup> we concluded that neither of these versions of the remedy was likely to be effective in remedying the AEC.

2.129 As part of the remittal process, we have reconsidered these potential remedies and whether they might be effective. We note that this type of remedy would not address the source of HCA's market power but rather would only mitigate the firm's ability to use this power to achieve prices above the competitive level.

### *Views of parties*

#### *PMIs*

- *Bupa*

2.130 Bupa told us that this remedy would not be effective as it was too open to circumvention. This remedy option would not address the underlying causes of the AECs.<sup>127</sup>

#### *Hospital operators*

- *TLC*

2.131 In its submission, TLC told us that it agreed that we should not take this remedy forward.<sup>128</sup>

#### *Others*

2.132 HCA, AXA PPP and Spire have not commented on Remedy 5 in their submissions.<sup>129</sup>

### *CMA assessment of 'tying and bundling'*

2.133 In the Final Report, we took the view that, if this remedy were to cover comprehensively all forms of conduct that would indicate the exercise of market power, it would need to be accompanied by a process for dispute resolution that would be expensive, complex and intrusive. On this basis, we

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<sup>126</sup> [Final Report](#), paragraphs 12.22–12.62.

<sup>127</sup> [Bupa response to Remedies Notice](#), p9, paragraphs 1.34 (ii).

<sup>128</sup> [The London Clinic response to Remedies Notice](#), p3.

<sup>129</sup> AXA PPP commented on a similar remedy proposal during the market investigation. See the [Final Report](#), paragraphs 12.22.

concluded that the remedy as specified would not address the AEC comprehensively and that it could only do so if significantly expanded in scope and accompanied by an oversight regime which would be complex and expensive to create and operate. We concluded that such a remedy, even if it were effective in addressing the AEC would, since it would be equivalent to certain types of regulation of the sector, be disproportionate.<sup>130</sup>

- 2.134 In response to our Remedies Notice, the parties did not suggest that our reasoning or conclusions from the Final Report were incorrect, or provide any evidence or argumentation that would lead us to review the position taken in the Final Report.
- 2.135 We continue to be concerned that any attempt to control the terms on which insurers and HCA contract would be incomplete as a means of preventing the exercise of market power – and, therefore, be ineffective – and could give rise to significant additional costs and possible distortions in the market.
- 2.136 In addition to concerns over the likely effectiveness of this remedy, we believe that setting up a complex and expensive monitoring and dispute resolution process to enforce this remedy could not be justified in order to resolve an AEC over the relatively short time frame over which we expect it to last, given the prospect of significant new entry ie the remedy would not be proportionate (even if it were effective).
- 2.137 We therefore provisionally conclude that it would not be appropriate for us to pursue this remedy any further.

***Remedy 6 (recommendations to NHS trusts/Department of Health and the government to facilitate site availability in central London for medical uses to private hospitals)***

*Aim of remedy*

- 2.138 We have considered whether a remedy that would help make more sites available in central London for private hospital use could be effective in addressing the AECs we have identified. In our Remedies Notice, we consulted on two potential versions of this remedy:
- (a) recommendation to NHS trusts and/or the Department of Health to sell surplus buildings for medical uses to private hospital operators; or

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<sup>130</sup> Final Report, paragraph 12.59.

(b) recommendation to the government to change planning regulations to facilitate entry/expansion by non-HCA hospital operators into central London.

2.139 The aim of the first version of this remedy would be to ensure that NHS sites that are being sold by NHS trusts are made available to private hospital operators who wish to enter (or expand in) the central London market rather than used for other purposes, eg converted for residential use. In effect, the remedy would recommend that the NHS marketed such sites to private hospital operators first and, only if there was no interest at a reasonable price, would the NHS then seek to market the sites more broadly, including for conversion to residential use.

2.140 The aim of the second version of this remedy would be to ensure that planning restrictions in central London are relaxed/changed in order to give priority to non-HCA hospitals being built. In order to be effective, we would have to recommend to the government that private hospital use was given preference over other uses in planning decisions.

### *Views of parties*

#### *PMIs*

- *Bupa*

2.141 Bupa told us that it was highly speculative to assume that recommendations to NHS trusts to sell more assets in London (or to constrain to whom these sites could be sold) or to the government to change the planning regime would deliver positive improvements within a reasonable period of time. Bupa said that it expected NHS trusts to be very uneasy to have the value of their sites reduced by obligations to market them first or only to private hospital operators (rather than a wider set of commercial developers), particularly in the current environment of financial stress on the NHS.<sup>131</sup>

2.142 Bupa also told us that a change to the planning regime would require significant public consultation and take several years. Therefore, credible and constraining entry on HCA would be speculative and, were it to appear at all, could take many years.<sup>132</sup>

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<sup>131</sup> Bupa response to Remedies Notice, p9, paragraphs 1.34(iii).

<sup>132</sup> Bupa response to Remedies Notice, p9, paragraphs 1.34 (iii).

## *Hospital operators*

- *HCA*

2.143 HCA pointed out that there were current and anticipated changes to the planning regime which promoted commercial over residential usage of sites which would make it more difficult for residential developers to outbid private hospital operators for future sites.<sup>133</sup>

2.144 HCA believed that a remedy which encouraged NHS trusts to dispose of sites specifically to private hospital operators was likely to be highly effective because of the volume of property which had been earmarked for sale, the fact that such sites already had C2 planning use consent, and as former hospital premises were capable of refurbishment into private hospitals within an even shorter time frame.<sup>134</sup>

2.145 HCA also told us that either version of this remedy would potentially be an effective and proportionate measure to deal with the CMA's concern about availability of new sites in central London, and merited further consideration as an alternative to divestment.<sup>135</sup>

- *TLC*

2.146 TLC told us that it agreed that the CMA should not take this remedy forward.<sup>136</sup>

## *Our assessment of recommendation remedy*

2.147 We have several concerns with both versions of this remedy. In either case, we noted that the likelihood of these recommendations being followed, and hence the effectiveness of the remedy, is highly uncertain.

2.148 The first version of this remedy could only be implemented via a recommendation to NHS trusts, rather than by means of an order or undertakings. Given that the latter need to prioritise their own financial viability, we believe that they would seek to sell unwanted sites for the greatest potential value and would be unlikely, therefore, to give priority to private hospitals when marketing their surplus land and buildings.

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<sup>133</sup> [HCA's response to the CC's Notice of possible remedies](#) (21 October 2013), p34.

<sup>134</sup> [HCA response to Remedies Notice](#), p50, paragraphs 4.15–4.19.

<sup>135</sup> [HCA response to Remedies Notice](#), p50, paragraphs 4.15–4.19.

<sup>136</sup> [The London Clinic response to Remedies Notice](#), p3.

- 2.149 The HM Treasury guidance on ‘Managing Public Money’, which NHS trusts are required to follow, states that ‘public sector organisations should take professional advice when disposing of land and property assets. [They have to] sell by public auction as seen; or by open tender’.<sup>137</sup> Furthermore, NHS Property Services (which manages all NHS trusts’ properties) has a fiduciary duty to ensure ‘that best value is achieved from any disposal, for reinvestment in the NHS’.<sup>138</sup>
- 2.150 NHS trusts are under financial pressures at present, as evidenced in the Five Year Forward View report,<sup>139</sup> and their aim is to gain the highest possible value when disposing of their assets, whether for medical or other use.
- 2.151 With regard to the second version of the remedy, it is unclear whether the government would be prepared to change planning laws to facilitate entry of private hospital operators. In its ‘Planning and Building’ policy, it states that ‘the government has simplified the planning system so councils have the freedom to make decisions in the best interests of their area.’ Therefore, each local authority will prioritise the types of developments that would benefit their area.<sup>140</sup>
- 2.152 Furthermore, prioritising healthcare uses over other land uses in central London would create distortions in the market and may have a detrimental effect on other sectors of the economy.
- 2.153 The effectiveness of this remedy is uncertain given that it would take a long time to remedy the AECs. Neither version of this remedy addresses the long lead times required for new hospitals to enter, in addition to the fact that any changes to planning legislation or guidance are also likely to take a reasonably long time to implement. This is unlikely to offer a timely solution and is unlikely to take effect prior to entry by Cleveland Clinic to remedy the AECs.
- 2.154 As noted in paragraph 1.85, we believe that, given the prospect of new entry, the AECs will only remain for a limited period of time. We believe that neither of the two versions of this remedy is likely to accelerate market entry or enhance competition constraints on HCA due to the long lead times required for the government to introduce new regulations.

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<sup>137</sup> HM Treasury (July 2013), *Managing public money*.

<sup>138</sup> NHS Property Services – Property Disposals.

<sup>139</sup> Five Year Forward View (October 2014).

<sup>140</sup> Planning and building policy areas.

2.155 In summary, our provisional conclusion is that neither the first version nor the second version of this remedy would be effective.

### **3. Provisional conclusion on remedies**

- 3.1 This document forms our provisional decision on the remedies required to remedy the AECs and the resulting customer detriment we have provisionally found, and serves as a basis for further consultation with interested parties. This provisional decision has been reached based on our consideration of all the evidence we have received to date through the course of our investigation.
- 3.2 If we find that there is an AEC, we are required under the Act to decide whether action should be taken, or whether we should recommend the taking of action by others, for the purpose of remedying, mitigating or preventing the AEC, or any detrimental effect in so far as it has resulted from, or may be expected to result from, the AEC.
- 3.3 If we decide that action should be taken, we must then decide what action should be taken and what is to be remedied, mitigated or prevented. In deciding these questions, the Act requires us '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 effect on customers so far as resulting from the adverse effect on competition'. To satisfy this requirement, in this paper we considered how comprehensively potential remedies address the AECs and resulting customer detriment, and whether they are effective and proportionate.
- 3.4 In Section 1 of this document, we provisionally found that large-scale entry in central London is likely to take place by early 2020 and it is likely to be an effective competitive constraint on HCA by early 2022. On this basis, in Section 2, we found that divestiture, although an effective remedy, would not be proportionate.
- 3.5 We have also considered whether there were any other remedies that would be both effective and proportionate in addressing the AECs identified. As we explain in more detail in Section 2, we do not believe that there are any behavioural remedies that would be effective in addressing the AECs by constraining the market power of HCA in central London, either with respect to self-pay patients or in its negotiations with the insurers. Similarly, we have considered, but rejected, the remedy of a price control (see Remedy 4). We thought that while, in principle, this could be effective in addressing the AECs arising from weak competitive constraints, there were a number of challenges to its effectiveness in practice. In addition, we thought that a price control would create potentially damaging distortions to the market, particularly with regard to quality and range, as well as being very costly to implement, monitor and enforce.

- 3.6 We have not, at this stage, made a final decision regarding the existence and form of any AEC and/or its resulting customer detriment. Our final decisions on any AEC, and appropriate remedies, will take into account the responses we have received to our PFs, and the responses we receive to this PDR.
- 3.7 Based on the evidence discussed in this paper, four out of five Group members provisionally concluded that there are no remedies that would be both effective and proportionate in addressing the features that we have identified. The remaining Group member believed that divestiture was both an effective and proportionate remedy to address the AEC.