

Land valuations

Introduction

1. As set out in Appendix 6.13, the balance sheet value of the land and buildings owned by each of the relevant firms¹ does not necessarily reflect the value to the business (deprivation value) of those properties, nor were they valued on a consistent basis across the relevant firms, with some using historic cost and others revaluing the assets on change of control or for the purposes of raising finance.²
2. In this appendix, we set out the various sources of information on land values that we have taken into account in assessing an appropriate value of land for the profitability analysis, including:
 - (a) the DTZ report, commissioned by the CC;
 - (b) the three Colliers reports, provided to the CC by BMI;³
 - (c) the Knight Frank and Ashkirk reports, provided to the CC by Spire; and
 - (d) the Altus Edwin Hill report, provided to the CC by HCA.
3. In addition, we discuss other submissions from the relevant firms in relation to the draft DTZ report, the CC's profitability working paper published on 1 March 2013 and the profitability sections of our provisional findings report.

The challenge of valuing land

4. The value of land in the UK is determined to a great extent by the type of planning permission that has been, or is likely to be, granted on that land. Agricultural land tends to be worth between £18,000 and £22,000 per hectare, while land with planning permission for residential development varies in price from around £775,000 per hectare in Stoke to just under £5 million per hectare in outer London areas and significantly more in central London.⁴ The price of land in central London depends largely on the size of the building that can be placed on it, rather than the size of the plot of land itself, as well as on the 'use' of the building, ie whether the building is residential, commercial, retail etc.
5. The planning permission use class relating to a hospital is 'C2 Residential institutions', which also includes uses such as residential care homes, nursing homes, boarding schools, residential colleges and training centres.⁵ As DTZ explains in its report, land is rarely offered for sale with C2 planning permission in place. As a result, PHPs may need to consider the acquisition of sites with alternative use classes in place, which could be converted to C2 use. In many cases, we understand

¹ The relevant firms are: BCH, General Healthcare Group (BMI), HCA, Nuffield, Ramsay, Spire and TLC.

² See Appendix 6.13 for discussion of the basis on which the relevant firms' financial information has been prepared and the valuation principles that we are applying in our profitability analysis.

³ These include a critique of the (first draft) DTZ report, a report on the market value of [§] of BMI's hospitals (both land and buildings) and a depreciated replacement cost valuation of [§] of BMI's hospitals (both land and buildings).

⁴ Source: Valuation Office Agency, *Property Market Report, 2011*: www.voa.gov.uk/dvs/_downloads/pmr_2011.pdf.

⁵ www.planningportal.gov.uk/permission/commonprojects/changeofuse/.

that offers made by PHPs to acquire land are contingent on receiving the appropriate planning permission.⁶

6. In addition to the existing use class of land, the price of a site suitable for a private hospital will depend on the level of competition for the site among PHPs. This, in turn, will often depend on the location of the site and the significance of location in terms of local competitive dynamics. A site close to the local NHS hospital at which consultants practise will attract a premium compared with a similar site in a less desirable location, as it gives the purchaser a significant competitive advantage in terms of attracting consultants to practise in the facility, and hence in attracting patients.⁷
7. There have not been many new hospitals built in the UK over the last five to ten years, which means that there are a limited number of transactions to serve as reference points when valuing hospital land. On the other hand, care homes also require C2 planning permission and there have been a larger number of transactions for this use which may serve as a suitable benchmark.

Our process

8. In our profitability methodology consultation document,⁸ published on 7 November 2012, we set out our intention to commission a report from DTZ to estimate the MEA value of land. In that document, we also highlighted both recent transactions and alternative uses as potential benchmarks for the value of land.
9. We asked DTZ to provide a draft report in the first instance, setting out its methodology in detail and providing initial estimates of the cost of acquiring the plots of land based on this methodology. Our instructions to DTZ were to estimate the cost of acquiring the relevant firms' hospital sites on the assumption that these sites were vacant and had achieved, or would be able to achieve, planning permission for hospital use.⁹ This draft report was sent to the relevant firms on 31 January 2013 for comment. Having received and evaluated their comments on the DTZ report, we agreed with DTZ a number of revisions to the initial approach. DTZ's final report (dated 4 June 2013) is based on this revised approach and is shown in Appendix 6.15.
10. Based on the relevant firms' comments and the CC's own views, DTZ's report was adjusted in the following principle respects:
 - (a) greater weight was placed on the estimated cost of the current hospital sites within an area, and relatively less weight on potential alternative sites in the same area;
 - (b) where sites were valued with reference to potential alternative site prices, DTZ ensured that the price per acre¹⁰ applied reflected any premium that would need

⁶ Circle told the CC that this was how it had acquired its plots of land in Bath, Edinburgh, Reading and elsewhere in the country.

⁷ For example, see our case study on Edinburgh in Appendix 6.14, which highlights Spire's concerns that consultants would move their practice to a competitor's hospital if one were available close to the Edinburgh Royal Infirmary.

⁸ www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/121107_profitability_methodology.pdf.

⁹ We provided DTZ with details of the size and location of the sites and asked it to make the assumption of both a willing buyer and seller of land.

¹⁰ An acre is equivalent to 0.4047 hectares. The large majority of reports that we received on land values used acres rather than hectares as the unit of measurement. In the interests of simplicity, we have not adjusted this information to quote figures in hectares.

to be paid for a plot that would be able to gain planning permission in a reasonable time frame; and

- (c) to provide an estimate of the costs of obtaining planning permission for the CC to include in our analysis.

DTZ valuation methodology¹¹

11. DTZ revised its report to reflect the adjustments set out above. DTZ explained its approach as:

The methodology adopted for our appraisal reflected elements of the RICS Appraisal and Valuation Standards 8th Edition and in particular VS 6 Valuation Standards and GN 6 Guidance Note, which is for the 'Depreciated replacement cost method of valuation for financial reporting.'

In appraising the sites, the fundamental principle of the above method is that a hypothetical buyer for a modern equivalent asset would purchase the least expensive site that would be suitable and appropriate for its proposed operations.

The manner in which the price for the site would be calculated would be based on alternative uses, with residential and employment land the two main use types which influence land prices.¹²

12. In most cases, DTZ valued the sites according to the prevailing land use in their current locations, with alternative site values taken into account where there were equally suitable and less costly sites in close proximity to the existing sites. DTZ assessed the suitability of a location with reference to proximity to the local NHS hospital, proximity to affluent residential areas where both potential patients and consultants generally live, and quality of transport links.
13. Where sites contained substantial quantities of land that was not in use as buildings, car parking, access roads or services, DTZ made adjustments to the site size in reaching a value. This was done on the basis that a PHP would not pay for land that it did not require for its hospital operations. Full details of DTZ's approach are set out in its report (see Appendix 6.15).
14. Table 1 shows the total land values estimated by DTZ for the non-London relevant firms. For the relevant firms operating in central London, DTZ estimated the cost of acquiring a replacement building rather than a plot of land. As discussed in Appendix 6.13, we have not used these alternative building costs in our profitability analysis and hence do not discuss them in detail here.

¹¹ This section sets out the methodology applied by DTZ in its final report to the CC.

¹² Appendix 6.15, DTZ Report, paragraphs 2.6–2.8.

TABLE 1 DTZ estimated land prices, by firm

Company	No of sites*	Total cost £m	Average cost per site £m
BMI	[REDACTED]	[REDACTED]	[REDACTED]
Nuffield	[REDACTED]	[REDACTED]	[REDACTED]
Spire	[REDACTED]	[REDACTED]	[REDACTED]
Ramsay	[REDACTED]	[REDACTED]	[REDACTED]

Source: DTZ Report, 4 June 2013.

*DTZ only provided values of owned hospital sites. All the operators leased at least some of their sites, with Ramsay leasing the large majority of its hospitals. Total costs here do not include stamp duty, land tax, fees or the costs of obtaining planning permission.

15. DTZ also provided an estimate of the cost of achieving planning permission for a new hospital:

Planning cost can vary significantly. For smaller hospitals on brownfield sites, costs are likely to be below £50,000. For hospitals on sites which are allocated for employment uses, we would expect planning costs to be higher, in the £100,000 to £150,000 range. Notwithstanding this, given the use of a hospital will be an employment creating use, planning should not be contentious on such sites.

Planning costs are likely to be most expensive for either larger city centre hospitals or hospitals which are situated on sites where any development may not accord with current planning policy. Planning costs and time are likely to range from £250,000 upwards, with DTZ aware that some hospitals may have expended in excess of £750,000 in planning fees.¹³

Views of the relevant firms

Overall valuation methodology

BMI

16. BMI submitted two reports prepared by Colliers in response to the DTZ draft report. The first of these provided a critique of DTZ's approach and proposed an alternative methodology, while the second comprised a valuation of BMI's land and buildings, undertaken in September 2012, employing a different approach both from that adopted by DTZ as well as that recommended by Colliers in its critique of DTZ's draft report. In this subsection, we describe these two alternative methodologies in turn.¹⁴
17. Colliers put it to us that the depreciated replacement cost approach was not the correct method of ascertaining the value of land and noted that it was considered to be the 'method of last resort' by the RICS. Instead, Colliers suggested that private hospitals should be valued on a profits basis, with reference to comparable sales transactions of both private hospitals and care homes:

The 'Profits Method' is made by assessing the Fair Maintainable Operating Profit ('FMOP') of the business in the hands of a reasonably competent operator. The FMOP is then capitalised at an appropriate

¹³Appendix 6.15, DTZ Report, paragraphs 2.16 & 2.17.

¹⁴ In addition, BMI made a number of submissions to us questioning the independence of DTZ's report and the extent to which the approach adopted in that report was anticipated by the profitability methodology consultation.

rate of return ('Year Purchase' multiplier) to reflect the risks and rewards of the property and its trading potential.

18. In addition, Colliers provided a small number of comparable transactions in the private hospital (five transactions) and care home (six transactions) sectors, although it did not provide (or seek to provide) a valuation on this basis.
19. The (separate) Colliers valuation report which was submitted by BMI as additional evidence provided a market value for 35 of BMI's hospitals on the basis of their trading potential, although the valuation was undertaken from the point of view of a property investor rather than a hospital operator. Colliers set out its approach to valuation as follows:

In reaching our opinions of value we have had regard to recent and current trading of the lessee as set out in the management accounts provided ... and our benchmarking tool to arrive at our assessment of current unit profitability (EBITDARM). We have assessed portfolio EBITDARM at £[redacted]m.

We have deducted from the unit EBITDARM a figure that represents an allocation of head office costs ... We have also deducted for Maintenance CapEx to arrive at unit EBITDAR. We have assessed portfolio EBITDAR at £[redacted]m.

To assess current Market Value we have decided to consider the current market rent based on delivering a rent cover of 1.5 and have, on a unit by unit basis, applied a yield to the resultant rental to reflect both market transactions, the covenant strength of the tenant and the location and quality of the real estate and rental income stream. [redacted]

20. The market valuation estimated on this basis comprised both the hospital buildings and land. Colliers did not, as part of this report, apportion the value between these two elements.
21. As part of its response to our provisional findings, BMI commissioned a further report from Colliers, which valued BMI's land on a depreciated replacement cost basis. While Colliers maintained that this was not the conceptually appropriate methodology to use to value BMI's land for the purposes of our profitability assessment, BMI argued that Colliers' approach provided far more robust evidence to that of DTZ as it was (a) based on 'full and detailed' inspections of the hospital sites whereas DTZ performed a "desktop survey" that did not result in a land 'valuation', (b) prepared in accordance with RICS professional standards for the DRC method, (c) performed by suitably qualified professional surveyors with significant experience in the valuation of independent hospitals, whereas the DTZ report was performed a residential housing team with no apparent input from valuers experienced in healthcare assets, and (d) did not ignore normal or average market conditions.¹⁵ Colliers explained that it had

assessed the value of the land where the current hospital buildings 'sit' where we consider that the hospital and grounds are of sufficient size to develop a hospital which would enable BMI to continue the current and anticipated levels of service delivery. Where we consider there to be surplus land, such as [redacted] which includes [redacted] (which we note DTZ allowed for to be developed for housing) we have not allowed for this.

¹⁵ BMI response to Provisional Findings, Annex 6, paragraphs 3.43 to 3.48.

We have assessed the value of the land selected having regard to the most likely alternate use, reflecting the real market that a hospital operator would have to enter to secure a site for the development of the hospital which can maintain the current and anticipated service delivery where the current locations would be a prerequisite. Given the locations of the hospital in all cases we have concluded that the alternate use (as defined above) would be for either residential or care home development (C3 or C2 Use Classes).

In all cases we have assessed both the residential land value and the land value for a care home site. We have then applied the highest value in each case to arrive at our assessment of the final land value we consider appropriate.

22. In calculating the value of land assuming a residential alternative use, Colliers made a number of assumptions, including:
- (a) assuming that 40 per cent of the land area is developable as built residential to allow for estate roads, gardens, drive ways etc;
 - (b) where the built area using the above assumption was less than the existing building, Colliers assumed that a development of the same size was achievable (this is particularly applicable with the city centre hospitals);
 - (c) where the Community Infrastructure Levy (CIL) is either adopted or under examination in a particular council district Colliers used it in the calculation, and where no CIL has been adopted Colliers used a flat rate of £100 per metre;
 - (d) Colliers included a 30 per cent affordable housing requirement unless otherwise stated by DTZ or known by the Colliers team (ie some London boroughs require 50 per cent affordable);
 - (e) the affordable sales value is 60 per cent of the private sales value; and
 - (f) to get a resale price per square metre, Colliers researched the asking price of number of properties in the local area and took an average and then added 10 per cent to allow for a new build premium.
23. Given the limited number of hospital sites exchanged in recent years, Colliers assessed the likely amount a purchaser would be willing to pay for the sites assuming they could be redeveloped as care homes on the basis of the transactions set out in Table 2, as well as the general assumption that a care-home operator will require approximately 0.4 hectares (1 acre) for every 60 beds.

TABLE 2 Colliers' care home transactions

[REDACTED]

Source: Colliers report.

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24. Using these reference points, Colliers estimated the value of BMI's land holdings to be approximately £[REDACTED] million.

Spire

25. Spire submitted two reports on land values to the CC: one prepared by Ashkirk, which provided a critique of the DTZ approach, and another prepared by Knight Frank, which also provided a critique of the DTZ approach and provided two alternative valuations of Spire's plots of land (one of these valuations is based on the DTZ approach using different assumptions and data, and the second is based on RICS valuation guidance).
26. Ashkirk suggested that the recent sale and leaseback transactions undertaken by Spire suggested a higher value of the plots of land, which could be estimated by applying a residual value approach to the acquisition price. This approach is similar to that suggested by Colliers in its report for BMI. Adopting this approach, Ashkirk estimated a land value of £[redacted] million for the Spire Bushey hospital (3.5 acres) and £[redacted] million for the Spire Bristol hospital (5.2 acres, of which 2.2 acres developable land). Table 3 sets out in full the Ashkirk valuations for five of Spire's sites on this basis.

TABLE 3 Ashkirk land valuations

Spire hospital	£ million		
	Hospital price	Hospital development costs	Gross site price
Bristol	[redacted]	[redacted]	[redacted]
Bushey	[redacted]	[redacted]	[redacted]
Edinburgh (Murrayfield)	[redacted]	[redacted]	[redacted]
Leeds	[redacted]	[redacted]	[redacted]
Southampton	[redacted]	[redacted]	[redacted]

Source: Ashkirk Report, April 2013.

Note: Hospital development costs include construction, fit-out, financing and sales costs, as well as fees, contingencies and an allowance for developer's profit.

27. Knight Frank provided two valuations of Spire's properties. The first was conducted based on RICS Valuation Guidance and uses information on recent private hospital land transactions in order to estimate a benchmark price per acre, whilst the second was conducted based on a valuation approach similar to that adopted by DTZ and considers alternative use values for the sites.

Knight Frank: approach 1

28. On the basis of the transactions set out in Table 4, Knight Frank estimated that the average price of hospital land in the UK was approximately £[redacted] per acre. Knight Frank used a band of ±15 per cent around this mid-point as the range of prices that would apply to Spire's hospitals, ie a price range of £[redacted] to £[redacted] per acre.¹⁶ It then reviewed Spire's portfolio in order to assess the quantity of land required by the hospitals, increasing the size of sites where necessary to account for off-site services provided by the hospital and reducing the size of others where there was excess land, for example woodland, included within the boundary of the site. Finally, Knight Frank graded the quality of Spire's sites using a grading scheme based on the value ranges seen in the comparable transaction data (A, B, or C) to account for the site size, site location and site defects/benefits. (Knight Frank identified the order of preference for site location for a private hospital as follows: (a) proximity to NHS facilities; (b) proximity to the local customer base, and (c) prominent position and

¹⁶ This range approximately mimics the range of transaction values used by Knight Frank.

transport connections. The best sites (A grade) were valued at £[redacted] per acre and the least desirable (C grade) at £[redacted] per acre (based on the adjusted site sizes). Finally, Knight Frank applied a regional adjustment to the land values, which ranged from a reduction of 15 per cent to an increase of 20 per cent.¹⁷ These adjustments were based on the Land Registry House Price Index¹⁸ and are set out in Table 4.

TABLE 4 Knight Frank list of comparable transactions

[redacted]

Source: Knight Frank Report, 8 April 2013.

TABLE 5 Regional price adjustments

Region	HPI Jan 2013	KF adjustment %
South East	293.46	20.00
South West	284.74	17.50
East Anglia	281.07	15.00
Wales	222.47	-5.00
North West	193.60	-10.00
Yorkshire	196.59	-10.00
North	177.35	-15.00
West Midlands	221.33	-5.00
East Midlands	219.37	-5.00
Average HPI	232.22	

Source: Knight Frank Report, 8 April 2013.

29. The total value of Spire's hospital portfolio was £[redacted] million on this basis.¹⁹

Knight Frank: approach 2

30. Knight Frank's second methodology was to adopt an approach similar to that adopted by DTZ. Knight Frank assessed the value of land required to replicate the current Spire estate based on an alternative use for either residential or care-home purposes. Knight Frank provided evidence of the depression in commercial property development during the recent economic recession and, on this basis, explained that it did not consider employment land as a likely alternative use for any of Spire's sites. Residential land prices were based on data provided in various Knight Frank publications and the VOA property market report, with Knight Frank using £[redacted] per acre for 'low'-value sites, £[redacted] per acre for 'medium'-value sites and £[redacted] per acre for 'high'-value sites. Care-home land prices were based on some recent transactions (see Table 5). Knight Frank used a price of £[redacted] per acre for 'low'-value sites and £[redacted] per acre for 'high'-value sites.

TABLE 6 Knight Frank list of care-home transactions

[redacted]

Source: Knight Frank Report, 8 April 2013.

Note: Knight Frank indicated that the above transactions were on sites that had C2 planning permission and were 'generally between 0.75 and 1.5 acres'.

¹⁷ In effect, this meant that the range of prices applied to sites was £[redacted].

¹⁸ Knight Frank identified this as being relevant to competing bidders for the sites on the basis that most hospital-appropriate sites also have good residential development potential.

¹⁹ For the 34 sites valued by DTZ, Knight Frank estimated their value to be £[redacted] million.

31. Knight Frank made the same adjustments to the size of the sites that it did in its first valuation approach. It also reviewed the sites and determined whether their most valuable alternative use was residential or care home and whether, in light of their location, the site was high, medium or low value. Finally, Knight Frank applied a regional adjustment to the land values as in its first valuation approach.
32. On this basis, the total value of Spire's hospital portfolio was £[redacted] million.²⁰ Knight Frank also provided these values for each year back to 2007, with adjustments based on changes in the house price index. (Knight Frank included charts evidencing a degree of correlation between development land and residential house price changes.) We set out in Table 7 the changes in total values over the period. This shows a decline of approximately 5 per cent between 2007 and 2011.

TABLE 7 Index of land values, Knight Frank

	2006	2007	2008	2009	2010	2011	2012
Aggregate land prices	100	104	91	96	95	94	94

Source: Knight Frank report and CC analysis.

Note: We have rebased the land values provided by Knight Frank to 100 as of 2006. Knight Frank provided figures for January each year. We used these as indicative of the year-end value of land for the preceding year, ie January 2007 figures were taken to be representative of 2006.

HCA

33. HCA submitted two valuation reports to the CC, the first prepared by Altus Edwin Hill on a depreciated replacement cost basis, and the second prepared by KPMG on an alternative use basis, which estimated a total value for HCA's hospital buildings and land. HCA told us that it considered that due to the methodology employed, the AEH valuations significantly underestimated the capital employed in its facilities, and therefore were not appropriate to use in the profitability analysis. HCA considered the KPMG report to be the relevant basis on which to value its properties as this took into account their opportunity cost of owning the buildings. The KPMG report is discussed in Appendix 6.13 as it primarily addresses buildings values, which it does not separate from land values due to the nature of the residual land calculation employed which values the collective site based on what could either be developed or reconfigured from the existing building(s).
34. Altus Edwin Hill's report calculates the value of land used by HCA's buildings with reference to the price of land for office use, which it considers to be the most appropriate comparable for a hospital. AEH describes its approach as:

In each case, a hypothetical site which would be designated for office development is likely to form the basis of the appropriate land value. These values have been arrived at using residual valuations using the Gross Internal Area of the hypothetical modern replacement hospital building adopted for the DRC of the building element.
35. In effect, this approach estimates the price of an office building of a similar size to the hospital building and deducts the costs of construction, including developer's profits, to arrive at the land value as a residual. The land values calculated by AEH are set out in Table 8.

²⁰ For the 34 sites valued by DTZ, Knight Frank estimated their value to be £[redacted] million.

TABLE 8 Land values of HCA's hospitals

<i>Building</i>	<i>Land value £'000</i>
Devonshire Hospital	[REDACTED]
Lister Hospital	[REDACTED]
London Bridge Hospital	[REDACTED]
Portland Hospital	[REDACTED]
Princess Grace Hospital	[REDACTED]
Wellington Hospital	[REDACTED]
Total	[REDACTED]

Source: Altus Edwin Hill report, January 2013.

36. HCA argued that AEH had underestimated the value of its land by between £[REDACTED] million and £[REDACTED] million as a result of:
- (a) using incorrect estimates of the floor space in HCA's hospitals: HCA estimated that AEH had omitted [REDACTED] from its estimates of the gross internal area of HCA's properties and that correcting these estimates could increase land values by £[REDACTED] million;
 - (b) using a conservative assumption regarding the ratio of gross internal area to net lettable space in its properties: HCA suggested that the ratio used by KPMG in its residential valuations of [REDACTED] per cent was more appropriate than the [REDACTED] per cent ratio used by AEH. It calculated that the use of the KPMG ratio would increase its land values by £[REDACTED] million;
 - (c) using inappropriately low rental rates for existing commercial offices, rather than new or completely refurbished buildings as would reflect accurately the hypothetical new office buildings in AEH's land valuations, and not taking into account the potential rental yields on residential property: HCA provided the evidence in Tables 9 and 10 on commercial rental yields, estimating that by using the Carter Jonas figures would increase the value of its land by between £[REDACTED] million and £[REDACTED] million;

TABLE 9 Typical quoting rent (per sq ft), Grade A commercial property

<i>HCA hospital</i>	<i>Carter Jonas geographical area</i>	<i>Minimum rent £/sq ft</i>	<i>Maximum rent £/sq ft</i>
Lister	Victoria Secondary	46.5	55.0
London Bridge	Southwark Prime River	42.5	49.5
Portland	Fitzrovia	55.0	69.5
Devonshire	Marylebone Secondary	52.5	
Princess Grace	Marylebone Secondary	52.5	
Wellington	Paddington	52.5	57.5

Source: HCA submission, based on Carter Jonas data, March 2013.

TABLE 10 Property rents in the vicinity of HCA's properties in central London

Property	Rent (£ per square foot)
1 & 2 Fitzroy Place	85.0
1 Pancras Square	55.0
2 Pancras Square	55.0
Fitzroy House, 355 Euston Road, London W1	53.5
Africa House, 70 Kingsway, WC2	62.5
10 Bloomsbury Way	60.0
20 Bentinck Street	89.5
95 Wigmore Street, London W1	83.5
10 Portman Square	90.0
The Wimpole Building	60.0
42-50 York Way	45.0

Source: HCA submission.

(d) using inappropriately high estimates for the yield required on commercial property: HCA argued that AEH applied a property yield of between [X] and [X] per cent but that property yields in central London could fall as low as 3.75 per cent and that a GVA Grimley Report (Q2 2013) listed commercial property yields of between 5.0 and 5.5 per cent for the areas in which HCA's hospitals were located. HCA calculated that the lower yields would increase the value of its land by up to £[X] million; and

(e) using a conservative required profit margin of [X] per cent, compared with the [X] per cent margin used by KPMG in valuing HCA's hospitals on a residential alternative use basis: HCA noted that using the KPMG assumption would increase the value of its property by £[X] million.²¹

Our views on valuation methodology

Valuation methodology outside central London

37. The profit-based approaches to land valuation put forward by Colliers (on behalf of BMI) and Ashkirk (on behalf of Spire) are not suitable for the purposes of profitability analysis since they risk capitalizing any excess profits that the businesses are able to generate in the value of land. This is demonstrated clearly in the valuation that Ashkirk highlighted for Spire's Bushey hospital, which equated to just over £[X] million per acre, despite residential land in a similar area (Enfield) selling for around £1.7 million per acre. Similarly, this approach values the Bristol site at around £[X] million per developable acre, compared with a residential land price of around £0.85 million per acre in Bristol.²² It is clear that these prices depend substantially on the profits generated by the hospital. As a result, they may introduce circularity into the profitability analysis by inflating the value of capital employed above its replacement cost. We have not, therefore, applied this approach in conducting our analysis.
38. The approaches to valuation put forward by Knight Frank and Colliers (in their DRC report) are, in principle, suitable for the purposes of profitability analysis in that they valued the land without reference to the profitability of the hospitals sited on the land. We did, however, have some concerns regarding both surveyors' execution of the methodology.

²¹ HCA response to Provisional Findings, paragraphs 5.79–5.94.

²² Residential land prices are sourced from the VOA Property Market Report, 2011.

39. As regards Knight Frank's report, in the first instance, we found the approach adopted in both valuations to be generic (or high level), with a small number of data points being used to estimate the values of 37 sites across the country, as opposed to being based on the specific conditions in each local property market. We consider that this approach risks introducing inaccuracies and/or biases into the analysis, which may be substantial when aggregated across a large number of sites. Second, we did not agree with the adjustments made by Knight Frank to increase the area of some of Spire's sites to reflect the size of site that a PHP would choose in an ideal situation. We consider that larger and hence more costly sites are likely to result in operational efficiencies for a PHP.²³ If this were not the case, then there would be no rationale for buying a larger site. However, in our profitability analysis, we have not made any adjustments to the operational performance of the hospitals to reflect the benefits associated with such sites. Therefore, we do not consider it appropriate to include the cost of larger sites in the value of capital employed.
40. Our principal concern with the first of Knight Frank's valuation methodologies is that the comparable transactions that form the basis of the valuation may not be representative of the market as a whole. These transactions are taken from relatively high-value areas of the UK, including Bath, Edinburgh, Reading, Cardiff and Kent, whereas Spire's hospitals are located throughout Great Britain, including in a number of lower-value areas, such as Wrexham, Sunderland and Blackpool.²⁴ By applying an average price per acre from these transactions to other areas of the UK, this methodology may overstate the average replacement cost of Spire's sites.²⁵ In addition, we note that these transactions may not be fully representative of the areas from which they are drawn. For example, the Shawfair transaction quoted is Spire's original purchase of the site in 2008, at which point it paid around £[redacted] per acre for land. However, in 2012, Spire acquired additional land in the same location and paid around £[redacted] per acre.²⁶ Similarly, information provided to us by Circle indicates that the price paid per acre at Bath was approximately £690,000 rather than £[redacted] per acre, as suggested by Knight Frank. In the case of KIMS, the business told us that it had paid a price equivalent to £800,000 per acre, rather than the £950,000 figure used by Knight Frank.
41. We had some similar concerns regarding how representative the care-home transactions used in the Knight Frank's second valuation approach were of the market as a whole. Of the ten transactions, five are located in relatively high-value areas of the country, including Sunningdale (near Windsor), Macclesfield and Lymm (Cheshire), Heswall (Wirral) and Cheltenham.²⁷ DTZ's report included details of a number of care-home transactions which were drawn from a broader geographical cross-section of the UK. (See Appendix 6.15, DTZ Report.) These had substantially lower average

²³ These may take the form of increased revenues or lower costs.

²⁴ High-value areas have been identified with reference to the VOA Property Market Report, 2011.

²⁵ Information provided to the CC by Circle highlights a number of additional transactions in other areas of the country. Many of these took place in 2007/08 (which was the peak of the market), and have values both higher and lower than the range used by Knight Frank. For example, Circle signed land purchase agreements at £[redacted] per acre for land in Plymouth and £[redacted] per acre in Southampton, as well as £[redacted] per acre in Tunbridge Wells. Hence, the approach of applying an average value from a limited number of transactions to estimate the value of all of Spire's sites in the UK does not appear to us likely to produce an accurate estimate.

²⁶ We understand that competition among the private hospital operators may put upward pressure on land prices. This appears to be a particular issue where the location of the site confers a particular competitive advantage to the owner of that site, as was the case in Edinburgh. We note that this dynamic may, in certain cases, result in some element of the profitability of the market being capitalized in the asset values of the businesses.

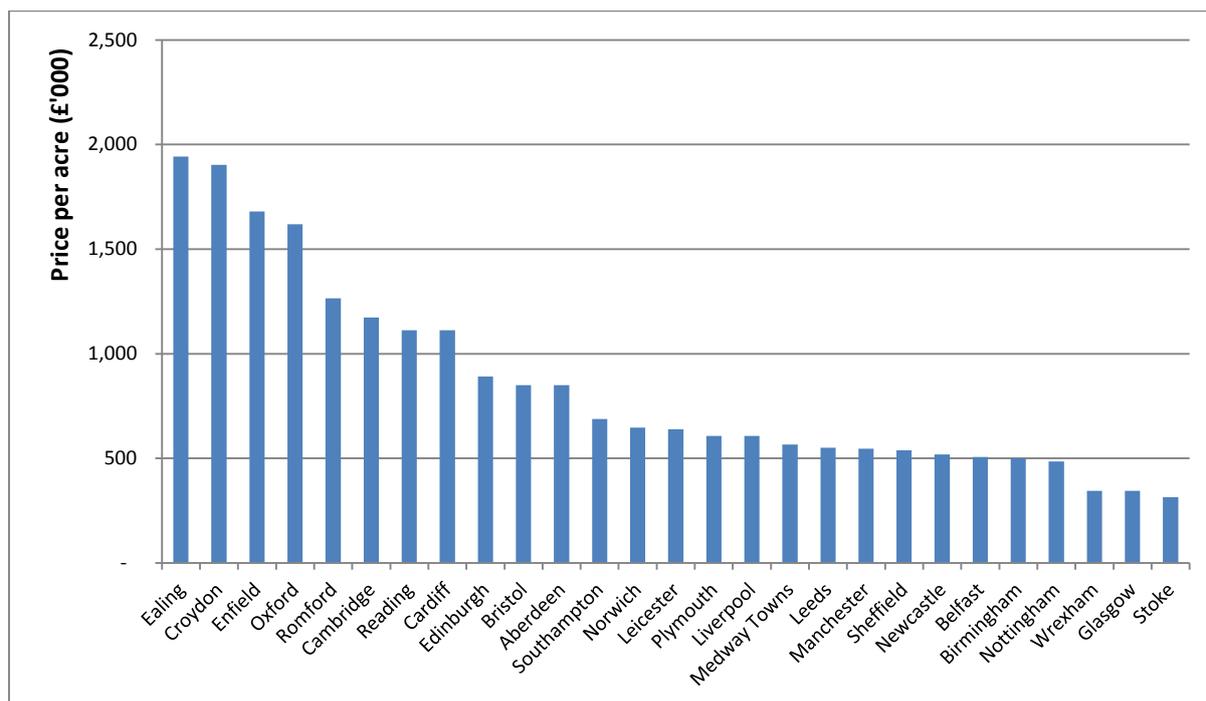
²⁷ Spire argued that Cheshire and Wirral were not particularly high-value areas of the UK. However, data on the specific wards of Heswall and Lymm indicates that these towns are significantly wealthier with higher property prices than the surrounding areas. See: <http://www.lymmvillage.co.uk/about/housing-statistics>; www.wirral.gov.uk/downloads/787; www.doriconline.org.uk/Resource.aspx?ResourceID=183&refP=PowerSearch.aspx?txtQuery=Lymm&rbISearchFor=Resources&rbISearchType=Wildcard.

values than those used by Knight Frank. Hence, we consider that the range of values used by Knight Frank is likely to overstate the alternative use value of Spire's sites.

42. Our review of the residential values used by Knight Frank (based on VOA data—see Figure 1) indicates that a reasonable range of values has been applied on the basis of the information supplied by the VOA. It was unclear, however, whether the VOA estimates, which focused on larger towns and cities around the UK, were necessarily representative of other areas of the UK which were not covered by the estimates.

FIGURE 1

Residential development land prices, VOA data, 2011



Source: VOA Property Market Report, January 2011.

43. We also had some concerns about the approach used by Colliers to valuing BMI's land. As Colliers highlights in its report, RICS GN 6 states that:

the initial stage of estimating the gross replacement cost has to reflect the cost of a site suitable for a modern equivalent facility. Often this will be a site of a similar size and in a similar location to the actual site. However, if the actual site is clearly one, that a prudent buyer would no longer consider appropriate because it would be commercially wasteful or would be an inappropriate use of resources, the modern equivalent site is assumed to have the appropriate characteristics. The fundamental principle is that the hypothetical buyer for a modern equivalent asset would purchase the least expensive site that would be suitable and appropriate for its proposed operations.

44. However, Colliers has not valued BMI's sites with reference to the least expensive site that would be suitable but, as set out in paragraph 21, with reference to the highest-value alternative use for the current site. While this may be appropriate in some cases, most new hospitals in recent years have been built on business parks or agricultural land (zoned for development), which suggests that PHPs demonstrate a greater flexibility in terms of choosing sites in order to reduce entry costs. There is

a risk, therefore, that Colliers' approach produces values that are higher than those incurred by an efficient entrant.²⁸

45. In addition, the valuations provided by Colliers are, in some cases, significantly higher than those estimated by DTZ, despite ostensibly being prepared on the same basis. For example, both surveyors have valued BMI's plots in Blackheath, Guildford, Windsor and Mile End on a residential alternative use basis (in their current locations), with DTZ estimating their values at £[redacted] million, £[redacted] million, £[redacted] million and £[redacted] million respectively, while Colliers put the values at £[redacted] million, £[redacted] million, £[redacted] million and £[redacted] million. The different valuations on these four sites alone account for just over 60 per cent of the total difference between the DTZ and the Colliers valuations. We consider that DTZ's estimates of residential land values, which were prepared by a residential team, are likely to be more accurate than Colliers' estimates, which were prepared by its healthcare team.
46. Our view is that DTZ's methodology is consistent with the value to the owner principles that we are using for our profitability analysis. We consider that its report provides the most comprehensive valuation of land outside central London, considering the dynamics of the local property market in each area and identifying the prices that would have to be paid at the current time for the various types of land that could be converted to private hospital use. The report identifies the key factors that the private hospital operators take into account in choosing where to locate and estimates the cost of a replacement plot of land within an appropriate catchment area. In particular, we note that despite the parties' objections to the use of lower-cost alternative plots, such as business park and agricultural land for development, recent hospital developments have been located on such plots (see paragraph 44).
47. However, we recognize that some recent transactions have taken place at higher values in certain areas²⁹ and that some of the alternative sites used by DTZ to estimate the value of the relevant firms' actual sites may not be fully equivalent.³⁰ In particular, we considered that agricultural land with a reasonable probability of gaining planning permission for development was likely to sell at a discount to land that had already achieved planning permission, in light of the delays and uncertainty involved in the planning process in the UK. Our base case analysis seeks to allow for these uncertainties by using a cost of obtaining planning of £250,000 per site, ie a figure towards the upper end of the range provided by DTZ. In addition, despite our concerns regarding the approaches adopted by Knight Frank and Colliers, we have used these valuations as the basis for a sensitivity in our profitability analysis. (See Appendix 6.13.)
48. In addition, we have used the land price index included in Knight Frank's report in our analysis, applying it to the land values of all the non-London hospital operators. This assumes that these land price trends would affect all the relevant firms similarly over the 2007 to 2011/12 period. We believe that this assumption is reasonable.

Valuation methodology in central London

49. We reviewed each of the arguments put to us by AEH in detail. In the first instance, we accepted HCA's submission that some of floor spaces used by AEH were incorrect and that it was clearly appropriate to use the right figures, which HCA told us

²⁸ Circle Bath, Circle Reading and Spire Shawfair were built on business parks. KIMS and Nuffield Hensol were built on agricultural land/parkland. In the case of Shawfair, this location was selected based on its proximity to the new Edinburgh Royal Infirmary, which is located just 2.4 miles from Shawfair. [redacted]

²⁹ Although we have already noted that other transaction values are lower than those used by Knight Frank.

³⁰ Several parties have raised issues regarding the assumed size, location and current planning use of the sites put forward by DTZ.

were contained in the Valuation Office Agency (VOA) reports (and were used by KPMG in its report). However, we disagreed with HCA's calculation of the increment in land values that would result from using the figures as set out in the KPMG report. In reaching its view on the residual land values, AEH used total floor space on the ground floor and above, ie excluding basement floor space. HCA has not provided any argument or evidence to suggest that this approach is not standard or appropriate in arriving at a residual land value. We see no reason, therefore, to change this approach. We have adjusted the AEH valuations to reflect the difference between the KPMG floor spaces and those used by AEH but continued to exclude the basement area as recorded by AEH from the valuations. We consider that this is likely to be conservative as AEH generally under-recorded the floor spaces of the buildings, such that one might expect the basement areas also to be under-recorded. This adjustment increased the land values by £[~~8~~] million.

50. We did not agree with HCA that it was appropriate to use the KPMG ratio of the gross internal area of a building to the net lettable or useable internal area rather than the AEH figure. The AEH valuation is based on the most comparable alternative use being commercial rather than residential. It seems quite likely to us that different building uses might result in a different ratio between gross and net usable space. HCA has not provided any evidence to suggest that, for a residual land value estimate on the basis of commercial use, AEH's assumption is unreasonable. Therefore, we consider it appropriate to use that assumption.
51. We reviewed the Carter Jonas report referred to by HCA and concluded that it was consistent with the rental values used by AEH in its estimates. The rental rates set out in Table 9 relate to the 'quoting rent' on commercial buildings in this area. However, these figures do not take into account either rent discounts or, more importantly, rent-free periods offered to new tenants. Carter Jonas estimated that tenants in the West End and South Bank areas were able to achieve rent discounts of between 3 and 5 per cent and rent-free periods of between 24 and 30 months on ten-year leases in 2009, with this narrowing to between 20 and 22 months by the first quarter of 2013.³¹ This represents a discount of between 15 and 20 per cent off the headline rents. On this basis, we consider that AEH's use of rents of £50 per square foot (£40 for the Wellington) is fully consistent with the evidence contained in the Carter Jonas report, particularly once we take into account the increase in headline rates over 2012 and (early) 2013.³²
52. We understand that the information on rents provided by HCA in Table 10 relates to the quoting or headline rents charged for these properties, ie excluding rent discounts and any rent-free periods, as of late 2013. As discussed in paragraph 51, net effective rents can be around 15 to 20 per cent lower once these are taken into account. In addition, we note that a number of the higher-value properties in this list, including 1 and 2 Fitzroy Place, 20 Bentinck Street, 95 Wigmore Street and 10 Portman Square are located in the 'north of Oxford Street' and 'Fitzrovia' areas. According to GVA Grimley, headline rents in these areas have increased very significantly between the end of the relevant period for our analysis and late 2013. For example, GVA Grimley's report indicates that headline rents in the 'north of Oxford

³¹ We note our review period ran from January 2007 to June 2012, such that the terms of commercial rent agreements as of 2013 are not as relevant as those during the period.

³² GVA Grimley (Central London Office Briefing series of reports) indicates that headline rates increased substantially between Q2 2011 and Q2 2013.

www.gva.co.uk/WorkArea/DownloadAsset.aspx?id=15032395727

www.gva.co.uk/Central_London_Office_Briefing_Q2_2011/

The evidence contained in these reports on headline rents and rent-free periods was consistent with that contained in GVA Grimley property reports taken from the relevant period.

Street' area increased by just over 40 per cent between Q2 2011 and Q2 2013, while those in 'Fitzrovia' increased by just under 40 per cent over the same period.³³

53. We next reviewed the evidence that HCA presented on commercial rental yields, notably the GVA Grimley report, dated quarter 2 2013. In addition, we reviewed early versions of this report to understand how commercial yields had changed over the relevant period. Table 11 provides a summary of rental yields in the areas of London in which HCA has hospitals.

TABLE 11 Office yields in central London

Area	per cent					
	Prime yields Q2 2013	Prime yields Q2 2011	Prime yields Q3 2010	Prime yields Q2 2009	Prime yields Q2 2008	Prime yields Q2 2007
North of Oxford Street/Fitzrovia	5.00	5.25	5.50			
Paddington	5.50	5.75	5.75	5.75–6.75	5.0–5.75	3.75–4.5
Southwark	5.50	5.75	6.25			
Victoria	5.00	5.50	5.50			

Source: GVA Grimley Central London Office Briefings.

Note: Figures for 2007 to 2009 relate to 'West End – Mayfair' and 'City core' rather than the specific local areas for which information is quoted for 2010 onwards.

54. The relevant period for our profitability analysis on HCA is 2007 to 2011. We consider, therefore, that the pertinent commercial yields are those required by investors during that period rather than those required before or after that period. On the basis of the information in Table 11, we concluded that AEH's approach of using yields of between [x] and [x] per cent appears to be reasonable and have not made any changes to the commercial yields assumed. We thought that the commercial yields quoted for 2007 to 2009 may be understated as these relate to the highest-value areas of the West End (Mayfair) and the City where yields are traditionally lower. However, we were unable to obtain information at a more disaggregated level for these earlier years.
55. Finally, we considered the level of developer's margin assumed by AEH ([x] per cent), compared with the level assumed by KPMG. In its report, KPMG stated that:

Within every residual calculation, there is an estimate for a developer's profit. This is the level of profit a purchaser/developer will factor into their calculation to represent a return on investment. This is calculated as a % of total development cost. The recognised industry standard range is between 10% and 25%. The more risky the development is considered to be, the greater the profit a developer will require for them to undertake this risk. The more secure the development, the lower the developer's return. Given that each of the HCA sites is situated in a prime residential location in central London, benefitting from strong demand, we have chosen to include a developer's profit for each of our valuations at [x].

56. It is clear from this that KPMG based its choice of [x] per cent, which it acknowledged was towards the lower end of the range, on the fact that it was valuing the property based on its conversion to residential use in an area of high residential

³³ GVA Grimley (Central London Office Briefing series of reports). www.gva.co.uk/WorkArea/DownloadAsset.aspx?id=15032395727
www.gva.co.uk/Central_London_Office_Briefing_Q2_2011/

demand. However, AEH has chosen to value HCA's land on the basis of commercial alternative use and it is not clear that the risks associated with such a development are the same as those for residential, particularly given the high level of demand for residential property in central London locations. HCA has not presented any evidence to suggest that AEH's assumption is inappropriate for a commercial developer. Therefore, we have not made any adjustments to HCA's land values in relation to developer's profit.

57. We consider that the AEH report provides a reasonable estimate of land values for central London hospitals (both HCA's and TLC's). Given the competitive market that exists for office space in central London, we do not believe that the use of the residual value methodology risks distorting the price of land. It appears highly unlikely that the price of office space is influenced by the profitability of any single industry and certainly not by that of the private hospital industry. We address the alternative use value of HCA's land and buildings in Appendix 6.17.

Application of valuation approach

Relevant firms' view

58. In addition to the views on the valuation methodology set out above, the relevant firms raised a number of more detailed points on DTZ's approach. In particular:
- (a) Ramsay and Nuffield questioned the net-down assumption made by DTZ, whereby gross land prices were reduced by 15 per cent to reflect the price that would be paid for a plot given limits on the proportion of any site that could be developed. Spire argued that DTZ's net-down assumption was 'unevidenced' and did not reflect the true nature of site-specific requirements.
 - (b) The Knight Frank and Ashkirk reports submitted by Spire questioned DTZ's approach to reducing the size of sites where DTZ considered that there was excess land that a new entrant would not acquire. Spire argued that the adjustments made by DTZ ignored commercial reality, failing to take into account sites that were constrained by either size or planning, where a new entrant would wish to acquire a larger plot, need to preserve boundaries with neighbours or situations where the land purchased may have been the only parcel of land offered for sale by the vendor.
 - (c) BMI put forward the view that DTZ should not have made adjustments to land prices based on affordable housing and section 106 requirements as these did not apply to private hospital operators.
 - (d) BMI argued that as DTZ's report did not constitute a 'valuation' under the RICS 'Red Book' standards but only an estimate of land prices or costs, it could not be relied upon.

Our views

59. As set out above, the relevant firms raised two points in relation to the area valued by DTZ. The first related to DTZ's assumptions regarding the size of sites required by the relevant firms where it considered that hospitals had excess land.³⁴ The second

³⁴ DTZ based its assessment of the existence of excess land on an inspection of satellite photos of the sites, as well as information on the built area of the hospitals.

was in relation to the 'net-down' assumption, which reduced land receipts by 15 per cent for sites larger than 1 acre.

60. We consider both these adjustments to be appropriate in the context of the land valuation methodology adopted. DTZ estimated how much a new entrant would pay for a plot of land that could accommodate the relevant firms' existing hospital operations in each local area. Where sites have large areas of park- or woodland, which are not being used to provide hospital services, it is logical that a new entrant would not pay for this space even if it were 'bundled' with the rest of the plot. We recognize that, in some cases, a larger site would be desirable in order to expand operations, operate more efficiently or be able to provide customers with greater parking facilities. However, these benefits could be expected to have an impact on the profits of the business, as well as the capital employed. Hence, a consistent treatment would require such a profit effect to be taken into account alongside the increase in capital employed. We have considered only the existing performance of the businesses and hence their existing asset bases.
61. The 'net-down' assumption reflects an adjustment to the gross price per plot to the net price per developable acre of land. It makes the assumption that a developer would only pay for usable land.³⁵ Although this assumption is likely to represent a simplification of reality, with the appropriate figure varying by site, none of the relevant firms has submitted an alternative figure that they consider to be more appropriate.
62. When estimating what an entrant would have to pay for a plot of land with reference to alternative uses, we consider it consistent to take into account the actual price the alternative use would pay. Where DTZ has valued a plot on the basis of residential alternative use, the affordable housing and section 106 adjustments reduce the gross price a residential developer would pay to the net price. Logically, it is this net price that a PHP would have to match or slightly exceed in order to secure the plot of land.
63. Finally, we note BMI's concern regarding DTZ's report not constituting a valuation under RICS standards. We understand that this is necessarily the case since DTZ did not inspect the sites, nor did it follow an RICS-recognized valuation methodology, although it had reference to VS 6 Valuation Standards and GN 6 Guidance Note, which is for the 'Depreciated replacement cost method of valuation for financial reporting'. In assessing which approach to 'valuing' land is appropriate for the purposes of profitability analysis, we have had reference to the value to the owner principles, articulated in Appendix 6.13. We consider that the approach employed by DTZ adheres most closely to these principles and hence is appropriate, although we have taken into account the uncertainty over land values by applying a sensitivity to our results. We do not have reason to believe that by conducting the analysis on a 'desktop' basis (as opposed to inspecting the sites), DTZ is likely to have systematically erred in its estimates.

³⁵ This adjustment is to price and not to the actual size of the plots, although we recognize that this was not clear in the DTZ draft report.

Building valuations

Introduction

1. As set out in Appendix 6.13, the balance sheet value of the land and buildings owned by each of the relevant firms¹ does not necessarily reflect the value to the business (deprival value) of those properties, nor were they valued on a consistent basis across the relevant firms, with some using historic cost and others revaluing the assets on change of control or for the purposes of raising finance.²
2. In this appendix, we set out the various sources of information that we have taken into account in assessing an appropriate value of hospital buildings for the profitability analysis, using the depreciated replacement cost or MEA approach, including:
 - (a) the reinstatement reports submitted by the PHPs in response to our Financial Questionnaire;
 - (b) the reports on the hospital buildings prepared by the VOA for the purposes of estimating business rates;
 - (c) the Colliers report, provided to the CC by BMI;³
 - (d) the Knight Frank and Mace reports, provided to the CC by Spire;
 - (e) the AEH and KPMG reports, provided to the CC by HCA; and
 - (f) information on the costs incurred in recent years in building new hospitals in the UK.
3. BMI argued that the MEA value or depreciated replacement cost approach was not the correct method for valuing buildings for the purposes of profitability analysis.⁴ We set out our consideration of this argument in Appendix 6.13. We address below the comments made by BMI in relation to the method we have adopted for valuing buildings.

Approach to valuing buildings

4. As set out in our guidance,⁵ the MEA value is the cost of replacing an old asset with a new one with the same service capability allowing for any differences both in the quality of output and in operating costs. The definition given emphasizes that this valuation should be based on the most efficient technology available at the time and assumes that assets are optimally configured. This is the case even if the assets in question actually use legacy technology and are not ideally situated for current market conditions.

¹ The relevant firms are: BCH, General Healthcare Group (BMI), HCA, Nuffield, Ramsay, Spire and TLC.

² See Appendix 6.13 for discussion of the basis on which the relevant firms' financial information has been prepared and the valuation principles that we are applying in our profitability analysis.

³ This is the Colliers report on the depreciated replacement cost valuation of 41 of BMI's hospitals (both land and buildings).

⁴ BMI response to provisional findings Annex 6: profitability analysis, paragraph 3.23, fn26.

⁵ CC3, Annex A, paragraph 14.

5. Therefore, in order to estimate the depreciated replacement cost value of hospital buildings, there are two basic elements that need to be measured:
- (a) the cost of replacing the existing building using modern technology (construction techniques and standards); and
- (b) the extent to which the existing building has depreciated or become obsolete in comparison with the MEA.
6. In our provisional findings, we used the reinstatement value of buildings, as measured by building surveyors employed by the private hospital operators to value their property for insurance purposes, as a proxy for the 'new' value of their hospital buildings. We then depreciated these values using the VOA's estimates of obsolescence as of 2008 as a starting point, applying a straight-line depreciation charge of 2 per cent per year. In addition, any expenditure by the PHPs on the maintenance or enhancement of their owned properties was capitalized from the date of the reinstatement estimates.⁶
7. We recognized that new hospitals may be more costly to build than the existing buildings of the PHPs due to changing building regulations and design improvements. However, we thought that these changes also tended to give rise to lower operating costs, for which we would also need to adjust in order to achieve a full MEA valuation. We reasoned that to make changes to the build costs of the hospitals but not to the operating expenses would result in a systematic distortion to our analysis such that, in the absence of evidence on the operating costs of MEAs, it would be more reliable to use the costs of replacing the actual hospital buildings, together with the actual profits generated from those buildings.
8. Table 1 shows the total 'new' buildings values estimated by the various surveyors for the relevant firms, together with the total capitalized freehold expenditure and the DRC of the buildings used in the profitability analysis for our provisional findings. All figures are quoted as of FY11.

TABLE 1 Composition of buildings DRC, by company

Company	Surveyor	Date of report	No of hospitals*	Total reinstatement cost £m	Freehold capex £m	Total 'new' replacement cost £m	DRC £m
BMI	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Spire	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Nuffield	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Ramsay	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
HCA†	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
TLC§	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Source: Various reinstatement reports and CC analysis of PHPs' financial information.

*We have only included the value of owned sites in this total. All the operators leased at least some of their sites, with Ramsay leasing the large majority of its hospitals.

†The Nuffield figures include the value of fixtures and fittings.

‡The figures shown here for HCA include all owned buildings, including its staff accommodation.

§The figures for TLC include both its Main Clinic and the Cancer Centre, as well as consulting, office and nursing accommodation.

Note: These figures excluded capitalized construction in progress, some of which is likely to relate to the PHPs' hospital buildings.

⁶ See Appendix 6.13.

9. In addition to information on reinstatement values estimated by surveyors for the PHPs, we also collected information on the depreciated replacement cost of the hospital buildings prepared by the VOA for the purposes of calculating business rates. These are set out in Table 2.

TABLE 2 VOA estimates of the depreciated replacement cost of hospitals, by company

Company	No of sites*	Total DRC value £m
BMI	[REDACTED]	[REDACTED]
Spire	[REDACTED]	[REDACTED]
Nuffield	[REDACTED]	[REDACTED]
Ramsay†	[REDACTED]	[REDACTED]
HCA‡	[REDACTED]	[REDACTED]
TLC	-	-

Source: VOA reports, 2008.

*We have only included the value of owned sites in this total. All the operators leased at least some of their sites, with Ramsay leasing the large majority of its hospitals. Nuffield was unable to provide a VOA DRC estimate for its Glasgow site, hence this total includes only 28 out of Nuffield's 29 owned hospitals.

†Ramsay provided a detailed assessment for its Nottingham Woodthorpe hospital only.

‡The VOA assessments for HCA do not include any of the owned buildings within the Harley Street Clinic or any of HCA's other buildings, such as nurses' accommodation etc.

10. We concluded that these values, being significantly below both the level at which the PHPs insured their buildings and the cost of constructing new facilities, were unlikely to reflect fully the replacement costs of the hospital buildings.

Views of the relevant firms

BMI

Buildings values

11. BMI argued that its reinstatement estimates were a poor proxy for and [REDACTED] the true replacement cost of its hospitals. It stated that:
- (a) Insurance reinstatement valuations were not a suitable proxy for the deprival value of an asset because (i) [REDACTED]; and (ii) insurance values did not include all relevant costs, such as developer's profit, start-up costs and interest charges.
- (b) The insurance reinstatement valuations were [REDACTED].⁷
12. BMI submitted a report it had commissioned from Colliers, which valued BMI's hospitals on a depreciated replacement cost basis as of September 2006 and September 2013. BMI argued that Colliers' DRC valuations were preferable to the insurance reinstatement estimates of CBRE as they were based on site-by-site inspections of BMI's hospital sites.⁸ Colliers explained that it had estimated the construction costs of a modern equivalent hospital with reference to recent comparable schemes from their database, including (but not limited to) those set out in Table 3.

⁷ [REDACTED]

⁸ BMI response to provisional findings, Annex 6, paragraph 3.21.

TABLE 3 A selection of sources of private hospital construction cost data used by Colliers International

Hospital operator	Location	Location	Status
Circle	Bath	Somerset	Built
Circle	Tunbridge Wells	Kent	Aborted
Circle	Reading	Berks	Built
Circle	Manchester		Plan
KIMS	Maidstone	Kent	Under construction

Source: Colliers International report, 2013.

13. Colliers stated that, in addition to this information, it had regard to both published and confidential data disclosed to it in connection with apportionment exercises for [redacted] other UK private acute hospital operators, as well as BCIS information on construction costs. Colliers' calculations take into account professional fees, short-term finance, start-up costs and developers' profit. By combining the Colliers' assessments of gross replacement cost and obsolescence, using the same methodology as that adopted by the CC in its model, BMI calculated the DRC value of its buildings to be approximately £[redacted] million (on average between 2007 and 2011).⁹ This was approximately 60 per cent greater than the values used by the CC in their provisional findings.
14. BMI also set out an analysis comparing its hospitals, in terms of the number of inpatient beds and theatres, with those of new facilities constructed between 2003 and 2013, adjusted for obsolescence as calculated by Colliers International. On this basis, BMI calculated what it considered to be a conservative replacement cost of its hospitals of approximately £[redacted] million for BMI's freehold buildings (on average between 2007 and 2011).¹⁰ The hospitals that form the basis of this analysis are set out in Table 4.¹¹ BMI argued that this was an important cross-check to the CC's DRC estimates and that the analysis provided support for Colliers' DRC valuation.
15. BMI stated that using this cross check was likely to be conservative, i.e. to understate the value of its average hospital, as the implied DRC per bed was at the lower end of the six hospitals used as comparators, with only one hospital (Leeds, which was built in 2003) indicating a lower DRC per bed than BMI.¹²

⁹ *ibid*, Appendix 2.

¹⁰ BMI stated that its analysis was conservative because many of its hospitals were significantly larger than the new entrants. BMI presented a figure that showed that every one of BMI's hospitals used in the analysis had a greater number of inpatient beds to the entrants. [BMI response to provisional findings Annex 6: profitability analysis](#), paragraph 3.37.

¹¹ BMI did not use TLC's Cancer Centre as a comparable.

¹² [BMI response to provisional findings Annex 6: profitability analysis](#), paragraph 3.39. Note that all comparators were depreciated on the same basis as BMI's hospitals for this comparison.

TABLE 4 Recent hospital build costs

<i>Hospital</i>	<i>Characteristics</i>	<i>Cost (including land and commissioning costs) £m</i>
Circle Bath	4 theatres, 28 IP beds, no ICU or HDU	30
Spire Montefiore	3 theatres, 20 IP beds, no ICU or HDU	29
London Clinic Cancer Centre	Specialist cancer equipment, 35 IP beds	90
HCA Christie Clinic	6 NHS theatres, 34 IP beds, no ICU or HDU	35
Circle Reading	5 theatres, 30 IP beds, no ICU or HDU	58
KIMS	5 theatres, 77 IP beds	90
Nuffield Oxford Manor	8 theatres, 71 IP beds, 7-bed ICU	50
Nuffield Leeds	6 theatres, 48 IP beds	40
Average		53
Average excluding LCCC		47

Source: BMI submission to the CC. We note that BMI did not use the London Clinic Cancer Centre in its calculation of average costs.

Obsolescence

16. In addition, BMI argued that the VOA's estimates of the obsolescence of its hospital buildings were inappropriate as they were not based on site-by-site inspections (except for two visits to Nottingham and Bath in 2010) and were determined 'mechanistically based on the year of building completion'.¹³ As such, BMI stated that they were likely to be materially misstated as a proxy for the actual obsolescence of BMI's hospitals. Moreover, BMI questioned why we had adapted our analysis between our working paper, which did not seek to depreciate buildings, and our provisional findings, which did.¹⁴
17. In addition to estimating the gross replacement cost of BMI's hospitals, Colliers also sought to assess the obsolescence of each facility, which it described as 'the variation that the hospital under review has to a modern purpose build replacement hospital that could continue with the services currently being delivered'. Colliers took into account three factors: economic, functional and physical, in reaching its overall view on the obsolescence of the facilities.¹⁵ Colliers determined that, on average, BMI's hospitals were approximately [X] per cent depreciated as of 2013, compared with a VOA estimate of approximately [X] per cent depreciated as of 2010. BMI stated that Colliers' calculations were more reliable as these were based on site inspections and were produced according to RICS professional standards for valuation rather than by the VOA for ratings purposes and based primarily on the age of a site.

Price index

18. Finally, BMI put forward the view that the use of the BCIS public sector non-housing construction price and costs index was inappropriate since its hospitals were private

¹³ BMI response to provisional findings, Annex 6: profitability analysis, paragraph 3.18.

¹⁴ *ibid.*, paragraphs 5.69–5.74.

¹⁵ Colliers described these factors as follows:

- Economic; for example the profitability of hospital relative to its peer group and its ability to operate economically;
- Functional; for instance are the theatres, bedrooms, consulting rooms all located suitably within the hospital to maximise performance; and
- Physical; this can be related to both the general state of repair and capital expenditure requirements to put the hospital into the same position as a modern equivalent, for instance a modern hospital may have more theatres.

sector commercial buildings. It proposed that the BCIS private commercial construction price and cost index would be more suitable.¹⁶

Spire

Buildings values

19. Spire argued that the estimates of reinstatement costs used understated the value of its buildings as they did not make any allowance for specialist plant, such as laminar flow and sterilization, which was separately insured. Spire told us that prior to the summer of 2013 it insured its buildings, plant and equipment for a total of £768 million, which it argued was the value which should have been used in the profitability analysis if the CC wanted to use values based on the 2008 insurance valuations.¹⁷ It contrasted this with the (depreciated) capital value of £544 million used in the CC's profitability analysis and argued that the difference between the two values was largely due to the CC's omission of specialist plant.
20. Spire argued that the building valuations used by the CC were unreliable as they were:
 - (a) based on a mixture of desktop assessment by Colliers and management estimates for the properties acquired in 2008. Some of these estimates were prepared by Spire's management and some were prepared by the former owners rather than qualified surveyors and, as such, were inappropriate and significantly out of date;
 - (b) Did not account for specialist plant, or fixtures and fittings, such as plant relating to sterilisation, laminar flow or MRI (for example, lead lining); and
 - (c) these reinstatement estimates were out of line with real world data, including Spire's current experience of building costs for new hospitals.
21. Spire submitted two reports on building values to the CC: one prepared by Knight Frank, which estimated the reinstatement value of its sites as at March 2013, and a report by Mace, which estimated the replacement cost of Spire's existing portfolio of hospitals (a) on the basis of current construction costs and (b) deducting the additional cost generated by changes in building regulations since 1980 (when the majority of the portfolio was built). Both of these estimates include the cost of replacing specialist equipment. Spire told us that it had submitted the Knight Frank report to its insurers and new insurance contracts were being redrafted on this basis.

Knight Frank

22. The Knight Frank report commissioned by Spire and based on an inspection of 25 of Spire's hospitals in March 2013 and a desktop assessment of 12 properties, estimated that the total reinstatement cost of Spire's 37 hospitals was £720 million as of April 2013. It highlighted that this figure made allowance for: (a) demolition and site clearance, and any necessary temporary shoring/support, (b) local authority requirements, (c) building reconstruction costs, underground services, paved and hard landscaped areas, boundary walls, fences and other property within the curtilage of the site, (d) fees for the required professional team, and (e) VAT at 20 per cent. In addition, Knight Frank made allowances, where applicable, for

¹⁶ BMI response to provisional findings, Annex 6 : profitability analysis, paragraphs 3.19 & 3.20.

¹⁷ Spire response to provisional findings, paragraph 5.21. This figure is the average total value for the FY08–FY11 period.

specialist/bespoke installations such as MRI scanners and radiotherapy units which require additional construction work beyond the standard base build for their installation. Costs for these were taken from recently completed private hospital projects.

23. Knight Frank explained that in undertaking its assessment it had had regard to Building Cost Information Service (BCIS) and specialist market data including Rider Levett Bucknall UK Construction Cost Data 2012. This sets out a range of £1,530 to £3,510 per square metre for private hospitals depending upon size and location. Knight Frank ‘averaged’ this rebuilt rate to £2,500 per square metre and applied to all the hospitals. It suggested that this allowed for replacement of the buildings on a like-for-like basis, however, meeting prevailing private hospital design standards and in turn meeting all current legislative and operational requirements (eg wholesale changes to Building Regulations Part L in 2010 covering conservation of fuel and power; and more stringent sterilization requirements). A UK regional factor (taken from BCIS) was then applied to allow for the specific location of each property which either increased or decreased the respective construction cost. Knight Frank measured the gross internal area at each of the inspected properties and applied this rate to calculate the base build construction cost.
24. Table 5 sets out Knight Frank’s estimate of the reinstatement cost of the buildings over the 2007 to 2013 period. It made allowances for ‘removing’ extensions which were undertaken over this period and has adjusted their value based on the BCIS All In Tender Price Index.

TABLE 5 Knight Frank reinstatement values, Spire’s hospitals*

£'000				
2007	2008	2009	2010	2011
742,651	711,369	614,742	658,699	682,323

Source: Knight Frank report, April 2013.

*These figures include the value of the ten hospitals acquired by Spire in 2008 in the 2007 figure.

Mace

25. Mace conducted a desktop review of Spire’s hospitals and estimated a ‘new-for-old’ and an ‘old-for-old’ valuation of £783 million and £693 million as of September 2013 (respectively). The ‘old-for-old’ value took into account the difference in building costs between 1980, when the majority of Spire’s portfolio was constructed, and those as of 2013. Mace deducted from the 2013 notional construction costs the additional cost generated by changes in building regulations since 1980, and indexed the new-for-old and old-for-old values back using the BCIS All-in Tender Index to give estimates of £828 million and £741 million as of 2008. Spire argued that this indicated that the CC had underestimated the value of its hospital buildings by as much as £400 million.

Obsolescence

26. Spire argued that the VOA rates of obsolescence were out of date, did not reflect the actual level of obsolescence of its buildings because Spire has invested ahead of depreciation to keep its hospitals fit for purpose and in line with changing regulations, and that individual site visits would be required in order to estimate this figure

accurately.¹⁸ Spire also argued that the VOA rates of obsolescence are an inappropriate guide to any individual site because they are based on ratings tables which necessarily make a number of simplifying assumptions and which use industry average obsolescence according to the year of building construction. While the obsolescence allowance can be adjusted to consider site-specific improvements, this is unlikely to have been done as the VOA had inspected only a small number (two) of its sites as part of its 2008 review. It noted that it had invested extensively in maintaining its buildings and that, as a result, it was not appropriate to apply any obsolescence factor to these buildings.

Price index

27. Spire put forward the view that the public sector non-housing construction index was inappropriate as a measure of inflation for its buildings and that the BCIS All-in Tender Price index was the best measure (and the one supported by RICS) since it reflects the price level at the point of 'commit to construct', thereby indicating the price that contractors would bid at a particular point in time. It stated that this index was the generally accepted standard index. Spire highlighted that the output price index used by the CC was intended for deflating industry level output and is not suitable for this application as it:
- (a) was based on work completed in a given period, reflecting the price level from when the work was originally tendered; and
 - (b) included contributions of tender prices from the previous two years.

HCA

28. HCA submitted two valuation reports to the CC, the first prepared by Altus Edwin Hill (AEH) on a depreciated replacement cost basis, and the second prepared by KPMG on an alternative use basis, which estimated a total value for HCA's hospital buildings and land. HCA told us that it considered the KPMG report to be the relevant basis on which to value its properties as this took into account their opportunity cost of owning the buildings. HCA highlighted that residential rental values were in the region of £[redacted] to £[redacted] per square foot and that this suggested a higher alternative use value for its properties than the replacement cost estimate prepared by AEH.¹⁹
29. HCA argued that its buildings would be likely to gain planning permission for conversion to residential use since:
- (a) its properties were located in highly-sought-after residential or mixed-use areas where there was unmet demand for residential property;
 - (b) HCA considered that the conversion of its hospitals in the Harley Street Special Policy area would not serve to change the character or function of the area because of its dual character as a residential and medical area, nor would the loss of medical use significantly affect demand for that particular specialism, given the range of alternative facilities that would be available to patients (both NHS and alternative private facilities); and

¹⁸ Spire response to provisional findings, paragraph 5.27.

¹⁹ HCA response to provisional findings, Appendix 5, paragraph 5.48.

- (c) there were examples of hospitals in London converting to residential use, including the Queen Mary's Hospital in Roehampton, St James Hospital in Balham, Atkinson Morley Hospital in Wimbledon and the Middlesex Hospital in Fitzrovia.²⁰
30. HCA stated that it had reviewed recent precedent for the planning authorities granting planning permission for conversion of properties to residential use in the borough of Westminster (where a number of HCA's facilities were located), and noted that as there were limited examples of medical facilities being converted into residential buildings (other than in the immediate vicinity of Harley Street), it had reviewed planning applications involving the change of use of (other) buildings. HCA stated that there were limited recent examples of applications for large-scale buildings involving change of use within central London. However, in the two cases identified, planning permission was granted:
- (a) The application to use of parts of Soho car parks as commercial offices and residential was granted.
- (b) The further application, also granted, was for a change of use and extension of use and extensions to 67–69 Whitfield Street to create 19 residential units; the erection of two additional floors and the partial change of use from office to residential to create 37 residential units.
31. HCA told us that 11 further examples of planning applications for smaller buildings involving a change of use to residential were also available for the time period over which applications had been reviewed. These included examples of properties on Harley Street and Wimpole Street with existing medical use being granted permission for conversion to residential properties.²¹
32. HCA recognized that KPMG's valuations did not make allowance for affordable housing requirements or section 106 costs, highlighting that it is a standard and reasonable assumption in valuations given that every planning application is judged on its individual merits. HCA noted that these costs would not apply to all its buildings and that, even where they did apply, the level of the obligation would vary based on the size and location of the property and would also be subject to negotiation. However, it estimated that the maximum impact on the KPMG valuation was a reduction of £[redacted] million and this assumed that all its properties were subject to the maximum social housing cost requirements, which based on precedents it considered to be highly unlikely to be realized. In addition, HCA stated that KPMG's valuations were conservative as they assumed the same floor space as the existing hospital buildings. It suggested that a property developer would, in all likelihood, seek to develop a larger floor space by increasing the height of the buildings (for example).²²
33. HCA argued that, in addition to valuing its hospitals on a residential basis, the CC should take into account the costs of fitting out those buildings for hospital use, in effect including the net book value of HCA's fittings and refurbishments in the capital employed by the business. It stated that this would add between £[redacted] million and £[redacted] million to the average level of capital employed over the period. HCA put forward the view that this reflected the costs that a new entrant would face in acquiring a building (in competition with residential developers) and then fitting it out to the standard of HCA's buildings. HCA argued that by omitting freehold

²⁰ *ibid*, Appendix 5, paragraphs 5.49 & 5.50.

²¹ *ibid*, June 2013.

²² [HCA response to the provisional findings, Appendix 5](#), paragraphs 5.64–5.70.

refurbishments, fixtures and fittings the CC was effectively double counting the omission of any operational fixtures from HCA's properties portfolio.²³

34. In relation to the use of a house price index to adjust the KPMG valuation to reflect changes in property prices over the period, HCA put forward the view that the CC should apply the principle of 'mean capital employed' rather than smoothing the increase in the value of the properties evenly over the relevant period. It suggested that the CC's decision to measure the increase in property values from December 2006 was 'arbitrary' given that the analysis of ROCE reported capital employed in the first of the years 2007 to 2011 as at December 2007. HCA highlighted that most of the increase in the value had been realized between December 2006 and December 2007 rather than in later years.²⁴
35. HCA estimated that if its buildings were to be valued at the same rate per square metre as buildings that it had examined for conversion in order to expand its hospital network, this would suggest a DRC value of £[redacted] million (as of 2011) for its portfolio. It provided four examples of buildings that it had considered acquiring for conversion to hospital use and estimated, on this basis, a DRC per square foot of £[redacted], which it applied to its estimated floor space of [redacted] square feet in its freehold and long leasehold buildings.²⁵
36. Finally, HCA argued that its leased buildings should also be included in its capital base as the accounting treatment of such assets was, to some extent, arbitrary and the results of ROCE analysis would vary substantially for different property financing structures. HCA calculated that under a strict interpretation of the relevant accounting standard, an additional £[redacted] million of property assets should be included on its balance sheet.²⁶

Our views on valuation methodology

Reinstatement values

37. Our review of the reinstatement reports submitted by the parties indicates that the values include the 'Full structural rebuilding costs including appropriate foundations', the costs of reinstating the on-site car parks, roads and building services within the boundaries of the sites, as well as an allowance for both professional fees²⁷ and 'un-measured' costs. We considered BMI's argument that the reinstatement values of its buildings were likely to understate the actual replacement cost as they excluded other relevant costs, such as developer's profit, start-up costs and interest charges. We observed that there were other areas in which reinstatement values may be overstated by including costs that would not be relevant to a new entrant, such as the costs of demolition and site clearance and (in some cases) the costs of any necessary temporary shoring/support of buildings.²⁸ We did not think, therefore, that BMI's argument that the reinstatement values were significant underestimates due to excluded costs was consistent with the evidence in this respect.
38. We also considered BMI's argument that its reinstatement costs were [redacted]. We reviewed the CBRE report and observed that it had explicitly taken into account extensions that had happened between [redacted] at the [redacted] hospitals. In addition, CBRE

²³ *ibid*, Appendix 5, paragraphs 5.71–5.77.

²⁴ *ibid*, Appendix 5, paragraph 5.78.

²⁵ *ibid*, Appendix 5, paragraphs 5.95–5.98.

²⁶ *ibid*, Appendix 5, paragraphs 5.99–5.117.

²⁷ We note that the allowance for professional fees includes planning fees, which we have also allowed for in the value of land.

²⁸ The costs of temporary shoring/support were included by Knight Frank in its reinstatement estimate for Spire.

indexed its estimates of the build costs over the period. CBRE did highlight that: ‘The hospitals have not been assessed from first principles since [X] and to update the properties further may lead to certain inconsistencies developing within the portfolio. It is therefore our recommendation that fresh assessments need to be undertaken.’²⁹

39. While this highlights the potential for further indexing to result in the misstatement of reinstatement values, it does not suggest that those values, as of 2008, are likely to be materially misstated. On this basis, we concluded that the fact that the reinstatement costs were based on an out-of-date site inspection did not give us reason to believe that they were likely to be significantly wrong, particularly given that we have reflected any maintenance/enhancement investment in the properties in the capital base of the business.
40. We considered Spire’s argument in relation to excluded specialist equipment separately. We collected evidence on the value at which Spire had insured its buildings, plant and machinery and other equipment (computers) in the 2009/10 and 2010/11 periods and we compared this with the total ‘new’ value attributed to these assets in our analysis.

TABLE 6 Comparison of the valuations of Spire’s assets

	<i>Spire insured sum</i>		<i>Total ‘new’ value—CC analysis*</i>		
	<i>2009/2010</i>	<i>2010/2011</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>
Buildings	565	574	570	563	583
Plant & machinery (incl computers)	190	211	138	167	196
Total	756	785	708	730	780

Source: Spire insurance documents and CC analysis.

*Figures include capitalized expenditure on freehold maintenance/improvements.

41. This analysis demonstrates that there are relatively small differences between the value of assets insured by Spire and the ‘new’ value used in our profitability analysis. These equal approximately £35 million per year, or around 5 per cent of Spire’s total ‘new’ asset base. We observed that the differences reported were not in buildings values but in the plant and machinery value. Therefore, the difference between the value of assets insured by Spire and the value used in our profitability analysis, highlighted by LEK in its report for Spire, was largely the result of the insured values being based on the gross replacement cost of assets rather than the depreciated replacement cost of those assets, which is the approach we have taken in assessing the value of capital employed by the business. The ‘depreciation’ of the assets has been recognized as an expense in the Spire’s profit and loss account, while expenditure on improving freehold buildings and replacing equipment has been capitalized in addition to the reinstatement value of the buildings. As a result, we consider that it would be logically inconsistent to maintain the value of assets at their ‘new’ or un-depreciated level.
42. This analysis indicates that the gross book value of equipment in Spire’s accounts does not reflect the value of specialist plant used by the business. We thought that it would be appropriate to include this additional plant in the value of capital employed by the business. Spire told us that it depreciated its freehold building services, such as plumbing, drainage, air conditioning, ventilation, wiring, alarm systems and lighting over a period of between 20 and 25 years. We did not have information on the extent

²⁹ *ibid*, 2008.

to which this plant was depreciated, although the age of Spire's buildings would indicate that it would have been fully depreciated if previous owners had not replaced it since the date at which the hospitals were constructed given that the majority of Spire's estate was built in the 1980s.³⁰ We thought, therefore, that it would be reasonable to assume that this equipment was approximately 50 per cent depreciated as of the middle of the period (2009) and to charge straight-line depreciation over 20 years. We recognize that this approach is necessarily approximate given the lack of specific information on this plant.

43. We reviewed the Colliers report (BMI) and the Mace report (Spire). We thought that the approach described by both these reports was consistent with the MEA valuation approach, which is our preferred methodology. We observed that Colliers had assessed the efficient size of a replacement hospital, [REDACTED], whereas, based on Spire's site plans and with input from Spire's architects, Mace arrived at floor space estimates for the modern equivalent asset that were approximately 4 per cent larger than those of Knight Frank.³¹ Despite this difference in approach, both BMI and Spire have relatively similar reinstatement cost estimates per square metre, as shown in Table 7.
44. We observed that the replacement costs estimated by Colliers and Mace were significantly higher than those estimated as the reinstatement cost of the buildings. In order to understand the sources of the differences, we estimated the implied total replacement cost per square metre of floor space under each of these approaches, as well as that estimated by AEH for HCA's hospitals. This analysis is set out in Table 7.

TABLE 7 CC analysis of hospital reinstatement/replacement cost estimates

	Reinstatement cost £m	Reinstatement cost per m ² £	Gross replacement cost £m	Gross replacement cost per m ² £
BMI*	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Spire†	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
HCA (AEH)	-	-	[REDACTED]	[REDACTED]

Source: BMI, Spire and HCA property reports and CC analysis

*BMI figures exclude Duchy, Manchester Lifestyle and Nuneaton as Colliers did not provide a valuation for these. BMI's reinstatement/replacement costs per m² are based on Colliers' estimates of the floor space required by a new hospital.

†Spire figures exclude Shawfair as Mace did not provide an estimate of the build costs of this hospital. These figures now include the £35 million of specialist plant discussed in paragraphs 39 to 42 to ensure comparability with the Mace's valuations, which included specialist equipment. Spire's reinstatement/replacement costs per metre are based on the floor spaces used in the Knight Frank report as this involved a detailed inspection of most of Spire's sites, while Mace relied on architectural drawings.

‡AEH, January 2013.

Note: The ranges for the reinstatement cost show the difference between the total reinstatement value as estimated by CBRE (BMI) and Colliers (Spire) and the reinstatement value plus capitalised freehold improvements. All reinstatement figures as of FY11.

45. We also collected detailed information on the total costs of building three hospitals, KIMS, Spire Shawfair and Nuffield Hensol. These hospitals vary in size but were all built on greenfield sites within the last five years, which we considered made them useful comparables for the portfolios of the national PHPs.³² In addition, we collected information on the basic build costs of several other facilities constructed in the last

³⁰ We did not have any information on whether such plant had been replaced or refurbished.

³¹ CC analysis of Mace & Knight Frank reports.

³² We have not had reference to the costs of developing the Montefiore hospital in Brighton as in this case a building was acquired and converted.

decade, including Circle Bath and Circle Reading, Nuffield Oxford, Nuffield Leeds and Nuffield Guildford.³³ These are set out in Table 8.

TABLE 8 Hospital build costs

Surveyor	Type of estimate	Basic build cost £/m ²	Total build cost £/m ²
KIMS, 2013	Actual build cost	-	3,495
Spire Shawfair, 2010	Actual build cost	-	4,000
Nuffield Cardiff, 2010	Actual build cost	1,950	3,440
Nuffield Oxford, 2004	Actual build cost	2,000	-
Nuffield Leeds, 2002	Actual build cost	1,970	-
Nuffield Guildford, 2010	Actual build cost	2,100	-
Circle Bath, 2009	Actual build cost	3,350	-
Circle Reading, 2012	Actual build cost	2,475	-

Source: KIMS, Spire, Nuffield and Circle information, CC analysis

Note: Nuffield provided all build cost figures in 2007 prices. We have not made any adjustments to these figures.

46. Total build costs include professional fees, VAT and the contractor's profit margin, in addition to the basic build costs.³⁴ We thought that the data collected on basic build costs may provide a useful indicator of the likely level of total build costs but we have placed less reliance on this data. For example, the basic build cost for Nuffield's hospitals are all fairly similar, which suggests that the total build costs may also be around the £3,400 to £3,500 per square metre level.
47. This analysis highlighted total build costs of between £3,440 and £4,000 for recently-constructed hospitals. Knight Frank's report stated that Spire Shawfair was constructed on abnormal ground conditions due to the existence of a mine beneath the site. Our inspection of the detailed breakdown of construction costs indicated that there were several additional costs incurred in relation to stabilizing the site. Hence, we thought that this hospital may provide a less reliable comparator than KIMS and Nuffield Cardiff. We concluded that a reasonable build cost for the MEA was between £3,400 and £3,500 per square metre.³⁵
48. We observed that AEH's estimates of gross replacement cost were slightly above this range, which we thought was likely to be due to the costs of building in central London. We concluded, therefore, that no adjustments should be made to the build costs of HCA's hospitals. However, we did adjust the AEH build costs to take account of the corrected floor space figures provided in the KPMG report.³⁶
49. We considered that this analysis indicated that the build costs per square metre used by Mace (£3,840 to £4,340) and Colliers (£4,365) were excessive in comparison with actual build costs. In addition, we considered that Mace's approach did not take into account the efficient size of a modern asset. Colliers estimated that the modern equivalent hospitals for BMI's estate would be [redacted] per cent smaller on average than BMI's current hospitals. BMI's portfolio of hospitals is older on average than that of Spire. However, Colliers estimated that for BMI's hospitals that were constructed in the 1980s, the MEA would be approximately [redacted] per cent smaller.³⁷ If the floor space

³³ In these cases, information on total build costs was not available.

³⁴ In some cases, they also include the costs of commissioning, eg Nuffield Cardiff.

³⁵ While we do not have the total build costs for Circle bath, this site also appears to have higher basic build costs than the Nuffield hospitals and KIMS. We understand that this was due to a combination of the building being constructed on a sloping site and the facility serving as a 'proof of concept' for Circle's construction model, with Circle enjoying a steep decline in build costs for the subsequent site in Reading as a result of learning from its first hospital build in Bath. <http://www.construction-manager.co.uk/on-site/healthy-discount/>

³⁶ See Appendix 6.16, paragraphs 33 to 36 for full details of HCA's submissions in this respect.

³⁷ [redacted]

of Spire's hospitals were reduced by a similar amount, this would increase the effective reinstatement cost per square metre to between £3,250 and £3,650, which is in line with the build costs of new hospitals.

50. We observed that the reinstatement estimates for BMI were slightly below the level indicated by the evidence of the costs of building an MEA and considered whether it would be appropriate to increase the reinstatement value accordingly. We reasoned that our analysis was already conservative in some respects; for example, it did not adjust for the lower operational costs associated with running a modern hospital, which includes the lower staffing costs associated with an optimally-designed hospital building,³⁸ as well as lower energy costs. In the case of BMI we thought that these additional costs might be quite significant as its portfolio of hospital buildings is relatively old, with approximately 40 per cent of the estate being built prior to 1950. Similarly, the analysis included the full value of BMI's Paddocks and Manchester Lifestyle facilities, despite being told by BMI that the former [X].
51. We concluded, however, that in order to be conservative it would be appropriate to make an adjustment to the level of capital employed to reflect the difference between the reinstatement cost estimates and the cost of building an MEA. We have, therefore, increased the reinstatement cost estimates by £200 per square metre (using the Colliers floor space estimates) to give BMI a total build cost of £3,400 to £3,480 per metre, which increases the 'new' value of BMI's buildings by £36.2 million as of FY11. We have applied the average level of obsolescence to this figure over the period and included a depreciation charge of 2 per cent per year in BMI's cost base. We note that we consider this to be a highly conservative approach given that we have not adjusted for operating costs as set out above.

Alternative use values

52. We considered HCA's argument that the appropriate means of valuing its buildings was on the basis of their alternative use for conversion to residential property. We thought that there were two logical inconsistencies in the arguments put forward by HCA. In the first instance, we observe that if it were generally straightforward to achieve planning permission to convert properties from other uses, whether medical or commercial, to residential use, there would not exist the significant difference in values between those uses and residential use highlighted by HCA, since landlords would have a strong incentive to convert commercial properties to residential use.³⁹ Therefore, the existence of a difference between the value of residential and commercial property in central London indicates that there are, in general, obstacles to converting properties to residential use. While this does not mean that any individual HCA hospital would not be able to obtain permission to convert to residential use, it does suggest that the assumption that all HCA hospitals could be converted is unlikely to be realistic. Second, it was not clear to us why, given the difference in value between commercial and residential properties (and HCA's assumption that change of use planning permission was relatively easy to obtain), a new entrant to the health-

³⁸ For example, Colliers DRC report for BMI (pp12 & 13) noted that:

Both Functional and Physical obsolescence factors impact on economic obsolescence which has regard to such factors as the cost of heating, lighting and maintaining the buildings, but also **the additional costs of staffing the hospitals to operate within a layout of amenities which is not optimum and not to the level noted in a modern purpose designed and built replacement.**

As an example a modern theatre block will be designed with patient and staff flow optimised, separating 'dirty' from 'ultra clean', ease of access from the bedroom block, through to anaesthetics, into the theatre out to recovery with ITU beds close by. [CC emphasis added.]

³⁹ The recent changes in planning regulations have stimulated a large quantity of applications to convert properties from commercial to residential use. See: www.parliament.uk/briefing-papers/SN00485.pdf.
<http://londonpropertymarket.kfh.co.uk/londonwide/commercial-property-grows-in-popularity-as-a-source-for-residential-conversions>

care market would seek to purchase a more expensive residential building when it could enter via the acquisition of a cheaper commercial property and convert this to medical use.

53. We reviewed the examples provided by HCA of buildings being converted to residential use from other uses, both medical and commercial. We concluded that these did not provide sufficient evidence to support the contention that a purchaser of HCA hospitals could relatively easily convert them to residential use. Some of the examples provided, such as the conversion of a car park in Soho to combined office and residential use, appeared irrelevant given the obvious differences between hospitals and car parks. Similarly, the conversion of a building from flats to a single dwelling does not appear pertinent to whether planners would permit medical to residential conversions. Several of the other examples of planning permission being granted were based on use swaps elsewhere within the Harley Street Special Policy Area (SPA), ie permission was granted to convert medical to residential use, at least in part, due to an opposite conversion elsewhere in the SPA.⁴⁰
54. However, we reasoned that, to the extent that it may be difficult to convert property from medical to residential use, this did not necessarily suggest that commercial use was a more appropriate valuation benchmark for hospitals since there may be similar obstacles to the conversion of commercial property to medical use (or vice versa). As a result, we considered that information on the rental costs of private hospital buildings could provide guidance as to whether medical buildings were closer in value to residential or commercial buildings. Therefore, we collected information on rents paid on a range of medical buildings. These were predominantly located in the Harley Street area. Given the strong medical reputation of this area, we thought that these rents were likely to be the highest for medical use in London.

TABLE 9 Rental rates for medical properties, Marylebone area

[✕]

Source: HCA information and CBRE and Strutt & Parker reports, 2008, prepared for TLC.

*Based on overall floor space.

55. We observe that these rental rates are approximately in line with the office rental figures used by AEH of between £40 and £50 per square foot, which indicates that medical use tends to attract a similar value to commercial use, particularly for larger medical buildings. A CBRE report for TLC highlighted that:

As a general observation, rents for larger medical buildings within the medical district (such as the Cancer Centre) tend to benchmark similar size offices in the vicinity albeit the consulting market remains characterised by the letting of suites within buildings, which we consider of little relevance to the rental valuation of larger premises.

⁴⁰ These examples include: 65-69 New Cavendish Street, 52 Harley Street and 17 Wimpole Street.

The Howard de Walden Estate (HdW) told us that the impact of planning restrictions in this area was such that, for a medical building to gain permission to be converted to residential use (or vice versa), its owners would usually have to ensure that another building in the area was converted from residential to medical use in order to maintain the mix of uses in this area. Similarly, a report prepared for TLC by CBRE (2012) stated that:

The property lies within the Harley Street Special Policy Area and is within Westminster's Central Activities Frontage Zone. Westminster's policy is to seek to protect and encourage the provision of private medical facilities that do not adversely affect local amenity or alter the balance of medical or residential uses. The aim is to protect the unique cluster of medical facilities to ensure they are not lost to other commercial uses. Alternative use would be a material departure from these policies, in view of the large size of the London Clinic. It is not possible to predict what alternative development might be permitted or the timescales for obtaining planning permission.

56. CBRE also noted that the difference in the level of rents for TLC's Cancer Centre and its Main Clinic reflected the smaller size of the Cancer Centre and the fact that it would be 'a state-of-the-art medical building and not a 75 years old inpatients hospital'.
57. We concluded, therefore, that AEH's approach to valuation which benchmarks land values to those of commercial property and estimates buildings values on a DRC basis is better supported by the evidence than the KPMG valuation, which assumes alternative residential use for HCA's properties. In addition, we did not agree with HCA's assertion that KPMG's approach was 'conservative' for the following reasons:⁴¹
- (a) KPMG does not take account of the impact of affordable housing requirements on the value that a developer would pay HCA for its properties. HCA estimated that this might reduce the value by as much as £[redacted] million, although it argued that this was an upper bound estimate.⁴²
 - (b) KPMG applies a uniform value to all the floor space in the building, noting that a residential developer may look to increase the total internal area by adding floors to the building. We agree that a developer may seek to increase the total floor space of the buildings as part of a conversion but we also thought that a developer would be unlikely to pay the same rate for a basement area which may be difficult to use for apartments and would almost certainly sell at a discount if it were used as ancillary space (such as car parking).
58. In spite of these reservations, we have applied a sensitivity to the value of HCA's buildings on the basis of the KPMG valuation. We have not, however, capitalized HCA's freehold improvements and refurbishments in addition to the KPMG building value as we reasoned that this was equal to approximately half the potential affordable housing liability that KPMG had not reflected in its valuation and, therefore, already represented a very conservative assumption from the point of view of our analysis.
59. Finally, we considered HCA's argument that the current costs of entry in London would value its property at around £[redacted] million. We considered each of the examples provided by HCA. We were concerned that several of these were not supported by evidence of actual purchase and conversion costs but, rather, were based on discussions that HCA had with developers and HCA's own estimates of conversion costs. We also had a number of reservations about the assumptions made by HCA in its analysis.
60. In the case of Harcourt House, we understand that the purchase price was £[redacted] million but that VAT would be payable on the sale as the result of the exercise of the option to tax the piece of land, increasing the price to £[redacted] million.⁴³ In general, VAT is not payable on the purchase price of second hand property but a business can opt for a building to be subject to VAT. HMRC explains:

⁴¹ These are reasons additional to the assumption that all the buildings could obtain planning permission for conversion to residential use.

⁴² We note that London has an overall target of 50 per cent affordable housing. Whilst this target comprises affordable housing from all sources, including housing association schemes and bringing vacant properties back into use, as well as through planning obligations on new developments and conversions, it does not appear reasonable to assume that no affordable housing would need to be provided in converting all of HCA's properties to residential use.

⁴³ www.primeresi.com/cavendish-square-mansion-block-goes-for-resi-conversion/24927/; www.propertyweek.com/sunley-buys-harcourt-house/5062652.article.

'Supplies of land and buildings, such as freehold sales, leasing or renting, are normally exempt from VAT. This means that no VAT is payable, but the person making the supply cannot normally recover any of the VAT incurred on their own expenses.

However, you can opt to tax land. For the purposes of VAT, the term 'land' includes any buildings or structures permanently affixed to it. You do not need to own the land in order to opt to tax. Once you have opted to tax all the supplies you make of your interest in the land or buildings will normally be standard-rated. And you will normally be able to recover any VAT you incur in making those supplies.'⁴⁴

61. We understand that hospital operators generally are not able to reclaim VAT since the supply of healthcare services is exempt from VAT.⁴⁵ However, we thought that, if this were the case for the purchase of a building for conversion to a hospital, this would provide a strong reason not to purchase a property where the option to tax had been exercised since such a building would, in effect, be 20 per cent more expensive than an equivalent building where the option to tax had not been exercised. This would suggest that this property might represent an unnecessarily expensive means of entry for a hospital business.
62. Second, we noted that HCA estimated that, having purchased the site, it would need to spend £[redacted] million converting and rebuilding it to form a high specification private hospital. This equated to a cost of approximately £[redacted] per square metre, which was twice the total reinstatement cost estimated by AEH in their property valuation and around three times the £[redacted] to £[redacted] per square metre residential conversion cost assumed by KPMG.⁴⁶ Similarly, in the case of the Danubius Hotel and 79 New Cavendish, HCA assumed a conversion cost of £[redacted] and £[redacted] per square metre, respectively. We did not, therefore, consider that these conversion costs represented a reasonable estimate in light of the expert property reports submitted by HCA.
63. In two of the four cases, the offer made to HCA was to rent the building at a given level. For Camden Town Hall Annexe, HCA has capitalized this level of rent and added on the costs of converting the building. However, [redacted]⁴⁷
64. Given that the lessor would bear the costs of the conversion such that the rent represented that for a fitted out hospital, we reasoned that it would be inappropriate to include these costs in a valuation of the building estimated by capitalising the value of rent.
65. As a result of these reservations, we concluded that we could not place any significant weight on these estimates and therefore we have not adjusted our base case (or property sensitivity) to reflect HCA's estimates of the cost of entry.

Capitalization of leased buildings

66. We considered HCA's argument that a ROCE calculation could be 'distorted' by the exclusion of leased buildings from the capital base of the business. We thought that the extent of this distortion and its direction, ie whether the exclusion of leased

⁴⁴ http://customs.hmrc.gov.uk/channelsPortalWebApp/channelsPortalWebApp.portal?_nfpb=true&_pageLabel=pageLibrary_ShowContent&id=HMCE_CL_000158&propertyType=document

⁴⁵ http://customs.hmrc.gov.uk/channelsPortalWebApp/channelsPortalWebApp.portal?_nfpb=true&_pageLabel=page_VAT_ShowContent&id=HMCE_CL_000121&propertyType=document

⁴⁶ See Table 7 above.

⁴⁷ [redacted]

properties from the capital base increased or decreased returns, would depend on the level of rent relative to the cost of acquiring the building. In some cases, the ROCE could be increased by renting buildings rather than acquiring them, whilst in others the ROCE would be reduced. The relative cost of buying or leasing assets, therefore, will be taken into account by firms when choosing which approach to take, bearing in mind the aim of maximizing returns to shareholders. However, firms may also take into account the other advantages and disadvantages that come with such a choice. For example, the purchase of an asset fixes its cost, removing the risk that rents may increase in the future. It also reduces the operational gearing of the business. On the other hand, leasing a building avoids the need to raise capital up front.

67. When determining which assets to include within capital employed and which to treat as 'rented', our principal concern was to distinguish between those assets that had been 'purchased' up front and those that were rented at a market rate since we considered that this captured the economic substance of the choice made by operators. Reflecting this approach, where leasehold buildings have been capitalized, we have not depreciated them over the life of the lease but according to the obsolescence of the building (as measured by the VOA), in effect treating them as freeholds. We recognize that different firms have made different decisions regarding leasing or buying their hospitals and that these decisions may, depending on the relative costs of replacing buildings versus renting them, have an impact on the returns earned by those firms. However, that impact could be either to increase or decrease ROCE since both returns and capital employed would increase. We note that, to the extent that capitalizing buildings would decrease ROCE, as HCA argued was the case for its leased buildings, this indicates that purchasing assets is less efficient than renting them such that the former would represent an inefficient choice by the PHPs. For the purposes of our analysis, we do not consider it logical to include leased buildings in the capital employed of the firms when those firms have not invested capital in acquiring the buildings and where the costs of renting the buildings are included as a cost in the profit and loss of the business. We have not, therefore, capitalized any of HCA's leased buildings.

Measurement of obsolescence

68. We considered BMI and Spire's arguments regarding the measurement of buildings obsolescence and the appropriateness of the VOA measures. In our initial working paper on profitability, we explained our approach as follows:

Although we consider that not depreciating the replacement cost of an asset is likely to result in its over-valuation, we recognize that there are several characteristics of these assets that make the approach of using the 'reinstatement cost' of buildings as a proxy for their MEA value still the most consistent estimate of capital employed in the provision of private healthcare services. First, the age profile of the buildings employed in providing hospital services demonstrates that the UEL of a hospital that is appropriately maintained is significantly in excess of 50 years. We note that approximately 20 per cent of the hospitals operated by the relevant firms were constructed (at least in part) prior to 1960 and hence are more than 50 years old. We considered whether it would be appropriate to depreciate the buildings over a longer period, for example, over 100 years. However, we note that even using this assumption there would still be a number of buildings in use that would be fully depreciated, such that this assumption would not provide an appropriate estimate of the capital employed in the industry. Second,

information provided by the Relevant Firms on their capital expenditure over the period indicates that they have high levels of recurring expenditure on the refurbishment of their hospitals, which may be expected to extend the life of the hospital buildings significantly. Therefore, we have used the (un-depreciated) reinstatement cost of the hospitals as their MEA value in our analysis.⁴⁸

69. We went on to explain that this approach of not depreciating the assets had two further logical implications for our analysis. The first was that the value of refurbishments to owned hospital buildings should not be recognized in the capital base, as this would result in double counting, nor should any such expenditure be deducted from profits. The second was that no depreciation should be charged against the hospital buildings over the period of analysis, with only the change in the gross value of the asset being recognized as an expense/income. We emphasized that we considered the approach to be highly conservative and indicated that we may adapt our approach to consider a range of profitability estimates including those based on DRC of buildings.
70. In response to this initial working paper, both BMI and Spire argued that our analysis should take into account the costs/investment incurred in maintaining their assets. Spire suggested that this should be done via a depreciation charge, while BMI suggested that we should recognize its capital expenditure on maintaining its buildings as an expense.⁴⁹ We thought that a combination of these proposed approaches—of including a depreciation charge and capitalizing capital expenditure on buildings—was logical. However, we did not agree with the logic of charging depreciation to the profit and loss but not reducing the value of the assets by the same amount. Either an asset declines in value due to wear and tear and/or obsolescence, or it does not. Following the publication of our initial working paper, we also gathered information on the VOA estimates of obsolescence,⁵⁰ which we considered could provide a consistent estimate of the obsolescence of the PHPs' buildings as of 2008.
71. BMI put forward Colliers' professional opinion on obsolescence as a more accurate reflection of the level of depreciation of its buildings, because these were based on site-by-site inspections by suitably qualified surveyors with experience in healthcare assets. The Colliers estimate was an average level of obsolescence of [X] per cent (as of 2013) compared with a VOA estimate of [X] per cent (as of 2010). Our review of the Colliers report in relation to build costs suggested that their estimates were significantly above the costs incurred recently in constructing new hospitals. We came to the view, therefore, that we should place more evidence on the VOA estimates which were prepared by a third party, independently of our investigation.
72. We considered Spire's suggestion that it invested sufficiently in its buildings to maintain them at their 'new' value and, indeed, enhance that value over time. While we recognize that the PHPs do invest in maintaining their assets, and that Spire in particular has invested heavily over the relevant period, we did not agree that such investment would ensure that all buildings maintained their new value at all times, or that such investment would necessarily counter the effects of obsolescence from changing medical technology. For example, a Colliers property report on Spire's portfolio stated that overall Spire's portfolio was maintained to a high standard but, in relation to Spire Norwich, Colliers noted that 'Ongoing repairs and maintenance are

⁴⁸ 'Profitability analysis' working paper, paragraph 47.

⁴⁹ BMI response to profitability working paper, paragraph 2.31;

⁵⁰ The VOA estimates the level of obsolescence of hospitals on a site-by-site basis. Its estimates are generally revised every five years. The methodology applied by the VOA is set out in *Practice Note 5: 2010: The Valuation for Rating of Private Sector Hospitals*.

required to help maintain the hospital's competitiveness, in a strong private care market'. Similarly, Colliers highlighted that 'The performance of Spire Southampton has generally been poor in recent years as evidenced by the Healthcare Report, customer satisfaction and financial performance. This may in part be due to the physical condition of the premises which are in need of some refurbishment.' We concluded, therefore, that it was appropriate to apply depreciation adjustments to Spire's hospitals, with the actual level of capital expenditure incurred recognized in the total value of capital employed.⁵¹

73. The VOA estimates of obsolescence are based on the age of the asset but take into account both significant refurbishments and additions to the hospitals over time. The level of obsolescence also takes into account the impact of the layout of a hospital on its functionality. For example, the 2005 VOA assessment for the Mount Alvernia hospital makes allowances for [X]. Hence, while the VOA does not inspect sites for every assessment, we consider that this evidence demonstrates that it does take into account the specific characteristics of the sites.⁵² In addition, the VOA does not apply an obsolescence charge of more than 50 per cent, which we thought represented a fair reflection of the fact that there is a limit to the extent to which a functioning build declines in value. We concluded that the VOA figures provided a reasonable estimate of the obsolescence of the PHPs' hospitals and that using these estimates had the advantage of ensuring a consistent approach across all hospitals.

Buildings cost index

74. We considered Spire and BMI's argument that the public sector non-housing output price index was inappropriate as a means of adjusting their building values over the period. We noted that Spire proposed that the BCIS All In Tender Price index should be used, while BMI argued that the BIS private sector commercial index was more appropriate for private hospitals. We chose the BIS public sector non-housing index over the equivalent private commercial index since it includes Department of Health construction projects, ie public hospitals. We considered that this would be more accurate than the commercial index, particularly given the small number of private hospitals built over the relevant period. We thought that an output price index would be more appropriate than a tender price index since the former reflects the cost of replacing a hospital during that period whereas the latter reflect the cost of replacing a hospital up to two years later given the time required to build a new hospital. This is demonstrated in the time lag between the decline in tender prices and the decline in output prices during the financial crisis.

⁵¹ The combined effect of depreciating buildings but also capitalizing investment in maintaining or enhancing them can result in an increasing, decreasing or steady level of capital employed over time.

⁵² Spire told us that the VOA inspected two of its sites in relation to the 2008 assessment.

Anaesthetist groups

Introduction

1. This appendix describes our analysis and results of the impact of anaesthetist groups on prices. It also summarizes the relevant findings from our survey of consultants.¹
2. Several insurers told us that some anaesthetists had formed groups that collectively set prices and shared revenue. They added that in some cases these groups accounted for a very large proportion of anaesthetic treatments in one or more hospitals. This, according to several insurers, resulted in higher prices set by anaesthetist groups compared with independent anaesthetists and, in turn, to higher average prices set by anaesthetists. On the other hand, anaesthetist groups and the AAGBI argued that group formation helped in delivering higher quality of service.²
3. Table 1 shows a relatively higher rate of anaesthetist groups being formed between 1981 and 1990 and another spike between 2001 and 2010. This is based on a sample of 45 anaesthetist groups who provided full responses to our questionnaire.³ Around five out of the 26 anaesthetist groups established between 1960 and 2000 either changed from loose associations to formal legal structures or moved to collective price setting between 2001 and 2010.

TABLE 1 Establishment of anaesthetist groups over time

<i>Time period</i>	<i>Number of anaesthetist groups established</i>
1960–1970	1
1971–1980	7
1981–1990	13
1991–2000	5
2001–2010	19
Total	45

Source: CC analysis.

4. Our analysis includes 11 local areas, and anaesthetist groups active in these areas, that insurers mentioned specifically, as these were likely to be among the most problematic ones (see paragraph 6).⁴
5. This appendix is structured as follows. First, it describes the analysis conducted on the impact of anaesthetist groups on prices. Second, it summarizes the relevant findings from our survey of consultants.

Price analysis of anaesthetist groups

6. We did not have enough information on the anaesthetist groups' presence across UK hospitals to test systematically their possible impact on average fees charged by

¹ Findings from our survey of consultants are similar to those previously presented in the [annotated issues statement, Appendix C](#).

² See [Annex A](#) for a summary of the view/evidence provided by various parties on the impact of anaesthetist groups.

³ The questionnaire was sent to over 100 anaesthetist groups.

⁴ The changes to the analysis undertaken by the CC as a result of comments received in response to the annotated issues statement are noted in paragraphs 10-14 below.

anaesthetists.⁵ Therefore, our analysis covered only a number of local geographic areas, and anaesthetist groups active in these areas, that insurers mentioned specifically (ie 11 in total), as these were likely to be among the most problematic ones. This section describes the data used, outlines the methodology applied and summarizes the results of our analysis.

Data

7. There are two key elements of information for this analysis: data on the treatments and data on the presence and importance of groups of anaesthetists. The data set containing this information was put together by merging two different databases.
8. The first database included anaesthetist data for insured patients at the treatment level for the period 2006 to 2012.⁶ The source was the invoice-level data provided by all insurers in response to our data questionnaire.⁷ It contained information on each treatment—ie type of treatment,⁸ the invoiced price, the hospital in which the treatment was administered and the GMC number of the anaesthetist who administered the treatment.⁹ We removed some outliers for each treatment by excluding all observations for which the fees charged by consultant anaesthetists fall in the top or bottom 1 per cent.
9. The second database contained information on membership of anaesthetist groups. We received full responses to our questionnaires from 45 anaesthetist groups,¹⁰ informing us of the dates the groups were formed, the rationale behind forming their groups, names of their members and the private hospitals in which they served private patients. We used this information to identify the anaesthetists in the first database that were in these groups. The groups also told us about their main centralized activities, requirements for group membership, any arrangements with hospitals and insurers and how they set their fees. We note that the database did not cover all the anaesthetist groups in the UK.

Methodology

10. A key aspect of the analysis was to find for each local area, and anaesthetist group, an appropriate control group that allowed us to compare the fees for treatments administered by consultants who belong to anaesthetist group(s) with the fees of the control group. The more similar the circumstances that affect the fee level of the treatment offered by the two groups, the more likely that any difference in prices can be attributed to the presence of the anaesthetist group. As our control groups will not, in general, capture all other factors, there is some uncertainty associated with our results from our analysis.

⁵ AAGBI does not maintain records of its members' membership of anaesthetist groups and was unable to provide a comprehensive list of anaesthetist groups and was not able to provide any information of their membership. The PMIs confirmed that they did not in many cases know whether an anaesthetist was part of an anaesthetist group when being invoiced. Similarly, the hospital operators had varying information on whether anaesthetist groups were operating in their hospitals and which anaesthetists were members of such groups.

⁶ Data for 2012 covered only part of the year. The period covered in 2012 varies among insurers. Therefore, all the analysis conducted for 2012 covered part of the year.

⁷ The composition of the clean insurer database, after removing outliers, was: 49.4 per cent Bupa, 29.5 per cent AXA PPP, 10 per cent Aviva, 7.3 per cent PruHealth, 3.3 per cent WPA and 0.6 per cent Simplyhealth.

⁸ The database contained codes which refer to each treatment. In most cases these refer to standardized treatments (eg knee replacement), though there may be some variation within the same treatment (eg different types of anaesthetic treatments for knee replacement). This may be one of the factors (alongside regional differences, the type of hospital, presence and importance of groups etc) that explain some of the price variation within the same treatment and which we cannot account for.

⁹ The GMC number allowed us to know if the anaesthetist belongs to a group through matching it with our second database.

¹⁰ The questionnaire was sent to over 100 parties identified from information provided by the AAGBI, the main hospital operators, the PMIs and from the Internet as potentially anaesthetist groups.

11. We controlled for the mix effect of different treatments performed in the different local areas by looking at six¹¹ of the ten most common treatments in the UK under general anaesthesia.¹² We adjusted our selection of treatments based on the AAGBI's response to the annotated issues statement. The AAGBI told us that two¹³ out of the six treatments presented in the annotated issues statement were most commonly used by anaesthetists as secondary procedures performed in addition to the primary procedure under general anaesthesia, which increasingly attracted no additional fees. When these codes are used alone, they are used primarily for chronic pain work which is only rarely part of anaesthetic group practice. Therefore, we have replaced these two treatments after consultation with AAGBI.
12. Where data was available, we have conducted the analysis for each of the six treatments. First, we conducted price analysis at the national level to give an overview on the UK anaesthetist market. Then, as mentioned above, we focused our price analysis on local geographic areas, where insurers complained specifically about the presence of anaesthetist groups. Based on the 11 areas identified by insurers, we conducted regional analysis and individual case studies. The different pieces of analysis undertaken are outlined below:¹⁴
 - (a) *National analysis.*¹⁵ We compared the average fees in the UK, between 2006 and 2012,¹⁶ charged by anaesthetists who according to the data collected belonged to any of the 45 groups we identified with anaesthetists who did not belong to a group. The latter include independent anaesthetists and anaesthetists who may belong to groups but which we could not identify.
 - (b) *Regional analysis.*¹⁷ Ten out of the 11 groups we examined are located in one of two regions in the UK. Accordingly, we conducted the following analysis for each of the two regions separately:¹⁸
 - (i) We compared average fees in the region, for each year between 2006 and 2012, charged by anaesthetists who we knew belonged to any of the 45 groups we identified with anaesthetists who we did not identify as belonging to a group. The latter includes independent anaesthetists and anaesthetists who may belong to groups but which we could not identify.
 - (ii) We compared the average fees charged by each group examined that operates in the region with the regional average (where we exclude from the regional average treatments provided by anaesthetists who are identified in our data set as members of any of the 45 groups) between 2006 and 2012.¹⁹

¹¹ Multiple arthroscopic operation on knee (including meniscectomy, chondroplasty, drilling or microfracture) (w8500); arthroscopic meniscectomy (including debridement) (w8200); phakoemulsification of lens with implant—unilateral (c7122); hysteroscopy including biopsy, dilatation, curettage and polypectomy with/without mirena coil insertion (Q1800); diagnostic endoscopic examination of bladder (including any biopsy) (m4510); surgical removal of impacted/buried tooth/teeth (f0910).

¹² These account for around 18 and 19 per cent of observations with non-missing CCSD codes by volume and by value respectively.

¹³ Local anaesthetic blockade of major nerve trunk (including occipital block, spheno-palatine block, diagnostic block of trigeminal branch, intercostal nerve block & supra-scapular nerve block) (A7350); and epidural injection (lumbar/caudal) (A5210).

¹⁴ The national and regional analyses were concluded following the annotated issues statement. In the annotated issues statement we examined three individual case studies using the methodology described in paragraph 12(c).

¹⁵ A minimum of 20 observations per treatment were required to calculate the average fees per treatment. Where we had fewer than 20 observations for some treatments, we note this in the results section.

¹⁶ This comparison is not conducted on an annual basis; for each treatment we compare two average prices calculated for anaesthetist services provided between 2006 and 2011.

¹⁷ A minimum of 20 observations per treatment were required to calculate the average fees per treatment. Where we had fewer than 20 observations for some treatments, we note this in the results section.

¹⁸ Three groups are located in Region 1, seven groups are located in Region 2 and one group is located in Region 3. We have conducted the regional analysis for Regions 1 and 2.

¹⁹ Similar to the national analysis, this comparison is not conducted on an annual basis.

(c) *Individual case studies.*²⁰ Depending on the information available and the facts in each case study, we carried out the following pieces of analysis for each of the 11 local areas to the extent we had the relevant data:

- (i) We compared annual price levels of anaesthetist groups with a regional average (where we exclude from the regional average treatments provided by anaesthetists who are identified in our data set as members of any of the 45 groups). This is different from the regional analysis above ((b)(ii)) as it compares price levels for each year between 2006 and 2012. The regional analysis did not look at price levels over time but rather looked at a single average price for anaesthetist services provided between 2006 and 2012.
 - (ii) We compared the price change of anaesthetist groups pre- and post-formation of the groups or changing of their legal status (where these were within the period covered by our data) with the price change of a regional average over the same period. The percentage change in price pre- and post-event is compared with regional average, which excludes the treatments provided by anaesthetists who belong to the group under study.
 - (iii) We compared the average prices of anaesthetist groups with independent anaesthetists (ie not belonging to the group) in the same hospitals in a given geographic area.
 - (iv) We compared prices in hospitals where the anaesthetist groups' presence is significant with those in nearby hospitals where groups are not present or are not present to the same extent. We considered that the best comparator would be nearby hospitals (as the price of the treatment may reflect some local factors, eg local supply of anaesthetists) and a hospital that belongs to the same corporate group (as prices of anaesthetic treatments may be influenced by the corporate group).
13. We observed that even for each specific treatment there is substantial price variation in anaesthetist fees across the UK. Therefore, any difference between the average fees set by members of group(s) and non-members of groups in the national and regional analyses could be explained by factors other than the presence of a group. We have taken this into consideration while interpreting the results of these analyses.
14. The individual case studies provide more detailed analyses that aim at better controlling for geographical variations. The pre- and post-event analysis is the most useful. The difference between the groups' prices pre- and post-event and those of non-groups, particularly in the same region, represents a good comparator as the only (observable) feature is the group formation or change in group legal structure. However, this could only be applied to three case studies where the group was formed during the period examined (2006 to 2012). The second best comparator is independents working in the same hospitals, which was applied to four case studies. In theory, comparing average fees between group members and independents in the same hospital is a good comparator as the only (observable) feature that differentiates them is that they are not part of a group. However, one possible disadvantage of this approach is that independents may choose to follow the prices set by the groups. The third best comparator is comparisons with nearby hospitals, which was applied in three case studies. We had difficulty conducting this analysis because of lack of data

²⁰The eligibility criterion to compare average fees per treatment is having at least 20 observations for four out of the seven years. We conducted case studies for the local areas where we were able to compare average fees for at least three out of the six treatments selected. We note in the results section the local areas, where we did not have enough observations for at least three treatments in order to conduct an individual case study.

and information about the presence and/or size of anaesthetist groups in nearby hospitals.

Results

15. The detailed results are summarized below. As noted in paragraph 13, as there is substantial price variation in anaesthetist fees even for each specific treatment across the UK, this is taken into consideration while interpreting the results from the national and regional analysis.

National

16. The analysis shows that average fees charged by anaesthetists identified to be members of any of the 45 groups across the UK appear to be higher than those charged by non-members (independents or members who are not identified in our database) for the six treatments examined between 2006 to 2012. The weighted average price difference between members and non-members is around 7 per cent.²¹

Regional

17. The first type of analysis (see paragraph 12(b)(i)) shows that average annual fees charged by group members in Region 1 appear to be higher than those charged by non-members (independents or members who are not identified in our database) for the six treatments examined between 2006 and 2012. For Region 2, average annual fees charged by members appear to be higher for five treatments. For the sixth treatment, fees charged by members were higher for the initial part of the period and reached levels below non-members between 2010 and 2012.
18. Tables 2 and 3 show the second piece of regional analysis (see paragraph 12(b)(ii)). They summarize the price differences between the ten groups that are located in Regions 1 and 2 and the relevant regional average.²² For seven groups, average fees charged by each group are higher than the relevant regional average (excluding treatments provided by anaesthetists identified to be members of groups in the region) for most of the treatments examined. In addition, we looked at the difference between the weighted average price charged by the groups for the six treatments and the relevant regional weighted average price.²³ For six groups, the weighted average price difference is at least 9 per cent. For three groups, the weighted average price differences range between 2 and 4 per cent. For one group it is -9 per cent.

²¹ The weights are the national volume of anaesthetic services provided for each treatment.

²² The 11th group is located in a third region that is not included in the regional analysis.

²³ The percentage price difference between average fees charged by the group and the relevant regional average is calculated separately for each treatment. A weighted average price difference for all treatments is calculated, where the weights for each treatment are the number of observations provided by the members of the group.

TABLE 2 **Region 1: Group members versus regional average fee comparison**

	<i>No of treatments where group prices are higher than regional average</i>	<i>No of treatments where group prices are lower than regional average</i>	<i>Weighted average price difference %</i>	<i>Individual case study below</i>
Group 1	6		18	A
Group 2	6		9	N/A*
Group 3	3	3	-9	D

Source: CC analysis.

*Denotes groups where we did not have enough observations to conduct individual case studies.

TABLE 3 **Region 2: Group members versus regional average fee comparison**

	<i>No of treatments where group prices are higher than regional average</i>	<i>No of treatments where group prices are lower than regional average</i>	<i>No of treatments where group prices are close to regional average*</i>	<i>Weighted average price difference %</i>	<i>Individual case study below</i>
Group 4†	5	1		13	C
Group 5	6			10	E
Group 6	2	2	2	2	B
Group 7	5	1		12	F
Group 8	4	2		4	N/A‡
Group 9§	6			12	N/A‡
Group 10¶	2	2	2	4	N/A‡

Source: CC analysis.

*Includes a price difference of less than or equal to 2 per cent.

†There is a low number of observations (ie less than 20) for two treatments (greater than regional average).

‡Denotes groups where we did not have enough observations to conduct individual case studies.

§There is a low number of observations (ie less than 20) for one treatment.

¶There is a low number of observations (ie less than 20) for two treatments (one greater than and one lower than regional average).

Case studies²⁴

19. We did not have enough observations to conduct the individual analysis for five out of the 11 anaesthetist groups. Results from the six individual case studies analysed are summarized below:

- (a) Results on two case studies (namely A and B below) were mixed. It is worth noting that the most significant result for the two groups is the pre- and post-event analysis.
- (b) Results on one case study (namely C below) were broadly consistent in showing that the anaesthetist group seemed to have an impact on prices. Again, the most significant result for this group is the pre- and post-event analysis.
- (c) Results on three case studies (namely D, E and F below) do not suggest that the presence of the group leads to higher prices. However, for these case studies we were unable to carry out what we regard as the strongest piece of analysis—the pre- and post-event price analysis—as the groups were formed before our period of study (2006 to 2012).

²⁴ The number of treatments we were able to examine for each case study may vary across the different pieces of analysis undertaken. For example, for some case studies we had enough observations to look at more treatments under the pre- and post-event analysis, which compares two time periods, compared with the other three pieces of analysis carried out, which compare annual fees. Another example is having enough observations for some treatments to compare the average fees charged by the group to regional averages but not having enough observations on fees charged by independents to compare fees.

*Case study A*²⁵

20. The anaesthetist group in this area has a high share of all anaesthetic treatments—over 80 per cent by volume. It told us that some group members charged below the fees set by the group.
21. The findings for case study A are:
 - (a) Average fees for the anaesthetist group for each of the six treatments are higher than the regional average fees for the period 2006 to 2012.
 - (b) There is more variation in fees for each of the six treatments before the group was formed than after it was formed.
 - (c) The increase in average fees of the anaesthetist group when the group was formed was higher than the increase in regional average fees for five treatments and lower for one. For three out of the five treatments (with higher prices), the differences in price rises were four percentage points, two percentage points and one percentage point. For the other two treatments, the differences in price rises were 13 and 15 percentage points. For the sixth treatment, the lower price rise was minus two percentage points.
 - (d) The level of fees for the anaesthetist group and independent anaesthetists in the same hospitals for two treatments are broadly the same. It is difficult to make comparisons for three treatments due to the low number of observations for the non-groups.²⁶ We are unable to compare fees for one treatment because there are no observations for the non-groups.
 - (e) There are higher average fees in one hospital, where the anaesthetist group operates, compared with another hospital in nearby areas, belonging to the same hospital group and where another group operates and accounts for less than 40 per cent of anaesthetist treatments, for three treatments for all years. We were unable to make comparisons for the other three treatments due to the low number of observations.

*Case study B*²⁷

22. The anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—around 60 per cent by volume. It told us that some group members had difficulty in charging at the level agreed by the group due to contractual arrangements with some insurers.
23. The findings for case study B are:
 - (a) Average fees for the anaesthetist group are higher than the regional average fees for two treatments for which we have sufficient data.
 - (b) The increase in average fees of the anaesthetist group when the group changed from a loose association to a formal partnership was higher than the increase in

²⁵ This is the same local area and anaesthetist group presented in the [annotated issues statement](#) under the name 'case study A'.

²⁶ There are few observations for anaesthetists not in groups for all treatments where we have made comparisons.

²⁷ This is a different local area and anaesthetist group from the ones presented in the [annotated issues statement](#) under the name 'case study B'. After changing the set of treatments, we did not have enough observations to present a separate case study on the local area/anaesthetist group previously presented in the [annotated issues statement](#) as 'case study B'.

regional average fees for four treatments and lower for one. For two out of the four treatments with higher prices, the difference in price rises was one percentage point. For the other two treatments, the differences in price rises were eight and 19 percentage points. For the fifth treatment, the price rise after the group changed from a loose association to a formal partnership was three percentage points lower than that for the region.

*Case study C*²⁸

24. The anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—above 50 per cent by volume. It told us that some group members charged fees below those set by the group.
25. The findings for case study C are:
 - (a) Average fees for the anaesthetist group are higher than the regional average fees for two treatments. For the third treatment, fees were higher between 2010 and 2012.
 - (b) The increase in average fees of the anaesthetist group when the group was formed was higher than the increase in regional average fees for four treatments, for which we have data. The differences in price rises for two treatments were eight percentage points. For the other two treatments the price differences were 10 and 14 percentage points.
 - (c) There were higher fees for the anaesthetist group than independent anaesthetists at the same hospital for two treatments and broadly the same fees for the other treatment.

Case study D

26. The anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—above 80 per cent by volume.
27. The findings for case study D are:
 - (a) Average fees for the anaesthetist group are broadly lower than the regional average fees for four treatments for which we have data.
 - (b) Average fees for the anaesthetist group for two treatments in one hospital are similar to those in another hospital in a nearby area (that belongs to the same hospital group where another group of anaesthetists operates but accounts for only 50 per cent of anaesthetist services).²⁹

Case study E

28. The anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—above 70 per cent by volume.
29. The findings for case study E are:

²⁸ This is the same local area and anaesthetist group presented in the [annotated issues statement](#) under the name 'case study C'.

²⁹ For one treatment we only have data to conduct the comparison between 2006 and 2009.

- (a) Average fees for the anaesthetist group are higher than the regional average fees for four treatments. For the other two treatments, fees were higher only in the initial part of the period before dropping to levels close to or below national and regional averages.
- (b) The level of fees for the anaesthetist group was higher than independent anaesthetists in the same hospitals for two treatments. However, the gap was decreasing over time to reach similar levels. For the third treatment, independents appear to charge higher fees for part of the period.
- (c) Average fees for the anaesthetist group for two treatments in one hospital were higher for part of the period only than those in another hospital in a nearby area (that belongs to the same hospital group where another group operates and is of similar size). This result demonstrates that prices can differ in these comparisons for reasons other than the size of the anaesthetist groups.

Case study F

- 30. The anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—over 70 per cent by volume.
- 31. The findings for case study F are:
 - (a) Average fees for the anaesthetist group are higher than the regional average fees for three treatments for the whole period, higher for one treatment towards the end of the period and lower for one treatment for the whole period.
 - (b) The level of fees for the anaesthetist group was close to independent anaesthetists in the same hospitals for one treatment. For the second treatment, it was lower till 2009, then exceeded fees charged by independents for the rest of the period.

Barriers to entry

- 32. In our provisional findings, we carried out an initial assessment of whether anaesthetist groups create barriers to entry for individual anaesthetists. However, as we have not found that the formation of anaesthetist groups adversely affects competition, we decided not to prioritize our resources in carrying out a detailed assessment of barriers to entry.

Consultants survey

- 33. Our survey of consultants found that:
 - (a) 39 per cent of anaesthetists were in groups. 22 per cent of other consultants were in groups.³⁰ 60 per cent of anaesthetists in a group said that they used the guidelines set by the group to set their fees. The proportion for other consultants was 51 per cent.³¹
 - (b) In terms of all anaesthetists (ie those in and not in groups), 24 per cent said that they used the guidelines set by the group to set their fees (14 per cent at the level

³⁰ GP and Consultants survey, E2/4.

³¹ *ibid*, E3.

specified by the group and 10 per cent with reference to the guidelines specified by the group). The proportions for other consultants are: 10 per cent (split 4 per cent and 6 per cent).³²

- (c) 10 per cent of those in consultant groups and aware of consultants not in a group said that those in groups (anaesthetists and other consultants) charged higher prices than those not in groups. Allocating 'don't knows' increases this proportion to 16 per cent.³³
- (d) For those not in consultant groups and aware of consultant groups and of other consultants not in a group, the proportions are 16 and 37 per cent.^{34,35}

³² *ibid*, E3.

³³ *ibid*, E6.

³⁴ *ibid*, E6.

³⁵ In response to the annotated issues statement ([AAGBI response to annotated issues statement](#)), AAGBI mentioned that the statistics provided under paragraph 36(c) and (d) did not support the argument that anaesthetist groups had market power, but actually showed the opposite. This actually means that 84–90 per cent of consultants thought there was no significant difference, or that group fees were lower, or that they did not know. AAGBI disagreed on allocating all the 'don't knows' to support the argument that anaesthetic groups charged higher fees.

Summary on views put forward by various parties

The PMI's viewpoint

1. The three main insurers (Bupa, AXA PPP and Aviva) provided some extensive responses and some analysis to illustrate their concern about the effect of groups of anaesthetists.
2. AXA PPP provided analysis for two anaesthetist groups:
 - (a) For the first group, it compared the average fees of anaesthetists in the local area between 2007 (when the group started to set fees collectively) and 2008 for the six most common procedures. AXA PPP claimed that the analysis showed that for one type of procedure, fees increased by 34 per cent. It also claimed that for the procedures examined, fees were 4 to 24 per cent higher than the national average. AXA PPP told us that it responded to such anaesthetist groups by adopting some of a number of strategies, in different cases. These included declining to pay excessive charges, warning its patients about the risk of shortfalls, negotiating with groups and in some cases delisting some consultants.
 - (b) For the second anaesthetist group, AXA PPP mentioned that the group charged 50 to 80 per cent more than its colleagues in a nearby area. It is worth noting that this analysis does not control for the different mix of treatments that can be performed by anaesthetists in the two geographic areas. AXA PPP added that 14 per cent of the group's patients had additional charges for full preoperative assessment against a national rate of approximately 3 per cent.³⁶
3. Bupa provided us with data on the frequency of shortfall (ie when patients have to cover part of the anaesthetists' fees), their magnitude and the proportion of treatments carried out by anaesthetist groups at the group's main hospital. They provided data on eight groups and argued that these had systematically charged above the Benefit Maxima³⁷ and they were sufficiently large that patients had no alternatives. Bupa mentioned that, in many cases, the alleged benefits of consultant groups did not appear to flow through to patients—a number of the largest anaesthetist groups charged the highest fees, for example. Bupa added that there was no objective evidence that it was necessary and proportionate to form a group with a uniform price structure (or profit sharing arrangement) to achieve these benefits.³⁸ In response to the annotated issues statement, Bupa raised the following points:
 - (a) Bupa was concerned about focusing analysis just on price as consultant market power could be exercised through volumes or restrictions of choice.
 - (b) Individual consultant fees were already above competitive levels. The situation was exacerbated (ie taken closer to the monopoly price) by consultant groups which could restrict rivalry further in local markets.
 - (c) Bupa noted the CC Consultant Survey findings that 39 per cent of anaesthetists were in groups and that 60 per cent of anaesthetists in a group said that they used the guidelines prepared by the group to set fees. However, Bupa cautioned

³⁶ AXA PPP response to annotated issues statement.

³⁷ This is the maximum reimbursement rate provided by Bupa.

³⁸ Bupa response to issues statement, paragraph 6.48.

that these results might understate the harm to competition and restriction of choice from groups. As a way of example, Bupa referred to the AAGBI statement that 64 per cent of anaesthetist groups 'share profits equally between members of the group', meaning that there was little reason to differentiate service for group members. These types of arrangement might lead to common prices across the group even if there was no explicit guidance to set uniform prices. The presence of groups also blunted the effectiveness of any new entry to stimulate competition. Bupa added that non-group members might simply follow a group's pricing, given the lack of price competition.³⁹

4. Aviva also argued that anaesthetist groups that were unwilling to use Aviva's fees had caused financial concerns and concerned customers.
5. PruHealth stated that it was aware of a large number of anaesthetic groups that set charges collectively and that several groups refused to discuss fees with it. In response to the annotated issues statement, PruHealth added the following:
 - (a) It compared the anaesthetic tariff of solo to group practices for ten commonly occurring procedures.⁴⁰ Solo practice was 5 per cent cheaper than group practice on a weighted average. The costs for most of the high-volume procedures were very similar, except for one treatment, where solo was actually more expensive on average.
 - (b) Group anaesthetic practices may deliver improved social value in their continued availability and hence justify their higher charges. The issue of group practices should include whether they served as a barrier to entry for solo consultants and this should not be restricted to anaesthetists as applied to all consultant groups.
6. WPA mentioned anaesthetist groups in four local areas and said that some of the fees set collectively were above their normal reimbursement rates.

The anaesthetist groups' viewpoint

7. Anaesthetist groups explained the main rationale behind group formation. The main arguments put forward by the anaesthetist groups, which we included in our case studies, can be summarized as follows:
 - (a) *Higher quality of service.* Groups allowed for providing emergency cover to patients 24 hours a day, seven days a week. Other benefits included enhanced routine follow-up and better pre-assessment services by anaesthetists. Involvement in discussing and creating clinical policies, pathways and guidelines as a group ensured high standards of care.
 - (b) *Communication and patient information.* The group's administration team provided a single, reliable point of contact for patients, surgeons, hospitals and insurers. This provided higher transparency and ability to address financial and non-financial queries from patients, hospitals or insurers.

³⁹ See www.aagbi.org/sites/default/files/AAGBI%20FINAL%20response%20to%20OFT.pdf (accessed June 2012). The AAGBI noted, for example, that 'The way that a newly appointed consultant will enter private practice will depend upon local circumstances. If there is a local AG, they will most likely seek to become a member of the AG, and indeed may be invited to join the AG as an automatic consequence of their taking up a consultant post'; *ibid.*

⁴⁰ PruHealth noted that this analysis was limited to one book of business (ie excluding ex Standard Life data): [PruHealth response to annotated issues statement](#).

- (c) *Finances.* Having a single billing system led to higher efficiency financial dealings, including estimates, invoicing, banking and accountancy. In addition, it allowed the group to provide estimates efficiently to all patients pre-operatively.
8. It is worth mentioning the following points regarding fees:
- (a) Some groups stated that not all members adhered to the level of fees set by the group as they had to follow the insurers' fee schedules. This was specially the case for new consultants who signed the new consultant contracts with Bupa and AXA PPP.
- (b) One anaesthetic group argued that anaesthetist charges were not an important factor when patients selected to have surgery in the independent sector as they relied upon the surgeon to select an anaesthetist. The Group argued that anaesthetist groups allowed the patient to have greater knowledge of their likely costs.
- (c) Some groups mentioned that they aimed at providing a single fair price for anaesthetist services to all patients regardless of their insurers. The guidelines used to set the prices varied among groups. For example, some groups followed the WPA schedule, which was the highest among insurers, others followed the Bupa fee schedule plus 10 per cent increase, and others constructed an average of the various reimbursement levels set by insurers.

AAGBI

9. The AAGBI is a voluntary professional and specialist organization with over 10,000 members that represents the substantial majority of consultant anaesthetists, intensivists and pain physicians clinically active in both the private and NHS healthcare sectors in the UK. The primary objects of the organization are safety, education and research.⁴¹
10. The AAGBI's central argument in response to the annotated issues statement can be summarized as follows:
- (a) any price effect arising from setting of prices by groups was small;
- (b) fees charged by consultant anaesthetists were in any case low, so there was no cause for concern if groups were achieving slightly higher rates;⁴² and
- (c) patients benefited from consultant anaesthetists being members of groups, so this justified, or might justify, higher fees.⁴³

⁴¹ [AAGBI response to annotated issues statement](#).

⁴² AAGBI mentioned in its response to the annotated issues statement that: patients may complain about shortfalls and top-up payments to anaesthetists. However, we assert that this derives primarily from the PMIs' contracts with their customers, which anaesthetists obviously have no control over, and from a historical and no longer justified inequity between the benefits allowed for surgeons and anaesthetists. Given that these two groups have similar training, experience, expertise, responsibility, and time input, and enjoy identical pay in the NHS and from services to other government bodies such as the Courts and armed forces, it is illogical that the benefit levels differ by up to 300 per cent, particularly given the additional, substantial sources of income that surgeons enjoy, eg outpatient activity.

⁴³ In response to the annotated issues statement, AAGBI mentioned that anaesthetist groups—as a result of their structure, shared expertise and ability to provide continuous, flexible cover—could provide a more consistent, reliable and therefore safer service to patients, surgeons and hospitals than could most individual anaesthetists. The AAGBI provided a summary of the benefits of anaesthetist groups. It also provided the results of a survey that it commissioned Enventure Research to conduct with anaesthetic groups. The purpose of the survey was providing useful information to inform the AAGBI's submission to the CC on the benefits of these groups.

11. The AAGBI added that, based on WPA data, consultant anaesthetic fees were only 12 per cent of all consultant fees and 2.6 per cent of the total cost. Therefore, it concluded that the issue of anaesthetic fee shortfalls was insignificant.
12. The AAGBI argued that, notwithstanding the limitations to the analysis provided in the annotated issues statement, in only one of the three case studies was there evidence that the anaesthetic group concerned charged more than the regional average for the majority of procedures. As the three groups concerned were targeted because they were representative of the nine groups that the PMIs were most concerned about, there was likely to be even less evidence that the remaining 91 groups surveyed charged fees that were significantly greater than the regional average.

The hospitals' viewpoint

13. Hospital views on anaesthetist groups were mixed, with little argument to support a negative impact on fees.
14. BMI mentioned that agreements between consultants might restrict competition and make it more difficult to manage a hospital or to implement efficiency measures. It could also impact the consultants' collective ability to obtain better fee settlements in cases where these were negotiated with the hospital and not insurer.
15. HCA stated that it had limited experience of working with consultant or anaesthetist groups that set their fees collectively, therefore any impact on HCA's business was likely to be immaterial.
16. Ramsay mentioned that there were advantages and disadvantages to consultants operating in groups.⁴⁴ Advantages included dealing with a single organization to get an anaesthetist, developing expertise in subspecialties and allowing the hospital to offer a whole specialty solution to patients. However, the groups typically set higher fees than levels reimbursed by PMIs, which resulted in a shortfall for patients. In addition, where there was a consultant group in place it could be difficult for new consultants to establish their practice if they did not wish to be (or could not be) part of the group.
17. Ramsay added that one key area where these groups did have an impact on its business was in relation to NHS patients. The NHS tariff was a fully inclusive price which included the cost of both the surgeon and anaesthetist and so Ramsay had to negotiate directly with these groups in relation to NHS fees.
18. [REDACTED] noted that different anaesthetist groups had a different impact on the business. It was the only hospital operator that provided a detailed list on its view on the impact of around 21 anaesthetist groups on its business. It identified groups which had no impact on its business, others which had a negative impact, and a third category where it believed that the higher fees charged by the group were outweighed by the benefits provided.
19. Two of the groups mentioned by [REDACTED] are part of our case studies:
 - (a) *Case study 1*. Our view is that evidence suggests an impact of the anaesthetist group on prices. [REDACTED] mentioned that the anaesthetist group set its own fees for private work, which were higher than market rates, so there was a shortfall for

⁴⁴ Ramsay reiterated the advantages and disadvantages of consultant groups in response to the AIS. ([Ramsay response to AIS.](#))

patients. The group was not Bupa fee assured and Bupa had recently placed restrictions on using non-fee-assured anaesthetists for corporate clients. [REDACTED] Therefore, unless the group members became Bupa fee assured, the hospital would not have sufficient anaesthetic cover.

(b) *Case study 2.* Our view is that evidence does not suggest an impact of the anaesthetist group on prices. [REDACTED] mentioned that a large majority of anaesthetists in the area were part of the group. It added that the group negotiated fees and had no impact on the hospital as far as [REDACTED] was aware.

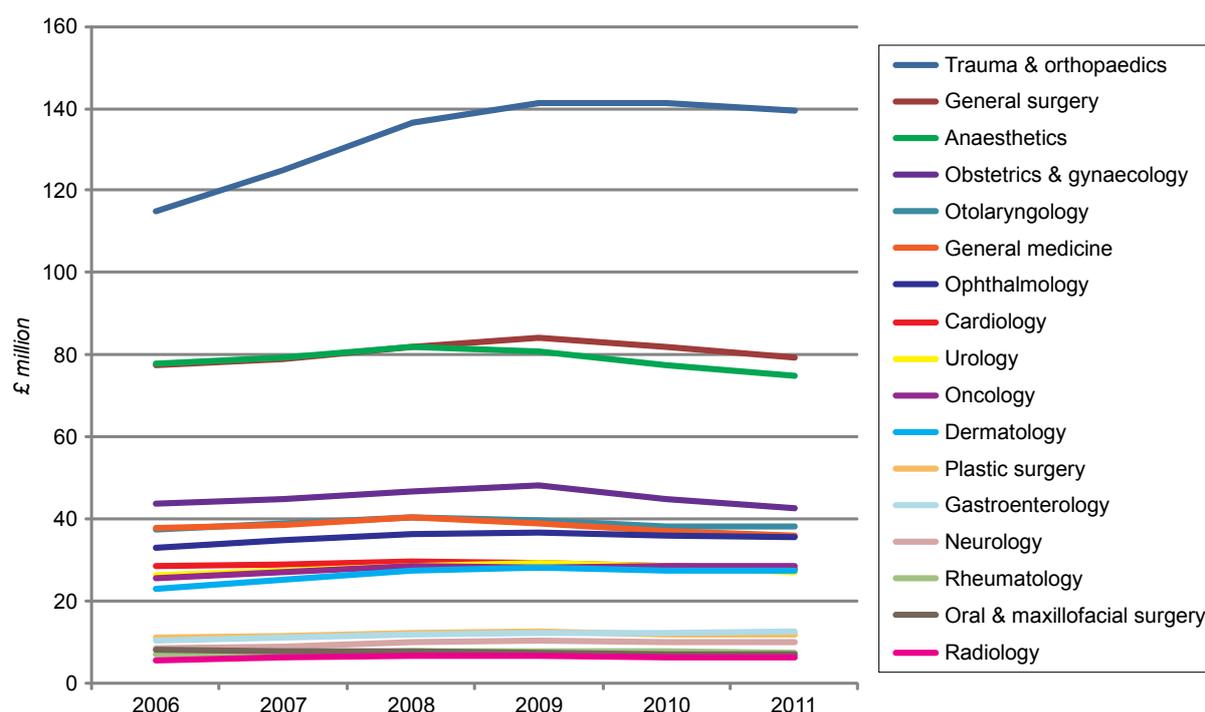
20. Nuffield believed that anaesthetist groups had the potential to have a material impact on the business, although it was not currently evident in any major way across the Nuffield Health Group.

Consultant remuneration

1. In carrying out an initial assessment of consultant charges, we tried to determine the size of the market for private consultant services by specialty. We looked at the relative market size by revenue by specialty and considered the change in revenues for each specialty between 2006 and 2011. Consultant revenue was calculated as the total fees billed by consultants to PMIs¹ in each specialty (Figure 1).

FIGURE 1

Total annual fees billed by consultants per specialty



Source: CC analysis.

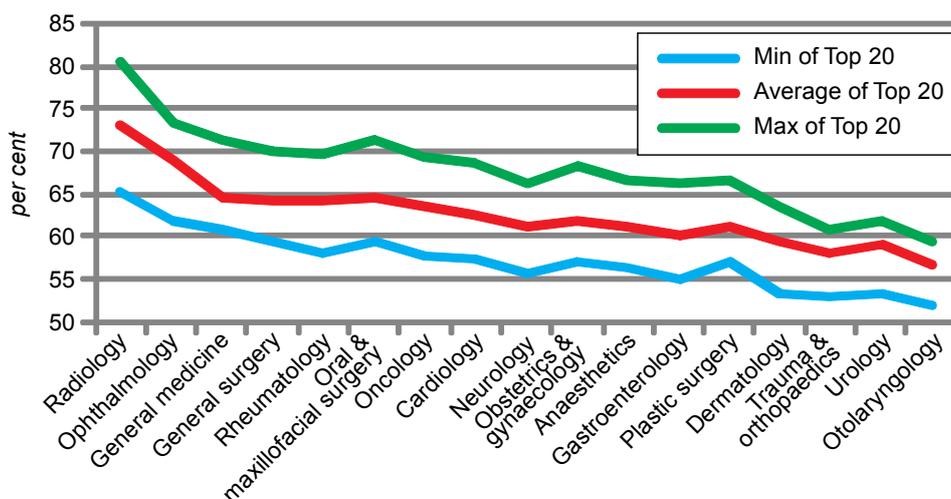
2. In many specialties, our initial analysis showed a real-term decline in revenues, in particular since 2008/09, depending on specialty. Trauma and orthopaedics was the largest specialty by revenue by a significant margin and it was the only specialty to have seen a significant increase in revenues between 2006 and 2011. However, this appeared to have levelled off since 2009.
3. As noted on several occasions, private consultant services are extremely fragmented. There is, in addition, significant variation in the level of fee income by consultant specialty and by individual consultant. In order to arrive at some form of concentration proxy, we used the percentage of fees paid to the top 20 per cent of the highest billing consultants by specialty out of the total percentage fees paid by PMIs² by specialty between 2006 and 2011—see Figure 2.

¹ Data was only available for Bupa, AXA PPP and Aviva.

² Data was only available for Bupa, AXA PPP and Aviva.

FIGURE 2

Share of fees paid to the top 20 per cent of the highest billing consultants, 2006 to 2011

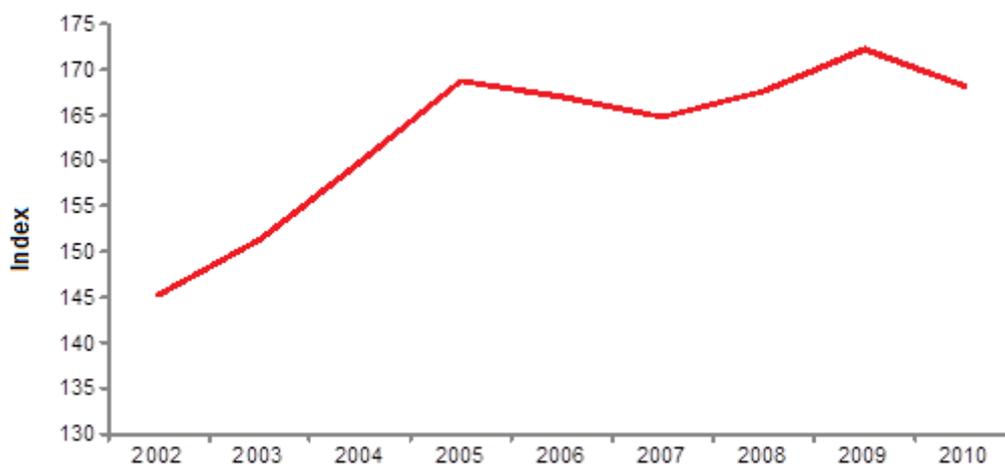


Source: CC analysis.

4. Our preliminary analysis showed that the average percentage of fees paid to the top 20 per cent of consultants by specialty ranged between 55 and 65 per cent except for radiology and ophthalmology where the range is 73 and 69 per cent respectively. This percentage may be explained by higher volumes and/or higher fees charged by such consultants.
5. Our preliminary analysis is broadly in line with analysis carried out by Laing & Buisson. According to Laing & Buisson's analysis, consultants' aggregate private fee income, in real terms, grew rapidly in the ten years to 2005 before it levelled off in the second half of the 2000s, growing by around 20 per cent between 2002 and 2009 (after which it fell)—see Figure 3.

FIGURE 3

Real index for specialist private practice fee income, 1995 = 100



Source: Laing and Buisson, *Private Acute Medical Care* 2012.

6. At the same time, ie between 2002 and 2009, the number of consultants increased, by about 35 per cent, and continued to rise while consultant fee income, in aggregate, fell post-2009—see Figure 4. Overall, whilst more was being spent on consultants' fees, there were more consultants, potentially at least, to share it. The total number of consultants in England grew from around 27,000 in 2002 to 40,000 in 2012. We do not have as complete a data series for the other nations but in Scotland, consultant numbers rose to just over 4,400 in late 2011, a rise of just over 1 per cent compared with the previous year.³ In Wales, there were around 2,000 consultants⁴ in 2011, representing an increase of more than 50 per cent over 2001.⁵

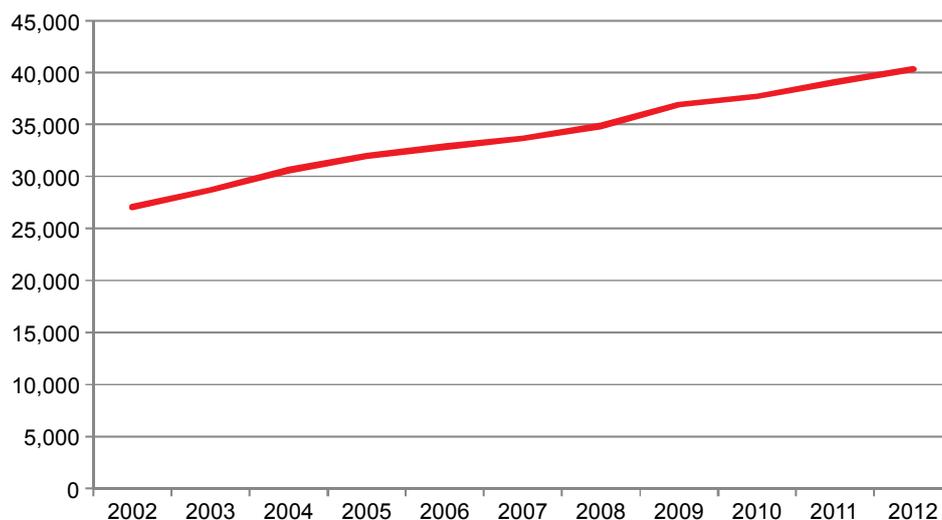
³ www.isdscotland.org/Health-Topics/Workforce/Publications/2011-06-28/2011-06-28-Workforce-Summary.pdf?81724184752.

⁴ www.wales.nhs.uk/sitesplus/documents/863/WORKFORCE%20FINAL.pdf.

⁵ www.cfwi.org.uk/publications/leaders-report-shape-of-the-medical-workforce/at_download/attachment1.

FIGURE 4

Consultant numbers, England, 2002 to 2012



Source: <http://www.hscic.gov.uk/catalogue/PUB09367/nhs-staff-earn-sept-2012-tab.xlsx>

7. We also looked to see whether the overall increase in consultant numbers concealed differences in growth rates between the main clinical specialities (see Table 1). We saw no evidence of significant differences between trends within particular specialities.

TABLE 1 **Medical and dental consultants within each speciality group, 2002 to 2012**

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Accident & emergency	533	561	618	689	725	749	819	938	1,053	1,145	1,279
Anaesthetics	3,874	4,121	4,355	4,502	4,698	4,791	4,991	5,369	5,618	5,824	6,026
Clinical oncology	315	347	392	438	482	506	533	543	524	544	588
Dental group	604	655	670	671	692	700	762	840	673	690	717
General medicine group	5,931	6,284	6,726	7,072	7,277	7,517	7,906	8,275	8,384	8,862	9,204
Obstetrics & gynaecology	1,308	1,353	1,413	1,458	1,506	1,506	1,570	1,670	1,789	1,855	1,957
Paediatric group	1,695	1,807	1,902	2,033	2,154	2,198	2,211	2,416	2,543	2,646	2,724
Pathology group	2,219	2,287	2,411	2,398	2,416	2,460	2,513	2,611	2,597	2,660	2,676
PHM & CHS group	779	857	926	927	885	897	914	943	935	851	827
Psychiatry group	2,979	3,229	3,555	3,759	3,805	3,957	4,021	4,236	4,320	4,394	4,435
Radiology group	1,745	1,860	1,928	2,058	2,105	2,133	2,269	2,400	2,442	2,528	2,620
Surgical group	5,088	5,389	5,754	5,988	6,129	6,260	6,401	6,709	6,977	7,217	7,467
All specialities	27,070	28,750	30,650	31,993	32,874	33,674	34,910	36,950	37,752	39,088	40,394

Source: Health and Social Care Information Centre, Medical and Dental Workforce Census.

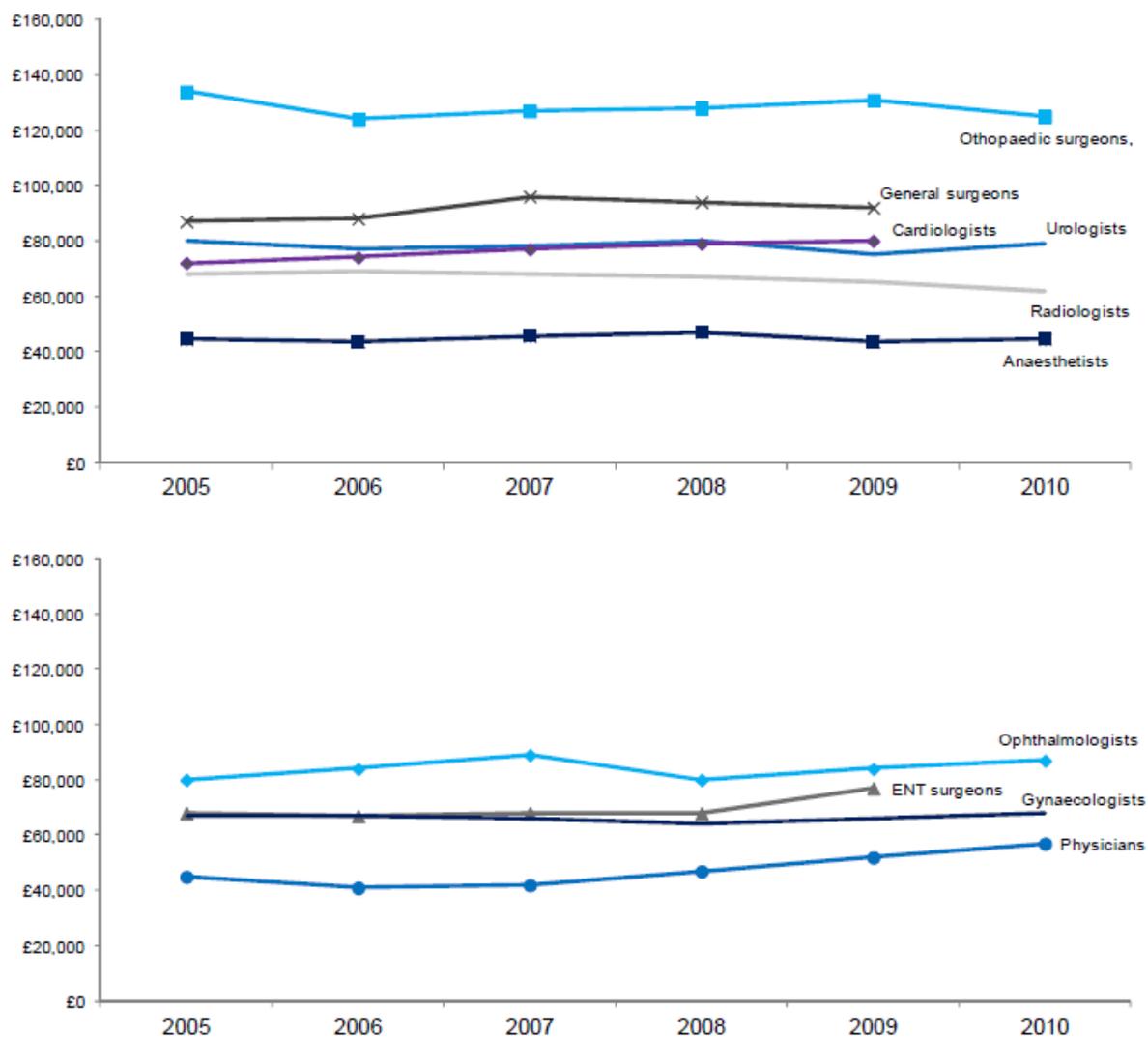
8. We also looked at a number of other data sources. Benchmarking data is collected by firms providing financial advice to clients in the medical sector, including consultants. However, these may not necessarily be representative of consultants as a whole since the firms concerned operate on a national basis and tend to deal with higher-earning consultants and partnerships rather than lower-earning, sole practitioners, for example, who may use a local firm. That said, this benchmarking data suggests, for example, that in 2011 orthopaedic surgeons were earning, on top of their NHS remuneration, gross income of around £180,000 a year from private

practice. Anaesthetists, by contrast, earned around £62,000 a year gross on top of their NHS remuneration.⁶

- The profitability (ie fees minus costs) of consultants in different specialisms within private practice appears to follow the same pattern as gross revenue with orthopaedic surgeons being, on average, the most profitable sector and anaesthetists the least. This pattern, as shown in Figure 5, appears to be very stable over time: there is no evidence of a sustained reduction in the profitability of private medical practice within any of the specialisms though ophthalmologists' average profits appear to drop between 2007 and 2008 and then remain relatively flat.

FIGURE 5

**Average private consultant profits by specialism
(after accounting for practice expenses)**



Source: *Independent Practitioner Today*, Stanbridge Associates Limited.

Note: Average pre-tax profit by specialism for consultants working in private practices is calculated after accounting for practice expenses such as staff costs, consulting room hire, professional indemnity, office costs, others. Earnings were not available for all specialisms in 2010.

⁶ www.independent-practitioner-today.co.uk/profits_focus_article.php?r=1616&a=Public.

10. Although based on data around ten years old, a study of consultant earnings in the *Journal of the Royal Society of Medicine* in 2008⁷ of the NHS and private earnings of consultants provides a potential comparator with today's earnings. The top earning categories are shown in Table 2.

TABLE 2 Analysis of consultants' NHS and private incomes in England in 2003/04

Speciality	Total earnings	£	
		NHS	Private
Plastic surgery	222,731	73,486	149,245
Trauma & orthopaedic surgery	183,933	74,339	109,594
Otolaryngology	162,486	77,361	85,125
Neurosurgery	161,259	80,342	80,917
Ophthalmology	144,370	77,081	67,289
Cardiology	146,503	78,555	67,947
Dermatology	129,587	69,555	60,032
Medical oncology	126,393	72,606	53,787
Clinical oncology	126,143	73,860	52,283
Urology	135,459	80,797	54,662
General surgery	135,912	81,676	54,235

Source: http://jrs.sagepub.com/content/suppl/2013/04/01/101.7.372.DC1/080004_appendix.pdf.

11. In 2012, consultants in England earned from the NHS, on average, and including extra payments on top of their basic pay, £109,600 a year.⁸ The Stanbridge Associates benchmark data in Figure 9 can provide a useful comparison to the *Journal of Royal Society of Medicine* data analysis. Table 3 indicates that orthopaedic surgeons, for example, were earning around £110,000 a year in private work in 2003/04 compared with approximately £120,000 after costs in 2010 according to the Stanbridge benchmark data in Figure 5. Similarly for ophthalmologists the data suggests that they were earning in private practice on average £67,000 in 2003/04 compared with approximately £80,000 after costs in 2010.
12. We also looked at evidence submitted by third parties. FIPO had conducted a survey of its members' earnings. This showed that consultants' earnings had fallen in real terms between 2009 and 2011, remaining stable in nominal terms. FIPO pointed out, though, that it was too early for any changes in consultant earnings that might result from Bupa's new fee arrangements to have become evident.⁹
13. The BMA's survey of consultant income¹⁰ indicated a mean income from private practice of around £72,000 and a median of £36,000, though this varied with both speciality and location. According to the BMA survey, the mean gross income from private practice for ophthalmologists was £145,000. The next highest earning specialties were surgery and obstetrics, with mean gross incomes of £112,000 and £103,000 respectively. Specialists in emergency medicine had the lowest mean gross income, of £14,000. Consultants in London reported the highest level of mean gross income (£111,000) and those in Wales the lowest (£27,000).
14. The BMA survey, in common with the benchmarking data, suggests that consultants' earnings from private work have been fairly flat or declining. 40 per cent of respondents said that their private practice income had stayed the same as the previous year, 45 per cent said that it had fallen, and just 15 per cent that it had risen.

⁷ Morris et al, *JRSM* 2008;101:372–380.

⁸ www.hscic.gov.uk/

⁹ FIPO response to AIS.

¹⁰ BMA survey of consultant income, May 2011.

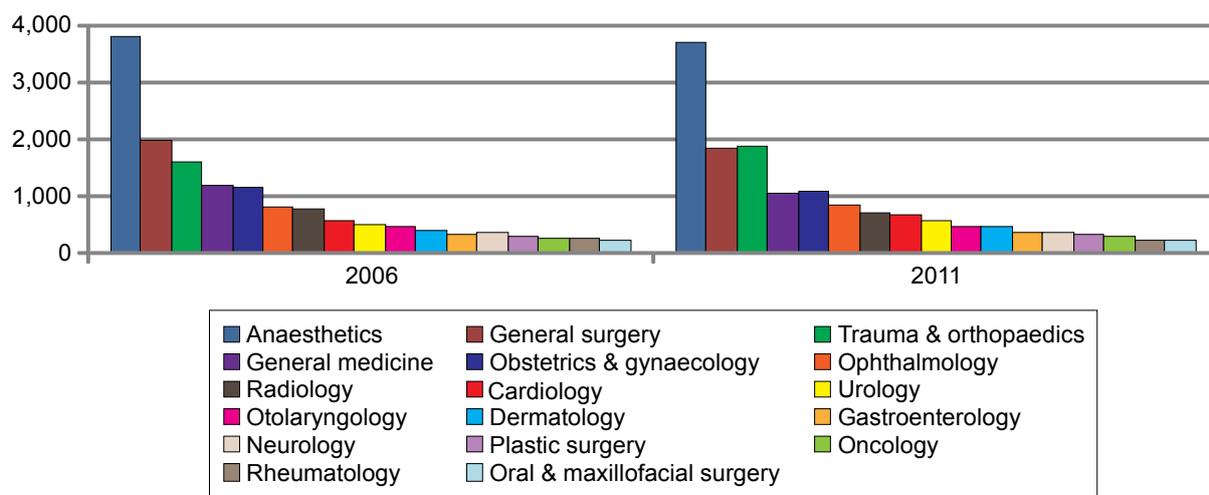
15. However, FIPO acknowledged that the net effect of a smaller proportion of consultants engaging in private practice together with an increase in their total number had almost balanced each other out: the number of consultants in private practice had declined only marginally, from 16,349 in 2000 to 15,745 in 2012.¹¹
16. That said, these factors might signal that the pool of NHS consultants available to the private sector might shrink in the future. However, drivers in the other direction include the fact that basic pay in the NHS has been frozen for the past two years and, as indicated by responses to our survey of consultants, even with a longer working week, 47 per cent of consultants who responded said that they had time available and would like to undertake more private work.¹²

Availability of consultants in private practice

17. A number of parties submitted that the number of consultants in private practice had decreased recently. Some quoted a recent NAO report¹³ which found that 39 per cent of NHS consultants undertook private work in 2012 compared with 67 per cent in 2000.
18. Figure 6 analyses the average number of consultants billing the three largest PMIs in 2006 and in 2011. Our analysis shows no material change in numbers by speciality.

FIGURE 6

Number of consultants per speciality



Source: CC analysis.

19. We also looked at the number of consultants between 2006 and 2011 by speciality billing the PMIs¹⁴ (Figure 7).

¹¹ FIPO response to AIS. FIPO explained to us that the number of consultants had already decreased both as a percentage and in numerical terms. This, coupled with the economics of private practice (evidencing that costs are increasing and income is declining) and the fact that consultants are expected to prioritize NHS work over private practice work, corroborates concerns that patients' choice of consultants will be reduced (see FIPO response to AIS, p11).

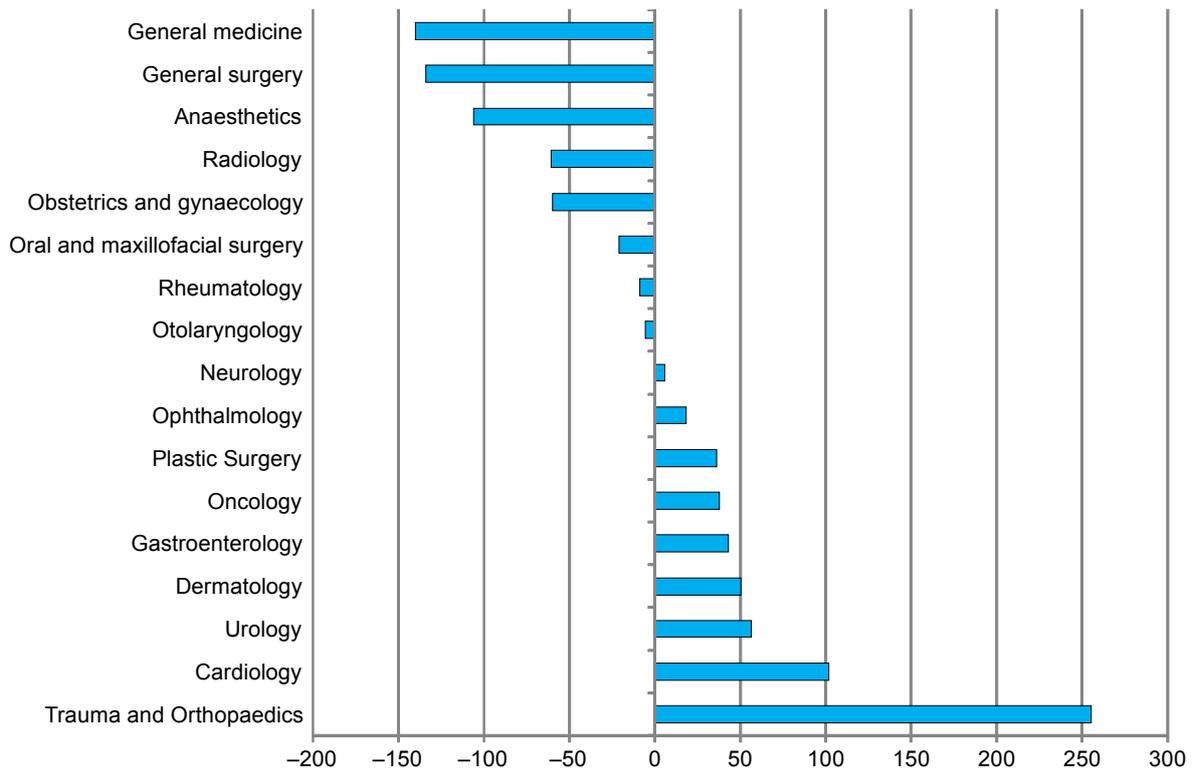
¹² Laing & Buisson *Private Acute Medical Care 2012*, p125.

¹³ www.nao.org.uk/wp-content/uploads/2013/03/Hospital-consultants-full-report.pdf, p21.

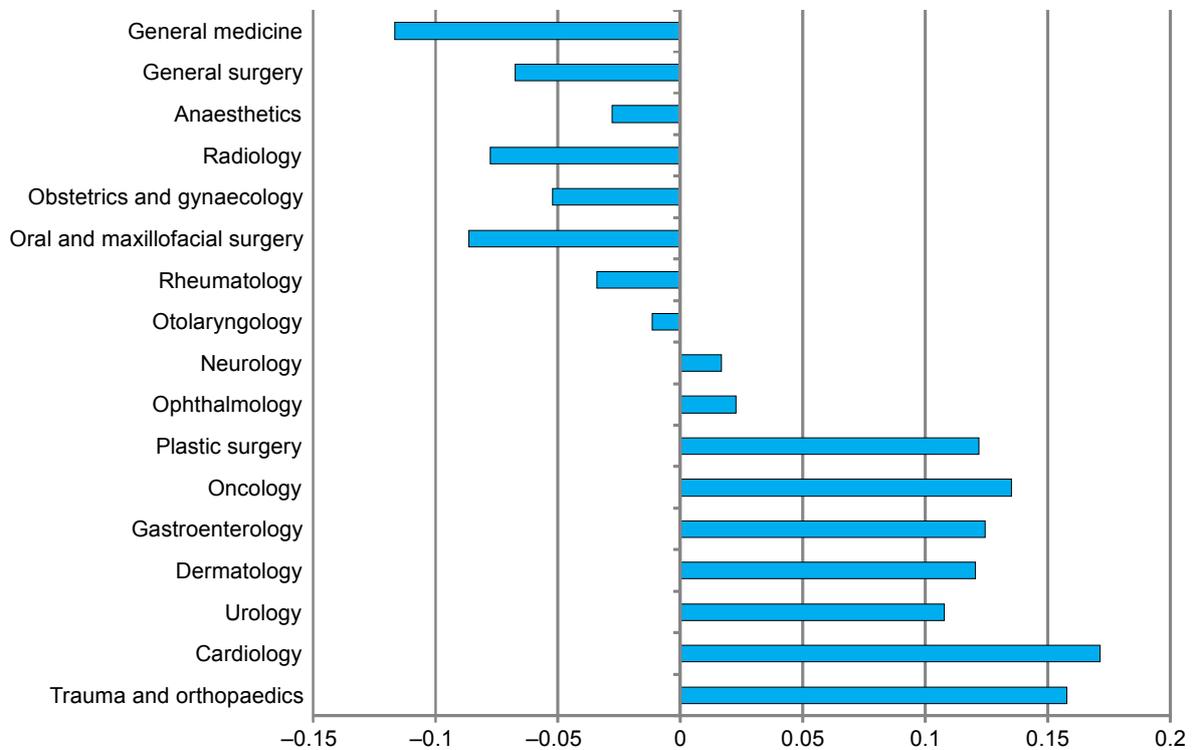
¹⁴ Again, data is only available for Bupa, AXA PPP and Aviva.

FIGURE 7

(a) Change in the number of consultants per specialty, 2006 to 2011



(b) Percentage change in the number of consultants per specialty, 2006 to 2011



Source: CC analysis.

20. Trauma and orthopaedics had the largest increase in the number of consultants between 2006 and 2011 which broadly matches the increase in revenue shown in Figure 7. On average, 250 more trauma and orthopaedic consultants were billing PMIs in 2011 compared with 2006. General medicine had the largest decrease in the number of consultants billing PMIs between 2006 and 2011 (140 fewer such consultants).
21. The vast majority of consultants who undertake private practice also work within the NHS: very few doctors who work in the private sector do so exclusively.¹⁵ There are a number of reasons why the percentage of consultants in the NHS also in private practice may have declined in recent years. Higher NHS starting salaries, more progressive pay structures and a longer working week introduced in 2006 with the aim of limiting private practice work by NHS consultants might be expected to lessen consultants' incentives to seek private work. Furthermore, the rising costs of professional indemnity insurance may also have been a factor depressing the numbers of consultants undertaking private practice as a proportion of the total number of NHS consultants. A BASS survey, for example, indicated that indemnity charges for spinal surgeons was the most commonly given reason for leaving or deciding not to enter private practice.¹⁶ As described in paragraph 2.8, there has also been a decline in demand for private work, at least outside London and the South-East, and an increased number of consultants competing for work.¹⁷
22. Most of the PMIs commented that they had not seen a decrease in the number of new consultants seeking recognition.
23. These factors might signal that the pool of NHS consultants available to the private sector might shrink in the future. However, drivers in the other direction include the fact that basic pay in the NHS has been frozen for the past two years and, as indicated by responses to our survey of consultants, even with a longer working week, 47 per cent of consultants who responded said that they had time available and would like to undertake more private work.¹⁸

¹⁵ Only 2 per cent of the consultants who responded to our [GP and consultant survey](#), all of whom undertook private work, said that they worked exclusively in the private sector.

¹⁶ [BASS response to AIS](#).

¹⁷ <http://careers.bmj.com/careers/advice/view-article.html?id=20007822>.

¹⁸ Laing & Buisson *Private Acute Medical Care* 2012, p125.

Summary of consultant and trade body/professional association submissions by theme

ToH 4: buyer power of insurers in respect of individual consultants

This table presents a summary of the submissions we received from consultants regarding interaction with PMIs with specific examples of the concerns that they raise. We also note some examples of where a similar point has also been made by a particular consultant trade body or professional association.

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
Fees		
1. Benefit maxima	Benefit maxima are not allowing consultants to recoup the expense they incur when performing a treatment or procedure.	Bupa
	Consultants are required not to charge above the maxima set by Bupa—rates have not changed even to take account of inflation. ¹	AXA PPP
	In April 2012 Bupa slashed fees by nearly 50 per cent for many surgical procedures. Bupa has now unilaterally restricted the maxima paid for an outpatient consultation.	Bupa
	Bupa virtually halved the cost of tariffs they would pay for procedures. This was a unilateral move on the part of Bupa with no consultation with specialists.	Bupa
	Benefit maxima were intended to be used by patients to identify levels of reimbursement, but are now used by PMIs as a basis to limit consultant reimbursement with compliance maintained through threat of de-recognition. ²	
2. Fee schedules	Insurers are requiring new consultants to sign up to fee schedules or else they won't be recognized—they must be 'fee-assured'. ³	Bupa
	Insurers are changing their fee-schedules and patients are being directed away from certain consultants on the basis that the consultant now 'over-charges' despite their fee level not having changed in a number of years.	AXA PPP

¹ See [BMA response to issues statement](#).

² See [BMA initial submission](#), p2.

³ See [FIPO initial submission](#), p6 .

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
3. Setting fees levels	<p>Surgical fees have not increased since 1992.</p> <p>Remuneration from the private healthcare companies have changed little if at all in that time, whilst the cost of doing business—secretarial support, malpractice insurance, room rental etc has rocketed.⁴</p> <p>Insurers work as a cartel in setting consultants' fees.</p> <p>PruHealth are asking some consultants to reduce their fees because they charge more than PruHealth's average.</p> <p>If insurers are suppressing consultant fees to a level below those which would prevail in a competitive market, this could lead to a reduction in the quality of service provided by consultants to patients and affect the incentives to innovate. In addition, there may be distortions to competition between consultants when caps on the reimbursement of fees are applied to some consultants (eg newer or junior consultants) and not to others (eg more experienced ones). In the longer term, this may result in a shortage of consultants willing to practise and in a reduction in the potential output of the sector.⁵</p> <p>Bupa have driven down procedure fees through threats of exclusion which has led to a distortion in the marketplace and a 30 per cent reduction in consultant income.</p> <p>Bupa has written to consultants where it suspects their fees have increased by more than 10 per cent in a 12 month period and asks them to justify their increases or consider reducing them.</p> <p>Bupa, with minimal notice decreased its fee for medical procedures involving subcutaneous central venous ports from £400 to £170, which is 30 per cent of the fee other PMIs provide. BUPA are reducing the number of competent clinicians available to their patients which are not prepared to carry out a high-risk 2.5 hour procedure for this fee.</p> <p>One consultant had been delisted by Bupa in December 2013 after they refused to meet a Bupa demand that they reduce their fees by 20 per cent for new and existing patients. The consultant is restricted from seeing BUPA patients, unless the patient self-pays for the entire treatment.</p> <p>Bupa recently cut its tariff for the excision of a ganglion from £289 to £167. The procedure requires general anaesthetic, one hour of operating theatre, pre and post-operative review, indemnity, travel and administrative costs, resulting in the consultant receiving £30 per hour before tax. Any attempt to pass on the extra costs is met with bullying tactics from Bupa including the threat of delisting.</p> <p>Medical practitioners should and will remain to be regulated with regard to the quality of medical care, but should be allowed to set their own fees consistent with the services provided and market demands. These fees should not be set by private medical insurers. My own fees have not increased since 1998 and in October 2013, Bupa halved the surgical fees. My practice expenses have doubled since 1998 and the practice is no longer viable.</p>	<p>Bupa</p> <p>AXA PPP</p> <p>PruHealth</p> <p>Bupa</p> <p>Bupa</p> <p>Bupa</p> <p>Bupa</p> <p>Bupa</p>

⁴ See [Independent Doctors Federation \(IDF\) response to issues statement](#), p2.

⁵ See [IDF response to issues statement](#), p2; [The London Consultants Association \(LCA\) response to issues statement](#), p2.

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
4. Reimbursement ⁶	Reimbursement levels of fees are all within a very narrow band.	Bupa
	Reimbursement from insurers to consultants has decreased steadily over the last 14 years while premiums paid to these companies have risen steadily over this time frame. ⁷	AXA PPP
5. Fee-capping of new consultants	Reimbursement arrangements are stifling the market and preventing development—innovation is not rewarded unless it has got a Bupa code.	Bupa
	New consultants are forced to agree to Bupa and AXA's fixed fee schedules. As Bupa and AXA together account for 80 per cent of the PMI market, it is difficult for new consultants to not agree to sign up to them, even though their fee schedules are significantly below market rates.	Bupa AXA PPP
	Attempting to ensure that all doctors charge the same fee is anti-competitive. There is no free market when all doctors have to charge the same despite varying practices, level of expertise and differing supply and demand. If a patient wishes to pay more to see a particular consultant, it should be their choice. ⁸	
	The actions of some of the PMIs in forcing newly appointed consultants to have to sign up to highly restrictive contracts to be allowed recognition is an anti-competitive restriction of trade, as well as being discriminatory.	
6. Top-up fees ⁹ / shortfall	New consultants now have to sign a contract with Bupa and AXA if they wish to see patients from these two insurance companies. To be eligible to sign such contracts, these consultants have to agree to consultation fees substantially lower than current market rates by as much as 40 per cent. If a consultant refuses to sign such a contract because they wish to charge a market rate for their service, they are not recognised by Bupa and AXA and thus have no access to 60 per cent of privately insured patients.	Bupa AXA PPP
	The very fact that the private medical insurance companies are forcing newly appointed consultants to sign up to highly restrictive contracts before they are recognized, is truly anti-competitive. The other thing that is clearly anti-competitive, in terms of restricting trade, is major insurance companies are, as far as I am aware, increasingly de-listing consultants by threatening them with this, on the basis of the fees an individual consultant is charging.	
	Transparency with regard to top-up fees should be encouraged.	Bupa
	Some companies such as AXA PPP and Aviva insist that the consultants charge their rates and do not charge patients for the shortfall.	AXA PPP Aviva
	Top-up fees should be allowed. It maintains competition as the patient can choose their consultant and it enables the consultant to provide a better level of service. If there is complete transparency on consultant fees, this weakens the need	Bupa

⁶ See [FIPO response to issues statement](#) .

⁷ See [FIPO initial submission](#), p6.

⁸ See [The London Consultants Association](#) and [FIPO](#) responses to the provisional findings.

⁹ See [British Osteopathic Association initial submission](#), p1; [FIPO initial submission](#), p5.

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
	for PMIs to control top-up fees, as the patients will be aware of fee structures and will be able to choose a consultant on the basis of their fees and expertise. ¹⁰	AXA PPP
	The practice by BUPA and AXA of not allowing new consultants to pass on fees to patients is anti-competitive. Consultants are not all the same and those with high levels of expertise and training quickly become in-demand and should be able to reflect this.	Bupa AXA PPP
	Bupa's desire to control the profession is highly dangerous in the long term for patient care and choice. It should at least be made explicit that top-up fees for consultants are OK. Bupa are relying on young consultants with small practises who run their offices on very low margins to effectively subsidise Bupa's poorly run business.	Bupa
	It is clear that Bupa in particular is driving down costs to the detriment of patient choice. They are refusing to pay excess bills to consultants with extra experience, even when the patients are happy to pay this excess in this way.	Bupa
7. Coding ¹¹	Insurers are introducing new codes by changing descriptors at will.	PruHealth
	Bupa has recently published new procedural codes that reduce significantly the level of complexity and therefore the remuneration paid for many procedures. This is an action taken by a major healthcare provider to drive down surgeons' fees under the pretext that somehow these surgical procedures have suddenly become less complex while requiring a lower level of competency to perform.	Bupa
	PMIs have managed to manipulate CCSD to introduce unacceptable coding combinations [and they] use the coding principles to control the healthcare market.	Bupa Aviva
	The process of 'bundling' a clinical procedure such as cataract surgery with a follow up consultation into a single CCSD code to reduce reimbursement is as unacceptable as the process of 'unbundling' procedures into multiple elements to fraudulently increase remuneration.	
Impact of PMI reimbursement rates		
1. Number of consultants in private practice	The CC argues that there has not been strong evidence that consultants are withdrawing from private practice due to uneconomic fees and restrictions on top-up fees by BUPA and AXA, ¹² however these initiatives are recent and in a few years there will be attrition of those who are unable to make private practice work.	Bupa AXA PPP
	Newly appointed consultants cannot be kept on grossly reduced fees by PMIs. Many young consultants are entering the market and exiting shortly afterwards. It cannot be in the interest of patients that consultants are leaving the private healthcare sector. ¹³	

¹⁰ See [BMA response to provisional findings](#), September 2013.

¹¹ See [FIPO response to issues statement](#).

¹² See [AAGBI response to provisional findings](#), September 2013.

Submission classification

Examples of complaints

Insurer(s)

One consultant (who works in a large teaching hospital in London) submitted that over the past three years, the hospital has had five newly appointed paediatric anaesthetists, none of whom have chosen to enter private practice because of the control of the market by the two dominant insurers and downward trend of fees.

The fee schedules imposed by PMIs act as a barrier to entry. The fees specified in PMI's fee schedules are gross, before the deduction of all business costs, indemnity insurance costs (which can be between 30-70 per cent of fees), so the net amount earned is very low and unviable for some consultants. The consultant is aware of four orthopaedic surgeons of their department of 11 who have withdrawn from private practice as a result of fees.

2. Quality

In circumstances where prices charged by consultants are capped by PMIs, the consultant is not able to raise their prices to one that the market may bear. This creates a lack of incentive to improve quality and attract patients, restricting competition.

PMIs have enormous power and a general negative effect on competition. They are able to intervene in the clinical referral and treatment pathway and process, reducing patient choice, stifling competition and ultimately impairing quality of care.¹⁴

Interference in clinical pathway

1. Managed care¹⁵

Insurers are diverting clinical referrals away from those consultants who charge their own fee schedules, and to cheaper consultants, stating that this is based on quality when it is absolutely only based purely on cost, and many of the cheaper consultants are actually less experienced, with poorer reputations.

'Managed care' cannot be in the patient's best interests since the restrictions to healthcare are being invoked by non-practising doctors and managers working for PMIs, ultimately with an interest in profitability rather than clinical excellence.

Patients are encouraged by insurers to contact them directly for a reference rather than to see a consultant recommended by their GP—the referring person in such a case is somebody, possibly without medical training and no detailed knowledge of the medical problem.

Bupa

2. Open referral¹⁶

Insurer-led referrals will severely limit patient choice of consultants.¹⁷

GPs should be able to choose to direct referrals based on their assessment of what is in their patient's best interest and insurers should not compromise their clinical judgement by insisting they make an 'open' referral.¹⁸

So called 'open' referral is a method of assuring referral to a 'closed book' of specialists and hospitals/clinics selected by

Bupa

AXA PPP

¹³ See [LCA response to provisional findings](#), September 2013.

¹⁴ See [FIPO response to provisional findings](#) (1), September 2013; [AAGBI response to provisional findings](#), September 2013.

¹⁵ See [BMA initial submission](#), p3; [LCA response to issues statement](#), p1.

¹⁶ See [IDF response to issues statement](#); [FIPO response to issues statement](#); [LCA response to issues statement](#).

¹⁷ See [LCA response to provisional findings](#), September 2013.

¹⁸ See [IDF initial submission](#), pp1-2; similar concerns raised in [FIPO response to provisional findings](#) (1), September 2013.

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
	<p>the PMI and not a referring doctor. This closed list often excludes access to doctors who are world leading authorities in their fields working in some of the best hospitals in the UK.</p> <p>PMIs' direct referrals create treatment pathways, including deciding whether a procedure is day-case or not, deciding what treatment is appropriate for back pain etc. This activity by PMIs is completely un-regulated. An individual consultant has nowhere to turn when an inappropriate referral or choice of treatment by a PMI may jeopardise patient safety.</p> <p>Open referral schemes deprive patients of GP's experience with particular consultants. GPs are familiar with specialists, have close contact with them and their selection is guided by colleague recommendations, meetings with specialists, attending lectures etc.¹⁹ To suggest that insurance companies can refer patients as well as GPs is ridiculous.</p> <p>PMIs incentives are purely finance-driven and they do not have the experience of GPs in being able to refer to or choose consultants.</p>	Bupa
	<p>The open referral method means that Bupa can choose to direct referrals to consultants whose fee levels are lowest. In many instances, this excludes consultants of immense experience and ability, and relegates the patients to seeing consultants of less experience²⁰ and often results in referrals to consultants for conditions which are not specific to the consultants' sub-specialist interest.</p>	Bupa
3. Quality of care	<p>This is being destroyed as a result of insurers making inappropriate referrals to consultants within their network.</p> <p>Insurance companies are ignoring GPs' recommendation for particular specialists—this is clinically dangerous.</p> <p>PMIs dictate where patients are treated based on money and not in the interests of the best quality and most appropriate care. PMIs will often seek out cheaper doctors and favour their services, regardless of which specialists would be able to deal with the individual case most effectively. This is to the detriment of patients.</p>	Bupa
4. Hospital choice	<p>Patients are being 'forced' into hospitals where the consultant does not regularly work, on the basis of an agreement between the patient's insurer and a hospital network.</p>	Bupa
5. Intervention in clinical decisions on treatment	<p>Insurers are introducing 'support teams' to complement consultant care manned by non-medical staff but giving advice on clinical matters.</p> <p>Bupa has set itself up as an authority to interfere in clinical decisions. It has done this by declining to cover procedures during the preauthorization process while at the same time contradicting the recommendations of certified clinicians.</p>	Bupa Bupa

¹⁹ See [IDF response to provisional findings](#) on open referral issues, September 2013.

²⁰ *ibid.*

Submission classification

Examples of complaints

Insurer(s)

Non-medical personnel are directing medical investigation & treatment: patients are being given permission to follow treatments according to protocols drawn up by non-specialists in the relevant field.²¹

Bupa now insist on filling in a form to approve an arthroscopy. This is then seen by a non-medical Bupa employee and the procedure is either approved or not.²²

The fact that GP's choice of consultants can be vetoed by insurance companies is dangerous and will lead to potential poor management and less successful outcomes. PMIs are making decisions which should be made by professionally qualified individuals and discriminating against senior and experienced consultants which may have higher fees.

Bupa, AXA and other PMIs are distorting the market by diverting patient referrals away from the consultant of the patients' and GPs' choice, instead forcing patients to see only the cheapest consultant, often without any regard to whether that consultant actually has the correct subspecialty interest for the patient's particular specific medical needs.

One consultant submitted that Bupa had refused to authorise knee surgery on four of their patients, as claims assessors at Bupa suggested that physiotherapy should be the appropriate treatment. This is not in the patients' interests and assessors are not qualified to make this judgment.

One consultant gave an example of a patient he recommended undergo foot surgery. The PMI intervened and referred the patient to a surgical podiatrist at a nearby hospital. The patient's deformity was not corrected, the wound became infected and the fixation failed. The patient was eventually re-referred to the consultant, who had to take them back to theatre and after 6 weeks of antibiotic therapy the wound healed, but the patient has a worse deformity than prior to the first operation.

One skin specialist raised concerns that Bupa is allowed to interfere with decisions made by consultants on clinical grounds. Previously, the consultant was able to excise lesions at the first consultation. They can no longer do so for BUPA patients as they need a letter prior to authorising any treatment. Bupa's actions have delayed biopsies and removal of pre-cancerous cells. It also increases costs to patients as they have to return to a follow-up appointment once treatment is vetted by Bupa.

Bupa is restricting the amount of follow-up appointments that patients can have with a consultant, which is clinically unacceptable. This affects patient care and is putting people's lives at risk.

Some of the major PMIs are actively diverting GP and physio referrals, interfering with the patient's medical care and removing the patient's right to choose which consultant they might want to see. By removing patient choice and also by removing the right of a patient to even be allowed to pay a top-up fee is an anticompetitive distortion of the market that is clearly to the detriment of the 'consumer'.

Bupa

Bupa
AXA PPP
other PMI

Bupa

Bupa

²¹ See [British Association of Spinal Surgeons \(BASS\) initial submission](#), p1.

²² See [British Orthopaedic Association \(BOA\) initial submission](#), p2.

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
6. Referral to the NHS	<p>PMI patients are being directed to the NHS for expensive treatment.</p> <p>A letter was received by a patient in May 2012 from Bupa offering cash payments to the subscriber if they opted for NHS treatment and not for Bupa reimbursed private care.</p> <p>Question the morality of Medical Insurers policies that provide incentives to not use private healthcare facilities but to rather use NHS facilities by providing kick back returns to policyholders or by imposing 6 week treatment restrictions.</p> <p>Insurance companies have cherry picked provision of cover for procedures in order to minimise their exposure to ongoing care and to pass the costs of any complications of treatment on to the NHS.</p>	Bupa
<i>Insurer approval and incentives</i>		
1. Recognition	<p>Insurers are requiring new consultants to sign up to fee schedules or else they won't be recognized.²³</p> <p>Recognition is purely based on cost—insurers are creating lists of 'recognized' medical practitioners irrespective of qualifications or recognized standards which are used to direct policyholders to limited numbers of medical practitioners for which levels of policy cover will be agreed.</p> <p>AXA PPP has an established record of derecognizing Consultants who question their practices.</p> <p>Bupa's new 'Premier Consultant Partnership' requires that you refer to Bupa-recognized consultants, and use only Bupa-recognized facilities and anaesthetists, unless you can make a clear clinical case not to.</p> <p>The concept and use of the term 'approved providers' from insurance companies suggests a certain element of quality assurance to the patient. It is of great interest that when a patient of mine asked for a list of approved providers for a specialist knee surgeon from a major insurer he was given a list of 3 surgeons; my patient visited these 3 surgeons websites and found that their main interest was hip surgery. Interestingly this same patient then Google searched knee surgeons in his local area and found a different list.</p> <p>Currently Bupa uses terms such as 'premier' consultants'. This simply relates to those consultants who operate within a fee agreed structure and have no relationship to quality of service or clinical outcomes.</p>	<p>Bupa</p> <p>AXA PPP</p> <p>AXA PPP</p>
2. Delisting	<p>Insurers are dropping established consultants from approved lists if they do not sign up to a fee-capping contract with the insurer.</p> <p>Insurers are dropping consultants from approved lists even if they adhere to benefit maxima (but are not contractually obliged to).</p>	<p>Bupa</p> <p>AXA PPP</p>

²³ See [BASS initial submission](#), p1; [LCA initial submission](#), p2.

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
	No appeal process and no recourse to any independent body.	
	Delisting gives patients the impression that the consultant is not fit and proper even if that is not the case. ²⁴	
	Bupa is de-recognising or threatening to de-recognise consultants on the basis of 'high consultant charges' where the consultants' fees are in the top 10% of their specialty. ²⁵ Consultants are advised to reduce their fees or will be de-recognised which will impact the quality of care provided to patients.	Bupa
	Bupa have demanded that consultants charge what it says with respect to consultant fees otherwise they will not reimburse the patient anything.	Bupa
	For all consultants starting in private practice after 2010, Bupa has complete control over their fees in accordance with their fee schedule. If the consultant charges above these fees, they will be delisted by Bupa (a consultant cannot set up a viable practice if not recognised by Bupa).	Bupa
	PruHealth has implemented a benchmarking exercise of consultant fees and where consultants' fee differs from the average rate on the list, PruHealth threatens the consultant with de-recognition.	PruHealth
	One consultant submitted that they had been de-recognised by AXA in September 2009 and PruHealth in 2013, for raising their fees in line with inflation. The consultant also suggested that they had been threatened with de-recognition by Bupa.	Bupa AXA PPP PruHealth
	Recognition of consultants should be left to an appropriate body, the General Medical Council (GMC) and should not be the responsibility of insurers. Insurers should clearly identify their maximum benefits and leave patients free to choose whether or not to meet any shortfall.	Bupa AXA PPP
	The ability of the major PMIs to delist consultants purely on the basis of fee levels (with the consultant having no right to any independent appeal) represents a clear anti-competitive restriction of trade. ²⁶	
3. Incentives to join	A consultant was asked to become a Bupa member and receive 10 per cent per annum as a lump sum of their earnings, but they are not aware of ever having received this.	Bupa
Change management		
1. Notice to consultants	Insurers do not communicate changes (to fees, benefit maxima etc.) to consultants in advance of implementation.	Bupa

²⁴ See [IDF initial submission](#), p2; [IDF response to issues statement](#), p2.

²⁵ See [FIPO response to provisional findings \(2\)](#), November 2013.

²⁶ See [LCA response to provisional findings](#), September 2013; [Private Patients Forum response to provisional findings \(1\)](#), 20 September 2013.

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
2. Responding to questions	Insurers are unresponsive to queries from consultants.	Bupa
	Bupa have made irrational and unilateral decisions regarding treatment; for example withdrawing funding for ultrasound guided foam sclerotherapy for varicose veins. This was based on a misinterpretation of the literature by the company. A consultant wrote directly to the medical director on many occasions and was blanked. They consider the failure to respond to enquiries from a fellow physician to be unacceptable.	Bupa
	A consultant had written to Bupa several times recently about these issues, first about their telephone operators suggesting other consultants when the patient has been referred to that consultant and second about reducing payment for procedures. The consultant received no reply.	Bupa
	Bupa wrote to a consultant in order for them to sign up to an agreement to provide outpatient diagnostics services. This would reduce fees due to the consultant by something like 40 per cent so they asked by email and in writing for clarification. None was forthcoming.	Bupa
	The consultant appreciated that fees need to be transparent and structured otherwise liberties will be taken. They have attempted on numerous occasions to engage Bupa and resolve this. They have not replied to their last 3 letters and 2 phone calls. What more can the consultant do?	Bupa

Information provided by PMIs

1. Information asymmetry ²⁷	Bupa advertises that all fees are covered, freezes and then reduces reimbursements, and then blames consultants for overcharging.	Bupa
	There is a rapidly growing number of patients who are bewildered by the lack of information they receive concerning their private medical insurance. Information almost invariably only comes to light once they are actively seeking medical care, the very worst time for them to be made aware of potentially significant deficiencies in their policy.	
	Patients need to know <i>exactly</i> what they are being offered when buying medical cover. ²⁸	
2. PMIs misleading policy-holders as to why they are directing	Bupa is providing misleading information to patients about why they are referring them to a particular consultant, suggesting it is because of their experience or expertise, when it is because the consultant has agreed to Bupa's fee schedule. ²⁹	Bupa
	There is a deliberate practice of Bupa directing patients to preferred clinics and practices (eg Optical Express) without informing patients of their available choice. Bupa does not do this in the 'best interests' of the patient, but due to volume	Bupa

²⁷ See FIPO response to issues statement; LCA initial submission, p3.

²⁸ See BOA initial submission, p2.

²⁹ Similar submissions made by FIPO, BMA and the Private Patients Forum in response to provisional findings, September 2013.

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
patients to one consultant or another	and cost-based contractual arrangements with such providers. PruHealth do not inform their insured or the public that services are only available from a limited number of consultants and that it will not be necessarily be to one of the patients' existing consultants or indeed the consultant of their choice or the choice of their GP.	PruHealth
3. Transparency	PMIs should be required to inform policyholders when a consultant is not available to them and the reasons. Often policyholders associate a consultant being de-recognised due to lack of ability or malpractice which may not be the case. ³⁰ Policyholders do not realize that they are under-insured until it is too late. Conditions to PMI contracts can be changed mid-policy, mid-year and without the client being made specifically-aware. The CC's report has not taken account of these issues. ³¹ Currently different insurance companies will insist, and have forced us, to charge different rates for the same procedure depending on which company it is. We have been told in many cases if we don't comply we will not be covered and therefore there are differences in the fees that I charge to different patients based upon this.	Bupa

Specialty specific submissions

1. Orthopaedics ³²	Bupa have recently reduced the cover offered for certain knee procedures by 60 per cent. Bupa have written to all consultants having re-graded many orthopaedic procedures to a lower fee. Bupa has bundled a number of procedures codes (which set out the complexity of a procedure) into one, eg. Arthroscopic codes in order that the fee provided to the surgeon be reduced. Bupa have just announced their new pricing schedule of remuneration to consultants in various specialities with effect from 23rd April 2012. For a lower limb surgeon they have made changes for 25 procedures, 6 have gone up and 19 have gone down, in one case by 40 per cent.	Bupa Bupa Bupa
2. Osteopathy ³³	A consultant was told by Bupa that new osteopath network fees of £40 for a new patient and £30 for an old patient were part of a standardised contract price for the whole of the UK. The consultant then learnt that the Bupa clinic in Canary Wharf is charging £84 for a new patient and £59 for an old patient.	Bupa
3. Ophthalmology	Cataract surgery has seen a 20 year freeze in insurers' benefit maxima followed by a 60 per cent reduction.	Bupa

³⁰ See [FIPO response to provisional findings](#), September 2013.

³¹ *ibid.*

³² See [BOA initial submission](#).

³³ *ibid.*

<i>Submission classification</i>	<i>Examples of complaints</i>	<i>Insurer(s)</i>
	Insurers introduced a clearly discriminatory contract that meant that new NHS consultants, appointed after 2010 were required to sign a contract that paid them much less for cataract surgery than a surgeon appointed before this time (£360 for the new consultant and 750-850 for the others) and are now moving to 'conquer' the profession by reducing fees further to just £250 per cataract to all consultants.	
4. Pain Medicine	Bupa excluded Pain Medicine Consultants from their list of consultants able to give spinal injections (or required them to give injections under the supervision of sometimes less qualified consultants), some of which these consultants are the only ones trained to do.	Bupa AXA PPP
	A consultant was informed by Bupa that procedures will now require the authorisation of another consultant in another speciality.	Bupa
5. Radiology	On many occasions, patients requiring complex radiological interventions have been refused care in an institution with far better equipment and trained staff because the institution is not a member of the network. Radiologists at BMI hospitals have had their fees slashed without any consultation and no right of appeal.	
6. Physiotherapy	There is an increasing trend for insurers to limit the treatments they will pay for by categorising certain treatments such as physiotherapy as 'rehabilitation' which is not covered by most policies. Even postoperative physiotherapy after spinal surgery is under threat.	
7. Oncology	The agreed maxima for the supervision of chemotherapy and other supportive therapies have hardly changed over a number of years. They do not reflect the increasing complexity of care and changes in toxicity caused. There are a number of expensive biological therapies, often administered along-side conventional cytotoxic therapies that are licensed to be administered continually until the patient's cancer shows signs of progression (ie no longer benefiting from therapy). Several companies sell policies that do not make it clear to patients that funding of such therapies will be limited to an arbitrary time such as 12 months. This has no basis in clinical evidence and leads to patients with confidence in an existing private provider having to switch to the NHS (if the treatment is available there) or stop a beneficial treatment. Insurers are 'bribing' customers with full insurance policies to switch their treatment to the NHS when faced with expensive and extended oncological therapies (eg radiotherapy).	
8. Anaesthesiology	88 per cent of procedure codes have had no change in reimbursement level in the last 11 years.	
9. Psychotherapy	Co-payment is standard in many insurance companies, and consultants wondered why Bupa and AXA PPP have forbid this practice in addition to imposing a fee structure.	Bupa AXA PPP

Relevant customer benefits—quality and innovation

Introduction and summary

1. In this section we first summarize the arguments put to us by HCA regarding the loss of RCBs in the form of quality and innovation in private healthcare services. We then set out our consideration¹ of those arguments and our conclusions on RCBs as they relate to quality and innovation. We address HCA's other arguments regarding the costs of the divestiture remedy, including the loss of economies of scale in so far as they would have an impact on price (rather than quality or innovation), in Section 11.

HCA

2. HCA said that the CC would need to take account of the RCBs which were a feature of the market. It said that these comprised:
 - (a) higher quality;
 - (b) greater innovation; and
 - (c) greater choice of products or services.²
3. HCA said that these were expressly included as RCBs in the Act.³ We set out the definition of RCBs, as defined by the Act, in Section 11, together with the relevant section of our guidance.

Higher quality

4. HCA told us that its services were differentiated from those of its central London competitors, both in terms of the range and depth of services offered and through the overall quality of care provided, which could, among several other factors put forward by HCA, explain any pricing differentials between HCA and selected central London competitors. It said that its high quality and strong record of innovation demonstrated that the market functioned competitively and benefited consumers by driving up quality.⁴
5. HCA said that it had an unparalleled record among private healthcare operators of providing the best quality of care in the private sector and that this had contributed to quality improvements in private tertiary care. It cited as examples of this:
 - (a) advanced clinical pathways (eg in cancer care), which ensured that patients received the best and most advanced proven care in a consistent and measured way;
 - (b) the ability to attract the highest calibre consultants;

¹ We also include a summary of AXA PPP's comments on HCA's submissions.

² The definition of RCBs in the Act also includes lower prices but HCA did not claim that prices would be lower absent the AECs.

³ [HCA response to the Remedies Notice](#), paragraphs 5.1 & 5.2.

⁴ [HCA response to the provisional decision on remedies](#), paragraph 5.2.

- (c) depth of resource in terms of clinical staff. It said that it was the only hospital operator to employ significant numbers of resident medical officers (RMOs);
 - (d) its commitment to critical care. It said that it was the only private provider with level 3 ITUs in all its hospitals;
 - (e) its use of technology, for example integrated IT systems which allowed patients' care plans and treatment protocols to be closely coordinated and monitored across HCA hospitals;
 - (f) its integrated care pathways across all its facilities which involved multi-disciplinary team meetings bringing together representatives from all treatment options to discuss and decide on a patient's treatment plan; and
 - (g) innovation with the introduction of new equipment and treatment technologies.⁵
6. HCA said that its higher-quality offering was measurable and quantifiable and cited several examples. It said that:
- (a) its regular patient experience surveys recorded very high levels of patient satisfaction and gave as an example that 99.1 per cent of patients were satisfied with their overall quality of care;
 - (b) its infection rates were low. Its MRSA rates were five times lower than the national average and there had been no cases of C Difficile in HCA hospitals;
 - (c) its cardiac surgery survival rates compared well with national and international benchmarks; it was the largest provider of critical beds in the private sector;
 - (d) its average waiting times for surgery for cancer were 21 days with a median of eight days, compared with 62 days in the NHS;⁶
 - (e) unplanned transfers out of HCA were 15 times lower than the national average;
 - (f) unplanned returns to the operating theatre were over ten times lower than the national average; and
 - (g) it was the only private operator to achieve 100 per cent compliance with all CQC clinical outcomes in 2012.⁷
7. HCA prepared a report for the CC on its quality offering with the assistance of health-care consultants Oliver Wyman. This benchmarked HCA's performance against other private hospital operators and the NHS. Measures of quality reported in the accompanying presentation submitted by HCA included:
- (a) 98.1 per cent of patients would recommend HCA hospitals to family and friends;⁸
 - (b) HCA's mean five-year survival rate for early treatment of breast cancer was 9 per cent higher than the England average (85 per cent vs 93 per cent);⁹

⁵ HCA response to the Remedies Notice, paragraphs 5.3–5.6.

⁶ In Award Winning Quality, 2013 presentation.

⁷ HCA response to the Remedies Notice, paragraph 5.7.

⁸ HCA response to the Remedies Notice, Annex 2 Attachment: Award Winning Quality, 2013 presentation.

⁹ *ibid.*

- (c) HCA's patients were 50 per cent more likely to survive after an aortic valve replacement than the England average;
 - (d) HCA PROMs data on hip replacement patients showed that 100 per cent of HCA patients reported improvement on their preoperative condition compared with 95.8 per cent of patients nationally; and
 - (e) hospital-acquired MRSA infections in HCA hospitals were zero for quarters 1, 2 and 4 of 2012 and 1 per 100,000 bed days in Q3 compared with 1.08 in NHS hospitals.
8. The report itself set out in more detail what HCA said would be the impact on quality of the proposed CC divestments. This included the loss of life which HCA said would result from disrupting HCA's network and hence degrading the quality of its health-care. It said that HCA breast cancer treatments saved 28 lives a year, for example. The report contained numerous comparisons with both the NHS and other hospital groups, for instance that HCA's mortality rate for cardiothoracic surgery was 50 per cent better than the NHS and patients were 50 per cent less likely to need revision surgery for hip or knee replacements after five years than those treated in the NHS.
9. The report also set out the patient benefits of HCA's hospital network that was characterized by three features: its larger-than-average full-service hospitals; their geographical closeness to each other; and their location in a major city. In combination, HCA said that it could operate a tightly integrated network delivering a number of benefits:
- (a) Patients could transfer between HCA hospitals and facilities seamlessly.
 - (b) Centrally shared functions could be larger and better equipped.
 - (c) Activity could be focused at certain locations, giving complex activities the critical mass needed for specialization and safety.
 - (d) Sharing of clinical best practices and collaboration of clinicians through multi-disciplinary teams produced higher-quality care.
 - (e) It facilitated benchmarking.¹⁰
10. HCA set out what it described as the risks of divestiture. It said that there were two scenarios for a divested HCA hospital: either it entered a much weaker, less tightly integrated private hospital network or it became a stand-alone operator. HCA said that in either case the hospital would no longer benefit from HCA's network infrastructure and investment, nor would it have access to quality monitoring systems and shared diagnostic and surgical equipment.
11. The report contained three case studies illustrating the patient pathways that HCA had developed for: breast cancer treatment, cardiac care and orthopaedic care.

Breast cancer treatment

12. HCA said that it had worked with [redacted] of the UK's most prominent clinicians over a three-year period to develop its 'Network of Excellence' programme in which it had, to date, invested well in excess of £[redacted] million. It said that as a result it delivered

¹⁰ *ibid*, p8.

breast cancer care demonstrably superior to any other provider in the UK. HCA told us that due to the difficulties of obtaining data from third parties such as TLC it was not in a position comprehensively to measure comparative levels of quality across hospital operators. It submitted data showing that HCA's five-year survival rates for breast cancer were, at 93 per cent, higher than the average UK rate (81 per cent), the England average (85 per cent) as well as the averages for other OECD countries including Switzerland (86 per cent) and the USA (89 per cent). It said that the quality of its care resulted in 140 extra patients remaining alive over the next five years who would not be if they had been treated elsewhere.¹¹

13. It described its patient pathway for breast cancer treatment. It said that many of the services that it provided were spread across different facilities and that HCA's tightly integrated network enabled it to combine these services into a seamless pathway, for example allowing patients to benefit from the diagnostic facilities at its Princess Grace Hospital combined with the chemotherapy treatment available at LOC. It said that no stand-alone hospital could deliver the full complement of specialist services required to achieve this level of excellence for its patients. It told us that no other UK provider had made a comparable commitment, and many were missing the key elements to deliver high-quality breast cancer care to all patients across their networks. It listed nine 'features of excellence' that characterized its cancer care and compared this with the NHS, BMI, Spire and Nuffield.
14. HCA set out the risks that divestment would pose. It said that any divested hospital would either enter a much weaker breast cancer treatment network or become a stand-alone operator. The hospital would no longer benefit from HCA's network structure including access to the full range of technology available across the HCA network. It said that breast MRI to aid accurate diagnosis for dense-breasted women might no longer be easily accessible and this could result in the hospital missing breast cancers which then developed into much more serious cancers by the time they were diagnosed.¹² HCA said that even a small drop in quality from HCA's current high standards (5 per cent) at divested hospitals would result in a decline in five-year breast cancer survival rates, resulting in approximately seven fewer patient lives saved every five years.
15. Finally, HCA said that the ability to spread costs across multiple hospitals would be reduced by any divestments. Over time this would result in a slower rate of improvement and innovation within the HCA network, which it said drove the wider UK market. Technologies such as automated ultrasound and 3D mammography for accurate diagnosis, inter-operative radiotherapy (IORT) and new breast cancer pharmaceuticals, it said, would proliferate more slowly.

Cardiac care

16. HCA said that it was the largest independent provider of cardiac surgery in the UK with major units at London Bridge Hospital, the Wellington Hospital and the Harley Street Clinic. HCA had developed a cardiac patient pathway that utilized HCA's integrated network to deliver a high standard of care for patients. It presented data showing that its in-hospital survival rate for cardiothoracic surgery patients was 98 per cent compared with the average across the NHS in London of 97 per cent. It said that over the past ten years HCA had worked with clinicians from top academic hospitals to build a service which it said was unmatched in the UK independent

¹¹ *ibid*, pp14&15.

¹² *ibid*, p27.

sector using clinical expertise to direct large investments in treatment technology as well as spending over £[redacted] per year on infrastructure to monitor and improve quality.

17. It set out the risks of divestment which it said could have a significant negative impact on patient experiences and outcomes. These included lack of visibility of outcome data as a divested hospital would no longer benefit from participation in the quality programme supported by the Dendrite database,¹³ fewer opportunities for cross-learning with other cardiac units and lack of scale to create specialized clinical environments and to invest in technological advances that would improve patient outcomes and associated staff training, for example transcatheter aortic valve replacement (TAVI). HCA submitted that this would, in turn, result in lower quality of care and lower patient demand.
18. HCA told us that in the year to June 2012 it conducted around [redacted] procedures across three of its hospitals, [redacted] of which were at the London Bridge Hospital. It quoted the British Cardiovascular Intervention Society and the Society of Cardiothoracic Surgeons as stating that 'small volume TAVI units should be actively discouraged' and suggesting that something in the order of 50 or more cases would be optimal. HCA inferred from this that a new owner of the London Bridge Hospital might therefore cease providing TAVI treatments or, if it did not, would do so on a suboptimal basis from a clinical perspective.

Orthopaedic care

19. HCA's third case study was orthopaedic care. It said that the provision of orthopaedic care was highly competitive and that it worked hard to stay at its forefront by tackling the most complex surgery, offering the best specialists and investing in the latest rehabilitation facilities. It said that it was, in particular, driving innovation in minimally invasive surgery.
20. HCA compared its five-year revision rates with those of the NHS for hip and knee replacements. It said that its five-year revision rates were 1.3 per cent for hip replacements, compared with the NHS 2.6 per cent, and were 1.2 per cent for knee replacement, compared with 2.6 per cent for the NHS. It said that patient recommendations to family and friends were 95 per cent for NHS patients but 96 per cent for HCA patients.
21. HCA said that all three of its major orthopaedic centres had all the features of its orthopaedic centres of excellence and compared these unfavourably with NHS, BMI, Spire and Nuffield hospital facilities.
22. HCA set out risks of divestment which may impact future patient experiences and outcomes. These included reduced access to sub-specialized clinicians, reduced clinical focus meaning specialized nurses and physiotherapists could no longer be justified, lower ability to invest in dedicated orthopaedic theatres and wards and loss of facilities such as 3T MRI. HCA submitted that these effects would have detrimental implications for patient safety and service quality and was likely to drive away top clinicians.

¹³ [Dendrite](#) is a supplier of clinical databases and consultancy services.

Further case studies

23. HCA submitted three further case studies in a similar format.¹⁴ These comprised two more case studies on the treatment of cancers (blood and prostate) and one dealing with neurosurgery. Two of these, blood cancer and prostate cancer, compared HCA's facilities, but not clinical outcomes, with those of TLC. HCA compared its clinical outcomes against the European expected outcomes and stated that the data showed that HCA compared highly favourably in terms of transplant survival levels. HCA's comparison of its facilities against competing hospital operators showed that HCA has a higher number of 'features of excellence' than its rivals, which HCA argued implied that HCA was better equipped to offer a higher standard of care. In the case study on prostate cancer, London Urology at the St John and St Elizabeth's hospital is not included in HCA's competitor comparison. St John and St Elizabeth's, like HCA, has a 3T MRI scanner and claims to have been the first private hospital in the UK to acquire one.¹⁵ HCA told us that 3T MRI was a key innovation in the diagnosis of prostate cancer.¹⁶

AXA PPP

24. AXA PPP commented on HCA's response to our Remedies Notice in respect of RCBs. It said that HCA had not demonstrated that clinical outcomes would decline post-divestiture. It said that this claim was based on fundamentally flawed and wholly unreliable evidence, citing, for example, HCA's claims for survival rates for its patients with breast cancer. It said that HCA had not demonstrated credible synergies and in any case failed to demonstrate that synergies were specific to the HCA ownership structure.

Assessment of relevant customer benefits

25. HCA's submission in response to our Remedies Notice and to the provisional decision on remedies set out the benefits that it said would be denied patients if our proposed divestiture remedy was adopted. It said that the divestiture remedy would have a highly detrimental effect on [redacted], including the remaining HCA hospitals, by damaging the existing hospital network synergies, thereby putting at risk the high level of clinical care which it was able to offer. HCA drew our attention to the fact that the particular benefits to which it referred were expressly included as RCBs in the Act. It argued that:
- (a) the quality of the healthcare that it provided, including its innovatory practices and the range of services that it offered, was superior to that of its competitors. This arose at least in part from the benefits of operating a network of hospitals. HCA said that it had attempted to operate its business as 'one hospital with multiple locations';
 - (b) a new owner would offer lower-quality healthcare services; and
 - (c) a new owner would not enjoy HCA's scale economies which enabled it to deliver healthcare services more cheaply than would an acquirer of some of its hospitals.

¹⁴ HCA response to the Remedies Notice, [Annex 2](#).

¹⁵ See the [London Urology website](#) and, regarding the acquisition of the 3T MRI, [St John and St Elizabeth's history presentation](#).

¹⁶ HCA response to Remedies Notice, [Annex 2](#), p30.

26. We considered this to be an argument for the existence of RCBs, as defined by the Act, which would be lost as a result of divestiture and assessed the argument accordingly.

Quality of care compared with competitors

27. In its Quality Report and case studies HCA provided a number of comparisons between the quality of its services and those of other providers. It said, for example, that the average waiting time for surgery for its cancer care patients was 21 days, with a median of 8 days, compared with 62 days in the NHS.¹⁷ We thought that this comparison was not particularly informative since waiting lists for treatment are generally longer for NHS patients than in the private sector, and this is a major factor for purchasing private healthcare.¹⁸ Further, it was incorrect: the 62-day NHS waiting time is the *maximum* considered acceptable, not the *average* achieved in practice. We thought in any case that a new owner or owners of the HCA hospitals would be likely to benchmark itself against private sector providers rather than the NHS.
28. Similarly, HCA compared its five-year survival rates for breast cancer with UK and England averages rather than figures from comparable private hospitals and PPUs. In addition, we thought that the wide confidence intervals on average HCA survival rates indicated that the differences between NHS England and HCA survival rates were not statistically significant and therefore did not consider it appropriate to express this performance data in terms of lives saved per year, as HCA has done.¹⁹
29. In addition to submissions from HCA we received 89 letters from consultants with practising rights at HCA hospitals in response to the provisional decision on remedies which was the first public document to disclose the identities of HCA and BMI hospitals that we proposed be divested. We received no letters from BMI consultants.
30. The letters were generally consistent with the arguments contained in HCA's submissions to us, stressing in particular the benefits to patients of the HCA 'network' structure. They said, for example, that individual hospitals in HCA's network were able to focus on a particular specialization, that it facilitated the sharing of patient data and enabled the formation of multi-disciplinary teams. Consultants who wrote to us told us that the quality of HCA's hospital facilities and its level of innovation were persistently higher than other private hospital operators in the UK, including TLC and Bupa Cromwell.
31. In addition to considering HCA's submissions and letters from consultants, we also reviewed CQC inspection reports concerning its London hospitals. In its most recent report on each hospital, the CQC found that all the hospitals concerned met its standards. A CQC report on the Portland Hospital in February 2012 listed a number of areas where it had 'minor concerns' but, overall, the CQC reports were favourable. However, CQC reports for the same period on TLC, King Edward VII Sister Agnes, St John and St Elizabeth's and the Royal Marsden PPU were as positive as HCA's.
32. Finally, we reviewed surveys that HCA had conducted for reasons not connected with this inquiry but for their own internal management purposes which, for that reason, we felt could be particularly informative. We reviewed a biennial survey that HCA commissions into the views of consultants with practising rights at its hospitals on the quality of care provided at HCA hospitals. The authors of the 2010 report

¹⁷ [HCA response to the Remedies Notice](#), paragraph 5.7.

¹⁸ See paragraph 5.14.

¹⁹ HCA said of its breast cancer survival rate, for example, that 'This means 28 HCA International patients who would have died are still alive after diagnosis'. HCA response to the Remedies Notice, [Annex 2](#), p1.

included a caveat to the effect that consultants who responded in most cases had a good working relationship with their hospital and the results, therefore, were 'likely to be positively skewed in favour of HCA.'

33. The 2010 survey included some comparisons of HCA hospitals with others at which HCA consultants practised. This showed that the King Edward VII hospital was rated as highly by HCA consultants as London Bridge hospital and that TLC was rated higher overall by consultants than the Princess Grace. We reproduce below a summary table from the report.

TABLE 1 HCA consultant survey, 2010

Consultant overall ratings ALL Hospitals			
	Responses	Average rating	Rank
London Bridge	44	4.2	1
Kind Edward VII	19	4.2	2
Harley St	17	4.1	3
Wellington	44	4.0	4
Lister	24	3.9	5
London Clinic	38	3.7	6
Great Ormond St	17	3.7	7
St John and St Elizabeth	21	3.7	8
Princess Grace	31	3.4	9
Sloane	8*	3.4	10
BMI Blackheath	12	3.3	11
Portland	40	3.2	12
Cromwell Hospital	16	3.2	13
Guys and St Thomas's	30	3.1	14
Chelsfield	5*	3.0	15
Chelsea & Westminster	10	3.0	16

* Low sample size. Figures not statistically accurate

Source: HCA.

34. In the 2012 survey the rating system was changed to create a consultant satisfaction index (CSI) score out of 100, but the aspects of quality measured and the comparators remained broadly the same.
35. In terms of the consultants' rating of 'overall quality of care provided', all the hospitals referenced achieved good ratings [✂].

FIGURE 1

HCA consultant survey, 2012—quality of care

[✂]

Source: HCA.

36. Consultants' ratings on the basis of 'overall nursing quality' showed a similar pattern to that of 2010, with all hospitals achieving good ratings but with the Lister and the Bupa Cromwell slightly behind. However, the King Edward VII hospital achieved the highest score for nursing quality, exceeding HCA's highest rated hospital, the London Bridge, albeit by a small margin.

FIGURE 2

HCA consultant survey, 2012—nursing quality



Source: HCA.

37. Other findings of the survey which are relevant to this analysis include the factors identified as 'top priority' for improvement by HCA management. These were identified as factors that 'have a high impact on CSI and a relatively low score' for HCA hospitals. These factors included [REDACTED],²⁰ [REDACTED] though it is unclear what the relevant benchmark was for respondents: other private hospitals or the NHS.
38. Finally, despite HCA's introduction of new patient record systems and technology we noted that [REDACTED].²¹

Conclusions on quality of care compared with competitors

39. Overall, we considered that the evidence available to us, including HCA's specific examples, did not lead us to conclude that HCA's quality was appreciably higher than that of close competitors in central London, for example TLC, St John and St Elizabeth and King Edward VII.

Innovation

40. Annex 3 of HCA's submission listed a number of what it considered innovative services launched at HCA hospitals. HCA said that it had led the way in the private healthcare sector in bringing new, innovative equipment, technologies and treatments into its hospitals. It cited examples of investment in new equipment, such as the CyberKnife, NanoKnife and Da Vinci robot system, and new diagnostic equipment such as advanced MRI facilities and super low-dose CT scanners. It said that it had introduced highly sophisticated and advanced care pathways using IT systems such as PatientKeeper and Mosaik, which it described as a unique IT system which had revolutionised turnaround times in oncology. Finally, it said that its Sarah Cannon Research Institute was the only CQC-accredited private research centre in the UK offering clinical trials to NHS and private patients. It said that the existence of the facility incentivised the pharmaceutical industry to bring to market new, clinically proven drugs against cancer.²²

Conclusions on innovation

41. We thought that a large proportion of the innovations²³ cited by HCA were concentrated in cancer care and resembled innovations introduced in leading NHS institutions or concerned drug trials that any hospital can participate in, the trial drugs in question being provided free by the relevant pharmaceutical company.

²⁰ Though this was borderline.

²¹ [REDACTED]

²² HCA response to the Remedies Notice, paragraph 5.11.

²³ HCA often referred in its submissions to 'innovation' as another dimension of non-price competition in the provision of health-care. As we discuss in Section 6, in this market 'innovation' mainly refers to the adoption of existing products, technologies, equipment, rather than the development of new ones. For this reason, we consider that non-price competition is adequately described in terms of quality and range. However, in this appendix we have adopted the terminology of 'innovation' used by HCA as this is one of the categories of RCBs that we take into account in assessing the proportionality of our remedies.

42. Some examples of innovation, for example its adoption of commercially available software such as Mosaiq, were difficult to characterize as innovation. We did accept that HCA had demonstrated that it had been willing and able to adopt and develop new techniques or technologies though this was, in some cases, in response to innovations introduced by other private hospitals.
43. HCA told us²⁴ that it had made a sizeable number of investments in direct response to competitors launching medical technologies or introducing improvements to the level of comfort offered to patients.²⁵ HCA also told us that it introduced the bedside medication verification system when it learnt that BCH was installing this technology. We therefore thought that the greater rivalry, which we consider will arise from our remedy, will provide a further stimulus to innovation rather than blunt incentives to innovate.
44. More generally, we observed that not all the innovations that HCA cited had been adopted by larger organizations enjoying network benefits. An HCA presentation submitted to the CC, for example, showed the adoption of three technology innovations: Da Vinci robotic surgery, Cyberknife and bar-coded medication. The first mover in the case of robotic surgery was the NHS and in the case of Cyberknife it was stated to be HCA, in 2007, though the decision to purchase a Cyberknife was taken by TLC in the same year. As mentioned above, bar-coded medication technology was adopted by Bupa Cromwell, not part of a network, in 2013. Finally, we noted that St John and St Elizabeth, an independent, was the first private hospital in the UK to install a 3T MRI scanner.²⁶ HCA said that its ability to acquire a 3T MRI scanner, which it said was a key innovation in the diagnosis of prostate cancer, arose from the fact that it operated a network.
45. We concluded that HCA had introduced innovations but so had smaller hospital operators who did not operate within a network. We therefore concluded that membership of a network was not a necessary condition for the type and extent of innovation undertaken by HCA.

Greater range of goods and services

46. HCA said that it had contributed significantly to the creation of new clinical treatments and services within private healthcare, for the first time offering patients an alternative to the NHS. It said that tertiary care was, until recently, provided almost exclusively within the NHS because of the clinical infrastructure and resource which the NHS had to treat high-acuity conditions, in particular ITU beds and specialist medical staff. It said that HCA had invested in high-acuity facilities which offered highly specialized treatments in areas such as cancer, cardiac treatment and neurosciences.²⁷

Conclusions on range

47. We considered that HCA's evidence on choice of treatments showed that it had been a leader in widening the range of, in particular, high-acuity treatments available outside the NHS. However, we noted that other hospitals in central London, for example TLC, had adopted a similar strategy as regards cancer treatment.²⁸ As we set out in

²⁴ [HCA response to provisional findings](#).

²⁵ *ibid*, paragraph 5.61.

²⁶ See [SJE presentation](#), slide 53.

²⁷ [HCA response to the Remedies Notice](#), paragraphs 5.18–5.20.

²⁸ See also our discussion of range differentiation in Section 6.

detail in Section 6, HCA told us that when it had been the ‘first to market’ with new treatments or diagnostic technologies, competitors had been quick to follow suit. Furthermore, in several cases, HCA has responded to investments by its competitors in new treatments/diagnostics, ie its competitors have been first to market.

The services that would be provided by an acquirer of HCA’s divested hospitals

48. Having considered the extent to which HCA currently provides higher-quality services than other hospital operators, we now consider whether any of these benefits would fall within the definition of RCBs including whether they are likely to be extinguished in the event of divestiture.
49. RCBs are limited to benefits to relevant customers in the form of:
- (a) lower prices, higher quality or greater choice of goods and services in any market in the UK; or
 - (b) greater innovation in relation to such goods and services; and
- a benefit is only an RCB if the CC believes that:
- (c) the benefit has accrued as a result of the features concerned; and
 - (d) the benefit was or is unlikely to accrue without the feature or features concerned.²⁹
50. We set out our consideration of whether the benefits of higher quality, greater innovation and wider range of high-acuity services that HCA had submitted it provided would only be likely to accrue while the features giving rise to the AEC persisted. In particular, we considered whether a new owner or owners of the divested hospital businesses would have the incentive and the ability to offer services comparable to HCA’s.

Incentives to maintain quality standards and range

51. We note that, were some of HCA’s hospitals to be acquired by another operator, it is possible that they (and HCA) might seek to reposition themselves both vertically, in terms of quality, and horizontally, in terms of the types and range of services they offer. A new operator might, therefore, choose to focus on less-complex, lower-acuity work and/or lower the quality of its service, for example by reducing nurse/patient ratios. While we believe such repositioning is possible, we believe it is unlikely.
52. HCA told us that its strategy was not a secret, that it had stated publicly that it was its intention to focus on high-acuity, tertiary care since ‘high acuity patients have a better return on capital.’³⁰ It accepted that another operator of the hospitals concerned could adopt the same strategy. It said, however, that this could not be guaranteed and that to date no other private hospital operator had invested to the same degree in highly complex, high-acuity treatment or offered the same clinical infrastructure as HCA.

²⁹ CC3, paragraphs 355-359.

³⁰ HCA response to provisional findings, Appendices, paragraph 5.335.

53. While we agreed that this could not be guaranteed, we disagreed with HCA's contention that no other private hospital operator had invested to the same degree. We noted that TLC had adopted a strategy very similar to HCA's, though in fewer medical specialisms, and had invested heavily to do so in its integrated Cancer Centre. We therefore thought it likely that, to the extent that the provision of high-acuity care continued to offer a profitable opportunity, the new owners of the HCA hospitals would pursue it. If it did not, and if the market signalled that another strategy would be more attractive, the new owner or owners might adopt a different strategy. We concluded that in either circumstance the more competitive dynamics in central London would make it more likely that private patients' needs would be adequately met.

Ability to offer services comparable to HCA's

54. We considered the extent to which the disruption of HCA's care pathways and the loss of scale economies that it claimed would arise from divestment would prevent a new owner or owners of the divested hospitals, or HCA itself, providing services comparable to those which HCA currently provides.
55. Before considering this issue, we note first that, in our general considerations regarding the criteria for suitable purchasers, we proposed that suitable purchasers should have expertise and experience in operating hospitals capable of delivering high-acuity services to a high standard and within specialisms appropriate to the hospitals being divested. The CC would thus be in a position to assess whether a potential purchaser or purchasers had the necessary ability, expertise and resources to provide high-quality services and to prevent purchasers not suitably qualified from acquiring the hospitals to be divested and to provide or withhold its approval of that purchaser accordingly.

Care pathways

56. We thought that a new owner of the divested hospitals would have the ability to retain an emphasis on high-acuity work. HCA had argued that its patients benefited significantly from the tight network of six geographically close facilities that it operated, enabling a seamless transition from one facility to another. It also argued that it benefited from scale economies, including the ability to support specialized facilities. It told us, for example, that staff development and skill would be enhanced by continual experience of the same area of care, such as breast cancer care. It said that even if a new owner was part of a hospital group, it could not benefit from a network of the size and quality of HCA's.
57. We thought that the unique benefits of the pathways between HCA's facilities had been overstated since we considered that they applied mainly to cancer treatment, and even then only to a limited range of hospitals and other facilities including the Harley Street Clinic and LOC. We did not consider that the divestments we were proposing would fundamentally affect HCA's cancer treatment pathway or pathways and that to the extent that it would be disrupted the effects could be mitigated.
58. We have not proposed that HCA dispose of its main chemotherapy centre (LOC), the radiotherapy facilities at the Harley Street Clinic or the radiosurgery facilities at the Wellington Hospital or its involvement within University College Hospital.³¹ As regards facilities at the Princess Grace Hospital, HCA could, for example, replicate

³¹ Harley Street at UCH and the 5th floor of the Macmillan Cancer Centre.

the imaging and diagnostic facilities, including breast MRI, elsewhere, thus preserving any RCBs arising from the existence of a care pathway using HCA hospitals exclusively.

59. Even were this not to be possible, consultants could still refer patients to or treat them at the facilities at the Princess Grace Hospital, under its new ownership, just as they are currently able to refer patients to, for example, LOC for chemotherapy but TLC for radiotherapy. While we acknowledge that stopping what internal HCA documents sometimes refer to as 'leakage' (ie patients following pathways which include facilities owned by other hospital operators) may be a benefit to the HCA business, remaining within one hospital group's pathway is not necessarily an RCB.

Scale economies

60. HCA provided estimates of the costs the retained business would face as a result of losing scale and scope economies lost as a result of the divestiture. We discuss these costs in Section 11. In addition to the costs it would face, HCA provided examples of some types of care it, or the new owners of its divested hospitals, would no longer be able to provide, or provide efficiently, as a result of loss of scale.
61. For instance, HCA cited its investment in IORT, which it said would not be possible unless leveraged across several hospitals. However, AXA PPP told us that IORT could be delivered using mobile technology, could be purchased on a per-patient basis and was currently being installed at the, stand-alone, Montefiore hospital in Hove. We noted that, in addition to Spire Montefiore, Spire Bristol, BMI Chelsfield and BMI Bishops Wood had also adopted IORT technology using the Xoft system.³²
62. HCA responded that it used the intrabeam system developed by UCH academics and Carl Zeiss. It said that the Xoft mobile technology system had not completed clinical trials and that there was no data to support the claim that it was clinically equivalent to the intrabeam system. HCA said that the use of the Xoft mobile technology system was not evidence based and its safety and efficiency had not been established. It further said that there was litigation in the USA concerning the use of the Xoft system that had raised questions about its safety. We put these points to BMI and Spire.
63. BMI confirmed that it was using the Xoft mobile IORT system at two of its hospitals but disagreed with HCA's statement that this system had not completed its clinical trials and that there was no data to support the claim that it was clinically equivalent to the intrabeam system. It told us that HCA's statement was disputed by the manufacturers of the Xoft system and by a number of leading clinicians. It submitted a number of academic papers to substantiate its view.
64. Spire confirmed that it was using the mobile Xoft IORT technology at its Montefiore and Bristol hospitals. [REDACTED]. The mobile system, coupled with the support provided by their third party contractor, Oncotherapy Resources Ltd, enabled the equipment to be used during surgery and then removed. Spire told us that the Xoft and Intrabeam technologies were very similar in terms of physics and dosimetry and that there was evidence that the two systems are clinically equivalent. The Xoft system, it told us, is medically appropriate for the indications that it is used to treat at the Montefiore and Spire Bristol. Spire told us that while there had been litigation in the USA concerning the use of the Xoft system this had been in connection with the use of a radiation shield manufactured using tungsten but this particular shield had never been used

³² See [press release](#) from Advanced Oncotherapy, the supplier of the system.

with the Xoft system in the UK. Those shields that had been used in the UK were made of different material and could not give rise to similar problems.

65. We concluded that the benefits of IORT could be provided at hospitals not belonging to a network equivalent to HCA's.
66. In addition, HCA cited the volume of TAVI procedures undertaken at the London Bridge Hospital (fewer than 50 per year) in the context of advice from the British Cardiovascular Intervention Society (BCIS) and Society of Cardiothoracic Surgeons (SCTS) that 50 procedures a year would be optimal for a TAVI unit. It suggested that a new owner might therefore cease offering the TAVI procedure or operate sub-optimally, from a clinical perspective. The BCIS and SCTS statement³³ cited by HCA suggests a minimum of 24 procedures a year, [X], with an optimum of 50, [X].

Conclusion on relevant customer benefits

67. We considered whether RCBs, as defined in the Act, were present and, if so, whether and to what extent we should modify our remedy in order to preserve them.
68. We concluded that to the extent that HCA services are of a good quality, that it has broadened the range of private hospital services and that it has innovated, these did not constitute RCBs since we do not expect that they would be extinguished by the remedy and would not depend on the AEC to continue.
69. We thought that the network benefits to patients in terms of quality of patient care claimed by HCA were generally overstated since these could be replicated by a consultant referring his or her patient to the most appropriate facilities irrespective of who owned or operated them.
70. As regards the range of services offered, we thought that the new owner or owners of the HCA hospitals would be likely to adopt the same strategy as HCA: a focus on high-acuity, tertiary healthcare services. However, even if this were not the case, we considered that the new owner or owners would be likely to have both the ability and incentives to pursue a strategy that does not disadvantage private patients in terms of either the quality or the range of medical services provided.
71. We therefore concluded that we did not need to vary our remedy in order to preserve any RCBs.

³³ www.bcis.org.uk/resources/documents/BCIS%20SCTS%20position%20statement.pdf.

Quantifying the price benefits of divestitures

Introduction

1. In ordering the divestiture of certain hospitals, the CC is aiming to increase the competitive constraints in central London and thereby reduce the market power of HCA, vis-à-vis UK and overseas self-pay patients, insurers and embassies.¹ We note that divestiture should not have an impact on NHS prices (and therefore revenue) since these are set via a national NHS tariff and are not negotiated by the private hospital operators.
2. In this appendix, we first set out the methodology that we have applied in estimating the likely price benefit to customers resulting from the divestiture of hospital facilities, before providing the range of estimates that form our 'base case'.

Methodology set out in the provisional decision on remedies

3. In the provisional decision on remedies, we set out the two main approaches that we thought could be taken to quantify the impact of divestitures on prices. For self-pay patients, we reasoned that our price concentration analysis provided the most rigorous means of estimating the likely decline in prices following a divestiture since this analysis was conducted using data on the prices paid by self-pay patients for four of the most common inpatient treatments undertaken in private healthcare in the UK. This analysis demonstrated a causal relationship between the prices charged in local areas and the level of market concentration in those areas. The coefficient estimate from this analysis indicates that, in response to a 20 percentage point fall in the weighted average market share of a hospital in an area, its self-pay prices would decline by approximately 3.4 per cent. The formula that we used to estimate the total revenue impact of our divestiture remedy was:

$$\text{Change in LOCI network effect} \times \text{PCA coefficient} \times \text{Relevant revenue}^2$$

4. For insured patients, on the other hand, we reasoned that there were two approaches that could be taken:
 - (a) First, we could make the assumption that the relationship between concentration and insured prices was similar to that discovered by our PCA, applying the approach set out in paragraph 3.
 - (b) An alternative approach would be to use the results of our insured pricing analysis, which estimated the average difference in the prices charged to insurers by the hospital operators. By comparing the prices charged by those operators which we found did have market power and the prices charged by those which we found did not, we could estimate the likely impact on insured prices of increasing competition. For example, according to our analysis, the difference between the prices charged by HCA and TLC was [redacted] per cent on average over the period between 2007 and 2011 and approximately [redacted] per cent in 2011.

¹ We note that an increase in competitive constraints could also be expected to have a positive impact on quality and range in local areas, which would benefit all patients, whether self-pay, insured or NHS. In this paper, however, we focus only on the *price* impact of divestitures.

² The 'relevant revenue' stream refers to private inpatient plus day-case revenues. See paragraphs 6 and 7 for further discussion of this.

5. Using this approach, we reasoned that we could estimate the potential price benefit to customers by applying the difference in prices charged by HCA and TLC to HCA's (total) insured revenues on the basis that the proposed divestiture package would be effective in creating a sufficient competitive constraint on HCA to reduce its prices to the level charged by TLC.
6. Next, we considered which of the private revenue streams—inpatient, day-case and outpatient—would be affected by divestiture. As noted in our findings, while we focused on private hospitals and PUs providing inpatient care, we considered that certain day-patient and outpatient treatments are likely to be subject to similar competitive conditions as those arising in the provision of inpatient treatments and, therefore, to similar price effects arising from weak competitive constraints (and, conversely, from divestments). In addition, we considered that hospital operators and insurers negotiate over the overall bundle of treatments, including inpatient, day-case and outpatient treatments, so that any price effect is spread across these treatments (see paragraph 6.484). We considered that the IPA provided evidence to support an approach which applied any reductions in prices to both inpatient and day-case revenues for HCA, since this analysis demonstrated that HCA was able to charge higher prices across both inpatient and day-case treatments than its closest competitor (TLC).
7. In estimating our 'base case' in the provisional decision on remedies, therefore, we applied the results of our PCA to the revenues relating to all private patients (self-pay, insured and international) being treated for inpatient or day-case procedures. We used the results of the IPA to estimate an upside case, again applying these price effects to all private patients (self-pay, insured and international) being treated for inpatient or day-case procedures. Although we estimated what the price benefits would be if we applied the PCA and IPA results to outpatient revenues as well, we did not place any weight on these calculations in our assessment of proportionality.

HCA's views

8. HCA argued that our quantification of the price benefits was significantly overstated. It stated that both the PCA and the IPA were flawed and could not be relied upon to estimate the potential price impacts of our divestiture remedy since neither provided evidence of a link between local market concentration and HCA's prices. HCA told us that the PCA did not have any relevance to HCA or to the London market and that the results of this analysis were incorrectly applied by the CC to insured and international patients and to day-case procedures.³ HCA argued that the application of the results to insured patients was contrary to the approach that had been taken throughout the inquiry, where the CC had argued that a bargaining framework should be used to analyse the interactions between insurers and hospital operators. HCA argued that this competitive framework was clearly very different from the one where hospitals interacted directly with self-pay patients. It argued that there was no economic justification to use the PCA results to estimate the relationship between concentration and insured prices.⁴ HCA told us that the PCA was based on inpatient procedures only, and the CC had not demonstrated that a similar relationship between concentration and prices held for day-case or outpatient procedures. Nor had the CC identified any AEC in respect to day-case patients or outpatients. Therefore, HCA argued that it was not reasonable to apply the findings of the PCA to those procedures.⁵ Finally, HCA argued that there was no evidence or justification to

³ HCA response to the provisional decision on remedies, Annex 2, Appendix 1 (summary and paragraph 2.4).

⁴ *ibid*, Annex 2, Appendix 1, paragraph 2.8.

⁵ *ibid*, Annex 2, Appendix 1, paragraphs 2.10–2.12.

assume that any price benefits to UK self-pay patients would be realized by international patients. The relevant competitive constraints on HCA in relation to international patients include hospitals in Germany, the USA and Singapore. It put forward the view that, without having conducted analysis on the basis for international patients' choices and the competitive constraints that HCA faces in the international market, the CC could not reach a view on the effect on prices to international patients.⁶ It also highlighted that the CC had not found an AEC in respect of international patients.

9. In relation to the change in network effect assumed, HCA argued that the CC's analysis overstated the change in network effect (and therefore overestimated the price benefits) as it assumed that the current network effect measured for the hospitals proposed for divestment would be fully dissipated following a divestiture. HCA stated that this assumed that the buyer or buyers of the hospitals would be new entrants to the market but that this assumption was questionable. It noted that the acquisition of one or more of its hospitals by other UK hospital operators might create another network effect for the hospital group even if its hospitals were not in close proximity to the divestiture facilities.⁷
10. HCA put forward the view that the IPA could not be relied upon to show that HCA charged significantly higher prices to PMIs than its competitors as a result of market power and therefore could not be relied upon to calculate the price benefits arising for the CC's divestment remedy. HCA submitted that the IPA was unreliable as it was based on episode charges rather than prices and the London index price differentials it showed were not statistically significant. Further, HCA argued that even if the differences in prices shown by the analysis were robust, they could not be imputed to different degrees of market power of the hospital operators. It cited the 'considerable variation' in the indices (for example, over time) and the example of King Edward VII's prices, which it suggested were at a similar level to HCA. HCA stated that, the fact that the indices varied significantly without a corresponding variation in local concentration, was inconsistent with the CC's view that the IPA was informative of not only of the relative prices of HCA and TLC but also of whether any differential could be attributed to market power held by HCA.⁸
11. In relation to the approach of using the IPA to estimate the potential price benefits, HCA argued that the CC could not apply the results of the analysis to self-pay or international patients, or to outpatient treatments as these were not used as inputs to the analysis and that the CC had no robust justification or evidence to do so.⁹ Finally, HCA suggested that the CC had (a) 'presumed' that any existing price differences did not reflect quality or cost differences but rather reflected some form of market power by HCA; (b) provided no evidence as to why current HCA prices would not be at the competitive level; (c) failed to set out any robust mechanism through which such prices would fall following the proposed divestitures; and (d) completely overlooked other competitors' price levels by only comparing HCA's prices with TLC's. As a result, HCA asserted that the CC could not assume that prices would fall to the same level as those of TLC following a divestiture.¹⁰

⁶ *ibid*, Annex 2, Appendix 1, paragraphs 2.13–2.15.

⁷ *ibid*, Annex 2, Appendix 1, paragraphs 2.21–2.23.

⁸ *ibid*, Annex 2, Appendix 1, paragraphs 3.1–3.15.

⁹ *ibid*, Annex 2, Appendix 1, paragraphs 3.16–3.18.

¹⁰ *ibid*, Annex 2, Appendix 1, paragraphs 3.19 & 3.20.

Our assessment

12. We consider HCA's arguments in respect of the reliability of the PCA and IPA in Section 6. We concluded that these analyses were robust. Our competitive assessment (Section 6) sets out the evidence that we have considered and our reasons for finding that HCA's prices are above the competitive level, while Section 11 explains in detail the mechanism by which we would expect prices to fall following divestitures and the evidence underlying our conclusions. In particular, we have sought to design a divestiture package that will be effective in remedying the AEC arising from HCA's market power. On this basis, we consider that it is reasonable to assume that following the implementation of our divestiture remedy, HCA's prices would fall towards the competitive level. We have used TLC's prices as the benchmark. We note that having found these analyses to be reliable, we concluded that it was reasonable to apply their results in estimating the likely impact on price that would result from the reduction in concentration brought about by our divestiture remedy.
13. We agreed with HCA that there were differences in the way in which prices were set for self-pay patients and insurers such that it would not necessarily be reliable to apply the results of the PCA to insured revenues, or the results of the IPA to self-pay revenues. We considered that the most reliable approach was to apply the results of the PCA to self-pay patients and those of the IPA to insured patients. We have updated our analysis accordingly.
14. We considered HCA's arguments that we should not apply the results of the PCA to day-case revenues. For the reasons given in Section 6, we believe that the internal documents provided support for our view (set out in paragraph 6) that concentration had a causal impact on price for day-case and outpatients as well as inpatient treatments. However, we have adopted a conservative approach to estimating benefits and as such we have only applied the results of the PCA to (self-pay) inpatient revenues in our 'base case'. However, in our 'upside' case, we have also applied the PCA results to self-pay day-case revenues. Again, this could be viewed as a conservative approach as we have not included outpatients.
15. We considered HCA's argument that the analyses that we had undertaken could not reasonably be applied to the revenues generated from international patients due to differences in the competitive dynamics of the international market that were not reflected in our analysis. We observed that international patients were funded by a number of different sources, including embassies/governments, insurers and self-pay. In Section 11 we set out in detail our reasons for concluding that a divestiture remedy would be effective in reducing the prices paid by both self-pay patients and insurers. Following an increase in competitive constraints, particularly for the higher acuity work in which HCA specializes and which HCA told us disproportionately attracted international patients, we could see no justification for assuming that these funders would not also benefit from greater competition and therefore an ability to negotiate lower prices with both HCA and the divested hospital(s). However, in our 'base case' we have taken the conservative approach of assuming that there would be no impact on the prices charged to international patients. We thought that since most international patients were charged according to framework-type contracts negotiated between insurers or embassies/governments and the private hospital operators, to the extent that there was an impact on the prices for international patients, the IPA was likely to provide the most relevant means of estimating that impact. In our upside case, therefore, we have applied the IPA results to international revenues earned from inpatient and day-case treatments.

16. Finally, we considered HCA's argument that the change in network effect that we had assumed was likely to be an overestimate as certain potential purchasers would have overlapping catchment areas such that a new network effect would arise, dampening the price benefits. We observed that we did not expect any of HCA's central London competitors to purchase the divested hospitals (see 11.151) due to the size of the package and the financial constraints of the charitable operators [§]. We considered that it was possible that operators with hospitals in the Greater London area might purchase one or more of the divested hospitals and thereby recreate some network effect, however, these hospitals exert weak competitive constraints on HCA and we thought it likely that such a network impact would be minimal in comparison with the current network effects enjoyed by HCA's hospitals. We reasoned that the size of the network effect was only relevant for the estimated impact on self-pay revenues which, as shown in Table 2 represented a relatively small proportion of the total estimated price benefit. We concluded, therefore, that the potential overestimate of the network effect would be best addressed qualitatively when assessing the overall proportionality of the divestiture remedy.

Quantification of price benefits

17. In this section, we set out our 'downside', 'base case' and 'upside' estimates of the price benefits that are likely to accrue to customers as the result of our divestiture remedy.¹¹ In Table 1, we set out which pricing analysis we have applied to which revenue streams.

TABLE 1 Basis of price benefit calculations

	<i>Downside case</i>	<i>Base case</i>	<i>Upside case</i>
(UK) Self-pay revenues	PCA results Inpatient revenues only	PCA results Inpatient revenues only	PCA results Inpatient and day-case revenues
(UK) Insured revenues	IPA results Inpatient and day-case revenues	IPA results Inpatient and day-case revenues	IPA results Inpatient and day-case revenues
International revenues	No price benefit	No price benefit	IPA results Inpatient and day-case revenues

Source: CC analysis.

18. In Table 2, we set out the price effect estimated for each revenue stream in each of our cases. When applying the results of the PCA, we noted that the coefficient on our preferred specification was 0.1717, which equated to a price change of approximately 3.4 per cent in response to a 20 percentage point reduction in the weighted average market share in a local area. We considered using a range of potential effects of between 3 and 4 per cent (as we did in the provisional decision on remedies) but concluded that it would be simpler to apply the point estimate. For the reasons given in Section 6, we see this estimate as being conservative.
19. When applying the results of the IPA, we noted that the difference in the prices charged to insurers by HCA and TLC had increased over the 2007 to 2011 period, with an average of [§] per cent for the period as a whole and a difference of [§] per cent in 2011. We thought it would be conservative to use the average price difference for the period, ie [§] per cent, in our analysis, but we noted that this might understate the actual impact of the remedy.

¹¹ We note that in terms of the price benefits, the downside and base-case estimates are the same. In Section 11 we set out our NPV estimates of the total costs and benefits of the divestiture remedy. In that analysis, we make different assumptions regarding the costs in the downside and base cases.

TABLE 2 Impact of divestitures on total private patient revenues

<i>Hospital divested</i>	<i>Revenue stream</i>	<i>Revenue reduction (£'000)</i>	
		<i>Downside & base case</i>	<i>Upside</i>
HCA London Bridge & HCA Princess Grace	Self-pay	[X]	[X]
	Insured	[X]	[X]
	Overseas	[X]	[X]
	Total	[X]	[X]
HCA Wellington	Self-pay	[X]	[X]
	Insured	[X]	[X]
	Overseas	[X]	[X]
	Total	[X]	[X]

Source: CC analysis.

Note: These estimates are based on FY11 revenue figures.

20. This analysis shows that our base-case estimate is a reduction in total revenues of approximately £[X] million per year, with an upside estimate of a reduction in revenues of up to £[X] million per year. As explained in paragraph 19, we thought that this estimate could be understated given that we have used the average [X] per cent difference in insured prices between HCA and TLC, rather than the [X] per cent difference measured in 2011 and that we consider that our PCA estimates are conservative. We observed that our estimate of the customer detriment arising from HCA's market power in central London was approximately £[X] million in 2011.

Approaches to clinician incentives in other jurisdictions

1. In this appendix, we set out the results of our research into the laws governing clinicians' incentives in the USA and, more briefly, Canada and Australia.

US restrictions on clinician incentives

Background

2. The USA has no general system of universal public health coverage equivalent to the NHS. Nevertheless, federal and state authorities in the USA spend hundreds of billions of dollars every year on various forms of assistance to those less able to afford medical coverage (poor Americans, the elderly, children).
3. Most of this assistance takes the form of refunds to private or non-profit healthcare providers who provide healthcare services for protected groups (such as the elderly through Medicare) rather than providing services directly. As a result, the US Government has a strong incentive to control the cost of such programmes.
4. Following the creation of Medicare and Medicaid in 1965, the US Federal Government looked to restrict practices which offered doctors incentives to refer patients on to particular medical facilities for inpatient treatment. The result was the 'Anti-Kickback Law' of 1972, which provided both civil and criminal penalties for anyone who, 'knowingly and willfully solicits or receives any remuneration' for the referral of Medicare or Medicaid patients.¹ Violations of the Anti-Kickback Law may result in exclusion from federal health programs, criminal penalties of up to \$25,000, civil money penalties of up to \$50,000 for each violation, and up to five years imprisonment.
5. The Anti-Kickback Law applies to all referrals and purchases and even prevents physicians from offering to waive co-payments that would otherwise be due from Medicare or Medicaid patients, unless the physician determines that the patient cannot pay or has made a reasonable effort to collect the co-payment. Inducements covered by the act include cash, services, overpaid directorships and other positions, and gifts.

Stark Acts

6. This legislation was supplemented by the 'Stark Acts', passed in 1989 and 1993, which further expanded the restrictions on referrals. The Stark Acts arose due to concerns in Congress that the Anti-Kickback Law offered insufficient protection against self-referral. Under the Anti-Kickback Law, prosecutions were rare as the 'knowingly and willfully' standard was very difficult to satisfy. The Anti-Kickback Law remains in force, but the Stark Acts were designed to supplement it.
7. The Stark Acts banned referrals of Medicare and Medicaid patients for clinical laboratory services where the referring physician has a financial relationship with the

¹ Various exceptions or 'safe harbours' have been built into the legislation, such as payments to bona fide employees, rental agreements, and investments in ambulatory surgical centres.

laboratory,² and also covered other designated medical procedures. Like the 'Anti-Kickback Law', the Stark Acts contain numerous exceptions, including an exemption where the ownership interest of referring physicians is minimal and permitting payments pursuant to employment relationships. Violations of the Stark Acts may be committed by physicians making unlawful referrals or by entities (including hospitals) which present claims for the health services provided as a result of unlawful referrals. Violators of the Stark Act face civil money penalties. In addition, many US states have 'topped up' the federal restrictions with complementary prohibitions of their own.

Patient Protection and Affordable Care Act

8. In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA, also known as 'Obamacare'). Among other provisions, PPACA included various reforms pertaining to the Stark Acts.
9. Major reforms include:
 - (a) Amending the exemption for 'In-House Office Ancillary Services'. The Stark Acts had generally permitted physicians to refer services that could be provided in the physician's office itself. In the case of PET, CT, and MRI scans (and such other equipment as the Secretary of State for Health and Human Services may determine), PPACA requires that the referring physician must notify the patient about alternative providers of the same service within the local area.
 - (b) Substantial limitations to the 'Whole-Hospital Exception'. Under the Stark Acts, self-referral had been permissible in instances where the physician's ownership interest was in the whole hospital rather than a particular subdivision. PPACA 'grandfathers' the exception to those hospitals which had a Medicare provider agreement in place as of 31 December 2010.
 - (c) Annual Reporting Requirements for Physician-Owned Hospitals: Physician-owned hospitals are required to submit an annual report to the Secretary of State for Health and Human Services detailing the nature and extent of each owner's investment interest in the hospital, which is to be made publicly available. Those hospitals which remain under the physician-owned hospital exception will be subject to certain restrictions, including mandatory disclosure of the hospital's physician-owned status and strict restrictions on the expansion of such hospitals.

'Qui tam' provisions under the False Claims Act

10. The False Claims Act³ is a federal statute which imposes liability on those who defraud government programmes and services. The False Claims Act covers a wide range of fraudulent conduct, so a fraudulent claim may concurrently violate the False Claims Act as well as the Anti-Kickback Law and the Stark Acts. It also covers conduct not covered by the Anti-Kickback Law or the Stark Acts, such as making false claims.
11. In addition, the False Claims Act provides for so-called *qui tam* provisions, which allow individual whistleblowers to bring suit against fraudsters and claim a share of the damages that are ultimately recouped by the Government. The *qui tam* provision

² Studies had shown that the problem of self-referral was widespread, and demonstrated, for example, that MRI owners referred patients for MRIs twice as frequently as non-owners.

³ Originally passed in 1863, at the height of the US Civil War to prevent sharp practices by contractors from defrauding the federal Government.

has been of vital assistance to the US federal Government in successfully counter-acting healthcare fraud.

12. *Qui tam* actions, though originally a creation of English law, have since passed into disuse in England and Wales. The Common Informers Act 1951 abolished a number of statutes which had previously supported *qui tam* actions.

Third party views on US restrictions

13. In their responses to the Remedies Notice, some parties, in particular HCA, Bupa and AXA PPP, provided their views on the effectiveness of the Stark Acts and other US legal provisions.

HCA

14. HCA said that the Stark Acts only prohibited referrals for designated health services that were covered by Medicare. They did not regulate privately-funded services paid for by patients directly or PMI companies. It said that the Stark Acts, with their maze of regulatory definitions, special rules, exceptions, and exceptions to exceptions, had had the opposite effect to that intended (ie simplifying conduct in the healthcare marketplace, improving the quality and cost of care, and promoting competition) by increasing transaction costs, limiting innovation, and placing a stranglehold on the implementation of healthcare cost-saving models.
15. It said that the sheer breadth and impracticability of the Stark Acts had resulted in virtually every arrangement between healthcare entities and physicians potentially coming within their ambit. The definition of the word 'referral', central to the Stark Acts, required more than 370 words. If an entity provided a physician with anything of value, regardless of how small (eg a coffee mug, or free parking), the physician could not refer Medicare patients to that entity for designated health services. Consequently, it said, there had been a proliferation of exceptions (nearly three dozen so far) to deal with the Stark Acts' unintended consequences.
16. It said that the challenges with the Stark Acts were compounded by a heavily reactive US governmental rulemaking regime that continually issued revised regulations and limited guidelines, which added to the complexities and further impeded the workability of the law. HCA thought that it was difficult to see how many of these provisions would apply in the very different structures and practices of the UK private healthcare market. It said that it would be challenging to justify the significant governmental infrastructure and support needed to oversee, adapt, interpret and enforce this type of law, and the related increased costs to healthcare entities and physicians. In light of these increased costs, coupled with the negative impact on innovation and a nimble, efficient healthcare marketplace, HCA did not consider the Stark Acts to be a particularly useful or effective model to apply to UK private healthcare providers.

Bupa

17. Bupa said that the Stark Acts had certain aspects which could usefully be employed in any CC remedy, notably in relation to fair market value, the ability to enforce and apply sanctions, and the ability to hold hospitals as well as doctors to account. Bupa noted that the onus, under the Stark Acts, was on physicians not to make referrals where they were party to a financial arrangement with a hospital operator, rather than on hospital operators either not to enter into incentive arrangements with physicians or not to offer such financial incentives to doctors and clinicians in the first instance. Bupa said that, in the context of the UK market, it was appropriate that an obligation

not to enter into incentive arrangements be imposed on hospital operators, since it was they who had market power.

18. Bupa said that a second element of the Stark Acts was that an entity providing certain designated health services could not present a claim to a third party (such as an insurer) for payment for those services if they were referred by a physician in contravention of the Stark Acts. It thought that an equivalent obligation, whereby a hospital operator could not bill an insurer or patient for work undertaken as a result of referrals from a doctor who was party to a prohibited incentive arrangement with that hospital operator, should be considered by the CC.
19. It said that the Stark Acts required the disclosure of hospitals' ownership, investment and compensation arrangements, which included holdings of shares or debt in a hospital operator or a hospital, as well as more straightforward incentive scheme arrangements. Bupa believed that this straightforward and comprehensive approach to disclosure should be applied in respect of any CC remedy, if the CC were minded to allow certain types of incentive scheme to continue.

AXA PPP

20. AXA PPP said that the Stark Acts, which concerned equity investments by physicians, suffered by setting out too precisely what could not be done, which meant they also set out where incentives could be applied. It said that enforcement actions under the Anti-Kickback Law had resulted in principals being liable for the acts of their agents. Of particular interest, according to AXA PPP, was the section of the statute which prohibited the offer or receipt of certain remuneration in return for referrals for or recommending purchase of supplies and services reimbursable under government healthcare programmes.
21. AXA PPP said that the USA had a strong regulatory regime policing the healthcare laws and their enforcement was high on the priority list of enforcement agencies including the FBI. It said that this robust enforcement framework did not currently exist in the UK. A current difficulty with the UK medical system was that regulation by the GMC and CQC was not effective. It said that consultation needed to take place with the regulators to ensure that their remit was extended to effective enforcement of legislation covering incentives, or else an alternative policing scheme needed to be implemented.

Canada

22. Healthcare in Canada is delivered largely through a publicly-funded healthcare system known as Medicare, which is mostly free at the point of use (like the NHS) and has most services provided by private entities. In each province, each doctor handles the insurance claim against the provincial insurer; there is no need for the patient to be involved in billing and reclaim. As with the NHS, Medicare in Canada can involve the patient in long waiting times for treatment.
23. Private health expenditure accounts for a little under 30 per cent of healthcare financing, half of which involves PMI and half is self-pay. This includes optometry, dentistry and prescription medicines, much of which is not covered by Medicare. According to Canadian Institute for Health Information estimates, 99 per cent of physician expenditures in Canada come from public sector sources.
24. Most hospital care is delivered by publicly-funded hospitals, each of which is an independent institution and required by law to operate within its budget. The Canada

Health Act does not directly bar private delivery or private insurance for publicly insured services, although there are laws prohibiting or curtailing private healthcare in some provinces.⁴ Doctors, whether GPs or specialists, by and large are not salaried but are paid on a fee per service basis. However, doctors and clinics providing private medical care are not permitted to charge fees any higher than those payable under Medicare unless they are treating non-Medicare-insured persons or providing services which are not available under Medicare.

25. There are some private hospitals in Canada (both for-profit and non-profit), but these are hospitals that existed prior to the shift by the provincial governments to the role of healthcare stewards, ie they were grandfathered. Additionally, many provinces have allowed the development of private, for-profit specialized medical facilities. These facilities do not operate as stand-alone hospitals, but offer specific services to complement those offered by traditional hospitals, eg MRI clinics. The Cambie Surgery Centre in Vancouver, which opened in 1996, describes itself as a free-standing private hospital, but though it has six operating theatres, it is a surgical centre rather than a full hospital.
26. Doctors can refer patients for tests to be carried out in clinics they own or have a financial interest in. However, in 2012 Ontario moved to cut fees payable for tests carried out in clinics owned by the referring doctor by 50 per cent, although it decided to postpone the decision and set up an expert panel to look at physicians' concerns after complaints from the Ontario Medical Association. Seven other provinces already regulate self-referrals.
27. There are no conflict of interest laws in Canada which prohibit doctors from owning equity in hospitals or clinics, or from referring patients to hospitals in which they are invested. In Ontario (and, we presume, similar provisions may exist in other provinces) the Medicine Act stipulates that it is a conflict of interest for a physician to receive any benefit, directly or indirectly, from a supplier to whom the physician refers his or her patients, so we understand that this would rule out the payment of referral fees, for example.

Australia

28. Approximately 70 per cent of total health expenditure in Australia is funded by government (federal, state and local). The public system, known as Medicare, typically covers 100 per cent of in-hospital costs, but only a proportion of the cost of seeing a general practitioner and specialist services (based on paying a proportion of the Medicare schedule of fees).⁵ Less co-payment may be required for those who are poor or those who have already spent more than a set amount on healthcare during the year. A patient going for treatment at a public hospital funded by Medicare will not be able to choose which doctor he/she sees, and may have to wait for non-emergency treatment.
29. The private healthcare system includes treatment in a private hospital, ambulance trips, dentistry, optometry and treatments such as physiotherapy and acupuncture.⁶ Patients can either self-pay or take out PMI to help cover the cost. The Government subsidizes private health insurance premiums (by up to 30 per cent for under-65s,

⁴ For example, the Medicare Protection Act in British Columbia forbids private clinics from billing patients who are registered under Medicare for treatment which is available under the publicly-funded system.

⁵ Medicare benefits are based on a schedule of standard fees for medical services. Doctors are free to set their own fees for consultations and procedures, and many follow the Australian Medical Association's list of suggested fees, which are higher than those in the Medicare schedule.

⁶ <http://www.nib.com.au/home/newtonib/whynib/Pages/Publicandprivatesystem.aspx>

and more for older citizens⁷) and nearly half the population is insured for hospital and/or ancillary benefits. The Government also encourages citizens to take out PMI by levying an additional Medicare charge on those with higher incomes who do not have private insurance. Private patients, whether treated in a private or public hospital, can choose their doctor.

30. The Health Insurance Act 1973 (as amended) makes it a criminal offence, punishable by up to five years' imprisonment, for a health professional to seek or obtain, and for a private hospital to offer or pay, without reasonable excuse, any benefit or advantage of any kind in return for a person being admitted as a patient in the hospital (provided that the patient is covered by PMI). The Act also prohibits providers of pathology and diagnostic imaging services from offering or providing benefits, or making threats, to requesters of those services (eg medical practitioners) to induce them to obtain services from the provider (or, conversely, for a medical practitioner to ask for or accept such benefits). This carries a civil penalty of A\$66,000 for an individual or A\$660,000 for a corporation. It may also be considered a criminal offence where the requester or provider has the intent that the payment or acceptance of the benefit, or making of the threat, would induce requests for services, with a penalty of up to five years' imprisonment. These provisions do not appear to be limited to PMI patients.
31. In 2010, the Government set up a taskforce under Medicare Australia to investigate claims of bribery and kickbacks in the industry. It was sparked by concerns that some operators of pathology services had been offering doctors and specialists discounted rent on their premises, cash and other inducements in return for patient referrals. Such conduct is illegal under the Health Insurance Act.⁸ The Government tightened up provisions in 2009 to crack down on GP practices leasing space to pathology providers at inflated rents. As a result, any deal where rents are 20 per cent or more above the usual market value are now deemed to be illegal. The Health Insurance Amendment (Pathology Requests) Act 2010 allows patients to take test requests to a pathology practitioner of their choice.⁹
32. The Medical Board of Australia Code of Conduct states that good medical practice involves not asking for or accepting any inducement of more than trivial value that may affect, or be seen to affect, the way a doctor prescribes for, treats or refers patients. It also says that a financial or commercial interest in a hospital or company providing healthcare services or products must not be allowed adversely to affect the way in which a doctor treats his patients, and any such interest by the doctor or his immediate family must be disclosed to the patient if it could be perceived to influence the care provided.¹⁰
33. There has been criticism in Australia¹¹ that senior surgeons may influence patients without PMI to have treatment at a public hospital as a self-pay patient rather than under Medicare. This allows them to choose their doctor surgeon rather than be operated on by, say, a registrar, and the doctor may accelerate the patient on the waiting list. The public hospital gets paid a fee for treating a private patient, and the doctor can also charge a higher fee than would be payable under Medicare. Some public hospitals have allegedly encouraged doctors to let their patients know about the private treatment option.

⁷ The rebate operates on a sliding scale and is means-tested.

⁸ In one civil case in the Victoria Supreme Court, it was alleged that a provider had paid for medical specialists' offices to be refurbished, made donations to their preferred charities and provided funds for staff education in return for business.

⁹ The requirement prior to the amendment was that the doctor had to specify a pathologist on the patient's referral form and the patient had to go to that pathologist. The doctor is no longer required to specify the pathologist.

¹⁰ Medical Board of Australia Code of Conduct for Doctors in Australia, section 8.11.

¹¹ 'Abuse of self-pay patient system widespread' by Henry Woo, *Medical Journal of Australia Insight*, 21 March 2011.

34. Although we understand that the direct involvement of doctors in hospital management and ownership is uncommon in Australia,¹² it is permitted and does occur.

¹² According to Independent Private Hospitals of Australia Pty Limited (<http://iphoa.com.au/index.asp>).

Glossary

Act	The Enterprise Act 2002.
Acute condition	A medical condition of typically short duration which has severe symptoms (as opposed to chronic conditions which are persistent and recurring).
Admission	A patient will be admitted to hospital where their treatment requires admission to a hospital bed. This is a clinical decision and a patient admitted may be admitted either as a day-case patient or as an inpatient .
AEC	Adverse effect on competition as set out in section 134(2) of the Act .
Annotated issues statement	The annotated issues statement published on 28 February 2013.
Aviva	Aviva Health UK Limited, a principal subsidiary of Aviva plc, provider of insurance, savings and investment products.
AXA PPP	AXA PPP healthcare, a subsidiary of The AXA Group and provider of PMI .
BMA	British Medical Association, the trade union representing registered medical practitioners including consultants.
BMI	BMI Healthcare Limited and any company in the group as appropriate, part of GHG , a private hospital group in the UK.
Bupa	The British United Provident Association Limited, a provider of PMI and a hospital operator .
Catchment area	Geographical area from which a hospital draws its patients.
CC	Competition Commission.
CC2	<i>Merger references: Competition Commission Guidelines</i> (June 2003).
CC3	<i>CC Guidelines for market investigations: Their role, procedures, assessment and remedies</i> (April 2013).
CCSD	The Clinical Coding & Schedule Development. A group consisting of representatives from five PMIs : Aviva , AXA PPP , Bupa , PruHealth and Simplyhealth , which establishes and maintains a common standard of procedure codes and narratives within the independent healthcare sector.
Central London	The area inside the North and South Circular Roads.
Circle	Circle Holdings PLC, a private hospital operator .
Clinician	A health professional such as a GP, consultant, other physician or nurse involved in the care of patients.

CMA	Competition and Markets Authority.
Consultant	A registered medical practitioner who holds or has held or is qualified to hold an appointment as a consultant in the NHS in a speciality other than general practice or whose name is on the register of specialists kept by the GMC . A consultant may work exclusively for the NHS or in private practice or a combination of the two. Except where the context otherwise provides, consultant refers to a consultant in private practice whether or not they also work in the NHS .
Consultant services	All services provided by a consultant to private patients .
Corporate PMI	PMI provided by an employer to its employees and in some cases dependants of the employee.
Corporate policyholder	A person who is covered by PMI through a corporate PMI .
Cost of capital	The return that investors in a project expect to receive over the period of that investment. It is an opportunity cost and can be seen as the yield on capital employed in the next best alternative use.
CQC	Care Quality Commission, a non-departmental public body established to regulate and inspect health and social care services in England.
Day-case patient	A patient admitted during the course of a day with the intention of receiving care without requiring the use of a hospital bed overnight. If the patient's treatment then results in an unexpected overnight stay they will be admitted as an inpatient .
DoH	Department of Health in England.
Drive-time	Time taken to drive from the patient's home to a hospital.
Duopoly areas	Local areas served by two hospitals with different operators. For the purposes of this provisional decision on remedies, 'Duopoly' areas include those with more than two hospitals all of which are run by different operators.
Fee-capping	The process by which some insurers require consultants to agree not to charge patients more than the relevant insurers' maximum reimbursement rate as a requirement to be recognized and therefore to treat the insurer's policyholders .
GHG	General Healthcare Group and any company in the group as appropriate, a private hospital operator . GHG is the parent company of BMI , which manages its hospitals.
GMC	General Medical Council, the independent regulator for doctors in the UK.

GP	General Practitioner, a doctor who works in a local surgery or health centre, providing medical advice and treatment to patients registered on their list.
GP referral	A referral from a GP for specialist treatment.
Greater London	The area broadly between the North and South Circular Roads and the M25 ring road.
HCA	HCA International Limited and any company in the group as appropriate, a private hospital operator .
Healthcare provider	A person that provides preventive, curative, promotional, or rehabilitative healthcare services including a hospital, clinic, GP , consultant or other medical professional.
Healthcode	A provider of online practice management software and services to the private healthcare market. Healthcode processes medical bills for private hospitals and PPUs , acting as an intermediary between private hospitals and PMIs .
Hospital services	All services provided by a private hospital including inpatient , day-case and outpatient services. Where it is necessary in this report to distinguish between different types of hospital services this is made clear in the text.
Hospital Group	A private hospital operator that operates more than one hospital.
ICU	Intensive care unit.
Independent hospital	A private hospital not belonging to a Hospital Group .
Individual PMI	PMI purchased by an individual for themselves and/or their dependants. An individual policyholder is a person who has individual PMI.
Inpatient	A patient admitted to hospital with the expectation that they will remain in hospital for at least one night.
Insured patient	A patient who will use PMI to pay (in whole or in part/the majority) for their medical care.
Insurer network	A list of private hospitals which are on a PMI's approved list. Some PMIs create narrower networks for different types of policies.
Issues statement	The statement of issues published on 22 June 2012.
LOC	Leaders in Oncology Care (previously London Oncology Centre).
LOCI	A measure of weighted-average market share used by the CC to measure local concentration. Based on the 'Logit Competition Index', a measure of competition that has been used to analyse healthcare markets.

London	The combined area of central London and Greater London .
Main hospital groups	BMI, HCA, Nuffield, Ramsay and Spire .
Monitor	The independent regulator of NHS foundation trusts, directly accountable to Parliament. Monitor was established in January 2004 to authorize and regulate NHS foundations trusts.
Medical treatment	Except where the context otherwise provides, medical treatment includes medical, surgical and/or diagnostic/pathology treatments.
NHSs	National Health Services in England, Scotland and Wales and the Health and Social Care Services in Northern Ireland.
NHS Trust	A public benefit healthcare organization created by Act of Parliament to treat NHS patients.
NICE	The National Institute for Health and Care Excellence. NICE's guidance supports healthcare professionals and others to make sure that the care they provide is of the best possible quality and offers the best value for money.
NPV	Net present value.
NRV	Net realizable value. The amount that can be obtained by selling an asset net of selling expenses.
Nuffield	Nuffield Health and any company in the group as appropriate, a private hospital operator .
OFT	Office of Fair Trading.
ONS	Office for National Statistics.
OPCS coding 1CD-10	An international standard for diagnostic coding.
Open referral	A referral from a clinician that does not name the consultant and/or private healthcare facility to whom/which the patient is being referred.
Outpatient	A patient treated in a hospital, consulting room or clinic, who is not admitted.
PCA	Price-concentration analysis.
PHIN	Private Healthcare Information Network, a body whose membership is made up of private hospital operators .
PMI/insurer	As the context provides, either a private medical insurer or private medical insurance. Private medical insurance is an insurance product under which an insurer agrees to cover the costs, in whole or in part, of acute medical care. Insurer in this report refers to a PMI.
PPU	Private patient unit, a facility within the NHS providing medical care to private patients. Such units may be separate units dedicated to private patients or be facilities within the main NHS

	site which are made available to private patients either on a dedicated or non-dedicated basis.
Privately-funded healthcare services/private healthcare	Services provided to patients via private facilities/clinics including PPUs through the services of consultants, medical and clinical professionals who work within such facilities.
Private healthcare facilities	Any facility providing medical treatments on an inpatient, day-case and/or outpatient basis which charges fees for its services including a PPU .
Private healthcare provider	A healthcare provider that charges fees for its services.
Private hospital	A facility which provides inpatient hospital services that charges fees for its services including a PPU . Except where the context provides otherwise, in this report hospital refers to a private hospital .
Private hospital operator	A person that operates a private hospital including where relevant the NHSs in relation to PPUs .
Private patient	A patient who is charged for medical services either as a self-pay patient or as an insured patient .
Provisional decision on remedies	The provisional decision on remedies published on 16 January 2014.
Provisional findings	The provisional findings of 28 August 2013.
PruHealth	Prudential Health Services Limited, Prudential Health Insurance Limited and any company in the group as appropriate, providers of PMI .
Ramsay	Ramsay Health Care UK Operations Limited and any company in the group as appropriate, a private hospital operator .
Relevant customer benefit	A benefit as defined by section 134(8) of the Act .
Remedies Notice	The notice of possible remedies published on 28 August 2013.
Scottish Government	The Department of National Services Scotland.
Self-pay patient	A patient who pays for their medical care themselves.
Simplyhealth	Simplyhealth and any company in the group as appropriate, a PMI provider.
Single areas	A local area served by one hospital.
SLC	Substantial lessening of competition.
SME	Small or medium-sized enterprise.
Specialties	The GMC divides areas of medical care into 65 specialties.

Spire	Spire Healthcare Limited and any company in the group as appropriate, a private hospital operator .
TLC	The London Clinic, a private hospital operator .
ToH	Theory of harm.
Welsh Government	The Department for Health and Social Services in Wales.
WPA	Western Provident Association Limited and any company in the group as appropriate, a PMI provider.