

## Divestitures in central London

### Introduction

1. In this section we set out the considerations and reasoning leading to our provisional decision on divestitures in central London, arrived at after taking account of further representations made by the parties and our own analysis. We first describe the AEC that we have provisionally found in central London.

### The AEC in central London

2. The AEC in central London arises from HCA's ownership<sup>1</sup> of eight acute healthcare facilities. These are: The Harley Street Clinic, The Lister Hospital, The London Bridge Hospital, The Portland Hospital, The Princess Grace Hospital and The Wellington Hospital, together with Leaders in Oncology Care/The LOC (LOC)<sup>2</sup> and the University College Hospital PPU.
3. Ownership of these facilities and its outpatient and diagnostic centres gives HCA a [X] per cent share of total admissions and a [X] per cent share of private healthcare revenue in central London. HCA's closest competitor, TLC, has a share of supply of admissions and revenue of [X] per cent. We show the share of supply of admissions and revenue of private hospital groups and PPUs in London below in Table 1.

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<sup>1</sup> Or operation in the case of the UCH PPU, comprising Harley Street at UCH and the 5<sup>th</sup> floor of the Macmillan Cancer Centre.

<sup>2</sup> LOC has a presence at the Platinum Medical Centre as well as Harley Street.

TABLE 1 Central London aggregate shares-of-supply, 2011

	<i>per cent</i>			
	<i>Inpatient admissions</i>	<i>Inpatient revenue</i>	<i>Total admissions</i>	<i>Total revenue</i>
HCA	[X]	[X]	[X]	[X]
TLC	[X]	[X]	[X]	[X]
BMI	[X]	[X]	[X]	[X]
The Bupa Cromwell Hospital	[X]	[X]	[X]	[X]
Aspen	[X]	[X]	[X]	[X]
Hospital of St John & St Elizabeth	[X]	[X]	[X]	[X]
King Edward VII's Hospital Sister Agnes	[X]	[X]	[X]	[X]
<b>Total private hospitals</b>	<b>85</b>	<b>89</b>	<b>86</b>	<b>86</b>
<b>Total PPU's</b>	<b>15</b>	<b>11</b>	<b>14</b>	<b>14</b>

Source: Parties.

4. We show in Table 2 the share of central London admissions of each of HCA's hospitals, PPU's and clinics in central London. In terms of admissions,<sup>3</sup> HCA's six largest facilities are the London Bridge, Wellington, Princess Grace, Portland and Lister hospitals and the LOC (Leaders in Oncology Care).

TABLE 2 HCA central London admissions by facility, 2011

<i>Hospitals and clinics</i>	<i>Admissions</i>	<i>Share of admissions in central London %</i>
London Bridge Hospital	[X]	[X]
Wellington Hospital	[X]	[X]
Princess Grace Hospital	[X]	[X]
Portland Hospital	[X]	[X]
LOC	[X]	[X]
Lister Hospital	[X]	[X]
Harley Street Clinic	[X]	[X]
NHS Ventures UCLH	[X]	[X]
HS Cancer Centre (LOC@HS)	[X]	[X]
Platinum Medical Centre	[X]	[X]
LOC @ PMC	[X]	[X]
Total central London	[X]	[X]

Source: HCA.

## How the remedy would address the AEC

5. We have set out elsewhere in this provisional decision on remedies (Section 1) the considerations that the CC takes into account in evaluating the appropriateness of divestiture remedies, including factors concerning their likely effectiveness, their proportionality and the extent to which they are likely to extinguish any RCBs.

<sup>3</sup> Inpatient and daycase.

6. We set out our estimate of the costs and benefits of the proposed divestitures in central London in Section 2 of this provisional decision on remedies where we deal with our proposed divestiture remedies as a whole.
7. In the next section of this appendix we reproduce our detailed evaluation of divestment options that we disclosed to HCA, Bupa and AXA PPP at the time we published our Remedies Notice and on which we based our initial specification of the remedy. We then set out the responses of these parties to our initial remedy design and of others to our Remedies Notice, before concluding on the likely effectiveness of this remedy.

### **An effective divestiture remedy package**

8. We considered which hospitals HCA would need to divest in order to remedy the AEC in central London. Our assessment took account of broadly the same factors that we had considered in specifying divestiture packages outside central London. However, we recognized that the central London market was characterized by particular factors, for example that hospitals were more likely to specialize in particular conditions, treatments or patient types compared with those outside central London and that it was relevant to take account of these factors in our analysis.

### ***Range of medical services provided by HCA's hospitals***

9. We first noted that we were unable to differentiate HCA's hospitals, as we had been able to do outside central London, on the basis of intensive care facilities since all offered critical care to level 3. We therefore examined the range of specialized services that HCA's hospitals provided and the extent to which this differentiated them.

10. Some of HCA's hospitals tend to specialize in particular patients, conditions or forms of treatment. The Portland Hospital, for example, specializes in the healthcare of women and children and LOC in the treatment of cancer patients, particularly chemotherapy.
11. We reasoned that, if divested, a more specialized HCA hospital might place less of a competitive constraint on the remainder of HCA's hospitals than one offering a broad range of services. We recognized that the specialisms offered by a hospital can be modified and developed over time. However, divesting a more specialized hospital would have less of an immediate effect on rivalry than divestment of hospitals offering a broader range of services. Our guidance requires us to consider how quickly a remedy is likely to take effect.<sup>4</sup>
12. We therefore looked at the proportion of revenue that each of HCA's hospitals generated by specialism to try and distinguish more specialized hospitals from those offering a broad range of services. We show this in Figure 1.

FIGURE 1

**HCA hospital revenue by specialism, 2011**



Source: HCA.

13. We thought that it was clear from this analysis that the London Bridge and Wellington were general hospitals since they both offered a broad range of services and also generated significant revenue from the more common specialties such as general medicine, general surgery and orthopaedics. We noted that the [✂].

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<sup>4</sup> CC3, [paragraph 337](#).

14. We considered that the London Bridge, the Wellington, the Princess Grace and to a lesser extent the Lister hospitals were general rather than more specialized hospitals and that their divestment could be expected to have a more immediate effect on rivalry in the London private healthcare market than divesting HCA's other hospitals.
15. We adopted the working hypothesis that any divestiture package would be unlikely to comprise all four of these hospitals, given the proportion of HCA's revenue in central London that this would represent. We therefore restricted the next stages of our analysis to the first three hospitals (the London Bridge, the Princess Grace and the Wellington) since the Lister exhibited fewer of the characteristics of a general hospital than the others. We reasoned that we could revisit this working hypothesis at a later stage of our analysis if this proved to be necessary.

### ***Location***

16. We next considered whether the location of hospitals included in the divestiture package would affect the effectiveness of the remedy. We show in Figure 2 where HCA's facilities, including diagnostic and outpatient centres, in London are located.

FIGURE 2

HCA's London facilities



Source: HCA.<sup>5</sup>

17. Two of the three hospitals (the Wellington and the Princess Grace) are located reasonably close together, the former in St John's Wood and the latter in the Harley Street area, whereas the London Bridge Hospital is located to the east, adjacent to the City of London. There is an outpatient centre located close by the Princess Grace Hospital and Harley Street Clinic, 30 Devonshire Street,<sup>6</sup> as is the Wellington's Platinum Centre. HCA operates a number of outpatient centres, including some located in the City, Docklands and Sevenoaks in Kent.
18. Other private hospitals in central London, including TLC, King Edward VII and St John and St Elizabeth, are located around the Harley Street area. The Bupa Cromwell hospital is in South Kensington and BMI operates two hospitals in London but outside the central zone, in Stepney (the London Independent) and in Blackheath (BMI Blackheath).

<sup>5</sup> Pre-read for Strategy Retreat 2011, Cowarth Park, BCG.

<sup>6</sup> The Princess Grace Hospital lists this as one of its five outpatient sites. None of these is listed by the Harley St Clinic as outpatient facilities in its Patient Guide, page 6.

### **Catchment areas and mix of patients**

19. Our analysis of the customer bases of the hospitals comprised reviewing where their patients lived and who funded their treatment.
20. We looked first at data supplied by HCA showing the home locations of patients attending the three hospitals. These are reproduced in Figure 3.

FIGURE 3

#### **Catchment areas of the London Bridge, Princess Grace and Wellington hospitals**



Source: HCA.

21. We noted first that there was substantial overlap in the catchment areas of these hospitals. However, the area from which the London Bridge Hospital draws patients was centred somewhat further to the east and south than that of the Princess Grace and the Wellington hospitals, whose patients tend to live in south-west or north-west London respectively. The catchment area of the London Bridge Hospital also extends further into south-east England than the other two hospitals, through the outer London boroughs and into Kent, for example.
22. We did not consider that this catchment area data in itself was particularly informative in differentiating the customer bases of the three hospitals. As we showed in our provisional findings,<sup>7</sup> central London hospitals draw patients from a wider area than hospitals elsewhere in the UK. Further, central London hospitals are located more closely together than they tend to be elsewhere, certainly in less densely populated areas. Consequently, and as can be seen from the maps, the overlap of central London hospitals' catchment areas is considerable. It is clear that proximity to home location is not a major factor in choosing a central London hospital, most obviously in

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<sup>7</sup> See Appendix 6.10, paragraphs 28–33.

respect of overseas patients who, as we show below, represent a large proportion of total revenue for some HCA hospitals.

23. We looked next at the revenue that these hospitals generated from different customer types: insured, self pay and overseas. The proportion of each hospital's revenue earned from each customer type is shown in Table 3.

TABLE 3 Revenue share by payer, 2011

	<i>per cent</i>				
	<i>PMI</i>	<i>Self-pay</i>	<i>NHS</i>	<i>Overseas</i>	<i>Other</i>
London Bridge	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Princess Grace	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Wellington	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Source: HCA.

24. We considered that this data did help differentiate the three hospitals. [REDACTED], as is shown in Table 4.

TABLE 4 PMI revenue 2011

	<i>PMI</i> <i>£m</i>
London Bridge	[REDACTED]
Princess Grace	[REDACTED]
Wellington	[REDACTED]

Source: HCA.

25. We were unable separately to identify corporate and individual PMI patient revenues though, in our research among employers offering private health cover as part of their employee benefits schemes,<sup>8</sup> City-based financial and professional services firms mentioned the London Bridge Hospital as important because of its location.

<sup>8</sup> Appendix 2.1 of our [provisional findings](#).

## Size of hospital business

26. We considered the size of the hospital business from two perspectives: the number of patients that the hospital admitted each year and the amount of revenue it generated annually. We first looked at patient admissions.
27. We looked at the effect on HCA's share of admissions in central London overall that divesting various hospital combinations would have. HCA's overall share of admissions in 2011 was [X] per cent. As is shown in Table 5, divesting either of the London Bridge or the Wellington hospitals would reduce HCA's share of admissions to [X] per cent. Divesting either, together with the Princess Grace, would reduce it to just below [X].

TABLE 5 Hospital divestiture and share of admissions, 2011

Divested hospitals	per cent	
	Share	HCA share
Princess Grace	[X]	[X]
Wellington	[X]	[X]
London Bridge	[X]	[X]
Wellington + Princess Grace	[X]	[X]
London Bridge + Princess Grace	[X]	[X]
London Bridge + Wellington	[X]	[X]
All three hospitals	[X]	[X]

Source: HCA, CC analysis.

28. We next looked at the share of central London revenue generated by HCA hospitals, [X]. We carried out the same type of analysis for revenue shares as we did for admissions, the results of which are shown in Table 6.
29. Our analysis showed that divesting any one of the three hospitals individually would leave HCA with [X] per cent share of revenue. Divesting one of the two larger hospitals plus the Princess Grace would reduce HCA's share of revenue to [X] per cent in the case of London Bridge and [X] per cent in the case of the Wellington. Divesting all three would [X], reducing it to [X] per cent.

TABLE 6 Effect on HCA's revenue share of divestment options

<i>Hospitals divested</i>	<i>per cent</i>	
	<i>Hospital share</i>	<i>Resulting HCA share</i>
Princess Grace	[X]	[X]
London Bridge	[X]	[X]
Wellington	[X]	[X]
London Bridge + Princess Grace	[X]	[X]
Wellington + Princess Grace	[X]	[X]
Wellington + London Bridge	[X]	[X]
All three hospitals	[X]	[X]

Source: HCA, CC analysis.

30. Our guidelines on market investigations do not indicate at what level of market share competition concerns would arise. Our merger guidelines note that in undifferentiated markets, shares of less than 40 per cent have not generally given the OFT cause for concern over unilateral effects.<sup>9</sup> Similarly, DG Comp has tended to regard it as unlikely for a firm with a market share of less than 40 per cent to be dominant.<sup>10</sup> However, the markets we are considering are not undifferentiated, ie they have a degree of product and geographic differentiation. In the CC's inquiry into the proposed joint venture between Anglo American PLC and Lafarge S.A., the CC used a 33 per cent threshold<sup>11</sup> due to the degree of product and geographic differentiation. Because of the extent of differentiation in the private healthcare market, we considered that a share of 40 per cent could be too high.
31. Our guidelines on divestitures in market investigations are that the scope of the divestiture package must be sufficient to address the AEC satisfactorily but that in order to achieve a proportionate solution the CC will seek to identify the smallest such package.<sup>12</sup>

<sup>9</sup> CC2, paragraph 5.3.5.

<sup>10</sup> See 'Guidance on the Commission's enforcement priorities in applying Article 82 of the EC Treaty to abusive exclusionary conduct by dominant undertakings (2009/C 45/02)', paragraph 14:

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2009:045:0007:0020:EN:PDF>.

<sup>11</sup> Final report, paragraph 8.18ff.

<sup>12</sup> CC3, Annex B, paragraph 9.

32. The smallest divestiture package that would reduce HCA's share of private health-care admissions in central London to below 40 per cent would comprise the Wellington Hospital, though divesting the London Bridge on its own would have almost the same effect. The smallest divestiture package that would reduce HCA's share of private healthcare revenue in London to below 40 per cent would comprise the London Bridge and Princess Grace hospitals.

### **What we were told**

33. We set out below a summary of the responses to our Remedies Notice, which was published on 2 September 2013, and our Divestment Options paper, which was provided to the five largest hospital groups and three largest private medical insurers and which identified the hospitals that we were considering as part of a divestiture package.

### ***Bupa***

34. Bupa told us that the only way to remedy the AEC in central London was for HCA to divest a package of several hospitals and to reduce the influence that it claimed HCA had over primary care referrals. It said that divestments should be targeted at fostering competition at the specialism level, not just at an aggregate market share level.<sup>13</sup>
35. Bupa said that our proposed divestiture package would be insufficient to address the AEC. It provided us with an analysis of its spend in central London broken down by HCA hospital and by clinical area of expenditure. We reproduce this in Figure 4.

FIGURE 4

### **HCA share of Bupa spend in central London, 2012**



Source: Bupa.

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<sup>13</sup> [Bupa response to Remedies Notice](#).

36. Bupa said that this analysis showed that HCA's 'big three' hospitals in central London were the London Bridge and Wellington hospitals and the Harley Street Clinic. It said that these [redacted]. It said that, by contrast, the Princess Grace and Lister hospitals were general hospitals which were significantly smaller than the 'big three' with a [redacted]. It said that any divestment package that was limited to these facilities (ie the Princess Grace and the Lister hospitals) would fail to address the AEC in central London. It said that this was especially the case in [redacted], which were [redacted].<sup>14</sup>
37. Bupa considered several of the scenarios illustrated in its table. It said that in order to reduce effectively HCA's high market share in a range of specialties, divestments needed to be targeted at HCA's 'big three' facilities. It maintained that the divestment of the inpatient and outpatient facilities of the London Bridge and Wellington hospitals would most meaningfully reduce HCA's market share in the high-spend specialties of cardiology and orthopaedics to more competitive levels and would also reduce market share across a range of other, lower-spend, specialisms.<sup>15</sup> It also said that, [redacted], any divestiture package should include the [redacted] as an absolute minimum.<sup>16</sup>
38. In addition, Bupa submitted that HCA's Roodlane practice must be divested. It said that Roodlane was an important referral channel into the London Bridge Hospital. If HCA retained ownership of it, Roodlane would be in a position to weaken the new owner of the London Bridge Hospital by redirecting patients away. Bupa said that Roodlane and London Bridge Hospital should be sold to different buyers.<sup>17</sup>
39. Finally, Bupa said that the divestment remedy would need to be accompanied by a number of behavioural remedies in order to ensure its effectiveness. These included a ban on consultant incentives, to prevent HCA poaching key consultants away from

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<sup>14</sup> *ibid*, p38.

<sup>15</sup> *ibid*, paragraph 4.93.

<sup>16</sup> *ibid*, paragraph 4.89.

<sup>17</sup> *ibid*, paragraph 4.94.

the facilities that it divested, restrictions on HCA's expansion through PPU joint ventures and [redacted].<sup>18</sup>

### **AXA PPP**

40. AXA PPP agreed with the CC that the most effective remedy that would address the AEC in central London would be to require HCA to divest a substantial part of its portfolio. AXA PPP said that it negotiated across HCA's portfolio of hospitals but that there was no opportunity for it to encourage hospitals in the HCA group to compete with each other and HCA had no incentive to allow this.
  
41. AXA PPP said that no remedy other than divestiture was likely to be effective. It considered whether requiring HCA to negotiate prices for each of its hospitals separately would address the AEC, but concluded that it would not do so.<sup>19</sup> It said that if AXA PPP chose to exclude certain HCA hospitals from its network, this would be likely to result in significantly higher prices at hospitals that it chose to include.<sup>20</sup>
  
42. AXA PPP said that the greatest competition would arise in London if all the major 'must have' hospitals were owned by different groups. However, bearing in mind the principle of proportionality, it was not proposing this but instead a divestiture that would give rise to three competing groups with a credible portfolio. These would comprise TLC, HCA and the new owner. AXA PPP said that the portfolio of each group would need to include:
  - (a) a significant flagship in central London;
  - (b) Harley Street provision;
  - (c) coverage for a full range of specialisms; high acuity cover; and

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<sup>18</sup> *ibid*, paragraph 4.100.

<sup>19</sup> [AXA PPP response to provisional findings and Remedies Notice](#), paragraph 2.4.

<sup>20</sup> *ibid*, paragraph 2.5.

(d) a full cancer service including radiotherapy.<sup>21</sup>

43. AXA PPP identified the three flagship London hospitals as TLC, the Wellington and the London Bridge, on which basis HCA should be required to divest either the Wellington or the London Bridge hospital, neither of which TLC should be permitted to acquire.
44. AXA PPP said that in terms of reputation, a Harley Street location was synonymous with top quality and was a trusted brand.<sup>22</sup> It said that HCA owned two of the largest facilities in the Harley Street area, in addition to running the PPU at UCL which it said was nearby.<sup>23</sup>
45. AXA PPP said that a Harley Street presence could be provided and specialism gaps filled by combining divestment of a flagship hospital together with other HCA facilities. It proposed that the Wellington or the London Bridge hospitals ought to be divested along with the Harley Street Clinic or the Princess Grace Hospital and that TLC should not be permitted to acquire either the Harley Street Clinic or the Princess Grace Hospital.<sup>24</sup> This arrangement would therefore result in three competing groups operating facilities in the vicinity of Harley Street.
46. In addition, AXA PPP said that it did not support the ownership by hospital groups of primary care facilities. It acknowledged that the CC had not found that these vertical relationships had influenced referral rates but felt that HCA could set up arrangements whereby its primary care providers made substantial referrals to their retained

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<sup>21</sup> *ibid*, paragraph 2.10.

<sup>22</sup> *ibid*, paragraph 2.21.

<sup>23</sup> *ibid*, paragraph 2.20.

<sup>24</sup> *ibid*, paragraph 2.25.

facilities. It therefore proposed that HCA be required to divest, as a minimum, either Roodlane or Blossoms Inn.<sup>25</sup>

47. AXA PPP said that LOC comprised a leading team of 50 oncologists who were responsible for the care pathways of a significant number of patients who received their treatment in London and that just under half of AXA PPP's patients received treatment provided by a LOC consultant.<sup>26</sup>
48. AXA PPP said that it considered that such an organization should be independent of any features that might influence its referral patterns and proposed that HCA also be required to divest LOC.
49. AXA PPP said that PPUs had the capacity to offer significant competition to private hospitals but that they would not do so if they were managed by the same hospital operators. It therefore proposed that HCA, and any new owner of London Bridge Hospital, be required to divest its contract to run the Guy's and St Thomas' NHS Foundation Trust PPU.<sup>27</sup>
50. Subsequently, 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.

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<sup>25</sup> *ibid*, paragraphs 2.29–2.32.

<sup>26</sup> *ibid*, paragraph 2.33.

<sup>27</sup> *ibid*, paragraphs 2.44–2.46.

## ***Other insurers***

51. Aviva said that it thought that a divestiture remedy was likely to have the greatest impact in central London given the area's importance to patients, the high prices that HCA charged to PMIs and the fact that HCA owned a cluster of eight hospitals in this area with a share of supply of above 45 per cent of inpatient admissions.
  
52. However, Aviva raised concerns regarding the risk that divestiture of, for example, the London Bridge Hospital could result in the transfer of market power from one operator to another.<sup>28</sup> The new owner of this hospital, for example, could continue to charge the same prices as HCA, initially at least. It said that it was therefore important that the CC adopted other remedies, such as checks on tying and bundling, as part of its package.<sup>29</sup>
  
53. Aviva said that it thought the divestiture should be designed so as to result in three operators each controlling one of the major London acute hospitals. It said that this could be achieved if HCA was required to divest the London Bridge and either the Wellington or Princess Grace hospitals. It said that if this could be achieved it could then offer corporate clients, for example, a 'tiered proposition' with a choice of prices and service levels which it was not possible to offer currently.
  
54. Aviva said that in order to enable the new owner of the divested HCA hospitals to place a competitive constraint on HCA, the divestiture package should include some of HCA's primary care, diagnostic centres and consulting rooms.
  
55. PruHealth, to which we did not disclose details of the proposed divestiture package, said that it was ambivalent as to whether HCA's divestment of one or more of its

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<sup>28</sup> Aviva said that BMI should be prevented from acquiring London Bridge Hospital and TLC from acquiring the Princess Grace Hospital.

<sup>29</sup> [Aviva response to Remedies Notice](#), p4.

private hospitals would benefit the market. It said that many of HCA's hospitals operated in an area of duopoly with another independent hospital within easy drive time, for example the Princess Grace Hospital and TLC. It said that the exception was the London Bridge Hospital, which would retain solus market power irrespective of its ownership.<sup>30</sup>

## **HCA**

56. HCA disagreed with the CC's provisional finding of an AEC in central London and submitted that divestiture was disproportionate and would not be effective. It listed a number of issues which it said affected the CC's assessment of competition in central London:

- The CC had adopted an incorrect and arbitrary geographic market definition that omitted key competitors from areas in which HCA drew patients, and therefore the CC's share of supply estimations were meaningless.<sup>31</sup>
- The CC had failed to consider the evidence of strong competition on investment and improving quality of care between hospital operators in London. The continuous product improvements and innovation and such high levels of quality found in London were simply inconsistent with the conclusion that HCA had a position of market power and faced 'weak' competitive constraints.
- The CC had underestimated the potential for supply-side substitution and therefore incorrectly assessed potential competition.
- The CC's share of supply calculations were flawed and overestimated HCA's share of supply and share of capacity in central London.<sup>32</sup>
- There was no convincing evidence that the market was not presently functioning competitively, whether based on levels of pricing or profitability.

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<sup>30</sup> PruHealth response to Remedies Notice, Issues for comment 1, paragraph (a).

<sup>31</sup> See also HCA response to Remedies Notice, paragraph 6.89.

<sup>32</sup> 5.133 – 5.144

- The CC's PCA was not robust and did not provide reliable evidence in relation to London.

57. HCA also disagreed with what it described as the central rationale behind the divestment remedy, which was to reduce HCA's market share to below a specific threshold. HCA said that there was no EU or UK case law or guidance which supported a benchmark of 40 or 33 per cent as being in of itself 'too high'. HCA noted that the OFT had cleared several mergers between parties that would have resulted in a market share in excess of 40 per cent, and said that HCA's share of supply was entirely consistent with a competitive market in which rival hospital operators competed on quality of care offered to patients.

58. HCA said that the effect of the CC's divestment remedy would be to penalize a hospital operator for being successful with its quality offering to the market and would chill future investment in private healthcare.<sup>33</sup> It said that potential investors, particularly overseas investors, would be concerned that long-term investment in healthcare could be put at risk through a compulsory divestiture of assets. It said that divestiture would send a signal that successful businesses which innovated and created efficiencies would be punished through the regulatory process.<sup>34</sup>

59. HCA said that the inclusion of outpatient facilities in any divestment remedy was 'inexplicable'. It said that the CC had not conducted any assessment of competition in the provision of outpatient facilities, and that there was strong competition among outpatient facilities and very low barriers to entry or expansion, therefore their inclusion was not justified.<sup>35</sup>

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<sup>33</sup> [HCA response to Remedies Notice](#), paragraphs 6.69 & 6.88.

<sup>34</sup> *ibid*, paragraph 6.55.

<sup>35</sup> *ibid*, paragraph 6.91.

60. 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.
61. HCA said that these were expressly included as RCBs in the Enterprise Act 2002 (the Act).<sup>36</sup> We set out the definition of RCBs, as defined by the Act, in Section 1, together with the relevant section of our guidance.

### *Higher quality*

62. 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;
  - (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 the patients' care plans and treatment protocols to be closely coordinated and monitored across HCA hospitals;

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<sup>36</sup> *ibid*, paragraphs 5.1–5.2.

- (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.<sup>37</sup>

63. 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.<sup>38</sup>
- (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.
- (g) It was the only private operator to achieve a 100 per cent compliance with all CQC clinical outcomes in 2012.<sup>39</sup>

64. HCA prepared a report on its quality offering with the assistance of healthcare 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:

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<sup>37</sup> *ibid*, paragraphs 5.3–5.6.

<sup>38</sup> In Award Winning Quality, 2013 presentation.

<sup>39</sup> [HCA response to Remedies Notice](#), paragraph 5.7.

- (a) 98.1 per cent of patients would recommend HCA hospitals to family and friends.<sup>40</sup>
- (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).<sup>41</sup>
- (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 pre-operative condition compared with 95.8 per cent of patients nationally.
- (e) Hospital-acquired MRSA infections in HCA hospitals were zero for quarters 1, 2 and 4 of 2012 but 1 per 100,000 bed days in Q3 compared with 1.08 in NHS hospitals.

65. 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 its 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.

66. 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:

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<sup>40</sup> Award Winning Quality, 2013 presentation.

<sup>41</sup> *ibid.*

- (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.<sup>42</sup>

67. 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.

68. 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*

69. 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 breast cancer care demonstrably superior to any other provider in the UK. 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

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<sup>42</sup> *ibid*, p8.

140 extra patients remaining alive over the next five years who would not be if treated elsewhere.<sup>43</sup>

70. 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.
71. 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 may 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.<sup>44</sup> 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.

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<sup>43</sup> *ibid*, pp14–15.

<sup>44</sup> *ibid*, p27.

72. 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*

73. 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 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.
74. 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,<sup>45</sup> 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

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<sup>45</sup> Dendrite is a supplier of clinical databases and consultancy services.

replacement (TAVI). HCA submitted that this would, in turn, result in lower quality of care and lower patient demand.

75. HCA told us that in the year to June 2012 it conducted around [X] procedures across three of its hospitals, [X] 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*

76. 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.
77. 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.

78. 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.
79. 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.

### ***Other hospital groups***

80. Neither BMI nor Spire commented on our analysis of the central London market or the conclusions we drew from it. Spire, however, did indicate that the acquisition of hospitals in London could fit with its strategy, though a purchaser would require non-solicitation warranties from the vendor regarding key staff, in this case including consultants, in particular because a divested hospital in London would draw its consultants from the same NHS trust as one or more of the hospitals being retained by the seller.
81. [REDACTED]

82. Nuffield said that it agreed that divestiture was the appropriate remedy for central London<sup>46</sup> and that the number of and particular hospitals proposed for divestiture were appropriate.
83. Circle said that it fully supported divestiture in central London and that it was an appropriate and proportionate remedy to the AEC. It said that, to ensure the effectiveness of the remedy, HCA should be prevented from running any more PPU's in London for at least five years from the date of the divestment and that consultants currently practising at the hospitals to be divested should not be permitted to move their practice to a hospital retained by HCA for a period of two years post-divestment.<sup>47</sup>

## **An effective divestiture package—our assessment**

### ***Prices***

84. We first considered whether divestment would reduce the detriment arising from higher prices as a result of the AEC since Aviva had suggested that a new owner of the London Bridge Hospital, for example, would have an incentive to charge prices similar to those charged by HCA. We considered this to be extremely unlikely and that the new owner of London Bridge would not have the ability to maintain prices at HCA's levels.
85. Given the high fixed costs inherent in a hospital business, an operator's profitability will be sensitive to volume changes, and we thought that in a more competitive environment the PMIs would be in a strong position to drive down both the new owner's or owners' and HCA's prices since they could credibly switch volume from one to the other and to TLC.

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<sup>46</sup> Nuffield response to Remedies Notice, p4.

<sup>47</sup> Circle response to Remedies Notice, Remedy 1.

86. Our estimate of the benefit to customers through lower prices is set out in Appendix 2.5.

### ***Divestiture risks***

87. As our guidance states, a divestiture package seeks to remedy an AEC by either creating a new source of competition through disposal of a business or set of assets to a new market participant or strengthening an existing source of competition through disposal to an existing market participant independent of the divesting party.<sup>48</sup> Our guidance sets out three broad categories of risk that may impair the effectiveness of a divestiture remedy:
- (a) composition risks;
  - (b) purchaser risks; and
  - (c) asset risks.

We consider each of these risks in turn.

### ***Composition risks***

88. Composition risks are risks that the scope of the divestiture package may be too constrained or not appropriately configured to attract suitable purchasers or may not allow a purchaser to operate as an effective competitor in the market. We considered composition risks in terms of the scale of the divestiture that would be necessary to address the AEC and the particular assets to be included in the package.

### ***Scale of divestment***

89. We noted earlier (paragraph 30) that our guidelines on market investigations do not indicate at what level of market share competition concerns would arise. Our merger guidelines note that in undifferentiated markets shares of less than 40 per cent have

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<sup>48</sup> CC3, Annex B, [paragraph 3](#).

not generally given the OFT cause for concern over unilateral effects.<sup>49</sup> Similarly, DG Comp has tended to regard it as unlikely for a firm with a market share of less than 40 per cent to be dominant.<sup>50</sup> However, the markets we are considering are not undifferentiated, ie they have a degree of product and geographic differentiation. In the CC's investigation of the proposed joint venture between Anglo American PLC and Lafarge S.A.,<sup>51</sup> the CC used a 33 per cent threshold due to the degree of product and geographic differentiation. Because of the extent of differentiation in the private healthcare market, we considered that a share of 40 per cent could be too high.

90. It is our provisional view that HCA's share of central London market admissions and/or revenue should be reduced below 40 per cent to enable divestiture to be effective in facilitating rivalry approaching that of a well-functioning market. In forming this view, we have taken account of the significant extent of differentiation in the central London market, high barriers to entry for full-service hospitals and that HCA's closest competitor, TLC, has a market share of just [ ] per cent. We have also taken account of the views of major PMIs that divestitures that would achieve this market share reduction would effectively be the minimum necessary to provide appropriate rivals to compete with the retained portfolio of HCA hospitals.

*Assets to be included in the package*

91. As we set out earlier, in considering the scope of the divestiture package we took account first of the range of specialties each of HCA's hospitals provided. Our reasoning here was that divesting a highly specialized hospital would not, certainly in the short term, enable the new owner to compete effectively with the retained hospitals operated by HCA and the other principal operator in central London, TLC. We

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<sup>49</sup> CC2, [paragraph 5.3.5](#).

<sup>50</sup> See 'Guidance on the Commission's enforcement priorities in applying Article 82 of the EC Treaty to abusive exclusionary conduct by dominant undertakings (2009/C 45/02)', paragraph 14:

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2009:045:0007:0020:EN:PDF>,

<sup>51</sup> See [CC website](#).

therefore sought to identify hospital assets which provided a broad range of services and identified the London Bridge, The Wellington and the Princess Grace hospitals as falling into this category.

92. We thought that requiring HCA to divest all three of these hospitals, or the London Bridge and Wellington hospitals, or the Princess Grace and either the Wellington or London Bridge hospitals, would effectively address the AEC. We noted that none of these packages would reduce HCA's share of oncology significantly but reasoned that our remedy 4, restricting the incentives that hospital operators may offer consultants, may be in particular be effective in promoting competition in cancer treatment in central London.
93. We considered the effectiveness of various divestiture options and concluded that a package comprising the London Bridge and Princess Grace hospitals was the smallest that was likely to be effective in providing a rival or rivals to compete with the retained portfolio of HCA hospitals.
94. The major PMIs undertook a similar analysis and came to broadly the same conclusions though laid more stress on the proximity of the Princess Grace Hospital to both HCA and TLC facilities in and around Harley Street than we had. However, both Bupa and AXA PPP proposed including other assets in the package, including additional hospitals, HCA's primary care services or joint ventures such as the LOC.
95. We considered that requiring HCA to divest additional hospitals or certain other assets would be disproportionate since the package that we proposed was the smallest that we thought would be effective in addressing the AEC (see paragraph 32). We thought that requiring HCA to divest GP practices that it owns, for example Roodlane, would be inappropriate since we had not found this instance of vertical

integration to give rise to an AEC. Similarly we thought that concerns as to referral patterns arising from HCA's ownership of LOC would be addressed by our remedy 4 in respect of clinician incentives and that a more intrusive remedy such as divestment would therefore be disproportionate.

96. However, our guidance states that the CC will need to specify a divestiture package that allows the purchaser to operate as an effective competitor in the market<sup>52</sup> and that it generally prefers divestiture of an existing business that can compete effectively on a stand-alone basis independently of the divesting party.<sup>53</sup> In specifying the package to be divested it will therefore be important to ensure that the purchaser(s) of the HCA hospitals acquires sufficient assets to enable it (or them) to compete effectively in central London hospital and preferable, in accordance with our guidance, that they are able to do so soon after making the acquisition(s).<sup>54</sup> These assets might include, for example, consulting rooms and diagnostic and testing facilities currently used predominantly by patients of the London Bridge and Princess Grace hospitals.

97. We have therefore provisionally decided that a divestiture package comprising the London Bridge and Princess Grace hospital businesses is likely to be the smallest divestiture package capable of effectively addressing the AEC.

### *Purchaser risks*

98. Purchaser risks are risks that a suitable purchaser is not available or that the divesting party will dispose to a weak or otherwise inappropriate purchaser.

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<sup>52</sup> CC3 (Revised), Annex B, [paragraph 6\(a\)](#).

<sup>53</sup> *ibid*, Annex B, [paragraph 12](#).

<sup>54</sup> *ibid*, [paragraph 337](#).

99. Existing UK hospital groups expressed an interest in acquiring hospitals that HCA was required to sell and the CC also received expressions of interest in acquiring UK hospital businesses from overseas hospital operators. We did not infer from the responses that we received from UK and overseas investors that a chilling effect on investment, as suggested by HCA, was evident. We did not consider that finding a suitable purchaser for these hospitals would represent a significant risk. However, we thought that in order to allow HCA sufficient time to identify suitable purchasers, it would be reasonable to permit a longer divestiture period than is our normal practice. We thought that [redacted] would be an appropriate initial divestiture period.

#### *Asset risks*

100. Asset risks are risks that the competitive capability of the divestiture package will deteriorate before completion of divestiture.

101. At several points in our provisional findings, and in particular in our case studies of entry and expansion, we have drawn attention to the importance to hospitals of attracting and retaining consultants. We thought it possible that HCA might use the divestiture period to encourage key consultants to transfer their practice from the hospitals being sold to those being retained. If HCA was successful in doing so, the new owner or owners of the hospitals might not be able to compete effectively with HCA. We reasoned that the same arguments would apply to key staff employed at the hospitals, including highly skilled nursing and technical staff.

102. In order to mitigate this risk we thought it would be necessary to:

- (a) seek undertakings from or order HCA to maintain the businesses being divested during the divestiture period and in particular refrain from any conduct which was intended to or could have the effect of causing consultants practising wholly or

- predominantly at the London Bridge or Princess Grace hospitals to switch all or some of their practice to HCA's retained hospitals;
- (b) similarly require HCA to refrain from any conduct which was intended to or could have the effect of causing key staff employed at the hospitals being divested to transfer to hospitals being retained; and
- (c) require HCA to appoint a Monitoring Trustee, paid for by it but approved by and reporting to the CC/CMA in accordance with a mandate approved by the CC/CMA to monitor HCA's compliance with the Undertakings or Order.

### ***Conclusions on an effective divestiture package***

103. On the basis of our reasoning as set out above, we have provisionally decided that a remedy requiring HCA to divest the London Bridge and Princess Grace hospitals to a suitable purchaser or purchasers through an effective divestiture process would effectively address the AEC that we have provisionally found, and that this is the least extensive and intrusive divestiture package likely to be effective in addressing the AEC.
104. We have provisionally decided that HCA should be required to appoint a Monitoring Trustee on the basis set out here in paragraph 102.
105. Having concluded on the effectiveness of the remedy, we now consider any loss of RCBs that might arise from divestiture.

### **Assessment of relevant customer benefits**

106. HCA's submission in response to our Remedies Notice 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 Enterprise Act (see paragraph 61). 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;
- (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.

107. 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***

108. 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.<sup>55</sup> 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.<sup>56</sup> In addition, 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.

109. 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

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<sup>55</sup> [HCA response to Remedies Notice](#), paragraph 5.7.

<sup>56</sup> See [provisional findings](#), paragraph 5.14.

but, and as was pointed out by AXA PPP, survival rates for breast cancer will be affected by many factors including the age of the patient, their social class and the stage of presentation. Attempting to draw inferences on the quality of care provided from survival rates could be highly misleading unless all of these factors could be controlled for. 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 significantly significant and did not believe it appropriate to express this performance data in terms of lives saved per year, as HCA has done.<sup>57</sup>

110. HCA compared itself with a broader basket of hospitals as regards infection control. It compared the all-England average rate of MRSA infection with its own, saying that its rate was five times lower.<sup>58</sup> We noted, however, that King Edward VII Hospital, a private sector competitor, claims never to have had a case of hospital-acquired MRSA.<sup>59</sup>
111. Elsewhere, HCA compared itself with other private providers but did not always include its closest competitors. For example, in its case study of breast cancer it compared itself to BMI, Spire and Nuffield but not TLC, which is a closer competitor to HCA, and went on to suggest that one risk to patients of the proposed divestiture would be lack of access to breast MRI, though TLC did offer this.<sup>60</sup> In another comparison it referred to the significant numbers of RMOs that it employed and contrasted this unfavourably with other private hospital operators. However, since HCA owns many more private hospitals with ICU facilities in central London than other operators, we did not find this particularly informative. Further, it was not evident that

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<sup>57</sup> 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 Remedies Notice](#), page 1.

<sup>58</sup> [HCA response to Remedies Notice](#), paragraph 5.7.

<sup>59</sup> See [King Edward VII website](#).

<sup>60</sup> See [TLC website](#).

a suitable acquirer would employ fewer RMOs in the particular circumstances of acquiring HCA's hospitals.

112. In addition to considering HCA's submissions, 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 on TLC, King Edward VII Sister Agnes and the Royal Marsden PPU were as positive as HCA's.

### *Conclusions on quality of care compared with competitors*

113. We considered that the evidence we had seen indicated that HCA did provide good-quality healthcare services, certainly in the three areas on which it submitted case studies, but that we did not have sufficient evidence to conclude that its service quality was higher than that offered by close competitors in central London, for example TLC and King Edward VII, that do not have access to the HCA network. However, and as we concluded in our provisional findings, there is currently very little comparative performance information available on which to assess hospital operators' service quality.

### ***Innovation***

114. 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 Mosaiq, 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 incentivized the pharmaceutical industry to bring to market new, clinically proven drugs against cancer.<sup>61</sup>

### *Conclusions on innovation*

115. We thought that a large proportion of the innovations 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. 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 new techniques or technologies. However, this was in some cases in response to innovations introduced by other private hospitals. HCA told us<sup>62</sup> 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.<sup>63</sup> We also noted that HCA 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.

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<sup>61</sup> [HCA response to Remedies Notice](#), 5.11.

<sup>62</sup> [HCA response to provisional findings](#).

<sup>63</sup> *ibid*, paragraph 5.61.

## **Greater choice of goods and services**

116. 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.<sup>64</sup>

### ***Conclusions on greater choice***

117. We considered that HCA's evidence on choice of treatments showed that it had, to a certain extent, widened the range of, in particular, high-acuity treatments available outside the NHS. We noted that other hospitals in central London, however, for example TLC, had adopted a similar strategy.

### **The services that would be provided by an acquirer of HCA's divested hospitals**

118. Having considered the extent to which HCA currently provides higher-quality services than other hospital operators, or innovates more or operates a wider range of services, in particular in relation to high-acuity work, we now consider whether any of these benefits would, if they existed, fall within the definition of RCBs and, if so, are likely to be extinguished or reduced in the event of divestiture.

119. 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

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<sup>64</sup> [HCA response to Remedies Notice](#), paragraphs 5.18–5.20.

(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.

120. We first considered 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 London Bridge and Princess Grace hospitals would have the incentive and the ability to offer services comparable to HCA's.

### ***Incentives to maintain quality standards and range***

121. 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.
122. We did not think HCA's submissions supported its contention that, were a competitor to take over the Princess Grace and London Bridge hospitals, the new owner(s) would have an incentive to offer lower quality of services than HCA or that it would switch its emphasis to lower-acuity work.
123. HCA sought to compare other hospitals' quality of care unfavourably with its own. It cited, for example, its nursing ratios, including that it operated a [REDACTED] patient/nurse ratio in its paediatric ITU and [REDACTED] in cancer, contrasting this with the 1:4 cancer care

nurse/patient ratio 'observed' at TLC. Since HCA is the only private hospital operator to have a paediatric ITU in central London, we did not find this statement informative and we note that the claimed patient/nurse ratio at TLC is HCA's assessment. In addition, HCA cited the fact that it employed more RMOs than other private hospital operators. Again, since HCA operates more ITUs than any other private hospital company in central London, we did not find this comparison informative.

124. More generally, we noted earlier in this document (paragraph 115) examples of quality improvement by HCA which had been motivated by competitive rivalry. In conditions of greater rivalry following divestiture, we consider that there would be greater incentives for all competing central London hospitals to improve quality and introduce innovative techniques.
125. As regards a change of focus away from complex, high-acuity work, 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 and it accepted that another operator of the hospitals concerned could adopt the same strategy, as TLC had. 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.
126. We thought that a new owner or owners would be likely to adopt a very similar strategy to HCA's, in much the same way that TLC had chosen to do in 2003, on the basis of its analysis of the growth and profitability characteristics of medical specialisms, particularly tertiary and high-acuity work. The new owner or owners, we thought, would probably have the incentive to pursue a similar strategy as it/they would be just as aware as HCA of the growth characteristics and profitability of higher-acuity work. Equally, however, the new owner or owners might adopt a

different strategy if this is what signals from the newly competitive London market suggested was optimal. We thought 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 current offering***

127. 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 of the divested hospitals or HCA itself offering services comparable to HCA's current offering.
128. Before considering this issue, we note 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.

***Care pathways***

129. We thought that a new owner 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.

130. We thought that the unique benefits of the pathways between HCA's facilities had been overstated since we thought 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.
131. 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.<sup>65</sup> As regards facilities at the Princess Grace Hospital, HCA could, for example, replicate 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.
132. 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)<sup>66</sup> may be a benefit to the HCA business, remaining within one hospital group's pathway is not necessarily an RCB.

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<sup>65</sup> Harley Street at UCH and the 5<sup>th</sup> floor of the Macmillan Cancer Centre.

<sup>66</sup> See, for example, Plenary for Strategy Retreat 2011.

## **Scale economies**

133. 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 2. In addition to the administrative costs it would face and the higher costs of employing, for example, agency rather than its own 'bank staff', 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.
134. For instance, HCA cited its investment in Intraoperative Radiation Therapy (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.
135. In addition, HCA cited the volume of Transcatheter Aortic Valve Implantation (TAVI) procedures undertaken at the London Bridge Hospital (less 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 suboptimally, from a clinical perspective. The BCIS and SCTS statement<sup>67</sup> cited by HCA suggests a minimum of 24 procedures a year, [redacted], with an optimum of 50, [redacted].
136. Further, we would expect that economies of scale would result in lower prices being charged in a well-functioning market. However, we know from our price analysis that HCA has charged prices approximately [redacted] than those of TLC (in 2011) which

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<sup>67</sup> [www.ucl.ac.uk/nicor/audits/tavi/pdfs/bcisposition](http://www.ucl.ac.uk/nicor/audits/tavi/pdfs/bcisposition)

operates one hospital. We have also previously concluded that there is no persuasive evidence that HCA's quality is higher than that offered by close competitors. It is therefore evident that even if scale economies exist they are not being passed on to customers in the form of lower prices or higher quality and therefore do not fall within the definition of RCBs. We also considered that if the hospitals concerned became part of another hospital group, then economies of scale would reappear in the new owner's business.

### **Conclusion on RCBs**

137. 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.
138. We provisionally decided that while 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 expect that they would not be extinguished by the remedy and would not depend on the AEC to continue.
139. We thought that the network benefits in terms of quality of patient care claimed by HCA were generally overstated from the patient's perspective 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.
140. 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 as regards 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.

## **Conclusion on the remedy**

141. We have provisionally decided that the divestiture of HCA's London Bridge and Princess Grace hospitals would be an effective remedy to the AEC we have provisionally found in central London and that this is likely to be the least extensive and intrusive divestiture package that will be effective in addressing the AEC. We have considered whether the remedy as specified would extinguish any significant RCBs and have provisionally decided that it would not.

## Consideration of divestiture remedies outside central London

### Introduction

1. In this appendix, we consider the effectiveness and proportionality of divestitures in each local area outside central London where we identified hospitals with overlapping catchment areas.<sup>1</sup> We consulted with the largest private hospital groups (BMI, HCA, Spire, Nuffield and Ramsay) as well as the largest two insurers, Bupa and AXA PPP, on a preliminary list of proposed divestitures. These parties were asked for their views on whether the divestiture remedies proposed by the CC would address the AEC effectively and comprehensively in each local area, whether the criteria we set out for specifying a divestiture package were appropriate, and whether the divestiture packages proposed would attract suitable purchasers who could operate them as effective competitors.
2. In the following sections, we provide an overview of each local area and the hospitals operating in that area, together with a summary of the views of the parties. We set out our assessment of the extent to which divestiture is likely to be effective in increasing competitive constraints in each area, as well as our conclusions regarding how any divestiture package should be specified to ensure that it is as effective and proportionate. We highlight any costs of divestiture proposed by the parties that relate to specific local areas. These costs and our estimate of the expected price benefits of divestitures form part of our overall proportionality assessment in paragraphs 4.37 to 4.48 of the provisional decision on remedies.
3. In considering the likely effectiveness of divestitures in each local area, we have taken into account the following factors:

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<sup>1</sup> We identified these areas using our LOCI network effect filter (a network effect of 0.2 or more), as well as a review of our local assessments to identify local geographic areas in which hospital groups owned two or more hospitals. The approach is set out in more detail in Appendix 2.4.

- (a) the range of medical services (specialties) offered by the hospitals, including the availability and type of ICU;
- (b) the proximity of the hospital of concern to other hospitals both owned by the same operator and by competing facilities;
- (c) the catchment areas of the hospitals in areas of concern, the extent to which co-owned hospitals have overlapping catchment areas and the location of insured patients;<sup>2</sup>
- (d) the mix of patients treated at the hospitals, ie insured, self-pay, overseas and NHS; and
- (e) the size and capacity of the hospitals in the relevant local area.

## **BMI**

### ***Clementine Churchill/Bishops Wood***

#### *Introduction*

4. Using our qualitative approach, we provisionally found that BMI faces weak competitive constraints in north-west London in the area around its Clementine Churchill (CCH) and Bishops Wood hospitals.<sup>3</sup> At the time we published our provisional findings, we reasoned that the co-ownership of two hospitals with overlapping catchment areas meant that divestiture may be an effective remedy to the weak competitive constraints we have identified, since it would introduce a new competitor into the local market. Therefore, we proposed that BMI should divest either Bishops Wood or CCH to a suitable purchaser.

#### *How the remedy addresses the AEC*

5. The divestiture of one of these two hospitals would significantly increase the level of competition for patients within their catchment areas by introducing another com-

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<sup>2</sup> As the local assessments consider the degree of competition faced by each hospital for insured patients, the maps show the location of insured, inpatients attending each hospital.

<sup>3</sup> BMI holds a weighted average market share of [%] and [%] per cent in the catchment area of the CCH and Bishops Wood hospitals respectively.

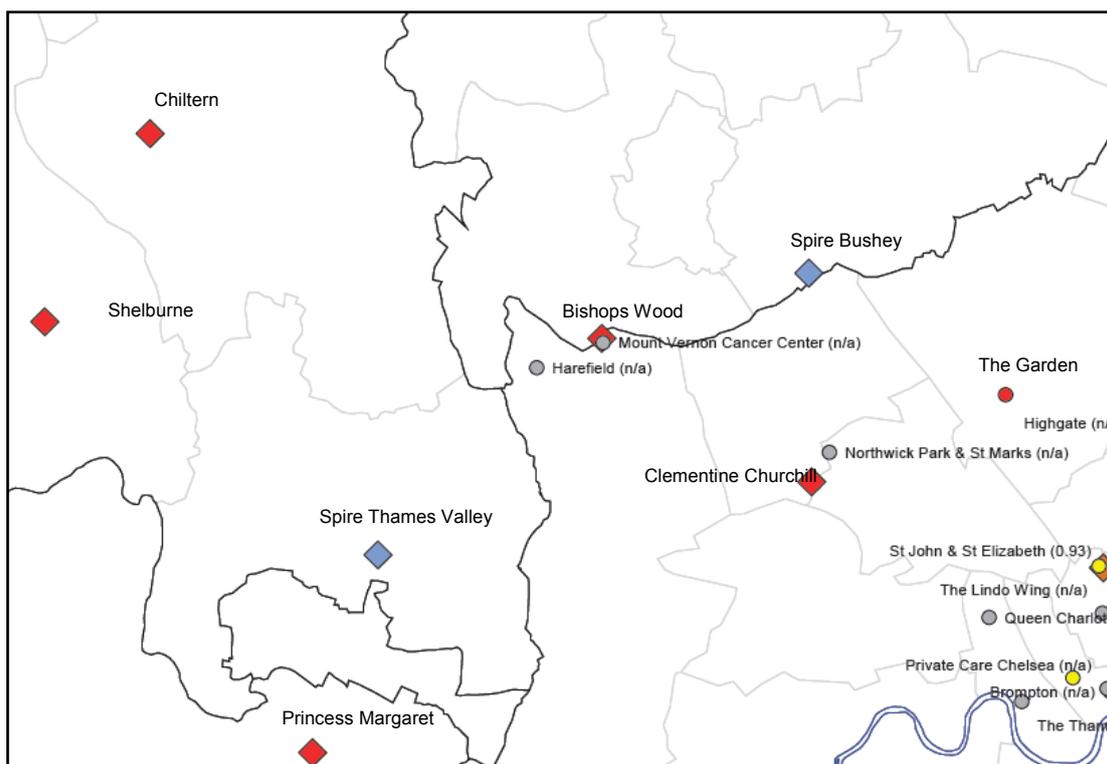
petitor, directly addressing the weak competitive constraints that give rise to the AEC in this area.

### *Background*

6. BMI Bishops Wood is a 47-bed, three-theatre private hospital with critical care level 2 facilities, located between Harrow and Rickmansworth. The hospital is operated by BMI but leased from the NHS Mount Vernon Hospital with which it is co-located. The catchment area of Bishops Wood Hospital is [X] miles, with the nearest other BMI hospital located 8 miles away in Harrow (CCH). CCH is BMI's second largest hospital in terms of revenues, bed numbers and the number of theatre procedures undertaken. It has 156 beds, six theatres and critical care level 3 facilities. CCH has a catchment area of [X] miles.
  
7. There are two Spire hospitals that also fall within Bishops Wood's catchment area: Thames Valley is 8 miles from Bishops Wood, and Bushey is 7 miles from Bishops Wood. The only other local competitors to Bishops Wood are NHS PPU's, the Mount Vernon Cancer Centre, the Harefield PPU and Northwick Park and St Mark's PPU.

FIGURE 1

**Map of private hospitals in north-west Greater London area**



Source: CC analysis.

8. Spire Thames Valley has 50 beds and two operating theatres, as well as critical care level 2 facilities. Spire Bushey has 70 beds, five operating theatres and critical care level 2 facilities. Both hospitals offer a large number of healthcare services to patients, comprising all 17 of the specialties used in our assessment.
9. A review of the characteristics of Bishops Wood and CCH indicates that both hospitals offer a full range of specialties, including oncology. However, [X]. CCH is able to provide higher acuity treatments due to its critical care level 3 facilities. In each case, private patients account for between [X] and [X] per cent of all admissions, with a [X] proportion of NHS patients.
10. We have found that both Bishops Wood Hospital and CCH are insufficiently constrained by competition.

## ***What the parties told us***

### ***BMI***

11. BMI argued that the CC had provided no or insufficient evidence that Bishops Wood and CCH were insufficiently constrained, nor that common ownership had ever been a feature of negotiations with insurers. It put forward the view that divestiture would be ineffective as a remedy for both insured and self-pay patients since these hospitals faced sufficient constraints from Spire's Thames Valley and Bushey hospitals, as well as the Royal National Orthopaedic Hospital, the Mount Vernon Cancer Centre, the Harefield and Northwick Park PUs, Watford General Hospital and central London facilities. In addition, BMI noted that Bupa had delisted both Bishops Wood and CCH during its dispute with BMI (not listing any other BMI hospital as an alternative), indicating that competition between the two hospitals was not the issue and hence that separation of ownership would not change any relative position in negotiations with insurers, who already have suitable and sufficient alternatives to BMI.<sup>4</sup>
12. BMI suggested that [REDACTED], even if this description were accurate, which BMI does not consider it to be, a divestiture would simply replace one competitor with another. Further, BMI argued that if the size of a hospital were relevant to the level of constraint that it exerted on a competitor, as the CC had claimed, then the CC would need to explain how Bishops Wood would be an effective competitor to CCH were it to be divested, since the former was approximately [REDACTED].
13. BMI also argued that the divestiture of either of Bishops Wood or CCH would be disproportionate since it would:

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<sup>4</sup> These views, as well as similar ones set out by BMI in relation to each local area, relate to the assessment of whether the relevant BMI hospital is subject to sufficient local competitive constraints and therefore are directed primarily at our AEC findings. As set out in paragraph 2.8 of the provisional decision on remedies, we have reviewed the local assessment of each of the hospitals considered for divestiture in light of parties' submissions in response to our provisional findings. We indicate where our view has changed. Our analysis of the effectiveness and proportionality of any individual divestiture is therefore on the premise that the relevant hospital is a hospital of concern and that the AEC findings are as set out in the provisional findings. Our final decision and our response to submissions relating to the AEC findings will be set out in our final report.

(a) prevent BMI from pursuing its strategy [redacted]. BMI questioned whether the CC could be confident that an eventual purchaser of one of these hospitals would be able to replicate an equivalent strategy;

(b) be likely to result in divestiture at an undervalue [redacted]; and

(c) even if considered effective in remedying any hypothetical AEC, even on the CC's case would benefit only private inpatients who were either self-pay or insured by an insurer other than Bupa. BMI stated that there was overwhelming evidence that Bupa had fully countervailing buyer power.<sup>5</sup> BMI noted that such patients comprised only [redacted] per cent of total patients to its Bishops Wood and CCH facilities (and would only be [redacted] per cent if Bupa-funded patients were included), with the remaining [redacted] per cent of patients receiving no benefit and being (at the least) inconvenienced by the divestiture of one of these hospitals. Moreover, of these, only a proportion lived in areas that, on the CC's catchment area analysis, would see an improvement in choice.

14. Given these points, BMI stated that a divestment of either Bishops Wood or CCH could not satisfy the double proportionality approach set out in the CAT's judgement in *Tesco v Competition Commission*.<sup>6</sup>

15. Finally, BMI put forward the view that unless the CC could motivate a powerful and compelling case, supported by robust evidence that a particular hospital must be divested, the principle of proportionality would call for the choice to be made by BMI.

### *Bupa*

16. Bupa argued that the divestiture of CCH rather than Bishops Wood had a significantly higher probability of promoting effective competition in this cluster since:

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<sup>5</sup> As set out in paragraph 1.7 of the provisional decision on remedies, this provisional decision on remedies is based on the AECs as set out in our provisional findings. In the provisional findings, paragraph 6.291, the CC found that no insurer, including Bupa, had countervailing buyer power that could fully offset the market power of the hospital operators including BMI.

<sup>6</sup> *Tesco Plc v Competition Commission (2009) CAT 6*, paragraph 139.

- (a) CCH was a significantly larger hospital and hence would be a more attractive option for a potential purchaser looking to enter the market;
- (b) Bishops Wood had a smaller presence than CCH in the majority of key specialism and hence would need to expand significantly in a number of specialisms to be a credible alternative for insurers; and
- (c) CCH would exert a stronger constraint on Bishops Wood and therefore would address consumer detriment more rapidly.

### *AXA PPP*

17. AXA PPP told the CC that it was ambivalent about the divestiture of one of Bishops Wood and CCH. [REDACTED] Even with significant investment, AXA PPP thought it unlikely that Bishops Wood would be able to compete with the BMI CCH or Spire Bushey for private patients to the extent that AXA PPP would be able to remove, or realistically threaten to remove, either of these hospitals given their size or significance in the market. Hence, AXA PPP considered that divestiture would have a limited effect on competition in this local market from an insured patient perspective unless a purchaser made substantial investments in Bishops Wood.

### **Assessment**

#### *Design considerations*

18. We considered how the factors set out in paragraph 3 would be likely to affect the effectiveness of divestiture in this area, taking into account the views of the parties as set out above.
19. There is significant overlap in the catchment areas of these two hospitals,<sup>7</sup> which indicates that they serve a similar geographic base of patients. This suggests that patients would, in theory, be happy to travel to either hospital for treatment. This is

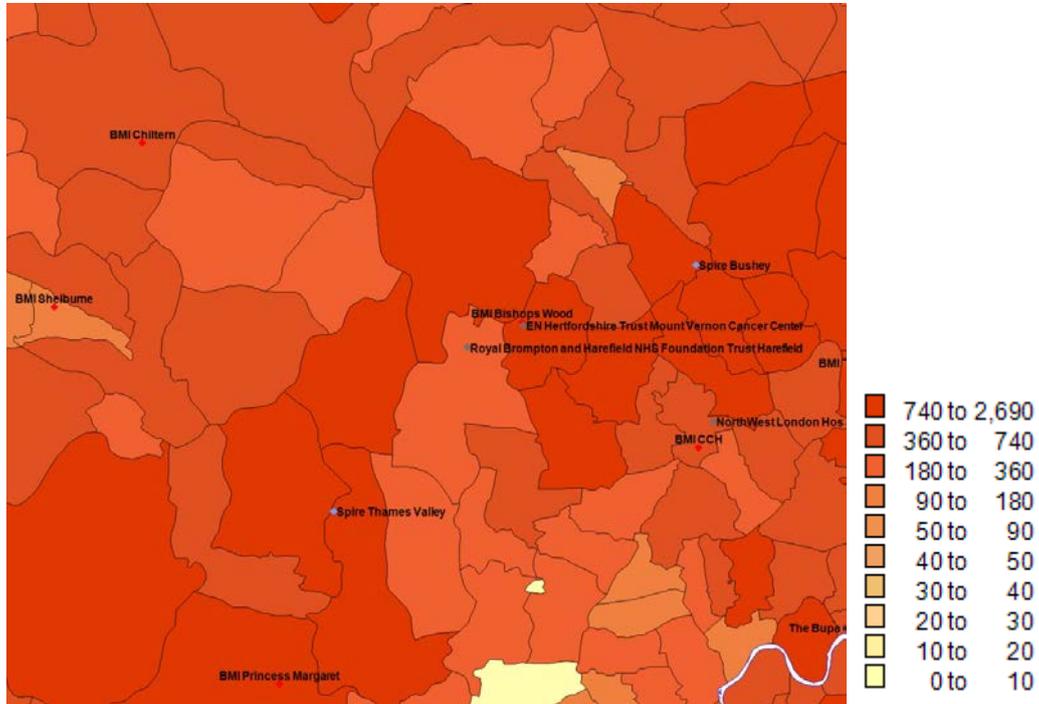
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<sup>7</sup> [REDACTED]

highlighted in the detailed catchment area maps below. As shown in Figure 2, these postcodes have a relatively large number of private patients.<sup>8</sup>

FIGURE 2

**Density of insured patients, north-west greater London**



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 3

**Bishops Wood, detailed catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 4

**CCH, detailed catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

- We next considered the extent to which Bishops Wood and CCH offered a similar range of healthcare services. We noted Bupa's argument that the CC should specify

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<sup>8</sup> The key refers to the number of insured patient episodes in each postcode over the 2009 to 2012 (part-year) period. The same key (colour scheme) is relevant for both the density of insured patients map and the specific hospital catchment area maps.

that CCH should be divested rather than Bishops Wood as the former offered a broader range of services within key specialisms, as well as higher acuity care, and therefore would be a stronger competitor than Bishops Wood. As set out in paragraph 9, there are some areas where the services offered by Bishops Wood and CCH differ, most notably in terms of the high acuity treatments which can be accommodated at CCH due to its level 3 ICU. In other areas, the specialization appears to be partial with the hospitals offering a similar range of services but focusing to an extent on different specialties. Bishops Wood currently offers a broad range of services, including all 17 of the mainstream medical specialties. We reasoned therefore that, under separate ownership, it could (a) compete directly for a large proportion of the patients treated at CCH, and (b) further extend the range of medical services provided, building on its current base, within a reasonable time period.<sup>9</sup> We thought that, in the current situation, where both facilities are owned by a single operator, there is an incentive for each hospital to specialize to an extent, rather than duplicating services, but that this incentive would change following a divestiture of one of the hospitals.

21. We considered BMI's argument that Bishops Wood might not be an effective competitor to CCH given its smaller size. We thought that, although Bishops Wood is smaller than CCH, it is in fact a mid-sized rather than small facility,<sup>10</sup> with a reasonable level of spare capacity (see Table 1). This suggests that it would be able to treat a significant number of additional patients, facilitating at least some insurers to switch their volumes away from BMI in this area. This possibility is supported by the existence of other, non-BMI hospitals in this local area, including Spire Bushey and Spire Thames Valley.

TABLE 1 **Bishops Wood and CCH capacity utilization**

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<sup>9</sup> This indicates that the facility currently has a wide range of consultants practising there.

<sup>10</sup> CCH is a particularly large facility.

	<i>Utilization (theatres)</i>				<i>Utilization (beds)</i>				<i>per cent</i>
	<i>FY2009</i>	<i>FY2010</i>	<i>FY2011</i>	<i>YTD Jul 2012</i>	<i>FY2009</i>	<i>FY2010</i>	<i>FY2011</i>	<i>YTD Jul 2012</i>	
Bishopswood	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
CCH	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

Source: BMI.

22. We noted AXA PPP's argument that, at least in the short term, the separate ownership of Bishops Wood would not allow it credibly to threaten not to recognize CCH. We thought that the main challenge in this respect was the existence of ICU level 3 facilities at CCH, which none of Bushey, Bishops Wood or Thames Valley offer. However, we did not consider that this was necessary for the level of competitive constraint acting on both BMI hospitals in this area to increase appreciably. For example, we thought that, even if insurers felt compelled to recognize CCH, they could still hold tender processes during which Bishops Wood would compete for recognition and CCH might compete for exclusivity in this area, exerting pressure on prices. We understand that, despite its ambivalence regarding this divestiture, AXA PPP has taken this approach in other markets.<sup>11</sup>
23. We did not agree with BMI's view that, to the extent that Bishops Wood operated within a duopoly, a divestiture would simply replace one competitor with another. Bishops Wood is located in close proximity to both CCH and to Spire's Thames Valley and Bushey hospitals. The sale of one of Bishops Wood or CCH to a suitable purchaser, therefore, would introduce more competition into the local area, increasing the overall level of competitive constraint acting on all hospitals in the market.
24. We agreed with Bupa that CCH would exert a more effective constraint on Bishops Wood than vice versa. Indeed, we thought that Bishops Wood would be likely to be

<sup>11</sup> [REDACTED]

sufficiently constrained following a divestiture since the insurers could choose not to recognize it at all, whereas CCH would be likely to retain some market power due to its differentiated service offering. However, we thought that this would be the case whichever of the two hospitals were sold with the overall competitive dynamics in the local area being much the same in either case. We concluded, therefore, that the sale of either hospital would be equally effective in increasing competition in the local area.

### *Implementation*

25. We examined [§] the [§] argument made by Bupa that the CC should specify that CCH should be sold since it was a more attractive asset to purchasers and, therefore, was more likely to be divested successfully. We took into account the likely impact on the hospitals' EBITDA of a reduction in prices as a result of the increased competition that would be created by the divestiture of one of the hospitals.<sup>12</sup> This analysis is set out in detail in Appendix 2.5.
26. We concluded that both facilities were likely to attract interest from purchasers since, in each case, the hospitals continue to generate a reasonable absolute level of profit following the sale of one or other of them and both hospitals have a level of rent cover [§].<sup>13</sup>

### *Conclusions*

27. We concluded, therefore, that in this local area the divestiture of either Bishops Wood or CCH would be effective in increasing the competitive constraints acting on both of these hospitals sufficient to remedy or mitigate the AEC we have found, although we

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<sup>12</sup> The likely level of EBITDA post-divestiture has been calculated on the same basis as the CC's estimates of the overall price/revenue benefits of divestiture. A full explanation of the methodology is set out in Appendix 2.5.

<sup>13</sup> We estimated that Bishops Wood would generate around £[§] million EBITDA post-divestiture, while CCH would generate between £[§] million and £[§] million EBITDA. The hospitals would have rent cover of around [§] and [§] EBITDAR respectively.

recognize that CCH is likely to continue to have some market power as a result of its size and partially differentiated product offering, particularly its critical care level 3 facilities. We thought that the sale of CCH would have a greater impact on the competitive constraints acting on other BMI hospitals outside the immediate cluster, due to its broader catchment area, than the sale of Bishops Wood.<sup>14</sup> However, we reasoned that requiring the sale of CCH would be likely to be imposing a remedy that was more onerous than needed to achieve its legitimate aim, namely remedying the weak competitive constraints in the local area around Bishops Wood and CCH. Since we thought that the divestiture of Bishops Wood would be sufficient to remedy the AEC, we concluded that this would be a proportionate divestiture package. However, we agreed with BMI that without a compelling reason to specify which hospital should be divested, we should allow BMI to choose.

28. We propose, therefore, that BMI be required to divest the operating business of either its Bishops Wood Hospital or its CCH to a suitable purchaser.<sup>15</sup>
29. We have addressed BMI's other arguments in relation to the proportionality of divestiture remedies, as set out in paragraph 13 above, in Section 2 of the provisional decision on remedies. We do not repeat this discussion here.

## **Kings Oak/Cavell**

### ***Introduction***

30. We provisionally found that BMI faces weak competitive constraints in the Enfield area where its Cavell and Kings Oak hospitals are located.<sup>16</sup> At the time we published our provisional findings, we reasoned that the co-ownership of two hospitals with overlapping catchment areas meant that divestiture may be an effective remedy

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<sup>14</sup> For example, BMI The Garden and BMI Princess Margaret.

<sup>15</sup> [REDACTED]

<sup>16</sup> BMI holds a weighted average market share of [REDACTED] and [REDACTED] per cent in the catchment area of the Cavell and Kings Oak hospitals respectively.

to the weak competitive constraints identified, since it would introduce a new competitor into the local market. Therefore, we proposed that BMI should divest either Cavell or Kings Oak to a suitable purchaser.

#### *How the remedy addresses the AEC*

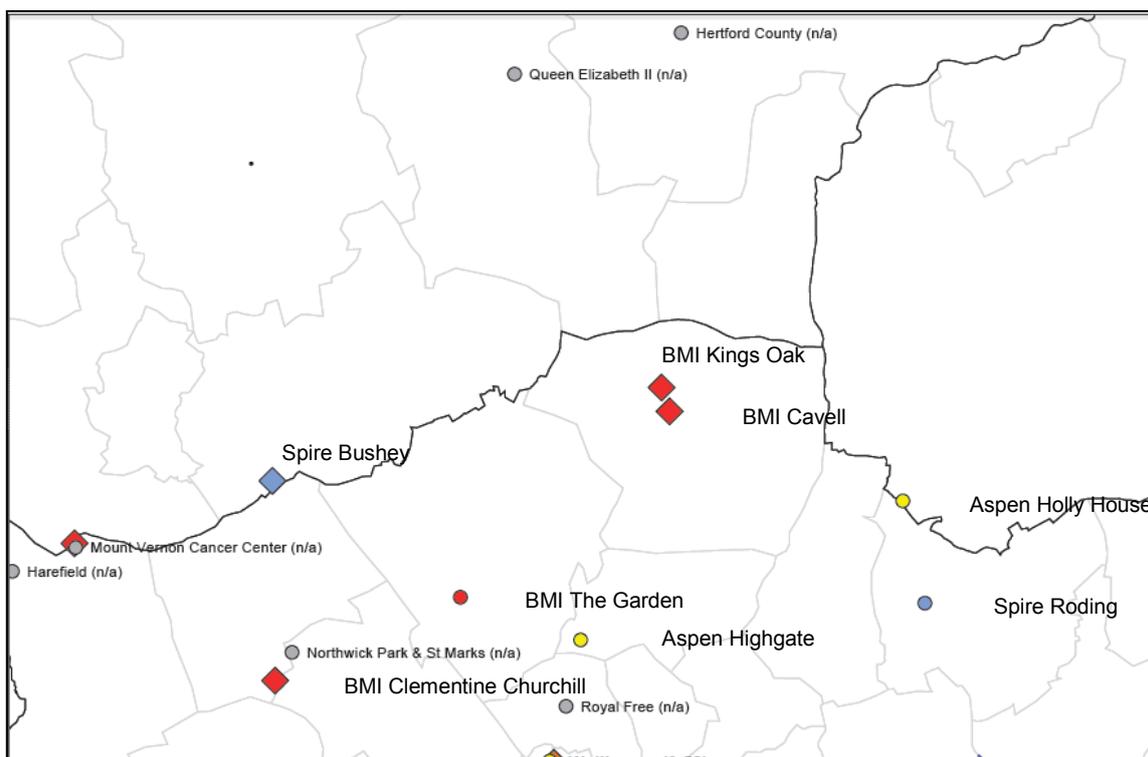
31. The divestiture of one of these two hospitals would increase the level of competition for patients within their catchment areas by introducing another competitor, and would directly address the weak competitive constraints that give rise to the AEC in this area.

#### *Background*

32. BMI Cavell is a 45-bed, three-theatre private hospital with critical care level 2 facilities located in Enfield, north London. It is in close proximity to BMI Kings Oak Hospital (0.6 miles away), which is also in Enfield. The latter is (very) slightly larger in terms of its facilities, with 47 beds and three operating theatres; however, it attracted [X] the number of admissions of Cavell in 2011. Kings Oak does not have critical care facilities.

FIGURE 5

**Map of private hospitals in Enfield/north London area**



Source: CC analysis.

33. The closest competitor to these two hospitals is Aspen's Holly House Hospital, which is approximately 7 miles away, [X] of the [X]-mile catchment area of Cavell and [X]-mile catchment area of Kings Oak Hospital. Spire Bushey is located 13 miles away from Cavell.
34. Aspen Holly House has 51 beds and three operating theatres, as well as critical care level 2 facilities. Spire Bushey has 70 beds, five operating theatres and critical care level 2 facilities. Both hospitals offer a large number of healthcare services to patients, comprising 16 and 17 of the specialties we used in our analysis respectively.
35. Cavell and Kings Oak provide a broad range of treatments, including all 16 of the mainstream specialties. Kings Oak also provides oncology treatments, whilst Cavell

has critical care level 2 facilities. In each case, around [REDACTED] of admissions are NHS patients. [REDACTED]

36. We have found that both Kings Oak and Cavell hospitals are insufficiently constrained by competition.

### ***What the parties told us***

#### ***BMI***

37. BMI argued that the CC had provided no or insufficient evidence that Kings Oak and Cavell were insufficiently constrained, nor that common ownership had ever been a feature of negotiations with insurers. It stated that divestiture would be ineffective as a remedy for both insured and self-pay patients since both these hospitals faced sufficient constraints from Aspen Holly House, as well as Spire's Bushey, Roding and Harpenden hospitals, Ramsay's Rivers Hospital and central London facilities, which were likely to be used by patients travelling to London for work. BMI highlighted that the OFT considered this area when BMI acquired Cavell from Nuffield and that it came to the view that BMI would be sufficiently constrained in this local area by competitor hospital groups and PPUs, including Queen Elizabeth II and the Royal National Orthopaedic Hospital. At that stage, the OFT had not required divestment of either of these hospitals, despite requiring a remedy in respect of other assets in lieu of a reference to the CC. BMI also highlighted the implications of the fact that Holly House had recently undergone a £21 million redevelopment— enhancing its competitive appeal but also indicating the presence of an underlying business case for (competition in) the area.
38. BMI told us that [REDACTED], showing that insurers had outside options in negotiations. [REDACTED], neither site was actually delisted by Bupa.

39. BMI stated that Cavell was a failing hospital prior to its acquisition from Nuffield by BMI and that under BMI's management ward utilization had increased from [REDACTED] to [REDACTED] per cent and its theatre utilization had increased from [REDACTED] to [REDACTED] per cent. [REDACTED]
40. BMI also argued that the divestiture of either of Kings Oak or Cavell would be disproportionate since it would:
- (a) remove efficiencies from BMI's operations by reducing both economies of scale within the BMI Group and [REDACTED];
  - (b) end BMI's current customer benefits-focused strategy, under which [REDACTED];
  - (c) be likely to take place at an undervalue [REDACTED];
  - (d) harm investment incentives in the UK in general and the private healthcare sector in particular as a result of perceived regulatory risk from the UK's market investigation regime (for example, in this case, overturning a merger that had already been cleared by the OFT); and
  - (e) even if considered effective in remedying any hypothetical AEC, even on the CC's case, benefit only private inpatients who were either self-pay or insured by an insurer other than Bupa. BMI contended that the evidence was overwhelming that Bupa had fully countervailing buyer power. BMI noted that such patients comprised only [REDACTED] and [REDACTED] per cent of total patients at its Kings Oak and Cavell facilities respectively ([REDACTED] and [REDACTED] per cent if BUPA-funded patients were included) with the remaining [REDACTED] to [REDACTED] per cent of patients receiving no benefit and being (at the least) inconvenienced by the divestiture of one of these hospitals. Of these, only a proportion lived in areas that, on the CC's catchment area analysis, would see an improvement in choice.

41. Given these points, BMI stated that a divestment of either Kings Oak or Cavell could not satisfy the double proportionality approach set out in the CAT's judgement in *Tesco v Competition Commission*.<sup>17</sup>
42. Finally, BMI put forward the view that unless the CC could motivate a powerful and compelling case, supported by robust evidence that a particular hospital must be divested, the principle of proportionality would call for the choice to be made by BMI.

### *Bupa*

43. Bupa suggested that the divestiture of Kings Oak was likely to be more effective in promoting competition in the local area as it was a better invested facility than Cavell and hence would exert a stronger competitive constraint on Cavell than vice versa. Bupa suggested that this stronger constraint would result in a more rapid resolution of the consumer detriment in the area.

### *AXA PPP*

44. AXA PPP supported the divestiture of one of Kings Oak or Cavell on the basis that the proximity of the two BMI facilities meant that, if they were separately owned, AXA PPP would be able to exclude or threaten to remove either one of these hospitals.

## **Assessment**

### *Design considerations*

45. We considered how the factors set out in paragraph 3 would be likely to affect the effectiveness of divestiture in this area, taking into account the views of the parties as set out above.

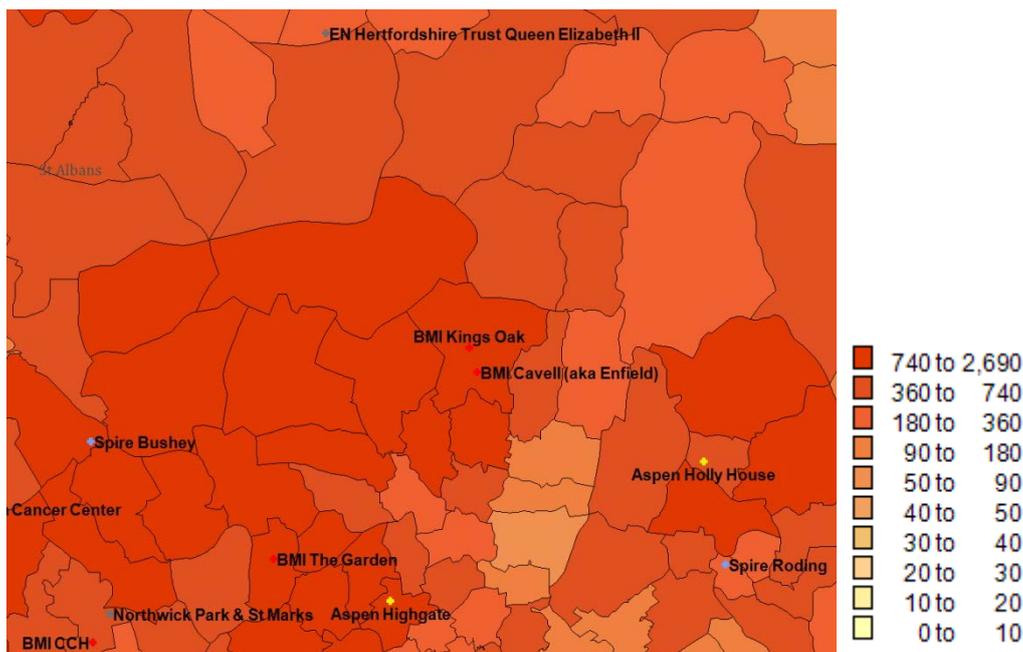
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<sup>17</sup> *Tesco Plc v Competition Commission (2009) CAT 6*, paragraph 139.

46. The catchment areas of the two hospitals [✂], indicating that they serve a similar geographic base of patients. Therefore, if separately owned they could act as substitutes. We observe that this is an area with a high density of private patients, which suggests that a large number of patients would benefit from any increase in competitive constraints.

FIGURE 6

**Density of insured patients in the Enfield area**



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 7

**BMI Cavell catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 8

**BMI King's Oak catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

47. Further, we thought that the similar range of specialties offered by these two hospitals, together with the existence of significant spare capacity at both facilities (see

Table 2), would mean that if they were separately owned, insurers could choose to recognize just one or other of the facilities, ie each facility could accommodate the switching of any one of the insurers' volumes. AXA PPP's response supported this view that an insurer would not need to recognize both facilities in this area in order to have a credible offering for its policyholders. This indicates that, under separate ownership, the hospitals should act as highly effective constraints on one another whereas, under common ownership, they do not compete and are not sufficiently constrained by other hospital operators such as Aspen and Spire (Holly House and Bushey).

48. We took into account Bupa's observation that Kings Oak was the better invested facility and might, therefore, exert a stronger constraint on Cavell than vice versa. We did not disagree with this analysis, although we observed that BMI invested a reasonably large sum (just under £[redacted] million) in maintaining Cavell during FY13, which we would expect to have reduced any difference in quality between the facilities.<sup>18</sup> However, as was the case for Bishops Wood and CCH, we reasoned that an asymmetry of constraint between two facilities did not indicate that the stronger of the two should be divested, particularly in the case where only two hospitals were co-owned in the local area.<sup>19</sup> In this instance, the divestiture of either facility would be equivalent in terms of the increase in overall competitive constraints in this area, ie the divestiture of either hospital would be equally effective as a remedy to the weak competitive constraints in this area.

### *Implementation*

49. We considered BMI's argument that [redacted].

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<sup>18</sup> [redacted]

<sup>19</sup> If there were three or more co-owned facilities in an area, there might be a rationale for divesting a single, stronger unit in order to compete effectively with the two (or more) weaker units.

50. We reviewed the capacity utilization of both Kings Oak and Cavell (see Table 2) and concluded that, while both had [redacted] spare capacity, their rates of utilization did not appear to be [redacted] at other BMI hospitals on average. In addition, BMI did not provide any explanation as to why capacity utilization of either hospital would fall if ownership were separated and we saw no reason to assume such an outcome, particularly in light of the current constraints on the NHS which appears to be driving the continued outsourcing of NHS treatment to private hospital operators.<sup>20</sup>

TABLE 2 Kings Oak and Cavell capacity utilization

	Utilization (theatres)				Utilization (beds)				<i>per cent</i>
	FY2009	FY2010	FY2011	YTD Jul 2012	FY2009	FY2010	FY2011	YTD Jul 2012	
Kings Oak	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
Cavell	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	

Source: BMI.

51. [redacted] We estimated the level of EBITDA that the sites could expect to achieve post-divestiture and the level of rent cover that this would imply, taking into account the impact of a reduction in prices as a result of the increased competition that would be created by the divestiture of one of the hospitals. The detailed calculations are set out in Appendix 2.5. This shows that Cavell could be expected to generate EBITDA of between £[redacted] million and £[redacted] million following divestiture, giving a rent cover of around [redacted] EBITDAR. We thought, therefore, that with its [redacted] in place, Cavell may not attract interest from purchasers, nor would a purchaser necessarily be able to compete effectively with Kings Oak.

52. As a result, we considered whether there was an alternative divestiture package that we could specify to ensure the success of a divestiture remedy.<sup>21</sup> We observed that [redacted] we thought that Cavell would become attractive to a number of purchasers and

<sup>20</sup> [www.ft.com/cms/s/0/4d76f796-4ab5-11e3-8c4c-00144feabdc0.html#axzz2nYPhAv8F](http://www.ft.com/cms/s/0/4d76f796-4ab5-11e3-8c4c-00144feabdc0.html#axzz2nYPhAv8F).

<sup>21</sup> As set out in CC3, Annex B, paragraph 15, in some circumstances, it may be appropriate to define a more extensive and/or more marketable divestiture package ('alternative divestiture package') which the CC would require the parties to sell if the initially proposed divestiture package were not sold within a specified period.

would gain the ability to compete effectively against Kings Oak. We reasoned, therefore, that in order to ensure the success of a divestiture remedy in this area, it would be appropriate to specify that if Cavell were divested, the operating business should be divested together with the freehold property. By specifying the divestiture package in this way, we would also ensure the independence of the hospital from BMI, [REDACTED].

53. Kings Oak generated a sufficient absolute level of EBITDA and a rent cover<sup>22</sup> to be attractive to purchasers with its current lease arrangements in place. We concluded, therefore, that if Kings Oak were divested, it would be sufficient to require that BMI divest the operating business.

54. We next considered BMI's contention that either of these hospitals would be sold at an undervalue due to the exclusion of [REDACTED] from a sales process. First, we reasoned that, to the extent that some parties did not have an interest in acquiring an asset, this could not be considered to contribute to a sale at an 'undervalue' since the level of purchaser interest is one of the principal factors which determines the market value of an asset. Therefore, if it were the case that [REDACTED] did not have an interest in purchasing either of these hospitals, we did not think this would contribute to a price being achieved that was below the fair market value. Second, we thought it highly unlikely that the CC would seek to exclude the number of parties suggested by BMI due to concerns about creating further competition problems. We concluded, therefore, that there was no reason to believe that either of these sites would be sold at an undervalue.

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<sup>22</sup> Kings Oak could be expected to generate between £[REDACTED] million and £[REDACTED] million in EBITDA following a divestiture, and a rent cover of around [REDACTED] to [REDACTED].

## *Conclusions*

55. We concluded that in this local area the divestiture of either Cavell or Kings Oak would be equally effective in increasing the competitive constraints acting on each other sufficient to remedy or mitigate the AEC we have found, provided that Cavell was sold with its underlying property in order to ensure its ongoing ability to compete effectively with Kings Oak. We reasoned that the least onerous effective remedy from BMI's point of view was likely to be the divestiture of [REDACTED]. However, we agreed with BMI that without a compelling reason to specify which hospital should be divested, we should allow BMI to choose.
56. We propose, therefore, that BMI be required to divest either the operating business of Kings Oak Hospital (ie with its current lease in place) or the combined operating company and property of Cavell to a suitable purchaser.
57. We have addressed BMI's other arguments in relation to the proportionality of divestiture remedies, as set out in paragraph 40 above, in Section 2 of the provisional decision on remedies. We do not repeat this discussion here.

## **Chiltern/Shelburne**

### ***Introduction***

58. We provisionally found that BMI faces weak competitive constraints in the area around its Chiltern and Shelburne hospitals (to the north-west of London).<sup>23</sup> At the time we published our provisional findings, we reasoned that the co-ownership of two hospitals with overlapping catchment areas meant that divestiture may be an effective remedy to the weak competitive constraints identified, since it would introduce a new competitor into the local market. Therefore, we proposed that BMI should divest either Chiltern or Shelburne to a suitable purchaser.

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<sup>23</sup> BMI holds a weighted average market share of [REDACTED] and [REDACTED] per cent in the catchment areas of its Chiltern and Shelburne hospitals respectively.

*How the remedy addresses the AEC*

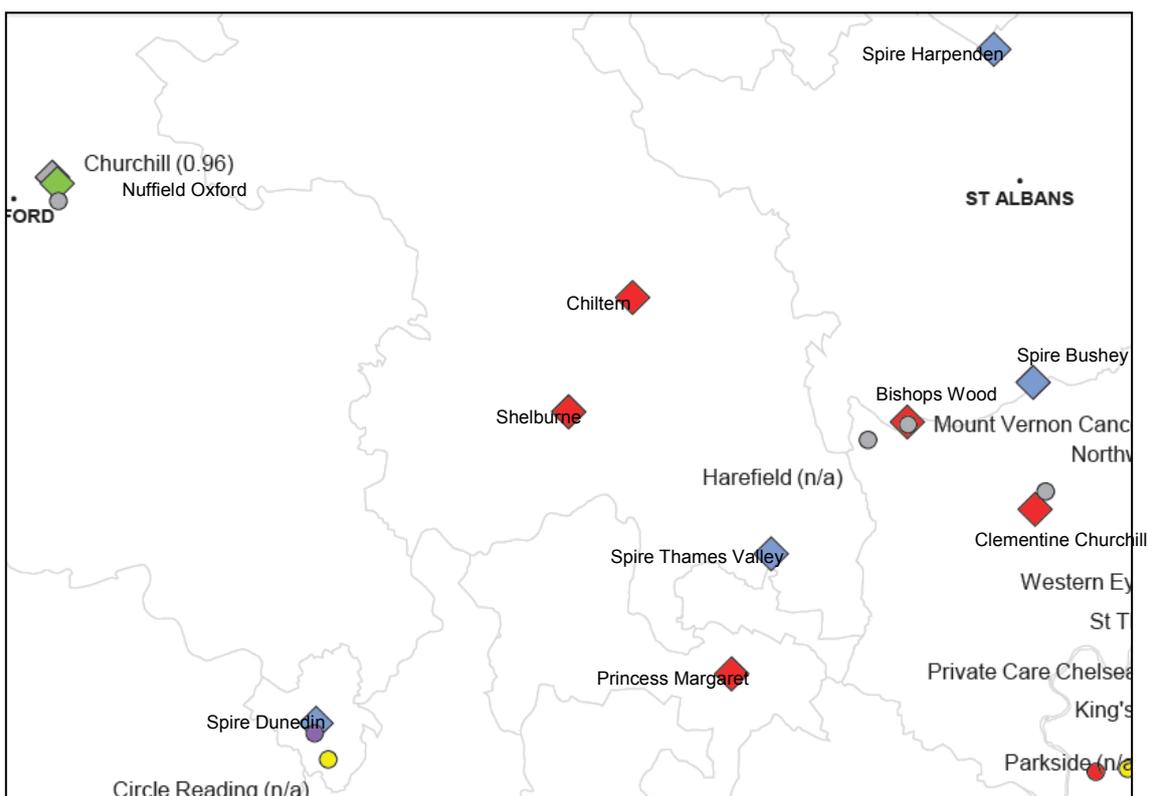
59. The divestiture of one of these two hospitals would increase the level of competition for patients within their catchment areas by introducing another competitor, addressing directly the weak competitive constraints that give rise to the AEC in this area.

*Background*

60. BMI Shelburne is a 29-bed, three-theatre private hospital located in High Wycombe.<sup>24</sup> The hospital has a catchment area of [redacted] miles, [redacted] the BMI Chiltern Hospital (located 9 miles away) in Great Missenden. BMI Chiltern has 58 beds, four operating theatres and level 2 ICU facilities, with a catchment area of [redacted] miles. [redacted]

FIGURE 9

**Map of private hospitals in north-west Greater London area**



Source: CC analysis.

<sup>24</sup> This hospital is co-located with the (NHS) Wycombe hospital.

61. The closest competitor facility to Shelburne is Spire Thames Valley, which is 14 miles away. There is a reasonable level of overlap between the catchment areas of the Thames Valley and Shelburne. There are no other competitor hospitals located within the catchment area of either Shelburne or Chiltern.
62. Spire Thames Valley has 50 beds and two operating theatres, as well as critical care level 2 facilities. Spire Bushey has 70 beds, five operating theatres and critical care level 2 facilities. Both hospitals offer a large number of healthcare services to patients, comprising all of the 17 specialties we considered in our assessment.
63. Both Shelburne and Chiltern offer a broad range of healthcare services, comprising all 16 mainstream specialties and oncology. However, Shelburne does not have ICU facilities. Approximately [X] to [X] per cent of the patients treated at both facilities are private, either insured or self-pay, with Chiltern admitting around [X] patients as Shelburne in 2011.
64. We have found that both Chiltern and Shelburne hospitals are insufficiently constrained by competition.

### ***What the parties told us***

#### ***BMI***

65. BMI argued that the CC had provided no or insufficient evidence that Chiltern and Shelburne were insufficiently constrained, nor that common ownership had ever been a feature of negotiations with insurers. It put forward the view that divestiture would be ineffective as a remedy for both insured and self-pay patients since both these hospitals faced sufficient constraints from Spire Thames Valley, the Mount Vernon Cancer Centre, Harefield PPU and central London facilities. BMI noted that central London hospitals were often used by patients who travelled to London for work. It

highlighted that Shelburne was delisted by Bupa during its dispute with BMI and that, although Chiltern was not delisted, it was also not included in Bupa's list of alternative facilities to Shelburne. BMI argued that this indicated that Bupa was able to shift all of its demand away from the Chiltern/Shelburne 'cluster' and therefore that divestment of either facility would not change the relative negotiating position with insurers, who already had suitable and sufficient alternatives to BMI. In addition, and notwithstanding its position that there was no causal relationship between self-pay prices and concentration, BMI noted that the CC's survey evidence showed that self-pay patients were prepared to travel further than insured patients and that this meant that a larger number of hospitals competed for these patients, including Wexham Park, Churchill Cancer Centre, John Radcliffe ISIS, Northwick Park and the Royal National Orthopaedic Hospital PPUs, as well as Spire's Bushey Hospital and Oxford Nuffield.

66. BMI noted that it was inconsistent for the CC to suggest that a divestiture would be effective in increasing competition to a satisfactory level in this case, given its conclusion in the provisional findings that markets served by two competitors exhibited insufficient competition.
  
67. BMI also argued that the divestiture of either of Chiltern or Shelburne would be disproportionate since it would:
  - (a) remove efficiencies from BMI's operations by reducing economies of scale: for example, it noted that Chiltern and Shelburne shared [REDACTED] which BMI estimated represented a saving of £[REDACTED] as against requiring [REDACTED] for each site;
  - (b) end BMI's current customer-benefits-focused strategy, [REDACTED]: BMI stated that the divestment of either hospital would end such an investment strategy by BMI and that it was unclear whether an unknown acquirer would pursue a similar strategy;
  - (c) be likely to take place at an undervalue or not occur at all: [REDACTED]; and

(d) even if considered effective in remedying any hypothetical AEC, even on the CC's case, benefit only private inpatients who were either self-pay or insured by an insurer other than Bupa. BMI stated that there was overwhelming evidence that Bupa had fully countervailing buyer power. BMI noted that such patients comprised only [X] and [X] per cent of total patients at its Chiltern and Shelburne facilities respectively (and [X] and [X] per cent respectively if Bupa-funded patients were included), with the remaining [X] to [X] per cent of patients receiving no benefit and being (at the least) inconvenienced by the divestiture of one of these hospitals. Moreover, of these, only a proportion lived in areas that, on the CC's catchment area analysis, would see an improvement in choice.

68. Given these points, BMI stated that a divestment of either Chiltern or Shelburne could not satisfy the double proportionality approach set out in the CAT's judgement in *Tesco v Competition Commission*.<sup>25</sup>

69. Finally, BMI put forward the view that unless the CC could motivate a powerful and compelling case, supported by robust evidence that a particular hospital must be divested, the principle of proportionality would call for the choice to be made by BMI.

### *Bupa*

70. Bupa suggested that the divestment of Chiltern had a significantly higher probability of promoting effective competition in this area on the basis that:

(a) Shelburne had a low beds-to-theatres ratio such that any purchaser would be at an inherent disadvantage to BMI as it would have insufficient capacity to provide an effective constraint;

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<sup>25</sup> *Tesco Plc v Competition Commission* (2009) CAT 6, paragraph 139.

- (b) the larger size of Chiltern made it a more attractive asset to purchasers and therefore increased the probability of effecting a successful divestiture; and
- (c) Shelburne was co-located on the site of the NHS Wycombe Hospital which had the potential to complicate investment for any potential buyers (depending on the specific property arrangements in place).

### ***AXA PPP***

71. AXA PPP supported the divestiture of Shelburne on the basis that, whilst the Shelburne facility would require some investment in order to compete effectively in this area, AXA PPP considered that this was reasonably likely in this case—since a lower level of investment would be required to bring Shelburne up to the same standard as Chiltern than would be required for Bishops Wood to compete with CCH. AXA PPP thought that Shelburne could be attractive to a management provider other than BMI and increase contestability in this area, which was densely populated in terms of private insured customers.

### ***Assessment***

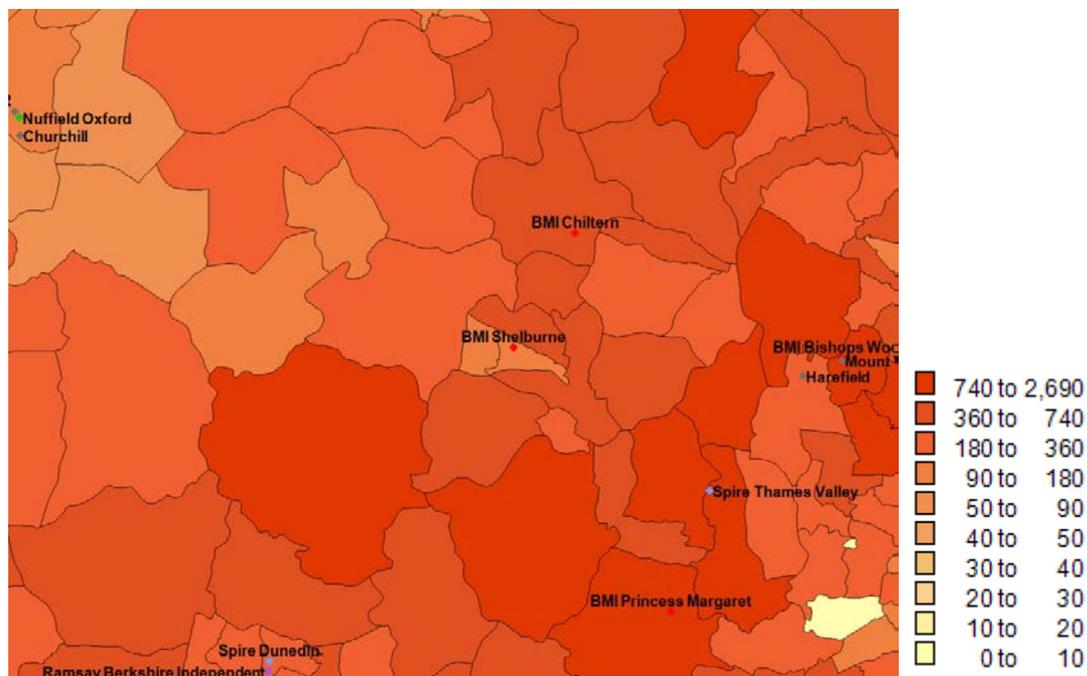
#### ***Design considerations***

72. We considered how the factors set out in paragraph 3 would be likely to affect the effectiveness of divestiture in this area, taking into account the views of the parties as set out above.
73. There is significant overlap between the catchment areas of these two hospitals, indicating that they serve a similar geographic base of patients. We examined which areas the hospitals currently drew their patients from, as well as the overall number of private patients in this area (see Figure 10). Both hospitals have catchment areas that encompass the other facility, [REDACTED]. In addition, we observe that this is an area

with a high density of private patients, which suggests that a large number of patients would benefit from any increase in competitive constraints.

FIGURE 10

**Density of insured patients in the area around BMI Chiltern and Shelburne**



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 11

**BMI Chiltern catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 12

**BMI Shelburne catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

74. We considered that the broad range of specialties offered by both of the hospitals meant that they would be able to compete across a full range of medical services, further supporting the substitutability of the hospitals, although we noted that Shelburne could not offer certain higher-acuity treatments due to its lack of critical

care facilities. AXA PPP's submission supported the view that insurers might be able to recognize one or the other but not both facilities in this area if they were separately owned, provided that Shelburne invested in developing its facilities, which AXA PPP considered to be a reasonable prospect.

75. We took into account BMI's argument that, given that we had concluded generally that two competitors were not sufficient to create an adequate competitive constraint on each other, it was inconsistent to believe that the sale of one of either Chiltern or Shelburne would create an area with sufficient competitive constraints. We observed that, in some cases, we had concluded that two competitors in an area could create sufficient competitive constraints where those competitors were located in close proximity, offered a similar range of services and where both facilities were of a reasonable size in the context of the level of local demand (size of the local market).<sup>26</sup> In the case of Chiltern and Shelburne, we concluded that the competitive constraint created by divestiture would be asymmetric, with Chiltern constraining Shelburne more than vice versa. As a result, divestiture would be unlikely to result in Chiltern being fully constrained, particularly initially given the need for investment in Shelburne to enable it to compete for higher-acuity work. However, we reasoned that the full competitive constraint of both/all facilities in an area was not a necessary condition for a divestiture to be considered to be effective but rather that an effective divestiture would be one which resulted in an increase in the level of competitive constraint acting on one or more hospitals in a local area sufficient to mitigate the AEC we have found. In this case, the divestiture of either Chiltern or Shelburne would introduce a new competitor located significantly closer to both these hospitals than the existing competing hospitals (Spire Thames Valley and Spire Bushey).

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<sup>26</sup> For example, we reached this conclusion in Leeds, Guildford and Woking.

76. We examined the capacity utilization of the facilities (see Table 3) and concluded that [redacted]. This indicates that the hospital is not capacity constrained and could carry out a [redacted] higher volume of work than it currently undertakes. We did not, therefore, agree with Bupa's argument that Chiltern should be divested in preference to Shelburne as the latter would not have the capacity to compete effectively.

TABLE 3 Chiltern and Shelburne capacity utilization

	Utilization (theatres)				Utilization (beds)				per cent
	FY2009	FY2010	FY2011	YTD Jul 2012	FY2009	FY2010	FY2011	YTD Jul 2012	
Chiltern	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Shelburne	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Source: BMI.

77. We noted AXA PPP's argument that Shelburne would need investment in order to compete across the full range of services with Chiltern. We thought that this did not provide a rationale for preferring (as more effective) the divestiture of Chiltern over Shelburne, as the investment would be needed whichever hospital were sold. However, we reasoned that such investment was most likely to take place if the hospitals were under separate ownership as it would give both facilities an incentive to compete with one another for consultants, patients and insurer recognition.

78. We reasoned that the divestiture of either Chiltern or Shelburne would be equally effective in increasing the competitive constraints in the local area. While there is some overlap between the catchment areas of Bishops Wood and Chiltern, which serves to increase the apparent effectiveness of divesting Chiltern, this would be addressed via the divestiture of Bishops Wood.

### Implementation

79. [redacted] We took into account the likely impact on the hospitals' EBITDA of a reduction in prices as a result of the increased competition that would be created by the divestiture of one of the hospitals. Our detailed calculations are set out in Appendix 2.5. We

observed that Shelburne had a relatively high level of rent cover,<sup>27</sup> even after taking into account the impact on EBITDAR of the lower prices that an operator could expect to receive following the divestiture of one of the hospitals. This suggests that it should be relatively attractive to purchasers. Similarly, we expect that Chiltern would generate sufficient profits and rent cover to be both attractive to purchasers and viable in the long run.<sup>28</sup>

80. We took into account the potential additional costs of recreating a management team at one of the hospitals, which BMI estimated to be £[§] per year. However, we did not think that, even with this incremental cost, either of the hospitals would be difficult to sell or unviable in the longer run given their absolute levels of (post-divestiture) EBITDA or their rent cover.
81. We did not think that the location of Shelburne—on the site of an NHS hospital—or its lease arrangements would create any additional complications for a divestiture remedy. We note that a large proportion of the hospitals that we are considering for divestiture are [§]. As a general principle, in order to resolve the AEC of weak competitive constraints, we consider that it is sufficient to separate ownership of the operating businesses. We do not think that it is necessary to force the divestiture of property that is not controlled by BMI where this is not required to ensure the success of the divestiture remedy.

### *Conclusions*

82. We concluded that in this local area the divestiture of either Chiltern or Shelburne would be equally effective in increasing the competitive constraints acting on each other. We reasoned that the least onerous effective remedy from BMI's point of view

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<sup>27</sup> Our estimates indicate that post-divestiture rent cover would be at least [§] EBITDAR.

<sup>28</sup> Chiltern is expected to generate post-divestiture EBITDA of between £[§] and £[§], with rent cover of between [§] and [§].

was likely to be the divestiture of [REDACTED]. However, we agreed with BMI that without a compelling reason to specify which hospital should be divested, we should allow BMI to choose.

83. We propose, therefore, that BMI be required to divest the operating business of either Shelburne or Chiltern to a suitable purchaser.
84. We have addressed BMI's other arguments in relation to the proportionality of divestiture remedies, as set out in paragraph 67 above, in Section 2 of the provisional decision on remedies. We do not repeat this discussion here.

## **Chelsfield Park & Sloane**

### ***Introduction***

85. We provisionally found that BMI faces weak competitive constraints in south-east London in the area around its Blackheath, Chelsfield Park, Shirley Oaks, Fawkham Manor and Sloane hospitals.<sup>29</sup> At the time we published our provisional findings, we reasoned that the co-ownership of these hospitals with overlapping catchment areas meant that divestiture may be an effective remedy to the weak competitive constraints identified since it would introduce one or two new competitors into the local market. Therefore, we proposed that BMI should divest both Chelsfield Park and Sloane, which are located in the middle of this cluster, to suitable purchasers.

### ***How the remedy addresses the AEC***

86. The divestiture of these two hospitals would increase the level of competition for patients within their catchment areas by introducing another one or two competitors, addressing directly the weak competitive constraints that give rise to the AEC in this area.

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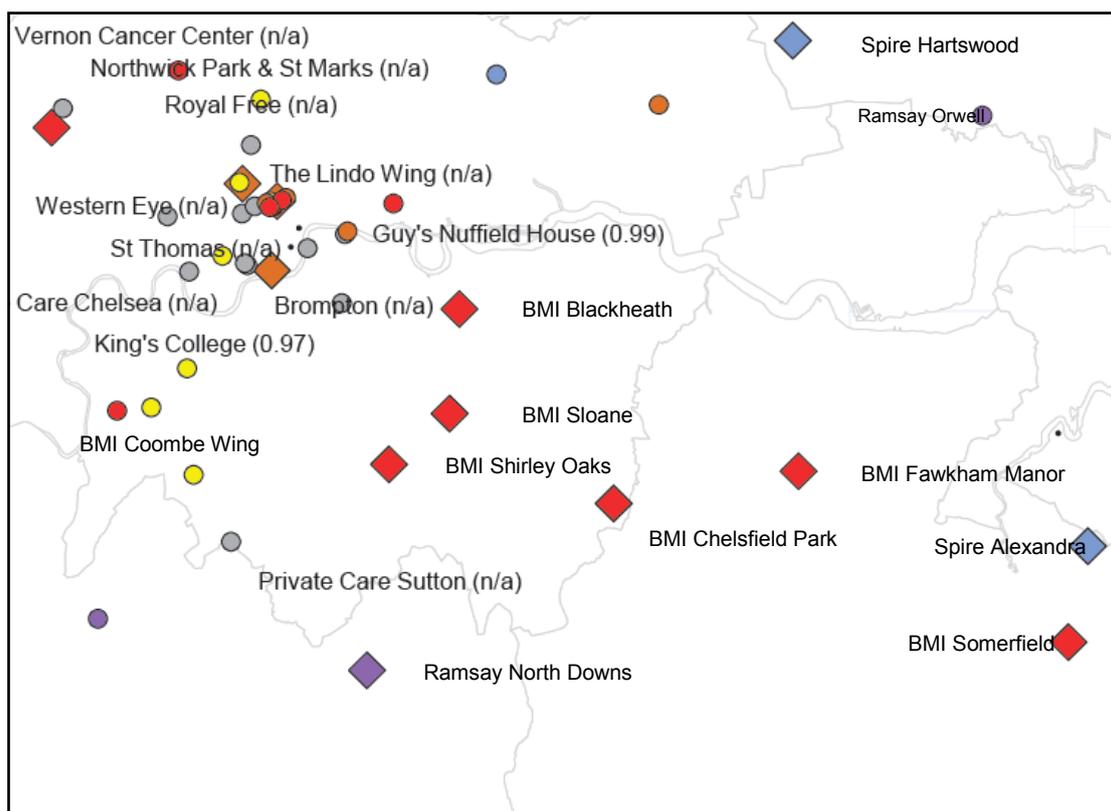
<sup>29</sup> BMI holds weighted average market shares in the catchment areas of these hospitals of between [REDACTED] and [REDACTED] per cent.

**Background**

- 87. BMI Sloane is a 32-bed, two-theatre hospital, with a catchment area of [X] miles, located in Beckenham, Kent. There are a number of other BMI hospitals located in close proximity to Sloane, including Shirley Oaks (4 miles away), Blackheath (5 miles away) and Chelsfield Park (9 miles away).
- 88. There are no competitors' hospitals located within Sloane's catchment area, although a number of hospitals have catchment areas which overlap with that of Sloane, including St Anthony's, Parkside (Aspen), The Royal Marsden NHS Trust's Private Care Sutton, King's College (NHS) Hospital and Ramsay North Downs.

FIGURE 13

**Map of private hospitals in the south-east Greater London area**



Source: CC analysis.

89. Sloane offers a full range of medical services but does not have a critical care unit. The hospital has a [redacted] private patients, which account for approximately [redacted] per cent of admissions.
90. BMI Shirley Oaks is a 43-bed, three-theatre private hospital with critical care level 2 facilities located in Croydon. It has a catchment area of [redacted] miles, [redacted]. Shirley Oaks offers a full range of medical services, including oncology, and does a [redacted]<sup>30</sup> proportion of NHS work, with NHS patients comprising just under [redacted] per cent of total admissions in 2011.
91. BMI Chelsfield Park is a 35-bed, two-theatre private hospital with critical care level 2 facilities, located in Orpington, Kent. It has a catchment area of [redacted] miles, which [redacted]. Chelsfield offers a full range of medical services, including oncology, and has a [redacted] on private patients, which account for almost [redacted] per cent of its admissions. The closest competitor to Chelsfield Park is Ramsay North Downs, which is 18 miles away. There is limited overlap between the catchment areas of the two hospitals.
92. Fawkham Manor is a 35-bed, two-theatre hospital with critical care level 2 facilities, located in Longfield,<sup>31</sup> Kent. It has a catchment area of [redacted] miles. The nearest competitor hospital is the Spire Alexandra, 17 miles away in Chatham. Fawkham Manor offers a full range of medical services. Around [redacted] of its admissions were NHS patients in 2011.
93. Ramsay North Downs has 20 beds and two operating theatres, as well as critical care level 2 facilities. Spire Alexandra has 30 beds, two operating theatres and critical care level 2 facilities. Ramsay North Downs offers a more limited range of medical treatments, comprising 13 of the 17 of the specialties used in our assess-

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<sup>30</sup> [redacted]

<sup>31</sup> Longfield is located between Dartford and Sevenoaks in Kent.

ment, while Spire Alexandra offers all 17 medical specialties used in our local assessments.

94. BMI Blackheath is a 75-bed, four-theatre private hospital with critical care level 3 facilities. It offers a full range of medical services to patients.
95. We have found that all five of the BMI hospitals in this area face insufficient competitive constraints.

### ***What the parties told us***

#### ***BMI***

96. BMI argued that the CC had provided no or insufficient evidence that Chelsfield Park and Sloane were insufficiently constrained, nor that common ownership had ever been a feature of negotiations with insurers. It put forward the view that divestiture would be ineffective as a remedy for both insured and self-pay patients since these hospitals faced sufficient constraints from the Princess Royal University Hospital PPU, HCA Sevenoaks Medical Centre, Aspen Parkside, St Anthony's, the New Victoria Hospital, Private Care Sutton (part of the Royal Marsden PPU) and central London facilities. BMI highlighted that both Fawkham Manor and Shirley Oaks were delisted by Bupa during its dispute with BMI and that, although Chelsfield Park and Sloane were not delisted, neither was included in Bupa's list of alternative facilities to Fawkham Manor and Shirley Oaks. BMI noted that this indicated that Bupa was able to shift all of its demand away from the Chelsfield Park/Sloane 'cluster' and therefore that divestment of either or both of these facilities would not change the relative negotiating position with insurers, which have suitable and sufficient outside options.
97. In addition, notwithstanding its position that there was no correlation between concentration and self-pay prices for BMI or at all, BMI noted that the CC's survey

evidence showed that self-pay patients were prepared to travel further than insured patients and that this meant that a larger number of hospitals competed for these patients, including the Royal Brompton & Harefield PPU, The Wells Suite PPU, Nuffield's Tunbridge Wells and Brentwood hospitals, Spire's Tunbridge Wells, Gatwick Park and Hartswood hospitals and the Orwell Cardiothoracic PPU.

98. BMI also argued that the divestiture of Chelsfield Park and Sloane would be disproportionate since it would:
- (a) end BMI's current customer-benefits-focused strategy, [REDACTED]. BMI noted that the divestment of either hospital would end such an investment strategy to the ultimate detriment of patients;
  - (b) be likely to take place at an undervalue [REDACTED]; and
  - (c) even if it were considered effective in remedying any hypothetical AEC, even on the CC's case benefit only private inpatients who were either self-pay or insured by an insurer other than Bupa, which BMI stated the evidence overwhelmingly showed had fully countervailing buyer power. BMI noted that such patients comprised only [REDACTED] to [REDACTED] per cent of total patients at its Sloane and Chelsfield facilities (only [REDACTED] and [REDACTED] per cent if Bupa-funded patients were included), with the remaining [REDACTED] to [REDACTED] per cent of patients receiving no benefit and being (at the least) inconvenienced by the divestiture of one of these hospitals. Moreover, of these, only a proportion lived in areas that, on the CC's catchment area analysis, would see an improvement in choice.

99. Given these points, BMI stated that a divestment of either Sloane or Chelsfield could not satisfy the double proportionality approach set out in the CAT's judgement in *Tesco v Competition Commission*.<sup>32</sup>

### *Bupa*

100. Bupa agreed with our initial analysis that the divestment of both Chelsfield Park and Sloane would be the most effective divestment option in south-east London, noting that the divestiture of a single facility would be ineffective that it was its understanding that the facilities had relatively solid financial performance which should increase their attractiveness of potential purchasers, increasing the probability of realizing a successful divestment.

### *AXA PPP*

101. AXA PP supported the divestiture of both Chelsfield Park and Sloane, noting that it currently had little opportunity to carry out a competitive tender in this area and [X]. AXA PPP agreed with our reasoning that the greatest effect would be achieved by breaking up the centre of the cluster, ie requiring the divestiture of Chelsfield and Sloane rather than other facilities in this area.
102. AXA PPP further believed that the facilities should be sold to two separate providers to achieve maximum opportunity for competition and to avoid creating another cluster. In this case, AXA PPP believed that it would have the opportunity to carry out a tender and exclude facilities where effective prices could not be achieved.

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<sup>32</sup> *Tesco Plc v Competition Commission (2009) CAT 6*, paragraph 139.

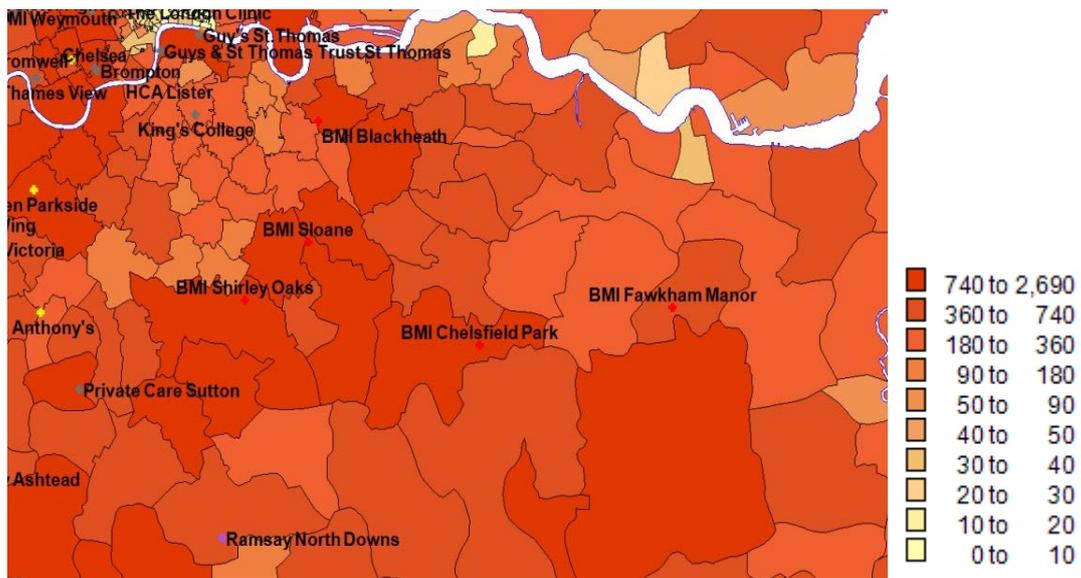
## **Assessment**

### *Design considerations*

103. We considered how the factors set out in paragraph 3 would be likely to affect the effectiveness of divestiture in this area, taking into account the views of the parties, as set out above.
104. We noted that all these facilities offered a broad range of medical specialties, indicating that they would be able to compete with each other for the large majority of patients, although some of the hospitals offered higher acuity services than others. We reasoned that the close proximity of Blackheath, Sloane and Shirley Oaks, with each of these hospitals located within the catchment area of the other two, meant that they were serving a similar geographic base of patients. Therefore, if one of these three facilities were separately owned, it could act as a substitute/alternative for the other hospitals from the point of view of both insurers and self-pay patients. Although Sloane does not have ICU facilities, we considered that its location in the centre of the cluster would make it an effective constraint on the other two hospitals. Alternatively, we thought that Shirley Oaks' ICU level 2 facilities could augment the level of constraint that it would offer despite its position on the edge of this cluster. On balance, we thought that if either of these hospitals were to be divested, it would increase the level of constraint as compared with the current situation where the nearest competitors are located a reasonable distance away to the west and to the south of the cluster. We reasoned that either divestiture (Sloane or Shirley Oaks) would be likely to be equally effective.

FIGURE 14

Density of insured patients, south-east Greater London



Source: CC analysis of Healthcode data, 2009 to 2012.

105. We observed that this area had a high density of private patients, particularly in the postcodes between Chelsfield Park, Sloane and Shirley Oaks, which suggests that a large number of patients would benefit from any increase in competitive constraints.
106. We next considered the size and capacity (utilization) of the hospitals. We thought that divestiture would be most effective where it gave insurers the ability to exclude at least one operator's hospitals from their networks. As set out in Table 4, [✂] utilization is relatively high at these facilities, such that a single hospital, such as Sloane or Shirley Oaks, would not be able to absorb all the demand of any one of the larger insurers (Bupa and AXA), although it might be able to do so for the smaller insurers. We reasoned that the capacity constraints of BMI's hospitals in this area were particularly pertinent due to the lack of nearby competitors who might also facilitate the switching of volumes by insurers, allowing the latter to exert pressure on private hospital prices.

TABLE 4 BMI south-east London hospitals, capacity utilization

	Utilization (theatres)				Utilization (beds)				per cent
	FY2009	FY2010	FY2011	YTD Jul 2012	FY2009	FY2010	FY2011	YTD Jul 2012	
Chelsfield Park	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Sloane	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Blackheath	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Shirley Oaks	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Fawkham Manor	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Source: BMI.

107. We concluded, therefore, that a second hospital should be divested from this BMI cluster in order to ensure the effectiveness of this remedy. Both Chelsfield Park and Fawkham Manor offer ICU facilities but we considered, on balance, that Chelsfield Park would be the more effective divestiture on the basis that it is located closer to the centre of the cluster and would, therefore, create a greater competitive constraint on both the remaining BMI hospitals and the other divested facility, whether it was Sloane or Shirley Oaks.

#### *Implementation*

108. [REDACTED] We examined the likely level of EBITDA and rent cover following a divestiture. See Appendix 2.5 for our detailed analysis on the impact of divestitures on the revenue and profits of the hospitals in areas where divestitures are required.

109. We concluded that Sloane was likely to be saleable since, post-divestiture, the hospital would have rent cover in excess of [REDACTED] EBITDAR, as well as a reasonable absolute level of EBITDA. However, we were concerned that Chelsfield Park and Shirley Oaks may not attract interest and/or may not be able to compete effectively post-divestiture with their [REDACTED] in place as our analysis suggests that following divestiture these facilities would have a rent cover of approximately [REDACTED] EBITDAR, as well as [REDACTED] profit (about £[REDACTED] million per year [REDACTED]).

110. We considered, therefore, whether Chelsfield Park and Shirley Oaks would be more likely to attract interest and compete effectively if an alternative divestiture package were specified; in particular, if the operating and the property company for each hospital were sold together, [X], we thought that this would make a significant difference. We concluded that, if packaged in this way, both hospitals could be sold and would be able to compete effectively against BMI's other hospitals in south-east London. Therefore, in the case where either Chelsfield or Shirley Oaks were to be sold, we considered that the appropriate divestiture package to specify would be the combined operations and property of the hospitals, rather than the operating businesses only.

#### *Conclusions*

111. We concluded that in this local area the divestiture of two hospitals would be necessary in order to create an effective competitive constraint on all of the BMI facilities in this area. The sale of a single hospital would not allow insurers to create a network in this area of the country that did not include at least one BMI hospital and hence would be significantly less effective as a remedy. In determining which hospitals should be sold, we thought that either Shirley Oaks or Sloane would create an equivalent increase in competitive constraint but that Fawkham Manor would be less effective than Chelsfield Park due to its location at the edge of the cluster and a greater distance from the other hospitals within the cluster.

112. We propose, therefore, that BMI should be required to sell:

- (a) the operating business of either Sloane or Shirley Oaks; and
- (b) the operating business of Chelsfield Park.

113. In addition, in order to ensure the successful divestiture of these assets, as well as the ongoing competitive effectiveness of the divested hospitals, we thought that it

was likely to be necessary to require [redacted]<sup>33</sup> to sell the Chelsfield Park property to the same purchaser that acquires the operating business and, if Shirley Oaks is sold, the Shirley Oaks property to the same purchaser that acquires the operating business. We consider that this alternative, more extensive, divestiture package may be required to ensure the marketability of the package and hence the effectiveness of the remedy. We believe that this alternative divestiture package is likely to represent the least onerous, effective measure that is required to achieve the aim of increasing competitive constraints in this local area. The two hospitals should be divested to different suitable purchasers in order to ensure the effectiveness of the remedy.

114. We have addressed BMI's other arguments in relation to the proportionality of divestiture remedies, as set out in paragraph 98 above, in Section 2 of the provisional decision on remedies. We do not repeat this discussion here.

## **Priory/Edgbaston & Droitwich Spa**

### ***Introduction***

115. We provisionally found that BMI faces weak competitive constraints in the West Midlands where its Priory, Edgbaston, Droitwich Spa and Meriden hospitals are located.<sup>34</sup> At the time we published our provisional findings, we reasoned that the co-ownership of four hospitals with overlapping catchment areas meant that divestiture may be an effective remedy to the weak competitive constraints identified since it would introduce one or two new competitors into the local market. Therefore, we proposed that BMI should divest either Priory or both Edgbaston and Droitwich Spa to a suitable purchaser or purchasers.

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<sup>33</sup> [redacted]

<sup>34</sup> BMI holds a weighted average market share of between [redacted] and [redacted] per cent in the catchment areas of these hospitals.

116. Following a review of the competitive constraints acting on the hospitals in this area, we have revised our assessment and concluded that BMI Edgbaston is sufficiently constrained. We have reflected this conclusion in our analysis below.

*How the remedy addresses the AEC*

117. The divestiture of one or two of these hospitals would increase the level of competition for patients within their catchment areas by introducing another one or two competitors, addressing directly the weak competitive constraints that give rise to the AEC in this area.

*Background*

118. BMI Priory (Birmingham) is a 118-bed, six-theatre private hospital with critical care level 3 facilities. The hospital has a catchment area of [REDACTED] miles, which [REDACTED].

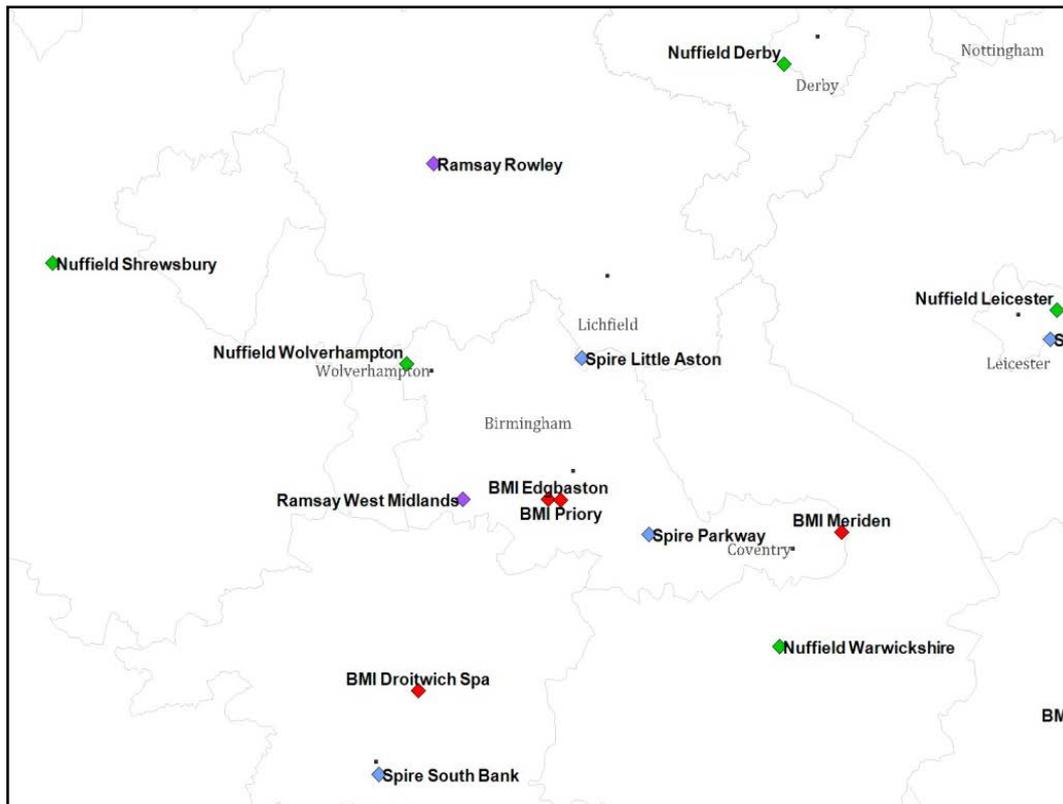
119. BMI Edgbaston is a 55-bed, three-theatre private hospital with critical care level 2 facilities. It has a [REDACTED] catchment area of [REDACTED] miles, which is driven by [REDACTED] (for which its catchment area is [REDACTED] miles).<sup>35</sup> Edgbaston offers a broad range of medical services, covering the 16 mainstream medical specialties. BMI's Edgbaston and Priory hospitals are 1 mile apart.

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<sup>35</sup> BMI Edgbaston has [REDACTED].

FIGURE 15

**Map of private hospitals in the Birmingham area**



Source: CC analysis.

120. There are two further BMI hospitals in the Birmingham area, BMI Droitwich Spa which is 18.5 miles from the Priory, and BMI Meriden (in Coventry) which is 28 miles from the Priory. Droitwich has 46 beds and four operating theatres, while Meriden has 46 beds and three operating theatres. Both of these hospitals have critical care level 2 facilities, provide a full range of medical services and have catchment areas of approximately [X] miles. In addition, both BMI's Droitwich and Meriden hospitals do [X] NHS work, accounting for [X] and [X] per cent of their admissions respectively.
121. There are four main competitors to BMI's Birmingham hospitals which are located within the catchment areas of Edgbaston and Priory:
- (a) Spire Parkway, which is 8 miles from the Priory to the south-east in Solihull;

(b) Ramsay West Midlands Hospital, which is 7 miles away to the west of Birmingham (Halesowen);

(c) Spire Little Aston, which is 15 miles to the north in Sutton Coldfield; and

(d) Nuffield Wolverhampton, which is 16 miles away to the north-west.

122. Spire Parkway has 50 beds and three operating theatres, as well as critical care level 3 facilities. Ramsay West Midlands has 30 beds and two operating theatres. It does not have critical care facilities. Spire Little Aston has 48 beds, three operating theatres and critical care level 2 facilities. Nuffield Wolverhampton has 42 beds and three operating theatres. It does not have critical care facilities. Spire South Bank has 38 beds, three operating theatres and critical care level 2 facilities. Four of these hospitals offer a full range of healthcare services to patients, comprising all 17 of the specialties used in our assessment. The fifth (Ramsay West Midlands) offers 15 of the specialties used in our assessment.

123. In addition, the Priory competes with the PPU of the Queen Elizabeth Hospital in Birmingham, which has a 20-bed critical care (level 3) unit, giving it strength in high-acuity work. BMI indicated that its Priory and Edgbaston hospitals [redacted]. Priory offers a full range of medical services, with [redacted] per cent of its patients coming from the NHS.

124. We have found that Priory, Meriden and Droitwich Spa are insufficiently constrained by competition, whereas Edgbaston is sufficiently constrained.

### ***What the parties told us***

#### ***BMI***

125. BMI argued that the CC had provided no or insufficient evidence that Priory, Edgbaston, Droitwich Spa and Meriden were insufficiently constrained, nor that

common ownership had ever been a feature of negotiations with insurers. It noted that Priory and Edgbaston [REDACTED].

126. BMI told the CC that divestiture would be ineffective as a remedy for both insured and self-pay patients since its hospitals in the West Midlands faced sufficient constraints from Spire's Parkway, Little Aston and South Bank facilities, Ramsay's West Midlands and Rowley hospitals, Nuffield Wolverhampton, The Hospital Group in Bromsgrove and the Queen Elizabeth Hospital (NHS FT). It also noted that the CC had not considered the impact and commercial implications of Circle's proposed new entry into Birmingham. BMI highlighted that Bupa delisted all four of the hospitals during its dispute with BMI, indicating that Bupa is able to shift all of its demand away from BMI hospitals in this area and therefore that divestment of any one or two of the facilities would not change the relative negotiating position with insurers. It also highlighted that [REDACTED]. BMI argued that this demonstrated that insurers had suitable and sufficient outside options, [REDACTED].
127. In addition, in relation to self-pay patients, BMI noted that—notwithstanding its argument that there was no correlation between concentration and self-pay prices in respect of BMI or at all—the CC's survey evidence showed that self-pay patients were prepared to travel further than insured patients and that this meant that a larger number of hospitals competed for these patients, including the Royal Orthopaedic, Gloucester Royal and Cheltenham General PPU's, Nuffield's Cheltenham and Warwickshire hospitals, and Ramsay Winfield.
128. BMI also argued that the divestiture of any of its hospitals in this area would be disproportionate since it would:
  - (a) remove efficiencies from BMI's operations by reducing economies of scale and synergies [REDACTED]. In addition, BMI noted that [REDACTED];

- (b) end BMI's current customer-benefits-focused strategy, [REDACTED]. BMI noted that the divestment of either Priory or Edgbaston would end such an investment strategy to the ultimate detriment of patients;
- (c) be likely to take place at an undervalue [REDACTED], BMI stated that the CC would be likely to believe that there would be a limited pool of potential purchasers for the hospital, reducing the price received and the certainty of the effectiveness of the remedy; and
- (d) even if it were considered effective in remedying any hypothetical AEC, even on the CC's case, benefit only private inpatients who were either self-pay or insured by an insurer other than Bupa, which BMI stated that the evidence overwhelmingly showed had fully countervailing buyer power. BMI noted that such patients comprised only [REDACTED], [REDACTED] and [REDACTED] per cent of total patients at its Edgbaston, Priory and Droitwich Spa hospitals respectively ([REDACTED] per cent even if Bupa-funded patients were included), with the remaining [REDACTED] to [REDACTED] per cent of patients receiving no benefit and being (at the least) inconvenienced by the divestiture of one of these hospitals. Moreover, of these, only a proportion lived in areas that, on the CC's catchment area analysis, would see an improvement in choice.

129. Given these arguments, BMI argued that a divestment of either Priory, Edgbaston or Edgbaston and Droitwich Spa could not satisfy the double proportionality approach set out in the CAT's judgement in *Tesco v Competition Commission*.<sup>36</sup>
130. BMI argued that the CC had a responsibility to choose the least onerous divestiture package that would be effective and that, on the basis that the CC wished to separate the ownership of Priory and Edgbaston, it was not clear why it would be necessary to include Droitwich Spa in the divestiture package.

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<sup>36</sup> *Tesco Plc v Competition Commission (2009) CAT 6*, paragraph 139.

131. Finally, BMI put forward the view that unless the CC could motivate a powerful and compelling case, supported by robust evidence that a particular hospital must be divested, the principle of proportionality would call for the choice to be made by BMI.

*Bupa*

132. Bupa argued that the divestment of the Priory Hospital, rather than Edgbaston and Droitwich Spa, had a significantly higher probability of promoting effective competition in this cluster on the grounds that:

(a) [REDACTED], a new owner would need to invest heavily in developing the facility causing a delay in the competitive pressure that would be exerted in the local market.

(b) Bupa did not have any [REDACTED] spend at either Edgbaston or Droitwich in 2012, hence divestiture of these hospitals would result in little increase in competition for this key specialty.

(c) The large size of Priory would make it more attractive to potential purchasers and therefore more likely to be successfully sold. In addition, the sale of Priory would do more to reduce the scale of BMI, which Bupa suggested enabled it to exert market power during national negotiations with PMIs.

*AXA PPP*

133. AXA PPP told the CC that it did not consider that the divestiture of Droitwich Spa would increase contestability in this area and hence did not support such a divestiture. It noted that it was ambivalent regarding the divestiture of BMI Edgbaston as the facility would require significant investment in order to compete effectively with BMI Priory, and it did not believe that such investment was likely to happen in the short term.

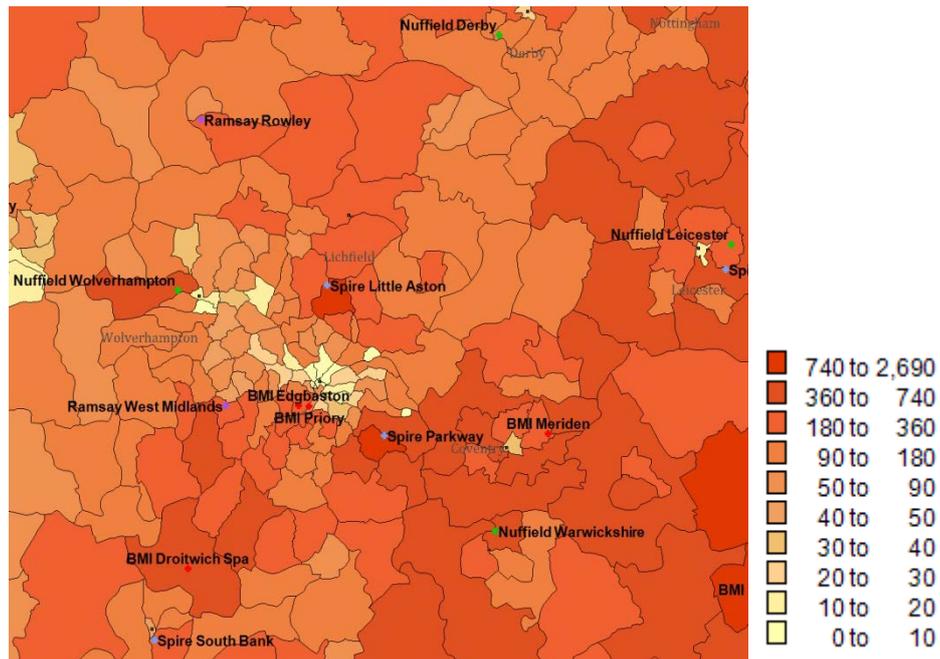
## **Assessment**

### *Design considerations*

134. We considered how the factors set out in paragraph 3 would be likely to affect the effectiveness of divestitures in this area, taking into account the views of the parties as set out above.
135. In the first instance, we examined in detail the postcodes from which Priory drew the majority of its insured patients and compared the overlap with the catchment areas of both its competitors and BMI Edgbaston and Droitwich Spa. We observed that in a number of the postcodes with a concentration of Priory-insured patients, which tended to be areas of high PMI penetration, at least one competitor hospital also served a large number of patients. This suggests that in these areas patients had the choice of at least two providers. We concluded that Priory was insufficiently constrained overall in large part due to its differentiated service offering, which included critical care level 3 facilities. However, we noted that the divestiture of one or more of BMI's facilities in this area would not, therefore, serve to increase the competitive constraint on this facility appreciably since no other BMI hospital in the area offered the same level of critical care services. AXA PPP's argument that Edgbaston would need a very significant level of investment to compete effectively with Priory supports this conclusion.

FIGURE 16

Density of insured patients, Birmingham area



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 17

BMI Priory catchment area



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 18

BMI Edgbaston catchment area



Source: CC analysis of Healthcode data, 2009 to 2012.

136. We observed that Edgbaston's catchment area was [redacted]. While we thought, therefore, that if Edgbaston were separately owned, there may be some increase in competition for [redacted] patients in the Birmingham area, we did not believe that this would increase competition significantly in other medical specialties.

137. We next considered whether the divestiture of Droitwich would increase the competitive constraints on this hospital such that it might be an effective remedy for the hospital's market power. We observed that, in the case where Droitwich were divested, the focus of the increase in competition would be for the patients located between Droitwich Spa and Birmingham who required the relatively more routine services offered by both hospitals. We observed that the road connections in this area (particularly the M5 and M42) suggested that both the Ramsay facility at Halesowen and the Spire Parkway facility in Solihull were likely to be as convenient, or more convenient, than either Priory or Edgbaston for patients travelling in to Birmingham for treatment from the direction of Droitwich Spa. We concluded, therefore, that divestiture of Droitwich (or Priory) would not significantly increase the competitive constraints acting on BMI Droitwich compared with the current situation.
138. Finally, we considered whether the divestiture of Meriden would increase the level of competition in this area. We reasoned that it would not, as a result of its relatively large distance from the other BMI facilities and its positioning to the east of Coventry with Spire Parkway located between Meriden and BMI's other hospitals in this area.
139. [REDACTED] However, this argument suggests that the AEC in relation to BMI arises from its national scale rather than simply the sum of its market power in a number of local markets. We did not find any support for the former theory in our provisional findings. We have not, therefore, taken this into account in considering the effectiveness of our remedies.
140. Having concluded that divestiture would not be an effective remedy for the AEC identified in this area, we did not examine the other questions raised by BMI, Bupa and AXA PPP further.

### *Conclusions*

141. We concluded that BMI should not be required to make any divestitures in the Birmingham area as we did not consider that divestiture was likely to be an effective remedy to the AEC identified in this area.

## **Saxon Clinic**

### ***Introduction***

142. We provisionally found that BMI faces weak competitive constraints in the area around its Saxon Clinic, Manor and Three Shires hospitals (in the Milton Keynes, Bedford, Northampton area).<sup>37</sup> At the time we published our provisional findings, we reasoned that the co-ownership of three hospitals with overlapping catchment areas meant that divestiture may be an effective remedy to the weak competitive constraints identified since it would introduce a new competitor into the local market. Therefore, we proposed that BMI should divest the Saxon Clinic to a suitable purchaser.

### *How the remedy addresses the AEC*

143. The divestiture of one of these three hospitals would increase the level of competition for patients within their catchment areas by introducing another competitor, addressing directly the weak competitive constraints that give rise to the AEC in this area.

### *Background*

144. BMI Saxon Clinic is a 37-bed, three-theatre private hospital located in Milton Keynes. The hospital has a catchment area of [X] miles, which [X]. These are the BMI Manor Hospital in Bedford, the BMI Three Shires Hospital in Northampton and the BMI Foscote Hospital in Banbury. Manor is located 18 miles from the Saxon Clinic and has a catchment area of [X] miles, whilst Three Shires is located 21 miles away

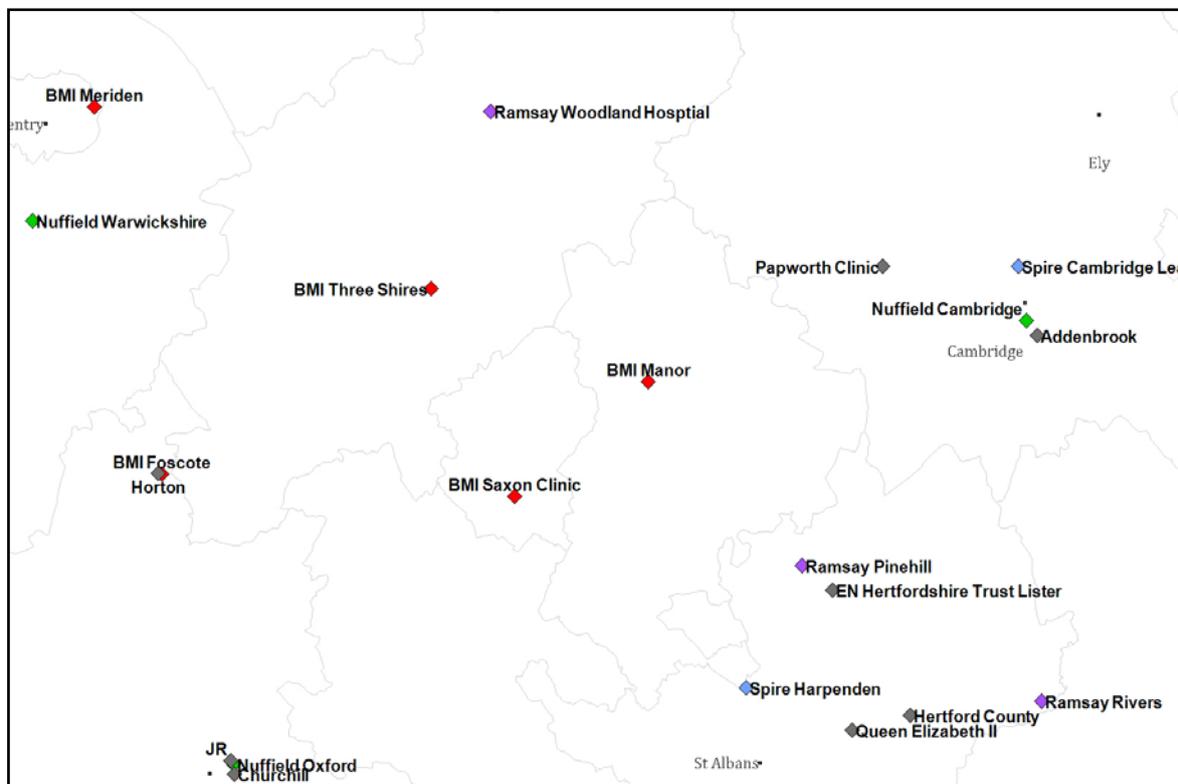
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<sup>37</sup> BMI holds a weighted average market share of between [X] and [X] per cent in the catchment areas of these hospitals.

and has a catchment area of [X] miles. ([X]). We have, therefore, excluded Foscoote from the following analysis.)

FIGURE 19

**Map of private hospitals in the Midlands**



Source: CC analysis.

145. The nearest competitor hospitals to Saxon Clinic are Ramsay Pinehill (Luton) and Spire Harpenden. Pinehill is 30 miles from the Saxon Clinic and Harpenden is 26 miles away, such that these hospitals' catchment areas overlap to a very minor extent with that of Saxon Clinic.

146. Spire Harpenden has 67 beds and four operating theatres, as well as critical care level 2 facilities. Ramsay Pinehill has 41 beds, four operating theatres<sup>38</sup> and critical care level 2 facilities. Ramsay Woodland has 34 beds, four operating theatres<sup>39</sup> and

<sup>38</sup> Including an endoscopy theatre.

<sup>39</sup> Including an endoscopy theatre.

critical care level 2 facilities. These three hospitals offer a large number of healthcare services to patients: Pinehill and Harpenden offer all 17 of the specialties used in our assessments while Woodland offers 15.

147. All three of BMI's hospitals in this area offer a broad range of 16 or 17 of the main-stream medical specialities, although only Three Shires has critical care facilities (level 2). [REDACTED] In contrast, around [REDACTED] of Manor's and Saxon Clinic's admissions are NHS patients.
148. We have found that all three of BMI's hospitals in this area face insufficient competitive constraints.

### ***What the parties told us***

#### ***BMI***

149. BMI noted that its catchment areas showed no overlap between Three Shires and Manor and [REDACTED] between Saxon Clinic and Manor such that it was incumbent on the CC to adduce compelling evidence of uncompetitive market outcomes arising from Manor and Three Shires' status as part of a 'cluster'. BMI highlighted that Three Shires and Manor had been classified as 'solus' in the CC's working paper 'Local competition assessment of hospitals of potential concern'. A solus hospital is typically described as such because it is the only hospital in a given market, but by including solus hospitals in a cluster, the CC anticipates that there is diversion between the solus hospitals and others.
150. BMI stated that the CC had provided no or insufficient evidence that Saxon Clinic, Manor and Three Shires were insufficiently constrained, nor that common ownership had ever been a feature of negotiations with insurers. It put forward the view that divestiture would be ineffective as a remedy for both insured and self-pay patients

since these hospitals faced sufficient constraints from Nuffield's Oxford, Cambridge and Warwickshire hospitals, Spire's Harpenden, Bushey, Papworth, Cambridge Lea and Leicester facilities, Ramsay's Pinehill and Woodland hospitals, and the Royal National Orthopaedic Hospital and Luton & Dunstable PUs. BMI highlighted that Manor was delisted by Bupa during its dispute with BMI and that, although neither Saxon nor Three Shires were delisted, they were also not included in Bupa's list of alternative facilities to Manor. BMI noted that this indicated that Bupa was able to shift all of its demand away from the cluster of BMI hospitals in this area.

151. In relation to self-pay patients, BMI noted that the evidence did not show a correlation between prices in terms of self-pay patients and concentration in respect of BMI or at all. Nonetheless, given that the CC's own patient survey evidence showed that self-pay patients could and did travel further than insured patients, the CC had also not considered the correct competitor set. BMI considered that there was no rational basis to consider that divestment would be effective in lowering self-pay prices.
152. BMI also argued that the divestiture of Saxon Clinic would be disproportionate since it would:
- (a) be likely to take place at an undervalue [REDACTED];
  - (b) even if considered effective in remedying any hypothetical AEC, even on the CC's case benefit only private inpatients who were either self-pay or insured by an insurer other than Bupa, which BMI stated the evidence overwhelmingly showed had fully countervailing buyer power. BMI noted that such patients comprised only [REDACTED] to [REDACTED] per cent of total patients at its Saxon Clinic and Manor facilities ([REDACTED] and [REDACTED] per cent if Bupa-funded patients were included), with the remaining [REDACTED] to [REDACTED] per cent of patients receiving no benefit and being (at the least) inconvenienced by the divestiture of one of these hospitals. On the basis of

its estimates of overlap, BMI suggested that this remedy was likely to benefit [REDACTED] patients using Saxon Clinic.

153. Given these points, BMI stated that a divestment of either Saxon Clinic, Manor or Three Shires could not satisfy the double proportionality approach set out in the CAT's judgement in *Tesco v Competition Commission*.<sup>40</sup>

154. Finally, BMI put forward the view that unless the CC could motivate a powerful and compelling case, supported by robust evidence that a particular hospital must be divested, the principle of proportionality would call for the choice to be made by BMI. It also highlighted the CC's acknowledgement in respect of Lincoln/Park that divestment was not an appropriate remedy where the impact of any anticipated increase in competition was likely to be limited to a relatively small number of patients in the overlap area, which applied in this cluster as well as more broadly.

### *Bupa*

155. Bupa agreed with the CC's preliminary suggestion that the Saxon Clinic should be divested, noting that the three hospitals in this area shared a [REDACTED] in key specialisms and that they were [REDACTED].

### *AXA PPP*

156. AXA PPP supported the divestiture of the Saxon Clinic on the basis that if it were owned by an alternative provider, AXA PPP would be able to carry out a competitive tender in the area and exclude, or have a credible threat of excluding, one of the facilities.

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<sup>40</sup> *Tesco Plc v Competition Commission (2009) CAT 6*, paragraph 139.

## **Assessment**

### *Design considerations*

157. We considered how the factors set out in paragraph 3 would be likely to affect the effectiveness of divestiture in this area, taking into account the views of the parties as set out above.
158. We examined BMI's argument regarding the level of overlap using information on the individual postcodes from which insured patients were drawn for each hospital. We observed that there was some overlap, although each hospital had different areas of focus. On the other hand, we noted AXA PPP's view that, if the hospitals were separately owned, it could run a tender in this area in order to exert downward pressure on prices, which suggests that the hospitals may be substitutable from an insurer's perspective.
159. We reasoned that, in the case where one of these three hospitals were divested, the focus of the increase in competition would be for the patients located in the triangle between them. There is a very high density of insured patients in the postcodes to the south of Three Shires, with reasonable density in the rest of the area, indicating that under separate ownership, these facilities would have an incentive to compete strongly for this sizeable local market. We thought that the road connections in this area (particularly the M1) meant that Three Shires and Saxon Clinic could compete more strongly with one another than either would with Manor despite the slightly larger distance between them.<sup>41</sup>
160. We concluded, therefore, that divestiture of either Saxon Clinic or Three Shires would significantly increase the competitive constraints acting on all three of the BMI

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<sup>41</sup> Manor is located in Bedford with A-road connections to both Milton Keynes and Northampton rather than motorways.

hospitals in this area compared with the current situation where they face insufficient competitive constraints.

FIGURE 20

### Density of insured patients in the Bedford, Milton Keynes and Northampton area



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 21

### Saxon Clinic catchment areas



Source: CC analysis of Healthcode data.

FIGURE 22

### Three Shires catchment areas



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 23

### Manor catchment areas catchment areas



Source: CC analysis of Healthcode data, 2009 to 2012.

161. We thought that the broad range of medical specialities offered by all three hospitals (16 or 17 of the mainstream medical specialities) meant that they would be able to compete for the same patients if they were under separate ownership. The size of the hospitals and the level of spare capacity suggest that insurers would be able to switch their volumes between them and could, therefore, credibly threaten not to recognize all of the facilities.

TABLE 5 Saxon Clinic, Manor and Three Shires capacity utilization

	<i>Utilization (theatres)</i>				<i>Utilisation (beds)</i>			
	<i>FY2009</i>	<i>FY2010</i>	<i>FY 2011</i>	<i>YTD Jul 2012</i>	<i>FY2009</i>	<i>FY2010</i>	<i>FY 2011</i>	<i>YTD Jul 2012</i>
Saxon Clinic	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Manor	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Three Shires	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Source: BMI.

### *Implementation*

162. Finally, we considered whether the facilities were likely to attract suitable purchasers and whether they would be viable and effective competitors in the longer run. We estimated the likely level of EBITDA and rent cover following a divestiture, taking into account the impact of increased competition on revenues and profits.<sup>42</sup> We concluded that Saxon Clinic was reasonably likely to attract purchaser interest given its post-divestiture level of rent cover of [redacted] EBITDAR and its post-divestiture EBITDA of just over £[redacted] million.

163. We did not have sufficient financial information (revenue figures) on Three Shires to estimate its post-divestiture EBITDA. However, we noted that the facility is managed by BMI on behalf of Three Shires Hospital Ltd and that it currently generates a [redacted] EBITDA for BMI (just over £[redacted] million in FY11) than Saxon Clinic. We considered,

<sup>42</sup> See Appendix 2.5 for our detailed calculations of post-divestiture EBITDA.

therefore, that a number of hospital operators would have a strong interest in acquiring this management contract.

### *Conclusions*

164. We concluded that the sale of either Saxon Clinic or Three Shires would increase the competitive constraints acting on all the BMI hospitals in this area sufficient to remedy or mitigate the AEC we have found. We thought that the sale of Manor would be somewhat less effective due to its poorer road connections to the other BMI facilities that might discourage patients from travelling between the hospitals. We agreed with BMI that in the absence of a compelling reason to specify which hospital should be divested, we should allow BMI to choose.
165. We propose, therefore, that BMI be required to divest either the operating business of its Saxon Clinic hospital, or the management contract over the Three Shires Hospital, to a suitable purchaser. If BMI is unable to divest either one of these businesses, we consider that it will be necessary to specify an alternative divestiture package that would attract greater interest from potential purchasers. We note that this package may include the freehold property of Saxon Clinic, which we would require to be divested in combination with the operating business.
166. We have addressed BMI's other arguments in relation to the proportionality of divestiture remedies, as set out in paragraph 152 above, in Section 2 of the provisional decision on remedies. We do not repeat this discussion here.

## **Beardwood and Highfield**

### ***Introduction***

167. We provisionally found that BMI faces weak competitive constraints in the area around its Beardwood, Gisburne Park, Beaumont, Highfield and Alexandra

hospitals.<sup>43</sup> At the time we published our provisional findings, we reasoned that the co-ownership of five hospitals with overlapping catchment areas meant that divestiture may be an effective remedy to the weak competitive constraints identified since it would introduce one or two new competitors into the local market. Therefore, we proposed that BMI should divest both Beardwood and Highfield hospitals to suitable purchasers.

### *How the remedy addresses the AEC*

168. The divestiture of these two hospitals would increase the level of competition for patients within their catchment areas by introducing another one or two competitors, addressing directly the weak competitive constraints that give rise to the AEC in this area.

### *Background*

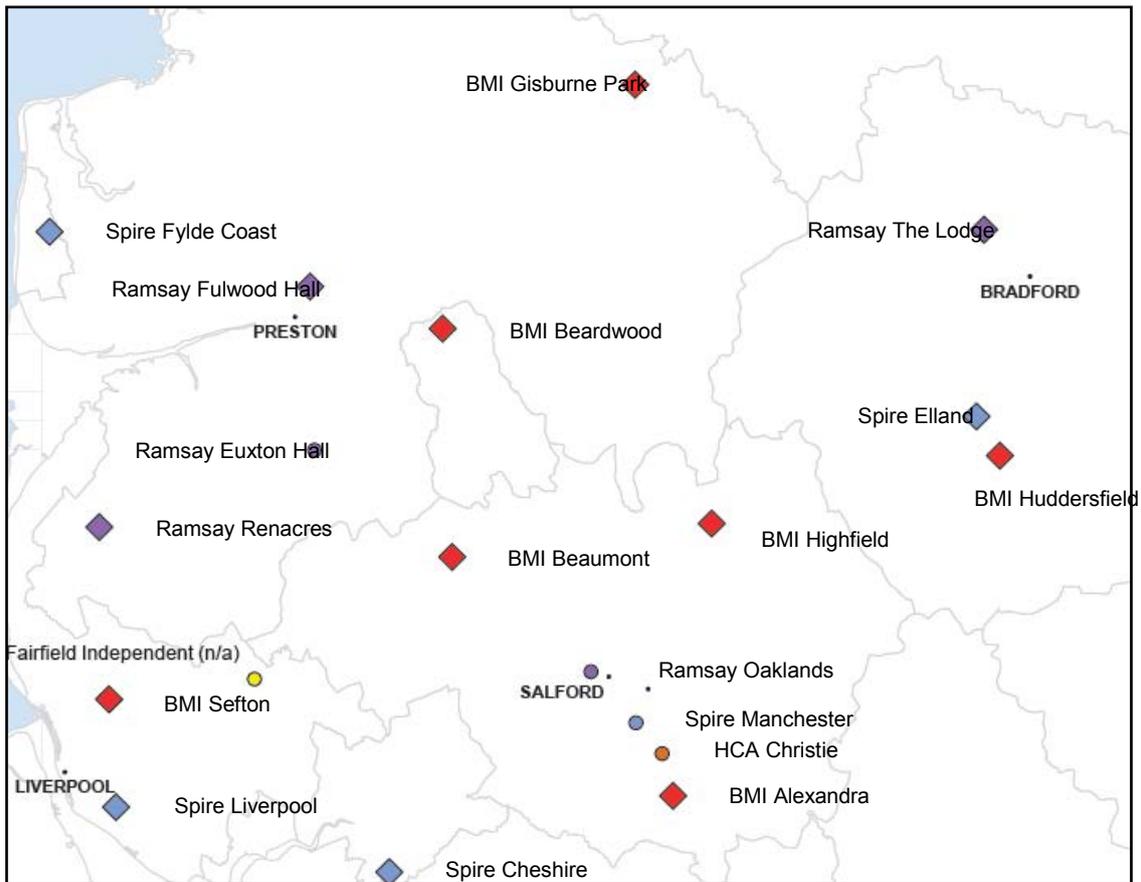
169. BMI Gisburne Park is a 35-bed, two-theatre private hospital located in Gisburn, Lancashire. The hospital does not have critical care facilities and offers a limited range of medical treatments, covering 12 out of the 17 mainstream specialties. It is located in a rural area and has a catchment area of [redacted] miles, with the closest other hospital being BMI Beardwood, 18.5 miles away in Blackburn. Beardwood has a [redacted]-mile catchment area, ie [redacted]. The closest competitor hospital to Gisburne Park is Ramsay Fulwood Hall, which is 25 miles away in Preston.

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<sup>43</sup> BMI holds a weighted average market share of between [redacted] and [redacted] per cent in the catchment areas of these hospitals.

FIGURE 24

Map of private hospitals in the North-West



Source: CC analysis.

- 170. BMI Beardwood is a 19-bed, two-theatre private hospital with critical care level 2 facilities. Its closest competitors are Ramsay Fulwood Hall, 9 miles away, and Ramsay Euxton Hall, 13 miles away. Both of these hospitals are located within Beardwood's catchment area. Beardwood [X], with almost [X] per cent of admissions in 2011 coming from the NHS.
- 171. BMI Beaumont is a 20-bed, three-theatre hospital with a catchment area of [X] miles, located in Bolton. The hospital provides a full range of medical specialties but does not have critical care facilities. Beaumont (like Beardwood) is [X]. Beardwood Hospital is 17 miles away and [X].

172. Beaumont's two closest competing hospitals are Ramsay Euxton Hall and Ramsay Oaklands, which are 10 and 14 miles away respectively [REDACTED].
173. BMI Highfield is a 47-bed, four-theatre private hospital located in Rochdale. The hospital is 20 miles from BMI Beaumont and has a catchment area of [REDACTED] miles. Highfield's two nearest competitors are Ramsay Oaklands (13 miles away) and Spire Manchester (14 miles away), both of which are outside but overlap with Highfield's catchment area. Around [REDACTED] per cent of Highfield's admissions in 2011 were NHS patients.
174. Spire Elland has 40 beds and two operating theatres, as well as critical care level 2 facilities. Ramsay Oaklands has 18 beds and two operating theatres, while Ramsay Euxton Hall has 29 beds and three operating theatres. Neither hospital has critical care facilities. Ramsay Fulwood Hall has 43 beds, four operating theatres and critical care level 2 facilities. These hospitals offer a broad range of healthcare services to patients, ranging from 14 to 17 of the specialties used in our assessments.
175. Beardwood, Beaumont and Highfield all offer a full range of medical services, covering the 17 mainstream medical specialties.
176. Both Beaumont and Highfield are located outside the [REDACTED]-mile catchment area of BMI Alexandra (Manchester), BMI's largest single hospital with 141 beds, nine theatres and critical care level 3 facilities. Beaumont is 23 miles away and Highfield is 21 miles away. [REDACTED]
177. We have found that all five of BMI's hospitals in this area face insufficient competitive constraints.

## ***What the parties told us***

### ***BMI***

178. BMI argued that the CC had provided no or insufficient evidence that Beardwood or Highfield were insufficiently constrained, nor that common ownership had ever been a feature of negotiations with insurers. It put forward the view that divestiture would be ineffective as a remedy for both insured and self-pay patients since both these hospitals faced sufficient constraints from Ramsay's Fulwood Hall, Euxton and Oaklands hospitals, Spire Manchester, HCA's Christie Clinic and the Bridgewater Hospital. BMI highlighted that all the hospitals in the cluster except Beardwood were delisted by Bupa during its dispute with BMI,<sup>44</sup> and that BUPA had not listed any BMI alternatives. BMI said that this indicated that Bupa was able to shift its demand away from the cluster of BMI hospitals in this area and therefore that divestment of either Beardwood or Highfield would not change the relative negotiating position with insurers since the insurers already had suitable and sufficient outside options.
179. BMI also noted that the OFT had assessed local competition in this area when it reviewed BMI's acquisition of four Abbey hospitals and found adequate competition existed and that Ramsay and Spire were just as present as BMI in the North-West. In addition, BMI noted that—notwithstanding its position that the evidence did not show a correlation between prices in terms of self-pay patients and concentration—the CC's survey evidence showed that self-pay patients were prepared to travel further than insured patients and that this meant that a larger number of hospitals competed for these patients, including Nuffield Leeds and the Manchester Eye PPU.
180. BMI also argued that the divestiture of either of Beardwood or Highfield would be disproportionate since it would:

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<sup>44</sup> With the exception of cardiology, cardiothoracic surgery and neurosurgery at the Alexandra.

- (a) remove efficiencies from BMI's operations by reducing economies of scale [redacted] across Lancaster, Beardwood and Gisburne Park;
- (b) be likely to take place at an undervalue [redacted], BMI suggested that there would be a limited pool of potential purchasers [redacted];
- (c) harm investment incentives in the UK and in private healthcare in particular by introducing regulatory uncertainty given that the OFT cleared BMI's acquisition of Gisburne Park having assessed competition between it and Beardwood; and
- (d) even if considered effective in remedying any hypothetical AEC, even on the CC's case benefit only private inpatients who were either self-pay or insured by an insurer other than Bupa, which BMI contended had fully countervailing buyer power. BMI noted that such patients comprised only [redacted] per cent of total patients at its Beardwood and Highfield facilities, with the remaining [redacted] per cent of patients receiving no benefit and being (at the least) inconvenienced by the divestiture of one of these hospitals.

181. Given these arguments, BMI argued that a divestment of either Gisburne Park or Beardwood could not satisfy the double proportionality approach set out in the CAT's judgement in *Tesco v Competition Commission*.<sup>45</sup>

### *Bupa*

182. Bupa put forward the view that the Alexandra Hospital should be divested rather than any of BMI's other hospitals in this area since:
- (a) The [redacted] of NHS patients at Highfield, Beaumont and Beardwood meant that a purchaser of these hospitals would need time to [redacted] in order to compete effectively with the Alexandra such that there would be delay and uncertainty about when and to what extent competitive pressure would come to bear in this area.

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<sup>45</sup> *Tesco Plc v Competition Commission (2009) CAT 6*, paragraph 139.

- (b) The Alexandra would be a more attractive target for acquisition by potential purchasers.
- (c) The divestiture of the Alexandra would have a more significant impact on reducing BMI's scale at a national level.
- (d) The Alexandra was dominant in a number of key specialisms, including [redacted], and although a potential purchaser would inherit these strengths, Bupa suggested that it would be easier to negotiate with the Alexandra in these areas if it were part of a smaller group.

### *AXA PPP*

183. AXA PPP agreed that one of BMI Beardwood or BMI Highfield—but not both—should be divested. It stated that given the concentration of BMI ownership in this area, the divestment of a facility would potentially increase competition to a small extent, although this was of limited potential value to an insurer given the relatively small pool of private patients in this area.

### **Assessment**

#### *Design considerations*

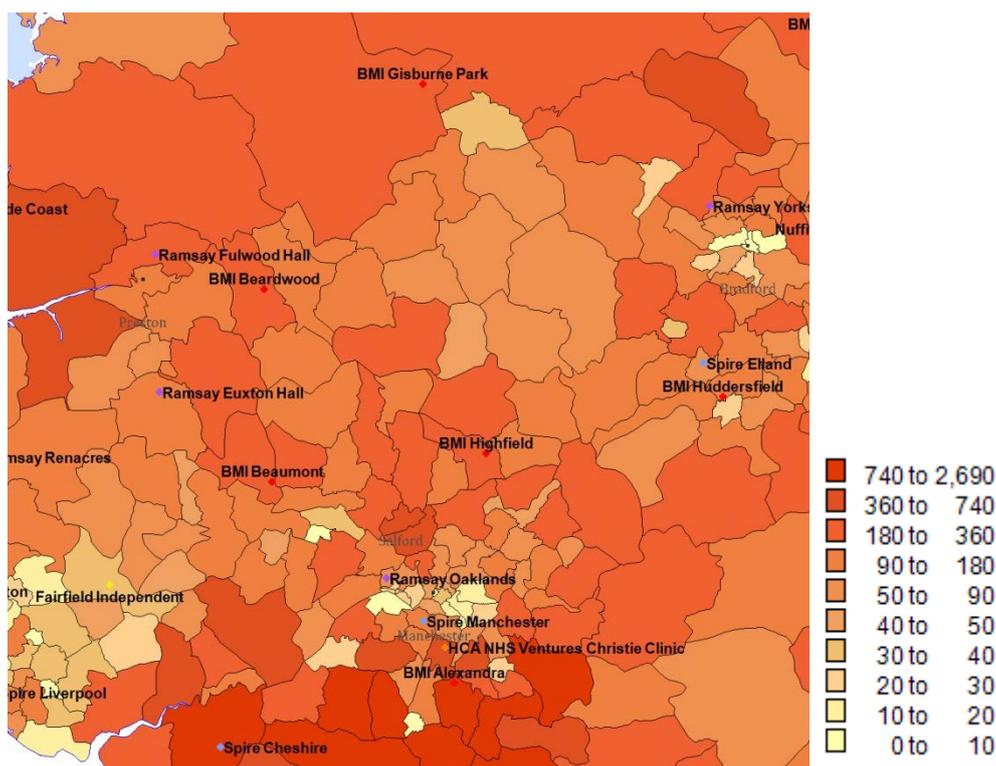
184. We considered how the factors set out in paragraph 3 would be likely to affect the effectiveness of divestiture in this area, taking into account the views of the parties as set out above.
185. We reasoned that, although these hospitals were not generally located within each other's catchment areas, there were significant areas of overlap between them, particularly between Highfield and both Beardwood and Beaumont, which indicates that both self-pay patients and insurers may view them as substitutes to an extent. We noted that the location of Gisburne Park on the edge of the cluster and the limited range of medical specialisms offered at the hospital meant that it was unlikely to be

an effective competitor to the other facilities if it were divested. In contrast, the location of Beardwood, Beaumont and Highfield, as well as their broad service offerings, suggest that they are likely to compete across a larger proportion of the cluster and across a greater number of specialisms, which is particularly important for insurers who need a full service offering for policyholders.

186. We thought that, of these three hospitals, the divestiture of Highfield was likely to be most effective due to its position towards the centre of the cluster (taking into account the location of BMI Huddersfield as well) and the lack of competitor facilities in its catchment area.<sup>46</sup>

FIGURE 25

**Density of insured patients in the North-West**



Source: CC analysis of Healthcode data, 2009 to 2012.

<sup>46</sup> Beardwood, in contrast, has two Ramsay hospitals located within its catchment area, which indicates that there will be greater competition in this area (albeit not sufficient to fully constrain Beardwood) than in the area around Highfield.

FIGURE 26

**Beardwood catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 27

**Beaumont catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 28

**Highfield catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

187. We also observed that, in contrast to AXA PPP's submission, there was a reasonably high density of private patients in this area, who would benefit from increased competition.
  
188. We considered Bupa's argument that [REDACTED] at Beardwood and Highfield meant that there would be a delay in the increase in competition due to the need for these facilities to [REDACTED] and, therefore, [REDACTED]. However, we thought that this delay would occur whichever of the hospitals in this area were sold and therefore this was not a reason to [REDACTED].
  
189. Similarly, we noted [REDACTED]. However, this argument suggests that the AEC in relation to BMI arises from its national scale rather than simply the sum of its market power in a number of local markets. We did not find any support for the former theory in our provisional findings. We have not, therefore, taken this into account in considering the effectiveness of our remedies.

190. We next took into account the size and capacity (utilization) of BMI's facilities in this area. Both Beardwood and Beaumont have relatively high levels of capacity utilization which suggests that they may struggle to increase volumes significantly (although they may be able to switch volumes away from NHS work and towards private work). We thought that the greater size of Highfield, together with the existence of a reasonable level of spare capacity at the facility, indicated that it might be a more effective competitor to the remaining BMI hospitals.

TABLE 6 Beardwood, Highfield, Beaumont, Gisburne Park and Alexandra capacity utilization

*per cent*

	<i>Utilization (theatres)</i>				<i>Utilization (beds)</i>			
	<i>FY2009</i>	<i>FY2010</i>	<i>FY 2011</i>	<i>YTD Jul 2012</i>	<i>FY2009</i>	<i>FY2010</i>	<i>FY 2011</i>	<i>YTD Jul 2012</i>
Beardwood	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Highfield	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Beaumont	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Gisburne Park	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Alexandra	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]

Source: BMI.

191. We considered whether two BMI hospitals would need to be divested to give insurers the ability to switch all of their volumes in this area away from BMI. We did not think this was the case given the proximity of nearby Ramsay and Spire facilities. We concluded that the single most effective divestiture in this area would be Highfield, with some incremental benefit from divesting Beardwood as well.

### *Implementation*

192. We then considered the extent to which Beardwood and/or Highfield could be sold and would continue to be viable in the longer term given their likely post-divestiture levels of EBITDA.<sup>47</sup> We concluded that Beardwood would be likely to attract interest from purchasers and compete effectively, as post-divestiture it would have rent cover in excess of [X] EBITDAR and EBITDA of around £[X] million. Highfield, on the

<sup>47</sup> See Appendix 2.5 for full details of our methodology and calculations.

other hand, is likely to generate EBITDA of [REDACTED] £[REDACTED] million following divestiture, with rent cover of [REDACTED] to [REDACTED] EBITDAR. As a result, we thought that it may not attract much interest from purchasers. We considered whether, if we specified an alternative divestiture package, which included both the operating business of Highfield and the hospital property, there was likely to be greater purchaser interest in acquiring the hospital. We concluded that this was the case as [REDACTED].

### *Conclusions*

193. We concluded that the divestiture of either Highfield or Beardwood would increase the competitive constraints in this area sufficient to remedy or mitigate the AEC we have found, by introducing another operator into an area where BMI currently has five hospitals which face insufficient competition. However, we thought that the divestiture of Highfield would be more effective due to the greater overlap between its catchment area and that of Beaumont, Beardwood, Alexandra and (to a lesser extent) Huddersfield than is the case for Beardwood, and due to its larger size and spare capacity which could facilitate the switching of volumes by insurers. We concluded that by requiring the divestiture of two hospitals in this area, there would not be an appreciable increase in the level of competitive constraint, as compared with the situation if just a single hospital were divested, and therefore we concluded that this would not be proportionate.
194. We propose that BMI be required to divest the operating business of Highfield to a suitable purchaser and that the freehold interest in the hospital property also be divested to the same purchaser.
195. We have addressed BMI's other arguments in relation to the proportionality of divestiture remedies, as set out in paragraph 180 above, in Section 2 of the provisional decision on remedies. We do not repeat this discussion here.

## **Spire Methley Park and Elland/Leeds**

### ***Introduction***

196. We provisionally found that Spire faces weak competitive constraints in the area around its Leeds, Methley Park and Elland hospitals. At the time we published our provisional findings, we reasoned that the co-ownership of three hospitals in relatively close proximity meant that divestiture may be an effective remedy to the weak competitive constraints identified since it would introduce one or two new competitors into the local market. Therefore, we proposed that Spire should divest either its Leeds hospital or both of its Methley Park and Elland hospitals to suitable purchasers.
197. Following a review of the competitive constraints acting on the hospitals in this area, we have revised our assessment and now consider that Spire Leeds Hospital is sufficiently constrained by the Nuffield Leeds Hospital. We have reflected this conclusion in our analysis below.

### ***How the remedy addresses the AEC***

198. The divestiture of one or two of these hospitals would increase the level of competition for patients within their catchment areas by introducing another one or two competitors, addressing directly the weak competitive constraints that give rise to the AEC in this area.

### ***Background***

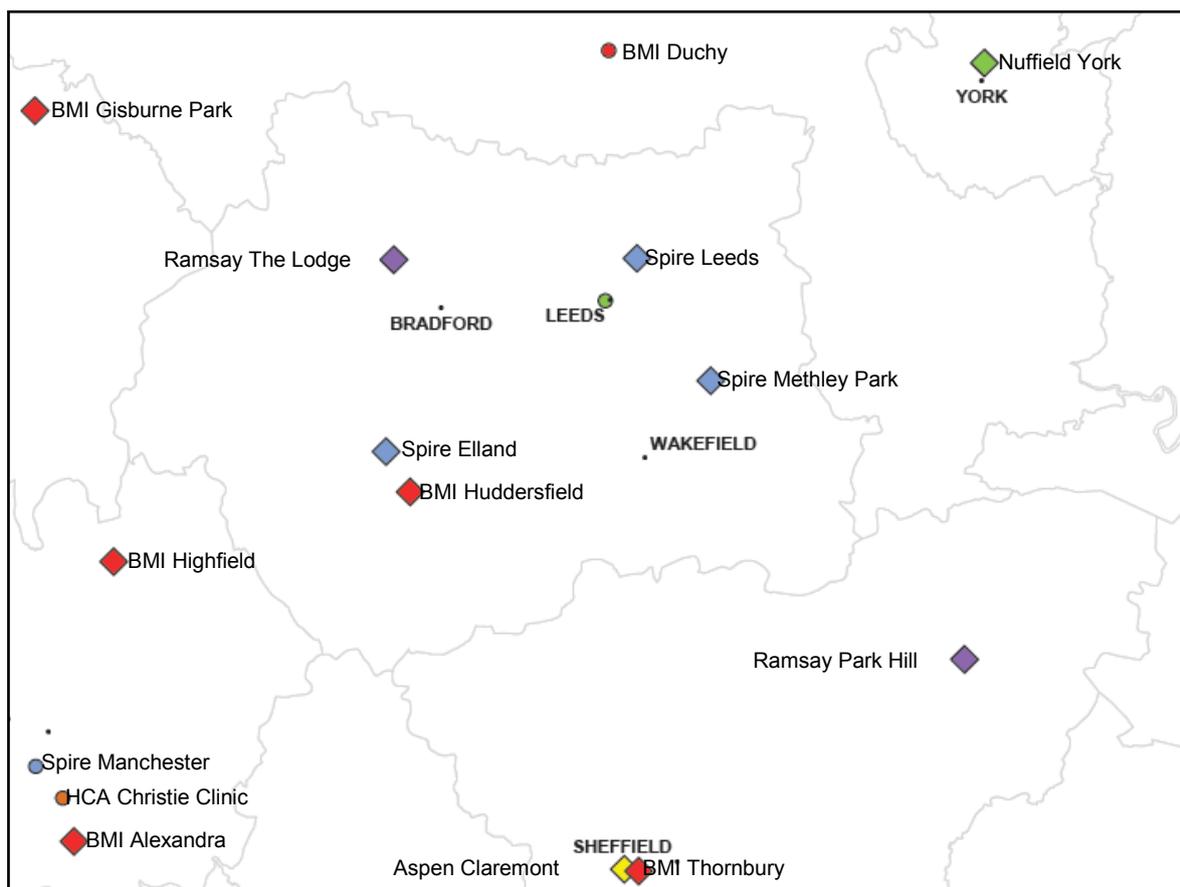
199. Spire Methley Park is a 27-bed, two-theatre private hospital with critical care level 2 facilities, located in Methley, Yorkshire. The facility has a catchment area of [X] miles, which encompasses both Nuffield's and Spire's Leeds hospitals, located 9 and 10 miles away respectively. Spire Leeds has a catchment area of [X] miles, which means that [X]. Spire Elland is located 20 miles away from Spire Leeds and has a

catchment area of [redacted] miles, which overlaps with the catchment areas of both Spire Leeds and (to a lesser extent) Spire Methley Park.

200. Spire Leeds has 80 beds and six theatres, while Spire Elland has 40 beds and two theatres.<sup>48</sup> All three of Spire's hospitals in the Leeds area offer a full range of private healthcare services, covering the 16 mainstream specialties plus oncology, as well as offering critical care level 2 facilities. Spire Leeds is significantly larger in terms of both facilities and admissions than the other two hospitals, with private patients comprising around [redacted] per cent of its admissions. Methley Park and Elland [redacted] NHS patients, which account for around [redacted] per cent of their admissions.

FIGURE 29

### Map of private hospitals in the Leeds area



Source: CC analysis.

<sup>48</sup> Spire told the CC that [redacted].

201. Nuffield Leeds has 81 beds and eight operating theatres, as well as critical care level 3 facilities. BMI Huddersfield has 29 beds and two operating theatres but it does not have critical care facilities. Both hospitals offer a large number of healthcare services to patients, comprising 17 and 16 specialties used in our assessment respectively.
202. We have found that Spire's Methley Park and Elland hospitals are insufficiently constrained by competition, while Spire Leeds is sufficiently constrained by Nuffield's Leeds hospital.

### ***What the parties told us***

#### *Spire*

203. Spire argued that for divestiture to be an effective remedy, the CC would need to demonstrate that the results of the PCA held for Spire in the Leeds area and not rely on national, cross-operator results. Spire asserted that it was not possible to read across from the PCA to insured prices given the material differences in the way that these were determined and that the CC's analysis of the latter indicated that Spire did not charge prices that were consistently or materially higher than operators without market power.<sup>49</sup>
204. Spire put forward the view that the divestiture remedy would be ineffective as there was already sufficient competition in the Leeds area and that the conduct of the key insurers demonstrated this. In particular, [REDACTED].<sup>50</sup>
205. Spire argued that if divestiture were required, [REDACTED] met the CC's network LOCI filter and hence only this facility should be considered for divestiture. Finally, Spire noted that given the OFT had cleared its acquisition of Classic Hospitals in 2008, the CC should be cautious in finding that there was a problem in this area. Spire suggested

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<sup>49</sup> Spire response to Remedies Notice, paragraph 2.7.

<sup>50</sup> Spire response to Remedies Notice, paragraph 2.7.

that the CC should consider the impact of its process on the availability of suitable purchasers for the divestiture hospitals.<sup>51</sup>

206. If divestment went ahead, Spire considered that the divestment packages for its three Leeds hospitals might have the following components:

- (a) Spire Elland: [REDACTED];
- (b) Spire Methley Park: [REDACTED]; and
- (c) Spire Leeds: [REDACTED].<sup>52</sup>

### *Bupa*

207. Bupa argued that the divestiture of Leeds (rather than Methley Park and Elland) would be the most effective means of increasing competition in this area since:

- (a) Leeds was the largest hospital in the area with a market share of more than [REDACTED] per cent in this area.
- (b) Leeds would attract a greater number of potential purchasers and be more likely to be able to function on a stand-alone basis than the other hospitals.
- (c) Methley Park and Elland had a strong focus on NHS-funded patients such that, if they were divested, a purchaser would need to invest significantly in the facilities and change their focus to enable them to compete effectively for private patients. This process would take time.
- (d) Bupa's [REDACTED] spend in this area was dominated by the Leeds hospital and Bupa considered that competition in this key specialism would be more effective if the Leeds hospital was in the hands of an independent or smaller hospital group owner.

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<sup>51</sup> Spire response to Remedies Notice, paragraphs 2.9, 2.10 & 2.12.

<sup>52</sup> Spire response to Remedies Notice, paragraphs 2.19, 2.20, 2.21 & 2.22.

## *AXA PPP*

208. AXA PPP told us that it did not support the divestiture of any of Spire's hospitals in the Leeds area as it believed that Nuffield Leeds and Spire Leeds effectively constrained one another. It noted that neither Methley Park nor Elland competed with Leeds from an insurer's perspective as whilst patients proximate to these facilities might travel to Leeds for treatment, the opposite would not happen.

## **Assessment**

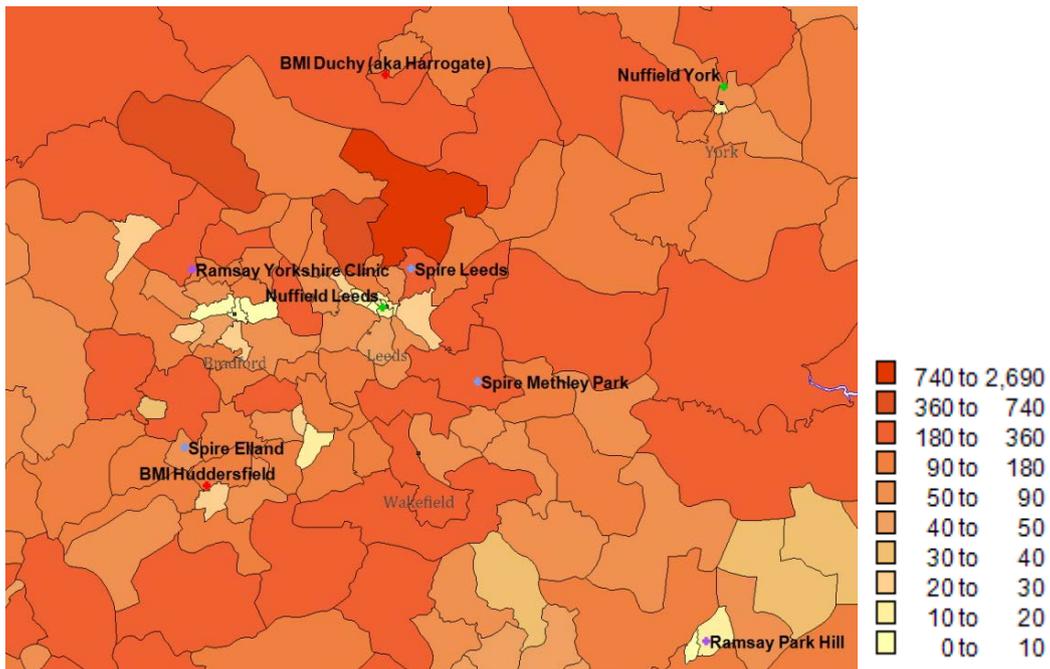
### *Design considerations*

209. We considered how the factors set out in paragraph 3 would be likely to affect the effectiveness of divestiture in this area, taking into account the views of the parties as set out above.

210. In the first instance, we observed that, since Spire Leeds was sufficiently constrained, any divestiture in this area could be effective only in imposing competitive constraints on Spire Elland and/or Spire Methley Park. We examined the detailed catchment areas from which these hospitals drew their patients, as well as the density of private patients in this area. We noted that Spire's Leeds hospital predominantly drew its insured patients from [X], with some overlap with Elland's catchment area. We thought that the divestiture of Elland was most likely to increase competition for those patients located between Elland and Leeds but we considered that the distance between Spire Elland and Spire Leeds, combined with the proximity of both BMI Huddersfield (to Elland) and Nuffield Leeds (to Spire Leeds), meant that it was likely to have a minimal impact on the level of competitive constraint acting on Elland. In particular, we noted that the Nuffield Leeds hospital, which sufficiently constrains Spire Leeds, is closer to Elland than Spire Leeds. Hence, we would expect little incremental constraint on Elland from separating its ownership from Spire Leeds.

FIGURE 30

**Density of insured patients, Leeds are**



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 31

**Spire Leeds catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 32

**Spire Methley catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 33

**Spire Elland catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

FIGURE 34

**Nuffield Leeds catchment area**



Source: CC analysis of Healthcode data, 2009 to 2012.

211. We next considered Methley Park. We observed that the greater proximity of this hospital to Leeds together with the lower level of competitive constraints in the Methley Park area (where there are no other operators present) indicated that, in this case, divestiture was more likely to be an effective remedy to the AEC identified. However, a review of the local road network indicates that, as was the case with Elland, the Nuffield Leeds hospital is effectively located between these two Spire hospitals. As a result, we thought that there would be a relatively minimal increase in the competitive constraint on Methley Park as a result of separating its ownership from Spire Leeds. Moreover, AXA PPP's submission suggested that the benefits of divestiture, at least in terms of price, were likely to be limited to self-pay patients as insurers did not view Methley Park (or Elland) as competing with the Leeds hospitals. Therefore, given the relatively small number of self-pay patients treated at Spire Methley Park (about [X] admitted in 2011), we did not believe that divestiture would be effective in increasing competitive constraints in this case.

### *Conclusions*

212. We concluded that the divestiture of Spire Elland was not likely to be an effective remedy to its market power due to the limited overlap between the catchment areas of Elland and Spire Leeds, which are 20 miles apart, and the presence of both Nuffield and BMI alternatives in the local area.
213. Similarly, we concluded that the divestiture of Spire Methley Park was unlikely to be effective in significantly increasing the competitive constraint acting on the facility due to the location of Nuffield Leeds between Spire Leeds and Methley Park and the view of the insurers that these hospitals did not act as substitutes for one another.
214. As a result, we propose that Spire is not required to make any divestitures in the Leeds area.

## **BMI Carrick Glen/Ross Hall/Kings Park**

### ***Introduction***

215. We provisionally found that BMI faces weak competitive constraints in the area around its Carrick Glen, Ross Hall and Kings Park hospitals, located between Ayr and Stirling. We considered whether the co-ownership of these three hospitals indicated that divestiture may be an effective remedy to the weak competitive constraints identified. However, at the time we published our provisional findings, we concluded that the divestiture of a hospital in these areas was unlikely to have a substantial impact on the extent to which these hospitals were competitively constrained due to the distances between the hospitals and the relatively small size of both Carrick Glen and Kings Park.<sup>53</sup>

216. We proposed, therefore, that BMI should not be required to make any divestitures in this area.

### ***Background***

217. BMI Carrick Glen is a 22-bed, one-theatre private hospital located in Ayr. The hospital offers critical care level 2 facilities and has a catchment area of [§] miles. It offers a relatively limited range of medical services, comprising 14 of the 16/17 mainstream specialties. The closest hospital is 36 miles away in Glasgow, which is BMI's Ross Hall facility (which has a [§]-mile catchment area). Nuffield Glasgow is 42 miles away and is the nearest competitor facility to Carrick Glen.

218. Nuffield Glasgow has 33 beds and three operating theatres, as well as critical care level 2 facilities. The hospital offers a full range of healthcare services to patients, comprising all 17 of the mainstream medical specialties used in our assessment.

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<sup>53</sup> Carrick Glen had [§] admissions in 2011 and Kings Park had [§].

219. [X] In 2010, BMI agreed (with the OFT) to sell Carrick Glen following its acquisition of the Abbey group of hospitals. It was subsequently released from this undertaking due to a failure to find a buyer for the hospital.
220. BMI Kings Park is a 21-bed, two-theatre hospital located in Stirling. It offers 15 of the 16/17 mainstream medical specialties. It has a catchment area of [X] miles with no other hospitals located in this area. There is some overlap between Kings Park's catchment area to the south and that of BMI and Nuffield's Glasgow hospitals and Spire Murrayfield, which are the two closest hospitals at 30 and 33 miles distance respectively. [X]

FIGURE 35

**Map of private hospitals in Scotland**



Source: CC analysis.

221. BMI Ross Hall is the largest of these facilities, with 101 beds, four operating theatres and critical care level 3 facilities. It offers a full range of healthcare services, covering all 17 of the mainstream medical specialties.
222. We have found that Carrick Glen, Ross Hall and Kings Park face insufficient competitive constraints.

### ***What the parties told us***

223. BMI did not make any comment regarding this area in its response to the Remedies Notice, as the CC had not proposed any of these hospitals for divestment. AXA PPP agreed with the CC's preliminary conclusions but made no further comment.

### ***Bupa***

224. Bupa agreed with the CC that in the cluster as identified by the CC, divestments would not be effective in addressing local market concentration. However, Bupa suggested that the CC should extend the definition of this cluster to include BMI's Fernbrae hospital in Dundee on the basis that there are good transport links between Edinburgh and Dundee such that private patients can easily choose between hospitals in either of these cities. In this case, Bupa put forward the view that the CC should consider requiring BMI to divest either Fernbrae or Ross Hall to promote effective competition in this more widely defined cluster.

### ***Assessment***

225. We considered how the factors set out in paragraph 3 would be likely to affect the effectiveness of divestiture in this area, taking into account the views of the parties as set out above.

226. We examined Bupa's argument that we should consider the broader 'cluster' of BMI hospitals, located between BMI Carrick Glen in Ayr and BMI Fernbrae in Dundee. We did not agree that it was reasonable to view these hospitals as being in a 'cluster' given the distance between them. Ayr is approximately 120 miles from Dundee, with an estimated drive-time of more than 2 hours from one to the other.
227. We reasoned that the divestiture of either Carrick Glen or Kings Park would not increase the competitive constraint on Ross Hall significantly due to the distance between the facilities and, to the extent that divestiture would increase competition between these hospitals, the effect would be likely to be limited to the small number of self-pay patients located in the areas between these facilities. We did not consider that the separate ownership of these hospitals would allow insurers to switch their volumes (and recognition) between for three main reasons:
- (a) The distance between the facilities means that patients are unlikely to view them as reasonable substitutes.
  - (b) The more limited range of services offered by Carrick Glen and Kings Park, particularly the lack of level 3 critical care facilities, indicates that these hospitals could not compete across a full range of services, at least initially, and we do not consider it likely that a new owner would consider it worthwhile developing them to the same level as Ross Hall due to their size and locations (outside Scotland's larger cities).
  - (c) Carrick Glen and Kings Park are both substantially smaller than Ross Hall, which indicates that they are unlikely to have the capacity to allow insurers to switch volumes from Ross Hall to these sites, [REDACTED].

TABLE 6 **Ross Hall, Carrick Glen and Kings Park capacity utilization**

	<i>Utilization (theatres)</i>				<i>Utilization (beds)</i>			
	<i>FY2009</i>	<i>FY2010</i>	<i>FY 2011</i>	<i>YTD Jul 2012</i>	<i>FY2009</i>	<i>FY2010</i>	<i>FY 2011</i>	<i>YTD Jul 2012</i>
Ross Hall	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Carrick Glen	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Kings Park	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Source: BMI.

228. Given the inability of insurers to switch recognition between these sites, we thought that divestiture would have a very limited impact on the competitive constraints acting on the hospitals. We considered that it might increase competition somewhat for self-pay patients located between these sites but we did not think, overall, that this would amount to an appreciable increase in the competitive constraint on these hospitals.

*Implementation*

229. We next examined whether the hospitals could be sold. We noted that without taking into account any impact of divestiture on their profitability, both sites generate EBITDAR of £[REDACTED] million per year and EBITDA of £[REDACTED] million. We thought, therefore, that in order to ensure the success of a divestiture, it would be necessary to specify a divestiture package that included both the operating businesses and the underlying property, [REDACTED]. In this case, we considered that it was likely that the businesses would attract purchaser interest.<sup>54</sup>

*Conclusions*

230. We concluded that divestiture was unlikely to be an effective remedy to the weak competitive constraints identified in this area. We propose, therefore, that BMI is not required to divest any hospitals in this area.

<sup>54</sup> We note that BMI was previously required by the OFT to sell Carrick Glen due to competition concerns but that BMI was released from its undertaking to do so when it was unable to attract a purchaser. We understand that, in this case, BMI was required to divest the operating business only, without the hospital property.

## **BMI Lincoln/Park**

### ***Introduction***

231. We provisionally found that BMI faces weak competitive constraints in the area around its Lincoln and Park (Nottingham) hospitals. We considered whether the co-ownership of these hospitals indicated that divestiture may be an effective remedy to the weak competitive constraints identified. However, at the time we published our provisional findings, we concluded that the divestiture of either BMI Lincoln or BMI Park was unlikely to be an effective remedy to the AEC identified in this area due to the large distance between the two facilities, which was limited to the overlap between their catchment areas and the relatively low level of PMI penetration in the Lincolnshire area.
232. We proposed, therefore, that BMI should not be required to make any divestitures in this area.

### ***Background***

233. BMI Lincoln is a 23-bed, two-theatre private hospital, with a catchment area of [REDACTED] miles. The closest alternative private hospital is the HMT St Hugh's hospital, 34 miles away in Grimsby. There is some, limited overlap between the catchment areas of with BMI Lincoln and St Hugh's. The BMI Park Hospital is 36 miles away in Nottingham and has a catchment area of [REDACTED] miles, [REDACTED]. Ramsay's Park Hill and Nottingham Woodthorpe hospitals also have catchment areas that overlap marginally with those of BMI Lincoln.
234. Ramsay Woodthorpe has 41 beds and three operating theatres, as well as critical care level 2 facilities.

235. BMI Lincoln offers a full range of medical specialties but does not have critical care facilities. It has [redacted] approximately [redacted] admissions in 2011. BMI Park is a larger hospital with 73 beds, five operating theatres and critical care level 2 facilities.

FIGURE 36

**Map of private hospitals in the Lincolnshire area**



Source: CC analysis.

**What the parties told us**

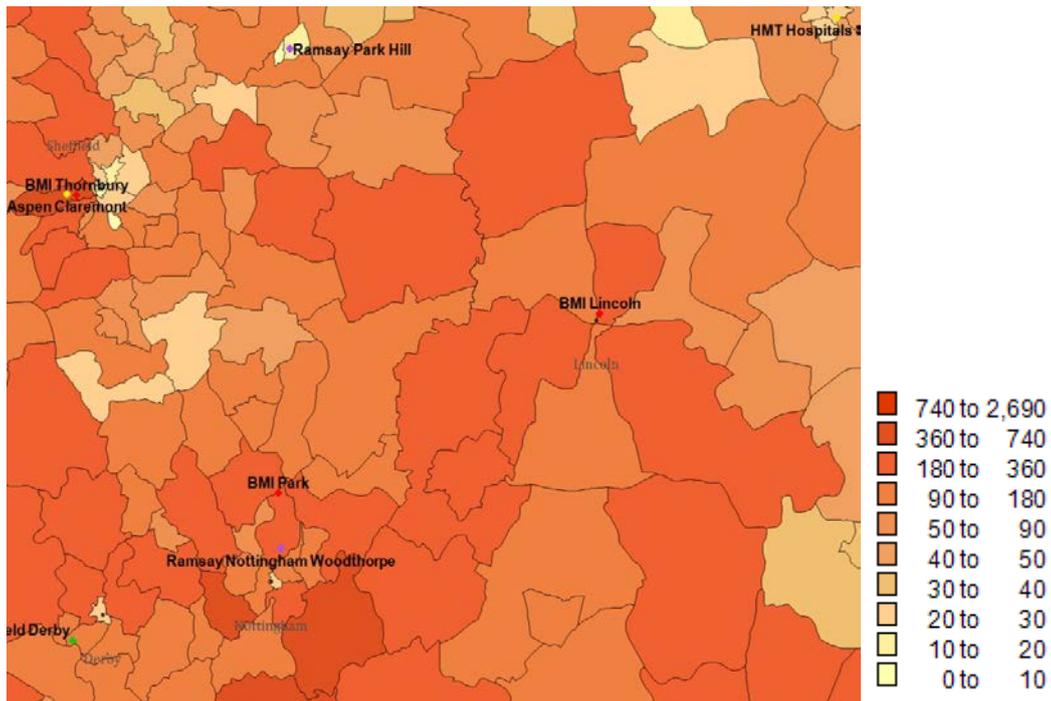
236. BMI did not make any comment regarding this area in its response to the Remedies Notice, as the CC had not proposed any of these hospitals for divestment. AXA PPP agreed with the CC's preliminary conclusions but made no further comment. Bupa suggested that the CC should reconsider its views in this area, highlighting [redacted] that divestiture would increase its options in this area. Bupa put forward the view that Park should be divested as it was the larger facility and therefore its divestiture would put insurers in a better position to negotiate with the remaining BMI group.

## **Assessment**

237. We considered how the factors set out in paragraph 3 would be likely to affect the effectiveness of divestiture in this area, taking into account the views of the parties as set out above.
238. We reasoned that the distance (36 miles) between Lincoln and Park, together with the lower level of acuity of services offered by Lincoln and its smaller size, meant that if ownership of these two hospitals were separated, Lincoln was unlikely to exert much of a competitive constraint on Park, particularly in comparison with the existing constraint from Ramsay Woodthorpe, which is significantly closer, larger and offers a similar level of acuity. Therefore, divestiture would be an effective remedy only to the extent that it increased the competitive constraints acting on BMI Lincoln.
239. We thought that the significant distance between the facilities made it unlikely that an insurer could credibly threaten to remove recognition from Lincoln and maintain a credible offering to its policyholders in this area. We considered that this would significantly limit the effectiveness of divestiture as a remedy for weak competitive constraints in this area since any price benefits were likely to be restricted to self-pay patients only. We noted that the effective distance between Lincoln and Park was augmented by a lack of motorway connections between the cities.
240. We examined the density of insured patients and noted that it was relatively low in the area between Lincoln and Park.

FIGURE 37

Density of insured patients, Nottingham and Lincoln area



Source: CC analysis of healthcode data, 2009 to 2012.

241. [X] However, this argument suggests that the AEC in relation to BMI arises from its national scale rather than simply the sum of its market power in a number of local markets. We did not find any support for the former theory in our provisional findings. We have not, therefore, taken this into account in considering the effectiveness of our remedies.

*Conclusions*

242. We concluded that divestiture would not be an effective remedy to the weak competitive constraints in this area. We propose, therefore, that BMI is not required to sell either Lincoln or Park.

## Divestiture remedies—views of the parties

### Main hospital groups

1. The established hospital groups strongly contested the CC's provisional findings and consequently the need for any remedies and, in particular, the proposals for divestitures.
2. HCA 'vigorously' rejected the provisional findings of AECs in the market for private healthcare in London, where HCA is predominantly based. In HCA's view, the CC effectively mistook success in a market for barriers to entry and the exploitation of market power and that divestment would punish HCA's successful strategy of investing in higher-quality care, innovation and efficiency.<sup>1</sup> Spire said that the CC had disregarded 'actual evidence of competition'. BMI similarly maintained that the CC had failed to establish that there was an AEC in the market.
3. The three hospital groups argued that the CC's analysis failed the legal tests for the remedies it was proposing. It fell short of the courts' 'double proportionality' judgment<sup>1</sup> that, while CC remedies must be proportionate, an even higher burden of proof—and therefore more detailed and deeper investigation—was needed when an intrusive or far-reaching remedy was proposed. This was particularly the case when property rights would be affected, given their protection under the European Convention on Human Rights. Spire, for example, considered the CC's provisional conclusions—and therefore the divestiture and other remedies—to be both 'unreasonable and unlawful'.

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<sup>1</sup> HCA response to Remedies Notice, paragraph 2.10.

<sup>†</sup> *Tesco v Competition Commission* (2009), CAT 6, paragraph 139.

4. The three groups maintained that competition for the services their hospitals offered was strong. They pointed to the clearance the OFT had given over recent years to at least five hospital mergers, some of which had led to the portfolios of hospitals the groups now held.
5. Even if the CC's findings had been well-founded, the three hospital groups argued, there were no grounds to support the CC's divestiture proposals. According to Spire: 'Even if any remedy were justified, the specific remedies proposed by the CC are in many cases simply not fit for purpose', and the other two groups agreed that the proposed divestitures would be both ineffective, as means to improve competition and benefit consumers, would be unduly onerous and would be wholly disproportionate to the harm the CC had provisionally found. The grounds on which the established hospitals rejected the divestiture proposals are set in the following sections on the proposed divestments (1) in London and (2) outside London.

***Proposed divestments in London: HCA views***

6. HCA submitted that there was a lack of justification for divestment of HCA's hospitals. HCA argued that the market for private healthcare in London was far more competitive than the CC recognized. Several other private providers in central London, including six other private hospital groups operating nine other hospitals, competed with HCA. PPUs in NHS premises—currently numbering 16—were contributing to growth in the London market and the absence of entry barriers was attested by, for example, the expansion of TLC and the prospective opening of the London International Hospital and the Kent Institute of Medicine and Surgery. A concentration of major NHS teaching hospitals in London provided further competitive interaction with HCA hospitals. HCA also pointed out that the London market continued to grow at a fast pace and was still evolving, eg with greater growth in the supply of outpatient and day care and a greater proliferation of new PPU

supply (HCA observed that PPUs in central London had grown by 36 per cent over the last three years).<sup>2</sup> The CC had failed to take account of the way in which these trends in aggregate were already reshaping private healthcare in London.

7. HCA disputed the rationale for the divestiture, ie to bring HCA's share of the market to below [redacted] per cent supply in private healthcare. The [redacted] per cent threshold was arbitrary, irrational and in conflict with the practice of other competition regulators, including that set out in the CC's market investigation guidelines.<sup>3</sup>
8. Moreover, divestiture was not the necessary route to market for new entrants. Investors seeking to enter the London market had found it far easier and potentially less costly to develop and expand a presence in London. HCA submitted the details of several properties, including former NHS hospital sites that were currently available for new hospital development, as well as PPU partnering opportunities.<sup>4</sup>
9. HCA noted that in 2000 the OFT gave unconditional clearance to HCA's acquisition of the St Martins' hospitals and that this decision allowed the acquisition of HCA's present portfolio of six London hospitals and, acting in reliance of this decision, HCA had made subsequent heavy investments in them. HCA submitted that, since OFT clearance, competition in London had become more, not less, competitive. HCA said that the CC had not addressed why it had reached a contradictory view to that of the OFT. HCA contended that it would be 'wholly unfair and unlawful, and a breach of HCA's legitimate expectations' for the CC to overturn the OFT's decision and confirm the proposed divestiture.<sup>5</sup>

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<sup>2</sup> [HCA response to Remedies Notice](#), paragraph 6.13.

<sup>3</sup> *ibid*, paragraphs 6.77–6.84, referencing CC3, [paragraph 190](#).

<sup>4</sup> [HCA response to provisional findings](#), Section 6.

<sup>5</sup> [HCA response to Remedies Notice](#), paragraphs 4.6–4.9.

### *Quality, innovation and choice*

10. HCA noted that the CC seemed to be concerned with market concentration in London for the supply of complex, high acuity specialisms, such as oncology, cardiology, and neurology. (According to the CC, HCA had a share of over 60 per cent for inpatient admissions in tertiary treatments in Central London and a high proportion of critical care level 3 beds.)
  
11. But HCA questioned whether a divestment remedy would be effective. HCA submitted that no other hospital group had demonstrated 'the same appetite for sustained capital investment and innovation'.<sup>6</sup> HCA also pointed to third party submissions that also noted HCA's leadership in highly complex clinical specialisms and its reputation for quality.<sup>7</sup> HCA therefore queried whether these high-level services would still be available in London if another group bought the two hospitals provisionally earmarked for sale. HCA argued that its investment in innovative high acuity services had been unique. While HCA might face some competition from other providers of tertiary care, it could not be guaranteed that a purchaser of the hospitals would pursue the same investment strategy as HCA or manage the assets with the same level of skill and diligence, providing the same high-quality clinical outcomes for patients. Some other providers, such as BMI and Spire, for example, focused historically on lower acuity clinical procedures than HCA's hospitals. The CC had no control over the long-term vision and strategy of the purchaser of the divested business.<sup>8</sup>

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<sup>6</sup> *ibid*, paragraph 6.24.

<sup>7</sup> *ibid*, paragraphs 6.20 & 6.41.

<sup>8</sup> *ibid*, paragraphs 6.21–6.25.

### *Relevant customer benefits*

12. Divestiture would reduce or even eliminate relevant customer benefits by reducing choice,<sup>9</sup> investment and innovation and creating poorer standards. HCA noted that reduced investment in the range of services provided at HCA's hospitals would have 'serious implications for clinical quality and care'.<sup>10</sup> For example, were the specialist tertiary services currently provided by the two hospitals to deteriorate in quality or be lost as a result of divestiture, this could be a matter of life or death for patients with serious medical conditions.
  
13. It would, in HCA's view, be 'perverse' to punish in this way a provider's investment in quality, innovation and efficiency and would have a substantial chilling effect on future private healthcare investment.<sup>11</sup>

### *Network synergies*

14. The divestiture of the two hospitals would destroy the network strategy which had allowed HCA to develop a different clinical focus at each of its facilities. HCA said that this network was unique and consisted of several facilities offering highly complex treatments within a tight geographical area. The network was tightly integrated and enabled HCA patients, know-how and personnel to transfer between hospitals seamlessly whenever necessary. Many of the innovations and new services in HCA hospitals had only been viable, financially and clinically, because these innovations could be utilized across the entire network.<sup>12</sup> A centralized IT system, with several applications, enhanced the hospitals' and consultants' abilities to deliver high-quality care.

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<sup>9</sup> *ibid*, paragraph 6.30.

<sup>10</sup> *ibid*, paragraph 6.52.

<sup>11</sup> *ibid*, paragraphs 2.10 & 6.55.

<sup>12</sup> HCA told the CC that it had made higher capital investments than its competitors in quality care, as attested by high patient satisfaction levels, extremely low MRSA rates, comparatively high survival rates and by a range of other indicators. It had led the way in bringing new, innovative equipment technologies and treatments into its hospitals, for example de Vinci robotic surgery, new diagnostic systems and tests, and new cancer therapies. HCA said that it had also contributed significantly to the creation of new clinical treatments and services within private healthcare, offering patients a real choice and alternative to the NHS (see [HCA response to Remedies Notice](#), paragraphs 5.4–5.7 and paragraph 5.18).

15. The two hospitals provisionally earmarked for divestiture each offered several services not provided elsewhere in the HCA network: London Bridge (eg [redacted]) and Princess Grace (eg [redacted]). They were not stand-alone, autonomous businesses which could easily be separated without damaging the network features. Moreover, divestiture would not create a new competitor for the treatments or specialized services currently provided by the two hospitals.
16. The hospitals remaining in the network would also be damaged by the loss of the network synergies the network created that were currently created. This might include the loss of specialized services that are no longer feasible and lower levels of investment in the overall network.<sup>13</sup>

### *Effect on prices*

17. In HCA's view, the CC had provided no concrete evidence that consumer detriments were sufficient to justify the proposed divestitures. On the CC's own assessment, a 20 per cent reduction in concentration would at most give rise to a 3 per cent price reduction for self-pay patients. Moreover, there was no evidence that PMIs would pass on any price reductions to subscribers. On the contrary, the evidence suggested that PMIs would not do so and therefore there would be no benefits to PMI subscribers.
18. HCA did not consider that divestment was likely to lead to any material reduction in prices. Its hospitals had substantial fixed costs; inflation in the medical sector was high; the CC had provided no robust or credible evidence that HCA's prices were significantly higher than those of comparable suppliers ([redacted] charged higher prices to BUPA and its charges to other insurers were not demonstrably much lower than those of HCA). Without the synergies of the services offered by the HCA network, a

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<sup>13</sup> [HCA response to Remedies Notice](#), paragraphs 6.42 & 6.43.

new entrant would struggle to replicate the same level of efficiency and quality and may have in some cases to raise its prices.

### *Two scenarios*

19. All in all, HCA said, divestiture of the two hospitals would be likely to lead to one of two scenarios, neither of which would address the CC's concerns:

#### *either*

(1) a new owner pursued an alternative strategy that did not maintain the same level of investment and would change the nature of the hospitals and their services thereby failing to create an additional effective competitor to HCA's hospitals;

#### *or*

(2) the new purchaser pursued the same strategy of maintaining high-quality advanced clinical services. But there would be little scope to reduce prices to PMIs and self-pay patients, and some prices could even rise because of the loss of synergies.<sup>14</sup>

### *Wider implications*

20. HCA identified several other negative effects arising from a divestiture process. These are summarized below.

#### *Effects on investments*

21. HCA's current investment plans for the two hospitals were substantial. These investments would not go ahead in the event of divestment.<sup>15</sup> Furthermore, HCA described the larger investment plans for its wider hospital network that would also be put at risk.<sup>16</sup>

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<sup>14</sup> [HCA response to Remedies Notice](#), paragraph 6.27.

<sup>15</sup> *ibid*, paragraph 6.47.

<sup>16</sup> *ibid*, paragraph 6.54.

22. Divestment of the two hospitals would also adversely affect HCA's business planning, putting at risk planned investments elsewhere in London. A compulsory divestiture of assets which had taken many years to develop would also be likely to have a chilling effect on investment in the UK. Potential investors, particularly from overseas, would be justifiably concerned that long-term investment in healthcare could be at the risk of similar treatment.<sup>17</sup>

*Staff recruitment and retention*

23. The process of divestiture would have other destabilizing effects—on recruitment and retention of consultants and other clinical staff and on the readiness of overseas patients to come to London. HCA said it was likely that leading consultants at the affected hospitals would shift their practice away as a result of the uncertainties created over the future of the business. HCA cited an example of how ownership uncertainty in the context of a US Federal Trade Commission investigation had caused a severe destabilizing effect on the hospital, including the large-scale defection of clinical staff.<sup>18</sup> This was a substantial asset risk for the hospitals.<sup>19</sup>

*New PMI contracts*

24. Under new ownership, the hospitals would not be covered by HCA's existing PMI contracts. These would need to be renegotiated.<sup>20</sup>

*Other remedies*

25. HCA noted that the CC had proposed other measures which were aimed at fostering greater competition and choice and limiting market power, such as relating to contractual restrictions between PMIs and hospital operators, terms of business with consultants and information availability. HCA also pointed to other remedies, not

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<sup>17</sup> *ibid*, paragraphs 6.54 & 6.55.

<sup>18</sup> *ibid*, paragraph 6.62.

<sup>19</sup> *ibid*, paragraphs 6.58–6.66.

<sup>20</sup> *ibid*, paragraph 6.68.

identified by the CC, that it considered could remedy the AEC the CC had provisionally found. These related to: lowering barriers to entry through greater assurance of PMI recognition to new entrants (which HCA noted was the core issue that reportedly triggered the OFT's original investigation, and was the key factor behind the failure and market exit of the London Heart Hospital);<sup>21</sup> a prohibition on fee-capping of consultants by PMIs; planning processes for new hospital developments; mandating the sale of surplus NHS properties in the NHS property portfolio on an open and transparent basis; limiting PMI market power; transparency of PMI/hospital operator contracts; dispute resolution for PMIs and hospital operators; and transparency on the availability of new sites.<sup>22</sup>

### ***Proposed divestments outside London: Spire and BMI views***

26. Both Spire and BMI criticized the CC for basing its remedy option on 'clusters' of hospitals owned by a single operator in the same 'local area', and were highly critical of the methodology used to define the clusters: ie network LOCI.<sup>23</sup> Both maintained that the CC's formulation of the proposed divestment was almost exclusively based on changes in the LOCI parameter and ignored available evidence relating to how the market actually worked in particular local area. In Spire's view, LOCI was not a proper basis on which to frame any divestment package 'because it cannot account for any qualitative assessment of competition in the relevant local area'.<sup>24</sup> BMI agreed that 'LOCI is simply not an accepted methodology for measuring concentration' and the decision to rely on it was unreasonable and irrational.

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<sup>21</sup> [HCA response to provisional findings](#), Section 7.

<sup>22</sup> [HCA response to Remedies Notice](#), paragraphs 6.72–6.75.

<sup>23</sup> LOCI = Logit Competition Index. BMI explained: 'Network LOCI measure the delta between an implied market share of an individual hospital and the implied market share of the entire BMI group in a given area'.

<sup>24</sup> [Spire response to Remedies Notice](#), paragraph 2.7(b).

27. Both hospital groups said that network LOCI overstated their competitive strength and that it was not capable of predicting the effect of a divestment on competition.<sup>25</sup> BMI said there was no or insufficient evidence to support the contention that ownership of hospitals within a cluster affected its bargaining power with insurers, the price that insurers could obtain, the conditions of competition for self-pay patients, or that any benefit conferred on insurers would reach consumers.

### *Spire Healthcare*

28. Spire maintained that there was already sufficient competition in the Leeds area. This was demonstrated by the market conduct of key insurers. For example, [REDACTED].<sup>26</sup> Further, the confidential qualitative evidence available to the CC clearly shows that there is already sufficient competition in the Leeds area.
29. Spire noted that the OFT had cleared its acquisition of the Classic Hospitals in 2008; this had given rise to the network effect that the proposed remedy was intended to remove. The OFT assessment had concluded that sufficient competition would remain after the merger despite having a standard of proof higher than the ‘balance of probabilities’ at the time.<sup>27</sup>
30. Spire argued that there was no reliable evidence that the divestiture of any of its hospitals in the Leeds area—the Elland, Leeds or Methley Park hospitals—would have the effect of increasing price competition and in turn lead to a reduction in price for self-pay and insured patients (the main rationale for the proposed remedy). The CC’s PCA, while it showed market-wide averages, did not suggest that divestiture of any individual Spire facility would increase price competition in the local area. The PCA carried out with respect to Spire did not show any effect of concentration on

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<sup>25</sup> See, for example, [Spire response to Remedies Notice](#), paragraphs 3.1–3.3.

<sup>26</sup> *ibid*, paragraph 2.7(d).

<sup>27</sup> *ibid*, paragraph 2.10.

self-pay prices. Moreover, insured prices were determined in a materially different way to self-pay prices and the CC's analysis of insured prices showed that Spire did not consistently or significantly price above operators with market power.<sup>28</sup>

31. The LOCI screen was misconceived (see paragraph 26 above) and (as with the PCA) provided 'no basis (even in theory) to presume the divestment of a Spire hospital in Leeds would be required, and hence no basis to presume it would increase local competition'.<sup>29</sup>

#### *Methley Park*

32. Spire argued that there was no evidence that requiring Spire to divest its Elland, Leeds or Methley Park facilities would be an effective means of achieving the CC's stated aim of increasing price competition in the Leeds area. The remedy proposed would not be effective and was therefore unlawful. Only the divestment of [X] could possibly meet the CC's LOCI-based test for divestment. If the CC were to insist on this divestment, there would be no need to divest any other facility, 'even on the basis of its own flawed test'.<sup>30</sup>
33. Spire gave another reason for suggesting that, if the divestment of any hospital were necessary, the most proportionate remedy would be the divestiture of [X]. The CC's theory of harm could logically only relate to lower acuity treatments offered by all three of Spire's Leeds hospitals. There was no overlap in the provision of high acuity treatments and procedures since Methley Park and Elland hospitals offered only lower acuity treatments, and no 'cluster' issue could therefore arise in relation to higher acuity treatments. 'Requiring Spire to divest its Leeds facility would be wholly

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<sup>28</sup> *ibid*, paragraph 2.7(a).

<sup>29</sup> *ibid*, paragraph 2.7(b).

<sup>30</sup> *ibid*, paragraph 2.9.

disproportionate because it would require Spire to divest assets (for higher acuity treatments) that play no part whatever in the CC's theory of harm.<sup>31</sup>

- *Costs*

34. Spire argued that, while no benefits were discernible, any divestiture could have significant costs for the divested asset:

- The considerable efficiencies Spire had brought to the hospitals it operated could be lost in the hands of another operator, ultimately leading to higher costs for consumers.
- The clinical excellence of its hospitals, in which Spire had invested heavily, could also be lost in the hand of another operator, resulting in a loss of competitiveness and reduced consultant confidence in the facility.
- [✂]. More generally, incentives for local entry or expansion by incumbent providers might be chilled because providers cannot assess whether the purchase or development of a new facility would lead to a 'cluster' in future.<sup>32</sup>

35. These cost disadvantages were important issues which were key to how a hospital competed, on quality and price, in a local area.<sup>33</sup>

- *Divestiture packages*

36. In considering whether divestment, if confirmed, would be sufficient to address the AEC, Spire suggested that it may be necessary to introduce a 'no poaching' agreement to guard against a situation where the divested hospital and a retained hospital drew consultants from the same Trust. (This, however, would not be an issue for Spire's hospitals in Leeds, which draw their consultants from different Trusts.)

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<sup>31</sup> *ibid*, paragraph 2.31(c).

<sup>32</sup> *ibid*, paragraph 2.29.

<sup>33</sup> *ibid*, paragraph 2.30.

37. If divestment went ahead, Spire considered that the divestment packages for its three Leeds hospitals might have the following components: [X].

38. Spire noted that the CC had concluded that inpatient, day-patient, and outpatient care were distinct product markets. In its analysis, Spire argued that the CC ignored outpatient and day-case providers as local competitive constraints on the basis that competitive conditions were different in those segments. There was no analysis or evidence as to why the CC's conclusions on in-patient care were relevant to outpatient or day-case care. Accordingly, Spire argued, it was not now open to the CC, as a matter of law, to extrapolate conclusions about competitive outcomes in inpatient care to outpatient and day-case care and accordingly any remedy must be limited to inpatient care and should not touch on outpatient or day-case care.<sup>34</sup>

- *Possible purchasers and timeline*

39. Should the divestiture remedy be confirmed, Spire considered that a large number of entities would have expertise, commitment and financial resources to run the divested facility competitively. These potential purchasers could be drawn from:<sup>35</sup>

- *Larger UK-based hospital operators.* In Spire's view, any constraints placed on such operators acquiring divested facilities (as BUPA advocated) would be unreasonable (as a matter of law, such restrictions would be inconsistent with the CC's theory of harm) and probably unworkable given the significant number of divested assets likely to come into the market. Spire suggested that acquisitions by existing operators should simply be subject to the same competition analysis as any other acquisition.

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<sup>34</sup> *ibid*, paragraph 2.31(d).

<sup>35</sup> *ibid*, paragraph 2.11.

- *Smaller UK-based operators.* Hospitals owned by several smaller operators (such as Aspen) already operated as effective competitors in various locations across the UK.
- *International operators.* Several could take an opportunity to enter the UK market, eg Nueterra Healthcare International from the USA, and Al Noor Hospitals Group from the UAE.
- *PMIs.* Some had previously purchased hospitals (eg BUPA acquired the Cromwell Hospital in London in 2008) and could be potential purchasers.
- *Private equity firms.* Several have previously purchased and operated private healthcare businesses, eg Cinven, Apax, and a financial purchaser could easily acquire the sector-specific expertise to run such a business.
- *NHS.* Depending on their location and proximity to other NHS facilities, the NHS might also be interested.

40. However, Spire suggested that potential purchasers might be put off by the outcome of the CC's market investigation into private healthcare, particularly its 'extraordinary approach to profitability and the risk-return available to investors'.<sup>36</sup> Moreover, it was not clear that there would be sufficient purchasers to acquire all of the divestment properties that would come on to the market at the same time.

41. With regard to the length of time that should be allowed for divestments, Spire commented that there might be several complicating factors:

- Spire—and other hospital groups—could not easily assess the full range of possible purchasers for each facility because the CC's local competition analysis is based on a flawed LOCI, which cannot be replicated.
- Only a buyer without facilities in the same geographic area as a divestiture hospital would be likely to meet the CC's approval criteria for suitable purchasers;

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<sup>36</sup> *ibid*, paragraph 2.12.

- there was likely to be an insufficient number of such suitable purchasers to acquire all the divestiture assets.
- Spire had limited internal resources to manage the divestiture process at the same time as assessing the potential purchase of assets divested by other providers.
  - In some cases, landlord or lender approval might be required for the disposal of a hospital site and might take some time to get.
  - It was likely that a potential purchaser would not proceed with a transaction unless the relevant PMIs confirmed that they would recognize the hospital as part of their network. 'Spire would expect PMIs to use the opportunity [of the divestments] to delay and/or deny recognition, and/or renegotiate existing agreements as a condition for continuing recognition.'
  - Purchasers would be required to obtain additional regulatory approvals, such as CQC registration (which can take up to eight weeks).<sup>37</sup>

42. While Spire considered that the standard six-month divestiture period the CC normally allowed should be sufficient, a flexible timeline and process might be needed.

### *BMI Healthcare*

43. BMI stated that [REDACTED].

44. [REDACTED]

45. [REDACTED]

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<sup>37</sup> *ibid*, paragraph 2.26.

46. Divestments are highly likely to remove efficiencies from BMI's operations that are currently benefiting patients. [✂]
47. BMI's ability to execute its investment strategy would also be undermined. [✂]
48. The investigation is likely to adversely affect investors' (particularly foreign investors') perception of the UK as a destination for their risk capital; 'the perception will be that the CC has targeted the predominantly foreign-owned private healthcare providers<sup>38</sup> and left entirely uninvestigated and uncriticized the UK-owned PMIs'.

#### *Analysis of clusters*

49. BMI conducted detailed analysis of the competitive situation in each of the clusters in which the CC had proposed divestments of BMI hospitals. By analysing each cluster against a series of criteria it concluded that no divestments would be justified. The general findings under each criterion are set out below.

#### *The CC case for divestiture*

50. As stated in paragraph 26, BMI considered the competition analysis divestment was intended to solve as almost entirely dependent on an unsound methodology.

#### *Effectiveness of divestment*

- *Insured patients*

51. BMI saw no evidence that ownership of hospitals within a cluster affected BMI's bargaining position or the price that insurers can obtain. There was no or insufficient evidence that divestment of such hospitals would be effective in improving the position of such insurers.

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<sup>38</sup> BMI, Ramsay, HCA and Aspen are ultimately foreign-owned.

52. Moreover, BMI questioned the extent to which lower prices charged by hospital groups would be passed through to patients. While the CC identified lower prices as an objective of the divestment remedies, it did not quantify or establish a framework for assessing how the windfall conferred on insurers would be passed through to customers. Lower prices that PMIs with market power had achieved in the past did not appear to have been passed on in lower premiums for customers.
53. There was evidence from other hospital operators and PMIs of a highly competitive local landscape. As AXA PPP had noted, the real basis for competition between hospital groups was for specialists rather than for patients.<sup>39</sup>
- *Self-pay patients*
54. BMI said that there was no rational basis for considering that divestments within clusters would be effective in reducing self-pay prices. The CC's patient survey evidence showed that self-pay patients travelled an average of 44 minutes' drive-time to their hospital of choice. The CC's analysis, based on network effect LOCI and catchment areas, overestimated the importance of patients living in the immediate vicinity of hospitals and did not accurately reflect the substitutes available to patients. The clusters did not represent the range of choices available to self-pay patients.
55. BMI emphasized that there would be no change in self-pay prices as a result of additional competition within a cluster as there was no evidence that self-pay prices were already affected by local concentration, and that many hospitals were already adequately competitively constrained by self-pay.

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<sup>39</sup> [AXA PPP hearing summary](#), paragraph 25.

### *Proportionality of divestments*

- *Ending BMI's current customer-focused strategy*

56. In addition to the general disproportionality of divestments (see paragraph 5 above) divestments would end BMI's current customer-benefits-focused strategy. [✂]

- *Potential purchasers*

57. BMI argued that it would face a small pool of potential buyers. It assumed that, for purposes of purchaser approval, the CC would exclude firms which already had a hospital in a nearby local area. [✂]<sup>40</sup>

58. In BMI's view, should the CC pursue a divestment remedy, a timetable of [✂] would be appropriate.

- *Proportion of benefiting patients*

59. The detailed cluster analyses showed that only a small percentage of patients at BMI hospitals would benefit from the proposed divestments. BMI pointed out that the CC analysis of market outcomes focused on providers that offered inpatient care. The CC had presented no evidence of an AEC in respect of outpatient, walk-in/walk-out, day-case or NHS work undertaken by those providers. Moreover, because the CC acknowledged that Bupa had some countervailing buyer power (which BMI said in fact amounted to fully-countervailing buyer power) Bupa patients could be excluded from those who might benefit from enhanced PMI power.

### **Other hospital groups**

60. The smaller hospital groups held certain general concerns about divestitures, which were to a large extent shared by the PMIs (see separate section below). These included:

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<sup>40</sup> AXA PPP hearing summary, paragraphs 13.1–13.8.

- (a) any divestment package should be structured so as to stimulate the entry of a viable competitor to the larger groups;
- (b) the growth of PPU's in NHS hospitals should be controlled; and
- (c) some measure should be aimed at preventing consultants moving between its divested and retained facilities.<sup>41</sup>

## **Circle**

61. Circle strongly supported 'the principle of divestiture as the most suitable remedy to redress the entrenched dominance of the national chains and HCA'.<sup>42</sup>
62. In London, Circle would not consider that separate sales of single HCA hospitals would remedy the AEC or ensure the creation of a sufficiently strong new competitor. But it also did not consider that the remedy would only be effective if the entire package was divested to a single owner and thought that ownership by two or more purchasers would be most effective. Circle also proposed that:
- (a) HCA should not be permitted to run more London PPU's or acquire healthcare assets for five years; and
  - (b) consultants at divested facilities should not be allowed to move to other HCA facilities for two years.
63. Outside central London, Circle recommended that anti-circumvention measures be put in place to prevent consultants moving to other hospitals in a group and PPU's operated by a divesting group should be included in the divestitures.
64. Both within and outside central London, Circle considered that sales should be made as soon as possible and completed within six months.

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<sup>41</sup> For example: 'If consultant drag cannot be overcome, then an acquirer might reasonably expect the attractiveness of any divested facility to decline materially post-acquisition as patients treated by top-performing consultants are distributed among other HCA facilities.' [Nuffield response to Remedies Notice](#), paragraph 2.9.

<sup>42</sup> [Circle response to Remedies Notice](#).

### ***The London Clinic***

65. TLC agreed that any divestments in central London should be structured as a package to ensure that any new entrant could be an effective competitor. In its view, a divestment package for central London should include:
- (a) one or more hospitals currently offering a range of tertiary treatments on a sufficient, viable scale (ie London Bridge Hospital, The Wellington Hospital and The Harley Street Clinic);
  - (b) oncology as a speciality within that range of tertiary treatments; the remedy should seek separate ownership of the assets and facilities which underpin HCA's dominant position in oncology;
  - (c) a break-up of HCA's 'superdominant' position at a sub-speciality level; in oncology, the Wellington and Leaders in Oncology Care (LOC) dominate in chemotherapy, the Harley Street Clinic and LOC hold a dominant position in radiotherapy; and
  - (d) a prohibition on hospitals with significant market power in central London from making further acquisitions of hospitals or relevant assets without prior approval from the CMA.
66. TLC considered that a suitably composed package would attract interest from several prospective purchasers, including from some not currently present in central London, and from overseas buyers. In the past American organizations had been keen to enter the London market and there had been recent interest from the Far East and Middle East.<sup>43</sup> It considered that six months was a sufficiently long divestiture period.

### ***Nuffield***

67. Nuffield believed a divestiture programme for central London would be an appropriate remedy that would enlarge the options open to PMI negotiators. However,

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<sup>43</sup> [The London Clinic hearing summary](#), paragraph 7.

divestment should be accompanied by other remedies to address tying and bundling and to overcome ‘consultant drag’. Nuffield considered that it would be helpful for assets in central London to be sold individually, rather than bundled for sale; the HCA hospitals in question were sufficiently large to be able to compete effectively on a stand-alone basis; selling single hospitals would widen the range of prospective purchasers, as well as offering more choice to the consumers and consultants; divestiture should be made fairly available to all suitable and interested parties.<sup>44</sup>

68. Nuffield broadly supported the CC’s possible remedy for a divestment of certain ‘cluster’ hospitals *outside London*. However, the remedy should be taken further and needed to rebalance the portfolios of hospital operators so that no single player controlled a critical mass of ‘must have’ hospitals—ie hospitals with a high market share in markets with a high concentration of corporate.<sup>45</sup> At present the number of ‘must haves’ in the portfolios of dominant hospital operators was far higher than those of other market participants; this had a direct negative impact on self-pay patients; the disparity should be narrowed, to the benefit not only of self-pay patients but, on a national level, of insured patients also.

69. Nuffield saw no justification for including GP clinics in divestiture packages. It considered six months an adequate time to allow for a divestment, recalling that its disposal of its nine hospitals (to BMI) took roughly that time.<sup>46</sup> Nuffield expressed confidence that appropriate purchasers, with the necessary expertise, commitment and financial resources, were available.<sup>47</sup>

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<sup>44</sup> See [Nuffield response to Remedies Notice](#), paragraphs 2.2–2.35 and [Nuffield response hearing summary](#), paragraphs 1–11.

<sup>45</sup> [Nuffield response to Remedies Notice](#), paragraph 2.25.

<sup>46</sup> [Nuffield response to Remedies Notice](#), paragraph 2.19.

<sup>47</sup> *ibid*, paragraphs 2.12 & 2.27.

## **Ramsay Health Care**

70. Ramsay believed that a divestment remedy needed to be structured to ensure that all hospitals could continue to operate as viable undertakings; ‘cherry-picking’ should be avoided and hospitals should be sold without delay because uncertainty about its future could be detrimental to a hospital’s performance and viability. Ramsay said that selling all the hospitals to be divested in one package would give a purchaser the chance to enter or expand and become a viable competitor in the private healthcare market. This would be particularly so if a package included hospitals in central London.<sup>48</sup>

## **Private medical insurers**

71. Some PMIs, including Bupa Health Funding (Bupa), welcomed the proposed divestments in around 20 cluster markets, including central London, since they considered that these would increase rivalry in the local markets (in many cases from two hospital operators to three) and would reduce the scale of some of the larger hospital groups. This would lead to some improvements for self-pay and insured customers.<sup>49</sup>

72. Others were not convinced that divestiture was a necessary remedy. PruHealth, for example, thought that behavioural remedies should first be applied to the large hospital groups.<sup>50</sup> Simplyhealth opposed a divestiture package. It believed that ‘a divestiture strategy, particularly outside of London, could impact smaller insurers disproportionately and detrimentally, resulting in less customer choice and a greater concentration of the PMI market in fewer providers’.<sup>51</sup>

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<sup>48</sup> [Ramsay hearing summary](#), paragraph 4.

<sup>49</sup> [Bupa response to Remedies Notice](#), paragraph 4.27.

<sup>50</sup> [PruHealth response to Remedies Notice](#).

<sup>51</sup> [Simplyhealth response to Remedies Notice](#).

73. Other PMIs maintained that divestments by HCA in central London were essential, but were less convinced that the proposed divestitures by BMI and Spire outside London would be effective.
74. Neither in central London nor outside the capital did the PMIs believe that divestments were sufficient. Bupa<sup>52</sup> gave the following reasons:
- some of the main hospital groups would be left ‘broadly, if not wholly, unchanged; the large hospital groups would still have significant scale—BMI, Spire and Nuffield in particular; small insurers would still have little buyer power;
  - the divestments seemed likely to create at best three competitors of similar scale and scope and this would be an asymmetric triopoly because they would have differing capacities and specialisms;
  - unintended consequences since, if hospital groups have the option to sell one of two facilities, they are likely to sell the smaller and weaker of the two; and
  - because divestments would be made in only some geographical areas, only a minority of self-pay patients would benefit from lower prices (the CC’s estimate that prices would fall there by 3 to 4 per cent, while material, was not transformational).
75. Several PMIs therefore believed that the proposed remedies were not sufficient. They argued that they should be supplemented by other measures, such as:
- price controls, for example, of single hospitals, which were in effect natural monopolies (eg Bupa, PruHealth);
  - a radical overhaul of the charges/tariffs so that prices reflected the costs of providing services (eg PruHealth); and
  - divestment of asymmetric single or duopoly hospitals (eg Bupa<sup>53</sup>).

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<sup>52</sup> [Bupa response to Remedies Notice](#).

### ***Divestment package: general principles***

76. Bupa said that it should be stipulated as part of the divestment package that, ideally, the operating company and underlying property should be sold together to the new owner. It understood that several large hospital groups (eg BMI) used Operating Company-Property Company (OpCo-PropCo) structures. A divested business might therefore be competitively constrained if it remained locked into high rental payments to the property owner.<sup>54</sup> The small hospital group, Circle, also raised this issue.<sup>55</sup>
77. PruHealth, in particular, was among PMIs arguing that, for a divestment package to be effective, it should extend across the whole estate, including consulting rooms and laboratories (see also paragraphs 90 to 93 below).
78. In Bupa's view, some potential purchasers were not suitable, for example one of the existing large hospital groups (BMI, HCA, Nuffield, Ramsay, Spire). There was also some concern that, if these groups participated in the divestment process, they would gain sight of confidential pricing data. If an insurer purchased a divested hospital (ie if there was any vertical integration), other insurers should have access to that facility on fair and reasonable terms.<sup>56</sup>
79. Bupa also warned that a single purchaser should not itself be allowed to become so large (particularly in central London)—an outcome some PMIs, such as Simplyhealth feared—as to be able to exert market power over insurers. Other PMIs (eg AXA PPP) said similarly that the CC should assess the overall make-up of the post-divestment holdings of individual hospital groups, both within and outside central London when it considered potential purchasers.

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<sup>53</sup> *ibid*, paragraphs 1.28 & 4.49–4.54.

<sup>54</sup> *ibid*, paragraph 4.56.

<sup>55</sup> [Circle response to Remedies Notice](#).

<sup>56</sup> [Bupa response to Remedies Notice](#), paragraphs 4.55–4.61.

80. Bupa considered that the timetable for divestment did not need to be longer than six months. If that proved unsuccessful, a divestment trustee should be appointed with a mandate to complete the deal within three months. AXA PPP would also support a relatively short timescale.
81. Divestment, several PMIs emphasized, should be part of a wider remedies package including several behavioural remedies, the appointment of a hold-separate manager and a ban on consultant incentives.

### ***Divestments in central London***

82. Some PMIs believed that the complete divestiture to a suitable purchaser of particular properties and assets by HCA in central London—a critical region for PMIs due to its importance for many corporate accounts—was the only effective remedy for the AEC the CC had identified in central London.
83. Most PMIs considered that a CC remedy requiring that different owners held each of the current HCA facilities would be disproportionate, and would want to see a larger divestment package implemented for central London, while avoiding the risk of a monopoly there.
84. Aviva, for example, saw a risk that that the divestiture of just certain key hospitals in central London would merely transfer market power from one owner to another. A different operator acquiring an HCA facility as a ‘going concern’ would be likely to continue to run it in the same way and with the same staff. There would not be likely to be any impact on price, at least for an initial period. The location of, for example, the London Bridge Hospital was likely to confer a degree of market power regardless of who owned it. For this reason, it was essential that additional remedies, such as behavioural remedies, be applied in central London. PruHealth, too, did not believe

that the sale of one or more of HCA's hospitals would necessarily exert downward pressure on prices; in all likelihood the new entrant would charge the same prices.<sup>57</sup>

85. Bupa believed the divested facilities should be sold to at least two separate acquirers; the effectiveness of the package would not then depend on a single purchaser; there were large hospitals, including some in London today, which could be run on a stand-alone basis.<sup>58</sup>

86. In Bupa's view, divestments in central London should aim to create effective competition in each of the nine main specialisms, not just in terms of aggregate shares. (Bupa claimed that HCA derived its strength from its dominance of key specialisms.) Further divestments, beyond those identified by the CC, would be required to remedy the AEC. Divestments should also be based on market share in terms of revenues, rather than admissions, 'because admissions are not like-for like from a funding perspective'.<sup>59</sup>

87. AXA PPP and Aviva considered that it was essential to have three 'credible groups' owning hospitals in London. AXA PPP would then be able to negotiate with each of these groups separately, requiring them to offer terms against each other, and AXA PPP would be able to offer patients a range of health insurance products.

88. To be 'credible', each group would need to include:

- a significant flagship hospital in central London; since the most significant hospitals in central London are TLC and the HCA-owned Wellington and London Bridge, HCA would have to sell one of these hospitals to an operator other than TLC;

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<sup>57</sup> PruHealth response to Remedies Notice.

<sup>58</sup> Bupa response to Remedies Notice, paragraph 4.102.

<sup>59</sup> *ibid*, paragraphs 4.65 & 4.100(i).

- Harley Street provision; since it owns two of the largest hospitals in the Harley Street area (The Harley Street Clinic and the Princess Grace), HCA would have to divest one of these to enable the three groups to compete in this area and to invest in any services they currently lacked;
- coverage of a full range of specialisms; this would require adding hospitals to the three groups to provide radiotherapy services in the case of London Bridge and Wellington, and cardiac surgery services in the case of TLC;
- high acuity cover; and
- a full cancer service, including radiotherapy (since this required capital investment and space, which most London hospitals did not have).<sup>60</sup>

89. AXA PPP also proposed that consideration also be given to HCA's position in relation to obstetrics and gynaecology (the Portland Hospital), and that HCA should be required to divest the primary care facilities it owned and LOC—a team of 50 leading consultants and specialists in that field—which it owned through HCA International.<sup>61</sup>

### ***Composition of packages***

90. The PMI's views on the hospitals and other healthcare assets that should be included in the packages were similar to those expressed by the smaller hospital groups and can be compared with those of at least one of the three large hospital groups (paragraphs 37 and 38).

91. Bupa's analysis showed that 'HCA must divest at least the inpatient and outpatient facilities' of certain hospitals.<sup>62</sup>

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<sup>60</sup> AXA PPP response to provisional findings and Remedies Notice, paragraphs 2.9–2.25.

<sup>61</sup> *ibid*, paragraphs 2.27–2.35.

<sup>62</sup> Bupa response to Remedies Notice, paragraph 1.15.

92. Several PMIs raised concerns about HCA-owned and operated PPUs in NHS facilities. AXA PPP said that HCA should be required to divest its PPU contract to run the private cancer unit at Guy's and St Thomas' NHS Foundation Trust and should be prevented from bidding for other PPU opportunities in central London. (HCA already runs the PPU at UCL.)<sup>63</sup> Bupa also said that there should be restrictions on HCA's potential expansion through PPU joint ventures (and the acquisition of GP clinics).
93. Aviva particularly emphasized that any divestiture package should include integrated GP practices so as to ensure that any new entrant could compete effectively against HCA and 'is not undermined by any attempts by HCA to use vertical integration to foreclose the market'.<sup>64</sup> Others, however, did not consider that HCA's ownership of GP practices contributed 'materially to consumer detriment'.<sup>65</sup>
94. PMIs expected strong interest from investors in acquired divested central London hospitals. Bupa suggested that potential purchasers included Circle, Aspen, private equity groups and overseas hospital groups.

### ***Concentration outside central London***

95. The PMIs in general considered that a divestiture package alone would not address the AEC outside central London. AXA PPP, however, did not experience the same level of disadvantage it experienced with HCA in London. In its experience 'while all the hospital groups have some areas where they are solus provider, this is, in most cases, broadly counterbalanced by them wanting to have as many of their facilities recognised as possible by insurers'.<sup>66</sup> AXA PPP was 'sceptical in the round of a remedy that requires BMI and Spire to divest hospitals', but nonetheless was open-

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<sup>63</sup> AXA PPP response to provisional findings and Remedies Notice, paragraphs 2.43–2.45.

<sup>64</sup> Aviva response to provisional findings and Remedies Notice.

<sup>65</sup> Nuffield response to Remedies Notice, paragraph 2.16.

<sup>66</sup> AXA PPP response to provisional findings and Notice of possible remedies, paragraph 2.56.

minded about the CC's approach.<sup>67</sup> PruHealth saw no evidence to suggest that there was any upward pressure on prices as a result of the dominance of hospital operators in certain important geographical areas.<sup>68</sup>

96. Aviva also thought that outside of London, divestiture remedies were less likely to be effective given the relatively small proportion of hospitals of concern that would be affected by the structural remedies. While agreeing that the CC should require divestitures in those areas where they would be expected to have a competitive effect, Aviva did not expect an immediate effect on prices. Rigorous behavioural remedies would also be required to address the market power of hospital groups.
97. Some PMIs considered that it could be difficult to sell divested hospitals outside London. Although Aviva, for example, believed that there would be buyers interested in acquiring hospitals in some areas outside central London, it thought it might be more difficult to find purchasers in some areas, based on demand, capacity and whether certain hospitals were specialists in an area.

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<sup>67</sup> *ibid*, paragraph 1.17.

<sup>68</sup> [PruHealth hearing summary](#), paragraph 12.

## Methodology for identifying 'clusters' of private hospitals

### Introduction

1. Our detailed local competitive assessments identified 101 hospitals outside central London which we provisionally found faced insufficient local competitive constraints and are therefore able to exercise a degree of unilateral market power.<sup>1</sup> However, as stated in the Remedies Notice, we did not consider that divestment was likely to be an effective remedy to the AEC in all these areas.
2. In this appendix, we set out our approach to identifying in which of these local areas a divestment remedy is likely to be effective in increasing competitive constraints. Our approach employed LOCI analysis, PCA and a detailed assessment of local areas which these led us to investigate further.

### LOCI

3. We first used the LOCI analysis to help us identify in a systematic way clusters of hospitals owned wholly or predominantly by one operator and where a divestiture remedy would be likely to increase the overall level of competitive constraints.
4. The LOCI analysis provided an indicative quantitative estimate of the effect of co-ownership on concentration in each local area. For each hospital we have calculated both an individual and a network LOCI based on data from insured patients, with the former identifying the market share of the individual hospital in the local area and the latter identifying the market share of the hospital group in the local area.<sup>2</sup> The difference between these two figures represents the 'network effect' or the increase in the hospital's market share that results from the co-ownership of other facilities in the

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<sup>1</sup> [X]

<sup>2</sup> See [provisional findings](#), Appendix 6.4, for a full description of the difference between individual and network LOCI.

local area. Where the network effect is small, a hospital is closer to the single/duopoly case and the divestment of a co-owned hospital in the local area is less likely to be effective in increasing competitive constraints.

- Table 1 sets out the number of hospitals of concern identified by our local assessments for each hospital group, which we have categorized by the size of the network effect.<sup>3</sup> The figures take into account our revised LOCI estimates.<sup>4</sup>

TABLE 1 Hospitals of concern (excluding central London)

Network effect	Number of hospitals of concern					Total
	BMI	Spire	Nuffield	Ramsay	Others	
[X]	[X]	[X]	[X]	[X]	[X]	[X]
[X]	[X]	[X]	[X]	[X]	[X]	[X]
[X]	[X]	[X]	[X]	[X]	[X]	[X]
[X]	[X]	[X]	[X]	[X]	[X]	[X]
[X]	[X]	[X]	[X]	[X]	[X]	[X]
[X]	[X]	[X]	[X]	[X]	[X]	[X]
[X]	[X]	[X]	[X]	[X]	[X]	[X]
[X]	[X]	[X]	[X]	[X]	[X]	[X]

Source: CC analysis.

## PCA

- While the existence of any network effect indicates that co-ownership is increasing concentration, we next considered the extent to which a decline in local concentration might be expected to lead to an improvement in competitive outcomes for consumers, such as lower prices and higher quality. We considered that this would help us to determine whether divestiture would be appropriate, since in areas where the network effect was present but weak, a divestment would not necessarily have a significant impact on prices.
- We considered that our PCA provided an insight into the likely impact of divestments on prices. The PCA identified and quantified a general relationship between concen-

<sup>3</sup> At this stage, we have not reflected in this table the impact of our revised local assessments in some areas since this analysis has not yet been conducted for all areas. However, we have removed those hospitals that are no longer considered to be of potential concern from Table 2 below.

<sup>4</sup> The LOCI figures have been updated in light of the data revisions made to the Healthcode data following provisional findings.

tration at the local level and self-pay price outcomes. It indicated that reductions of around 20 percentage points in a hospital's weighted-average market share are expected to lead to, on average, a 2 to 6 per cent decline in the average price charged to self-pay patients, with our preferred estimates lying between 3 and 4 per cent.<sup>5</sup>

8. We recognize that, while we have provisionally found that weak competitive constraints arising from local concentration, combined with barriers to entry, increases insured prices,<sup>6</sup> the relationship identified in the PCA does not provide direct evidence regarding the size of the effect of concentration on insured prices, since it relates to self-pay patients only. However, we believe that the PCA is likely to be illustrative in terms of the size of the effect and that an average price reduction in the region of 3 to 4 per cent for self-pay patients is a reasonable starting point for our analysis of in which local areas divestment would be an effective remedy, since we consider that 3 to 4 per cent, corresponding to a 20 percentage points decline in market share, represents a material reduction in prices.<sup>7</sup>

## ***Hospitals of concern***

### *Detailed local assessment*

9. On the basis of this analysis and reasoning we focused initially on those hospitals of concern (outside central London) with a network effect of 0.2 or more, of which there were 20 at the time we published our provisional findings (see Table 1). We have revised our assessment of two of these hospitals, BMI Edgbaston and BMI Runnymede, such that we no longer consider these to be hospitals of concern.<sup>8</sup> The

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<sup>5</sup> See [provisional findings](#), Appendix 6.9.

<sup>6</sup> See [provisional findings](#), paragraph 6.305.

<sup>7</sup> While the PCA is illustrative of the local price effects that are likely to result from reductions in concentration, the existence of national tariffs prices for insured patients means that a decline in concentration in one local market is likely to mean a decline in the overall national tariff price agreed between the PMIs and the PHP affected. Appendix 2.5 sets out our approach to quantifying the likely impact on prices of divestitures in more detail.

<sup>8</sup> As a result of these changes, there are no longer any hospitals in the Guildford–Runnymede–Windsor area that are both of potential concern and are caught by our LOCI filter. We have not, therefore, considered divestitures in this area.

18 (remaining) hospitals are located in ten separate local areas, with some areas containing more than one hospital of concern. We considered that divestitures may be an effective remedy in these local areas. As set out in paragraph 2.94 of the provisional decision on remedies, within these areas, we have considered a range of factors in coming to a view on whether a divestiture would in fact be appropriate in the local area.

10. Table 2 lists the hospitals of concern that have been identified based on having a network effect of 0.2 or more.

TABLE 2 **Hospitals identified in areas of concern (network effect)**

BMI Gisburne Park	BMI Chiltern	Spire Methley Park
BMI Shelburne	BMI Beaumont	
BMI Cavell	BMI Fawkham Manor	
BMI Bishops Wood	BMI Kings Park	
BMI Sloane	BMI Saxon Clinic	
BMI Highfield	BMI Beardwood	
BMI Chelsfield Park	BMI Lincoln	
BMI Carrick Glen	BMI Kings Oak	
BMI Droitwich Spa		

Source: CC analysis.

11. At the time of publishing our provisional findings, we had also reviewed our local assessments, which identified areas in which there appeared to be clusters of co-owned hospitals. In some cases, this approach identified clusters of co-owned hospitals in which the network effect associated with each hospital in the area fell below the 0.2 network effect but where there appeared to be the potential for divestments to have an impact on competitive dynamics. However, we thought that by applying a filter but then including some areas that had not been caught by the filter, this approach may result in inconsistent treatment. In coming to a view on divestitures, therefore, we have only reviewed those areas that were highlighted to have overlapping catchment areas on the basis of our LOCI network effect filter (of 0.2).

12. Each of the areas identified by this LOCI network effect filter is assessed in detail in Appendix 2.4.

## 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 a number of local areas and thereby reduce the market power of the private hospital operators, both vis-à-vis self-pay patients in the local markets where facilities are divested and with respect to the insurers who contract nationally with the PHPs.<sup>1</sup> 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'. In the final section, we apply these price falls to the EBITDA of the hospitals affected to show the 'pro-forma' post-divestiture EBITDA for each unit. This EBITDA estimate has been used to assess whether or not the hospitals that we propose should be divested are likely to attract interest from purchasers, as well as to estimate the proceeds that may be achieved from the sale of those hospitals.<sup>2</sup>

### Methodology

3. We thought that there were a number of approaches that 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

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<sup>1</sup> We note that an increase in competitive constraints could also be expected to have a positive impact on quality and innovation 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.

<sup>2</sup> [REDACTED]

on the prices paid by self-pay patients 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 between 3 and 4 per cent.<sup>3</sup>

4. For insured patients, on the other hand, we thought that there were three main options available to us:
  - (a) First, we could make the assumption that the relationship between concentration and insured prices was similar to that discovered by our PCA. This approach is consistent with our understanding of how prices are determined as set out in our provisional findings.<sup>4</sup>
  - (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 approximately [REDACTED] per cent in 2011.
  - (c) A third approach would be to consider the difference in prices charged by a single operator to insurers in competitive and less competitive areas. AXA PPP told us that in some areas it received discounts from the national tariffs agreed with some of the private hospital operators. For example, [REDACTED].

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<sup>3</sup> Provisional findings, paragraph 6.197.

<sup>4</sup> In effect, we found that the national prices paid by insurers were equivalent to the weighted average of the local prices that they would have paid for each hospital if all prices were negotiated separately. We did not find a compelling theory, or evidence to suggest that local market power could be magnified via common ownership.

5. In local areas outside central London, we thought that the most appropriate method of estimating the likely change in total private revenues resulting from a change in concentration would be to apply the coefficient identified in our PCA analysis to the changes in the weighted average market share of the hospitals following divestment to identify the price effect for both self-pay and insured patients. By taking into account the actual change in local market shares, rather than assuming a binary move from 'insufficiently constrained' to 'sufficiently constrained' (which would be necessary if using the insured price differences between those hospital operators with market power and those without), this approach provides an estimate of the total reduction in private revenue that is likely to occur in each area taking into account the specific competitive dynamics of that area. However, we reasoned that this approach might give a 'conservative' estimate of the impact of divestitures on insured prices given the size of the price differences we observed for single hospital operators between competitive and less competitive areas, as well as the differences between hospital operators with market power vis-à-vis the insurers and those without.
  
6. In central London, we thought that it was appropriate to estimate the likely reduction in prices (and hence revenues) using both the PCA approach, as described above, and by applying the difference in insured price between HCA and its closest London competitor (TLC) to HCA's private revenues. While we thought that this approach may be inaccurate in any given local area outside central London, we considered that it was more relevant within the central London market. In the former, the observed price differences exist at the national level and therefore will be the result of the level of market power held by a hospital operator across a relatively large number of local areas and not just that in which a divestiture is proposed, whereas in central London the difference in insured price between HCA and TLC is purely 'local'.

7. Next, we considered which of the private revenue streams would be affected by divestiture. As noted in our provisional findings (paragraph 6.4), while we focused on private hospitals and PPUs 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, as noted in our provisional findings (paragraph 6.203), 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. Therefore, we reasoned that it was appropriate to apply the estimated price effects to different private revenue streams in order to estimate a range of price benefits. We used the private revenue arising from inpatient treatments and day-case treatments to determine a base-case quantification of the benefits arising from divestments. However, we consider that our base case is conservative as we have assumed that the price of outpatient treatments would not decline as a result of divestitures, with only inpatient and day-case revenues being affected.<sup>5</sup> We used inpatient private revenue and total private revenue as sensitivities around our base case.

### **Quantification of price benefits**

8. For each potential divestiture, we have estimated the likely impact on the revenues of the divesting hospital group. We note that the decline in revenue relating to self-pay patients would be expected to take place via local price changes only. The decline in revenue relating to insured patients would be expected to take effect either via a (much smaller) decline in national prices, or via specific local discounts to the

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<sup>5</sup> We note that our PCA was based on inpatient procedures, while our insured price analysis was based on a common basket of both inpatient and day-case procedures.

national tariff, depending on how the insurers and hospital groups choose to negotiate.

9. The formula used to estimate the total revenue impact of a divestiture is:

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

10. The 'relevant revenue' stream refers to private inpatient plus day-case revenues, although we have also conducted sensitivities using just private inpatient revenues and total private revenues, as a down-side and up-side case, respectively. For example, the sale of Bishops Wood hospital reduces the weighted average market share of BMI in Bishops Wood's catchment area by [X] percentage points, which equates to a decline in prices of between [X] and [X] per cent.<sup>6</sup> Private revenues account for [X] per cent of total revenues, which leads to a decline in total revenues of between £[X] and £[X] on our base case at Bishops Wood.<sup>7</sup> The table below also shows the impact on CCH of the sale of Bishops Wood.

11. We note that the estimate of the price benefit is different depending on whether Bishops Wood is sold or whether CCH is sold. While these differences may give some indication of the extent to which alternative divestments are effective (in terms of reducing prices), given the necessarily approximate nature of these estimates, we consider that the two sets of figures are likely to provide a range within which we would expect the actual impact of the divestiture of either hospital would fall. We have assessed the effectiveness of alternative divestitures as set out Appendix 2.2.

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<sup>6</sup> Assuming a range of between 3 and 4 per cent decline in prices for every 20 percentage point fall in weighted average market share.

<sup>7</sup> [X]

TABLE 1 Estimate of the impact on hospital private revenues from the divestiture of Bishops Wood or CCH\*

FY11 revenues									
Hospital	Self-pay	Insured	NHS	Inpatient	Day-case	Outpatient	Total		
Bishops Wood	[£]	[£]	[£]	[£]	[£]	[£]	[£]		
Clementine Churchill	[£]	[£]	[£]	[£]	[£]	[£]	[£]		
Revenue reduction (£'000) (3%)					Revenue reduction (£'000) (4%)				
Impact on divestitures	Change in LOCI	Change in price %	IP	IP+DC	IP+DC+OP	Change in price %	IP	IP+D C	IP+DC+OP
<i>Sale of Bishops Wood</i>									
Bishops Wood	0.37	5.6	[£]	[£]	[£]	7.4	[£]	[£]	[£]
CCH	0.075	1.1	[£]	[£]	[£]	1.5	[£]	[£]	[£]

Source: CC analysis.

\*IP = inpatient, DC = day-case and OP = outpatient.

12. On this basis, we estimate that the divestiture of Bishops Wood would have a total revenue benefit of between £[£] and £[£] a year (base case).

13. We have conducted the same analysis for all the potential hospital divestitures, with the results set out in Table 2.

TABLE 2 Impact of divestitures on total private patient revenues

Hospital divested	Revenue reduction (£'000)		
	Inpatient only	Inpatient and day-case	Inpatient, day-case and outpatient
BMI Bishops Wood	[£]	[£]	[£]
BMI Clementine Churchill	[£]	[£]	[£]
BMI Chiltern	[£]	[£]	[£]
BMI Shelburne	[£]	[£]	[£]
BMI Kings Oak	[£]	[£]	[£]
BMI Cavell	[£]	[£]	[£]
BMI Chelsfield Park & BMI Sloane	[£]	[£]	[£]
BMI Chelsfield Park & BMI Shirley Oaks	[£]	[£]	[£]
BMI Saxon Clinic	[£]	[£]	[£]
BMI Three Shires	[£]	[£]	[£]
BMI Highfield	[£]	[£]	[£]
HCA London Bridge & HCA Princess Grace	[£]	[£]	[£]

Source: CC analysis.

Note: These estimates are based on FY11 revenue figures, including the split between inpatient, day-case and outpatient treatment and NHS- and privately-funded patients. As BMI did not provide revenue figures for Three Shires, we have not sought to quantify the price benefits of divestiture for this hospital. However, for our calculation for Saxon Clinic, we have made the assumption that Three Shires generated revenues of around £[£] million a year with a similar mix of patients (NHS/private and inpatient/day-case/outpatient) as Saxon Clinic and Manor.

14. This analysis shows that our base-case estimate of the impact of the divestiture of seven BMI hospitals is a decline in revenues of between £4.4 million and £5.9 million

a year (assuming that BMI divests the smallest possible divestiture package). For HCA, our base-case estimate of the decline in revenue resulting from the sale of the Princess Grace and London Bridge Hospitals is between £9.5 million and £12.7 million a year.

15. In central London, we also considered a second approach, which was to apply the [x] per cent difference<sup>8</sup> between the prices of HCA and TLC to HCA's various revenue streams. This approach assumes that, in a competitive market, HCA's prices would fall to match those of its closest competitor as it would no longer be able to exercise its market power vis-à-vis patients and insurers. We consider that this might be an underestimate of the benefit as TLC may be using HCA's price level as a benchmark, effectively pricing up towards the HCA level, whereas in a competitive market, it may also be forced to lower its prices in order to compete.
16. The estimated price benefits of divestiture are significantly larger using this approach, with an estimate of a £29.5 million decline in revenues on the basis that both inpatient and day-case revenues are affected by the increase in competition.

TABLE 3 Impact of divestitures on HCA prices

<i>Hospital divested</i>	<i>Revenue reduction (£'000)</i>		
	<i>Inpatient only</i>	<i>Inpatient and day-case</i>	<i>Inpatient, day-case and outpatient</i>
HCA London Bridge & HCA Princess Grace	[x]	[x]	[x]

Source: CC analysis.

Note: These estimates are based on FY11 revenue figures, including the split between inpatient, day-case and outpatient treatment and NHS- and privately-funded patients.

### Post-divestiture EBITDA (pro-forma)

17. In the case of BMI, we used the results of our analysis on the likely reductions in revenue that would result from divestitures, to estimate the EBITDA of each of BMI's

<sup>8</sup> Full details of our insured price analysis are set out in our provisional findings, Appendix 6.12.

hospitals following divestiture. We used these estimates to assess whether a hospital could be sold with its existing lease arrangements in place.<sup>9</sup> [✂].

18. Our estimates of post-divestiture EBITDA are based on the assumption that any reduction in revenue would be passed directly through to profits, ie for every pound reduction in revenue, EBITDA would also decline by one pound. This reflects the fact that our remedies are assumed to reduce prices but not to affect either the number of patients treated, or the variable costs of treating each patient. We note that this is a reasonably conservative assumption since we would expect a decline in price to stimulate an increase in demand, which would partially mitigate the decline in EBITDA, although we have not sought to model this increase in our current analysis. In addition, we have assumed that in each case, where BMI faces a choice of hospitals to divest, it will choose to sell the hospital with the lower level of profits (EBITDA).<sup>10</sup>

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<sup>9</sup> This also informed our assessment of the related question of whether a hospital facility would be an effective competitor if divested.

<sup>10</sup> [✂]

TABLE 4 Impact of divestiture on EBITDA of affected BMI hospitals, base case

	FY13 EBITDAR	FY13 rent	FY13 EBITDA	Range of impact on revenue		Post-divestiture EBITDA*		Post- divestiture rent cover
				Low	High	Low	High	
Bishops Wood	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Clementine Churchill	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Kings Oak	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Cavell	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Chiltern	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Shelburne	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Chelsfield	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Sloane	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Blackheath	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Shirley Oaks	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Fawkham Manor	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Saxon Clinic	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Three Shires	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Manor	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Alexandra	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Beardwood	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Beaumont	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Highfield	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]
Gisburne Park	[£]	[£]	[£]	[£]	[£]	[£]	[£]	[£]

Source: CC analysis.

\*This is based on our base-case estimates, ie applying the 3 to 4 per cent range of price effects to inpatient and day-case revenues.

Notes:

1. The impact on revenue estimates assumes that divestitures affect both inpatient and day-case private revenues but do not have an impact on outpatient (or NHS) revenues, ie this reflects our base case estimates. The 'Low' end of the range has been calculated on the basis of the low-end estimate of the PCA coefficient (3 per cent), while the 'High' estimate is based on using the upper estimate of the PCA coefficient (4 per cent).
2. BMI did not provide revenue figures for Three Shires, which it operates under a management contract. We have, therefore, made some high level assumptions in order to understand the impact of divestitures on its revenues. In particular, we have assumed that Three Shires generates revenue of approximately £[£] million a year.

[REDACTED]

## **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.<sup>1</sup> 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.

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<sup>1</sup> 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.

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 laboratory,<sup>2</sup> 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.

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<sup>2</sup> 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.

## ***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 Act<sup>3</sup> 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 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

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

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.<sup>4</sup> 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.

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<sup>4</sup> 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.

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).<sup>5</sup> 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.

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<sup>5</sup> 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.

29. The private healthcare system includes treatment in a private hospital, ambulance trips, dentistry, optometry and treatments such as physiotherapy and acupuncture.<sup>6</sup> 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, and more for older citizens<sup>7</sup>) 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.

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<sup>6</sup> [www.nib.com.au/home/newtonib/whynib/pages/publicandprivatesystem.aspx](http://www.nib.com.au/home/newtonib/whynib/pages/publicandprivatesystem.aspx).

<sup>7</sup> The rebate operates on a sliding scale and is means-tested.

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.<sup>8</sup> 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.<sup>9</sup>
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.<sup>10</sup>
33. There has been criticism in Australia<sup>11</sup> 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

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<sup>8</sup> 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.

<sup>9</sup> 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.

<sup>10</sup> Medical Board of Australia Code of Conduct for Doctors in Australia, section 8.11.

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

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.

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

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

## Bupa's proposed basic safety indicators

### Clinical audit

#### Deaths

Post operative:

- CVA (cerebro vascular accident)
- MI (Myocardial infarction)
- DVT (Deep vein thrombosis)
- PE (Pulmonary embolism)

Peri-operative mortality  
 Unplanned critical care Level 2  
 Unplanned critical care Level 3  
 Adverse—moderate  
 Adverse—severe  
 Adverse—death  
 Critical incidents/near misses

Patients undergoing local anaesthetic procedures who require admission  
 Hospitals acquired pressure sores  
 Stress urinary incontinence  
 Cardiac arrest/resuscitation events  
 Unscheduled return to theatre  
 Surgical patients requiring unplanned high-dependency care following surgery  
 Medical patients requiring HDU  
 Day cases not discharged as day case—medical indication for overnight stay  
 Patients transferred to other hospitals  
 Unplanned readmission within 31 days of discharge

Patients diagnosed with:

- MRSA
- MSSA
- E Coli
- C Difficile

#### Hips, knees and other

Hip SSI Risk 0  
 Hip SSI Risk 1  
 Hip SSI Risk 2  
 Hip SSI Risk 3  
 Knee SSI Risk 0  
 Knee SSI Risk 1  
 Knee SSI Risk 2  
 Knee SSI Risk 3  
 Hip surgery PROMS  
 Knee surgery PROMS  
 Varicose veins PROMS  
 Groin hernia PROMS  
 Cataracts PROMS

#### Complaints

Complaints—written

Stage 1 complaints % of activity  
Number of open complaints  
Average number of days to close complaints  
Complaints stage 2  
Complaints stage 3

### **WHO surgical safety checklist**

Patient falls  
Risk assessed  
Serious injury  
Unplanned daycase admission  
Blood prescribed 'off schedule'  
Blood transfused off schedule/wasted top ups  
Number of successful resuscitations  
Compliance to care map  
VTC risk assessment  
Prophylactic interventions

### **Audit**

Health & safety  
Medicines management  
Blood transfusion (see section above for alternative metrics)  
Radiology protection  
Infection prevention

### **Training**

MAT mandatory % of average contracted staff  
MAT safeguarding children % of average contracted staff  
MAT vulnerable adults % of average contracted staff

### **Length of stay by procedure**

**WPA consultant fees template letter**

**Mr John Smith FRCS**  
Consultant Orthopaedic Surgeon

Mr A Patient  
1 Lane  
New Town  
NT1 2AB

The Consulting Rooms  
XYZ Hospital  
123 Road  
Any Town ABC 123

11 September 2013

Dear Mr Patient

Following your referral to me by your GP Dr Brown with regards to you knee problem, I am pleased to confirm your appointment to see me on Wednesday 14<sup>th</sup> September at 2.30pm at my consulting rooms at XYZ Hospital.

It is possible that at the time of this consultation you may well undergo an x-ray or other diagnostic tests and I am pleased to attach a copy of my standard terms of business and other additional information which I trust you will find useful.

In the event that this appointment is not suitable please contact my secretary Jane Smith on 01651 355466.

Yours sincerely

John Smith FRCS

**Mr John Smith FRCS** Consultant Orthopaedic Surgeon,  
The Consulting Rooms, XYZ Hospital, 123 Road, Any Town, ABC 123  
GMC number 123456 Tel: 01651 355 466 email: [john.smith@ortho.com](mailto:john.smith@ortho.com)

# Mr John Smith FRCS

Consultant Orthopaedic Surgeon

The Consulting Rooms, XYZ Hospital, 123 Road, Any Town, ABC 123  
GMC number 123456 Tel: 01651 355466 email: [john.smith@ortho.com](mailto:john.smith@ortho.com)

## Terms of business 2013

Initial consultation fee £200  
Follow-up consultation fee £120

At the time of your consultation, you may be required to undergo some tests or treatment to help with your diagnosis or care and you will be billed direct by XYZ hospital for these.

### Please see below examples of XYZ hospital prices for your information:

X-ray knee	£90	Full blood count	£50
X-ray hip	£100	Bone density scan	£150
X-ray spine lumber	£140	Injection of joint	£150
Ultrasound scan	£220	CT scan	£400
MRI scan 1 area	£350	Physiotherapy	£40/30mins

XYZ hospital will be pleased to provide you with a detailed cost estimate of any tests you may require in advance. A more detailed list of prices is also shown in the Outpatient waiting room.

In the event that you subsequently require an operation, Mr Smith will provide you in advance with a written estimate of his surgical fees and also that of any anaesthetic fee. XYZ Hospital will also provide you with a separate written estimate.

### An indication of typical surgeon and anaesthetist fees is shown below:

Diagnostic arthroscopy of joint W8700	Surgical fee £300	Anaesthetic fee £200
Therapeutic knee arthroscopy W8520	Surgical fee £550	Anaesthetic fee £270
Knee replacement surgery W4210	Surgical fee £1,100	Anaesthetic fee £525
Hip replacement surgery W3712	Surgical fee £1,000	Anaesthetic fee £450

Sometimes surgical operations may be less or more complicated than originally planned. Unless otherwise agreed, any fee billed will reflect the treatment actually carried out. Mr Smith will discuss the likelihood of this with you.

If you have health insurance you are strongly advised to contact them and discuss fees and the extent of your cover in advance. Please note that the contract for treatment is between you and Mr Smith not an insurance company—any shortfall in fees will remain your liability. All fees are payable within 21 days.

For further information on Mr Smith's qualifications, experience, outcomes data and a full list of fees please see: [www.johnsmith.orth.com](http://www.johnsmith.orth.com)

Mr John Smith is an equity partner in XYZ hospital.

## Glossary

<b>Act</b>	The Enterprise Act 2002.
<b>Acute condition</b>	A medical condition of typically short duration which has severe symptoms (as opposed to chronic conditions which are persistent and recurring).
<b>Admission</b>	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 <b>day-case patient</b> or an <b>inpatient</b> .
<b>AEC</b>	Adverse effect on competition as set out in section 134 of the <b>Act</b> .
<b>Annotated issues statement</b>	The annotated issues statement published on 28 February 2013.
<b>Aviva</b>	Aviva Health UK Limited, a principal subsidiary of the Aviva plc, provider of insurance, savings and investment products.
<b>AXA PPP</b>	AXA PPP healthcare, a subsidiary of The AXA Group and provider of <b>PMI</b> .
<b>BMA</b>	British Medical Association, the trade union representing registered medical practitioners including consultants.
<b>BMI</b>	BMI Healthcare, part of <b>GHG</b> , a private hospital group in the UK.
<b>Bupa</b>	A provider of <b>PMI</b> and a <b>hospital operator</b> .
<b>Catchment area</b>	Geographical area from which a hospital draws most of its patients.
<b>CC</b>	Competition Commission.
<b>CC2</b>	Merger references: Competition Commission Guidelines (June 2003).
<b>CC3</b>	CC Guidelines for market investigations: Their role, procedures, assessment and remedies (April 2013).
<b>CCSD</b>	The Clinical Coding & Schedule Development. A group consisting of representatives from five <b>PMIs</b> : <b>Aviva</b> , <b>AXA PPP</b> , <b>Bupa</b> , <b>PruHealth</b> and <b>Simplyhealth</b> , which establishes and maintains a common standard of procedure codes and narratives within the independent healthcare sector.
<b>Central London</b>	The area inside the North and South Circular Roads.
<b>Circle</b>	Circle Holdings PLC, a <b>private hospital operator</b> .
<b>Cluster areas</b>	Areas where a private hospital operates two or more facilities in the same local area such that the facilities have overlapping catchment areas.

<b>CMA</b>	Competition and Markets Authority.
<b>Consultant</b>	A registered medical practitioner who holds or has held or is qualified to hold an appointment as a consultant in the <b>NHS</b> in a speciality other than general practice or whose name is on the register of specialists kept by the <b>GMC</b> . A consultant may work exclusively for the <b>NHS</b> 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 <b>NHS</b> .
<b>Corporate PMI</b>	<b>PMI</b> provided by an employer to its employees and in some cases dependants of the employee.
<b>Corporate policyholder</b>	A person who is covered by <b>PMI</b> through a <b>corporate PMI</b> .
<b>Cost of capital</b>	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.
<b>CQC</b>	Care Quality Commission, a non-departmental public body established to regulate and inspect health and social care services in England.
<b>Day-case patient</b>	A patient admitted electively 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 <b>inpatient</b> .
<b>DoH</b>	Department of Health in England.
<b>Drive-time</b>	Time taken to drive from the patient's home to a hospital.
<b>Duopoly areas</b>	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.
<b>GHG</b>	General Healthcare Group, a <b>private hospital operator</b> . GHG is the parent company of <b>BMI</b> , which manages its hospitals.
<b>GMC</b>	General Medical Council, the independent regulator for doctors in the UK.
<b>GP</b>	General Practitioner, a doctor who works in a local surgery or health centre, providing medical advice and treatment to patients registered on their list.
<b>GP referral</b>	A referral from a <b>GP</b> for specialist treatment.
<b>Greater London</b>	The area outside <b>central London</b> but within the London Government Region defined by <b>ONS</b> .

<b>Healthcare provider</b>	A person that provides preventive, curative, promotional, or rehabilitative healthcare services including a hospital, clinic, <b>GP</b> , <b>consultant</b> or other medical professional.
<b>Healthcode</b>	A provider of online practice management software and services to the private healthcare market.
<b>Hospital Group</b>	A <b>private hospital operator</b> that operates more than one hospital.
<b>ICU</b>	Intensive care unit.
<b>Independent hospital</b>	A private hospital not belonging to a <b>Hospital Group</b> .
<b>Individual PMI</b>	<b>PMI</b> purchased by an individual for themselves and/or their dependants. An individual policyholder is a person who has individual PMI.
<b>Inpatient</b>	A patient admitted to hospital with the expectation that they will remain in hospital for at least one night.
<b>Insured patient</b>	A patient who will use <b>PMI</b> to pay (in whole or in part/the majority) for their medical care.
<b>Insurer network</b>	A list of private hospitals which are on a <b>PMI's</b> approved list. Some <b>PMIs</b> create narrower networks for different types of policies.
<b>Issues statement</b>	The statement of issues published on 22 June 2012.
<b>LOC</b>	Leaders in Oncology Care (previously London Oncology Centre).
<b>LOCI</b>	Logit Competition Index, a concentration measure which formed the basis of the <b>CC's</b> use of weighted market share.
<b>London</b>	The combined area of <b>central London</b> and <b>Greater London</b>
<b>Main hospital groups</b>	<b>BMI, HCA, Nuffield, Ramsay</b> and <b>Spire</b> .
<b>Monitor</b>	The independent regulator of <b>NHS</b> foundation trusts, directly accountable to Parliament. Monitor was established in January 2004 to authorize and regulate <b>NHS</b> foundations trusts.
<b>NHSs</b>	National Health Services in England, Scotland and Wales and the Health and Social Care Services in Northern Ireland.
<b>NHS Trust</b>	A public benefit healthcare organization created by Act of Parliament to treat <b>NHS</b> patients.
<b>NICE</b>	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.

<b>NRV</b>	Net realizable value. The amount that can be obtained by selling an asset net of selling expenses.
<b>Nuffield</b>	Nuffield Health, a <b>private hospital operator</b> .
<b>ONS</b>	Office for National Statistics.
<b>OFT</b>	Office of Fair Trading.
<b>OPCS coding 1CD-10</b>	An international standard for diagnostic coding.
<b>Outpatient</b>	A patient treated in a hospital, consulting room or clinic, who is not admitted.
<b>PCA</b>	Price-concentration analysis.
<b>Provisional decision on remedies</b>	The provisional decision on remedies published on 16 January 2014.
<b>PHIN</b>	Private Healthcare Information Network, a body whose membership is made up of <b>private hospital operators</b> .
<b>PMI</b>	Private medical insurer/insurance. An insurance product under which an insurer agrees to cover the costs, in whole or in part, of acute medical care.
<b>PPU</b>	A private patient unit is a facility within the <b>NHS</b> providing medical care to private patients. Such units may be separate units dedicated to private patients or be facilities within the main <b>NHS</b> site which are made available to private patients either on a dedicated or non-dedicated basis.
<b>Provisional findings</b>	The provisional findings of 28 August 2013.
<b>Privately-funded healthcare services</b>	Services provided to patients via <b>private hospitals</b> and other facilities, including <b>PPUs</b> through the services of consultants, medical and clinical professionals who work within such facilities.
<b>Private hospital</b>	A hospital that charges fees for its services including a <b>PPU</b> . Except where the context provides otherwise, hospital refers to a <b>private hospital</b> .
<b>Private hospital operator</b>	A person that operates a <b>private hospital</b> .
<b>Private healthcare provider</b>	A <b>healthcare provider</b> that charges fees for their services.
<b>Private patient</b>	A patient who pays for medical services either as a <b>self-pay patient</b> or as an <b>insured patient</b> .
<b>PruHealth</b>	Prudential Health Services Limited and Prudential Health Insurance Limited, providers of <b>PMI</b> .
<b>Ramsay</b>	Ramsay Health Care UK Operations Limited, a <b>private hospital operator</b> .

<b>Relevant customer benefit</b>	A benefit as defined by section 134(8) of the Act.
<b>Remedies Notice</b>	The notice of possible remedies published on 28 August 2013.
<b>Scottish Government</b>	The Department of National Services Scotland.
<b>Self-pay patient</b>	A patient who pays for their medical care themselves.
<b>Simplyhealth</b>	A <b>PMI</b> provider.
<b>Single areas</b>	A local area served by one hospital.
<b>SLC</b>	Substantial lessening of competition.
<b>SME</b>	Small or medium-sized enterprise.
<b>Specialties</b>	The <b>GMC</b> divides areas of medical care into 65 specialties.
<b>Spire</b>	Spire Healthcare Limited, a <b>private hospital operator</b> .
<b>ToH</b>	Theory of harm.
<b>TLC</b>	The London Clinic, a <b>private hospital operator</b> .
<b>Welsh Government</b>	The Department for Health and Social Services in Wales.
<b>WPA</b>	Western Provident Association Limited, a <b>PMI</b> provider.