



# **Private healthcare market investigation**

## **Response to Divestment Options**

### **Bupa Health Funding**

**October 2013**

**Redacted version for publication**

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## INTRODUCTION

- 1.1. Bupa Health Funding ("BHF") welcomes the opportunity to assist the Competition Commission ("CC") in considering the proposed divestment remedies as set out in the CC's confidential Divestment Options Paper ("DOP") received by BHF on 19 September 2013. We have already provided separate responses to the CC's Remedies Notice and Provisional Findings which should be read in conjunction with this response.
- 1.2. BHF agrees that divestments in cluster markets offer an opportunity to improve hospital rivalry, in the short term, and so achieve better outcomes for self-pay patients and insured customers. Divestments are necessary and proportionate. The scale of the consumer detriment from hospital market power runs into the hundreds of millions of pounds per annum. The precarious trajectory of the market means transformation change is justified and is needed quickly. However, to achieve this change, **the choice of the appropriate hospital to divest in each cluster is essential**. Each divested business must be saleable (i.e. attractive to acquirers) and must be able to compete effectively and vigorously post transaction.
- 1.3. With this in mind, BHF believes the CC should amend some of its proposed divestments in the DOP. The table below summarises BHF's views on the divestment proposals.

**Table 1: Executive summary of cluster divestitures**

#	Local Area	Operator	CC proposed divestment	BHF proposed divestment
1	Central London	HCA	London Bridge <u>AND</u> Princess Grace	[X<]
2	Greater London (North West)	BMI	Bishops Wood <u>OR</u> Clementine Churchill	[X<]
3	Greater London (North West)	BMI	Chiltern <u>OR</u> Shelburne	[X<]
4	Greater London (North)	BMI	Cavell <u>OR</u> Kings Oak	[X<]
5	Greater London (South East)	BMI	Chelsfield Park <u>AND</u> Sloane	[X<]
6	Greater London (South West)	BMI	Runnymede <u>OR</u> (Princess Margaret <u>AND</u> Mt. Alvernia)	[X<]
7	Midlands (Birmingham)	BMI	Priory <u>OR</u> (Edgbaston <u>AND</u> Droitwich Spa)	[X<]
8	Midlands (Milton Keynes/Northampton)	BMI	Saxon Clinic	[X<]

#	Local Area	Operator	CC proposed divestment	BHF proposed divestment
9	North West (Manchester)	BMI	Beardwood <u>AND</u> Highfield	[REDACTED]
10	North West (Liverpool)	Spire	None proposed	[REDACTED]
11	Yorkshire	Spire	Leeds <u>OR</u> (Methley Park AND Elland)	[REDACTED]
12	Lincoln	BMI	None proposed	[REDACTED]
13	Essex	Ramsay	None proposed	[REDACTED]
14	Scotland	BMI	None proposed	[REDACTED]

1.4. BHF has explained in its response to the Remedies Notice that the CC must consider more far-reaching divestment options – in particular, in Single and Asymmetric Duopoly markets. Cluster divestments, while welcome, will not be sufficient on their own to deliver the scale of change required to put insurers on a level playing field with hospital groups, to alleviate consumer detriment and to put the market on a sustainable footing. Please see Section 4 (p17 to 28) of BHF’s Response to the Remedies Notice.

1.5. In particular BHF notes:

- i. The cluster divestments as proposed by the CC will leave Spire, Nuffield and Ramsay substantially (or wholly) unchanged in terms of scale and strength. Therefore, the divestments do little to improve the position (or resolve the detriment) of self-pay and insured customers of these operators.
- ii. As currently proposed, the CC’s remedies will not change to the levels of concentration in Scotland. [REDACTED] will continue to dominate this entire region. It is, therefore, extremely difficult to launch a low cost ‘national’ network attractive to customers (particularly corporates) where there is so little rivalry in Scotland. [REDACTED]

1.6. The additional divestments that BHF considers necessary are set out in paragraphs 4.52 and 4.53 of BHF’s response to the Remedies Notice. They are:

- i. If there is a price control on Single hospitals, a package of divestments of Asymmetric Duopoly hospitals to include:
  - a. **BMI:** [REDACTED]
  - b. **Spire:** [REDACTED]

- ii. If no price control was to take place, then in addition to the package of Asymmetric Duopolies above, the following Single hospitals should be divested:
  - a. **BMI:** [X]
  - b. **Spire:** [X]
  - c. [X]

## **PROCEDURAL POINTS**

- 1.7. The CC released the DOP to a defined list of employees and advisers of BHF under the terms of strict confidentiality undertakings. The information contained in this submission has been prepared under the conditions of the undertakings.
- 1.8. However, we note that at various points in the DOP, data and tables are fully redacted. This negatively impacts BHF's ability to make a full response.

## GENERAL COMMENTS ON DIVESTMENTS

- 2.1. Before examining each of the CC's proposed divestment areas in detail, this section sets out some general comments on the divestment packages:
  - i. Part A below sets out comments on the criteria the CC used to identify hospitals for divestment.
  - ii. Part B notes specific conditions we believe should be applied to the divestment packages.

### PART A: CRITERIA TO SELECT DIVESTMENT OPTIONS

- 2.2. The Appendix to the Remedies Notice explains how the CC selected the divestment options. The CC undertook a series of steps to identify the areas in which to consider divestments and then, within those areas, which facilities to choose as appropriate divestments.

#### *Step 1: Focus on clusters*

- 2.3. The CC focusses only on cluster markets, and rules out divestments in Single and Duopoly markets – e.g. “*Divesting a Single hospital would not remove market power*” (paragraph 4). BHF disagrees with the argument that divestments in Single or Duopoly areas would not improve outcomes for customers. The CC focuses only on the local dimension and rules these markets out because divestments would not increase the number of competitors in that local market. However, when you consider how hospital groups use these ‘hospitals of concern’ in negotiations with insurers, BHF believes that a divestment of (say) a Single hospital out of a larger group would improve (a) the insurer’s ability to negotiate improved terms with the residual group that has now had a key bargaining chip removed, and (b) the insurer’s ability to negotiate better terms with the Single hospital itself (e.g. because the reputational damage for the insurer of an out of contract situation would be contained to the single local market). Therefore, divestments in these markets must be considered. We will follow up with a separate paper explaining this view further.

#### *Step 2: Examine central London*

- 2.4. The CC identifies central London as a cluster market and says that divestments will be effective in removing the AEC (paragraph 6). BHF agrees that HCA divestments are necessary and proportionate in central London. However, we note that divestments on their own are not sufficient to address the AEC, and additional behavioural commitments are required (as described in Part B below).

### Step 3: Examine network effect for clusters outside London

- 2.5. The CC used the LOCI index to determine “in a systematic way” the cluster areas outside of central London where a single operator owned a number of facilities and where the divestment of a facility could improve competition in the cluster. The CC calculates the difference between a hospital’s “individual LOCI” and “network LOCI”<sup>1</sup> – this difference being the “network effect”, an indicator of the increase in the strength of the facility due to it being part of a wider group. The CC focusses on those facilities that have “a network effect of 0.2 or more” (paragraph 16) of which the CC identifies around [§<] in 11 local areas.
- 2.6. We agree that remedying this network effect is critical and that divestment is a clear cut way of doing so. However, as we have noted previously<sup>2</sup>, BHF has some concerns about the LOCI measure:
- i. It is computed on an assumption of a high level of aggregation of specialisms (considering 17 together) and also omits some important ‘less common’ specialisms. In this respect it may understate the importance and strength of a hospital.
  - ii. It does not capture the importance of some hospital facilities to key corporate accounts.
  - iii. It understates the importance of local access for insured customers at the point of buying PMI. The LOCI is based on observed patient travel patterns (at the point of consuming care) where the patient may travel further (e.g. to get to a specialist facility) than they *ex ante* would be willing to do at the point of buying the PMI cover.
- 2.7. Given the weaknesses in the LOCI measure, and so the resulting network effect, BHF has some concerns about the CC mechanistically using the LOCI metric to (a) identify relevant cluster options, but (b), more importantly, using the network effect alone to rule out certain divestments in cluster markets. For example, we note that were the CC to adjust down its threshold to a network effect of 0.15 there would have been a further 12 hospitals added to the list for further investigation (we estimate [§<] of these would be in Single or Duopoly areas<sup>3</sup>). We do not believe these 12 should be ruled out from consideration on ground only of not meeting the 0.2 network effect threshold.

### Step 4: Price effect from divestments

- 2.8. The CC explains that the self-pay price concentration analysis (“PCA”) found that a 0.2 change in the LOCI was likely to result in a 3 to 4 per cent change in prices – this implies that the

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<sup>1</sup> It is not explicitly stated in Appendix 1, but we assume the CC has used the LOCI base on patient admissions (rather than on revenues).

<sup>2</sup> See BHF’s response to the Annotated Issues Statement.

<sup>3</sup> [§<].

removal of a network effect of 0.2 would lower self-pay prices in that local market by just over 3%. BHF agrees that this PCA relationship (while based on self-pay analysis) “*is likely to be illustrative*” of the reduction in insured prices that could be achieved in that local market.

Increasing local rivalry will give insurers more choices in the local market and so may allow them to achieve better prices (and quality) on behalf of their customers. However, BHF observes further that:

- i. The price effect, of course, omits the other mechanisms through which customers may get a better deal – e.g. quality, innovation and efficiency. Therefore, we consider that the PCA will understate the improvement in outcomes for consumers.
- ii. The price-reducing effects may be far greater for insured customers than observed in self-pay PCA. Increasing hospital choices for insurers in local markets may allow them to launch low cost PMI products (e.g. products with narrower network configurations) which will welcome more people into the market (risk pool) and so assist in bring down costs for all insured customers. Similarly, if the cluster divestments materially reduce the size of the larger groups, insurers will get additional bargaining position relative to the residual group that will allow them to achieve better prices not only in the cluster market but also in other markets. Therefore, the potential gains from the cluster divestments will be large for insured patients (and may be understated by the self-pay analysis). However, this benefit will be unlocked fully only if more significant change is made to the bargaining positions of insurers relative to larger hospital groups.

2.9. As noted in our Remedies Response, BHF is very concerned that currently the proposed cluster divestments have little (or no) material impact on the strength of three of the main hospital groups – Spire, Nuffield, and Ramsay. This does not suggest that consumer detriment will be addressed fully. The price-reducing effect will be more muted for those insurers that remain in a position where they have no bargaining power against the larger hospital groups (even after the divestments). The largest groups, even after divestments, may retain the power to induce insurers to take all their (remaining) hospitals at a high price.

#### **Step 5: Identifying the relevant facilities in the cluster**

2.10. Finally, with the cluster hospitals identified, the CC undertakes a detailed investigation of each cluster area by looking at the criteria:

[><]

2.11. To this list BHF would add the following criteria:

- i. Hospital size and importance must also be assessed in revenue terms (and not just based on admissions). Admission shares will overstate the importance of hospitals that focus on routine, less complex, high volume procedures. Central London provides a



good example. HCA is able to exercise market power through having a large share of specialisms in which average cost per treatment (admission) is extremely high. Examining only admissions data will incorrectly rank the importance of HCA's facilities. To illustrate, [X] BHF also believes that revenue size will be important to potential acquirers and should, therefore, be used in determining which facilities will be 'attractive' to potential acquirers.

- ii. Market share and market size analysis must be conducted at a specialism level. Market shares within key specialisms are often very substantially higher than the hospital's aggregate share. Insurers need competition to function effectively within specialisms. Central London is again a key example where even if HCA divested The London Bridge and The Princess Grace it would maintain a very powerful share in [X]. There must be a particular focus on rapidly growing specialisms such as [X]<sup>4</sup>. In central London if HCA continues to dominate these specialisms it will have growing power over insurers in negotiations. The CC's assessment must be forward-looking in this regard.
- iii. The CC must assess the spare capacity and room for expansion available in the divested facilities. If the divested facilities are significantly capacity constrained then they may not be able to act as effective competitors to other facilities.
- iv. The CC must assess the cost and profitability of the divested facilities – "the economics" of the hospital. A 'high cost' facility (or one requiring significant additional investment to bring it up to specification) will be a weaker competitor, and so will not be able to lower prices effectively post divestment. Clearly, divestments with sound economics will be most attractive to acquirers. BHF is not itself best placed to comment on the underlying economics of individual facilities; however, we strongly request the CC to undertake this due diligence.
- v. BHF is concerned that a divested business may be restricted in its ability to compete (and reduce prices) if it remains locked in to high rental payments to the property company (landlord) owning the underlying property. BHF understands that a number of the large hospital groups (such as BMI) use Operating Company - Property Company (OpCo-PropCo) structures. The divestment package must take account of these structures, ideally selling the operating company and underlying property together to the new owner.

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<sup>4</sup> For example, research by Bupa in 2011 showed that the costs of cancer diagnosis and treatment in the UK can be expected to increase by over 60% in real terms by 2021. This would place significant additional pressure on NHS and private resources. See Cancer Diagnosis and Treatment: a 2021 projection, available at [http://www.bupa.com/media/355766/cancer\\_diagnosis\\_and\\_treatment\\_-\\_a\\_2021\\_projection\\_-\\_final.pdf](http://www.bupa.com/media/355766/cancer_diagnosis_and_treatment_-_a_2021_projection_-_final.pdf)).

2.12. BHF notes that, in most cases, divestment of the *largest* hospital in a cluster is likely to be the most effective option:

- i. Larger hospitals will attract a greater number of buyers, as they will be more attractive than smaller assets. The larger facility is likely to have a broader range of specialisms (and the capacity to switch between specialisms). Larger facilities may benefit from some economies of scale within the hospital. Larger facilities may also benefit from a more-established reputation in the local area which will improve the likelihood of attracting relevant consultants. The attraction of a greater number of buyers will increase the probability of a successfully implemented divestment.
- ii. The scale of large hospital groups in and of itself drives hospital group market power in negotiations with insurers. By divesting the larger of the hospitals in a given cluster, the CC will achieve more in reducing the total scale of large hospital groups (particularly BMI) which will temper their significant market power and improve the chances that insurer can negotiate effectively.

2.13. Finally, we note that the CC mentions an important additional criterion in the central London section of the DOP that we believe has relevance to all of the assessments. The CC notes:

*“Our guidelines on market inquiries 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.[footnote omitted] 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.[footnote omitted] 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., 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” (paragraph 27).*

2.14. BHF strongly agrees that, because private healthcare is differentiated, a hospital with an aggregate market share of under 40% may still have considerable market power. This is a further reason that specialism-level analysis should be conducted (it will help identify pockets of market power). We would agree that the [ $\geq$ ] benchmark provides a more useful benchmark. Indeed, there is differentiation even within a specialism that would justify an indicator level of under 40% applying within each specialism.

## PART B: CONDITIONS TO BE APPLIED TO THE DIVESTMENT PACKAGES

### *Suitability of purchasers for divested assets*

2.15. BHF expects that there will be significant interest from parties in acquiring the divested assets. These are likely to include private equity and international healthcare operators (US, Middle Eastern and European). [redacted]

2.16. In BHF's views, some potential purchasers are not suitable:

- i. We would have significant concerns (indeed would consider it counterproductive) if the purchaser is one of the other existing large hospital groups (BMI, HCA, Nuffield, Ramsay, Spire). This will simply expand that group's scale, which would be a concern in its own right, and could also increase the proportion of the group's portfolio that comprises 'must have' facilities. BHF's analysis of the CC's proposed list of facilities for divestment suggests that [redacted] of the facilities are either Single or Asymmetric Duopoly facilities which would simply bolster the strength of the large hospital group acquiring them. It would not be appropriate, for example, to have HCA buy non-London divested facilities from BMI/Spire as this would expand HCA's already significant scale.
- ii. We also have concerns about the other main hospital groups participating in the sales processes and in so doing gaining sight of confidential pricing data at the divesting groups.
- iii. The London Clinic should not be allowed to purchase The London Bridge Hospital, The Wellington Hospital or The Harley Street hospital. This would create a new operator with significant strength in central London.
- iv. A single purchaser may seek to buy a bundle of the divested hospitals. However, the CC must take care that this single purchaser does not itself become so large that it is able to exert market power over insurers (particularly smaller insurers). BHF particularly raises this concern in relation to:
  - a. Central London: a single acquirer should not be able to buy two (or more) of the three facilities: The London Bridge Hospital, The Wellington Hospital, and The Harley Street Clinic.
  - b. The larger BMI facilities considered for divestment. For example, were a single acquirer to buy the [redacted], the resulting group [redacted] would be of a similar scale in

terms of BHF's spend to that of [§<]<sup>5</sup>. Indeed, were a single acquirer to buy each of the largest BMI facilities in the proposed Cluster markets the resulting "NewCo" would be [§<]. BHF considers that creating groups of similar scale to [§<] would mean insurers would still not have sufficient bargaining power.

2.17. In principle, we would not object to another insurer purchasing a divested hospital (i.e. vertical integration between funder and provision). However, if that hospital is a 'must have' hospital or is particularly critical to serving corporate customers, then steps would need to be taken to ensure other insurers still have access to that facility on fair and reasonable terms. For example, if an insurer were to buy [§<].

### ***Timetable for divestments***

2.18. The timetable for divestment does not need to be longer than six months. If the divesting groups are unable to reach a deal within this period a divestment trustee should be appointed to make the sale within three months. It is in our view unfair to consumers for there to be a significant delay before the remedies take effect.

### ***Divestments must be part of a wider remedies package***

2.19. To be effective, divestments will need to be supported by a number of behavioural remedies:

- i. A hold-separate manager should be appointed immediately to avoid the divesting group using the period until divestment to redirect key staff (consultants), assets (medical equipment) and patient activity from the divested hospital to its retained facilities in the local area. The divesting group must not be allowed to devalue the competitive position of the divested facility.
- ii. A ban on consultant incentives should take immediate effect for the divesting group to avoid it 'poaching' all the key consultants from the divested hospital.
- iii. Any contractual clause in existing contracts between insurers and hospital groups that restrict the insurer's ability to guide volume away from the hospital group or to launch products and networks must be removed. If these clauses remain, the group may remain protected from the new rivalry created by the divestment.
- iv. In central London there must be a restriction on PPU partnership to prevent HCA reinforcing and growing its position post divestments.

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<sup>5</sup> We note that Ramsay, the smallest of the large groups, already earned excessive profits in 3 of the 5 years of investigation despite its lower margin NHS activities. This illustrates that groups even of Ramsay's size can exert market power.

2.20. We have assumed that insurers would be given the opportunity to negotiate terms with the divested facility. However, to maximise consumer benefits insurers must also be given the option (but not the obligation) to renegotiate existing contracts with the hospital groups that have divested facilities. Following divestment, the main hospital groups will have changed in size and composition. It would be inappropriate to allow the group to retain, for the full terms of the existing contract, the higher prices that it had negotiated when its market power was stronger.

## VIEWS ON SPECIFIC PROPOSED DIVESTMENTS

- 3.1. This section comments on the CC's specific proposed divestments (or lack thereof) in each of the 14 local cluster markets considered in the DOP.

### CENTRAL LONDON

- 3.2. Central London is an absolutely critical market to private healthcare in the UK because of its size and its importance to corporate customers of PMI. If HCA's stranglehold in central London can be broken, the market has strong potential for competition. We set out in detail our views on the structural and behavioural remedies that are required to address HCA's dominant position in central London in our response to the Remedies Notice (see Part 2 of Section 2 of BHF's Response to Remedies Notice). Therefore, we provide only brief comments here why we believe the CC's proposed divestment of The London Bridge AND The Princess Grace is insufficient.
- 3.3. In sum, the CC's proposed package will not be effective. HCA will retain too much power in central London, particularly in key specialisms. As the package will not satisfy the 'effectiveness' threshold, it is not necessary to assess its proportionality against other packages. A more far-reaching package is required for the remedy to be effective and for there to be a realistic prospect of the consumer detriment (already established and that will arise in future if insufficient action is taken) being addressed.
- 3.4. As presented in BHF's Remedies Notice response, our analysis shows that HCA must divest at least the inpatient and outpatient facilities of [X]. This is both effective and proportionate. It is both practical and desirable that [X] sold to separate acquirers. This would introduce two new competitors into central London, both with sufficient size and scope to be able to compete across the main specialisms. HCA itself would retain a share in central London of [X].
- 3.5. We discuss how we have arrived at this view and compare it against the CC's assessment method (as set out in paragraphs 3 to 37 of the DOP).

#### *The strength of the individual HCA facilities*

- 3.6. First, the CC examines the strength of the HCA facilities (a) at an aggregate level rather than at a specialism level and (b) based on admission shares. It is absolutely critical that the CC examines the central London market at the specialism-level and looks at shares in revenues terms. As shown in Figure 1 below (which is explained in further detail in our Remedies Response) HCA has far greater strength in key specialisms than is reflected in aggregate terms. There is a long tail of less important specialisms in which HCA has a smaller share.

## Figure 1: HCA's market share of BHF central London spend (2012)

[<]

- 3.7. Effective competition must be created in each of the main specialisms, especially the ones that are growing very rapidly (e.g. oncology). HCA currently controls over [<] (we assume this is broadly representative for other insurers too). Within key specialisms, certain hospitals in the HCA portfolio individually account for a large proportion of BHF's total spend on that specialism in central London (e.g. [<]). For there to be a realistic prospect of competition in central London, there needs to be effective competition within specialisms.
- 3.8. Looking only at admissions will also deliver a distorted view as it overstates the importance of high-volume hospitals that do routine procedures, where the higher complexity specialisms are the key areas of dominance for HCA (and a key reason why insurance networks cannot exclude HCA's hospitals). For example, [<]<sup>6</sup>.

### *Focussing on general hospitals*

- 3.9. We note the CC's statement that: *"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"* (paragraph 8). This is true only to a certain extent. We agree that divesting a very specialised facility like the Portland or Leaders in Oncology would not, on its own, introduce sufficient new competition across other specialisms. However, it should be recognised that there is a spectrum between general and specialised facilities. And, in fact, it can be harder for a general hospital to move up the complexity spectrum and start competing in more complex specialisms such as oncology (as it may require significant investment in equipment, specialist staff and reputation) than for a more specialist hospital to start offering more general treatments. [<]
- 3.10. To emphasise, if HCA divested The London Bridge and The Princess Grace, HCA would still maintain a share [<]. BHF (and we expect other insurers) would, therefore, still be beholden to HCA in out of contract scenarios, limiting BHF's negotiating power. We do not believe that The Princess Grace could expand sufficiently, within a reasonable period of time, to offer competition and choice in these important specialisms.

### *The CC proposed package*

- 3.11. The CC identifies four general hospitals ([<]): The London Bridge, The Wellington, The Princess Grace and The Lister. As noted, we do not believe the CC should have discounted

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<sup>6</sup> [<]

The Harley Street Clinic. Therefore, BHF believes the CC should re-include [redacted] in its evaluation.

- 3.12. The CC then says it does not believe a divestment package of all four would be proportionate (paragraph 12). We agree that a divestment of [redacted] would be effective, and so more proportionate than requiring all four to be divested.
- 3.13. The CC did not examine The Lister further as it exhibited fewer attributes in line with the other general hospitals. We agree that The Lister should not be considered further. However, rather than the concern about it being less of a general hospital, BHF is concerned it is too small, capacity constrained, and high cost to be an effective competitor (see Figure 1). Indeed, it would be a less attractive acquisition on a standalone basis meaning that it would likely have to be sold in conjunction with another flagship hospital and so would introduce fewer new competitors into the central London market.
- 3.14. The CC then examined the catchment areas of each facility and found a “*substantial overlap*” between The London Bridge, The Wellington, and The Princess Grace, although the catchment area of The London Bridge extends further towards the South East (paragraph 18). We cannot comment on this analysis – as it is redacted. However, we agree that there is an overlap between the three facilities. We emphasise that the location of The London Bridge is particularly important to serve the City and, therefore, BHF strongly agrees with the CC that The London Bridge must be part of the divestment package.
- 3.15. The CC then seeks to differentiate the three hospitals by payor type – PMI, self-pay, international. The CC says “*these data did help differentiate the three hospitals*” (paragraph 21); however, BHF is prevented from commenting because the tables are fully redacted. The CC notes also that it did not have the data to look at a segmentation based on corporate and personal spend. However, BHF considers this an important lens. If the facility is important to corporates it can have bargaining power over insurers. Figure 4 of BHF’s Remedies Response segmented by facility the spend of BHF’s Top 20 corporate customers. This showed [redacted]. There is also the risk that overtime the proportion of PMI customers that are Personal will shrink (as it has done over the past 15 years) relative to Corporate customers. Therefore, a hospital with existing strong corporate activity will likely remain a viable competitor (by contrast a facility that is very dependent on Personal customers may face a more challenging future).
- 3.16. The CC then examined the size of the hospitals. [redacted]. We agree strongly that the divestment of a single facility is insufficient and HCA would retain significant market power.
- 3.17. Therefore, the CC considers [redacted]. Figure 1, however, demonstrates why we believe the latter package would be ineffective.
- 3.18. [redacted]



3.19. [REDACTED]

3.20. [REDACTED]

### **Proportionality**

3.21. The CC considered that either the package of [REDACTED] would be effective in remedying the AEC in central London. Therefore, as The London Bridge AND The Princess Grace would comprise “the smaller package” it was more proportionate. BHF disagrees that this smaller package is effective; as explained, it would not introduce sufficient rivalry into many of the main specialisms.

3.22. The divestment of [REDACTED] is proportionate when one considers the scale of existing consumer detriment. Even with this divestment, HCA would remain [REDACTED] as large as other players in central London. Further, HCA is already poised to reinforce and expand its position in central London. For example, recent news reports show that HCA is taken the lease for three floors of The Shard as a site for a new private medical facility<sup>7</sup>.

### **Further divestments**

3.23. [REDACTED]

3.24. Provided HCA divests [REDACTED], BHF does not believe it is necessary for HCA to divest its existing PPU arrangements in central London. However, BHF strongly believes that HCA should be restricted from further expanding its scale in central London through new PPU arrangements.

3.25. We also note that AXA’s response to the Remedies Notice suggests that divestment of Leaders in Oncology to an independent and standalone operator would be welcome. We agree that this business appears easily separable from HCA (having only recently been bolted on to HCA). If HCA is obliged to divest [REDACTED] then BHF does not believe it is necessary to further require LOC to be divested (both the larger facilities would have the potential to expand their oncology activity). However, were the CC to continue with its proposed package of The London Bridge AND The Princess Grace we believe it would be critical to divest the LOC to create alternative provision in oncology, as [REDACTED].

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<sup>7</sup> <http://www.costar.co.uk/en/assets/news/2013/October/Shard-lands-biggest-tenant-so-far/>

## GREATER LONDON (NORTH WEST): BISHOPS WOOD AND CLEMENTINE CHURCHILL

- 3.26. The CC argues that the divestment of either Bishops Wood or the Clementine Churchill (CCH) would be effective in addressing BMI's market concentration in the cluster located around Harrow and Rickmansworth in North West London. However, the CC does [REDACTED].
- 3.27. BHF believes the **divestment of** [REDACTED] has a significantly higher probability of promoting effective competition in this cluster:
- i. [REDACTED]
  - ii. [REDACTED]

### Figure 2: Segmentation of BHF's specialism spend 2012

- [REDACTED]
- iii. [REDACTED]

- 3.28. We note also that the CC agrees that the CCH will exert a stronger constraint on the Bishops Wood than vice versa and [REDACTED]. This suggests that CCH would be able to compete more vigorously and more quickly. Given the scale of BMI and its strength in pricing relative to other operators, stronger and more vigorous competitors like an independent [REDACTED] would be welcome. It would more quickly address the consumer detriment.

## GREATER LONDON (NORTH WEST): CHILTERN AND SHELBURNE

- 3.29. The CC says that the divestment of either Shelburne or Chiltern hospital would be effective in addressing BMI's market concentration in the cluster located around High Wycombe and Great Missenden. The CC argues that [REDACTED].
- 3.30. BHF believes the **divestment of the** [REDACTED] has a significantly higher probability of promoting effective competition in this cluster:
- i. [REDACTED]
  - ii. [REDACTED]

### Figure 3: Segmentation of BHF's specialism spend 2012

- [REDACTED]
- iii. [REDACTED]

3.31. In BHF's view, [X] would therefore be a more effective competitor than [X] can be post divestment and will be able to play this role more quickly.

## GREATER LONDON (NORTH)

3.32. The CC identifies a cluster of two BMI hospitals in north London around Enfield – the BMI Cavell and BMI Kings Oak hospitals. The CC suggests that divestment of either of the two facilities in the cluster is likely to be effective in addressing local market concentration and suggests there is no strong case for proposing one facility ahead of the other.

3.33. Although the two hospitals are of similar size, the **divestment of the [X]** is likely to be more effective in promoting competition in the local area [X]. This means that [X] will struggle to compete with [X] without significant investment to bring it up to the standards expected by private patients. This would delay the competitive influence any purchaser of a divested [X] could exert within the cluster market.

## GREATER LONDON (SOUTH EAST)

3.34. The CC is proposing the **divestment of BMI's Sloane AND Chelsfield Park hospitals** within a wider cluster of five BMI hospitals in South East London (Blackheath, Chelsfield Park, Fawkham Manor, Shirley Oaks and Sloane).

3.35. We agree with the CC that divestment of these facilities is likely the most effective option in promoting competition within this cluster:

- i. We agree with the CC's analysis that a divestment of only a single facility in this area would be ineffective. Therefore, a package including two facilities is necessary.
- ii. As noted by the CC, these two facilities sit in the geographic centre of the cluster. Their divestment means a new entrant will be able to compete across the greatest number of catchment areas within this cluster.
- iii. We understand that both of these facilities are relatively solid financial performers within the BMI portfolio. This should increase the attractiveness of the assets to potential buyers and increase the probability of realising a successful divestment.

[X]

3.36. The CC identifies a cluster of [X] hospitals. It argues that the divestment of either the [X] hospitals would likely be effective in remedying local market concentration. However, the CC notes that forcing divestment of both the [X]. It notes also that the [X] sits in the middle of the

chain of hospitals in the cluster and has a catchment area that overlaps that of each of the other hospitals. Its divestment, it is argued, is thus “[X].

3.37. [X]

3.38. BHF understands that the divestment of both [X] is significant, but we believe it is necessary to solve the AEC. [X]<sup>8</sup>. As noted in paragraph 2.13 above, the CC must apply the additional criterion that an operator that retains more than 33% of the market is likely to retain unilateral market power. Therefore, on this basis, the AEC in this local area is not resolved by divesting only one of either [X]. For this reason, BHF believes both should be divested and that the CC should seek separate buyers for each. Introducing two new competitors would significantly improve outcomes for consumers in this area.

3.39. If the CC is minded to propose BMI divests only one of either [X], then BHF believes the [X] should be required. [X]. This increases the relative attractiveness of the asset to potential new patients in the area, so will assist any new owner with driving levels of demand.

[X]

3.40. The CC identifies a cluster of [X] hospitals are located very close to each other, with the other hospitals located further outside of the city centre.

3.41. The CC suggests that the divestment of either (i) [X] (ii) [X] facilities would likely be effective in addressing local market concentration, but expresses [X].”

3.42. It is BHF’s view that **the divestment of the [X]** has a significantly higher probability of promoting effective competition in this cluster:

i. [X]

ii. [X]

iii. [X]

## **MIDLANDS (MILTON KEYNES/NORTHAMPTON)**

3.43. The CC focusses on a cluster of three BMI facilities in the Northampton-Milton Keynes-Bedford triangle – the Three Shires, Saxon Clinic and Manor hospitals. [X]

3.44. The CC proposes **the divestment of the [X]** as it argues it is the most effective single divestment in the cluster (in terms of reducing weighted average market share) and given that

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<sup>8</sup> [X]

the “the increment in competitive constraint resulting from two divestments as compared with one is likely to be sufficient to make this proportionate.”

3.45. Given that [redacted], BHF agrees with the CC’s proposed divestment in this cluster.

## NORTH WEST (MANCHESTER)

3.46. The CC identifies a cluster of five BMI hospitals in and around Manchester – the Gisburne Park, Beardwood, Beaumont, Highfield and Alexandra<sup>9</sup>. The Alexandra is the largest hospital in the cluster by a significant margin, having 141 beds (the next largest, the Highfield, has 47 beds).

3.47. [redacted].

3.48. The CC is considering a proposed divestment of [redacted] on the basis that it [redacted]”. This is due to the position of [redacted] being towards the centre of the cluster and the impact such divestments would have on local market concentration. The CC does note, however, that for a single hospital divestment “[redacted]”.

3.49. BHF believes that **divestment of the [redacted]** is the most appropriate course of action in this market:

- i. As is recognised by the CC, the fact that the [redacted]. Therefore, there would be delay and uncertainty about when and to what extent competitive pressures would come to bear.
- ii. [redacted]
- iii. [redacted]
- iv. [redacted]

### Figure 4: Segmentation of BHF’s specialism spend 2012

[redacted]

[redacted]

3.50. Three [redacted] hospitals are identified as forming a cluster in the [redacted]. The CC is not proposing any divestments in this cluster given that “[redacted].”

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<sup>9</sup> [redacted].

3.51. BHF believes the CC's analysis underestimates the competitive impact that divestments would have in this market. [redacted].

3.52. BHF's **preference would be for** [redacted], given the [redacted] which will mean these facilities may be slower to become effective competitors in the private market.

## YORKSHIRE

3.53. In Yorkshire, the CC identifies a cluster of three Spire hospitals located in and around Leeds: the Leeds, Methley Park and Elland hospitals. With 80 beds, Leeds is the largest hospital by a significant margin. Both Methley Park and Elland [redacted]. [redacted].

3.54. The CC considers the divestment packages of either (i) Leeds or (ii) Methley Park and Elland. It argues that the divestment of [redacted] would be the most effective option in terms of reducing local concentration, but that divesting [redacted] would "[redacted].

3.55. BHF believes that [redacted] is the most appropriate in introducing effective competition in the cluster:

- i. [redacted]
- ii. The [redacted] will attract a greater number of potential buyers and be more likely to be able to function on a standalone basis than the other hospitals.
- iii. [redacted] If divested, it will take a period of time for their business models – and potentially require additional capital expenditure – to adapt to enable them to compete effectively in the private patient market.
- iv. [redacted] Competition in this key specialism will be more effective if the [redacted] hospital was in the hands of an independent or smaller hospital group owner.

## LINCOLN

3.56. In the East Midlands, the CC identifies a cluster of two BMI hospitals – the Lincoln hospital (located in Lincoln) and the Park hospital (located in Nottingham). Both hospitals offer services across a broad range of specialisms.

3.57. Although the CC identifies that the divestment of either of these facilities would "[redacted]", it proposes no divestments within the cluster. This is due to (i) the relatively small private patient market in Lincolnshire and (ii) the fact that there is a significant distance between the two hospitals.

3.58. BHF would urge the CC to reconsider its decision not to recommend any divestment in this market. Currently BHF faces limited outside options on hospitals for customers that reside in the area, particularly between [redacted]. Ordering the divestment of either of these hospitals will

reduce local market concentration, increase customer choice and strengthen BHF's ability to secure competitive prices for its customers in the area. BHF believes there is no prospect of growing private patient activity in the affected area unless competition and choice is introduced.

3.59. BHF notes also that [redacted]

[redacted]

3.60. The CC has identified a cluster of [redacted]. Based on analysis of the impact on market concentration of divestments within this cluster, the CC argues that divestment of the [redacted] hospital would be most effective at reducing local market concentration. However, the CC stops short of proposing any divestments in this cluster as the "[redacted]".

3.61. First, we note that the CC deemed that the [redacted]. We note, however, that it has a low LOCI number (this is shown in Figure 11 of the DOP) which suggests a high weighted average market share of over 60%. This suggests the [redacted] will have a degree of market power.

3.62. BHF agrees that **the divestment of the [redacted] hospital** is likely to be the most effective option within this cluster. The [redacted] hospital sits in the geographic centre of the cluster and as such its divestment will promote competition in the greatest number of catchment areas. [redacted].

3.63. However, the CC argues that no divestment should be made because divestment does not change the levels of LOCI for the individual hospitals significantly. However, [redacted], BHF estimates that the network effect of divesting the [redacted]. This is below the 0.2 threshold the CC applies elsewhere. However, as explained above (paragraphs 2.5 to 2.8), BHF has concerns that the CC rules out divestments based only on the LOCI metric because (a) of imperfections in its computation, and (b) the fact that the PCA analysis captures only the price effect where the benefit for customers could be much more significant.

3.64. BHF believes that given the CC has identified an AEC in the region (with [redacted] controlling two hospitals of concern with high weighted average market shares) a divestment of the [redacted] hospital will improve outcomes for consumers and so must be considered in further detail.

## SCOTLAND

3.65. In Scotland, the CC identifies a cluster of three BMI hospitals in the greater Glasgow area: the King's Park, Ross Hall, and Carrick Glen. The most effective divestment packages are identified as being [redacted]. However, given the very small size of Carrick Glen and King's Park relative to Ross Hall, combined with the relatively large distances between hospitals, the CC does not propose any divestment within this cluster.

3.66. BHF agrees with the CC that, in the cluster as defined, divestments will not be effective in addressing local market concentration. As recognised by the CC, King's Park and Carrick Glen are significantly smaller facilities than Ross Hall – [X].

3.67. [X].