

BMI HEALTHCARE

**RESPONSE TO PROVISIONAL FINDINGS
RELATING TO THE PRIVATE HEALTHCARE MARKET INVESTIGATION**

11 November 2013

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BMI Healthcare
Response to Provisional Findings
relating to the Private Healthcare Market Investigation

11 November 2013

1. OVERVIEW

1.1 The CC's provisional findings are unsupported and indefensible

1.1.1 The evidence does not support the conclusions reached by the CC in its Provisional Findings Report ("PFs") and cannot form the basis of the sweeping remedies package which the CC has proposed in its Notice of Possible Remedies (the "**Remedies Notice**"). This paper and the attached annexes set out in detail the reasons why this is the case.

1.1.2 The essence of the CC's AEC finding is that weak competitive constraints in a number of local markets and high barriers to entry for full service hospitals have resulted in a market in which BMI (and certain other private healthcare operators) have local market power in relation to acute inpatient services. The CC has failed to support this finding with adequate evidence, and has equally failed to take account of substantial evidence that contradicts its conclusions. The CC has therefore failed to discharge its statutory duty to establish the AEC to the requisite standard¹.

1.1.3 In fact, an objective review of the evidence demonstrates that:

- a) BMI is prevented from exercising market power by a number of competitive constraints;
- b) barriers to entry are, in fact, low;
- c) BMI is not making excessive profits; and
- d) the features identified by the CC are a function of the commercial dynamics of a private healthcare market which is currently static (at best). They are not competition problems that it is within the CC's power to remedy.

¹ i.e., on the balance of probabilities ("*is it more likely than not that features or a combination of features lead to an AEC?*") – para. 320, *Guidelines for market investigations: their role, procedures, assessment and remedies* ("**Market Investigation Guidelines**").

- 1.1.4 Each of these points will be discussed in the subsequent sections of this response, with greater supporting detail provided in the papers annexed to this response regarding elements of the CC's case which contain the greatest flaws, notably:
- a) the CC's local assessments (Annex 1);
 - b) the CC's insured pricing analysis (Annex 2²);
 - c) the CC's analysis of bargaining and insurer negotiations (Annex 3³);
 - d) the CC's price concentration analysis (Annex 4⁴);
 - e) the CC's analysis of barriers to entry (Annex 5); and
 - f) the CC's assessment of private hospitals operators' profitability (Annex 6).
- 1.1.5 Without prejudice to the above position, and whilst supportive of some of the CC's proposals, BMI has serious concerns with most of the remedies proposed in the CC's Notice of Possible Remedies (which it has outlined in a separate response). The proposed divestiture remedy and behavioural pricing remedy in particular will be ineffective in addressing the alleged AEC. Both remedies fail under the principle of proportionality since each is more onerous than is necessary and produces disadvantages that far outweigh the stated objectives. The CC has made no effort to demonstrate that patients will benefit from either of these remedies and has not clearly considered the divestiture remedy's numerous consequences, [X].
- 1.1.6 Perhaps as a result, the consumers on whose behalf the CC is supposed to be intervening have shown little enthusiasm for the CC's proposals. Rather than seeking to understand and address those features of the private healthcare market which concern patients, the CC has allowed this market investigation to be effectively hijacked by a small number of vocal corporate participants (notably [X]), and used by those participants as a vehicle to promote their own interests. Given that the PMI market is highly concentrated and characterised by a dominant firm, there is no reason why the CC should simply assume that patients will see their share of PMIs' benefit. The PFs are unsupported and indefensible.

² This paper was submitted to the CC within the data room.

³ This paper was submitted to the CC within the data room.

⁴ This paper was submitted to the CC within the data room.

2. CONSTRAINTS ON THE EXERCISE OF MARKET POWER

2.1 Hospital operators are adequately constrained

2.1.1 Competitive constraints exist which prevent BMI and other private hospital operators from exercising any market power they may be alleged to possess. As set out below and in greater detail in Annexes 1-4 to this response:

- a) the method the CC has used to determine both local market concentration and local market power (LOCI) is untested, unreliable and its use undermines the CC's provisional findings;
- b) the CC's approach to catchment areas understates (and in some cases completely ignores) competitive constraints;
- c) the minimal assessment of local competition the CC has attempted is unreliable, particularly in light of its access to empirical evidence on market outcomes in solus markets and substantial additional evidence submitted by BMI that it has disregarded;
- d) private hospitals compete strongly with each other and also face competition from smaller-scale day-case/outpatient facilities and the NHS;
- e) private hospitals have no local market power over PMIs, with at least the largest of the PMIs possessing fully countervailing buyer power; and
- f) evidence does not show that private hospitals exercise local market power over self-pay patients, who additionally have a compelling (free at the point of use) alternative in the NHS.

2.2 The CC used an untested, unreliable metric (LOCI) in its market power analysis

2.2.1 The Logit Competition Index ("**LOCI**") which the CC has used as the basis for its determination of local market concentration is of dubious pedigree. It is based on an unpublished draft manuscript, clearly marked "*NOT FOR CITATION OR QUOTATION*" that has not been peer reviewed⁵. The CC has dismissed parties' concerns that LOCI has not been widely used and instead noted that it is healthcare-specific and has "*intuitive and economic appeal*"⁶. However it is not enough simply for methodology to be 'of intuitive appeal'; an investigation with such serious commercial consequences must be based on reliable, rather than intuitive, metrics. This issue is described in greater detail

⁵ YAA O.D. Akosa Antwi, M. Gaynor and W.B. Vogt. 2006. "A competition index for differentiated products oligopoly with an application to hospital markets", unpublished manuscript available at: <http://www.krannert.purdue.edu/faculty/smartin/ios/gaynor.pdf>.

⁶ Appendix 6.4, paras. 6-19, PFs.

in the BMI paper on the CC's local assessments attached as Annex 1 to this response and the Compass Lexecon report on the CC's price concentration analysis attached as Annex 4 to this response, as well as previous BMI submissions⁷.

- 2.2.2 LOCI is a problematic analytical tool because it is self-fulfilling and over-inclusive. LOCI attaches extra weight to the postcodes with the highest number of a given hospital's patients and attaches less weight to postcodes in which that hospital has fewer patients, thus overstating that hospital's share of patients in its catchment area⁸. Nearby postcodes in which other hospitals compete for patients are understated or not taken into account at all in the resulting weighted "market share". By understating the actual market share of these competitors, LOCI fails to accurately reflect the competitive constraint they pose. Those consumers who would be most likely to switch providers are deliberately not counted. The Office of Fair Trading has correctly expressed concerns with this "*postcode bricks*" approach as leading to potentially unexamined "*gaps*" that could result in a "*skewed picture*"⁹.
- 2.2.3 As a result of the LOCI approach to market concentration, the vast majority of hospitals surveyed by the CC have high weighted market shares (as seen in the CC's identification of [\times] BMI hospitals as "*of potential concern*"¹⁰). These shares are understandably even higher when combined with those of nearby hospitals owned by the same group, as the CC has done with its analysis of hospital "clusters". In presenting the difference between this "cluster" share and the individual hospital share as a measurement of "network effect", the CC has attempted to use LOCI not only as a measurement of local market concentration, but as an indicator of local market *power*. This represents a departure by the CC of its own making from an already-untested methodology, and it is a fundamentally unsound approach. LOCI (whatever its merits as a market share measurement) has no connection whatsoever with market power in any established economic model¹¹.

⁷ E.g. Annex 1 to BMI's response to the Annotated Issues Statement.

⁸ BMI also notes that the CC's rigid adherence to catchment areas based on an 80% insured inpatient distribution (Appendix 6.5, para. 6, PFs), contrasts with its recently expressed view that such an approach in dynamic markets renders only a "*snapshot of the position at any given time*" (*Tesco v Competition Commission* (2009), CAT 6, para. 158).

⁹ *Completed acquisition by the Cooperative Group (CWS) Limited of Fairways Group UK Limited*, decision published 26 July 2006.

¹⁰ Appendix 6.6, PFs.

¹¹ Including either the benchmark Hotelling model or the benchmark Cournot model – see Annex 1 of this response. LOCI corresponds only to a measure of market power in a model which is based closely on the Logit model. That model is widely discredited as a basis for meaningfully measuring market power. The "network" LOCI that the CC uses in its analysis has no known theoretical underpinning as a basis in a benchmark model at all.

2.2.4 As a mere measure of market share/concentration, LOCI notably fails to account for a number of factors (such as fixed costs, differences in demand sensitivity and hospital efficiency, quality and geography) that affect a hospital's ability to exercise market power and alter prices. The creators of LOCI themselves noted that it was unlikely that market prices could be determined based on market shares alone "*independent of unobserved factors*"¹². Essentially the CC seems to have abandoned the standard practice of using market shares as no more than a screen, followed by an in-depth assessment of competitive constraints. It has placed too much weight on a questionable market share measure and has done no meaningful analysis to support its local competition assessment.

2.3 Private healthcare providers compete strongly against each other

2.3.1 Significant evidence exists demonstrating that private hospital operators face a number of material competitive constraints. However, as a result of its LOCI-skewed view of market power and its disregard of that evidence, the CC has provisionally found that nearly 62% of private hospitals outside Central London and [X] of BMI hospitals are subject to insufficient competitive constraints¹³. In addition to being overstated by LOCI, these numbers fail to account for significant evidence suggesting that private hospital operators face a number of material competitive constraints.

2.3.2 For example, private hospitals' practices of offering engagement arrangements to consultants and offering volume-related discounts to PMIs (notwithstanding the concerns the CC has expressed with some of these practices) are evidence of continual competition among them. The CC has recognised that, in a time of spare capacity such as that which currently prevails, hospitals can adequately constrain each other by pricing to increase volume¹⁴.

2.3.3 The CC's entry and expansion case studies¹⁵ also reveal both established operators and new entrants competing for local market share in a variety of competitive paradigms. These include small-scale entry (Edinburgh), successful large-scale entry (Bath), demonstrable inability to deter entry (Bath), successful expansion to increase competition (London) and successful expansion to discourage additional large-scale entry (Edinburgh).

2.3.4 As demonstrated in the case studies, the best initial competitive entry tactic in the current private healthcare market is often to enter on a smaller-scale by

¹² Akosa Antwi, Gaynor and Vogt, p. 12.

¹³ Para. 6.117, PFs.

¹⁴ Para. 6.113(b), PFs.

¹⁵ Appendices 6.1, 6.2 and 6.3, PFs.

opening an outpatient or day-case facility. The CC has focused its analysis on competitive constraints in the narrow segments for inpatient treatments and has dismissed both outpatient and day-case care as separate product markets¹⁶. It is clear, however, that the parties to the CC investigation all compete to offer outpatient and day-case care. Given the importance of non-inpatients to private hospitals, competition for such patients is arguably keener and is expected to increase as treatment previously delivered in an inpatient setting moves to being delivered in a day-case or outpatient one. The failure to consider the competitive constraint of outpatient and day-case only providers is a material weakness in the CC's analysis and undermines the CC's case for remedies.

2.3.5 As the CC has acknowledged¹⁷, modern medicine is increasingly accessible though outpatient and day-case procedures. This is a result of a combination of changes in medical technology and changing medical and hospital practices, most notably (i) advances in surgical and anaesthetic techniques, (ii) advances in pre-operative assessment and (iii) more intensive perioperative care and nursing. As a result, the demand for inpatient facilities has declined and the average length of stay of patients in inpatient facilities has likewise declined, despite the fact that patients' conditions are (on average) more complex or of higher acuity. The natural consequence of these trends is excess inpatient capacity. This change in healthcare delivery is also being driven by PMIs, who are increasingly encouraging outpatient and day-case treatment protocols.

2.3.6 As seen in the chart below¹⁸, privately-funded inpatients make up a [X] portion of those treated by BMI. BMI competes for the much larger pool of day-case patients with not only other hospital chains, but also numerous independent hospitals and smaller-scale clinics (most of which were excluded from the CC's analysis).

[X]

2.3.7 The CC, while suggesting that the boundaries between the inpatient, day-case and outpatient markets are "*blurred to some extent*", believes that day-case/outpatient-only operators are unlikely to exercise a proper competitive constraint, as they are unable to offer the full range of treatments offered by full-service hospitals. Though the CC has failed to provide any further analysis as to the treatments for which wider competition does or does not take place, it clearly ought not to entirely dismiss competitors offering day-case and

¹⁶ Para. 5.53(b)(ii), PFs.

¹⁷ Para. 2.17, PFs.

¹⁸ Prepared by Compass Lexecon from BMI patient data.

outpatient treatments as a constraint, especially when common assets and staff are used to service both.

2.3.8 The minimal assessment of local competition the CC has attempted is unreliable. As set out in Annex 1 to this response, the CC's assessments fail to accurately portray the strength of local competitive constraints due to a number of flaws and inconsistencies. For example:

- a) the CC has chosen a catchment area methodology so as to exclude otherwise effective nearby competitors from catchment areas, then circularly argued that small non-overlapping catchment areas are evidence of a lack of competitive constraint;
- b) the CC has refused to accept constraint from outside a catchment area as effective (no matter how nearby the potential competitor is or how much its catchment area overlaps);
- c) the CC has incoherently applied hospital size as a determiner of competitive constraint without any reference to capacity constraints or analysis as to why a smaller hospital could not constrain a larger hospital;
- d) the CC has grouped many BMI hospitals with nearby BMI facilities and considered them together (overstating BMI's strength), but has not adopted the same approach with BMI's competitors; and
- e) the CC has made no changes to its local assessment after reviewing BMI's internal documents, and has failed to consider the only empirical evidence it has been given on competition for quality (the Compass Lexecon paper on market outcomes for patients in solus markets that BMI submitted earlier this year¹⁹).

2.3.9 There is no lack of competition in the private healthcare market, even within the inappropriately narrow pool of inpatient-capable hospitals considered by the CC.

2.4 The NHS is a competitive constraint

2.4.1 The NHS is a competitive constraint, particularly for self-pay patients. The CC cannot dismiss this. The NHS' economies of scale and funding commitment cannot be matched, and its "free at the point of delivery" services cannot fail to represent an attractive alternative. The CC cites, as its reason for not considering the NHS as a competitor, a lack of compelling evidence that private hospitals monitor NHS offerings and waiting times and adjust their

¹⁹ Peter Davis, Erik Langer and Stefano Trento, "Do private healthcare providers have market power in solus hospitals", 11 January 2013.

products/services in response²⁰. This is despite internal documents BMI has shared with the CC²¹ which reveal that BMI is keenly interested in differentiating itself from the NHS. The existence of a free alternative that is staffed largely by the same consultants who work at BMI hospitals requires BMI to actively position its services as higher quality, more efficient and more attractive.

- 2.4.2 Evidence BMI has submitted to the CC clearly shows [redacted] BMI continues to embrace NHS patients (as have other private hospital operators). Due to its unique role, the NHS is thus both a competitive constraint and a market to be competed for.
- 2.4.3 Competition among private hospital operators for NHS business (and with the NHS) is particularly keen in higher acuity work – an area in which the private sector is often almost entirely absent. BMI has provided the CC with numerous examples of investment in a number of locations²² being predicated on switching patients from NHS to private provision, and has explained its current [redacted] strategy at its hearing with the CC earlier this year and in strategy documents it has submitted to the CC. The CC has disregarded this evidence.
- 2.4.4 The CC has also failed to take into account how the interplay between PMIs and the NHS acts as a competitive constraint on private hospital providers. For example, PMI policies which encourage insured patients (through generous per-day cash incentives) to use the NHS are profitable for PMIs but reduce revenue for private hospitals and increase costs for the NHS. More generally, the NHS imposes an indirect constraint on private hospital operators for the "derived demand" of PMIs' customers for hospital services. To the extent that PMI-insured patients would switch to the NHS if their costs (whether excess charges or self-pay prices as an alternative) rise past a certain point, the NHS can be said to constrain private hospital operators' pricing²³. The CC should not dismiss the significance of this constraint without undertaking a proper analysis.
- 2.4.5 The NHS also constrains BMI and other private hospitals in its growing role as a private healthcare provider. With NHS Foundation Trusts now authorised to receive up to 49% of their income from private sources under the Health and Social Care Act 2012, the fact that the NHS (particularly, though not

²⁰ Para. 6.112(g), PFs.

²¹ [redacted].

²² [redacted].

²³ See Gavin Wallis of the Office of National Statistics' October 2003 paper on, "The Determinants of Demand for Private Medical Insurance: Evidence from the British Household Panel Survey", available at: <http://repec.org/res2004/Wallis.pdf>.

exclusively, through Foundation Trusts) is a constraint on private hospital providers is no longer debatable. The CC has nominally included NHS PPUs as competitive constraints in its analysis and has acknowledged their growing role, but has in practice universally dismissed their importance as a competitive constraint and has ignored completely other, non-PPU, private activity carried out in NHS hospitals. The CC has downplayed the extent of the material changes to competitive dynamics that will inevitably result from the Act. The CC has also failed to recognise that there are other ways in which the NHS can compete with private hospitals, for example by providing treatments at NHS hospitals as a low-excess (or cash back) option for purchasers of low-cost alternative PMI policies. With PMI customers looking for more cost-effective options, such offers are likely to provide an increasing constraint. The NHS cannot be summarily dismissed as a competitive constraint.

2.5 BMI has no local power v PMI providers

2.5.1 The CC's provisional finding that high national insured prices result from ineffective local constraints is not supported by evidence²⁴. In its most recent attempt to analyse hospital/insurer negotiations the CC has adopted a revised empirical approach, and considered various parties' views but even now has failed to empirically demonstrate its provisional finding.

2.5.2 Evidence of a connection between allegedly high national insured prices and allegedly weak local constraints is not robust. As set out in the Compass Lexecon report on insured pricing attached as Annex 2 to this response:

- a) in spite of previous methodological criticisms²⁵ the CC has repeated the flaws in its analysis, including questionable over-reliance on the views of certain (typically larger) PMIs, the use of limited data and the failure to account for significant factors (such as costs, hospital quality and range of service).
- b) evidence that does not support (or conflicts with) the CC's argument has been omitted. For example, the CC's "revenue per admission" figures are calculated using overall revenue in the numerator but excluding outpatient admissions in the denominator. This obviously produces a distorted result, depicting hospital operators who undertake a lot of outpatient work [X] as higher priced than equivalent hospitals that serve fewer outpatients. As another example, the fact that national negotiations "lock-in" prices at a

²⁴ Para. 6.242, PFs.

²⁵ E.g., BMI's response to the CC's "Empirical analysis methodology of price outcomes in negotiations between hospital operators and insurers" working paper.

local level, leaving room for a new entrant to locally undercut incumbents that have PMI deals, is not mentioned; and

- c) a review of the underlying pricing data the CC originally withheld from the parties upon the publication of its PFs has failed to provide further proof of a connection between national prices and local constraints.

- 2.5.3 Market power is a *cause*, rather than a *consequence*, of high prices. The CC's (ultimately unconvincing) focus on effect (prices) throughout its bargaining analysis does not obscure its inability to demonstrate the alleged cause (the hospital market power that would arise from the CC's alleged lack of local constraints). The CC's acceptance that its bargaining analysis was inconclusive as to whether hospital operators have market power underscores this point, and bears repeating for the subsequent analysis:

*We did not find that the evidence on bargaining on its own indicated whether hospital operators had market power or that PMIs had buyer power. PMIs do have scope to take some business away from hospital operators, but that does not of itself constitute buyer power. Under certain circumstances the scope to delist hospitals, because of the potential damage to a hospital operator, could give a PMI buyer power. However delisting is damaging to a PMI and is not an option that can be freely used. The evidence does not indicate that it is a realistic option for any PMIs other than the largest (Bupa and AXA-PPP) and it does not indicate that for these PMIs the bargaining strength conferred amounts to fully countervailing buyer power.*²⁶

- 2.5.4 This statement is particularly noteworthy because it reveals just how contradictory the CC's logic is in the face of evidence that contradicts its conclusions. Having stated that insured prices are high because hospitals lack competition, the CC admits that at least two PMIs can take business away from hospitals (and goes on to discuss how Bupa successfully did so in early 2012). This evidence contradicts the CC's initial view in two ways: (i) it shows that hospitals do not lack competition (as their delisted customers obviously had somewhere else to go) and (ii) it shows that PMIs have enough countervailing buyer power to negotiate insured prices downwards. Instead of altering its initial conclusion, however, the CC insists that the observed ability to delist a major hospital chain does not constitute buyer power and justifies this with an additional statement ('delisting hurts PMIs too') for which it offers no evidence in support.

²⁶ Para. 6.189, PFs.

- 2.5.5 Such evidence is in the CC's possession, though it has only recently (and reluctantly) been revealed to BMI. It is clear from the material disclosed in the data room that Bupa has demonstrated its ability to effectively switch demand to BMI's competitors, [§<], and that doing so would result in little detriment to Bupa. Though the CC refuses to acknowledge it, Bupa incontrovertibly possesses fully countervailing buyer power, and therefore has the power to insist on lower insured prices. This is discussed in detail in the BMI paper on the CC's bargaining analysis attached as Annex 3 to this response.
- 2.5.6 Examples of similarly flawed or contradictory logic and failures of consideration appear throughout the PFs. Examples include the CC:
- a) downplaying the effect on negotiations of PMI tactics such as open referrals, restricted networks, service line tendering and influencing care pathways due to the alleged "*resistance*" such tactics face from hospital operators²⁷ even though:
 - i. PMIs have openly admitted that all are successful price-reduction strategies;
 - ii. the incentive to drive volume means that hospital operators are very unlikely to deny PMIs access;
 - iii. [§<]; and
 - iv. BMI's negotiating strategy clearly demonstrates this;
 - b) asserting PMI power in cases where it helps to support its conclusions (e.g. that the lack of AXA PPP recognition served as a barrier to successful Circle entry in Bath²⁸); and
 - c) ignoring PMIs' own statements (e.g. AXA PPP's statement that hospital market power is counter-balanced outside of London and does not enable hospitals to charge significant amounts²⁹).
- 2.5.7 The cumulative weight of these contradictions vitiates the CC's views on countervailing buyer power. It is impossible to pin the blame for "high" insured prices entirely on hospital operators (nor does the CC, due to its failure to analyse the PMI market, have any evidence to suggest that insured prices actually *are* high in any relevant sense). Any conclusion that the clearly dominant Bupa, in particular, does not have fully countervailing buyer power

²⁷ Appendix 6.11, para. 122, PFs.

²⁸ Appendix 6.1, para. 96, PFs.

²⁹ Para. 2.56, AXA PPP Response to PFs and Remedies Notice.

is plainly irrational and gives rise to concerns that the CC is a victim of regulatory gaming by a company that does not wish to seriously engage in negotiations with hospital operators.

- 2.5.8 BMI's concerns with the CC's acquiescence to PMI arguments³⁰ are lent further credence by the CC's failure to conduct a "pass-through" analysis of how the fees charged by hospitals to PMIs translate into the fees paid by patients (both self-pay and insured excess payments). The CC has rightly accepted that a narrow interpretation of its statutory duty to identify detrimental effects on "customers"³¹ is inappropriate and it must therefore place its focus on the interests of patients (the ultimate consumers of private healthcare)³². Nevertheless, the CC has refused to conduct what should be a standard analysis of pass-through to patients.
- 2.5.9 The CC has failed to consider the strong arguments supporting the intuitive consumer view that PMIs, rather than hospital operators, are the source of consumer harm. Indeed, in this investigation's focus on hospital operators (and inadequate scrutiny of PMIs) little attention has been paid to the effects of hospital/PMI pricing battles on patients. Though (unsurprisingly) few members of the public have submitted responses to the CC's provisional findings, the general sense of the comments of those who made the effort is that PMIs are letting patients down with unjustified fee caps, technical glitches, random exclusions, wasteful expenditure of premium money, opaque pricing and lack of portability through pre-existing condition exclusions. One respondent in particular expressed his outrage that the self-pay charge for an operation was less than the excess he would have to pay for the same procedure through his PMI policy³³. A lesson to be learned from this is that an excessive focus on hospitals as a source of competitive harm may, in addition to being inaccurate, do nothing to address the market failures perceived by the end users of private healthcare.
- 2.5.10 To remedy this, the following rudimentary comparison of BMI revenue and the average price of private medical cover (for lack of a more comprehensive pass-through analysis) reveals a widening gap. This gap can arguably be attributed to PMIs' failure to pass on to their patients the discounts they extract from hospitals though promising increased volumes or threatening delistings

³⁰ Previously set out in the email from James Webber to John Pigott dated 26 September 2013 and letter dated 1 November 2013..

³¹ s134(4) Enterprise Act 2002.

³² Letter from the Treasury Solicitor (representing the CC) to the Competition Appeal Tribunal dated 7 October 2013. See also "Ensuring that patient's interests are at the heart of assessing public hospital mergers" - joint statement from the OFT, the CC and Monitor, 17 October 2013.

³³ Member of the Public #4 response to the PFs and Notice of Possible Remedies.

[§]. These findings are quite striking and would have been corroborated or refuted by an objective competition authority much earlier in this investigation. Nevertheless, the CC has thus far refused to conduct a pass-through analysis on patient pricing. This calls into question not only the CC's market power assessment and the basis of its alleged AEC, but the very nature and extent of the "consumer detriment" of up to £193 million that it has purported to identify. It is incumbent on the CC to fully investigate the issue of pass-through prior to the publication of its Final Report.

[§]

2.6 **BMI does not exert local market power v self-pay patients**

- 2.6.1 BMI has consistently found (in consultation with economists from Compass Lexecon) that the CC's attempts to correlate local concentration and self-pay prices have been flawed, and rejects the CC's finding that it possesses market power (due to this alleged correlation or any other cause) for reasons already discussed.
- 2.6.2 Unlike nationally-negotiated PMI prices, self-pay prices can be set locally and are thus, in theory, subject to hospital operators' alleged local market power. In its first study of self-pay prices Compass Lexecon found no systematic evidence of higher self-pay prices for the majority of treatments offered in the wider set of "solus" hospitals³⁴ and later found the results of the CC's initial price concentration analysis ("**PCA**") working paper (which attempted to show a correlation between high local concentration and self-pay prices) to be entirely driven by Nuffield data, with otherwise no statistically significant correlations³⁵.
- 2.6.3 The CC has now revised its approach to the PCA but maintained its conclusion that there is a causal relationship between self-pay prices and local concentration resulting in self-pay prices being higher in more concentrated local areas³⁶. However, as set out in the Compass Lexecon report on the CC's PCA attached as Annex 4 to this response, the CC's approach still suffers from a number of major analytical flaws caused by both the narrow set of data used and the consideration of invalid or irrelevant variables (including but not limited to LOCI) which cumulatively render it "*profoundly unreliable*". The CC has also, as in other aspects of this investigation, failed to distinguish price

³⁴ "Do private healthcare providers have market power in solus hospital markets?", 3 January 2013.

³⁵ "Comments on the CC's working paper entitled: 'Empirical analysis methodology of price outcomes in negotiations between hospital operators and insurers'", 21 June 2013.

³⁶ Para. 6.196, PFs.

variations caused by concentration with those caused by regional variations in quality or costs.

2.6.4 Apart from the analytical concerns set out in Annex 4 to this response (which, as suggested, ought to be re-evaluated along with an independent expert econometrician such as the CC has available to it via its academic panel), the CC's conclusions regarding the effect of concentration on self-pay prices generally fail to convince. Specifically, the CC's interpretation that a hospital facing either (i) one rival within a nine-mile radius or (ii) a rival with a weighted market share of at least 20% lower should be expected to charge self-pay prices of 3-4% more³⁷ suffers from the following flaws:

- a) its conclusions are inappropriately read across from self-pay to insured patients³⁸, despite obvious observable differences between these two groups of patients such as the constraint posed by the prices offered by PMIs who negotiate with hospitals nationally (and that posed by the "free-at the point of delivery" NHS, as discussed below);
- b) it underestimates the appropriate catchment area size for self-pay patients³⁹; and
- c) it is based on overstated LOCI-based market shares.

2.6.5 The NHS also must be considered as a credible competitive constraint for self-pay patients in particular. It is free (at the point of delivery), offers treatment by the same consultants that operate in private hospitals and, thanks to the "Choose and Book" reforms, can now be provided in a private hospital in England. In an odd twist on the notion of the NHS as a constraint on private hospitals, evidence submitted by BMI to the CC shows that up to [~~8~~] of Choose and Book referrals are actually patients who, prior to Choose and Book, would have self-paid to be treated in a private hospital⁴⁰.

2.7 Conclusion on local constraints

2.7.1 The CC has failed to adequately prove that weak competitive constraints in a number of local markets result in BMI and other private hospital operators exercising market power. This failure undermines the CC's case that weak constraints are a structural feature leading to an AEC, thereby undermining the AEC finding itself.

³⁷ Para. 6.197, PFs.

³⁸ Para. 6.291, PFs.

³⁹ According to the CC's own patient survey (conducted in November/December 2012 for the purposes of this investigation) self-pay patients will travel an average of 44 minutes to get to hospital – slide 48.

⁴⁰ [~~8~~].

3. BARRIERS TO ENTRY ARE LOW

3.1 Barriers to entry for full-service hospitals are in fact low

3.1.1 Though it is one of the two key alleged features contributing to the CC's AEC finding, the existence of high barriers to entry for full service hospitals is the most weakly supported of the CC's provisional findings. As set out below and in greater detail in Annex 5 to this response:

- a) the costs of building a hospital are not "high" in a relevant sense, and can be met as funding is available to prospective entrants who are prepared;
- b) the CC has overstated the importance of economies of scale to entry – in reality successful entry can and does occur at the appropriate scale to match the market opportunity;
- c) given that the CC's "highest" barriers to entry (costs and economies of scale) are so readily disproven, the rest of the CC's alleged barriers to entry (site availability/planning permission, consultant commitment and PMI recognition), for which support was weaker, needs little attention beyond that discussed in Annex 5 to this response. As noted in that paper, there is no evidence that incumbent pressure on PMIs not to recognise entrants has ever thwarted entry.

3.2 Cost is not a barrier to entry

3.2.1 Cost is not a significant barrier. While building a new hospital is clearly not inexpensive, there is little evidence that those operators who have recently attempted entry have had any difficulty obtaining the necessary funding. As recent entrant Circle has stated, "*the costs of entry are not insurmountable . . . provided that the potential new entrant can demonstrate a compelling business plan*"⁴¹. If companies with a persuasive plan and good enough credit are able to obtain the necessary financing to build and operate a hospital, it would be ludicrous to state that high fixed costs are an insurmountable barrier merely because a prospective entrant must be prepared and make a substantive case for funding.

3.3 Scale is not a barrier to entry

3.3.1 The CC has overstated economies of scale as a barrier to entry. The appropriate entry scale for a given hospital property can vary greatly. Moreover, an entry need not be a full-service hospital with inpatient facilities

⁴¹ Section 4 of Circle's response to the Provisional Findings and Notice of Possible Remedies.

to compete with such incumbents. Indeed, full-service entry in today's private healthcare market is commercially less attractive.

- 3.3.2 As seen in the growth figures and future prospects cited by the CC⁴² (and as described above in relation to competitive constraints) the vast majority of the people who use private hospitals are not inpatients. Partial or incremental entry through day-case/outpatient facilities or PPU contracts, therefore, has the potential to capture incumbents' revenue. There is no rational basis for the CC to attribute barriers to entry due to scale economics only to "full service" hospitals, given that such barriers do not apply in relation to smaller-scale facilities. The CC possesses sufficient data on the cost structure of each hospital to quantitatively analyse how hospitals' costs vary with their scale. Doing so would refute its claims on scale as a barrier to entry.
- 3.3.3 All of the case studies cited by the CC as evidence of barriers to entry⁴³ contain examples of *successful* entry or expansion, albeit not all of them at the full-service hospital level the CC would apparently prefer. The lesson from the case studies is that, where there is a perceived market opportunity, successful entry will occur on a scale to match the market opportunity.
- a) The Bath case study shows how a new entrant can open a full-service hospital despite the CC's alleged barriers, and provides a salutary example of how the appropriate scale of entry can be misjudged. As set out in Annex 5 to this response, [§<].
- b) The Edinburgh case study is portrayed by the CC as a story of Circle's failed attempt at entry. It ought instead to be viewed as the successful and appropriately-scaled expansion of Spire (with a smaller day-case facility), combined with the successful *de novo* entry of an independent clinic which soon attracted investment from Aspen. The scale of both expansion and entry was well judged to adapt to the needs of the local private healthcare market.

3.4 Entry depends on demand

- 3.4.1 The reason why successful entry is still entirely possible at a smaller scale but "*unusual*"⁴⁴ at the full-service hospital level is that, outside London, demand for private healthcare is flat or falling. In general, elective private medicine has shifted away from inpatient toward day-case and outpatient procedures.

⁴² Paras. 2.16-2.27 and Appendix 3.1, PFs.

⁴³ Appendices 6.1, 6.2 and 6.3, PFs.

⁴⁴ Para 6.14, PFs.

The lack of growth in the private healthcare market, which the CC has acknowledged⁴⁵, can partly be attributed to:

- a) the fallout of the financial crisis;
- b) the increasing involvement of the NHS in the market (whether through PUs or private provision in NHS Foundation Trust hospitals); and
- c) improvements in diagnostic tools and treatment protocols that have obviated the need for the inpatient treatment of many conditions and made smaller-scale treatments delivered in outpatient and day-case settings increasingly appropriate and attractive.

3.4.2 In such a low-demand economic climate, entry on a large scale can be inefficient [X] and the absence of such entrance should be viewed as evidence of a properly-functioning market rather than the presence of barriers to entry. We note, for example, that the CC has admitted that the small-scale expansion of Spire in Edinburgh (rather than a large-scale Circle entry) "*increased the range of private medical services offered to patients in Edinburgh*"⁴⁶.

3.5 Conclusion on Barriers to Entry

3.5.1 The CC's failure to adequately prove the existence of barriers to entry undermines its case that such barriers are a structural feature leading to an AEC, thereby undermining the AEC finding itself.

4. NO EXCESSIVE PROFITS

4.1 BMI does not earn excessive profits

4.1.1 The CC's provisional conclusions on BMI's profitability are weak and unsupported by evidence. As set out below and in greater detail at Annex 6 to this response:

- a) the CC's profitability analysis is flawed, materially overstating BMI's profitability;
- b) this overstatement is in large part due to the CC's material undervaluation of hospital land and buildings, based on an inaccurate and methodologically unsound land valuation report, its insistence that

⁴⁵ Paras. 2.12 and 6.47, PFs.

⁴⁶ Para. 6.36, PFs.

buildings be valued at insured reinstatement value and its refusal to consider clearly [X] as costs; and

- c) the CC has inaccurately and illogically cited this overstated profitability as evidence of both barriers to entry and BMI's weakly constrained local market power.

4.2 Overview of profitability concerns

4.2.1 The CC believes that BMI (along with HCA and Spire) is excessively profitable. This belief is cited as evidence of both of the two alleged structural features contributing to the alleged AEC. The conclusions drawn, however, are weak:

- a) in relation to barriers to entry the CC has concluded that "*returns in excess of the cost of capital*" could not be "*persistently obtained*" without barriers, as prices would be levelled in their absence⁴⁷. This is at best an example of correlation rather than causation;
- b) the CC's view on the connection between profitability and local competitive constraints/hospital market power is equivocal – the three hospital groups' allegedly high profit is indicative of "*some limitations in the competitive process*" and "*suggests that*" the price/cost relationship "*may be*" higher than that in a competitive market⁴⁸.

4.2.2 Such circumspection is understandable given the uncertain connection between profits and anti-competitive market conditions and the generally acknowledged economic view that "perfect competition" is not realistic (i.e. that profits *can* exceed the cost of capital in normal competitive market dynamics). As the CC's former Chairman once noted,

*[t]here is no per se reason why profits in excess of the cost of capital represent anything other than the effective working of a competitive market. It is only where profitability is (a) substantially above the cost of capital, (b) across most or all companies in a market over (c) a sustained period of time, that concerns arise."*⁴⁹

⁴⁷ Para. 6.86, PFs

⁴⁸ Paras. 6.283-284, PFs.

⁴⁹ Sir Derek Morris, "Dominant Firm Behaviour under UK Competition Law", paper presented to the Fordham Corporate Law Institute Thirtieth Annual Conference on International Antitrust Law and Policy, 23-24 October 2003.

- 4.2.3 Assuming that the above criteria are cumulative, the profits of the three hospital groups concerned are not indicative of any market problems. Of Sir Derek's criteria quoted above:
- a) criterion (a) is not an issue because, as set out in the BMI paper on the CC's profitability analysis attached as Annex 6 to this response, the CC's profitability findings are materially overstated due to a number of incorrect allocations and exclusions, an unsuitably-short five-year review period and (as discussed below) its drastic underreporting of capital costs;
 - b) criterion (b) is also not met since the three hospitals concerned only make up (on the CC's calculations) 53% of the private healthcare market⁵⁰ – far from "*most or all*" of the market (and begging the question of just what percentage of firms in a functioning market can acceptably earn profits, or of how the other 47% are managing to survive and continue investing);
 - c) criterion (c) cannot be accurately determined as the five-year period assessed by the CC is too short a period of time in the life of a hospital.

4.3 **Methodological flaws**

- 4.3.1 The methodology used by the CC in its profitability analysis is flawed resulting in an inflated calculation of BMI's ROCE. This in turn resulted in a profitability figure that greatly overstates BMI's actual ROCE. The BMI paper on the CC's profitability analysis attached as Annex 6 to this response explains this in detail.
- 4.3.2 The CC's view of BMI's excess profitability is based on its calculation that BMI's average return on capital employed ("**ROCE**") over a five-year period through 2011 was [~~£~~] than the industry's weighted average cost of capital ("**WACC**") over that period⁵¹. When correctly calculated, however, BMI's ROCE is [~~£~~] (in contrast to the CC's calculated ROCE of [~~£~~]). [~~£~~].
- 4.3.3 The CC's over-estimation of BMI's ROCE primarily stems from its under-valuation of capital employed, specifically its unfeasibly-low valuations of the modern equivalent asset ("**MEA**") value of BMI's land and buildings. The CC has committed a number of methodological irregularities in its approach to valuation, such as its attempt to determine land and building values separately rather than valuing the land and the buildings on it as one unit. Though the CC describes this exercise as a determination of MEA "values", the true value of land must reflect the use to which it is put. Separate valuations of land and buildings do not accomplish this task as meaningfully.

⁵⁰ Para. 6.86, PFs.

⁵¹ Paras. 6.272-6.274, PFs.

4.4 [REDACTED]

4.4.1 [REDACTED].

4.4.2 [REDACTED].

4.4.3 [REDACTED].

4.5 Flaws in land and buildings valuations

4.5.1 [REDACTED], the CC's analysis still grossly understates the value of the capital employed. Though BMI has already submitted numerous critiques of the CC's land and buildings valuations, the main criticisms set out below bear repeating for not having been adequately addressed by the CC.

4.5.2 The CC's land valuation cannot be relied on because:

- a) the land valuation report the CC commissioned from DTZ is, by DTZ's own admission, little more than a desktop survey by a non-specialist team of the asking prices for alternative sites, rather than a true physical survey-based valuation of the land on which the hospitals stand⁵²;
- b) this superficial analysis contrasts markedly with the independent valuation (unlike the DTZ report, in full compliance with RICS professional standards) conducted by healthcare valuation specialists Colliers International⁵³, which found that DTZ had under-estimated BMI hospital land value by an average of [REDACTED]. The DTZ analysis also contrasts with other reference points (including BMI's book value, bank valuations, rental income and the observed cost of comparable new entry which the CC included in its PFs⁵⁴); and
- c) the CC has failed to adjust its view in relation to its previous admission to BMI that the DTZ report was not commissioned as expert advice that was "independent" of the CC, and that this lack of independence from the CC would be taken into account in its findings, with appropriate weighting attached to it⁵⁵. This has not yet occurred. No rational authority could attach weight to such an erroneous report. Without prejudice to BMI's

⁵² Paras. 1.1 and 3.1 of the Colliers report attached as Annex 1 to the response of General Healthcare Group to the CC's draft methodology and land valuation report, 26 February 2013.

⁵³ Conducted since the Provisional Findings – its results are incorporated into the paper on the CC's profitability analysis attached as Annex 6 to this response.

⁵⁴ Compared to which the average valuation of a BMI hospital [REDACTED] the average observed costs of a modern equivalent asset set out in Figure 3 in Appendix 6.16 of the PFs.

⁵⁵ Letter from Christiane Kent to James Webber dated 24 May 2013.

argument that "DRC"⁵⁶ represents an inappropriate method of valuation in these circumstances, the CC must consider the Colliers valuation, which adopts the same DRC methodology the CC requested DTZ to use, but is an independent valuation based on full site visits and prepared to appropriate professional standards.

4.5.3 Given the CC's insistence on valuing land and buildings separately, it is apparent that the CC's modest valuation of BMI *buildings* (rather than land) account for [X] of the CC's over-statement of ROCE⁵⁷. The Colliers valuation of BMI's hospital portfolio (attached to Annex 6 to this response) indicated that the CC's building values were on average [X] too low). This discrepancy is due to the CC's choice of insurance reinstatement value (i.e. what BMI would receive as compensation for a hospital burning down – not the costs of building one) as a proxy for the MEA value of hospital buildings, along with incorrect adjustments to these values for obsolescence.

4.5.4 [X]:

- a) [X]; and
- b) [X].

4.6 Weak connection between profitability and the alleged AEC features

4.6.1 The CC has failed to consider the logic of its profits-as-barrier-to-entry argument. As noted above the CC considers that hospitals' allegedly excessive profits could not exist without high barriers to entry. Yet the highest barrier to entry posed by the CC (high costs of entry) depends on the cost of land and buildings being high, rather than the low costs suggested by the CC's ROCE calculations. Indeed the CC's valuation of an average BMI hospital is less than [X] of the average observed costs of an MEA cited by the CC as evidence of high cost barriers. Costs can obviously not be both high and low at the same time. BMI believes that the costs of building a new hospital are far more significant than the CC has accepted in its profitability analysis, but not significant enough to pose a barrier to entry (given, as set out in section 3 above, that prospective entrants – who have incurred the "high" costs – have not had difficulties obtaining funding). This logic flaw is discussed further in Annex 5 to this response.

⁵⁶ I.e. the depreciated replacement cost method. As set out in Annex 6 to this response BMI believes that DRC is not an appropriate valuation approach (RICS guidance refers to it as a "*method of last resort*"), and that DRC materially underestimates the value of the assets.

⁵⁷ See para. 2.10 of the response to the CC's profitability analysis attached as Annex 6 to this response.

- 4.6.2 Similarly, BMI's alleged excess profitability should not be viewed as either a cause or symptom of the CC's other alleged AEC feature (locally-unconstrained market power). BMI is not nearly as profitable as the CC's analysis would indicate, [§<].
- 4.6.3 [§<], however, it would be too blithe of an assumption on the CC's part to equate returns over the cost of capital with market power. There are simply too many other legitimate factors which can lead to profitability, including better efficiency, investments in systems and procedures, a preponderance of particularly ill patients and other short-term market dynamics. Though BMI believes that all these factors apply to its hospitals in varying degrees, such factors have not been adequately considered in any of the CC's analyses (insured prices, self-pay PCA or profitability). As a result the CC's assertions of local market power have not been fully tested and are largely based on correlation with no real proof of causation. The assertions do not stand up to proper analysis and are not robust.
- 4.6.4 Given its similar failure to support its allegations of high barriers to entry, the CC has failed to adequately establish its alleged AEC.

4.7 Conclusion on Profitability

- 4.7.1 The CC has failed to adequately prove that BMI is excessively profitable, This undermines the CC's key argument supporting the existence of both of the alleged structural features leading to its alleged AEC, and thereby undermines the AEC finding itself.

5. CONCLUSION

5.1 Given:

- a) the CC's inadequate proof of market power (as set out in section 2);
- b) the CC's inadequate proof of barriers to entry for full service hospitals (as set out in section 3); and
- c) the CC's inability to either establish excessive profitability (the focus of its proposed divestment remedy) or to convincingly portray this alleged profitability as either cause or symptom of either of the aforementioned alleged AEC features (as set out in section 4);

the CC has clearly failed to discharge its statutory duty to establish the AEC to the requisite "balance of probabilities" standard, much less the "double proportionality"⁵⁸

⁵⁸ *Tesco v Competition Commission* (2009), CAT 6, para. 139 - "it may well be sensible for the Commission to apply a 'double proportionality' approach: for example, the more important a particular factor seems to

approach required to justify a remedy as drastic as the divestment and behavioural remedies currently under consideration.

6. PRIVATE HEALTHCARE MARKET FEATURES

6.1 Though the CC has failed to establish an AEC to the requisite standard in its PFs, BMI accepts that the private healthcare market faces a number of structural difficulties. The main features of low growth and cost inflation, however, do not reflect competition problems (i.e. a problem with the process of rivalry between firms) but are a result of other external factors. Examples include:

- a) weak / thinly-spread demand (outside London) – not concentrated in hospitals due to wide PMI networks;
- b) excess capacity (outside London) – structural as a result of changing hospital use patterns, which increases the activity that can be done on an outpatient or day-case basis and reduces Average Length of Stay in in-patient facilities;
- c) the importance of quality to the decision making of patients⁵⁹ and consultants⁶⁰, neither of whom pay directly for the service, which increases costs. Healthcare is not an industrial process in which technological improvements lower costs over time. New equipment, drugs and medical advances tend to increase costs, which are reflected in prices;
- d) the critical importance of local provision – a top priority for patients⁶¹ and consultants⁶², which prevents demand from being concentrated in fewer locations and economies of scale bearing down on price;
- e) low alternative use value of hospitals, which slows exit from the market;
- f) the charitably-funded (or otherwise non-full-capital cost bearing) nature of competitive alternatives, which slows exit from the market; and

be in the overall proportionality assessment, or the more intrusive, uncertain in its effect, or wide-reaching a proposed remedy is likely to prove, the more detailed or deeper the investigation of the factor in question may need to be".

⁵⁹ Only timing (appointments and waiting) and the obvious ("because I have private medical insurance") are cited more often than quality of accommodation and quality of care by patients as reasons for choosing private treatment over NHS treatment – slides 70-71 of Patients Survey conducted for the CC by GfK.

⁶⁰ Quality of facilities and quality of care are the first and second-most important criteria taken into account by consultants in deciding whether to recommend a particular private hospital or PPU to a patient – slide 175 of Consultants Survey conducted for the CC by GfK.

⁶¹ Only 13% of private healthcare patients would be willing to travel for more than 60 minutes to see a better consultant – slide 421 of Patients Survey conducted for the CC by GfK.

⁶² A convenient geographic location for the patient ranks behind only quality of facilities, quality of care and PMI recognition in influencing consultants' decision on whether to recommend a particular private hospital or PPU to a patient – slide 175 of Consultants Survey conducted for the CC by GfK.

- g) the "free at the point of delivery" alternative of the NHS, which (whether or not the CC considers it a competitive constraint), inarguably drains huge amounts of potential demand from private healthcare.
- 6.2 Other hospitals have taken steps to embrace these dynamics, or have reacted to them in other ways. Examples with which the CC is familiar include:
- a) other hospital operators' (and particularly Ramsay's⁶³) embrace of NHS work;
 - b) Covenant Healthcare's 2007 collapse and subsequent exit from the market;
 - c) Nuffield's 2008 sale of ten under-performing hospitals⁶⁴;
 - d) Aspen's recent attempts to expand in outpatient and daycase work⁶⁵;
 - e) Circle's NHS led business and equity incentives for consultants⁶⁶; and
 - f) BMI's various strategies for adapting to market challenges, including:
 - i. [REDACTED];
 - ii. [REDACTED];
 - iii. [REDACTED];
 - iv. [REDACTED]; and
 - v. [REDACTED].
- 6.3 As seen in these examples, most of the major private hospital groups are doing what is necessary to adapt, compete and attempt to grow in an unfavourable market characterised by competitive constraints, the threat of entry (particularly in the smaller-scale treatments that are the market's future) and powerful buyers (including a downstream dominant firm). It is efforts such as these, rather than an unnecessary and distortive regulatory intervention, that are more likely to result in positive outcomes for the private healthcare market and the ultimate consumers of its services, patients.

⁶³ Total NHS admissions up 50% between 2008-2012 - para. 3.33, PFs.

⁶⁴ Para. 3.26, PFs.

⁶⁵ Paras 3.41-3.42, PFs.

⁶⁶ Paras 3.45-3.47, PFs.

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11 November 2013

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