

Response of



to

the CC's Provisional Findings: Barriers to entry

Annex 5

11 November 2013

Barriers to entry

1. Introduction

- 1.1 The CC's preliminary conclusion in its Provisional Findings report that barriers to entry for full service hospitals are high, giving rise to an AEC, is a crucial element of its case against BMI. Given the drastic impact on private healthcare operators of the divestiture remedies set out in the CC's Notice of Possible Remedies, a strongly reasoned argument that barriers to entering the private healthcare market are high ought to have been expected.
- 1.2 Moreover, clear and robust evidence that barriers to entry are high is also essential in supporting one of the CC's other provisional findings – that certain hospital operators are earning excessive profits. The CC's provisional views on profitability depend on that "excessive" profit being protected by high entry barriers.
- 1.3 In its Provisional Findings report, however, the CC has not advanced the strong, reasoned argument expected or required. Instead its Provisional Findings regarding barriers to entry are among the weakest limbs of its case against BMI and other private healthcare operators. The weakness stems from both a lack of evidence or irrational interpretations of evidence presented as well as from various inconsistencies between the CC's work on barriers and other areas of the CC's analysis – particularly profitability.
- 1.4 We note that a finding can only be lawful where "*the reasoning supportive of the finding ... is not logically self-contradictory*"¹, and submit that the CC's Provisional Findings regarding barriers to entry are self-contradictory and cannot be upheld on this basis.
- 1.5 There are three core logical flaws the panel should be aware of:
- (a) the high capital barriers to entry in the CC's barriers analysis and low replacement hospital values in the CC's profitability analysis are mutually inconsistent;
 - (b) the CC's excess profitability finding would suggest a very large incentive to enter the market. The CC's barriers analysis would therefore need to demonstrate very high barriers to entry to be consistent with the observed low actual entry. Instead the CC's assessment has found relatively low barriers apart from the previously mentioned high capital costs; and
 - (c) the CC maintains that incumbent private healthcare operators respond aggressively to foreclose new entrants, yet also maintains that markets served by two competitors exhibit insufficient competition. Both cannot be correct, especially where there is significant excess capacity in "duopoly" markets.

¹ *Mahon v Air New Zealand Ltd and others* [1984] 3 All ER 201 at 211.

2. **Logic flaw 1: There cannot both be high capital barriers to entry and low replacement hospital values**

- 2.1 The CC has come to the conclusion that “[t]he cost of designing, building and equipping a private hospital able to provide a full range of inpatient, day-case and outpatient facilities is high”² and, furthermore, that “the high sunk costs of incumbents [...] constitute a barrier to entry.”³ According to the CC these high capital costs combine with economies of scale to produce “the greatest barrier to entry”⁴ to the private healthcare market.
- 2.2 The CC has noted that its profitability analysis is closely related to its barriers assessment, in that it “was carried out on a replacement cost basis and therefore suggests that, in the absence of barriers to entry, a new entrant could expect to produce strong returns.”⁵
- 2.3 The CC does not specify what “high” sunk capital costs are, or against what comparator “high” is to be measured. However, the previously-noted CC assessment of the capital valuations of private hospitals’ land and buildings on the basis of replacement cost (intended to represent the costs an entrant would expect to bear) should be the obvious place to consider what these costs are and how high they might be.
- 2.4 Though BMI believes replacement cost to be a flawed basis for the CC’s assessment we will, for the sake of argument in this paper, assume that the approach to valuation is correct and that the value calculated is in fact accurate.
- 2.5 The CC undervalued GHG’s real estate assets by [X]% (land) and [X]% (buildings) on average⁶. The aggregate value that the CC ascribed to BMI’s land and buildings was only [X]% of the value at which these assets are reflected on the financial statements of BMI as of 30 September 2011. The CC’s valuation was nominally based on the replacement costs of modern equivalent assets. On this analysis BMI is currently funding invested capital that is far far higher than the capital costs a new entrant would have to incur. The sunk capital costs therefore cannot be “high” relative to the actual capital currently deployed by BMI.
- 2.6 This inverse relationship between the incumbent’s and new entrant’s capital costs is actually the opposite of a barrier to entry as defined by the CC’s guidance - “any feature of the market that gives incumbent suppliers an advantage over efficient potential entrants or rival incumbent firms”.⁷ Based on the CC’s analysis, an efficient new entrant

² PFs, paragraph 6.46.

³ PFs, paragraph 6.49.

⁴ PFs, paragraph 6.79.

⁵ PFs, paragraph 6.86.

⁶ As revalued by Colliers (using the same methodology as that used by the CC) and set out in the paper on the CC’s profitability analysis attached as Annex 6 to BMI’s response to the PFs – see in particular paragraphs 2.12 and 2.20.

⁷ CC *Guidelines for Market Investigations* paragraph 207.

would need nearly [X]%⁸ less capital than BMI⁹ – representing a very significant advantage that a new entrant would have over the incumbent and therefore a strong inducement to entry.

- 2.7 The CC offers no reasoning or evidence to suggest that costs are high in some other relevant sense. Indeed, the available evidence suggests they are not.
- 2.8 The case studies do not disclose that entrants had any difficulty in obtaining financing.
- (a) Circle Bath's finance was arranged “seemingly without difficulty”¹⁰. In Circle's own admission *“the costs of entry are not insurmountable . . . provided that the potential new entrant can demonstrate a compelling business plan”*¹¹.
 - (b) The London Clinic (TLC) built and equipped its Cancer Centre for £90 million without any apparent financing difficulty.¹²
 - (c) Though Circle Edinburgh failed to obtain financing, this is not considered a generally applicable barrier in the case study. As the CC notes, Circle's fund raising attempt occurred in 2009, in the midst of the financial crisis. Moreover, the specific investment concerned Edinburgh, a city that was particularly severely affected by the crisis in terms of professional employment and likely insured lives.

The CC has cited no other evidence suggesting that hospital providers face particular hurdles in securing financing for new hospitals.

- 2.9 BMI notes that the costs incurred by these entrants, though financed without great difficulty, are nevertheless far higher than the costs that the CC's profitability analysis suggests would be incurred by a new entrant.
- 2.10 The CC valued BMI's [X] freehold estates (comprised of land and buildings) at [X] for FY 2011 (on the basis of the replacement cost of a modern equivalent asset), equating

⁸ Based on a comparison of the CC's Capital Employed figure for the most recent full financial year (FY2011) with the readjusted FY2011 Capital Employed figure set out in the table following para 2.7 of the BMI paper on the CC's profitability analysis attached as Annex 6 to BMI's response to the PFs. Note that the readjustments (corrections to the originally undervalued land and buildings figures) were made using the CC's DRC valuation methodology. Using market based values the readjusted figure would be much, much higher.

⁹ Note that this figure is calculated as the proportion of the difference between the CC's capital employed figure and the total capital employed after all corrections (using a DRC valuation) - all divided by total capital employed after all corrections (using a DRC valuation). Using market based values this figure would be much, much higher.

¹⁰ PFs, appendix 6.1, paragraph 99.

¹¹ Section 4, Circle Response to Provisional Findings and Notice of Possible Remedies.

¹² PFs, appendix 6.3, paragraph 39.

to a value of just over [X] per hospital.¹³ The table below¹⁴, however, shows that the CC's average valuation of a BMI hospital is lower than a [X] of the average observed costs (£52.75 million) of a modern equivalent asset.

What's the cost of a Modern Equivalent Asset?		
Hospital	Cost (Land, Building and Commissioning)	Characteristics
Circle Bath	~£30 million	4 theatres, no ICU, no HDU, 28 IP beds
Spire Montefiore	~£29 million	3 theatres, no ICU, no HDU, 20 IP beds
London Clinic Cancer Centre	~£90 million	Specialist cancer equipment, 35 IP beds
HCA Christie Clinic	~£35 million (excluding land costs)	PPU (6 NHS theatres), no dedicated ICU or HDU, 34 IP beds
Circle Reading	~£58 million	5 theatres, No ICU or HDU, 30 IP beds
KIMS	~£90 million	5 theatres, 77 IP beds
Nuffield Oxford Manor	at least £50 million	8 theatres, 7 bed ICU, 71 IP beds
Nuffield Leeds	at least £40 million	6 theatres, 8 bed ICU, 88 IP beds
Average	£52.75 million	5 theatres, 48 IP beds
Average excluding London Clinic CC (LCCC)	£47.42 million	

- 2.11 The huge difference between the actual observed costs of modern hospital assets and the CC's valuation of BMI's assets strongly suggests that both sets of numbers cannot be correct. Since we know the observed costs from empirical evidence, the only conclusion possible is that the theoretically calculated and derived values for the BMI assets must be wrong.
- 2.12 The CC has sought to address this by suggesting that the hospitals above are not comparable to BMI's hospitals, citing that the most costly ones outside of London (Circle Reading, KIMS and the two Nuffield hospitals) are larger than the average BMI hospital and offer more advanced facilities.¹⁵ This narrative is not credible for the reasons explained in BMI's response to the CC's working paper on profitability¹⁶ and still fails to account for why smaller hospitals that the CC might consider more comparable to the BMI portfolio (such as Circle Bath¹⁷ and Spire Montefiore), are approximately [X] as costly.

¹³ The [X] million figure excludes equipment. If one includes the cost of equipment "as new", the figures are [X], which equates to an "as new" figure of [X] per hospitals. The inclusion of equipment is preferable as it is more comparable with the observed entrants as most of these (but not Circle Bath) include equipment. Under this approach, the CC's valuation is approximately [X]% of the average new build, or [X]% of the cheapest (and smallest) observed entrant.

¹⁴ Produced by BMI from publicly available sources, presented to the CC at BMI's Hearing, and reproduced as Figure 3 in Appendix 6.13 to the CC's Provisional Findings Report.

¹⁵ PFs, appendix 6.13, paragraph 107.

¹⁶ BMI's Response dated 6 April 2013 to CC working paper on profitability, paragraphs 3.19 et seq.

¹⁷ The CC reports AXA PPP as concluding that "Circle Bath did not offer any additional services to the BMI Bath Clinic" (PFs, appendix 6.1, paragraph 70).

2.13 The CC's finding of a barrier to entry on the basis of high capital barriers to entry is contradicted by the evidence its own case relies upon in respect of its profitability finding. It is therefore logically self-contradictory and cannot lawfully be sustained.

3. Logic Flaw 2: Failure to prove barriers are high enough to overcome the strong incentive to enter that the CC's profitability analysis suggests

3.1 The CC claims that in 2011 BMI had a ROCE of [X] and is therefore making excessive profits based on a WACC estimate of 10%.

3.2 The CC also claims at paragraph 6.86 that *"the extent of entry at the full service hospital level (essentially Circle's two private hospitals) is less than we would expect were there not high barriers to entry. Indeed in the absence of high barriers to entry we would expect entry and/or the threat of entry to have driven prices to a level that did not allow returns in excess of the cost of capital to be persistently obtained."*

3.3 The barriers to entry the CC has identified are as follows.

High capital cost

3.4 As explained above, this finding is both factually incorrect as well as inconsistent with the CC's profitability analysis.

Economies of scale

3.5 The CC has found that *"some economies of scale associated with private hospitals, particularly full service hospitals with inpatient facilities"* combine with high fixed costs to create a situation in which *"small-scale entry in order to offer inpatient facilities is unlikely to be profitable."*¹⁸

3.6 The CC has not attempted to quantify the extent of this barrier and how it might be overcome. This is despite the fact that the CC holds the full cost data for the industry and has a complete understanding of volumes in local areas. It would therefore be possible to empirically test how large an inpatient hospital would need to be before it reached an efficient scale. BMI requested the data to be able to perform this analysis itself.¹⁹ The CC's refusal to provide this information is before the CAT.

3.7 While it is the case that there is a minimum efficient scale for a private hospital offering inpatient services, it is not obviously particularly large. BMI owns 5 hospitals that have a single operating theatre, all of which offer inpatient services. In any event, inpatient services are not a good proxy for minimum efficient scale. Spire Shawfair Park has two theatres and only offers day case surgery, the Edinburgh Clinic is considered to have *"entered the market on a smaller scale"*²⁰, yet has a single operating theatre, as do BMI Carrick Glen, Foscote, Lancaster, Sefton and Werndale hospitals – all of which are "full

¹⁸ PFs, paragraph 6.48.

¹⁹ Webber/Pigott Letter dated 16 September 2013.

²⁰ PFs, paragraph 6.31.

service” hospitals offering inpatient services. The new HCA Wilmslow hospital will have two theatres and will not treat inpatients yet is larger than some BMI hospitals that do.

- 3.8 As the CC notes, few new firms have entered the private healthcare market through the establishment of full service hospitals.²¹ This is not, however due to the barriers to entry caused by cost or scale that the CC cites in its findings. In reality, the reason for the lack of new entry at the full-service end of the private healthcare market in recent years is (as the CC has acknowledged) that *"the market for private healthcare has been flat for several years, and is expected to remain so for the foreseeable future."*²²
- 3.9 Where demand is flat, in a market already characterised by excess capacity,²³ new full-service entry would not be expected as a new entrant could not generate a return. These market realities cast doubt on the CC's underlying concern that the lack of profitability of small-scale inpatient facilities somehow represents a barrier to entry. The current market simply does not demand new inpatient facilities. As the CC's own figures show, daypatient treatments are one of the few growth areas of the private healthcare market, growing over the past decade to represent nearly 70% of all admissions while overnight bed capacity has contracted²⁴. The lack of entry lamented by the CC is belied by numerous examples of small-scale/specialist facilities founded during the recent general economic downturn, including those cited by the CC itself²⁵.
- 3.10 Avoiding overnight stays is the goal in today's technologically-efficient and cost-conscious healthcare market. In such a market any attempt at breaking down alleged barriers to the entry of new inpatient services providers may still result in no new entry or (perhaps worse) may result in unnecessary entry that would be inefficient and therefore unwelcome from a consumer welfare perspective.
- 3.11 Both PMIs and hospital operators recognize this. AXA PPP has stated *"we do not believe that a new entrant guarantees a price reduction. Indeed our view is that cost increases are more likely as competition for consultants (and thereby patients) can lead to incentives/gold plating of services resulting in higher prices."*²⁶ Similarly, the CC has recorded Bupa's concerns *"about areas where there was limited demand, and there was one private hospital that was not fully utilized and another one opened up. Hospitals had high fixed costs, and in such circumstances what tended to happen was that the prices rose overall and customers ended up paying for it."*²⁷
- 3.12 The CC's case studies on the Edinburgh and Bath markets provide instructive examples of how prospective entrants assess the appropriate scale for entry, as well as the

²¹ PFs, paragraph 6.11.

²² PFs, paragraph 6.47.

²³ PFs, paragraph 4.8.

²⁴ PFs, paragraph 2.18.

²⁵ PFs, paragraph 6.13.

²⁶ AXA PPP Response to Provisional Findings and Notice of Possible Remedies, paragraph 2.94,

²⁷ Bupa Hearing Summary, paragraph 42,.

consequences of misjudging the size of a market opportunity. The CC, however, has advanced a different view of the studies, focusing its analysis on one instance of successful-yet-flawed entry, conflating this entrant's misjudgments of appropriate scale with a barrier to entry and failing to grasp the broader lesson that entry can be precisely tailored to the market opportunity.

3.13 The Edinburgh case study reveals a number of the possible strategies that are available to tailor entry to the size of market opportunity. BMI, for example, considered entry as a new build private hospital, as a PPU and as a day-case/outpatient facility. Spire both expanded its inpatient hospital and entered with a day-case facility. Edinburgh Clinic entered via an outpatient diagnostic facility which it later expanded to form a day-case facility. Aspen entered by purchasing and investing further in the Edinburgh Clinic. Circle considered entry with a new build private hospital. Each of these parties made an assessment of the market opportunity and the scale of entry that might be profitable. Economies of scale will apply to all these forms of entry. The CC's view that economies of scale apply to "full service hospitals" implicitly accepts that economies of scale are not a material barrier in day case and outpatient work.

3.14 The following charts show the importance of different work types to certain BMI hospitals of potential concern measured by patient volume:²⁸

[✂]

3.15 An entrant into any of these markets will consider the efficient scale of entry across the total expected addressable demand – including NHS demand (inpatient and day case). Entry therefore can and as the CC Edinburgh case study shows, in fact does occur without reference to private inpatient demand.²⁹ If entry can and does occur without servicing private inpatients, the relevant question is then the existence of barriers to *expansion* from day case and outpatient work to inpatient work. Despite the CC's provisional conclusion that economies of scale affect "full service" hospitals specifically, the CC provides no evidence relating to the scale of barriers (if any) to expansion between day case and inpatient provision. Evidence in this respect was requested (and provided) in Section 10 of the market questionnaire yet is not referred to. Once the theatres, recovery suites and patient rooms are installed the main costs associated with an expansion to inpatient provision are variable (staff, energy, hotel services etc.). These costs cannot be a barrier as they also need to be borne by an incumbent providing inpatient services.

3.16 The CC Bath case study also involved some procedural lapses on the CC's part. Despite BMI being the incumbent hospital operator in Bath and therefore having key insight into the local private healthcare market, and despite BMI being the subject of Circle's somewhat overstated complaints, the CC declined the opportunity to ask BMI any questions (either in writing or in person or on the phone) when conducting its case study. Perhaps as a result of this failure to take relevant information from both sides into

²⁸ [✂]

²⁹ BMI notes also that the CC discounts large number of day-case and outpatient facilities in its local assessments (further discussed in BMI's response to the local assessments, attached as Annex 1 to BMI's response to the PFs), on the basis that they are not "full service". The presence and relevance of day case and outpatient facilities is not limited to the Edinburgh case study.

account (an oversight that has continued through to the publication of the Provisional Findings report, notwithstanding BMI's submissions), the CC has overlooked Circle's failure to correctly judge the extent of the available market opportunity.

- 3.17 The graph below³⁰ shows that not only has demand for private healthcare (measured by number of patients) in Bath not grown since Circle's entry in 2010, it has in fact declined. This is the opposite effect that efficient entry should create.

[REDACTED]

- 3.18 [REDACTED]. This is precisely the concern Bupa articulated at its hearing. It was also a key reason AXA PPP stated for its hesitance in recognising Circle Bath given that it "*did not need additional provision in the Bath area based on existing subscriber numbers there*".³¹ Indeed AXA PPP acknowledges that "*in many local markets, overall demand is not sufficient to support an additional, efficiently-sized private hospital*."³²
- 3.19 Circle's difficulties in successfully entering Bath are not evidence that economies of scale are a relevant barrier to entry. They are simply a result of its misjudgement of the extent of the available demand. This was a mistake that Aviva and AXA PPP (at least) were concerned about and appear to have warned Circle about either directly or indirectly. Had Circle entered in a way that responded to latent demand, such as The Edinburgh Clinic did in Edinburgh, it may well have been more successful.
- 3.20 The CC's finding of a barrier to entry on the basis of economies of scale is centred on a failure to take relevant considerations into account despite having the evidence, a failure to quantify the scale of the barrier, and a failure to consider alternative plausible hypotheses for observed outcomes. The provisional conclusions therefore are irrational, contrary to evidence and cannot be lawfully sustained.

Site availability and planning permission

- 3.21 The CC's analysis conflates site availability and planning permission, though they are two discrete issues and difficulty with one will not always (or indeed be expected) to correspond to difficulty with the other. Nevertheless, the CC has not managed to present convincing evidence that either is a barrier to entry.
- 3.22 Though BMI agrees with the CC's view that there are issues with site availability in central London in the W1 Marylebone area surrounding Harley Street, the CC has adduced no evidence to support its conclusion that this should also apply to other areas of the UK.³³ The CC has offered no evidence of scarcity of sites outside central London and cannot therefore consider site availability outside central London to be a relevant barrier.

³⁰ Sourced from BMI data.

³¹ PFs, appendix 6.1, paragraph 70(b).

³² AXA PPP Response to Annotated Issues Statement, paragraph 5.43.

³³ PFs, paragraph 6.65.

- 3.23 The CC's land valuation exercise³⁴ in January 2013 anticipated a large number of readily available alternative sites to the existing base of hospitals. In the Provisional Findings report the CC has retreated slightly from using the values of these alternatives in place of the valuation of the actual sites - "*greater weight was placed on the estimated cost of the current hospital sites within an area and relatively less weight on potential alternative sites in the same area*"³⁵ This does not change the fact that the CC's valuers, purely on a desktop basis, easily identified a large number of alternative sites. Even where the actual site was used, it merely implies that an alternative would not be cheaper than the actual site – not that no alternative site would be available to a new entrant
- 3.24 The CC's assessment presents a mixed picture of planning experiences. Some, such as Circle Bath, were very straightforward, others were more complex. There is no evidence, however, of a consistent refusal to grant planning permission, or even persistent local resistance to private hospital development. The experiences are all highly site specific and the CC's finding is expressed in noticeably mild language: "*obtaining planning permission for a new general hospital site[] could raise the costs and risks of the entry or expansion*"³⁶ and "*we recognize that the evidence received is location and circumstance specific and therefore does not necessarily apply to the whole of the UK*"³⁷.
- 3.25 The CC's conclusion in its profitability analysis that £250,000 should be added to the value of alternative sites to account for obtaining planning consent, and description of this figure as at the upper end of expected costs, adequately illustrates the scale of planning as a barrier. Expressed as a percentage of a typical recent entry such as Spire Montefiore, this sum equates to 0.86% of the capital cost of entry, hardly a high barrier to overcome.
- 3.26 The CC's finding of a barrier to entry on the basis of site availability and the difficulties of obtaining planning permission is based on insufficient evidence, and cannot therefore be lawfully sustained.

Strategic Barriers – PMI recognition.

- 3.27 The CC has not found PMIs' choices in respect of network recognition to be a barrier. It has arrived at this conclusion without any comparative analysis (as repeatedly recommended by BMI) of the foreclosure effects that result from a PMI's choice to operate exclusive networks (or networks with exclusive characteristics) with the benefits that exclusive agreements may confer by lowering costs through increased competition for network "slots".
- 3.28 Instead of adopting this very well-established and understood method of assessing the potential foreclosure effects of PMI's choices to pursue exclusive networks, the CC has

³⁴ Provided with the DTZ Draft Report attached as Appendix 6.15 to the Provisional Findings Report.

³⁵ PFs, appendix 6.16, paragraph 10(a).

³⁶ PFs, paragraph 6.65.

³⁷ PFs, paragraph 6.87.

adopted the unusual argument that *"large hospital providers may have the ability to induce a PMI to refuse recognition to a new entrant locally"*.³⁸

- 3.29 We note that this argument represents a change of view from the position initially stated by the CC in the Annotated Issues Statement (*"[w]e have seen no evidence that hospital groups have the ability to deter entry by forcing a PMI to deny recognition to an entrant even if they have an incentive to do so"*³⁹) and that the CC has provided no reasoning or evidence for this change of view.
- 3.30 The only evidence the CC has put forth in support of this allegation relates to a single event, namely AXA PPP's refusal to recognise Circle Bath for a short period after it opened. The proposition that this incident is indicative of a strategic barrier to entry is inconsistent with the evidence, given that Circle did in fact enter the market and captured half of the available market. Though BMI has commented extensively on this in its response to the CC's working papers on barriers to entry, its submissions do not appear to have been taken into account by the CC. BMI will therefore repeat the key points below.
- 3.31 The CC states that *"the main impediment to Circle's entry and expansion in Bath was the lack of PMI, and in particular the lack of AXA PPP recognition."*⁴⁰ However, as the CC itself has demonstrated, Circle was fully aware that AXA PPP would not recognise Circle Bath - *"AXA PPP told Circle it already had a provider in Bath and that in order to recognise Circle there it would need to conduct a formal tender which it had no immediate plans to do."*⁴¹
- 3.32 Furthermore, AXA PPP has an established and well-known policy of tendering its acute network slots. Where there are two directly competing hospitals in an area it will typically grant recognition to only one. This is a procurement strategy based on exclusive purchasing. It is a very common commercial choice that allows the procuring firm to generate competition for the whole of their demand and hence obtain a keener price. In order to offer that price, however, the supplier typically seeks a volume commitment or at least an exclusive supply relationship so that it might obtain the sales volume to justify its lower price. AXA PPP chose this strategy for itself almost 20 years ago. Others have chosen other strategies. Neither BMI nor anyone else "induced" them to do so. If AXA PPP has claimed to the CC that its network strategy was determined or maintained as a result of "inducements" by BMI, please provide some evidence to this effect so that BMI may comment on it.
- 3.33 As AXA PPP has stated, *"the key objectives behind the creation of the network were to streamline the providers available to our members whilst fulfilling the need for national coverage and access to timely, quality treatment. This thereby increased the volumes of patients treated at network facilities and enabled us to benefit from reduced prices."*⁴²

³⁸ PFs, paragraph 6.84.

³⁹ Annotated Issues Statement, appendix E, paragraph 47.

⁴⁰ PFs, appendix 6.1, paragraph 96.

⁴¹ PFs, appendix 6.1, paragraph 62.

⁴² AXA PPP Response to Issues Statement, paragraph 8.1.

Tendering on this basis gives AXA PPP buyer power, enabling it to provide patient volumes to hospitals and thereby secure discounts. AXA PPP's strategy in this respect is very widely known. No new entrant that undertook even minimal market research could therefore expect AXA PPP recognition immediately, as that is not the basis on which its network is constructed. There are many examples across the country of neighbouring hospitals where one has AXA PPP recognition and the other does not. Examples of this include [redacted].

- 3.34 The evidence shows that Circle not only should have known but actually did know in advance that AXA PPP would not recognise Circle Bath. Circle was explicitly told it would not be given recognition in Bath⁴³ but entered the market regardless. There is no rational basis therefore to consider the lack of AXA PPP recognition to be “*the main impediment to Circle’s entry.*” This conclusion is flatly contradicted by the evidence.
- 3.35 Further to describing the lack of AXA PPP recognition as the main impediment to Circle’s entry, the CC considers the main reason for this lack of recognition as AXA PPP’s concern to maintain its national commercial relationship with BMI⁴⁴ and states that this broader commercial relationship included (according, allegedly, to AXA PPP) “*the need to secure agreement over BMI’s participation in AXA PPP’s Corporate Pathways product.*”⁴⁵ The evidence contradicts, rather than supports, this view.
- (a) Firstly, AXA PPP has told the CC that “[*it*] considers that PMIs have not in fact been unreasonably deterred from recognising new hospitals as a result of the prospect of losing volume related discounts, or by threats of substantial price rises if volumes are reduced.”⁴⁶
 - (b) Secondly, the Corporate Pathways product was a BMI initiative. As AXA PPP has stated, “*BMI approached us, keen to innovate in the market by developing a lower cost proposition to offer corporate customers.*”⁴⁷ If the negotiation of this Corporate Pathways product suggests anything about the relevance of the parties’ broader commercial relationship at the time, it is that BMI was keen to secure an agreement from AXA PPP, not that it had any leveraging ability.
 - (c) Thirdly, the fact that AXA PPP recognised Circle Bath seven months after conclusion of the Corporate Pathways product agreement with BMI is inconsistent with the view that participation in Corporate Pathways was its overriding consideration. If the Corporate Pathways product was blocking AXA PPP from recognising Circle Bath, AXA PPP would not have recognised Circle after entering into the Corporate Pathways agreement with BMI. The CC will recall that the Corporate Pathways agreement anticipated (at least initially) a “BMI only” network. AXA PPP’s reliance on BMI is therefore more likely to have

⁴³ PFs, appendix 6.1, paragraph 61 *et seq.*

⁴⁴ PFs, appendix 6.1, paragraph 97.

⁴⁵ PFs, paragraph 6.22.

⁴⁶ AXA PPP Response to Annotated Issues Statement, paragraph 1.5(d).

⁴⁷ BMI response to Annotated Issues Statement, paragraph 4.11.

increased not decreased as a result of signing the Corporate Pathways agreement.

- (d) Fourthly, [REDACTED].
- (e) Finally, AXA PPP possesses countervailing buyer power. It has consistently maintained it has countervailing buyer power opposite BMI, as noted by the CC (*“AXA PPP’s response to the CC’s issues statement certainly suggested that it regarded itself in a position to negotiate with most hospital operators”*⁴⁸). Though AXA PPP’s stated view is that it has no countervailing bargaining power opposite HCA (as opposed to BMI), BMI notes that HCA’s attempts to persuade AXA PPP not to recognise TLC’s London radiotherapy facilities did not succeed. A failure to take into account the inability of an allegedly stronger party (HCA) to induce AXA PPP not to recognise new entrants, while concluding that an admittedly weaker party (BMI) would have the ability to assert itself in this way, suggests that the CC is stretching logic in order to present its own view of AXA PPP’s bargaining strength over AXA PPP’s own expressed view.

The evidence does not suggest AXA PPP could be dictated to by BMI, it shows the opposite.

- 3.36 Moreover, the CC has ignored or downplayed the other criteria cited by AXA PPP in its internal documents (i.e. insufficient population and lack of demand for services) that informed its decision to delay recognition of Circle Bath⁴⁹. AXA PPP believed it had adequate provision in Bath due to the fact that, in its judgment, the market only required one private hospital. AXA PPP therefore simply did not need to recognise Circle as well. Nevertheless, [REDACTED], AXA PPP did in fact recognise Circle Bath. [REDACTED].
- 3.37 This fact pattern is not consistent with the view that AXA PPP delayed recognition out of fear of how BMI may react. The CC has not provided any reasoning for why it considers AXA PPP’s broader commercial relationship with BMI to have been sufficiently important to enable BMI to “induce” AXA PPP to refuse to recognise Circle in March 2010 but not 18 months later when BMI was unable to “induce” the same result.
- 3.38 Similarly the CC has not provided an adequate explanation as to why BMI’s ability to induce PMIs not to recognise Circle was only effective with AXA PPP. When Circle entered the Bath market it was immediately recognised by Bupa and WPA and was also subsequently recognised by Aviva. The CC has recorded the efforts that BMI took among these PMIs to warn PMIs of the downside of adding more fixed cost to the market when there was insufficient demand⁵⁰, yet these efforts were ineffective. None of them considered their “broader commercial relationship” with BMI to be a reason not to recognise Circle Bath. Aviva recognised Circle Bath as part of its key network as from January 2011 and notably told the CC that *“it did not consider itself constrained by any*

⁴⁸ Annotated Issues Statement, appendix D, paragraph 30.

⁴⁹ [REDACTED]

⁵⁰ Circle has attempted to make much of this following PFs. We note that BMI raised the same concern about inefficient entry as the insurers themselves articulated in their own evidence to the CC.

*agreement with BMI.*⁵¹ AXA PPP informed Circle it would recognise its Bath facility in October 2011, and did so on 1 January 2012, on substantially the same terms that were initially offered to it. [S]. AXA PPP told the CC that it accepted “*that operators have not in practice been precluded from entering markets.*”⁵²

- 3.39 Finally, the CC’s own evidence demonstrates that any increase in entry costs arising from its alleged difficulties in securing PMI recognition would in any case be negligible and temporary. In entering the Bath market, Circle treated AXA PPP insured patients at its own expense from its opening in 2010 until June 2011. We are told that, had Circle billed the AXA PPP insured patients in full, the total amount would have been £775,000⁵³. Though BMI believes Circle’s actual costs from treating AXA PPP insured patients at its own expense for that period would be much lower, £775,000 nevertheless represents only 2.6% of the £33 million cost of Circle’s entry cited by the CC. The additional costs are therefore effectively negligible, especially in the context of a sum that was financed “*seemingly without difficulty*”.
- 3.40 BMI submits that the CC cannot claim there is a relevant barrier to entry that costs less than £775,000 to overcome while at the same time suggesting that there is a market opportunity across the UK worth at least £175 million in excess profit to be competed for every year. The CC’s finding of a barrier to entry on the basis of the ability of large hospital groups to induce a PMI to refuse a new entrant is contradicted by its own evidence, and cannot therefore be lawfully sustained.
4. **Logic flaw 3: The CC maintains that incumbent private healthcare operators respond aggressively to foreclose new entrants, while holding that markets served by two competitors experience ineffective competition.**
- 4.1 The CC has found “*that the necessity of incurring high levels of sunk costs to set up a hospital with inpatient services meant that in a static market any incumbent could be expected to react very aggressively to entry, and that this expected reaction would deter entry.*”⁵⁴
- 4.2 However, when assessing strength of local competition, the CC claims that “[*i*]n the absence of other constraints (or when these are weak), in general, we consider two hospitals (or hospital operators in case of common ownership of hospitals nearby) imposing a similar competitive constraint on each other to be insufficiently constrained as they would not be expected to compete effectively against each other.”⁵⁵
- 4.3 The CC thus expects aggressive reaction to entry, while at the same time maintaining that when two hospitals are actually present in a local market, they would not effectively compete against each other. It is not rational for the CC to sustain both positions, particularly when the two incumbent hospitals both have spare capacity.

⁵¹ PFs, appendix 6.1, paragraph 83.

⁵² AXA PPP Response to Annotated Issues Statement, paragraph 5.42.

⁵³ PFs, appendix 6.1, paragraph 73.

⁵⁴ Summary of the PFs, paragraph 24.

⁵⁵ PFs, paragraph 6.113.

- 4.4 Though the CC is silent on this discrepancy, a consideration of the post-entry timeframe may allow the two positions to be reconciled. The question would then become: how long after entry can an entrant expect the aggressive incumbent to give way to the weak competition the CC claims? Economic theory tells us - and the evidence suggests that - it is unlikely that competition would give way to cohabitation in this way.
- 4.5 The CC acknowledges “*that there is significant excess capacity in the private hospital industry.*”⁵⁶ Private hospitals outside central London are typically struggling to cover fixed costs, which are high as a proportion of total cost. Theory suggests that firms in such a position (typically in a market consisting of a few large firms) will compete keenly to cover fixed costs⁵⁷. Those that have covered fixed costs can expect to generate large margins from incremental volume, with the possibility of such margins driving further competition.
- 4.6 This is consistent with the CC's observation of BMI's response to Circle's attempted entry in Bath, which included “*attempting to persuade PMIs not to recognize the entrant, the introduction of a ‘consultant loyalty scheme’ and price reductions in the self-pay sector.*”⁵⁸ While stressing this behaviour as an example of “aggressive” competition (we assume not pejoratively), the CC has failed to refer to other competitive steps taken by BMI, such [X].
- 4.7 At the same time the CC maintains, “*unless we have seen evidence of competition (or potential competition), for example, hospitals having adjusted their competitive offering in response to changes made or expected by other hospitals, we do not regard two similar competitors to be sufficient.*”⁵⁹
- 4.8 This raises two points.
- (a) Firstly, the CC's current stance suggests it has misunderstood the evidence provided to it and ignored the evidence from its own Bath case study. The example of Bath is clear evidence of hospitals competing for survival in an over-served market. Aggressive response to entry is symptomatic of a competitive market and need not be a barrier to entry for an entrant that is prepared with the necessary finance and a correct identification of a market opportunity (or even, as in the case of Circle Bath, a poorly-identified market opportunity). The current deadlock between the parties is not an example of cozy cohabitation. [X].
- (b) Secondly, and more fundamentally, by effectively requiring the parties to show it evidence of competition (while ignoring the evidence before it) the CC has inverted the burden of proof. The Enterprise Act does not anticipate that the CC proceeds by inventing whatever presumptions suit it then simply inviting parties such as BMI to provide evidence to overturn that presumption before deciding that insufficient positive evidence has been provided so the presumption holds.

⁵⁶ *Ibid.*

⁵⁷ Perloff, J., *Microeconomics Theory & Applications with Calculus*. Boston: Pearson. 2008. p. 485.

⁵⁸ PFs, paragraph 6.47.

⁵⁹ PFs, paragraph 6.113.

The position is particularly egregious here as the CC's chosen presumption (that two hospitals do not provide sufficient competitive constraint on each other) is contrary to observed market and basic economic theory and is contradicted by the CC's assertion that an incumbent will react aggressively toward a new entrant – and that such reaction constitutes a barrier to entry.

5. Conclusion

- 5.1 The three core logical flaws discussed above render the CC's conclusions on barriers to entry self-contradictory and thereby undermine the CC's finding of an AEC in the private healthcare market. Such self-contradiction is to be expected, however, given that the premise for the argument is flawed to begin with. The CC has made a substantial effort to take the observable fact that unnecessary new large private hospitals have not been opening with any frequency and derive quite dire conclusions from this about the state of competition in the private healthcare market as a whole. Such an effort inevitably involves stretching arguments to the point where their flaws become apparent.
- 5.2 In reality, the new private full-service hospitals the CC would like to see are simply not necessary due in large part to a number of cyclical and structural issues unrelated to competition, most of which BMI has mentioned either in this paper or elsewhere, but which bear repeating. Among these issues, BMI notes that:
- (a) due to healthcare innovation, change in diagnostic techniques and therapeutic procedures new in-patient facilities are not required – most care can be delivered through day-case and outpatient facilities;
 - (b) demand for private healthcare has been generally stagnant throughout the financial crisis;
 - (c) demand for PMI coverage has suffered in particular given that the level of unemployment has been and remains high and PMI is generally an employment related benefit;
 - (d) PMIs are helping drive the decline in inpatient admissions by discouraging costly overnight admissions and driving activity to outpatient protocols;
 - (e) there was more than sufficient capacity in the market prior to the crisis to serve the currently flat-to-declining demand;
 - (f) the financial crisis not only impacted employment but also investor confidence and interest in pursuing new investments; and
 - (g) as a result of the crisis financial institutions have had little interest in funding new large construction projects.
- 5.3 All of these factors are unrelated to competition in the UK private healthcare market and beyond the CC's power to remedy.