

Response of



to

Private Healthcare Market Investigation
Remedies Notice – Remedy 1

Non-Confidential Version

11 November 2013

Table of Contents

	Page
REMEDY 1.....	1
1. Executive Summary	1
2. Effectiveness - Unsound Methodology	3
3. Effectiveness - The CC's methodology cannot predict the effect of a divestment on competition.....	5
4. Effectiveness – there is no rational basis to consider divestments would alter the terms of the bargain with insurers.....	6
5. Effectiveness – the CC has no basis to believe that divestment would result in improved conditions of competition for self-pay patients	7
6. Effectiveness – the CC has no basis to believe that any benefit conferred on insurers would reach consumers.....	8
7. Actual effect of remedies on PMI costs	9
8. [X]	13
9. [X]	14
10. Proportionality – divestments are highly likely to remove efficiencies from BMI’s operations currently benefiting patients	15
11. Proportionality – double proportionality	15
12. Proportionality - Divestment is highly likely to harm investment incentives in the UK and in private healthcare in particular through substantial increase in perceptions of regulatory risk	16
13. Proportionality – divestment is highly likely to occur at an undervalue or not at all.....	18
14. Proportionality – Divestment is extremely disruptive to patients.....	19
15. Proportionality – the CC's substantive case against clusters, and indeed single and duopoly areas, is far too weak to pass the legal standard.....	21
16. Proportionality - divestments are not supported by key beneficiaries.....	22
17. Proportionality – there are remedies that are far less onerous and would be effective	23

REMEDY 1

REQUIRE BMI AND SPIRE TO DIVEST ONE OR MORE HOSPITALS (THE DIVESTITURE PACKAGE) IN THOSE LOCAL AREAS WITH CLUSTERS TO A SUITABLE PURCHASER

1. Executive Summary

- 1.1 As set out in BMI's separate response to the CC's Provisional Findings report, the CC has failed to establish its alleged AEC to the requisite standard. Notwithstanding this, even if the CC had adequately established its alleged AEC, its proposed divestment remedies would fail to address the alleged AEC effectively and comprehensively.
- 1.2 The proposed divestment remedies are inappropriate as they will be ineffective:
- (a) The competition analysis describing the problem divestment is intended to solve is almost entirely dependent on an unsound methodology (LOCI, in fact a newly-created CC invention based on this unsound methodology called 'network LOCI') that pre-determines the outcome;
 - (b) There is no or insufficient¹ evidence to support any rational prediction of improved competition or other beneficial effects from divestment;
 - (c) There is no or insufficient evidence to suggest the proposed divestments would improve the bargaining position of insurers. Indeed the available contemporaneous evidence of observed market behaviour consistently shows that it would not;
 - (d) There is no evidence to suggest that any benefits conferred on PMIs through additional bargaining leverage (if any) would result in a reduction in consumer detriment.
- 1.3 The proposed divestment remedies are manifestly disproportionate:
- Divestment on the scale proposed or worse would be highly likely to result in
- (a) [REDACTED]
 - (b) [REDACTED]
 - (c) Only a proportion of the (already tiny) number of privately funded inpatients who could (on the CC's own case) benefit live in areas that (on the CC's catchment area analysis) would see an improvement in choice. All other patients – the overwhelming majority of people who walk through the door of a BMI hospital will suffer the consequences of divestment and see no advantage whatsoever.

¹ Insufficient evidence should be read to mean that "*The evidence taken as a whole is not reasonably capable of supporting the finding of fact*" - De Smith's Judicial Review, 7th Ed, paragraph 11-052.

- (d) [REDACTED]
- (e) Divestment will remove efficiencies from BMI's operation that permit better, safer and more efficient and effective patient service. [REDACTED].
- (f) [REDACTED].
- (g) [REDACTED].
- (h) [REDACTED]
- (i) Divestment of any scale will be highly disruptive to patients, especially those in the middle of a care pathway. The limited evidence provided to the CC from patients themselves demonstrates the costs of such disruption.²
- (j) The CC's flawed provisional finding of features of high barriers to entry and weak competitive constraints in local areas resulting in an adverse effect on competition is based on evidence of market outcomes that concern privately funded inpatients only (approximately [REDACTED] of BMI's total patient episodes in FY 2012). The CC's price concentration analysis is limited to four inpatient treatments only and covers at most less than [REDACTED] of BMI's total patient episodes in 2009-2012. [REDACTED] The "barriers" the CC has (incorrectly) identified relate to "full service" (i.e. inpatient) hospitals. The local assessments dismiss competitors that are less than "full service" as insufficient to provide a constraint, despite the continuing shift in patient care delivery from a full service inpatient setting towards delivering care to patients in a day case or outpatient setting. A hospital divestment, however, would concern the entire service offering, well over [REDACTED] of which, on average, is not privately funded inpatient work, and for which parties dismissed as appropriate competitors are in fact highly appropriate.
- (k) The evidence of structural features and the adverse effects resulting from them is far far too weak to support divestments. It categorically fails the CAT's "double proportionality" approach.³

1.4 This section of the response addresses in greater detail the effectiveness and proportionality of the CC's divestment proposal. Annex 1 contains a detailed examination of the CC's case for divestment in respect of each of its identified hospital "clusters".

² See for example Private Patient Forum Letter to the CC, dated 20 September 2013, p. 2: "*However, PPF is mindful that reductions in quality often follow large scale market disruption such as is contemplated in the proposed remedies.*"

³ CAT in *Tesco v Competition Commission* (2009), CAT 6, (paragraph 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 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'.

1.5 BMI has considered what the CC's proposal might mean and what it might be trying to achieve. There are a number of questions regarding interpretations, contingencies and potential consequences of divestment. Although the discussion of these questions overlaps with many of the CC's consultation questions in the Remedy Notice, it is important that the debate is not constrained by these questions which are poorly suited to exploring many of the key issues. That said, for the CC's convenience, a table cross referencing the points relevant to its consultation questions is provided at the end of this section. This does not obviate the need to read the text below.

2. Effectiveness - Unsound Methodology

2.1 The CC's divestment remedy only applies to "clusters" of hospitals owned by a single operator in the same "local area" such that the facilities have overlapping catchment areas.

2.2 The CC explains that: "*the clusters have (at least thus far) been defined with reference to the CC's LOCI analysis, which has been disclosed, as has the underlying data*".⁴

2.3 LOCI is simply not an accepted methodology for measuring concentration. It has never been used in the UK before. Neither has it ever been used in a published decision of any competition authority globally. The measure is based on a single draft article that has not been published in a peer reviewed journal and carries a citation: "Rough Draft: Not for Citation or Quotation".

2.4 Leaving aside LOCI's lack of standing, neither is there any rational basis to consider that LOCI gives a useful proxy of market power. This is because there is no known economic model where LOCI would be a good proxy for market power – except the LOGIT model, which the CC accepts is not appropriate.⁵ To be useful proxies for market power concentration, measures must be justified by some accepted economic theory that explains the link between the measure observed and competition outcome. HHI for instance, a common concentration measure used by competition authorities around the world, is motivated by the Cournot model of competition.

2.5 The CC selected LOCI and has stoutly defended this choice through consultation round after consultation round. Rather than meaningfully engage with the comments of stakeholders, the CC has disregarded the near universal, consistent and strongly worded criticism from the professional economists participating in this case. The decision to rely on LOCI is and always has been an irrational one.

2.6 The CC's cluster analysis relies on a particular observation of LOCI called network LOCI. This observation is an invention entirely of the CC's own making – it is not mentioned even in the draft unpublished paper that the CC relies on as academic justification for its choice.

⁴ Letter Treasury Solicitor (acting for the CC) to the Competition Appeal Tribunal, 7 September 2013.

⁵ PFs, A6(4)-2 paragraph 7.

- 2.7 Network LOCI measures the delta between an implied market share of an individual hospital and the implied market share of the entire BMI group in a given area. The CC refers to these latter numbers as "weighted average market shares (network LOCI)". Even if the methodological concerns above can be disregarded (which they cannot be), weighted average market shares derived from network LOCI are not a reasonable or rational way to measure local market share as they systematically overstate BMI's competitive strength.
- 2.8 BMI would estimate that the areas closest to the hospitals are likely to be given the greatest weight in the calculation as hospitals will attract a high proportion of the available demand that is near to them. This is obvious and applies to all businesses offering services to people in local markets (e.g. grocery stores, garages, restaurants, GP or dental surgeries). The CC duly finds that people living close to a BMI hospital are highly likely to use it. They then give these areas the heaviest weighting in the LOCI methodology, thereby inflating BMI's market position *ab initio*.
- 2.9 Moreover, the areas closest to BMI hospitals (and further away from a competitor hospital) contain those patients who are least likely to shift their demand to an alternative. Competition for private hospitals, just like all other business, is primarily about attracting the marginal customer. Changes in volume come primarily from these marginal rather than the infra-marginal patients. Given BMI's high fixed costs as a proportion of total cost, BMI has an enormous incentive to attract marginal patients. Either they contribute toward fixed cost or they represent the profit opportunity once such costs are covered. These are the patients (and the consultants who might 'represent' and treat them) who in reality have the greatest effect on the competitive constraints faced by a hospital – and also where BMI's share is likely to be lowest. **Yet these are just the patients the network LOCI observation is designed to ignore.**
- 2.10 Network LOCI also penalises operators who deliver the same volume of services through more than one hospital. Consider a single large BMI hospital which treats all the patients treated by BMI in a given area. The network LOCI and the individual hospital LOCI will be identical. However, if the single large hospital is replaced with two BMI hospitals which together treat exactly the same number of patients as the single large hospital, but where each treats half the patients, there will be a very large delta between each hospital's individual and its network LOCI. This, the CC would claim, is the basis of a "common ownership concern" or cluster vulnerable to divestment. For example, [§].
- 2.11 The analysis is confused, but BMI understands that the CC has identified "clusters" by identifying hospitals with a network effect (i.e. delta between individual and network LOCI) of 0.2, and then grouped them together with any hospital owned by the same operator which has an overlapping catchment area.
- 2.12 The catchment areas therefore are used to determine the hospitals within the cluster. The CC's catchment areas are categorically not local geographic

markets.⁶ But they are treated as if they were by the CC in the local market assessments. For instance, there is not a single occasion where the CC has found a hospital outside a catchment area to amount to an effective constraint to a BMI hospital.

- 2.13 Conversely, catchment areas are a reflection of the presence of competition. Figure 1 below shows the relationship between distance to closest hospital and the CC's 80% catchment area for all the hospitals included in the CC's local assessments. A key takeaway from Figure 1 is that the CC's estimated catchment areas vary wildly – from very small to very large. Conventional economics considers it likely that catchment areas will depend materially on competitive conditions. In particular, hospitals with lots of nearby rivals will - all else equal – tend to have smaller catchment areas.

[✂]

Figure 1. Relationship between distance to closest hospital and the CC's estimated catchment area in miles for hospitals outside central London

- 2.14 An in-depth analysis of the relationship between catchment areas and the distance to other local hospitals is provided at Annex 2.
- 2.15 In practice the CC does not do what it claims to have done in paragraph 5.64. it uses this catchment methodology to identify hospitals for divestment is unsound and pre-determines the cluster definition with no adjustment for other empirical or contemporaneous evidence.
- 3. Effectiveness - The CC's methodology cannot predict the effect of a divestment on competition**
- 3.1 The CC's evidence – particularly when determining which hospitals belong in a cluster and which hospitals should be divested – is based overwhelmingly on LOCI. There is patchy reference to other sources, and these other sources are used to describe hospitals as insufficiently constrained, rather than to analyse the actual effects potential divestment would have.
- 3.2 This reliance on LOCI and the CC's "cluster" theory is not robust. The CC treats LOCI not merely as a filter – a role which it is anyway incapable of performing for the reasons noted above – but as the determining criteria for divestment.
- 3.3 A direct consequence of motivating the case for divestments on such a weak evidential basis, is that the CC can have no reliable and rational way of predicting the effect that such divestments will have on competition. For

⁶ PFs, paragraph 5.64: "The catchment area around a hospital reflects the area from which the hospital draws the majority of its patients and does not necessarily fully reflect patients' willingness to travel in response to a small change in the price or quality of the services provided by the hospital they have attended. This may result in geographic markets defined on the basis of catchment areas possibly being too narrow in some instances. However, as explained below, we have considered in our local competitive assessment the constraints on each hospital, whether arising within or outside the hospital's catchment area."

example, if a hospital is sufficiently constrained by its marginal patients, its prices will already be competitive. Simply adding a new competitor may reduce a weighted average market share but it will not change prices, and will therefore not be effective.⁷ Specific defects include:

- (a) First: The CC's LOCI methodology for local competitive assessments (and we assume divestments) only analyses data from insured patients in a sub-set of a sub-set of competitors⁸. Inpatients represent only [X] of hospital revenue – and a far smaller part of volume. As the CC's consumer survey showed, insured patients will typically travel less far on average than self-pay patients. This is intuitive as insured patients are choosing between two "free"⁹ options, care on the NHS or in their local private hospital whereas self-pay patients have rejected the free NHS alternative and are shopping around to pay for what they perceive to be a better service.
- (b) Secondly, the results yielded by the LOCI are inconsistent with the rest of the body of evidence and in particular the insurer bargaining analysis, BMI's internal documents and the CC's consumer survey evidence. Many of the hospitals in the clusters have been delisted (most recently by Bupa [X]). Recall that this means that all demand from a customer is diverted to BMI's competitors. The divestment seeks to remedy BMI's market power that supposedly derives from BMI's common ownership of a group of hospitals. Yet many of these hospitals were delisted by Bupa in early 2012 and patients directed to *non-BMI alternatives* not the other BMI hospitals in the "cluster". PMIs are therefore able to direct *all* their demand from these hospitals to a hospital other than one owned by BMI – even in a cluster. Normally a sufficient competitive constraint to each hospital in the cluster is presented by a substitute to which a customer can switch enough demand to constrain a price rise. Yet, in this case, the CC ignores the ability to switch out *all* of it in defining the cluster.

4. Effectiveness – there is no rational basis to consider divestments would alter the terms of the bargain with insurers.

- 4.1 Clusters have never been a feature of BMI's negotiation with insurers. The CC has reviewed the extensive correspondence and evidence body associated with insurer hospital negotiations. It has not found a single reference in the contemporaneous evidence body to suggest that clusters are used in negotiations with PMIs.

⁷ Indeed, Aviva Health UK does not believe that divestiture is likely to have an immediate effect on prices. Aviva Health UK Response to Provisional Findings and Possible Remedies, p. 5.

⁸ PFs, Appendix 6(4) paragraph 34. The CC only looks at "full service" i.e. Inpatient hospitals. Of these, the LOCI measure ignores 46 leaving a total competitor set of 173. This compares against Laing & Buisson's estimate of >500 private patient facilities in the UK.

⁹ Subject to payment of any excess and policy limits which apply to a particular patient's policy and any 'incentives' which a PMI may pay to a patient for choosing to have their treatment in the NHS rather than privately.

- 4.2 PMIs did not complain to the OFT and the CC or to BMI about clusters of hospitals. The complaints about "clustering" have only arisen *after* the CC decided to pursue this idea. They played no role in the OFT investigation. They played no role in the market questionnaire. They played no role in any PMI submission to the CC until *after* the CC decided its innovation of network LOCI was suggesting a clustering problem. An open-minded decision maker would both notice this and question why this was.
- 4.3 The CC has no rational basis and has presented no or insufficient evidence to support the contention that ownership of hospitals within a "cluster" affects BMI's bargaining power or the price that insurers can obtain. There is therefore no or insufficient evidence that divestment of such hospitals would be effective at improving the position of such insurers.¹⁰
- 5. Effectiveness – the CC has no basis to believe that divestment would result in improved conditions of competition for self-pay patients**
- 5.1 The CC has stated that self-pay prices increase in areas where there is a concentration of hospitals run by the same operator (PCA). This is wrong. The PCA analysis is so profoundly flawed that *"the CC simply cannot rationally place any evidential weight on the econometric results presented in the PCA"*¹¹.
- 5.2 The CC's patient survey evidence shows that self-pay patients *actually did* travel an average of 44 minutes' drive time to their hospital of choice.¹² Proposed divestments based on concentration measured by network effect LOCI and catchment areas described above grossly over-estimate the importance of patients living in the immediate vicinity, and does not accurately reflect the substitutes available to patients willing to travel the distance the CC's own consumer survey evidence suggests patients have in fact travelled. BMI emphasizes this is not a response to a hypothetical question about how far *would* you travel. It is a statement of how far they *actually did* travel. The response is therefore inherently more reliable and should have materially more probative value.
- 5.3 The clusters do not represent the range of choices available to self-pay patients. The self-pay PCA is also incapable of supporting the conclusion that additional concentration leads to increased price. There is no rational basis therefore to consider that divestments within clusters will be effective at reducing self-pay price.

¹⁰ AXA PPP explicitly states it is sceptical of a remedy requiring BMI and Spire to divest hospitals. AXA PPP feedback to the Competition Commission ("CC") on the provisional findings and notice of possible remedies, paragraph 1.17.

¹¹ Dr Peter Davis, "*Comments on the CC's revised price concentration analysis*", paragraph 1.1.

¹² Private Healthcare Market Investigation, Surveys of Patients – November/December 2012, slide 48.

6. Effectiveness – the CC has no basis to believe that any benefit conferred on insurers would reach consumers

6.1 The CC's assessment of divestment and indeed of any remedy that is designed to improve the position of insurers relative to hospitals, must determine whether and to what extent the remedy benefits will lower premiums charged by PMIs to final consumers. In other words, whether and to what extent lower prices charged by hospital groups would be passed through to patients and thereby reduce the (alleged) consumer detriment.

6.2 The CC accepts that this is necessary:

*[The CC] nevertheless recognises that the level of such consumer detriment will depend in part on the extent to which any reductions in insured prices would be passed through to consumers. This is an issue which the CC will be considering as part of the remedies phase of its investigation.*¹³

6.3 The CC has not, as yet, conducted a pass-through analysis. It says that

"However, the CC does not currently envisage a detailed empirical or quantitative analysis of the extent of pass through, nor does it have the data which would be required for such a quantitative analysis. The most pertinent evidence the CC has is evidence requested from the insurers on the interrelationship between their prices and the prices charged to them by the hospital operators, which the CC will review.

As matters stand however, the CC is yet to carry out that work."¹⁴

6.4 As the CC no doubt appreciates this is far from sufficient. A detailed and empirical understanding of pass through is essential if it is to comply with its obligation under the Act and its Guidelines to "pay particular regard to the impact of remedies on customers"¹⁵ or to sustain its intervention case against BMI – as it currently seeks to - by reference to any assessment of consumer detriment.¹⁶

6.5 The CC identifies lower prices as an objective of the divestment remedies,¹⁷ however it does not quantify or even establish a framework for assessing how the windfall conferred on insurers will be passed through to customers.¹⁸

¹³ TSol letter to Shearman & Sterling, 7 October 2013.

¹⁴ *Ibid.*

¹⁵ CC3, Guidelines for market investigations: Their role, procedures, assessment and remedies, paragraph 348.

¹⁶ PFs, paragraph 10.9. BMI notes that the CC made much of its consumer detriment assessment when publicising its provisional findings – for instance Roger Witcomb's interview on BBC Radio 4 *Today*, 28 August 2013.

¹⁷ Remedies Notice, Divestment Options Annex; paragraphs 13-14.

- 6.6 The CC recognizes that “*divestiture represents a very significant intervention in property rights*”¹⁹ and that it has a “*significant impact*”²⁰ on the businesses to which it is applied. As such, under the “double proportionality principle” the CC should investigate the particular effects of divestiture in great detail.²¹
- 6.7 The CC’s persistent failure to meet this standard is already noted throughout this response and by others in their responses. The OFT, for example, raises this question with regard to Remedy 2, though it applies equally to divestiture: “*How would it be proved that a change in a hospital’s prices were [sic] linked to a change of policy of a PMI rather than other factors?*”²²
- 6.8 Similarly the Association of Anesthetists of Great Britain and Ireland states: “*It would be unwise to assume that a buyer with market power sufficient to unilaterally reduce its suppliers’ prices without prior notice will actually pass these savings on to its customers.*”²³
- 6.9 There is compelling evidence that were the CC to consider pass-through, it would conclude that windfall gains for insurers would not confer lower costs onto patients, but rather that, should any such gains arise, they would remain with the downstream intermediaries.
- 6.10 To consider pass-through, it is necessary to assess: (i) the size of the actual likely effect of divestment on PMI costs; and (ii) the extent to which that reduction in PMIs’ costs would be passed through to patients.

7. Actual effect of remedies on PMI costs

- 7.1 As the CC itself acknowledges “*Bupa and AXA PPP obtain much lower prices than the other PMIs, Bupa obtaining lower prices than AXA PPP*”. The CC concludes “*that smaller PMIs have no countervailing buyer power, that larger PMIs have some countervailing buyer power, Bupa more than AXA PPP and that no PMI had countervailing buyer power that could fully offset the market power of all hospital operators.*”
- 7.2 Bupa and AXA PPP therefore already benefit from reduced costs and thus any hoped-for PMI cost reductions arising from divestment are already to a greater or lesser degree realized by the two largest PMIs. Yet other PMIs are able to compete on price in the PMI market against them. This strongly suggests that AXA PPP and Bupa are not currently passing on the full benefit of their lower prices – they simply do not need to.

¹⁸ The CC’s obligation to properly assess the effects of remedies is set out *inter alia* at paragraph 351 CC3 Guidelines for market investigations: Their role, procedures, assessment and remedies

¹⁹ *Groceries* Final Report, paragraph 11.265.

²⁰ *BAA* Final Report, paragraph 10.117.

²¹ See paragraph 349 CC3 Guidelines for market investigations: Their role, procedures, assessment and remedies, and *Tesco v Competition Commission* (2009), CAT 6, paragraph 139.

²² OFT Response to PFs, paragraph 22.

²³ AAGBI Comments on PFs, p.2.

7.3 In the absence of compelling evidence to the contrary therefore, it cannot be expected that any windfall drop in input prices for these PMIs will be passed on to their policy holders. The remedy will, at a minimum, transfer wealth from hospital operators to Bupa and to a lesser degree AXA PPP. These two insurers account for approximately 66% of the UK PMI market.²⁴

No pass-through to patients

7.4 The lack of pass-through is evidenced in BMI's negotiating history with [REDACTED] would materially lower prices to policy holders and therefore expand the market and ultimately volumes in BMI's hospitals.

7.5 [REDACTED]

[REDACTED].

7.6 [REDACTED]

7.7 [REDACTED]

7.8 [REDACTED].

7.9 This lack of pass-through is *inter alia* a function of price setting in the PMI market. Most PMI is bought by insurance brokers who have a keen understanding of pricing. Their role is to seek out the most cost effective deal for their corporate clients. As shown in Figure 2 below, the PMI industry unit cost curve moves upwards in steps: at the bottom left the lowest-cost producer (Bupa) enjoys very low unit costs, with progressively more expensive producers on the right. The market price is set by the intersection of the downward sloping demand curve and the "stepped" industry supply curve.²⁵

²⁴ PFs, Figure 3.15.

²⁵ BMI notes that this stylised model represents just one way of thinking about how pass-through might work in the PMI industry and is used here to illustrate the issues which the CC should be considering. There are a number of models which would indicate different things about pass-through depending on the facts at hand.

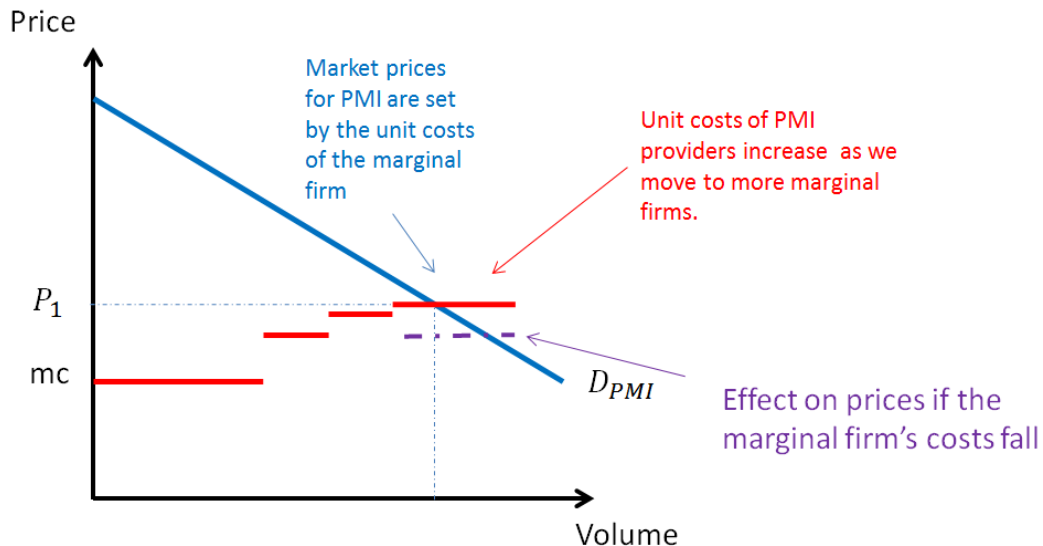


Figure 2. Stylized model of sales of PMI with price set by marginal producer

- 7.10 This model suggests that the costs of the highest-cost producer are key to pass-through. The remedies, both behavioural and structural, only affect price to the extent they lower costs for the PMIs with the highest costs of hospital provision. By attributing remedy benefit to both Bupa and the marginal PMIs, the CC would be "cushioning" Bupa – allowing it to lower prices as well as to meet competition from the marginal PMIs while continuing to make at least the same surplus as it does now – more if the PMI market were to expand from lower prices.
- 7.11 [X].
- 7.12 This concern is expressed by Aviva which urges the CC to be *“be mindful of the risk that changes to the market resulting from this investigation may disproportionately advantage Bupa and Axa. These larger insurers are already likely to benefit from higher volume discounts from hospital operators, they have an operational advantage resulting from their size and their higher market shares bring stronger bargaining power than smaller insurers enjoy.”*²⁶
- 7.13 Similarly, PruHealth states that a *“change in structure may well work to the advantage of the dominant PMI (Bupa & AXA PPP), but not to others, putting others (including PruHealth) at a further disadvantage, as a result of the undue influence that larger insurers have on the function and structure of the market.”*²⁷
- 7.14 Any remedy must therefore focus to the fullest extent possible on benefit for the smaller insurers if it is to be effective. Conferring benefit on Bupa at hospital operators' expense when it is possible not to would directly infringe the

²⁶ Aviva Response to Notice of Possible Remedies, paragraph 7.

²⁷ [X].

CC's legal obligation to select a remedy that is the least onerous of several effective choices.

7.15 Whilst it is impossible to exclude Bupa and AXA PPP from any benefit of divestiture remedies, it is certainly possible to exclude them from the benefit of behavioural remedies anticipated at Remedy 2 (on which we comment below).

7.16 [REDACTED]:

[REDACTED]

7.17 [REDACTED].

7.18 [REDACTED].

7.19 [REDACTED]

7.20 [REDACTED].

[REDACTED]

7.21 The CC currently has no basis on which to consider that any benefit of the remedy conferred on PMIs will reduce consumer detriment and therefore be effective.

7.22 The CC must conduct a detailed analysis of pass through. As BMI explains above, there are good and coherent theoretical reasons supported by the submissions of PMIs to believe that the rate of pass through for some insurers – [REDACTED] - will be extremely low.

7.23 The CC is simply unable to rationally consider either the effectiveness or the proportionality of its intervention unless it understands pass through. Specifically, given the significant harm (both foreseeable and immediate) that will occur to patients, the NHS and BMI from the CC's proposed intervention, it is incumbent on the CC to consider – in accordance with the CAT's "double proportionality" approach – whether the disadvantages of the remedy are disproportionate to its aim:

"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".²⁸

7.24 The fact that the CC does not currently have the data to permit this analysis is obviously not an acceptable answer. The CC has been warned repeatedly since the beginning of this investigation of precisely this issue. The CC decided to ignore these warnings. That error cannot and does not now absolve the CC of its legal responsibility to properly consider the effectiveness and proportionality of its remedies.

²⁸ *Tesco v Competition Commission* (2009) CAT 6 paragraph 139

8. [REDACTED]

8.1 [REDACTED].

8.2 [REDACTED].

8.3 [REDACTED].

8.4 [REDACTED].

8.5 [REDACTED].

8.6 [REDACTED]

8.7 [REDACTED].

(a) [REDACTED].

(b) [REDACTED].

(c) [REDACTED].

(d) [REDACTED].

(e) [REDACTED]

(f) [REDACTED].

(g) [REDACTED].

8.8 [REDACTED].

(a) [REDACTED].

(b) [REDACTED].

(c) [REDACTED].

(d) [REDACTED].

(e) [REDACTED]

8.9 [REDACTED].

(a) [REDACTED].

(b) [REDACTED].

(c) [REDACTED].

(d) [REDACTED].

(e) [REDACTED].

8.10 [REDACTED].

8.11 [REDACTED]:

(a) [REDACTED];

(b) [REDACTED];

(c) [REDACTED];

(d) [REDACTED];

(e) [REDACTED].

8.12 [REDACTED].

8.13 [REDACTED].

8.14 [REDACTED]:

[REDACTED]

8.15 [REDACTED].

8.16 [REDACTED].

8.17 [REDACTED].

9. [REDACTED]

9.1 [REDACTED].

9.2 [REDACTED]:

(a) [REDACTED];

(b) [REDACTED];

(c) [REDACTED]

(d) [REDACTED].

9.3 [REDACTED]²⁹

9.4 [REDACTED].

9.5 [REDACTED]:

9.6 [REDACTED]

²⁹ [REDACTED]

9.7 [REDACTED]

9.8 [REDACTED].

10. Proportionality – divestments are highly likely to remove efficiencies from BMI’s operations currently benefiting patients

10.1 Divestment will diminish the economies of scale that currently permit BMI to provide cost efficient service, as shared central service costs would need to be recouped from a smaller chain of hospitals, requiring prices to rise. As a chain business BMI has a large amount of costs that are incurred centrally in order to support and increase efficiency at the local hospitals. Examples include: [REDACTED].

10.2 Divestment will diminish BMI’s economies of scale covering these costs by requiring it to recoup them across the remaining hospitals. [REDACTED].

10.3 Divestment will diminish BMI’s ability to provide better, safer and more reliable patient service in other ways such as staff training, development and career progression, innovation in referral and care pathways [REDACTED].

11. Proportionality – double proportionality

11.1 The "double proportionality" approach set out in the CAT's judgement in *Tesco v Competition Commission*³⁰ (2009) and the CC's Market Investigation Guidelines provides that where a proposed remedy is intrusive, uncertain in its effects, or wide reaching (a test easily satisfied by a forced divestment remedy), the CC must investigate the impact of that remedy (i.e. its effectiveness in remedying the AEC in the market, weighed against any adverse effects that flow from its implementation to patients and the market in question) in a "more detailed or deeper" manner than usual. The CC must "do what is necessary to put itself into a position properly to decide the statutory questions."³¹

11.2 The CC fails by a large margin to reach the required standard in this case. Whilst the CC states in its Remedies Notice that divestment may be appropriate in addressing hypothetical higher prices for self-pay patients and decreased quality of service which could arise from a hospital's common ownership of a "cluster" of hospitals, the CC fails to consider:

(a) The effectiveness of the remedy, by conducting any - let alone "deep and detailed" - investigation into whether the divestment of a hospital will:

(i) Reduce prices paid by self-paid and insured patients. For example, there is not even the most basic consideration of pass through from PMIs to consumers. Nor can the CC guarantee that benefits will flow to patients, as PMIs are outside the terms

³⁰ [2009] CAT 6, paragraph 139.

³¹ *Ibid.*

of the market investigation reference (see paragraphs 7.4 to 7.24); or

- (ii) Achieve better quality of services for patients. Clearly this will not be the case. The only party that has considered quality competition and other non-price competitive parameters is BMI. The CC has not considered this evidence at all. [§<]. The CC does not appear to have yet considered how serious adverse effects will negatively impact upon quality of healthcare provision nationally, both at BMI and across the industry (including impacting upon the NHS which is both a customer of, and alternative to, private hospitals).
- (b) The proportionality of the proposed remedy. The CC has posited divestment as an option to remedy hypothetical higher prices which affect only a very small percentage of patients at BMI hospitals – see the detailed cluster analyses at Annex 1 to this response. This suggests the CC has not yet conducted even the most basic proportionality assessment, let alone a deep and detailed assessment. Even were the CC to quantitatively prove on the basis of a sound methodology (not the flawed measure of network LOCI) that patients, the NHS and the private healthcare industry would see reduced prices and better service as a result of divestment (it must prove this comprehensively, under the double proportionality test), it would then have to justify the severely adverse effects upon both BMI and patients that the remedy would entail.

12. Proportionality - Divestment is highly likely to harm investment incentives in the UK and in private healthcare in particular through substantial increase in perceptions of regulatory risk

- 12.1 The UK private healthcare market (like many markets in an open economy such as the UK) has traditionally been characterised by large foreign direct investment. BMI, Ramsay, HCA and Aspen are ultimately all foreign-owned. The CC must recognise that the UK's market investigation regime and accompanying remedial power is highly anomalous internationally – no other major economy anywhere in the world has a system like it.
- 12.2 The fact that the Enterprise Act anticipates wholesale intervention by the CC in wide areas of the UK economy based merely on the view of an unelected and politically unaccountable panel of experts and without even the allegation – let alone proof on the balance of probabilities – that anything unlawful has occurred, is quite alarming in general and to foreign investors in particular.
- 12.3 In a system that has so few checks and balances and with such draconian and unusual State power, a great deal rests on the perception and reputation of the CC to use its power responsibly, demonstrably fairly and transparently and only where there is compelling evidence. The CC no doubt thinks that this is what it does and is doing in this case, but it is not the CC's view that is the relevant one. The opinion of others and their perception of regulatory risk in the UK is what matters to the health of the system.

- 12.4 In this case foreign investors are told that the CC has identified – at the behest of and following complaints from obviously self-interested commercial counterparties and competitors - "features" of the market that are causing an "adverse effect on competition". The perception will be that the CC has targeted the predominantly foreign-owned private healthcare providers and left entirely uninvestigated and uncriticised the largely UK-owned PMIs. The CC will no doubt consider this irrelevant and not a factor in its assessment. But such significant windfall benefits to a dominant British firm like [X] will act to raise such suspicions. All real life markets exhibit "features" that cause an adverse effect on competition as, outside economics textbooks, there is no such thing as perfect competition. The emphasis therefore falls on robustness of the CC's analysis in demonstrating the type and quantum of the harm and how this is caused by defects in competition – rather than some other external factor.
- 12.5 In this case as BMI's response to the PFs makes clear, the CC's case in attempting to identify these features and show adverse market outcomes from the features is exceptionally frail. This is clear across PCA, profitability (especially land and building valuation and intangible assets), barriers to entry, bargaining, insured price analysis and local assessments. Again, ultimately for the purposes of this point, it does not much matter whether the CC agrees with this assessment. The point is that the case is perceived to be frail or non-existent by others.
- 12.6 Will investors looking at private healthcare or indeed any other UK industrial sector [X] feel confident that they and their advisers are able to predict where the CC's attention will fall next and what the outcome of that will be, or will the CC's capricious and arbitrary adjudication of the facts in this case give investors material pause? Having seen how successful [X] and Circle have been in obtaining the State's assistance will other players in the economy be tempted to seek similar 'help'?
- 12.7 Historically, this concern has been tempered by the reality that the CC took a cautious and responsible view of its power in market investigations seeking remedies that worked with the flow of the industry to improve the way the market worked in the interest of consumers. Divestments have almost never been contemplated and only once have they been imposed - in *Airports*. This case is nothing like *Airports*. The competition harm from owning all three major London airports when it was literally impossible to build a new competitor was intuitively obvious to the most casual observer. British Airways was not able to switch their entire demand at LHR, LGW and STN to alternative airports (such as CDG, Schipol, Luton, Southend or LCY). By contrast, Bupa is already easily able to de-list all hospitals in a BMI 'cluster' naming a number of substitutes for each of the hospitals in the cluster (for example, [X]). In other words, Bupa is able - and has proved that it is able – to remove its entire demand [X] and to shift it to competitors avoiding the BMI "cluster" in its entirety. The same would apply equally to other PMIs.
- 12.8 From the perspective of everyone who invested in UK private healthcare, this was a market that exhibited a normal level of concentration, a normal level of profitability (in the real world), and had realistic long term growth prospects. It

also faced a demand side that was characterised by very high concentration (including a longstanding dominant firm) and competition from a universal free alternative. Would a competently advised investor have been able to spot that the CC would judge there to be excess profitability using real estate values 50% or below - not only market rates actually paid - but the MEA costs incurred by recent new entrants? Or that local market share and the basis for divestment would be undertaken on a concentration measure that is unknown to industrial economics? [X]

12.9 The CC now proposes to forcibly deprive BMI's investors of their investment – with no regard had to the capital value that investors may obtain. BMI's investors are incredulous that such an outcome is even legally or politically possible in a country like the UK. Many others will be too. The CC no doubt disagrees with this assessment and regards its processes as fair, transparent, robust and in the interests of consumers. The nature of the BMI response and the weight of evidence suggests otherwise. The CC's opinion is, again, beside the point. The point is how this investigation might affect investors' (particularly foreign investors') perception of the UK as a destination for their risk capital.

12.10 The CC has robustly denied that it is undertaking an exercise in confiscation or expropriation. The OED defines confiscate: "(3) seize by authority or summarily". Expropriate: "(2) dispossess (a person) of ownership, deprive of property". Whether the CC finds the terms offensive or not, to potential investors in the UK, the CC's proposed divestments look vanishingly close to confiscation and expropriation.

12.11 The CC has not assessed the adverse consequences this intervention may have for its own reputation and for the regulatory risk that attaches to the UK's market investigation regime in this market or any other. BMI accepts that this risk is forward looking and is a matter of judgment that is difficult to measure. Difficulties in measurement however do not mean it does not exist. Likewise the CC is not rationally able to rely on historic evidence of investor sentiment to dismiss this risk as this evidence self-evidently does not consider the CC's intervention. BMI considers that a disinterested observer would find the adverse impact of the proposed intervention to be very significant indeed.

13. Proportionality – divestment is highly likely to occur at an undervalue or not at all

13.1 Each hospital in each cluster is characterised by competition from at least one other and usually most of the national hospital providers. [X].

13.2 [X]

13.3 [X]

(a) [X]

(b) [X]

(c) [X]

- (d) [REDACTED]
- (e) [REDACTED]
- (f) [REDACTED]
- (g) [REDACTED]
- (h) [REDACTED]
- (i) [REDACTED]
- (j) [REDACTED]
- (k) [REDACTED]

13.4 [REDACTED] The CC would have to assume that prices would fall following the divestment, or else the divestment remedy will not be effective. There is no evidence to suggest that such price falls would result in market growth via PMI as the CC has made no assessment either of pass through or of price elasticity of demand for PMI. [REDACTED]

13.5 The CC considered rent cover of 1.5x EBITDA to be the minimum the market would accept. Of course, the level of rent cover a buyer would accept is likely to be adversely affected by the CC's intervention which is explicitly designed to strengthen the position of PMIs and make hospitals less profitable and higher risk.

13.6 [REDACTED].

13.7 BMI's shareholders, [REDACTED] in the event of divestiture are highly unlikely to obtain anything like full value for the hospitals subject to divestment, [REDACTED].

13.8 [REDACTED]

14. Proportionality – Divestment is extremely disruptive to patients

14.1 [REDACTED], there are still significant costs to patients associated with wholesale restructuring of the UK private healthcare sector via divestments. This is compounded if – as [REDACTED] insist should be the case – the divestments are accompanied by changes to the underlying contracts at the same time. Hospitals would not only change ownership but would drop in and out of insurer networks causing widespread confusion amongst GPs, consultants and patients. This is not a concern that [REDACTED] has considered in its submission.³²

14.2 [REDACTED].

³² This is however a concern raised by the Private Patient's Forum, citing reductions in quality and large scale market disruption following the proposed remedies, see Private Patient's Forum's response to PFs, p. 1.

- 14.3 In the Groceries Market Investigation the CC rejected divestiture remedies, acknowledging that "*divestiture could have a disruptive effect on consumers in the short term.*"³³ The CC considered that "*those customers who have chosen to shop at the divested store and who are familiar with that store will either find their store operated by another retailer or will have to find an alternative store to continue shopping with the same retailer.*"³⁴
- 14.4 Finding that the Tesco store one is accustomed to shopping in has turned into a Sainsbury's store and that their favourite pudding was no longer readily available may well be annoying. It may even necessitate consumers driving further to find another Tesco or being put to various other inconveniences such as having to enrol in a new loyalty card scheme or re-orientating themselves to a new layout. However, whilst these are no doubt real customer concerns, they are merely minor inconveniences relating to the purchase of what are essentially commodity products with limited health and safety concerns.
- 14.5 Healthcare delivery is a highly personal service with a complex supply chain that, if disrupted in the ways anticipated, can have long term life and death consequences, somewhat different than disruption to grocery shopping. Consider the consequences of delayed treatment in an urgent case. How does the CC regard the risk of a patient death or some other serious side-effect / consequence precipitated by a delay in treatment brought about through the dislocation created by forced wholesale divestitures? To conclude that the divestments are proportionate the CC must cost these outcomes explicitly into its cost/benefit analysis.
- 14.6 There are a huge number of other scenarios in which this may work through. It is clear however that any disruption – even if resolved in the end - should not be imposed lightly on patients with potentially time critical medical referrals. These issues always require very careful management even in an agreed sale scenario of a small number of facilities. The systems of the acquired and acquiring hospital have to be aligned, agreement reached on a large number of transitional services and arrangements to minimise patient disruption. [§<]. In a usual (non-forced) sale scenario, to ensure that patients are not affected by the transition most acquired hospitals start and remain in PMI networks both before and after the acquisition.
- 14.7 The CC, and it appears a large number of the PMI respondents, anticipate some sort of global change as a result of the remedies in both divestments and contract renegotiation, the likes of which the UK industry has never seen before, all to be completed within 6 months. Not one competitor or PMI has considered how disruptive this will be for patients or how that might be reduced. The CC will not want to ignore these impacts on patients.

³³ Groceries Final Report paragraph 11.266

³⁴ Groceries Final Report paragraph 11.266

15. Proportionality – the CC's substantive case against clusters, and indeed single and duopoly areas, is far too weak to pass the legal standard

15.1 The CC's analysis of market outcomes are all focused on *providers* that provide inpatient care.³⁵ The CC accepts that this means the market investigation has only considered a sub-set of the full competitor set. Having narrowed its focus to a sub-set of the players in the market, the CC has then focused its analysis of market outcomes in barriers, PCA, and assessment of local competition only on the *inpatient* services offered by those providers who offer inpatient care. In other words, the CC's analysis concerns a sub-set of a sub-set of the total competitor set.

15.2 The CC has therefore presented no evidence of an AEC in respect of outpatient, walk in walk out, day case or NHS work that is undertaken by the competitor set considered, despite the move in delivery of care towards these environments rather than the more traditional full inpatient care service delivery model. Neither has it considered the role in the market that competitors *outside* the competitor set it has chosen to focus on may have.

15.3 The CC's decisions in these respects have substantial consequences for the proportionality of the divestment remedy proposal.

15.4 These are illustrated by the chart below for [X].

[X]

15.5 The CC is proposing to force BMI to divest the [X] on the basis of an analysis which only considers the market outcomes for privately funded inpatient work. This is not limited to one hospital – it is a longstanding feature of BMI's entire business as the chart below showing the proportion of inpatient to other work demonstrates:

[X]

15.6 The CC narrows the category of affected patients even further by acknowledging that Bupa has some countervailing buyer power.³⁶ [X]. Therefore, even if the remainder of the CC's analysis were to be entirely robust (which it is not) the only benefits from divestment would accrue to [X] of the patients who come through the doors of BMI [X] of the patients who use BMI's service would, even on the best case basis of the CC's case against BMI, see no benefit whatsoever from the remedy and may well suffer some detriment for all the reasons given elsewhere in this paper.

15.7 In fact, the position is even worse than that. Of the non-Bupa funded private inpatients (the [X] in the example above), only a small minority live in areas where the catchment areas of the cluster hospitals overlap. In the case of [X], for instance this is illustrated by the maps below:

³⁵ See PFs, paragraph 6.3.

³⁶ PFs, Summary, paragraph 41.

[REDACTED]

15.8 On the CC's analysis it is clear that [REDACTED] the BMI [REDACTED] catchment area would see greater choice as a result of the divestiture. The [REDACTED] therefore, shrinks still further.

15.9 Indeed on BMI's own catchment area analysis, which unlike the CC's is not based on simple road distances in miles (i.e. a weak theoretical proxy for patient location) but on the postcode districts where patients actually come from (i.e. actual empirical data on actual observed activity) and is used in BMI's business planning the overlap shrinks still further:

[REDACTED]

15.10 Here there is no overlap at all with [REDACTED] and only a single postcode district where [REDACTED] catchment area overlaps with [REDACTED].

15.11 The CC has acknowledged in its analysis of BMI [REDACTED] hospitals that divestment of a hospital is not an appropriate remedy where the impact of any anticipated increase in competition is likely to be limited to a relatively small number of patients in the overlap area.³⁷ The CC is invited to apply this analysis consistently to other proposed divestment hospitals.

15.12 The price for adding an additional effective choice for [REDACTED] people is heavy indeed. BMI considers that divestment would clearly produce adverse effects that are disproportionate to the aim pursued.

16. Proportionality - divestments are not supported by key beneficiaries

16.1 PruHealth has repeatedly advised the CC that it *“did not believe that competition outside of London caused [it] any adverse effect. It is however of concern that any proposed divestment would adversely affect [it] to the extent that it unnecessarily disrupts the existing structure of supply in particular geographic areas (currently unknown) which [it] believe[s] currently works effectively and to the advantage of PruHealth and [its] customers.”*³⁸

16.2 Simplyhealth reflects these concerns stating that it *“believes that the impact of a divestiture strategy, particularly outside of London, could impact smaller insurers disproportionately and detrimentally, resulting in less customer choice and a greater concentration of the PMI market in fewer providers.”*³⁹

16.3 The CC cannot ignore such comments without explaining why it prefers the view of (stronger) parties such as [REDACTED] over other (weaker) PMIs and PHPs. We note in this context that only [REDACTED] – and more recently [REDACTED] - have been granted (and taken up) privileged access to the confidential version of the

³⁷ Divestment Options Paper, paragraph 162.

³⁸ PruHealth, Response to PFs, p. 2.

³⁹ Simplyhealth, Response to PFs p.1.

Divestment Options paper – such is the importance of [X]’s support to the CC’s case.

- 16.4 BMI notes that the CC ruled out divestments in *Local Buses* saying it "*did not receive any submissions advocating divestiture and ... therefore did not pursue them further.*"⁴⁰ The CC has clearly received submissions in support of divestiture on this occasion. The reason for the difference is obvious. Local bus companies operate in a consumer market. Their customers are normal people who travel by bus. The third parties in the inquiry were local authorities or other public sector organisations.
- 16.5 In this inquiry, BMI faces highly motivated complainants who stand to make huge financial gains from CC intervention in their favour. Many of these companies are large international undertakings many times larger than BMI, with teams of in-house lawyers and specialist antitrust advisers. It would be remarkable if they had not spotted the opportunity the CC has apparently created for them and provided suitably supportive submissions.
- 16.6 BMI notes, however, that not a single one of these enterprises, who now so loudly demand BMI's breakup, started this inquiry calling for divestiture of BMI's hospitals. Neither did a single insurer start this inquiry or the market study that preceded it complaining about the "clusters" on which those divestitures are now predicated. The market questionnaire for example did not contain – despite its extraordinary length – a single question about hospital clusters.
- 16.7 BMI asks the CC to consider with an open mind when weighing those submissions, why the view has changed and whether it represents credible evidence or merely opportunistic self-interest.
- 16.8 The CC has no visibility into the effect of any proposed divestment on the already high profits of the PMIs, or the trickle down benefits which may accrue to consumers.
- 17. Proportionality – there are remedies that are far less onerous and would be effective**
- 17.1 Even if the CC's case were well founded and supported by evidence (which it is not), there are a series of measures available to the CC, which would likely be more effective and are also less onerous to BMI and its patients. These include the CC's suggested remedies #3-7 which, with some conditions as set out in subsequent sections of this response, BMI (notwithstanding its firm belief that there is no AEC to be remedied) would be prepared to accept.
- 17.2 These remedies are likely to be more effective at addressing the low barriers to entry that exist and improving the functioning of the market by empowering patients (and GPs and consultants on their behalf) to seek out the best quality service. If any features of weak competitive constraints in local areas were to

⁴⁰ *Local Buses* Final Report, paragraph 15.476.

in fact exist, this would in turn allow competition and the market itself to resolve them.

BMI's response to the CC's Remedies Notice (Remedy 1)

(a) *Would a divestiture remedy address the AEC effectively and comprehensively? Are the criteria that we have set out for specifying a divestiture package appropriate? If not, what criteria should we use to specify the divestiture package and what assets should be included in it?*

No. See sections 2 to 7 of this part.

(b) *Are there suitable purchasers available with the appropriate expertise, commitment and financial resources to operate and develop the divested hospitals as effective competitors without creating further competition concerns?*

Each hospital in each identified "cluster" is characterised by competition from at least one other and usually most of the other hospital providers. Were the CC to use this to restrict the potential buyers, it would directly contradict the competition case supporting divestiture. [§].

(c) *Would a divestiture remedy on its own be sufficient to address the AEC or would additional measures be required to ensure a comprehensive solution. Would, for example, the remedy be liable to circumvention through arrangements with consultants that would result in them conducting their private practice wholly or predominantly at the divesting hospital operator's remaining hospitals? Are there other ways in which BMI or Spire could circumvent a divestiture measure?*

A divestiture remedy is not suitable to address any hypothetical AEC, for the reasons described at sections 2 to 17 above and would in fact manifestly harm patients' interests and the UK healthcare sector more widely.

Further intervention beyond divestiture will reduce the prospects of successful divestiture, reduce investment incentives, and increase the costs of capital for the reasons discussed above.

[§].

(d) *Are there other assets or businesses, besides hospitals and their outpatient facilities, which it would be necessary or appropriate to include in a divestiture package? These could be physical assets, such as consulting rooms, or, for example, they could be joint ventures with others or NHS contracts to operate PPUs. Would divestiture of any such assets*

or businesses present particular problems?

No. For clarity the CC has considered PPU contracts not as ancillary assets but as private hospital facilities in their own right. Divestiture would have to be justified on its own terms not merely as an ancillary asset to bolster the sale of another facility.

(e) *Are there particular assets whose divestiture would confer market power on the acquirer? To avoid creating further competition concerns would it be necessary to exclude certain assets from the sale?*

The CC should consider the implications of allowing vertically integrated PMIs to acquire a divested hospital.

(f) *How long should BMI and Spire be given to effect the sale of the divestiture package? Our guidelines^[1] state that in relatively straightforward divestiture cases a maximum period of six months is appropriate. Is that sufficient in this case?*

Hospital sales are complex. Patient interests require significant attention to be paid to transitional arrangements to ensure continuity of care and service provision. [X]

Should the CC pursue a divestment remedy, a timetable of 18 months would be appropriate.

(g) *What are the relevant costs and benefits that we should take into account in considering the proportionality of the divestiture options?*

The divestments are manifestly disproportionate. See paragraphs 6 to 17 above.

(h) *Are there other remedies that would be as effective in remedying the AEC that would be less costly or intrusive?*

Yes. See paragraphs 17.1 to 17.2 above and BMI's comments on Remedies 3 – 7 below.

The effectiveness of these remedies is a contributing factor to the disproportionality of the divestiture remedies.

^[1] Guidelines for market investigations, (CC3, Revised) Annex B, paragraph 27.