

Response of



to

the CC's profitability analysis

Annex 6

11 November 2013

Non-Confidential Version

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1. Introduction and structure of this submission

- 1.1 This submission forms part of BMI's response to the Competition Commission's ("CC") private healthcare market investigation provisional findings, dated 28 August 2013 ("Provisional Findings"). Specifically, this submission considers the CC's calculation of BMI's Core Hospital Business return on capital employed ("ROCE").¹
- 1.2 The ROCE calculated by the CC is ***materially overstated***. The CC has calculated an average ROCE of [X]%. We demonstrate below that a more appropriate estimate of ROCE is [X], which [X] the 7.2% to 9.9% WACC range calculated by the CC for the UK private hospital industry. Even then, we consider that this adjusted estimate of ROCE is likely to overstate BMI's actual ROCE as it has been prepared on a conservative basis.² This proves that BMI has not made persistent excessive returns. [X].
- 1.3 In this submission, we comment on the CC's analysis and highlight where the CC has made:
- errors of fact;
 - invalid assumptions; and
 - methodological errors.
- 1.4 We have reviewed the information provided to the CC and have found that certain [X] other costs and fees ("Other Project Costs") were not included in the financial data originally requested by or provided to the CC. This data is now provided with this submission.
- 1.5 We also comment on how the CC wrongly interpreted its findings and identify areas where the CC's conclusions are so erroneous that if sustained, they would lead to a significant decline in investment in healthcare assets across the wider market by both new entrants and existing operators.
- 1.6 In March 2013, the CC provided BMI with its preliminary analysis. In a submission

¹ Referred to as "Acute ex-NUK" by the CC. The remainder of the BMI Group, comprising Netcare UK, CARE Fertility and Transform is referred to as the "Excluded Businesses".

² For example, asset valuations were prepared on a conservative DRC basis, no value has been attributed to intangible assets not capitalised on BMI's balance sheet and no goodwill was included in the calculation of capital employed.

dated 6 April 2013, we set out a number of arithmetical and conceptual errors made by the CC in the Preliminary CC Model. These errors led to the CC overstating EBIT and understating capital employed and hence a material overstatement of ROCE.³ The CC's current calculation of EBIT and capital employed has changed significantly from its preliminary analysis. However, despite these changes, we continue to have considerable – and fundamental – concerns with respect to the CC's analysis. These concerns are set out in detail in the sections that follow.

- 1.7 The CC has calculated ROCE using an Excel model entitled “*BMI profitability model.xlsx*” (the “CC Model”). The CC provided BMI with the CC Model on 12 September 2013. We have had to review, analyse and comment on a large amount of information in a short period. The CC took a period of almost 5 months to consider our response to the profitability working paper. BMI has had just 2 months to consider and prepare its response to the CC Model. Consequently, BMI reserves the right to provide additional submissions after 11 November 2013, should we consider it necessary, useful or appropriate.

BMI's view of the PMI market in the UK

- 1.8 [REDACTED]. We consider that in the UK the real issues with the UK private health market stem from structural features unrelated to rivalry between hospitals and the market power of the PMIs and not the hospital operators. By focussing on the hospital operators, the CC will not correct the underlying problems in the private healthcare market and will instead cause greater damage by consolidating more market power in the hands of the PMIs.
- 1.9 [REDACTED]:
- 1.10 [REDACTED].
- 1.11 The policy and product changes introduced by [REDACTED] have worked to reduce PMI cover, increase co-payment from consumers and reduce differentiation between private healthcare services and the NHS – often in the environment of rising PMI premia. This has the effect of increasing [REDACTED] profitability. BMI again states that the CC is incorrect not to investigate the PMI market.

Structure of this report

- 1.12 We have structured our report as follows. In Section 2, we provide a summary of our

³ Throughout this report, references to EBIT, capital employed and ROCE relate to BMI's Acute ex- Netcare UK business [REDACTED].

analysis and our review of the CC's methodology, the adjustments that are necessary to correct for material errors and the impact these adjustments have on BMI's ROCE. The remainder of this submission is divided into two parts as follows.

Part I – corrections to the CC's calculations

1.13 In Part I, we consider the CC's approach of looking at BMI's Core Hospital Business on a consolidated level, [REDACTED].⁴ Part 1 is structured as follows:

- Section 3 corrects the calculated ROCE by using actual DRC values for BMI's land and buildings. These values were prepared by independent professional property expert valuers, with recognised specific healthcare expertise, and are based on full physical site inspections of all properties. This correction allows us to avoid using the highly inappropriate proxies for land and building values used by the CC;
- Section 4 corrects other errors made by the CC in the calculation of EBIT and capital employed. We also refine the ROCE calculation using the additional information now provided to the CC; and
- Section 5 explains why the CC has interpreted its results incorrectly.

1.14 We attach as Appendix 1 an updated model setting out the detail of our corrections and any additional data.

Part II – [REDACTED]

1.15 [REDACTED].

2. Executive summary

Introduction

2.1 Properly conducted, the CC's analysis does not in fact show that BMI has made (and is making) persistent excessive returns over the period FY 2007 to FY 2011 (the "Review Period"). The CC has calculated that BMI had an average ROCE of [REDACTED]. It has calculated a nominal industry WACC of between 7.2% and 9.9%. This equates to a gap between the WACC and ROCE of [REDACTED] to [REDACTED] percentage points. From a comparison of an over-inflated ROCE to a conservative average industry WACC, the CC concluded that BMI has "been earning returns substantially and persistently in

⁴ [REDACTED].

excess of the WACC” and that this is consistent with BMI having market power.⁵

2.2 However, there are a number of material errors and omissions in the CC’s analysis. Together these render the CC’s conclusion of ROCE of [redacted] highly unreliable. These errors and omissions include:

- (1) the CC has used an inappropriate and out of date proxy for the MEA value of BMI’s buildings. The CC should have determined the actual MEA value of BMI’s buildings;
- (2) the CC has used an inappropriate “desktop exercise”, undertaken by a non-specialist valuer as a proxy for the MEA value of BMI’s land. The CC should have determined the actual MEA value of BMI’s land;
- (3) [redacted] other costs and fees (“Other Project Costs”) were, in error, not requested by or provided to the CC. These costs should be included in the CC’s analysis as they represent operating costs in BMI’s business validly, appropriately and actually incurred historically and their ongoing spend is properly anticipated in the future;
- (4) the CC has incorrectly omitted capitalisation in progress (“CIP”) from its analysis;
- (5) the CC has incorrectly included profits from [redacted]. These profits do not form part of the CC’s investigation. The CC cannot assume that such sales would be undertaken by an efficient market operator unless it has evidence that most other operators undertake similar sales;
- (6) the CC has repeatedly and incorrectly allocated central costs directly incurred by the Core Hospital Operations to parts of the Excluded Business; and
- (7) the CC has not considered land and building market values that were prepared on a basis designed to explicitly exclude the capitalisation of excessive profits.

2.3 We have corrected the CC’s analysis for these errors and omissions. The figure below shows the cumulative impact of each of these errors and shows that a more appropriate calculation of BMI’s ROCE over the Review Period is [redacted] on a DRC basis and [redacted] if a market based asset valuation is used.⁶

⁵ Provisional Findings, paragraph 43.

⁶ I.e. that the valuation is performed on a fair maintainable operating profits basis and then basing the residual valuation on the turnkey value. See the Colliers International Market Value Report.

[REDACTED]

2.4 In the section below, we summarise each of these adjustments in more detail.

Part I – corrections to the CC’s calculations

The CC has understated the MEA value of BMI’s buildings

2.5 The most material error contained in the CC’s analysis relates to the value for BMI’s buildings. The CC’s figures are based on inappropriate and out of date proxies. As such, they do not provide a robust assessment of the MEA value of BMI’s land and buildings.⁷

2.6 We previously provided compelling expert evidence to the CC that explains in detail that its proxies are wrong and that they are wholly unsuited to calculating the value of the hospital portfolio and hence BMI’s profitability.

2.7 The CC has sought to discredit and discount our evidence so that it could proceed as it had first determined in August 2012 when it instructed DTZ. BMI has now been forced to go to the very considerable expense⁸ of instructing independent experts, Colliers International, to perform a full valuation of the land and buildings currently operated by BMI in all [REDACTED] freehold sites⁹. This valuation has been prepared on a basis that is consistent with the CC’s preferred depreciated replacement cost (“DRC”) approach.¹⁰

2.8 The DRC valuation performed by Colliers International provides considerably more robust evidence of the MEA value of BMI’s buildings than the CC’s proxies for the following reasons:

- (1) the Colliers International valuation is based on full and detailed site inspections of all [REDACTED] freehold sites. The reinstatement figures used by the CC were not based on site inspections and [REDACTED]. The CC’s valuations are out of date;

⁷ [REDACTED]

⁸ Colliers International charged BMI [REDACTED] for conducting a DRC valuation of its [REDACTED] in compliance with RIC standards. The CC paid DTZ £27,000 plus VAT for its "desktop exercise" over the entire industry.

⁹ See Appendix 2 and Appendix 3 of this paper.

¹⁰ Colliers International does not consider that DRC is an appropriate method of valuation for independent hospitals in the UK, where there is an active market, in which hospitals are bought and sold. The DRC approach will underestimate the value of hospitals.

- (2) Colliers International performed an actual DRC valuation to RICS professional standards. The CC's insurance reinstatement valuations are based on an incomplete desk-top proxy for DRC and exclude a number of material components;
- (3) the Colliers International valuation is performed by suitably qualified professional surveyors who have significant experience in the valuation of independent hospitals; and
- (4) Colliers International is independent as required by RICS guidelines. BMI has not influenced – or sought to influence – the valuations performed by Colliers International in any way.

2.9 The CC cannot reasonably dismiss the results of this valuation on the basis that it implies that BMI's hospitals were under-insured for the following reasons. First, [X]. Second, insurance values do not include all relevant costs. To the extent that these actual DRC-based valuations are higher than the insurance valuations that were submitted previously, this simply reflects the fact that the latter were estimates, rather than actual valuations.

2.10 Using actual DRC values determined by Colliers International for BMI's buildings reduces our ROCE by [X] percentage points to [X]. This is based on BMI's "actual hospital buildings". As a cross check to Colliers International, we have also performed our own assessment of the replacement cost of BMI's buildings. We have compared BMI's hospital portfolio to the building costs of observed entrants over the last decade. This approach leads to ROCE declining to [X] which is similar to and supports our findings using Colliers International DRC valuations.

2.11 It is important to state that undertaking this valuation exercise using the same methodology as the CC has mandated does not mean we now concede that the DRC valuation basis is an appropriate approach. BMI provided significant expert evidence on the unreasonableness of the DRC methodology choice in February and April 2013. However, by providing calculations on a wholly comparable DRC basis we have provided evidence to the CC, prepared in accordance with professional standards, to demonstrate that the CC may not rationally use the indexed insurance building replacement values that BMI has historically used for insurance purposes as an accurate proxy for the MEA value of its hospital buildings.

2.12 Colliers International have also performed a valuation of the land and building as an owner operated property, using market based methods and RICS valuation standards

that explicitly do not include the capitalisation of any potential excess profits.¹¹ Using a current market value, BMI's ROCE falls to [§<].

- 2.13 We discuss our analysis regarding the MEA value of building in paragraphs 3.5 to 3.26 below. We discuss our comparative approach in paragraphs 3.28 to 3.42 below. We also discuss the impact of the market valuation in Section 3.

The CC has understated the MEA value of BMI's land

- 2.14 The CC continues to rely on a flawed and biased DTZ "desktop exercise" to value BMI's land. The CC has not given due weight to the evidence submitted by BMI on land values. The CC has either misunderstood or ignored our submissions.

- 2.15 We do not repeat (or abandon) any of BMI's earlier submissions in respect of DTZ and the CC's approach in respect of land valuation. However, we provide a summary of the key substantive points regarding the DTZ analysis adopted by the CC below:

- (1) DTZ did not perform a valuation and its own report clearly states this;
- (2) DTZ did not perform a full and proper valuation based on full site inspections. Instead, DTZ conducted a simple "desktop exercise" that is profoundly deficient;
- (3) the DTZ residential team performed the analysis - a valuation team specialising in hospital valuations should have been engaged;
- (4) the DRC method is widely understood to be an inappropriate measure of value for land. A market-based approach should be used to value land. We note this was also the CC's intention when it originally consulted on its profitability methodology in this case; and
- (5) DTZ has ignored normal or average market conditions, contrary to DTZ's instructions from the CC.

- 2.16 Notwithstanding our objections that land should be valued using a market based approach, we engaged Colliers International to perform an independent DRC valuation of BMI's land portfolio. This valuation corrects some of the major flaws in DTZ's analysis, for example being performed by experts in hospital valuations and based on

¹¹ The CC originally anticipated (and consulted upon) obtaining "*comparable and objective valuations*" using "*current market value as estimated by a third party expert*". See Profitability analysis of private hospital operators: planned methodology, paragraph 72.

full inspections of all sites.¹²

- 2.17 The Colliers International's DRC land valuation finds that the CC has understated land values by [X] on average. In combination with using actual DRC values for buildings, BMI's ROCE falls to [X].
- 2.18 We discuss our analysis regarding the MEA value of BMI's land in paragraphs 3.43 to 0 below.

Other corrections required to ROCE

- 2.19 In addition to the points above, we have made the following corrections to the CC's analysis:
- (1) Other Project Costs have not been included in the CC's analysis. These legitimate costs have not been allocated to particular sites or to central costs. We discuss Other Project Costs in further detail in paragraphs 4.3 to 4.6 below.
 - (2) The CC incorrectly excluded capitalisation in progress in its calculation of capital employed. The CC does not explain why these assets are excluded. We discuss the inclusion of CIP in further detail in paragraphs 4.7 to 4.10 below.
 - (3) The CC has incorrectly included the profits from BMI's [X] in its analysis. These activities sit outside the defined scope of the CC's analysis. In this regard, the CC has misinterpreted or ignored our prior submissions on this matter.¹³ We discuss this issue in further detail in paragraphs 4.11 to 4.23 below.
 - (4) The CC has misinterpreted or ignored our prior submissions on central costs and has erroneously allocated central costs that are directly attributable to BMI's Core Hospital Operations to parts of the Excluded Businesses. We discuss the allocation of central costs in further detail in paragraphs 0 to 4.28 below.

Adjustments required to correct the CC's errors

- 2.20 The table below shows the combined adjustments to EBIT and capital employed to correct the CC's calculations.

¹² For example, DTZ's analysis was limited to a desktop review, whereas Colliers International performed a DRC valuation based on actual site inspections. DTZ's review has not been carried out to professional standards whereas the Colliers International review has.

¹³ The CC may have misunderstood that we were seeking to exclude both the revenues and the direct costs [X], rather than purely excluding the revenues and retaining the costs.

[REDACTED]

[REDACTED]

[REDACTED].

Additional points the CC must consider when interpreting its results

- 2.21 After making the adjustments above, BMI's average ROCE falls to [REDACTED]. However, there are good reasons for an objective decision-maker to conclude that this figure will overstate true profitability due to the conservative (non-market) values included for land and buildings and the failure to allocate significant value to intangible assets. Even on this basis, however, the evidence very obviously shows that BMI has not made excessive profits during the Review Period.
- 2.22 Even if the CC were irrationally and wrongly to discount the evidence of DRC values and the other corrections to the CC's analysis highlighted in this response, the CC would still be wrong to conclude there was evidence to support a finding of excessive profits. The CC seeks to impose extraordinarily intrusive and costly remedies with unintended and far-reaching consequences in order to solve a problem for which there is either no or, insufficient, evidence.
- 2.23 Importantly, the CC must consider carefully how large the gap between ROCE and WACC must be before it can rationally arrive at a judgement of persistent excessive profitability. The gap in this case must be large for the following reasons, *inter alia*:
- (1) the Review Period does not provide an accurate picture of profitability over the life of BMI's investments. It is a matter of fact that hospitals are large investments, which require many years before they become profitable. Measuring profitability during the Review Period alone fails to recognise lower profitability in earlier years, and will lead to a biased assessment of profitability;
 - (2) there is significant uncertainty in the calculation of the WACC, which has many input variables, each of which has large standard errors. The CC has not had due regard to these estimation issues, and has derived a range for the WACC that is too narrow;

- (3) conceptually, above average returns for BMI cannot indicate excessive profits by themselves (and it certainly does not suggest market power). This point is very well understood and has been stated by a former Chairman of the CC;¹⁴
- (4) the CC's approach will inappropriately restrict investment into the private hospital industry and will force industry operators to earn returns below the average WACC;
- (5) there is significant uncertainty in the calculation of ROCE. Most importantly, the CC has not fully considered intangible assets, which are especially important in a knowledge and reputation dependent service sector like healthcare. The CC knows that ROCE is overstated because of this omission; and
- (6) the CC has adjusted its building valuation methodology without explanation. In the absence of any explanation for this change – which operates to BMI's detriment – we conclude that it reflects an attempt by the CC to sustain or bolster its early conclusion. To adjust a methodology to sustain a prior conclusion is unfair and provides evidence of pre-determination and therefore bias.

2.24 We discuss each of these issues in Section 5 below.

Part II - [REDACTED]

2.25 [REDACTED]

2.26 [REDACTED]

2.27 [REDACTED]

2.28 [REDACTED]

¹⁴ "There is no per se reason why profits in excess of the cost of capital represent anything other than the effective working of a competitive market. It is only where profitability is a) substantially above the cost of capital b) across most or all companies in a market over c) a sustained period of time, that concerns arise". Source: Sir Derek Morris, Chairman Competition Commission, Paper presented to Fordham Corporate Law Institute 13th Annual Conference on International Antitrust Law and Policy, October 2003.

Part I

Corrections to the CC's calculations

3. The correct MEA value of BMI's land and buildings

Introduction

- 3.1 In this section, we examine the CC's approach to determining the MEA value of BMI's land and buildings. We conclude that the CC has understated the MEA values for BMI's land and buildings and has materially overstated ROCE. The CC based its analysis on insurance reinstatement values, Valuation Office Agency ("VOA") obsolescence factors and a "desktop exercise", none of which involved site surveys or inspections and all of which are prepared for other purposes. The combination of these inputs obviously provides a flawed estimate of the MEA value of land and buildings.
- 3.2 Consequently, BMI has engaged suitably qualified and experienced hospital valuation experts from Colliers International, an independent, reputable and professional firm of property experts and surveyors, to determine the MEA value of BMI's land and buildings using the CC's preferred DRC methodology. They have performed this valuation based on a full review that includes site inspections. This valuation, unlike the insurance reinstatement and land "desktop exercise" values used by the CC, has been prepared to the appropriate professional RICS standards. This evidence proves that the CC has materially understated the MEA value of BMI's land and buildings.
- 3.3 Correcting the land and building values alone has the effect of lowering BMI's ROCE to [3.3] This alone proves that BMI has not made persistent excessive profits.
- 3.4 The remainder of this section is structured as follows:
- (1) we discuss why insurance reinstatement values do not provide a suitable proxy for the MEA value of BMI's buildings, the errors in the CC's analysis and the effect of correcting the CC's analysis using DRC values based on the Colliers International DRC building valuation;
 - (2) we present an analysis of the comparability of BMI's hospital portfolio to observed new entrants, which supports the analysis and conclusions from the Colliers International DRC building valuation;

- (3) we discuss why the “desktop exercise” prepared by DTZ is an inappropriate proxy for the DRC of BMI’s land and show the effect on ROCE when these figures are corrected using DRC values based on actual site inspections; and
- (4) we show the effect on ROCE if market based land and building valuations are considered.

The MEA value of BMI’s buildings

3.5 The CC has not correctly calculated the MEA value of BMI’s buildings. The CC stated:¹⁵

“The approach to valuing assets should reflect their current value to the business, which is the loss the entity would suffer if it were deprived of the asset involved.”

3.6 Typically, the CC considered the current replacement cost of replacing an old asset with a new one with the same characteristics. This is known as the DRC approach. The CC stated:¹⁶

“Where an asset is worth replacing, its value to the business will be its current replacement cost, or more precisely the replacement cost of a modern equivalent asset (MEA) determined in a fully competitive market and allowing for the asset’s remaining useful life. The MEA value is the cost of replacing an old asset with a new one with the same service capability allowing for any differences both in the quality of output and in operating costs.”

3.7 To estimate the DRC of BMI’s buildings, the CC used 2008 reinstatement valuations, which were prepared for setting insurance premia. The CC adjusted these valuations by a public sector construction output price index to determine an “as new” replacement cost for each year. It then reduced these “as new” values for obsolescence as determined by the VOA in its 2010 business rate valuation.¹⁷ Thereafter, it depreciated the buildings on a 2% straight-line basis. This is a convoluted approach. It is also a radically different approach to the gross insurance reinstatement

¹⁵ Provisional Findings, Appendix 6.13, paragraph 40.

¹⁶ Provisional Findings, Appendix 6.13, paragraph 44.

¹⁷ Obsolescence reflects the fact that BMI’s buildings are not “as new”, and may be physically deteriorated or deteriorated due to technological or functional changes.

value approach used in the CC's preliminary analysis. The CC has not explained why it changed its methodology.

3.8 The CC's approach and assumptions are fundamentally flawed. The CC has understated the MEA value of BMI's hospital buildings due to the following factors:

- (1) insurance reinstatement valuations are not a suitable proxy for the deprival value of an asset;
- (2) the insurance reinstatement valuations and obsolescence adjustments were out of date and not based on a site-by-site survey;
- (3) the CC used a public sector construction output index, when it should have used a private sector commercial index.

3.9 We comment on each of these factors in turn below. We then show the effect of using DRC values based on the Colliers International DRC building valuation.

Insurance reinstatement valuations are not a suitable proxy for deprival value

3.10 We have consistently explained that insurance reinstatement valuations are not a suitable or reasonable proxy for deprival value. Insurance reinstatement values understate the MEA value of BMI's buildings.

3.11 The CC stated that:¹⁸

"We believe that the relevant firms have an incentive to ensure that their reinstatement estimates reflect the actual costs they would incur in rebuilding their existing hospital buildings since significant deviations from this level would result in either the buildings being under-insured, leaving the business exposed to the costs of rebuilding, or paying unnecessarily high insurance premiums."

3.12 The evidence shows that the CC's belief is incorrect in this case for a number of reasons which we set out below.

3.13 First, [§<].

3.14 Second, insurance values do not include all costs. The Colliers International Report states that:¹⁹

¹⁸ Provisional Findings, Appendix 6.13, paragraph 104.

¹⁹ The Colliers International DRC Valuation Report.

“it is inappropriate for the CC to utilise reinstatement valuation for insurance purposes as an equivalent for the value of an asset. Estimates for insurance purposes are not required to include for developers profit, start-up costs, and interest charges for financing the reinstatement.”

- 3.15 Clearly, insurance reinstatement values do not include a range of material replacement costs. For these two reasons, it is not appropriate to use insurance reinstatement values as a proxy for DRC values. If an insurance reinstatement valuation is to be used it will understate the value of BMI’s buildings and incorrectly overstate ROCE.

The insurance reinstatement valuations and obsolescence adjustments were out of date and not based on a site-by-site inspection or survey

- 3.16 The CC stated:²⁰

“the value at which the relevant firms insure their building assets do provide a measure of replacement costs. These estimates were prepared for the relevant firms by surveyors with reference to the actual hospital buildings owned by the relevant firms and industry-level cost indices.”

- 3.17 This statement is wrong in respect of BMI. [X] The insurance reinstatement values used by the CC will therefore provide a materially incorrect proxy for a DRC valuation. As noted elsewhere within this submission, BMI has therefore instructed Colliers to prepare a full DRC valuation.

- 3.18 The CC also stated that VOA obsolescence allowances, which were used for setting business rates, were based on site inspections.²¹ This is demonstrably incorrect. The VOA does not perform site inspections to determine the level of obsolescence. The VOA website clearly states that it calculates the obsolescence adjustment mechanistically based on the year of building completion.²² On that basis, the CC’s obsolescence allowances are likely to be materially misstated.

The index used by the CC is not appropriate

- 3.19 The CC used the public sector non-housing construction price and cost index prepared by the Building Cost Information Service (“BCIS”) under contract to the department of

²⁰ Provisional Findings, Appendix 6.13, paragraph 104.

²¹ Provisional Findings, Appendix 6.13, paragraph 112.

²² <http://www.voa.gov.uk/> - Practice Note 5: 2010: “The Valuation for Rating of Private Sector Hospitals”.

Business Innovation and Skills (“BIS”) to index asset values.²³ However, a public sector construction price and cost index is clearly not an appropriate index to apply to a private sector commercial building value. Of the seven new construction price and cost indices published by BCIS and BIS,²⁴ the most appropriate index to apply would be the private commercial construction price and cost index.

- 3.20 The simple act of replacing the CC’s incorrect index with the private commercial construction output prices and costs index leads to a reduction in ROCE of [X] The CC’s choice of index operates to BMI’s detriment. This fits within an established pattern of the CC, that is – when facing a choice of approach – the CC invariably chooses the approach that operates most to BMI’s detriment.

The effect of using an up-to-date DRC valuation based on the work of Colliers International

- 3.21 Due to the material flaws in the CC’s approach, we have engaged Colliers International to provide a full independent DRC valuation of the [X] hospitals within the BMI portfolio. This provides a DRC valuation of BMI’s hospitals as of both September 2006 and September 2013 based on a site-by-site inspection and survey.
- 3.22 Colliers International has determined the MEA value of BMI’s land and buildings using the CC’s now preferred DRC methodology. The valuation has been completed in accordance with RICS professional standards.
- 3.23 The CC stated in many parts of its Provisional Findings that it considers that valuations based on site inspections should be preferred.²⁵ Yet it is clear that the CC’s approach is not based on site inspections. Consequently, the DRC valuations performed by Colliers International, which are based on site inspections, provide empirical evidence that should be preferred to the incorrect theoretical proxies used by the CC.²⁶

²³ <https://www.gov.uk/government/collections/price-and-cost-indices>

²⁴ All new construction, infrastructure, private commercial, private housing, private industrial, public housing and public non-housing.

²⁵ See for example, Provisional Findings Appendix 6.13, paragraph 104 and Appendix 6.13, paragraph 112.

²⁶ Although we have performed a full DRC valuation this does not mean we now agree that the DRC methodology is the most appropriate approach to take. We still consider that this approach will understate asset values. We have previously stated that the correct method to value private hospitals in the UK is using the FMOP method of valuation.

- 3.24 Analysis of the Colliers International DRC values shows that:
- (1) the correct DRC value is on average [x] greater than the out-of-date and incorrect insurance reinstatement values used by the CC;²⁷ and
 - (2) the average level of obsolescence, based on site inspections, is [x] compared to the CC's average of 26%; and
- 3.25 Applying Colliers International's assessment of the DRC leads to a significant increase in capital employed and a significant decrease in EBIT. The table below sets out our adjustments to EBIT and capital employed. The net effect of this single change acts to reduce average ROCE during the Review Period by [x] percentage points to [x].
- [x]
- 3.26 Colliers International has provided DRC valuations as of both September 2006 and September 2013. The table above shows the effect of using the 2013 values and adjusting them using the same methodology used by CC.²⁸
- 3.27 Using 2006 DRC values and depreciating them from 2006 generates a slightly higher average ROCE of [x].

Comparison of BMI's hospital portfolio with observed entrants

- 3.28 In our submission dated 6 April 2013, we provided the CC with a list of seven recently-built hospitals with completion dates of between 2003 and 2014. These hospitals had building costs ranging from £29 million to £90 million. We pointed out – by way of illustration – that even if only half of the hospitals in BMI's portfolio were comparable to the average of these hospitals (excluding the London Clinic Cancer Centre) this would reduce the ROCE to close to the WACC range.
- 3.29 The CC rejected this analysis, stating that the comparisons were not informative because a:²⁹

²⁷ As the valuations were performed on a DRC basis, they already fully reflect obsolescence.

²⁸ Our approach uses the corrected construction prices and costs index as indicated in paragraphs 3.19 to 3.20 above. As Q3 2013 index values were not available during the preparation of this report, all values were indexed from Q2 2013.

²⁹ Provisional Findings Appendix 6.13, paragraph 107.

“number of the examples given are significantly different from the ‘average’ hospital in the portfolio of the relevant firms in terms of both the size and the specification of the units, with the figures quoted including the costs of all equipment”.

- 3.30 The CC has been too quick to dismiss this evidence and has ignored the salient point that the cost of new builds show that the CC’s approach significantly understates the value of buildings. BMI’s submission illustrated that the CC’s analysis was not robust to a straightforward cross-check. This should be a cause of concern for the CC. The range of values indicated by recent new builds was between £29 million and £90 million. However, the CC assumes an average “as new” MEA of approximately [redacted] for each of BMI’s hospitals (including land and equipment), which it then depreciates significantly.³⁰ From this, it is clear that the CC has significantly understated the MEA value of BMI’s hospitals.
- 3.31 We have performed a more detailed and robust comparison of our hospital portfolio to the recently observed entrants over the last decade. This provides a further cross-check on the MEA value of BMI’s buildings. We set out the detail of our comparisons and associated calculations in [redacted].
- 3.32 In summary the following comparisons are appropriate and certainly rebut the criticism the CC has levelled at this approach noted above:
- (1) Spire Montefiore: (cost £29 million – the cheapest of the comparator hospitals) has three theatres, 20 inpatient beds and publicly available information indicates that it has no ICU beds.³¹ We have identified eleven hospitals in our portfolio that we consider are **at least** comparable to Spire Montefiore. These hospitals each have three theatres, between 20 and 75 inpatient beds and eight out of the eleven hospitals have at least one ICU bed.³²

³⁰ The CC assumes an average DRC of [redacted]. In other words, the CC is assuming the average BMI hospital is equivalent to [redacted] the value of the cheapest new build in the last decade.

³¹ Spire Montefiore’s website does not state whether it has any ICU beds (<http://www.spirehealthcare.com/montefiore/our-treatments-and-facilities/our-facilities/>), however, Spire Southampton’s website indicates that Southampton does have ICU beds (<http://www.spirehealthcare.com/southampton/our-facilities-treatments-and-consultants/our-facilities/>). Therefore, it appears likely that Spire Montefiore does not have ICU beds.

³² With an average of 43 inpatient beds (compared to Spire Montefiore’s 20) and 1.6 ICU beds.

- (2) Circle Bath (cost £33 million, excluding equipment) has four theatres and 28 inpatient beds. Circle Reading (cost £58 million) has five theatres and 30 inpatient beds. Publicly available information does not state whether these hospitals have any ICU beds. A further eleven BMI hospitals are comparable to these hospitals, each with four theatres and greater than 30 inpatient beds.³³ In addition, nine out of these eleven comparable hospitals have between three and eight ICU beds (with an average of four). Hence, eleven hospitals are **at least** comparable to Circle Bath and Circle Reading.
- (3) KIMS (cost £90 million), Nuffield Oxford (cost £50 million) and Nuffield Leeds (cost £40 million) have on average six theatres, 79 inpatient beds and 7 to 8 ICU beds. Three further hospitals in BMI's estate are comparable to these entrants. The comparable BMI hospitals have an average of six theatres. All three of the BMI hospitals have a considerably greater number of IP beds.³⁴ BMI's three hospital comparators have, on average, eight critical care beds.³⁵

3.33 The CC commented that "*KIMS and Nuffield's Oxford and Leeds hospitals all offer (or will offer) state-of-the art facilities, including intensive care units and advanced treatment and diagnostic capabilities*".³⁶ The CC suggested that these were therefore not comparable with BMI hospitals. This is incorrect. BMI operates modern acute hospitals many of which include intensive care units and advanced treatment and diagnostic capabilities. Examples include: the Nuclear Medicine Centre at BMI The Alexandra Hospital, which incorporates a SPECT/CT Scanner and 3 Tesla MRI; a new 'state of the art' endoscopy suite, cath lab and CT at BMI Ross Hall Hospital; the O-Arm scanner at BMI The Clementine Churchill Hospital (the first O-Arm scanner in the independent sector in the UK), the Thornbury Gamma Knife Centre (a National Referral Centre) at BMI Thornbury Hospital; the 128 Slice CT Scanner at BMI The Thornbury Hospital; and a new 'state of the art' ITU at BMI The Park Hospital.

3.34 The CC also states "*The Cancer Centre offers a range of cutting-edge equipment, including Cyberknife and RapidArc technologies, the costs of which are included in BMI's estimate of the costs of building the facility*". BMI's previous comparison excluded the London Clinic Cancer Centre value from its analysis and again we have

³³ The range of these six hospitals is 38 to 118 inpatient beds, with an average of 70.

³⁴ On average, BMI's comparable hospitals have over 50% more IP beds than the entrants.

³⁵ Twelve of these beds are critical care level three.

³⁶ Provisional Findings, Appendix 6.13, paragraph 107.

not used the value of the London Clinic Cancer Centre as a comparator in this updated analysis. We have made hospital comparisons based on discussions with our clinical leads - we do not consider that the CC has the expertise to opine on the appropriateness of comparisons between hospitals.

- 3.35 The table below sets out our calculation of a revised DRC value for BMI's hospitals based on this data.

[REDACTED]

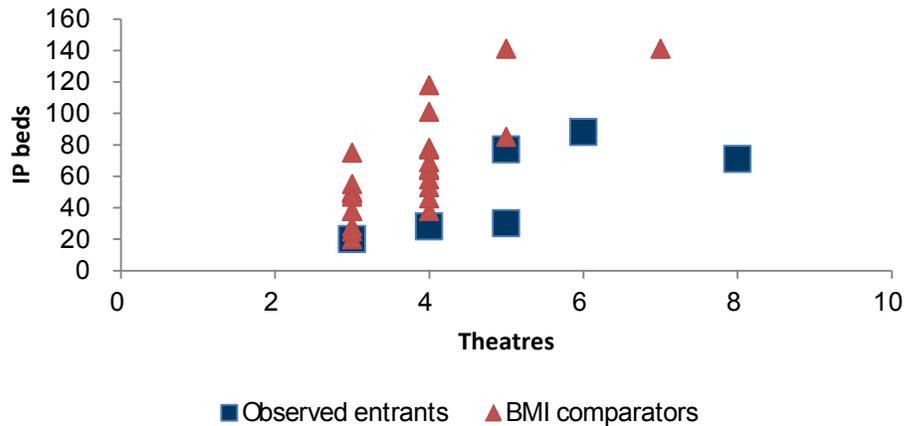
- 3.36 The costs for each comparator hospital typically included land and equipment.³⁷ We have reduced the total "all in cost" (column A in the table above) to include only building values (column B).³⁸ We have then applied an obsolescence adjustment, which was calculated by Colliers (column E in the table above), and have calculated the change in building values over time following the same methodology as the CC. For BMI hospitals that were not directly comparable to one of the new entrants (second to last row in the table above), we uplifted their reinstatement values by the average percentage difference between the cost of the observed entrants and their BMI comparators' insurance reinstatement values.

- 3.37 These assumptions are extremely conservative, since many of our hospitals are significantly larger than the entrants. To demonstrate this, the figure below compares the number of inpatient beds and theatres in each BMI hospital compared to the number of inpatient beds and theatres of the entrants discussed above. The figure shows that every one of BMI's hospitals has a greater number of inpatient beds in comparison to the entrants. We note that this also illustrates why the CC's decision to focus the inquiry on inpatient provision is misplaced. That is, newer hospitals have consistently shown a far lower IP beds to theatres ratio, reflecting the changes in the way private acute medical care is delivered.

³⁷ Circle Bath's cost of £33 million, however, is exclusive of equipment.

³⁸ [REDACTED]

Figure 3-1: BMI's inpatient bed and theatre numbers compared to the observed entrants



Source: Appendix 1-3-4.

3.38 The figure below shows that the cost per bed is significantly lower for each of BMI's hospitals compared to the observed entrants, again indicating that our illustrative analysis is conservative.

[]

3.39 Finally, the figure below illustrates the implied DRC per bed for each of the entrants.³⁹ All values are shown inclusive of land and equipment.⁴⁰ The cost per bed of the entrants has been reduced by the average obsolescence of BMI's buildings as assessed by Colliers International to ensure comparability.⁴¹ The figure shows that the CC's assumed building values are significantly lower than all the comparators between 2003 and 2014.

[]

³⁹ With the exception of the London Clinic Cancer Centre which BMI has not argued is comparable to its hospitals.

⁴⁰ For BMI's "new build" comparison, Colliers International's DRC land values are used.

⁴¹ Although land values of the entrants should not be reduced for obsolescence and equipment should potentially be reduced more, we do not have the breakdown between equipment, land and buildings cost for these entrants to perform the calculation more robustly. However, we do not consider that there would be a material difference in the values calculated.

3.40 The figure shows that the Colliers International DRC valuation and the comparisons to the observed entrants are very similar and comparable to Nuffield Oxford and Nuffield Leeds, which have the lowest cost per bed, again showing that the assumptions and values used by BMI are conservative. Nuffield Leeds and Nuffield Oxford were completed in 2003 and 2004, respectively. Circle Bath and Reading were completed during 2010, Spire Montefiore during 2012 and KIMS is due to open in 2014. All of these values are higher than the CC's values, indicating that the CC has materially understated the DRC value. It can clearly be seen that BMI's DRC and new build assumptions are therefore conservative in comparison to these hospitals.

3.41 In conclusion, it is clear that from our comparison of BMI's hospitals to the observed entrants into the UK private hospital market over the past decade, that building DRC values are significantly in excess of the insurance reinstatement values used by the CC. The table below sets out how EBIT and capital employed change based on these findings alone. We note that this is a conservative estimate as Colliers International consider that the average fit out cost for an MEA will in fact cost significantly more than the net book value of BMI's equipment of approximately [redacted] – Colliers International estimate that for a similar level of obsolescence as BMI's assets the MEA value would equate to [redacted].

[redacted]

3.42 The effect of applying these adjustments alone reduces average ROCE over the Review Period from [redacted] to [redacted] a reduction of [redacted]. This produces a helpful cross-check and similar result to our assessment using the Colliers International DRC valuation.

The CC has incorrectly calculated the MEA value of BMI's land

3.43 To determine the MEA value of land, the CC has relied on the "desktop exercise" performed by the DTZ residential team.⁴² This "desktop exercise" has been updated since the CC's preliminary analysis. The values used by the CC are approximately 40% higher than those used in the CC's preliminary analysis. The CC now includes:

- stamp duty land tax at 5%;

⁴² The DTZ hospital team previously valued BMI's land and buildings for the purposes of bank loan security at approximately [redacted] (and is currently performing a new valuation for the same purpose at present). The approach now taken by DTZ on behalf of the CC is at odds with this valuation. Please confirm whether DTZ's healthcare team have been shown their colleagues' work and what their comment as to its fitness for purpose has been.

- an allowance of 0.8% for professional fees; and
 - £250,000 per site to allow for the additional cost associated with purchasing sites that require specialised planning permission.
- 3.44 In addition, the CC states that DTZ has placed greater weight on current sites as opposed to potential alternative sites. The CC also states that where valuations were made with reference to potential alternative sites DTZ's "valuation" reflected any premium required to acquire planning permission.
- 3.45 However, despite these adjustments, the CC has not addressed the fundamental flaws associated with its methodology. BMI has provided the CC with a detailed critique of its methodology in a report prepared by Colliers International dated 26 February 2013. This critique was further summarised in a letter to the CC from BMI, dated 26 February 2013.
- 3.46 Apart from the changes made to the CC's approach described above, all of our criticisms of the DTZ desktop survey remain un-met. These include *inter alia*:
- the DTZ team did not perform a proper valuation. DTZ themselves labelled the valuation as a "*desktop exercise*". DTZ's updated report stated "*Given the instruction is a desktop exercise, DTZ is of the opinion the above approach, whilst not a formal Red Book valuation, will provide an indication of the desktop land prices for each of the private hospitals*".⁴³ DTZ is still not able to state that they have performed a land valuation, despite the fact that this is what they were originally instructed to prepare;
 - DRC is not the appropriate measure of determining the value of land because it is universally accepted as the 'measure of last resort'. Despite this, the CC and DTZ have not applied their minds to the alternatives;
 - the applicable professional standards with respect to land valuation have not been followed. The CC has no expertise in land valuation and is plainly not in a position to decide which RICS professional standards are important and which are not;
 - no regard was given to normal or average market conditions, contrary to DTZ's instructions. A market based approach should be used to value land consistent with the methodology that the CC consulted upon; and

⁴³ Provisional Findings, Appendix 6.15, paragraph 2.25.

- that a residential team were not appropriately qualified to perform a valuation of land required for private hospitals.

3.47 Hence, the “land values” used by the CC are significantly understated. The CC has no rational basis on which it can rely on them in the face of well-founded criticism that has been made and our objection to DRC as an appropriate approach to land valuation. Despite this, the CC has firmly demonstrated its determination to stand by its approach and use of DRC.

3.48 Consequently, BMI engaged Colliers International to perform a full DRC valuation of all of BMI’s land based on site inspections. Leaving aside that RICS professional standards would not permit a valuation of private hospitals based on DRC in the first place, the Colliers International valuation has been prepared in full compliance with RICS professional standards for the DRC method (Guidance Note 6 of the RICS Red Book).

3.49 The Colliers International DRC land valuation indicates that DTZ has under-estimated land values on average by [redacted] even after adjusting for stamp duty land tax, professional fees and £250,000 per site for planning permission.⁴⁴

3.50 We have also considered other evidence to corroborate our findings. We have already provided this evidence to the CC. [redacted]

3.51 The table below shows the adjustments to EBIT and capital employed that are required to adjust for a DRC land valuation.

[redacted]

3.52 Adjusting only for actual land values on a DRC basis, independently determined according to RICS professional standards by Colliers International, leads to a reduction in the average ROCE over the Review Period of [redacted] percentage points from [redacted] to [redacted].⁴⁵

The effect on ROCE using market based land and buildings valuations

3.53 The CC stated that it is inappropriate to calculate ROCEs using market-based values of land and buildings as these are based on the trading potential of the business at each site, which may lead to excessive profits being capitalised. This may lead to an

⁴⁴ See the Colliers International DRC Report Valuation and Appendix 1-3-6.

⁴⁵ Using a market based land valuation, the ROCE declines to [redacted] in isolation of any other changes.

incorrect conclusion on profitability. The CC has been so concerned about this issue that it has allowed it to determine its entire approach to land and building valuation. However, there comes a point when excessive concern over this circularity risks predetermining the outcome. The CC assumes that all market valuations reflect excess profit and seeks to depress all market land values without considering whether excess profit is plausible for a given hospital.

- 3.54 The CC has failed to take account of the fact that RICS market valuation standards do not require that actual trading performance is used, instead results are adjusted to remove any element of excess profit. As Colliers International state in their report:⁴⁶

“By using both an assessment of FMOP [Fair Maintainable Operating Profit] against a range of UK and European benchmarks and then basing the residual valuation on the Turnkey Value (i.e. before the hospital has established a market presence) rather than the value as an operational concern this should overwhelmingly take out any circular element from an assessment of profitability of UK private acute hospitals. We would note in this respect that our international hospital performance benchmarks indicate a wide degree of similarity in the trading performance of comparable hospitals in the UK and overseas markets.”

- 3.55 It is plainly possible, even based on the CC’s analysis, to identify hospitals where their land value is not affected by excess profitability. Rather than focus on this or use it as a cross-check, the CC inappropriately directed DTZ to move directly to DRC – which is universally accepted as the valuation method of “last resort”.
- 3.56 In the table below, we show the adjustments that would be required to the CC’s calculation of EBIT and capital employed when a market-based valuation of land and buildings that explicitly excludes any potential excess profitability is used.

[redacted]

- 3.57 Using market land and building values independently determined by Colliers International (instead of the CC’s inappropriate proxies) leads to a reduction in the average ROCE over the Review Period of [redacted] percentage points from [redacted] to [redacted].

Conclusions on land and buildings values

- 3.58 The CC continues to insist that the correct methodology to assess the MEA value of

⁴⁶ Colliers International’s critique of the DTZ report dated 26 February 2013.

BMI's land and buildings is based on a DRC approach. However, the CC did not attempt to perform a proper DRC valuation of BMI's buildings. Instead it adopted a short cut based on outdated and inappropriate proxies. To rectify the deficiencies in the CC's approach, BMI has incurred considerable expense to perform a full DRC valuation of the portfolio of [redacted] freehold land and buildings [redacted].

- 3.59 The figure below compares each of the land and building valuations prepared by Colliers International (both DRC and market based valuations), our "new builds" comparative analysis and the CC's incorrect building valuation.

[redacted]

- 3.60 Clearly, an independently performed valuation performed to professional standards and based on site inspections **must** have more evidential weight than an outdated and inappropriate proxy of building values based on a "desktop exercise". Hence, the CC has no choice but to disregard its provisional findings on profitability. It is clear, using appropriate DRC values, that BMI's average ROCE over the Review Period is below [redacted] which is [redacted] the WACC as calculated by the CC. The average ROCE falls to [redacted] once the additional corrections discussed in Section 4 below are made.

- 3.61 BMI notes that to instruct Colliers International to carry out a DRC valuation of the [redacted] freehold sites [redacted] to full RICS standards cost BMI [redacted]. The DTZ "desktops", which valued the real estate assets of the **entire healthcare industry**, cost just £27,000 plus VAT.

4. Other corrections required to the CC's calculation of BMI's ROCE

Introduction

- 4.1 We have reviewed the calculations performed by the CC in its assessment of BMI's profitability. In this section, we set out the results of our review. In summary:
- (1) Other Project Costs which were not previously requested or provided to the CC and accordingly were not used in its assessment of ROCE. These costs must now be included;
 - (2) the CC has erroneously excluded CIP from capital employed;
 - (3) the CC has wrongly included the EBITDA of BMI's [redacted] from its warehouse in its calculation of EBIT; and
 - (4) the CC has wrongly allocated central Core Hospital Business costs to Netcare UK.

4.2 We discuss the effects of each of these corrections below. Together these corrections reduce the CC's calculation of ROCE by [redacted] percentage points to [redacted].

Other Project Income and Costs

4.3 In addition to central costs, BMI incurs costs related to specific strategic and operational projects that are not accounted for at a site level or included in the central costs figures provided to the CC. Examples of these costs include:

- [redacted];
- [redacted];
- [redacted];
- [redacted];
- [redacted];
- [redacted];
- [redacted]; and
- [redacted].

4.4 These costs are required in the normal running of BMI's business, but are usually outside of the control of staff at a particular site or head office department. BMI does not treat these as "operational" costs for the purposes of management financial reporting. As such, these costs were not included in the financial data provided to the CC on a site or central basis.

4.5 Allocating these costs to hospitals or central functions would cloud the underlying operational costs and performance of each site making it difficult to assess the underlying profitability on a site-by-site basis. Although these costs can vary considerably year to year, these types of costs are typically incurred in every year. In addition, as the underlying site profitability is used to determine potential bonus payments and the quantum of these costs can be unpredictable, it would lead to significant difficulties in calculating staff compensation packages.

4.6 The CC calculated EBIT using EBITDAR figures that were provided to the CC on a site-by-site basis. This calculation did not include Other Project Costs. This leads the CC to overstate BMI's EBIT and hence ROCE. The table below sets out the net amount of Other Project Costs that should be included in the calculation of EBIT.

[redacted]

- 4.7 CIP accounts are holding accounts for development costs that have not yet been capitalised and codified into an alternative asset class such as buildings or equipment. These assets are held in holding accounts because either: i) the assets are not complete; ii) the assets are not yet ready to be depreciated; or iii) the allocation has not yet been completed. These assets are capital costs which have not been expensed in income statement (i.e. they have no impact on EBIT). The CC gives no reason why CIP assets have been excluded from their ROCE calculations (i.e. these genuine costs are excluded in both EBIT and capital employed).
- 4.8 We provided the CC with a spreadsheet in our submission dated 25 April 2013 (referred to as “Annex 3”) that contained the central equipment CIP that the CC has excluded. In addition to central equipment CIP, we now realise that no CIP assets were included in the CC’s calculation of capital employed in either the Preliminary CC Model or the CC Model at all.⁴⁷ Information relating to all CIP assets was presented in BMI’s financial statements and in the spreadsheets provided to the CC in response to its financial questionnaire.
- 4.9 CIP represents a real cost to BMI, which needs to be financed in the short term and needs to generate a return in the medium to long term. There is no justification for excluding these assets from the CC’s calculation of profitability.
- 4.10 We confirm that CIP is not included in any of the other asset categories provided to the CC. The table below sets out the amount of CIP that must be included in the calculation of capital employed in each year.
- [X]
- 4.11 [X]
- 4.12 We accept that the storage and logistics of medical supplies, drugs and prostheses is an activity that should be included in the CC’s investigation. However, we consider that [X] should be treated as an excluded activity, for the reasons set out below.
- [X] is not part of the CC’s investigation**
- 4.13 The CC defined the relevant markets of its investigation as the “*product markets in the provision of hospital services for individual specialties and, for each specialty, separate markets for inpatient, day-patient and outpatient care*”.⁴⁸ It should be clear that the [X]

⁴⁷ That is, no central CIP assets or CIP assets at hospital sites.

⁴⁸ Provisional Findings, paragraph 16.

does not form part of the provision of hospital services or inpatient, day-patient or outpatient care markets. Given that the CC's investigation does not include the [X] should be excluded from the calculation of BMI's EBIT.

The CC has misunderstood the financial data provided by BMI

- 4.14 The CC has misunderstood the financial data and explanations provided previously by BMI. The CC stated the following as its rationale for including [X].⁴⁹

"BMI put forward the view that we should include the costs of operating its warehouse facility (storage and logistics for drugs and prosthesis), which was integral to its private hospital operations, but not [X]."

It is reasonable to assume that an operator will seek to run its affairs as efficiently as possible. If by investing in a warehouse facility, which is required to support its core business, an operator is able to cover the costs of that facility (or generate a small profit), we see no reason why the costs should be attributed wholly to the hospitals and the revenues be excluded. We have included the net profit generated by BMI's warehouse facility in our analysis."

- 4.15 The CC is incorrect to state that our view is that "costs are attributed wholly to the hospitals and revenues are excluded". The warehouse is required for the efficient operation of BMI's hospitals, the [X] is not. Indeed the CC has not suggested that other PHPs have undertaken [X] and that it is a normal efficiency in the industry to use [X]. It is not.

- 4.16 Therefore, income and costs associated with the warehouse function should be included in the calculation of EBIT. However, the income **and costs** associated with the incidental [X] should be excluded from the calculation of EBIT. Our previous submissions to the CC said that both the costs and income associated with the [X] should be excluded. We did not suggest that all the costs should be included in the CC's assessment and none of the income.

The CC makes an inconsistent comparison of profitability across hospital groups

- 4.17 The Provisional Findings show that BMI was the only private hospital provider that made [X] over the Relevant Period. If the CC includes income and costs associated

⁴⁹ Provisional Findings, Appendix 6.13, paragraph 138.

with this [X], it will assess BMI's profitability on a different basis to other private healthcare providers. The CC will not compare like with like.

[X]

- 4.18 [X].
- 4.19 [X]. However, BMI will incur its warehouse costs – just as all other private healthcare providers do.
- 4.20 [X]. If [X] are included in the CC's assessment this will provide a biased estimate of profitability over the life of an investment, when in fact it represents a brief period of innovation. Furthermore, [X].

Including the profit of [X] will distort the calculation of ROCE

- 4.21 [X]. Hence, any incremental EBIT from [X] will have a distortive effect on the ROCE. This is because EBIT is increased, but in accounting terms the level of capital employed used to generate this profit is zero. Clearly, there is an economic cost to generating EBIT, but the simple ROCE measure fails to capture this cost appropriately.

Conclusion on warehouse and [X] and costs

- 4.22 The CC has not adequately explained why it considers that it is appropriate to include [X] revenues and costs in its investigation of hospital operations profitability, when it is unrelated to the Core Hospital Operations. For the reasons set out above, it is inappropriate to include these revenues and costs in the assessment of BMI's profitability.

4.23 The table below sets out the adjustment required to the CC's calculation to correct for the improper inclusion of warehouse revenues and costs associated with the [REDACTED].

[REDACTED]

4.24 The CC states:⁵⁰

“on the whole, we accepted the firms’ own cost allocation methods in allocating corporate overhead costs to their private hospital businesses. Therefore, we made few adjustments to the profit and loss data submitted to us by the relevant firms, with a notable exception being to the depreciation charge on buildings to ensure consistency with the value of capital used in our analysis.”

4.25 This statement is not true with respect to BMI. The CC did adjust BMI's profit and loss data. We provided the CC with a breakdown of costs by hospital. [REDACTED].

4.26 Despite our explanations, the CC has reallocated the central costs of the Core Hospital Business back to [REDACTED].

4.27 This treatment is incorrect and leads to costs being understated and EBIT to be overstated for the Core Hospital Business. All of the central costs line relates solely and directly to BMI's Core Hospital Business and none of the central costs line should be allocated to the Excluded Businesses.

4.28 The table below sets out the CC's calculation of central costs, the corrected figure that should be included in the CC's assessment of ROCE and the adjustment required to the CC's EBIT figure.

[REDACTED]

Conclusions

4.29 The CC overstates EBIT because it does not include Other Project Costs, it includes profits from an Excluded Business and incorrectly allocates the Core Hospital Business' central costs to parts of the Excluded Business. The table below shows the adjustments to EBIT required to correct these errors.

[REDACTED]

4.30 In addition, the CC has not included CIP in its calculation of capital employed. The

⁵⁰ Provisional Findings, paragraph 6.258.

table below sets out the correction to capital employed required.

[REDACTED]

- 4.31 In isolation, these corrections cause ROCE to decline by [REDACTED] to [REDACTED]. Combined with actual DRC valuations, the ROCE declines to [REDACTED] the CC's estimate of the WACC.

5. Considerations in the interpretation of results

Introduction

- 5.1 In this section, [REDACTED], we explain why the gap between ROCE and WACC must be large to draw a conclusion of excessive profitability. A higher WACC is also justified. On a conservative basis, we have increased the WACC by 1% to adjust for specific risk associated to allow the comparison of ex post profits with an ex ante WACC calculation.⁵¹ Based on the CC's own calculations, this increases the WACC range to 8.2% to 10.9%.
- 5.2 In addition, even if the CC were to disagree with the evidence and adjustments proposed by BMI above, we consider that the gap calculated by the CC - of [REDACTED] percentage points - is insufficient to support a finding of persistent excessive returns. Put differently, we consider that a much larger gap between ROCE and WACC is required before the CC can conclude with reasonable certainty that BMI has been earning persistent excessive returns. The CC has misinterpreted its own results heavily to BMI's detriment and seeks to impose [REDACTED] remedies to solve a problem for which the CC's evidence across bargaining, price concentration, local assessments, barriers to entry and this profitability assessment is very, very weak.⁵²
- 5.3 Given the profound weakness across the central limbs of its case, the gap between WACC and ROCE must be particularly large and persistent across the whole industry for the CC to fairly and rationally conclude that the profitability assessment is indicative of a competition concern. As the CC has itself stated:⁵³

⁵¹ See paragraphs 5.35 to 5.41 for our discussion on why an adjustment is required to the WACC. The adjustment is required to account for specific risk not assessed in ex-post profits.

⁵² See Annexes 1, 2, 3, 4, 5 and 6 to BMI's response to Provisional Findings.

⁵³ Sir Derek Morris, Chairman Competition Commission, Paper presented to Fordham Corporate Law Institute 13th Annual Conference on International Antitrust Law and Policy, October 2003.

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

- 5.4 Importantly, the CC has never defined how big the gap between the estimates of ROCE and WACC need to be to confirm a case of excessive profitability. All that it says is that profitability has to be “substantially” above the cost of capital. The CC does not provide any case precedent to support the point at which profits can be said to be substantially above the cost of capital. It reserves this judgment to itself in each case. This explicitly requires the CC to adjust the gap depending on the circumstances of each case. In this case, when the substantive evidence across virtually the whole of the substantive analysis is so weak; and the profitability so heavily dependent on judgments the CC has made about land and building valuation which are themselves deeply deficient on their own terms and demonstrably not robust, a gap of up to [x] percentage points is not substantial when all relevant factors have been considered.
- 5.5 In this section, we set out our views on conceptual issues that are important in the assessment of profitability. First, we provide a summary of case law precedent and decisional practice in excessive pricing cases. This provides important evidence on the point at which profits can be deemed excessive. Second, we discuss the reasons why the gap between ROCE and WACC must be large before a case of sufficient persistent excessive profitability can be supported. In summary, the gap must be large for the following reasons:
- (1) the Review Period will not provide an accurate picture of profitability over the life of the investment;
 - (2) there is significant uncertainty in the calculation of the WACC;
 - (3) conceptually, above average returns do not indicate excessive profits (and it certainly does not suggest market power);
 - (4) the CC’s approach will inappropriately discourage investment in the private hospital industry and will force industry operators to earn returns below the average WACC;
 - (5) there is significant uncertainty in the calculation of ROCE. Most importantly, the CC has not fully considered intangible assets and hence it knows that the ROCE is overstated; and

(6) the CC has adjusted its building valuation methodology without explanation. In the absence of any explanation for this change, the change – which operates to BMI's detriment (under the CC's analysis) - has been adopted to allow the CC to sustain or bolster its early conclusion. To adjust a methodology to sustain a prior conclusion is unfair and, because it provides indication of a predetermined conclusion, also evidence of bias.

5.6 As the CC failed to give due consideration to these issues (notwithstanding the many errors set out in Sections 3 and 4 above), the gap between ROCE and WACC must be wide to support a conclusion that BMI has made and will continue to make excessive returns.

Case law precedent / decisional practice

5.7 A firm that makes excessive profit is equivalent to a firm charging prices that are in excess of its economic cost. In excessive pricing cases, the authorities typically perform price cost tests to determine the extent to which prices (and revenues) are above economic cost.

5.8 The ROCE calculation performed by the CC can be simply rearranged to determine economic cost. Economic cost can be expressed as:

$$\text{Economic cost} = \text{operating expenditure} + \text{depreciation} + \text{capital employed} \times \text{WACC}$$

5.9 The extent of excessive pricing can then be calculated by comparing the economic cost to the revenues charged. The table below compares BMI's revenues to economic cost over the Relevant Period using the CC's calculation of revenue, operating costs (as contained in EBIT), depreciation, capital employed and WACC for BMI's Core Hospital Business (i.e. before any corrections are made).

5.10 The CC's unadjusted analysis implies that BMI's prices exceed economic cost by just [§<] during the Review Period (and to [§<] if 2012 and 2013 financial data is also included).⁵⁴ Making the adjustments summarised in Section 3 and 4 would reduce this to [§<].⁵⁵

5.11 Comparing prices to costs suggests a smaller gap than the CC's ROCE calculation. However, the ROCE calculation is extremely sensitive to assumptions regarding the

⁵⁴ Appendix 1-5.

⁵⁵ Appendix 1-5.

capital base. It is for this reason that most competition authorities rely on comparisons of price to cost, rather than on profitability.

- 5.12 In most European cases where prices have been found to be excessive, the difference between price and cost has been significantly higher than [3<]. For example:
- the range of price differences was 33% to over 1000% in *Napp*;⁵⁶
 - 100% to 500% in *General Motors*;⁵⁷
 - 400% to 700% in *British Leyland*;⁵⁸ and
 - 25% to 43% in *Deutsche Post II*.⁵⁹
- 5.13 Additionally, in *Attheraces*, the Court of Appeal overturned the High Court's ruling that had established excessive pricing, despite the 300% difference between prices and costs.⁶⁰
- 5.14 Although it is not clear which benchmarks should be applied in excessive pricing cases, an important common feature of cases in which excessive prices have been found is that the price was not merely above the relevant benchmark, but was *significantly* above it. By ensuring that the price should be significantly above the competitive level, and not merely above it, this criterion helps avoid the costly errors of falsely finding an excessive price where there is none. Two Commission officials noted as follows.⁶¹

⁵⁶ Napp Pharmaceuticals Holdings Ltd and Subsidiaries, Decision of Director General of Fair Trading [2001] and Case 1001/1/1/01, Napp Pharmaceuticals Holdings Ltd and Subsidiaries v Director General of Fair Trading, CAT [2002].

⁵⁷ Case IV/28.851 General Motors, Commission Decision of 19 December 1974 and Case 26/75, General Motors Continental NV v Commission [1975] ECR.

⁵⁸ British Leyland, Commission Decision of 2 July 1984 and Case 226/84 British Leyland v Commission, [1986] ECR.

⁵⁹ Case COMP/36.915, Deutsche Post II, Commission Decision of 25 July 2001, Case A3/2006/0126.

⁶⁰ *Attheraces Ltd & Anor v. The British Horseracing Board Ltd & Anor*, [2007] EWCA.

⁶¹ See M Haag and R Klotz, Commission Practice Concerning Excessive Pricing In Telecommunications, II (1998) 2 Competition Policy Newsletter.

“It is clear that a market comparison can only provide an indication of an abuse, if the difference between the prices charged on the various markets is significant. On the contrary, in cases where the prices charged deviate only slightly from the price level on comparative markets, this disparity could not be considered as giving a prima facie indication for abuse. Depending on the merits of each individual case, the benchmark for Commission intervention may vary considerably. In [one case], a difference of more than 100% between the price examined and the price levels in comparative markets was found to be unacceptable. In other cases, however, the Commission might have to intervene even if this difference is significantly smaller. In any event, even where a significant difference exists, the undertaking concerned always has the possibility of demonstrating that higher prices are objectively justified.”

- 5.15 In a case involving Deutsche Telekom, a comparative market study ordered by the Commission, the Commission assumed that, in the absence of special circumstances, a price is highly likely to be abusive if it is considered more than 100% higher than prices in comparable competitive markets.⁶² A similar margin was considered excessive in the circumstances of the *ITT/Promedia* case.⁶³ More generally, the OFT's (draft) *Guidelines On The Assessment Of Conduct* state that:⁶⁴

*“In assessing questions about excessive pricing, the OFT would usually look for evidence that prices are **substantially higher** than would be expected in a competitive market...” Emphasis added.*

- 5.16 We consider that the CC's findings ignore the case law precedent and decisional practice that prices need to be significantly in excess of economic cost before they can be considered “excessive”.

The relevant time period reviewed

- 5.17 In a competitive market, a firm can expect to earn a reasonable return (i.e. its cost of capital) over the life of its investment. There is nothing in the economic literature to suggest that a firm must earn a constant annual return or a particular return at a point

⁶² Commission Press Release IP/96/975 of 11 November 1996.

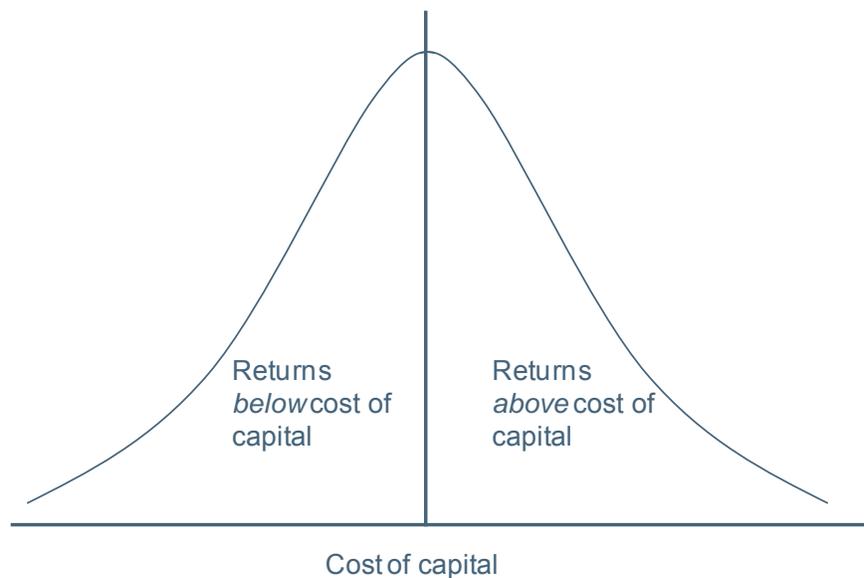
⁶³ Commission Press Release IP/97/292 of 11 April 1997.

⁶⁴ Assessment of Conduct, Office of Fair Trading Draft Competition Law Guideline For Consultation (April 2004) para. 2.6.

in time. It is only natural that firms may earn lower profits in some years and higher profits in other years. This may be due to economic cycles, competitive dynamics and product life cycles.

- 5.18 From a theoretical perspective, the cost of capital reflects the return that an entity requires in the long term. In the chart below, we show a hypothetical distribution of profits. The portions of the bell-curve reflect that, in some years, an entity's profits are in excess of the cost of capital and, in other years, they are below the cost of capital.

Figure 5-1: Hypothetical distribution of profits



Note: For simplicity, we have shown the returns as being normally distributed. In fact, the CAPM model assumes that asset returns are (jointly) normally distributed random variables. It is observed, however, that returns in equity and other markets are not necessarily normally distributed. That said returns would normally be distributed above and below the average, irrespective of the true distribution. Note also that some of the returns in the graph above may be negative.

- 5.19 On an annual basis, an entity's actual profits are unlikely to equal its cost of capital. However, over the long term an entity would seek to earn a return equal to its cost of capital. Even then it might be difficult for an entity in an uncertain cyclical environment to balance loss making and profit making periods, such that it earns its cost of capital precisely. This has important implications for a price / cost analysis as follows:

- in a single period, or over a very limited number of periods, it would be inappropriate to conclude that profits are excessive simply because the entity achieves profits that are in excess of its cost of capital. This is because profits might offset losses in other periods (either in the past or in the future).⁶⁵ To ensure that the comparison is valid, one must compare profits over the longer term with the cost of capital, which reflects a long-term average level of profitability.⁶⁶ This is an issue relating to consistency;
- even over a medium term (e.g. say 10 years), an individual entity may not actually be able to earn a profit that is precisely equal to its cost of capital due to the dynamic nature of the market. It may be slightly higher, or slightly lower, than the theoretical benchmark. On this basis, higher returns should not signal excessive profits.

5.20 The CC has analysed profits over the period FY 2007 to FY 2011. In doing so, it implicitly assumes that the Review Period appropriately reflects profitability over the life of the asset. In the Provisional Findings, the CC states:⁶⁷

“We consider that a five-year period is sufficiently long for us to evaluate the persistence of profitability, although we have taken into account both the likely impact of the recession and the growth in NHS demand on the profits of the relevant firms over the period. Moreover, we note that changes in the structure of the market mean that the financial performance of the sector prior to 2007 is unlikely to be a relevant indicator of the current competitive conditions in the market.”

5.21 A five-year period is not sufficient for the CC to conclude that BMI is making “persistent excessive returns”. Over a relatively short time period there may be a number of reasons unrelated to market power or to anti-competitive practices which lead to

⁶⁵ In BMI’s context, one cannot rule out the possibility that in the future it might incur significant losses that offset its alleged high profitability in the Relevant Period.

⁶⁶ This point can be explained slightly differently as follows. If a firm’s returns were found to be above the cost of capital in a given period, these returns should not be price-controlled such that the firm can never earn a return on the right portion of the bell curve. If this occurred, then the firm would only be able to earn returns equal to its average cost of capital or below its cost of capital (i.e. the left portion of the bell curve above). If a firm’s returns were capped at the average cost of capital, then over time it would make a return below the average cost of capital.

⁶⁷ Preliminary Findings, paragraph 6.254.

temporarily high profits.

- 5.22 Moreover, all other things being equal, the profits at a new hospital are likely to start low, as it gains scale, invests in processes and training and gains local reputation and other intangible assets over time. There is a significant initial outlay required to construct and equip the hospital. Greater sums are spent in earlier years on recruiting, staff training, advertising, etc. thereby increasing the cost base in earlier years. Revenues are also lower as utilisation at new hospitals is likely to be lower in earlier years. Hence, profits are likely to be low or negative in early years. To cover these initial early losses, profits must be higher in later years. [redacted]. On the CC's analysis, the costs for this are not in BMI's profit and loss in the Review Period but BMI is now benefiting from the spend made in prior periods.
- 5.23 Put differently, losses in early years will need to be offset by higher profits in later years so that BMI can recoup the cost of its investment and earn at least the average WACC. It follows that if the CC constrains BMI's profits to the Review Period, then BMI will not be able to earn an average WACC on its investment, as these early start-up losses will not be recovered.
- 5.24 Typically, BMI internally assesses its investments [redacted]. This is because reviewing investments over shorter periods is meaningless. We would rarely invest in any assets if we only considered these over such a short timescale.
- 5.25 The CC is also wrong in its reasoning. The CC claims that because the Review Period covers a recessionary period, all other things being equal, this will lead to profitability being suppressed. Consequently, the CC concludes that its estimates of profitability may "*understate the returns that could be earned in more "normal" market conditions*".⁶⁸ We have the following concerns with this statement:
- the CC is simply guessing. The CC has performed no analysis to determine the profitability of a hospital over its life, and the extent to which hospitals can be expected to earn lower profits at start up; and
 - [redacted].
- 5.26 The CC acknowledges in its guidelines that the relevant time period of investigation needs to be carefully considered:⁶⁹

⁶⁸ Provisional Findings, Appendix 6.13, paragraphs 183 and 184.

⁶⁹ "Guidelines for market investigations", CC, paragraph 121. Emphasis added

*“The appropriate time period over which to examine the persistence of the gap between profitability and the cost of capital may therefore vary according to the specific market. The pattern of investment and the nature of sources of competitive advantage (advertising, research and development (R&D), more efficient production) may affect the CC’s view of the relevant timescales over which it would expect to see competition playing out in the market. **Where large and risky investments have been made, the CC would expect to see a normal level of profitability restored over a relatively long timescale**” Emphasis added.*

- 5.27 The private hospital business requires making large and risky investments. Indeed, this is a fundamental part of the CC’s allegation that the private hospital sector is characterised by high capital barriers to entry. A five-year period does not reflect the life of the major assets in the industry. BMI should be allowed to earn at least a normal rate of profit over the life of its investments, which are estimated to be [\geq] years or more for buildings and [\geq] years or more for equipment. In addition to start up losses, one might also expect that returns will be lower at the beginning of the life of certain assets because of higher costs to build up intangible assets (such as training and know-how, which the CC has excluded).
- 5.28 In conclusion, the CC has not considered these factors when assessing whether the observed gap between profits and the cost of capital is significant. No allowance has been given for the chance the profits may have been lower in different periods. By looking at a short time period, the CC’s results are insufficiently robust for it to conclude that any firm is making persistent excessive profits. This error will mean that the CC is likely to overstate profitability and in any event make its conclusions unreliable.

There is significant uncertainty around the calculation of the WACC

- 5.29 The CC presents a WACC range of between 7.2% and 9.9%. This implies that the CC considers (i) that a range of WACCs is appropriate (which we agree with) and (ii) that it has been able to calculate the upper and lower bounds of this narrow range with precision (which we do not agree with).
- 5.30 Most economists and valuation experts acknowledge that the WACC cannot be estimated precisely and that there is a high degree of uncertainty around each variable in the WACC. Around each parameter, there is a wide margin of error.
- 5.31 In addition, most economists acknowledge that the WACC can be calculated in a number of different ways. The most common approach is to use the CAPM. However,

there are a number of other models used to calculate the WACC such as Fama French, APM, or the building block approach. The methods do not always yield similar results.

5.32 Within each of these methods, different variables need to be considered and estimated. For each variable, a number of issues need to be addressed. For example:

- risk free rates – what bond or bonds should be used as a proxy for the risk-free rate?;
- betas – what comparators should be used?, how many data points should the regression use?, what time period will the regression cover?, what assumptions are used to de-gear and re-gear the beta?;
- market risk premia – should a geometric or an arithmetic mean be used?;
- tax rates – should a marginal rate or effective rate be used?;
- gearing – should gearing be calculated using the market value of debt or the book value of debt, should gearing be calculated on actual values or target values?

5.33 In general, there is no single correct answer to the questions above. In addition, once a methodology has been selected, it must be acknowledged that each calculated variable will have high statistical errors. For example, the calculation of beta alone has high standard errors. Damodaran has determined the distribution of standard errors for beta estimates for U.S. stocks. He notes a high number of beta estimates have standard errors in excess of 0.50.⁷⁰ Hence, the true beta for many firms, with 67% confidence, could be plus or minus 0.5. With 95% confidence, this range increases by plus or minus one. Applying these errors to the WACC would increase the CC's range materially.

5.34 As a result, WACC estimates must be used with care. There is always some uncertainty around calculating the cost of capital. There is significant risk that the actual range of the WACC could be significantly larger than that calculated by the CC. The solution to this uncertainty is to account for the uncertainty by adopting a suitably wide range, and to take care when interpreting the gap between the ROCE and WACC. As explained above, this suggests that the gap needs to be significantly wide before a finding of excessive profits can be supported.

⁷⁰ <http://pages.stern.nyu.edu/~adamodar/pdfiles/papers/beta.pdf>, page 16.

Specific risk

- 5.35 The cost of capital measures expected future returns. Theoretically, the cost of capital measures only market risk (i.e. the risk that cannot be diversified away by holding a portfolio of shares) and not specific risk, such as the possible failure of the project. When performing a valuation or an investment appraisal, specific risks are normally modelled explicitly in the cash flows of the project (i.e. a probability-weighted cash flow). Hence a valuation or project appraisal is based on an *ex ante* cost of capital and on an *ex ante* set of cash flows. In this respect, the calculation is internally consistent and all risks are properly accounted for.
- 5.36 In a profitability assessment, the cash flows that are considered are *ex post* in nature and this potentially creates an inconsistency when compared to an *ex ante* cost of capital that has not been adjusted for specific risks. This can be explained by way of a simple example.
- 5.37 Let us assume that a discrete project can end in either success or failure with equal probability. The expected outcome is the probability-weighted outcome of both scenarios. If this project were repeated many times, then on average we would expect the weighted outcome. However, if the project turned out to be successful, then on an *ex post* basis it would appear to earn a return in excess of the WACC. Conversely, if the project failed, then, on an *ex post* basis, it would appear to earn a return below the project's WACC.
- 5.38 Hence, a comparison of an *ex ante* cost of capital to *ex post* returns without an adjustment for project failure fails to measure a range of specific risks that would normally be included in an investment appraisal exercise or in a price setting exercise. Oxera has noted the importance of this issue, and stated:

*"In profitability assessments of realised rates of return, the relevant cost of capital is the ex ante cost of capital — i.e. the cost of capital that was used in assessing the project at inception. This is particularly important for risky projects that carried a high likelihood of failure. The ex ante cost of capital has to be adjusted upwards to capture the inherent risk (the result is commonly known as a hurdle rate). When a competition authority is assessing returns that have been realised, a comparison of the realised rate of return with an ex post cost of capital that does not reflect the risk of failure of the project could lead to an overstatement of profitability."*⁷¹

⁷¹ Oxera Report, (http://www.offt.gov.uk/shared_offt/reports/comp_policy/off657.pdf) paragraph 7.9.

- 5.39 The practical (and perhaps only) solution to this issue is to increase the *ex ante* cost of capital to reflect specific risks, and to compare this to *ex post* returns. Oxera notes:

“it is common to see companies marking up the cost of capital when setting ‘hurdle rates’ (i.e. required returns) to appraise individual projects or investment plans (see Graham and Harvey, 2001). This premium accounts for project-specific risks, which are not reflected in the company’s cost of capital generated by the CAPM approach or other asset pricing models. One clear example where a mark-up is applied is for large investment projects with a high degree of asymmetric risk, i.e. when there is a relatively large downside risk of failure compared with the likelihood of success. The CAPM and other models do not capture such asymmetric risk.”⁷²

- 5.40 This is consistent with the “fair bet” principle applied by Ofcom in its review of next generation networks.⁷³ Ofcom states:

“Ofcom believes that the fair bet is likely to be a more relevant concept. An investment is a “fair bet” if, at the time of investment, expected return is equal to the cost of capital. This means that, in order to ensure that an investment is a fair bet, the firm should be allowed to enjoy some of the upside risk when demand turns out to be high (i.e. allow returns higher than the cost of capital) to balance the fact that the firm will earn returns below the cost of capital if demand turns out to be low.”⁷⁴

“When a firm makes an investment in a situation when demand may be highly uncertain, the firm’s actual achieved returns may vary significantly depending on whether demand for the services in question turn out to be high or low. Absent regulation, a firm would invest and bear the full risks of favourable or unfavourable demand outcomes, resulting in expectations of a specific return.

⁷² Oxera Report, paragraph 7.28.

⁷³ “Future broadband: Policy approach to next generation access”, Ofcom, 26 September 2007

⁷⁴ “Proposals for WBA charge control”, Ofcom, 20 January 2011, paragraph A8.27.

If the demand outcome was favourable then it may make significant returns and if it was unfavourable it may make significant losses. Given the range of possibilities on each favourable and unfavourable outcome, the firm would make its investment decision where the expected returns exceeded its cost of capital.”⁷⁵

- 5.41 It is clearly difficult to determine an appropriate allowance for specific risk. However, we noted that BMI’s WACC is assessed annually by a third party for use in its impairment reviews. During the Review Period, the specific risk included in this WACC calculation was [X]. At the very least, therefore, we consider that [X] should be included in the WACC calculated by the CC to account for specific risk.

Above average returns do not indicate excessive pricing

- 5.42 The CC has concluded that because 53% of the private healthcare market in the UK made returns above the WACC these firms made persistent excessive profits.⁷⁶ This means that the remaining 47% of hospital providers made returns equal to or below the WACC. The CC states that BMI, HCA and Spire:⁷⁷

“account for more than half (53 per cent) of the private healthcare industry, indicating that the industry as a whole is likely to be making excess returns on average.”

- 5.43 We disagree with the CC’s conclusion. First, even if approximately 50% of the market is making an excessive return (which we do not consider is the case), then this does not logically indicate that the market as a whole is likely to be making excessive returns. Second, there are many legitimate reasons for why firms can earn returns above the WACC. Third, as explained above, profitability may change over time. The CC itself recognises this in its guidelines:⁷⁸

⁷⁵ “Future broadband: Policy approach to next generation access”, Ofcom, 26 September 2007, paragraph 5.14.

⁷⁶ The CC does not define 53% of what. We assume as a proportion of revenues.

⁷⁷ Provisional Findings, paragraph 6.86.

⁷⁸ “Guidelines for market investigations”, CC, paragraph 117.

“In practice, a competitive market would be expected to generate significant variations in profit levels between firms and over time as supply and demand conditions change, but with an overall tendency towards levels commensurate with the cost of capital of the firms involved. At particular points in time the profitability of some firms may exceed what might be termed the ‘normal’ level. There could be several reasons, including cyclical factors, transitory price or other marketing initiatives, and some firms earning higher profits as a result of past innovation, or superior efficiency”

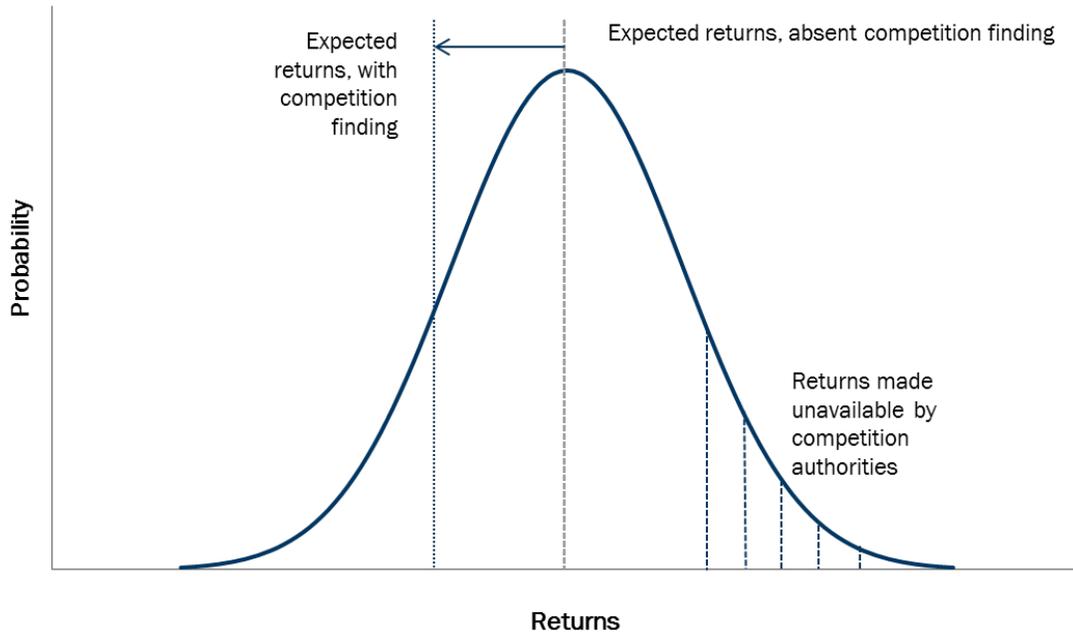
- 5.44 It is important to note that BMI’s financial data shows [×].
- 5.45 Fourth, it is unclear why the CC considers the relevant benchmark to be the “average” cost of capital. The cost of capital simply calculates the mean return in the market adjusted for risk. Statistical theory suggests that circa 67% of firms earn a return within one standard error of this mean and 95% of firms earn a return within two standard deviations of this mean. The key question, therefore is, at what point the return becomes excessive. Clearly, it cannot be a return within 1 standard deviation of the average, because up to 33% of firms earn this level of return. The CC does not explain why it thinks the average cost of capital is the appropriate benchmark. We explain below, that adopting this policy is likely to constrain future investment, with (adverse) consequences for quality of patient service over the long term. Quality competition is key to the interests of patients in healthcare as the CC has acknowledged in other contexts⁷⁹

The CC’s approach will starve the private hospital industry of investment

- 5.46 Firms invest because they expect to earn **at least** a normal rate of return on their investment. Firms condemned to achieving the average return as a maximum, will, by definition achieve returns less than the industry average over the life of the investment as any returns above the average will be constrained, but returns below the average will be allowed. This will act to discourage future investment in the private hospital industry. We illustrate this concept in the figure below.

⁷⁹ Joint Statement CC, OFT and Monitor: “Ensuring that patients’ interest are at the heart of assessing public hospital mergers”, 17 October 2013

Figure 5-2: Effect of constraining returns



- 5.47 This phenomenon has been recognised by academics⁸⁰ and industry regulators such as Ofcom. Ofcom accepts that forms of regulation may skew expected investment returns if regulation removed any super normal profits from an NGA investment. In turn, this would limit future investment. It stated:⁸¹

“This approach would cap the total returns that the firm could make if demand turned out to be high but force the firm to bear all of the losses in the event that there was virtually no demand”

- 5.48 This will have significant consequences in the market because firms would be not incentivised to invest. In fact, this form of intervention in the market would be even more constraining than utility regulation, where at least the regulator considers incentives to invest, and ensures that actual investments are allowed to earn a reasonable rate of return, without any risk of asset stranding. Indeed, there are a

⁸⁰ See, Excessive prices: using economic to define administrable legal rules, David S. Evans and A. Jorge Padilla, CEMFI Working Paper No. 0416, September 2004.

⁸¹ See, Ofcom, Future broadband Policy approach to next generation access, Consultation, 26 September 2007.

number of efficiency incentives that regulators offer regulated companies to allow them to outperform their WACC for a period of time.

Errors inherent in calculating ROCE

Sensitivity of the ROCE approach

- 5.49 Calculating the ROCE also relies on a number of assumptions. The ROCE is sensitive to the assumptions adopted. Like the WACC, there is not one unique approach to calculating the ROCE. In fact, the calculation is not stable, and it is sensitive to a range of subjective assumptions including inflation, the age of the assets and the approach taken to value assets. Any comparison of ROCE to WACC will be sensitive to the age of the underlying assets.
- 5.50 It is unreasonable to conclude that BMI has made persistent excessive profits when small changes in approach result in materially lower ROCEs. Perhaps the most material of these assumptions relates to the MEA value of assets. As detailed in Section 4 above, there are a number of different valuation bases. Each method provides a significantly different asset value. For example, Colliers International's DRC land valuation is circa [3x] higher than those provided by DTZ. The Colliers International's DRC building valuation is [3x] higher than the values used by the CC on average. Using market valuations yield even higher valuations of almost [3x] more.
- 5.51 The CC has not properly considered these competing asset valuations. It simply dismisses the higher valuations. However, this is contrary to best practice and contrary to the approach of an evidence led authority keen to cross check the robustness of its conclusions against the available evidence. For example, German law has adopted a significant excess approach to unfair pricing in a number of cases.⁸² Under this approach, a company's pricing policy is abusive, within the meaning of section 19(4) of the German Act against Restraints of Competition, if its prices *significantly exceed* the competitive comparison price. This high threshold is imposed in part to correct for possible errors when comparing the prices of the dominant firm to costs.
- 5.52 In conclusion, the CC has not given due regard to the evidence we have provided. Our evidence shows that more robust asset valuations reduce the ROCE materially. Our analysis also shows that small sensitivities to the CC's capital employed values reduce

⁸² See *Flugpreisspaltung*, Bundesgerichtshof, judgement of 22 July 1999, NVZ 2000, 326. A similar approach is taken by the Dutch Competition Authority. See D Geradin, — The Necessary Limits On The Control Of Excessive Prices By Competition Authorities — A View From Europe. *Tilburg University Legal Studies, Working Paper* (2007), p. 27.

the ROCE materially. On this basis, the CC is wrong to (and may not lawfully) conclude that BMI is making excessive profits. The CC has comprehensively failed to implement a sufficiently high evidence led threshold to correct for possible errors in its calculations.

The value of intangible assets

- 5.53 With the exception of some small central IT and bid costs, the CC has not ascribed any value to BMI's intangible assets. These assets include brand, know-how, institutionalised training, hospital licences and associated costs. Hence, the CC understates the value of economic capital employed and overstates ROCE. The CC's approach contains a powerful indication of bias against BMI.
- 5.54 In essence, the CC considers that the value of a private hospital is driven only by the cost of its large tangible assets. It ascribes no value to the service element of hospital activities. This is clearly wrong, and highlights a general issue with the ROCE methodology.
- 5.55 The ROCE methodology only provides stable calculations in highly capital-intensive industries, where tangible asset values are relatively high and intangible assets are relatively low. Most regulated, capital-intensive industries in the UK have prices set by reference to the level of capital employed (i.e. operating costs plus tangible assets x WACC), because in these industries it is the size of these tangible asset bases that matters and the contribution of intangibles and people based services is less important.
- 5.56 However, the ROCE methodology would not be appropriate in industries where value is derived in whole or in part from labour-based or intangible assets. For example, we would not assess the profitability of a law firm by reference to invested tangible assets. The CC chose not to assess the profitability of the accounting firms in this way during the recently concluded statutory audit market investigation. If a private healthcare provider had a model where doctors visited people in their homes the level of invested capital would be close to zero (on the CC's approach), which would result in extremely high levels of ROCE. This does not signal a competitive problem. It simply signals a problem with the profitability measure.
- 5.57 The capital intensity of the UK private hospital industry is lower than that of a regulated utility, whose profitability is set by reference to their capital employed. In 2011, under the CC's calculations, BMI had fixed assets of [x] and revenues were [y] (i.e. a capital intensity ratio to turnover ratio of [z]). If one compares this to truly capital intensive industries such as water, a much higher capital intensity ratio is observed. In

2012, for example, Severn Trent Water had fixed assets of £6,500m and turnover of £1,700m a ratio of 4:1.⁸³ This might indicate either that: i) the CC has understated the value of tangible assets; ii) has not adequately allowed for intangible assets; and / or iii) the ROCE is not an appropriate profitability measure for the private hospital industry.

- 5.58 Clearly, hospitals do have high levels of tangible assets, but that is only part of the value proposition. The CC acknowledges that its estimates of ROCE may be “slightly overstated” by not quantifying intangible assets.⁸⁴ However, the CC has not included a value for any intangible assets in its assessment of BMI’s profitability other than the small amount that BMI has been able to capitalise under IFRS.⁸⁵ The CC’s statement of “slightly overstated” is simply not credible.
- 5.59 The CC has not assessed the value of intangible assets from an economic perspective. It adopts a largely accounting perspective. This is the opposite of the approach that the CC has adopted with respect to valuing land and buildings. In each case, the CC has chosen the approach that would operate most aggressively against BMI. BMI has set out its arguments in relation to this point previously in its submission to the CC dated 6 April 2013.⁸⁶ In summary, the guidelines followed by the CC will understate the true economic value of these assets. The CC has confused the economic value of BMI’s intangible assets with the accounting treatment of intangible assets. Accounting standards tend to be conservative and adopt a cautious view in measuring intangible assets. The CC should not adopt a cautious accounting approach, but instead seek to determine the economic value of BMI’s intangible assets
- 5.60 We note that there is inconsistency with the CC’s approach with respect to the use of accounting data. The CC does not accept building values as per BMI’s financial statements, but if intangible assets are not included on the balance sheet the CC does not even attempt to determine an MEA value for these.
- 5.61 Ascribing a zero value to assets such as BMI’s brand, built up over decades, is clearly wrong. BMI invites the CC to carefully consider why an evidence-led decision maker seeking to fairly assess profitability would chose to do that? Even if the CC is unable

⁸³ Severn Trent financial statements.

⁸⁴ Provisional Findings, paragraph 6.263. The CC does not state how they are able to derive that ROCE might be “slightly overstated” as opposed to significantly overstated.

⁸⁵ This comprises the net asset value of internally generated computer software and bid costs.

⁸⁶ BMI Submission, dated 6 April 2013, paragraphs 3.30 to 3.38.

to estimate the value of these assets, due consideration should be given for this factor when considering any gap between the ROCE and the WACC.

The treatment of goodwill

- 5.62 The CC acknowledges that:⁸⁷
- “purchased goodwill is generally composed of two elements: the first is the value of intangible assets that were not separately identified on acquisition, while the second is the value of expected future economic profits of the business.”*
- 5.63 For the purposes of assessing profitability, the CC states that it wishes to exclude the latter, but not the former. However, the CC excluded all goodwill because it assumes *all* purchased goodwill represents super-normal profits. This is an extreme position in contravention of its own acknowledgement that purchased goodwill also contains some elements of intangible assets not separately identified on acquisition.
- 5.64 By excluding these assets, the CC is more likely to confirm a hypothesis that goodwill represents the purchase of excessive profits. However, this assumption is self-fulfilling and circular. The CC could have assumed that the profits were not super-normal, and that purchased goodwill should be included in the ROCE calculation. Under this set of alternative assumptions, BMI would not have a ROCE in excess of WACC.⁸⁸
- 5.65 A second alternative approach would have been for the CC to include a portion of goodwill in its assessment of ROCE. The CC has not adopted either of these two alternatives. The CC should consider why an evidence-led decision maker attempting to fairly assess profitability would take such an extreme position with respect to goodwill, especially when the approach generates a clear risk of pre-determination without any attempt to seek to test the robustness of this decision against the evidence.
- 5.66 Commercially, the CC’s approach does not make sense. If an investor pays more for the right to higher revenues, then he will not benefit if any excessive value is given away to the seller. In the CC’s scenario, only the seller would gain in the transaction.⁸⁹

⁸⁷ Provisional Findings, paragraph 6.264.

⁸⁸ See BMI submission dated 6 April 2013. Including goodwill leads to ROCEs of [\gg] even with no other adjustments to the CC’s figures.

⁸⁹ If there were many competing investors, the price would be bid up to where the successful bidder’s NPV equals zero.

The CC assumes negligible amounts of intangible asset value. If hospitals were merely investments in tangible assets, that required no investment in intangible assets, firms would not overpay for the assets, because the profit streams could be secured at lower cost (i.e. building a replacement). Put differently, BMI would never purchase an existing hospital, but would build them de novo instead. At a very minimum, one must consider the location of the hospital as a reason why a provider might pay more for a particular site. If the hospital is in the incorrect location it will not be able to attract staff, consultants, or patients.

- 5.67 However, it is clear that when a hospital is purchased, the purchaser is buying a collection of processes, knowledge, reputations, relationships and expertise. It also avoids start-up losses associated with low capacity and initial recruiting costs, agreeing contracts with service providers etc. All of this has value to the purchaser over and above the depreciated replacement cost of assets.
- 5.68 In summary, the CC has taken an extreme approach to assessing the intangible assets of BMI and this has led it to materially understate capital employed and hence overstate ROCE.

The CC has changed its methodology with respect to building valuation

- 5.69 In submissions dated 6 April and 25 April 2013, we noted that there were a number of arithmetic and modelling errors in the CC's analysis, which when corrected, led to significantly lower EBIT values.⁹⁰
- 5.70 In its preliminary analysis, the CC assessed building MEA value on an un-depreciated basis. The CC concluded that there were a number of fully depreciated buildings still in use and that significant capital expenditure maintained the asset lives.⁹¹
- 5.71 The CC now considers building MEA value on a depreciated basis. The CC calculates the MEA value of buildings based on the 2008 reinstatement cost as prepared for insurance purposes.
- 5.72 We acknowledge that the CC stated in its preliminary analysis that it "*may in due course consider a range of profitability estimates including those based on DRC of*

⁹⁰ EBIT is on average approximately [3x] lower each year in the Provisional Findings than in the preliminary analysis.

⁹¹ Preliminary analysis, paragraphs 47 and 48.

buildings".⁹² However, we have the following concerns:

- the analysis and methodology now adopted was not set out by the CC in its preliminary analysis;
- the CC has not provided a range of profitability estimates as previously indicated. Instead, the CC has selected the DRC methodology only, which inflates the ROCE. The CC has not explained why it now prefers the DRC method and why its previous methodology is no longer valid;
- had the CC continued to use the un-depreciated value approach, this would have produced an average ROCE of [x] (using its own numbers). This is some [x] less than the figure of [x] now put forward by the CC. This is a material difference, especially given the magnitude of the additional corrections we consider should be made to EBIT and with respect to asset valuations;
- we are concerned that the two different methods yield such different results. If the profitability analysis is performed correctly (with appropriate and consistently applied adjustments), it should yield similar results. If the methods provide different results, the CC should have due regard to all methods. If different methods show significant differences in results, then it might imply that either ROCE is not an exact measure of profitability, or that there are issues with some of the assumptions used and subjective judgments applied; and
- under the CC's current assumptions, a new entrant or an over-specified competitor would be allowed to charge prices considerably in excess of BMI as its asset base would have a higher value. Under the approach taken by the CC, an older hospital would have a higher ROCE, even if profits were identical. Under the CC's un-depreciated approach, all industry players were put on a level playing field.

5.73 This last point above can be illustrated by way of a simple example. Consider two businesses; both require an asset costing £1,000, which has an expected life of 10 years. One business has been in operation for one year, the other for five. Under the CC's approach, the first business would have a capital employed of £900 and the second £500. If both make a profit of £100 then the CC will calculate that the first business will have a ROCE of 11% and the second 20%.⁹³ This does not make sense

⁹² CC's preliminary analysis, paragraph 48.

⁹³ £100 / £900 = 11.1%, £100 / £500 = 20%

as both hospitals have the same profits and have invested the same amount of capital, the only difference being the time over which they operate. The CC therefore does not compare like for like and its approach benefits new operators such as Circle. Using an undepreciated replacement cost will assess the different industry players on a more consistent basis.

- 5.74 In the absence of an explanation of why the CC has changed its methodology there is a suspicion that the CC's changes were made to counteract legitimate corrections that lowered ROCE. This combined with the CC's other extreme choices in respect of profitability is gravely concerning. The CC should consider carefully what a reasonable and impartial observer would conclude from this.

Part II

[8]