

Response of



to

Private Healthcare Market Investigation
Local Assessments

11 November 2013
(NON-CONFIDENTIAL)

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[X]

BMI Healthcare Response to PFs: Local Assessments

1. Introduction

- 1.1 The CC's assessments of local competition underpin its case against BMI; it has provisionally found [§K] of BMI's 59 hospitals to face insufficient constraint. The evidence does not support this provisional finding.
- 1.2 The CC, despite having abandoned its previous categorisation of BMI's hospitals as solus, asymmetric duopoly, symmetric duopoly and subject to common ownership concern, still retains these distinctions for the purposes of remedies.
- 1.3 Specifically the CC intends to apply its divestment remedy to hospitals with common ownership concern – a term that has largely been dropped in favour of "clusters". This response focusses on the faults in the CC's local assessment of these hospital clusters and explains the reasons why these local assessments fail to support the CC's provisional findings of inadequate constraint.
- 1.4 The CC maintains that [§K] hospitals operated by BMI outside clusters are also insufficiently constrained. Again, the evidence does not support this provisional finding.
- 1.5 BMI has always acknowledged that some of its hospitals face limited local competition. BMI's persistent point however has been that these hospitals provide vital local services in markets where only one hospital is viable and that a thorough and reasonable look at market outcomes in these areas does not suggest consumers are suffering any detriment through excessive prices, poor investment, poor healthcare or other quality outcomes. In these areas therefore, the evidence shows BMI hospitals are sufficiently constrained. In relation to insured patients, PMIs negotiate access to these hospitals as part of a bundle where BMI is dependent on the volumes that PMI represents across its wider business.¹ They are constrained in respect of self-pay patients, due to the presence of the NHS as a free alternative. Self-pay patients are overtly trading off waiting times against price. Self-pay patients, as indicated by the CC's patients' survey, are willing to travel further than insured patients to a private facility from their home. Very few, if any, hospitals are solus for self-pay patients.
- 1.6 The OFT, CC and Monitor have made clear in their recent joint statement that the quality and the interests of patients is of fundamental importance to the assessment of competition in healthcare.

¹ AXA PPP response to the PFs, paragraph 2.66.

"The Office of Fair Trading (OFT), the Competition Commission (CC) and the sector regulator Monitor work together to ensure that the interests of patients are always at the heart of this process."²

1.7 BMI agrees. That is why it commissioned of its own initiative an econometric study by Dr Peter Davis (submitted to the CC on 11 January 2013) looking at the effect of solus hospitals on patient outcomes. This remains the only evidence before the CC in this inquiry that considers in a systematic way (or indeed, in any way) quality competition in market outcomes for patients.

1.8 That evidence shows that:

"(i) solus hospitals are typically in market areas with very much smaller local populations than non-solus markets and (ii) that small local populations are associated with lower bed- and theatre-utilisation rates and these in turn are associated with lower hospital margins. Thus solus hospitals will tend to have lower margins than an average BMI non-solus hospital because they are in markets with small local populations.

Since hospitals clearly have fixed costs which must be recouped, taken in the round the evidence does not indicate that there is a problematic degree of market power being exercised by solus hospitals."³

1.9 BMI revisits these points below at paragraphs 10.1 to 10.18.

1.10 In addition, those non-solus hospitals which are not in clusters and which the CC still considers to be insufficiently constrained are typically those that face a single competitor.

1.11 The CC's approach in these situations is based on bald assertion. It is not evidenced and a review of the evidence shows it to be wrong as explained below at paragraphs 10.19 to 10.28.

2. Clusters

2.1 The CC predicates its divestment case on clusters:

"We use the term "cluster where a private hospital operates two or more facilities in the same local area, such that the facilities have overlapping catchment areas.

A divestiture remedy would [] only be appropriate in those areas where we have competition concerns in which Clusters of hospitals are owned by the same operator."⁴

² "Ensuring that patient's interests are at the heart of assessing public hospital mergers" – Joint statement from the Office of Fair Trading, the Competition Commission and Monitor, 17 October 2013.

³ Paragraphs 20-21, "Do private healthcare providers have market power in solus hospital markets?", Peter Davis, Erik Langer and Stefano Trento, 11 January 2012.

⁴ Remedies Notice, paragraphs 23 and 25.

- 2.2 This statement belies significant confusion as to how clusters have been defined and used. This confusion is illustrated by two letters from the Treasury Solicitors on behalf of the CC:

*"the clusters have (at least thus far) been defined with reference to the CC's LOCI analysis."*⁵

It then elaborated on this and said in a letter shortly afterwards:

*"The CC has not used LOCI or any other concentration measure in a mechanistic way. In its local assessment, such measures have been used as filters. In the CC's consideration of possible remedies, it has, thus far, used LOCI to identify in the first instance those hospital clusters where a divestment remedy might be appropriate before considering in detail the local competitive dynamics in each identified area."*⁶

- 2.3 A review of the local assessment methodology in the Provisional Findings ("PFs") suggests:

*"For each hospital of potential concern, in assessing whether common ownership was a concern [the basis for clusters], we have taken into account the ownership and location of other nearby private hospitals or PPUs as identified in 6.104 and the network effect as measured by the difference between individual and network LOCI."*⁷

- 2.4 Taking these various explanations together, the CC's clusters analysis is apparently driven therefore by:

- (a) The use of LOCI as a concentration measure;
- (b) Followed by the insight the CC has derived from its innovation of "network" LOCI;
- (c) Followed by the "location and ownership of other nearby hospitals/PPUs" – i.e. a map showing the location of various facilities.

- 2.5 Essentially, therefore, at the heart of the common ownership concern is the CC's own network LOCI and a map of hospital locations.

- 2.6 The CC sometimes suggests, such as in its letter of 10 October 2013, that network LOCI is merely a "filter" i.e. further evidence has been applied to the results of this filter before arriving at a common ownership or cluster concern.

⁵ Letter from Treasury Solicitor to CAT 7 October 2013.

⁶ Letter from Treasury Solicitor to Shearman & Sterling (London) LLP 10 October 2013.

⁷ Paragraph 6.112(e).

2.7 The filter is extremely inefficient. The initial LOCI filter suggested that [redacted] out of 59 BMI hospitals were of potential concern. This number is very obviously far too high. If it were to truly function as a filter:

- (a) Bupa would not be able to delist [redacted] of these hospitals;
- (b) [redacted];
- (c) [redacted] original complaints to the OFT would have consistently reflected concern over a large number of BMI hospitals. From the disclosures made to date, they do not; and
- (d) The CC's bargaining analysis would have yielded a very clear result as to bargaining power. It did not.

Ramsay and Nuffield own 27 hospitals of concern yet they apparently do not earn excessive profits. Fairly considered on a non-discriminatory basis, BMI does not earn excessive profits either. In fact, Pruhealth, AXA PPP and Simplyhealth have all said they do not have a significant problem negotiating with BMI. This would be very odd if [redacted] out of 59 hospitals were of potential concern.

2.8 BMI would therefore expect the application of the "detailed local assessment" to result in a dramatic change in the number of hospitals caught. It did not. The working paper removed just [redacted] from the list – [redacted].⁸

3. Point at which evidence considered

3.1 There is a rich body of evidence at the CC's disposal, much of which contradicts the outcome of the CC's "filter", as set out in its PFs. The reason that this did not change the results of the "filter" as detailed by the CC in the working paper is because it was considered by the CC after the working paper was published. In respect of timing, the table below, sent by BMI to the CC in a letter of 31 July,⁹ illustrates that although BMI provided vast amounts of evidence at least 6 months before the working paper was published, this was not considered by the CC when preparing the working paper:

Relevant Date	Document	Point Arising
10 August 2012	BMI Response to Financial Questionnaire	BMI provided its investment committee minutes and papers. Detailed BMI's entry strategy and capital investment over six years in relation to individual sites.

⁸ The working paper also dropped concern about [redacted]. BMI had told the CC [redacted] were on the list of potential exits in any case, so there was no utility in pursuing the case against them, and [redacted].

⁹ [redacted].

11 September through 23 October 2012	BMI Response to the Market Questionnaire	BMI provided large quantities of information (including internal documents) relevant to local competition.
SIX MONTHS OF CC ANALYSIS		
21 May 2013	CC publish WP on Local competition assessment of hospitals of potential concern	WP states: <i>"In particular, in respect of each private hospital and any nearby private hospitals, we have assessed the factors listed below:</i> <i>(j) internal documents from the hospital operators (so far for hospitals with LOCI close to the 0.6 threshold, but the review is on-going);"</i>
24 May 2013	S&S write raising questions about WP	S&S ask <i>inter alia</i> which of the submitted internal documents the CC has used in respect of its analysis of BMI's hospitals
30 May 2013	S&S send chasing email	
7 June 2013	S&S send chasing letter to John Piggot	
11 June 2013	John Piggot letter	J Piggot says that the CC has not identified any BMI documents relevant to local competition
21 June 2013	BMI submit "Summary of Key Points"	BMI expresses great concern that the CC has presented a WP on local competition without having considered BMI's evidence. Provides extensive cross references to BMI's evidence already submitted.
28 June 2013	Chairman's letter	Chairman accepts that the CC failed to consider BMI's internal documents.
22 & 25 July 2013	Putback	BMI receives putbacks on local competition with references for the

		first time to the evidence BMI submitted in August, September and October 2012.
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- 3.2 This represents a major procedural failure. It meant that BMI's evidence had not been considered before the working paper with detailed local assessments was published. Indeed, BMI's evidence was not reviewed until the preparation of the PFs – apparently too late to actually change the CC's direction of travel which had been set by them. BMI therefore saw the treatment of this evidence for the first time in the put-back process. As the CC's Market Investigation Guidelines explain: "*the put-back process is separate from disclosure of the CC's developing thinking.*"¹⁰
- 3.3 Having accepted that it had arrived at conclusions in a working paper without having considered the relevant evidence, BMI expected the CC, as an evidence-led authority, to make significant revisions to the findings in its working paper in the light of the evidence.
- 3.4 However, the CC in its PFs arrived at *precisely the same substantive conclusion* in respect of *all* BMI's hospitals as it had in the working paper. The entire body of evidence¹¹ BMI had provided about its own business and the competitive environment in which it operates had made no difference *whatsoever* to the CC's conclusion. This is despite the numerous occasions in which not only BMI's evidence, but evidence from PMIs and other PHPs actually contradict the CC's conclusions. These are elaborated below in BMI's response to the local assessments.
- 3.5 More worrying still, the CC appears to have approached the BMI evidence with a view to "mining" it for elements that support its filter prediction and which support the view the CC had arrived at anyway. An example of this:
- [redacted]
- 3.6 In this example, the CC has sought out BMI internal documents that appears to support its conclusion but disregards [redacted] and the facts on the ground in order to sustain the CC's conclusion that this hospital is a "hospital of potential concern".

¹⁰ CC 'Guidelines for market investigations: Their role, procedures, assessment and remedies', April 2013, paragraphs 75 and 76. Put backs are intended to afford parties the opportunity to check factual accuracy and suggest confidentiality excisions.

¹¹ For example these documents included in response to section 2 of the market questionnaire response, Annexes 6 (BMI maps showing market penetration), 7 (catchment analyses), 12 (competitor analyses) and 13 (list of competitors and the commentary on same compiled after interviews with Executive Directors in all BMI's hospitals); and in response to section 3, Annexes 5 (catchment area) analyses for potential acquisitions), 6 (national competitor analyses), 7 (corporate review presentations) and 8 (BMI 5 year plans).

- 3.7 Why is this? There are only three options for how the CC has arrived at its local assessment conclusions; however, and with respect to the CC, two are unlawful and one is implausible:
- (a) The CC is applying a "filter" of its own design mechanistically and without regard to the countervailing evidence;
 - (b) The CC has pre-determined the outcome of the local assessments and has approached evidence with this objective in mind; or
 - (c) The CC has, with an open mind, fairly considered a large body of contemporaneous evidence it had not considered before. Having done so, it has reasonably found that its initial conclusions in respect of all its local market assessments were correct in all respects.

4. The appropriate evidential standard

- 4.1 BMI understands the intuitive appeal of "clusters". We understand why, when a decision maker is looking at a map with hospital fascia plotted on it, there are areas of the country where there appear to be concentrations of BMI hospitals. BMI also understands that such a decision maker may intuitively believe that by "dividing up" those clusters he may inject additional competition into the market place and that that would be a good and useful thing to do for consumers.
- 4.2 BMI would however also expect that decision maker to recognise that this observation is not enough [§]. The threshold for intervention is higher than that – in fact it is much much higher than that.
- 4.3 The CC must have evidence that common ownership causes an adverse effect on competition. Moreover, that that adverse effect on competition is resulting in poor market outcomes for *consumers*, not merely for BMI's counterparties and competitors whose commercial self-interest in [§] is obvious. The CAT has made clear that the more onerous and severe the intervention, the greater the confidence in that evidence must be before it can reasonably be relied upon.¹²
- 4.4 The CC's local assessments are, like other critical parts of the CC's analysis, far from providing even a reasoned case let alone one capable of carrying the weight the CC seeks to place upon it.
- 4.5 The CC has proposed divestment remedies to resolve this "common ownership concern". Such remedies involve forcibly depriving BMI of its lawful property rights [§] when BMI has done nothing wrong and broken no law. This is the most extreme and draconian power available to the CC. Truly exceptional care is required when contemplating such a step to ensure that the evidence supporting it is robust and the CC is therefore able to justify its decision to itself, the competition community in terms of its own professional

¹² CAT Judgment: Tesco v CC paragraph 137.

reputation, patients, the courts, media, government and UK healthcare and other investors. It must be able to defend its decision as reasonable and rational.

- 4.6 This task has been made far more difficult – if not impossible – by the CC's decision not to undertake any assessment of the PMI market. BMI has always considered this a significant mistake and encouraged the CC to seek an amendment to its terms of reference in its responses to the first Issues Statement¹³ and Annotated Issues Statement¹⁴. The PMI role as financial intermediary between consumers and hospitals is a critically important part of the value chain. There can be no understanding of the effect on patients/consumers of intervention in PH without understanding the nature, profitability, efficiency, behaviour and incentives of PMIs to pass through benefits conferred upon them through regulatory intervention.

5. **Reliability of Network LOCI**

- 5.1 The CC explains that: "*the clusters have (at least thus far) been defined with reference to the CC's LOCI analysis, which has been disclosed, as has the underlying data.*"¹⁵
- 5.2 LOCI is simply not an accepted methodology for measuring concentration. It has never been used in the UK before. Neither has it ever been used in a published decision of any competition authority globally. The measure is based on a single draft article that has not been published in a peer reviewed journal and carries a citation: "Rough Draft: Not for Citation or Quotation".
- 5.3 Leaving aside LOCI's lack of standing, neither is there any rational basis to consider that LOCI gives a useful proxy of market power. This is because there is no known economic model where LOCI would be a good proxy for market power – except the LOGIT model, which the CC accepts is not appropriate.¹⁶ To be useful proxies for market power concentration, measures must be justified by some accepted economic theory that explains the link between the measure observed and competition outcome. HHI for instance, a common concentration measure used by competition authorities around the world, is motivated by the Cournot model of competition.
- 5.4 The CC selected LOCI and has stoutly defended this choice through consultation round after consultation round. Rather than meaningfully engage with the comments of stakeholders, the CC has disregarded the near universal, consistent and strongly worded criticism from the professional economists participating in this case. The decision to rely on LOCI is and always has been an irrational one.

¹³ Response to the Issues Paper, paragraph 2.3(c).

¹⁴ Response to the Annotated Issues Statement, paragraph 4.4.

¹⁵ Letter Treasury Solicitor (acting for the CC) to the Competition Appeal Tribunal, 7 September 2013

¹⁶ PFs, appendix 6(4)-2 paragraph 7.

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

individual and network LOCI) of 0.2, and then grouped them together with any hospital owned by the same operator which has an overlapping catchment area.

- 5.11 The catchment areas therefore are used to determine the hospitals within the cluster. The CC's catchment areas are categorically not local geographic markets.¹⁷ But they are treated as if they were by the CC in the local market assessments. For instance, [X].
- 5.12 This methodology is unsound and pre-determines the cluster definition with no adjustment for other empirical or contemporaneous evidence.

6. Novelty of the "cluster" problem

- 6.1 This investigation has been on-going for 19 months. Prior to that the OFT investigated the sector for a year. Before that, [X] and others were evidently complaining to the OFT in an attempt to start a market study.
- 6.2 There has therefore been at least 37 months (over 3 years) for those complaining about the performance of the private healthcare market and hoping to extract benefits for themselves from the regulatory action to have focused on "clusters" of hospitals as a feature of the market/negotiations with insurers.
- 6.3 Instead, the focus of these complaints have been BMI's and others' ownership of "must have" hospitals. The meaning of this term has flexed depending on who used it and what regulatory assistance they were seeking – however, the kernel of "must have" hospitals has been based around two ideas:
- (a) Geographical "must haves": the idea that a private hospital is simply too far away from competitors for it to be adequately constrained. Such hospitals have come to be known as "solus" in the industry. BMI has always accepted it owns solus hospitals; and
 - (b) Hospital characteristic "must have", i.e., a hospital has particular characteristics or accounts for a particularly large proportion of PMI expenditure which increases PMI dependence on it. This concept has never been adequately articulated – it still has not been. BMI therefore has not and is still not in a position to respond to any such allegation. BMI does not accept that any of its hospitals are "must have" in this context.

¹⁷ PFs, paragraph 5.64: "The catchment area around a hospital reflects the area from which the hospital draws the majority of its patients and does not necessarily fully reflect patients' willingness to travel in response to a small change in the price or quality of the services provided by the hospital they have attended. This may result in geographic markets defined on the basis of catchment areas possibly being too narrow in some instances. However, as explained below, we have considered in our local competitive assessment the constraints on each hospital, whether arising within or outside the hospital's catchment area."

- 6.4 These two types of "must have" hospital were noted in the OFT's MIR decision.¹⁸
- 6.5 Hospitals with these characteristics were the source of local market power complained of to the OFT. Such hospitals also formed the core of the OFT's concern about local market power in its MIR. No reference is made about "clusters" of hospitals, or anything analogous. This is striking. The complainants are all sophisticated commercial entities advised by large law firms with competition expertise. They would be well aware of the intuitive appeal of a competition argument built around "clusters". They would also be aware that this would be a route towards divestiture remedies. If this could be expected to resolve the alleged competition issues complained of, there is every reason to believe the complainants would have raised it in terms. But they did not. Indeed, the fact that they did not is not merely a tactical continuity error in gaming the investigation that they themselves started, but it is wholly consistent with the evidence and history of the bargaining framework as discussed below. The reason PMIs did not complain about "clusters" is that they do not exist in the market as experienced by those who work in it.
- 6.6 This illustrates a tension at the heart of the CC's case. The insurers as a group consider that BMI's market power comes from solus hospitals. The CC considers it also comes from clusters but then, oddly, puts solus hospitals into those clusters.¹⁹
- 6.7 The CC in the local assessment suggests there are monopoly suppliers, yet they can still be part of a problematic group – *"as they give the group greater incentives to, for example, worsen the quality of service by enabling the group to capture some of the lost business from the hospitals worsening the quality and services"*. A solus hospital is typically described as such because it is the only hospital in a given local market. However, by using the argument above to include solus hospitals in a cluster, the CC anticipates that there is diversion (i.e. substitution) between the solus hospital and others. This observation has important consequences for the CC's approach to catchment areas and patients' willingness to travel. If patients in solus areas will travel (or could travel) out of that solus area to another hospital, it suggests that the hospital is a) not a local monopoly and b) that substitutes located outside the catchment area are important.
- 6.8 The CC says that substitutes outside the local area are important to competition as implied by the CC's justification to include solus hospitals in clusters. In fact, they are so important that a divestment is warranted within clusters on that basis. The CC must recognise that this undermines its rationale for finding local market power on the basis of narrow catchment areas, distance and hence insufficient constraint on BMI's hospitals.

¹⁸ OFT Report on the market study and final decision to make a market investigation reference, paragraph 1.13.

¹⁹ Examples include [X<]

6.9 The approach of focussing on the two types of "must have" hospitals continued into the CC investigation. The PMIs and Nuffield, in their initial submissions, highlighted their view that PHPs obtain market power as a result of ownership of "must have" hospitals as defined above:

- *"We highlight some of the main issues that we believe the CC should take into consideration in its inquiry..."*
 - *Competition between PH providers – the impact of solus and "must have" hospitals..."* – Aviva
- *"There are limits to the ability of PMI providers to exercise buyer power due the control of PH providers over the patient journey, the need to have access to key ('must have') hospitals"* – Bupa
- *"Furthermore, as a result of PMI market concentration, the buyer power of the larger PMI providers gives them the ability to exert excessive price pressure on other PH providers who do not possess a critical mass of 'must-haves' to exert any bargaining power"* – Nuffield

6.10 The CC adopted these complaints and included them in its issues statement published in June 2012:

"Several factors may result in a hospital operator holding local market power in a particular area. These include:

- (a) *A limited number of rival hospitals nearby;*
- (b) *A limited number of rival hospitals nearby that offer or specialize in a particular treatment; or*
- (c) *A limited number of rival hospitals nearby with significant spare capacity."*

6.11 The source of local market power included a limited number of rival hospitals nearby ((a) above). With hindsight, this could be understood to encompass clusters. At the time, however, it was quite clear that this was intended to capture the concern the OFT had expressed about solus hospitals. This is reflected by the fact that, for instance, the CC did not ask a single question about clusters in the market questionnaire – despite a consultation on the questions to be asked.

6.12 There was no explicit mention of the CC's cluster theory until the AIS in February 2013. At this point, the CC had decided to use LOCI as its concentration measure. It also came up with the idea of adjusting individual hospital LOCI to account for network ownership.

6.13 The CC described this adjustment as "simple and intuitive"²⁰:

²⁰ Annotated Issues Statement, Slide 21, Appendix B Annex 1.

Methodology (VIII)—market shares



- Caveats to the market share measure
 - Ignores the potential competitive constraint posed by hospitals for which we do not have invoice records
 - LOCI calculated for 173 hospitals
 - Missing invoices for remaining 50 hospitals, 8 of which are private general hospitals (i.e., not PPU's, and not specialized)
 - Likely to be smaller hospitals and so the magnitude of missing invoices may only be limited
 - The modification for network ownership is a simple and intuitive approach that we have proposed
 - Other, significantly more complex, modifications are possible (e.g., as motivated by the theoretical LOCI interpretation)

Annotated issues statement - Appendix B

Slide 21

6.14 Following the AIS, the CC then started to warm considerably to its network LOCI and related cluster or common ownership concern. BMI's hearing in March 2013 contained a number of questions about clustering, surprising at the time as up to this point the focus had always been on the competition that each hospital faced in its local market. There had been no suggestion that BMI exercised market power over a wider "nearby local area" or similar term as a result of ownership of a cluster of hospitals. BMI's main PMI negotiator answered this question clearly:

[REDACTED]

[REDACTED]

6.15 By the time of BMI's hearing on 27 March 2013 it was therefore clear the CC was trying to collate real world evidence about the competitive harm "clustering" represents to support the intuition network LOCI appeared to be suggesting.

6.16 The difficulty was (and remains) that in the real world, no one has ever referred to a hospital provider having a cluster of hospitals in "the northern edge of Greater London" or any other "nearby local area" the CC refers to in its local assessments. The terms used, including the "nearby local areas" the CC cited were meaningless in the real life of the sector, as BMI's questioning of where these terms had come from and what their meaning was when the local assessments were issued, illustrated:

"The CC says that 'common ownership of several hospitals in nearby local areas tends to undermine constraint from other operators in a local area' – what does that mean? How big are the 'nearby local areas'? Is that the same as catchment areas? Do catchment areas of these hospitals have to be contiguous? If so what are the boundaries of the 'nearby local area'?"

*How has the CC included some hospital catchments and excluded others?
On what evidential basis have these decisions been made?"²¹*

- 6.17 These questions were asked on 24 May, three days after the CC's cluster analysis was revealed. Most of these questions remain unanswered even now.
- 6.18 As BMI and indeed other market participants have explained, what matters for competition are the competitive conditions each local hospital faces. For instance, we assume the CC asked the same sort of questions during the PMIs' hearings about the role of clustering in negotiations. If the hearing summaries are accurate, Bupa, Pruhealth, WPA, Aviva and Simplyhealth did not refer to it. BMI requested the actual transcripts of these hearings on 30 September 2013 amongst other things to verify this point.²² This request was refused by the CC.
- 6.19 [X], although it did not think BMI had in fact sought to leverage this strong position. There is no mention of clusters of hospitals. Does that not appear odd? The CC is anticipating forced divestitures of BMI's assets on the basis of its "cluster" and common ownership concern – yet this was not considered of sufficient importance for any major insurer to even mention in their hearing?

6.20 By the time that the local assessments working paper was published, [X].

6.21 [X]

7. **Distinction between local competitive assessment and clusters**

7.1 The local competitive conditions a hospital faces (which BMI has always accepted is relevant) are different from the CC's clustering theory.

7.2 This is best illustrated by an example: [X].

[X]

7.3 The question in the industry and that is relevant in price setting and negotiations is whether each hospital is sufficiently constrained (i.e. do customers have an alternative they would switch to in response to a SSNIP or quality equivalent). The evidence shows that they do for reasons described in paragraph [X] below, but this can be summarised as:

- (a) Bupa de-listed [X] hospitals in the cluster naming substitutes for each of the hospitals in the cluster. Recall that delisting removes Bupa's *entire* demand from these [X] hospitals²³ and shifts it to competitors

²¹ Email from James Webber to Christiane Kent dated 24 May 2013.

²² Letter from James Webber to John Pigott dated 16 September 2013.

²³ [X]

avoiding any remaining BMI hospitals within this "cluster" in its entirety²⁴. Imagine this in the context of the *Airports* inquiry. British Airways had been able to switch their *entire* demand – not just at LHR but at LGW and STN as well to – say CDG, Schipol, Luton, Southend, LCY;²⁵

- (b) In undertaking this delisting Bupa did not increase its referrals of patients to any other BMI hospital. In fact the list of alternative hospitals (to those it delisted) Bupa published on its website for its subscribers excluded any reference to any other BMI hospitals;
- (c) [REDACTED];
[REDACTED]
- (d) BMI has provided business plans, catchment area analyses, PMI negotiation scenario planning, investment cases, consultant incentive and JV arrangements all prepared in the ordinary course of business and all of which refer to the presence of effective competition to each hospital in the cluster;
- (e) [REDACTED], each of these hospitals has at least one substitute hospital within its catchment area even on the conservative basis used by the CC;
- (f) [REDACTED];
- (g) The PMIs have complained about BMI's market position in certain local markets [REDACTED] deriving from "solus" and "must have" hospitals. There has never been a complaint about BMI clustering these hospitals;
- (h) BMI has never presented these hospitals as a single "cluster" to PMIs. The CC has reviewed and found no evidence of BMI ever using its common ownership of these hospitals in insurer negotiations; and
- (i) The [REDACTED] has been subject to new entry, [REDACTED].

7.4 The CC's cluster theory anticipates interactions between local geographic markets in a wider "local area". The Remedies Notice says: "*We use the term cluster where a private hospital operates two or more facilities in the same local area, such that the facilities have overlapping catchments.*"²⁶

7.5 The difference between the local competitive assessment and the CC's cluster theory is highlighted by the presence of solus hospitals in clusters. Some of these hospitals are, in the CC's case, inadequately constrained because they

²⁴ Bupa did not shift this demand to alternative BMI hospitals.

²⁵ The CC had a large body of evidence that it was not possible for airlines to substitute cluster airports for non-cluster airports, see paragraphs 3.117 to 3.119 *Airports* Final Report.

²⁶ Remedies Notice, paragraph 23.

face no local competition in their local market as there are no other hospitals nearby, i.e., not merely no rival hospitals. [X] is an example of this, as is [Y].

- 7.6 This contradicts the approach that the CC has taken to assessment of local competition. In this local assessment, the CC has consistently relied on its LOCI calculations and catchment area definitions. The CC has ignored constraint from outside the catchment area, where the catchment of that hospital does not overlap. Even where there is overlap, the CC has always dismissed as ineffective the constraint from a competitor whose fascia sits outside the BMI catchment. The cluster approach therefore directly undermines other aspects of the CC's local assessment.
- 7.7 The failure of this "cluster" approach to properly capture local constraint is illustrated by slide 20 of AIS, Appendix B Annex 1. Consider the following stylised map:

	Nuffield	
BMI	Overlap Area	BMI
	Spire	

- 7.8 Each BMI hospital has focused its competitive response on the Spire and Nuffield hospitals. Even so the catchments of the two BMI hospitals overlap in the "Overlap Area" and are therefore a cluster on the CC's definition. The network LOCI of each hospital will obviously be higher than an individual hospital's LOCI²⁷ as both hospitals are pulling patients from the Overlap Area. The delta between the individual and network LOCI represents the CC's "network effect" from common ownership on the CC's analysis.
- 7.9 There is no reason to believe however that each BMI hospital above is not adequately constrained by the Nuffield and Spire hospital they each face. To prove this, the CC would have to consider evidence of market outcomes. Indeed the CC's guidance anticipates this need to focus on "market outcomes"²⁸. The evidence of market outcomes as a result of clusters shows there is no adverse effect on competition.

²⁷ See PFs, appendix 6(4)-23.

²⁸ 'Guidelines for market investigations: Their role, procedures, assessment and remedies', paragraphs 103 to 105.

Market outcomes

103. Outcomes of the competitive process in their different forms in a market—eg prices and profitability, levels of innovation, product range and quality—can also provide evidence about its functioning. Evaluating these outcomes helps the CC determine whether there is an AEC and, if so, the extent to which customers may be harmed by it, ie the degree and nature of 'customer detriment'. This can be an important factor in any later consideration of possible remedies.
104. Prices and costs are among the more observable and measurable outcomes and an analysis of these may be useful in quantifying the extent and nature of competition and can be helpful in measuring customer detriment. However, the other, less-quantifiable factors, such as quality and innovation, are no less important to customers.
105. Although the outcomes of the competitive process may differ in character, there may be linkages between them, and the CC does not therefore consider each in isolation. The extent to which prices respond to changes in costs and the question of whether those costs are at an efficient level, for example, may have implications for a firm's profitability, and the level of investment may have implications for efficiency and product or service quality.

8. Market Outcomes

8.1 Looking at this evidence of market outcomes relevant to its cluster analysis:

PCA:

"We have concluded that operators in relatively more concentrated areas, thus facing insufficient competitive constraints have market power in respect of self-pay patients".²⁹

- 8.2 This conclusion is wrong. As we explain in our response on PCA, evidence in the CC's PCA analysis, even as adjusted, would not allow a rational evidence-led authority to conclude as above. It is just not possible that the CC can find a relationship between price BMI charges and the level of local concentration, based on the evidence before it.

"the flaws in the CC's work render it profoundly unreliable as a basis of establishing the relationship between price and concentration in local markets. In our opinion, the CC simply cannot rationally place any evidential weight on the econometric results presented in the PCA"³⁰

Insured Price Analysis:

"We found certain characteristics of hospital portfolios, including in particular there being an insufficiency of competitive constraints on

²⁹ PFs, paragraph 6.202.

³⁰ Peter Davis, Erik Langer and Andy Parkinson – Compass Lexecon.

*average at a local level were associated with [emphasis added] high levels of insured prices at a national level."*³¹

- 8.3 This analysis is not evidence of adverse market outcomes. As the CC accepts *"these findings on their own did not demonstrate that an insufficiency of constraint at a local level caused higher insured prices"*.
- 8.4 This outcome was anticipated by the CC staff team in email correspondence in June 2013. BMI's solicitors remarked then:

*"In your email below, the CC acknowledges that its work on insurer pricing is unlikely to be of assistance to the inquiry "in isolation". It is reassuring that the CC recognises this. Even so, the CC must be careful that **any analysis (including this work) that it wishes to give any weight to whatsoever** in substantiating a theory of harm as part of the "wider assessment" **must be robust enough to be treated as evidence**. To be clear about what we mean by this: **it is not enough to accept issues with this particular workstream but then, for instance, to simply note in the provisional findings that the conclusions are anyway consistent with other pieces of work which support theory of harm [x]**. If this work is not robust it cannot reasonably be said to support the relevant theory of harm at all, i.e. the appropriate inference is that it does not support the theory of harm. The conclusions of work in these circumstances cannot be included (however tacitly) in support of the posited theory of harm during the CC's wider assessment."*³²

- 8.5 Unfortunately, this is precisely what the CC did in the PFs. Having acknowledged that insurer prices are not evidence of adverse outcomes the CC says:

"These findings [on insurer price]: are consistent with HCA, BMI and Spire having market power in negotiations with PMIs".³³

- 8.6 The reality is that insured price analysis does not bear any evidential weight. It does not therefore assist the CC in showing adverse market outcomes. This difficulty is amplified by the CC's attempt to support its case by reference to both bargaining and insured price analysis – neither of which are evidence on their own but each is pointed to the other to justify the CC's conclusion on the basis of "consistency".

Evidence from negotiations in respect of local assessments

- 8.7 The CC's claim for this is merely that the negotiations show *"the position of hospital operators in one or more local markets is important"*. This is self-

³¹ PFs, paragraph 6.290.

³² Email Webber/Kent dated 21 June 2013.

³³ PFs, paragraph 6.248.

evident. Access to hospitals which are desirable and local to patients are what BMI and its competitors have to sell³⁴.

8.8 This rather bland statement says nothing about clusters at all – and for good reason.

8.9 Not a single insurer negotiation, in the entire timeframe that the CC has analysed, has made reference to clusters of hospitals. [X]:

[X]

8.10 [X]

8.11 [X]

8.12 [X]

BMI's strategy for investment

8.13 One of the CC's theories of harm is that common ownership of a "cluster" of hospitals may result in a reduced quality of service for patients, either from BMI's ability to leverage a cluster in negotiations with insurers, or because hospitals within a cluster will absorb any patients choosing to leave an inferior hospital in that same cluster. This theory is not supported by the evidence. [X]

8.14 The CC has no direct evidence at all for adverse market outcomes arising directly from BMI's ownership of clusters of hospitals, whether through impact on self-pay and insured pricing, or on quality of service.

8.15 That said, as acknowledged at the beginning of this paper, hospital clusters have intuitive appeal as a competition issue. Why is it therefore that this intuition does not bear out in reality in market outcomes? What is the alternative explanation? This takes us to the CC's local assessments.

9. Summary of BMI's critique of the local assessment

9.1 The analysis below is organised around the clusters indicated in the CC's Remedies Notice, and by reference to the factors to which the CC purports to consider in its local competitive assessments (at PFs paragraphs 6.105 et seq – in particular the subheadings at paragraph 6.112 - and Appendices 6.7 and 6.8 of the PFs). The use of such headings is purely for the sake of analysis, and it should not be construed that BMI agrees with the use of the concept of clusters or the manner in which the CC has grouped the hospitals.

9.2 BMI's response to the local assessments is organised around the hospital "clusters" indicated in the CC's List of Hospitals for Potential Divestment.³⁵

³⁴ Private Healthcare Market Investigation – CC Surveys of Patients November/December 2012, slide 43.

- 9.3 In its PFs, the CC sets out the factors it considers relevant when assessing the extent of competition faced by each hospital of concern: hospital characteristics, characteristics of the local area, documentary evidence and parties' views.³⁶ BMI agrees that this is the right framework for the CC's assessment. However, the CC has assessed these characteristics in a mechanistic (and inconsistent) manner, without application to the particular fact pattern around a local area. This means the CC fails to assess the choices facing patients when deciding which hospital to visit and consultants when deciding which hospital to practice in.
- 9.4 In the remainder of this Annex, BMI highlights, in relation to each hospital on the divestment shortlist, how the CC's conclusion that it is insufficiently constrained results from an incomplete analysis, which only partially follows the methodology set out in the PFs. The reason the evidence does not reflect the cluster intuition is because each hospital is adequately constrained.
- 9.5 In particular, the CC's approach manifests the following general failures:
- (a) Inconsistency in choice of a comparison metric – In assessing an individual BMI/competitor hospital's characteristics in its analysis of competitive constraints (e.g. size, proximity, range of specialties, NHS provision, common ownership etc.), the CC has failed to explain the relevance of these factors in the context of the evidence. This was a strong criticism made of the local assessments working paper³⁷. The CC has responded by listing a large number of factors and discussing how they might theoretically be relevant to local competitive interactions in the PFs³⁸. This generic listing is helpful but it is not sufficient. The CC is required to apply these factors to the specific facts present in a local assessment.
 - (b) Failure to weigh evidence according to the facts – The CC does not weigh or treat these factors consistently when analysing the constraint exerted by a competitor. Neither does it explain the basis for inconsistent treatment. Failing to explain why factor A is decisive in one situation but not another illustrates powerfully BMI's point about predetermination made at paragraph 3.7(b) above. The CC "cherry picks" factors helpful to the view that a competitor exerts insufficient constraints upon BMI.
 - (c) Failure to allow evidence to lead to the conclusion. BMI notes again that the CC's local assessments have *not once* been altered as a result of the CC's review of BMI, or indeed any other, contemporaneous

³⁵ Sent by Megan Stewart on 28 August 2013 at 18:08.

³⁶ PFs, paragraphs 6.105 et seq (in particular the subheadings at paragraph 6.112) and Appendices 6.7 and 6.8.

³⁷ BMI Commentary on the CC's Detailed Assessment of the Local Markets of Concern (outside London), 27 June 2013, paragraphs 3 and 4.

³⁸ PFs, paragraph 6.112.

evidence. BMI assumes that even if the CC affirms its PFs in the final report, it will be advised to offer at least a couple of examples where the local assessment evidence alters the outcome of the network LOCI filter as applied in the working paper, in order to help 'appeal proof' the decision. For completeness, this will not alter the clear pattern BMI identifies, or the fundamental defect in local assessments arising from their having been approached in reverse. Evidence has been used selectively by the CC to justify prior conclusions. The CC has not allowed the evidence to lead to the conclusions. The fact that there is not a single instance where the enormous body of contemporaneous evidence – that was only read after the working paper³⁹ - has overturned the initial conclusions in a working paper that were based overwhelmingly on the obviously over-inclusive network LOCI filter serves to demonstrate this. A wholesale change of approach is needed to overcome this unusual and exceptionally serious problem; a few token examples will not suffice. Having raised this problem repeatedly with the CC [§] since the first local assessments were published in May, BMI unfortunately has no confidence that the CC will have the time or inclination to make the necessary change now. Nevertheless, the detailed response to the CC's local assessments in below provides further recent evidence in the form of internal documents. The CC must take this new evidence into account, especially since they directly rebut limbs of the CC's local assessment.

- (d) Failure to recognise or account for data limitations – There are limitations to any assessment which relies on any, some or all of these factors as determinative, given the nature of the information that the CC has at its disposal. In particular, the dataset is characterised by incomplete information on hospital size metrics, catchment areas based on only 80% of private insured inpatient episodes (which, even if 100% of private insured inpatient episodes were to be considered, typically only account for less than [§]% of BMI's total patient episodes) and a competitor set that is incomplete specifically in relation to PPU's managed by the NHS. The CC cannot rely on any one of these factors as determinative in isolation when assessing the constraints against each hospital – yet this is frequently the approach;
- (e) Failure to consider factors relevant to observed outcomes – The CC's analysis of local area characteristics is limited entirely to common ownership concern (illustrated by network effect LOCI) or proximity to a city. There is no evidence that the CC has considered fairly – in relation to each hospital – the type of population in areas (in terms of estimated private patient episodes), road network and transport connections, population size, population distribution, NHS locations, public and political attitudes to private health, commuting patterns, evidence of

³⁹ See table at paragraph 2.8 whereby the Chairman accepts that the CC has – as at 28 June 2013 – failed to consider BMI's internal documents - over one month after publication of the CC's working paper.

consumer habits and preferences from the CC's own surveys, robustness of conclusions to differing catchment areas based on broader patient types or catchment areas based on centres of demand rather than hospitals;

- (f) Failure to consider internal documents fairly or at all – The CC often determines that internal documents are inconclusive even where, considered fairly, they are quite obviously supportive of sufficient constraint. For example, [3<].

9.6 The majority of the CC's analysis pertains to hospital characteristics (range of specialties offered; availability and type of ICU; hospital size by total admissions; proportion of patients funded by the NHS; location and distances between hospitals; and size of the catchment area in miles and the extent of any overlap between catchment areas), which the CC has analysed in a very mechanistic way which is inconsistent between hospitals. The analysis is consistent however in that factors that work to the detriment of BMI are accorded more weight in any given scenario than those that support BMI's arguments. The following are metrics or hospital characteristics the CC has either considered inconsistently, relied upon without sufficient evidence or reasoning or where the CC has failed to consider the relevant issues.

9.7 **Size:** The CC often relies on the size of a hospital in determining the strength of the constraint it exerts upon BMI. However, the CC offers no explanation – based on a standard approach to competition – why the relative size of hospitals is relevant in the absence of capacity constraints.⁴⁰

The CC has the data but has not assessed whether competitors are capacity constrained or explained how a smaller hospital (by admissions and/or revenue) is less of a constraint on a larger hospital (by admissions and/or revenue) if it has the capability and capacity to treat significant additional volumes. BMI has seen no evidence to suggest that any competitor outside central London is capacity constrained. The CC considers it is entitled to ignore the presence of excess capacity unless the parties can bring forward specific evidence of capacity affecting price. This misunderstands the CC's role. The CC has to show why it is rational and reasonable to ignore spare capacity that BMI's rivals hold whilst arguing those rivals are too "small" to offer a constraint to BMI. It is for the CC to prove its case, not BMI to prove a negative.

Separately, although the CC has stated that no measure of size is determinative,⁴¹ on occasion the CC represents a competitor hospital as smaller than BMI, although on closer assessment it may be larger than BMI on one or all measures. The CC has not explained which size criteria (volumes or revenues) have more weight when evaluating size and why it

⁴⁰ CC Guidelines for market investigations: their role, procedures and remedies, April 2013 paragraphs 196-197; EU Horizontal Merger Guidelines paragraph 187.

⁴¹ PFs, paragraph 6.107(c).

considers in any given situation why the criteria that presents BMI as the "larger" (for which read stronger) competitor is the one the CC selects.

The CC cannot, without more evidence, use size as a determinative factor in assessing the competitive strength of a competitor. There is no rational basis for doing so. As discussed below, the CC is consistent in selecting the measure that is most detrimental to BMI.

- 9.8 **Location and distance:** The CC has stated that its definition of catchment areas is conservative.⁴² Conservative in this context means it will operate to underplay competitive constraint to BMI's detriment. The CC's catchment areas only take into account 80% of private insured inpatient episodes. However even 100% of private insured inpatient episodes would typically account for fewer than [X]% of the patient episodes at a given hospital. The CC also uses road miles rather than drive times, although the latter is the industry standard⁴³. In fact, the CC's patient survey suggests that self-pay patients travel 35% further on average than insured patients, another factor which makes the CC's catchment areas – based exclusively on insured patients - even more conservative. The CC says that it considers the competitive constraints provided by hospitals located inside and outside the hospital's catchment area. Despite this acknowledgement in theory, in practice the CC effectively treats the catchment area as a 'hard boundary' – either ignoring or dismissing constraints outside it. The CC often relies heavily on the limited size of the catchment overlap to dismiss a competitive constraint. [X].

BMI commented in its response to the AIS on the limitations of determining a hospital's catchment area by reference to the distance travelled by 80% of the hospital's patients. Firstly, BMI noted that due to the high fixed costs incurred by hospitals, revenues attributable to the 20 per cent of patients falling outside this catchment area could make a significant impact on the profitability and viability of the hospital. Secondly, BMI commented that the additional 20 per cent of patients not included in the CC's assessment may also be important in that they may represent those customers whose business is most immediately contestable, particularly where they are the closest to competing hospitals.

These considerations appear to have been reflected by the CC's acknowledgement that these factors would result in "conservative" catchment areas – welcome so far as it goes - but it has made no difference to the actual application of catchment areas in practice.

- 9.9 **Catchment areas are not geographic markets:** The CC has not defined geographic markets in this case. This is deliberate as it is one of the main purported advantages of the LOCI concentration measure.

⁴² PFs, appendix 6(5) paragraph 6.

⁴³ BMI also notes the CC is disparaging about drive times in this inquiry but has had no problem using them in its Poole/Bournemouth merger decision (Final report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, paragraph 5.58).

Despite this, and consistently throughout its local market assessments, the CC has treated catchment areas as if they were geographic markets. For instance, [redacted].

A catchment area is a snapshot of competition – the shape and size reflects the outcome of the local competitive environment around a hospital (for [redacted]% of a hospital's volume). The catchment area is often determined by the presence of competition. It therefore does not (and cannot) reflect the geographic area within which the relevant substitutes for a given set of customers are situated. The reason for this is that a smaller catchment area is consistent with BMI's footprint being constrained by a competitor. It is unlikely to attract many episodes from a postcode near a competing facility – this postcode is therefore unlikely to be in the nearest 80% of its insurer-funded inpatients. A smaller catchment, even if it is small because of the presence of effective competition, would also be likely to reduce the number of competitors within the catchment and the extent of catchment overlap with competitors – both factors the CC uses as evidence to show limited constraint. The CC's use of catchment areas to delimit geographic range of competition is therefore circular.

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

[redacted]

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

Appendix 1 contains an analysis of catchment area sizes in comparison to the distance to the nearest local competitor, as well other flaws of using catchment areas as geographic markets (for example, it does not take into account constraint faced by a competitor due to *quality* of services).

- 9.10 **Range of specialties:** The CC has stated, correctly, that there is a high level of supply-side substitutability between hospital specialties.⁴⁴ PHPs are able to increase their range of specialties should they choose to, subject to the availability of qualified consultants and the demand for it. Indeed we have explained in the tables below exactly this occurring in respect of the HCA Christie Clinic in Manchester which is recruiting consultants to expand from cancer services into other specialties using common equipment. The CC has not provided any evidence that there is a lack of consultants in any specialty, nor evidence that it would take a high⁴⁵ level of capital expenditure or indeed

⁴⁴ PFs, paragraph 5.31

⁴⁵ "High" in a relevant sense – i.e. sunk investment relative to the expected return or project risks.

long for a PHP to adjust in order to be able to supply these services. The CC's frequent comment that a competitor offers a narrow range of specialties and that this makes them a weak constraint is therefore inconsistent with the CC's approach to barriers and aggregation of product markets. This inconsistency operates to BMI's detriment as BMI has no "specialist" facilities.

- 9.11 **Proportion of NHS patients:** The CC in its PFs has stated that hospitals with a high proportion of NHS patient admissions may be stronger potential competitors than their current share of supply of private healthcare services suggests to the extent that they can convert those resources for private patients.⁴⁶ This is true.

Yet the CC frequently decides to dismiss a competitive constraint on the basis that it has a higher proportion of NHS patients than a BMI hospital. The CC does not explain why this would make a PHP a weak constraint on a BMI hospital with a lower proportion of NHS patients where the same facilities are easily able to serve private patients and at higher margins than the NHS, and how this is consistent with the CC's description in the PFs. The CC is also inconsistent in its application of this factor. In some instances this factor is given weight when assessing the competitive constraint of a competitor, in others it is not.⁴⁷ The CC is consistent however, in taking the approach that is most to BMI's detriment.

- 9.12 **PPUs:** The CC has evidence of the constraint PPU's exert but has consistently downplayed this and ignored completely the advantages that PPU's have over BMI hospitals. Such PPU's are generally on NHS sites in population areas (often in hospitals well respected for their high acuity work) and this NHS 'co-location' makes it convenient for consultants to see and treat patients at the PPU's and gives these PPU's easy access to diagnostics and HDU/ICU. This contradicts the evidence in the CC's barriers to entry case studies where location close to a NHS site was key to entrants' entry plans. PPU's are universally considered in the PFs to be weak competitors, unless they are operated by BMI in which case they are typically considered the stronger of two competitors (see for example the assessment of [X]). Conversely [X]. Here the CC finds [X]. The CC's approach to PPU's is consistent however, in opting for the approach that is most to BMI's detriment.

- 9.13 **Specialty focus:** The CC has ignored competitors that specialise in one area, despite evidence that such specialists would normally have newer or more impressive facilities and reputation. For example, Mount Vernon Cancer Centre has recently invested in a £21 million radiotherapy wing and received £6.5 million government funding for a replacement radiotherapy machine.⁴⁸

⁴⁶ PFs, paragraph 6.112(f).

⁴⁷ [X]

⁴⁸ <http://www.enherts-tr.nhs.uk/files/2010/04/ENH0262-New-%C2%A321-million-radiotherapy-facility-gets-official-seal-of-approval.pdf>; and http://www.enherts-tr.nhs.uk/files/2012/03/Trust_gets_%C2%A36.5_million_for_new_equipment_at_the_Lister_and_Mount_Vernon.pdf.

Competition ought to be intense in these specialties. This is particularly the case when the specialty is the same as that which is the focus of the private hospital (e.g. the constraint exerted by [X] on [X] due to the latter's focus on [X]). The CC has also failed to consider the ability of such specialist units to expand their capability as the HCA Christie Clinic has done in Manchester. The CC's approach to discount specialist facilities consistently operates to BMI's detriment as BMI operates no specialist facilities.

- 9.14 **Central London hospitals being weak constraints:** The PFs state that *"hospitals in Greater London (but outside of central London) and in the surrounding commuter areas are likely to be constrained to some extent by hospitals in central London, particularly for non-routine, high-acuity treatments. This constraint has been considered, taking into account the relative location of hospitals in suburban areas, the evidence on catchment areas, the common ownership of several hospitals, travel patterns and the prices charged, noting that hospitals in central London, on the whole, have higher prices than hospitals outside central London."*⁴⁹ Between 1 – 1.15 million people travel into Central London every day for work.⁵⁰ However, throughout the CC's local assessments, the CC has dismissed Central London hospitals as weak constraints on Greater London BMI hospitals due to "high prices" and distance. Firstly, the CC has not explained what is meant by London's high prices. For example, how high is "too high"? Are all prices for all procedures and all operators in central London high? Even if prices are higher why does that mean they are not potential substitutes? People who live in Greater London are likely to be well accustomed to paying higher prices for services in central London. Might people trade off price and convenience for international reputation and perceived high quality?⁵¹ If not, why would large corporate employees and PMIs regard central London hospitals as must-haves when many of these employees will commute into central London? Secondly, the CC has not explained the issue of distance. Having accepted that patients in Greater London may travel into Central London for work etc., why does distance matter sufficiently in every individual case to dismiss constraint from central London hospitals? The CC holds the data necessary to assess this quantitatively. It would be a straightforward matter to do this work. The CC should do this especially as it is suggesting conclusions about movements that are both contrary to evidence and inconsistent.

The CC uses this same analogy of the strength of central versus outskirts hospitals when provisionally finding that the hospitals that are outside central urban areas are weak constraints on BMI hospitals in central urban areas (such as [X]). It is inconsistent that the CC has not considered this in its analysis of the constraints faced by hospitals in Greater London. Again the

⁴⁹ PFs, paragraph 6.112(d). See also paragraph 43 of the CC's London Working Paper for further analysis of the asymmetric constraints between hospitals in Central London and Greater/Outer London.

⁵⁰ Transport for London, 'Travel in London', 2008, Report page 39.

⁵¹ Annotated Issues Statement, Appendix F, paragraph 30.

CC's approach is inconsistent with its other findings and evidence. The CC is consistent however, in opting for the approach that is most to BMI's detriment.

- 9.15 **Common ownership concerns:** As noted above, the CC's theory of common ownership concern is entirely reliant on the flawed measure of network LOCI and network effect. The CC considers that the presence of a secondary BMI hospital near to a first BMI hospital affects the ability of a competitor to compete with the first BMI hospital. This effect is completely unexplained. Nor has the CC provided any evidence that BMI has treated any of the indicated group of hospitals as clusters in negotiations, as discussed at "Insured Price Analysis" in paragraph 8. Nor has the CC offered any evidence from competitors that common ownership creates difficulties for competitors. This is because there is no such evidence. Again the CC's approach is inconsistent with its other findings and evidence but it is consistent with taking the approach most to BMI's detriment.
- 9.16 **Unequal treatment:** The CC has on a number of occasions decided to "cluster" BMI hospitals but fails to consider the constraint posed by two competing hospitals under common ownership in the same local area – i.e. effectively *within* the cluster. The relevant distance for hospitals of common ownership to be clustered is not defined and there are clear inconsistencies throughout the CC's analysis. For example, due to the hospitals being "located close to each other" ([X] miles), [X] and [X] are analysed together; yet [X] are not analysed together. Again the CC's approach is inconsistent with its other findings and evidence but it is consistent with taking the approach most to BMI's detriment.
- 9.17 **Cumulative constraint:** The CC finds that many hospitals face 'weak' constraints from a number of competitor hospitals. Even if the constraints were weak or moderate (rather than effective as BMI contends), the CC fails to acknowledge the cumulative effect on contestable patient episodes that being surrounded by multiple alternative providers may have on a hospital, particularly where high fixed costs mean extreme sensitivity to even the slightest change in volumes. [X].
- 9.18 **Strong competitor:** BMI objects to the excessively high and unfair threshold the CC has created for a competitor to be a "strong constraint". It appears that a competitor needs to be very nearby, with a more extensive catchment area and at least a similar size to be considered a strong (i.e. effective) constraint. In particular, we note that when hospitals are similar, i.e. they have similar characteristics including size and they are located close to each other with similar catchment areas, they are likely to impose strong competitive constraints on each other. This does not mean that hospitals that are different do not impose a strong constraint on each other. For example, as the CC notes, a larger hospital (in terms of characteristics including size) can be a strong constraint on a smaller hospital (again in terms of characteristics including size) when these hospitals are not close together but there is a large overlap in their catchment areas. Again, the unifying theme is that the CC adopts the approach that is most to BMI's detriment.

- 9.19 **No distinction between moderate and weak competitors:** BMI notes that there is no practical difference between the CC's conclusion that a competitor is a "moderate" or "weak" constraint in terms of determining that it is an ineffective constraint on BMI. The distinction is meaningless.
- 9.20 For completeness, BMI notes that the tables which follow at section 11 et seq below should be read in conjunction with this section 9. Whilst BMI's response in relation to each hospital cross-refers where relevant to those points highlighted in this section which are most relevant to a rebuttal of the CC's case against an individual hospital, the fact that a generalised point is not specifically repeated should not be construed as BMI having dropped the point. It is for the CC to ensure that its analysis is consistent across all the hospitals, particularly in light of the remedies proposed.

10. **Other BMI hospitals that are "insufficiently constrained"**

Solus Hospitals

- 10.1 In the CC's local assessments, it identified [X] BMI hospitals as "insufficiently constrained" that are, by the OFT's definition (i.e. no private hospital or NHS PPU competitors within a 30 minute drive-time), solus hospitals. These are: [X].

Background

- 10.2 There are a number of private hospitals which do not have a private competitor nearby. These hospitals are commonly referred to as solus. They are typically located in relatively sparsely populated areas of the country where there is only sufficient demand to sustain a single (usually small) private hospital. The CC need not have invested significant resources in identifying these phenomena. BMI has never denied that it exists nor has it denied that it owned solus hospitals.
- 10.3 Given that it was obvious that certain markets exhibited solus characteristics, BMI assumed that the challenge for the CC was to investigate whether there was evidence of adverse market outcomes for patients in these areas – such that intervention by the CC might be merited. BMI based this view on the CC's guidance which anticipates that it will examine market outcome:

"Evaluating these outcomes helps the CC determine where there is an AEC and, if so, the extent to which customers may be harmed by it i.e. the degree and nature of 'consumer detriment'. This can be an important factor in any later consideration of remedies."⁵²

- 10.4 In order to make a positive contribution to this work, BMI commissioned a detailed econometric study by Dr Peter Davis ("the Davis Solus Paper"). In January 2013, BMI submitted this piece of work to the CC, looking at

⁵² Guidelines for market investigations CC3, paragraph 103.

the evidence of competitive outcomes in solus hospitals versus hospitals in non-solus locations. BMI considered this evidence to be an important and serious contribution to the inquiry and requested a meeting in respect of this work. BMI was looking forward to engaging with the CC about its findings, specifically as this work responded exactly to the exercise that the CC's guidance anticipated would be done, was prepared and submitted at an early stage before the CC had released any of its work and had been prepared by a leading econometrician and former Deputy Chairman of the CC in accordance with the CC's best practices on submission of economic evidence.

- 10.5 The CC said in an email to our solicitors: "*As I stressed on the phone, please reassure BMI/Compass Lexecon that the paper is being actively reviewed, the members will be making a decision on next steps and we will revert in due course in terms of in particular nature of any meeting. I hope you can advise them accordingly and that it is not unreasonable to allow the CC some time to consider the paper in detail.*"⁵³
- 10.6 Having discussed with the members the CC wrote to say: "*Having reviewed the paper, we have discussed your request with the members who have indicated that they do not consider it necessary to have a meeting to discuss the paper. To the extent to which we have any clarifications or have any queries we will of course be in touch.*"⁵⁴
- 10.7 BMI and its advisers were frankly astonished at this decision. We could not understand why the CC would refuse to engage with the principal main party to the inquiry over such a serious piece of work covering an important and central area of the investigation. Nevertheless, BMI did not press the matter further. Given that the CC had been very clear that it was considering the paper and that the members themselves had decided a meeting was undesirable, BMI judged that pressing for such a meeting would be counterproductive and serve only to irritate both the staff and group.
- 10.8 Following this exchange, there was then no assessment of or engagement on solus hospitals until a working paper on 21 May 2013. The word "solus" does not even appear in the AIS or its appendices⁵⁵. When this working paper arrived in late May BMI saw, for the first time, that the CC had identified a cohort of solus hospitals. Although not stated in the working paper, it was apparent to BMI that the CC had changed the definition used by the OFT as the hospitals within the solus cohort had altered. We asked the CC why this was and to explain its approach to solus on 24 May. The CC responded in its letter of 11 June with a generic explanation:

⁵³ Email Kent/Webber 16 January 2013.

⁵⁴ Email Kent/Webber 23 January 2013.

⁵⁵ Although we note that the Chairman referred to solus hospitals and having read Dr Peter Davis's paper at the hearing.

*"Solus hospitals have been identified primarily on the basis of catchment areas, fascia count, distances to rival hospitals, transportation links in the local area and population location... When defining these hospitals we have taken account of competition from outside a particular town or city where relevant."*⁵⁶

- 10.9 In the CC's working paper 'Local competition assessment of hospitals of potential concern', the first discussion about solus hospitals that the CC has produced, there is not a single reference to the detailed empirical study submitted in respect of solus hospitals by BMI in January. Despite describing the Davis Solus Paper as being "under active review" in January, and firmly refusing a meeting and advising the arguments were all well understood; the paper and the evidence it contained was simply ignored.
- 10.10 Since the CC's May 2013 working paper, the CC moved away from using terminology to describe a hospital as "*insufficiently constrained as solus hospital*" to describing a hospital which "*face[s] no or weak competitive constraints from other hospitals to be insufficiently constrained*"⁵⁷. Despite BMI's commentary on the CC's detailed assessment of the local markets of concern (outside London) submitted 17 June 2013, other than no longer using the term "solus", the CC has not substantively changed its assessments of these hospitals, and simply refers to them as "insufficiently constrained" based entirely on the geographical position of competitors.
- 10.11 This change in use of terminology is at odds with the CC's Remedies Notice, which, when discussing Remedy 1 (Divestments), states that "*In local areas where we have identified competition concerns (other than **Single** or Duopoly areas) the relevant hospital operator would be required to divest to a suitable purchaser, through an effective divestiture process, one or more hospitals and other assets it would be appropriate to include in the divestiture package in order to address the AEC.*"⁵⁸. The CC does not explain and BMI has had no opportunity to comment on the CC's methodology for determining what is a "Single" area when considering proposed divestments – specifically which hospitals fall to be considered within the category and whether they are the same as the "solus" hospitals. BMI has been able to piece together, by comparing the list of proposed divestments and the CC's statement that it will not require divestments in "Single" areas, that there are differences from the working paper. For example, the working paper categorised [X] as solus hospitals, but has since not only classified them all as part of a cluster, but has even proposed divestment of [X] of these ([X]). The unexplained change in approach is presumably to allow the CC to identify these

⁵⁶ CC's letter from John Pigott to James Webber, dated 11 June 2013.

⁵⁷ PFs, paragraph 6.113.

⁵⁸ Remedies Notice, paragraph 27.

hospitals for divestment. This is an example of a pronounced feature of this inquiry, whereby the CC has reverse-engineered its competitive assessment of the hospital from the remedy it wishes to impose rather than allowing the evidence to lead to the AEC thence to the remedy.

- 10.12 The lack of any clear definition or coherent attempt to correlate the CC's remedy approach with that in the local assessments relating to solus or "Single" areas makes it impossible for BMI to comment, correct or contradict the CC's case against hospitals in this position.

BMI's evidence and analysis ignored

- 10.13 In determining the above listed solus hospitals as "insufficiently constrained", and therefore subject to Remedies 2 and 3 the CC has ignored the analysis and evidence provided by BMI in the Davis Solus Paper. Namely:

- (a) The evidence shows that:
 - (i) They have catchment areas with a far smaller population living near the hospitals and lower PMI penetration rates than an average BMI facility. In particular, the population within a 30 minute drive time of an average solus hospital is approximately one-fifth the average population within the same drive-time of a non-solus BMI facility;
 - (ii) On average, solus hospital catchment areas have a greater preponderance of over 45s than the non-solus hospitals; and
 - (iii) Solus areas appear to have greater variance in the wealth of the population. In particular, there seems to be a considerably higher proportion of Wealthy Achievers in solus areas compared to non-solus areas and a lower proportion of those classified as Moderate Means or Hard Pressed. The much lower percentage of Urban Prosperity category in solus 30 minute drive-time areas reveals that the solus facilities are more likely to be located in more rural areas than non-solus hospitals. The proportion of the ACORN mixed category of individuals is higher in the average solus catchment area than in the average non-solus catchment area.
- (b) In terms of market outcomes, there are indications of higher self-pay prices in some solus hospitals for some treatments but that in other outcome variables including volumes, capacity utilisation, investments, margins and quality metrics for BMI, there appears to be little evidence suggesting that outcomes are systematically worse for consumers in solus markets;
- (c) While self-pay prices are found to be higher in some treatments/solus hospitals, they do not appear to result in higher overall hospital margins

in solus markets than in non-solus markets. Rather, the evidence suggests:

- (i) Solus hospitals are typically in market areas with very much smaller local populations than non-solus markets; and
 - (ii) That small local populations are associated with lower bed- and theatre-utilisation rates and these in turn are associated with lower hospital margins. Thus solus hospitals will tend to have lower margins than an average BMI non-solus hospital because they are in markets with small local populations.
- (d) Since hospitals have high fixed costs which must be recouped, taken in the round the evidence does not indicate that there is a problematic degree of market power being exercised by solus hospitals.

10.14 As the conclusions above make clear, the Davis Solus Paper was not a submission that could be treated simply as a party's "views". It represented hard evidence of direct relevance to the inquiry. The CC's local assessments in no way take into account the economic analysis based on *evidence* in determining that such hospitals are insufficiently constrained. Instead, the CC bases its analysis on catchment area overlaps, size, range of specialties offered, etc. – the same factors it bases its analyses on the non-solus hospitals. At no point does the CC analyse the features of their local markets (population demographic, bed- and theatre-utilisation, etc.) which effectively constrain the market behaviour of solus hospitals.

10.15 The CC also offers no analysis of quality competition and outcomes that patients see. As cited above at paragraph 1.6, the CC, OFT and Monitor's recently issued joint statement after the CC's first prohibition of a merger between NHS Foundation Trusts states:

*"The Office of Fair Trading (OFT), the Competition Commission (CC) and the sector regulator Monitor work together **to ensure that the interests of patients** are always at the heart of this process."*⁵⁹
[emphasis added]

10.16 The interests of patients in healthcare are overwhelmingly concerned with quality of care. The market investigation will have sensitised the CC to the great importance patients attach to quality of care – indeed this is the reason why private healthcare exists at all in a country with a free alternative available. The characteristic split between the payor and patient in healthcare markets emphasizes the importance of quality competition. Patients (whether publicly or privately funded) will typically be price insensitive as they do not pay for the service. There is therefore not

⁵⁹ "Ensuring that patients' interests are at the heart of assessing public hospital mergers" – Joint statement from the Office of Fair Trading, the Competition Commission and Monitor, 17 October 2013.

the usual price/quality trade-off captured in individual purchasing decisions. Quality therefore is of paramount concern to patients.

10.17 It is odd therefore that the CC has chosen in this investigation not only to avoid measuring quality metrics in its assessment of market outcomes, but to ignore the only evidence that has been submitted to it that seeks to measure these outcomes empirically. Even now the CC has only commented on the aspect of the work above about self-pay prices (ignoring the crucially related evidence of hospital margins). There is no comment at all about the work looking at quality outcomes for patients using solus hospitals – and showing empirically across a wide range of measures that solus status does not result in adverse outcomes for patients – the very essence of what these hospitals do for the consumers who use them.

10.18 The CC provides no evidence that might suggest solus hospitals are not a normal competitive outcome for the areas they serve or that solus hospitals confer any problematic market power on BMI in negotiation with insurers or in any other respect.

Insufficiently constrained hospitals – non-cluster hospitals

10.19 The remaining [X] BMI hospitals "of potential concern" were classified by BMI as "insufficiently constrained", but not defined as part of a "cluster". In the CC's working paper, these hospitals were termed as either "solus", "largest hospital in an asymmetric duopoly", in a "symmetric duopoly" or "insufficiently constrained in a multi-provider environment". In the CC's local assessments, the CC no longer refers to these categories. Instead, it considers that in addition to hospitals that face no or weak competitive constraints from other hospitals being insufficiently constrained, "*in the absence of other constraints (or when those are weak), in general, [it] consider[s] two hospitals (or operators in case of common ownership of hospitals nearby) imposing a similar competitive constraint on each other to be insufficiently constrained as they would not be expected to compete effectively against each other*"⁶⁰.

10.20 This change in use of terminology is again at odds with the CC's Remedies Notice, which, when discussing Remedy 1 (Divestments), states that "*In local areas where we have identified competition concerns (other than Single or **Duopoly** areas) the relevant hospital operator would be required to divest to a suitable purchaser, through an effective divestiture process, one or more hospitals and other assets it would be appropriate to include in the divestiture package in order to address the AEC.*"⁶¹ It is unclear what the CC's methodology is to determine what is a "Duopoly" area when considering proposed divestments. From some of the proposed divestments, it is clear that the CC's working paper

⁶⁰ PFs, paragraph 6.113(b).

⁶¹ Remedies Notice, paragraph 27.

categorisations are not indicative. For example, the working paper categorised [X] as the largest hospitals in asymmetric duopolies and [X] as part of a symmetric duopoly. The CC has since classified them all as part of a cluster, and proposed divestment [X]. Again, this illustrates the CC's approach of approaching the analysis in reverse – considering the remedy it wishes to impose and retrofitting the competition analysis around this conclusion. There is no other reason disclosed for the change in treatment between the working paper and the PFs.

- 10.21 The lack of any clear definition of what is a "Duopoly" area makes it impossible for BMI to comment, correct or contradict the method by which the CC has found these hospitals to be insufficiently constrained and proposed to divest these hospitals.
- 10.22 Nevertheless, detailed rebuttals explaining why these remaining "insufficiently constrained" hospitals in fact face effective local constraint are outlined below. As above, the CC has similarly ignored internal documents from BMI, competitors, PMIs, the Bupa delisting, and instead relied haphazardly upon whichever factors support intervention against BMI. The factors used include "size", lack of or small size of catchment area overlap and proportion of NHS patients, amongst other similar factors, to dismiss competitors as insufficient. As with the rest of the analysis, there is no explanation as to why these factors suggest compellingly that the hospital under investigation is insufficiently constrained.
- 10.23 In addition, the CC has simply (but wrongly) assumed that hospitals that have one strong competitor are insufficiently constrained in the absence of any "*evidence of competition (or potential competition), for example, hospitals having adjusted their competitive offering in response to changes made or expected by other hospitals*". Firstly, in most cases, the CC has routinely ignored just such evidence in the form of contemporaneous internal documents or the 2011 delisting by Bupa. Secondly, it is for the CC to make the case that one strong competitor does not sufficiently constrain a BMI hospital. It cannot presume **without evidence** that a hospital is insufficiently constrained – particularly when it is presented with evidence proving the contrary. The CC cannot simply set up a presumption and invite a party to rebut it, especially when it has no coherent reason to believe that competition would not be effective under the presumption.
- 10.24 In the course of this investigation the CC itself has stated that under some circumstances competition in a symmetric duopoly may provide an adequate constraint. Decisional practice from the CC has established that "*competition between duopolists is likely to be stronger*" when the two companies price their products independently and where there are no high barriers to entry⁶². As discussed in BMI's response to the PFs:

⁶² The acquisition by CHC Helicopter Corporation (CHC) of Helicopter Services Group ASA (HSG) 1999.

Barriers to Entry paper, the private healthcare market has low barriers to entry. Prices are obviously set independently – especially with respect to PMI⁶³. A BMI hospital that faces a single competitor where both are not fully utilised is therefore powerfully constrained in its current competitive environment – for precisely the same reason as the CC itself believes with respect to predicting "aggressive" responses to entry.

- 10.25 Examples supporting the premise that a duopoly can provide sufficient constraints include the recent CC decision in Cineworld/City screen. The CC concluded that the acquisition of Picturehouse by Cineworld was unlikely to lead to an SLC in the Brighton area, despite the fascia count reduction of three to two based on a 20 minute isochrones, due to "*the closeness of Odeon's multiplex to the two Picturehouse cinemas*"⁶⁴. In this scenario, the merging cinemas accounted for 55% of all seats in the Brighton area. The constraint imposed by this single competitor was considered sufficient, the CC having based its analysis on a customer survey response to a SSNIP test⁶⁵. The CC has conducted no such analysis to demonstrate that in duopoly areas, hospitals are not already sufficiently constrained.
- 10.26 Further, in the context of State aid, the European Commission has issued guidance stating there is "*no need for State intervention... When in a given geographical zone at least two broadband network providers are present and broadband services are provided under competitive conditions.*"⁶⁶ Far from viewing "broadband duopoly" competition as a problem to be fixed, the European Commission has unequivocally sided against a third Government-supported broadband network as necessary to support competition.
- 10.27 The private healthcare market is subject to thin demand and high fixed costs – in markets where there are "duopolies" it simply is not sustainable to have a third "strong" competitor – the two existing facilities already compete aggressively with one another.
- 10.28 The CC has not explained which hospitals are characterised as duopolies. It in any event provides no evidence that might suggest duopoly hospitals are not a normal competitive outcome for the areas they serve or that duopoly hospitals do not compete powerfully with each other. The CC's view of duopoly hospitals also flatly contradicts the CC's assessment of the response of a single hospital to new entry, with no explanation or attempt to reconcile the two positions.

⁶³ Price parallelism in self-pay plays no role in the CC's case against BMI.

⁶⁴ Cineworld Group plc and City Screen Limited CC Final Report 8 October 2013 paragraph 6.69 *et seq*

⁶⁵ *Ibid*, paragraph 6.70.

⁶⁶ EU Guidelines for the application of State aid rules in relation to the rapid deployment of broadband networks (2013/C 25/01), paragraph 72.

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