

SPIRE HEALTHCARE

COMPETITION COMMISSION

PRIVATE HEALTHCARE MARKET INVESTIGATION

RESPONSE TO THE PROVISIONAL FINDINGS REPORT

11 NOVEMBER 2013

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GLOSSARY OF KEY TERMS

<i>AEC</i>	Adverse effect on competition
<i>IPA</i>	Insured pricing analysis
<i>LOCI</i>	Logit competition index
<i>PCA</i>	Price concentration analysis
<i>PHP</i>	Private healthcare provider
<i>PMI</i>	Private medical insurer
<i>WAMS</i>	Weighted average market share

EXECUTIVE SUMMARY

1. INTRODUCTION

1.1 The analysis in the Competition Commission's (*CC*) Provisional Findings Report (the *Report* or the *PFs*) disregards evidence of real world competition between private healthcare providers (*PHPs*). Instead, the PFs are based on a mechanistic and formulaic account of the market that is both inappropriate and wrong.

1.2 The flaws in the PFs are fundamental and include:

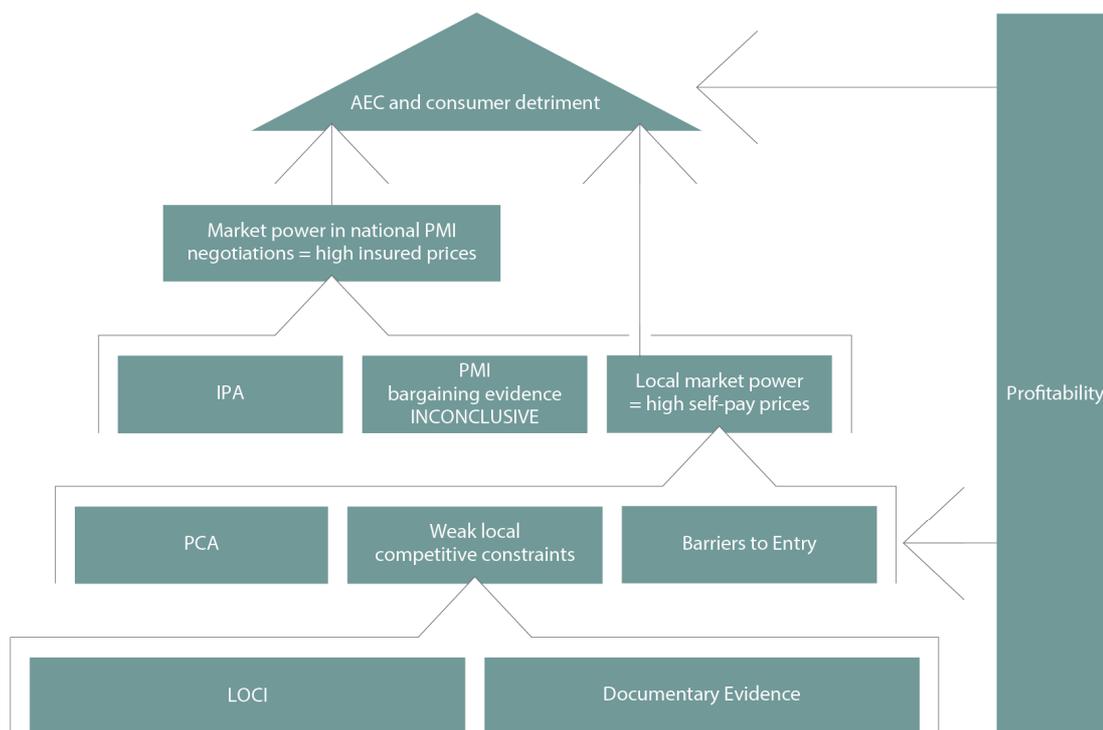
- (a) Evidence being misinterpreted or ignored (including even evidence of competition provided by the Private Medical Insurers (*PMIs*))
- (b) Tenuous assumptions being substituted in place of concrete evidence and robust analysis.
- (c) Basic mathematical errors that substantially change the *CC*'s calculations.
- (d) Reliance on unproven and seriously misconceived economic models.

1.3 In view of the above, the only outcomes that a reasonable decision-maker can reach are:

- (a) The PFs are unsustainable in their entirety.
- (b) The theories of harm articulated are not supported by the evidence, and certainly not to the "clear, coherent and compelling" standard required.
- (c) The standard of proof (i.e., establishing an AEC on the balance of probabilities) is not discharged.
- (d) The provisional conclusion that the *CC* has identified a feature (or features) of the market which give rise to an Adverse Effect on Competition (*AEC*) pursuant to s134 of the Enterprise Act 2002 is unreasonable and unlawful.
- (e) Since there is no AEC, there is no need for a remedy; in any event divestment is not a remedy legitimately open to the *CC*.

1.4 It is disappointing that after an eighteen month review of the market, extensive cooperation from Spire Healthcare Group (*Spire*) and other market participants and having rejected repeated offers to make external or internal experts available to assist the *CC* in understanding the market, the analysis remains so deeply flawed.

1.5 Spire has developed the following diagram to reflect the construction of the *CC*'s conclusions in the PFs, and uses this diagram throughout this response to assist the reader in understanding the relevance of Spire's concerns to those conclusions:



1.6 The CC’s case construction however is not based on concrete, real-world such evidence. The CC has consistently disregarded evidence in favour of hypothetical constructs. This is true of the CC’s assessment of local markets, its assessment of bargaining between hospital providers and insurers and its profitability analysis. Many points made by Spire previously are ignored.

- (a) With respect to the CC’s assessment of local markets:
- (i) **The price-concentration analysis (PCA) does not show a statistically significant relationship between local concentration and self-pay prices charged by Spire or more generally.**
 - (ii) **The CC’s case rests on its use of the flawed LOCI measure.** This measure is so problematic that one cannot predict whether the LOCI will increase or decrease in response to an increase in local competition; as such, an *increase* in competition may trigger the CC’s screen for a divestment. Such absurd outcomes do not support the CC’s case; and
 - (iii) **It is clear from the detail of the assessments that the CC has not done what it claimed: they are driven by a formulaic and mechanistic application of LOCI, admission and revenue statistics rather than evidence.** Real world evidence of local market conditions from PMIs, consultants and operators is simply ignored. The CC identifies substantially more Spire hospitals as being “of concern” than any view of the evidence shows.

- (b) With respect to the CC's assessment of bargaining between PHPs and PMIs:
- (i) **The CC's insured pricing analysis does not support a conclusion that Spire's prices are consistently or significantly higher than those of firms that lack market power.** Relevant, material exculpatory evidence from the CC's own IPA analysis is not reflected in the main PF report. It is not sufficient that relevant exculpatory evidence can be found in tables included in an appendix to the report, particularly when this evidence contradicts the evidence presented in the main report and supports the conclusion that Spire does not have market power in negotiations with PMIs;
 - (ii) **The balance of power in negotiations between PHPs and PMIs is not weighted in favour of Spire or other hospital providers outside London. Even evidence from PMIs supports this proposition; and**
 - (iii) **The CC has assumed that the PMI market functions effectively to pass on any reductions in costs to patients.** There is no evidence, investigation or proper consideration of the issue.
- (c) With respect to the profitability analysis:
- (i) **There are significant flaws in the CC's methodology and even in applying this methodology, there are significant errors in the calculations.** Spire's capital base has been understated by approximately £429 million and its return on capital employed (*ROCE*) has been overstated by approximately 8 percentage points;
 - (ii) **The analysis disregards actual market evidence in favour of assumptions.** The CC's proposition that real world evidence is not informative as to the capital employed to operate a hospital is extraordinary; and
 - (iii) **To the extent that Spire is more profitable than other firms while its prices are not significantly or consistently higher than the prices of firms without market power must be explained by Spire's greater efficiency and consistent with effective competition.** The fact that the PFs do not seek to understand why the profitability of firms differs materially when their prices do not is illustrative of a lack of rigour in the CC's analysis.

1.7 The CC's claim that the evidence is consistent with its AEC finding is therefore untenable. Indeed, the CC's "competition story" is not consistent with the evidence at all. Spire's explanation of competition is the only one that explains the observed market outcomes, the market evolution in the last five years, and the profitability of Spire and the PHPs.

1.8 It is important that the outcome of the CC's investigation does not remove the benefits that private healthcare offers in the UK. PHPs offer patients in the UK an alternative to the NHS. PHPs have invested significantly to provide patients with a range of services that is superior to that offered by their competitors. This is best illustrated by the development of private healthcare outside London over the past 10 years. Private operators have invested significantly to increase the availability of services such as MRI scanning and radiotherapy, provision of which is significantly below the OECD average across the UK public and private sectors. In addition, patients have traditionally been required to travel to London to access most complex surgery in a private hospital setting, but Spire has invested to significantly develop the private offering of complex surgery outside London.

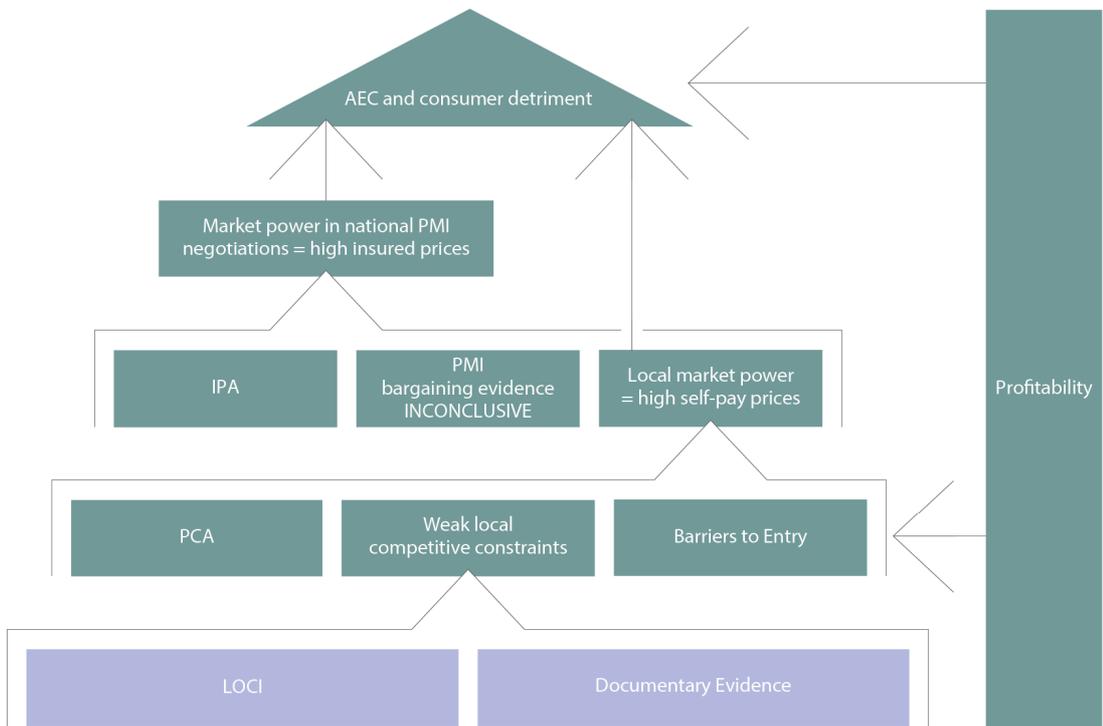
1.9 The PFs ignore these patient-focused developments. The PFs also ignore other indicators of competition: such as PMIs suggesting that the CC has overstated the number of hospitals with local market power and understated the power of PMIs in negotiations with PHPs; evidence of the outcome of negotiations between PHPs and PMIs including PMIs negotiating price reductions from PHPs; and evidence of both actual and planned hospital entry in various local markets. All of this evidence of actual competition is ignored in favour of an unduly simplistic analysis of hospitals' patient revenue and admission data.

1.10 The problems in the analysis are most crisply illustrated by the CC's remedies proposed. Its divestment proposals for Spire are flatly contradicted by evidence from PMIs. Other remedies proposed by the CC are already behind market developments since they do no more than reflect historical negotiating strategies in the marketplace. It is symptomatic of the CC's cursory analysis that after 18 months of this MIR the CC does not know how PMI negotiations currently work. An adverse decision based on such inadequate analysis would be unfair and unreasonable.

1.11 The remainder of this Response follows the structure of the reasoning set out in the PFs. Spire's response focuses on the key factors relied on by the CC to conclude provisionally that hospital operators (including Spire) have market power in certain local areas which feeds through into national negotiations with PMIs.¹

¹ Formerly described as Theories of Harm 1 & 3 in the CC's AIS.

1. THE PFs' CONCLUSIONS IN RESPECT OF LOCAL MARKET COMPETITION ARE UNREASONABLE AND UNFAIR



1. THE PFs' CONCLUSIONS IN RESPECT OF LOCAL MARKET COMPETITION ARE UNREASONABLE AND UNFAIR

Overview

The PFs in respect of local market competition are wrong and unfair:

- **Having ignored outpatient and day-case competitors, and excluded this part of the market place from its analysis, it is not now open to the CC to extend its finding of an AEC to cover outpatient and day-case provision.**
- **The LOCI measure is not a credible basis for any sort of analysis or early-stage screening. Reliance on this measure is irrational.**
 - **The LOCI is highly sensitive to minor changes in assumptions, in particular, changes in the definition of the geographic submarkets (contrary to the PFs' claim that the LOCI avoids the need to identify geographic boundaries).**
 - **The LOCI measure is so problematic that a decrease in LOCI is in fact consistent with an increase in competition.**
 - **The LOCI is so flawed that the impact of greater competition on a hospital in a cluster area could cause that hospital to become a more likely candidate for divestment when, if competition were weaker, the hospital would be "safe".**
- **The local market assessments in the PFs are overwhelmingly driven by a simplistic formulaic and mechanistic application of LOCI, admission and revenue statistics**
 - **The analysis simply ignores evidence of local competitive pressures and responses; and**
 - **This deficiency is illustrated by the fact that, based on its theoretical construct, the CC identifies substantially more Spire hospitals as being "of concern" than any of the PMIs do in their submissions and evidence.**

1.1 The CC's assessment of hospitals of concern is not based on sound reasoning, evidence or analysis. The assessments have been driven by mechanistic application of simple thresholds, and the underlying evidence submitted by the parties has been ignored to the extent that the CC finds market power where no-one else (not even a PMI) thinks that it exists. The problems in the analysis of particular local areas are set out in full in Confidential Annex 2, and some of these problems are summarised at a general level below.

- (a) On closer inspection, the CC's local hospital assessment effectively penalises higher levels of acuity and superior quality services.
- (b) Because the CC does not take proper account of how competition works in a specific area (substituting for actual competition a simplistic set of thresholds and assumptions), the CC ignores the evidence of competition-related investment, introduction of new services to compete, and other key competitive dynamics.

1.2 The approach to assessments of local areas leads the CC to a series of conclusions unsupported by the evidence.

1. The CC's findings cannot apply to outpatient or day case treatment

1.3 Spire has previously pointed out that, by focusing only on inpatient treatments and providers, the CC misses a significant section of the market and a significant number of competitors. The majority of Spire's revenues and the majority of patient episodes at its facilities relate to outpatient and day-case treatment. The CC has not considered between 40% and 79% of private revenue at Spire facilities identified by the CC as a concern.

1.4 The PFs in fact conclude that inpatient, day-patient and outpatient care are distinct product markets. There is no analysis or evidence as to why the CC's conclusions on in-patient care are relevant to outpatient or day-case care, and the PFs do not assess the competitive constraints from providers of outpatient or day-case care. It is not now open to the CC, as a matter of law or fundamental fairness, to extrapolate conclusions about competitive outcomes in inpatient care to outpatient and day-patient care.

2. The CC's use of the LOCI measure is irrational

1.5 The CC's reliance on a mechanistic application of the LOCI measure to assess local markets, even where there are clear deficiencies in the measure and the results are clearly divorced from the reality of the local market is symptomatic of the general problems with the PFs. Some of the key problems with the CC's use of the LOCI measure, and the weighted average market share (*WAMS*) on which the LOCI is based, are set out below. These problems are explained in more detail in an expert report from RBB Economics (attached at Annex 1).

1.6 ***First, the LOCI measure is so problematic that a decrease in LOCI is in fact consistent with an increase in competition.*** The CC assumes that a high (network) *WAMS* / low (network) *LOCI* indicates poor local competition and that a high "cluster effect" (ie the increment in a hospital's *WAMS* caused by the presence of another hospital on the same network) is a potential concern, so great that a divestment might be required.

- (a) However, the *WAMS* and the "cluster effect" of a facility may actually increase when competition *increases*: the *WAMS* is the weighted average of a hospital's share of admissions or revenue in each

submarket from which it draws patients with the weights being the share of patients a hospital draws from a given submarket.

- (b) Where a hospital loses patients in a given submarket due to, for example, delisting or new entry, the weight attributed to other submarkets increases, which may in turn result in an overall increase in WAMS and the “cluster effect” (see Annex 1).
- (c) This means that a hospital facing an increase in competition may become a potential candidate for divestment on the CC’s screen when, had it faced less competition, it would not have been a potential divestment. This illogical outcome illustrates that the LOCI is an inadequate and inaccurate filter for identifying hospitals of potential concern, and an inadequate and arbitrary basis for mandating divestments.

1.7 *Second, the LOCI does not avoid subjective decisions regarding geographic market definition; the results are very sensitive to changes in the definition of sub-markets.* The CC asserts that the LOCI measure avoids the need for “*sharp delineation*” of geographic boundaries of markets and avoids the “*subjective decisions*” of other measures of market concentration. This is demonstrably wrong.

- (a) As Spire has previously shown, the LOCI results are extremely sensitive to changes in the definition of the submarkets. The identification of these boundaries determines the outcome of the LOCI analysis and a correct identification is crucial for arriving at reliable results.
- (b) The CC’s chosen sub-markets (which it now acknowledges were selected on the basis of convenience rather than for any evidence-based or analytically-valid reason) are overly narrow given the distances that patients are willing to travel and do not reflect an economic market for which market shares are informative about the extent / degree of a hospital’s local power.
- (c) However, the CC assumes that the aggregation of share across meaningless submarkets represents an economically meaningful number. This is neither coherent nor plausible and the PFs do not contain any reasoning to explain why the CC believes this to be a legitimate analytical step.

1.8 *Third, the LOCI measure does not reflect changes in local market dynamics over time.* The CC’s submarkets are so narrow that they require data to be aggregated over *four years* to reduce the risk of measurement error. The LOCI therefore fails to capture the impact of any of: new entry; new procedures; innovation; quality improvements; temporary delisting; and patient steering. These are factors that the CC must consider in order to properly assess the market. Given its *failure to capture any of the measures which are at the heart of the private healthcare market inquiry*, it

is irrational for the CC to consider the LOCI measure of specific value in private healthcare markets or to base a drastic remedy such as divestments on this measure.

1.9 *Fourth, the CC acknowledges that data is missing from its LOCI calculations, but has not addressed the effect of the missing data on its conclusions.*

The CC acknowledges that its data set is “not fully comprehensive”² such that the LOCI will be biased. The CC asserts that the omitted data will not make a significant difference on a local basis. It is fundamentally unfair for the CC to simply assume or assert that the omitted data would not affect its results materially, it must assess and disclose the impact of missing insured patient invoices on the insured LOCI for individual hospitals.

1.10 *Fifth, the CC still does not advance any compelling justification for using the LOCI in the assessment of local competition.*

This is notwithstanding the extensive criticism of LOCI by parties to the market investigation reference (*MIR*).³ The lack of justification for relying on LOCI is all the more surprising given that the LOCI model is used by the CC to justify the most draconian of remedies – divestment.⁴ Even the very few sources cited by the CC in support of LOCI use⁵ (i) do not endorse the model (the only academic source written by an author other than the individuals who first developed LOCI is simply a survey of many possible methodologies for assessing local competition); and (ii) note specifically that the LOCI should be treated with special caution because its results are subject to “meaningful measurement error,” particularly in regard to geographic submarket definition.

1.11 *The CC should not have chosen an unproven theory as the cornerstone of its analysis.*

It is not reasonable for the CC to hinge its analysis in this investigation on an analytical measure with so many flaws. LOCI is at the heart of much of the CC’s analysis, conclusions on price effects at local and national level and the discussion of divestment remedies. There are many other measures which could have been used by the CC and which, while not perfect, do not feature the fundamental problems cited above. For example, demand centring fascia count measures (possibly in combination with market shares within a well-defined catchment) is preferable to LOCI. A demand-centred approach shows the actual choice of private hospitals available to any given patient that attended a Spire facility, and reflects changes over time.

² See paragraph 44 of Appendix 6.4 to the Report.

³ See for example, Spire’s Response to the AIS, Appendix J; BMI’s response to the CC’s AIS (paragraphs 1.11, 7.2-7.3 and Annex 1), HCA’s response to the CC’s AIS (paragraphs 4.5 – 4.25) and Ramsay’s response to the CC’s AIS (paragraphs 2.19, 5.9).

⁴ When such a significant remedy is proposed, it is reasonable to expect the CC to base its conclusions on the soundest of methodologies, properly tested for sensitivity and error. The use of an untested and (at best) experimental methodology for such a purpose is not a reasonable or robust analytical step.

⁵ The limited references to LOCI in the economic literature focus primarily on an article co-authored by one of the originators of the LOCI approach in private healthcare (i.e. the CC cites an author referring to his own work, which in turn is based on an unpublished working paper): M Gaynor and R Town (2012), ‘Competition in Health Care Markets’, *Handbook of Health Economics: Volume two*, edited by Mark V Pauly, Thomas G McGuire, Pedro Pita Barros.

1.12 Furthermore, the CC has not taken into account the practical problems that flow from its use of the LOCI. As the CC correctly acknowledges, the LOCI has “significant data requirements and this is likely to prevent its use in many situations.” The CC has rendered future assessment of competition in this marketplace impossible, including the implementation of the CC’s contemplated remedy divestments.

3. The CC’s analysis of local competition has failed to take proper account of the evidence of local competitive dynamics.

1.13 The evidence record disclosed by the CC does not support the conclusions reached. In particular, the CC’s conclusions on local hospital assessments have overlooked evidence of: the general competitive climate facing an individual hospital; competitive responses in specific areas from Spire and other operators, to each other and to the general NHS; actual competition from PPUs, privately-funded NHS and the general NHS winning business away from private hospitals; capacity of competitors; and therefore the possibility of both supply-side and PMI switching. It appears that evidence (from PMIs) of effective competition in specific local areas has been disregarded and the CC has instead substituted its own views. The CC’s local assessments instead focus on a formulaic application of LOCI, admission and revenue statistics.

1.14 *First, substantive exculpatory evidence of local competition has been omitted or not taken properly into account in reaching the PFs’ conclusions.* The CC’s analysis of local competitive constraints suffers from serious evidential omissions. The PFs ignore substantial evidence of the constraints imposed by rival local facilities.

- (a) **Even where PMIs have indicated that local rivals provide an adequate alternative, or that they could shift a significant proportion of their customers from Spire to rival hospitals, the CC has disregarded this evidence** (see Confidential Annex 3 for specific examples). There is no justification at all for this.
- (b) **Rivals are unreasonably discounted by the PFs on the basis of the proportion of NHS work they undertake.** The CC often wrongly concludes that local rivals offering the same services and even, in many cases, the same level of critical care as Spire exercise only a weak constraint because of their high proportion of NHS work. The CC ignores the ability of these rivals to switch capacity to private provision, and has adduced no evidence to indicate that these rivals cannot increase their volume of private care.
- (c) **Demand-centred analysis confirms that the CC understates the constraint from rival hospitals.** In fact, in most areas several alternatives are available to a significant proportion of Spire hospital’s inpatients.
- (d) **The CC also ignores competitive constraints posed by outpatient and day-case providers.** Ignoring outpatient and day-case competition

significantly understates the competitive constraints faced by Spire hospitals since outpatient and day case revenues provide a crucial contribution to the fixed costs associated with the operation of a hospital. Two of the sixteen specialties considered by the CC are primarily (ophthalmology) and entirely (clinical radiology) outpatient or day-case procedures with no requirement for inpatient support. Even for outpatient specialties requiring access to greater critical care support, an inpatient facility is not necessary: for example, the cardiac catheterisation lab at the Edinburgh Shawfair Park day-case facility has rapid access to the local NHS for critical care support.

1.15 The CC overlooks the combined constraint provided by local rivals to a Spire hospital. Consideration of the contribution of smaller facilities to the aggregate competitive constraint on a given hospital is a basic point of competition assessment that the CC itself routinely considers in other cases. It is not sufficient to assess and dismiss individual local rivals in isolation. Further, the CC's approach is illogical and inconsistent; having considered the aggregate competitive impact of hospitals owned by one operator in that same area (through the network LOCI and 'cluster' analysis), the CC should have also properly considered the aggregate competitive impact on Spire of several hospitals owned by other operators in a given area. It is unreasonable and illogical to take a different approach to assessing a group of Spire hospitals than to assessing a group of competitor hospitals. Evidence shows that in most local areas, there is sufficient capacity in proximity to a given Spire facility to capture a significant proportion of that facility's inpatients. Ignoring the capacity of several smaller competitors understates the alternatives available to patients.

1.16 The CC also ignores evidence of Spire's competitive responses, including substantial and sustained investment in facilities and services in direct response to development by local rivals. The CC often incorrectly assumes that the motives for these investments are anti-competitive (i.e. to strengthen the given Spire hospital's position), when in fact the relevant Spire hospital is worried about and is reacting to competition. For example, Spire Bristol invested in upgrading its diagnostic equipment and endoscopy suite in response to the development of the Nuffield Chesterfield Hospital; Spire Leeds accelerated development of its paediatric offering to compete with Nuffield Leeds; and Spire Cambridge Lea developed a fifth theatre ✕.

1.17 *Second, while the CC says it has considered constraints exerted by NHS hospitals as providers of NHS-funded treatments, on a case-by-case basis, it is unclear whether it really has done so in any individual case.* There is significant evidence of the importance of the NHS, which the CC appears to have ignored in conducting local assessments. The CC's own extensive patient survey indicated that 1/5 of insured patients considered having their treatment carried out by the NHS⁶ and that self pay patients are even more likely to consider switching to the NHS.⁷ In any

⁶ Since 15% of people with an insurance policy actually end up being treated in the NHS, the CC's survey method is likely to understate the true percentage of insured patients that *consider* having treatment at the NHS.

⁷ See paragraph 3.10(a) of Spire's AIS response.

other competition case, diversion of 20% or more would be considered meaningful by the CC, but it is ignored here. Spire highlighted a number of cases in which its hospitals responded to competitive pressures from the local NHS.⁸

1.18 ***Third, evidence of actual competition from PPUs and other private provision by the NHS has been overlooked.*** It is unclear whether the CC has considered: (i) all PPUs (as opposed to merely the ones used for its initial filtering); and/or (ii) non-PPU NHS private work, which accounts for £100 million revenue in England.⁹

1.19 There is significant evidence that PMIs view private provision in the NHS as a real alternative to private facilities.

- (a) During Bupa's delisting dispute with BMI, Bupa circulated to all of its intermediaries a list of hospitals that it recommended be used instead of the delisted BMI facilities. That list contains PPUs and general NHS hospitals in addition to other private hospitals (including Spire hospitals).
- (b) Ramsay emphasised the non-PPU private work within the NHS and the ability this gave the NHS to compete directly for private patient work. For example, when Bupa tendered for MRI scans, it chose the NHS as its provider for private MRIs in Truro. Bupa clearly found the NHS to be a credible alternative to Ramsay for the provision of private care in that specific area.

1.20 The CC's suggestion that it would not expect the lifting of the private revenue cap to change the competitive environment radically in the near future is not consistent with the balance of the evidence. Multiple parties, including PMIs, have pointed to significant changes within the NHS. For example, SimplyHealth (at its Issues Hearing) stated it believed that the NHS market was changing, with more focus being placed on the PPUs. Indeed, SimplyHealth told the CC that it was increasingly being approached to review NHS facilities for private patient recognition. SimplyHealth considered that PPUs and the opening of foundation trusts added an element of competitive pricing to the marketplace. The evidence cited by the CC itself suggests that PMIs (such as Bupa) have considered supporting the entry of PPUs.¹⁰

1.21 There is, in fact, significant evidence of recent or pending entry by PPUs changing the competitive dynamics of areas \times . This evidence has been omitted from the PFs.

- (a) Ramsay has been awarded the contract to operate the Addenbrookes PPU in Cambridge. Spire understands that this will be a significant facility consisting

⁸ See Appendix H to Spire's AIS response.

⁹ See paragraph 3.9 of Spire's AIS response.

¹⁰ Paragraph 223 of Appendix 6.11 to the Report.

of 64 in-patient beds and 5 theatres opening in summer 2016. Again this has been omitted by the CC.

- (b) The Royal Derby Hospital has announced that it will be opening a new private patient ward providing inpatient services in October 2013¹¹. The CC has identified the Nuffield Derby hospital located 1.8 miles away as a solus facility in its local areas working paper.
- (c) The Poole Hospital opened the new Cornelia Suite for private patients in October 2012. The Cornelia Suite offers bariatric surgery, cardiology, endoscopy, general surgery, gynaecology, orthopaedics, paediatrics, maxillo-facial surgery, and ENT surgery, as well as a variety of outpatient services.¹² The Cornelia Suite is located 6 miles from the Nuffield Bournemouth Hospital and 0.2 miles from the BMI Harbour Hospital, which the CC characterised as being in a symmetric duopoly in its local areas working paper.

1.22 The CC cannot properly assess the private healthcare market in the UK without a complete and accurate assessment of the role of the NHS. The evidence demonstrates that PMIs do see PPU's and the NHS as a legitimate source of competition. PMIs use the NHS strategically, as part of their bargaining position, to bring pressure to bear on hospital operators, both in general and in specific areas. This competitive factor has not been taken into account by the CC.

1.23 *Fourth, the PFs irrationally assume there is inadequate competition in duopolies.* A duopoly may, in fact, be an effective competitive structure. The effectiveness of competition in a duopoly must be assessed based on the evidence in individual situations.

1.24 Given the significant fixed costs associated with the operation of a full service hospital (which the CC has recognised), a loss of only a small fraction of work to a rival can significantly harm profitability. As a result, a single competitor can impose a significant competitive constraint, even if this competitor is smaller (or has fewer patients) than a given Spire hospital. Moreover, PMIs can and do steer patients between 'duopolists' thereby incentivising competition between them.

- (a) Even setting aside evidence from the hospital operators as to the degree of competition that they face, the CC's PFs conclusions are inconsistent with the evidence on duopoly competition. AXA highlighted that two hospitals in a medium sized city will generally provide sufficient constraint on each other.
- (b) ✗.

1.25 These examples demonstrate the unreasonableness of the CC's conclusions: the CC has simply rejected concrete, but inconvenient, evidence from customers and

¹¹ See: <http://www.derbyhospitals.nhs.uk/about/latest-news/?entryid22=49139>.

¹² <https://www.poole.nhs.uk/about-us/latest-news/2012-news-archive/new-private-patient-suite-open.aspx>

substituted its own view. The CC has no evidential or analytical basis for general concern in duopoly areas, and to assume otherwise is unfair and unreasonable. In this context, the CC's analysis falls far short of the standard of analytical coherence and cogency needed to sustain an AEC finding.

1.26 ***Fifth, no AEC arises from Spire's common ownership of facilities in a local area.*** The assessment of "common ownership concerns" is flawed for several reasons including the following:

- (a) The analytical framework for reviewing so-called 'clusters' remains vague and confused. Nowhere has the CC properly articulated how and why 'clusters' give rise to competition problems. The CC has, therefore, failed to meet its public law obligation to provide proper reasons for its provisional conclusions, and has then failed to reach a reasonable decision based on understandable and disclosed reasons. The CC must provide further disclosure of this, including details of diversion ratios calculated for all hospitals in the area.
- (b) The CC has identified hospitals with a "common ownership concern" by means of a "cluster effect" calculated as the difference between a hospital's individual and network LOCI. However, as shown in RBB's paper on LOCI (Annex 1), this cluster effect may be higher at facilities that are subject to greater competition. The CC's approach to identifying a cluster cannot therefore be regarded as evidence that such a "common ownership concern" is in fact present.
- (c) The PFs do not provide any evidence that diversion between Spire facilities in a cluster is sufficiently strong for a "common ownership concern" to arise. The CC states that "hospitals that are near one another may be expected to exert a stronger competitive constraint than hospitals located further away". This is nonsensical, for all of Spire's cluster hospitals, there is at least one strong competitor hospital that is closer than the other Spire facilities, so the CC cannot just assume that diversion between Spire hospitals is high enough to cause concern and merit divestment. The CC's own analysis of the effect of hospital proximity suggests, in fact, that diversion may be limited.
- (d) The CC fails to understand that, as a matter of economic theory, Spire's ownership of hospitals A and C does not impact on the diversion ratio from A to rival B, i.e. a measure of how much rival B constrains Spire hospital A. The CC therefore incorrectly *assumes*, without presenting any analysis or evidence, that diversion between Spire hospitals is significant.

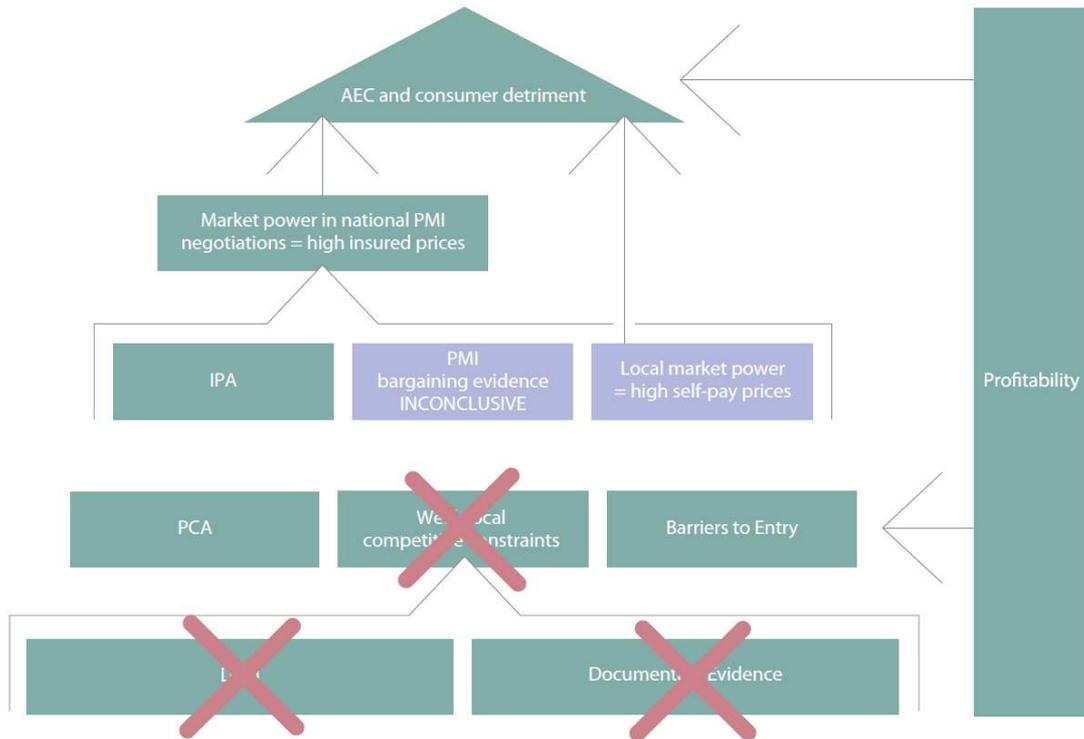
1.27 ***Summary.*** The CC's assessment of local market power does not therefore stand up to scrutiny. Put simply:

- (a) Having ignored outpatient and day-case competitors and excluded this part of the marketplace from its analysis, it is not now open to the CC

to extend its finding of an AEC to cover outpatient and day-case provision.

- (b) The LOCI analysis on which it is based is flawed, heavily skewed to show adverse results and plainly not well-suited to the assessment of private healthcare, being unable to capture competitive dynamics. It is highly sensitive to minor changes in assumptions and to changes in the definition of the submarkets. This latter point is key because the CC wrongly claims that the LOCI avoids this problem. Further, it is an unreliable measure for identifying potential divestments since an increase in WAMS (and the cluster effect) does not necessarily show poor local competition and may actually result from an *increase* in competition.
- (c) Finally, the CC's mechanistic assessment of local competition omits proper analysis of key evidence, as a result the CC fails to take into account relevant information and consistently understates the competitive constraints experienced by Spire facilities.

2. THE EVIDENCE DOES NOT SHOW THAT ANY ALLEGED LOCAL MARKET POWER FEEDS THROUGH INTO NATIONAL BARGAINING



2. THE EVIDENCE DOES NOT SHOW THAT ANY ALLEGED LOCAL MARKET POWER FEEDS THROUGH INTO NATIONAL BARGAINING

2.1 The PFs ignore actual evidence of interactions between PHPs and PMIs in order to conclude that PHPs have power in national negotiations. In fact, the picture that emerges from the evidence is one of a highly competitive sector.

2.2 It is striking that the PFs themselves acknowledge that the evidence on bargaining power is, at best, inconclusive. The PFs state that the CC “did not find that evidence on bargaining on its own indicated whether hospital operators had market power or that PMIs had buyer power.”¹³ Yet, the conclusion is based on a stylised and theoretical assessment of bargaining power, ignoring evidence that contradicts this theory including:

- (a) PMI evidence on the proportion of Spire hospitals that could potentially raise concerns (which is substantially smaller than the proportion suggested by the CC; see Confidential Annex 3 for further details);
- (b) the outcome of actual negotiations which show, at minimum a balance of power between PHPs and PMIs, and in many cases show PHPs have to accede to significant demands made by PMIs;
- (c) the effect of steering and de-listing by PMIs and the role this plays in negotiations; and
- (d) finally, the CC’s conclusion is based on an unsupported assumption that the PMI market would work effectively to pass on any price reductions to policyholders.

2.3 Properly analysed, the evidence actually shows that the bargaining position of PHPs is even weaker than the CC’s PFs acknowledge, and that at least the larger PMIs have significant buyer power in negotiations with PHPs.

A. The negotiating power of hospital operators has been overstated

2.4 The CC finds an AEC by concluding that, where a number of a PHP’s hospitals face weak local competitive constraints, this strengthens the position of a hospital operator, and is likely to lead to higher prices to PMIs at the national level.¹⁴ According to the CC’s local competitive assessment (which is flawed for the reasons described above), Spire has \times hospitals which face insufficient competitive

¹³ See paragraph 6.189 of the Report.

¹⁴ See paragraph 10.3 of the Report.

constraints (significantly more than has been suggested by any PMI), the evidence in fact shows that:

- (a) PMIs contradict the CC's view on Spire's position in local markets;
- (b) Even if Spire did have local market power, there is no evidence of Spire leveraging any alleged local market power in negotiations; and
- (c) Actual market outcomes are inconsistent with the theory of harm set out in the PFs.

2.5 *Spire does not have local market power and therefore could not leverage local market power in national negotiations with PMIs.* The available evidence flatly contradicts the CC's suggestion that Spire has \gg hospitals of concern. To the extent Spire does have 'must-have' hospitals,¹⁵ these are significantly fewer than those identified by the CC. The extent of this contradiction is discussed in further detail at Confidential Annex 3, but highlights are outlined below.

- (a) The evidence shows that neither any PMI nor Spire has ever considered Spire to have anywhere close to \gg hospitals facing limited local constraints.
- (b) AXA, the second largest PMI, only mentions HCA and BMI as having 'must-have' hospitals. While AXA mentions Spire as owning some solus hospitals, it places Spire in the same category as Ramsay and Nuffield: that is, operators who do not have market power, and it concludes that "in the round, there was a balance in the relative levels of commercial leverage between Spire, these hospital operators and PMIs".¹⁶
- (c) Those PMIs that suggest Spire does have some "must have" hospitals or hospitals for which there are limited local alternatives put the number of such hospitals far lower than the CC \gg .¹⁷
- (d) All the evidence also contradicts Bupa's submission that Spire has a "significant number" of must-have hospitals. Even where a much smaller PMI has suggested that some of Spire's hospitals are "must have", those hospitals only amount to between \gg .
- (e) Finally, the hospitals for which Bupa considered that alternatives were poor do not represent a significant part of Bupa's spend on Spire.¹⁸

¹⁵ Bupa argued that where a hospital was located in an area with no, or a very limited number of rival hospitals located nearby (or where rivals lacked sufficient capacity or key specialisms), the hospital was 'must-have' to serve policyholders in the area.

¹⁶ See paragraph 14 of Appendix 6.11.

¹⁷ Three PMIs gave estimates of the number of Spire hospitals in areas of "poor alternatives", "lack of competitors" or "little competition". See paragraphs 28, 34 and 37 of Appendix 6.11 to the Report. See also redacted version of the data room report prepared by Spire's advisors.

This simple, yet important, fact has not been considered in the PFs and undermines the hypothesis that Bupa is captive to Spire for a very substantial proportion of its business (see Confidential Annex 3 for further details).

2.6 The picture that emerges is one where the CC has disregarded the views of customers and substituted its own view rather than follow the preponderance of the evidence. The CC's conclusion that Spire has \times hospitals of concern is not supported by any of the evidence. Further, even if the CC can construct a model that suggests that Spire has \times hospitals of concern, this model is not relevant to an assessment of bargaining between Spire and the PMIs. As the evidence shows, neither Spire nor any PMI has ever negotiated on the basis that Spire had anything close to \times hospitals facing limited local constraints.

2.7 The unbalanced and unfair nature of the PFs' analysis is underscored by the fact that, although the CC finds hospital operators to have 'must-have' hospitals, the CC does not engage properly with the fact that PMIs are 'must-have' customers, the loss of whom would significantly harm hospitals. Put differently, if Spire were delisted this would have a material adverse impact on its profitability as the CC itself recognises (see paragraph 2.21 below), \times .

2.8 ***The evidence suggests that the PFs significantly over-state the strength of Spire's negotiating levers.*** If the PFs' analysis that Spire could leverage hospitals in negotiations with PMIs were correct, one would also expect to find some documentary evidence of Spire achieving higher prices because of the strength of its network. However, no such evidence has been put forward.¹⁹ The PMI documents only indicate in general terms that PMIs consider the number of Spire hospitals located in areas of lesser competition when evaluating their bargaining position. There is therefore no documentary evidence to support the CC's hypothesis of limited "aggregate substitution."

- (a) Far from suggesting that Spire can leverage local hospitals in negotiations, evidence from AXA says it could operate entirely without Spire.²⁰
- (b) PruHealth said that it did not see examples of hospital groups being able to exert market power because of individual local strengths. It believed it negotiated successfully on a national basis, and did not consider that this enabled those hospital groups with a greater number of solus or must-have hospitals to have market power in negotiations.²¹

¹⁸ See paragraph 28 of Appendix 6.11 of the Report.

¹⁹ In this connection, Spire notes that unless the evidence on which the CC relies has been fairly and properly disclosed to Spire, the CC may not, as a matter of public law, rely on that evidence in reaching its decision.

²⁰ See paragraph 35 of Appendix 6.11 of the Report.

²¹ See summary of Issues Hearing with PruHealth.

- (c) Spire considers it to be instructive that the CC has substituted its own assumption for critical evidence from both large and small insurers. If these players are well-placed to negotiate with Spire, it is unclear on what basis the CC could possibly conclude that a much larger PMI such as Bupa lacked sufficient power in its negotiations with Spire, in particular given the CC's finding that Bupa, with a market share of around 40%, is the strongest of the PMIs.

2.9 The absence of documentary evidence consistent with the theory of harm set out in the PFs should have given the CC significant cause for concern as to accuracy of its assumption; particularly when the actual documentary evidence sets out clearly, in a number of material respects, evidence from PMIs which contradicts the CC.

2.10 Had the CC assessed the outcome of negotiations, it would have discovered that, the evidence weights in favour of a finding that PMIs have substantial buyer power. For example, in its negotiations with Bupa on its 2012 contract, Spire sought a price increase, but only achieved which was.

2.11 Even where a PMI has taken action with a view to harming or disciplining Spire, Spire has not been able to respond in response to PMIs' recognition of rival hospitals.

(a) .

(b) .

2.12 This is a critically important part of the analysis. There is no evidence to show that Spire can dictate terms to PMIs or that actual market negotiations have played out in the way hypothesized in the PFs. Flatly, the evidence simply does not support the conclusion that Spire can use its local market position to charge higher insured prices.

B. The bargaining strength of PMIs has been understated: PMI patient diversion techniques give PMIs significant buyer power

2.13 *The evidence shows that large PMIs (Bupa, AXA, Aviva) can (and are increasingly able to) derive significant bargaining strength from their ability to steer patients to specific facilities.* Indeed, despite expressing some concern about poor competition in certain areas, not one of the PMI documents made available to Spire suggests that it is not feasible to shift volumes from Spire hospitals to rival facilities. The CC downplays the force and effect of the various techniques used by PMIs to exert purchasing power. The effectiveness of the PMI patient diversion techniques, including hospital delisting, steering (so-called guided or open referral) and restricted networks, place PMIs in a significantly stronger bargaining position than the hospital operators.

2.14 The PFs suggest that the “[k]ey to understanding the negotiating position of hospital operators and PMIs is the extent to which PMIs can exert meaningful control over where their policyholders are treated.” PMIs have a number of mechanisms for exerting control over where their policyholders are treated including delisting,

restricted networks and open referral. The evidence in the PFs suggests that all of these mechanisms provide PMIs with meaningful control over where their policyholders are treated, and that PHPs do not have any meaningful way of counterbalancing these mechanisms. As such, the preponderance of the evidence shows that PMIs, or at least the larger PMIs, have substantial buyer power in negotiations with PHPs.

1. The evidence before the CC, from both the PMIs and Spire, shows that delisting is a significant and credible threat

2.15 The preponderance of the evidence shows that at least for large PMIs the scope to delist even the larger hospital operators gives a PMI buyer power. For example, AXA thought that “outside of London the threat of delisting a hospital could have a disciplining effect”.²² Given its recent delisting of 37 BMI hospitals it is extremely unclear why Bupa would think that “the threat to delist was often of limited credibility.”²³ In Spire’s view, the CC is right to view Bupa’s commentary on the BMI-Bupa de-listing episode with a high degree of scepticism; this commentary does not correspond with the evidence, as set out in further detail in Confidential Annex 3.

2.16 ***The evidence shows that PMIs are confident that they could delist even the large hospital operators.*** The CC has not fully taken into account the evidence from the PMIs as to the proportion of Spire’s portfolio that could be delisted. AXA indicated that it would be prepared to go out of contract with Spire if it did not agree to its commercial proposals, noting that AXA volumes are “critical to Spire and that they [Spire] will agree to our terms rather than go out of network.”²⁴ All three PMIs’ that identified Spire as having hospitals located in areas of weaker competition estimated that fewer than 30% of Spire hospitals were located in such areas, suggesting that, \propto .²⁵

2. The available evidence demonstrates that the effects of a delisting are much more severe for hospital operators than PMIs

2.17 ***As the CC correctly acknowledges, there is no evidence to suggest that hospital operators consider they would be able to replace lost insured revenue from other sources, such as NHS revenue or self-pay patients.***²⁶ According to the evidence, PMIs make up the single largest source of revenue for each hospital operator (except Ramsay). Since Bupa makes up the largest source of Spire’s PMI revenue, Bupa is clearly an essential customer.²⁷ Likewise, AXA reported it was prepared to go out of contract with Spire, but it believed this was unlikely to happen

²² See paragraph 74 of Appendix 6.11 of the Report.

²³ See paragraph 73 of Appendix 6.11 of the Report.

²⁴ See paragraph 113 of Appendix 6.11 of the Report.

²⁵ See redacted version of the data room report prepared by Spire’s advisors.

²⁶ See paragraph 241 of Appendix 6.11 of the Report.

²⁷ As Ramsay pointed out at its Issues Hearing, the two largest PMIs account for 65% of the market and the top four account for 87% of the market and they are therefore obligatory trading partners.

as its volumes were so critical to Spire.²⁸ Loss of insured volumes could be significant. Unlike PMIs which can direct patients to particular PHPs for treatment, PHPs have no ability to direct their patients between PMIs.

2.18 Further, as is acknowledged in the PFs, PMIs are able to select which hospitals to delist, allowing them to maximise harm to a PHP while minimising harm to themselves. This was Bupa's approach in its dispute with BMI.²⁹

2.19 ***The CC overlooks strong evidence suggesting that hospital operators are harmed*** by (at least) the larger PMIs. The evidence and even the CC's analysis suggests that, while both parties are likely to be harmed, BMI.³⁰ The PFs specifically state: "Hospital operators appear most unlikely to be able to replace any lost business rapidly and would be severely impacted by delisting."³¹

2.20 This much is clear first from the BMI and Bupa evidence concerning the delisting of BMI facilities. That evidence in fact shows that:

- (a) Almost all the internal Bupa evidence³² relating to the effect of the delisting on BMI suggests that the effects of delisting were more severe for BMI than Bupa.
- (b) SimplyHealth also expressed concern in this regard: "in the event that a hospital was delisted by a major insurer, the concern was that this could impact the long-term sustainability of that hospital or hospital group."³³

2.21 This evidence is consistent with Spire's own internal analysis, which shows that delisting would be harmful and a significant delisting would be very harmful (See Annex 4). Spire has instructed L.E.K. to prepare additional evidence concerning the effect a delisting would have on Spire. L.E.K.'s report is attached as Annex 4. This analysis shows that:

- (a) Harmful.
- (b) Very harmful.
- (c) Very harmful.

2.22 By contrast, evidence suggests that Bupa and AXA are likely to be *less* severely affected by a delisting and could, for example, offer national coverage without the inclusion of all Spire hospitals. For example, AXA thought it could shift

²⁸ See paragraph 113 of Appendix 6.11 of the Report.

²⁹ See, Provisional Findings, 6.168.

³⁰ See paragraphs 97-100, 103-104, 229, 244, 256 and 257 of Appendix 6.11 of the Report.

³¹ Provisional Findings, para 6.159.s

³² Four out of the five documents referred to.

³³ See SimplyHealth's Issues Hearing summary.

Spire volumes to rival providers without incurring a material adverse cost effect. In the best case, it could use the additional Spire volumes to negotiate a *discount* and end up with an overall cost saving.³⁴ If AXA thinks it could mitigate the effects of a delisting in this way, it is unclear why Bupa could not do the same.

2.23 Although some PMIs expressed concern about retaliatory price increases in general, only one (smaller) PMI raised this concern specifically with respect to Spire. But equally, it did not say that it would not be feasible to delist or shift Spire volumes to rivals where it could potentially negotiate discounts.

2.24 The PFs do not properly assess the consequences of this analysis. It is not sufficient to simply reference the lack of alternatives available to PHPs, the effect of this lack of alternatives on the outcome of negotiations must be assessed. Had the CC done so, it would have concluded beyond any doubt that the PMIs enjoy very substantial market power.

2.25 ***When considering the impact of delisting on a PMI or hospital operator, the PFs do not reflect evidence showing that the financial position of PMIs puts them at an advantage in negotiations because they are better able to withstand the financial consequences of a dispute.*** This is despite the PFs acknowledging that financial positions are relevant to the threat of delisting. PMIs have a relatively entrenched position and benefit from a stable cash flow from policyholders.³⁵ Indeed, Bupa at times considers itself to have the upper hand in negotiations over hospital operators.³⁶ Hospital operators, on the other hand, have a high proportion of committed and operational costs, which means any immediate disruption to cash flow in the event of a dispute is likely to be more severe for hospital operators than for PMIs.

3. Although open referral is a relatively new strategy, the CC's analysis does not adequately reflect the PMIs' confidence in open referral as a tool to constrain hospital operators

2.26 Evidence from PMIs supports the view of hospital operators that guided referral is a growing trend and that the PMIs consider (and describe it internally) as a tool with great potential to discipline hospital operators. The evidence highlights the PMIs' strategy of, and confidence in, using guided referrals.³⁷ As Spire notes, X .³⁸ Aviva noted that "routing is a top *business* priority",³⁹ suggesting that it is an effective

³⁴ See paragraphs 35, and 36 with respect to Nuffield, of Appendix 6.11 of the Report.

³⁵ See paragraph 232 of Appendix 6.11 of the Report.

³⁶ See paragraphs 97-103, 244, 256-257 of Appendix 6.11 of the Report.

³⁷ See paragraphs 182, 184 and 190-194 of Appendix 6.11 of the Report.

³⁸ See paragraph 193 of Appendix 6.11 of the Report.

³⁹ See paragraph 149 of Appendix 6.11 of the Report.

mechanism to discipline hospital operators. Aviva's experience⁴⁰ suggests at least some success of such initiatives, and Bupa's internal documents show that [X].⁴¹

2.27 Evidence of Spire's recent negotiations with AXA clearly shows that open referral is a growing trend⁴² and PMIs use it to steer patients to hospitals where they get the best price but not necessarily the best quality. Since Spire declined to participate in AXA's core corporate open referral product, AXA offered to direct open referrals to Spire in exchange for a discount. X.

2.28 X.

2.29 Similarly, Bupa will *extend* its guided referral product to individuals, which also suggests that the policy is effective. Other hospital operators have also pointed to the significance of open referral, Ramsay indicated at its Issues Hearing that Bupa operated open referrals which are more active and aggressive in directing patients and limiting patient choice.

2.30 Smaller insurers are also launching open referral schemes. Aviva launched a new corporate open referral scheme on 1 July 2013 stating that it had been "developed to both manage the rising cost of claims and to meet an increasing need by some corporate clients to control their healthcare spend." Aviva has also indicated that a substantial proportion of its claims are open referral claims: "18% of all Aviva PMI claims met in 2012 were on an open referral basis."⁴³ SimplyHealth have recently launched an open referral policy for personal customers.⁴⁴

2.31 Further information about the growth and significance of open referral policies is provided in Confidential Annex 3.

2.32 In short, the evidence shows PMI confidence in guided referral policies, which implies at least some effectiveness in diverting patients away from certain hospitals.⁴⁵ The evidence allows the CC to reach a firmer conclusion with respect to PMI steering and the additional leverage / bargaining strength this gives to PMIs. As the CC seems to acknowledge, there is scope for the growth of PMI steering in the future.

4. The CC has acknowledged that PMIs have significant scope to adjust restricted networks to constrain hospital operators, but appears not to have considered the effect of the substantial number of restricted networks in the market

⁴⁰ See paragraphs 196-197 of Appendix 6.11 of the Report.

⁴¹ See paragraphs 200 and 202 of Appendix 6.11 of the Report.

⁴² See Confidential Annex 3: National Negotiations.

⁴³ See: <http://www.aviva.com/media/news/item/uk-aviva-launches-guidewell-making-pmi-more-sustainable-and-affordable-for-large-corporates-17164/>.

⁴⁴ See: https://www.simplyhealth.co.uk/shcore/sh/content/pdfs/tsandcs/simplypersonalhealth_ts_cs_c.pdf.

⁴⁵ See also Bupa internal evidence which points to the effectiveness of steering: Figure 4, paragraph 182 of Appendix 6.11 of the Report.

2.33 As the CC notes, where PMIs operate relatively restrictive networks, they have additional scope to adjust these whilst maintaining satisfied customers who recognize that they have foregone some choice in exchange for other benefits.

2.34 Adjusting the composition of networks is an effective and potentially less costly mechanism than delisting for PMIs to shift volumes from hospital operators to rivals. Although Bupa notes that non-participation of BMI and Spire meant that its low-cost network was unsuccessful, AXA's low cost network has shown growth after a challenging start. Interestingly, the smaller PruHealth was very successful in securing "excellent pricing *submissions* from the main five hospital groups" when it introduced a restricted network.⁴⁶

2.35 The evidence cited by the CC in the PFs does not support the CC's conclusions. Rather, evidence shows that the balance of power weighs in favour of (at least the large) PMIs in negotiations with hospital operators:

2.36 There is therefore no reasonable basis for the CC's provisional conclusion that Spire has market power in negotiations with PMIs arising from high concentration and insufficient competitive constraints at the local level. The CC has failed to show on a balance of probabilities with respect to Spire that it is more likely than not that features of the private healthcare market lead to an AEC. The conclusion reached by the CC is not one that a reasonable authority could have reached.

C. Proper functioning of the PMI market is assumed

2.37 *The CC's assessment of potential consumer benefits from discounting by hospital operators relies on the significant and unsubstantiated assumption that PMIs pass on the benefits of discounts to consumers.* The CC *assumes* that PMIs pass on cost savings from guided referral policies to policyholders because it has "no evidence to suggest that in particular the corporate sector, where many of these initiatives have been launched, will not respond accordingly".⁴⁷ This is wholly inappropriate. It is impermissible for the Commission to assume the accuracy of a core fact underlying its conclusions: facts must be founded on proper investigation and consideration.⁴⁸

2.38 There is no evidence on which the CC could reach this conclusion. In fact, as WPA noted at its Issues Hearing, there is a risk that the two larger insurers could be in a position where they could dictate terms with hospitals as well as consultants. Other hospital operators have also expressed concern in this regard. Ramsay, for example, did not see PMIs driving down costs and improving efficiencies within their own businesses. In fact, the CC *specifically* excluded PMI competition from the scope of its initial investigation and gathered no evidence or analysis on the point. This

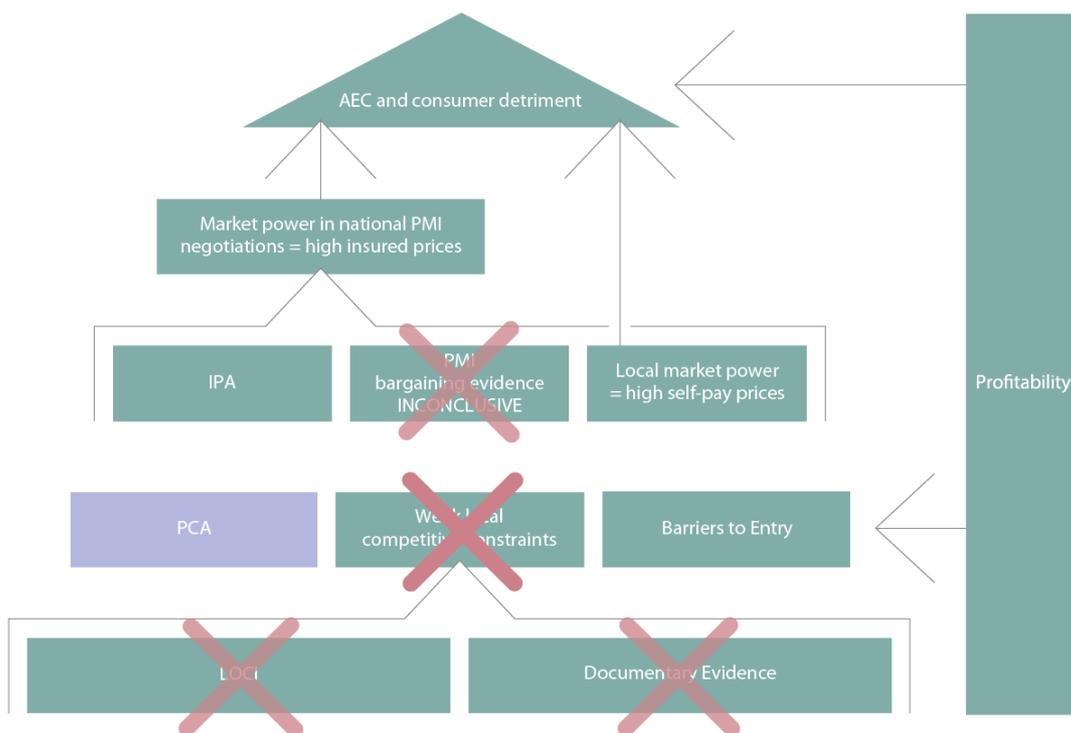
⁴⁶ See paragraph 147 of Appendix 6.11 of the Report; PruHealth's comment related to a tender exercise it organised in August 2009 to reconfigure its hospital networks and to launch a series of new insurance products.

⁴⁷ See paragraph 7.78 of the Report.

⁴⁸ *Tesco plc v Competition Commission* [2009] CAT 6 at para 124.

exclusion was in spite of the large volume of initial submissions from the main parties and third parties including members of the public and consultants indicating that this would be an important aspect of any review of the market. The argument now that “there is no evidence not to believe” that benefit will be passed on to consumers is inadequate to support this finding. Absent a proper investigation of the competitiveness of the PMI marketplace, it is not open to the CC as a matter of law to reach this conclusion on benefits to consumers.

3. THE PRICE CONCENTRATION ANALYSIS DOES NOT SUPPORT THE CC'S PROVISIONAL CONCLUSION THAT SPIRE HAS MARKET POWER WHICH IT EXERTS TO CHARGE HIGH PRICES TO SELF-PAY PATIENTS



3. THE PRICE CONCENTRATION ANALYSIS DOES NOT SUPPORT THE CC'S PROVISIONAL CONCLUSION THAT SPIRE HAS MARKET POWER WHICH IT EXERTS TO CHARGE HIGH PRICES TO SELF-PAY PATIENTS

Overview

For the reasons described in Section 1 above, the analysis contained in the PFs of local competitive conditions is fundamentally flawed.

The PFs seek to bolster the local competitive assessments through the PCA analysis: aiming to identify a broad relationship between self-pay prices and concentration that is representative of the industry.

The CC has failed to identify a relationship between self-pay prices and concentration both in general and in relation to Spire in particular.

The data included in the CC PCA is not representative of the industry, and even within this limited data set, the conclusions are driven by a very small subset of the data.

It is unlawful to seek a remedy for market power from a firm when it cannot be shown that that firm is charging higher prices. Results of a broader averaging exercise across a market are insufficient as a matter of law and fact to support such a draconian remedy.

3.1 The PCA is a central pillar supporting the provisional finding of an AEC for both self-pay and insured patients.

- (a) With respect to self-pay patients, the PFs conclude: "Our PCA shows that there is a causal relationship between self-pay prices and local concentration... As a result, we conclude that hospital operators with hospitals in relatively more concentrated areas, thus facing insufficient competitive constraints, have market power in relation to self-pay patients in these areas. Self-pay prices in these areas are currently at higher levels than would be expected if there were lower levels of concentration."⁴⁹
- (b) With respect to insured patients, the PFs indicate that the "analysis of insured price outcomes and their drivers does not, on its own provide evidence of a causal relationship between a given characteristic reflecting the substitutability of hospitals ... and insured price outcomes"⁵⁰, but relies on the PCA as evidence to support a conclusion

⁴⁹ Provisional Findings, para 6.202.

⁵⁰ Provisional Findings, para 6.239.

that a hospital operator can charge higher prices to a PMI where it has more hospitals facing weak competitive constraints.⁵¹

3.2 Given the importance of the PCA as a basis for conclusion, extrapolation and conjecture in the PFs, the PCA must itself be robust and sustainable. As set out below, and in greater detail in Confidential Annex 5, it is not. The analysis is based on an extremely small dataset, and even within that dataset the result is driven by a very small subset of the data, is not robust to sensitivity testing and does not show a relationship between price and concentration for Spire. In sum, the analysis does not provide a lawful basis for the CC to conclude that there is a positive relationship between price and concentration, or that there is an AEC with respect to either self-pay patients or insured patients.

A. The CC's provisional conclusion that there is a general and causal relationship between higher local concentration and higher self-pay prices is not borne out by the CC's own analysis.

3.3 The PCA cannot support industry-wide conclusions about the relationship between price and concentration. The CC's analysis raises a range of specific concerns. These concerns as set out below are explained in greater detail in RBB's report attached as Confidential Annex 5. These are serious and material problems with the CC's PCA and mean that none of the PCA analysis can be relied upon.

- (a) ***The dataset relied upon in the PCA is inadequate and cannot support general conclusions.***
 - (i) The admissions data included in the PCA dataset are no longer representative of the underlying positions of the operators. BMI is the largest provider of self-pay treatments, yet the data set used in the analysis includes 40% more admissions for Nuffield than for BMI. This skewing of the data is a result of the CC's data cleaning process, which involved inter alia dropping a substantial proportion of the data on the basis that they were "irregular" observations. This skewing of the data alone should have caused the CC to question the reliability of the results. Although the CC's original inpatient data set contained approximately 3,000,000 admissions, the PCA analysis is conducted across a data set consisting of only approximately 10,600 admissions (or less than 1% of the total admissions in the original data set).
 - (ii) The data included in the analysis represents a very small proportion of the total data. The PFs state that the four treatments included in the analysis account for almost 60 per cent of acute self-pay inpatient episodes and over 60 per cent of revenue. However, the observations included in the CC's analysis represent less than 40% of self-pay inpatient revenues at all but one Spire hospital, and the data used represents only 15% of Spire's total self-pay inpatient revenue and 7% of Spire's total self-pay inpatient admissions. The PFs therefore

⁵¹ Provisional Findings, para 6.240.

convey a false impression of the representativeness of the data included in the analysis.

- (b) ***The CC's results are driven by an extremely small and unrepresentative fraction of the data.*** The CC's base specification and sensitivities cannot establish a statistically significant effect of concentration on price with the exclusion of *only two treatments in one single region, UKH. Moreover, the results based on the self-pay LOCI are no longer statistically significant with the exclusion of the observations for the same two treatments of single operator in a single region.* Consequently it is clear that the CC's results crucially and erroneously rely on an extremely small subset of observations in one single region only. The CC's general conclusion cannot be said to be a valid estimate of the general effect of concentration on price present across the industry. Instead it is a distorted estimate which appears to be driven by a small subsection of the industry, if at all.
- (c) ***As a matter of theory, the CC incorrectly concludes that the results of its IV estimation are not biased.*** The CC has not resolved the problem of "endogeneity", i.e. the problem that its LOCI measure cannot be treated as determined independently of the self-pay price or variables omitted from the estimated model. The CC has sought to address this problem by using an instrumental variable (IV) approach. However, fundamental errors remain. First, the CC ignores the endogeneity on the *supply* side and uses instruments which fail to satisfy the necessary conditions, they are themselves likely to be correlated with both demand and supply variables omitted from the analysis. Second, the CC does not correctly interpret the outcome of its own analysis, such that the conclusion it draws from them are incorrect. Finally, the CC's IV estimation does not satisfy the conditions required for this method to identify the general causal relationship between concentration and price; the CC's results are therefore unreliable and cannot be said to measure the average relation between concentration and price present across the industry. This is not a lawful basis on which the CC can reach an AEC finding.
- (d) ***LOCI is not reliable as a measure of local market power, and therefore should not be used to infer the existence of a price concentration relationship.*** As discussed in greater detail at paragraph 1.5 and following, the LOCI measure is not a meaningful indicator of local competition. Given this warning, it is remarkable that the CC has persevered with LOCI analysis and used such a flawed measure at the very heart of its analysis.
- (e) ***The CC has not correctly controlled for all relevant factors that affect both concentration and price.*** The CC recognizes that treatment prices may vary considerably at a given hospital, and has attempted to account for this by controlling for a number of factors (e.g. provision of level 3 critical care, average direct costs to the

hospital, local area characteristics). However, nearly all control variables are either constant across patients treated at a given hospital, or constant for all hospitals within a given region (e.g. Nuts 1 dummies). The only patient-specific control variables used by the CC are patient age, patient gender and the number of nights per episode (which is used as a partial proxy for the severity of the particular treatment), which cannot sufficiently control for all crucial factors affecting patient specific treatment costs. Furthermore the CC's IV estimation cannot control for this issue as the instruments selected are not exogenous, and in any case, do not correlate well with all sub-segments of the data. Other relevant variables that should have been considered by the CC include drugs, prosthesis, patient BMI, treatment option chosen by the consultant and inclusion (or exclusion) of follow-on treatment from the package. As long as the CC does not correctly control for patient level variation in the treatment cost, or identify valid and relevant instruments, the estimated relation between price and concentration is likely to be biased and unreliable for the purpose of the CC's conclusions.

- (i) In fact, in Spire's response to the CC's initial PCA data room, Spire's advisors showed that additional controls were able to address a crucial driver of omitted variable bias. As a result, the magnitude of the effect of concentration on price was reduced so considerably that it was no longer statistically significant. Rather than resolve these concerns raised by Spire, the CC has simply *removed* the treatments for which Spire expressly identified the existence of this concern. Not only does this further limit the generality of its PCA results, it also fails to recognise that the remaining treatments are subject to the same bias.

3.4 The series of concerns and problems set out above in relation to the revised PCA analysis mean that the conclusions set out in the PFs based on the PCA are unreasonable and irrational. No authority properly addressing the questions and issues faced would have decided to use the PCA analysis as the CC has done: especially not an analysis where its underlying robustness cannot be demonstrated, and where the available data show that there are underlying problems with the analysis.

B. The CC's analysis does not show any results consistent with local market power for Spire

3.5 However, the problems with the PCA analysis are not limited to those mentioned above. The PCA set out in the AIS did not find any individual result for Spire consistent with market power in local areas. Significantly, the revised PCA analysis set out in the PFs again finds no result consistent with local market power for Spire. Nonetheless, the CC concludes that the evidence shows that Spire has local market power because, the CC claims, the averaging effect across all hospital operators does show such an effect.

3.6 This is a legally and economically flawed argument. Without prejudice to the argument made above regarding the validity of the PCA as conducted, even if that analysis showed a statistically significant effect across the board but not for Spire, that would not justify a finding that Spire had local market power because:

- (a) The CC's statutory task, of considering whether any features of a market result in an AEC and then to remedy that effect, requires the CC to identify the true cause of the AEC: the CC's argument amounts to no more than a broad assertion that a remedy can be attached to a firm regardless of whether it has market power or not. The CC's argument is simply that a firm can be sanctioned so long as it is active in a given market. Put another way, the PCA does not provide any evidence to suggest that Spire's pricing behaviour is the *cause* of any self-pay (or insured pricing) AEC.
- (b) The CC's economic analysis renders moot any actual discussion of market power: the thrust of the CC's argument is that, if other firms in a market appear to have market power, then a firm without market power can be found nonetheless to have such power. Moreover, the CC's PCA results appear to be driven by the inclusion of an operator that the CC subsequently finds does not have market power. This is nonsensical.
- (c) The illogicality and inconsistency of the CC's analysis is underscored by the fact that Spire is said to have market power because of a general industry result, but Ramsay is found not to have achieved excess profits notwithstanding the CC's conclusion on industry-wide profitability.

3.7 In sum, the PCA does not identify a relationship between price and concentration for Spire hospitals and does not therefore show Spire market power over self-pay patients. No rational authority could rely on the results of this analysis, and especially not to mandate divestment remedies. Such a drastic remedy cannot be founded on an unsubstantiated assumption of local market power against an individual firm.

C. The CC illogically and inappropriately uses the PCA results on self-pay pricing to weight evidence on Spire's strength as regards insured prices and negotiations

3.8 The CC's approach to evidence is demonstrably illogical.

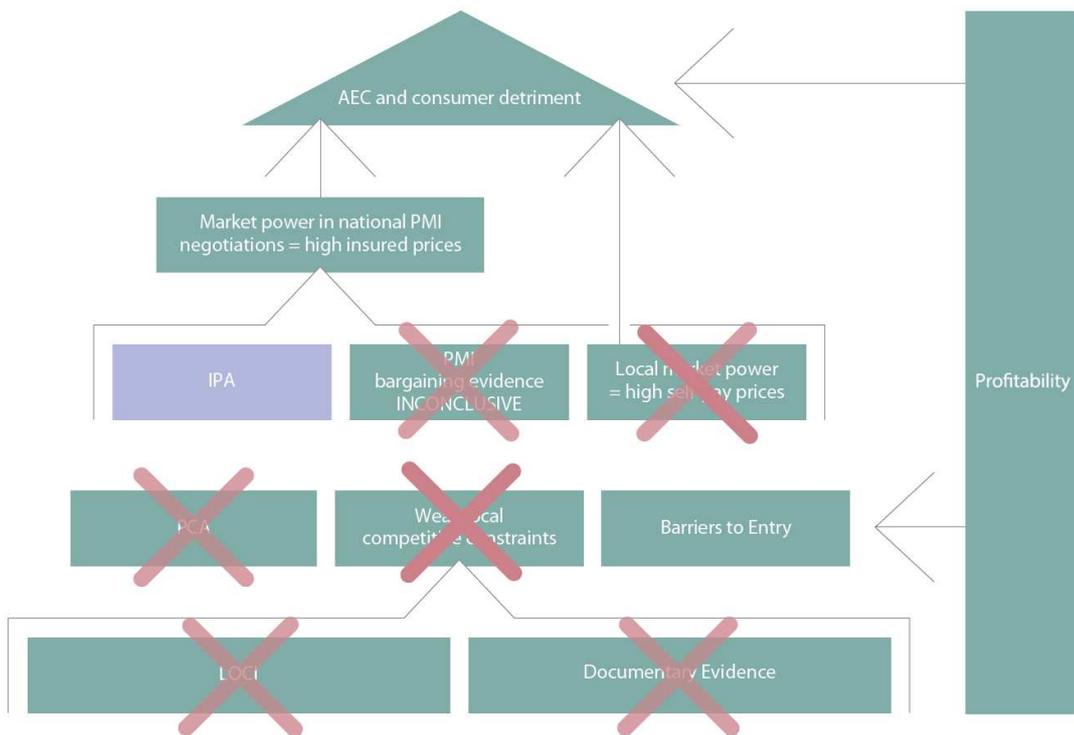
- (a) First, as set out above, the CC in any event presents no evidence to support the view that Spire sets higher self-pay prices in areas where local concentration is higher.
- (b) Second, the CC acknowledges that when assessed on its own, evidence on national bargaining does not indicate a causal relationship between higher concentration and higher insured prices for Spire (see above).

- (c) Third, the CC explicitly states that the evidence on Spire's insured prices does not demonstrate that higher concentration causes higher prices (see below).

3.9 Given these conclusions, this should be the end of the analysis. There is, concretely, no evidence whatsoever advanced against Spire specifically which can demonstrate that Spire achieves higher prices at a local or national level.

3.10 However, the CC does nonetheless conclude that Spire, alongside HCA and BMI, has market power and has been charging higher prices. As regards national pricing, the CC cites its findings on the insured pricing analysis and the PCA as a reason to infer against Spire, despite the evidence lacking analytical robustness and inconsistent results. Likewise, the CC infers that higher concentration leads to higher insured prices in the case of Spire (citing its findings on national bargaining and the PCA as a reason to find against Spire). This reasoning is specious: it is based essentially on a circular reasoning that prices must be higher because the CC thinks that they must be and this is consistent with a finding of excess profitability. It amounts to the CC arguing that the flaws and errors in its analysis and reasoning should be overlooked because it has generated consistent results. This logic does not mean that the PFs are correct and it would be irrational for the CC to seek to proceed to an adverse finding of AEC on this basis.

4. THE INSURED PRICING ANALYSIS IS NOT CONSISTENT WITH THE CC'S PROVISIONAL CONCLUSION THAT SPIRE HAS MARKET POWER IN NEGOTIATIONS WITH PMIs WHICH IT EXERTS TO CHARGE HIGHER INSURED PRICES



4. THE INSURED PRICING ANALYSIS IS NOT CONSISTENT WITH THE CC'S PROVISIONAL CONCLUSION THAT SPIRE HAS MARKET POWER IN NEGOTIATIONS WITH PMIs WHICH IT EXERTS TO CHARGE HIGHER INSURED PRICES

Overview

The insured pricing analysis is the cornerstone of the CC's conclusion that Spire has market power in negotiations with PMIs and its finding of an AEC with respect to insured pricing. This analysis, however, is seriously flawed and cannot support the CC's conclusions in the provisional findings.

The presentation of the results of the CC's own IPA analysis in the main PF report is materially incomplete and raises serious questions as to whether relevant materials is being considered in assessing the market.

Spire has not, over the reference period, consistently priced above hospital operators that do not have market power. A comparison of insured price outcomes does not support a finding that Spire has market power.

The evidence further shows that, where Spire has priced above hospital operators that do not have market power, the price differential to at least one operator without market power has typically not been significant or economically meaningful. An insignificant price differential between Spire and PHPs found not to have market power does not provide a basis for a conclusion that Spire has market power.

The analysis of insured price drivers does not support a finding of causality between measures of hospital substitutability and insured prices. The finding is based on inadequate evidence and assumption and cannot, as a matter of law, be maintained.

4.1 The PFs specifically state that the evidence on bargaining is inconclusive: “[w]e did not find that evidence of bargaining on its own indicated whether hospital operators had market power or that PMIs had buyer power”.⁵² As such, the insured pricing analysis (*IPA*) is the main support for the conclusions in the PFs (i) that certain PHPs have market power in negotiations with PMIs; and (ii) that weak competitive constraints in local markets give rise to an AEC and are likely to lead to higher prices for insured patients. Given the huge weight placed on the IPA, this analysis must be robust and careful. As demonstrated below, the IPA is not robust and does not form a basis to support the CC's conclusions.

4.2 The presentation of the results of the CC's own IPA analysis in the main PF report is materially incomplete and raises serious questions as to whether relevant materials is being considered in assessing the market. A significant body of relevant,

⁵² Provisional Findings, para 6.189.

material, exculpatory evidence is omitted in the main PF report. It is not sufficient that relevant exculpatory evidence can be found in tables included in an appendix to the report, particularly when this evidence contradicts the evidence presented in the main report and would lead to a conclusion that Spire does not have market power in negotiations with PMIs.

4.3 There are two aspects to the IPA. First, the CC has sought to assess insured price outcomes across hospital operators. Second, the CC has sought to assess the drivers of insured price outcomes. The PFs indicate that: “[t]he analyses of price outcomes and drivers of price outcomes across hospital operators can provide a useful insight into the degree of any market power held by hospital operators in negotiations with PMIs”⁵³ Each aspect of the IPA is addressed below and neither withstands scrutiny.

A. The CC’s assessment of insured price outcomes across hospital operators is not consistent with the CC’s conclusion that Spire has market power in negotiations with PMIs

4.4 The IPA is not consistent with the proposition that Spire has “market power in negotiations with PMIs arising from high concentration and an insufficiency of competitive constraints at the local level”. In particular, the evidence does not show that Spire prices consistently above hospital operators that do not have market power. Even in those instances where Spire’s prices were higher than those of hospital operators that were found not to have market power, the price differences to at least one such operator are, in almost all cases, very small.

1. Spire does not consistently price above hospital operators without market power

4.5 According to the PFs, Spire’s portfolio includes hospitals that are on average less substitutable than those of Ramsay and Nuffield (hospital operators without market power) and this allows Spire to charge higher prices to PMIs. To be consistent with this hypothesis, Spire’s prices *for each individual PMI* should materially exceed those of operators with hospitals that are on average more substitutable. After all, Spire’s portfolio of hospitals does not vary according to each PMI, and the outcome of the insured price rankings should therefore be consistent across PMIs and over time if a general relationship between price and portfolio substitutability exists.

4.6 The conclusion in the PFs is detached even from the analysis in the PFs. The CC concludes that Spire has market power, yet acknowledges that Spire’s prices are not consistently higher than those of hospital operators found not to have market power: “Spire is the second highest price operator, after BMI, to PMIs ... on the basis of the price index in the last two years 2010 to 2011”.⁵⁴ This assessment in itself does not tell a convincing and compelling story of market power. Further representations regarding the probity of the CC’s analysis are contained in Annex 3 prepared on

⁵³ Provisional Findings, para 6.205.

⁵⁴ Provisional Findings, para 6.247(c).

Spire's behalf in the data room. That submissions further addresses the fact that the CC's analysis has weakened still further following correction of the data.

4.7 The lack of support for the PFs' conclusion that Spire consistently prices above PHPs found not to have market power is further elaborated in Spire's Confidential Annex 6. One important point to note, for which evidence is provided in Confidential Annex 6 is that the CC's reliance on weighted average price indices to rank hospital operators according to prices charged masks significant variations in the rankings of hospital operators across PMIs.

4.8 It simply cannot, therefore, be the case that the insured price analysis supports the proposition that Spire earned excess profits as a result of market power. If the CC wishes to reach a finding of market power on the part of a firm, it can only do so on the basis of clear, coherent and compelling evidence. The CC's own evidence base does not provide that clear and compelling perspective. The PFs' conclusion is therefore irrational and unlawful.

2. Where Spire's prices are higher than those of hospital operators without market power, the difference is not significant or economically meaningful

4.9 It should also be noted that this observation is particularly important given the limitations of the analysis (as recognised by the CC at paragraphs 5 and 6 of Appendix 6.12). The shortcomings of the analysis suggest that the ranking and relative pricing of operators may not be reliable where the differences in price indices are small. More specifically, PHPs and PMIs typically negotiate over a basket of treatments, rather than the price for each individual treatment. As a result, a PHP may charge a relatively high price for one treatment, and a relatively low price for another. Particular caution should therefore be taken when ranking operators according to a basket including only a restricted set of treatments. Where basket prices are very similar the inclusion of an additional treatment may change the basket price such that the ranking of operators is altered. As discussed in the next section, we find that this is the case for some PMIs. This in itself does not provide the clear and compelling evidence to support the CC's conclusion.

4.10 ✕.

4.11 ✕.

The PFs' assessment of drivers of insured price outcomes does not show causality between measures of hospital substitutability and insured prices

4.12 The CC's analysis correlating hospital characteristics and price indices cannot meaningfully inform the CC as to the ability of PHPs to exert market power.

- (a) There are many reasons why a PHP charges a higher price for a given basket of treatments, other than this PHP extracting higher prices due to market power. For example, cost differences, as opposed to market power, may explain higher prices. Other than HCA, the CC has not

accounted for costs (or other factors such as quality), and its analysis is therefore insufficient to identify market power.

- (b) The hospital characteristics used by the CC to assess the “desirability” of a PHP’s portfolio can justify a higher basket price for reasons other than market power. For example, the CC has counted a PHP’s hospitals with critical care level 3 as a way to identify the desirability of that PHP’s portfolio. However, the operator of a critical care level 3 is associated with significant costs. Higher prices earned by a PHP with more critical care units may thus simply reflect the higher costs and complexity associated with the operation of such units.

4.13 It is also striking that the PFs acknowledge that the IPA findings do not show causality between measures of hospital substitutability and insured prices.⁵⁵ The CC nevertheless concludes causality based on its expectation that hospital operators with more hospitals facing weak competitive constraints in locations important to PMIs charge higher prices to PMIs. The CC is required by law to set out clearly, cogently and in detail the evidence, analysis and reasoning on which it relies. The PFs with respect to insured pricing do not meet this standard; they are based on inadequate evidence and assumption. In particular, the CC claims that its view on the relationship between hospital substitutability and insured pricing is supported by the results of three pieces of its analysis:

The CC’s basis for its conclusion on the relationship between hospital substitutability and insured prices:

1. “our analysis of insured price outcomes is consistent with this relationship”

The CC itself has acknowledged an inadequate evidentiary base: “our price measures do not fully control for differences in the mix and the analysis does not control for all factors that influence negotiations”

2. “evidence from the PCA shows that weak competitive constraints at the local level result in higher prices for self-pay patients”

Improper assumption: the CC cannot simply assume that any conclusion regarding the self-pay market is necessarily informative regarding national PMI negotiations. In any event, the analysis does not hold for Spire even when the CC’s results are taken at face value.

3. “evidence from the negotiations, and the planning of negotiations, between hospital operators and the larger PMIs indicated that the position of the hospital operators in one or more local areas is important to hospital operators and PMIs.”

The CC itself has acknowledged an inadequate evidentiary base: “We did not find that the evidence on bargaining on its own indicated whether hospital operators had market power or that PMIs had bargaining power”.

⁵⁵ See paragraphs 6.239-6.240 of the Report.

4.14 Simply asserting that its conclusions from distinct sets of analysis point in the same direction is not a clear, coherent and compelling evidence basis: this is especially true where the CC cannot itself identify any causal link to higher prices in its analysis and cannot advance any documentary evidence of the same. Moreover, it is not clear that the analysis does point in the direction of market power – with mixed evidence on bargaining, no evidence to substantiate the view that Spire sets higher self-pay prices in areas where local competition is weaker, and several instances of Spire’s insured prices being below a PHP without market power, one can reasonably conclude that Spire is pricing competitively.

4.15 The analysis in the PFs has failed again to assess whether the observed market outcomes may, in fact, reflect buyer power on the part of PMIs. The PFs indicate that the CC has considered “whether, and to what extent, a low substitutability of hospitals at the local level and, possibly, a low substitutability of hospital portfolios as a whole lead to higher insured prices.” The CC’s findings would be equally consistent with a conclusion that high substitutability of hospitals at the local level and high substitutability as a whole lead to lower insured prices due to insurer buyer power. The CC has failed even to consider this possibility, which would correspond to the evidence on bargaining power discussed in section 2 above. The failure to consider this relevant interpretation of the evidence has introduced confirmation bias into the analysis and led to an unsupportable conclusion.

4.16 The CC’s evidential and analytical base for its provisional conclusion is manifestly inadequate. No reasonable authority could have arrived at such an adverse conclusion based on the incomplete and unreliable analysis featured in the PFs, especially where the basis for that conclusion is no more than self-referencing circularity.

C. The CC’s insured pricing analysis is in any event flawed and does not withstand basic sensitivity tests

4.17 In any event, the CC should abandon its insured pricing analysis because it is flawed and does not withstand sensitivity testing. The shortcomings of the analysis (as recognised by the CC itself)⁵⁶ suggest that the ranking of operators may not be reliable, especially where the differences in price indices are small.

- (a) The CC has based its analysis of pricing to insurers on price indices based on baskets of treatments representing less than 35% of these insurers’ purchases (by revenue). Since PMIs and hospital operators negotiate over the price of an entire basket of treatments rather than of individual treatments in a basket, poor coverage of the baskets casts doubt on the reliability of the outcome.
- (b) The price ranking based on the CC’s preferred common basket of treatments is not robust to the variation of the treatments included in

⁵⁶ See paragraphs 5 and 6 of Appendix 6.12 to the Report.

the baskets.⁵⁷ Sensitivities confirm that the CC's preferred baskets (i.e. based on the common basket across hospital operators for a given PMI) and the pair-wise baskets do not lead to the same conclusions for some of the smaller PMIs. More specifically, the sensitivity based on pair-wise baskets suggests the CC's common basket overstates the price difference between Spire and [REDACTED].

- (c) The assessment of average revenue per discharge is flawed and irrelevant. Treatment and patient mix vary across PHPs for a given PMI. As a result, a comparison of ARPD will identify differences in treatment and patient mix rather than only differences in underlying prices. Further, the analysis takes all patient revenue and then calculates ARPD on the basis of inpatient and day-case admissions only: differences in the proportion of outpatients will skew the results of this ARPD calculation. This is a basic mathematical mistake.

4.18 **Conclusion.** The CC's insured pricing analysis is flawed and fails sensitivity testing. Even the CC's own view is that the results produced cannot in themselves establish a causal relation between concentration and price.

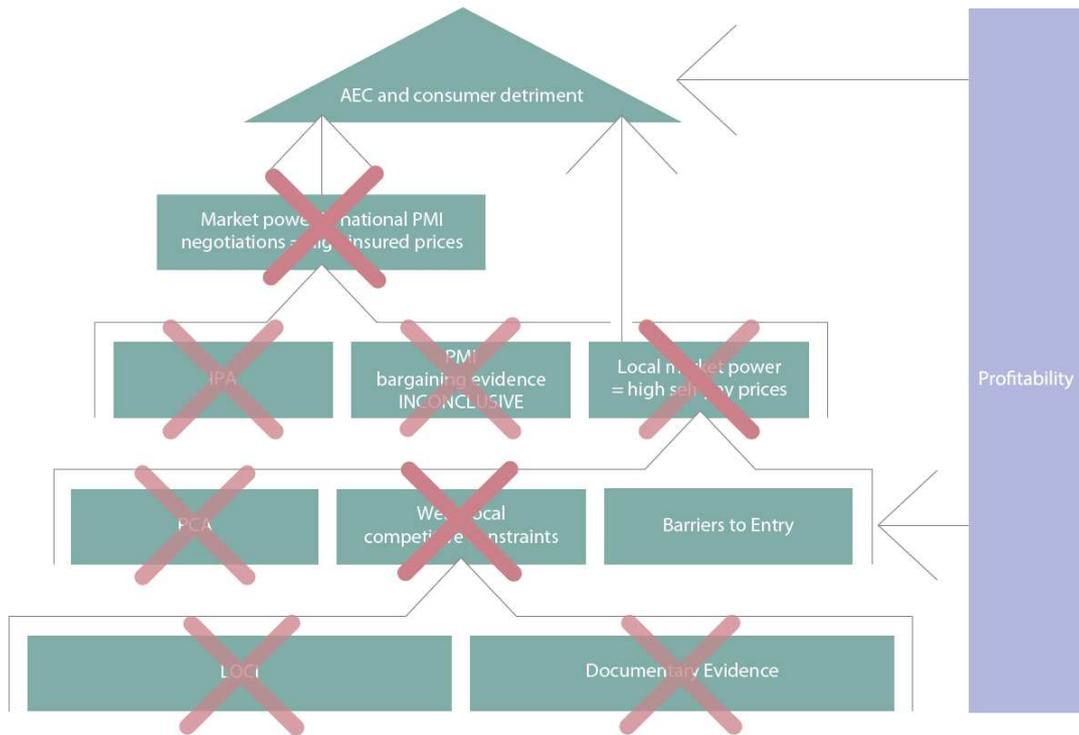
4.19 Spire has also demonstrated that the results are not merely unreliable: they are without any analytical or evidential probity. The PCA and national bargaining evidence do not support this conclusion either. When subjected to proper scrutiny, the evidential record does not support the provisional finding.

4.20 Against this backdrop, the IPA evidence assembled by the CC is shown to be vague, unreliable and overstated. It lacks the necessary degree of robustness to play a key part in supporting the PFs' conclusions. When checked against other evidence, the IPA also comes up short and inconsistent. And perhaps most damaging, the PFs gloss over the CC's own caveat on the reliability of the IPA results.

4.21 The IPA is therefore far from the clear, coherent and compelling evidence base that the PFs require to ground and adverse finding. The deficiencies of the IPA are therefore serious: this analysis is the cornerstone of the CC's finding of market power on the part of certain PHPs, and of an AEC with respect to insured prices. These findings simply cannot be maintained in light of the fundamental unsoundness of the IPA.

⁵⁷ See Section 4 and Table 4 of the unredacted version of Spire's submission in the Data Room, dated 10 September 2013.

5. THE PROFITABILITY ANALYSIS DOES NOT ACCURATELY REFLECT SPIRE'S PROFITABILITY AND DOES NOT THEREFORE SHOW THAT SPIRE HAS MARKET POWER / SUPPORT A FINDING OF AN AEC AGAINST SPIRE



5. THE PROFITABILITY ANALYSIS DOES NOT ACCURATELY REFLECT SPIRE'S PROFITABILITY AND DOES NOT THEREFORE SHOW THAT SPIRE HAS MARKET POWER / SUPPORT A FINDING OF AN AEC AGAINST SPIRE

Overview

The methodology used to assess profitability is not fit for purpose: it is not based on the evidence and is internally inconsistent. Even in applying this flawed methodology, the CC has made significant errors that must be corrected. For instance, specialist plant has been entirely omitted from the assessment of the value of Spire's buildings resulting in a significant understatement.

The profitability analysis in the PFs is based on a series of assumptions that are abstract and disconnected from reality. The CC's proposition that real world evidence is not "informative" is extraordinary; this evidence may be inconvenient to the CC's conclusions, but it cannot be irrelevant. For example, on building cost, the CC has ignored valuations and assessments prepared correctly due to a lack of understanding and instead used an incomplete desktop analysis.

The PFs set out no compelling reasons for the CC's failure to adopt the rigorous (independently verified) approach to profitability proposed by Spire despite the substantial evidence from multiple sources that this approach more accurately reflects reality.

The effect of the flaws in the profitability analysis is material to the CC's investigation and cannot be ignored. Spire's capital employed has been understated by approximately £429 million and Spire's ROCE has been overstated by approximately 8 percentage points.

The CC has failed to undertake or report key pieces of analysis that would have highlighted the flaws in its approach to profitability:

- **Proper sensitivity testing of judgments underlying the profitability analysis has not been carried out, and such sensitivity testing would raise serious concerns about those judgments; and**
- **The CC has made no attempt to assess the commercial drivers of profitability. The finding that Spire is more profitable than other firms while its prices are not significantly or consistently higher than the prices of firms without market power is explained by Spire's greater efficiency and consistent with effective competition. No attempt has been made in the PFs to understand or assess these issues. Had the CC conducted a proper analysis of the commercial drivers of profitability, that analysis would have highlighted the errors in the profitability assessment.**

5.1 The PFs' profitability analysis is not fit for purpose. Errors in the application of the methodology mean that the output is incorrect even on its own terms. However, the methodology is itself inadequate as it omits significant portions of Spire's capital base. The profitability analysis also suffers from inadequate sensitivity testing: the PFs rely on subjective judgements rather than reasoned consideration of the accuracy of estimates and assumptions. Finally, the PFs inappropriately assume that recognised inaccuracies in the analysis will be offset by counterbalancing inaccuracies in other untested sections of the data: there is no evidence to support such assumptions.

5.2 The PFs rely on pricing and profitability analyses to find market power and an adverse effect on competition: "*Our finding of excess profitability suggests that the price of private healthcare services may be high in relation to the costs incurred by private hospital operators in providing those services, and thus higher than we would expect to find in a competitive market*"⁵⁸. The weight placed on profitability in reaching the CC's conclusions is inappropriate because earning profits persistently above the cost of capital is consistent with an efficient firm facing effective competition. The analysis of profitability therefore needs to be rigorous, accurate and careful. The CC's analysis of Spire's profitability does not pass this test.

5.3 In the case of Spire, the PFs gloss over the absence of direct, evidential or causative link between local concentration, bargaining power and higher local/national prices by saying that the inconclusive evidence on these points is nonetheless consistent with an adverse finding because of the findings on high profitability. This approach is inadequate as a general matter (because it relies on a self-referencing circularity to find a problem). But it is particularly problematic when it is underpinned by an unreliable profitability analysis. Put differently, another way to square the lack of evidential support for the view that Spire has market power at a local or national level with a finding that Spire's profit exceeds its weighted average cost of capital (WACC) is that the CC's profitability assessment (i) is misconceived and/or (ii) fails to capture dynamics such as Spire maintaining superior efficiency and quality over time. Both explanations are likely.

5.4 The result of the PFs' profitability methodology and analysis is categorically not, as the PFs suggest, that "the numbers that we rely on in our assessment are more likely to be recognised by the individual firms involved." In fact, the PFs' analysis of profitability is unrecognisable to Spire – whether on an economic or accounting basis. This is not simply a case of differing technical approaches to the question of profitability: Spire simply does not understand how the PFs could postulate that a hospital group could operate on the basis that the CC seems to think it does.

5.5 Spire has commissioned L.E.K. Consulting to prepare a detailed assessment of its profitability and to assess the approach taken in the PFs. L.E.K.'s analysis and conclusions are set out in Annex 7, where L.E.K. explains the serious deficiencies in the assessment of Spire's capital base in the PFs. This assessment has been conducted using a bottom up approach rather than a top down approach (as used in the PFs).

⁵⁸ Provisional Findings Report, para 6.292.

The issues identified by L.E.K. (resulting in a shortfall of c£429 million in the assessment of Spire’s capital base) can be summarised as follows:

Asset type	Significant limitations of the CC’s approach
Buildings	<ul style="list-style-type: none"> ○ Suggested DRC approach is highly theoretical, difficult to calculate in practice and fraught with problems that could be addressed by a site-specific approach ○ The CC removes accounting values and replaces them with an incomplete assessment of replacement cost (missing specialist plant) ○ Obsolescence charges are applied to assets where actual investments have outpaced depreciation over an extended period of time ○ Reliance on a largely desktop approach for valuation ignores mitigating details that a site-specific approach (such as the Mace and Knight Frank assessments provided by Spire) would capture
Equipment	<ul style="list-style-type: none"> ○ The CC excluded the possibility of an MEA or DRC approach by dismissing Spire Brighton as a comparator, a decision mainly substantiated by a quote in Brighton Hospital’s promotional material ○ While use of net book value is simple and convenient, it is inconsistent with the CC’s own guidelines and it excludes fully-depreciated assets from the capital base, which all hospitals continue to use ○ Analysis is incomplete: the CC considered but did not run a sensitivity analysis due to “complexity”
Land	<ul style="list-style-type: none"> ○ Original and part of current evaluation relies on desktop approach and benchmarking against the price of agricultural land, both of which ignore the importance of location and understate the economic value of the deployed land ○ DTZ’s desktop analysis is based primarily on theory and ignores real-life physical constraints, such as inability to reshape parcels of land available for purchase and need to preserve boundaries with neighbours
Intangibles	<ul style="list-style-type: none"> ○ The CC’s analysis effectively asserts that hospitals can be opened without any intangible assets (e.g. staff recruitment and training, physician / consultant relationships, etc.), aside from the website. In practice, significant upfront non-recurring investment is required.
Working capital	<ul style="list-style-type: none"> ○ The CC uses annual average net working capital, which is insufficient to cover cash needs during peak usage periods (e.g. monthly payroll, creditors, etc.), and does not account for the cost of a revolving credit facility or more flexible terms with suppliers and thereby assumes a liquidity crisis in at least 6 out of every 12 months

5.6 The conclusions of L.E.K.’s analysis are clear: the profitability assessment in the PFs is economically flawed, based on inaccurate data, and reaches conclusions that no reasonable authority could reach. This is underscored by L.E.K.’s recalculation of Spire’s profitability, which shows that:

- (a) Applying an evidence-based approach to calculation of economic costs, L.E.K.’s stand-alone recalculation of ROCE is 10.7%; and
- (b) applying the PFs’ litmus test of using insurance replacement values, had the PFs used the correct insurance replacement values, that would have shown the CC that its estimated asset base for Spire of £428 million was well below either Spire’s 2007 insurance value of ~~£~~

million or its 2012 revised insurance values. Both of these calculations therefore show that the PFs' ROCE calculation grossly over-states the correct position.

5.7 The PFs also fail to assess the commercial drivers of Spire's profitability. The PFs conclude that Spire earns returns significantly above the WACC (which Spire disputes), yet the CC's analysis also shows that Spire does not price significantly or consistently above those PHPs without market power. If Spire achieves significant profits without higher prices, the CC should have considered whether there is a dynamic of competition the PFs have failed to consider. Spire has provided the CC with significant evidence of steps it has taken to improve efficiency, which have improved its profitability. The failure to consider these dynamics in the PFs is further evidence of a failure properly to consider or understand the market, or to present relevant exculpatory evidence in the PFs. It is symptomatic of a general lack of rigour throughout the evidence review which characterises the CC's whole report and process.

A. The PFs do not reflect appropriate sensitivity testing, which would have shown the approach to measuring profitability is highly sensitive to even small changes in assumptions

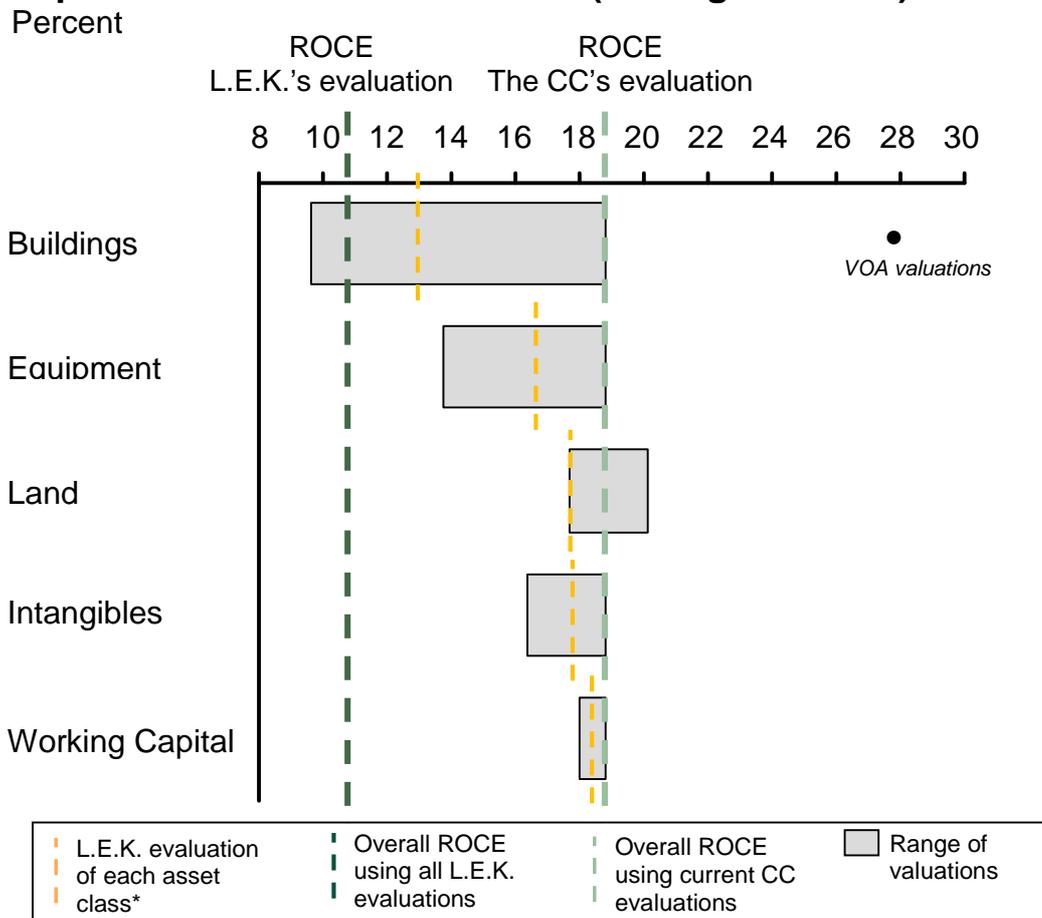
5.8 The sensitivity analyses reported in the PFs are deficient primarily in two respects. First, the sensitivities tested are generally restricted to items that could not make a material difference to the analysis, but the sensitivity of the analysis to assumptions that could significantly alter the outcome has not been tested. Second, the sensitivity tests appear to have been developed without reference to concrete analysis or facts. They reflect instead arbitrary tests of the effect of increasing or decreasing particular factors.

5.9 As a result, the approach to the profitability assessment is neither conservative and prudent, nor robust to sensitivity testing as is claimed in the PFs. In fact, the results are sensitive to the correction of errors in the methodology (such as the CC's omission of the value of Spire's specialist plant from its calculation of the value of Spire's buildings, plant and equipment), and the comparison of theoretical estimates used in the valuation to real world examples. This approach falls far short of the standard of rigorous evidential analysis that the CC is required to undertake as a matter of law

5.10 For example, the CC has ruled out the use of the Knight Frank replacement cost assessment for buildings because it is the cost of replacing exactly the same building but complying with current building regulations. The reason the CC gives is that a building built to current regulations would have lower operating costs that cannot be quantified. However, consulting a construction expert would quickly show that all the material changes to building regulations relate to energy efficiencies and can be quickly estimated and understood not to be material to the ROCE calculation. A sensitivity check using the Knight Frank assessment (the only complete assessment available to the CC or Spire) would reduce ROCE by over 3% on its own.

5.11 L.E.K.'s review of the PFs' profitability assessment demonstrates clearly that the CC's ROCE calculation is highly sensitive to the underlying components of capital employed and that the CC has adopted in almost all cases the lowest possible valuation. Valuation of major fixed assets such as land and buildings has largely been determined through the CC's discretion over methodology; the range of values for each category illustrates the degree to which judgment is deployed. The decision on which valuation approach to use has a significant effect on the resulting ROCE. The lack of both sensitivity analysis, and an appropriately detailed analysis, is again symptomatic of the cursory and inadequate analysis of profitability. These issues are illustrated in the table below.

Impact of sensitivities on ROCE (Average 2007-11)



5.12 The current profitability assessment does not provide a sufficient basis on which the CC can lawfully conclude that Spire is making excess profits. L.E.K.'s analysis clearly demonstrates that Spire does not make excess profit.

B. The PFs have not conducted the profitability analysis on the basis claimed

5.13 Following the CC's published guidance, the PFs state that the objective of profitability analysis is to calculate the economic costs of the Spire business, as opposed to the accounting costs of the business. The PFs do not, however, consistently apply an economic approach to assessing asset values. Instead, the PFs alternate between an economic and an accounting approach and, in some cases, a mix of both. The application of inconsistent approaches to cost valuation is not explained by any principled approach to profitability assessment.

- (a) The CC says it wishes to understand the economic value of equipment used in hospitals, but then uses the accounting principle of net book values as an estimate of costs. One key flaw with net book value is that it omits the value of fully depreciated assets that are still in use, which is a substantial omission. To comply with the CC's own stated methodology, the PFs should have considered the true economic costs of replacing the equipment (as indeed the PFs said they would under the DRC approach). Had the CC in fact done so, it would have appreciated that the capital employed in equipment for a hospital is substantially higher than the current net book value of the equipment in a hospital.
- (b) The PFs initially remove the value of intangible assets from Spire's accounts on the basis of an economic argument: some of the intangible assets were included within goodwill, but then not shown separately. Where there are economic arguments to include certain intangible assets in the valuation (such as staff recruitment costs), the PFs rely on accounting principles to exclude these costs ("The standard accounting treatment of staff training and recruitment is to write off the costs to expenses as they are incurred"). Even this attempt to apply accounting principles is incorrect: the quoted principle is drawn from UITF abstract 24, which address recoverability for start-ups: it is not relevant to an economic analysis of intangible assets.
- (c) A true economic approach to the valuation of intangible assets would require consideration of organisational capital: how a hospital actually wins patient flows, wins contracts with PMIs and retains staff to open a hospital. There are significant non-recurring recruiting costs associated with opening a hospital. The CC would have needed to consider properly the importance of Spire's investment in reputation as a key way in which a hospital attracts a flow of patients. That is not necessary with an accounting treatment, but is imperative to understanding the economic costs of the business. Had the CC done so, it would have appreciated that a hospital business possesses and invests in more intangible assets than £500k in a web-site.

5.14 L.E.K. identifies a wide range of other mis-treatments of costs where the PFs apply accounting rather than economic valuation methods. The CC must revisit the basis of all of its profitability calculations in order to produce an analysis that complies with its stated methodology, is capable of being understood by the business, and is capable of surviving scrutiny by the courts. The current analysis is an unreasonable and unfair basis for a decision.

C. The treatment of profitability in the PFs contains basic mistakes of fact or takes positions that are not grounded in the evidence

5.15 There are numerous aspects of the CC's profitability analysis where the positions taken by the CC are simply wrong.

5.16 L.E.K.'s report sets out a substantial number of such errors, for example:

- (a) As regards the cost of equipping a new hospital, the PFs dismiss evidence of these costs based on the cost of equipping Spire's new Brighton Montefiore hospital. This evidence is dismissed on an assumption that because this hospital is said to be "state of the art", then it would not be a representative hospital. This is a sweeping generalisation not supported by the facts, Montefiore's offering in terms of facilities and diagnostic equipment is standard against the rest of Spire's estate (detailed comparisons are included at Annex 7, further, the quality and cost of Brighton's equipment is demonstrably representative of the broader Spire estate (again, detailed comparisons are included at Annex 7). This approach is also inconsistent with a "modern equivalent asset" approach to assessing profitability: the modern equivalent assets would be the "state of the art" (i.e. modern) asset.

5.17 Perhaps more concerning is the regularity with which the PFs ignore persuasive, probative evidence of economic costs, and instead substitute assumptions or presumptions in place of concrete evidence. Again, the L.E.K. report identifies a number of instances where the PFs conclusions are inconsistent with the evidence:

- (a) When valuing the land used for a hospital site, Spire has submitted concrete, up to date, land valuations for every one of its sites: however, the PFs rely on an abstract desktop analysis, conducted without inspection of even one single site. The analysis relied upon in the PFs includes two fundamental assumptions: (i) the hospital in question could be uprooted and moved to a new site somewhere else (although not clear where, despite the CC's belief that location is a critical factor in private healthcare) and; (ii) alternative land is available for the purpose. In other words, the PFs prefer an entirely hypothetical and unrealistic construct for real-world evidence. This is not a reasonable approach (especially not when viewed against the PFs' Paragraph 56 litmus test.)

- (b) When seeking to depreciate the value of property, the PFs apply a basic VOA obsolescence table to all properties equally, without considering, for example, the effect of investment on the obsolescence of a particular property. Such an approach is simply the product of an unevidenced assumption being applied without verifying that it applies to the facts at hand.

5.18 The PFs must focus on the evidence and not substitute assumption for concrete evidence and facts. When this exercise is undertaken rigorously, L.E.K.'s report demonstrates that the basis for the PFs' calculation of profitability analysis is wrong.

D. Material areas of the profitability analysis: building values

5.19 There are numerous flaws in the valuation of the buildings in both the selection and application of the methodology. Sensitivity tests have not been carried out on judgments where the choices made are highly material to the analysis. These judgments have rejected alternative values (that are in almost all cases higher) on the basis of very limited investigation, extrapolation of points of limited relevance and flawed assumptions based on no evidence.

Building base cost (2008)

5.20 The CC has relied on insurance values as stated in the PFs "[f]or freehold and capitalized leasehold buildings, we gathered information from the relevant firms on the reinstatement values of their hospital properties. These estimates had been prepared for the firms as the basis for their insurance policies. They take into account the costs of demolishing the existing structures, clearing the site and reinstating the building and building services, car parking and other external landscaping, as well as professional and planning fees and an allowance for 'un-measured costs'. We also considered the VOA's replacement cost estimates for each hospital."⁵⁹

5.21 There are two significant problems with this approach. First, even on its own approach, the CC has substantially understated the value of the estate. In relying on outdated valuations and insurance estimates, the CC has omitted the value of Spire's specialist plant, which represents a significant proportion of the estate. The Colliers valuation, which underpins Spire's old building insurance policy explicitly does not include specialist plant (e.g. laminar flow, sterilisation). The CC has assessed the value of equipment based on the fixed asset register, but that also does not include specialist plant. In addition to the insurance policy that the CC relied upon to value Spire's buildings, Spire had a second insurance policy covering plant and equipment; the two policies valued the buildings, plant and equipment together at $\pounds 60$.⁶⁰ This is the number that the CC should have used in its analysis, if it wanted to use 2008 insurance values. Second, the CC has relied on out-dated analysis conducted on the

⁵⁹ Provisional Findings, page 6(13)- 97

⁶⁰ Spire's specialist plant was included in its old insurance policies on the basis of an estimate. The only valuation of Spire's estate that specifically includes a valuation of the specialist plant is the Knight Frank building valuation previously submitted to the CC.

basis of limited information regarding the hospital estate instead of current valuations based on detailed consideration of the estate.

5.22 The valuations relied on by the CC are inadequate for several reasons:

- (a) These valuations consist of a mix of management estimates and a desktop assessment prepared by Colliers that was very limited in scope;
- (b) The estimates do not include all plant within the buildings; Colliers' valuation excluded specialist plant;
- (c) Some of the estimates for hospitals acquired by Spire were estimates prepared by former owners, and were significantly out of date; and
- (d) These assessments are out of line with real world data including Spire's current experience of buildings costs for new hospitals.

5.23 The CC has pointed to the use of these estimates in insurance valuations for Spire hospitals as evidence of their validity. This reasoning is flawed. As Spire has already advised the CC, once Spire had obtained accurate assessments of the values of its hospitals, it reported these assessments to its insurers and its insurance contracts are being re-drafted on the basis of the new estimates.

5.24 The basis on which the PFs reject the current detailed valuation of Spire's buildings prepared by Knight Frank is incorrect. It appears that this valuation has been rejected on the basis that it would reflect "significant additional costs in constructing more complex and flexible buildings, rather than the less costly alternatives currently used". This statement wrongly states the basis of the valuation prepared by Knight Frank. The relevance of the Knight Frank valuation is further bolstered by a second valuation prepared by Mace, attached as Annex 8. The more detailed Mace valuation suggests that Knight Frank, in fact, has understated the value of Spire's buildings using the replacement cost approach defined in the CC's own methodology.

5.25 The Knight Frank valuation was not prepared on a full MEA basis as the CC claims. The Knight Frank assessment is based on the replacement cost of Spire's current buildings, in their current layout, with the current plant specification, and built to current building regulations (this is the replacement cost of the current hospital as defined in the CC's own methodology). New building regulations are generally focused on improved environmental efficiency and these new regulations have been applied to many of Spire's hospitals as plants have been repaired or buildings updated. Although constructing to the new standards would reduce the operating costs of the hospitals, such reductions would not be material to the ROCE calculation.

Use of VOA Obsolescence Percentages

5.26 VOA obsolescence percentages do not provide an adequate basis for assessing property values. The basis for relying on these obsolescence percentages, as set out in the PFs is factually incorrect:

- (a) Contrary to the statement that these percentages “were calculated in some detail by surveyors, following an inspection of each site”, very few of Spire’s hospitals were reviewed in detail in the VOA’s 2008 review.
- (b) Contrary to the statement that these percentages take into account “both age, structural and functional sources of obsolescence”, only age was taken into account for individual hospitals, not structural and functional sources of obsolescence.
- (c) These percentages do not benefit from “consistency in terms of approach across all hospital buildings owned by the relevant firms”, the percentages were applied on a standard basis across the industry without taking account of actual investment levels either for individual hospitals or for relevant firms.

5.27 These obsolescence percentages do not accurately reflect actual obsolescence in Spire’s hospitals. The VOA obsolescence percentages are averaged across the industry and, as a result, are increased by the lower levels of investment in some of the other hospital groups. These obsolescence percentages cannot be relied on to carry out an assessment of the value of Spire’s estate, which has benefited from substantial ongoing investment.

Indexation Movements Charged to Profit

5.28 The PFs rely on a methodology that imports changes in reinstatement cost of the buildings into the EBIT number in the ROCE calculation within the depreciation charge. This means the changes in the cost index and changes in the VAT rate for building hospitals have a significant effect on the calculation of profitability. The effect of this approach is that a small change in the index or the rate of VAT has a significant impact on the profitability analysis.

5.29 The accounting principle quoted by the CC in support of this approach is outdated and incorrect. The CC has quoted an accounting text from 1987, which states that: “the accounts should be fully articulated, such that the whole of any change in the value of capital employed flows through the profit and loss account.” The principle of taking account of movements in building costs in a profitability calculation is out of date and incorrect. Such an approach may have been relevant during a period of higher inflation (as at the time of the quoted text) where the value of assets in use changed significantly within a relatively short period of time. Inflation for buildings during the period of the CC’s review, however, was low, and in some indexes even negative. As such, this approach is inappropriate. Under modern accounting standards, accounts are “fully articulated” through the use of reserve accounting and these types of movements in building costs are unrealised, cannot be incorporated into profitability calculations, and should not be included in an economic analysis.

5.30 In addition to relying on an inadequate approach to accounting, the PFs have selected the wrong cost index. The PFs rely on the construction costs index, which

reflects the cost of all individually purchased items for a building. In the real world, a hospital group would sub-contract a hospital construction project and, as such, the tender price index is the more appropriate index because it is the standard used by the industry. Reliance on the tender price index has a material effect on the outcome of the assessment.

Conclusion on Building Values and Effect on ROCE

5.31 The assessment of building values in the ROCE calculation contains errors of fact, assumption and methodology. L.E.K. has highlighted these points in the attached Annex 7 and their view is that ROCE would fall to around 13% if these errors were corrected. Spire's firm view is that L.E.K.'s methodology is the correct methodology. At a minimum, the CC must consider the corrections proposed by L.E.K. as a relevant sensitivity test. Correcting the assessment of the value of Spire's buildings alone would have a significant effect on the ROCE calculation, even without considering the additional issues in the profitability calculation.

E. Material areas of the profitability analysis: equipment

5.32 The PFs rely on an accounting measure, net book value, to assess the cost of equipment. This approach is inconsistent with the PFs' stated approach and the CC's own guidelines, which indicate that an economic measure of value should be used. In addition, this measure excludes fully depreciated assets from the capital base, which all hospitals continue to utilise.

5.33 The PFs reject the possibility of an MEA or DRC approach to valuing equipment by dismissing the relevance of Spire Brighton as a comparator. As noted above, the basis on which the PFs dismiss the cost of equipping the Montefiore hospital as a relevant point of reference is unreasonable and reflects assumption rather than a consideration of the objective evidence. A comparison of the facilities and diagnostic equipment at Spire Brighton with the facilities and diagnostic equipment across the rest of the estate illustrates that the offering at the hospital and the quality and cost of the equipment is demonstrably representative of the rest of the estate (the hospital is, in fact, smaller than average in terms of beds and consulting rooms).

5.34 No sensitivity analysis has been conducted with respect to the valuation of the equipment due to the "complexity" of the analysis and the assumptions that would have been required. The equipment valuation, however, has a significant effect on the ROCE. Had the CC conducted a sensitivity analysis, it would have found, for instance, that relying on a realistic acquisition cost valuation would change the ROCE by 2.3%.

F. The PFs contain no effort to understand the drivers of profitability

5.35 The PFs make no attempt whatsoever to consider the drivers of Spire's profitability despite the evidence that Spire does not charge prices consistently or materially in excess of competitors that do not have market power. This evidence alone suggests that there is a dynamic of competition that the PFs have failed to consider. Put differently, if the PFs' analysis of profitability and competitive

conditions is right, one would expect to see Spire prices substantially higher than those charged by other hospital operators, particularly Ramsay and Nuffield, but that is not the case. This evidence makes no sense alongside the PFs.

5.36 The failure to consider or understand the drivers of Spire's profitability is symptomatic of a more general failure to properly assess or understand the commercial reality of the business. A reasoned consideration of the structure of the business and the drivers of profitability would have led the CC to appreciate its understatement of the capital employed. The CC's profitability assessment is premised on one very significant assumption: that any difference between ROCE and cost of capital is "excess profits". The CC's own guidance recognises that such an assumption would be analytically flawed. Hence, the failure to consider the question of the drivers of profitability is in breach of the CC's own guidelines.

5.37 Basic economics indicates that, in a competitive market, infra-marginal firms may earn above their cost of capital in the long run where they are more efficient. In that situation, the marginal firm would not make excess profits (i.e. Ramsay or Nuffield), whereas more efficient firms could sustain similar prices to the marginal firm(s) and, due to their lower cost base, earn above their cost of capital (e.g. Spire, though Spire refutes the CC's evidence that it earns returns above its cost of capital). The CC's assessment of Spire's profitability alone is not an appropriate basis for concluding that Spire is earning excessive profits or that Spire has market power.

5.38 Changes in the structure of the market can also affect profitability. Over the past few years, significant growth in NHS Choose and Book work has generated significant new revenue for many hospitals, enhancing (at least temporarily) their profitability. The role of developments such as the growth of Choose and Book must be considered in assessing the significance of profitability.

5.39 Both L.E.K. in their first report (appended to Spire's response to the AIS and profitability working paper) and Spire's CFO, Simon Gordon, at the issues hearing have highlighted to the CC the importance of understanding Spire's profit growth in the period under review. From 2007, when the hospital moved from Bupa ownership to Spire ownership, until 2011, private patient volumes have fallen slightly and Spire's prices for private patients have been in line with those of hospitals found not to have made excess profits. ✕. Spire's profitability has been driven by a focus on increasing efficiency in the business while still delivering a high level of patient care and outcomes. Key aspects of this increased efficiency include significant reductions in central support functions (and associated costs), growth in work for the NHS (mainly under Choose and Book) to maximise the use of available capacity, and a focus on different strategies for pathology, pharmacy, sterilisation and logistics.

5.40 The CC's own guidelines for market investigations state that, where a firm earns profits above the WACC: "There could be several reasons, including cyclical factors, transitory price or other marketing initiatives, and some firms earning higher profits as a result of past innovation, or superior efficiency". In breach of its guidelines, the CC has not considered whether Spire developed a comparative advantage over the period of review as a result of improvements in the efficiency of its business despite clear evidence that this is the case.

5.41 The failure to consider the actual drivers of profitability is a serious omission. It is all the more surprising since the CC uses evidence of excess profitability as an essential part of its circular market failure reasoning, which it relies on to justify remedies. However, there is no evidence, analysis or reasoning to explain why the CC concludes that the difference between ROCE and WACC is indicative of a market failure for Spire when prices charged are at the same level as prices of companies that the CC has concluded do not have market power.

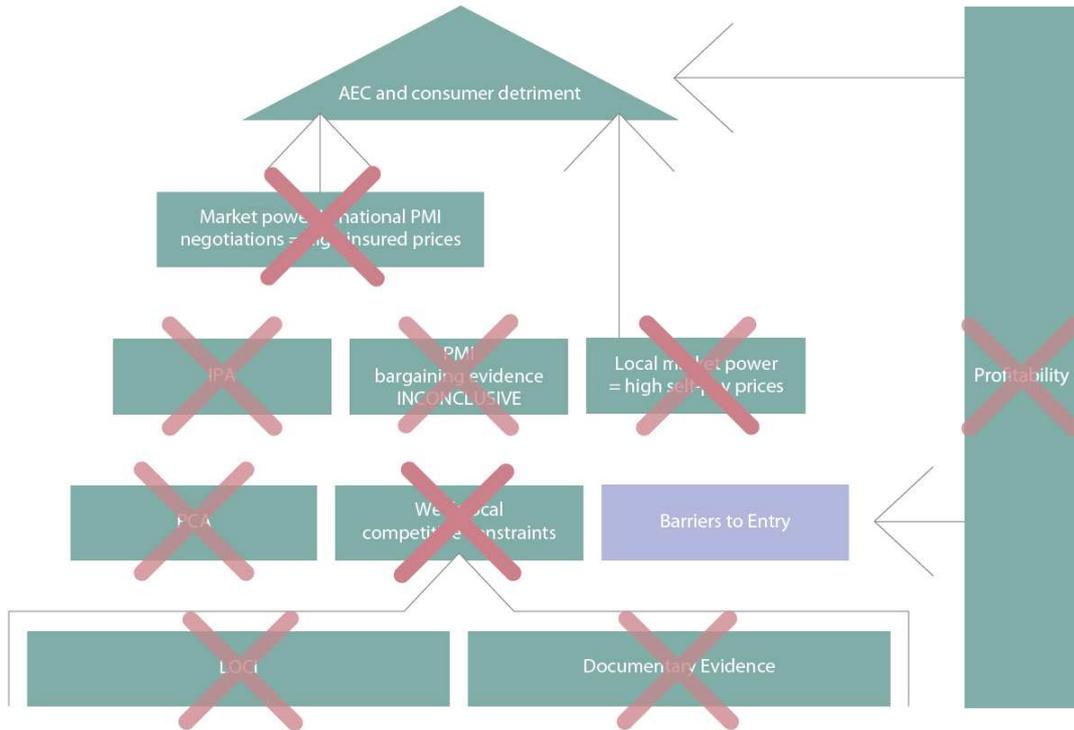
5.42 In the absence of any such investigation, it would be unlawful for the CC to conclude that any claimed excess profitability is due to an AEC.

5.43 Had the CC carried out an assessment of the drivers of profitability, it would have discovered that Spire's ability to improve its profitability has not come from price increases – as the CC has hypothesized. Spire's improved economic profitability is a function of increased efficiency and competitive success. The irony of the PFs is that, because of the analytical gap in the PFs, the CC is seeking to penalise Spire for seeking to compete for business, improve patient choice and deliver its services more efficiently. This is an important, but simple, proposition with which the CC simply has not engaged.

G. Summary

5.44 In summary, the CC's profitability assessment is untenable. The CC's profitability analysis is characterised by unlawful application of the CC's guidelines, errors of fact, unfair and discriminatory treatment of Spire, and an unreasonable conclusion that bears no relation to the real world. The simple consequence of the CC's refusal to grapple properly with the profitability drivers of hospital operators is that the CC is likely to damage the competitiveness of the industry, reduce incentives to invest and raise costs to private and NHS patients. These are precisely contrary to the outcomes that the CC seeks to achieve through a market investigation reference.

6. THE CC'S CONCLUSION ON BARRIERS TO ENTRY IS ILLOGICAL



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Overview

The CC's conclusion that the ability and readiness of large PMIs to withhold recognition from a new facility is not a barrier to entry is illogical.

This conclusion disregards the evidence that PMI recognition is critical to success in the private healthcare market place, despite the CC's acknowledgment that:

- PMIs declining to recognise new healthcare facilities is a potential restriction on entry and expansion; and
- The high fixed costs of hospital businesses make their profitability (and, by implication, their sustainability) very sensitive to patient volumes.

Entry of new PHPs (or indeed new facilities) may introduce more price competition into the local market place.

One logical conclusion regarding the lack of support for new entrants by the large PMIs is that these PMIs already have sufficient bargaining strength to constrain the PHPs absent new entry.

A. The threat of non-recognition by PMIs of new facilities is a barrier to entry and expansion that constitutes an AEC

6.1 PMI recognition is a far more serious barrier to entry than the CC recognizes. The CC's dismissal of the significance of this barrier is at odds with its approach to the underlying evidence:

- (a) The CC acknowledges that "The high fixed costs of hospital businesses make their profitability very sensitive to variations in patient volumes."⁶¹
- (b) The CC also acknowledges that, as a result, hospital providers offer deals to PMIs to secure the necessary volumes: "For this reason, private hospital operators are willing to offer significant price discounts to PMIs who are able to deliver large or increased numbers of patients."⁶²

⁶¹ See paragraph 6.67 of the Provisional Findings Report.

⁶² See paragraph 6.67 of the Provisional Findings Report.

- (c) With respect to new facilities, the CC has said “We agree with the hospital operators that the PMIs generally have a relatively strong negotiating position...”.⁶³
- (d) Further, as the CC acknowledges, there is no evidence to suggest that hospital operators consider they would be able to replace lost insured revenue from other sources, such as NHS revenue or self-pay patients.⁶⁴

6.2 All of these conclusions point to the significance of PMI recognition as a factor affecting entry. The CC even appears to suggest that PMI recognition could be a barrier to entry, if a refusal to recognise a new facility was encouraged by another player in the market: “we have found that some large hospital groups may have the ability to induce a PMI to refuse recognition of a new entrant locally, even one offering lower prices or higher quality services”.⁶⁵ It is unclear why non-recognition would be a concern with respect to entry barriers if it were influenced by another player in the market, but not if it were implemented independently by a PMI.

6.3 Spire is not the only hospital operator to point to PMI recognition as a barrier to entry, Circle and HCA have also done so.⁶⁶ With respect to Circle, the CC has already acknowledged the importance of PMI recognition: “PMI recognition, particularly by AXA PPP; was a very important issue for Circle in Bath and also of some importance to the Edinburgh Clinic”.⁶⁷ In its response to Provisional Findings, Circle has specifically addressed this point again: “Circle does not agree with the CC that PMI recognition is not in itself a barrier to entry ... and recommends that the CC considers mandatory PMI recognition of hospital operators.”⁶⁸

6.4 The CC fails to accord sufficient weight to the evidence, and even to its own separate assessment of the relevant evidence, and illogically concludes that PMI recognition is not a barrier to entry. It fails to recognize that the credible threat of non-recognition is a barrier to entry that distorts competition and therefore constitutes an AEC, which requires a remedy (non-recognition being credible due to the bargaining strength of PMIs, notably Bupa and AXA).

- (a) There are several reasons that PMIs may elect not to recognise new entrants, and that such non-recognition may create barriers to entry. For example, PMIs may not have an incentive to recognise new higher quality hospitals as they may have higher costs.

⁶³ See paragraph 6.175 of the Provisional Findings Report.

⁶⁴ See paragraph 241 of Appendix 6.11 of the Report.

⁶⁵ See paragraph 6.84 of the Provisional Findings Report.

⁶⁶ See paragraph 7.2(iii) of HCA’s response to the CC’s AIS.

⁶⁷ See paragraph 6.45 of the Provisional Findings Report.

⁶⁸ See page 4 of Response from Circle to Provisional Findings and Remedies Notice (September 2013).

- (b) Alternatively, large PMIs may consider that they receive competitive prices already such that encouraging new entry would benefit their rivals more than it would benefit themselves.

B. Non-recognition has a detrimental impact on profitability and threatens hospitals' viability

6.5 Recognition by the key insurers is fundamental to the viability of any given facility.⁶⁹ As Laing's Healthcare Market Review 2011/2012 notes, "the impact of network exclusion on a hospital's business can be significant."⁷⁰

6.6 As the CC is aware, the initial lack of recognition of the Spire Brighton Montefiore Hospital by AXA, ~~§~~,⁷¹ ~~§~~,⁷² especially when the delay in obtaining recognition meant that the two largest PMIs were not allowing their insured patients to use the hospital for a considerable period of time.

6.7 Inevitably, experiences of non-recognition condition how PHPs view the prospects of future investments and affect their strategic discussions with PMIs. It is very surprising that this point is not considered by the PFs. Future decisions by Spire on investment and planning will need to take into account the likelihood of PMIs recognising the new facility, together with any expected delay in obtaining recognition. Excessive pressure from PMIs to secure discounts at new facilities may reduce the incentive for PHPs to develop such facilities. This will have inevitable consequences for the nature and type of future investment in the sector.

6.8 **Conclusion.** The CC fails to explain why it finds that PMI recognition, the single most important driver of demand, is not in itself a barrier to entry. Given that recognition by PMIs is critical to success ~~§~~ in the marketplace, the CC cannot reasonably conclude that threat of non-recognition by PMIs is not a barrier to entry that distorts competition and thus constitutes an AEC, which requires a remedy. A possible remedy, based on Circle's proposition, could be for automatic recognition of providers by PMIs to be the norm, with PMIs being entitled to refuse recognition only on the basis of objective transparent criteria such as clinic quality.

6.9 If new entry leads to greater competition, and if failure by PMIs to recognise new entrants is not considered to be an AEC, one logical conclusion regarding the lack of support for new entrants by the large PMIs is that these PMIs already have sufficient bargaining strength to constrain the PHPs absent new entry.

⁶⁹ ~~§~~

⁷⁰ See paragraph 7.24 of HCA's response to the CC's AIS.

⁷¹ ~~§~~

⁷² See Freshfields letter on behalf of Spire to the CC dated 29 May 2013 updating the CC on the progress of negotiations with AXA PPP ~~§~~.

7. INCENTIVE SCHEMES TO ENCOURAGE PATIENT REFERRALS FOR TREATMENT

Overview

Spire agrees that certain incentive schemes, such as volume and revenue incentives, may have the potential to distort competition by interfering with consultants' clinical judgement, which may in turn affect patient choice.

The analysis of consultant arrangements in the PFs, however, is deficient.

The reasoning in the PFs does not support the conclusions drawn. A nuanced analysis of different types of arrangements and their impact on clinical decisions is jettisoned for a sweeping and unsubstantiated conclusion.

There is a spectrum of arrangements between hospital providers and consultants, many of which have pro-competitive effects.

The CC's finding risks banning beneficial arrangements, which would distort competition, harm patient care and reduce the range of services available to patients.

7.1 Spire agrees with many of the CC's conclusions on consultant incentives. Spire agrees that direct incentives in the form of payment for referrals should not be allowed as a general ethical principle (whether or not such arrangements raise competition issues). Spire also agrees that some arrangements between hospitals and consultants can have significant pro-competitive effects, for example, equity participation can be an effective way to incentivise consultants to commit to working at a new hospital and, therefore, can support entry by new facilities. Finally, Spire agrees with the CC's view that ethical and regulatory constraints on behaviour can be expected to offset to a substantial extent any economic incentive for a consultant to offer advice, as regards treatment, that was otherwise then in the patient's best interest.

7.2 The following table summarises the assessment in the PFs of arrangements with consultants:

Assessment of arrangements with consultants in the PFs

Category	Type of arrangement	CC assessment
Arrangements relating to consultants' advice on choice of hospital	Direct incentives: (e.g. rewards for referrals, in the form of cash, equity, or subsidised services, the provision of which is explicitly or implicitly linked to income generated)	Implicitly problematic.
	Indirect incentives: (usually take	Likely to have less effect on

	the form of equity or other of profit-sharing where the incentive effect arises from the fact that directing a patient to a particular hospital is likely to increase the profits of that hospital in the longer term)	behaviour than referral fees; share of total profit is usually low and the financial benefit is, less immediate. Pro-competitive effects associated with consultants taking equity shares in new hospitals, which can support entry.
Arrangements relating to consultants' advice on diagnostic tests and treatment	Advice on treatment	Ethical and regulatory constraints likely to offset to a substantial extent any economic incentive regarding treatment advice. On some occasions, some consultants might be influenced by economic incentives to over-treat, but such incidents are likely to be few and far between. Schemes where consultants share in the profit from use of a single piece of equipment have an incentive effect closer to referral fees than those of a more dilute share in the profit from a wide range of health activities, such as a whole general hospital.
	Advice on diagnostic tests	It is less clear that any benefits that may arise from schemes where, for example, consultants share the profit from use of a single piece of equipment, such as encouraging investment in new equipment outweigh their adverse effects. Ethical and regulatory considerations are less likely to affect decisions. Some (probably very few) consultants, on some occasions, may suggest unnecessary diagnostic tests or consultation.

7.3 Although, Spire agrees with most of the CC's views, Spire is concerned that the provisional conclusion overstates the above analysis and applies to many arrangements that benefit patients by bringing new services to the market. Despite the analysis in the PFs, which states that it would be very rare for arrangements relating to diagnostic tests or treatment to affect the advice a consultant provides to patients (which Spire believes to be correct), the PFs nonetheless conclude that "incentive schemes do affect consultant behaviour" and that "incentive schemes operated by private hospital operators which encourage patient referrals for treatment at their facilities... are a feature of the market that gives rise to an adverse effect on competition".

7.4 ***An outright ban on consultant arrangements may raise the costs of consultants entering private practice.*** The CC has failed to identify that offering free or discounted consulting rooms and administrative support to consultants entering private practice for the first time, for a limited period, facilitates entry into the market by new consultants. The CC has assumed that hospital operators would only invest in such arrangements if they believed them to be effective in attracting business and that they are therefore bad because they affect patient choice “in a way that would not occur in a well-functioning market”.

7.5 However, the CC has not adduced any evidence that these precise practices have an adverse affect on competition. In fact, it has discounted the fact that such arrangements are effective in attracting extra business precisely because they facilitate consultant entry by positively influencing consultants’ choice whether or not to enter private practice in the first place, which increases the supply of consultants to the market. The BMA also notes that secretarial services and free consulting rooms are widespread and unlikely to act as a barrier to entry⁷³ or thereby distort competition.

7.6 Several Spire hospitals offer free or discounted consulting rooms and secretarial services to new consultants entering private practice for the first time. These services can provide important support for a consultant as he or she starts to build a private practice, and benefit patients by bringing new supply into the market.

7.7 ***No evidence, reasoning or analysis is advanced in the Report to support the assertion that all schemes relating to a single item of equipment or another service below the level of a full scale hospital are problematic.*** The CC has identified schemes relating to a single item of equipment as being potentially problematic. However, the CC’s initial view that arrangements relating to diagnostics are rarely an issue, combined with the CC’s recognition that equity-type incentives may lower barriers to entry sufficient to outweigh any distortion to competition,⁷⁴ implies that equity or partnership arrangements for diagnostics or other equipment can facilitate entry, even if on a smaller scale.

7.8 This is because certain schemes can frequently result in the delivery of a new service, treatment, or even a new competitor to the marketplace, and that would not happen absent the scheme. Co-investment vehicles are necessary to support hospital investment and to “develop new and enhanced patient services”.⁷⁵ This is all the more important in face of aggressive PMI cost pressure motivated solely by cost savings at the expense of innovation and without any regard to patient welfare.

7.9 ***In fact, the evidence supports the need for certain arrangements to counter PMI actions.*** As FIPO points out,⁷⁶ “under circumstances where fee schedules were

⁷³ See paragraph 8.113 of the Report.

⁷⁴ Cf. paragraphs 8.130 and 8.125 of the Report.

⁷⁵ See BMI’s comment at paragraph 8.15 of the Report.

⁷⁶ See paragraph 8.115 of the Report.

inflexible, prices had not increased in 18 years, PMIs were unilaterally implementing reduction in the reimbursement rates and patients were not able to decide on co-payments and top-ups, then some form of incentivisation could be pro-competitive.”

7.10 Indeed, while the CC recognises that a number of PMI actions have the potential to distort competition, and implicitly recognises that top-up fees are an important counterbalance to the actions of PMIs in driving down consultant fees,⁷⁷ the CC should have recognised that top-up fees for hospitals can be an effective tool for ensuring that PMI buyer power does not drive down quality and stifle innovation at hospital facilities.

7.11 ***Hospital top-up fees would benefit competition.*** In the same way as removing the current PMI bar on consultant top-up fees would promote diversification, enhance patient choice and drive competition on consultant price and quality, so too would hospital top-up fees have the same effect on hospital competition. Quite simply, this parameter of competition has not flourished in recent years because of PMI efforts to commoditise the nature of private healthcare. This is not a PMI policy that the CC should endorse: indeed, it would run contrary to the CC’s statutory mandate to endorse a policy that restricted competition, customer choice and innovation. The CC should therefore recognise explicitly that hospital top-up fees provide a useful mechanism for patients to select alternative services or facilities if they so wish.

The CC’s AEC finding does not capture certain anti-competitive arrangements

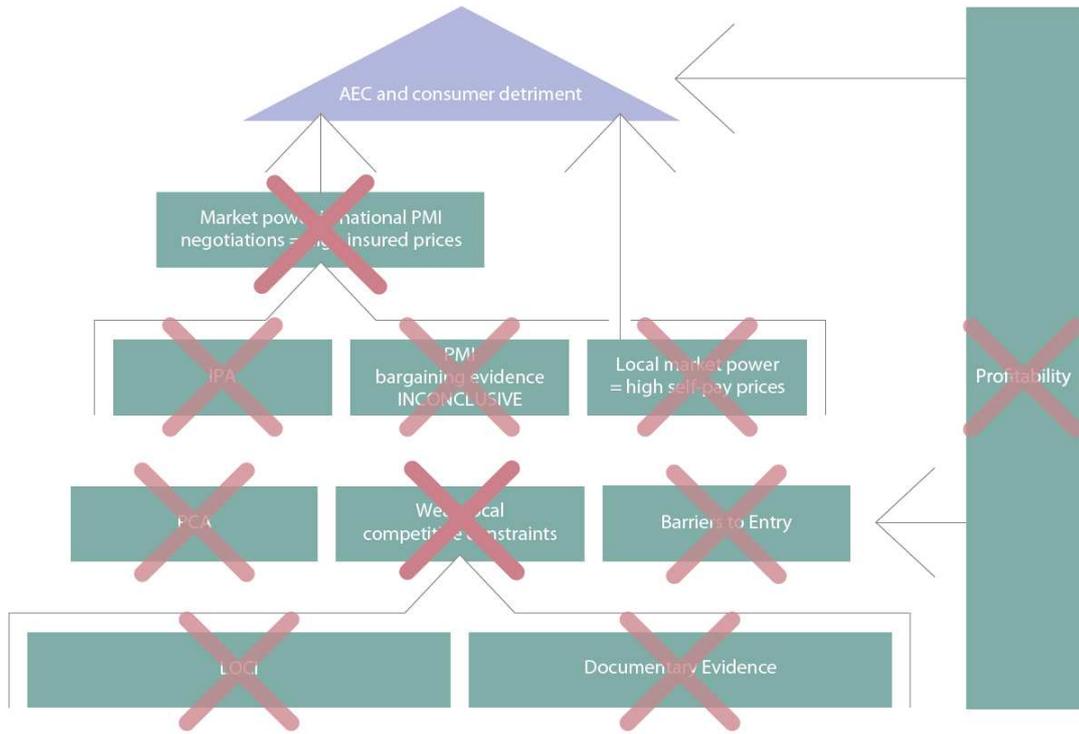
7.12 ***The CC does not address GP incentives in its conclusions.*** It is surprising that the CC does not recognize that GP incentives may give rise to similar adverse effects despite noting that most patients are referred to consultants by GPs and that hospitals may try to encourage GPs to refer patients to consultants who use their facilities. In addition, the BMA highlighted that GP incentives raise ethical issues and would be contrary to GMC guidance.⁷⁸ The CC should clarify that GP incentives may give rise to an AEC.

7.13 ***Conclusion.*** The CC’s finding of an AEC is too broad and is therefore unlawful. It risks capturing beneficial arrangements. As the CC itself identifies, there is a spectrum of consultant arrangements, from marketing activities, to consulting rooms or secretarial services and financial benefits, not all of which are distortive of competition (and the CC has not assessed the impact on competition in any event). As indicated, certain equity partnerships may have the pro-competitive effects of facilitating hospital entry (for example, Spire Brighton), or the introduction of new equipment, treatments and services to the market. Equally, provision of discounted consulting rooms and medical secretarial support to new consultants, for a limited time, may facilitate entry of consultants. Conversely, the CC fails to recognise that hospital and consultant top-up fees would be an important counter-balance to excessive PMI cost pressures which risk stifling innovation and patient choice.

⁷⁷ See paragraph 7.73 of the Report.

⁷⁸ See paragraph 8.113 of the Report.

8. THE ANALYSIS OF CONSUMER DETRIMENT IN THE REPORT IS NOT TENABLE



8. THE ANALYSIS OF CONSUMER DETRIMENT IN THE REPORT IS NOT TENABLE

Overview

The CC's analysis of alleged consumer detriment is not economically sustainable.

The CC's analysis relies on an interpretation of the PCA as showing higher prices in concentrated areas. The PCA does not show higher prices in concentrated areas for Spire hospitals. The analysis also relies on an interpretation of the IPA as showing higher prices for PHPs whose hospital portfolios are less substitutable. The IPA shows that Spire does not charge prices that are consistently or significantly above those of hospital operators without market power.

The CC assumes that reducing NHS work would reduce operating costs for hospitals. This is inconsistent with the finding in the PFs that most hospital costs are fixed and the fact that the main driver for Spire's investment in hospitals is to serve private patients.

The CC assumes that any benefits of lower prices will be passed through to consumers. This is pure assumption with no evidence of analysis and the CC cannot, as a matter of law, reach a conclusion based merely on assumption.

Spire has explained elsewhere in this Response why the calculation of profitability set out in the PFs is inaccurate.

8.1 In considering estimates of consumer detriment arising from the AEC in relation to private healthcare, the PFs essentially rely on three core points. For the reasons explained below, none of these three propositions can be sustained to the requisite legal standard.

8.2 *First, the use of a 3% estimate of the extent of an "overcharge" due to weakness of competition is unlawful.* This estimate is predicated on the PCA, but that cannot be relied upon by the CC. As described above, the analysis is irrational. This part of the CC's analysis and reasoning on consumer detriment needs to be omitted from the Final Report.

8.3 *Second, there is no economic or commercial logic in seeking to apportion costs between private and NHS work.* While Spire understands the conceptual point that the CC's investigation relates only to private healthcare and it thus wishes to take account only of private healthcare revenues and costs, the PFs' methodology which apportions operating costs *pro rata* between private and NHS provision is not an appropriate methodology. This is because, having rightly concluded that NHS work undertaken by private hospitals should be viewed as ancillary to privately-funded work, the PFs then wrongly assume that costs and assets could be avoided in direct proportion to NHS revenue if NHS work were not undertaken.

8.4 There is no evidence to support this assertion. The PFs contain no such supporting evidence or assessment. Although some costs (variable costs might be saved by not conducting NHS procedures), such variable costs are not a significant proportion of the total costs. Moreover, the provisional conclusion in the PFs is internally inconsistent with:

- (a) the conclusion of the PFs regarding the ancillary nature of NHS work;
- (b) other analysis of hospital costs, none of which concluded that hospitals incurred costs and acquired assets only to carry out publicly-funded NHS work, as a result the PFs cannot lawfully conclude that there are any costs/assets that would be saved by avoiding NHS work; and
- (c) the CC's own analysis, which concluded that private care is characterised by its significant fixed cost nature.

8.5 ***Third, there is no evidence on which the CC can conclude that consumers will benefit from the proposed steps envisaged by the PFs.*** This is a particularly serious omission. In fact, the CC has failed entirely to investigate the competitiveness of the PMI marketplace. Spire – along with other private hospital operators – urged the CC at the outset of this investigation to ensure that it understood properly and fully the operation of the PMI marketplace. The CC decided not to pursue this evidence gathering and so is now precluded from asserting that the downstream PMI marketplace is more or less competitive.

8.6 In consequence, it is not open to the CC as a matter of law to reach any conclusion about the benefits of pass-through to patients. Any such conclusion would be assumption-driven and unsustainable. Spire notes, for example, that Bupa UK's profits on private medical insurance increased 124% year on year between the first half of 2012 and the first half of 2013. Bupa has stated: “[w]e saw an encouraging upswing in profits in the UK, as initiatives taken by our health funding business to improve claims management, began to deliver benefits.”⁷⁹ These benefits have not been shared with consumers in the form of premia reductions and there is no reason to believe that any other cost savings to Bupa would be passed on to consumers.

8.7 In addition to the three core points underlying the assessment of the consumer detriment, there are two further problems with the analysis. First, the analysis of the private healthcare market has been limited to inpatient services, it is not possible to extrapolate a finding of an AEC or consumer detriment relating to inpatient services to separate product markets including day and outpatient services. Second, the CC's finding of excess profitability (which Spire refutes), which underlies the consumer detriment analysis, relies on a comparison of companies' ROCE to the industry WACC. The CC has assessed Spire's WACC to be 11.2%, which is higher than the industry WACC. Relying on the industry WACC to assess Spire's profitability level will overstate the amount of any returns above the cost of capital.

⁷⁹ See: “Bupa achieves growth amid falling customer numbers”, Cover Magazine (7 August 2013), available online at: www.covermagazine.co.uk/cover/news/2287453/bupa-achieves-growth-amid-falling-customer-numbers (accessed 7 November 2013).

8.8 In reality, the CC's proposals are more likely to benefit Bupa than anyone else. That is also the conclusion reached by PruHealth in its response to the PFs and Remedies Notice. PruHealth's submissions underscore the simple fact that the CC's analysis and reasoning are fundamentally flawed. Where benefits are not industry wide but are instead firm specific, they are much less likely to be passed on to consumers.

9. THE PFs ARE UNFAIR AND UNSUBSTANTIATED

Overview

The provisional conclusions reached are vitiated by fundamental unfairness.

The overall conclusions of the PFs are not supported by the analysis and evidence.

The adverse finding in relation to the provision of privately-funded healthcare by hospitals is not supported by any evidence of analysis as to why this conclusion is relevant to outpatients or day-cases.

It is not open to the CC to reach an adverse finding in relation to those aspects of private healthcare.

9.1 The overall conclusions of the PFs are not supported by the analysis and evidence. Although the overall adverse finding of the PFs in relation to hospitals is described as applying to the overall provision of privately-funded healthcare by hospitals, there is no evidence or analysis as to why such conclusions are relevant to outpatient care or day-cases. In this context, it is not open to the CC to reach an adverse finding in relation to those aspects of private healthcare.

9.2 Adverse findings, especially ones leading to drastic remedies, must be based on sound reasoning and analysis and must be firmly anchored in evidence. However, in this case, the PFs' analysis, reasoning and the evidence presented do not support a finding of an AEC. Even taking the analysis and evidence at face value, they do not support the AEC. In each segment of the analysis, there is a disconnect between the evidence and the PFs' findings. Put simply, the building blocks of the CC's analysis cannot sustain the PFs.

- (a) First, the AEC is expressed to apply to all privately-funded healthcare provision in hospitals. This has not been investigated. The CC has not reviewed competition in outpatient provision, notwithstanding that Spire has consistently said that this represents an important part of the competitive dynamic and the majority of its patient admissions and revenues. The CC has not properly investigated day-case provision. Although the CC oscillates between inclusion and exclusion of day-case data, the CC never once properly considers the competitive constraints relevant to day-case procedures. Again, Spire has consistently explained the importance of doing so, but has been ignored. The CC cannot now seek to brush over this lacuna in its investigation and analysis by simply asserting that the AEC applies to all privately-funded healthcare provision in a hospital: it plainly does not.

- (b) Second, the PFs rely heavily on a legally and economically flawed and circular argument to sustain the AEC finding that weak local competitive constraints are likely to lead to higher self-pay and insured prices, because this circularity is the only way it can justify its finding. First, the CC concludes that PHPs with a large number of hospitals facing weak local competitive constraints charge higher prices to PMIs despite acknowledging that its “analysis of insured price outcomes...does not, on its own, provide evidence of a causal relationship” between average substitutability of hospitals or hospital portfolios and insured price outcomes.⁸⁰ Second, the PFs nonetheless infer from the IPA that Spire has market power in PMI negotiations, claiming that this is consistent with the results of its PCA and the PMI bargaining evidence. But none of these pieces of analysis or evidence supports the conclusion drawn, nor does it support more broadly the finding of an AEC in relation to Spire:
- (i) the IPA is inconsistent with the PFs because it does not show that Spire consistently or significantly prices above operators without market power;
 - (ii) the local assessment of Spire hospitals is based on a flawed indicator of local competition (the LOCI) and is contradicted by PMI evidence and other evidence of the reality of local competition and is not therefore consistent with Spire having a large number of hospitals facing weak competitive constraints;
 - (iii) the results of the PCA do not show that Spire charges higher prices to self-pay patients in areas of higher local concentration and they do not identify a “general” relationship between higher prices and higher concentration; and
 - (iv) the evidence from PMI bargaining does not show a causal relationship between higher concentration and higher insured prices for Spire.

Therefore, the conclusion is legally and economically flawed, does not show what it claims to show, and cannot be sustained.

- (c) Third, the PFs assert that, in direct contradiction with patient survey evidence, catchment areas are reflective of geographic markets. Despite acknowledging this contradiction, the PFs take each hospital’s catchment area “as a pragmatic definition of the geographic market”.⁸¹ There is a disconnect between survey evidence showing patients’ willingness to travel further for quality and the CC’s narrow geographic market definition that claims to encompass sets of private

⁸⁰ See paragraph 6.239 of the Report.

⁸¹ See paragraphs 5.64 and 5.68 of the Report.

hospitals and PPU's competing closely *because enough patients consider them to be substitutes in terms of distance*.⁸² It cannot be assumed, essentially on convenience grounds, that catchment areas equate to properly defined geographic markets that encompass all relevant local competitive constraints. A demand-centred analysis is better reflective of patient choice.

- (d) Fourth, despite stating that “hospitals that are near one another may be expected to exert a stronger competitive constraint than hospitals located further away”,⁸³ the PFs have assumed that despite there being closer rivals to a given Spire hospital, common ownership of Spire hospitals in local areas is nevertheless a concern. Despite claiming to have considered the different levels of constraints in its assessment, the PFs have evidently failed to do so.
- (e) Fifth, in its assessment of local competition, while the PFs refer to PMI evidence of effective competition in specific local areas (which often directly contradicts its conclusions), the CC largely ignores this in favour of its own views.
- (f) Sixth, the profitability methodology departs from traditional accounting methodology and economic analysis, is inconsistent and is far removed from reality and evidence.
- (g) Seventh, the AEC finding with respect to consultant incentives is unclear. The evidence does not provide a sufficient basis for an AEC finding with respect to all types of incentive arrangements: the evidence to suggest that economic incentives relating to diagnostic tests are likely to result in unnecessary diagnostic tests or consultations only on “some occasions” and for “some (probably very few) consultants”.⁸⁴ Yet, the PFs leap to the conclusion that “*on balance, the evidence indicates that incentive schemes are likely to lead to excessive diagnostic tests or consultations.*”⁸⁵

9.3 In light of the above, even if the CC were to maintain its analysis, reasoning and conclusions in the PFs (which is not in fact an option given the deficiencies explained above), then the CC would nonetheless have to narrow considerably the scope of the identified AEC.

⁸² See paragraph 5.70 of the Report.

⁸³ See paragraph 5.65 of the Report.

⁸⁴ See paragraph 8.130 of the Report.

⁸⁵ See paragraph 8.133 of the Report.

10. CONCLUSION

Summary of Conclusions

The PFs (as set out in the Report) cannot be sustained.

The PFs:

- 1. Do not show, on a balance of probabilities, that there are features of the market that result in an AEC;**
- 2. Are not based on a fair reflection of the record of evidence;**
- 3. Rely in a number of key respects on flawed economic analysis; and**
- 4. Rely on a series of unfounded assumptions or circular argumentation.**

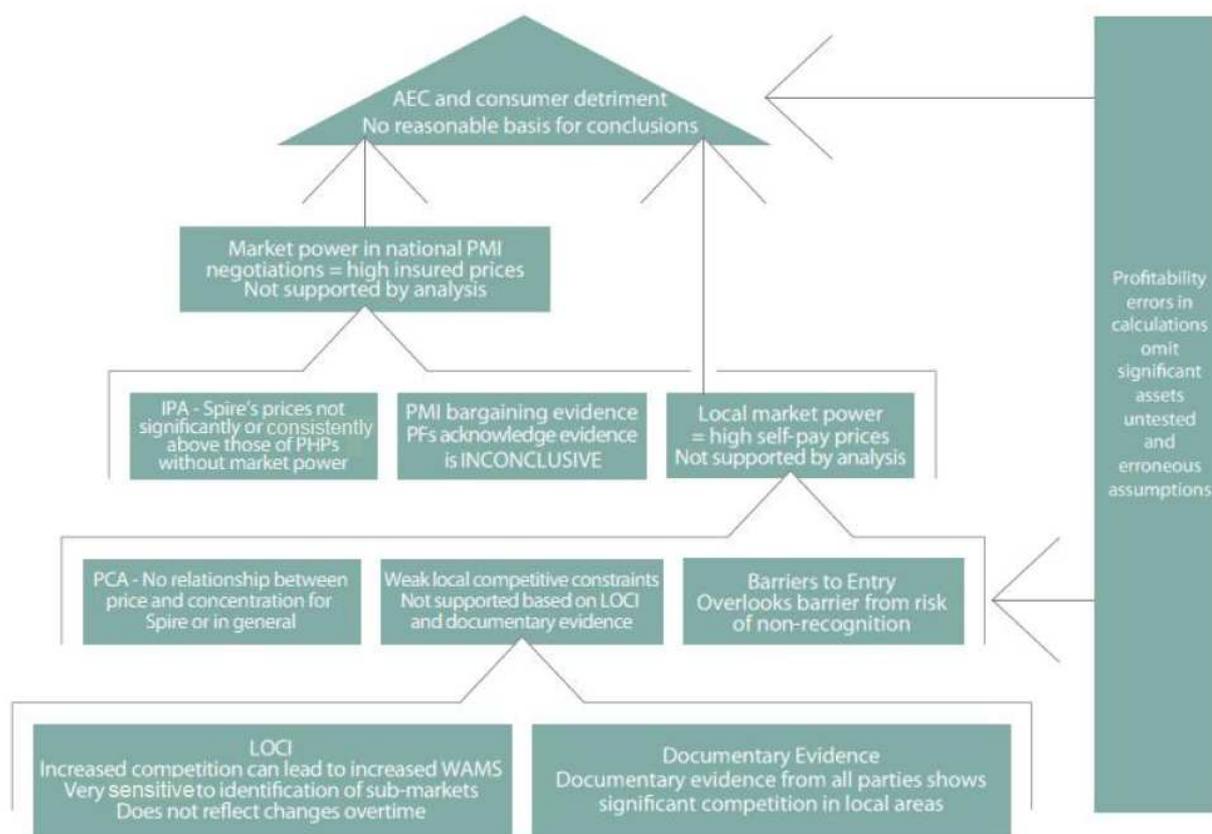
The CC has fundamentally misunderstood how competition works in the UK healthcare market.

The reality of the CC's misunderstanding is now very clear: the CC's conclusions and Remedies Notice threaten to distort competition in the marketplace to the extent that PMIs other than Bupa are extremely concerned about their own ability to compete and about the impact of the CC's PFs and Remedies Notice.

This is plainly an unsatisfactory outcome which will harm competition, reduce patient choice, and investment within the industry thereby reducing quality for UK patients

10.1 These are fundamental flaws, many of which have been raised before by Spire, and by other participants in the MIR, but which remain unaddressed and unconsidered by the CC. These errors are so serious that, whether taken individually or collectively, the CC cannot reasonably maintain the provisional views expressed in the Report. In simple terms, the CC's standard of proof (i.e., establishing an AEC to the balance of probabilities) is not discharged, and hence the provisional conclusion that the evidence supports the CC's analysis is unreasonable:

10.2 The main flaws in the PFs are summarised in the graphic below:



10.3 It is not therefore open to the CC to reach a conclusion that it has identified a feature (or features) of a market which give rise to an AEC pursuant to s134 of the Enterprise Act 2002.

10.4 The CC has fundamentally misunderstood how competition works in the UK healthcare market. Spire, along with other parties, has sought to explain and evidence this from the very beginning of the MIR.

10.5 The reality of this position is now very clear: the CC's conclusions and Remedies Notice threaten to distort competition in the marketplace so materially that patient groups are extremely concerned about the impact on patient care, and even PMIs other than Bupa are extremely concerned about their own ability to compete, and about the impact of the CC's PFs and Remedies Notice. This is plainly an unsatisfactory outcome.

10.6 The CC needs to reconsider its PFs as a matter of urgency before significant damage is done to the delivery of healthcare in the UK. As matters stand, the

Provisional Findings – if maintained – will harm competition, reduce patient choice, and investment within the industry thereby reducing quality for UK patients.

11. LIST OF ANNEXES

1.	RBB LOCI Analysis
2.	CONFIDENTIAL: Local Assessments
3.	CONFIDENTIAL: National Negotiations
4.	LEK Insured De-listing
5.	CONFIDENTIAL: Price Comparison Analysis
6.	CONFIDENTIAL: Index Price Analysis
7.	LEK Profitability Analysis
8.	Mace Property Valuations

