

Response of



to

Provisional Decision on Remedies
(Non-Confidential)

7 February 2014

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Response of BMI Healthcare to Provisional Decision on Remedies

1. Overview of the PDR

- 1.1 BMI welcomes the CC's provisional decision to drop Remedies 2 and 8 as well as the divestment case against a number of BMI hospitals. This revision still leaves 7 BMI hospitals in respect of which the CC seeks divestiture. The CC has not made out a case for this.
- 1.2 The CC has still to revise Provisional Findings (PFs) in light of comments received. BMI has made a large number of comments and provided significant supporting evidence to the effect that the PFs are substantially flawed and do not provide a sufficient evidential basis for the proposed AEC finding. BMI maintains its submissions in response to PFs but does not repeat them here. However in the Provisional Decision on Remedies (PDR) the CC appears significantly to adjust the gist of the case that it has previously made.
- 1.3 In para 2.67 of the PDR the CC distances itself from the use of LOCI. It states that it has used LOCI only as a filter to identify areas in which co-owned hospitals have overlapping catchment areas. This is not the case. LOCI is hard-baked into the overall CC methodology and case against BMI. Without the use of LOCI the CC would have no measure for 'weighted average market share' outside central London, no price concentration analysis (PCA), no NPV to assess the potential effectiveness of remedies and would thus not be considering these divestments at all. BMI would be delighted if the CC were to abandon the use of LOCI entirely: BMI – along with many others – has consistently argued that it is inappropriate. The CC's chosen analytical tool identified [3<]¹ hospitals of concern when first applied. The CC now identifies just 9 for remedial action. That level of false positives itself shows how ill designed and unreliable LOCI is. False positives remain. However until the PDR the CC has robustly defended its choice of LOCI to measure concentration and market power throughout. It does not address the parties' critique now simply to downplay LOCI and present it as a mere 'filter' so implying it was/is not that important after all. If the CC now wishes to use the conventional approach, of defining local markets, calculating market shares, conducting a detailed analysis of the competitive dynamics and rates of diversion between facia in a local area as a basis for its conclusions, it should do so and do so consistently.
- 1.4 BMI has commented extensively on the flawed PCA that piles assumption upon conjecture to achieve the result the CC requires for it to be able to intervene and assess the effectiveness of that intervention. The PCA is a genuinely troubling piece of work for an authority of the CC's stature. The remarkably strong criticism made against it by Dr. Peter Davis should be ringing alarm bells, especially given his long experience of econometric analysis on behalf of the CC itself. It would be a serious mistake to dismiss such an assessment as advocacy.
- 1.5 The PCA is the basis for the CC's predictions about the price benefits of breaking up clusters of BMI hospitals via divestment remedies². BMI notes that the CC has not

¹ Issues Statement Appendix B para 9

² PDR para 2.148

proceeded by investigating the likely diversion and gross margin data within clusters as would be conventional in a merger case concerning local markets. Neither has it compared the actual price data in the clusters with areas in which it has found competition to be effective. The CC has the data to do this but has inexplicably chosen not to. In fact the CC has not conducted any empirical analysis at all within these markets – or even the wider 'local areas' that the clusters sit within. The price effect of divestment has merely extrapolated the national PCA to these local areas without thought as to its relevance. Doing this disguises an inconvenient truth: the CC's own PCA does not in fact show a causal relationship between concentration and price for BMI hospitals. In respect of BMI's 'clusters' therefore the CC's PCA does not predict that divestment to another firm would result in any price effect at all in that cluster. The CC is assuming that a national relationship posited by the CC across the whole industry (which itself is not robust) applies in local areas the CC has not empirically assessed, and in respect of a firm for whom the national relationship posited demonstrably does not hold.

- 1.6 The PDR attempts to place greater reliance on local market analysis and less on the aspects of other problematic parts of the PFs (PCA, LOCI, IPA, profitability, bargaining assessment etc). The CC asserts in para 2.67 that it has: "*conducted a detailed analysis of the competitive dynamics in the local area in order to come to a view on the extent to which a divestiture may be an effective and proportionate remedy*". This is not what the CC sets out in the PFs or the PDR. The reality is a top down assessment based on an early intuition about "clusters" that has entirely driven the CC's approach to local competition. That intuition has been obvious throughout. It is apparent for example in the use and/or interpretation of the flawed LOCI and PCA analysis – as well as the questioning in BMI's hearings. Nothing has changed in the PDR.
- 1.7 In respect of the local assessments and the cluster intuition, recall that a competition problem resulting from 'clusters' is an invention of the CC. Such 'clusters' formed no part of the original extensive submissions by the complainants in this case – which focused exclusively on solus and 'must have' hospitals; nor did they form any part of the OFT conclusions from the market study. There is still no evidence of clusters ever having been referred to in all the insurer/hospital negotiation documentation the CC has reviewed. The clusters themselves are defined by a crude catchment overlap analysis that was never intended – by the CC's admission - to describe the geographic market and gives as much weight to fields filled with sheep as it does to populated areas with high PMI penetration. On the face of it this is perverse and cannot be an appropriate measurement for a public body with the reputation of the CC.
- 1.8 Recall also that the CC issued its 6 page working paper and spreadsheet on local assessments in May 2013 - by its own admission - without having first reviewed BMI's evidence. The local assessments the CC now seeks to rely on for the 7 proposed divestments have not materially progressed from that first flawed working paper. They still use market share calculated by LOCI as a filter, followed by a series of naïve and static assumptions. Entry and expansion (both potential and actual) have still not been considered; false overlaps have been generated by the CC's crude catchment definitions that take no account of where patients actually live; overlaps have been generated by centering catchments on hospitals rather than demand; there is almost no analysis of transport networks and location of population centres within catchments; there is no examination of the impact of the NHS and the impact it and NHS Trusts and CCGs have on patient referrals through consultant working locations and GP referrals; there is also

no analysis (empirical or otherwise) of diversion ratios within 'clusters'. The CC has not attempted to differentiate plausible and implausible patient movements within and outside 'clusters'. It is not even clear whether the CC knows where patients move from and to.

- 1.9 The analysis still depends on rudimentary criteria such as hospital size which have been inconsistently applied and used as a proxy for competitive strength and potential across a large number of differentiated highly personal services in local markets displaying generally high levels of spare capacity; the views of insurers (whether supported by evidence or not) have been accorded great weight, despite their incentives in the inquiry and inconsistencies with their own prior submissions and demonstrated interaction with competitors has been ignored.
- 1.10 Over the period of the investigation there have been multiple entry and expansion actions (actual and potential) that have taken place (contradicting the CC's conclusion on entry barriers). The CC has overlooked these and conducted a static review. The most striking examples are:
 - (a) The complete failure in the Chelsfield & Sloane section of Appendix 2.2 PDR to even mention the Kent Institute of Medicine and Surgery (KIMS), a 100 bed tertiary hospital that the CC is aware is actively soliciting in the Chelsfield Park catchment area as it launches in a matter of weeks.
 - (b) The complete failure in the Beardwood and Highfield section of Appendix 2.2 of the PDR to even mention the new HCA Wilmslow and HCA Wythenshawe hospitals in South Manchester. The former opens on 1 March, even before the CC will report. The latter is to open in mid-2015. HCA Wythenshawe will be a 40 bed, ITU level 3 hospital with tertiary capabilities sited in the MediPark adjoining the University Hospital of South Manchester. 52 Alderley Road (HCA Wilmslow) will be, according to its website, "a £10m private diagnostic, treatment and surgical centre".
- 1.11 There are many more examples. These initiatives have fundamentally changed the local market dynamics. Any detailed analysis of the competitive dynamics in the local area such as that claimed by the CC in the PDR would have taken these into account. The CC's conclusion on both competitive constraint and cost-benefit of divestments would be different. Multiple other entry/expansion stories exist, but the CC seems unwilling to consider them either in the PDR or PFs. They go to show that the CC's entry barrier story is not robust.
- 1.12 That cost-benefit analysis can in any event be no more than a cockshy. It fails to take into account the most elementary adjustments to ensure a fair presentation of the price benefits the CC claims will arise. For instance, it assumes that the assumed price impact comes entirely from divestitures and not at all from remedies 3 to 7. The CC cannot have it both ways: on this basis it should drop remedies 3 to 7 having argued elsewhere that they will improve competitive outcomes including price. As such the cost-benefit analysis is no basis for the divestitures proposed. Rather it provides a loose analysis of possible upside outcomes. When properly founded, the cost-benefit analysis gives a range of outcomes, both positive and negative. The CC must form an expectation about the level of price benefits within the range, not simply look at the top end in hope. In

forming an expectation it needs to be rooted in what it can reasonably forecast. 20 year time horizons in this market are too extended for any reliable assumptions to be made. Moreover the CC must apply the analysis to the realities of each proposed divestment, which have been over-looked.

- 1.13 Any fair minded observer can see that the competitive assessment underpinning divestiture falls far short of the standard for a proper understanding of the competitive interaction of the BMI and other hospitals in the clusters. Were this analysis presented in a merger case it would be no more than a first cut to narrow the areas for in depth review. It is quite implausible to think that the CC would seek to block a merger between hospitals within the 'clusters' it now seeks to break up on the evidential basis presented.
- 1.14 The CC informed us on 6 February that it has made substantial amendments to the insured pricing analysis. Although the CC is prepared to set up a data room for Nuffield to view this it is not prepared to do so for BMI. Clearly BMI is not only a party to the inquiry but also subject to intrusive remedies. BMI does not understand this approach. The CC says that BMI's position is currently unchanged from that set out in PFs. While that may be CC's view, due process requires that BMI be given the opportunity to review that information. The extra effort for the CC is minimal: the data room is being set up anyway; BMI and its advisers have already agreed undertakings and the CC clearly has the resources to do this. It is clearly practicable for the CC to allow BMI as one of only two parties the CC is proposing should divest assets to have access to the data room. Moreover it took the CC a substantial time to set up the first such data room: and the CC must have taken time to prepare for this second exercise during which it could have warned BMI. BMI consequently requests access.
- 1.15 **Section 1** considers these issues in detail. We conclude that on the CC's own analytical framework and examining the facts therein, there is no case for the divestment identified by the CC as necessary of:
- (a) Bishops Wood or Clementine Churchill;
 - (b) Kings Oak/Cavell;
 - (c) Chelsfield Park or Shirley Oaks;
 - (d) Saxon Clinic or Three Shires;
 - (e) Highfield.
- 1.16 [X]
- 1.17 Insofar as the effectiveness and proportionality is not addressed in the discussion of each of the divestiture remedies, Sections 2 and 3 consider these issues in detail.
- 1.18 BMI's comments on remedies 3 to 7 are set out in **Section 4**.

2. SECTION 1 – BMI'S RESPONSE TO REMEDY 1

A. PMIs do not support the CC's approach outside of London

2.1 The CC fails in the PDR to take account of the scepticism of the PMIs on the divestment proposal.

2.2 Among the smaller PMIs, for instance, PruHealth states:

*"[w]e have some concerns that enforced divestment of facilities could result in the reduction of patient choice, and costs increase in remaining facilities. As stated above PruHealth did not express concerns about the structure and functioning of the market outside of London. It seems that the change in structure is at the behest and design of the two largest insurers, and we do not believe this to be equitable or in the markets best interest, as the unplanned consequences may be in the short – medium term to reduce the range of available facilities."*³

2.3 Similarly Simplyhealth told the CC:

*"Simplyhealth believes that the impact of a divestiture strategy, particularly outside of London, could impact smaller insurers disproportionately and detrimentally, resulting in less customer choice and a greater concentration of the PMI market in fewer providers."*⁴

2.4 Even the larger insurers are not supportive. AXA PPP told the CC:

*" [O]utside of London, although we agree that BMI and Spire may have a greater degree of market power in some geographical regions, we do not currently experience the same level of disadvantage that we do with HCA in London. We are sceptical in the round of a remedy that requires BMI and Spire to divest hospitals."*⁵

2.5 The CC has accepted this viewpoint in relation to Spire but not as yet to BMI. Worryingly the CC goes to great lengths in its PDR to quote where insurers are supportive of the remedies the CC proposes to pursue but does not even reference these doubts among the PMIs. The PMIs are more than able, and well incentivised, to support a proposed regulatory intervention explicitly designed to advantage them. That the CC ignores them and continues to pursue the early intuition which it has been unable to support with evidence is telling. The CC should properly weigh these concerns in coming to its view on whether to pursue the divestiture remedy outside London at all. It is clear from these statements that the PMIs' concern is primarily about London.

³ PruHealth Insurance, Response to Notice of Possible Remedies September 2013 page 5

⁴ Simplyhealth Response Document page 1

⁵ AXA PPP, Response to PFs and Notice of Possible Remedies, paragraph 2.57

2.6 Nor is it clear that PMIs have any appetite to pursue the CC's favoured local tendering option, and it must be doubtful that they would on the evidence.

B. Unsustainable CC Catchment Area Analysis

2.7 The CC's fixed road distance radii catchment areas are fundamentally flawed. The CC states "*[w]e defined a hospital's catchment area as the radius within which a given percentage of the hospital's patients originate from. We have used 80 per cent as the proportion of patients, and have measured the radius based on road distances (in miles) between patient home postcodes and hospital postcodes.*"⁶ This method is far too prescriptive; isodistances emanate from the hospital in a uniform manner, failing to reflect actual competition faced by a hospital. The reality is far more nuanced. The approach is even more rudimentary than the techniques used in the industry as rough catchment definition tools, and is inconsistent with the CC's own decisional practice in hospital mergers – such as Poole/Bournemouth (see below).

2.8 BMI has provided the CC with its own catchment areas analyses used in the ordinary course of business. BMI considers the catchment area of their hospitals on the basis of those postal districts that account for at least 80% of a given hospital's episodes. This is achieved by ranking the top postal districts by number of private inpatient and day case episodes and taking the postal districts which account for 80% of episodes. Other postal districts are then added to form a sensible contiguous catchment area – thus often resulting in a total greater than 80%. This method generates what BMI refers to as the Core Catchment Area ("CCA"). The CCAs reflect how BMI views the competitive landscape and are a key input into informing its commercial strategy.

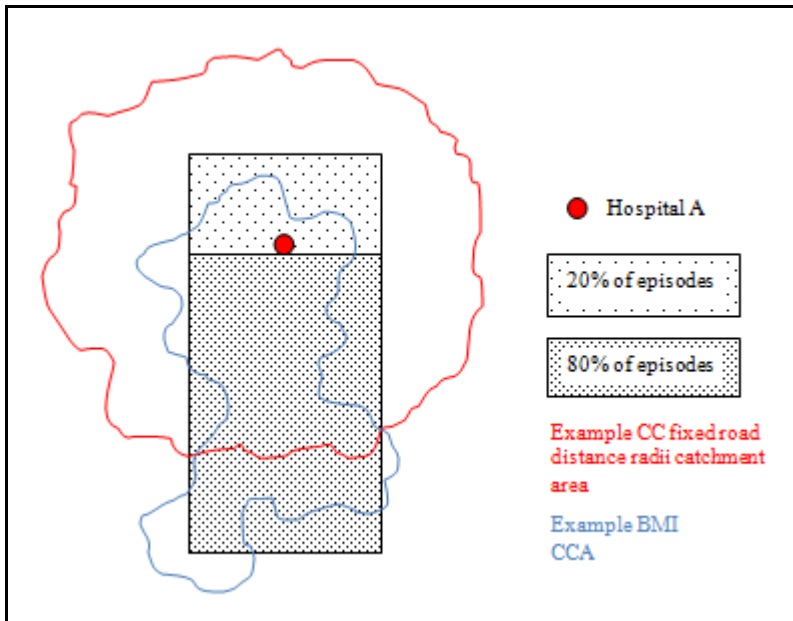
2.9 This approach portrays more accurately the size and shape of the catchment area as it will be informed by the variations in demand and alternative sources of supply around a hospital which are reflected in the number of episodes it draws from a given postal district. The method is an ordinary course business tool – which of itself suggests it has significant evidential value, reflecting as it does BMI's analysis of its own business and the markets that it has operated within for more than 30 years. That said CCA catchments were not designed to define antitrust markets. In particular, the catchment size / shape is affected by the presence of competition. A competing hospital reduces the number of episodes that BMI might win from a postcode district – such an area may well be highly contentious but BMI wins too few episodes for it to appear in the top 80%. Nevertheless BMI's CCAs have the advantage of describing patient location more accurately than the use of fixed road distance radii in the CC's method – which will inherently describe a uniform almost circular catchment area, regardless of the actual location of patients.

2.10 Compounding the problem with the use of radii is the CC's choice of metric. The CC has used road distances. This is a highly unorthodox choice for competition assessments in local markets where the evidence shows (as it does here) that customers travel by car. Even drive-time isochrones, although less effective than a CCA approach, more accurately represent the accessibility of a hospital than road distance as not every mile is treated equally when measured by drive time. Isochrones therefore more closely

⁶ PFs, Appendix A6(5), paragraph 6.

mirror actual catchments. Indeed drive times are also plotted alongside BMI's CCAs in its internal catchment area analyses, which state "[o]ur standard definition of the catchment area for independent hospitals and NHS Private Patient Units is 30 minutes drive time, as this generally accounts for at least 80% of private patient episodes." Drive-times are an industry standard and have been preferred in all recent studies and investigations relating to private healthcare.⁷ The rationale for the CC adopting something wholly different is still not clear.

- 2.11 The CC's choices regarding catchment areas have important consequences. A key premise of the CC's cluster theory and its case for divestment is the overlap between catchment areas of BMI hospitals within a 'cluster'. Yet in many cases these are minor or are simply a function of overlapping circles on a map and bear no resemblance to the choices that patients actually have. The danger of the CC's approach is represented by a hypothetical example below:



- 2.12 Hospital A may draw the vast majority of its patients from the south, with hardly any patients from the north. This could be for a number of reasons. It could be due to the competitive constraints exerted by rival hospitals to the north, the referral patterns of the GPs to the north who use a different consultant population based at a different NHS Trust – usually due to established NHS referral patterns, the location of areas with high PMI penetration, the road network that facilitates transport from the south more than the

⁷ In all recent studies and investigations relating to private healthcare, drive time isochrones have been preferred as more appropriate than fixed road distance isochrones. In The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH)/Poole Hospital NHS Foundation Trust merger review by the CC during the course of this investigation, the CC used drive-time isochrones of 17 minutes for RBCH and of 22 minutes for Poole. In both the GHG/Abbey merger and GHG/Nuffield merger both the OFT and the parties used 30-minute drive time isochrones (representing roughly 80% of hospital episodes). The OFT also used 30-minute drive time isochrones for the Spire/CHG merger investigation.

north, or simply consumer preferences and habits. A market investigation is an opportunity to consider all these variables. It is naïve and more likely to be wrong than right to simply draw a circle round a hospital and effectively use that as a local geographic market definition. This is especially problematic when such drastic intervention is promoted by such an approach. There is no evidence to suggest this is a rational approach – no doubt a matter of great concern to the group. The approach to catchment area definition undermines and contaminates the whole of the CC's divestiture analysis.

C. Divesting either Bishops Wood or Clementine Churchill would be ineffective and disproportionate

- 2.13 Bishops Wood and CCH are complements not substitutes. This is consistent with the evidence of both Bupa and AXA PPP. They are highly asymmetric in their service offerings. Neither is capable of performing the specialisations of the other. If specialisation is 'hard wired' into the hospital it means that there is no realistic prospect that an insurer would threaten to delist one to obtain an exclusive contract at a lower price with the other as the insurer needs access to both service offerings.
- 2.14 In relation to the specialties in which they do overlap, Bishops Wood is not a credible competitor to CCH such that CCH would be incentivised to compete for an exclusive contract if a PMI threatened to move work to Bishops Wood. [REDACTED].
- 2.15 CCH is in any event already adequately constrained for non-specialist episodes that are or could be contestable with Bishops Wood. An insurer can already delist CCH for these contestable episodes. This is consistent with AXA PPP comments and past Bupa practice. Self-pay patients in Harrow have a very large number of choices available to them within the drive time that the CC's survey suggests they would be prepared to travel. [REDACTED].
- 2.16 In respect of patients at Bishops Wood, for those episodes that overlap with CCH there is already intense competition with Spire's multiple local facilities and those of others. The CC chooses not to acknowledge or analyse that competition, which is abundantly evidenced. Any further competition with CCH in the non-differentiated overlap could only provide a very small price benefit. That benefit is insufficient to outweigh the costs.
- 2.17 BMI's detailed analysis is in Appendix 1.

D. Divesting either Kings Oak or Cavell would be ineffective and disproportionate

- 2.18 Kings Oak and Cavell are operated as a single hospital. There is no other instance of the CC attempting to "split" hospitals up – most notably in single or duopoly areas, yet in practice that is what is attempted here. In CC terms, BMI achieves the benefits for patients of operating a 90 bed better equipped facility, as well as the benefits for itself of better theatre and facility utilisation. Separating the hospitals will lose these benefits and each of Kings Oak and Cavell will need to invest to be able to be independent self-standing hospitals.
- 2.19 [REDACTED]

2.20 It is quite unrealistic to expect that there will be two similar hospitals facing each other to compete across the seventeen specialties as the CC envisages. The divestment of one of these hospitals will not meet the CC's objectives, will be ineffective and, as such, proceeding with such a divestment is disproportionate.

2.21 BMI's detailed analysis is in Appendix 2.

E. Divesting Chelsfield Park would be ineffective and disproportionate. [REDACTED]

2.22 The CC has provided no evidence that Blackheath should be in this cluster. Despite the CC's catchment analysis, Shirley Oaks does not in fact overlap with the other identified hospitals. The relevant 'cluster' is therefore Sloane, Fawkham Manor and Chelsfield Park.

2.23 Chelsfield Park is already significantly constrained, both competitively and in terms of capacity. Divestment therefore cannot achieve the benefits the CC claims.

2.24 In any event, [REDACTED].

2.25 [REDACTED]

2.26 BMI's detailed analysis is in Appendix 3.

F. Divesting either Saxon Clinic or Three Shires would be ineffective and disproportionate

2.27 The CC has not presented a coherent evidence-based case on which it can rationally conclude that Three Shires, Saxon Clinic and Manor form a cluster. The CC's catchment areas are inaccurate and the purported overlaps greatly exaggerated. Divestment would not improve the competitive choices for anyone save a tiny number of patients. Any benefits (pricing or otherwise) of divestiture are outweighed by the costs.

2.28 BMI's detailed analysis is in Appendix 4.

G. Divesting Highfield would be ineffective and disproportionate

2.29 Alexandra and Gisburne Park operate in markets distinct from the cluster and are already significantly competitively constrained. Beaumont, Highfield and Beardwood do not in reality overlap to any material extent.

2.30 Divestment of Highfield would be highly disproportionate, and any pricing benefits of divestiture are outweighed by the costs.

2.31 BMI's detailed analysis is in Appendix 5.

H. [REDACTED]

2.32 [REDACTED]

2.33 [REDACTED]

2.34 [X]

2.35 [X]

I. Pass-through of price benefits

2.36 In paras 2.70 to 2.79 of the PDR the CC addresses the issue of pass-through in relation to divestments. This is inconsistent with the letter from the Treasury Solicitors to the Competition Appeal Tribunal of 7 October 2013. There it is clear that the CC accepts that pass-through from PMIs to consumers is relevant, and it was stated that the CC would be doing work on this. What has happened to that work? What should be inferred from the lack of reference to it in the PDR?

2.37 We note that in para 2.74 the CC implicitly accepts that the bulk of the claimed benefits achieved from the remedies will not flow through directly to consumers. In para 2.75 the CC bases its views on claims by AXA PPP, an obviously self-interested party, rather than on any attempt to analyse evidence obtained by the CC for the purpose of assessing pass-through. Aviva does not believe that there is likely to be an immediate effect on prices as a result of the changed competitive dynamic from the proposals.⁸ More recently there have been public statements by the Chief Executive of BUPA to similar effect.⁹

2.38 At no stage does the CC attempt to quantify the amount of pass-through. In para 2.76 reference is made to the CC's profitability finding and the implication is that this is the amount that is to be passed through. The PDR goes on however to claim a much lower level of price benefit to customers.

2.39 The CC's approach to pass-through is incoherent, incomplete, does not describe how consumers will benefit from its intervention and is not fit for purpose.

J. Divestiture process and period

PMI roll-over of terms

⁸ Aviva Health UK Response to PFs and Possible Remedies page 4

⁹ 'However, speaking to the Financial Times, Mr Fletcher said that even if they failed to overturn it, consumers were unlikely to benefit from the regulator's intervention through lower premiums – at least in the short term.

"It will make a significant difference, but it's not the only driver", he said. "I don't think we're going to see a reduction in premiums." (emphasis added) "Bupa examines single-condition policies to reverse patient exodus" - FT 26 January 2014

- 2.40 The CC anticipates that PMIs will be required to offer purchasers the same terms as BMI currently obtains for 18 months from acquisition of a divested hospital. There are major issues with this:
- (a) This will give the purchaser sight of BMI's commercial terms locally and nationally. This is highly sensitive commercial information which the CC has gone to inordinate lengths to protect during the inquiry, even where the information is historic and disclosed to vertically related – rather than horizontally related parties. In the scenario where Ramsay, Spire and Circle were each to buy one or more hospitals, the BMI PMI pricing information would be accessible by the majority of the industry. This is completely prejudicial to BMI and inconsistent with the approach the CC has taken to restricting access to evidence on grounds of confidentiality and commercial sensitivity in the inquiry.
 - (b) Apart from the impact on the competitive environment as a practical matter, this will cement the current BMI pricing structure into the new hospitals as it will form the basis for onward price negotiations. It is unclear how the CC expects to obtain the assumed price benefits of competition. Certainly it should factor this into the cost-benefit analysis.
 - (c) During the 18 month period BMI will be in contract renegotiations with PMIs on a national basis and the terms agreed will change. It is not appropriate that purchasers have either insight into or benefit from these negotiations.
 - (d) There is in any event no obstacle to the purchaser negotiating new terms with an insurer – as would be the case in conventional hospital M&A activity, of which there is more than adequate historic evidence. On the CC's analysis PMIs should be willing sellers to new owners given the opportunity to generate competition. PMIs are free to contract with new owners.
 - (e) If the CC is concerned about the time it will take to do this it would be preferable to extend the divestment period than to give visibility of BMI PMI pricing to its competitors. Should the CC require further assurance an obligation can be imposed on the PMIs to offer terms within a specified time frame. The CC should consider in the divestment process requiring PMIs to offer terms to prospective purchasers at an early stage so that prospective purchasers can properly plan.

Kings Oak/Cavell de-merger

- 2.41 As discussed elsewhere, Kings Oak/Cavell operates as a single hospital. To effect the divestiture a de-merger process will need to be put in place. This will require allocation of assets, staff, consultants and contracts between the two. The usual hold separate undertaking will not work in these circumstances.

Inducements to Consultants

2.42 The CC proposes that after divestment BMI commit not to compete for, encourage or induce consultants to move their practice to the group's retained facility. Consultants are a key input to enable hospitals to compete and as in any market the most desirable ones are in limited supply. It is implausible that the customer benefits the CC outlines can be achieved if BMI is not allowed to attract consultants to its hospitals. Patient choice will not exist, without which competition cannot work. There should be no constraints on consultant mobility. Consultants are independent contractors and today move about facilities or have practice privileges at more than one. BMI cannot stop consultants from moving away from a BMI facility nor be expected to reject consultants that request practicing privileges. The CC should have at the front of its mind that parties suggesting that BMI ought to be restrained from competing for consultants have a powerful commercial incentive to say so – it will make their life far easier and dramatically reduce the uncertainties that competition brings. Their views cannot rationally be accepted as reliable evidence.

3. **SECTION 2 – [X]**

3.1 [X]

3.2 [X]

3.3 [X]

3.4 [X]

3.5 [X]

3.6 [X]

4. **SECTION 3 - EFFECTIVENESS AND PROPORTIONALITY OF THE REMEDIES**

4.1 The CC's analysis of the NPV of the divestments proposed is neither refined nor justified by reference to a robust evidence base, which means that it is difficult to engage with meaningfully. However it is very clear that, given the evidence actually presented in the CC's PFs and PDR, the CC is making a number of highly speculative and likely over-optimistic assumptions when considering its "base case".

4.2 In particular, the CC bases its prediction of the price effects of divestiture on the PCA presented in the PFs, which was performed across four self-pay inpatient treatments. Despite the narrow scope of the findings of the PCA, the CC assumes that the price effect of reducing concentration in local markets found by the PCA is applicable to all self-pay and insured inpatients and day-cases.

4.3 The price effect that the CC anticipates from the remedies, on the basis of the PCA, is likely to be significantly overstated because:

- (a) The CC assumes in its base case a price effect larger than that reported in its preferred specification using LOCI as a concentration measure (L7);
 - (b) The CC assumes that the price effect estimated using data on inpatient treatments is equally applicable to day-case treatments, despite acknowledging that existing competitive conditions are not the same for the two categories of treatments;
 - (c) The CC assumes that no countervailing buyer power is currently exercised by insurers, even Bupa and AXA PPP, such that the same price effect applies to all insurers as to all self-pay patients;
 - (d) The CC assumes that there is complete pass-through of the price benefits from the insurance companies to final PMI consumers, despite acknowledging the potential for limited pass-through; or, alternatively, the CC considers that transfers of profits from hospital groups to insurance companies should be taken into account in the proportionality calculation as insurance companies are “customers”; and
 - (e) The CC assumes that there is no effect of any of the other remedies proposed by the CC, particularly the information remedies or the remedies relating to consultant incentives, such that the price effect of divestitures would be overstated by the PCA; nor any reduction in expected effects due to [§<].
- 4.4 None of these assumptions appear to be convincingly argued and firmly grounded in the competition case presented in the PFs. Indeed, there are good reasons to believe that the CC’s assumptions relating to the magnitude and extent of the price effect of divestitures, and the degree of pass-through of any price benefits, are ill-founded.
- 4.5 The CC also assumes that the one-off and ongoing costs of divestiture are limited. However, in reaching this conclusion, BMI believes the CC underestimates or neglects significant categories of one-off and ongoing costs.
- 4.6 In particular, BMI believes that the CC has understated the one-off transaction costs associated with divestment. In addition, BMI believes that the CC has neglected the one-off costs associated with:
- (a) The investments required to equip Kings Oak and Cavell as independent competitors; and
 - (b) [§<].
- 4.7 Moreover, the CC has not taken into account certain ongoing costs of divestitures:
- (a) BMI believes that the CC has inappropriately dismissed the evidence submitted in relation to economies of scale in central costs, and that central costs cannot be treated as fully scalable in proportion with the size of the hospital estate;
 - (b) The CC has not taken into account any cost arising from the loss of savings from shared management, the subject of a detailed submission by BMI; and

- (c) The CC has not taken into account any cost incurred by hospital groups or insurers of holding competitive tenders, which are advanced as a likely method by which insurers will extract price decreases from hospitals.
- 4.8 In addition, the CC has not allowed for:
- (a) Any adjustment to the price that would be paid by customers as a result of these additional ongoing costs; or
- (b) Any impact from the loss of convenience that would arise should such a local tendering exercise mean that patients lose access to excluded hospital facilities.
- 4.9 Finally, BMI considers that the CC's assumed time horizon of 20 years entirely discards the possibility of new entry in the relevant local markets during the whole of that period, and that such an assumption is inappropriate given the evidence of new entry recorded in many local markets and reflected in the cluster-specific appendices to BMI's response to the PDR, the trend in the NHS towards increased private activity and also the actual extent of the foreseeable future.
- 4.10 There are certain cluster-specific considerations that reduce the expected price effect and accordingly the NPV. Adjusting the CC's calculation to reflect these considerations, in a range of more plausible circumstances than the CC's model assumes, the NPV of the divestiture of BMI hospitals proposed by the CC is substantially negative, implying that the costs of the proposed divestitures are greater than the benefits.
- 4.11 Appendix 7 looks at the totality of the CC's cost-benefit analysis in the context of the divestments as a whole and in respect of each cluster. It arrives at a range for the overall NPV, incorporating cluster-specific adjustments, of between [X] and [X].
- 4.12 Other considerations come into play outside of those set out in Appendix 7. The divestitures would inevitably lead to displacement of volumes of NHS work in the hospitals affected [X]. The CC places no value on the loss of capacity or disruption to the NHS. Although the CC has shied away from the interactions of private and NHS provision, the two are inextricably inter-linked. The interventions the CC proposes will impact on NHS provision. This impact needs to be internalised in the CC's assessment.

5. SECTION 4 - REMEDIES 3 TO 7

- 5.1 BMI has already commented on these remedies in its response to the Remedies Notice but sets out further practical issues below.

A. Remedy 3 – PPU's

- 5.2 BMI supports the CC's proposals set out in PDR regarding PPU's. However, we continue to dispute the existence of an adverse effect on competition giving rise to a requirement for this remedy, for the reasons set out in our submission on the CC's PFs.

- 5.3 In its PDR, the CC proposes use of a competition test similar to the SLC test, as opposed to something more akin to the ‘bright line’ competition test. Whilst BMI would prefer as clear a test as possible, it seems to us to be preferable that the chosen test enables “*all relevant circumstances to be taken into account when making a competitive assessment*”¹⁰. BMI is therefore supportive of the proposed use of the SLC test.
- 5.4 The CC also proposes (at paragraph 2.258) that all PPU arrangements be pre-notified. BMI considers this to be extremely important. Some PPU opportunities are not advertised in the Official Journal of the European Union, because of the way they are structured (e.g. a pilot, [X]) and publishing proposed PPU arrangements would ensure this area was as transparent as possible. BMI also considers it important that the definition of ‘PPU arrangements’ is sufficiently broad to capture both the outsourcing of an existing PPU and what on the face of it appears to be a straightforward property transaction between an NHS Trust (or Foundation Trust) and a private hospital operator conducted ‘off market’.
- 5.5 Given the broad way in which PPU arrangements may be structured – and the possibility that a PPU might start as a pilot arrangement and develop, at a later stage, to a more traditional PPU arrangement - BMI considers it sensible that a proposed ‘safe harbour’ or de minimis provision (as described in paragraph 2.251 of the PDR) be approached with some caution. BMI would hope that the case by case approach proposed by the CC would be able to address these potential complications.
- 5.6 We would also suggest that timeframes are published for the assessment by the OFT/CMA of PPU arrangement pre-notifications, to ensure there is clarity of expectation and no undue delay caused to tender processes.
- 5.7 Our final point is to emphasise the importance of the issues noted in paragraphs 2.262 and 2.263 of the PDR. BMI is pleased to see that the CC has addressed these in a sensible way in its proposals.

B. Remedy 4- Consultants Incentives

- 5.8 Further observations on practical issues relating to consultants’ incentives are in Appendix 8.

C. Remedies 5- 7 - Information

- 5.9 BMI supports the CC’s information-based proposals set out in the PDR. However, we continue to dispute the existence of an adverse effect on competition giving rise to a requirement for this remedy, for the reasons set out in our submission on the CC’s PFs.

Information on providers and consultants

¹⁰ Para 2.244 of the PDR

- 5.10 We note the divergent views submitted to the CC in this area and applaud the CC in its provisional proposals in this area, which we consider are of real benefit to patients and others in making choices about private healthcare.
- 5.11 BMI is unequivocally supportive of PHIN's role being extended to perform the CC's proposals in this area, including wider PHIN membership. It may be helpful to reiterate to the CC the extreme sensitivity amongst all private healthcare operators regarding the level of access to data which private medical insurers may have or ask for, specifically their ability to extract commercially sensitive information relating to their direct competitors in the PMI market.
- 5.12 We are also supportive of the CC's proposals regarding the collection of HES-equivalent information for private patients, moving to OPCS coding and linking consultants (with their GMC numbers) and patients (with their NHS numbers). We would suggest patients and other commissioners would benefit from further performance indicators being published – such as access to diagnostic procedures and indicators around convenience and choice – and so we think the CC's proposed review at five years post-implementation is entirely sensible. An interim report from PHIN at the three year point may also be of assistance.

Information on consultants' fees

- 5.13 BMI is also fully supportive of the CC's proposals in this area which we consider will make the costs of private healthcare more transparent. We think it important that whilst details of fees are as clear and specific as possible, where a range might apply – for example because of the consultant's choice of consumables or prosthesis – this is also spelled out for patients.
- 5.14 We also suggest the CC require consultants to confirm their compliance with its requirements on fee information as part of the consultants' GMC revalidation paperwork.