

Response of



to

Provisional Decision on Remedies
(Non-Confidential)

Appendix 4

7 February 2014

1. **East Midlands: Three Shires / Saxon / Manor**

- 1.1 The CC has provisionally found that BMI faces weak competitive constraints in the area around its Three Shires, Saxon Clinic and Manor hospitals. It states “[w]e concluded that the sale of either Saxon Clinic or Three Shires would increase the competitive constraints acting on all the BMI hospitals in this area sufficient to remedy or mitigate the AEC we have found.”¹

The CC has not made a coherent cluster theory

- 1.2 BMI maintains that the CC has not presented a coherent evidence-based case on which it can rationally conclude that Three Shires, Saxon Clinic and Manor operate as a ‘cluster’.
- 1.3 The CC’s analysis in respect of these hospitals remains confused. Its cluster theory anticipates interactions between local geographic markets in a wider “local area”: the Remedies Notice says: “We use the term cluster where a private hospital operates two or more facilities in the same local area, such that the facilities have overlapping catchments.”² However, under the CC’s local assessments, each of Three Shires, Saxon Clinic and Manor are inadequately constrained because they face no local competition in their local market as there are no other hospitals nearby. Indeed until the CC adapted its terminology, Three Shires and Manor were [redacted] on the CC’s definition.
- 1.4 The network effect on patient LOCI for Manor is [redacted], for Three Shires it is [redacted] and for Saxon Clinic it is [redacted]. The CC designed network LOCI to operate as a filter to provide “an indication of the effect that the common ownership of hospitals has on each individual hospital’s LOCI.”³ It noted that “[t]he modification for network ownership is a simple and intuitive approach that we have proposed,”⁴ yet the results in respect of [redacted] show that even the CC’s own intuitive analysis suggests BMI’s market presence is not enhanced by common ownership of nearby hospitals.
- 1.5 Further, recall that St Andrew’s owns 50% of Three Shires hospital. It is currently managed by BMI, who also own 50% of the equity. [redacted]. It is widely accepted within competition policy and economics that partial ownership does not result in the same change in incentives when setting prices as full ownership and control.

¹ Provisional Decision on Remedies, Appendix 2.2, paragraph 164.

² Remedies Notice, paragraph 23.

³ CC Working Paper, Assessment of hospitals of potential concern (excluding central London), footnote 5.

⁴ AIS, Appendix B, Annex 1, slide 21.

This topic has, for example, been studied by Salop and O'Brien (2000).⁵ Those authors show that it is appropriate to modify measures of concentration which attempt to measure market power in the presence of partial ownership stakes. Specifically, they derive the theoretically coherent modified HHI measure which adapts the conventional HHI measure of concentration to account for the degree and nature of partial control that arises from a partial ownership stake. In a conventional analysis, the right calculation of the 'HHI Delta' that would result from a merger (or demerger) would be directly affected by the partial nature of BMI's ownership stake in Three Shires. The CC should similarly properly adjust its Network LOCI calculation to account for such differences in an analogous manner to the Modified HHI calculation (and delta Modified HHI).

- 1.6 [REDACTED]. Recall that the CC's catchment areas are actually just circles drawn around hospitals based on road distance radii: they tell us nothing about where patients actually come from.
- 1.7 Conversely on the basis of BMI's own contemporaneous catchment area analysis (used in the ordinary course of business), which unlike the CC's analysis is not based on simple road distances in miles but on the postal districts where patients actually come from: [REDACTED]. There is a striking consistency between BMI's ordinary course of business catchment area definition and the CC's network effect. Both are suggesting that there are very few patients choosing between these hospitals.
- 1.8 In reality, these hospitals are [REDACTED]. BMI has explained in Section 2B of its covering response to the CC's Provisional Decision on Remedies why the CC's fixed distance radii catchment areas are fundamentally flawed and produce outcomes that do not square with the reality of the competitive landscape. It is irrefutable that BMI's core catchment areas more accurately describe the areas from which a hospital draws its patients – despite still not being a perfect guide to geographic market definition. The arguments are not repeated here but the points are well illustrated by the example of the 'cluster' of Three Shires, Saxon Clinic and Manor.

The CC's catchment area assessments are fundamentally flawed

- 1.9 The following maps overlay the CC's catchment area (based on a hypothetical as to where patients will travel from) with BMI's core catchment area (based on where patients actually do travel from) in respect of each hospital within this 'cluster'. It is striking how out of kilter the CC's catchment areas are in respect of each of the three hospitals. Because the CC has adopted the inflexible approach of using isochrones based on fixed road distances, the shape of the catchment area is a circle – it does not reflect where patients actually come from.

⁵ Salop, S. C. and O'Brien, D. P. (2000) "Competitive Effects of Partial Ownership: Financial Interest and Corporate Control", Vol. 67, *Antitrust Law Journal* pp559-614; available from <http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1200&context=facpub>

- 1.10 The CC's Three Shires catchment area exaggerates the extent to which it [REDACTED].
[REDACTED]
- 1.11 The CC's Saxon Clinic catchment area exaggerates the extent to which it [REDACTED].
[REDACTED]
- 1.12 The CC's Manor catchment area exaggerates the extent to which it [REDACTED].
[REDACTED]
- 1.13 The CC's catchment areas clearly do not accurately reflect where a hospital's patients actually come from. Simply put, they are demonstrably inaccurate and too unreliable to establish and sustain a case for divestment.
- 1.14 Recall that the CC's initial analysis into local competition produced 147 hospitals of concern – which represents a considerably large number of false positives.⁶ That error persists as the CC has not moved from the filter to an examination of the actual demand pattern for each of the hospitals.
- 1.15 [REDACTED]
- 1.16 [REDACTED]. There are two alternative conclusions and avenues for enquiry these questions suggest: (i) the CC's approach to cluster definition was wrong or at least over-inclusive. [REDACTED]; or ii) the approach to cluster definition is correct but the cluster in this case did not confer market power – might this be a characteristic of other clusters?
- 1.17 [REDACTED]

A detailed assessment of the extent of the overlap shows it is insignificant

BMI's core catchment area approach

1.18 On BMI's core catchment area analysis it can be seen that:

(a) [REDACTED]

(b) [REDACTED]

[REDACTED]

1.19 By contrast, the CC models BMI's catchment area as follows:

⁶ Issues Statement Appendix B para 9

[REDACTED]

- 1.20 The different geographic outcomes produced by the two approaches to defining the catchment areas are stark. The maps above show how the CC's catchment areas have been distorted by: (i) only considering a small (and declining) fraction of the total private healthcare market (insured inpatients, rather than all private inpatients and day cases); and (ii) using an overly simplistic fixed road distance radii which describe circles around hospitals (rather than trying to ascertain where patients actually come from).
- 1.21 A detailed assessment of the extent of the overlap shows it is insignificant. The only actual overlap in this 'cluster' is [REDACTED]. When we further analyse the extent of this overlap, its insignificance becomes clear.⁷ It is estimated that [REDACTED] had [REDACTED] private inpatient and daycase episodes in FY2013 (the CC has the actual number), of which [REDACTED] ([REDACTED]) were recorded at BMI hospitals. Of these [REDACTED] ([REDACTED]) were at Manor, while Saxon recorded only [REDACTED] and Three Shires just [REDACTED]. This shows that the actual overlap is minimal. This can be explained by socio-geographic features [REDACTED], being mostly rural farmland, villages and containing few towns. Manor is ideally located to attract the majority of private patients living here as it is [REDACTED] from the [REDACTED]:

[REDACTED]

- 1.22 Furthermore, [REDACTED] the data shows the overlaps are even more limited. The majority of private patients are located in [REDACTED], corresponding to the areas of highest PMI penetration.

[REDACTED]

[REDACTED]

- 1.23 These areas are serviced almost entirely by Manor. [REDACTED] of [REDACTED] patients and [REDACTED] of [REDACTED] patients went to Manor. Less than [REDACTED] of patients in either of these [REDACTED]. When we analyse the actual figures – where the patients are located and which hospital they are going to - we can see that [REDACTED] in any meaningful way.
- 1.24 The CC states "*[t]here is a very high density of insured patients in the postcodes to the south of Three Shires, with reasonable density in the rest of the area, indicating that under separate ownership, these facilities would have an incentive to compete strongly for this sizeable local market.*"⁸ However, it is clear the density of insured patients is not as high when we look at the 'cluster' in the

⁷ Note: BMI's data analysis is based on all private inpatient and daycase episodes. This is a larger data set which provides a more accurate indicator of actual patient referral patterns.

⁸ Provisional Decision on Remedies, paragraph 159.

context of the surrounding area. We find that the areas with the largest number of episodes are actually located in postal districts outside of the ‘cluster’.

[REDACTED]

- 1.25 Not only do these areas outside of the ‘cluster’ (e.g. [REDACTED])[REDACTED], they are also closer to competing facilities, which are well placed to service this demand. For example, Hinchingsbrooke, Papworth, Spire Cambridge and Cambridge Nuffield in respect of [REDACTED]; Ramsay Pinehill, Luton & Dunstable and Spire Harpenden in respect of [REDACTED]; and Ramsay Woodland in respect of [REDACTED]. To say BMI’s hospitals are inadequately competitively constrained is to fail to recognise that the non-BMI alternative hospitals are located predominantly in the areas where there are a greater number of private patient episodes, [REDACTED].
- 1.26 The actual overlap, based on empirical data of actual referrals, cannot justify a ‘cluster’ theory. There is overlap in [REDACTED] across all three hospitals. That [REDACTED] rural and sparsely populated [REDACTED]. Patients are being referred overwhelmingly to Manor, largely because it is [REDACTED]. Moreover, Manor attracts the vast majority of patients from the most significant [REDACTED]. By contrast, few patients are referred to [REDACTED]. In reality the only overlap in [REDACTED] (and thus in the entire ‘cluster’) is completely immaterial and insufficient to adjust the competitive response of either hospital – regardless of who has ownership of each facility.

CC's catchment area approach

1.27 The CC's cluster theory is premised on the overlap of hospital catchment areas, yet in this 'cluster' these overlaps are purely a function of the CC's choices. There is simply no evidence the CC's catchments describe the number of patients whose choices would be enhanced by the divestment – and a lot of evidence that they do not. The east Midlands 'cluster' is a good example of this problem. The CC's analysis wrongly shows [redacted]:

[redacted]

1.28 The CC has then made no attempt to analyse the nature of the overlaps it has designed into the catchment area definition. Had it done so, it would realise that the extent of these overlaps in terms of actual patients is minimal. Even on the basis of the CC's own catchment areas, using the Healthcode data relied on by the CC, an assessment of the number of patients in each of the catchment overlaps, as a proportion of (i) the number of patients in each hospital's catchment area; and (ii) the total number of patients treated at each hospital, demonstrates the actual extent of each of the overlaps between the three hospitals is extremely limited.⁹ This is demonstrated below in respect of Saxon Clinic [redacted]; the extent of the overlap will be [redacted] in respect of both Three Shires and Manor.

1.29 The table below demonstrates that cumulatively across the years 2009-2012, the number of patients in the catchment area of Saxon Clinic which the CC says overlaps with [redacted] represented just [redacted] of the total number of patients in the Saxon Clinic catchment area. [redacted]. This cross-check again demonstrates that even on the basis of the CC's own catchment area definition – which creates the appearance of overlap – the data shows that the overlap is so small as to be insignificant. All the evidence suggests that these three hospitals actually have almost [redacted] catchment areas.

[redacted]

1.30 The table below shows the total number of Saxon Clinic patients in 2011 (the last full year of data) that the CC says came from an area overlapping with another

⁹ The above table was prepared from the Healthcode data across the years 2009-2012. We have considered a postal district to be an overlap if (regardless of the year) two hospitals each recorded a patient episode where the patient was: (i) from within that postal district; and (ii) from within that hospital's isodistance catchment area. All the patients: (i) within that postal district; and (ii) within the catchment area of the hospital, were then counted as 'overlap' patients. Note this method can only serve as an overestimate due to (i) postal districts being considered overlaps based on data across 3.5 years, rather than a single year (which could therefore include outliers); and (ii) all patients in an overlap postal district also within a hospital's isodistance catchment being counted as overlapping (even when they may not in fact be located in an area that overlaps).

BMI hospital's catchment area was [X].¹⁰ This is [X] out of a total insured inpatient population of [X] ([X]). This is simply not a sufficient number for the CC to claim divestment will make any difference to a hospital's pricing strategy in relation to self-pay pricing, or of the ability of insurers to secure better prices by tendering an exclusive contract – regardless of who owns the hospitals.

[X]

- 1.31 The chart below is based on episode volumes (2011 to align with the last complete year of CC data), which is the appropriate measure for proportionality assessment as it treats all patients equally – regardless of spend. A proposed divestment of Saxon Clinic would only be capable of conferring a benefit on [X] of patients, since the CC's analysis only takes into account private insured inpatient work and Bupa has fully countervailing buyer power.

[X]

- 1.32 As a proportion of Saxon Clinic's total volumes, the actual number of episodes in the catchment area identified by the CC was just [X] of the total. This is not a sufficient number to either: (i) create increased competition with competitor hospitals in respect of self-pay pricing; or (ii) enable an insurer to delist one of the hospitals following an exclusive tender.
- 1.33 In *Tesco v Competition Commission* the CAT stated in respect of the proportionality of divestments, "*it may well be sensible for the Commission to apply a 'double proportionality' approach: for example, the more important a particular factor seems to be in the overall proportionality assessment, or the more intrusive, uncertain in its effect, or wide-reaching a proposed remedy is likely to prove, the more detailed or deeper the investigation of the factor in question may need to be*".¹¹ The CC's catchment analysis is formulated on the basis inpatients *exclusively*, fails to accurately describe their actual location, and even then fails to consider the numbers of patients within the overlaps. Consequently the CC still faces a major evidential hurdle if it is to demonstrate that the divestment is proportionate; the CC has defined a separate product market for inpatients and simply cannot rely on vague statements about blurred boundaries between the classification of patients and suppositions about the patient journey to argue the remedies are proportionate.¹²
- 1.34 People will find it almost impossible to believe that the immense resources already consumed defending and prosecuting this case – let alone the public and

¹⁰ This is based on catchment area overlaps defined on the basis of data from years 2009-2012, as described in footnote 10, above.

¹¹ (2009), CAT 6, paragraph. 139.

¹² Provisional Findings, paragraph 5.54.

private costs associated with seeking to impose a divestment remedy – have been for the sake of improving the choice of such a tiny number of people – who have [X] alternative non-BMI facilities within a 44 minute drive of each of Saxon Clinic¹³ and Three Shires¹⁴ – and only then if they do not wish to use the NHS. The comparison with the significance of similar action in the BAA Airports case will be painfully obvious.

Any remedy involving a divestiture of either Saxon Clinic or Three Shires will be highly disproportionate

- 1.35 Any remedy imposed by the CC must be proportionate. Forced divestments are an extremely intrusive and draconian remedy and the CC relies solely on its assessment of overlapping catchments as justification. The obvious shortcomings in the CC's catchment area analysis are highlighted by the discrepancies that arise when compared with BMI's more accurate core catchment areas, which also reflect the reality of the competitive environment as experienced by BMI over many years and guide the strategic thinking of the business. Basing a divestment on such an evidently flawed assessment would not only fall far short of the double proportionality approach articulated in *Tesco v Competition Commission* but would be contrary to the evidence. The CC's Market Investigation Guidelines state "[i]n considering the reasonableness of different remedy options the CC will have regard to their proportionality."¹⁵ The CC simply cannot order the divestment of a hospital on the basis of overlapping catchment areas when:
- (a) an evidence-led authority could only rationally place greater weight on BMI's core catchment. The CC catchment areas are demonstrably inaccurate and the purported overlaps thereby exaggerated;
 - (b) BMI's core catchment areas reveal only [X] of Saxon Clinic's private inpatient episodes came from the overlap, this represented just [X] of its total patient episodes;¹⁶
 - (c) even the CC's own analysis finds only [X] of the Saxon Clinic's insured inpatient episodes came from the overlap, also representing just [X] of its

¹³ [X]. Note the CC's patient survey indicated 44 minutes was the average time self-pay patients were willing to travel.

¹⁴ [X]

¹⁵ CC Guidelines for market investigations: Their role, procedures, assessment and remedies (April 2013), paragraph 342.

¹⁶ Based on BMI's FY2013 volume data.

total patient episodes – again wholly insignificant in proportion to the whole.¹⁷

- 1.36 The CC has not made a coherent case establishing a cluster. It has mis-characterised these hospitals, which are more akin to [X]. The evidence of this is clear. Suffice to say the disruption caused by the divestiture of a hospital will be undeniably many magnitudes more serious than other markets where divestitures have been dismissed as disproportionate, such as groceries and local buses. Furthermore, the apparent costs saved to the number of patients affected as claimed by the CC would not be more than the cost of selling the hospital. The remedy is therefore entirely disproportionate. Therefore on the grounds of proportionality, the CC has not made the case to the requisite legal standard that Three Shires, Saxon Clinic and Manor operate as a ‘cluster’.

Divestment of Three Shires or Saxon Clinic would be ineffective

- 1.37 There are a number of reasons why [X]. Far from being the result of strategic choices by BMI, it is in fact the result of factors inherent in the private healthcare market and beyond BMI’s control.

- 1.38 Even if a hospital was divested, this would not change where patients are referred.

Divestment will not affect to where patients are referred

- 1.39 The GP is often considered the gatekeeper of the patient pathway as they heavily influence, through referrals, recommendations and advice, where a patient will go for treatment. The CC recognised in its Provisional Findings that “[t]he pathway to private healthcare for most people starts with a visit to a GP”¹⁸ and the CC’s Patient Survey revealed that 60% of respondents said they were referred by a GP.¹⁹ When GPs make referrals, they primarily do so within the context of the Clinical Commissioning Group (CCG) to which they belong. A CCG is a regional NHS organisation, comprised of all the GP practices in the area, which give GPs and other clinicians the power to commission NHS elective and emergency care.

- 1.40 When GPs make NHS referrals, they usually do so within the boundaries of the CCG to which they belong. While the CCGs were only introduced in April 2013, replacing Primary Care Trusts (PCTs) following their abolition by the Health and Social care Act 2012, many boundaries have remained untouched. This is so in

¹⁷ Based on CC’s catchment area data from Healthcode (2011) and BMI’s FY2011 total volume data.

¹⁸ Provisional Findings, paragraph 2.40.

¹⁹ CC Patient Survey, slide 25.

respect of the east Midlands ‘cluster’, meaning already entrenched referral patterns have not been disrupted.

PCT boundaries:



CCG boundaries:



1.41 Over time, these referral patterns become entrenched and while the boundaries are more directly correlated with NHS work (because GPs refer far more NHS patients than private patients) they tend to do so along the same referral patterns as they use in the NHS. In other words, GPs make private patient referrals to the same group of consultants that they use in the NHS.

1.42 For each of Three Shires, Saxon Clinic and Manor, we plot the overlap of BMI’s core catchment areas with the boundaries of their CCGs (NHS Nene, NHS Milton Keynes and NHS Bedford, respectively). [REDACTED].

[REDACTED]

[REDACTED]

1.43 Saxon Clinic [REDACTED]. CCG boundaries are not impermeable barriers – they just help to explain why patient movements are as they are. [REDACTED], demonstrated to be insignificant in terms of Saxon’s patient numbers in the discussion above.

[REDACTED]

1.44 [REDACTED] suggests that BMI’s core catchment areas are better than the CC’s fixed road distance radii in describing the extent of any likely overlap.

1.45 CCGs are regional organisations and would ordinarily have more than one private hospital located within their boundaries. Both NHS Milton Keynes and NHS Bedford have just one, and while although NHS Nene has two, it is the largest of these CCGs. This helps explain the trend in referral patterns in this

region, [X], and is again evidence that these hospitals are essentially [X] in respect of their referral patterns. The other hospital in the same CCG region as Three Shires is Ramsay Woodland and in this regard it poses more of a competitive constraint on Three Shires than Saxon Clinic could.

- 1.46 BMI has had recent experience of a real world event that has confirmed there is [X]. In 2013, Manor was closed for 8 weeks from the start of July to the end of August to undergo theatre refurbishment. [X]. If Manor, Saxon Clinic and Three Shires are effective substitutes and realistic alternatives for patients in their catchment areas you would expect that [X]. In total [X] switched to Saxon Clinic and [X] to Three Shires.

[X]

- 1.47 In the context of Manor's total volumes, which were [X] in the corresponding months in 2012, the number that switched to Saxon Clinic is [X] of potential business. The fact that such an [X] proportion switched to Saxon Clinic²⁰ suggests that patients within the catchment area of Manor [X].

Divestments will not increase competition opposite PMIs

- 1.48 The CC has considered the sale of one of Saxon Clinic or Three Shires to a competitor could increase competition in the area through the insurer's exclusive tender. An exclusive tender would not increase competition because, as demonstrated by the extensive evidence above, these 'cluster' hospitals are effectively [X]. It has been shown there is no significant overlap between the catchment areas of these hospitals such that the number of patients that could possibly benefit is immaterial.
- 1.49 The CC must seriously examine the extent to which it relies on, as evidence to suggest a divestment should be made, AXA PPP's view that "*if the hospitals were separately owned, it could run a tender in this area in order to exert downward pressure on prices, which suggests that the hospitals may be substitutable from an insurer's perspective.*"²¹ In fact AXA PPP has told the CC that it does not believe divestments outside central London are required: "*[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*

²⁰ Despite the fact that the closure of Manor is akin to price rise far larger than would be appropriate in the SSNIP test.

²¹ Provisional Decision on Remedies, Appendix 2.2, paragraph 158.

*hospitals.*²² AXA PPP is the only insurer likely to run an exclusive tender, yet it is uncertain as to whether AXA PPP fully supports divestment in this area.

- 1.50 Similarly, PruHealth submitted, “[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 market’s best interest, as the unplanned consequences may be in the short – medium term to reduce the range of available facilities.”²³ It also said it “was not aware of any evidence to suggest that there was any upward pressure on prices as a result of the dominance of hospital operators in certain important geographical areas and any such impact on the prices would be diluted.”²⁴
- 1.51 The CC has not registered these concerns in its Provisional Decision on Remedies, yet these statements must be given increased weight by the CC as on its case they apparently run contrary to self-interest. With many insurers clearly either sceptical or even against divestitures outside of London the CC cannot credibly make the case that an exclusive tender in an area following divestment will have the effect of increasing competition in a given area sufficiently to bring about a price effect.²⁵

Conclusion

- 1.52 The CC has not presented a coherent evidence-based case on which it can rationally conclude that Three Shires, Saxon Clinic and Manor operate as a ‘cluster’. The catchment overlap is too small and the number of patient episodes available within the overlap too insignificant (on the basis of both BMI’s and the CC’s data and methodologies) for the CC to claim divestment of Saxon Clinic or Three Shires will make any difference to a hospital’s pricing strategy in relation to self-pay pricing, or of the ability of insurers to secure better prices by tendering an exclusive contract – regardless of who owns the hospitals.

²² AXA PPP, Response to Provisional Findings and Notice of Possible Remedies, paragraph 2.57.

²³ PruHealth, Response to Provisional Findings and Notice of Possible Remedies.

²⁴ PruHealth Hearing Summary, paragraph 12.

²⁵ The CC states in its Provisional Decision on Remedies, Appendix 2.3, paragraph 74, that “[n]either in central London nor outside the capital did the PMIs believe that divestments were sufficient.” This statement serves to give undue prominence to the views of Bupa (whose reasons are cited in support of the statement) while it misrepresents the views of other insurers, such as AXA PPP and PruHealth, who have stated in their responses to the CC that they are concerned or sceptical as to whether divestitures outside London would be necessary or suitable.

1.53 Furthermore, any possible price benefits that will occur to patients will not outweigh the costs of divestment; the remedy is therefore disproportionate. No divestment is justified.