

Response of



to

Provisional Decision on Remedies  
(Non-Confidential)

Appendix 5

7 February 2014

## **North West: Highfield/Alexandra/Beaumont/Beardwood/Gisburne Park**

- 1.1 The CC has provisionally found that BMI faces weak competitive constraints in the area around its Beardwood, Gisburne Park, Beaumont, Highfield and Alexandra hospitals. This has led the CC to provisionally conclude “*that BMI be required to divest the operating business of Highfield to a suitable purchaser and that the freehold interest in the hospital property also be divested to the same purchaser.*”<sup>1</sup>
- 1.2 BMI maintains that the CC has not presented a coherent evidence-based case on which it can rationally conclude that any of Beardwood, Gisburne Park, Beaumont, Highfield and Alexandra operate as a ‘cluster’.

### There is no meaningful cluster that involves Alexandra

- 1.3 The CC’s theory of common ownership concern is entirely reliant on the flawed measure of network LOCI and network effect. [X]. The CC has not provided evidence as to why Alexandra Hospital is part of a “problematic group” beyond [X]. Given that [X], the CC must provide truly compelling evidence of adverse competition in reaching its conclusion. It has failed to do so. Indeed, it has systematically ignored or discounted exculpatory evidence.
- 1.4 The CC has included Alexandra within its ‘cluster’ solely on the basis of [X] without any assessment of [X]. BMI has already submitted extensive evidence in respect of the competitive landscape in which Alexandra operates. BMI does not repeat this evidence in full here, but refers to the evidence submitted in Annex 1 (Local Assessments) of its response to the CC’s Provisional Findings. BMI urges the CC to give full and proper consideration to BMI’s evidence in the preparation of its Final Report.
- 1.5 In overview, alternatives for the Alexandra included Spire Manchester, Spire Cheshire, Spire Regency, Christie Clinic, Oaklands and Bridgewater (there is, in addition, imminent new entry by HCA in Wilmslow and the University Hospital of South Manchester PPU (Wythenshawe) as well as expected new entry on a significant scale by Circle).
- 1.6 It is also worth repeating that Bupa delisted [X]. BMI’s Local Assessments response shows that there are a number of effective alternatives.<sup>2</sup> It is not possible to leverage a group of hospitals when each has compelling substitutes for which there is powerful evidence of actual switching. It is untenable that these hospitals have (or even could) operate as a ‘cluster’ capable of giving rise to an adverse effect on competition.
- 1.7 [X]

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<sup>1</sup> Provisional Decision on Remedies, paragraph 194.

<sup>2</sup> Alternatives for Gisburne Park included Fulwood Hall and Yorkshire Clinic; for Beaumont: Spire Manchester, Euxton Hall, Fairfield Independent, Oaklands and Wrightington PPU. Alternatives for Highfield included Spire Manchester, Oaklands, Royal Oldham, Christie Clinic and Bridgewater Hospital.

[REDACTED]

1.8 [REDACTED]

[REDACTED]

1.9 The Alexandra does not target patients in the same areas as the other BMI hospitals – this is because it is in a different local market. The CC cannot reasonably argue that a common ownership concern arising from a ‘cluster’ exists between Alexandra and the other BMI hospitals. The CC would have to provide compelling evidence to demonstrate how [REDACTED] Alexandra should be included in the same ‘cluster’ as Highfield and Beaumont.

1.10 [REDACTED]

[REDACTED]

[REDACTED]

1.11 [REDACTED]

[REDACTED]

1.12 [REDACTED]

1.13 [REDACTED]

[REDACTED]

1.14 As described above, HCA Wilmslow is a new diagnostic and day-case hospital with 12 beds, two theatres and is due to open on 1 March 2014. The HCA Wythenshawe PPU will be located in a new adjoining building to the University Hospital of South Manchester and have approximately 40 beds, a 6 bed ITU level 3, 2-3 operating theatres plus catheterisation and hybrid capability together with diagnostic scanning to include MRI and CT. It will cover all specialties already covered by the University Hospital of South Manchester, a strong likelihood of tertiary services new to South Manchester and some services not previously available in the private sector outside London. It is expected to open mid-2015, and will form part of the new MediPark centre. Entry on this scale will certainly increase the already significant competitive pressures felt by Alexandra.

1.15 [REDACTED]. A hospital that is insufficiently constrained (as the CC has so concluded) would not need to take such steps in anticipation to a new entry, but would instead be leveraging its ‘cluster’ advantage (shifting its focus to central Manchester) or even “size” advantage.

[REDACTED]

[REDACTED]

1.16 [REDACTED]

1.17 Circle has also announced plans for major new entry in Manchester and is actively raising funds for the development. The latest intelligence states “Circle said it intends to use approximately £19 million of the raised funds on set-up costs, commissioning and working capital for a mix of up to three to generic service lines and/or hospital franchises; potential expansion into large markets such as Manchester and Birmingham with independent hospitals, and to pursue growth opportunity in current operating assets.”<sup>3</sup> It is also expected the facility will be in close proximity to the Alexandra [REDACTED], again acting as a further barrier between Alexandra and Beaumont and Highfield in the north. It is expected to be a full-scale inpatient facility and represents major investment in a new hospital. It is well established in competition assessment that potential competition as well as actual competition can act as a constraint.<sup>4</sup>

1.18 The imminent entry of HCA, in addition to the potential entry of Circle, not only indicates [REDACTED]. BMI’s immediate and direct response to such entry is a prime example of effective competition in a market.

1.19 The CC cannot ignore the fact that [REDACTED].

1.20 The CC must also be consistent in its assessments of hospital ‘clusters’. The CC said in its Provisional Decision on Remedies in respect of BMI’s Birmingham ‘cluster’:<sup>5</sup>

*“Finally, we considered whether the divestiture of Meriden would increase the level of competition in this area. We reasoned that it would not, as a result of its relatively large distance from the other BMI facilities and its positioning to the east of Coventry with Spire Parkway located between Meriden and BMI’s other hospitals in this area.” [Emphasis added]*

1.21 This is the entirety of the CC’s reasoning. By “*relatively large distance from the other BMI facilities*” the CC is referring to 28 miles (Priory) and 29 miles (Edgbaston), while the CC said these hospitals’ catchment areas overlapped with Meriden’s by 16 miles (Priory) and 21 miles (Edgbaston). It also cites one competitor hospital located between them.

1.22 The CC must be internally consistent in its approach and cannot rationally maintain that Alexandra is part of a ‘cluster’ when:

<sup>3</sup> <http://www.healthinvestor.co.uk/ShowArticle.aspx?ID=3116&utm>

<sup>4</sup> Competition Commission Market Investigation Guidelines, paragraph 175(b).

<sup>5</sup> Provisional Decision on Remedies, paragraph 138.

- (a) it states in respect of the Alexandra that “*Beaumont is 23 miles away and Highfield is 21 miles away*” (i.e. still “a relatively large distance”), especially when the CC acknowledges that there is only “*some (limited) overlap between the catchment areas of these hospitals and that of the BMI Alexandra*”<sup>6</sup> (i.e. presumably of no concern);
- (b) there are no fewer than four actual competitors located in between Alexandra and the other BMI hospitals;
- (c) the entry of two new competitors, each within 10 miles of Alexandra, is imminent; HCA Wilmslow and the HCA PPU at Wythenshawe (University Hospital of South Manchester); and
- (d) Circle has announced plans for major new full-scale entry in Manchester, [REDACTED].

1.23 The provisional finding that Alexandra is part of a ‘cluster’ with other BMI hospitals is contrary to the evidence and unsustainable. It must be corrected in the Final Report.

#### There is no meaningful cluster involving Gisburne Park

- 1.24 [REDACTED]. AXA PPP has told the CC it did not think that BMI has sought to leverage its strong position in national negotiations.<sup>7</sup> Indeed, they have stated that although in theory BMI should have the ability to leverage its market power, it has not sought to do so. The relevant factor is whether there are any indicators of market power being exploited. There are none. [REDACTED].
- 1.25 PMIs do not consider that Gisburne Park is capable of being leveraged as part of a wider group of BMI facilities. Not a single PMI or competitor saw any point complaining to the OFT when BMI acquired Gisburne Park from Abbey in 2010. The OFT citing, among others, “*a lack of third party concerns,*” concluded “*the acquisition of Gisburne Park does not create a realistic prospect of a substantial lessening of competition [between Gisburne Park and Beardwood].*”<sup>8</sup> The CC provides no reasoning for why the position could have changed. There is no new evidence to suggest that Gisburne Park can now be leveraged as part of a ‘cluster’, [REDACTED].
- 1.26 Evidence from the Bupa delisting in 2012 confirms that Gisburne Park is still not capable of being leveraged, either on its own or in conjunction with any other hospital. [REDACTED]. Delisting essentially means that all demand from a customer is diverted to BMI's competitors. [REDACTED].

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<sup>6</sup> Provisional Decision on Remedies, paragraph 176.

<sup>7</sup> Provisional Findings, Appendix 6(11) paragraph 12(b).

<sup>8</sup> Completed acquisition by General Healthcare Group of control of four Abbey hospitals and de facto control of Transform Holdings Ltd, previously part of the Covenant Healthcare Group ME/4560/10, paragraph 74.

[REDACTED]

- 1.27 The CC has ignored the fact that the largest PMI was able to send all its patients to alternatives. This clearly demonstrates that there are suitable alternatives to Gisburne Park; where else were Bupa members being treated in this period? [REDACTED].

[REDACTED]

- 1.28 This proves Bupa is capable of diverting patients to alternative facilities outside the 'cluster' and again completely undermines claims that the supposed clusters could confer market power or in any way be leveraged. A common ownership concern cannot exist if [REDACTED] out of 5 of the hospitals in the 'cluster' were delisted. The CC therefore cannot rely on common ownership concern to argue that a hospital is insufficiently constrained. The CC has failed to respond to this and is simply ignoring the evidence presented.
- 1.29 Further, the CC acknowledges that "*the location of Gisburne Park on the edge of the cluster and the limited range of medical specialisms offered at the hospital meant that it was unlikely to be an effective competitor to the other facilities if it were divested.*"<sup>9</sup> This presents a logical inconsistency in the CC's approach. If the CC is of the view that Gisburne Park is unable to act as a competitive constraint on any of the other BMI hospitals then there is no basis on which to include it in the 'cluster'.
- 1.30 The provisional finding that Gisburne Park is part of a cluster with other BMI hospitals is contrary to the evidence and unsustainable. It must be corrected in the Final Report.

There is no evidence to suggest Beardwood, Beaumont and Highfield operate as an effective cluster

- 1.31 The Alexandra and Gisburne Park cannot be considered part of a northwest 'cluster' on the basis of the evidence. We now consider the remaining hospitals: Beardwood, Beaumont and Highfield. It is clear that not only has the CC misrepresented and exaggerated the nature of their catchment areas [REDACTED].

*The CC's catchment area assessments are fundamentally flawed*

- 1.32 BMI has explained in Section 1B of its covering response to the CC's Provisional Decision on Remedies why the CC's isodistance radii catchment areas are fundamentally flawed and produce outcomes that do not square with the reality of the competitive landscape. 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 a geographic market for antitrust

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<sup>9</sup> Provisional Decision on Remedies, paragraph 185.

purposes. The arguments are not repeated here but the points are well illustrated by the example of Beardwood, Beaumont and Highfield.

- 1.33 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 come 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 artificial approach of using fixed road-distance isochrones, the shape of the catchment area is a circle – it does not reflect where patients actually come from.
- 1.34 The CC's Beardwood catchment area [REDACTED].  
[REDACTED]
- 1.35 BMI's core catchment area for Beaumont [REDACTED]. A detailed assessment of the extent of patients within Beaumont's core catchment area is required to understand the true nature of the overlap. The CC has not conducted any such analysis.  
[REDACTED]
- 1.36 The CC's Highfield catchment [REDACTED].  
[REDACTED]
- 1.37 The CC's catchment areas do not accurately reflect where a hospital's patients actually come from. Simply put, they are demonstrably inaccurate and too crude and unreliable a tool to establish and sustain a case for a remedy as intrusive and serious as divestment.<sup>10</sup>
- 1.38 In any event, as stated in BMI's response to the CC's local assessments in the Provisional Findings, each hospital is sufficiently constrained by its competitors.

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

*BMI's core catchment area approach*

- 1.39 On BMI's core catchment area analysis it can be seen that:
- (a) [REDACTED]
  - (b) [REDACTED]
  - (c) [REDACTED]

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<sup>10</sup> Motivating a divestment on this basis would not fulfil the double proportionality requirement articulated in *Tesco v Competition Commission* (2009), CAT 6, paragraph 139.

(d) [REDACTED]

[REDACTED]

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

[REDACTED]

1.41 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 private inpatients and day cases); and (ii) using an overly simplistic isodistance radii which describe circles around hospitals (rather than trying to ascertain where patients actually come from). A detailed assessment of the extent of the overlap shows it is insignificant.<sup>11</sup>

*Overlap between Beardwood and Beaumont* [REDACTED]

1.42 [REDACTED]

1.43 [REDACTED]. Each hospital cannot serve the catchment area of the other – they are both required, regardless of who owns them. [REDACTED].

1.44 [REDACTED]. This competition comes from Ramsay Euxton Hall and Ramsay Fulwood Hall. The CC cannot conclude that Ramsay Euxton Hall and Ramsay Fulwood Hall are a moderate (and not effective) constraint on this postal district. Travel from Beaumont in Bolton to Euxton Hall in Charley is far easier and quicker (19 minutes) than Beaumont in Bolton to Beardwood in Blackburn (29 minutes). Indeed, it is necessary to drive past Euxton Hall to get from Beardwood to Beaumont.

1.45 This factor was considered when the CC decided not to propose the divestment of Meriden in the west Midlands 'cluster', citing that the "presence of Spire Parkway located between Meriden and BMI's other facilities" was a factor.<sup>12</sup> As noted in Annex 1 (Local Assessments) of BMI's response to the CC's Provisional Findings, the CC cannot rely on a hospital having a higher proportion of NHS patients as a determinative factor of competitive constraints (Ramsay Euxton Hall and Ramsay Fulwood Hall) when it also argues that hospitals with greater NHS values are strong potential competitors due to the ease and incentives to switch to private.

1.46 When the geographies of these postal sectors are analysed, it is evident that [REDACTED].

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<sup>11</sup> BMI's 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.

<sup>12</sup> Provisional Decision on Remedies, paragraph 138.

*Overlap between Highfield and Beardwood* [REDACTED]

1.47 [REDACTED]

1.48 [REDACTED] a PMI would not be able to credibly threaten to exclude one hospital in favour of another – each hospital cannot serve the catchment area of the other – they are both required, regardless of who owns them. [REDACTED].

*Overlap between Highfield and Beaumont* [REDACTED]

1.49 [REDACTED]

1.50 [REDACTED]

1.51 [REDACTED]

1.52 [REDACTED] a PMI would not be able to credibly threaten to exclude one hospital in favour of another – each hospital cannot serve the catchment area of the other – they are both required, regardless of who owns them. [REDACTED].

1.53 [REDACTED]. The CC has based its case for divestment on the basis of a far narrower data set of just private insured inpatient episodes and has made no attempt to even quantify the overlaps in its catchment area.

*CC's catchment area approach*

1.54 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 north-west 'cluster' is a good example of this problem. [REDACTED].

[REDACTED]

1.55 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 [REDACTED]. **Even on the basis of the CC's own catchment areas**, using the Healthcode data relied on by the CC [REDACTED].

1.56 [REDACTED]

[REDACTED]

1.57 In its reasoning as to why there should not be a divestment in the Lincoln/Park 'cluster', the CC focused on the credibility of a PMI to threaten to remove recognition and maintain a credible offering to its policyholders in the area. Further the CC stated that the inability to do so would "*significantly limit the effectiveness of divestiture as a remedy for weak competitive constraints in this area since any price benefits were likely to be restricted to self-pay*

*patients only.*<sup>13</sup> In this case, [redacted]. Consistent with the CC's own reasoning in respect of Lincoln/Park therefore divestment cannot be an effective remedy.

Any remedy involving divestment would be highly disproportionate

1.58 [redacted]

1.59 Did Parliament intend the CC to use its power to deprive BMI of its lawful property rights in order to confer an additional choice on [redacted] people (even fewer on the analysis the CC has conducted) – who in any event have a choice of no fewer than 11<sup>14</sup> non-BMI hospitals within a 44 minute drive-time of Highfield, the time the CC's own patient survey suggests patients would be prepared (and do in fact) travel for such care.

1.60 The charts below are based on volume (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 any of the three remaining hospitals in the 'cluster' could only confer a benefit on [redacted] of patients in Beardwood, [redacted] in Highfield and less than [redacted] of patients in Beaumont, since the CC's analysis only takes into account private insured inpatient work and Bupa has fully countervailing buyer power:

[redacted]

[redacted]

[redacted]

1.61 As a proportion of Highfield's total volumes, the actual number of episodes in the catchment area identified by the CC was just [redacted] 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.

1.62 People will find it almost impossible to believe that the immense resources already consumed defending and prosecuting this case – let alone the public and 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 no fewer than 11 alternative non-BMI facilities within a 44 minute drive of Highfield – and only then if they do not wish to use the NHS.

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<sup>13</sup> Para 239, Provisional Decision on Remedies.

<sup>14</sup> Spire Elland (25 minute drive); Ramsay Oaklands (27 minute drive); Bridgewater Hospital (32 minute drive); Manchester Eye (33 minute drive); Spire Manchester (36 minute drive); HCA Christie Clinic (36 minute drive); Nuffield Leeds (40 minute drive); Bradford Royal Infirmary PPU (40 minute drive); Ramsay Euxton Hall (43 minute drive); Spire Cheshire (44 minute drive); and Spire Methley Park (44 minute drive).

The comparison with the significance of similar action in the BAA Airports case will be painfully obvious

- 1.63 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*".<sup>15</sup> 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 in the context of the hospital's total volumes; 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.<sup>16</sup>
- 1.64 Finally, the CC has not made any case against Huddersfield. The CC's local assessments analysis found that Huddersfield faced significant competitive constraints. Further it is situated in a 'cluster' of Spire hospitals. The CC cannot now say (in passing) that it has taken its location into account in coming to its view of which hospital is appropriate to divest. It is an irrelevant consideration. This is particularly relevant where the area between Highfield and Huddersfield is incredibly sparsely populated with very low levels of PMI density. The CC has no basis on which to consider Huddersfield within the context of the competitive assessment of this 'cluster' of hospitals in its Final Report.

### Conclusion

- 1.65 The CC has not presented a coherent evidence-based case on which it can rationally conclude that Alexandra, Highfield, Beaumont, Beardwood and Gisburne Park hospitals operate as a 'cluster'.
- 1.66 In any event, the Alexandra and Gisburne Park operate in markets distinct from the 'cluster' and are already effectively competitively constrained. There is no evidence to support the case that they can operate as part of a 'cluster'.
- 1.67 [X] for the CC to claim divestment of Highfield 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.

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<sup>15</sup> (2009), CAT 6, paragraph. 139.

<sup>16</sup> Provisional Findings, paragraph 5.54.

- 1.68 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.