COMPETITION COMMISSION

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with BMI held on 14 February 2014

Introduction

1. BMI said that the approach taken by the Competition Commission (CC) in its competitive assessment was manifestly unreasonable and stated that the evidence did not support the CC's case and conclusions. BMI advised that the basic intuition about a market characterized by hospital clusters, giving BMI market power, was very wrong and stated that the CC did not have a coherent body of evidence to support the conclusion it sought to arrive at.

2. BMI had 'conceded' remedies 3 to 7 and considered that much of the change that these remedies would bring about, particularly the information remedies and in respect of consultant incentives, would be very much for the better.

3. BMI considered that the effect of remedies 3 to 7 would be material and would deliver a price effect, with the consequence that the incremental impact of remedy 1 would be lower than that assumed by the CC.

Methodologies employed by the CC

4. BMI raised a number of issues with 'four key pillars' of the CC's position—Logit Competition Index (LOCI), price-concentration analysis (PCA), barriers to entry and bargaining—and concluded that they were all defective.

5. First, BMI explained that LOCI was not, and never had been, an appropriate basis to measure concentration and further noted that it did not offer any reasonable proxy of market power. It stated that LOCI consistently and systematically overstated BMI's market position; BMI explained that it had no sound, theoretical basis in industrial economics as a measure of market power and it was neither an accepted nor an acceptable way to measure concentration.

6. Second, BMI stated that the PCA was completely unreliable on the basis that it attempted to consider the relationship between price and concentration in an industry on the basis of half of 1 per cent of its revenues. BMI stated that the CC's analysis found no price-concentration relationship for BMI. BMI further stated that the CC made a series of inappropriate assumptions in order to reach its conclusion, such as assuming that:

   (a) the average relationship for the industry as a whole applied to BMI, even though it knew it did not;

   (b) the same relationship for [✂] BMI patient episodes per year across four self-pay inpatient procedures applied to all other BMI self-pay procedures;

   (c) this self-pay relationship applied to insurer pricing, despite the fact that demand from national insurers was priced completely differently from local, self-pay customers; and finally

   (d) the relationship also applied to day-case procedures, despite the fact that the CC collected the data for day-case procedures, but chose not to use it.

BMI held that without the PCA, the CC had no evidential basis for its claim that divestment would result in benefits for insurers and self-pay patients and, as a result, had no basis for divestments.

7. Third, BMI asserted that the CC's case on barriers to entry was profoundly confused and inconsistent with the CC's profitability assessment. BMI also stated that there had been substantial entry and expansion since the start of the investigation and that there were no material barriers to entry outside central London.

8. Fourth, BMI stated that the CC's conclusion in relation to Bupa's buyer power against BMI was flawed and could not be reached by a rational decision-maker. BMI stated that Bupa exercised overwhelming dominance in this market.

Cluster area analysis

South-east London

9. BMI presented maps setting out catchment areas for the hospitals based on looking at looking at where patients really came from , on a historical basis, and plotting them by postcode. Using this methodology, BMI argued that there was little overlap between the areas from which [✂] and [✂] actually drew patients. The same was true in respect of [✂] and [✂]. BMI argued that it would be disproportionate to require BMI to divest [✂].

10. BMI noted in relation to Chelsfield Park that KIMS was not a *potential* competitor but an *actual* competitor and that this hospital needed to be included in the CC's cluster analysis on a local assessment basis. BMI further considered that Chelsfield Park was significantly constrained [✂] on a competitive [✂].

11. BMI presented a three-step process whereby it first said that Blackheath should be dropped from the cluster since BMI could see no reason for it being included in the cluster (and no case was contained in the provisional decision on remedies as to why Blackheath was included in the cluster beyond the catchment area analysis that the CC did) and that there was no evidence that it interacted competitively in the way put forward by the CC. Secondly, using its own catchment methodology, BMI sought to demonstrate that [✂] should be excluded on the basis that [✂]. Thirdly, BMI said the CC had failed to take into account two developments which were adding to the constraint on Chelsfield Park: KIMS (which BMI already considered to be a significant constraint) and the HCA Sevenoaks outreach centre. In any event, [✂].

12. Somerfield did not play a part in the analysis on the basis [✂].

13. The CC asked BMI to elaborate on the extent to which the BMI-calculated catchment areas would change if hospitals were operated by other operators. BMI said that there might possibly be changes at the margins. BMI explained there was a significant rigidity underlying the way patients moved and argued that the rigidity came from NHS geographic structures. Typically, a general practitioner would refer private patients in the way they would refer an NHS patient. And that typically meant that specific GPs within clinical commissioning groups (CCGs) would tend to refer to specific consultants, or groups of consultants, which was why the competition for consultants was always a factor. BMI said that the CCG geography around [✂] gave quite a high degree of predictability as to where that hospital's patients would come from.

14. BMI also said that the Midlands cluster demonstrated the point. On the CC's catchment area methodology, [✂] but the overlaps were small. BMI regarded these

as three services sitting alongside each other and therefore argued that if the CC required any one of them to be sold, the competitive impact against the others was going to be negligible.

15. BMI further noted in relation to the Midlands cluster that, using BMI's methodology, the only overlap was a [✂] rural [✂] with the vast majority of BMI patients in this overlap going to [✂]. BMI noted that in this cluster there was a correlation between [✂]. A further reason for the correlation was the impact of each of the district general hospitals at Bedford, Milton Keynes and Northampton which would be [✂].

North-West

16. BMI considered that the CC's cluster (the Alexandra, Highfield, Beaumont, Beardwood, and Gisburne Park) did not exist.

17. BMI first sought to show that the Alexandra and Gisburne Park could not be meaningfully considered as a cluster [✂]. Alexandra was part of a south-Manchester/Cheshire area with high private medical insurance demand and high opportunity. BMI further noted that the Alexandra did not aspire to penetrate the areas in the North and that it was constrained in different ways, particularly by Spire Macclesfield and the other Spire hospitals. HCA's new investment in MediPark would also have an impact on the Alexandra.

18. In relation to Beaumont and Beardwood, BMI stated that the overlap identified by the CC [✂] if analysed using BMI's methodology. BMI explained that there [✂], based on the number of episodes available in that postal district, had a [✂] per cent market share. BMI explained that this was because of the impact of Euxton Hall and Fulwood Hall which were drawing a lot of the rest of this.

19. In relation to Highfield and Beardwood, BMI said that there was [✂] and a price benefit analysis on this area would show a small price benefit. The scale of the overlap and price benefit meant that divestment would be disproportionate. In relation to Highfield and Beaumont, the overlap was [✂].

20. In relation to Bishops Wood and CCH, BMI argued that divestiture would not be effective and that, furthermore, it would be disproportionate. BMI's view was based on an analysis of the [✂]. BMI also referred to comments made by AXA PPP which stated that divestiture would have limited effect on competition in that market. BMI invited the CC to consider why the CC considered its view and judgement to be more accurate than that of AXA PPP. BMI also stated that the hospitals were already constrained by Spire.

21. BMI argued that Kings Oak and Cavell operated as a single hospital and that this had important consequences if the divestment remedy sought to generate two competing hospitals. In particular, reconfiguration into two free-standing, separate hospitals would have a series of costs associated with it, which would make the remedy disproportionate. BMI estimated that the costs would be in the region of £[✂] a year in lost efficiency and £[✂] of capital to establish two free-standing units. BMI considered that under separate ownership, without further, rapid investment, [✂]. If the CC accepted any one of BMI's arguments with regard to efficiency savings or one-off capital costs it proposed, the CC's base case net present value (NPV) was reduced to the extent that the remedy would be disproportionate, even if no adjustments were made for day cases, tender costs, or buyer power on the part of the Bupa and AXA PPPs of the world.

[✂]

22. [✂]

23. [✂]

24. [✂]

25. [✂]

26. [✂]

27. [✂]

28. [✂]

29. [✂]

30. [✂]

31. [✂]

32. [✂]

33. [✂]

Valuation of benefits of divestment

34. BMI said that the CC's £57 million base-case figure for the NPV of divestiture was substantially overstated. Reasons for this were that the CC erroneously: *(a)* assumed that no countervailing market power was exercised by insurers—this was implausible as Bupa and AXA PPP had substantial existing buyer power; *(b)* assumed a 100 per cent pass-through of any reduction in prices to insurers to patients—despite acknowledging the potential for limited pass-through; *(c)* assumed that day-case patient prices would drop by the same amount as inpatient prices—despite the fact the CC had argued that the competition for day cases was subject to different competitive conditions; *(d)* assumed nothing would happen to offset the adverse effect on competition over the next 20 years—a quite implausible idea in the context of the shift seen over the previous 20 years, and more so if the CC believed that its profitability analysis and the excess profits identified attracted entry and expansion; *(e)* assumed there would be no loss of economies of scale as a result of divestiture—despite the evidence of the central and regional costs BMI incurred now, which would only be incurred, [✂], if they provided real efficiencies; *(f)* ignored the cost of running local tenders in the clusters subject to divestment—despite the fact that the insurers considered such costs to be so prohibitive that not a single one of them, save Bupa, supported a remedy that would require BMI to offer local pricing; *(g)* disregarded [✂]; *(h)* ignored the cost to convert Kings Oak and Cavell into competitors; *(i)* ignored the shared management savings achieved at various hospitals; and *(j)* assumed that there were no effects from any other remedies proposed by the CC.

35. BMI explained its view on the economies of scale and concluded that if this were taken into account, the NPV would be brought down considerably and this would lead to quite large negative numbers from any divestments. The detailed arguments were included in BMI's submission.

36. [✂]

37. BMI did not believe there was a competition case to justify the forced divestment of any of its hospitals. [✂]