Completed acquisition by Spire Healthcare Limited of Classic Hospitals Group Limited

ME/3610/08

The OFT's decision on reference under section 33(1) given on 18 June 2008. Full text of decision published 1 July 2008.

PARTIES

1. **Fox Healthcare Acquisitions Limited** (Fox) is a special purpose acquisition vehicle that is part of **Cinven Group Limited** (Cinven), a private equity business. Cinven controls **Spire Healthcare Limited** (Spire), a provider of acute hospital services in the UK to both the public and private sectors. Spire operates 26 acute care hospitals spread throughout the UK. Cinven acquired Spire from BUPA in August 2007.

2. **Classic Hospitals Group Limited** (Classic) also provides private medical services, with ten hospitals in England and North Wales. Nine of these hospitals were acquired from BUPA in July 2005. Classic's UK turnover in the financial year ended 31 December 2006 was £78.8 million.

TRANSACTION

3. The transaction concerns the acquisition of Classic by Cinven. The transaction completed on 18 March 2008. Initial undertakings were accepted by the OFT on 25 March. The statutory deadline for the OFT to make a decision on reference to the Competition Commission (CC) is 17 July 2008, and the administrative deadline is 18 June 2008.

JURISDICTION

4. As a result of this transaction Cinven and Classic have ceased to be distinct. The UK turnover of Classic exceeds £70 million, so the turnover test in section 23(1)(b) of the Enterprise Act 2002 (the Act) is satisfied.

The OFT therefore believes that it is or may be the case that a relevant merger situation has been created.

MARKET DEFINITION

Product scope

5. In their initial submission the parties based their analysis on the market definition applied by the CC in the BUPA/CHG Report,[1] that is, private medical services (PMS) provided by private acute hospitals and NHS private patient units (PPUs). This approach is also consistent with the OFT's recent decision in the GHG/Nuffield case.[2]

6. Two private medical insurance (PMI) providers presented market share estimates for the local areas of overlap. In a number of local areas, they excluded from the total market estimates treatments carried out at NHS PPUs. This could suggest that these two third parties do not perceive NHS PPUs as good substitutes to private hospitals. However, both of them have agreements with NHS PPUs in most of the areas that are affected by this transaction, which suggests that NHS PPUs are considered as alternatives to private hospitals.

7. There are a number of variables that might affect the closeness of competition between private acute hospitals and NHS PPUs. These are, for example, the hospital's fascia, the size of the hospital, whether it is part of the network of PMI providers (in particular the two largest ones, BUPA and AXA PPP), the geographic distance between it and competing hospitals, the types of treatment offered and/or is known for and the level of care provided (for example, whether it provides tertiary services[3]).

8. In this case, the OFT considered appropriate to apply the market definition discussed in paragraph 5 above, but also took into account the impact

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[1] Competition Commission *British United Provident Association Limited and Community Hospital Group plc - A report on the proposed merger; and British United Provident Association Limited, Salomon International LLC and Community Hospitals Group plc; and Salomon International LLC and Community hospitals Group plc - A report on existing mergers* December 2000 (Cm 5003) (the BUPA/CHG Report).

[2] OFT *Completed acquisition by General Healthcare Group of assets of Nuffield Hospitals* 1 May 2008.

[3] Specialized consultative care by specialists working in a center that has personnel and facilities for special investigation and treatment.

that the above variables have on the competitive interaction between hospitals. Based on the evidence available, the OFT did not consider it appropriate to exclude any PMS fascia (including NHS PPUs) from the analysis, but, given that all of the merging parties overlapping hospitals provide core services,[4] the OFT considered that only hospitals providing core services can be effective competitive constraints on the merging parties. The OFT also took into account whether competing hospitals are part of the network of at least one of the two largest PMI providers (BUPA and AXA PPP) although it considers that the fact that a PMI provider chooses not to list a particular hospital might be due to commercial bargaining reasons (which can be revised if appropriate) and therefore is not sufficient to lead to the conclusion that such hospital is not an effective competitor. Finally, the OFT only considered as part of the competitors set those NHS PPUs where facilities are available to private patients on a full-time basis.

9. The OFT also received limited evidence about the impact that the level and type of treatments offered in different hospitals can have on the competitive dynamic between them. For example, in the local area comprising Classic's Methley Park and Spire's Leeds hospitals, the OFT found that the constraint posed by these two hospitals on each other is asymmetric (that is, Leeds is a stronger constraint on Methley Park than the other way around) given that a good portion of Leeds's revenue derives from tertiary services (which are more complex) not offered in Methley Park. The OFT also received some evidence that Methley Park's main strength is cosmetic treatments, in relation to which some aspects of the market dynamics (such as patients' choice of hospital, discussed below) might be different. Nonetheless, based on the evidence available, the OFT does not consider that in this case it was necessary to segment the market according to type or level of treatment offered, but it did take into account these particular characteristics of the overlapping hospitals when appropriate to assess the closeness of competition between them.

The patient journey (route to market)

10. In the GHG/Nuffield case, the patient's route to a PMS provider was described in detail. In the first instance the majority of patients will approach their general practitioner (GP). Most PMI policies treat the GP as

[4] Core services include orthopaedics, urology, general surgery, ophthalmology and gynaecology.

the gatekeeper to the plan benefits and a referral by a GP is necessary before a consultant can be seen. The GP will then refer the patient to a consultant, taking into account whether the patient wishes to consider NHS treatment as an option; has PMI and wants to use it and/or is willing to self-pay for private treatment.

11. Should the patient require further treatment, the patient will agree with the consultant where this will take place (which at this stage could still be either as an NHS patient or as a private patient). If the choice is for a private treatment, the hospital in which the treatment is conducted will depend on the hospitals in which the consultant has admitting rights. As such, consultants are usually the primary decision makers in determining where a patient's treatment will take place.

12. The OFT has received evidence, discussed in further detail below, that consultants tend to have admitting rights at more than one private hospital[5] (which the OFT will for present purposes refer to as multi-homing), and that, in at least some of the local areas very few (if any) consultants operate at both the overlapping Spire and Classic hospitals.

13. If in a given local area there are no consultants operating at both the merging parties' hospitals, one possible interpretation is that few patients actually have a choice between Spire and Classic to the extent that they are referred to, and wish to obtain treatment from, a specific consultant. In other words, the only patients who have the choice are those who are given a choice of consultants by their GPs and pick a consultant based on the hospital in which he or she has admitting rights (in other words, the choice of hospital determines the choice of consultant) or those who contact the hospital directly, as might be the case for example for a proportion of cosmetic treatments.

14. However, the OFT notes that even where no consultants are operating at overlapping hospitals, this does not mean that competition does not exist between hospitals to attract consultants, and through them attract more patients (this being one of the ways private hospitals compete against each other).

[5] The OFT does not have estimates of the average proportion of consultants multi-homing, but it has received evidence that, in some hospitals at least, multi-homing consultants represent well above 50 per cent of all consultants.

15. For these reasons (that is, not all consultants multi-home, some patients—especially cosmetic surgery patients—deal directly with hospitals, and GPs may recommend different consultants to conduct the same type of treatment), the fact that there are no consultants practising at both hospitals in an overlap area cannot in itself be regarded as conclusive of the absence of competition between them, although in conjunction with other indicators might point towards that conclusion.

Geographic scope

16. The parties consider the relevant geographic market to be national. However, the parties also provided information on local markets consistent with the methodology used in the BUPA/CHG Report, that is, on the basis of 30-minute drive time isochrones.

17. For the majority of the ten Classic hospitals being acquired and the proximate Spire hospitals, the proportion of discharges made within a 30-minute drive-time of the hospital is close to or exceeds 80 per cent of episodes treated by that hospital, and therefore the parties consider that the 30-minute measure is a good proxy for the size of local PMS markets, and a useful starting point for the analysis.

18. In the recent GHG/Nuffield case, the effect of the merger was considered at both national and local (30 minute drive-time isochrones) levels. In the course of this investigation the OFT did not receive any evidence that led it to believe that it should assess this case under a different frame of reference. However, given that a number of Classic hospitals are concentrated in the North West of England and North of Wales, the effects of the merger on a regional level were also considered.

Significance ratios

19. In the BUPA/CHG Report the CC applied an overlap significance test based on the number of discharges by the merging parties in the areas of geographic overlap between the 30-minute drive time isochrones centred on each of the merging parties' overlapping hospitals as a proportion of the overall number of discharges within each hospital's isochrone. This gives an indication of the extent to which two hospital's catchment areas overlap. In that case, a threshold of five per cent of all discharges by one

of parties' hospital in its primary isochrone was applied to filter out the areas in which the overlap was considered not to be significant. A similar exercise was conducted by the parties (the results are hereinafter referred to as the overlap significance ratio on the 30-minute basis).

20. The parties submit that there are a number of shortcomings with the 30-minute basis, including that it does not indicate where within an isochrone a given hospital draws its patients from and is not sensitive to asymmetries in the catchment areas of hospitals. The parties therefore also conducted an analysis of the postcode areas from which two proximate hospitals actually draw the large majority of their patients. The parties identified the catchment areas (which are made up of a number of postcode sectors) that cumulatively comprise 80 per cent of the total discharged private patients for each Spire and Classic hospital and identified the commonality between those in each local area (the results are hereinafter referred to as the overlap significance ratio on the 80 per cent basis).[6]

21. Given the number of variables that affect competition between hospitals offering PMS and the consequent pitfalls in adopting measures that are too strongly linked to binary isochrone analysis,[7] the OFT agrees that the 30-minute basis is not a particularly good indicator of competition between hospitals. This is evident for instance in the local area around Classic's Yale hospital, where most postcode sectors accounting for 80 per cent of the patients fall outside the primary isochrone.

22. The OFT considers that in some instances, the overlap between hospitals' catchment areas (that is, the overlap significance ratio) may not be well-captured on the 30-minute basis, in particular where hospitals' catchment areas are not well-described by a 30-minute drive-time isochrone because they are skewed in one direction or another. (This may be because, in the PMS market, socio-economic factors have a bigger impact on demand than, say, in the case of grocery stores.) In these cases, the OFT considers that the overlap significance ratio on the 80 per cent basis may better capture where customers are actually located and consequently

[6] For the Classic hospitals the parties used the postcode sector in which a patient's GP is located as a proxy for the location of the patient due to the unavailability of patient location data.

[7] This issue is further discussed above in the product scope section and below in the 'methodology used by the parties' section.

where hospitals fight for their business. However, the overlap significance ratio on the 80 per cent basis is itself not immune to criticism, in particular because capturing only the top 80 per cent postcode sectors might ignore substantial competition between the merging parties in postcode sectors just above that threshold.

23. Although the OFT believes that there are practical and substantive difficulties associated with the use of the two overlap significance ratios, it considers that both are useful indicators of the overlap in the catchment areas of hospitals providing PMS. In addition, the OFT considers that overlap significance ratios can be indicators of the closeness of competition between overlapping hospitals when used in conjunction with other indicators.

HORIZONTAL ISSUES

METHODOLOGY USED BY THE PARTIES

24. In the BUPA/CHG Report and in the recent GHG/Nuffield case, market shares were calculated on the basis of patient discharge data. The parties submit that they were not able to calculate local market shares on this basis due to the lack of accurate information about the total number of PMI patients in a given catchment area. The parties have therefore calculated local market shares on a basis which weights available bed capacity according to the number of insured individuals in a postcode sector.

25. Two caveats are noteworthy in this respect. In general, the OFT notes that in markets with highly differentiated products (such as PMS), isochrone-based market shares —however calculated —may not properly capture closeness of competition between competitors. In addition, in this case, market shares based on the number of beds are shares of capacity (as opposed to actual usage) that may not accurately reflect the actual historical choices of consumers, and as such they do not take into account important drivers of competition, such as quality and the range of services available at each hospital. Also, the allocation of beds from an overlapping hospital according to what proportion the intersection postcodes account for the total number of insured patients in the target isochrone does not necessarily bear a direct relation to the relative

strength of the overlapping hospital in that local area. Finally, the methodology used by the parties ignores the number of episodes attributable to self-pay patients, which accounts for a sizeable portion of Spire's business. The OFT considers market shares represent useful information when assessed in conjunction with other evidence, but may not on their own be a good proxy for competition in the PMS sector. Furthermore, given the limitations associated with market shares based on number of available beds weighed according to the number of insured individuals in a local area, in coming to its overall conclusion, the OFT placed relatively less weight on the market share data in local areas in this case than it attributed to them in the GHG/Nuffield case, where shares based on discharge data were available.

26. Two PMI providers have provided their own market share estimates in certain overlap areas based on number of discharges (of their own insured patients in certain health areas). However, although they might be indicative of which hospitals those third parties perceive as being in competition with Spire and Classic and their relative strength, the OFT does not consider that they can be relied on as market share estimates as such. First, as discussed above, in a number of local areas discharges from NHS PPUs and other local private hospitals are not included in the total market. Also, the market share estimates tend to include only those hospitals included in the PMI provider's own network and therefore do not reflect the competitive constraint posed by other private hospitals or NHS PPUs in the local area. Second, the catchment areas used by these third parties bear little relation to the geographic market definition used by the OFT (and are not considered by the OFT to be appropriate geographic market definitions) and therefore cause significant distortions in market share estimates. Nonetheless, when there are significant differences in the market share estimates provided by the parties and by third parties, a more detailed assessment was conducted and the reasons for giving less weight to one or the other is explained below.

27. In sum, the OFT does not consider that the local market share estimates available in this case are reliable indicators of competitive strength on their own. However, the OFT believes that they still are a helpful piece of evidence when considered together with all other evidence in the round.

LOCAL ISSUES

28. The OFT assessed the impact of the merger on competition in the local areas around each of the ten Classic hospitals: Methley Park, Yale, Lourdes, Regency, Elland, St Saviours, Clare Park, Dunedin, Fylde Coast and Hull & East Riding.

Methley Park

29. This local area is the only one in which the merging parties overlap within each other's 30-minute drive time (that is, primary) isochrone. Almost the totality of the two primary isochrones (centred on Classic Methley Park and Spire Leeds) are covered by isochrones of competing hospitals. The merger reduces the number of fascia in the isochrone around Methley Park from five to four.

Extent of pre-merger competition

30. The evidence before the OFT suggests that the constraint posed by Leeds and Methley Park on each other is asymmetric and that Methley Park is a weaker constraint on Leeds than the other way around. Methley Park offers a more limited range of treatments than Leeds; in fact, of the [ ] episodes arising in 2007 in the most important postcode areas covered by both the Leeds and the Methley Park isochrones, [ ] per cent of episodes treated in Leeds could not have been treated at Methley Park. The catchment areas of both hospitals are also different. While Leeds draws a significant number of patients from outside its primary 30-minute drive time isochrone, most of Methley Park's patients are drawn from postcodes located in the centre of its primary isochrone. This is confirmed by data provided by the parties that indicates that [ ] per cent of Methley Park discharges are made within a 30-minute drive time from the hospital, whereas the same figure for Leeds is only [ ] per cent.

31. Information on consultant multi-homing indicates that:

- None of the top 20 consultants at Leeds also have admitting rights at Methley Park, while the majority do in fact multi-home: [ ] of the top 20 consultants at Leeds (accounting for [ ] and [ ] per cent of the hospital's revenue, respectively); and

- Only [ ] of the top 20 consultants at Methley Park have admitting rights at Leeds, while the majority do in fact multi-home: [ ] of the top 20 consultants at Methley Park (accounting for [ ] and [ ] per cent of the hospital's revenue, respectively), and
- Nuffield Leeds is the preferred second home for multi-homing consultants at both Leeds and Methley Park.[8]

32. Nuffield Leeds is located in between Spire Leeds and Methley Park, and geographically closer to Spire. Given the important role played by consultants in the patient's choice of PMS provider (as discussed above), the OFT considers that the fact that very few consultants operate at both Leeds and Methley Park (only [ ] consultants out of a total of [ ] consultants who work at those two hospitals) limits the choice between these two hospitals available to patients to some extent (see paragraphs 10 to 15 above).

33. The significance ratios on the 30-minute basis are relatively high ([40-50] per cent of the Leeds isochrone overlaps with that of Methley Park and [20-30] per cent of Methley Park isochrone overlaps with that of Leeds), which is consistent with the fact that the two hospitals are within each other's primary isochrones, that is, a large proportion of their primary isochrones will overlap. On the 80 per cent basis the significance ratios are much lower: [5-10] per cent of Leeds' top 80% postcode catchments overlap with those of Methley Park and [10-20] per cent of Methley Park's postcode catchments overlap with those of Leeds.[9]

Competitive constraints post-merger

34. Within the wider conurbation around Leeds, Spire's Leeds hospital is constrained by NHS PPUs and in particular by Nuffield's Leeds Hospital and Ramsay's Yorkshire Clinic, which are both large hospitals. As discussed above, there are three remaining competing fascias within

[8] For the [ ] multi-homing consultants in Methley Park's top 20, [ ] also work at Nuffield Leeds, [ ] at BMI Huddersfield, and one each at BMI Harrogate, Nuffield York and Park Hill Ramsay. For the [ ] multi-homing consultants in Leeds' top 20, [ ] work at Nuffield Leeds, [ ] at BMI Harrogate, [ ] at Nuffield York and [ ] at Ramsay Oaklands. The totals do not match as some consultants practice at more than two hospitals.

[9] These significance ratios exclude those treatments offered in Leeds but not in Methley Park. The reason for this is that a large proportion of Leeds revenue refers to such non-common treatments, given its position as a regional tertiary referral centre, and as a consequence considering the totality of episodes to calculate the significance ratio might exaggerate the extent to which Leeds is actually constraining Methley Park.

Methley Park's primary isochrone (BMI, Nuffield and NHS PPUs), and Ramsay's Park Hill hospital is located just outside the primary isochrone.

35. The parties estimate that their combined market share is [35-45] per cent (increment [10-20] per cent) considering the isochrone centred on Methley Park.[10] Nuffield's market share is around [20-30] per cent and BMI's is around [5-15] per cent. Two PMI providers estimated that the combined market share is higher, at around 80 per cent. However, the OFT considers that there are fundamentals differences in the methodology used by these two third parties which makes these estimates less reliable. In particular, hospitals that are within Methley Park's primary isochrone (such as Nuffield Leeds) or have overlapping isochrones (Ramsay's Yorkshire Clinic), as well as all NHS PPUs, were excluded from the market share calculation and as a consequence the estimates inflate the parties' combined market share.

Conclusion

36. Given the evidence discussed above, the OFT considers that the constraint posed by Methley Park on Leeds is limited. Although it appears that the constraint posed by Leeds on Methley Park is more substantial, sufficient competition remains post-merger, in particular from Nuffield Leeds, BMI and the NHS PPUs. As a consequence, the OFT does not believe that the merger raises a realistic prospect of substantial lessening of competition in this local area.

Yale

37. Within the primary isochrone around the Classic Yale (Wrexham) hospital, there is no overlap between the parties before the merger. However, the 30-minute drive time isochrone around the Yale hospital overlaps to some extent with the isochrones around Spire's Wirral and North Cheshire hospitals. Other hospitals in the area include BMI South Cheshire, Nuffield Grosvenor and NHS PPU.

[10] The increment is lower ([10-20] per cent), with a higher combined market share ([40-50] per cent) if the isochrone around Spire's Leeds is considered.

Extent of pre-merger competition

38. The parties estimate that their combined market share in this local area is [60-70] per cent (increment [15-25] per cent) considering the isochrone centred on Yale, [65-75] per cent (increment of [5-10] per cent) considering the isochrone centred on Wirral and [30-40] per cent (increment [5-10] per cent) considering the isochrone centred on North Cheshire. Nuffield has a market share of [10-20] per cent (centred on Wirral, [20-30] if centred on Yale and [0-5] per cent if centred on North Cheshire) and NHS PPUs have a market share of [5-15] per cent on all basis. In the isochrone centred on North Cheshire, BMI has a market share of [35-45] per cent. However, as discussed above, the weight that can be given to these market share figures is limited.

39. Notwithstanding the market shares above, the evidence before the OFT indicates that there was limited competitive interaction between Wirral and North Cheshire on the one hand and Yale on the other pre-merger, in particular in view of the very different catchment areas of these hospitals. In view of all evidence available, the OFT considers that these market share figures overestimate the competitive constraint posed by the merging parties' hospitals on each other.

40. The postcode location of 80 per cent of the patients of each of the parties' hospitals indicates that Yale, Wirral and North Cheshire draw the majority of their patients from very different geographic areas. Yale draws a considerable portion of its patients from areas to the west and southwest of the hospital in Wales. Wirral is located to the north of Yale and draws most of its patients from the Wirral peninsula. North Cheshire's catchment area is concentrated around Cheshire and has a very limited number of patients coming from postcodes within the isochrone centred on Yale. Together with the evidence discussed below, this indicates that Yale and Wirral are not sufficiently close competitors to raise concerns.

41. In addition, a 30-minute drive time isochrone around Yale (and as a consequence market share estimates on that basis) is not a particularly good measure of that hospital's catchment area given that only [60-70] per cent of Yale's patients are drawn from this area. This information is consistent with the differences between population density in the areas to

the east and west of the Yale hospital and the consequent willingness of local residents to travel.

42. The OFT considers that a possible explanation for the asymmetric catchment area of Yale (that is, a catchment area that overflows significantly outside the primary isochrone's boundaries and extends to the west of Yale into North Wales) is that, due to the usual practices for NHS referrals, GPs and consultants based in Wales are more likely to use a hospital in Wales.

43. The evidence discussed above is consistent with the fact that, according to the parties, only [5-10] per cent of Wirral's and [5-15] per cent of Yale's patients[11] are resident in the areas of overlap between the isochrones centred on Wirral and Yale (the 30-minute basis), and that less than one per cent of both parties' patients are resident in postcode sectors that comprise the top 80 per cent catchment areas (the 80 per cent basis). Between North Cheshire and Yale, the significance ratio on the 30-minute basis is less than [0-5] per cent and [0-5] on the 80 per cent basis.

44. Furthermore, of the top 20 consultants at the Wirral hospital, [ ] also practice at other local hospitals, but [ ] of them practices at Yale. Most consultants' other home hospital is the Park Suite Wirral NHS, but [ ] of them also practice at Nuffield Grosvenor. Given the route to hospital discussed above, the OFT believes that this means that, in fact, the choice between these two hospitals is somewhat limited.

Competitive constraints post-merger

45. The merger will not change the number of PMS providers available to patients located to the west of Yale, and for patients located to the north and east of Yale there will continue to be alternative providers available.

46. In addition to the limited competition between the parties pre-merger, the evidence before the OFT shows that for those customers most likely to perceive Yale and Wirral or Yale and North Cheshire as substitutes to each other (that is, patients geographically located in between the two areas), Nuffield's Grosvenor hospital in Chester is also likely to be an

[11] Or, rather, their GPs, whose surgeries were used as a proxy for patient location.

attractive option and a stronger constraint on Wirral and on North Cheshire than Yale was before the merger and vice-versa. It has more beds than Yale (36 versus 24), and it is part of both BUPA and AXA PPP's networks. In addition, the Grosvenor hospital is located in between Yale and Wirral and between Yale and North Cheshire and as a consequence conveniently located for the marginal customers mentioned above.

47. The existence of alternatives for patients is also illustrated by the fact that the majority of Yale's and North Cheshire's primary isochrones and the totality of Wirral's are covered by other hospitals' isochrones. Indeed, very close to Wirral there is a NHS PPU (Park Suite) and there are a number of competitor hospitals around North Cheshire, including BMI's large Alexandra hospital, a number of NHS PPUs and other competing fascia.

Conclusion

48. In view of the limited competition between Yale and Wirral and Yale and North Cheshire pre-merger, coupled with the fact that there continue to be sufficient competitive constraints on the merging parties post-merger, in particular posed by Nuffield's Grosvenor hospital, the OFT does not believe that the merger gives rise to realistic prospect of substantial lessening of competition in this local area.

Lourdes

49. There is no overlap within the primary isochrone around the Lourdes hospital. However, the 30-minute drive time isochrone around the Lourdes hospital overlaps with the equivalent isochrones around Spire's hospitals in Manchester, North Cheshire, and Wirral.

50. There are a number of other players present in the area, including two independent hospitals (Abbey Sefton Suite and Fairfield Independent Hospital) and one NHS within the primary isochrone, as well as Ramsay, BMI and NHS PPUs in the surrounding area which are included in both BUPA's and AXA PPP's networks. Indeed, the 30-minute drive time around the non-Spire and non-Classic private hospitals that overlap with the Lourdes isochrone cover the entirety of Lourdes's isochrone. As such, all patients within the Lourdes isochrone are able to access at least one

competing hospital within a 30-minute drive-time. The parties estimate that their combined market share in this local area is [30-40] per cent (increment [10-20] per cent).

51. Given the extent of competition remaining post-merger, the OFT does not consider that competition concerns arise from the transaction in this local area.

Regency

52. The 30-minute drive time isochrone around Classic's Regency hospital overlaps with the equivalent isochrones around Spire's hospitals in Manchester and North Cheshire. Within the primary isochrone around the Regency hospital there is no overlap between the parties, although Spire's Manchester hospital is just outside the primary isochrone's boundaries.

53. The main competitive constraint in this local area is BMI's Alexandra hospital, a large flagship hospital which has more beds than Regency, Manchester and North Cheshire combined. BMI's Alexandra is located in between Manchester and Regency, and is equidistant, and closer to North Cheshire and Regency than the latter two are between themselves.

54. The evidence before the OFT indicates that there is limited competitive interaction between Regency and the two Spire hospitals in this local area. Of the top 20 consultants at Manchester and North Cheshire, [ ] of them also practice at Regency. Given the route to hospital discussed above, the OFT believes that this means that, in fact, very few patients will actually have a choice between these two hospitals.

55. In addition, maps indicating the location of 80 per cent of Regency's patients demonstrate that Regency's catchment area is restricted to the 30-minute isochrone ([85-95] per cent of the discharges comes from a 30-minute drive time from Regency). The parties estimate that their combined share of supply in the local area around Classic's Regency hospital is [30-40] per cent (increment [5-15] per cent). According to their estimates, BMI is the leader in that local area with a market share of [50-60] per cent. Two third parties estimated the parties' combined market share in the area as being between 45 to 55 per cent, but these do not include all competing fascia in the local area and therefore overplay the parties' combined market share.

56. The significance ratios between the parties' hospitals also points towards limited competition between them: based on the 80 per cent postcode sectors there is no commonality at all between Regency and North Cheshire, and a [0-10] per cent commonality between Regency and Manchester, although the commonality between Manchester and Regency is [20-30] per cent.[12]

57. In view of all of the above, the OFT considers that there was limited competition between the parties in this local area before the merger, and that sufficient competition remains post-merger, in particular from BMI Alexandra. Therefore, no competition concerns are considered to arise in this local area.

Elland

58. There is no overlap between Spire and Classic within Classic's Elland's primary isochrone. The 30-minute drive time isochrone around the Elland hospital overlaps to some extent with the equivalent isochrones around Spire's hospitals in Leeds, and to a more limited extent with Spire's hospital in Manchester.

59. There are a number of PMS providers present in the area between the parties' hospitals, including BMI, Nuffield, Ramsay, and NHS PPUs, all of which provide core services and are included in BUPA's network of hospitals.[13] The entire primary isochrone is covered by isochrones of competing hospitals. The parties estimate that their combined market share in this local area is [25-35] per cent (increment [5-15] per cent).

60. Based on the extent of competition remaining post-merger, the OFT considers that the transaction does not raise competition concerns in this local area.

St Saviours

61. St Saviours is considered to be a solus hospital, that is, there is no other competing hospital within the primary isochrone. The nearest Spire

[12] On the basis of a 30-minute drive time isochrone, the overlap significance ratio is [15-25] per cent between Regency and Manchester and [0-10] per cent between Regency and North Cheshire ([15-25] per cent in total).
[13] Only the two BMI hospitals, however, are included in AXA PPP's network.

hospital is Alexandra, located 46 minutes away (drive time). There are two BMI hospitals in the primary isochrone centred on Spire's Alexandra, and there is another BMI and an independent hospital (Benenden) that are nearer to St Saviours than to Spire's Alexandra.

62. Third parties that responded to the OFT did not consider St Saviours and Spire's Alexandra as being competitors. This is consistent with the parties' estimated market shares for the local area around the Spire Alexandra hospital – combined [30-40] per cent, with an increment of [0-5] per cent. The parties also estimate that BMI is the largest player in the area with a market share of [45-55] per cent.

63. Given the limited competitive interaction between the parties pre-merger and the existence of sufficient competition post-merger, the OFT does not consider that the transaction raises competition concerns in this local market.

Clare Park

64. The nearest Spire hospital to Clare Park is Portsmouth, located 49 minutes away (drive time). However, third parties do not consider that these two hospitals compete against each other. This is consistent with the fact that Clare Park draws [85-95] per cent of patients from within a 30-minute drive time of the hospital and the very limited commonality between them (on the 30-minute basis the overlap significance ratio is less than [0-5] per cent, and it is [0-5] on the 80 per cent basis for both hospitals).

65. The OFT therefore does not consider that the transaction raises competition concerns in this local market.

Dunedin

66. There is no overlap between Spire and Classic within the primary isochrone around Classic's Dunedin hospital. The 30-minute drive time isochrone around the Dunedin hospital overlaps to some extent with the equivalent isochrone around Spire's Gerrards Cross hospital which is 45 minutes away (drive time). According to information provided by the parties, the totality of Dunedin's isochrone is covered by overlapping isochrones of competing hospitals, such that all of the postcode sectors

within the Dunedin isochrone are also within 30 minutes drive time of at least one competing PMS provider.

67. Post-acquisition, the parties estimate that their combined market share in this local area is [20-30] per cent (increment [0-5] per cent). Two third parties estimate that the combined market share in the local area is at around 38 per cent but this does not include NHS PPUs nor some of the other private hospitals in the local area. Two competitors of the parties list a number of alternative hospitals and fascias present in the local area that pose a competitive constraint on the merging parties.

68. Given the small increment in market shares resulting from the transaction, and the competition constraints that remain in the local market post merger, the OFT considers that the transaction does not raise competition concerns in this local area.

Hull & East Riding and Fylde Coast

69. The isochrones centred on Classic's Fylde Coast and Hull & East Riding do not overlap with the isochrones centred on any of Spire's hospitals. In fact, the drive time between Fylde Coast and Hull & East Riding and the nearest Spire's hospital (North Cheshire for Fylde Coast and Leeds for Hull & East Riding) is 64 and 70 minutes, respectively.

70. This information is supported by maps provided by the parties and is consistent with information provided by third parties. The OFT therefore considers that the parties do not overlap in these two local areas and therefore no competition concerns arise.

Regional issues

71. Given that a number of Classic hospitals are clustered in the North West of England and North Wales, the OFT also considered the impact of the merger in the region comprising the following hospitals: Elland, Fylde Coast, Lourdes, Methley Park, Regency and Yale (all Classic) and Leeds, Manchester, Warrington and Wirral (all Spire). The parties' combined share of supply in the smallest area comprising all of these hospitals based on number of beds is [25-35] per cent (increment [10-20] per cent).

72. The parties submit that price and services are not determined on a regional level, and that the majority of price decisions are agreed on a national basis (and by construction the remainder are set locally). Information provided by third parties does not suggest that the impact of the merger on a regional level could cause competition concerns. In particular, the OFT has no evidence that specific bargaining between PMS and PMI providers occurs at regional level. As a result, the OFT considers that the current transaction does not give rise to competition concerns at the regional level.

National issues

73. The parties' combined share of supply at the national level is [15-25] per cent (increment [0-5] per cent) based on number of beds and [15-25] per cent (increment [0-5] per cent) based on revenue. There are a number of other national players active in the market such as BMI, Nuffield and Ramsay, as well as NHS PPUs. These market share figures indicate that the merger cannot be expected to raise competition concerns at a national level.

74. In the BUPA/CHG Report the CC considered whether BUPA was acquiring additional must-have (from a PMI provider's perspective) solus hospitals, broadly defined as 'hospitals which are the only providers of PMS services in their area'. In GHG/Nuffield the OFT considered whether GHG could use its alleged strong local market position (that is, solus position within local catchment areas) to improve its ability to negotiate nationally on price and ensure that hospitals facing local competition are included on PMI networks through the use of 'one-in, all-in' clauses. However, the OFT concluded that, in that case, there was no realistic prospect of a substantial lessening of competition based on such a theory.

75. Before the transaction Spire owned three solus hospitals: Edinburgh, Southend (Wellesley), and Sussex (Hastings). In turn, just one of Classic's hospitals (St Saviours) can be defined as solus hospitals given that there is no other competing hospital within the primary isochrone. Consequently, the number of must-have solus hospitals controlled by Spire could be said to have increased from three to four as a result of the

merger. As a comparison, GHG currently owns 19 hospitals that can be nominally regarded as solus.[14]

76. The parties argue that the transfer of ownership of a hospital which is already in a solus situation does not impact the competitive scenario in the local area around such a hospital. However, this argument ignores the fact that the addition of a solus hospital to its portfolio might increase the parties' bargaining position at a national level (for instance by allowing it to use one in, all in clauses).

77. In any event, in the present case the OFT considers that the small increase in the number of solus hospitals owned by Spire (and effective decrease in the share of solus hospitals from 12 per cent (three out of 25) to 11.5 per cent (four out of 35) is too small to raise any competition concerns.

BARRIERS TO ENTRY AND EXPANSION

78. In the BUPA/CHG Report the CC found that entry into the PMS market was subject to 'a range of entry barriers'. While the parties have not disputed the existence of barriers to entry mentioned above in this sector, they argue that recent changes in the market such as the opportunity to develop services target at both NHS and PMI providers and the increased prevalence of single service line facilities have reduced their extent.

79. Although changes in the private healthcare market may have reduced the importance of barriers to entry, there are a number of reasons why the OFT believes they are still high enough to make entry insufficient to deter attempts to exploit market power. First, the costs involved in building a new hospital are very high (even though estimates vary widely). Second, there is no firm evidence that the market for PMS is growing, and a competitor pointed out it is actually stagnant. Third, service line tenders represent only a limited proportion of a PMI's overall purchases of PMS. Fourth, recent entry (for example, that of Circle) has occurred only on a small scale basis. Fifth, planning restrictions to the building of new hospitals and the need to attract a sufficient number of doctors still

[14] See paragraph 102 of the OFT decision on the GHG/Nuffield case, with the qualification explained on paragraph 95 of the same paper.

represents significant barriers to entry. Finally, the parties estimate that there is significant spare capacity in the sector.

BUYER POWER

80. The parties submit that PMI providers and the NHS exert considerable buyer power and this effectively constrains their conduct.

81. In particular, in relation to PMI providers, the parties note that the two largest providers account for about [40-50] per cent of Spire's total revenues. In addition, the parties note that in the BUPA/CHG Report the CC found that BUPA, AXA PPP, Norwich Union and Standard Life accounted for 82.8 per cent of the PMI market – a proportion which the parties now estimate to be around 83.5 per cent, with BUPA and AXA PPP alone accounting for approximately 67 per cent of the market.

82. According to the parties, the high concentration in the PMI market implies that access to at least BUPA's and AXA PPP's respective networks is of critical importance to PMS providers. The parties detailed a number of ways in which PMI providers can exert buyer power and also noted that the NHS has become a significant PMS purchaser.

83. Although third party PMS providers agree that the major insurers have a certain degree of buyer power, the OFT was also told by PMI providers that their ability to negotiate largely depends on the ability to switch to alternative PMS providers and therefore on the degree of competition existing in local areas. In addition, PMI providers submitted that the insistence by hospital groups on 'one-in, all-in' negotiations reduced their power to negotiate terms.

84. In any event, given the conclusions on the lack of competition concerns raised by the merger, it is not necessary for the OFT to conclude on the issue of countervailing buyer power.

THIRD PARTY VIEWS

85. A number of third parties responded to the OFT's requests for information, the majority of whom were unconcerned about the merger. One competitor raised concerns that were not competition-related. Two

PMI providers were concerned about the impact of the merger on a national and local level. On a national level, as discussed above, the merger does not raise competition concerns in view of the limited increment in market share and in the proportion of solus hospital in relation to Spire's full hospital portfolio. On a local level, concerns have been dealt with in the assessment of each local area above.

ASSESSMENT

86. The transaction concerns the acquisition of Classic by Fox, a company under the same control as Spire, and the consequent amalgamation of their portfolio of hospitals. In line with the CC's BUPA/CHG Report and the recent OFT decision on GHG/Nuffield, the relevant product market is the supply of private medical services provided by private acute hospitals and NHS private patient units. However, the OFT considers that different fascia and different hospitals within the relevant product market, while effective competitors, might pose different degrees of competitive constraint and took this into account in the local market analysis. The effects of the transaction were assessed at national, local and regional levels. For the local market analysis, 30-minute drive time isochrones were considered, but the OFT also considered the competitive constraint posed by PMS providers located in neighbouring areas, and to the extent possible weighted the competitive threat posed by a hospital according to its catchment area.

87. On a national level, the merger does not raise any competition concerns in view of the small increment ([0-5] per cent) and limited combined market shares ([15-25] to [15-25] per cent). At a regional level, the highest combined market share is [25-35] per cent (increment [10-20] per cent) in the North West/North Wales area. However, the OFT does not have any evidence that negotiations take place, nor that parameters of competition are set, on a regional level.

88. The OFT carefully assessed the impact of the merger in all ten local areas, and, based on a range of evidence, concluded that sufficient competition remains post-merger in all of them such that in no area could the merger be said to create a realistic prospect of a substantial lessening of competition. In some local areas the OFT also found that there was limited competition between the parties pre-merger.

89. Although the evidence available suggests that barriers to entry are high and that countervailing buyer power is not sufficient to deter a market participant from exercising market power, it was not necessary to conclude on these issues given that the merger does not raise competition concerns.

90. Consequently, the OFT does not believe that it is or may be the case that the merger has resulted or may be expected to result in a substantial lessening of competition within a market or markets in the United Kingdom.

DECISION

91. This merger will therefore not be referred to the Competition Commission under section 22(1) of the Act.