OFFICE OF FAIR TRADING

# Anticipated acquisition by Hospedia Ltd of Premier Telesolutions Limited

ME/3788/08

The OFT's decision on reference under section 33(1) given on 7 October 2008. Full text of decision published 6 November 2008.

**Please note that square brackets indicate figures or text which have been deleted or replaced at the request of the parties for reasons of commercial confidentiality.**

## PARTIES

1. **Hospedia Ltd** (Hospedia) is a newly-formed entity which acquired the Patientline business (Patientline) from Patientline plc immediately after Patientline plc being placed into administration. Patientline was the first company to offer integrated patient bedside entertainment and communications systems (BECS) in the UK. Established in 1993, by 2000 Patientline had installed BECS systems at a total of 25 hospitals. Following the launch of the Patient Power Initiative, installation of BECS accelerated and Patientline's one hundredth site was installed by 2004.

2. **Premier Telesolutions Limited** (Premier) is a wholly-owned subsidiary of Pretel Group Limited. The principal shareholders in Pretel are Tim Weil and funds managed by Milestone Capital, with the remaining shares held by the current management team. Premier provides hospital communication and multimedia services in the UK to both patients and hospital staff. Premier has been operating for over 15 years, having originally been established to provide and manage payphone services within the UK healthcare market. With its payphone business, it has contracts with over 50 UK hospitals and supports a base of over 1,800 managed payphones.

3. Following the introduction of the PPI, Premier extended its activities in 2003 to include the provision of BECS. Excluding payphones, Premier has operations in 40 NHS hospitals and manages 12,050 BECS terminals. In the year ended 31 December 2007, Premier's UK turnover was £6.1 million.

## TRANSACTION

4. Hospedia has agreed to acquire all of the issued share capital of Premier [ ].

5. The transaction was notified to the OFT on 4 August and the extended administrative deadline for a decision is 7 October 2008.

## JURISDICTION

6. As a result of this transaction Hospedia and Premier will cease to be distinct. The parties overlap in the supply of free-managed BECS to NHS hospitals and the share of supply test in section 23 of the Enterprise Act 2002 (the Act) is met. The OFT therefore believes that it is or may be the case that arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation.

## BACKGROUND

### Patient Power Initiative (PPI)

7. The Government introduced the PPI in 2000, as a commitment to provide a personal bedside TV and telephone for every patient at a major NHS hospital in England by 2004[1]. These BECS were intended to replace existing TV day rooms, payphones, and hospital trolleys.

8. Prospective providers of BECS tendered for 'National Licences' from NHS Estates, which then allowed holders to tender for the exclusive right to install and operate BECS at individual NHS Trusts. Concession agreements awarded by NHS Trusts were generally based on the NHS template agreement and typically had an initial duration of 15 years with a provision for an extension for a further three to five years.

[1] 115 major hospitals were subsequently identified by NHS Estates.

9. Three companies, Patientline (now Hospedia), Hospital Telecommunications Services Limited (HTS) and the Wandsworth Group Limited (Wandsworth)[2] were awarded National Licences in 2000/01.

10. Providers under these licences were required to provide a single integrated unit with telephony and TV services at every suitable bedside (regardless of projected use). In addition, terminals had to include a free radio, children's TV and hospital TV channel. Outgoing calls (but not incoming ones) from the bedside telephones were subject to a price cap which was no higher than the standard national rate.

11. Providers were encouraged to install units offering enhanced functionality, allowing patients and clinicians to access value added services which could be purchased by the Trusts, for example, on-line meal ordering, access to electronic patient records and x-rays at the bedside. The intention was that providers would bear the cost of installation but would recover this and the on-going operational costs by levying charges directly on patients and the NHS Trust for their use of the systems. In practice, however, Trusts have not made significant use of the additional functionality offered by the first BECS systems. As a result, this potential income stream has largely not been available to providers such as Patientline. Patient demand for the terminals may also have been lower than originally anticipated. Since the PPI was introduced the length of a typical patient stay in hospital has declined and ownership of mobile phones has increased.

12. In addition to the three original National Licences in 2000/01, a further four companies were awarded Provisional Licences, which allowed the provider to roll out services at a pilot hospital. Then, subject to approval from the relevant Trust and Department of Health, these firms could have been allowed to proceed to a full licence. In the event only one company, Premier, successfully converted to a full licence in 2003.

13. An OFCOM investigation in 2005[3] ('the OFCOM report') subsequently found that - for reasons including the requirement to install terminals at all suitable bedsides and disappointing use by the Trusts - providers were

[2] In 2003 Wandsworth sub contracted management of its terminals to Premier. It now supplies bedside entertainment on an outright sales basis (mainly) to overseas customers.

being forced to increase incoming call charges (which were not capped by the terms of the PPI National Licence) in order to recover the costs of installation and operation. Call charges were found to be usually 49/39 pence per minute peak/off peak and were preceded by a lengthy recorded message that callers could not skip. The OFCOM investigation concluded that high prices charged for making inbound calls were the result of a complex web of Government policy and agreements between providers and the NHS – but not the result of unilateral conduct by the providers themselves. As part of this review, it was recommended that the Department of Health should revisit the existing guidance on the use of mobile phones by patients and visitors, in hospitals and other NHS premises. As a result, the Department of Health produced guidance which was posted on its web site in August 2006[4].

14. The Department of Health withdrew the PPI scheme in February 2007. NHS Trusts are no longer obliged under the PPI scheme to have BECS provision, however, any existing concession agreements will remain valid for their specified duration.

## MARKET DEFINITION

15. The parties overlap in the provision of free-managed BECS to NHS hospitals, in other words BECS systems that do not require any payment (initial or ongoing) by the NHS Trust in which they are installed. However, the OFT has considered whether the market is any wider than this to include, for example, paid-managed systems, other on-ward facilities and personal entertainment devices.

### Product scope

16. BECS are terminals that allow patients direct access to some or all of the following: telephone, television, radio, games and Internet. The provision of these services under the PPI scheme is discussed above. The parties have suggested that, once the requirements of the PPI were no longer applicable, the sector was opened up to new providers to offer alternative

[3] Ofcom own-initiative investigation into the price of making telephone calls to hospital patients – CW/00844/06/05 – 18 January 2006.
[4] Patient Power Review Group: Use of mobile phones in hospitals and other NHS premises – 25 August 2006.

services under different business models, that is paid-managed systems, to NHS Trusts that had not already entered into concession agreements.

17. In considering this matter there are two distinct customer groups: individual NHS Trusts and individual patients. The OFT considers market definition from the perspective of both sets of customers.

**NHS Trusts**

**BECS vs. other in-hospital communication and entertainment options**

18. The BECS terminals are designed to replace TV rooms, payphones and TVs on trolleys, and external callers ringing through to ward receptions. The OFCOM report did not identify any obvious alternative to BECS. While hospitals may find it difficult to quantify in monetary terms the savings that BECS provides to them (in terms of staff time saved and so forth), anecdotal evidence from third parties confirmed the desirability of the terminals over many of the alternative facilities hospitals could otherwise provide, citing the freeing up of medical staff's time that would otherwise be spent supervising the use of other systems.

**Types of BECS and free-managed vs. other procurement models**

19. Not only do the NHS Trusts have to consider the 'value' of BECS terminals, but they have to consider whether different types of BECS are substitutable, and the OFT must also consider whether sufficient NHS Trusts would switch to paid-for BECS to discipline a monopoly supplier of free-managed BECS.

20. Two providers, Premier and HTS, both offer telephone-only systems as well as full function (radio/telephone/television/games/internet) terminals. In the case of free-managed systems the Trust faces a similar 'cost' whether installing telephone only or full function terminals - ward closure for laying cables, disruption and so forth[5]. This would not include direct payment costs in the case of traditional free-managed systems, although third party enquiries suggest that, more recently, Trusts have been asked to contribute

[5] Although we understand that the installation 'costs' may be somewhat less onerous for the telephone only solutions which have lower infrastructure requirements.

towards the cost of installing BECS on new wards (particularly where the number of beds being cabled is modest (less than 50)).

21. Since the demise of the PPI scheme, the hospitals' willingness to pay themselves up-front for BECS on a paid-managed basis appears to vary. Many Trusts did not consider it a high enough priority to justify a call on their financial resources, given their preference to spend limited NHS budget on clinical and related needs, rather than, say, ancillary entertainment needs. Other Trusts have either paid/contributed towards the cost of installation. Some, for example, consider the provision of BECS as important for attracting patients to their hospital and greater competition between hospitals in light of government initiatives to facilitate patient choice could change hospital preferences with respect to paying up-front for BECS over time.

22. Overall, the OFT had insufficient evidence on hospital preferences to conclude that paid-managed BECS provision should be included in the relevant market alongside free-managed BECS. To date, no NHS hospital has elected to purchase BECS wholly on this basis. Other evidence considered below under horizontal issues, entry and expansion also cast doubt on whether the constraint from paid managed provision would be sufficient to constrain a free-managed monopolist. The extent to which the viability of the free-managed model on the supply side means that the market will in any event transform is a complex issue ripe for further inquiry and evidence-gathering. Given the OFT's ultimate decision, this will be for the Competition Commission to determine.

**Patients**

23. The OFT has received conflicting evidence of the importance of BECS to patients. The Department for Health provided survey evidence that showed that BECS were considered a low priority by patients. However this appeared to be contradicted by [ ].

24. The choice facing patients, however, is primarily limited to the BECS facilities present in the hospital that they are being treated in. While it is possible that BECS facilities are one of a number of factors patients will consider when taking into account which hospital to be treated at (when a choice is available), it is most appropriate in this assessment to consider the impact of the merger on patients having made a choice or having no

choice of hospital, that is, the issue is whether there is a satisfactory alternative to the BECS system installed at the hospital in question.

25. NHS Trusts' views on the desirability of BECS for patients have also been canvassed. Trusts with high levels of BECS service generally considered the service to be good, albeit in some cases outdated. One recognised that services are 'essential' for some patients, 'preferred' by the majority and 'disliked' by a minority. Trusts indicated that utilisation rates among patients are fairly low, with between 35 per cent and 45 per cent of patients using the services. One Trust stated that patients were more likely to complain if they did not have access to the system.

26. On balance, it appears reasonable to consider that the desirability of BECS will vary substantially from patient to patient depending on personal preference, the length of stay in hospital, whether they are bed-bound, the proximity of family/friends as well as the availability of alternative entertainment / communication facilities. Some may consider BECS essential, but in the absence of price discrimination (which appears possible in respect of hospitals, but not in respect of patients) the issue will be to what extent marginal end-users, who would switch away from BECS, would render a price increase by a BECS monopolist supplier unprofitable.

27. For the marginal user, alternative entertainment/communication facilities may in principle include those offered by the individual hospital. However, third party enquiries with Trusts confirmed that alternative hospital facilities are fairly limited and are not considered a realistic or desirable substitute to BECS.

28. Patients, of course, are not restricted to just choosing between BECS and alternative hospital services. The patient may opt to use their own mobile phone and other handheld entertainment devices such as MP3 player, portable DVD and/or laptop, and it is worth distinguishing between telephony and other services given relative usage and ownership.

**Substitutes to the TV and entertainment components of BECS**

29. Television and video entertainment services and computer games available on some BECS terminals may be substituted with personal handheld devices such as portable DVD players and laptops. From OFT enquiries, it was evident that individual Trusts' policies on such electronic devices

varied. Some Trusts discouraged their use because if requiring a mains connection they need to be first checked by hospital staff (one third party stated that there had been instances where a patient's electronic device had resulted in electrical problems on wards).

30. In any event, it is clear that the current penetration of personal DVD, internet, television or other entertainment devices is significantly lower than penetration of mobile phones, with the result that such devices are likely to form far less of an alternative for patients overall than mobile telephones would do in relation to telephony services. At present, the OFT has insufficient evidence to conclude that switching by NHS patients to personal portable entertainment devices would be sufficient to render a price increase by a BECS monopolist unprofitable, in respect of such services – for example, the beside user rates for watching television on BECS.

**Mobile phone usage as a substitute to BECS telephony services**

31. Following the termination of the PPI scheme the Department of Health, in May 2007, issued its most recent best practice guidance on using mobile phones in hospitals.[6] This best practice guidance offered Trusts a legal framework and evidence base to use in compiling mobile phone policy for individual Trusts.

32. Although it is up to individual Trusts to decide where mobile phones may be used, the Department of Health's guidance suggests that, for safety, privacy and dignity and annoyance reasons, mobile phones should not be used in: wards, intensive therapy units, operating theatres, maternity wards, special care baby units, children's wards/areas. The guidance goes on to suggest that Trusts may, after carrying out a risk assessment, wish to consider allowing their use in hospital reception and entrance areas, non-clinical communal areas – which may including day rooms and café areas, specially designated rooms/areas, and public corridors.

33. During its third party enquiries with Trusts, the OFT asked about the use of mobile phones and other handheld devices on their wards. Mobile phones are generally allowed within hospitals, although this was not the case in

ward areas where their use was often at the discretion of the ward manager. However, the position was not universal across different hospitals with the result that there are likely to be a number of patients who are not able to use mobile phones as an alternative to an installed BECS system.

34. The parties submitted the results of a patient survey [ ]. While further analysis may reveal that permissible or tolerated usage of personal mobile phones within NHS hospitals may constrain a monopolist BECS supplier, the OFT cannot discount the possibility that a small but significant price rise would be profitable.

**Conclusion**

35. Hospitals have suggested that the limited alternative facilities that they would be able to offer would not be considered an acceptable substitute to BECS terminals, and while mobile phones can provide an alternative to bedside telephony for patients with them, hospital policy towards their use varies. Other electronic devices which may substitute for TV and computing services are not encouraged by some Trusts and are less widespread.

36. In conclusion, the OFT considers that, on a cautious view, it cannot be confident that sufficient demand – reflecting hospitals and patient – would switch to alternatives to free-managed BECS supply to render a monopoly supplier's price increase unprofitable. On this basis, the relevant market that frames the following competitive assessment is the supply of free-managed BECS terminals, which have some or all of the following features: telephone, television, radio, games and Internet.

**Geographic scope**

37. PPI only applied to English hospitals, however, in practice, this funding model has been used by some hospitals in Scotland, Northern Ireland and Wales.

[6] Using mobile phones in NHS hospitals – 3 May 2007 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074396

38. The OFT has considered whether the individual home countries hospital Trusts should be considered separately. While the PPI only applied to English Trusts, explaining the greater penetration of BECS at English hospitals, the OFT received no evidence which suggested that the situation and decisions concerning BECS today varies by locality within the UK.

39. The most appropriate relevant market is therefore the provision of free-managed BECS to NHS Hospital Trusts in the UK.

## HORIZONTAL ISSUES

### Market shares and competitive position

40. The transaction will result in the merger of the first and second largest providers of free-managed BECS to hospital Trusts in England in terms of installed base.

41. In terms of contracted beds already installed the transaction creates a combined share of 85 per cent (increment 10 per cent) of a free-managed BECS market comprising some 128,472 beds.

42. The parties argued that Patientline's large share of free-managed BECS systems should not be seen as equating with a strong competitive position in the current market, or going forward, on the [ ].

43. [ ] However, it is also the case that there was evidence that Patientline was in the early stages of developing a new, simplified and more economical BECS terminal (T3). When this fact is coupled with the significant incumbency advantage that Patientline enjoys as the first-mover in the market, the OFT considers that the fact that [ ] should not lead to the conclusion that it could not realistically be expected to play a competitive role in the market going forward in the short to medium term. [ ].

44. There are few other active players in the provision of free managed BECS terminals. HTS has around 8 per cent of hospital contracts currently in force, while Wandsworth with 7 per cent has subcontracted the management of the majority of its terminals to Premier.[7]

[7] See footnote 2.

45. [ ].

46. Further, one customer of HTS highlighted concerns over the compatibility of HTS' cabling infrastructure compared to Patientline/Premier's[8], which would make it hard for hospitals to switch to it as a provider in future. HTS may, therefore, be a lesser substitute to Premier/Patientline (where infrastructure is already installed) than the parties are to one another.

47. The parties have stated that there are at least seven manufacturers and suppliers of entertainment equipment used in private hospitals and hotels that could, if they considered it financially viable, provide free-managed BECS.

48. The main third party supplier identified in third party enquiries was Airwave Europe Limited (Airwave), which markets patient information and television services to individual hospitals and NHS Trusts, on a paid-managed basis. However, it has no plans to enter on a free-managed basis as it does not believe the free-managed business model to be viable. Airwave itself actually thought it could be more cost effective for hospitals to buy their system and to take modest revenues than to rely on free managed providers.

49. Other providers of BECS suggested by third parties, include Static Systems Group, which supplies on a paid-managed basis and eMedys. The latter, the parties have told the OFT, has gone into administration.

50. The OFT was not able to identify any potential provider operating on a paid-managed basis that was clearly willing to enter as a free-managed provider.

51. The OFT considers that BECS installations already in place should not be considered to represent part of a normal contestable market, particularly given the duration of the contracts (in many cases fifteen years) and the absence of any evidence that hospitals would be willing unilaterally to break contracts in order to appoint an alternative provider. By contrast,

[8] HTS provides a fully digital system which is not compatible with the 'older' infrastructure used by the parties.

contracts in breach by the BECS provider or that are subject to renewal are considered separately below.

52. However, the OFT did receive evidence that incumbent suppliers of free-managed BECS systems might constrain each other in a more indirect manner. In particular, the OFT received evidence that it was important in reputational terms for a BECS provider not to be perceived publicly as the most expensive operator in the market.[9] In this way, the existence of alternative, independent, free-managed BECS providers may constrain, to some extent, the pricing of other BECS providers.

53. The OFT examines below the competitive dynamic in each of the three situations in which there is a contestable market.

**Competition for trusts currently without BECS provision**

54. The parties identified [ ] hospitals in the UK containing a total of [ ] beds where BECS could potentially be provided in the future economically by either party (this market would be smaller at present for Patientline since, with more expensive terminals, it would only be able economically to serve fewer hospitals [ ].

55. For those Trusts without BECS terminals, it appears from third party enquiries that hospitals' first preference is generally for a free-managed service rather than a service requiring payment by the hospital.

56. As noted above, the parties argued that [ ].

57. The merger will therefore result in a reduction in the potential for future competition between the parties for contracts [ ]. Although the OFT accepts that it is not certain that Patientline would have become a bidder for new contracts, the balance of the evidence suggests that the prospect of this occurring is, at least, realistic. In that case, the merger would combine the closest and largest bidders for installation of free-managed BECS systems.

[9] Premier stated that most people believe that Patientline provides all BECS systems and that therefore, when they read press reports of price rises, the belief is that these increases will also apply to Premier. Following Patientline's increase in outgoing call costs from 10p to 26p in April 2007, both Premier and HTS undertook an advertising campaign to inform customers that their prices were still 10p. [ ].

**Competition for Trusts who have awarded a concession or preferred supplier status, but are yet to receive BECS installation**

58. The OFT is aware of an additional 30 hospitals (representing some 12,015 beds) that have awarded preferred supplier status to either Patientline or Premier that have not yet been taken forward (that is, where the system has not yet been installed).

59. The parties questioned whether these hospitals are really contestable since they could identify only [ ] occasions where a Trust has subsequently switched away from a preferred supplier. One third party stated that switching was unlikely since the time between awarding preferred supplier status and the contract being enforced was typically short. However, evidence from the parties suggests that some Trusts have been waiting for over a year for their BECS terminals since awarding preferred supplier status.

60. Third party responses [ ] confirm that Premier was, until very recently, actively vying to secure unfulfilled contracts originally awarded to Patientline (but which had yet to be taken forward). It is a reasonable conclusion to draw from this that Premier considered there was at least some prospect of being able to persuade the hospital in question to switch future supplier, and this is reflected in the evidence of actual switching provided by the parties ([ ] occasions being a material number in comparison to the 30 hospitals where preferred supplier status has been awarded but the contract has yet to be taken forward). However, Premier's progress at securing contracts appears to have been frustrated on occasion by promises extended by Hospedia/Patientline to honour these contracts. The OFT was told by the parties that Premier had been unable to install any terminals in any of these 'switching' hospitals over the past two years.

61. Absent the merger [ ] evidence presented to the OFT suggests that it is at least realistic to consider that unfulfilled contracts would normally be competed for by both parties until installation had occurred.

**Competition for BECS contracts in breach or up for renewal**

62. The parties have not provided information on the exact number of installed contracts that are only partially honoured (for example, where services are

not being fully maintained) although the OFT is aware of two hospitals that brought their Patientline contracts to an end, and were in the process of switching to Premier – and which therefore might technically be considered contestable since they comprised breached original concession contracts. However, between them, Patientline and Premier are contracted to provide BECS at 109,818 bedsides, yet are doing so only at [ ] bedsides. That leaves a provision-gap of [ ] beds. In reality, a large number of contracts may require less than 100 per cent coverage of beds. Hospitals with a high proportion of beds serviced with BECS may not be inclined to switch while those with low coverage may be more inclined to switch to achieve a better service. Overall, the third party evidence received by the OFT casts doubt on the proposition that hospitals would be prepared to switch mid-contract on the basis of breach of the contractual requirements by the BECS provider.

63. With respect to contract renewals, given the substantial duration of many BECS contracts (often 15 years), the OFT is aware of only one BECS contract that has expired so far. While the majority of contracts are due to expire between 2017 and 2020, a not insignificant number ([ ]) will expire over the next five years, accounting for [ ] beds in total.

64. The parties suggest that contracts that are in breach or up for renewal are not really contestable since hospitals are unlikely to switch providers once they have installed their systems. In support of this argument, the parties state that although the cabling used by Patientline and Premier may be interchangeable, additional work will be required to ensure compatibility with incoming systems. Further, the parties state that a major barrier to hospitals switching supplier is that hospitals would rather choose to retain an existing supplier (even given that a contract may not be being wholly contractually fulfilled) than undergo the administrative burden and disruption, over several months, that switching would entail. The parties provided an example of a hospital whose contract expired in 2004 who, rather than negotiate a new contract with either of the parties, preferred to allow the existing contract to roll over.

65. However, the OFT considers that the parties' argument that hospitals would not be willing to switch supplier when they had an existing supplier must be treated with caution. First, the parties stated that they were only aware of one contract that had come up for renewal to date. Second, as hospital Trusts become more competitive with other hospitals in their

competition for patients,[10] the provision of BECS may be seen as an additional plus factor for the hospital, particularly given the evidence that at least some patients place weight on the presence of a BECS system. This is particularly so given that there has been considerable public comment about the level of pricing for use of the telephone services in BECS.[11] Hospitals will therefore be expected to seek to ensure the best price/service balance for their patients by negotiation at renewal. Since the parties are currently the two major suppliers of free-managed BECS, the merger may be expected to reduce the scope for such future competition to take place.

66. As noted above, the parties have stated that there has been no competitive rivalry between Patientline and Premier for either new contracts or renewals for at least two years. Therefore, since Premier has been the only free-managed company pursuing new contracts or renewals during this time, it follows, they argue, that the merger will not result in a lessening of competition. That Premier has been in negotiation with Trusts to replace Patientline has been confirmed by a number of Trusts (including one dissatisfied Patientline customer). However, for the reasons given in paragraph 57 above, the OFT does not consider that it would be correct to conclude that there was no realistic prospect of Patientline competing for future contract renewals, particularly when it enjoyed such a large incumbent position. In addition, it is also credible that Patientline was more incentivised to honour satisfactorily its existing contractual terms pre-merger as a result of Premier's efforts to win business from it than it would have been had it not had such a challenge. That degree of ongoing competition would be lost by the merger.

67. The OFT considered whether a hospital that had a BECS system installed but where the contract was being breached or was up for renewal could conceivably provide its own BECs system on a paid-for basis (that is, self supply). Views from third parties about their willingness to self-supply varied from hospital to hospital. One third party commented that some systems cost £2,000 per bed and are simply not viable on a free managed

[10] See www.dh.gov.uk/en/Healthcare/PatientChoice/index.htm and the Department of Health's initiative to introduce greater choice for patients with respect to the NHS service they receive.

[11] *How to save a packet on NHS treatment* Daily Mirror, September 2008, House of Commons Health Committee - NHS Charges Third Report of Session 2005–06 – paragraph 93, page 40.

basis. They considered that some hospitals will take them and some will not – depending on their financing and views towards patient satisfaction. Another third party estimated that BECS would cost them £2 million to install with little evidence of the impact on patient care or satisfaction. A third hospital suggested that BECS was low down their list of priorities. Conversely, however, one third party stated that if Patientline would not update its services then it would manage a system that met its requirements itself. Overall, the evidence suggests that the threat by hospitals to self-supply by switching to paid-for BECS services is likely to be insufficient to constrain free-managed BECS providers in most cases. In this respect, it is relevant that all contract prices are individually negotiated, permitting BECS suppliers to price discriminate between those hospitals that may have greater latitude to consider alternatives, such as self-supply, and those that do not.

**Prospects for entry and expansion**

68. Patientline's market share was built up during the existence of the Department of Health's PPI scheme (that is when certain hospitals were obligated to arrange BECS provision for patients).

69. The main barrier to new entry into the free-managed segment of BECS supply is the difficulty of achieving a profitable business based on this model. None of the evidence received by the OFT suggested that any other providers would wish to enter into the supply of BECS terminals based on this model. One third party did not believe any firm would be willing (or have the required experience) to enter the market for low-cost terminals today, and another did not believe that the free managed business model is workable and considered it particularly high risk in the current business climate.

70. In relation to competition for new contracts, since Trusts no longer have an obligation to provide BECS, a further important barrier to entry will be the individual Trust's view on the importance of having such a system for its patients. The ranking of such a system may depend on whether the Trust is being offered a free-managed system or one that they have to pay for, either in full or in part.

71. Where BECS contracts are in breach, some trusts raised the issue of not knowing whether or not they could easily terminate their existing contracts

where the service was unsatisfactory, potentially raising a barrier to switching supplier for such Trusts. The Department for Health considered that hospitals could exit contracts which had been breached - although an incumbent operator might seek to recover money when exiting a hospital with respect to infrastructure installed. A third party stated that NHS Trusts were generally not keen to terminate legal contracts without NHS guidelines. This unwillingness to act may be seen as a further barrier to entry in this area.

72. The parties also indicated that competition for contract renewals was limited by an incumbency advantage that arises from the disruption that installing new facilities may cause. However, an outgoing provider would have the burden of making good any damage caused by removing existing cabling and equipment. The incentive therefore lies with the incumbent to sell on this infrastructure to the new provider if possible.

73. The low infrastructure requirement of Premier's Easitalk terminal and the possible introduction of wireless technology are used as further examples of possibly lower future barriers to switching provider.

74. The OFT considers that barriers to switching, while present, are not necessarily prohibitive to a Trust agreeing to an alternative provider. Indeed, several Trusts raised the possibility of coinciding BECS installation with general refurbishments of wards which would appear further to reduce the disruption of installing BECS. The OFT considers that the negative reputational consequences that would result if an incumbent provider refused to allow another provider to reuse its existing infrastructure would appear a sufficient deterrent to such behaviour. The OFT has been provided with examples where the prior incumbency of a provider and/or its infrastructure has not been a prohibitive barrier to customer switching between providers in the past.

75. Overall, therefore, whilst there appear high barriers to entry into the free-managed BECS model for new providers, barriers to expansion for existing suppliers are not insuperable where there is no existing provider, or where the existing contract has not been fulfilled or is up for renewal. The ability of Trusts to switch between providers represents a clear opportunity for the parties to compete for future contracts.

**Countervailing buyer power**

76. Hospitals selecting a BECS provider may be considered to have buyer power to the extent that either there are (a number of) providers willing to finance free-managed BECS installation (and hospitals are able to switch) or hospitals are able to move to a paid-managed model or indeed forgo BECS installation or renewal entirely. Each of these points has been discussed above. Although some hospitals may be willing to pay for a paid service, and some may be willing not to have a BECS system at all, there are a significant number of hospitals that are (at least at present) realistically reliant on sourcing from a free-managed BECS provider.

77. For the individual patient, buyer power must be considered to be weak, being primarily dependent on whether the patient is able to use personal mobile and handheld devices. This may be the case for mobile phones (depending on hospital policy) but will be less likely to be the case for televisual services. The parties stress that when deciding whether to use the BECS a patient will have a number of non BECS comparators in mind, such as mobile phone charges, DVD rental costs, and Sky charges for TV. If BECS charges are considered to be too high the patient will not use them, or will only use the free radio service. However, overall, patients cannot be said to have buyer power such as to undermine any market power of the merged firm.

**THIRD PARTY VIEWS**

78. The OFT spoke to a number of third party Hospital Trusts and other providers and potential providers. The main points of their comments have been discussed above. Hospital Trusts were divided on whether the proposed transaction caused concerns. Some of those Trusts that said they had no concerns were unaware of the lack of choice in the free-managed sector. Others had no concerns because they saw the merger as a way of ensuring their BECS provider continued to meet existing contractual obligations. Where Hospital Trusts had concerns they were related to performance, reduction in the number of providers and pricing. Indeed, two third parties considered that regulation of prices would be beneficial in the absence of competition.

## COUNTERFACTUAL

79. In order to decide whether the duty to refer applies, the OFT must consider the merger's impact relative to the situation that would prevail absent the merger (that is, the counterfactual).

80. The OFT's general approach is that it relies on pre-merger conditions as the appropriate proxy for the counterfactual and will 'test' the competitive impact of any transaction against such a standard before proceeding to consider whether another counterfactual should be substituted. In general, where the merger raises no concerns relative to pre-merger conditions, nothing will turn on the OFT's adoption of its default counterfactual of pre-merger conditions and there will be no need to consider the detailed factual questions that arise under substitute counterfactuals that, for example, the failing firm defence engages.

81. Where the merger does raise concerns relative to pre-merger, the OFT is slow to clear a transaction based on the 'inevitability' of exit of the target business. That is why, where a seller wishes to exit a market because the relevant business is failing or distressed, the OFT will not lightly depart from judging the impact of such a sale as against pre-merger conditions, and will only do so when it has sufficient compelling evidence that exit is inevitable, in line with the two criteria of the failing firm defence, namely:

    - inevitability of market exit of the firm (or relevant division or business) in question absent the merger, with no serious prospect of re-organisation, and

    - no less anti-competitive alternative to the merger, in other words, that is no realistic acquisition by a less anti-competitive purchaser and no substantially better competitive outcome following failure of the firm in question).[12]

82. In this case, as discussed above, competition concerns do arise on the basis of the pre-merger competition (that is, that both parties were present in the provision of free-managed BECS systems with Patientline's incumbent position being actively challenged by Premier, albeit that [ ].

[12] See further OFT *Anticipated acquisition by Tesco Stores Limited of five former Kwik Save stores (Handforth, Coventry, Liverpool, Barrow-in-Furness and Nelson)* 11 December 2007.

83. In this case, the parties put forward evidence that alternative counterfactuals should be considered to reflect the financial condition of both parties. The condition of each party is discussed below.

**Patientline**

84. Hospedia, the owner of Patientline, is a newly formed entity which acquired the Patientline business from Patientline plc immediately after Patientline plc being placed into administration. [ ].

85. In its original submission to the OFT, Patientline said that absent the merger [ ].

86. [ ].

87. [ ].

88. The parties did not seek to argue that Patientline would have exited the market absent the merger. The OFT accepts the parties' evidence that Patientline was not in a vibrant state prior to the merger, and this has been factored into the competitive analysis set out above. However, given Patientline's installed market share of free-managed BECS services of some 75 per cent, the OFT considers it inappropriate to conclude that Patientline could have not exerted any competitive constraint going forward [ ]. For this reason, the position of Patientline has already been addressed in the decision above and does not warrant the substitution of an alternative counterfactual at this point.

**Premier**

89. [ ].

90. [ ].

91. [ ].

92. [ ].

93. [ ].

94. [ ].

95. [ ].

96. [ ].

97. [ ].

98. [ ].

99. [ ].

100. [ ]

101. [ ]

102. [ ].

103. [ ].

104. [ ].

105. [ ].

106. [ ].

107. [ ].

108. [ ].

**ASSESSMENT**

109. The parties overlap in the provision of free-managed BECS to Hospital Trusts.

110. The OFT has examined the scope for adverse merger effects in relation to three 'contestable markets' - (i) Hospital Trusts without a contract for BECS terminals, (ii) Hospital Trusts that have awarded a contract or preferred supplier status, but where the contract has yet to be fulfilled, and

(iii) Hospital Trusts whose BECS contract is coming up for renewal. BECS suppliers negotiate individual contracts with hospitals, allowing them to price discriminate according to the relative strength of that customer's outside options (for example, self-supply of BECS, or foregoing BECS entirely).

111. Although Patientline [ ], the OFT considers that Premier and Patientline should nevertheless be considered each other's closest competitors for each of these contestable markets going forward, and that the merger will consequently remove the competition that would have been expected to exist for installation of new terminals absent the merger.

112. Although there are other providers of free-managed BECS services, these are not expected to be of equivalent competitive strength given that they lack Patientline's incumbency position and do not appear to be a dynamic current competitor (as Premier).

113. In addition to competition for the placement of additional, or replacement, BECS terminals, there is also some limited evidence that the existence of another competing provider may constrain the pricing of installed providers by existing providers competing to avoid being publicly regarded as the highest priced supplier (and hence attracting potentially damaging publicity).

114. The parties have stressed that Trusts have highlighted the importance of the free-managed business model, but that this is inherently difficult to make profitable.

115. Given that both Premier and Patientline have been loss making (Patientline having been bought out of administration in August 2008 by Hospedia) the parties argue that in the absence of the transaction [ ]. The parties consider that the merger will maximize the chances of retaining the free-managed business model, as well as improving services and reducing prices for patients.

116. The OFT acknowledges that there is evidence that the parties have struggled to be profitable based on their free-managed business models. However, it does not follow from this that a merger between them would not be capable of leading to a substantial lessening of competition given the priority a significant number of hospitals currently attach to acquiring

BECS services on a free-managed basis. [ ]. However, it remains realistic [ ] that Patientline would seek to compete in the future given its incumbency strength. In addition, it is reasonable to consider that some degree of competitive pressure may be being placed on Patientline by Premier as a result of Premier's efforts to take share from Patientline, which would be lost by the merger.

117. The OFT, therefore believes that it may be the case that the merger will give rise to competition concerns based on the pre-merger conditions of competition. The parties submitted an alternative counterfactual, as discussed above. The OFT has carefully examined all the available evidence presented by the parties, but has concluded that it is unable to dismiss the realistic prospect that, [ ].

118. The parties made no offer of suitable undertakings in lieu of reference in this case.

119. Consequently, the OFT believes that it may be the case that the merger may be expected to result in a substantial lessening of competition within a market or markets in the United Kingdom.

**DECISION**

120. This merger will therefore be referred to the Competition Commission under section 33(1) of the Act.