

# 2 Conclusions

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## The references

2.1. On 12 June 2000 the Secretary of State, acting under the merger provisions of the Act, referred to us the proposed acquisition of CHG by BUPA. On 8 August 2000 he made a related reference concerning the acquisition by SBUIKE, a subsidiary of SIL, of 26.8 per cent of the ordinary share capital in CHG. Our report deals with both references (see Appendix 1.1).

## The companies concerned

### BUPA

2.2. The history and activities of BUPA, a provident association, are set out in paragraphs 3.25 to 3.104. It is the largest provider of PMI in the UK with a market share by sales value of about 40 per cent. It is also the second largest provider of PMS, with a UK market share of about 17 per cent. BUPA also has several subsidiaries that provide nursing home and healthcare services in the UK and overseas.

2.3. BUPA's corporate structure is shown at Appendix 3.4. It is a private company, limited by guarantee, and with no share capital. It has no access to equity funding and finances its acquisitions from the trading or investment profits it realizes or from external borrowing. Each of its divisions is operated as a separate profit centre.

2.4. BUPA's financial position is described in Chapter 3. In 1999, it reported an operating surplus before tax of £47 million on a turnover of £1,905 million and had net assets of £737 million. It told us that over the last five years it had spent about £726 million on acquiring new businesses (in part related to the acquisition of hospitals from Goldsborough in 1997 for £40 million (see paragraph 2.13). As a result of the acquisitions the value of assets held as hospitals, care homes and equipment had increased from £362 million in 1995 to £1048 million in the year ended 31 December 1999. BUPA told us that it expected its operating surplus before

tax to [ *Details omitted. See note on page iv.* ] (see paragraph 3.102).

## **CHG**

2.5. CHG's history and activities are described in paragraphs 3.105 to 3.127. CHG, a publicly-quoted company, is the fourth largest PMS provider in the UK by bed capacity (see Table 4.4) and the fifth largest by sales value, with a market share of about 5 per cent.<sup>1</sup> It has a range of healthcare businesses. In its last financial year CHG made operating profits of £22.8 million and pre-tax profits of £19.4 million. Its market capitalization at 27 October 2000 was £188.3 million (see paragraph 3.105).

## **SIL and SBUKE**

2.6. SIL is a wholly-owned subsidiary of Citigroup Inc, of New York. It owns [ 30 ] per cent of SBUKE, whose principal activities are those of a dealer and market maker in UK equities and related contractual products. On 5 May 2000, under an agreement with a BUPA subsidiary, BUPA Finance Plc, SBUKE acquired 26.8 per cent of the ordinary share capital of CHG. In paragraphs 2.13 to 2.25 we set out the circumstances that led to the acquisition.

## **The terms of reference**

2.7. Under the reference made to us on 12 June 2000, we are required to investigate and report whether arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a merger situation qualifying for investigation as defined in the Act in that:

- (a) enterprises carried on by or under the control of BUPA will cease to be distinct from enterprises carried on by or under the control of CHG; and
- (b) the value of the assets taken over exceeds £70 million ('the assets test') or the share of supply test, set out in section 64(2) and (3) of the Act, is satisfied.

2.8. Section 63(2) of the Act defines 'enterprise' as the activities or part of the activities of a business. Section 65 of the Act specifies the circumstances when two enterprises are to be regarded as ceasing to be distinct. One of the circumstances is where they are brought under common ownership or control.

2.9. If we find that such arrangements are in progress or contemplation, then we are further required by our terms of reference to consider whether the creation of the merger situation may be expected to operate against the public interest.

2.10. Under the reference made to us on 8 August 2000, we are required to investigate and report whether a merger situation qualifying for investigation as defined in the Act has been created in that:

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<sup>1</sup>HCA UK Holdings Ltd (HCA(London)), the fourth largest PMS provider by sales value, has a UK market share of 8.1 per cent, but operates solely in London (see glossary).

- (a) enterprises carried on by or under the control of SIL have, within the four months preceding the date of the reference, ceased to be distinct from enterprises carried on by or under the control of CHG;
- (b) enterprises carried on by or under the control of BUPA and SIL have, within the four months preceding the date of the reference, ceased to be distinct from enterprises carried on by or under the control of CHG; and
- (c) in either case the assets test or share of supply test is satisfied.

2.11. In respect of this reference, too, if we find that a merger situation has been created, then we are further required by our terms of reference to consider whether the creation of the merger situation operates or may be expected to operate against the public interest.

2.12. Both references require us to exclude from our consideration either the assets test or the share of supply test if we find the other is satisfied.

## **Background**

2.13. In 1997 BUPA sought to acquire Goldsborough, a PMS provider, which in turn had a 21 per cent shareholding in IBH, another PMS provider. The merger with Goldsborough was cleared by the Secretary of State subject to the undertaking (which remains in place) that BUPA should divest, and not in the future acquire directly or indirectly, any interest in IBH or any interest in any company having control of IBH. It was also a term of the undertaking that BUPA would not ‘... participate in formulation or making of, or influence or attempt to influence, the policy of IBH, whether directly or through any person having control of IBH’.

2.14. IBH was acquired by CHG in February 1998.

2.15. CHG told us that in December 1999 it had decided to put itself up for sale. In the recent past its efforts to expand by acquisition of healthcare groups had been thwarted twice and this failure coincided with informal approaches it had received from private healthcare groups. Its rate of earnings growth had been slowing over the last few years, reflecting the maturity of the market. Shareholders’ expectations were for growth of the order of 15 per cent a year, which could not be achieved without expanding the business. The problems associated with its share price had become particularly acute towards the end of 1999 and it had reached the conclusion that shareholder value would be served best by CHG being sold (see paragraph 5.100). Early in April 2000 an informal tendering exercise had been carried out by CHG’s financial advisers, Granville Baird. BUPA had made the best offer.

2.16. BUPA retained J Henry Schroder & Company Limited (JHS) to take the matter forward (with a success fee of £[ 3 ] million).

2.17. On 25 April 2000 BUPA filed a merger notice with the Office of Fair Trading (OFT) and at the same time formally applied for the undertaking (see paragraph 2.13) to be lifted.

2.18. On 28 April 2000 the BUPA board met to discuss bidding tactics. JHS, which had been one of BUPA’s financial advisers for several years, was present. The board was told that General Health Care Group (GHG), one of BUPA’s main competitors in the PMS market (see paragraph 3.130), was a potential bidder for CHG, capable of countering BUPA’s offer. BUPA was itself unable to buy shares in CHG because the undertaking was still in force.

2.19. Hence the board considered an arrangement proposed by BUPA’s legal advisers which the advisers believed would avoid a breach of the undertaking. Counsel’s opinion had been sought, which confirmed this understanding. Under the arrangement, JHS would purchase

shares in CHG, with finance lent by BUPA Finance and with BUPA assuming all economic risk. JHS would retain full discretion over any CHG shares it acquired.

2.20. The BUPA board discussed the risks and benefits of this arrangement. [

*Details omitted. See note on page iv.*

]

2.21. BUPA told us that it had not expected its bid for CHG to be referred to us. It had believed that the OFT would call for undertakings in lieu to be agreed. It was within this context that it had decided to enter into the proposed arrangement with JHS (see paragraph 5.15).

2.22. At this time JHS was about to become a subsidiary of SIL (as part of an acquisition by the Salomon Smith Barney (SSB) unit of Citigroup of substantial elements of Schroder plc that had been agreed earlier in the year) and so it was decided that it would be inappropriate for JHS to be a party to the arrangement. Instead, SBUKE, a SIL subsidiary (and hence a sister company of JHS) was chosen to be the other party to the arrangements with BUPA Finance.

2.23. SIL, JHS and SBUKE<sup>1</sup> each trade under the name Schroder Salomon Smith Barney (SSSB). We use SSSB not only to refer to the trading name but also to describe these companies collectively.

2.24. SSSB told us that the reasons SBUKE, rather than another investment house, had been chosen to facilitate the arrangement included:

- (a) the need for speed and confidentiality;
- (b) the fact that the rules of the Takeover Panel precluded any company entering into such an agreement for profit; and
- (c) the fact that other companies would not have been interested in the commission and costs-only fees arranged.

2.25. On 28 April it was announced that BUPA would be bidding for the entire share capital of CHG at £6.50 per share.

### ***The loan agreement between BUPA Finance and SBUKE***

2.26. An agreement signed on 5 May 2000 gave effect to the proposals for SBUKE to purchase shares in CHG. Under the agreement:

- (a) BUPA Finance agreed to make an interest-free loan facility of up to £70 million available to SBUKE. The purpose of the loan facility was declared to be the purchase of shares in CHG.

(b) [

*Details omitted. See note on page iv.*

]

- (c) The loan would be discharged by SBUKE paying BUPA Finance the total proceeds of disposal of the CHG shares less any expenses incurred, less the commission due to

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<sup>1</sup>And a company in the group named Salomon Brothers International Limited.

SBUKE and less the cost of capital payment, plus an amount equal to any distribution received. BUPA Finance would not have any other recourse against SBUKE for repayment.

- (d) BUPA Finance acknowledged that it would have no interest in the shares acquired nor any entitlement to exercise any right, nor to control the exercise of any right, in respect of such shares and that SBUKE, as the legal and beneficial owner of the shares, would be free to deal with the shares acquired using the loan facility and to exercise rights in respect of those shares, as 'it may in its absolute discretion determine'. There was no requirement for SBUKE to notify BUPA Finance of its actions in relation to the shares.
- (e) BUPA Finance agreed to indemnify SBUKE and other companies in the group against loss and liabilities.

2.27. SSSB's offer document subsequently issued to CHG shareholders disclosed that the loan facility was structured so that BUPA Finance bore all the risk and received all the benefits from the shares.

2.28. On 5 May 2000 SBUKE, in accordance with the agreement, acquired 26.8 per cent of the ordinary share capital of CHG just over three months before the reference to us. On 24 May 2000, JHS (under the trading name SSSB), on behalf of BUPA Finance, made a public offer for all the CHG shares of 650p in cash (or a loan notes alternative) for each ordinary share held. It was a term of the offer that it would lapse if the proposed merger were referred to us before 3 pm on 14 June 2000. The merger was referred to us on 12 June 2000, hence the offer lapsed on that date.

## **The assets test**

2.29. The terms of both references require us (see paragraphs 2.7(b) and 2.10(c)) to establish the value of the assets to be taken over. Appendix 3.12 shows that the gross value of CHG's assets at 30 June 2000 was £269 million. We are therefore satisfied that the value of the assets taken over, assessed in accordance with section 67 of the Act, is above the £70 million threshold set for the assets test. We therefore find that the assets test is satisfied and in accordance with our terms of reference we exclude the share of supply test from consideration under both references.

## **Merger situations qualifying for investigation**

### ***The proposed merger of BUPA and CHG***

2.30. We have seen that, on 28 April 2000, BUPA announced a public bid for the entire issued share capital of CHG and that an offer document was posted on 24 May. The offer lapsed when the proposed merger was referred to us on 12 June but BUPA told us that it wished to renew its bid and proceed with the merger if permitted to do so on terms acceptable to it (see paragraph 3.24). We are satisfied therefore that under this reference arrangements are in progress or in contemplation which, if carried into effect, would result in the creation of a merger situation qualifying for investigation.

### ***Possible existing merger situation involving CHG and SIL***

2.31. Section 65(3) of the Act provides that a person or group of persons able, directly or indirectly, to control or materially to influence the policy of a body corporate, or the policy of any person carrying on an enterprise, but without having a controlling interest in that body corporate or in that enterprise, may for the purposes of section 65(1) and (2) be treated as having

control of it. The provision confers on us a discretion to treat or not to treat a person who has the ability materially to influence the policy of a body corporate (but without having a controlling interest) as having control of it for the purposes of section 65(1) and (2).

2.32. SSSB told us that it recognized that a shareholding of more than 25 per cent would ordinarily be regarded as conferring the ability to exercise material influence over policy, on the grounds that it enabled the shareholder concerned to block a special resolution. On that basis SSSB accepted that, in theory, SBUKE's 26.8 per cent shareholding might confer the ability materially to influence the policy of CHG. SSSB suggested, however, that in considering whether this stake conferred the ability to exercise material influence over policy, it was necessary to consider not simply the theoretical ability to block special resolutions, but the likelihood of CHG needing to propose special resolutions during the expected period of SBUKE's ownership of the stake. SSSB further suggested that it was unlikely that CHG would need to propose special resolutions during the expected lifetime of SBUKE's holding in CHG other than on matters of a purely routine nature, such as the annual disapplication of pre-emption rights sought by most listed companies (see paragraphs 5.162 and 5.163).

2.33. We do not accept these suggestions. As the MMC said in relation to material influence in its report on the Swedish Match/Gillette merger:<sup>1</sup>

It is not necessary for there to be evidence that the ability materially to influence the policy has been exercised or even that it is intended to be exercised, but it has to be concluded the ability materially to influence policy exists. Material influence is not defined in the Act, so the particular circumstances have to be considered in each case.

2.34. We consider that SBUKE's ability to block a special resolution is sufficient to justify a finding that it has the ability materially to influence the policy of CHG.

2.35. Furthermore, we consider that SBUKE's ability to influence the policy of CHG is not limited to its power to block special resolutions (see paragraphs 3.19 to 3.22). As at 26 October 2000 SBUKE had a 26.8 per cent shareholding, making it the largest shareholder in CHG. The next largest shareholder held around 7 per cent; only another six investors held more than 2.5 per cent (see Table 3.1). We consider that with this spread of holdings, SBUKE would be able to affect CHG's ability to pass an ordinary resolution. Accordingly, we find that SBUKE and hence SIL are able materially to influence the policy of CHG.

2.36. SSSB invited us, in the event of SBUKE being regarded as having the ability materially to influence the policy of CHG, to exercise our discretion so as not to treat this as control (see paragraphs 5.166 and 5.167). SSSB referred us to the Mid Kent report<sup>2</sup> where the MMC decided not to treat a company with such ability as having control. SSSB said that because 'it was no part of SBUKE's plan to exercise control over CHG' we should not treat it as having control. However, as stated in paragraph 2.41 of the Mid Kent report, the circumstances in that case were very special. We consider that SBUKE's ability to influence the policy of CHG is a matter worthy of further investigation under our terms of reference.<sup>3</sup> For that reason we consider that we should find that SBUKE and hence SIL has control.

2.37. We have decided that SBUKE's influence over the policy of CHG should be treated as control. We have found that SBUKE acquired its holding in CHG within four months of the reference having been made, and therefore obtained its influence within that period. We have found that the assets test is satisfied. We conclude, therefore, that a merger situation qualifying

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<sup>1</sup>*Stora Kopparbergs Bergslags AB/Swedish Match NV, and Stora Kopparbergs Bergslags AB/The Gillette Company: a report on the merger situations*, HMSO, Cm 1473, March 1991.

<sup>2</sup>*Mid Kent Holdings plc and General Utilities PLC and SAUR Water Services plc: a report on the proposed merger*, The Stationery Office, Cm 3514, January 1997; paragraph 2.40.

<sup>3</sup>This approach was adopted by the House of Lords in interpreting 'substantial part of the United Kingdom' in *R v MMC ex parte South Yorkshire Transport Limited* (1993 1 WLR at page 32B).

for investigation has been created as a result of the enterprises carried on by or under the control of SIL having, within four months preceding the date of the reference, ceased to be distinct from enterprises carried on by or under the control of CHG.

### ***Possible existing merger situation involving BUPA, CHG and SIL***

2.38. Section 77 of the Act provides that, for the purpose of determining under section 65 whether any two enterprises have been brought under common control, ‘associated persons’ are to be treated as one person. The section goes on to provide that ‘two or more persons acting together to secure or exercise control of a body corporate’ are to be regarded as associated with one another.

2.39. BUPA said that the arrangements between BUPA and SBUKE were intended to assist a possible future acquisition of control of CHG by BUPA once it was released from the IBH undertaking. It told us that it was normal practice for a bidder to attempt to acquire a blocking stake in the market, and that, but for the undertakings, BUPA would have been free to do so. A release from the undertaking would enable BUPA to seek control of CHG. Hence the arrangement with SBUKE had to be distinguished from arrangements whereby persons acted together to ‘secure control’.

2.40. SBUKE said it accepted that it and BUPA could be regarded as having acted together in formulating arrangements under which SBUKE purchased shares in CHG, but it was clear from the terms of the agreement with BUPA Finance that there was no continuing co-operation between them in relation to the manner in which voting rights attaching to those shares were to be exercised. It said the fact that, for the purposes of the City Code on Takeovers and Mergers (the Code), SBUKE and BUPA were concert parties was irrelevant to the question of whether they were associated persons for the purpose of the Act. SBUKE and BUPA fell within the Code’s definition of a concert party because of the advisory relationship between JHS and BUPA and because the acquisition of shares in CHG by SBUKE was intended to protect BUPA’s offer for CHG.

2.41. We believe that SBUKE would not have acquired the shares in CHG if the loan had not been available and BUPA had not been taking all the economic risk. BUPA incurred heavy costs under the arrangements. BUPA and SBUKE must each have had an expectation that SBUKE would retain the shares until after the competition authorities had reached their conclusions and that must have been the commercial reality of the arrangement. This is reinforced by the relationship between JHS and SBUKE. It would have been surprising if one part of the corporate group (JHS) was trying to bring about the merger while another part (SBUKE) was making it less likely to come about by selling the shares. Indeed SBUKE told us that, subject to its principal concern to safeguard the reputation of SSSB, SBUKE would not wish to acquire a reputation for acting in a manner wholly at variance with the interests of a client of another SSSB company.

2.42. We conclude that BUPA and SBUKE should be regarded as acting together to secure control of CHG when they entered into the agreement. We also conclude that BUPA and SBUKE should be regarded as continuing to act together to secure control of CHG. This is because the loan is still in place and SBUKE is still holding the shares. The arrangements between BUPA Finance and SBUKE have not changed since they entered into the agreement. Furthermore the parties continue to have the expectation that SBUKE will retain the CHG shares until the competition authorities have reached their conclusions and beyond (see paragraphs 5.174 to 5.179).

2.43. We conclude, therefore, that BUPA and SBUKE are associated persons. We must, therefore, treat BUPA and SBUKE as one person for the purposes of section 65 of the Act. We have already found that, as a consequence of SBUKE's purchase of 26.8 per cent of the share capital of CHG, there is a merger situation qualifying for investigation between SIL and CHG (see paragraph 2.37). We therefore find that a merger situation qualifying for investigation has been created as a result of the enterprises carried on by or under the control of BUPA and SIL within four months preceding the date of the reference having ceased to be distinct from enterprises carried on by or under the control of CHG.

## **The markets affected**

2.44. The competition authorities have investigated the PMI and PMS markets several times in recent years (see Appendix 4.1). In 1990, the MMC reported on BUPA's acquisition of HCA United Kingdom Ltd<sup>1</sup> (the 1990 report) and in 1994 on consultants' fees<sup>2</sup> (the 1994 report). Since then there have been several important changes in both markets. The OFT reported on PMI in 1996 and 1998, and undertook a review of some aspects of the PMI and PMS markets in 1999. We begin this section by describing and defining these markets, and later in the chapter we describe the main changes that have taken place, and the effects of these changes on the proposed BUPA/CHG merger.

### **Private medical services**

#### ***PMS providers***

2.45. In the UK there are 216 private acute hospitals.<sup>3</sup> About two-thirds of them belong to five large hospital groups: GHG (see paragraph 2.18) owned by BC Partners, a venture capitalist group; Nuffield Nursing Homes Trust (Nuffield), a charity; BUPA's hospital business (BUPA PMS); CHG; and HCA(London). In this report we are concerned with PMS competition in the UK market but (for reasons explained in paragraph 2.71) we regard London as a separate market segment.

2.46. Only four PMS providers have a presence throughout the UK: they are GHG, BUPA PMS, Nuffield and CHG. These, in that order, are the largest PMS providers measured by capacity (see paragraph 4.130). Measured by 1998 revenues HCA(London) is larger than CHG, but all its hospitals are within London. On the other hand, all the BUPA PMS, CHG and Nuffield hospitals are outside London, as are all but three of those of GHG. In discussing competition at the national level we frequently find it necessary to refer, collectively, to these four groups (GHG, BUPA PMS, Nuffield and CHG) and so for convenience we describe them as 'the four national PMS providers' throughout our report.

2.47. Apart from the four national PMS providers and HCA(London) there are around 70 independent hospitals, some belonging to smaller PMS provider groups and many run by charitable, often religious, organizations. We refer to these hospitals as 'the independents'.

2.48. Table 2.1 shows the UK distribution by share of revenue, number of hospitals and number of beds of each of GHG, BUPA PMS, Nuffield and CHG.

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<sup>1</sup>*The British United Provident Association Ltd and HCA United Kingdom Ltd: a report on the merger situation*, HMSO, Cm 996, March 1990.

<sup>2</sup>*Private medical services: a report on agreements and practices relating to charges for the supply of private medical services by NHS consultants*, HMSO, Cm 2452, February 1994.

<sup>3</sup>Excluding psychiatric hospitals and those dealing solely with pregnancy termination or cosmetic surgery.

TABLE 2.1 **The four national PMS providers by share of UK revenue, 1998; number of hospitals and beds, 1999**

<i>Operator</i>	<i>Share of revenue %</i>	<i>Number of hospitals</i>	<i>Number of beds</i>
GHG	20.1	40	2,146
BUPA PMS	17.4	36	1,808
Nuffield	11.7	40	1,617
CHG	<u>5.1</u>	<u>22</u>	<u>843</u>
Total	54.3	138	6,414

*Source:* CC based on information from PMS providers.

2.49. Private patients also receive treatment in dedicated Private Patient Units (PPUs) established within NHS Trust hospitals. There are just under 100 PPUs in the UK, representing about 18 per cent of the PMS market (by value), and accounting for about 1,500 beds. Another 1,500 or so pay-beds are available in NHS public wards when not required by the NHS.

2.50. Most of the treatment that private patients receive in private acute hospitals is undertaken by consultants (see paragraph 4.21). It is rare for a consultant to be employed by a private hospital. Virtually all consultants who have the right to admit patients to such hospitals hold, have held, or are qualified to hold, consultant appointments in NHS hospitals, and under the terms of their NHS contracts are able to undertake private practice in varying degrees. The nature of this arrangement restricts the days and times that consultants are able to devote to private practice, and hence the ability of private hospitals to maximize bed occupancy, and use of operating theatres and consulting rooms. Around 70 per cent of the 23,000 or so consultants practising in the UK, but particularly surgeons and anaesthetists, undertake private practice.

### ***Utilization of hospitals***

2.51. Some of those that gave evidence to us, for example PPP Healthcare Group (PPP), the second largest PMI provider (see paragraph 4.96), and Medisure, a Third Party Administrator (TPA—see paragraph 4.59), suggested that there was excess capacity in the PMS market. Medisure and others told us, for example, that private acute hospitals were much underused, especially in the evenings, weekends and holiday periods, and that there was a clear potential for achieving far higher levels of activity. The traditional measure of PMS capacity usage has been overnight accommodation ‘occupancy levels’, expressed as a percentage of available beds across a seven-day week. On this basis, the average occupancy (capacity usage) is currently just under 50 per cent.

2.52. Others (including BUPA) told us that there was not much excess capacity in the PMS market and that ‘occupancy level’ was not of itself a useful or meaningful indicator of capacity utilization. BUPA said that in large part this was because the measure failed to take account of the inevitable restrictions on evening, weekend and holiday work described in the previous paragraph; the need for private hospitals to be able to offer treatment without delay; and the dramatic shift from inpatient to day-case work (see paragraph 4.126). BUPA estimated that private hospital occupancy was as much as 75 per cent when measured using ‘effective patient days’, which took into account day-case patients, which it said was much closer to the maximum levels of occupancy a private hospital could sustain (ie full capacity). BUPA said that even using the traditional ‘occupancy level’ measure the break-even level was about 40 per cent or so, suggesting that, on average, private hospitals were performing reasonably efficiently.

2.53. For the purpose of our inquiry, we do not consider it necessary to take a view on whether or not there is significant excess capacity in the PMS market. We note, however, that there has been a net reduction in capacity in recent years, in part reflecting hospital closures (see paragraph 4.128). We note also that the average ‘occupancy level’ is said to be just under 50 per cent and that part of the rationale for the introduction of hospital ‘networks’ (see paragraphs 2.59 and 2.60) was to improve capacity utilization within hospitals included in the network, and thereby drive down average fixed costs. For hospitals not in a network, however, the effects on capacity utilization are likely to be adverse (see paragraph 2.141).

## **Private medical insurance**

2.54. Demand for PMI in the personal sector expanded in the early 1990s but the steep increase in premiums, the ending of tax relief on premiums for the over-60s in 1997, and the introduction of insurance premium tax (IPT), have contributed to a reduction in numbers in the late 1990s; individual subscribers to PMI are now nearly 9 per cent fewer than in the peak year of 1996. There has been some offsetting growth in corporate sector subscribers, however, with the result that the total number of subscribers increased by about 5 per cent overall during the 1990s. In 1999 it was estimated that there were nearly 3.5 million subscribers to PMI policies, covering 6.4 million people (just under 11 per cent of the UK population). Outside London three-quarters or more of private patients were covered by PMI; the rest were self-payers, whose numbers have risen in recent years as premiums have increased. There were marked regional variations—subscriber numbers were heavily weighted towards the South-East of England. The treatment of about two-thirds of subscribers<sup>1</sup> was paid for by corporate PMI schemes.

2.55. For the PMI providers, on the other hand, there has been substantial growth in revenue, both in nominal and real terms over this period, with total subscriptions doubling to £2.3 billion in 1999. The PMI providers told us that this largely reflected increases in the cost of PMI premiums, which had risen to meet the greater frequency of claims and rising hospital costs (caused partly through advances in medical technology).

2.56. Some large companies choose to meet the costs of their employees’ private medical cover directly rather than through PMI. They may simply process any claims themselves and pay the expenses directly, or they may use a TPA to undertake the administration work, including the authentication of claims and any costs incurred, and either fund the risk themselves or pay the TPA to arrange underwriting.

## ***PMI providers***

2.57. Until the 1990s, PMI was provided almost exclusively by provident associations.<sup>2</sup> In 1999, by far the largest PMI providers by sales value were BUPA’s PMI business (BUPA PMI) (40.1 per cent) and PPP (29.1 per cent). Other providers with a market share of more than 2 per cent by value were: Norwich Union Healthcare Limited (Norwich Union) (7.6 per cent); Standard Life Healthcare Limited (Standard Life) (6 per cent); Western Provident Association Limited (WPA) (4.6 per cent); Royal & Sun Alliance Insurance plc (RSA) (4.4 per cent); and Bristol Contributory Welfare Association Limited (BCWA), (2.0 per cent). The market shares of the PMI providers in 1990, and from 1995 to 1999, are set out in Table 4.2.

2.58. PPP, which was formerly a provident association, is now owned by AXA UK plc, although it still trades under the well-established PPP brand name in the PMI market. Norwich Union started its PMI business in 1990; Standard Life’s PMI business (formerly named Prime

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<sup>1</sup>‘Subscribers’ is a misnomer in this sense as it is the company that pays the subscription.

<sup>2</sup>See glossary.

Health Ltd) has been established for 13 years; and RSA bought Mutual of Omaha in 1989. WPA and BCWA are long-established provident associations.

### ***PMI products***

2.59. There are a wide variety of PMI policies available, with a complexity of cover provisions. One group of policies offers full, or virtually full, cover, range and choice (within which there may be different price ‘bands’ of accommodation). In recent years, and in response to rising premiums, PMI providers have developed lower-cost policies with more restrictions attached to them. These more restricted policies chiefly fall into two categories. The first limits cover for the types of treatment available (for example, no cover for outpatient treatment, or for treatment that can be obtained through the NHS within a specified period). Some of these policies offer greatly reduced rates if the subscriber accepts an excess on the amount payable by the PMI provider. The second category limits the hospitals at which subscribers may choose to receive their treatment; these policies are generally referred to as ‘network’ policies.

2.60. The introduction of network policies by BUPA, PPP, and also, though to a lesser extent, Norwich Union, Standard Life and RSA, has been one of the most significant developments in the PMI and PMS markets in recent years, and is of importance to our inquiry. It is clear that networks have become, and are likely to remain, an important feature of both the PMI and PMS markets. The extent of penetration of network products is significant. Around [ 30 ] per cent of BUPA’s policy-holders are on network products and over 90 per cent in the case of PPP. Other PMI providers (Norwich Union, Standard Life and RSA) also have partial networks at present and seem likely to develop fully national networks in the coming years. We return to hospital networks later in the chapter when we discuss competition in the PMS and PMI markets.

2.61. In 1999, BUPA PMI offered four policies to new personal subscribers. These are described in paragraph 4.79. Broadly speaking two of the policies are of the first type described in paragraph 2.59, offering full or near full cover at hospitals on BUPA’s approved list. The other two were network policies, offering cover only for hospitals in the BUPA hospital network (see paragraphs 2.137 and 2.138).

### **Characteristics of the PMI and PMS markets**

2.62. The PMI and PMS markets are characterized by unusual features and market imperfections, which have an effect on competition. The most obvious feature is the existence of the NHS, free at the point of treatment, and with nearly 15 times more beds than those available within the PMS market. Many patients who might otherwise use the NHS choose to pay for PMS because of the relative advantages it offers, chiefly because of NHS waiting lists for elective surgery but also for the reasons of convenience, personal preference and amenity. However, the availability of the NHS may have the effect of limiting the level of PMI premiums.

2.63. An unusual feature of both markets is that most insured patients are not directly involved with payment for their treatment. Individual subscribers have to pay their full PMI premiums, but for those insured under corporate schemes the employer’s contribution constitutes a taxable benefit, and the tax charge to the employee is at most only 40 per cent of that amount. Moreover, for all subscribers the larger PMI providers have arrangements with PMS providers, and consultants, for direct billing. Thus subscribers in the personal sector, and employees who enjoy the benefits of PMI cover under a corporate scheme, are generally not price sensitive to the cost of their treatment, and unlikely to switch provider frequently. We were told that corporate demand for PMI was marginally more responsive to price signals than the personal sector (albeit still price inelastic).

2.64. Also unusual in the PMS market is the influence of third parties—in this case general practitioners (GPs) and consultants. We were told that a patient usually accepts the advice of the GP, or consultant recommended by the GP, when choosing the hospital at which treatment is to be undertaken. Furthermore, the patient is dependent on the consultant as to the appropriate treatment, and length of hospital stay that is necessary. However, the introduction of network policies has limited the choice of the hospital—giving the PMI provider a far greater say in the matter and the consultants commensurately less.

## **Market definition**

2.65. We first consider whether there could be a single economic market incorporating PMI, PMS and consultants' services. For that to be so the various services would need to be seen as economic substitutes: consumers might reasonably be expected to switch between them in response to price signals or suppliers could quickly move from one to the other. We do not believe that either of these is the case, because of major differences in demand characteristics and in supply arrangements. We regard PMS and consultants' services as falling in separate markets, providing independent services but with close links between them. We also see PMI as having strong vertical links with both PMS and consultants' services. Accordingly, we see PMI, PMS and consultants' services as being separate but complementary.

### ***Definition of the PMS market***

#### *Scope of services and range of suppliers*

2.66. A reasonable definition of the scope of services of the PMS market might reflect the range of treatment covered by PMI. This would exclude specialized medical services (for example, psychiatric treatment) and be based on privately paid-for hospital services relating to elective treatment of acute medical conditions (see paragraph 4.64).

2.67. We then need to address whether services provided in NHS-owned hospitals should be included in addition to those in private acute hospitals. As regards the free services provided by the NHS we take the view that although they provide an element of price constraint, the willingness of consumers to pay an extra charge for private healthcare indicates that the free services fall in a different market. None of the parties suggested otherwise. We now have to consider the position of the PPUs and NHS pay-beds. All the parties said that we should not differentiate between private acute hospitals and PPUs. BUPA told us that as PPUs had been set up using the NHS infrastructure they had lower costs of entry and could operate more profitably on a smaller scale than other operators. Other parties replied in similar vein. We take the view that, whatever the competitive strength of the PPUs, there is no reason to exclude them from the market provided that in each case their facilities are available to private patients on a full-time basis. We do not believe, on the other hand, that NHS pay-beds are close substitutes for private hospital facilities (see paragraph 4.65), and we do not therefore include them within the PMS market.

#### *The geographic market for PMS*

2.68. We now turn to the geographic definition of the PMS market. Arguments have been put to us that would indicate a national, a regional and a local basis for it.

2.69. Most patients (whether insured or self-payers) do not travel far for their treatment (see paragraph 4.66); and similarly consultants normally operate out of private acute hospitals that are close to the NHS hospital where they are based. (We were told that there was competition

among private hospitals to retain consultants operating locally.) To that extent, there might appear to be a series of local markets for PMS.

2.70. Most parties thought that this was so but said that the market also had a national dimension. Our view, too, was that over the last decade the PMS market has become much more of a national one. We have seen that the four national PMS providers operate hospitals that are widely distributed across the UK (although typically they are clustered around the main centres of population) and that for these PMS providers the pricing of hospital services is largely, although not wholly, determined nationally rather than directly reflecting local market conditions. National price negotiations are conducted by reference to the PMI providers' standard tariffs, or rack rates, from which discounts are negotiated for non-network and network business as appropriate (see paragraph 2.119 et seq). Charges for self-pay patients, too, are often fixed by reference to tariffs set nationally, although the rates are applied more flexibly depending on local conditions (see paragraph 4.139). We believe the PMS market should generally be viewed as national but with local aspects.

2.71. There are also some regional aspects. In particular, for the purposes of our inquiry we consider that London is a distinct and separate segment of the PMS market. This is because of the markedly different market conditions in London compared with other areas of the UK. Many of the large NHS teaching hospitals are located in London, and the PPUs attached to them appear to play a different, and more effective, competition role than do PPUs in other areas. This is partly because of the PPUs' ability to take advantage of the proximity of leading consultants who are based at the teaching hospitals and who bring private patients to the PPUs. These consultants, too, often engage in private practice in one or more of the well-known independent hospitals in London. The higher cost base of these hospitals results, in many cases, in prices well above the average for the UK (so that such hospitals usually appear in the higher price bands of PMI providers' policies). Other distinguishing features of the London market include the substantial proportion of patients from overseas among self-paying patients, many of whom are resident and visiting foreign nationals; different travel patterns and higher disposable income. An indication of the different market conditions in London is provided by the fact that the hospitals of the four national PMS providers are located almost exclusively outside London. BUPA did not agree that London was a distinct market segment. It said that regional factors were not a consideration in the analysis of competition in the PMS market (see paragraph 5.37).

2.72. We considered two other reasons for identifying a regional aspect of the PMS market. First, we were told that private patients requiring certain specialist treatment, for example the more complex heart surgery or cancer care, may have to travel further afield to receive treatment as these specialist facilities do not exist in all private hospitals. Second, some third parties had expressed concern that there would be little effective competition to BUPA across wide areas of the country. We address these matters in paragraphs 2.97 and 2.98.

### ***The PMI market***

2.73. In considering the scope of the PMI market we clearly have to decide which insurance products should be included, but we also have to deal with the existence of self-payers (who may be seen as carrying out a form of self-insurance) and with TPAs. We note that for self-payers the only economic transaction involved is between the self-payer and a PMS provider. We therefore view self-payers as simply those that choose not to buy a PMI product but deal direct with PMS providers. We see the TPA as providing a comparable service with that provided by a direct PMI provider, albeit without underwriting or bearing any of the risks itself. TPAs thus appear to provide an economic substitute for PMI and we therefore include them within our definition of the PMI market.

2.74. As regards the policies themselves, most of those in the personal sector are readily substitutable and we consider that they fall within the same market. There are product differences between personal and corporate policies (the latter tend to be specific to particular requirements) but there is, nonetheless, a high degree of substitutability on the supply side. For that reason we consider that both types form part of the same economic market. All the parties that gave evidence to us agreed. We regard other forms of insurance products such as cash plans, income protection and critical illness policies (see paragraphs 4.56 and 4.57) as complementary to PMI rather than as substitutes. Accordingly, we do not regard them as part of the PMI market.

2.75. As regards the geographical market, we consider that the PMI market is national. Subscription rates do not vary according to locality, and insurers look for the widest possible geographic coverage.

### **Changes in the PMI and PMS markets since 1990**

2.76. As indicated in our earlier description of PMS and PMI (see paragraphs 2.45 to 2.61), several important changes have occurred in these markets during the 1990s. Both the markets have been relatively static and incumbent players and new entrants have tended to concentrate on redistributing market shares rather than on achieving aggregate market growth. The key factor has remained the perceived performance of the NHS. Against this background, we have seen during the decade:

- (a) a fall in market shares of the two largest PMI providers, BUPA and PPP, following the entry of commercial insurers to the PMI market (although not all of the latter remain—see paragraphs 4.93 and 4.94). PPP, now a commercial insurer itself, has recovered its position, but BUPA PMI's share has fallen from 50 per cent in 1990 to about 40 per cent in 1999;
- (b) an increase in the average cost of PMI premiums at roughly twice the rate of inflation, occasioned, we were told by PMI providers, by a large increase in the number of claims, and rising hospital costs—partly as a result of advances in medical technology;
- (c) substantial growth in the self-pay market. The numbers of self-payers now represent on average over 20 per cent of the patients in private acute hospitals; and
- (d) increased concentration among PMS providers and the closure or acquisition of many smaller, independent hospitals. The four-firm (C4) concentration ratio has risen from 44.5 per cent in 1988/89 to 57.3 per cent in 1999, and is far greater if London hospitals are not included.

2.77. Most important of all in the context of the merger have been the growing inter-linkages between the PMI and PMS markets:

- (a) the concentration in the PMS market has enhanced the importance of national price negotiations between the four national PMS providers and PMI providers;
- (b) the introduction of network products by PMI providers in response to rising costs has had important, directional effects through the restrictions imposed on the use of non-network hospitals by subscribers to these policies;
- (c) networks have also led to what has been described as 'consultant drag' (see paragraph 2.141)—as consultants have found it convenient or necessary to treat all their patients (including those on non-network policies) from a base in a network hospital; and

- (d) moves by the major PMI providers to require direct billing from PMS providers rather than patients (see paragraph 2.63) have placed the insurers (rather than subscribers) at the front line in efforts to contain PMS costs and BUPA's Benefit Maxima have emerged as a de facto national yardstick for consultants' fees following the prohibition of publication of the BMA guidelines (see paragraph 4.22).

2.78. BUPA is currently unique in having a presence in both the PMS and PMI markets. Later in the chapter (see paragraphs 2.150 to 2.161) we examine the opportunities that this dual presence affords for the exercise of leverage between the two markets by BUPA.

### ***NHS changes***

2.79. During the last decade there have also been several important changes within the NHS. During the early 1990s there was a marked increase in private acute bed capacity resulting from the development and expansion of NHS PPUs. This was accompanied by greater use of PMS facilities by the NHS itself. PMS providers also entered into agreements with NHS Trusts to build private hospitals in Trust grounds, or to manage PPUs.

2.80. In 1997, the policy emphasis within the NHS shifted towards improving standards and service delivery, and in August 2000 the Government published the NHS Plan, setting out policy objectives that would entail large increases in funding over the next few years and which could have substantial implications for the private healthcare sector. The implications were the subject of an official concordat, signed by the Secretary of State for Health and representatives of the private sector on 31 October 2000. However, we concluded that the effects of the concordat could not be expected to bear on the merger.

## **Competition in the PMS market**

2.81. In considering competition in the PMS market we first looked at the national picture, and we then turned to local and regional competition. We also considered the financial position and business plans of BUPA PMS and of CHG.

2.82. The market is mature and static. Pricing is largely determined at national level as described in paragraph 2.121.

### **Competition at national level**

2.83. BUPA told us that the PMS market was not concentrated. The four national PMS providers (who are also the four largest providers by bed capacity—see paragraph 2.46) accounted for about 54 per cent of PMS market revenues in 1998/99. The rest of the market is fragmented; no other PMS provider—whether a PPU or a private hospital or hospital group—had a share of 2 per cent or more.

2.84. The smaller independent hospitals do not present a significant competitive challenge to the four national PMS providers and we were told that some of these independents were finding it hard to survive. Indeed, as we have described, several independents have closed or been acquired by the larger groups. The pressures on independents have intensified since the introduction of the BUPA PMI and PPP networks which have tended to favour the four national PMS providers at the expense of smaller providers.

2.85. In our view, the principal competitive pressures in the PMS market arise from the nature of national negotiations between PMS and PMI providers. We return to this point later.

The national PMS providers seek to maximize their value to PMI providers by offering wide geographical coverage and a degree of ‘indispensability’ to PMI providers.

## **Competition at local level**

2.86. Competition for PMS at the local level arises out of the interactions between hospitals, consultants, patients and PMI providers. The convenience of the hospital in terms of travelling time is important for both consultant and patient (and for the PMI provider on the patient’s behalf). Hospitals also seek to attract consultants on the basis of the quality of facilities provided. Price is not a significant element in local competition: it is only for a proportion of self-payers that price is determined, at least in part, locally. In considering the effect of the merger we looked at local competition in two ways. We looked for:

- (a) the local areas in which either a CHG hospital was the only one in its area (a ‘solus hospital’) or it would after the merger be the only one except for any BUPA PMS hospitals (a ‘solus situation’); and
- (b) the local areas where the merger would mean a significant reduction in competition.

2.87. The main difficulty in assessing local competition lies in determining the appropriate areas within which the analysis should be conducted. A choice has first to be made between basing the analysis on the areas where patients live and, on the other hand, using areas centred on hospital locations.

2.88. The former has considerable practical difficulties because of the wide dispersion of patients/consultants and the lack of a rationale for determining appropriate areas. BUPA, however, carried out a study of this kind and provided us with the results. Its study concentrated on areas near to the CHG hospitals about which the OFT had raised competition concerns (see paragraph 4.166). The data used were patient discharges at the postal sector level (the areas vary in size, the average being 26 square kilometres). BUPA examined the extent of overlap in each sector between CHG patients from a given hospital and BUPA patients from any nearby hospitals, and in this way sought to build up a picture of the extent to which there was local competition between CHG and BUPA PMS hospitals. However, for the reasons set out in paragraph 4.169, we consider that the study produced some anomalous results. At the same time it was difficult to choose parameters for identifying overlaps that were not arbitrary. We did not therefore think we could rely on this study.

2.89. Instead we carried out our own study using hospital locations as the starting point. The first question was how to identify the appropriate areas. There appeared to be three main possibilities:

- (a) The 1990 report referred to the distance patients were prepared to travel to the hospital and considered that a distance varying between 15 and 20 miles was appropriate; the OFT used a distance of 20 miles.
- (b) A more sophisticated measure of the approach based on patient preferences would be to use isochrones, which measure the time taken to travel to the hospital. This would also take into account consultants’ preferences as regards travel.
- (c) A different approach would be to use the boundaries of the Health Authorities (HA) as that could be said to reflect the referral practices of GPs—we were told by several parties that GPs tended to refer patients to consultants working in the same HA area.

2.90. Another useful source of information is the working patterns of consultants (as between hospitals); this does not provide a measure of an area but may help to indicate whether

neighbouring hospitals should be seen as falling within the same area, ie are in competition with each other. BUPA told us that the most important factors determining local markets were HA boundaries, consultants' working patterns and geography.

2.91. We decided to employ a combination of two of the methods just described, using both isochrones and HA boundaries, to produce alternative versions of the catchment of each CHG hospital. As regards isochrones, we inferred from evidence provided by BUPA PMS, CHG and GHG (see paragraph 4.171) that a 30-minute isochrone would be the most suitable.

2.92. So using both the isochrone and the HA approaches we identified possible catchment areas for each of the 21 CHG private acute hospitals and estimated the proportion of actual CHG discharges that fell within each defined area. The results are shown in Table 4.11. We then selected whichever one (the isochrone or the HA approach) was the better fit for each hospital, but checked the result for consistency with the consultant working pattern statistic. The resulting choice of catchment area for each hospital was then used as the basis both for identifying solus hospitals and solus situations, and also for examining market shares in each case.

2.93. For both solus and market share analysis we also used BUPA PMI and related consultants' working patterns as a check. The data we used were provided by BUPA PMI and related to admissions by 'key' consultants.<sup>1</sup> It showed the proportion of its members being admitted to a given hospital out of the total number treated by those consultants. There are certain difficulties in interpreting these statistics as indicators of competition between hospitals (see paragraph 4.176), but we thought that very high figures could be taken as indicative of a solus position and relatively low figures as indicating competition.

2.94. Using our various sources of information, our conclusion on the solus position (see paragraphs 4.180 and 4.181 for details) was that there would be two CHG hospitals (Duchy, in Truro, and New Hall in Salisbury) that had solus status if more reliance was placed on the isochrone approach and also two hospitals (Duchy and Mount Stuart, in Torquay) if more reliance was placed on consultants' working patterns.

2.95. Our examination of market shares was based principally on discharge data for BUPA PMI subscribers. As these subscribers form around 25 per cent of total private acute hospital patients, they provide a large sample in proportionate terms. While at the same time the fact that the sample comprises only BUPA PMI subscribers may lead to some understatement of the shares of hospitals that are not members of the BUPA PMI network, we do not think that this is such as to invalidate the use of the data. We also took into account in assessing the effects of the merger in each area the data on consultant working patterns as they again provide a cross-check on likely competitive relationships between hospitals.

2.96. Each of the 11 areas where there appeared to be a prima facie case for considering that there might be a reduction in competition is discussed in detail in Appendix 4.5. The results of the analysis (see paragraphs 4.186 and 4.187) are that there are eight areas where there is likely to be, as a result of the merger, a significant overlap between CHG and BUPA PMS hospitals and a relatively large combined market share indicating a likely reduction in competition. These areas are the catchments of the Berkshire Independent (Reading), Euxton Hall (Chorley), Renacres Hall (Ormskirk), Fitzwilliam (Peterborough), Oaks/Springfield (Colchester/Chelmsford), Pinehill (Hitchin), Rivers (Sawbridgeworth) and Rowley Hall (Stafford) hospitals.

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<sup>1</sup>Defined as consultants making at least five admissions to that hospital in the time period (1999/2000).

## Competition at regional level

2.97. As we said in paragraph 2.72, there are two dimensions (the London issue apart) that are involved in a consideration of the geographic effects of competition in the PMS market going beyond the local level. The OFT identified what some parties have called flagship hospitals, ie those possessing an intensive care unit, coronary care and major diagnostic facilities. The OFT said that such hospitals tended to draw patients from a wider catchment area. It identified eight such hospitals, of which five would be owned by BUPA following the merger. However, BUPA, and several third parties including Norwich Union and WPA, said that a hospital might draw from a wider catchment area if it specialized in a particular treatment, but not merely by offering an intensive care unit, coronary care and major diagnostic facilities (see paragraph 4.189). We do not consider that the flagship concept is pivotal to our conclusions.

2.98. The second dimension concerns the effects of the merger on the clustering of BUPA-owned hospitals over wider geographic regions, or swathes of the country. GHG told us that following the merger BUPA would control 'high-activity', cardiac specialist hospitals in the Leeds/Bradford area and have total control of Essex, within the important South-East market (see paragraph 6.14). BCWA was also concerned about these two wider areas. It said that such regional monopolies might be open to excessive charges to competing PMI providers, resulting in increased premiums (see paragraph 6.98). PPP was similarly concerned about Leeds/Bradford and several other regions where it said there would be few alternative providers to BUPA PMS (see paragraph 6.130).

2.99. While these local and regional effects are of significance, we did not find them to be conclusive in terms of our public interest findings on the merger situations before us. As indicated below, we find that the primary effects of the merger occur at the national level.

## The financial performance of BUPA PMS and CHG

2.100. We now turn to the financial performance of BUPA PMS and CHG, which gives some insight into their relative competitive positions, and their efficiency.

### *BUPA PMS's financial performance*

2.101. The profitability of BUPA PMS for 1997 to 1999 is shown in Table 3.5. Overall, revenue has increased from £[ ] million in 1997 to £[ ] million in 1999, partly owing to the acquisition of Goldsborough (see paragraph 2.13). However, the profitability of BUPA PMS has decreased from £[ ] million in 1997 to £[ ] million in 1999. This was because of a [ ] percentage point decline in the operating margin of BUPA PMS from [ ] per cent in 1997 to [ ] per cent in 1999. Part of the decline was because BUPA adopted a new methodology of recharging shared costs to its separate divisions and BUPA PMS was allocated higher central and shared costs (see paragraph 3.78). BUPA told us that prior to the restructure its divisions were set targets only at the pre-interest level.

2.102. BUPA PMS was projected to deliver profits of £[ ] million in 2000, increasing to £[ ] million in 2003. Hospital revenue was projected to grow from £[ ] million in 1999 to £[ ] million in 2003, which equated to a cumulative annual average growth rate of [ ] per cent. Revenue growth was expected to be achieved from a combination of price increases and market share growth. Operating efficiencies were projected to be achieved from further centralization of certain hospital activities and enhancement of electronic methods of communication and activity, resulting in the operating margin improving from [ ] per cent in 1999 to [ ] per cent in 2003 (see paragraph 3.104).

### ***CHG's financial performance***

2.103. Details of CHG's financial performance since 1995 are set out in Chapter 3. In 1997, a strategic change by CHG resulted in the sale of 14 nursing homes and other assets, in order to concentrate on its PMS business. For the financial year ended 30 June 2000, CHG reported turnover of £124 million, an increase of 9 per cent over 1999. Over the same period, operating margins declined by 1 per cent to 18 per cent, chiefly through increases in labour costs. The hospitals it acquired from IBH (see paragraph 2.14) have tended to operate on lower margins than the existing CHG hospitals. This contributed to a small decline in CHG's overall operating margin in 1999 (see paragraphs 3.115 to 3.117).

2.104. CHG told us that its hospitals were the subject of a continuous investment programme to provide for their refurbishment, modernization and upgrading, essentially by making better use of available space and providing more operating theatres and outpatient facilities, and reducing the number of beds (see paragraph 5.128). CHG's past capital expenditure and its forecast capital expenditure for 2001 is set out in Table 3.19.

### ***BUPA's plans for former CHG hospitals***

2.105. In 1999 BUPA Hospitals achieved an operating profit as a percentage of operating revenue of 23 per cent; CHG's margin was 28 per cent (see Table 3.16). BUPA told us that the difference in margins of the two groups did not necessarily reflect a difference in the efficiency of the two businesses. It believed the differences resulted from a difference in case mix (see paragraph 3.134) that led to higher labour costs, and a greater number of high-cost medical procedures undertaken at BUPA hospitals. (By comparison, the operating profits for the other two national PMS providers were: GHG 29 per cent; Nuffield 19 per cent.)

2.106. [

*Details omitted. See note on page iv.*

]

2.107. BUPA told us that it saw CHG as an efficient business, hence its attraction. CHG had an attractive portfolio of hospitals, [

*Details omitted. See note on page iv.*

]. CHG's current standards of quality meant that it could be assimilated reasonably easily into BUPA PMS's operations. Nevertheless BUPA expected to improve CHG's margins by centralizing certain functions. BUPA said that patients and consultants would benefit from the investment BUPA PMS would be able to make in terms of capital resources to improve facilities and equipment, and also in the development of high standards of management, training and care. BUPA believed it would be able to make good hospitals even better.

2.108. CHG told us that apart from rationalizing certain functions, it believed there was no scope for BUPA to increase margins in CHG hospitals by improved operational performance—this could only be achieved by 'improving the revenue side of the equation'.

2.109. Some third parties told us that the acquisition of Goldsborough by BUPA in 1997 had led to substantial price increases at those hospitals and that this might be expected to occur again following BUPA's acquisition of CHG. Norwich Union told us that the 'Goldsborough increases' had contributed to its claims costs and it expected that the BUPA/CHG merger would result in a substantial increase in CHG's tariffs (see paragraph 6.116). PPP said that the loss of CHG as a competitor to BUPA PMS was likely to lead to increased hospital charges (see paragraph 6.131).

2.110. BUPA told us that, in respect of prices at former Goldsbrough hospitals, BUPA PMS had taken steps to standardize the tariffs at the former Goldsbrough hospitals with those charged by other BUPA hospitals in accordance with its normal practice; on acquisition the prices at the Goldsbrough hospitals had been about 15 per cent below those at BUPA PMS's other hospitals and the prices had been harmonized in two phases. BUPA said that this price harmonization went hand in hand with, and was justified by, the investment programme BUPA PMS had instigated to improve the quality of the hospitals concerned. As regards prices at former CHG hospitals following the proposed merger, BUPA expected to bring CHG's prices into line with those of BUPA PMS, following and reflecting the additional investment that BUPA PMS would expect to undertake in former CHG hospitals (see paragraph 4.147).

2.111. [

*Details omitted. See note on page iv.*

]

2.112. [

*Details omitted. See note on page iv.*

]

## **Competition in the PMI market**

2.113. Notwithstanding the modest growth in the corporate sector, for the most part the PMI market is static, and some parties told us that they thought it had reached saturation. Despite the fall in concentration in the market during the 1990s (see paragraph 4.99 and Table 4.2), in 1999 the four largest PMI providers still accounted for over 80 per cent of the market by value. While PMI providers clearly compete to attract and keep personal subscribers, demand inelasticity, lack of transparency about product variations and pre-existing policy conditions have restricted growth.

2.114. As we have seen, premium rates have risen substantially in the personal sector and some of the larger insurers have introduced cheaper products such as network policies to stimulate growth and increase overall levels of business. But these attempts have not been universally successful. For the most part, PMI providers who do manage to increase their market share do so at the expense of others, and not by attracting large numbers of new subscribers.

2.115. Competition for corporate PMI business is more effective in driving down subscription costs and purchasers are likely to be better informed. But margins in this sector are far lower than those that prevail in the personal sector, largely because of the higher ratio of claims per cost of premium. Premiums per 'subscriber' are about one-half of those for a personal subscriber, although the difference reflects many factors apart from competition—in particular a younger age profile of those covered and risk pooling effects.

## **The financial performance of PMI providers**

2.116. At the time of our inquiry nearly all the large PMI providers were part of larger groups of companies whose accounts were not reported separately. Most of the PMI providers told us that they made underwriting losses that were offset by the returns they made through the investment of subscribers' premiums. BUPA differed as it told us that it did not allocate investment income separately to BUPA PMI in either its management accounts or statutory accounts, but recorded it as group income. Norwich Union told us that its PMI business had operated at a loss for some years although in recent years it had achieved modest profitability. Similarly, Standard Life has made underwriting losses in PMI in most years since its entry.

### ***The financial position of BUPA PMI***

2.117. BUPA PMI's profitability (excluding investment income) for 1997 to 1999 is set out in Table 3.4. It made underwriting losses of £[ ] million in 1999 and [ *Details omitted.* See note on page iv. ]. In common with other PMI providers it is faced with an increasing number of claims. Its loss ratio, which measures the cost of claims incurred as a percentage of premium income, increased from under [ ] per cent in 1997 to [ ] per cent in 1999. [

*Details omitted. See note on page iv.*

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## **The relationship between the PMS and PMI markets**

2.118. In paragraphs 2.76 to 2.78 we summarized the changes that have occurred in the PMS and PMI markets during the 1990s. We now go on to describe the effects of these changes on the competition in the interrelated PMS and PMI markets.

### ***Hospital charges***

2.119. 80 per cent of the total revenues of all PMS providers come from hospital charges made to PMI providers, amounting to about £1.7 billion in 1998/99 (see Table 4.4). Most contracts between PMS and PMI providers are for three-year periods, reviewed annually, mainly in relation to the level of discounts off the PMS provider's standard, low-volume business tariffs or 'rack rates', and percentage annual increases reflecting inflation in medical costs. BUPA told us that it negotiated PMI prices annually in the light of experience of PMS charges and no longer wholly in terms of discounts off the rack rate.

2.120. WPA told us that it negotiated nationally with BUPA PMS, which insisted that the negotiations embraced all BUPA PMS hospitals, irrespective of location. Various rates were set for particular procedures wherever they were performed (whether or not it was advantageous to WPA and its members to have procedures performed at a particular BUPA hospital). WPA had to bargain with BUPA on the basis that all of BUPA's PMS were covered by the negotiation.

2.121. The main PMI providers and the four national PMS providers negotiate on the basis of average prices and charges for all the hospitals within each of those groups, effectively agreeing a national average price. This practice developed and became of greater importance during the 1990s, particularly as concentration in the PMS market increased and network policies were developed. The nature of these price negotiations is described more fully in paragraphs 4.138 to 4.142.

2.122. Because PMS charges to PMI providers are largely an outcome of a bargaining process on a national basis they reflect the bargaining strength and abilities of the two sides, rather than the underlying structure of supply costs. We were told that the four national PMS providers enjoyed great advantages relative to the smaller hospital groups and independents by virtue of their greater scale of operation, wider geographical coverage and the solus and flagship hospitals they owned. These features are particularly valuable in price negotiations with PMI providers concerning network arrangements and associated charges.

2.123. The two largest PMI providers, BUPA PMI and PPP, are in a far stronger bargaining position than their smaller competitors, primarily because of their greater scale of operation: taken together they account for about 70 per cent of PMI business with PMS providers (see Table 4.2). They also gain from their wide knowledge of procedural and hospital costs—but with BUPA having the greater advantage because of its ownership of both PMS and PMI businesses.

2.124. Comparisons of PMS charges to PMI providers and self-payers are difficult because of the complexities involved (see paragraph 4.142). Notwithstanding this, we sought to explore where possible:

- (a) the relative level of charges by different PMS providers (particularly BUPA and CHG (see paragraphs 2.126 to 2.130);
- (b) the scale of standard and network discounts obtained by different PMI providers (see paragraphs 2.131 and 2.132);
- (c) the relationship between PMS charges to insured and self-pay patients (see paragraphs 2.133 and 2.134); and
- (d) whether BUPA PMI obtained preferential terms from BUPA PMS (see paragraphs 2.152 to 2.154).

2.125. There were difficulties in making like-for-like comparisons because the charges covered a wide range and quality of services and the dates of the annual price reviews differed. Nonetheless, we believe that the evidence presented to us showed sufficient commonality for our findings to be valid. The results are shown below.

#### *Relative levels of charges made by PMS providers*

2.126. BUPA provided data to us based on its ‘episode cost index’ (ECI). This is a BUPA-calculated weighted average of PMS charges to BUPA PMI (see paragraph 4.144). BUPA PMI uses the ECI to compare the weighted average prices of different PMS providers in relation to each other and to the national average. For 1999, the index for in-patient charges showed that those of both BUPA PMS and CHG were at the average level; GHG’s were 2.5 per cent higher; and Nuffield’s were 3.1 per cent lower. The ECI data for day-case business showed that BUPA PMS’s charges were 3.5 per cent higher than those of CHG; about 14 per cent higher than those of GHG; and about 30 per cent higher than those of Nuffield.

2.127. Our own analysis examined the charges for non-network business made by the four national PMS providers to five PMI providers for:

- (a) four of the most common hospital services; and
- (b) six of the most common surgical procedures.

2.128. Regarding the common services, GHG and other PMS providers told us that the overnight and day-case accommodation rates were regarded as especially important by them and by PMI providers. As shown in Table 4.5, the charges made by BUPA PMS for overnight accommodation were in almost all instances higher than those made by the other national PMS providers: BUPA PMS's charges to PPP, Standard Life and Norwich Union were about [ 30 ] per cent higher than those of CHG. For the other hospital service charges listed, the position was less clear-cut. For the same service BUPA PMS charged more than its competitors to some PMI providers and less to others, in part reflecting the complexities of the pricing arrangements.

2.129. As for the surgical procedures, the charges we looked at were those to five PMI providers in respect of the six surgical procedures which, taken together, account for nearly [ 30 ] per cent of BUPA PMS's 'common procedure' charges to BUPA PMI (see Table 4.6). Comparisons between PMI providers are affected by differences in the proportion of the average charge accounted for by network business, where discounts are higher (over 90 per cent of the average charges to PPP relate to network business, for example, compared with 40 per cent of those to BUPA PMI). Nonetheless, the data indicate the broad level of charges for different procedures, and meaningful comparisons between BUPA PMS and CHG are possible (see paragraph 4.149).<sup>1</sup> We found, as we had with charges for hospital services, that CHG's charges to PMI providers for these six procedures were mostly below those of BUPA PMS, markedly so in some instances. For example, CHG's charges to Norwich Union for both cataract and knee operations were about [ 30 ] per cent less than those by BUPA PMS.

2.130. One clear conclusion from our analysis relates to the higher charges made by BUPA PMS compared with those made by CHG. BUPA itself acknowledged that CHG's charges were generally lower than those of BUPA PMS (see paragraph 4.147), and that BUPA PMS planned to align CHG's prices with its own (see paragraph 2.110). BUPA PMS's higher prices and the loss of CHG as a lower price competitor gives us grounds for concern about the effects of the merger on price competition in the PMS market.

#### *Differences in the discounts obtained by different PMI providers*

2.131. BUPA and others told us that the larger PMI providers secure higher discounts from all PMS providers than do their smaller competitors, because of the greater volume of business generated. The smaller PMI providers and some hospitals put it to us that these discounts were disproportionately large, reflecting greater bargaining power rather than genuine cost savings. Their views are set out in Chapter 6. Some parties told us that some time ago BUPA PMI had asked them for written confirmation that it would always be given the best price (ie the lowest). BUPA told us that BUPA PMI's contracts with PMS providers had at one time contained 'best price' clauses, and agreed that it had sought letters to this effect; it had wished to show these letters, in confidence, to corporate clients (see paragraph 5.79).

2.132. The data we collected suggested that BUPA PMI in most instances obtained better terms than its competitors did from all PMS providers (see paragraph 4.151). BUPA itself told us it believed that BUPA PMI, on average, obtained discounts (off the PMS providers' rack rates) of 25 to 35 per cent for non-network business, and a further [ 30 ] per cent for BUPA PMI's network business. PPP, the second largest PMI provider, had also been able to negotiate high levels of discount, related to the volume of extra business generated. BUPA PMI does not give hospitals any guarantee of volume for the discounted price it obtains. [

*Details omitted. See note on page iv.*

] Smaller PMI providers fared less well.

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<sup>1</sup>though there may be some differences in the make-up of charges and also the basis of calculation as between different PMI providers.

## *Relationship between PMS charges to insured and self-pay patients*

2.133. Prices charged by PMS providers to self-pay patients are usually determined individually between the patient and the hospital, although the patient's consultant may also be involved. Some PMS providers advertise self-pay prices. [

*Details omitted. See note on page iv.*

] WPA, the fifth largest PMI provider by sales value (see Table 4.2), told us of a survey which showed that, on average, self-payers were charged 26 per cent less than insured patients (see paragraph 6.163). WPA said that the large PMS providers abused their position by charging PMI providers more than self-payers.

2.134. Data from BUPA PMS on the average charges it made to seven PMI providers (including BUPA PMI) for the six procedures referred to in Table 4.6 showed a more varied picture (see paragraph 4.156 and Table 4.8). For three of the six procedures, charges were highest for self-payers; for one procedure, they were next to highest; for one they were joint next to lowest. For only one of the six procedures were self-payers charged less than insured patients. BUPA told us that prices charged to self-pay patients were determined by the hospital concerned and each individual patient was quoted an individually assessed price reflecting the procedure to be undertaken and the patient's medical condition. This meant that there was a range of prices at BUPA PMS hospitals for self-pay patients for any particular procedure, but the average aggregated episode price for self-payers correlated with the price paid by a PMI provider with similar volume. BUPA said that hospitals used self-pay to try and stimulate the local market so prices were perhaps keener where there was a fair amount of local competition. The picture was, however, not straightforward because BUPA PMS hospitals also dealt with NHS waiting list work and cosmetic surgery. BUPA said that its charges for self-payers were not generally lower than those for insured patients, although it accepted that it had issued guidance to individual hospitals, the effect of which could be to raise charges to self-pay patients.

## ***Hospital networks***

2.135. Many parties put it to us that BUPA PMI and PPP had been able to exert buyer power through the construction and maintenance of their networks. In itself, we do not believe the network concept is inherently anti-competitive: indeed, the OFT noted in its 1999 review that the development of networks had been a reasonable response to relatively static demand for PMI coupled with rising costs and possible excess capacity in the PMS market (see Appendix 4.2). Although differing views have been put to us on the extent of current capacity and usage, we do not dissent greatly from this OFT view. We also agree with the OFT that network products offered by PMI providers have widened the choice of lower-cost PMI available; and that this may have enabled some personal subscribers to remain in the PMI market at a time of steeply rising premiums for non-network products.

2.136. However, we consider that the creation of networks also has the potential to facilitate leverage and the exercise of market power by the larger PMI providers vis-à-vis PMS providers, and has therefore introduced a significant additional element to the competitive dynamics of the relationship between PMI and PMS providers. Our own analysis of the discount structure associated with network products (see paragraphs 4.150 and 4.151)—which was not available to the OFT—illustrates this point.

2.137. As regards the hospital networks themselves, the two main networks—as shown in Table 4.3—are those which have been developed by BUPA (165 private acute hospitals) and PPP (158 private acute hospitals, plus 45 PPU's), both of which—we were told—offer comprehensive national coverage, but which limit the choice of hospitals for subscribers in at least some local areas. The criteria for inclusion of hospitals within PMI providers' networks have

varied, and in some areas PPP developed a system of open competitive tendering. When BUPA PMI introduced its current network in 1996, it contracted chiefly with the four national PMS providers, using independent hospitals only where there was no hospital group presence. It told us that the main chains provided the 'spine' of the network and that independents had tended to be included only in areas where there was no group hospital.

2.138. All BUPA PMS's hospitals are in BUPA PMI's network, as are most of those belonging to the other national PMS providers. Three former Goldsborough hospitals (see paragraph 2.13) that were not in BUPA PMI's network at the time BUPA PMS acquired them in 1997 were brought into the network in 1998. Three of CHG's hospitals are excluded from BUPA PMI's network: Berkshire Independent (Reading), North Downs (east Surrey) and Oaklands (Manchester area). BUPA told us that IBH, the previous owner of the hospitals in question, had not been interested in joining the BUPA PMI network, and that since CHG's acquisition of the IBH hospitals, BUPA PMI had had no need of additional facilities in the areas concerned. BUPA said that the three hospitals were not excluded because of their proximity to BUPA PMS hospitals. CHG, on the other hand, told us that the reason for exclusion was that these three hospitals were in direct competition with BUPA PMS. They were, in fact, the three hospitals BUPA had identified as having the most significant overlap between BUPA and CHG during discussions with the OFT.

2.139. Many of the independent hospitals, including those which had current contracts with BUPA (typically for two to three years), complained to us about the uncertainties and lack of transparency of BUPA PMI's network selection. They said that the process was discriminatory and unfairly disadvantaged them. BUPA told us that it intended to publish its eligibility criteria and had agreed that it should be included in our report (it is at Appendix 5.2). However, BUPA PMI did not consider it appropriate to make public the selection procedure it used in assessing eligibility; it was essential to its ability to negotiate the best network for its customers that this was not the case.

2.140. Earlier in the chapter we described the role of the GP, and of the consultant in private patients' choice of hospital (see paragraph 2.64). Most patients accept their consultant's guidance on which hospital to use, although insured patients may in practice be limited by their PMI cover to network hospitals (see paragraph 2.59).

2.141. Consultants, save in exceptional circumstances, are able to treat patients who have network policies only at network hospitals. But we were told that consultants would treat more of their other patients at network hospitals too, so avoiding the inconvenience of splitting their patient lists between different hospitals. This is called consultant drag (see paragraph 4.111 and BUPA's view in paragraph 5.61). It also affects self-payers, whose choice of hospital is likely to be heavily influenced by the consultant who treats them. This was a source of concern expressed to us by some of the hospitals not selected for network membership by BUPA or PPP.

### ***Relations with consultants***

2.142. BUPA PMI sets maxima for the reimbursement of consultants' fees for each of the many hundreds of procedures they undertake, and will exceed these maxima only in special circumstances. The maxima have not changed for several years and act as a powerful price control, not only over consultants treating BUPA PMI's subscribers, but because of their use as a benchmark throughout the PMI industry (see paragraphs 4.22 and 4.26). An aspect of BUPA's market power is that it has the ability to sustain these maxima, and to act as a price setter. BUPA told us that PMI providers represented the only real constraints on consultants' charges, and that this had been noted by the MMC in the 1994 report.

2.143. Another important influence is BUPA's Consultant Partnership Scheme (CPS—see paragraph 4.31 et seq). The principal objective of the CPS, BUPA told us, was to give subscribers the assurance that their consultants' fees would be fully covered, or to allow them to make an informed choice about whether to proceed with treatment by a consultant who might charge in excess of BUPA's Benefit Maxima.

2.144. When the CPS was introduced in 1997 participating consultants were required to use hospitals in the BUPA PMI network wherever possible, and to charge within the BUPA Maxima, other than in exceptional cases. In return, BUPA PMI undertook to provide a retrospective annual payment to consultants, amounting to 5 per cent of the fees charged over the previous year. For patients admitted to hospitals not within its network, BUPA PMI undertook to reimburse at the Benefit Maxima in the normal way, ie without the 5 per cent bonus payment.

2.145. During the course of our inquiry, in July 2000, and in response to consultants' criticisms, BUPA PMI withdrew the directional element of the terms of the CPS by removing the requirement that treatment should be given in a hospital in the BUPA PMI network, and it increased the annual retrospective bonus payment to 10 per cent of the fees charged. Under BUPA's current CPS, there is still the requirement to charge within the BUPA Benefit Maxima (other than in exceptional cases), but there is now no requirement to use a hospital in BUPA PMI's network. BUPA told us that the number of consultants participating in the CPS had grown from 5,600 in June 2000 to nearly 6,250 in August 2000.

2.146. The CPS was a source of many complaints to us from consultants, and from the BMA (see paragraph 6.178 et seq). In its evidence to us, the BMA argued that the CPS amounted to an unwarranted interference into consultants' professional activities, clinical judgement and governance. The BMA said that the extra payments did not in any event cover all consultant services and were therefore less generous than appeared at first sight, and certainly a poor substitute for uprating BUPA's Benefit Maxima in line with increases in medical costs. The BMA said that the CPS in its original form also distorted the pattern of hospital use, diverting both BUPA-insured patients not on network policies and other private patients towards BUPA network hospitals. The BMA took the view that the CPS was a reflection of BUPA exercising its market power in the PMI market to its advantage.

### ***Pre-authorization***

2.147. Within the last five years BUPA PMI has introduced two types of pre-authorization which it requires to be met before it will accept claims for payment from PMS providers. Some third parties alleged that either or both of these requirements were evidence of BUPA's market power. They are:

- (a) a pre-verification by BUPA PMI of appropriate PMI cover for a proposed procedure or treatment; and
- (b) authorization of certain specified procedures, most notably hysterectomies and wisdom teeth extraction.

2.148. As regards pre-verification, BUPA PMI subscribers are asked to contact BUPA PMI's helpline before arranging for any treatment, or the use of any particular consultant. Some third parties told us that they believed the helpline system had a directional bias, in that BUPA PMS hospitals would be suggested to callers in preference to hospitals owned by other PMS providers; or that consultants providing treatment within the BUPA Maxima would be suggested, rather than consultants known to charge in excess of these maxima. We observed the helpline system in operation and found no such evidence of bias.

2.149. We also did not regard it as unreasonable for BUPA PMI to require subscribers to seek a second opinion before undergoing a hysterectomy or extraction of wisdom teeth. Moreover, BUPA told us that it would not refuse to pay for such procedures if the patient refused to seek a second opinion, but nonetheless wished to proceed with the treatment (see paragraph 5.63).

## **BUPA's dual presence in PMI and PMS**

2.150. As we said in paragraph 2.78, BUPA is unique in having a presence in both PMS and PMI. Its brand name has become synonymous with the provision of healthcare in many forms. Its dual role has attracted the attention of the OFT over many years. We received many complaints from third parties about the vertical links between BUPA PMS and BUPA PMI, which most complainants said would be exacerbated by the merger. These complaints are set out in Chapter 6.

2.151. A common allegation was that BUPA PMS gave favourable rates to BUPA PMI for hospital charges. We examined whether this might be so by undertaking an analysis of the terms BUPA PMI receives from BUPA PMS for a range of common services and surgical procedures.

### ***Terms obtained by BUPA PMI from BUPA PMS***

2.152. Price negotiations in this industry are highly confidential, and PMI providers do not know the charges agreed by their competitors with PMS providers. None of the third parties who expressed concern about BUPA's prices had any evidence that BUPA PMS favoured BUPA PMI and BUPA told us that it would not make commercial sense for it to do so. Bearing in mind its scale of operations in the PMI market, it might be expected that BUPA PMI would get better terms from BUPA PMS than other PMI providers. BUPA PMI's ECI calculations (see paragraph 2.126) did not indicate that BUPA PMS's charges to BUPA PMI were markedly lower than those charged by the other national PMS providers.

2.153. The data we used in our analysis, however, was on a more disaggregated basis than BUPA's ECI. As shown in Table 4.5, BUPA PMS's charges to BUPA PMI were generally lower than those to other PMI providers for hospital service charges for non-network business. BUPA PMI appeared to get a particularly favourable rate from BUPA PMS for overnight accommodation: it was markedly lower than for the other three national PMS providers and was more than [ 3% ] per cent below the equivalent charge by CHG. Moreover, the equivalent BUPA PMS charge to PPP was about [ 3% ] per cent greater than its charge to BUPA PMI; the equivalent charge to Norwich Union was over [ 3% ] per cent more.

2.154. Our analysis of comparison of hospital charges in index form, showing non-network and network business separately (see Table 4.8), showed that BUPA PMS charged the smaller PMI providers substantially more than BUPA PMI: for knee operations, for example, the difference was around 50 per cent. For network business, BUPA PMS charged BUPA PMI up to 20 per cent less than for standard business. By contrast, BUPA PMS network-based charges to PPP for three of the six procedures were around 10 per cent more than the equivalent charge to BUPA PMI for non-network business. As a far higher proportion of PPP's business is on network products, so the volume of PPP network business with BUPA PMS is likely, other things being equal, to be greater than for BUPA PMI. In these circumstances, it is far from obvious that the lower BUPA PMS charges to BUPA PMI are fully justified on a volume basis or because of genuine cost savings.

## *Vertical integration*

2.155. A thread that ran through many of the concerns expressed to us about the merger was the degree of vertical integration of BUPA's PMS and PMI businesses. BUPA told us that it did not regard itself as a vertically integrated organization. It said that it had a detailed and rigorous set of rules governing all data flows and interactions between its PMI and PMS businesses. They were operated wholly independently of each other and had been run at arm's length for many years. It said that it was in its best interest to preserve an arm's length arrangement to optimize the competitive performance of the businesses. Moreover, BUPA said that the confidentiality guidelines governing the relationship took account of the recommendations of the 1990 report and the views of the OFT. But the OFT told us that it had never sought to evaluate, approve or monitor these arrangements.

2.156. However, many third parties told us that they doubted the effectiveness of these arrangements. A common concern was the possibility of a misuse of information. Also, GHG told us that it was concerned that increased vertical integration by BUPA would serve to increase barriers to entry in the PMI market, further enhancing BUPA's existing dominance in that market (see paragraph 6.11). [

*Details omitted. See note on page iv.*

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2.157. In considering the extent of BUPA's vertical integration, we noted that BUPA had a policy of not allocating investment income or interest expense to the divisions. This issue was discussed in the 1990 report, which accepted BUPA's explanation of the way in which Chinese walls operated between the two sides of BUPA's business but added that 'it may be that it would be to BUPA's own benefit to amend its organisation in certain respects: the separate and efficient management of BUPA Hospitals might be strengthened if there was to be an actual charge for the cost of any funds provided'. The OFT told us that it had been concerned about the degree of BUPA's vertical integration since that time. BUPA told us that it was not unique in its arrangements. It said that in diversified companies other business units commonly had access to funds generated in other parts of the business.

2.158. We put it to BUPA that it had little incentive to maintain the Chinese walls guarding BUPA PMS information from BUPA PMI because there were no commercial penalties for breaching them. We suggested that in other organizations subject to Chinese wall arrangements, there were penalties for unauthorized disclosure—and the real risk of customers taking their business elsewhere (for example, in City investment banks where clients of fund management businesses police pressure from related corporate finance businesses, and corporate finance clients police leakage of information to fund managers). However, in BUPA's case, we suggested that its policy-holders lacked knowledge and interest in the vertical links between PMI and PMS and had no awareness of the need for Chinese walls, and that most of BUPA PMS's clients were dependent on BUPA PMI to varying degrees. We said it was likely that other hospitals and PMI providers lacked the leverage needed to prevent any breaches of the Chinese walls while, at the same time, PMI clients might benefit from the relationship with BUPA PMS. BUPA did not agree with our hypothesis. It told us that any failure to observe the Chinese walls would lead to widespread customer criticism and the adverse publicity would have damaging effects on BUPA (see paragraph 5.29).

2.159. We are sure BUPA seeks in good faith to maintain the Chinese walls but we do not believe that these arrangements can be relied upon: the external pressures are too great for their integrity to be sustained. Essentially, this is a matter of judgement about the behaviour of colleagues within an organization. We do not suggest that the managers of the BUPA PMS and PMI businesses exchange price information: all that is necessary is for them not to adopt the

sort of rigorous bargaining stances when dealing with each other that they would adopt when dealing with other providers.

2.160. Another aspect of third parties' concern about the common ownership of BUPA's PMS and PMI businesses was the requirement of BUPA PMI that PMS providers should complete lengthy and detailed documentation giving highly confidential information about their businesses (see paragraph 4.46). BUPA told us that the documentation was necessary for BUPA PMI to assess and monitor the quality and safety standards of the hospitals with which it did business. We accept that any responsible PMI provider should seek to safeguard itself and its subscribers from poor standards of service and safety. But we believe it is understandable that in the circumstances of BUPA's dual ownership there should be such concerns. The knowledge BUPA is able to gain through this process cannot but strengthen its position.

2.161. As regards links between the BUPA businesses, our view is that BUPA is able to exploit its PMI buyer power to extract benefit from other PMS providers whilst using its own PMS business to its strategic benefit. It is able to exert leverage between BUPA PMS and BUPA PMI by the non-transparent and subjective process it uses to select hospitals for its network; through its pricing strategy, in particular by offering preferential discounts to BUPA PMI at BUPA hospitals; by the management of the CPS, through the use of the bonuses to consultants; and by the imposition of stringent conditions on PMS providers (as a result of which highly confidential information about their businesses is made available to BUPA).

## **Entry and growth conditions in the PMI and PMS markets**

### ***Barriers in the PMI market***

2.162. The 1990s saw the entry of several commercial companies to the PMI market, which is largely unfettered by regulatory barriers (see paragraph 4.102). It is noticeable, however, that all of the new entrants except Abbey National plc have been major insurers in other fields, with the resources necessary to withstand the substantial start-up and initial investment and marketing costs involved in PMI. We were told that revenues of between £50 million and £100 million a year might be necessary to cover fixed costs.

2.163. Norwich Union, which entered the PMI market in 1990, told us that its entry had cost £[ 30 ] million. It operated at a loss for some years, despite increasing its market share to around 5 per cent, and has only recently begun to show modest profitability. In its view a new entrant would need annual subscription revenues of at least £[ 30 ] million to earn an economic level of profit on the investment required. [ 30 ], Standard Life's PMI business, at a comparable market share, has accumulated underwriting losses in most years amounting to £40 million to £50 million.

2.164. Medisure (see paragraph 6.242 et seq) told us that barriers to entry were relatively low but barriers to growth were substantial; the market itself was saturated. RSA said that the main barriers to entry were the need to establish credibility in the field and to build critical mass when competing with the strong brands of BUPA and PPP. RSA believed, in the medium term, that there would be no substantial growth in the PMI market and that it was probable that there would be a decline as premiums increased to reflect rising costs and higher frequency of claims. However, it saw potential for growth in the corporate and company sector, and for more innovative products.

2.165. It seems to us that if a company wants to establish a token presence in the PMI market solely to widen its portfolio of financial services, it would have no great difficulty. But it would face barriers if it sought to grow. These barriers strengthen BUPA PMI and PPP in particular, both of which have positions of high market share and brand recognition. A few companies, notably Standard Life and RSA, appear to have found niche markets within PMI, but at a heavy cost to short- and medium-term financial gain.

## ***Barriers in the PMS market***

2.166. Barriers to entry and growth in the PMS market are no less severe. The cost of building a new hospital is high, and the acquisition of suitable land is subject to planning restrictions, particularly on out-of-town sites. Furthermore, we were told that there were few areas in the country where there was still a demand for a private hospital that could not be met by existing facilities.

2.167. Acquisition of an existing PMS provider is therefore the route that a new entrant might prefer. But most of the hospitals likely to be for sale would not be in one of the PMI providers' networks which, as we have described earlier, would be a competitive disadvantage. Finally, a new entrant would need to gain credibility with consultants, most of whom are able to choose the hospital in which they work.

## **The effects of the proposed merger**

2.168. We wish to stress that this inquiry is concerned solely with the existence and the effects of existing and proposed merger situations. Many of those who gave evidence to us raised issues concerning alleged anti-competitive practices in the PMS and PMI markets, which would perhaps have been more appropriate to a monopoly investigation. We have found this material useful in giving us a sense of possible weaknesses in competition in the relevant markets and in illustrating their evolving dynamics during the 1990s, but our inquiry must address the specific question of whether the mergers operate or may be expected to operate against the public interest. Furthermore, should we make an adverse finding, any remedies we might recommend should be linked strictly to the identified detriments of the merger situations. Our inquiry is not the occasion, as some of those who gave evidence might have wished, to develop a complete new blueprint for PMS and PMI.

2.169. In our assessment of the effects of the proposed merger, we begin by considering its immediate impact on the PMS market both at the national and local level. We then look at the effects in terms of the interactions between the PMS and PMI markets and the effects on competition and consumers.

2.170. The BUPA/CHG merger would result in an increase in BUPA PMS's ownership of hospitals from 36 to 58,<sup>1</sup> including two additional solus hospitals. BUPA would become the largest PMS provider as well as the largest PMI provider. The merger would also mean a greater concentration in the PMS market, as the number of national PMS providers would be reduced from four to three. Moreover, BUPA PMS would have a 42 per cent share of the total revenues of those three. It would also account for 33 per cent of the BUPA PMI network, and 35 per cent of PPP's network. We regard these as important changes.

2.171. The loss of CHG as an independent player in the PMS market would be particularly significant for several reasons: its position—unique among the national PMS providers as a listed company—and thus subject to the market disciplines that entails; its role as an important comparator; its ownership of solus hospitals; and the fact that it appears to be one of the most efficient PMS providers (see paragraph 2.105).

2.172. BUPA said that we should address the effects of the proposed merger solely by reference to local markets. We do not agree with this view. For the reasons given in paragraph 2.70, we see PMS as essentially a national marketplace. As regards a methodology for assessing local effects, BUPA told us that we should focus on the existing overlaps between CHG and BUPA hospitals. We note, however, that the local market can change as volumes of business between hospitals alter, influenced by whether a hospital is included in a PMI provider's

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<sup>1</sup>Including one CHG-managed NHS hospital.

network, and the consequent use of that hospital by consultants. We have nevertheless undertaken our own local market analysis and have described its conclusions in paragraphs 2.94 and 2.96. In summary, we consider that there are eight areas in which there would be a substantial overlap between BUPA PMS and CHG, and their combined share would be large, indicating that there is likely to be a reduction in competition as a result of the merger. There are also two areas in which BUPA PMS would inherit the solus position of the CHG hospital.

2.173. In reaching our conclusions on the proposed merger we have to consider not only whether the merger would affect the structure of the market (at national and local levels), but whether the consequences may be expected to have adverse effects on the public interest.

2.174. We have identified several ways in which the merger would have a direct effect:

- (a) BUPA's increased market share in PMS, giving it greater bargaining power;
- (b) the increase in the number of solus hospitals under BUPA PMS's control (see paragraph 2.94), also adding to its bargaining power;
- (c) the added advantage to BUPA PMI, deriving from its increased ability to resort if necessary to BUPA PMS hospitals, in its negotiations with other PMS providers;
- (d) the increased concentration in the PMS market as represented by the reduction from four to three in the number of national PMS providers;
- (e) the elimination of CHG as an efficient competitor capable of constraining the costs of other PMS providers; and
- (f) the likely increase in the prices at the former CHG hospitals through the process of price harmonization with hospitals currently operated by BUPA PMS (see paragraph 2.130).

2.175. The way in which these factors are likely to interact in the marketplace and lead to further effects depends on the dynamics of the linkages between the PMS and PMI markets, including the interrelationships of BUPA's PMS and PMI businesses and the growth of BUPA PMI's network products. We noted the following factors:

- (a) The BUPA PMI network affects the competitive relationship between BUPA PMI and the PMS providers' hospitals at which insured patients are treated. We have been told by some of the independents that the effects on hospitals not selected for inclusion in a network can be severe. BUPA PMI has been able to establish its network in the confident expectation that PMS providers would participate in it despite the lower returns to themselves. It has been strengthened in this knowledge (unlike PPP) by the knowledge that it had a solid base of BUPA-owned hospitals to underpin its strategy. The strengthening of that network through the inclusion of more BUPA-owned hospitals increases BUPA PMI's market power (see paragraph 2.178).
- (b) The operation of the BUPA PMI network, and in particular its non-transparent and subjective selection criteria, is an important aspect of BUPA's market power. We think this power would be increased by the merger because BUPA PMI would be able to profit from its ownership of a larger proportion of the network by excluding hospitals owned by other PMS providers.
- (c) Through its discount structure, which does not appear to fully reflect costs, BUPA PMI places upon PMS providers a disproportionate element of the financial risk in the supplier and buyer relationship, without (unlike PPP) any compensatory rebate system if expected volumes of business do not materialize.
- (d) BUPA has demonstrated its market power in the influence it has exercised over consultants through bonus payments to attract them into its CPS and through the explicitly

directional nature of the original CPS which was linked to the use of hospitals in the BUPA PMI network (see paragraph 2.144 and 2.145). Another illustration of BUPA's power can be seen in its attempts to contain consultants' charges through the use of the BUPA Maxima levels (see paragraph 2.142).

- (e) The demands made by BUPA PMI in the recent past that PMS providers offer it the best price for hospital services is a further example of BUPA's market power. We take no comfort from the fact that BUPA told us that BUPA PMI had discontinued this practice. The merger would increase the potential for such leverage.

2.176. BUPA has argued that effects of this latter kind could not occur since its PMS and PMI businesses trade at arm's length. As we have said earlier (see paragraph 2.159), we are not persuaded that the Chinese wall between BUPA PMS and BUPA PMI provides an effective safeguard against BUPA's capacity to exploit the opportunities for inter-market leverage that the merger will further facilitate. On this point we perhaps take a different view from that at the 1990 report—but the degree of vertical integration created by the HCA (UK) acquisition was far below that which would result from the proposed BUPA/CHG merger. We think that the integrity of the Chinese wall concept depends on BUPA's judgement of where its overall business interests lie. A recent MMC report on Milk<sup>1</sup> commented that 'wherever the commercial interests of a company conflict with the demands of arm's length trading, there is a strong likelihood that the commercial interests will prevail'. We believe this observation has general validity and that it is applicable to BUPA's operations.

2.177. We consider that BUPA's dual position in the PMS and PMI markets puts it in a unique position among PMI and PMS providers and this position would be strengthened further through the merger. BUPA is not accountable to a body of shareholders and, as it has told us, is able to take far longer-term strategic decisions than might otherwise be the case (see paragraph 5.25). Its dual position gives it some ability to vary the extent to which profits arise in either its PMI or PMS businesses.

2.178. Moreover, the increased size of the BUPA PMS' hospital estate would, in our view, make it even more unlikely that a competing PMI provider would be able to offer a mainstream network product aimed at corporate as well as personal clients without including all or most of the hospitals which would then be in the ownership of BUPA PMS. The limited cases in which PMI providers have launched niche products without using hospitals of the national PMS providers do not invalidate this general proposition.

2.179. In summary, we conclude that BUPA's inter-market links have already given it a position of great strength in the PMS and PMI markets, particularly in view of the static nature of both markets and high barriers to entry. The merger would substantially enhance that position of strength.

2.180. We expect that the main effects of this enhancement of BUPA's market position would be that:

- (a) BUPA PMS's increased bargaining power (see paragraph 2.174(a) and (b)) would lead to higher prices for PMI providers (other than BUPA PMI); this increase in costs would in turn create pressures for higher prices in the PMI market.
- (b) BUPA PMI's increased bargaining power (see paragraph 2.174(c)) vis-à-vis PMS providers would mean lower prices for BUPA PMI that would be expected to lead in turn to compensating increases by the other national PMS providers in their charges to smaller PMI providers; the result would be pressures on those smaller PMI providers to increase their prices.

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<sup>1</sup>*Milk: a report on the supply in Great Britain of raw cows' milk*, The Stationery Office, Cm 4286, July 1999; paragraph 2.320.

- (c) BUPA argued that any lower prices BUPA PMI might secure from PMS providers (as would be implied in the scenario in subparagraph (b) above) would be passed on in lower prices in the PMI market because of the competitive nature of that market. But we have noted that BUPA PMI's forecast was for premium income to grow by over [ 3% ] per cent compound a year between 2002 and 2003, and its number of subscribers by [ 3% ] per cent (see paragraph 2.117). This leads us to the conclusion that BUPA PMI's premiums will have to rise if the [ 3% ] per cent growth is to be achieved. This increase in BUPA PMI's prices would, we expect, make it easier for the other smaller PMI providers to raise their own prices, as suggested in subparagraphs (a) and (b).
- (d) The inclusion of the former CHG hospitals in the BUPA PMS estate, and their probable early incorporation into the BUPA PMI network, would further limit the scope for independent hospitals to gain access to the BUPA PMI network; and other PMI providers would be even more dependent on BUPA PMS hospitals if they wished to offer national coverage to their subscribers. These outcomes would exacerbate the adverse effects identified in (a), (b) and (c) above.

2.181. Furthermore, in our analysis of the prices that the four national PMS providers charged PMI providers for some hospital services and surgical procedures we found that BUPA PMS's charges were mostly higher than those charged by CHG (see paragraphs 2.128 to 2.130). We also noted BUPA PMS's intention to bring CHG's prices in line with its own. In our view these increased prices will be to the ultimate detriment of insured patients, and in the short term they will have a particularly severe impact on self-payers.

2.182. We expect, therefore, that the proposed merger would have the effects adverse to the public interest of reducing competition in the PMS market; and higher prices for PMI and PMS than would otherwise be the case.

### **Benefits of the BUPA/CHG merger**

2.183. BUPA argued that the proposed merger was in the public interest. It said that as a provident association it had led the field for 30 years in improving standards of quality and safety and in containing costs, which it believed had been identified as being needed in the 1994 report. The merger would allow it to further this objective. The local nature of competition meant that with only a few exceptions, where BUPA PMS and CHG hospitals overlapped, the effects of the merger in local markets would simply reflect a change of ownership. However, patients and consultants in those local markets would benefit from the investment BUPA PMS would be able to make in these hospitals, both in terms of capital resources to improve facilities and equipment and also in the development of high standards of management, training and cover.

2.184. BUPA said that it was committed to protecting the interests of the consumer, both through investment to upgrade facilities and improve services, and by measures to contain costs—and so provide better value for money. The acquisition of the CHG hospitals would allow BUPA PMS to rationalize its portfolio, which in turn would improve its ability to meet the demands for higher standards and increased investment in the years ahead. The merger would add momentum to the developments it had already put in place to meet these standards.

2.185. BUPA saw itself as the standard bearer for the consumer and said that in setting a benchmark for quality in the private health sector it had raised standards in the industry as a whole. For these reasons, it believed it was in the public interest to allow it to strengthen its presence in PMS. Prohibition of the merger, or the imposition of an unacceptable remedy, would adversely affect the interests of all users of private healthcare services.

2.186. CHG also saw the merger as benefiting the public interest in that it would allow BUPA PMS access to new markets and enable it to expand the range and quality of its service.

2.187. We acknowledge the important contribution that BUPA has made to the development of private healthcare in the UK. However, for the reason given in paragraph 2.180(c), it is uncertain whether any cost savings would be passed on to subscribers. In any event any benefits, in our view, would be greatly outweighed by the disbenefits we have identified.

## **Conclusions on the proposed merger**

2.188. We therefore find that the proposed merger may be expected to operate against the public interest with particular effects adverse to the public interest of reducing competition in the PMS market; and of higher prices for PMI and PMS than would otherwise have been the case.

2.189. The competition authorities have at various times in the last decade signalled that they would have concerns about further vertical integration of BUPA's PMS and PMI businesses. BUPA's share of the PMI market has decreased over the decade but although it remains at a level which confers market power. But the proposed merger would elevate BUPA into the largest single provider of PMS services in a market characterized by significant concentration (see paragraph 2.76). Because of the interrelationship between the PMS and PMI markets we believe that the proposed merger constitutes a decisive step into the zone where the competition authorities are bound to find that the prospective effects justify their previously expressed concerns about increased vertical integration.

## **The effects of the CHG/SIL and the BUPA/CHG/SIL merger situations**

2.190. Having established that there are existing merger situations as a consequence of SBUKE's purchase of 26.8 per cent of CHG's shares, we consider whether those situations operate or may be expected to operate against the public interest, and because the situations relate to the same transaction we make a single finding that covers both. We have considered them separately from the proposed merger. In particular, we have disregarded SBUKE's shareholding in our consideration of the effects of the proposed mergers. (We were advised by counsel that we should look at the existing merger situations and proposed merger situation separately.) Thus SBUKE's shareholding should be disregarded when we consider the effect of the proposed mergers, and the effect of the existing merger situations should be assessed on the basis of the proposed merger not going ahead.

2.191. We note that the two existing merger situations arose from an arrangement entered into on BUPA's initiative with the specific objective of facilitating the proposed merger while avoiding a breach of the undertakings which prevented BUPA from buying CHG shares directly. We take no view on whether a breach of the undertakings has or has not occurred. That is a matter for the Secretary of State.

2.192. We have assessed, first, the actual effects of the existing mergers during the period from the acquisition of the SBUKE shareholding in CHG up to the time at which we submitted our report and, second, the expected effects of a continuation of the existing mergers thereafter.

2.193. As noted in paragraph 2.37, we have found that SBUKE's shareholding has enabled it to exercise material influence over CHG. Our assessment of the public interest implications of this finding is as follows:

- (a) It became public knowledge from SSSB's offer document of 24 May 2000 that the purchase by SBUKE of 26.8 per cent of CHG shares on 5 May 2000 was funded by the loan arrangement with BUPA and was in contemplation of an acquisition of CHG by BUPA.
- (b) The offer lapsed when the proposed merger was referred to us on 12 June. But the continuation of the original SBUKE shareholding may have had, and can be expected to continue to have for the duration of the loan arrangement, the effect of discouraging other potential purchasers from mounting a bid for CHG.
- (c) CHG told us that such purchasers had already been inhibited from bidding for the company's shares and that this inhibitory effect was adverse to the interests of other CHG shareholders. We accept that this might be so but we consider that, in the period prior to the announcement of the Secretary of State's decision on the proposed merger, while this is likely to be a private detriment to those shareholders we do not consider it to be a detriment to the public interest.
- (d) We also accept SSSB's assurance that, up to the time we submitted our report, SBUKE had not in practice exercised material influence over CHG in any matter.
- (e) However, a different set of considerations apply when the existing mergers are considered on the basis of the proposed merger not going ahead.
- (f) In its effects on the public interest in the period following the announcement of the Secretary of State's decision we see little difference between SBUKE owning the shares and BUPA owning them.
- (g) A continuation of the SBUKE shareholding would provide a means of limiting the potential of CHG as an important competitor in the PMS market. The shareholding would be seen by the public as a continuing BUPA presence to the detriment of CHG's ability to maintain its competitive position and to promote its growth. The CHG board put the company up for sale because it thought this the best way to secure the new investment needed for that growth, which could not be financed from CHG's own resources. The inhibiting effect of the SBUKE shareholding on prospective new bidders for CHG at this stage would have a wider impact than only on CHG's shareholders.
- (h) SSSB indicated to us that SBUKE would have no incentive to retain the CHG shares if BUPA could not proceed with a bid for CHG. But we note that another SIL company, JHS, has for some time been financial adviser to BUPA (and indeed was closely involved in the loan arrangement leading to the purchase of the CHG shares). SSSB told us that in these circumstances it would expect to see some balancing of interests within SSSB between the desire to act in a way which was not detrimental to the interests of an important client and the desire to protect the financial reputation of SSSB.
- (i) The public would think that BUPA's board of directors, or indeed any reasonable board, would not have entered into the loan agreement without being wholly confident that SBUKE would act in BUPA's interests. We share this view and are strengthened in it by the fact that there is no record that the BUPA board, in considering the merits of the loan agreement, discussed what would happen if SBUKE chose not to act in BUPA's interests. CHG, too, told us it would be unrealistic to assume that BUPA would have found SBUKE the money to purchase CHG shares without there being any intention or understanding that SBUKE would vote on the shares or act in any way other than in accordance with BUPA's interests (see paragraph 5.110).

2.194. The result in total would be to create a damaging degree of uncertainty about SBUKE's intentions in relation to the CHG shareholding. The longer the uncertainty lasted—and SSSB told us that it could take 12 months or more for SBUKE to dispose of the shares in an orderly way—the worse the cumulative effects would be: the uncertainties would exist not only for CHG's shareholders and prospective purchasers of CHG's shares, but also for CHG's management, employees and contractors, for patients and consultants who use or may use CHG's hospitals, and for PMI providers. These effects, in our view, would be clearly contrary to the public interest.

## **Conclusions on the CHG/SIL and BUPA/CHG/SIL merger situations**

2.195. We find, therefore, that the merger situations created by SBUKE's 26.8 per cent shareholding in CHG may be expected to operate against the public interest. The particular adverse effects we expect to occur are that CHG's ability to invest in the development of its hospitals and to provide effective competition to BUPA PMS, or to offer more competitive facilities to PMI providers and their subscribers, or both, would be inhibited because BUPA would be seen as exercising material influence over CHG for the duration of the SBUKE shareholding. The resulting uncertainty—which could last for 12 months or more—would be damaging to CHG's management, employees and contractors and to patients, consultants and PMI providers. Other prospective bidders for CHG would also be deterred to the detriment of a normal competitive market in CHG shares.

## **Recommendations**

2.196. Where we have found that a merger situation operates or may be expected to operate against the public interest we are required by section 72(2) of the Act to consider what action, if any, should be taken for the purpose of remedying or preventing the adverse effects which we have identified and we may, if we think fit, include recommendations as to such action. This section sets out the steps we took at this stage.

2.197. Standard Life told us that it believed the Competition Act 1998 (1998 Act) provided all the necessary powers and remedies, should the allegations that BUPA was not conducting itself in the interest of the consumer be substantiated (see paragraph 6.147). Section 18 of the 1998 Act prohibits conduct which amounts to 'an abuse of a dominant position in the market'. The 1998 Act also gives the DGFT power to investigate and, where he finds there has been a breach, to take enforcement action. However, the principle behind the merger control regime set out in the Fair Trading Act 1973 is to prevent expected adverse effects on the public interest arising from a merger—not to wait until such adverse effects arise. Accordingly, we reject Standard Life's argument.

2.198. In letters to BUPA, CHG, SIL and SBUKE we identified the remedies that we might recommend for the adverse effects arising from the three merger situations. The remedies relating to the proposed BUPA/CHG merger are set out in the following paragraph. They are followed by the views that BUPA and CHG put to us in response, and then by our conclusions on which of the remedies we should put to the Secretary of State. We then turn to the remedies we identified in respect of the CHG/SIL and BUPA/CHG/SIL existing merger situations: these are set out in paragraph 2.210. They are followed by the views that BUPA, CHG and SSSB (for SIL) put to us in response, and then by our conclusions on which of these remedies we should put to the Secretary of State.

## **The BUPA/CHG merger situation**

2.199. The possible remedies we identified for the adverse effects of the BUPA/CHG merger situation were:

- (a) prohibition of the merger;
- (b) disposal of BUPA's PMI business;
- (c) separation of BUPA's PMI and PMS businesses under distinct ownership and control in a form to the satisfaction of the DGFT;
- (d) behavioural undertakings by BUPA to strengthen the arm's length relationship between its PMI and PMS businesses;
- (e) divestment of a proportion of BUPA's total post-merger estate to reduce its market power;
- (f) divestment of certain hospitals where there were adverse post-merger effects on competition in local or regional markets;
- (g) a combination of both (e) and (f); or
- (h) divestments under (e) and (f) being agreed with third parties before the merger took effect.

### ***BUPA's views***

2.200. BUPA told us that if the merger were prohibited it would continue with its business as usual. But it thought prohibition a totally disproportionate remedy that would signal that the competition authorities thought BUPA should be capped at 15 per cent of the PMS market. This would mean that BUPA would be unable to grow except by building hospitals, which would be a slow and expensive process. BUPA believed that the competition issues that would arise were local in character, so that a national remedy would be entirely inappropriate and should be contemplated only if no behavioural or divestment remedies could meet the competition concerns expressed. BUPA noted that HCA(London)'s acquisition of St Martin's Healthcare Limited in August 2000, which had not been referred to us gave the enlarged group 40 per cent of the London PMS market.

2.201. BUPA said that its reaction to possible divestments would depend more on the size and location of the hospitals identified for divestment than on their number. Its aim was to improve its hospital portfolio in line with the strategic objectives of growth and achieving economies of scale. It accepted that competition issues arose in those areas and that there were other areas where the proximity of BUPA PMS and CHG hospitals needed to be carefully considered. But BUPA thought divestment of the eight largest CHG hospitals would not be an attractive proposition.

2.202. BUPA told us that it would not wish to proceed with the CHG merger if it was conditional upon BUPA's PMI and PMS businesses being demerged; this was a disproportionate remedy and was at odds with BUPA's strategy.

2.203. BUPA thought concerns about the operation of its PMI and PMS businesses at arm's length could be met by behavioural undertakings. These might include the following matters:

- (a) reissuing BUPA's confidentiality guidelines on relationships between its PMI and PMS businesses as a binding obligation on all staff, with breaches of the guidelines subject

to disciplinary proceedings. All staff could be required to sign that they had read and understood the guidelines, and they could be given a much higher profile in induction courses. The guidelines could also be published on the Group's web site;

- (b) formalising the separation of the PMI and PMS businesses with regard to their managing directors, finance functions, executive management committees, reporting lines and business plans; and
- (c) publishing BUPA PMI's network eligibility criteria.

2.204. On divestment remedies of any sort BUPA said:

- (a) it would be unjustified to cap its share of the PMS market at any particular level, that it would be wrong to adopt either a national or regional approach to divestment, and that specific target hospitals based on local competition concerns should be identified;
- (b) it would be wrong to insist that any divestments were agreed with third party purchasers prior to the proposed merger taking effect: this would operate unfairly on BUPA, and the undertakings normally sought by the OFT in such circumstances would be entirely sufficient to avoid any degradation to the assets concerned; and
- (c) a realistic period for the disposal process would be nine months.

### ***CHG's views***

2.205. CHG thought that the divestment remedies that BUPA had suggested to the OFT were sufficient to meet local competition concerns. There would be interested purchasers for all the hospitals that might be divested. The hospitals to be disposed of should be named and the sales carried through as quickly as possible to ensure that there was no adverse effect on performance and staff morale. CHG did not regard the vertical integration of BUPA as an issue and did not consider that it needed to be addressed. In its view BUPA's arrangements for the separation of the PMS and PMI businesses were effective. It considered, however, that greater transparency in BUPA PMI's network selection criteria would be desirable.

### ***SSSB's views***

2.206. SSSB (on behalf of SIL) said that it had no views on remedies relating to adverse effects of the proposed BUPA/CHG merger.

## **Conclusions on BUPA/CHG merger remedies**

2.207. Our principal conclusions on the effects of the BUPA/CHG merger (see paragraph 2.188) were that they would undermine competition in the PMI and PMS markets and strengthen the market power and the vertical linkages between BUPA PMI and PMS respectively. But in considering remedies we concluded that none of the divestment options set out in paragraph 2.199(e) to (h) would have substantial effects on BUPA's market power or on the strength of vertical linkages within BUPA's structure either as it was at the time of our inquiry or as it might be if modified in the way BUPA had proposed to us. We then considered behavioural undertakings against the same criterion. We did not think it possible (despite BUPA's assurances to the contrary) that structural or administrative barriers would prevent senior staff in the PMS business from having close regard to the effects that their decisions would have on the PMI business (and we noted the strength of support for this view among third parties). We

thought the common concern of BUPA's PMI and PMS businesses to promote the interests of the group as a whole must be such that nothing short of the complete separation of the businesses would constrain BUPA's buyer power.

2.208. We turned, therefore, to consider the possibility of setting up wholly separate PMS and PMI companies, one of which would be owned and controlled by BUPA and one of which would not. The purpose of the proposed merger was to strengthen BUPA's PMS operations, so the only disposal to consider was that of the PMI business. However, we did not take this further because BUPA declared (see paragraph 2.202) that it would not proceed with the merger on these terms.

2.209. We therefore thought that the right course would be to recommend that the Secretary of State should prohibit the proposed BUPA/CHG merger.

### **The CHG/SIL and BUPA/CHG/SIL merger situations**

2.210. The possible remedies we identified for the adverse effects of the existing merger situations involving CHG/SIL and BUPA/CHG/SIL were that:

- (a) SBUKE should sell the shares it has acquired in CHG in a manner, or at a time, or to a purchaser or purchasers, subject in each case to the approval of the DGFT; and
- (b) during SBUKE's stewardship of the shareholding it should be prohibited from exercising its rights to vote on any matter without the consent of the DGFT.

### ***BUPA's views***

2.211. BUPA said it could see no grounds for concluding that SBUKE's holding of CHG shares operated against the public interest, so it would be inappropriate to require SBUKE to sell the shares.

### ***CHG's views***

2.212. CHG said that if we were to find that the proposed merger operated or might be expected to operate against the public interest the aim should be to restore CHG to a position as close as possible to that which existed before BUPA made its bid. CHG would want in these circumstances to be able to conduct a thorough review of its strategic options and this would not be possible if SBUKE were to be allowed to retain its shareholding. It was perhaps unlikely that those who had sold shares to SBUKE would wish to repurchase them, but CHG would wish to be involved in the process of finding purchasers for the shares. CHG believed that the main options were purchase by a new third party, or for CHG to remain an independent entity and perhaps seek to take advantage of the opportunities presented by development in the NHS to develop another strand to the business. In this context the buy-back of shares was a real possibility and needed to be carefully considered. CHG said that SBUKE should not be allowed to vote on matters relating to the disposal of its shareholding. Steps would also need to be taken so that the shareholding was not used against the wishes of the CHG board and other shareholders, either by SBUKE voting against resolutions or failing to vote where a vote was required. CHG would like:

- (a) SBUKE to be required to assent to any offer to CHG shareholders that was recommended by CHG's board;

- (b) to have a right of veto over the sale of the shares held by SBUKE to prevent any dumping of them;
- (c) to be allowed to have a positive role in seeking a purchaser for the shares held by SBUKE; and
- (d) to be allowed to buy back all or part of the shares held by SBUKE.

2.213. CHG thought we should require SBUKE to divest its current shareholding in CHG in its entirety within a reasonable time, say 12 months, which would allow CHG six months to review its strategy and six months for the actual disposal of the shares. If SBUKE were allowed to retain its current shareholding it would be highly detrimental to CHG and its shareholders in terms of its future operations. Even the retention of a small holding by SBUKE would blight the shares because it would be seen as evidence of BUPA's continuing influence.

### ***SSSB's views***

2.214. SSSB (on behalf of SIL) said that if the BUPA/CHG merger were found to operate against the public interest and was prohibited, it would not be necessary or appropriate to impose a remedy on SIL. A forced sale of the CHG shareholding should not be imposed on SBUKE because it would depress the sale price. SBUKE would not suffer any loss because of the terms of its agreement with BUPA, but such an outcome could reflect badly on the reputation of SSSB, so SBUKE would seek to ensure that the best possible price was obtained for the shares. There would be no question of SBUKE dumping the shares. The best way of proceeding would be by auction. This approach might still be possible with a forced sale, but the bidders would know that SBUKE had no alternative but to sell and this would inevitably mean that bidders were restrained. SSSB said that many practical problems would ensue if it were suggested that the SBUKE shareholding should be split between a minimum number of purchasers or that no purchaser should be offered more than a certain proportion of the holding. SSSB suggested that if a forced sale were proposed, a disposal period of 12 months should be allowed. SSSB thought that realistically it would take up to six months to find a purchaser and if the DGFT's approval were a requirement, an additional two months would be needed, with the prospect of a further period of, say, four months if the original proposed purchaser was not acceptable to the DGFT. In SSSB's view, the DGFT involvement in the process would create uncertainty and serve to depress the sale price.

2.215. SSSB thought that if a forced sale were proposed it should not be necessary to require divestment below a 15 per cent holding; at that level it was inconceivable that any public interest detriments concerning the exercise of voting rights could arise. SSSB said that SBUKE had no intention of holding its CHG shares for any length of time, but flexibility in the disposal of a 15 per cent holding would be a further aid to ensuring that the best price was obtained.

2.216. SSSB believed that if we were to impose a divestment requirement no further remedy would be necessary. Alternatively, if a behavioural remedy was sought regarding the voting rights attaching to the CHG shares, no divestment order should be imposed. If our concern was BUPA's possible influence on CHG then a behavioural remedy should be sought from BUPA, not from SBUKE. Prohibition on voting was in effect disenfranchising a key stakeholder in CHG. To do so would mean that SBUKE would be disadvantaged regarding any proposals tabled at an AGM which would be to its detriment. Conversely, SBUKE would be unable to initiate or support proposals that were to its benefit.

## **Conclusions on CHG/SIL and BUPA/CHG/SIL merger remedies**

2.217. Our conclusions on the adverse effects of these existing mergers (see paragraph 2.195) is that they would cause damaging uncertainties to CHG, to the market in CHG shares, to many parties concerned with CHG and to PMI providers.

2.218. We therefore recommend that the Secretary of State should adopt both of the remedies set out in paragraph 2.210. We also recommend that the share disposal should be completed as soon as possible, so that the uncertainties may be quickly removed. SSSB told us that an orderly disposal could take as long as 12 months. On the one hand we think this unacceptably protracted in view of the adverse effects we have identified. On the other hand we think it would be wrong to require precipitate disposal action that could depress CHG's share price to a level that would have adverse effects on CHG and its shareholders and impose serious losses on BUPA. We think the right course, therefore, would be for SBUKE to put proposals to the DGFT to reduce its CHG shareholding as soon as market circumstances are favourable and with a view in any event to complete disposal within six months from the date of publication of this report, or within such time as the DGFT thinks fit.