


6 Views of third parties

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Introduction

6.1. We invited views from PMS and PMI providers; from associations representing consultants and other medical staff; from the NHS Executive and Health Boards; and from members of the public. Hearings were held with the BMA, the Charity Hospitals Federation, Consumers' Association, Griffiths Bradwell Associates, GHG, Guy's & St Thomas's Trust, Health Care Navigator, Hospital and Consultants Specialist Association, The Hospital Management Trust, Laing & Buisson, Medisure, Norwich Union, NHS Executive, Nuffield, PPP, RSA, Standard Life, The Kings Fund and Western Provident Association.

PMS providers

Charity Hospitals Federation

6.2. The Charity Hospitals Federation (CHF) said it considered that the informal inquiry made by the OFT, which was the subject of a press release in November 1999 (see Appendix 4.2), was an inadequate study which failed to understand the implications of network arrangements and of partnership policies and how these worked together to affect the market. It was also its view that BUPA's network arrangements, together with a more aggressive approach by PPP over the last few months, were direct results of the implied consent by the OFT to its actions and an opportunity for both companies to strengthen their domination of the PMS market.

6.3. Ever since the referral of this issue to us, BUPA had sought to further exploit its dominance by changing the terms of the consultant partnership whereby with effect from 1 July 2000 consultants would be paid a bonus if they signed up to a series of points of practice which for the vast majority of consultants were no more than they complied with for any insurer or any patient.

6.4. CHF said it had been told by BUPA that the number of consultants charging more than its Benefit Maxima was a small proportion of the whole. If that was the case, then CHF calculated that the 10 per cent bonus would add substantially to BUPA's benefit payments and therefore increase the cost of patient treatment overall. CHF was suspicious of BUPA's motivation in introducing this revised scheme, particularly at a time when in theory it was being questioned on transparency by the OFT. It confirmed its suspicion that BUPA's long-term plan was to recognize only a limited number of consultants and ultimately to reduce the level of fees which they were paid. CHF did not believe that the quality clauses were relevant to the overall plan because both the medical profession and all independent hospitals were committed to the highest standards of quality assurance through clinical governance and accreditation procedures.

6.5. Furthermore, CHF said that if BUPA acquired CHG it would own some 35 per cent of its network hospitals and it was also a fact that several of the smaller and independent charitable hospitals had been forced out of business by the network activities of BUPA and PPP. Accordingly, the combination of the revised consultant partnership together with the changed ownership structure of hospitals would give BUPA even greater control of the private medical market.

6.6. CHF was concerned that the relative location of BUPA and CHG hospitals would create monopoly situations in several areas which, coupled with the reduction in hospital numbers by exclusion from networks, would limit consumer choice and would work substantially against the public interest. This was particularly relevant given the recent change in proposed policy on the use of the independent sector for the treatment of NHS patients.

6.7. A frequently-used argument on networks and hospital supply was the allegation that there was a large amount of spare capacity within the independent sector. CHF rejected this argument. The basis of the PMI providers' arguments—primarily from BUPA and PPP—related only to midnight bed occupancy which for many reasons was a misleading measure of actual activity.

6.8. Whilst it was impossible for CHF to provide evidence because it was not made available commercially, it was its firm belief that the pricing policies of BUPA Hospitals to various PMI providers and self-pay patients were geared to giving undue favour to BUPA PMI and were designed to discriminate against the smaller PMI providers. Evidence that these practices took place could be drawn from the requirement that both BUPA and PPP imposed upon their network hospitals that patients were not allowed to be given copies of their hospital bills. In other words, BUPA and PPP patients had no idea how their treatment costs had been calculated by the hospitals and yet consultants were expected to give precise figures of their fees in advance even though they might not know what complexities might arise during treatment.

6.9. CHF said that it was doubtful that Chinese walls existed within BUPA. CHF considered that the proposed acquisition coupled with the extension to the BUPA consultant partnership were attempts to establish a pattern of dominance by BUPA which, if allowed to succeed, would lead to a major threat to patient choice. Even more seriously, it could lead to a level of control on consultants and medical practice which might adversely affect the future availability of good-quality medical practitioners in Great Britain. CHF said that the separation of the PMI and PMS parts of BUPA would not provide a suitable remedy as the existence of long-term contractual arrangements between BUPA PMS and BUPA PMI would continue to put both in dominant positions. Neither did CHF consider that undertakings with regard to Chinese walls or the divestment of hospitals in specific locations would provide suitable safeguards.

General Healthcare Group

6.10. GHG said that BUPA was already vertically integrated and the manner in which it presently undertook its business was a cause for concern. BUPA was the UK's largest PMI provider, and the acquisition would also make it the largest PMS provider. GHG was concerned that if such a takeover were permitted it would further strengthen BUPA's vertical integration between its PMI and PMS activities, which had previously raised concerns with both the MMC and the OFT.

6.11. GHG contended that this increase in vertical integration raised the following major competition issues:

- (a) It would lead to the predominant PMI provider also becoming the predominant PMS provider, a significant structural change in the market with an unprecedented level of vertical integration.
- (b) The structural change was inconsistent with conclusions of previous investigations into the issue by the MMC and the OFT and would represent a substantial relaxation of competition policy.
- (c) The 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.
- (d) Such a level of vertical integration could, especially over time, operate to the detriment of competition in both the PMS and the PMI markets through the potential for exclusionary and discriminatory practices to the detriment of the PMI subscriber, ie the ultimate consumer.
- (e) Given the market power that the acquisition would give BUPA over the PMS market, it would weaken the competitive position and the attractiveness of the other hospitals. The acquisition would thereby deny BUPA's competitors in the PMI market effective access to adequate hospital capacity and further exacerbate the barriers to competition that already existed within the PMI market.
- (f) Significant inherent conflicts of interest arose, with BUPA PMI being incentivized to force insured customers into its hospital networks irrespective of whether this was the best option for the patient.
- (g) The domination by BUPA in PMI and its market leadership in PMS would lead to reduced competition in the PMI market, less innovation and might lead to higher PMI premiums.

6.12. More specifically, the vertically integrated nature of the BUPA operation had at various times over the last ten years (since BUPA's acquisition of HCA in 1990) been considered by the OFT. The proposed merger would make BUPA the leader in the PMS market, with a 23 per cent market share, whilst also being the dominant purchaser of these services, with a 40 per cent share of the PMI market,

which funded some 70 per cent of all acute care within independent hospitals. Given BUPA's behaviour over the last five years and most recently in respect of the strategic stake acquired in CHG to support its bid, GHG urged us to be sceptical of BUPA's motivation and the impact the acquisition would have on the markets affected.

6.13. GHG said that approximately 12 per cent of the UK population used PMI. This included both individual subscribers and companies purchasing PMI for employees. This market was highly concentrated, with BUPA being the biggest provider (40 per cent of market share). PPP, the second largest PMI provider, had a 31 per cent share. The price of PMI had been trending upward since 1990, when BUPA acquired HCA and its hospitals. Accurate calculation of prices was complicated by changes in coverage. However, GHG estimated that the price increases were 4 per cent during 1994, 5 per cent in 1995, 8 per cent in 1996, 6 per cent in 1997 and 1 per cent in 1998: a 26 per cent increase between 1993 and 1998.

6.14. GHG believed that the proposed merger would diminish the ability of BUPA's PMI competitors to use high-quality, good-value hospital beds with adequate geographic coverage. The merger increased the negotiating leverage that BUPA PMS would have with the PMI providers which had to offer both geographic coverage and inclusion of what their subscribers regarded as the higher-quality hospitals. Consequently at times a PMI provider would not have an effective choice other than to list the BUPA hospital on the best terms that it could secure. The national price paid by PMI providers would reflect the fact that BUPA owned some hospitals that had to be used. Particular issues that arose from the proposed merger included BUPA's increasing pricing leverage by increasing its solus hospital areas (including acquiring the only other hospital in the leading area); controlling both high activity, cardiac-capable hospitals in the Leeds/Bradford conurbation; and securing total control of Essex, within the important south-east market.

6.15. GHG said that the high concentration and high barriers to entry were conditions ripe for abuse by a vertically integrated entity. The proposed merger raised fundamental concerns regarding the effect of substantial increases in vertical integration. BUPA would have even stronger incentives to channel its PMI subscribers through BUPA hospital beds. Other hospitals—be they part of BUPA's network or outside—would lose business. BUPA would also close hospitals where there was a regional overlap. In addition, BUPA might have more power to dictate the terms under which other hospitals were allowed to be part of the network, lowering their prices and weakening their competitive position; and hospitals not part of BUPA's network would be insufficient in number or geographic coverage or both to allow other PMI providers to compete effectively without BUPA hospitals. Both factors strengthened BUPA's position vis-à-vis existing and potential PMI providers. Increased vertical integration could lead to consumers paying higher prices than necessary for PMI.

6.16. BUPA had the incentive to keep competitive hospitals from inclusion in BUPA PMI listings, thereby foreclosing them from access to BUPA PMI patients. Alternatively, BUPA could redirect BUPA PMI patients to BUPA PMS, foreclosing other hospitals from access to the patients. This could easily be accomplished by giving BUPA PMI patients who used BUPA PMS lower prices than patients who used competitive hospitals. GHG estimated that BUPA customers restricted to the group's own network of hospitals already paid about 8 per cent lower premiums than those who bought a more comprehensive policy allowing more choice of hospital. BUPA PMI would also have the incentive to cycle hospitals through its preferred network, whereby hospitals in the network for a three-year period were out of the network for the following cycle. This practice had the effect of limiting other hospitals' ability to fund the investments in equipment which were critical to a hospital's continuing viability, because of uncertainty of future coverage and pressure on its cash flow. This would lead to a downward spiral, as lack of investment reduced consultant and therefore patient usage.

6.17. GHG said that the proposed merger would increase BUPA's pricing leverage because it would increase its number of flagship hospitals from five to eight; secure dominance in Leeds/Bradford; and secure total control in Essex.

6.18. GHG said that its experience over the last ten years could lead only to the conclusion that the requirement of the MMC, in its 1990 report, that BUPA continued to operate its PMS and PMI businesses on an arm's length basis, had been largely ignored. Within BUPA it was clear that the businesses were run on a fully integrated basis, with common support and management services, and a commonality of decision-making.

6.19. During the mid-1990s the Chinese walls between PMI and PMS provision within BUPA seemed to crumble. The BUPA 1998 Report and Accounts was blatant, speaking of having an integrated company. BUPA's current Operational Board comprised Group Finance, Marketing, Medical, IT and Human Resources directors, but did not feature either a Head of Insurance Division or a Head of Hospitals. The management structure was that of an integrated company. Frequent movement of staff at the senior level took place between the PMI and PMS businesses.

6.20. Further evidence of the ineffectiveness of these Chinese walls had arisen as a result of BUPA's acquisition of Goldsborough in 1997. The plan by BUPA Hospitals to increase prices to PMI providers above inflation at around 7 to 8 per cent for 1999 again raised questions about the Chinese walls structure within the BUPA organization. BUPA blamed these larger-than-normal price increases on, among other things, changes to VAT rules on medicines and equipment. However, PMS providers were able to keep price rises at half that level, leading to suggestions within the industry that the price increases were a response to losses by BUPA's PMI business and that the high increases were part of a move to recover the Goldsborough acquisition costs. In addition, it was understood that BUPA increased Goldsborough's prices to other PMI providers by 22 per cent.

6.21. GHG said that, since submitting the merger notice to the OFT on 25 April 2000, BUPA had acquired 26.8 per cent of the shares in CHG through SBUKE. The offer document issued by SSSB to acquire shares in CHG outlined the arrangement by which SBUKE purchased this shareholding. BUPA Finance agreed to make available a loan facility of up to £70 million to be used by SBUKE in acquiring CHG shares and in paying the expenses of such acquisitions and subsequent disposals. In economic terms, BUPA Finance bore all the risk and would receive all the benefits associated with the purchase of the shares. GHG believed that whilst this structure might not technically breach the 1997 undertakings to the OFT, it was firmly a breach of their spirit. The shareholding in SBUKE's hands still left BUPA with the ability to influence CHG and it was implicit that SBUKE was simply acting as a conduit for BUPA to develop a significant stake in CHG.

6.22. GHG said that it was not clear what we had in mind in our suggested remedy that effective measures be taken to separate BUPA's PMI and PMS businesses. GHG assumed that we were suggesting an institutional demerger of the two parts of BUPA's business. Anything less than a complete structural and legal separation would not be sufficient to address the current problems endemic within BUPA, caused by its vertically integrated structure and the conflicts of interest between the two arms of the business.

6.23. GHG believed that the only practicable remedy that would adequately address the merger's potential detriment to the public interest was its prohibition. The scope of any future acquisitions by BUPA acceptable to us (if any) should also be made clear.

6.24. GHG did not believe that BUPA should be permitted to choose hospitals from a total post-merger portfolio, as this would enable BUPA to further develop its bargaining strength by retaining the best hospitals. However, if we decided that divestments were an appropriate remedy, GHG suggested we should specify that the following hospitals be divested: the Yorkshire Clinic, Bradford; Berkshire Independent, Reading; Pinehill, Hitchin; Rivers, Sawbridgeworth; and Springfield, Chelmsford; plus Fitzwilliam, Peterborough; New Hall, Salisbury; Winfield, Gloucester; Mount Stuart, Torbay; and Duchy, Truro.

6.25. GHG considered that divestments could only be effectively agreed prior to the proposed merger since otherwise BUPA was likely to influence a switch of allegiance or a transfer of services, which would weaken the hospital businesses being acquired by its competitors. BUPA should also be required to divest by means of an open competitive tender. This would prevent BUPA selling hospitals to those PMS providers that it believed would be weak competitors.

6.26. The MMC and the OFT had on previous occasions suggested behavioural undertakings as a suitable remedy. The view of GHG, as illustrated by the acquisition by SBUKE of a 26.8 per cent shareholding in CHG on BUPA's behalf, was that BUPA would again find a way to avoid the intended effect. GHG agreed with the potential remedy that SBUKE should, subject to the approval of the DGFT, sell its shareholding and in the meantime be prohibited without the consent of the DGFT from exercising its voting rights.

Guy's & St Thomas's Hospital Trust

6.27. Guy's & St Thomas's Hospital Trust (Guy's & St Thomas's) said that it had some 80 private beds. It was not part of either the BUPA network or PPP's list of PMS providers. It had over 300 consultants in the Trust with 150 undertaking private practice.

6.28. Guy's & St Thomas's said that it thought the NHS Plan would have an impact on the private sector but that it would probably be highly differentiated in different parts of the country. In London there was a substantial PMS capacity and in some areas constrained NHS capacity and staffing.

6.29. The volume of self-pay patients appeared to relate to the length of NHS waiting lists. A further factor was the increase in PMI premiums as people got older and the fact that it might be more sensible for some patients to pay from their savings rather than insure. 30 per cent of the patients at Guy's were self-pay. Guy's & St Thomas's said that it saw BUPA's consultant partnership, the hospital networks and the managed care as being a means of increasing control in the insurer's interests.

6.30. Most of Guy's & St Thomas's insured patients were BUPA or PPP subscribers. It did not think that it had much spare hospital capacity. Guy's & St Thomas's was doubtful that BUPA operated effective Chinese walls between its PMI and PMS businesses.

Nuffield Nursing Homes Trust

6.31. Nuffield believed the proposed merger between BUPA and CHG would, as a consequence of BUPA's vertical integration, strengthen BUPA's position in the private healthcare market overall, with adverse consequences for competitors in the provision of PMS, for other health insurers, and, importantly, to the detriment of consumer choice.

6.32. BUPA would own approximately 25 per cent of the beds in the PMS market. This would allow BUPA PMI to give preference to BUPA PMS and exert undue influence upon other PMI providers. The abundance of BUPA PMS provision could operate to the detriment of hospitals—especially unaffiliated private hospitals with little market power—which could find themselves removed from preferred networks in favour of BUPA hospitals. Nuffield also remained concerned about the effect that the proposed acquisition might have on the PMI market generally in view of BUPA's position of market power.

6.33. The position of BUPA as a vertically integrated undertaking in the healthcare marketplace had been well documented over several years. The proposed acquisition of CHG raised again the issue of the vertical integration of BUPA's PMI and PMS businesses, the extent of BUPA's PMS ownership, and the impact of both these features on the PMI market. Nuffield believed that there should be an absolute separation of BUPA PMI from BUPA PMS.

6.34. The merger would considerably increase the number of hospitals operated by BUPA. This might put BUPA in a position to deny its members access to hospitals operated by other PMS providers, because it would have no incentive to go outside the group. There would be sufficient BUPA hospitals in many geographical areas for BUPA effectively to be able to operate a closed network. Even if BUPA did not require its network policy-holders to use only BUPA hospitals, BUPA could reclassify non-BUPA hospitals into higher bands to prevent lower-banded BUPA PMI policy-holders from using such hospitals. The threat to reclassify, or exclude from the network, would enable BUPA to negotiate reduced rates with non-BUPA hospitals.

6.35. [

Details omitted. See note on page iv.

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6.36. [

Details omitted. See note on page iv.

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6.37. [

Details omitted. See note on page iv.

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6.38. If BUPA were to retain ownership of both its PMI and PMS businesses, Nuffield believed that we should seek their verifiable separation, leaving the two new entities under separate management and financial control, able to operate only at arm's length and physically apart in separate buildings.

6.39. [

Details omitted. See note on page iv.

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6.40. [

Details omitted. See note on page iv.

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St Anthony's Hospital

6.41. St Anthony's said that it did not believe the acquisition of CHG by BUPA was in the public interest. One of the concluding recommendations of the 1990 report was that further investigation would be warranted should there be any reduction in the nature of the arm's length working relationship between BUPA's PMI and PMS businesses. Not only had recent restructuring of BUPA increased the vertical integration of the organization, but the proposed acquisition would make BUPA by far the largest and most powerful PMS and PMI provider.

6.42. There were many problems inherent in one organization being the dominant PMI and dominant PMS provider. St Anthony's said that it had become used to the purchaser/provider split of the 1990s introduced by the previous Government under the terms of which the provision of the service was separated from the financing of the service. Yet in the case of BUPA, one organization not only provided the service to the customer, wherever possible in its own hospital, but also was the financial representative of the customer at the same time.

6.43. If this merger went ahead, almost 60 of the current 160 network hospitals would be owned by BUPA. This amounted to approximately 35 per cent of the whole market. It must be expected that all of the CHG hospitals would be made network hospitals, all of which were selected by BUPA PMI. There had been instances in the past when an individual hospital had not been incorporated within the network of BUPA-selected hospitals, but when it had changed ownership it had indeed become a member of the network.

6.44. In the 1980s BUPA used funds from BUPA PMI to purchase and run hospitals. Accordingly it was quite possible that premiums might have been unnecessarily high. Now the position was probably the reverse: BUPA PMS was subsidizing BUPA PMI, as a result of which BUPA PMS had unnecessarily high charges. The national BUPA bed price for an A room was £442 a night and for a B room £360 a night. This was substantially higher than the prices of most hospitals and was double the price of St Anthony's which had the only brand new fully-staffed intensive care unit in the area, performed cardiac and other complex surgery, had CT and was about to install MRI. St Anthony's believed that it would be appropriate for us to consider why BUPA's prices were so high and to consider further the extent to which the takeover would raise the prices of the CHG hospitals to the same level.

6.45. BUPA PMS charged higher rates to patients who were not insured by BUPA. The effect of this was that other PMI providers, as well as self-pay patients, were having to subsidize the BUPA PMI/PMS complex. The Competition Act's provisions on both anti-competitive agreements and on the abuse of a dominant position referred to directly or indirectly fixing the purchase or the selling price and the appli-

cation of dissimilar conditions of equivalent transactions with other trading parties, thereby placing the latter at a competitive disadvantage. It was St Anthony's belief, and that of others who worked in healthcare, that these two prohibitions were already being infringed by BUPA and would be proportionately more so if the merger went ahead.

6.46. There was one further prohibition within the Competition Act which was also relevant. That was the prohibition on limiting or controlling production or markets. The essence of the BUPA network of selected hospitals was designed to do just that. By excluding St Anthony's from the network, BUPA was not only denying all its network subscribers access to the only intensive care unit in the area but was also denying the hospital the opportunity to admit patients and look after them at similar or lower prices and with similar or higher quality.

6.47. If BUPA acquired CHG it would be in a position to force more of its work through its own hospitals. Such actions reduced patients' choice considerably. St Anthony's did not believe that any of BUPA's own hospitals were not on BUPA's list of selected network hospitals.

6.48. St Anthony's had on several occasions made representations to the OFT about the establishment of local healthcare monopolies by PMS providers; hitherto the four main providers had been General Healthcare, Nuffield, BUPA and CHG. Once these local monopolies had absorbed the competition, there would be nothing to prevent them from markedly increasing their prices. This appeared to be precisely what was happening, for BUPA was now intent on absorbing CHG and had raised its prices considerably.

6.49. The enlargement of the BUPA hospital network would also impact upon the way consultants were urged to join the CPS. It needed to be understood how the hospital Partnership Network worked in conjunction with the CPS. A patient who wished to retain the choice of where to be treated, rather than be required to use BUPA's nominated hospitals, would pay an additional premium to BUPA in order to preserve that choice. If, however, that patient then found himself referred to a consultant who had been prevailed upon to join the CPS that patient would find himself being forced into the BUPA network which he had sought to avoid. One of the conditions of the CPS was that consultants admitted patients to network hospitals only.

6.50. It looked as though the merger would increase prices within the market. The only way which the OFT could satisfy itself on this point was to ask for copies of all the pricing agreements which BUPA PMI gave to hospitals with which it did business. St Anthony's said that it would be interested to know the stance of the OFT should it discover that the takeover of CHG had raised prices substantially to a level which was above the average within the market. There would then exist a deleterious alliance between a dominant PMI provider and its PMS subsidiary which was well known for its excessive charging. One effect of BUPA directing patients to its own hospitals was that individual hospitals, which were not part of any group, were already closing down. There had been several instances when charitable hospitals, often with much lower prices than BUPA's, had ceased to trade, owing to the actions of the PMI provider in directing patients to higher-cost providers. The Hospital Director of St Anthony's Hospital was also the Chairman of CHF, a federation of charitable hospitals, and it had been dispiriting to note how many of these had closed down on account of the understanding which BUPA PMI had with chains of commercial hospitals, several of which were, or had been, foreign-owned.

6.51. The report of the OFT of 5 November 1999 into the effect of network hospitals referred to quality within the following context: 'Hospital Networks have been successful in encouraging hospitals to compete on price and quality. The evidence so far suggests that consumers are benefiting from these improved efficiencies through wider choice of lower cost PMI.' St Anthony's believed this statement was flawed, as the OFT had failed to take evidence from hospitals on the quality or the price which applied to hospitals both in and outside the network.

6.52. If BUPA acquired CHG, BUPA's spread of hospitals would geographically increase. This would allow it to acquire all sorts of demographic information which could then be fed back to BUPA PMI. This would place other PMI providers at a disadvantage. Likewise, the more BUPA would be able to instruct patients, through its 'Call BUPA first' policy, to go to its own hospitals, the more other companies would be at a disadvantage. There was disconcerting evidence that doctors were being urged by BUPA to refer to consultants who had joined the CPS. Referral was a clinical process first and foremost. Many consultants believed that their primary obligation was to the patient and that the consultant's choice of where to treat the patient should not be determined by the PMI provider. The more hospitals which BUPA owned, however, the more it was possible for BUPA to limit the options of the consultant to stay

out of the CPS. BUPA had recently doubled the incentive payment to consultants from 5 to 10 per cent if they joined the CPS.

6.53. St Anthony's said that BUPA had directed a patient to a BUPA hospital even where the individual was a self-payer and would have to travel a considerable distance. St Anthony's said that when BUPA had excluded St Anthony's from its network it had prohibited patients from going to it even though their policies had some months to run. St Anthony's said that some BUPA patients were required under the terms of their policy to pay the first, say, £200 of a bill. If a patient holding such a policy were to run up a day-case bill of £240, the patient would pay the first £200; BUPA would pay £40 and then would take as a rebate from St Anthony £48 (20 per cent of £240). St Anthony's said it was bizarre that BUPA should expect a rebate from the hospital on money paid by somebody else. St Anthony's said that BUPA's HAP indicated that it was BUPA's sole decision as to what it would pay; that the hospital could not ask the patient to pay any part of the bill that BUPA chose not to pay; and the hospital was not permitted to discuss the HAP with any third party. St Anthony's said that there were ongoing instances of BUPA, without adequate explanation, deducting sums relating to past events from current patient accounts.

6.54. St Anthony's said it was doubtful that there were Chinese walls, because the same doctor spoke on behalf of BUPA PMI and BUPA PMS and because there was so much interchange of staff. BUPA was indifferent about whether profits were made within its PMI or PMS businesses and it was in a position to manipulate the market to make profits in one area at the expense of the other. Since the Chief Executive of the PMI and PMS businesses was the same person there could be no proper division. St Anthony's said that the merger should be allowed to proceed only if BUPA were to take effective measures to separate its PMS and PMI businesses.

St Mary's Hospital, Bristol

6.55. In August 2000 we visited St Mary's Hospital Bristol. It told us that it was an independent charity, associated with a religious order. It had 42 beds, two operating theatres and a recovery unit. It offered general surgical services, but 60 per cent of its cases were orthopaedic. Its midnight bed occupancy was about 50 per cent. It told us that its turnover was £2.5 million. St Mary's said that 55 consultants used its facilities. It had 7 management staff, 70 nurses and 53 ancillary staff.

6.56. St Mary's said that its principal competition came from the local Nuffield hospital, the CHG hospital at Gloucester and the Bath Clinic. It had a good relationship with the local NHS Trust, which provided 11 per cent of its patients. St Mary's also drew patients from further afield, including the Midlands and overseas.

6.57. St Mary's said that it was not on any PMI provider's network, although it had formerly been on both BUPA's and PPP's. The only advantage of being on a network was increased volume of business, although this had not been so apparent with St Mary's in the case of BUPA. St Mary's had a two-year contract with BUPA, at what it considered unfavourable rates. This provided 10 to 15 per cent of its business. St Mary's also offered self-pay packages, the prices of these being generally similar to those paid for insured patients.

6.58. As regards the proposed BUPA/CHG merger, St Mary's said that it believed local disadvantages might result for it if the Gloucester CHG hospital were to be taken over by BUPA, but felt that its religious background and local support would help to mitigate these.

The Bath Clinic, Bath

6.59. The Bath Clinic, which we visited, is a hospital within the GHG group: it had 75 beds and three theatres and offered a wide range of general surgery, specializing in orthopaedic cases. It did not offer intensive care or major thoracic or intensive neurosurgery. Including the increasing numbers of day-cases, the Clinic worked at fairly full capacity, the bottleneck being the lack of a second orthopaedic theatre. The Clinic said that it had a turnover of £10.5 million and was used by some 200 consultants. It had a total of about 201 staff, including 12 management staff and about 48 nurses, and 67 ancillary staff.

6.60. The Clinic told us that its principal competing hospitals were St Mary's, Bristol, the Chesterfield Nuffield and the CHG hospital at Salisbury. It said that it had a good relationship with the

local NHS Trust, and substantial orthopaedic contracts with it as well as contracts in the areas of infertility and ophthalmology. The Clinic said that it was on the BUPA and PPP networks, these groups providing 26 per cent and 18 per cent respectively of its patients. It believed the advantages of being on a network were the publicity gained and the possibility of more volume, although the latter question was still open. Disadvantages included lower prices, lack of flexibility and cumbersome administration. The Clinic said that 24 per cent of its patients were self-pay. Self-pay packages were offered, the prices of these generally being set centrally.

6.61. On the question of a possible BUPA/CHG merger, the Clinic could see a specific problem of possible patient direction to the present CHG hospital at Salisbury while, more generally, a merger could increase BUPA's market dominance, reduce patient choice and inhibit the market entry of new health insurers. As regards safeguards should the merger be permitted, the Clinic considered the separation of the BUPA PMI and PMS businesses to be essential.

The Hospital Management Trust

6.62. The Hospital Management Trust (HMT) said through the CHF that it had submitted substantial evidence in the past about its concerns on numerous aspects of BUPA and PPP activities both in relation to network hospitals and to consultant partnerships.

6.63. HMT said that it had made what it believed to be the first material complaint to the OFT about BUPA's tactics and predatory pricing as long ago as February 1996. Many of the practices and problems which it drew attention to at that time still pertained and had expanded greatly as a result of the network activities of the last couple of years.

6.64. HMT said that BUPA was a complex organization, which enjoyed a monopoly position in the supply of PMI in the UK in terms of the Act and was also a non-monopoly supplier of hospital services. It was unique in being involved in both markets. BUPA PMI historically placed hospitals in one of three scales, A, B or C. There was a substantial benefit to a PMS provider in being within scale C because any patient covered by a BUPA subscription might choose that hospital and have the costs reimbursed in full.

6.65. HMT said that the BUPA Index purported to represent a weighted average of the charges made by the hospitals in the appropriate scale. BUPA used the Index to negotiate the agreed level of charges to be made by the individual hospital to BUPA subscribers or, failing this, placed the hospital in a higher, more expensive scale. The Index was compiled internally by BUPA and could not be verified by hospital operators.

6.66. The BUPA Index included BUPA PMS which was one of the largest groups of private hospitals in the UK and which charged BUPA a highly preferential rate. HMT had been shown figures for BUPA PMS indicating a room rate to BUPA subscribers of about 40 per cent of the standard room rate, whilst other charges, notably theatre charges, were broadly comparable. When translated into total hospital charges, this equated to a discount on BUPA's standard charge of at least 25 per cent for the average hospital charge per patient episode. This pricing policy inevitably pushed down the BUPA Index by a material amount.

6.67. The artificial depression of the BUPA Index by the inclusion of BUPA PMS enabled BUPA to provide misleading data and place added pressure on the other PMS providers to reduce charges to BUPA subscribers or be placed on a higher, more expensive scale. The viability of the PMS provider was threatened by either uneconomic margins or the need to charge unsustainable prices to the subscribers of other PMI providers. Additionally, BUPA PMI effectively influenced the charges made by the hospitals which were used by its subscribers by insisting on a substantial discount as compared with all other PMI providers. HMT believed that the process outlined amounted to a form of predatory pricing, engaged in by a monopolist if BUPA's pre-eminence in the insurance market was considered, or by a non-monopolist if one considered only BUPA PMS. In either case, the result was contrary to the public interest because it led to a reduction in competition in the private healthcare market and monopolization of that sector by BUPA.

6.68. HMT said that evidence from smaller PMI providers was that similar differentials applied to this day. If HMT's assumptions were correct, it was evident that some of the smaller PMI providers were

being penalized to a degree which was grossly anti-competitive and which would lead to even greater dominance of the market by BUPA and PPP unless corrective action was taken. HMT said that it also had evidence of BUPA selling PMI products that were linked specifically to a BUPA hospital even though it was a substantial distance from the patient's home and even though there was a local PMS provider with an agreement with BUPA. HMT said that it was also aware of a non-BUPA hospital which was in a monopoly position that came into a potentially competitive position with another PMS provider. BUPA PMI initially sought a £350,000 rebate for the year and a 5 per cent reduction in costs on the basis of the possible alternative prices that the other PMS provide might offer. The request for a rebate was later dropped but the 5 per cent reduction was still under negotiation.

6.69. BUPA had told HMT that it was not particularly interested in the actual hospital price but in the relative price. HMT had been effectively forced into a discount of about 11 per cent below rates to other PMI providers. Generally, BUPA sought a price 20 per cent below its competitors, particularly for network products. HMT said that a consequence of the merger was likely to be that the BUPA network would particularly focus on 160 hospitals out of the overall 800 because they were the primary focus for consultants. The 160 hospitals were therefore likely to attract a substantial proportion of patients. HMT said that five years ago self-pay patients represented 15 per cent of the market but this was now closer to 25 per cent. HMT said that it was doubtful whether there were effective Chinese walls between the BUPA PMS and PMI businesses. An example of this was that BUPA PMI and BUPA PMS reported to the same Managing Director. HMT said that it considered the merger should be prohibited; that the BUPA PMI and PMS businesses should be separated into independent corporate entities; and that it did not believe that divestment of less than 50 per cent of the BUPA post-merger estate would be an effective remedy. HMT considered that any pre-agreement with a third party purchaser prior to the proposed merger would exacerbate matters. HMT believed also that differential pricing should not be permitted for similar medical conditions and that consultants should not be restricted on where they could admit their patients for treatment for similar conditions.

The Mount Alvernia Hospital, Guildford

6.70. The Mount Alvernia Hospital, Guildford, which we visited, said that it was a registered charity operated by Catholic Franciscan Sisters, from whom the Trustees were also drawn. Surpluses were devoted to the Sisters' missionary and hospital work, mainly in Central Africa.

6.71. The Mount Alvernia said that it had 76 beds and a three-theatre operating suite, plus a day-care unit and an oncology unit. It specialized in oncology. It offered general surgical services, but no cardiac or intensive care. Over 50 per cent of patients were day-care, which resulted in a relatively low midnight bed occupancy. The Mount Alvernia said that it had a turnover of £12 million; 120 consultants used its facilities; and it had a total of 300 staff.

6.72. The Mount Alvernia said that its local competing hospitals were the BUPA Clare Park Hospital, Farnham, Ashted (CHG) and the Guildford and Woking Nuffield hospitals. The NHS Trust boundary defined the local market since GPs used the same consultants for both NHS and private work, although this factor naturally became less effective near Trust boundaries.

6.73. The Mount Alvernia said that it was in the BUPA and PPP networks and that these two PMI providers together accounted for about 60 per cent of the hospital's workload. The hospital also worked with all other PMI providers, and these together accounted for about 25 per cent of its work, with the balance of income coming from self-pay patients. This meant that the networks had a marked effect on the hospital, although it did not expect them to deliver increased volume. The Mount Alvernia said that its negotiations with BUPA had been exceptionally protracted, with great pressure being exerted on its prices. Negotiations with PPP had been more straightforward. The Mount Alvernia also had a good relationship with the NHS Trust, although there existed an exceptionally close geographical and financial relationship between the Trust and the Nuffield hospital, which led to the Trust's giving priority to the latter.

6.74. The Mount Alvernia said that it offered packages for self-pay patients, who, together with small insurers, generally paid more than large insurers.

6.75. On the 'Consultants' Network', the Mount Alvernia was aware of its general operation but did not believe that it had any significant effect on fees or otherwise.

6.76. Mount Alvernia considered that the proposed merger should not be approved: BUPA already had excessive dominance in the industry. The Mount Alvernia considered BUPA's ownership of both PMI and PMS businesses to be the least acceptable aspect: nobody had confidence in any 'Chinese walls'.

The New Victoria Hospital, Kingston

6.77. The New Victoria Hospital, Kingston, which we visited, is a registered charity, established in 1958, having replaced the Victoria Hospital which was established in 1898. It had 37 beds and three operating theatres and provided an acute medical surgical service. 30 per cent of revenue came from outpatients. Its turnover was £7 million.

6.78. The New Victoria told us that 120 consultants used its facilities. There was a total of 170 staff, of whom 25 were management, administrative and clerical, 115 nurses and 30 ancillary.

6.79. The New Victoria said that there were no competing hospitals within the local NHS Trust area, other than Coombe Wing which was Kingston General Hospital's private wing. Other private facilities provided little competition and to some extent the area could be seen as a series of local monopolies. The New Victoria had reason to believe that its costs were among the lowest in the area.

6.80. The New Victoria said that it was on the BUPA and PPP networks. It believed these were essential to its survival. It believed the 'Consultants' Network' was a matter of concern.

6.81. The New Victoria said that it offered fixed-price packages to self-payers. Generally self-payers paid about 5 per cent more than small insurers.

6.82. As regards the possible BUPA/CHG merger, the New Victoria did not think it would directly affect it locally, [*Details omitted. See note on page iv.*].

The Nottingham Nuffield Hospital

6.83. The Nottingham Nuffield Hospital (NNH), which we visited, has 38 beds, having had to reduce the number as a consequence of the hospital's exclusion from both the BUPA and PPP networks. Changes in medical technology and the trend towards day and outpatient treatment had also been factors in reducing total bed numbers. The NNH said that it had two operating theatres, with a third for day-patient procedures under consideration. With the substantial increase in daypatient and outpatient treatments and therapies there was increasing pressure on operating theatre availability and average overnight bed occupancy was no longer a reliable measure of hospital activity.

6.84. The NNH said that it offered general medical and surgical services, but did not cater for highly complex surgical procedures. It specialized in ophthalmic cases, in which it was regarded as a centre of excellence. It had good relations with the local NHS Trust and an agreement on winter-planning requirements and in other areas.

6.85. The NNH said that about 150 consultants had practice privileges at the hospital which itself employed some 120 members of staff. Of this total, 30 were qualified nurses, 30 were professionals allied to medicine and 60 were support services and administrative staff. It regarded as its principal competitors The Park Hospital and the Derby Nuffield. The NNH said that the local market was determined largely by the GPs, their knowledge of local consultants and the hospitals in which consultants were prepared to work (within about 30 minutes' drive-time). GP referrals were largely determined by the NHS Trust boundaries, cross-boundary referrals being relatively rare since the NNH did not offer those types of speciality (such as cardiac surgery) in which such referrals most often take place.

6.86. The NNH said that the hospital had been acquired from a religious order in 1998. It had been excluded from both the BUPA and PPP networks prior to the acquisition and remained outside them. Some 20 per cent of its patients were BUPA subscribers, 10 per cent PPP and 30 per cent self-pay. 80 per

cent of self-pay comprised joint replacements and cataracts. The NNH offered a self-pay package which included consultants' fees and had a 30-day guarantee covering complications following surgery.

6.87. As to the wider implications of the possible BUPA/CHG merger, NNH said that one consequence would be that BUPA could direct its members to its own hospitals. For example, in the North of England BUPA would have a very strong hospital representation in the Leeds/Bradford and Halifax areas. The NNH said that we should consider the merger in the light of such regional and local markets and if the merger was allowed to proceed there should as a condition be a complete split of BUPA's insurance and hospital activities.

The Park Hospital, Nottingham

6.88. The Park Hospital, Nottingham, which we visited, told us that it was the seventh largest GMG hospital, having 69 beds, of which three were intensive care. It said that it had three main operating theatres, plus an intensive care unit and a new five-bay treatment area for cancer cases. It was operating at a 48 per cent capacity on the midnight bed basis, and a 67 per cent capacity on a bed-use basis. Its annual turnover was £10 million.

6.89. The Park told us that about 350 consultants used its services for most types of operation, including some cardiac and neurosurgery. It employed 12 management staff and 150 nurses, with about 88 ancillary staff.

6.90. The Park told us that its principal competitors were the NNH, the Queens Medical Centre, the Nottingham City NHS Hospital and, for some cases in the south of the county, the Leicester BUPA Hospital. The local market tended to be defined by NHS Trust boundaries. The Park was on the BUPA and PPP networks, the former providing 34 per cent of patients and the latter 17 per cent. The Park believed that being on the networks provided useful publicity and increased volume, but networks had the disadvantage of much lower pricing and were disliked by some consultants because of the element of direction. The Park had no views on the operation of the insurers' 'Consultants' Network'.

6.91. The Park said that it offered packages for self-pay patients, who generally sought the best deal. Prices were reached on a market basis. As a result there was no great difference between what self-pay and insured patients paid.

6.92. On the proposed BUPA/CHG merger, the Park told us that it believed this must be generally disadvantageous. BUPA was already one of the largest PMS providers and absorption of another group of hospitals could only enhance its bargaining power, principally because it was so heavily represented on both the insurance and hospitals sides. More specifically, the Park feared possible direction to the CHG Fitzwilliam Hospital at Peterborough.

The Staffordshire Physiotherapy and Sports Injuries Clinic

6.93. The Staffordshire Physiotherapy and Sports Injuries Clinic (SPSIC) said that it had been established for ten years, and treated patients referred to it by GPs and consultants, and also self-referring patients. Many of these patients were privately insured and the SPSIC had to claim the cost of any treatment directly from the insurers.

6.94. The SPSIC said it was concerned that BUPA was attempting to use its dominant market position in an attempt to force it to reduce charges. BUPA was claiming that these charges were high by comparison with local and national averages. However, the SPSIC had been in touch with the BUPA Parkway Hospital, Solihull, which charged £36 per physiotherapy session compared with the average charge by the SPSIC of £33. The SPSIC said BUPA also proposed that the SPSIC surcharge other patients and insurance companies as a method of meeting BUPA's proposals on reduced charges.

PMI providers

Bristol Contributory Welfare Association Limited

6.95. BCWA said that it wished to make representations against the proposed acquisition of CHG by BUPA, because the acquisition would materially change the respective market shares of the four national PMS providers.

6.96. Almost 87 per cent of private acute hospital beds in the UK were provided in some 177 non-NHS units, with PPU's accounting for the remaining 13 per cent of the provision. GMG, BUPA, Nuffield and CHG owned 138 (78 per cent) of these units. Since BUPA also had a 40 per cent market share of the PMI market, there was a concern that this enlarged healthcare organization would have an undue, possibly uncompetitive, influence on the UK private healthcare market.

6.97. BCWA said that BUPA hospitals already accounted for a large proportion of the UK's private acute hospital provision. This proportion would grow substantially if the proposed acquisition were allowed. Also, in the event that BUPA were to seek to impose an unreasonable price increase, then the responses available to insurers would be limited. Excluding BUPA hospitals from an insurer's hospital directory would be impractical because the resulting, reduced, directory would not be acceptable to many PMI purchasers. The ability to use market size to increase prices was demonstrated in 1999 when BUPA PMS's price increase was substantially higher than the increases agreed with the other hospital operators.

6.98. The risk of abuse of pricing power was reinforced in those areas where the expanded group would have local monopolies. Areas such as Essex, Reading and Leeds were examples of hospital markets where BUPA and CHG had a dominant market share. Such regional monopolies might be open to restrictive pricing to competing insurers resulting in increased premiums to customers.

6.99. BCWA believed that possible safeguards, such as a requirement that BUPA dispose of certain hospitals in areas where local monopolies existed, might prove ineffective. The only options available to BUPA were:

- (a) the closure of units—the existing business of the closed units would transfer to the remaining local BUPA hospitals, sustaining the local monopoly;
- (b) the disposal by sale to a smaller hospital owner—such a competitor might not be viable in the longer term, particularly in view of BUPA's ability to direct its insurance policy-holders to its own hospitals through the use of network products; and
- (c) to sell to another of the large hospital groups—while avoiding local monopolies, this option promoted the extension of a national oligopoly.

None of these options provided adequate protection for the interests of the consumer.

6.100. With BUPA's large share of the PMI market and an increased share of the private acute healthcare provider market, BUPA would be able to manipulate the market in a variety of ways. First, it would be able to offer network products with reduced premiums to direct business into BUPA hospitals and away from competitors, possibly forcing some competing hospitals to close. In the longer term, with local competitors eliminated, BUPA would have the ability to force hospital price increases upon other insurers and subsequently to increase premium levels to its own customers.

6.101. Second, the influence on the market through the use of differential pricing might pose barriers to entry to the market by new insurers and increase competitive advantage over insurers already in the market. By exercising regional dominance in some local markets, any other insurer would be unable to exclude many BUPA hospitals from their hospital directories if they were to offer products with adequate geographical coverage. In the longer term, this was likely to result in reduced choice and higher premiums for purchasers of PMI.

6.102. Lastly, there was continued concern that BUPA had not maintained the degree of separation between its provider and insurer businesses required by the 1990 report. Even before the planned acquisition, BUPA had been referring to its strategy as an 'integrated provider' of healthcare. BUPA had

maintained that internal Chinese walls were sufficient to ensure proper and adequate separation between its business operations. The creation of this enlarged group would exacerbate the concerns set out in the original 1990 report, further exposing BUPA to the charge that it had the ability to manipulate the UK private healthcare market to its own advantage, and raise barriers to entry against the interest of the consumer.

6.103. BCWA believed that the proposed acquisition raised fundamental concerns. It shared the OFT's concern over any further extension of BUPA's share of the private acute healthcare market and it felt that there would be real concerns for the future competitiveness of the UK private healthcare market and PMI market post-acquisition. The potential threat to consumer choice and insurance premium levels posed serious questions as to whether such an acquisition was in the public interest.

CIGNA Healthcare and Group Life

6.104. CIGNA Healthcare and Group Life (CIGNA) said that it had two areas of concern regarding the proposed merger between BUPA and CHG. The first related to BUPA being the dominant party in both the PMI and PMS markets should the merger be allowed. BUPA had long dominated the PMI market, despite much effort and expense by other providers. Only one, PPP, had managed to get close to it in terms of scale. If BUPA dominated the PMS market as well this would give it the opportunity to behave in a predatory way with regard to either insurance or hospital services.

6.105. CIGNA also remained unconvinced that Chinese walls existed between BUPA PMS and BUPA PMI. An example of this was that BUPA's Strategic Director looked after strategy for all parts of BUPA and there was an overall Medical Director for BUPA. It seemed unlikely that these individuals could be aware of confidential information and yet not use it to consider the implications for other BUPA divisions.

6.106. CIGNA's second concern related to brand dominance in the private healthcare sector. BUPA continued to be the main PMI brand in the UK. If it owned the majority of private hospitals it was likely that members of other insurance companies would be treated in a BUPA hospital. Given BUPA branding, patients were likely to believe they were BUPA customers. This undermined the efforts by other providers to bring their brands to life or to differentiate their service.

Exeter Friendly Society Limited

6.107. Exeter Friendly Society Limited (Exeter) said that the proposed merger would reduce customer choice of available hospitals, something which had been eroded considerably in recent years particularly with the closure of several charitable hospitals. However, it found it difficult to put forward arguments that the merger between BUPA and CHG would be against the public interest.

6.108. Nevertheless, there was a widespread industry belief that a business relationship must exist between BUPA PMI and BUPA PMS and the merger would create an organization which had about 40 per cent of the PMI market and more than 30 per cent of acute surgical private beds (excluding NHS pay-bed units) in the UK. The result therefore must increase further the possibility that terms unfavourable to other PMI providers would be levied to the benefit of BUPA PMI.

6.109. Exeter said that it knew from charges levied against its members that BUPA's costings were marginally higher than those of CHG in some cases, but believed that if BUPA's pricing schedule was adopted by the new group then the position would probably be neutral or possibly even marginally in Exeter's favour.

Norwich Union Healthcare Limited

6.110. Norwich Union said that it had strong concerns regarding the impact which BUPA's acquisition was likely to have on the PMI market. Norwich Union was the third largest provider of PMI in the UK, after BUPA and PPP. In 1998 it had total PMI gross written premiums of £155 million, representing about 8 per cent of total UK PMI revenues. It offered a range of PMI policies, aimed at both individual and corporate subscribers, for example: 'Express Care', which provided comprehensive cover for acute

medical care; 'Fair and Square', which offered lower premiums, with a money-back option if the subscriber chose NHS treatment, and with a reduced list of approved hospitals; and 'Trust Care', which enabled policy-holders to be treated in NHS PPUs. It currently had approximately 500,000 UK customers for PMI products.

6.111. Depending on the product, Norwich Union offered its policy-holders a list of about 274 approved private hospitals where they could go for treatment and where their costs would be wholly or partially reimbursed (this figure, however, included NHS PPUs and specialist tertiary centres). Its network products were based on much shorter lists. Norwich Union aimed to ensure that policy-holders under each of its policies had access to high-quality, specialist facilities in a wide range of locations throughout the UK. Any insurer seeking to compete in the PMI market had to make available to its subscribers a sufficiently wide range of quality hospitals, for the convenience of the patient.

6.112. BUPA was the largest UK PMI provider, accounting for about 40 per cent of total UK subscription revenue. In addition, BUPA was a large PMS provider in the UK. Its acquisition of CHG would make it the largest PMS provider in the country.

6.113. As a consequence of the acquisition, BUPA would increase its share of independent acute hospital beds from 17 to 26 per cent. Its market share excluding specialist abortion clinics and NHS pay-beds would be even higher, about 29 per cent. Norwich Union believed the merger would considerably strengthen BUPA's vertically integrated PMI and PMS businesses, to the detriment of competitors in both markets.

6.114. Norwich Union's principal concerns related to the impact of the acquisition on its own approved list of hospitals, on claims costs, and hence premiums. Both BUPA hospitals and CHG represented a major part of Norwich Union's approved list. If the merger proceeded, the BUPA/CHG hospitals would account for about 16 per cent (28.5 per cent in the case of its 'Fair and Square' policy) of approved hospitals, heavily increasing Norwich Union's dependence on BUPA's provision of private hospital beds. Furthermore, BUPA/CHG hospitals would represent an even higher percentage of the commonly used hospitals on Norwich Union's list.

6.115. Norwich Union asked us to investigate the potential for discriminatory pricing in favour of the BUPA hospitals which were currently on its approved list. There was no mechanism to ensure that these hospitals offered comparable, non-discriminatory prices and terms to BUPA's competitors in the PMI market. Indeed, it was widely perceived in the industry that BUPA paid lower prices than other insurers for accommodation and other facilities at BUPA hospitals. As a result of the merger, BUPA would now be able to obtain improved prices and terms from CHG hospitals, thereby further reducing its cost base and its premiums compared with competing insurers.

6.116. Furthermore, Norwich Union expected that the merger would result in a substantial increase in CHG's tariffs. It said that BUPA's acquisition of the Goldsborough hospitals in 1997 had led to increase, which had contributed to Norwich Union's claims costs during this period. Increases in the prices of the CHG hospitals would have an even larger impact on Norwich Union's claims costs, since these hospitals accounted for a sizeable proportion of the approved hospitals on Norwich Union's network.

6.117. Norwich Union said that there were several CHG hospitals which enjoyed a virtual monopoly position within their catchment areas and there were no alternative clinics which Norwich Union could offer to subscribers seeking private treatment in the relevant localities.

6.118. Norwich Union was committed to ensuring that its policy-holders had access to private treatment in these locations and therefore to ensuring that these hospitals were on its network. BUPA would be able to increase CHG's prices, secure in the knowledge that in these locations there were no alternative competing facilities. Even prior to the acquisition of CHG, there were several BUPA hospitals around the UK which had an effective monopoly, with no constraints on BUPA's pricing. Following the merger, over one-third of BUPA's hospitals would be local monopolies.

6.119. Norwich Union felt the acquisition would generally strengthen BUPA's position on the PMI market in relation to policy-holders. The extension of its vertically integrated network would give it an even more powerful position from which to market its insurance products to individual and corporate customers.

6.120. Norwich Union said that BUPA could now decide to give priority or preferential treatment to BUPA over non-BUPA patients, for example in terms of prioritizing accommodation, clinical facilities

and services. Again, there were no independent mechanisms which required that vertically integrated hospitals provided the same levels of service to competing insurers and their policy-holders. Prospective policy-holders frequently perceived that vertically integrated hospitals were only available to policy-holders of the insurer owning the hospital. This provided BUPA with a strong marketing advantage in relation to its PMI policies.

6.121. Norwich Union also asked us to consider whether there was any potential for the leakage of highly confidential information with regard to Norwich Union's activities, particularly prices and other terms agreed with Norwich Union. The PMI providers generally entered into annual negotiations on charges and terms with hospitals. The confidentiality of these discussions was critical to the assessment and listing of competing hospitals. BUPA would no doubt argue that its PMI and PMS businesses were conducted separately. However, Norwich Union believed there was common reporting for both the PMI and PMS businesses at senior management level, and therefore a real concern that BUPA could obtain information concerning its immediate competitors in the PMI market, thus potentially giving BUPA an unfair advantage.

6.122. There were some CHG hospitals which competed directly with existing BUPA hospitals in certain local catchment areas. Norwich Union was aware of three specific overlaps:

- (a) CHG's Berkshire Independent Hospital in Reading (50 beds) competed directly with BUPA's Dunedin Hospital.
- (b) CHG's Pinehill Hospital in Hitchin (33 beds) competed with BUPA's Harpenden Hospital (62 beds). The only directly competing hospitals were two small NHS units, Hemel Hempstead General (12 beds) and Queen Elizabeth II (10 beds).
- (c) CHG's West Midlands Hospital in Halesowen (32 beds) competed with BUPA's Parkway Hospital in Solihull (57 beds) and BUPA's Little Aston Hospital in Sutton Coldfield (67 beds).

In these cases, the aggregation of BUPA and CHG removed, or at any rate reduced, the choice of hospitals available to insurers and their policy-holders in the relevant locality.

6.123. Norwich Union asked us to consider the potential for cross-subsidization between BUPA's PMI and PMS businesses. In particular, revenues and profits from the PMS business could be applied in the PMI business (where margins were low), allowing BUPA to offer artificially low subscription rates.

6.124. Norwich Union believed that BUPA's market position in both the PMI and PMS markets had already reached such a level that any further extension of its vertically integrated network created considerable competition concerns.

PPP healthcare group

6.125. PPP said that it had concerns about the proposed acquisition by BUPA of CHG. BUPA was already the market leader in the market for PMI with a market share of 40 per cent and would become the leader in the PMS market. The merger would have a marked impact on the PMS market at the national level and in particular regions or local areas where the degree of concentration of BUPA and CHG hospitals would be high. PPP also had concerns about the vertical integration between BUPA PMI and BUPA PMS. In PPP's view, BUPA's acquisition of CHG could materially disadvantage consumers, competing hospitals and insurers and was therefore against the public interest.

6.126. In recent years, there had been a particular focus in the PMI market on the establishment by insurers of preferred hospitals and products had been launched on the basis of the cost advantage that such networks could give PMI providers. The move towards developing networks provided a further indication of the national scope of the insurance product. It was apparent that different insurers had developed hospital networks on the basis of different approaches. For example, BUPA tended to consider entire chains of hospitals and would admit each hospital in the chain to its network. By contrast, PPP's network strategy involved a local tendering process. It carried out a detailed assessment in each local area of the different hospitals by reference to a variety of measures, but principally focusing on costs, quality and the range of services offered. Thus, unlike BUPA, hospitals which formed part of a larger chain were admitted to PPP's network on an individual basis and only when they scored more highly in the assessment than the other hospitals in the local area.

6.127. Assessment of the proposed merger on a national basis was relevant since there were a number of hospital chains which owned hospitals throughout the country, including not only BUPA and CHG, but also Nuffield and GHG. In this case, the combination of BUPA and CHG would create the largest hospital owner in the UK and reduce the number of national PMS providers from four to three. The significance of the increase in the number of private hospitals BUPA would acquire was all the greater since BUPA was also the largest PMI provider with the highest premium income in the country. Thus, considering BUPA and CHG's position on a national basis was key to the overall assessment of the merger since the merged entity's increased bargaining power vis-à-vis PMI providers impacted on the likely vertical effects of the merger.

6.128. Since PMS were provided on a local basis consideration of the overlap between BUPA and CHG in certain local or regional areas was also key to an assessment of the overall merger. The combined entity's percentage market share by total number of beds was 64 per cent in East Midlands and East Anglia, 38 per cent in the North-West, 45 per cent in Surrey/Kent, 48 per cent in West Midlands and 76 per cent in West Yorkshire.

6.129. PPP said that, as a result of the merger, BUPA would become the largest PMS provider in the country with more hospitals than GHG, the current market leader. PPP provided market information about the four national PMS providers (which would become three if the merger was allowed to proceed). Of that pool of hospitals, BUPA's share following the merger would increase from 26 to 41 per cent by total number of hospitals and from 29 to 41 per cent by total number of beds. It would also own 7 out of the 11 non-London flagship hospitals; making a total of 33 solus and flagship hospitals.

6.130. On a regional basis, the proposed merger would result in several areas in which there would be a concentration of BUPA and CHG hospitals. For example, in Reading, BUPA would own both the private hospitals. In the Leeds/Bradford area, BUPA would own four hospitals, and in the Birmingham area it would own three. In these areas, the proposed acquisition would increase the concentration of BUPA-owned units in local markets with few alternatives. There would also be several regions in which there would be a major overlap. These included:

- (a) *Surrey/Kent*. BUPA and CHG had 8 hospitals out of 16 hospitals, representing [] per cent of PPP healthcare's acute hospital costs in the area.
- (b) *Merseyside, Lancashire, Greater Manchester and Cheshire*. BUPA and CHG had 9 out of 21 hospitals, representing [] per cent of PPP healthcare's acute hospital costs in the area.
- (c) *East Midlands and East Anglia*. BUPA and CHG had 14 out of a total of 24 hospitals, representing [] per cent of PPP's acute hospital costs in the area.
- (d) *West Midlands*. BUPA and CHG had three out of five hospitals, representing [] per cent of PPP's acute hospital costs in the area.
- (e) *West Yorkshire*. BUPA and CHG had four out of six hospitals, representing [] per cent of PPP's acute hospital costs in the area.

6.131. Recent market trends had shown an increase in the number of patients using private hospitals who did not have PMI. It was estimated that up to 20 per cent of patients using private hospitals were self-paying. Patients requiring medical care were increasingly interested (subject to their consultants' admission rights and preferences) in comparing different hospitals and in negotiating a package. To the extent that patients currently had choice, it would decrease as a result of the merger. In certain areas, particularly those identified above, the patient would have few or no alternatives to a BUPA/CHG hospital. According to the information available to PPP, BUPA and CHG hospitals charged prices which on average tended to be [*Details omitted. See note on page iv.*]. Following the merger, the loss of CHG as a competitor to BUPA and the reduction of the four national PMS providers to three would result in a loss of competitive pressure which would be likely to result in increased hospital charges.

6.132. The effects of the merger might be different for those who had PMI. The loss of CHG as an independent competitor to BUPA would be detrimental to insurers who bought hospital care. Price competition would be reduced in certain areas; insurers would find it more difficult to enforce standards of care and would have less choice in selecting hospitals for the networks, particularly in certain areas where there was a high concentration of BUPA/CHG hospitals. Insurers seeking to offer cost-effective insurance packages to consumers would also increasingly find themselves dealing with BUPA as hospital owner as they sought to compete for PMI business with BUPA. BUPA PMS would also be able to negate the

effects of the local competition which was encouraged through a hospital network such as the one operated by PPP by forcing insurers into nationally inclusive agreements.

6.133. PPP said that the potential vertical effects could be dealt with by reference to the analysis of the vertical integration issues in the 1990 report. It recognized that the market had changed to some extent since 1990, largely as a result of the development of insurers' networks, but that this did not fundamentally alter the analysis—particularly as it involved a 40 per cent share in PMI being combined with market leadership and a share, albeit of the main chains of hospitals, of 41 per cent in PMI provision. The potential effects of the merger could be summarized as follows:

- (a) the risk that BUPA PMI would divert its subscribers to BUPA PMS or exert influence over a subscriber's or consultant's choice of hospital;
- (b) the addition of CHG's hospitals would enhance BUPA PMI's ability to extract more favourable terms from third party hospitals;
- (c) the risk that the approach adopted to the development of networks by PMI providers such as PPP would be threatened following the BUPA/CHG merger;
- (d) the risk that the vertical link would act as a deterrent to new entry either to the PMS or the PMI market;
- (e) the risk that BUPA PMS would reduce the availability of facilities to other PMI providers or increase its charges to them. Its enhanced bargaining power as a PMS provider following the merger was illustrated by the fact that the total number of BUPA beds occupied by PPP subscribers would, after the merger, increase to [38] per cent. PPP would, in effect, become largely dependent on its principal competitor for a large proportion of its input costs, and if BUPA/CHG increased its prices by 10 per cent, it would cost PPP an extra £[38] million;
- (f) it would give BUPA PMI a unique competitive advantage in that it would know the price at which PPP bought one of its key inputs;
- (g) the risk that BUPA PMI would offer preferential and non-commercial rates to its subscribers or corporate clients to the detriment of other PMI providers; and
- (h) the risk of cross-subsidies: for example, BUPA PMS might increase its hospital charges so that BUPA PMI could reduce its insurance premiums. If BUPA PMI won more subscribers and succeeded in diverting them to BUPA PMS this would result in higher occupancy rates and its costs base would be reduced.

6.134. In its 1990 report, the MMC had concluded that the increase in vertical integration would not operate against the public interest because BUPA's share of the PMS market would only be 14 per cent (with an increment as a result of the merger of only 4 per cent) and that BUPA intended to operate the two businesses on an arm's length basis. However, the MMC concluded that further increases in vertical integration in the market or a change in BUPA's practices would be of concern. In the case of the BUPA/CHG merger, the vertical integration concerns were substantially increased, not least because BUPA would become by far the leader in the PMS market and its share, albeit of total number of beds owned by the four national PMS providers, would increase to 41 per cent (an increment of 12 per cent). As such BUPA would become both the leading PMI provider as well as the leading PMS provider.

6.135. PPP understood from press reports that BUPA had entered into warehousing arrangements for the acquisition of a 26.8 per cent stake in CHG. BUPA Finance had made an interest-free loan of £70 million to SBUKE, a member of the SSSB unit of Citigroup, to acquire the stake in CHG ordinary shares. Under the terms of the facility, it appeared that BUPA Finance would bear all the risk and receive all the benefits of the shares. The facility did not give BUPA Finance an interest in the shares nor the entitlement to exercise any right, or control the exercise of any right, in respect of the shares. SBUKE, as legal and beneficial owner of the shares, was free to deal with any of the shares and rights attaching to them as it may in its absolute discretion determine. The circumstances in which SBUKE would transfer the stake in CHG to BUPA were not clear. It appeared that SBUKE was the addressee of irrevocable undertakings to accept BUPA's offer announced on 28 April. However, elsewhere it was stated that the warehousing arrangement was intended to remain in place until shares in the six CHG hospitals, which

were the subject of the undertaking given by BUPA to the OFT following its acquisition in 1997 of Goldsborough, were sold. The precise terms on which BUPA had acquired a 26.8 per cent stake in CHG were unclear from the press reports. However, PPP considered that these arrangements ought to be considered closely since it seemed likely that BUPA might have acquired material influence over CHG by virtue of the arrangements.

6.136. PPP said that the acquisition by BUPA of CHG would operate against the public interest and should be prohibited. PPP considered that there was a conflict of interest between PMS and PMI. It thought measures to strengthen the arm's length relationship between BUPA's PMS and PMI would be inadequate to remedy the adverse effects of the increased vertical integration. PPP considered that the only effective way to prevent the adverse consequences was to separate BUPA's PMS and PMI businesses. PPP's concerns about the ineffectiveness of Chinese walls and other measures designed to ensure that the businesses operated on an arm's length basis were based both on its own experiences of operating in the PMI market whilst at the same time holding an interest in the PMS market, and also on its observations on the way in which BUPA itself operated. So far as its own experiences were concerned, PPP found it difficult to operate on an arm's length basis during the period in which it had a minority (49 per cent) share, which did not include control over day-to-day operations, in Columbia Hospitals Group. These difficulties arose notwithstanding the fact that PPP paid Columbia a fee to manage the hospitals, and under an agreement which meant that it did not have operational involvement in them. Furthermore, detailed codes of policy establishing Chinese walls and governing flows of information were drawn up and approved by the OFT. Indeed, the conflict of interest and the difficulties of maintaining robust Chinese walls were two principal reasons for PPP's decision to leave the PMS market.

6.137. PPP said that any divestment of specific hospitals would need to address both the national and local effects of the merger. PPP said that with regard to SBUKE's ownership of CHG shares, the only course of action was for it to sell the shares.

Royal & Sun Alliance Insurance Plc

6.138. RSA said that it had about 6 per cent of the PMI market by gross premium income. It now had some 450,000 persons covered as compared with 200,000 at the start of 1998.

6.139. RSA said that the main barriers to entry were establishing credibility as a PMI provider and building critical mass when competing with the strong brands of BUPA and PPP. RSA recognized that, in the medium term, there would be no substantial growth in the PMI market and that it was probable that there would be a decline in the consumer market as premiums increased to reflect rising costs and higher frequencies. However, in the longer term, it saw potential for growth as employers took more responsibility for the wellbeing of their workforces. RSA said that its PMI growth had come through the corporate and small and medium enterprise markets and, from this base, it planned to cross-sell the wider healthcare and assistance offerings to its clients. In addition, RSA would be using its competency in bodily injury management to introduce rehabilitation services to its life, motor and commercial liability customers. Subscribers who were injured in a motor accident, or at work, would be channelled to PMS providers to facilitate their speedier return to health and to work.

6.140. RSA said that it was not so far restricted to particular hospital networks but could see that this might happen in the future if the market consolidated further. It noted that BUPA's PMI business made a trading loss of about £40 million in 1999, while BUPA PMS made a profit of £60 million. However, it was difficult to conclude from this that there was differential pricing or cross-subsidization.

6.141. With regard to potential remedies, RSA thought concerns about the domination of particular local hospitals were a red herring. The important issue was the degree to which the merger gave added strength to BUPA as a vertically integrated business. It thought that BUPA's Chinese walls needed to be strengthened and that consideration might be given to floating the BUPA PMI business. A published hospital tariff for all PMI and PMS providers regardless of size was also worth considering.

Standard Life Healthcare Limited

6.142. Standard Life said that it was currently the fourth largest PMI provider with a market share of about 6 per cent.

6.143. There were two main issues raised by the potential purchase of CHG by BUPA. First, there was the growth in size of BUPA PMS and its resultant dominance of the PMS market, and second, there was the issue of opportunities for vertical integration between BUPA PMS and BUPA PMI. Although statistics varied, BUPA PMI enjoyed somewhere in the region of 40 per cent of the market, which placed it in a dominant position. BUPA PMS, likewise, would enjoy a pre-eminent position and had more hospitals and potentially more beds than either GHG or Nuffield. It was the potential misuse of the dominance in the PMS and PMI businesses, and the fact that both were in the same ownership, that concerned Standard Life. It was unlikely in itself that an increase in the size of BUPA PMS would pose any material threat to free competition and, consequently, to the consumer for achieving value for money. Apart from that, natural business dynamics would certainly require BUPA PMS to consolidate its facilities and, as a consequence, the net growth in the number of hospitals owned and operated by BUPA would be small in total. Standard Life expected BUPA PMS to offer six to ten hospitals for sale as a result of the consolidation. The likelihood of this having a detrimental impact on the consumer was negligible. Standard Life's experience over the years was that BUPA PMS operated a competitive pricing policy and it had never had reason to be concerned that BUPA had misused the dominance of its PMI business to the disadvantage of other PMI providers. BUPA's PMI market share had fallen from about 75 per cent in the mid-1970s to about 40 per cent currently.

6.144. Moreover, if CHG were to be sold to a PMS provider other than BUPA, there was a possibility that it could be acquired by one who currently had higher market prices than BUPA PMS. This would increase the cost of PMI premiums in the short to medium term and would have a greater detrimental effect on the consumer than the proposed purchase by BUPA.

6.145. The second and potentially more important issue was of vertical integration. Critics of BUPA were concerned that having a dominant position in both PMS and in PMI would lead to anti-competitive practices between the two businesses, which would have a fundamental disadvantage for other PMI providers. The assumption here was that BUPA PMS, with its dominant provider position, would provide artificially low pricing to BUPA PMI, thus enabling premiums on the PMI policies to artificially undercut competitors' rates. Through this mechanism, BUPA PMI would be able to squeeze out many of its competitors (particularly in view of the small market share enjoyed by the majority of the industry) and thus grow its monopoly position well above the current 40 per cent market share. Consequently, the supposed likelihood was that premium rates would increase with little effective competition to keep them at an appropriately competitive level and BUPA's profit margins would grow accordingly. Standard Life said, however, that it had never at any time been aware, or even suspected, that relationships between BUPA PMS and BUPA PMI were in contradiction to the 1990 report and that BUPA was in fact pursuing a line of vertical integration. Standard Life was in direct competition with BUPA PMI, but it had enjoyed a healthy trading position with BUPA PMS and had negotiated pricing with it which was very competitive within the PMS provider market. BUPA PMS was by no means the most expensive PMS provider. It had entered into agreements with Standard Life in spite of the fact that it might at times help it to acquire business from BUPA PMI or business which might otherwise have been attracted by BUPA PMI. These did not appear to be the tactics of a company showing signs of vertical integration. Standard Life said that it had some concerns about BUPA's CPS, primarily of an ethical nature with regard to the offering of bonuses.

6.146. Standard Life did not believe that the net increase in the size of BUPA PMS would represent any threat to the consumer but, if anything, was likely to increase the quality of PMS provision in the UK. There was no evidence that BUPA had intended, or indeed would intend, to vertically integrate BUPA PMS and BUPA PMI and Standard Life's own experience over several years was in contradiction with such a hypothesis. Naturally, it believed that it would be appropriate for us to seek a formal commitment from BUPA that it had no intention to pursue any elements of vertical integration and would continue to run the two businesses at arm's length. To safeguard the possibility that BUPA PMS might in subsequent years increase its charges to other PMI providers for the benefit of BUPA PMI we should seek an undertaking from BUPA PMS that it would agree to abandon centralized pricing negotiations in favour of individual hospital negotiations should a PMI provider in the future have reason to believe that centralized pricing was seeking to impose increases out of line with other providers' settlements.

6.147. Standard Life did not therefore see any reason why we should intervene in the proposed purchase of CHG by BUPA and moreover, on the basis of its own historical experience, would support the merger. In addition, the new competition law introduced in the spring of 2000 provided all the necessary powers and remedies should evidence or suspicions emerge that BUPA was not conducting itself in the

interest of the consumer. Standard Life expected that over the next five to ten years there would be other mergers and the number of competitors in the market would halve.

6.148. BUPA had always attracted criticism from within the industry largely because of its size and dominance. This was a separate issue from whether it had ever demonstrated behaviour which gave rise to concerns that the position of the consumer would be prejudiced. Standard Life did not believe this had been the case and it would be anathema for us to rule against the merger on the basis of what BUPA might do in the future (although Standard Life noted that the Act required us to consider whether the merger might be expected to operate against the public interest).

Western Provident Association Limited

6.149. WPA was a specialist PMI provider whose roots could be traced back to 1901. The organization was a not-for-profit provident association, with no shareholders. Any surplus monies made through its activities were used for the benefit of its customers, either through investments, the improvements in benefits offered on its schemes, or by containing any increases in premiums. In 1998 WPA had a market share of 4.5 per cent of the total PMI market of £2,182 million. In 1999, WPA had a turnover of £102 million. It did not own any hospitals. With its commitment to customer service it structured its policies to allow consultants to exercise discretion in meeting the clinical needs of patients and did not seek to exclude the use of any accredited hospital. WPA said that it was against further concentration in the hospital market as this would lead to less choice for WPA, other PMI providers and patients in selecting appropriate hospitals, more power for BUPA PMS in negotiating charges with WPA and others, and higher charges generally.

6.150. BUPA was the leading PMI provider with a market share of 40 per cent. In addition, according to *Laing's*, BUPA owned 36 acute hospitals containing 1,108 beds which comprised 17.1 per cent of the total number of beds available. In 1998 it had 21 per cent of the acute medical and surgical market, expressed in terms of revenue. CHG owned 22 hospitals in 1998 and had 843 beds, which amounted to about 8 per cent of the total number of beds. Its share of revenues in 1998 was reported as about 6 per cent.

6.151. The merger would affect the markets for PMS and for PMI. The market for acute medical and surgical hospital care was dominated by three undertakings: GHG, which had 24 per cent of the market, BUPA with 21 per cent and Nuffield with 14 per cent. The acquisition of CHG would augment BUPA's share by 6 per cent making it, in revenue terms, larger than the other two PMS providers.

6.152. There was evidence of hospitals seeking to attract self-pay patients, but there was little competition to attract members of PMI schemes to use one hospital as opposed to another. Competition between PMS providers was not aggressive and took the form of attracting consultants to make a particular hospital their base.

6.153. The merger had implications for the PMI market in that the largest PMS provider, BUPA, would be owned by the largest PMI provider. The PMI sector was acknowledged to be highly competitive. [*Details omitted. See note on page iv.*] Apart from the enhanced ability to increase charges to PMI patients, the opportunities to place the patients of competing PMI providers at a disadvantage were obvious.

6.154. In relation to the PMS market, the relevant service market was the provision of acute medical and surgical hospitals. This sector had undergone major restructuring over the last few years as the larger PMS providers had expanded their networks and increased their market share at the expense of commercial diversity. Several long-established hospitals had been forced to close as a result of the introduction of hospital networks. These hospitals had provided cost-effective treatment alternatives to the network hospitals. WPA said that it believed these hospitals were excluded from the networks owing to their being located in an area of competition with a hospital belonging to one of the larger PMS providers.

6.155. To some extent this concentration had been triggered by the emergence of the larger PMI providers' hospital network initiatives. If a hospital could not secure admission to the network of the two principal PMI providers it was disabled from dealing with a section of the market which accounted for over 70 per cent of total PMS revenue. WPA believed that both BUPA and PPP were aggressively marketing their own network hospitals to their members. It said that the number of individual customers covered by PMI was now 23 per cent below the 1990 level.

6.156. By comparison with PPP, the penetration of BUPA PMI's network products was low, but BUPA PMI had taken steps to increase it, for example by paying financial incentives to consultants to practise at BUPA PMS network hospitals.

6.157. The action of BUPA (and PPP) as PMI providers in establishing networks would lead to an even more concentrated hospital structure. WPA expected BUPA PMI to use its position as the leading provider to encourage patients to use its own network hospitals. WPA's experience in dealing with PMS providers, including BUPA, which had merged or made acquisitions was that charges increased. BUPA PMS's charges were higher (about [30] per cent) than those of most PMS providers and around [30] per cent more expensive than those of PPUs.

6.158. BUPA had a conflict of interest owing to its position in the PMI market as well as its large-scale ownership of hospitals. In WPA's view it was inevitable that members of PMI schemes and patients would be worse off because, although there might be economies of scale within the hospitals, they would not be passed on to members and patients because competition was weak.

6.159. WPA said that BUPA PMI provided inducements to consultants, taking the form of financial payments, which were not revealed to patients, of 10 per cent of the professional fees involved, to be included within BUPA's CPS. WPA found it difficult to understand how this could be compatible with the exercise of objective clinical judgement.

6.160. WPA said it was doubtful whether BUPA's Chinese walls had operated effectively over the last decade. WPA's experience was that knowledge gained from the PMI business was shared with the PMS business, and staff frequently seemed to change posts between them, carrying their knowledge with them.

6.161. WPA negotiated nationally with BUPA. In doing so, BUPA insisted that the negotiations embraced all its hospitals, irrespective of location, and 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 PMS on the basis that all of its hospitals were covered by the negotiation.

6.162. WPA offered its services on a national basis and accordingly, from its point of view, the merger should be assessed on the basis of its effect nationally. The degree of local concentration might have an impact upon that section of the PMI market which entered into bilateral contractual relations with particular hospitals, notably the individual self-pay market, which accounted for 20 to 25 per cent of total revenue. From the point of view of a patient seeking to pay medical bills directly, the merger should be assessed on the basis of the reduction in choice that it imposed at a local level.

6.163. WPA noted that on average self-pay patients were charged much less than insured patients: a sample suggested 26 per cent less. WPA said it considered that the proposed merger would be contrary to the public interest and therefore should not be allowed to take place. For the same reason it also recommended that there should be a restriction on any PMS provider having a market share beyond that currently controlled by the largest PMS provider. WPA recommended that the PMS and PMI parts of BUPA should be separated.

Consultants and representative medical bodies

British Association of Plastic Surgeons

6.164. The British Association of Plastic Surgeons (BAPS) said that it was concerned about the market effects of a merger between BUPA and CHG. BUPA was already in a position to manipulate the private healthcare sector because it had both BUPA PMS and PMI. It was BAPS' understanding that BUPA was asked to keep separate organizations for insurance and healthcare provision. This had not happened and because of several reorganizations there was now a common policy stem at the head of the organization.

6.165. This situation had allowed BUPA PMI to manipulate the market in an unfair way. It had the ability to limit the hospitals to which its clients might be admitted. BAPS understood that there were many different types of PMI policy but the bulk now included restriction of cover to the BUPA network. This was a group of hospitals which were acceptable to the BUPA PMI. This allowed it to control the potential customer base so that vulnerable hospitals might no longer be financially viable. Once they were

in financial difficulty BUPA was able to buy them and include them in its network. A merger with CHG would enable BUPA to have a bigger control of the hospital base and allow it to increase its control over the market.

6.166. Clinical governance, which was designed to improve the quality of healthcare, should be carried out at a local level under national guidelines by the healthcare provision sector. The only point of view that a PMI provider might reasonably have in relation to clinical governance was that it had the right to insist that its clients were treated in hospitals which had adequate clinical governance provision. It was already clear from recent meetings and events that BUPA PMI wished to interfere with this process. It was therefore possible that its commercial interests as a PMI provider might affect the nature of medical practice and therefore the efficiency of clinical governance and the safety of medical care. It was obvious that having a single medical director for both the PMS and the PMI businesses produced an internal conflict of interest, which would only increase if BUPA took over CHG.

6.167. There was evidence that BUPA PMI had sought to unfairly manipulate the PMS market. It had, along with others, sought to peg remuneration to medical staff at the same level since 1989. This was reasonable if it could be demonstrated that medical staff and indeed hospital events were too expensive at that time. The overall cost of hospital events had continued to rise steadily during this decade and therefore the share that the PMI provider paid to PMS had increased sharply. It was also true that the cost of premiums had increased sharply. This meant that the proportion of the event cost that went to PMS had risen in a disproportionate manner. This was to the benefit of a PMI provider that was competing with others and owned a significant proportion of the hospitals. As BUPA ran common profit and loss accounts it mattered little to BUPA PMI how much a BUPA client was charged provided that the hospital costs were covered. It could be seen that monies paid to BUPA PMS would be recovered directly by BUPA PMI. This was not so for its PMI competitor.

6.168. The fact that BUPA PMI had adopted the CPS was evidence that it was willing to act in a questionable way. It sought to pay different consultants different amounts for the same work. One of the benefits to BUPA PMI of this behaviour was that to qualify for the additional payments consultants might only practise in BUPA PMS network hospitals. That meant that for the last few years BUPA PMS had had an additional method of financially disadvantaging its competitor hospitals.

6.169. BAPS felt strongly that if the merger were to be allowed we should recommend that BUPA's PMS and PMI businesses were kept as separate organizations with no common management and with separate accounting.

British Association of Psychotherapists

6.170. The British Association of Psychotherapists (BAP) said that it could not comment on the wider implications of the merger between BUPA and CHG but it wished to focus on the effect it might have on patients who sought psychotherapy. Not all PMI schemes granted approval for the financing of psychotherapy consultations. The merger might restrict choice of therapeutic input which could currently be obtained by patients. It might be that the merged group would decide to offer such financing but BAP recognized that there could be no guarantee. BAP said that it had insufficient knowledge of how the merged group would handle inpatient care but its concerns were similar.

British Medical Association

6.171. The BMA, the registered trade union and professional association for the medical profession, said that it was concerned about the acquisition of CHG by BUPA and various current BUPA business activities.

6.172. BUPA proposed to reduce the choice that its PMI subscribers and their GPs had of consultants. BUPA was reducing the number of consultants recognized for treatment of BUPA subscribers, as well as openly directing patients away from consultants who chose not to join the CPS. Many consultants had ethical objections to the principle of contracting with a PMI provider, whether or not their charges were within the BUPA Maxima, preferring instead the traditional contract between doctor and patient.

6.173. Consultants who did not join the CPS were increasingly being excluded from treating BUPA-insured patients: there was a clear statement in the CPS literature that 'in due course BUPA will be

launching new products which will enable members to select to be treated by CPS consultants only'. BUPA had made it clear in discussions that once enough CPS consultants had been reached access to the CPS would be closed. Lists of CPS consultants would be issued to GPs in localities where sufficient had joined the partnership—a clear attempt to influence referral patterns—and BUPA had made it clear that both patients and their GPs would actively be directed to CPS and away from non-CPS consultants.

6.174. BUPA had reduced the choice that PMI subscribers and their GPs had of hospital treatment. The BUPA hospital network had been portrayed as a relatively minor exercise intended to reduce surplus capacity in the PMS market by reducing the number of hospitals at which BUPA PMI subscribers were treated. The BMA understood that this objective was based on an assessment within BUPA that private hospitals had an occupancy rate of 50 per cent or less, but in reality, when day surgery, early admissions and late discharges were taken into account, the effective occupancy rate was 75 per cent. In other words, private hospitals were operating close to optimum occupancy and there was little surplus capacity. This reinforced the BMA's view that the real intention of the BUPA network was to drive non-BUPA network hospitals out of business. The BUPA network effectively reduced more than 800 hospitals to approximately 170, inevitably leaving BUPA-owned or -managed hospitals in a dominant position in what remained of the market. The BMA had no doubt that once this objective had been achieved, and BUPA's dominance of the PMS market had been reinforced, hospital charges would be allowed to rise to whatever level the PMI market could bear.

6.175. The BMA believed that all NHS and private hospitals should be allowed to compete for BUPA patients on a level playing field. During its discussions it challenged BUPA because they appeared to be excluding NHS private wings and pay-bed units from the network. NHS hospitals relied on income from pay-beds or private wings or both to support core clinical services, and NHS facilities for the treatment of private patients were invariably less expensive, and had better facilities, than commercially-owned independent hospitals. Where it was an option for them, many consultants preferred to treat their private patients in such facilities. In many cases BUPA recognition had been withdrawn from NHS facilities, often explicitly in favour of a nearby BUPA hospital. The BUPA PMS network, therefore, directed BUPA subscribers to more expensive hospitals with poorer facilities.

6.176. These activities could only be described as anti-competitive when undertaken by an ordinary PMI provider. When they were undertaken by a PMI provider that was at the same time the largest owner of private beds, the argument that it operated against the public interest was overwhelming.

6.177. The proposed vertical integration would allow the same company to increase its dominance of the PMI and the PMS markets by driving its competitors in both out of business. The BMA believed that the simultaneous creation of the BUPA PMS network and the CPS showed that BUPA intended to act as a single corporate entity in both markets, in defiance of the strictures placed upon it by the MMC in 1990.

6.178. BUPA intended to use its Benefit Maxima, in conjunction with the CPS and the network, to continue to restrain consultants' fees artificially by reference to a rigid and static formula. The 1994 report referred to BUPA's successful efforts to restrain consultants' fees throughout the 1980s, a time of major expansion of the PMI and PMS industries. The result of the 1994 report banning the BMA's guidelines had been that these artificial restraints continued, to the benefit of BUPA and to the detriment of consultants. BUPA had tried to make its unchanging Benefit Maxima the ongoing rate for specialists' fees. The BMA also had concerns that the offer of a 10 per cent bonus to CPS consultants at the end of the year provided they agreed to charge within the BUPA Benefit Maxima altered the traditional relationship between consultant and patient, and, in combination with the absence of any mechanism for reviewing the BUPA Benefit Maxima, whether for CPS consultants or for the generality, further indicated BUPA's intention to control consultants.

6.179. Since the BUPA CPS proposals emerged at the end of 1996 the BMA had been deluged with complaints from consultants. Throughout 1997, until they ended on 11 November, the BMA therefore held extensive discussions with BUPA in an attempt to make what was being proposed more ethically acceptable.

6.180. Initially these discussions focused on revised procedures that BUPA introduced, without consultation, for the recognition of consultants for the treatment of BUPA PMI subscribers. The revised recognition process at first asked consultants to agree, as a precondition to reimbursement for treatment of BUPA PMI subscribers, to charge only within the BUPA Benefit Maxima, to provide NHS audit data unrelated to private medical practice, and to inform BUPA if their NHS employment was suspended or terminated, even if that action had been taken for non-clinical reasons. It also initially insisted that consultants served a probationary period before their full recognition was granted. The BMA remained con-

cerned that a PMI provider should not be in the position of assessing the clinical expertise of consultants who went through lengthy training and rigorous NHS appointments procedures. It believed, and was discussing this with the representatives of PMS managements, that the medical staff of private hospitals themselves should exercise these quality control functions. Notwithstanding these obstacles, the BMA discussions with BUPA did lead to agreement on revised procedures for consultant recognition.

6.181. Further extensive discussions with BUPA about the CPS did not, however, result in agreement. The 1997 Annual Representative Meeting of the BMA, the doctors' parliament, representing the entire medical profession, unanimously passed the following resolution: 'That this meeting believes that the BUPA partnership scheme is a threat to the traditional practice of medicine and must be rejected by the profession.'

6.182. The BMA believed that BUPA PMI was anti-competitive. BUPA PMI sought to restrict the number of consultants eligible to treat its subscribers, to make those consultants charge the lowest possible fees and to drive competitor hospitals and PUs out of business. The BMA could not accept that it was in the interest of patients to have their consultants, the consultants' fees and their hospitals dictated by a PMI provider.

6.183. The BMA was not strongly opposed to the BUPA Benefit Maxima. It did not object to PMI provider publishing fee schedules for their subscribers, but it believed that the profession was entitled to receive its own advice on fees. Consultants did object to the fact that the BUPA had for several years not been increased in line with inflation or with medical earnings, both when the PMI market was buoyant and, as now, in leaner times. This was the reason for the production of the BMA guidelines to which the MMC had objected.

6.184. The BMA had never accepted that the only definition of a fair market or fair competition was downward pressure on prices. This definition was adopted by the MMC in its decision that the BMA fee schedule contributed to a complex monopoly and should be banned, but the MMC had not always taken that view in other fields (for example, the sale of perfumes and compact discs). The BMA recognized that there had to be changes in the relative values of procedures from time to time: new procedures tended to acquire higher relative values when they were introduced, but over time found their place in a hierarchy of relative values. A dynamic process should therefore also permit upward movement. The BMA did not accept that other companies were prone to fall in line with BUPA by accepting the BUPA Benefit Maxima as the going rate. In fact, experience was that the BUPA Benefit Maxima had tended to be treated by other companies (for example, WPA) as the floor rather than the ceiling.

6.185. The BMA had views on the funding of the 10 per cent bonus that was payable a year later to CPS participants who agreed to restrict their fees to the BUPA Benefit Maxima. The CPS literature was explicit that the money for the partnership practice award would come from the economic efficiencies in using network hospitals. The BMA did not, therefore, see this as a philanthropic gesture by BUPA PMI, but as part of its strategy to gain control of consultants and to dictate their fees by implying that if they did not join the CPS their practice would be forfeited. This would apply particularly if, as seemed likely, BUPA PMI decided to market policies which were confined to network hospitals and CPS consultants, and would be magnified if BUPA were to restrict access to the CPS scheme. BUPA had admitted that the number of consultants who charged more than the BUPA Benefit Maxima was less than 10 per cent, and that many of these were anaesthetists. It was therefore likely that the cost to BUPA of the 10 per cent bonus would be greater than current Benefit Maxima payments, at least until BUPA had achieved sufficient control to reduce fees.

6.186. The BMA did not know how many consultants had joined the CPS. In the 29 January 1998 edition of the magazine *Hospital Doctor* Dr Vallance-Owen of BUPA claimed that 4,000 consultants had joined. The BMA's impression was that many fewer than this had joined, certainly fewer than 25 per cent, and that the BUPA figures were inflated. Some consultants had told the BMA that they had received letters from BUPA welcoming them to the CPS when they had not, in fact, agreed to join. In more than one case a request from a consultant to have his name removed from the CPS was not acknowledged, despite having been requested. It was significant that the *Hospital Doctor* statement in January 1998 was the first public declaration by BUPA of its success in persuading consultants to join the CPS since its was launched. The BMA believed that BUPA's activities were against the public interest and had been moving in that direction for many years.

Hospital Consultants and Specialists Association

6.187. The Hospital Consultants and Specialists Association (HCSA) had concerns about the proposed merger between BUPA and CHG, particularly as certain parts of the country would find that BUPA was the only provider of facilities for the provision of private care. This was bound to limit competition and freedom of choice for the consumer.

6.188. The position might be further compounded by the lack of clear water between BUPA in its role as a PMI provider and a PMS provider. There was an argument that the acquisition of CHG would result in services offered to patients limited only to those which BUPA was prepared either to fund or provide. This acquisition would extend BUPA's ability to constrain services only to those managed care programmes within its financial and procedural protocols. These might not be compatible with the clinical opinion of the medical practitioner. HCSA said that it thought the aim of the BUPA consultant partnership was to obtain a critical mass of consultants and then for the door to be shut.

6.189. HCSA said that it was not for it to comment on behalf of the other private healthcare organizations, but opportunity for the public to select the PMI provider of choice, the hospital of choice and the consultant of choice was paramount. Whether such choice would still be available should this acquisition proceed was arguable.

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Details omitted. See note on page iv.

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6.191. [

Details omitted. See note on page iv.

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London Consultants' Association

6.192. The London Consultants' Association (LCA) said that it represented several hundred senior doctors in London and wished to register its objection to the proposed merger between BUPA and CHG. Whilst central London was not directly affected in hospital ownership terms by the proposed acquisition, there were knock-on effects which would impact on the whole country and particularly on the already difficult relationships between BUPA PMI and consultants.

6.193. The OFT had argued that there was overprovision of PMS, and that networks were a reasonable approach to rationalization, and that they did not significantly affect the position of some of the smaller and charitable hospitals. The LCA contended that that argument was flawed by BUPA's merger proposal and by the fact that in recent months three more charitable hospitals had announced their closure or disposal because of exclusion from network policies. If there was overprovision in the market, why was BUPA prepared to pay £230 million (equivalent to some £270,000 a bed) for another group of hospitals?

6.194. If BUPA succeeded in its bid, it would own 57 out of 162 network hospitals. This was equivalent to a 35 per cent share of the network market. Given that BUPA already had slightly over 40 per cent of the PMI market, this combination of factors could only be detrimental to consumer choice, both for patients and doctors.

6.195. The fact that PPP and a few minor PMI providers also had hospital network products surely created a complex monopoly which acted against the public interest in supporting a substantial reduction in choice. The LCA had evidence that the selection of network hospitals was a matter of economics and market protection and had little to do with the quality of care.

6.196. BUPA gave a 10 per cent (previously 5 per cent until 30 June 2000) enhancement in fees to consultants who both joined its CPS and admitted its patients to network hospitals. Non-CPS consultants or consultants admitting to other hospitals did not receive this enhancement although their basic fees were likely to be identical for the same procedures. The LCA considered the whole principle of bonus payments as unethical, potentially anti-competitive and with a clear aim of reducing the number of consultants eligible for BUPA fees. It also believed that there should be a requirement from the CPS member to inform a patient in advance if he or she benefited from a bonus payment for undertaking the treatment.

6.197. Increasingly the LCA was made aware that BUPA had arrangements with a number of major organizations for fee levels which were not published but which exceeded the Benefit Maxima in BUPA's published information to doctors.

6.198. The LCA understood that the OFT report had stated that it was satisfied that Chinese walls were in place and that vertical integration was not seen as a problem. If that was the case, how was it that the Medical Director of BUPA appeared regularly in the press speaking on behalf of both BUPA PMI and BUPA PMS and the Managing Director of BUPA behaved similarly? There was no one the LCA knew of in the medical profession or in the independent hospitals world who believed that Chinese walls existed within BUPA.

6.199. The LCA said that it was undertaking research among consultants and GPs which increasingly showed that there was interference by both BUPA and PPP in the proper referral mechanisms between GPs and consultants. When patients sought pre-authorization there were attempts by BUPA to persuade patients to see CPS members or to go to hospitals which were in its network.

6.200. As part of the code of practice considerations two factors had become evident. First, the LCA was aware that some PMI providers, notably BUPA PMI and PPP, were selling network and partnership policies to their subscribers without subscribers always being aware of the limitations which might apply on the choice of doctor or hospital. The more that BUPA extended its network and CPS, the more of a danger this became. Secondly, the LCA understood that BUPA and PPP both required network hospitals not to give patients copies of their hospital bills. The reason given was that patients did not need to know the bills they had incurred because they were fully covered. This seemed to be a gross lack of transparency which could not conceivably apply in hotel or other service industries.

6.201. The LCA was greatly concerned about the dominance of BUPA PMS over the PMI market which the CHG purchase would bring about if it was allowed to proceed. The LCA said that the activities of both BUPA and PPP were matters of major concern which if allowed to continue at their current rates would put the control of independent medicine in the hands of two PMI providers with a resulting impact on the quality of medical care and more importantly on the availability of consumer choice. It was clear, for example, that the PPUs in London teaching hospitals were excluded from some network schemes and this could not be in the interests of the patient.

Dr Peter Magauran, the Lord of Santon

6.202. Dr Peter Magauran, the Lord of Santon, said that he was writing as a local doctor, to express his concern about the proposed merger between BUPA and CHG. In his local area there was BUPA Gatwick Park Hospital, BUPA Redwood Hospital ('2 miles'¹ apart) and BUPA Hospital Tunbridge Wells. If the merger were to go ahead BUPA would take over the North Downs Hospital at Caterham and the Ashted Hospital at Leatherhead, giving it almost a complete monopoly in the area. This would leave patients in the surrounding area with little alternative but to use a BUPA hospital or inconvenience themselves considerably by travelling up to London or to the South Coast. As BUPA PMS was not universally respected by either the doctors or staff that worked in it, he regarded this as a serious situation. He hoped that any agreement would include BUPA PMS having to divest itself of certain hospitals in the area to allow for competition and a better alternative for the local inhabitants. BUPA PMS owned about 36 hospitals and CHG about 22 facilities, which gave them an unfair advantage over any competition.

Mr Nigel P M Sacks

6.203. Mr Nigel P M Sacks, a consultant surgeon, said that he wished to express his concern about some recent developments with PMI providers. It had been a widely accepted practice that (a) the duty and contract of care was between the patient and the treating doctor and (b) ideally all patients and certainly all private patients should have freedom of choice in choosing their consultant. Recent developments had greatly undermined this relationship and trust. These developments included:

- (a) consultants being asked to obtain pre-authorization from the PMI providers before they saw private patients;
- (b) financial incentives being paid by the PMI providers (for example, the BUPA CPS) to certain consultants if they agreed to lower fees, and in return for this a bonus fee payment was made;
- (c) patients were being restricted in their choice of consultants by the PMI providers; and
- (d) when medical fees were not fully covered by a patient's PMI policy, the PMI providers incorrectly stated that the patient had been overcharged. In fact the true situation was that patients had an inadequate level of insurance cover for a variety of reasons, including failure to increase cover with the cost of living index, inflation and other cost pressures, some of which were associated with medical practice in central London.

6.204. The PMI providers, particularly BUPA and PPP, had tried to give the erroneous impression to patients that they were acting in their interests as gatekeepers. Mr Sacks felt that the country was drifting towards managed packaged care like the private system prevalent in the USA. Having visited the USA Mr Sacks said that such an event would be a disaster for British medical healthcare.

6.205. Mr Sacks said that he was also concerned about the virtual monopoly by HCA(London) of private hospitals in central London and was surprised that this had not been referred to us.

A consultant histopathologist

6.206. A consultant histopathologist working in the NHS in England said that one of BUPA PMS's national policies was that all pathology and radiology should be done on BUPA PMS's sites, where possible. While for laboratory-based disciplines such as clinical chemistry and haematology it made a lot of sense as these specialities were largely automated, it did not take account of the needs of histopathology and cytopathology and to a lesser extent of microbiology.

6.207. The consultant said that histopathology was hugely intensive in terms of medical input. Every specimen was examined, blocks were selected and examined microscopically and reported by consultant staff.

6.208. The reason why BUPA had a policy of requiring all pathology to be done on-site was to ensure that it controlled the laboratories, their costs and their outputs. BUPA operated pathology laboratories as

¹3.22 kilometres.

cost centres and the charges from pathology were kept as low as possible to ensure that profits arose elsewhere in the business.

6.209. The consultant said it was unreasonable that BUPA PMI should insist that cellular pathology specimens from patients seen as outpatients or operated upon in BUPA PMS hospitals must be examined in BUPA PMS's pathology laboratories. This was anti-competitive. The consultant's NHS hospital could not, for example, easily bid for the BUPA PMS histopathology workload, nor could another private pathology laboratory. Similarly the consultant was prevented by BUPA PMS rules from taking pathology specimens to the NHS hospital where the consultant worked for examination, unless there was a clinical case for this. The practice of bundling pathology with other patient charges was also anti-competitive, as it was impossible then to separate pathology or radiology charges from other patient charges.

A consultant, South Hampshire

6.210. A consultant from South Hampshire said that BUPA PMS controlled 40 per cent of both the PMS market and the majority of the PMI market. All consultants who now applied to BUPA for recognition as had to fill in a legally-binding application form, which allowed BUPA to remove recognition without giving a reason.

6.211. This had been highlighted recently by the case of an orthopaedic consultant in Bristol who sued for libel, received an out-of-court settlement, but despite this was removed from BUPA recognition and admitting rights to his local BUPA hospital.

A consultant surgeon

6.212. A consultant surgeon said that BUPA PMI had recently written to all physiotherapists in the North-West of England requesting that they reduce their fees by 30 per cent for a period of two years if they wished to continue seeing BUPA PMI insured patients. But the consultant learned, having talked to the BUPA PMS national physiotherapy manager and BUPA hospitals in the North-West, that this policy applied only to independent practitioners and not to BUPA PMS's physiotherapy departments. The consultant asked whether BUPA PMI was abusing its power by forcing independent practitioners to reduce their rates whilst the same policy was not applied to its hospitals.

6.213. The consultant said PMI providers also demanded that self-paying patients pay the same fees as those levied on insured patients. In many cases this would lead to an increase in fees for self-paying patients. PMI providers should not be able to dictate what hospitals charged other patients: they were supposed to be separate organizations.

NHS Executive

6.214. The NHS Executive told us that the proposed merger would not affect its relationship with the private sector. It said that the aim of the concordat (which the Secretary of State for Health signed on 1 November 2000) was to involve the private sector much more in the planning of service delivery. It was the intention of the NHS Executive to create a framework in which private capacity could be utilized on a short-term basis to supplement NHS facilities, and for emergency and winter planning.

6.215. The NHS Executive understood that the private sector was running at 40 to 50 per cent of its maximum capacity and was encouraging NHS Trusts to take account of this when planning their services. Under the NHS Plan the number of sessions that consultants were required to work in the NHS might be changed and this would affect their availability for private sector work. The concordat would enable the private sector to plan ahead thereby enabling it to have more confidence that it could retain facilities, know what size the facilities should be and whether it should employ sessional or full-time consultants.

6.216. One of the issues addressed in the concordat was that of clinical guarantees. Any PMS providers entering into a contract with the NHS would be expected to conform with NHS procedures and processes. Under the terms of the NHS Plan NHS Trusts would have the use of private hospitals' facilities and access to them for their consultants. The NHS Executive confirmed that it was an objective of the NHS Plan that if a patient had an operation cancelled on the day it was intended, it would be rescheduled

within a 28-day period, or be funded at the patient's convenience in a private hospital of the patient's choosing.

6.217. The NHS Executive believed that the BUPA/CHG merger would not affect the ability of the private sector to respond to the NHS Plan, or the value-for-money arrangements which the NHS would seek from the private sector. The NHS Executive said that it wanted to see as much transparency as possible while keeping bureaucracy to the minimum. It was discussing with the private sector the issue of sharing information on the use of private sector facilities by NHS consultants.

Ayrshire and Arran Health Board

6.218. The Ayrshire and Arran Health Board said that the merger could potentially compromise the interest of the consumer.

Organizations or companies providing healthcare information

Griffiths Bradwell Associates

6.219. Griffiths Bradwell Associates (GBA) is a private healthcare consultant's practice.

6.220. GBA published two annual subscription reports: *The Thousand Patient Study* and *The Private Practice Review*. The former covered the recent hospital experiences of at least 1,000 patients. The latter covered the views of 500 to 600 consultants on PMI and PMS providers.

6.221. One of the findings of *The Thousand Patient Study* was that only 71 per cent of PMI subscribers found that their PMI covered all their PMS costs. The remainder were having to top up their PMI cover. However, there also appeared to be a trend towards self-payment for fairly expensive procedures. The NHS waiting lists appeared to be patients' principal reason for using PMS. The corporate sector, on the other hand, was becoming more restrictive in the PMI cover its employees and their dependants received.

6.222. GBA said that the BUPA/CHG merger did not present problems at the national level because it involved only 21 CHG hospitals, all of which were well run and equipped. At the local level, in two or three places, CHG hospitals had failed to get into the BUPA network because there was a local BUPA-owned hospital.

6.223. The proportion of the UK population covered by PMI was fairly static. There was movement between PMI providers but not many new subscribers for PMI policies.

6.224. Consultants were not generally in favour of network hospitals because of the restriction on where they could practise. Network hospitals could also lead to the underutilization of non-network hospitals.

6.225. GBA did not think that barriers to entry were high and any general insurer could open up a PMI operation quickly if it chose to do so. But it was not an attractive market to be in at the present time.

6.226. BUPA over the years had improved its customer service but it was difficult to know whether its PMI business would get back into a profit. It needed to attract more subscribers. GBA said that it was difficult to describe BUPA as a single integrated business. It appeared to be two quite distinct operations in terms of PMI and PMS.

Health Care Navigator Ltd

6.227. Health Care Navigator Ltd (Health Care Navigator) said that we should consider not only BUPA's proposed acquisition of CHG but the entire scope of its business activity. BUPA's dominant position in the market and continuing aggressive behaviour (it had purchased 26.8 per cent of CHG in spite of having given an undertaking that it would not attempt to acquire former Goldsborough or IBH hospital properties) provided reasonable grounds for a Chapter II Prohibition.

6.228. The following aspects of BUPA's business operations required particular scrutiny:

- (a) barriers to entry and the effectiveness of competition in the private healthcare marketplace, arising from BUPA's brand and financial strength;
- (b) cross-subsidy of business units in the BUPA portfolio;
- (c) the company's management culture and recent behaviour, and the likely effectiveness of behavioural undertakings which BUPA might be asked to give to the OFT;
- (d) the poor financial performance of recent BUPA acquisitions; in particular, BUPA's inability to create returns better than the cost of capital; and
- (e) how BUPA would be able to achieve a better than market rate of return on its proposed acquisition of CHG, bearing in mind the high value which it had ascribed to the business.

6.229. The factors which seemed to require investigation by CHG included:

- (a) the strength of the contribution of the private sector to the whole of UK healthcare and how BUPA's market position might be holding back its development;
- (b) the lack of growth in BUPA's PMI business and, as a consequence, the switching of assets created by the not-for-profit provident association to commercial enterprises, in particular private hospitals and residential nursing homes;
- (c) the DGFT had made it clear that he was concerned that the PMI industry (of which BUPA was the leader) had not been effective in containing premium costs;
- (d) the unique advantages of a not-for-profit organization compared with public companies whose prime responsibilities were to their shareholders. Not-for-profit status was a legitimate corporate structure for any business, but distortions could be created when the business had a dominant market position, was vertically integrated and had revenues in excess of £1.9 billion;
- (e) the impact of BUPA's business strength on the marketplace, both as a PMS and PMI provider and as a vertically-integrated organization; and
- (f) BUPA's belief that it could act as it saw fit in the pursuit of its business objectives and that it was not bound by undertakings, such as those given to the Department of Trade and Industry which had been set aside with its attempted acquisition of CHG.

6.230. Health Care Navigator said that even if BUPA's business approach was not intentionally predatory, the impact was the same. Its scale and reach had an effect on nearly every part of the value chain. Indeed, BUPA was continuously redefining the healthcare value chain by its behaviour.

Laing & Buisson/HCIS

6.231. Laing & Buisson/HCIS said that it produced the *Laing's Healthcare Market Review* and the *Fitzhugh Directory of Independent Healthcare*. The former provided an analysis of the independent healthcare sector and the latter financial data about the operating companies. HCIS also produced a database: 'NHS Trusts' Financial Information data on Disk'.

6.232. Laing & Buisson said that the value of the PMI sector was about £2 billion a year. It had grown rapidly after the war but stalled with the recession in the early 1990s. It had not re-emerged from that, at least in terms of volume and demand. At one time BUPA had about 70 per cent of the PMI market, but was now around 40 per cent. PPP's share had not declined but many small PMI providers came and went. The most significant change in recent years had been the development of network products; essentially these were an attempt by PMI providers to gain higher discounts from those hospitals to which they directed their customers and, other things being equal, to offer a lower price for a higher quality of service to their customers.

6.233. About 12 per cent of the UK population was covered by PMI. This appeared to be something of a plateau, with growth mainly related to company schemes. PMI was a competitive market, with providers having to fight to retain their position. It was also difficult for companies to enter the PMI market

and establish themselves in a substantial way. Currently BUPA PMI, PPP and probably Norwich Union tended to make small underwriting profits and in some years had made underwriting losses.

6.234. Laing & Buisson said that PMS providers tended to set their rack rate and then provide a discount to PMI providers like BUPA PMI and PPP (and also to self-payers). If the NHS were to endeavour to take up any spare capacity which might exist in private hospitals it would be necessary to increase their numbers of consultants and nurses. Laing & Buisson said that it saw the consolidation in the PMS industry continuing with the elimination of the old-style hospitals.

6.235. Laing & Buisson said it was reported that BUPA had Chinese walls within its organization, but BUPA executives could be moved from the PMS business to the PMI business, which could lead to information being exchanged. BUPA's costs as a PMS provider were probably high relative to those of its competitors, and its operating margins were certainly lower than those of GHG and CHG.

6.236. Laing & Buisson said that it saw BUPA's strategy as being to diversify out of PMI because it was a mature market, and to spend money on nursing homes or PMS hospitals both in the UK and abroad.

The King's Fund

6.237. The King's Fund is a charity founded towards the end of the nineteenth century and based principally on a trust established by the future King Edward VII. It undertook a wide range of activities in the health and social care fields and for the last 18 months had been making a study of the private healthcare sector.

6.238. The King's Fund said that the main issues of the BUPA/CHG merger appeared to be, first, the extent to which it consolidated PMS provision in a way which might act against the public interest. Second, would the merger provide BUPA PMI with additional, perhaps unwarranted, market power? Third, would BUPA be able to create a market niche in intermediate care?

6.239. The King's Fund said that the NHS might become powerful in the PMS market. A key matter was whether there were sufficient consultants, particularly in certain specialties.

6.240. The King's Fund thought vertical integration was undesirable and was doubtful that effective Chinese walls existed between BUPA's PMI and PMS businesses. The private healthcare market was generally saturated and static but appeared to be reasonably competitive. Moreover, while the NHS Plan might reduce NHS waiting lists, it was also likely to have an impact on the private sector.

6.241. The National Beds Inquiry suggested, among other things, that the NHS was short of certain consultants but that the private sector had excess bed capacity. The King's Fund said that it did not see any particular problem with BUPA's desire to arrange particular contracts with consultants. However, it considered that greater thought needed to be given to the different regulatory regimes surrounding the NHS and private care.

Others

Medisure

6.242. Medisure said that it was a TPA and performed most of the activities of a PMI provider but did not bear risk. Medisure was the largest medical insurance TPA in the UK.

6.243. About 60 per cent of its business was non-insured, usually with larger companies; the other 40 per cent consisted of traditional insurance policies underwritten by an insurance company. Medisure said that it undertook annual negotiations with individual providers in the same way as the major PMI providers. It also had negotiations with individual hospitals.

6.244. Medisure said that parts of the PMI market were very competitive. In other parts, for example relating to small company schemes, it was relatively easy to produce a proposition that was cheaper than an established product. Medisure said that the barriers to entry to the PMI market were relatively low but the barriers to growth once a company was in the market were substantial. The PMI market itself was saturated.

6.245. Medisure said that if BUPA was using its hospital position to cross-subsidize its PMI or as a mechanism to keep out new or small entrants, then it would probably not be in the best interests of consumers. Medisure was doubtful that the restrictive hospital network concept was sustainable in the longer term because of the reduction in customer choice. Medisure said that it offered 300 to 400 hospitals nationally. The corporate side could be more restricted and depended on the particular circumstances. Medisure said that there was probably overcapacity, particularly in the small independent chains.

6.246. Medisure considered that if the CHG hospitals were sold to GHG it would probably provide for a more competitive market. It could not see the point of BUPA having both a PMI and a PMS business unless it was going to squeeze the maximum efficiencies out of the combined business and it should be possible to demonstrate that that was in the public interest. Medisure said that from its point of view the potential merger did not make a great deal of difference to what was already a difficult market that uniquely contained a major operator which had both a substantial PMS and a substantial PMI business.

Consumers' Association

6.247. The Consumers' Association (CA) said that the proposed acquisition of CHG by BUPA presented two sets of problems. First, there were the horizontal issues related to competition in the PMS market. Second, there were a series of vertical ties between BUPA PMI and BUPA PMS. The impact of horizontal mergers on concentration in a market could be measured in several ways. CA said that it used the HHI as a guide to market concentration and the degree to which a proposed merger was likely to increase it.

6.248. The provision of hospital cover in the private healthcare market was heavily weighted towards acute medical and surgical activities which accounted for nearly 90 per cent of the independent healthcare market by value. The PMS market share of BUPA and CHG, measured both in terms of beds and of hospitals, came to a little over 25 per cent. The pre-merger HHI placed the hospital market, depending on the measure used, either just in the unconcentrated bracket or just in the moderately concentrated category. CA thought that the latter was probably the better.

6.249. The concentration level in the pre-merger market was relatively high, but the increase in concentration caused by the proposed merger did not greatly add to it. The number of effective competitors in the market pre-merger was roughly 7½. In cases of very large mergers, the numbers equivalent tended to fall by a greater factor than the removal of one competitor would indicate. In this case the numbers equivalent for post-merger industry fell from 7.44 to 6.09.

6.250. It was also important to look at the market in a less static manner. The dissimilarity index for the PMS market indicated that a reasonable amount of market share had changed hands. It was then necessary to assess the relative size of the remaining providers. CA said that it looked at the relationship between the market share for the four national PMS providers in relation to that for the next four. The top four had a very large share of the market, which the merger would increase, and the market share of the next four was low and likely become lower, given the effects of the merger.

6.251. Given the specialization of some of the smaller PMS providers, CA estimated that the merger would have a significant impact on competition in surgical and acute medical cases. The increase in concentration on its own was probably not enough to block the merger, but it raised questions about the future direction of the industry.

6.252. The PMI market was highly concentrated in HHI terms. However, it also indicated that the position of BUPA had decreased markedly during the period 1988 to 1998. The market had 2.77 effective competitors in 1988 and only 3.31 in 1998. This would indicate that, despite changes in market share and the entry of new providers, the impact of entry had been fairly muted, adding less than one effective competitor to the market. Indeed the dissimilarity index for this market was zero, indicating a cancelling out of the redistribution of market shares.

6.253. CA said that the proposed merger could have no impact on the distribution of market shares within the PMI market. However, the market was still highly concentrated and any vertical relationships in the industry needed to be carefully assessed.

6.254. The assessment of vertical restraints was always difficult. CA thought that the rule of thumb developed (but not used) by the US Department of Justice in vertical restraints cases was a useful guide. It argued that such a restraint would be worrying when:

- (a) concentration was high in the primary market;
- (b) the companies in the secondary market using the restraint accounted for a large portion of sales in that market; and
- (c) entry into the primary market was difficult.

6.255. CA said that the PMI market was concentrated and thus satisfied the first criterion. The secondary market, that for PMS, appeared to qualify on two grounds: first, the merged entity would have a substantial share of the market, and second, BUPA, through its contracting relationships with other PMS providers, had a powerful position in the market. However, the exact nature of that relationship was unclear and in need of further investigation. The third criterion was more difficult to assess. First, entry into an insurance market should not be difficult and a number of firms had entered the PMI market over the last few years, most notably Norwich Union. However, the entry that had occurred had had relatively little effect on the number of effective competitors in the market. It was also unclear what effect the contracting relationships between BUPA and individual PMS providers had on this market.

6.256. CA said that the solution to the problems of the strength of vertical ties in the market could range from a requirement for the merged hospital group to divest some hospitals to limit any potentially harmful effects of the agglomeration of market power. BUPA could be required to undertake behavioural modifications to ensure that its vertical relationships did not restrict competition in the wider market. The merger itself could be opposed on the grounds of market power and vertical relationships. The particular aspects of market power that caused concern related to a strengthening of a position in the PMS market and the possibility of using existing vertical relationships more effectively to leverage PMI market power by discriminating between PMS providers. CA was not in favour of any of these options and concluded that the merger required a closer analysis by us.

Mr G T Denton

6.257. Mr G T Denton questioned the status of BUPA as a provident association and whether such an organization was appropriate for a commercial operation of BUPA's size.

6.258. Mr Denton said that when he joined BUPA in 1979 such associations were viewed as philanthropic and semi-charitable and thus qualified for favourable tax concessions. After 21 years he still had no real knowledge of BUPA, as membership gave no rights other than the specific service for which he subscribed. There were no annual accounts or voting rights.

6.259. The cost of membership had escalated dramatically. Since 1990 PMI premiums had been age-related but from this year they would be based upon each individual covered, with annual age-related increases. In practice, the premium paid to BUPA had risen from £54.63 in 1990 to £202.74 a month in 2000, an increase of 270 per cent in ten years (compared with the increase in the RPI of 35 per cent). This increase, said Mr Denton, was in spite of reducing his cover from scale B to scale C in 1996 and then taking on an excess of £100 in 1998. If he had not taken these steps the increase would have been 483 per cent over the ten years. The actual cost to members was even higher than those quoted because of the cancellation of income tax relief in 1998 and the imposition of insurance premium tax of 2.5 per cent in the same year (since doubled to 5 per cent). He contended that these figures indicated a high profit margin, although the prices charged by BUPA PMS to BUPA PMI would be a further factor.

6.260. Unless BUPA became a more transparent organization, with published scales for all ages and proper financial reports, Mr Denton would oppose any further expansion by acquisition. He believed that BUPA must be split into two distinct parts—the PMI business and the PMS business—with no cross-subsidies. The PMI business might perhaps still operate as a provident association provided it reported results similar to the way mutual societies operated and was more open about its subscription scales. The PMS business now needed the discipline associated with PLC status, and should therefore be floated on the market. Existing members should benefit in some way from this flotation to cover their past contribution to its expansion. Future expansion should be financed by shareholders or borrowing. If BUPA agreed to these steps then he could see no harm in its acquisition of CHG. Mr Denton said that he could

visualize considerable benefit to the NHS if it acquired a 20 to 25 per cent stake in the merged company, and negotiated equivalent patient entitlement to be agreed on a hospital by hospital basis in the appropriate regions.

Mr John E Hailwood

6.261. Mr John E Hailwood said that the majority of healthcare in the UK was provided through the NHS, probably in excess of 80 per cent of medical health provision.

6.262. The BUPA/CHG acquisition was relatively small but we should recommend the break-up of the NHS to foster competition with a view to the improvement of the health service throughout the country.

Mrs Patricia Kidds

6.263. Mrs Patricia Kidds said that she was against the proposed BUPA/CHG merger because:

- (a) medical treatment was always traumatic and the degree of control that patients enjoyed was an important element of successful recovery: a choice of hospitals gave patients control;
- (b) having both BUPA and CHG in her area enabled her to make a choice;
- (c) surgeons often operated at both BUPA and CHG hospitals but the quality of aftercare, pain control and food were unique to a particular hospital;
- (d) healthy competition kept companies alert whereas a guaranteed customer base encouraged standards to drop; and
- (e) consideration (d) was important in the Wokingham area where probably a greater number of people had PMI.

J A REES (*Chairman*)

K M H MORTIMER

A J PRYOR

P A BOYS (*Secretary*)

8 November 2000