

Completed acquisition by General Healthcare Group of assets of Nuffield Hospitals

ME/3468/08

The OFT's decision on reference under section 22(1) given on 1 May 2008. Full text of decision published 16 May 2008.

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

PARTIES

1. **General Healthcare Group (GHG)** is a provider of independent healthcare services in the UK. GHG operates two primary businesses: BMI Healthcare Limited (BMI), which operates 48 acute care private hospitals, and Netcare Healthcare (UK) Limited, which provides specialised clinical services to patients under contract to the NHS.
2. **Nuffield Hospitals (Nuffield)** is a not-for-profit organisation, which prior to the transaction owned and operated 40 acute care private hospitals.

TRANSACTION

3. GHG originally acquired a package of nine hospitals (the Purchased Hospitals) from Nuffield's estate of 40 private hospitals, comprising:
 - Nuffield Hospital Birmingham
 - Nuffield Hospital Bury St Edmunds
 - Nuffield Hospital Gerrards Cross
 - Nuffield Hospital Harrogate
 - Nuffield Hospital Huddersfield

- Nuffield Hospital Lancaster
 - Nuffield Hospital Lincoln
 - Nuffield Hospital North London (Enfield), and
 - Nuffield Hospital Nottingham.
4. Nuffield offered the Purchased Hospitals as a package. GHG has said it believed that these Nuffield hospitals were selected for sale because there were alternative Nuffield hospitals in each area, although not necessarily in the catchment area. This meant that Nuffield considered that it would still be in a position to offer a national network after the sale.
 5. GHG undertook its own competition analysis of the nine hospitals and concluded that the acquisition of two Nuffield Hospitals, Gerrards Cross and Nottingham, would likely give rise to a substantial lessening of competition. GHG has therefore sought to remedy this loss of competition (on a fix it first basis) by selling Nuffield Hospital Gerrards Cross to Spire Healthcare Limited (Spire) and Nuffield Hospital Nottingham to Ramsay Health Care UK (Ramsay).
 6. The OFT's initial investigation covered the acquisition by GHG of all nine Purchased Hospitals.¹ The OFT's starting point is therefore that its decision will be expected cover the full set of assets acquired by GHG from Nuffield. To the extent that remedies are required to resolve competition concerns arising in certain local areas, the Enterprise Act 2002 (the Act) provides for these to be given by means of undertakings in lieu of reference.
 7. In this case, GHG entered into agreements to on-sell Nuffield Hospitals Gerrards Cross and Nottingham to third party purchasers. During the course of its investigation, the OFT considered the competitive impact of these on-sales. In particular, it has been satisfied that each on-sale comprehensively remedies the substantial lessening of competition that would have otherwise have resulted from the GHG/Nuffield transaction and that the acquisition by the relevant third party does not itself raise competition concerns. Given that the OFT was satisfied that the on-sale transactions were to suitable purchasers, where appropriate, it gave

¹ For this reason, the discussion in this decision covers all nine Purchased Hospitals.

consent under the initial undertakings provided by GHG for the relevant Nuffield hospital to be divested.²

8. To the extent that any fix-it-first remedies proposed by the acquiring party remain provisional at the time of the OFT's decision, the OFT will require that such remedies are enshrined by means of undertakings in lieu. In this case, however, both on-sale transactions had completed by the time of the OFT's decision on reference. As a result, the OFT's decision covers the seven Purchased Hospitals of which GHG retained ownership at the date of its decision.
9. The original transaction was completed on 1 February 2008, the administrative deadline for a decision is 1 May, and the statutory deadline expires on 31 May 2008.

JURISDICTION

10. As a result of this transaction, GHG and the seven retained Purchased Hospitals have ceased to be distinct. The parties overlap in the supply of private medical services through the operation of private acute care hospitals in the UK. By beds, the merger creates a combined share of 28.3 per cent (increment 4.2 per cent) if all nine of the Purchased Hospitals are included; or a combined share of 27.7 per cent (increment 2.6 per cent) in respect of the seven retained hospitals; therefore the share of supply test in section 23 of the Act is met. The OFT therefore believes that it is or may be the case that a relevant merger situation has been created.

MARKET DEFINITION

11. GHG and the Purchased Hospitals overlap in the supply of private medical services (PMS) through private acute care hospitals.
12. GHG provided the following explanation of the patient's journey, that is how a patient comes to be treated at a private acute general hospital. In the first instance the majority of patients will approach their general practitioner (GP). Most Private Medical Insurance (PMI) policies treat the GP

² This does not, in any event, prejudice the OFT's ability to review a qualifying on-sale transaction as a separate merger situation.

as the gatekeeper to the plan benefits and a referral by a GP is necessary before a consultant can be seen.

13. The patient's medical condition, and the identity of the most appropriate consultant or hospital, is discussed with the patient. The GP will also determine whether the patient has PMI and whether they wish to use it or rely upon the National Health Service (NHS) or equivalent. At this stage, the patient could be referred to any appropriate consultant, not necessarily one who works in the closest geographic PMS hospital. For this reason, a critical part of PMS marketing is aimed at the GP, making them aware of the consultants listed at their hospitals and the facilities on offer.
14. Once a consultant has been identified, the patient will arrange an appointment. This appointment and any diagnostic testing may or may not be carried out at the hospital where any eventual procedure is carried out. If going private the patient's PMI provider will generally pay the consultant and hospital separately, but directly for consulting time and tests according to their respective framework agreements.
15. Should the patient require further treatment, the patient will agree with the consultant where this will take place (which at this stage could still be either as an NHS patient or as a private patient). Consultants usually have practising privileges (for example, are able to admit patients) at more than one PMS hospital or NHS Private Patient Unit (PPU). The consultants' judgement on which hospital to use will depend on geographic proximity, but also issues such as the quality of the nursing team, facilities, patient specific risk issues etc. As consultants are the primary decision maker in deciding where a patient's treatment will take place, the objective of the marketing aimed at consultants by PMS providers is to encourage consultants using other hospitals to switch to their hospitals, new consultants to join and current consultants to use their hospital more. Usually, in making this choice of hospital, the consultant will also take into account those hospitals included in the patient's PMI provider's network. However, if, for whatever reason, a patient attends a hospital not on his PMI provider's network the patient will pay the hospital direct and the PMI provider will reimburse the patient up to the sum usually paid to an equivalent network hospital (referred to usually as top up).

Product scope

16. In previous cases in this area³ the Competition Commission (CC) concluded that the relevant product market was the supply of PMS, excluding some specialised medical services (for example, psychiatric treatment) based on privately paid-for hospital services relating to elective treatment of acute medical conditions. The CC also included PPUs as part of the appropriate product market; although it appears that they were excluded from the local analysis, but excluded NHS pay beds.⁴ This view was supported by the European Commission's decision in the Capio case⁵ which considered that there was good reason to define a separate market for private acute general hospitals in the UK.
17. We have considered whether there have been any changes within the market that would suggest that the relevant product scope is either wider or narrower than before; in particular whether standard NHS Trust hospitals could be considered to be part of the relevant product scope. While the CC in the BUPA/CHG Report considered that such hospitals provide an element of price constraint, the willingness of customers to pay an extra charge for private healthcare indicated that free services fell into a separate market. GHG broadly agreed with this conclusion.
18. One third party competitor suggested that given the developments that have taken place over the last few years there is a strong case for including all NHS services as part of the appropriate frame of reference. However, no other third party considered that NHS free services should be considered in the same product scope. Given the limited evidence provided by the third party competitor and other third party comments, we do not consider it appropriate to consider free services from NHS Trust hospitals in the same product scope as private hospitals, which is consistent with precedent.
19. Finally, we considered the constraint exerted on GHG by NHS PPUs. In the BUPA/CHG Report the CC considered that these were broadly similar to

³ *British United Provident Association Limited and Community Hospital Group plc - A report on the proposed merger; and British United Provident Association Limited, Salomon International LLC and Community Hospitals Group plc; and Salomon International LLC and Community hospitals Group plc - A report on existing mergers* - Competition Commission, December 2000 (Cm 5003) (the BUPA/CHG Report).

⁴ Beds within NHS hospitals on normal NHS wards that are available to privately funded patients. Any bed in an NHS hospital can be used for private patients, subject to NHS clinical priorities.

⁵ *COMP/M.4367 Apax Partners Worldwide LLP (APW), Nordic Capital Fund VI, Apax Partners SA (APSA) and Capio AB*, European Commission, March 2007.

private acute hospitals and therefore should be included in the product scope where their facilities were made available to private patients on a full time basis. As well as providing similar services, NHS PPUs are often included on the hospital networks of PMI providers, alongside private acute hospitals. GHG considers that the constraint provided by NHS PPUs has increased since the time of the BUPA/CHG Report.

20. Two third party PMI providers made comments that suggested that either they did not consider NHS PPUs as direct substitutes to private hospitals or that, whilst NHS PPUs can offer an alternative, the degree of substitutability depends on size, capacity and range of services on offer. However, notwithstanding these statements, the OFT notes that both third parties have agreements with NHS PPUs in at least some of the areas which are affected by this transaction.⁶
21. There is some evidence that NHS PPUs provide a weaker constraint on the parties than other independent hospitals. However, PMI providers clearly contract with a large number of NHS PPUs for the provision of PMS and PPUs may gain some competitive advantage from being located on larger NHS Trust estates. On balance, we consider, on the basis of the overall evidence, that NHS PPUs should be included in the product scope where their facilities are available to private patients on a full-time basis.
22. It has not been considered necessary to narrow the product scope further by considering the provision of specific medical treatments; however, third parties did comment that in order to be an effective competitor a hospital would need to offer a wide range of medical treatments. Where this is relevant to the competitive assessment, this has been taken into consideration. Previously, certain specialised services, in particular psychiatric services, pregnancy termination and cosmetic surgery, were excluded from the relevant frame of reference; no evidence has been provided that suggests that it would be appropriate to depart from this approach in this case.
23. On the basis of the evidence provided the OFT therefore considers the appropriate product scope to be the provision of a wide range of medical treatments either by a private acute hospital or a NHS PPU.

⁶ [].

Geographic scope

24. The BUPA/CHG Report considered that the PMS market should generally be viewed as national but with local and potentially regional aspects. Given the location of the overlap hospitals in this case, regional issues were not considered relevant and are therefore not considered further.

Local dimension

25. Previously, the geographic scope of the market has been based on 30 minute drive time isochrones – broadly based on the area that account for 80 per cent of a hospital's patients. Most patients do not travel long distances to receive treatment, and, similarly, consultants normally operate out of private acute hospitals that are close to the NHS hospital where they are based. However, the CC considered that in some cases a wider catchment may be appropriate, particularly in rural areas.⁷
26. GHG provided a report by Frontier Economics commissioned to assist GHG in developing the appropriate methodology for analysing competition in local markets. The report confirmed that on average 80 per cent of episodes⁸ across all GHG Hospitals are associated with patients who live within a 30 minute drive time of the hospital at which they receive treatment. GHG therefore consider a 30 minute drive time to be the appropriate geographic frame of reference for the purposes of the competitive assessment.
27. One third party stated that the majority of patients were not willing to travel more than an hour to a private acute hospital for routine procedures and a significant proportion would not be willing to travel more than 30 minutes. However, for more specialist/complex procedures patients may be willing to, and may have to, travel further, for example to regional centres of excellence.
28. Another third party's comments were also broadly in line with GHG's assertions stating that patients would be willing to travel for, on average,

⁷ The CC also noted that some flexing may be required as the 30 minute isochrone makes no distinction between a hospital in the middle of a catchment area and one close to the boundary, while any hospital just outside the boundary is excluded.

⁸ An episode is a revenue generating unit of treatment.

30 minutes (or approx 20 miles), but that this would depend on where they lived.

29. While GHG consider that a 30 minute catchment is the most appropriate geographic frame of reference, it provided share of supply information (following the CC's approach) that takes into account the impact on competition within the catchment from hospitals located outside. Specifically, GHG considered the total number of episodes treated in private acute hospitals⁹ which arose within the 30 minute catchment area of each overlap Nuffield hospital and then the proportion of those episodes treated in either a GHG hospital or the overlap Nuffield hospital, regardless of whether the GHG hospital(s) is located within the 30 minute catchment.
30. The share of supply figures created by this method provide a better reflection of actual competition between GHG and the Purchased Hospitals, rather than simply considering whether they are within 30 minutes drive time of each other.
31. Based on the evidence received, the OFT considers a 30 minute drive time catchment to be the appropriate **local** geographic frame of reference. However, given the relatively small number of overlaps we have been able to consider local competition on a case by case basis by considering whether GHG (and other private) hospitals outside the 30 minute catchment compete to treat episodes arising from within the catchment area.
32. GHG consider that a wider geographic frame of reference is appropriate in London, and this view is supported by a third party competitor with private hospitals in Central London. It considered the relevant geographic scope to be wider for London, on the basis that a substantial percentage of its patients lived outside the M25 and therefore travelled a considerable distance. This may indicate that a wider geographic frame of reference is appropriate for London.
33. In the BUPA/CHG Report the CC considered that Central London may be a distinct geographic area, since there were markedly different conditions in London compared to the rest of the UK. For example, many of the large teaching hospitals are located in Central London and as a result the NHS PPUs attached to these hospitals play a more effective competition role in

London than they may do in other areas. Some evidence has also been received from customers (PMI providers) to support the assertion of a wider catchment within London. For example, one PMI provider stated that in North London (Enfield) they contract with []. The majority of these hospitals are located more than 30 minutes from the Enfield Nuffield.

34. The distinct nature of Central London private hospital catchments was noted in the BUPA/CHG Report and more recently in the CC's evaluation report.¹⁰ The BUPA/CHG Report does not define London as a completely separate geographic market from the rest of the UK, but argues that the competitive conditions in London differ markedly from the rest of the country. Specifically stating that, whilst hospitals in London did operate within catchment areas, these catchment areas were atypical due to the nature of competition in London.
35. Enfield is considered to be part of North London rather than Central London and there is no evidence that the atypical nature of hospital catchments in Central London is also relevant in North London. In particular, 80 per cent of patients treated at the Enfield London are located within the 30 minute isochrone.
36. Therefore, for London the OFT has taken a cautious approach and considered a narrow 30 minute isochrone, and, as part of the competitive assessment, has also considered the constraints, if any, placed on GHG and the Purchased Hospital by PMS providers outside the catchment area and, in particular, PMS providers located in Central London.

National dimension

37. Most third parties also considered that the supply of PMS by private acute hospitals and NHS PPUs has a **national** dimension. In the BUPA/CHG Report, the CC found that competition in the private hospital market was mainly national with some local and regional elements. They found that over the previous decade the PMS market had become much more national in structure with four national providers operating hospitals across the UK and that, for these providers, pricing was largely determined nationally through price negotiations with PMI providers.

⁹ Including PPUs.

¹⁰ *Evaluation of the Competition Commission's past cases* CC January 2008.

38. GHG do not consider that the situation has changed much since the BUPA/CHG Report. The majority of third parties also indicated that there was a national dimension to competition. For example some PMI providers stated that they consider that membership of a national private hospital group can result in advantages in price negotiations for that PMS provider. Since prices are negotiated nationally, if PMIs have to include at least some of a PMS provider's hospitals in their PMI network, due, for example, to a lack of an alternative, then this strengthens the PMS provider's ability to negotiate for greater inclusion of its other hospitals.

Conclusion

39. Based on the evidence received, and consistent with the previous CC decision, the OFT believes it is appropriate to consider the effect of the merger using both national and local (30 minute isochrone) geographic scopes.

HORIZONTAL ISSUES

The counterfactual

40. The OFT's general approach is to rely on pre-merger conditions as the appropriate proxy for the counterfactual and to test the competitive impact of the transaction against such a standard before proceeding to consider whether another counterfactual should be substituted. In general, where the merger raises no concerns relative to pre-merger conditions, nothing will turn on the OFT's adoption of its default counterfactual of pre-merger conditions and there will be no need to consider the detailed factual questions that arise under substitute counterfactuals.
41. Given that the Purchased Hospitals were put up for sale by Nuffield by means of an auction process, then if not acquired by GHG it is possible that these hospitals could have been acquired by another hospital group, or private buyer, or possibly retained by Nuffield (if no bids were acceptable). Since it is not possible for the OFT to determine with any confidence the identity of any alternative owner of the Purchased Hospitals absent this merger the appropriate counterfactual therefore remains the pre-merger conditions of competition with the Purchased Hospitals in the ownership of Nuffield.

42. The OFT has also been notified about a further transaction in this same sector. Fox Healthcare Acquisitions Limited (a company under the same control as Spire) agreed to acquire the entire issued share capital of Classic Hospitals Group Limited (Classic) pursuant to the terms of a share purchase deed. That transaction completed on 17 March 2008. However, for the purposes of the substantive assessment in this decision, we have considered Classic and Spire as separate competitors, since the Classic/Spire merger was completed and notified to the OFT after the GHG/Nuffield merger. In practice, however, this does not affect the competition analysis in this case at either the national or local level.

Share of supply measures

43. Previously, the CC considered share of supply both by number of beds and number of discharges (a measure of patient numbers). The CC favoured the latter measure, stating that 'the number of beds is not a wholly satisfactory measure of its capacity, and does not account for differences in capacity utilization.'¹¹

44. In this case, GHG stated that shares of episodes¹² drawn from the relevant catchment is the appropriate measure, but has also provided shares by number of beds within the 30 minute catchment. On the basis of the available evidence, we consider that shares of episodes arising from the catchments around the Purchased Hospitals to be the more accurate reflection of the market structure for each local area and accordingly have used these as the basis of our analysis. We have also, given the limited number of providers in each local area, considered the fascia count for each local area post-acquisition.

Local market analysis

45. In the BUPA/CHG Report the CC discounted areas of overlap where either the combined share of episodes drawn from the relevant catchment would be less than 40 per cent or where the increment would be less than 10 per cent (the so-called 40/10 rule).

¹¹ Para 4.167 BUPA/CHG Report.

¹² GHG confirmed that there is no difference between the measure they use episodes and the measure used by the CC discharges.

46. The limited number of overlaps in this case means that the OFT has not needed to apply such a rule and has been able to consider the competitive impact of the transaction in relation to each local overlap. In any event, in the context of its statutory duties under the Act and given its extensive experience of economic evaluation in merger analysis, the OFT generally avoids applying such threshold rules as determinative of the competitive impact of a transaction without consideration of empirical evidence. That is not to say that thresholds, particularly ones with an empirical or otherwise robust basis, do not have validity as screening principles or as measures to rank overlap areas in examining a transaction with a large number of local overlaps.
47. The OFT has specific concerns about the inherent probative value of the 40/10 rule in particular. The relevant CC report predates the Act and does not elaborate on any empirical basis for such a rule, and its application would lead to troubling results under certain fact patterns. For example, the rule would discount an area in which a transaction resulted in the creation of a monopoly position through an acquirer with a 91 per cent share purchasing the sole competitor accounting for nine per cent; equally, an increment of nine per cent to a share considerably lower than 91 per cent could also give rise to local unilateral effects concerns. The OFT therefore has given no substantive weight to this rule and is not minded to do so in future hospital merger cases. In addition, the OFT has particular concerns about strictly applying that rule in the circumstances of this case given that the figures used in this case are based on internal GHG estimates rather than the actual data available to the CC in the BUPA/CHG case.
48. GHG provided maps for each local area showing the 30 minute primary catchment centred on the acquired Nuffield hospital. It also provided maps that showed the overlapping 30 minute catchments of the competing hospitals. As explained in paragraph 29 above, GHG has estimated the total number of episodes within the catchment of each of the Purchased Hospitals and the proportion of those episodes carried out by any GHG hospital and the relevant Nuffield hospital. However, it has not been possible for GHG to allocate the remaining episodes to specific other hospitals. This evidence has been considered in the analysis of the various local areas listed below.

Gerrards Cross

49. As noted above, GHG conducted its own analysis of the effect that the GHG/Nuffield transaction would have on competition and concluded that, in the case of Gerrards Cross, the acquisition would likely result in a substantial lessening of competition. The Nuffield Gerrards Cross is surrounded by three GHG hospitals within the 30-minute catchment with a further three GHG hospitals just outside this area. Within the catchment there are three PPU's but no other private hospitals. The merger created a combined share of episodes within the 30 minute catchment around the Gerrards Cross Nuffield of [65-80] per cent, increment [10-25] per cent.
50. In order to address the competition concern arising in the Gerrards Cross catchment area, GHG agreed to sell Gerrards Cross Nuffield to Spire as a going concern. On the basis that the on-sale to Spire had completed prior to the OFT's decision under section 22 of the Act, the OFT no longer considers Gerrards Cross Nuffield to be part of the GHG/Nuffield transaction at the time of the decision on reference.
51. The OFT considered the competitive impact of the sale of Gerrards Cross Nuffield to Spire. In particular, it has been satisfied that the on-sale remedies the substantial lessening of competition that would otherwise have resulted from the GHG/Nuffield transaction because (i) Spire, as an existing UK operator of a hospital network, has the relevant ability and expertise to compete and (ii) Spire is not present in the 30 minute catchment (although there is a Spire hospital in the vicinity beyond 30 minutes), and in these circumstances the OFT does not consider the divestment itself raised competition concerns. Accordingly, the OFT is satisfied that Spire is a suitable purchaser to resolve competition concerns in relation to Gerrards Cross.

Nottingham

52. GHG's own analysis of the competitive effect of the purchase of the Nottingham Nuffield hospital concluded that this would be a problem overlap area. In that area, the merger would have resulted in a combined share of episodes in the 30 minute catchment of [55-70] per cent, increment [10-25] per cent. Within this catchment there are no other private hospitals or PPU's – outside the catchment there is another GHG

hospital (Chatsworth) at Chesterfield to the north, Derby Nuffield to the east, Burton PPU to the south east and Spire at Leicester to the south.

53. To resolve this self-identified loss of competition, GHG agreed to sell the Nottingham Nuffield to Ramsay. Similarly to Gerrards Cross, the OFT examined the competitive impact of the sale of Nottingham Nuffield to Ramsay and was satisfied that Ramsay was a suitable purchaser given that this on-sale recreates the level of competition in the pre-merger situation in the Nottingham Nuffield catchment area.
54. This on-sale also completed during the course of the OFT's investigation, with the result that Nottingham Nuffield is no longer considered as part of the GHG/Nuffield decision for the purposes of the OFT's decision.

Huddersfield

55. There is no GHG hospital within the 30 minute catchment of the Huddersfield Nuffield. There is, however, a GHG hospital (Highfield) located just outside the isochrone; therefore for completeness this area has been considered in more detail.
56. While there is no direct overlap between the parties within the catchment, GHG Highfield does provide PMS for [0-15] per cent of the episodes arising from the Huddersfield Nuffield catchment. The parties therefore have a combined share of the episodes arising in the Nuffield catchment of [20-35] per cent.
57. This suggests that the parties do compete, to some extent, for patients within the Huddersfield area. However, it is considered that sufficient competition will remain post-acquisition. Classic Elland is, geographically, the closest competitor to Huddersfield Nuffield and offers more beds. Further, there are several other competitors' hospitals located just outside the Huddersfield Nuffield catchment, at a similar distance from the Nuffield as the GHG hospital, including two NHS PPUs, Spire Leeds, Leeds Nuffield, Yorkshire Clinic (Ramsay/Capio) and Methley Park (Classic).¹³
58. Third parties largely confirmed that competition between the parties was limited – [] stated that they did not contract with a GHG hospital in the

¹³ GHG has confirmed that there are no procedures currently undertaken by Huddersfield Nuffield that cannot be undertaken by overlapping competitor hospitals.

Huddersfield area (as they defined this area). No third party raised competition concerns in relation to Huddersfield. Given this and the relatively low combined share of episodes, the OFT believes that the acquisition of the Huddersfield Nuffield does not create a realistic prospect of a substantial lessening of competition. We therefore do not consider Huddersfield Nuffield further.

Harrogate

59. Harrogate Nuffield hospital is located well over an hours drive from the closest GHG hospital. However, GHG does provide PMS to a small proportion of patients within the Harrogate Nuffield catchment. GHG's combined share of episodes arising in the catchment is [25-40] per cent, with an increment of [less than five] per cent.¹⁴
60. GHG contended that it will continue to face competition from several private hospitals and PPU's, in particular Leeds Nuffield, Spire Leeds and York Nuffield. GHG stated that there are no procedures that can be undertaken by the Harrogate Nuffield that cannot be undertaken by these alternative hospitals.
61. Third party PMI providers have confirmed that they contract with [] in the Harrogate area.
62. Given the distance between the GHG and Harrogate Nuffield, the alternative hospitals and the small increment in terms of share of episodes arising from the Nuffield catchment, we do not consider that the acquisition will give rise to local competition concerns in relation to the Harrogate catchment. There are no non-PPU competitor hospitals located within the 30 minute catchment of Nuffield Harrogate. However, as Nuffield Harrogate treats less than 40 per cent of the episodes arising in the catchment, it suggests that a wider isochrone, including the next geographically closest competitors would be more appropriate in this area. On this basis we do not consider that the Nuffield Harrogate operates as an effective solus hospital.¹⁵

¹⁴ Given that over 60 per cent of episodes are treated by hospitals located outside the catchment, it may be the case that a wider catchment is relevant in the area, but given the limited increment from the merger this issue has not been considered further.

¹⁵ Following the BUPA/CHG Report a solus hospital is generally taken to mean a hospital where there are no other PMS hospitals in a 30 minute catchment. Third parties have also raised

Lancaster

63. There is no overlap with a GHG hospital within the 30 minute isochrone based on the Lancaster Nuffield. However, GHG has a hospital (Beardwood) located just outside the isochrone; therefore for completeness this area has been considered in more detail.
64. GHG Beardwood accounts for [0-15] per cent of episodes arising from the Lancaster Nuffield catchment giving a combined share of the episodes arising in the Nuffield catchment of [30-45] per cent. There are three competitors located either closer to Lancaster Nuffield or a similar distance away as GHG Beardwood, namely: Fulwood Hall (Cario/Ramsay); Blackpool Victoria (NHS PPU) and Fylde Coast (Classic) – all of which are able to offer at least the same level of care and procedures as the Lancaster Nuffield. The OFT notes, however, that the NHS PPU is small, with only 10 beds, and therefore may not provide a strong constraint on the parties.
65. Evidence provided by GHG suggests that the area served by the Lancaster Nuffield is a minor market for PMI, and we are aware that two of the three biggest PMI providers do not have a PMI contract with a GHG hospital in the Lancaster area. Given the limited PMI market in the Lancaster area, the number of alternative providers and the lack of third party concerns, we do not consider the acquisition will give rise to a realistic prospect of a substantial lessening of competition in the Lancaster catchment. We therefore do not consider Lancaster Nuffield further.

Bury St Edmunds

66. Bury St Edmunds is in a rural area with the Nuffield hospital located well over 30 minutes from any competitor hospital and well over an hour from the nearest GHG hospital in Sandringham. However, GHG does provide PMS to a small proportion of patients within the Bury St Edmunds Nuffield catchment. The combined share of episodes arising in the catchment is [45-60] per cent, with an increment of [less than five] per cent.
67. GHG consider that the Bury St Edmunds Nuffield will face particularly strong competition from Spire Cambridge Lea, Cambridge Nuffield and Ipswich Nuffield, which all offer, at least, comparable facilities. This is

concerns about near solus positions where they consider there is limited effective competition in the catchment area.

supported by the fact that [35-50] per cent of episodes arising from within the catchment are served by hospitals located outside the catchment. This would tend to indicate that a wider isochrone may be more appropriate in Bury St Edmunds, which would include these next geographically closest competitors. In this wider catchment the Bury St Edmunds Hospital is not regarded as a solus hospital.

68. Given the distance between the GHG hospital in Sandringham and Nuffield Bury St Edmunds, the closer alternative hospitals which will provide sufficient effective competition post merger and the small increment in terms of share of episodes arising from the Nuffield catchment, we do not consider that the acquisition will give rise to a realistic prospect of a substantial lessening of competition in the Bury St Edmunds catchment.

Lincoln

69. Lincoln Nuffield hospital is located over 30 minutes from any competitor hospital and over an hour from the nearest GHG hospital (BMI Park). However, GHG provides PMS to a proportion of patients within the Lincoln Nuffield catchment, resulting in a combined share of episodes arising in the catchment of [85-100] per cent, with an increment of [0-15] per cent ([0-15] per cent at BMI Park and [0-15] per cent at other GHG hospitals). However, it should be noted that the [0-15] per cent of episodes from the Lincoln Nuffield catchment treated by BMI Park only represents [less than 5] per cent of BMI Park's total episodes.
70. GHG argue that Lincoln Nuffield is a relatively small hospital with 32 beds offering mainly critical care level 1¹⁶ procedures, which can all be carried out by the nearest alternative hospitals (Scunthorpe PPU, St Hugh's (HMT), BMI Park, Nottingham Nuffield,¹⁷ Leicester Nuffield and Spire Leicester). In contrast BMI Park is a large hospital with 85 beds offering a significantly broader range of procedures than Lincoln Nuffield. These include cardiology, oncology and other surgical procedures requiring critical care level 2 and above. As such, GHG considers that patients travelling to BMI Park from the Lincoln Nuffield catchment are likely to be doing so for

¹⁶ Critical care levels provide an indication of the type of treatments that can be offered by a hospital. Level 1 is the lowest level of care. Major surgical procedures across all specialities will require at least level 2 (High Dependency Units) and commonly level 3 (Intensive Care Units).

¹⁷ On-sold to Ramsay Healthcare.

procedures not available at the Nuffield Lincoln hospital and therefore that there was limited competition between the parties pre acquisition.

71. GHG also argued that it expects competition to increase post transaction as a result of the on-sale of the Nottingham Nuffield to Ramsay Health Care. GHG contended that pre-transaction Nottingham Nuffield would have been unlikely to have sought to persuade consultants to switch from the Lincoln Nuffield since both hospitals were part of the same Nuffield Group. However, with the Lincoln Nuffield, post-transaction, being owned by GHG and the Nottingham Nuffield by Ramsay the two hospitals will actively compete for consultant referrals in the future. The Nottingham Nuffield (Ramsay) is just under five minutes drive from BMI Park (both just over an hour's drive from the Lincoln Nuffield); therefore GHG consider that any competitive constraint lost from BMI Park (notwithstanding their assertion that competition was limited) will be replaced by the Nottingham Ramsay hospital. Ramsay Health Care has confirmed that, prior to its acquisition of the Nottingham Nuffield, the hospital did not seek to win referrals from areas covered by the catchments of sister Nuffield Hospitals; namely Leicester, Derby and Lincoln. However, as Ramsay has no other hospitals in this region it will be actively seeking to extend its catchment area to its full potential, competing actively for referrals in all these areas.
72. Given both the likelihood of increased competitive interaction between the Nottingham Ramsay hospital and the Lincoln Nuffield hospital post-acquisition as well as some evidence of the limitations on the constraint provided pre-transaction by BMI Park, the OFT considers that there is no realistic prospect of a substantial lessening of competition in the Lincoln area as a result of the transaction. However, on the basis that Lincoln Nuffield treats over [85-100] per cent of the episodes arising within the 30 minute isochrone and that there are no other hospitals located in the catchment, we consider that the acquisition has resulted in the transfer of an effective solus hospital from Nuffield to GHG.

North London (Enfield)

73. The package of Nuffield Hospitals GHG has acquired included the Enfield Nuffield in North London. Within a 30 minute drive time of the Enfield Nuffield hospital there are two GHG hospitals – Kings Oak (geographically its closest competitor) and The Garden. Data on share of episodes arising from the Enfield Nuffield catchment indicates that GHG will have a

combined share of episodes of [35-50] per cent with an increment of [0-15] per cent.¹⁸

74. However, in the 30 minute catchment area there are also two NHS PPU's (Queen Elizabeth II and the Royal National Orthopaedic Hospital), Spire Roding, Spire Bushey, The Rivers (Cario/Ramsay) and Aspen Holly House. Therefore, following the acquisition there will be a reduction in effective competitor fascia within the 30 minute catchment from six to five.¹⁹ Furthermore, evidence provided by GHG show that the Enfield catchment area is covered (at least in part) by the overlapping catchment areas of 28 other hospitals.
75. However, one PMI provider stated that in North London it only contracts with [] and it considers GHG's share of admissions post-acquisition in the North London catchment (as it defines this) to be over 85 per cent.²⁰ In total two PMI providers raised concerns specifically in relation to North London.
76. GHG argue that hospitals in Central London operate within wider catchment areas, which extend to, and potentially beyond, Enfield and therefore exert a competitive constraint on GHG's hospitals in North London.
77. The distinct nature of Central London private hospital catchments was noted in the BUPA/CHG Report and more recently in the CC's evaluation of that report.²¹ The BUPA/CHG Report does not define London as a completely different geographic market from the rest of the UK, but argues that the competitive conditions in London differ markedly from the rest of the country. Specifically stating that whilst hospitals in London did operate within catchment areas, these catchment areas were atypical due to the nature of competition in London.
78. GHG provided additional information to support their argument that Enfield Nuffield faced competition from Central London hospitals. In particular GHG stated that the characteristics of Central London PMS hospitals suggest

¹⁸ Of GHG's share of [30-45] per cent of episodes from the Enfield catchment, [10-25] per cent are represented by BMI Kings Oak, [0-15] per cent by BMI The Garden and the remaining [0-15] per cent by other more distant GHG hospitals.

¹⁹ Or five to four excluding NHS PPU's.

²⁰ However, it is not clear on what basis these figures were calculated

²¹ *Evaluation of the Competition Commission's past cases* CC January 2008.

that they may have unusually large catchment areas stretching out to, and potentially beyond, Enfield:

- High density of teaching hospitals in Central London which strengthens the reputation of the attached PPU
- The relationship between Central London hospitals and a consultant's reputation is generally mutually reinforcing, confirmed by the CC in the BUPA/CHG Report
- Central London hospitals tend to offer a broader range of treatments, and
- Greater London has a mobile commuter population prepared to travel into Central London for a variety of services.

79. GHG has only one hospital in Central London, The London Independent, in Stepney. Of episodes arising in the Nuffield catchment, [0-15] per cent is accounted for by The London Independent, which is equivalent to some [10-25] per cent of its total episodes. A Central London competitor, provided data that shows that [] per cent of episodes from across its Central London hospitals originated from the Enfield Nuffield catchment.

80. On the basis of all the evidence provided, the OFT believes that GHG will continue to be constrained post-acquisition by the four competitor hospital groups (including the PPUs) within the 30 minute isochrone and by wider constraints. There is good evidence to suggest that there is an asymmetric constraint from Central London hospitals on the private acute hospitals operating in the Enfield Nuffield catchment. As a result the OFT does not believe that the acquisition will give rise to a realistic prospect of a substantial lessening of competition in the Enfield catchment.

Birmingham

81. Within a 30 minute drive of Birmingham Nuffield Hospital there are two GHG hospitals – Priory (geographically Birmingham Nuffield's closest competitor) and Droitwich Spa. Additionally, within the isochrone there are two NHS PPUs, Capio West Midlands and Spire Little Aston

82. GHG's estimates of their shares of supply within the 30 minute isochrone show a combined share of [35-50] per cent (increment of [0-15] per cent

provided by the Nuffield hospital). Third parties raised concerns in relation to Birmingham on the basis of the parties' high shares of supply.²²

83. Within the catchment the acquisition results in a reduction in fascia from five to four (counting the PPUs as one but with only 20 beds combined the constraint may be limited). GHG will continue to face significant competitive constraint in the catchment from Spire, Capio/Ramsay and two NHS PPUs. Furthermore GHG has stated that 13 competitor hospitals²³ have 30 minute catchment areas that overlap to some extent with the Birmingham Nuffield catchment, indicating that they will be able to compete for at least a proportion of the episodes arising in the Nuffield catchment. It could be argued that with the motorway network around Birmingham the 30 minute drive time catchment should be stretched to include the Wolverhampton and Warwickshire Nuffields, Spire South Bank (south of Droitwich Spa) and Spire Parkway.
84. GHG state that there are no procedures undertaken by Birmingham Nuffield that cannot be undertaken by any of these alternative hospitals. Moreover, the Nuffield accounted for less than [0-15] per cent of the episodes in the whole of the catchment area. The OFT has seen pre-acquisition internal documents from Birmingham Nuffield that suggest that it was regarded as one of the weaker hospitals in Birmingham. GHG point out that the Birmingham Nuffield can only offer critical care level 1 whereas its competitors all offer at least critical care level 2 (GHG's Priory also offers critical care level 3).
85. The OFT has concluded that, on the basis of all the evidence discussed above, the constraint provided by Birmingham Nuffield is limited and, given the wider constraints that will remain post merger, the merger can not be expected to give rise to a realistic prospect of a substantial lessening of competition within the Birmingham area.

National issues

86. The divestment by Nuffield of the nine Purchased Hospitals does not significantly alter the market structure at the national level. Nuffield will continue to operate 31 hospitals after the transaction, and the OFT

²² Although it should be noted that third parties referred to different supply measures and that these shares were not always based on a 30 minute catchment area.

²³ Nine excluding PPUs.

believes that the rationale for the selection of the hospitals to be sold was to ensure that it could remain a national player.

87. GHG argues that post-transaction (and after the two on-sales) there will still be four national players: GHG, Nuffield, Spire, and Capió/Ramsay, with 56, 31, 27 and 32 hospitals respectively, and therefore it considers that sufficient competition will remain post-transaction as the acquisition does not significantly change the national position.
88. Overall, the low increment (<three per cent) to GHG's share of supply at a national level suggests that the acquisition does not raise national competition concerns.
89. However, notwithstanding this low increment and apparent modest change to competitive conditions at national level, significant concerns were raised by some PMI providers that GHG's would use its alleged strong local market position (that is solus position within local catchment areas) to improve its ability to negotiate nationally on price and ensure that hospitals facing local competition are included on PMI networks.
90. One third party stated that hospital groups with national coverage can exert undue influence to include their hospitals. As a result, it is alleged, it may be the case that the most suitable hospital in a local area in terms of quality and cost may not necessarily be selected due to overall cost pressures at a national level.
91. Another third party stated that as they operate a network system, in order to ensure national coverage they enter into contract(s) with major hospital group(s) to provide the spine of a network and then add local hospitals to ensure full coverage. It was considered that GHG was already an obligatory trading partner who, it was alleged, insists on one-in, all-in contracts. It was argued that the transaction improves the negotiating position of GHG and consequently diminishes their ability to use Nuffield as an alternative spine. However, the same third party also stated that it contracts with all major providers in each area on the basis that all the major providers insist on one-in all-in contracts. This suggests that even pre-transaction there was no real opportunity to use an alternative spine.
92. Furthermore, this suggests that all the major hospital groups are able to insist on such contracts. Therefore, the OFT is not persuaded that the

acquisition will significantly change GHG's negotiating power. Pre-acquisition Spire had 26 hospitals and Capio/Ramsay 31 located throughout the country; if both groups were able to negotiate one-in all-in contracts it seems likely that, post-acquisition, Nuffield with 31 remaining hospitals will continue to be able to negotiate such contracts, alongside the other national hospital groups. The OFT does not therefore believe that this particular acquisition will significantly worsen the position for the PMI providers in their negotiations with GHG.

93. Based on the local market analysis above, the acquisition adds to GHG's local presence in three local areas – Enfield, Birmingham and Lancaster. However, the OFT considers that on the basis that the parties' combined share of episodes in each of these catchments will remain below 50 per cent post acquisition and that they will continue to face sufficient competitive constraint from a number of national players in each area, the strengthening of GHG's position will not be sufficient to significantly change their ability to negotiate nationally.
94. As a result of the merger, GHG also acquired hospitals in three local areas where pre-acquisition there were no other PMS hospitals²⁴ within a 30 minute drive time of the purchased Nuffield hospital – Bury St Edmunds, Harrogate and Lincoln, nominally solus hospitals.
95. As discussed above, the proportion of episodes arising within the 30 minute isochrones around Bury St Edmunds and Harrogate Nuffield that are treated by hospitals located outside those isochrones, suggests that in these areas a wider catchment area would be more appropriate. On this basis neither Bury St Edmunds Nuffield nor Harrogate Nuffield are, in reality, considered to be effective solus hospitals.
96. With regard to Lincoln, the hospital will continue to account for over 85 per cent of episodes arising in the 30 minute catchment, and therefore should actually be considered to be a solus hospital.²⁵ The OFT therefore considers that the merger results in the transfer of merely one solus hospital from Nuffield to GHG.

²⁴ Excluding PPUs.

²⁵ For the reasons explained in paragraphs 69 to 72 the merger does not give rise to competition concerns at a local level.

97. However, GHG argue that the operation of solus hospitals does not alter its ability to negotiate with PMI providers. GHG also stated that whilst it is true that negotiations with PMI providers do typically take place on a full network basis this is to the advantage of both parties. Negotiations with PMI providers are, it says, typically on a price/volume basis, specifically the more estimated volume that is likely to flow to GHG hospitals the greater the discounting that can be agreed. Therefore insurers who are willing to list GHG's full network, and who are therefore likely to bring higher volumes to its hospitals, will receive better terms.
98. GHG consider that in most cases insurers will want to negotiate on a full network basis in order to achieve better terms and provide greater choice to their customers, particularly as the downside risk to the insurer of listing an additional hospital is small. The typical patient's journey, as described in paragraphs 12 to 15 above, shows that including a hospital in a network does not mean PMI providers are committing to actual volumes, as PMI providers do not usually have the power to direct patients and / or consultants to specific hospitals.
99. GHG considers that its approach to national pricing and negotiation does not indicate either an ability or desire to force insurers to use its hospitals either through one-in, all-in contracts or other agreements. This would, it believes, undermine the value of GHG's network to insurers and would therefore undermine the rates they were able to achieve. Furthermore they consider that the addition of one solus hospital would not significantly alter their ability to negotiate.
100. Responses from competitors were limited in this case, but those competitors that responded to the OFT commented that they believed that the largest PMI providers wield considerable buyer power. They have, it is said, negotiated lower prices than their competitors with all major PMS providers despite not giving any assurances on volume or risk sharing agreements. Examples were provided [].
101. A competitor also stated that it believes that there are several examples of the major PMI providers excluding major well-known hospitals from their networks.

102. GHG already has a number of hospitals that could be described as being solus hospitals;²⁶ however it has provided a number of examples of arrangements with insurers that still contain a variety of exceptions to the full-network approach. As mentioned above, the question for the OFT is whether this merger changes the market structure to such an extent as would give rise to a strengthening of GHG's negotiating position. Based on all the available evidence, the OFT believes that the addition of the seven retained hospitals to the GHG network will not have a material adverse effect on the negotiating power of GHG as against the PMI providers. The OFT notes that smaller PMI providers, who also need to be able to offer national coverage, did not raise any concerns. The OFT considers only one of the retained Purchased Hospitals could in reality be classed as a solus hospital but, for reasons outlined above, the OFT does not believe on the evidence available that GHG's alleged market position in this area will be such as to be able to change its negotiating power *vis-à-vis* the PMI providers, and therefore discounts a realistic prospect of a substantial lessening of competition based on such a theory.

Coordinated effects

103. The OFT is aware of no evidence that the merger will result in or strengthen the ability or incentive of PMS providers to coordinate their behaviour.

Barriers to entry and expansion

104. Previously, barriers to entry have been found to be relatively high and GHG has not argued this had changed significantly. However, a competitor argued that it is relatively easy to set up a new private medical facility in the UK and provided several examples of recent/prospective entry/expansion in London.

105. The third party stated that it understood that one operator had made up to 21 planning applications for new facilities which are due to be operational in the next two-five years. It also considered that the NHS was a source of new entry and expansion through its PPU's as they can easily convert public trust facilities into private facilities.

²⁶ On the basis of the previous definition pre merger GHG had 16 hospitals that nominally could be regarded as solus hospitals. On the same basis the merger results in the transfer of three solus hospitals, although see paragraph 95 in this respect.

106. Costs, however, vary according to the size of the facility, the type of services offered and local variations such as labour and property costs. Despite evidence of new entry in London, it is not clear whether this is replicated across the UK.

Buyer power

107. Buyer power has largely been discussed above in relation to the national price negotiations. In summary, GHG and a competitor consider that the large PMI providers have significant buyer power and are able to use their size, in terms of volume of subscribers, to negotiate keenly on price. This view also appears to be supported by small PMI providers.

108. [].

109. In contrast the large PMI providers consider that GHG (and the other major PMS providers) are able to use local market solus positions within negotiations. This may lead to higher prices and ensure that hospitals that do face competition in local markets are included on PMI networks through the use of one-in all-in contracts.

110. Given the conclusions on the competitive effects set out above it has not been necessary for the OFT to conclude on countervailing buyer power.

THIRD PARTY COMMENTS

111. Third party comments have been discussed in detail above. Three PMI providers all raised concerns that the acquisition would strengthen GHG's ability to negotiate nationally on price by increasing the number of areas where they operate a solus hospital. Two smaller PMI providers both stated that they had no concerns, but did not wish to answer any further questions.

112. Two PMI providers raised concerns about GHG changing prices at the Purchased Hospitals, aligning them with those charged at GHG hospitals. Nuffield has remained active in the market after the merger, and consequently was not in a position to reveal to GHG its pricing arrangements. Therefore, as the Purchased Hospitals were sold with out

any pricing arrangements in place, GHG stated that it was necessary to introduce GHG's own pricing arrangements.²⁷

113. Only one competitor made a full response to our enquiries and had no concerns regarding the acquisition as it considered that the largest PMI providers had the negotiating power in the market. Other competitors stated that the transaction raised no concerns.

ASSESSMENT

114. GHG and the Purchased Hospitals overlap in the supply of private medical services.

115. The merger originally resulted in the acquisition of a package of nine private hospitals by GHG, of which two²⁸ have been identified by GHG as likely creating a substantial lessening of competition in a local market and have been subsequently on-sold to Spire and Ramsay. Given that, in both cases, the on-sale transactions have completed at the time of the OFT's decision, the OFT's decision relates to GHG's retained acquisition of seven Nuffield hospitals.

116. The acquisition of the seven retained Nuffield hospitals does not significantly lower the intensity of competition at the national level: Nuffield will continue to operate 31 hospitals after the transaction and GHG has stated that the rationale for the selection of the hospitals to be sold was to ensure that Nuffield could remain a national player. There remain four competing national PMS providers and the OFT considers that the low increment (<three per cent) to GHG's national share does not give rise to any competition concerns at the national level.

117. The effect of the transaction on the nine local markets where GHG originally acquired a Nuffield hospital has also been considered. As a result of the analysis outlined above, it has been concluded that only in respect of the two local markets around the Gerrards Cross and Nottingham Nuffield would the acquisition have given rise to a substantial lessening of competition. In Nottingham, this has been remedied by the on-sale of the

²⁷ That these prices were higher than Nuffield's is not merger specific; we understand that the fact that GHG's prices are higher is due, in part, to the non charitable status of its hospitals in contrast to those of Nuffield.

²⁸ Nuffields Gerrards Cross and Nottingham.

Nottingham Nuffield, which has restored the pre merger competitive landscape. With regard to the Gerrards Cross area, the on-sale of the Gerrards Cross Nuffield has also restored pre merger competitive levels. For the reasons discussed in detail above, the OFT considers that in none of the remaining seven local markets does the acquisition give rise to a realistic prospect of a substantial lessening of competition.

118. The OFT has also considered carefully the complaints raised by third parties about the effect of local market strength impacting on GHG's negotiating strength. Based on the available evidence, the OFT has concluded that the addition of these seven hospitals to the GHG network will not have a material adverse effect on the negotiating power of the PMI providers.

119. Consequently, the OFT does not believe that it is or may be the case that the merger between GHG and the seven retained Nuffield hospitals has resulted or may be expected to result in a substantial lessening of competition within a market or markets in the United Kingdom.

DECISION

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