"C"

CMA
Competition & Markets Authority

Private healthcare market investigation

Final report

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CMA 25

number of hospitals sold. We reasoned that BMI would incur around 30 per cent of the total costs for each hospital sold, ie £[✂] million.

TABLE 12.3 **NPV of the price benefits of individual hospital divestitures**

Divestiture	*NPV of benefits £m*	*Total transaction and reorganisation costs £m*	*NPV of divestiture remedy*
Bishops Wood	[✂]	[✂]	[✂]
Shelburne	[✂]	[✂]	[✂]
Cavell	[✂]	[✂]	[✂]
Chelsfield & Shirley Oaks	[✂]	[✂]	[✂]
Saxon Clinic	[✂]	[✂]	[✂]
Highfield	[✂]	[✂]	[✂]

Source: CC analysis.

12.20 As the transaction and reorganization costs are incurred at the beginning of the period, these can be directly compared with the NPV of the price benefits. This analysis demonstrates that, in each case, the costs of the divestiture remedy would outweigh the benefits, on our base case assumptions. We note that this analysis does not take into account the loss of any potential economies of scale as a result of the divestiture remedy, ie it does not show the downside case.

12.21 We concluded, therefore, that while divestitures in cluster areas were likely to be effective in increasing the competitive constraints acting on BMI hospitals in the relevant local areas vis-à-vis self-pay patients, the divestitures proposed in the provisional decision on remedies would not be proportionate on this basis. Therefore, we will not require BMI to make any divestitures of assets.

Remedies contained in our Remedies Notice

Remedy 2 (constraints on private medical insurer/private healthcare provider contract terms ('tying and bundling'))

12.22 In our provisional findings we identified two structural features in the provision of privately-funded healthcare by hospitals:

(a) high barriers to entry and expansion for private hospitals; and

(b) weak competitive constraints in many local markets, including central London.

12.23 We provisionally concluded that, together, these features gave rise to AECs in the markets for hospital services that were likely to lead to higher prices for self-pay patients in certain local markets and to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and Spire) that had market power in negotiations with PMIs.[1147]

12.24 Our Remedies Notice included divestitures which would address the AECs effectively in certain local areas but would not do so in what we characterized as single and duopoly areas.

12.25 We therefore set out in our Remedies Notice a behavioural remedy (Remedy 2), that sought to address two specific types of conduct that PMIs had said that hospital

[1147] Provisional findings, paragraphs 6.248*(a)* & 10.3.