

3 The merger situations and the companies involved

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Introduction

3.1. In this chapter we present the facts relating to the three merger situations referred to us as possibly qualifying for investigation: first the two situations reflecting the loan facility under which SBUKE acquired 26.8 per cent of the ordinary shares of CHG, and then the situation reflecting the proposed merger of BUPA and CHG. We set out the circumstances leading to SBUKE's acquisition of shares in CHG and the proposed merger. We consider the history and legal structure of BUPA, its Articles of Association and financial information relating to it and CHG. A chronology of relevant events is at Appendix 3.1.

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

The parties

3.2. SIL is an indirectly wholly-owned subsidiary company of Citigroup Inc (Citigroup) of New York and owns [26.8] per cent of SBUKE. SBUKE's principal activities are those of a dealer and market maker in UK equities and related contractual products. A structure chart showing the organization of the SSSB group of which SIL and SBUKE form part is at Appendix 3.2. It will be seen from this that JHS is also a subsidiary of SIL.

3.3. It was announced on 19 January 2000 that the SSB unit of Citigroup would be acquiring certain investment banking and equity businesses of Schroders plc. Consequently on 1 May 2000 SIL became the parent company of JHS and JHS became a sister company of SBUKE. SIL, SBUKE and JHS now trade as SSSB. JHS has acted as one of BUPA's financial advisers on mergers and acquisitions for several years and was retained by BUPA in late March to advise on a possible offer by BUPA for CHG. In late December 1999 the board of CHG decided that the company should be sold if its future growth was to be assured. Several offers were considered including one from GHG but (see paragraph 3.23) agreement was reached on an offer from BUPA.

Events leading up to the merger situations

3.4. In 1997 BUPA gave an undertaking to the Secretary of State in connection with its acquisition of Goldsborough (see paragraph 3.28). The undertakings provided that BUPA would not, without the consent of the Secretary of State, directly or indirectly acquire any interest in IBH or in any company having control of IBH. It also provided that BUPA would not without such consent 'participate in formulation or making of, or influence or attempt to influence, the policy of IBH, whether directly or through any person having control of IBH'. For these purposes, a person is deemed to have control of a company if he has an interest in it of 10 per cent or more.

3.5. IBH was acquired by CHG in February 1998.

3.6. On 25 April 2000 BUPA submitted to the OFT a formal request for the discharge of the undertaking. At the same time it submitted a Merger Notice relating to the proposed BUPA/CHG merger. The matter of the discharge of the IBH undertaking (which was for the Secretary of State to decide) was unresolved before the merger reference was put to us and was not pursued by BUPA subsequently, in view of this reference.

3.7. On 28 April, the boards of BUPA and CHG announced that they had reached an agreement on the terms of a recommended offer for the shares in CHG. The offer would be subject to the condition that the Secretary of State did not refer the merger to us.

3.8. On 28 April, too, the BUPA board met and representatives of JHS were present by telephone conference. It was told that GHG was a potential bidder for CHG and that it had the capability to counterbid BUPA's offer. BUPA was itself unable to acquire shares in CHG because the undertaking was still in force. Hence the board considered an arrangement (which had been suggested by its legal advisers at a meeting of a committee of the board on 20 April) whereby JHS would acquire up to 29.99 per cent of

CHG's shares as principal. The board noted counsel's opinion that this arrangement would not constitute a breach of the undertaking.

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

Details omitted. See note on page iv.

]

3.10. [

Details omitted. See note on page iv.

]

3.11. In conclusion, the BUPA board agreed to go forward with the arrangement proposed (see paragraph 3.8). Following the meeting JHS decided that it would be unable to be a party to the arrangement as it was in the process of being sold to SSB (see paragraph 3.3). Instead SBUKE was chosen to be the other party to the arrangement with BUPA. SSSB told us that the reasons SBUKE had been chosen included the need for speed and confidentiality, and that the rules of the Takeover Panel precluded any company entering into such an agreement from profiting from it. SSSB said that it was unlikely that any other investment house would have taken on that role without the related advisory role because of the limited financial returns and complexity of the arrangement. [

Details omitted. See note on page iv.

]

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

The BUPA/SBUKE loan

3.13. An agreement dated 5 May gave effect to the proposals for SBUKE to purchase shares in CHG with loan finance from BUPA Finance. It was agreed that BUPA Finance would make available to SBUKE an interest-free loan facility of up to £70 million.

3.14. Under the loan arrangement (which was in the form of a letter signed between BUPA, BUPA Finance and SBUKE) any loan money advanced by BUPA Finance would be discharged by SBUKE paying the total proceeds of disposal of the CHG shares less any expenses incurred, less the commission due to SBUKE and less the cost of capital payment, plus an amount equal to any distribution received. BUPA Finance would not have any other recourse against SBUKE for repayment.

3.15. BUPA Finance acknowledged that it would have no interest in the shares acquired nor any entitlement to exercise any right, nor to control the exercise of any right, in respect of such shares and that SBUKE, as the legal and beneficial owner of the shares, would be free to deal with the shares acquired using the loan facility and to exercise rights in respect of those shares, as it might in its absolute discretion determine. There was no requirement for SBUKE to notify BUPA Finance of its actions in relation to the shares.

3.16. The loan facility was structured so that BUPA Finance bore all the risk and received all the benefits from the shares. This objective was supported by an indemnity clause in the agreement. BUPA

and BUPA Finance agreed to indemnify the ‘indemnified persons’ against all ‘indemnified losses’. ‘Indemnified persons’ meant SBUKE, its ultimate holding company and all other subsidiaries of that holding company. ‘Indemnified losses’ included all liabilities, damages, costs and expenses as a result of any ‘indemnified claim’. ‘Indemnified claim’ included all investigations, proceedings and regulatory inquiries. It also included some tax indemnities. The indemnity did not, however, apply to indemnified losses finally judicially determined to be owing to the ‘negligence or wilful default of the relevant indemnified person or persons’.

3.17. [

Details omitted. See note on page iv.

]

3.18. A standard ‘entire agreement provision’ declared, among other things, that the letter constituted the whole and only agreement between the parties relating to the matters contemplated. For example, any previous understanding between the parties relating to the timing of the sale of the shares would be unenforceable.

The CHG share purchase

3.19. On 5 May, pursuant to the agreement, SBUKE acquired 9,000,000 ordinary shares in CHG at 650p per share and a further 500,000 at 649p per share, thus securing 26.8 per cent of the share capital of CHG for £61.7 million. We noted from documents provided by SSSB that, at the time of the purchase, the shares were acquired from 16 of CHG’s larger shareholders who, after the sale, still held a further 35.6 per cent of the share capital of CHG.

3.20. SBUKE told us (see paragraph 5.163) that it regarded the shareholding in CHG as a short-term investment, likely to be disposed of following our inquiry. Hence it did not intend to seek representation on CHG’s board. However, SBUKE also told us that ‘in the event that BUPA’s proposed acquisition of CHG were allowed to proceed and BUPA re-bid, SBUKE would expect (other things being equal) to assent its shares to such an offer’.

3.21. CHG told us (see paragraph 5.119) that it believed BUPA had the ability to influence SBUKE with regard to the CHG shareholding. CHG said that SBUKE’s ownership was damaging to it as the shareholding had conferred on SBUKE substantial voting rights, enabling it block special resolutions at general meetings. Table 3.1 lists the eight largest CHG shareholders as at 26 October 2000.

TABLE 3.1 **CHG’s larger shareholders at 26 October 2000**

	%
1. Salomon Brothers Asset Management (SBUKE)	26.74
2. Market makers	7.55
3. Legal and General Assurance Society Limited	6.68
4. Deutsche Asset Management	4.70
5. Framlington Investment Management Limited	4.26
6. Schroder Investment Management Ltd	3.29
7. Standard Life Investments Limited	3.21
8. Barclays Global Investors	<u>2.84</u>
	59.27

Source: CHG.

3.22. From Table 3.1, as at 26 October 2000 SBUKE was the largest shareholder in CHG with 26.74 per cent of CHG’s share capital. The next largest other than market makers was Legal and General Assurance Society Limited with 6.68 per cent. The eight largest shareholders in total held 59.27 per cent of CHG’s share capital.

The proposed BUPA/CHG merger

3.23. On 28 April the boards of BUPA and CHG announced that they had reached agreement on the terms of a recommended offer for all CHG shares at £6.50 each (in cash or a loan note alternative). On

24 May SSSB issued an offer document on behalf of BUPA Finance setting out the full details of the offer.

3.24. It was a term of the offer that it would lapse if the proposed merger were referred to us before 3 pm on 14 June. The merger was referred to us on 12 June, hence the offer lapsed on that date. BUPA subsequently told us that it would renew the offer if the merger were approved on terms acceptable to it.

BUPA

History of the group

3.25. BUPA was formed in 1947 by the amalgamation of 17 provident associations and initially operated solely in the field of PMI. It first became involved in PMS in the 1950s through the provision of funds for the formation of Nuffield Hospitals, a charitable trust which now owns 41 hospitals and which has operated wholly independently of BUPA since the late 1970s.

3.26. BUPA built its first hospital in 1975. Since then BUPA's hospital activities have grown through construction, acquisition and extension of capacity at existing hospitals.

3.27. By January 1989 BUPA owned 15 acute care hospitals and later that year it gained 13 more, including ten through the acquisition of HCA United Kingdom Ltd. This acquisition was referred to the MMC and was found not to operate against the public interest.¹ In its report (the 1990 report) the MMC stated that it did not expect the increase in BUPA's PMS market share from 9 to 14 per cent significantly to reduce competition or choice on a national or local basis. However, the MMC expressed concern about BUPA's vertically integrated business (BUPA in 1988 also had 52 per cent of the value of the PMI market) but noted its policy of 'operating its insurance and hospitals businesses on an arm's length basis'. The MMC concluded that if BUPA were to change this policy or use its position to the detriment of its competitors, or acquire more hospitals than the 35 envisaged in its five-year plan, further examination by the DGFT might be required.

3.28. In August 1997, BUPA sought to acquire Goldsborough, which in turn had a 21 per cent ownership in IBH. At that time BUPA owned 29 private hospitals, Goldsborough² 6 and IBH 11. Together they represented 22 per cent of private hospitals (18.2 per cent of capacity using beds as the measure). The merger was cleared by the Secretary of State subject to the undertakings discussed in paragraph 3.4. BUPA sold its 21 per cent stake in IBH to CHG and this enabled BUPA to complete the Goldsborough acquisition and so gain a further six hospitals.

3.29. After the completion of the Goldsborough acquisition in 1997, BUPA built a further hospital in Hastings. This increased the number of hospitals under its ownership to 36.

3.30. At the time of our inquiry BUPA was the largest PMI provider in the UK and the second largest PMS provider. In addition, it had a wide range of other healthcare operations in the UK and abroad.

Legal structure

3.31. BUPA is a private company limited by guarantee and having no share capital. As it has no share capital it is unable to raise equity funds. However, it has no requirement to pay dividends or provide dividend cover and so has greater borrowing capacity.

3.32. BUPA's group structure in October 2000 (see Appendix 3.4) shows The British United Provident Association Limited as the holding company of the group. Its main subsidiaries are shown at Appendix 3.3. The group's PMI activities in the UK and Ireland were operated by the holding company and all other activities by its subsidiaries. A summarized structure of BUPA's PMS, PMI and related companies is at Appendix 3.4. BUPA Investments Limited and BUPA Finance were intermediate holding companies. BUPA Investments Limited had ownership of hospitals (through BUPA Hospitals Limited and subsidiaries) and some of the nursing homes, health screening, nursing services and over-

¹See Appendix 4.1 item 1.

²Goldsborough also owned 42 care homes and a homecare business.

seas PMI.¹ The main subsidiaries of BUPA Hospitals Limited are also shown at Appendix 3.4. The group owned 36 hospitals (BUPA PMS) that are held in the following subsidiary companies: BUPA Hospitals Limited (30 hospitals, excluding the six Goldsbrough hospitals), Goldsbrough Developments Limited (four Goldsbrough hospitals), Goldsbrough East Surrey Limited (one Goldsbrough hospital) and Tunbridge Wells Independent Hospital Limited (one Goldsbrough hospital). BUPA Investments Limited held the liquid cash assets of BUPA's investment portfolio (other than investments held by BUPA's overseas insurance activities) and BUPA Europe Limited held the equity investment portion of BUPA's investment portfolio.

3.33. At the time of our inquiry BUPA was in the process of reorganizing its corporate structure. It planned to establish a new subsidiary under BUPA Finance called BUPA Insurance Limited to act as the underwriting vehicle for the PMI business. In addition, two new service companies, BUPA Membership Limited and BUPA International Insurance Services Limited, would be established for the employment of staff and the provision of services to BUPA's insurance business in the UK and to BUPA International. This proposed structure is at Appendix 3.5.

3.34. BUPA said that the main reason for the reorganization was to ensure compliance with future regulatory requirements. BUPA is subject to FSA regulations, which require the insurance company to maintain a certain level of regulatory capital, used in the calculation of its solvency margin (see paragraph 3.42). In the current structure BUPA's care homes and hospitals formed part of the total assets used to calculate the regulatory capital and solvency margin of the insurance business. BUPA told us that the reorganization would result in the insurance company not being dependent upon these assets if it were to comply with the expected Group Solvency Directive.

3.35. BUPA said that another benefit of the reorganization was to align the legal structure of the group with the management structure. In the proposed structure both the insurance and hospital activities would be subsidiaries of the parent instead of its current structure where the insurer owned the hospital business.

3.36. The reorganization would also involve financial assets and liabilities being allocated to the businesses as opposed to being held centrally at group level. The forecast balance sheet post-restructuring is shown at Appendix 3.6. Accordingly, insurance assets such as equity, cash and bond investments would be held within the insurance companies and borrowings would be specifically allocated to the individual operating divisions.

3.37. BUPA told us that the main financial limitation it faced when making its offer for CHG was to ensure that it complied with the FSA requirement that its solvency margin did not fall below 35 per cent. With BUPA's current structure its capacity for any further acquisition would be limited by this constraint. However, with the proposed restructuring, BUPA would not face the same restrictions so long as it was not its insurance business that was making the acquisitions. BUPA's other businesses were unregulated and would not be subject to the same solvency margin restrictions.

Tax status

3.38. Prior to January 1998, the Inland Revenue deemed BUPA to be a mutual business and it was taxed accordingly. As such, BUPA paid no corporation tax on any of its UK underwriting surpluses (profits) and received no tax relief on any of its UK underwriting deficits (losses). After January 1998 this was no longer the case and BUPA's underwriting business became subject to corporation tax. The change in BUPA's tax status affected only this business as it had always paid corporation tax on its investment income, hospital profits and other activities.

Regulatory governance

3.39. The legislation regulating insurance companies and private hospitals is summarized in Appendix 3.7.

3.40. The legislation regulating insurance companies is contained in the Insurance Companies Act 1982 (the 1982 Act) and regulations made under it. Its object is to ensure that insurance companies are

¹Other than BUPA International which is part of BUPA Limited.

able to meet their financial obligations to their policy-holders. However, for companies engaged in PMI (and not in investment business) there is little legislation concerning their conduct in relation to their customers and potential customers.

3.41. As an insurance company, BUPA is authorized to underwrite business in classes 1 (Accident) and 2 (Sickness) of Schedule 2 of the 1982 Act. BUPA told us that its insurance activities were administered strictly in accordance with codes promulgated from time to time by the Association of British Insurers (ABI) in so far as they applied to them. BUPA said that it had been awarded a Grade A for its compliance procedures in 1999. BUPA is currently not part of the Insurance Ombudsman Bureau Scheme but expects to be within the scheme by December 2000. BUPA said that it subscribes to the Personal Insurance Arbitration Service.

3.42. Insurance companies are required to maintain a margin of solvency in accordance with the Insurance Companies Regulations 1994 (as amended) which are made under the 1982 Act. However, the Financial Services Authority (FSA) has power under section 45 of the 1982 Act to take specified action for the purpose of protecting policy-holders against the risk that an insurance company may be unable to meet its liabilities or to ensure that the company is soundly and prudently managed. BUPA told us that the FSA expected BUPA Limited to maintain target solvency margins¹ of at least 35 per cent of premiums receivable. The FSA confirmed to us that it would normally look to see general insurance companies maintaining their solvency margin at a level in excess of the statutory minimum, and that it had in the past made it clear to general insurers that in most cases and in normal circumstances it would expect to see at least this level of cover. BUPA told us that its hospital business was also subject to FSA regulations, but only to the extent that the FSA had an interest to ensure that the valuation of hospitals in BUPA's accounts was accurate. This was because the hospital's assets were currently included within the assets of the insurance business. At the end of 1999 BUPA's solvency margin was 37.3 per cent.

3.43. Private hospitals in England and Wales have to be registered under the Registered Homes Act 1984 (see Appendix 3.7, paragraphs 14 to 20). HAs are required to inspect each registered hospital at least twice in every period of 12 months.

3.44. As a private company limited by guarantee and with no share capital, BUPA has no obligations to comply with the Stock Exchange listing requirements, although it told us that it sought to comply with the requirements of the Combined Code so far as was appropriate for a private company.

Objectives of BUPA

3.45. The main objectives of BUPA under its Memorandum of Association may be summarized as to prevent, relieve and cure sickness and ill health of every kind; to promote health in any way; and to engage in activities in or related to the fields of healthcare and health-related insurance and, in particular, to raise, establish, maintain and administer a fund for defraying the cost of medical, surgical and other treatment of and services to contributors, their dependants and others.

Association Members

3.46. BUPA's Articles of Association provided for the appointment by the board of up to 200 Association Members (although the board might increase this number if it thought it necessary). The Articles required every Association Member to the best of his or her ability to further BUPA's objects and interests. BUPA told us that Association Members performed a role similar to that of shareholders, although without any rights to BUPA's profits and assets. The Memorandum of Association states that all income and property be applied solely towards the promotion of the objects of BUPA and no portion can be paid to the members. The Memorandum also states that, on a winding up or dissolution, none of the surplus would go to Association Members but must be transferred to one or more institutions with similar objects.

¹Section 32(5) of the 1982 Act provides that, for the purposes of the Act, the margin of solvency of an insurance company is the excess of the value of its assets over the amount of its liabilities, that value and amount being determined in accordance with any applicable valuation regulations.

3.47. The Articles provided that, for an Association Member admitted on or after 12 May 1999, the admission was to be for a term of ten years. Association Membership terminated when the holder reached 70 or, in some cases, at the annual general meeting following his or her 70th birthday. In the past, some Association Members on reaching 70 had been invited to become Honorary Members. Honorary Members were invited to attend all general meetings but were not entitled to vote. In September 2000, there were 92 Association Members of whom 19 were present or former members of BUPA's main board, 27 were current or former employees of BUPA and 46 were otherwise unconnected with the company. There were also 55 Honorary Members of whom 18 were former directors, 8 were former employees and 31 were otherwise unconnected with the company. Members not connected with the company were chosen from a wide range of backgrounds.

3.48. BUPA told us that Association Members attending the annual general meeting would receive the group's accounts and vote on the submission for election of the board and would be free to ask the board questions. BUPA told us that in common with most private companies it was rare for the board to seek the approval of Association Members prior to taking a particular course of action. The Articles did not provide for approval to be sought and it was the board's view that actions requiring prior approval of the Association Members must be 'fundamental and out of the normal course of business'. We asked BUPA whether the board regarded the Association Members' function as 'rubber stamping' given that Members' approval was not sought to the proposed merger with CHG. The Chief Executive said:

... the authority is vested in the board to make these decisions and I do not think the Association Members have any expectation that they would be consulted about an acquisition. They ... have the opportunity ... at an Annual General Meeting to question the board and to express ... opinions about the strategy we are adopting, which is broadly explained at each Annual General Meeting. They have every opportunity to raise an issue, question us closely, and I suppose *in extremis* they could do something about it in a negative sense, rather than being asked in advance to approve it, if they felt the company was being led in totally the wrong direction, or mis-managed in some way.

Board of directors

3.49. The articles contain provisions for the appointment and retirement of directors broadly along the lines of Table A as prescribed under the Companies Act 1985. All directors on the main board had to be elected by the Association Members at the first annual general meeting following their initial appointment. One-third of the board had to retire by rotation at each AGM but the directors who retired were eligible for reappointment. The Association Members could remove a director by ordinary resolution in accordance with the Companies Act 1985.

3.50. The board currently consists of three executive directors and six non-executive directors (including the Chairman). The three executive directors currently hold the positions of Chief Executive, Finance Director and Managing Director: New Businesses.

3.51. It was the board's practice to hold nine regular board meetings and an all-day strategy meeting each year with other meetings convened as needed. In addition, the board had standing committees responsible for audit, remuneration, nomination and treasury as well as a medical advisory panel.

Policy on remuneration of executive directors

3.52. BUPA's 1999 Annual Report stated that the remuneration of executive directors comprised a basic salary, benefits in kind, an annual performance-related bonus, a long-term incentive scheme and pension benefits. BUPA's remuneration committee (which comprised the Chairman and two non-executive directors) determined the level of remuneration, taking into account independent advice on the remuneration packages being offered externally.

3.53. BUPA told us that the annual performance-related bonus paid to executive directors was linked to the financial performance of the group. The main board set the financial targets for the group and the Remuneration Committee set the level of bonus paid. The absence of a traditional share capital structure meant that share options could not be offered as a management incentive.

3.54. The long-term incentive scheme was designed to attract and retain members of BUPA's senior management team over several years and to reward them for the part they played in the group's long-term success. The scheme provided monetary rewards dependent on the group's performance against predetermined targets to be achieved over a period of time.

Policy on remuneration of non-executive directors

3.55. BUPA told us that, in appointing non-executive directors, the board sought to appoint individuals with a variety of experience that would support the different interests within the business. Non-executive directors were appointed for a three-year term, with the possibility of extension. Each was paid a fee (determined by the board as a whole) and received PMI cover. Non-executive directors were not entitled to participate in any bonus, profit-related scheme or pension arrangements.

Management structure

3.56. At the time of our inquiry, BUPA was organized into six business units. Each was set targets by the main board for profits (before allocated central costs and interest), cash flows and returns on capital and each had its own executive management team that included a managing director and a finance director. Managing directors of the business units were paid bonuses based upon the business unit and the group as a whole achieving the financial targets set by the main board. The managing directors of the business units (apart from New Businesses) were not on the main board. The two business units within the scope of our inquiry were as follows.

3.57. *BUPA PMI* comprised BUPA's UK PMI business. In addition to its PMI activity it also offered health cash plan products and long-term health insurance. Health cash plan products provided a cash sum that could be used without restriction in the event of a claim. Long-term health insurance products included critical illness cover, permanent health insurance and long-term care cover as well as life insurance. The executive team responsible for running the membership division (effectively BUPA PMI) comprised: the Managing Director; Deputy Managing Director; the Directors of Finance, Marketing, Human Resources, Sales and Health Care Partnerships; and Actuary/Managing Director, BUPA Health Assurance.

3.58. *BUPA PMS* comprised BUPA's 36 private acute hospitals and one part-owned hospital in Ireland and was run by a six-person hospitals executive team. The team comprised: the Managing Director; and Directors of Operations, Finance, Marketing, Human Resources and Clinical Services.

Financial information

3.59. Appendix 3.8 summarizes BUPA's consolidated balance sheet over the five years to 31 December 1999. BUPA told us that over the last five years it had spent about £726 million (including adopted debt) on acquiring new businesses. Most of this had been spent on building its position in care for the elderly services, through the acquisition of Care First Group Plc (£410 million) in 1997, Goldsborough's Care Services business (£96 million) in 1997 and Country House Nursing Homes (£73 million) in 1996. Part related to the acquisition of Goldsborough hospitals (£40 million) in 1997. The balance was made up of smaller health- and care-related businesses both in the UK and abroad. As a result of the acquisitions and property revaluations the value of assets held as hospitals, care homes and equipment (as shown in BUPA's balance sheet) had increased from £362 million (1995) to £1,048 million (1999).

3.60. BUPA told us that its recent acquisitions had been funded by a combination of new debt and existing reserves. The existing reserves had been generated from all parts of BUPA's businesses, including PMI and PMS. BUPA believed that it was entirely normal that its business units had access to funds generated in other parts of its business. BUPA told us that other diversified businesses operated in the same manner. BUPA said that £[] million of the cost of acquiring CHG would be financed in the short term from group reserves (see paragraph 3.162).

3.61. As a result of the acquisitions referred to in paragraph 3.59, the total value of assets held as financial investments fell from £753 million in 1995 to £593 million in 1999. These investments comprised both BUPA's insurance technical provisions (relating to the cash-flow benefit of the payment of premiums in advance of the settlement of resultant claims) and the investment of the surplus cash of the group. A further analysis of BUPA's financial investments is provided in Appendix 3.9.

3.62. The level of debt in BUPA's balance sheet increased from £256 million in 1995 to £710 million in 1999 as a result of the acquisitions. BUPA said that the increase in debt related to the financing of long-term property assets and not to insurance liabilities. BUPA's debt-to-net-assets ratio increased from 45 per cent in 1995 to 96 per cent in 1999 and its debt-to-total-assets ratio increased from 16 per cent in 1995 to 30 per cent in 1999. BUPA told us that in its recent securitization of the income of 116 of its care homes, where £235 million in bonds were issued, £170 million of debt was given AAA credit ratings and £65 million of junior debt was given A credit ratings. A further analysis of BUPA's debt structure is provided in Appendix 3.9.

3.63. Appendix 3.10 summarizes BUPA's income and expenditure account over the five years to 1999. BUPA's operating surplus (before tax) declined by £65 million over the five years, from £114 million in 1995 to £49 million in 1999. The main elements of the decline were insurance business (£40 million) and investment income (£43 million) whilst interest expenses increased by £22 million. The decline was offset by a £40 million improvement in the profits of the health provision business (comprising hospitals and care homes). Appendix 3.11 summarizes BUPA's cash-flow statement over the five years to 1999.

3.64. Over the last five years, BUPA's headline return on capital employed (ROCE) declined from 18 per cent in 1995 to 7 per cent in 1999 (as shown in Appendix 3.8). This was owing to the decline in BUPA's operating surpluses (before interest) and the increase in its debt levels. But BUPA told us that its weighted average cost of capital (post-tax WACC) in 1998 was 8.3 per cent reducing to 7.1 per cent by 2001.

3.65. BUPA told us that the main cause of the reduction in its ROCE from 18 per cent in 1995 to 7 per cent in 1999 was the cyclical underperformance of its PMI business. Table 3.2 shows the effect of the PMI result on the comparison of 1995 and 1999.

TABLE 3.2 BUPA: restatement of BUPA's operating surplus for 1995 and 1999

	<i>£ million</i>	
	1995	1999
Operating surplus (before interest and tax)	147	105
Adjustments		
PMI under-performance		+40
Gains on investments	<u>-26</u>	<u> </u>
Restated operating surplus (before interest and tax)	121	145
Capital employed	829	1,447
ROCE (%)	14.6	10.0

Source: CC using data provided by BUPA.

3.66. Table 3.2 shows that BUPA's operating surplus (before interest and tax) was £147 million in 1995 and £105 million in 1999. BUPA told us that the cyclical underperformance of its PMI business was the main factor adversely affecting its ROCE. In Table 3.2, we show the effect of restating BUPA's 1999 operating surplus (before interest and tax) by £40 million to eliminate the effect of the underperformance of the PMI business over this period. BUPA told us that the equity investment result for 1995 was high relative to 1999. BUPA made gains on investments (realized and unrealized) of £45 million in 1995 in comparison with £19 million in 1999 (see Table 3.6). We also show in Table 3.2 the effect of decreasing BUPA's operating surplus in 1995 by £26 million to eliminate the effect of the higher level of gains on investments in 1995. Table 3.2 shows that had it not been for these two items, the ROCE in 1999 would have been 10 per cent in comparison with 14.6 per cent in 1995 and there was still a shortfall of 4.6 percentage points or 31.5 per cent. BUPA told us that this was owing to (a) the decline in long-term interest rates over this period by 4.2 per cent which led to a decline in hurdle rates, and (b) the acquisitions, mainly in care homes, referred to in paragraph 3.59.

3.67. Table 3.3 segments BUPA's operating surplus (before tax) over the last three years by division and shows how each division contributed to the group's operating surplus. BUPA (which provided this further analysis) said that it included adjustments made to its management accounts. The areas of interest to us in the context of the merger are BUPA PMI, BUPA PMS and Investment Activities. In 1999 BUPA PMI reported losses of £[30] million, BUPA PMS reported profits of £[30] million and Investment Activities reported a loss of £[30] million. Each is discussed in detail below.

TABLE 3.3 BUPA: operating surplus (before tax) by division, 1997 to 1999

	£ million		
	1997	1998	1999
<i>Health insurance</i>			
BUPA: UK PMI			
BUPA: other PMI			
BUPA Health Assurance			
Other UK companies			
Ireland			
Hong Kong			
Thailand			
Spain			
Subtotal			
<i>Health provision</i>			
Hospitals:			
BUPA PMS			
Barbican			
Occupational healthcare			
Spain			
Ireland			
Other			
Subtotal			
Care services			
Dental activities			
Trading activities			
Investment activities			

Figures omitted.
See note
on page iv.

Source: BUPA.

BUPA PMI

3.68. BUPA's analysis of the results of its PMI business is set out in Table 3.4. BUPA said that the further analysis included adjustments made to its management accounts, which were reported before the allocation of central cost. The management accounts of BUPA PMI reported losses of £[30] million in 1997, £[30] million in 1998 and £[30] million in 1999. This compared to adjusted losses of £[30] million in 1997, £[30] million in 1998 and £[30] million in 1999 reported in Table 3.4.

3.69. BUPA PMI receives revenue in the form of premiums or subscriptions from subscribers. Premium income increased by £[30] million ([30] per cent) from £[30] million in 1998 to £[30] million in 1999. BUPA told us that £[30] million of this increase reflected corporate customers changing their policy types, resulting in the shift of corporate long-term PMI income from BUPA Health Assurance to BUPA PMI. The balance of £[30] million principally related to price increases of about [30] per cent. The main costs incurred were subscribers' claims, costs of running the division and allocated costs from the Head Office.

3.70. The loss ratio, which measures the cost of claims incurred as a percentage of premium income, increased from [30] per cent in 1997 to [30] per cent in 1998 and [30] per cent in 1999. BUPA told us that about [30] of this adverse movement was because of an increase in the number of claims and a further [30] because of BUPA's decision to increase outpatient limits. The remaining [30] reflected its membership structure (loss of personal members substituted by corporate members).

3.71. In Table 3.4, operating expenses as a proportion of premiums earned were reported as [] per cent in 1997, [] per cent in 1998 and [] per cent in 1999. Operating expenses comprised direct costs and allocated costs. Direct costs consisted mainly of staff costs and commissions. Staff costs could be attributed to selling, processing claims and customer services. BUPA told us that its direct costs had remained stable over the last three years (1997: £[] million, 1998: £[] million and 1999: £[] million). [Details omitted. See

note on page iv]

TABLE 3.4 BUPA PMI profit and loss, 1997 to 1999

	£ million			per cent								
	1997	1998	1999	1997	1998	1999						
Premiums earned*	())	())						
Claims incurred							Figures omitted.			Figures omitted		
Claims handling costs							See note			See note		
Contribution							on page iv.			on page iv.		
Operating expenses												
Allocation of head office costs												
Exceptional/restructuring												
Net result BUPA PMI												
Net result reinsurance												
Underwriting loss BUPA PMI												

Source: BUPA.

	1997	1998	1999			
Growth in premium income (%)	[]]			
Note: Break-up of direct costs (£m)	1997	1998	1999			
Sales force	())			
Commission				Figures omitted.		
Processing claims				See note		
Customer services				on page iv.		
Other						
Shared services						

3.72. Allocated costs were the costs associated with shared services and central overheads. Shared services included the costs of information systems, marketing and property/purchasing. Central overheads included the costs associated with group policy units, namely the executive board, group finance, legal, development/strategy, corporate communication, human resources, and the medical team. We were told that BUPA adopted a new methodology of recharging shared costs to the divisions in 1999. In 1999, allocated costs to Membership totalled £[] million, which represented 67 per cent of BUPA's overall allocated costs. The allocation was based on measures determined by BUPA, based on its assessment of the resources used by each division.

3.73. BUPA PMI reported underwriting losses of £[] million in 1997, £[] million in 1998 and £[] million in 1999 (see Table 3.4). Underwriting losses in 1998 and 1999 were mainly because of the increase in the loss ratio to [] and [] per cent respectively, for the reasons given in paragraph 3.70. The operating results do not include investment income. Third party evidence suggests that PMI businesses tend to make underwriting losses that are offset against investment income. BUPA told us that investment income was not allocated to BUPA PMI in either its management or statutory accounts.

BUPA PMS

3.74. BUPA provided us with a further analysis of the results of its PMS business (see Table 3.5) and said that it included adjustments made to its management accounts, which were reported before the allocation of central cost. The management accounts of BUPA PMS reported profits of £[] million

in 1997, £[20] million in 1998 and £[20] million in 1999. This compared with the adjusted profits of £[20] million in 1997, £[20] million in 1998 and £[20] million in 1999, shown in Table 3.5.

TABLE 3.5 BUPA PMS profit and loss, 1997 to 1999

	£ million			per cent		
	1997	1998	1999	1997	1998	1999
Revenue	<i>Figures omitted. See note on page iv.</i>	<i>Figures omitted. See note on page iv.</i>	<i>Figures omitted. See note on page iv.</i>	<i>Figures omitted. See note on page iv.</i>	<i>Figures omitted. See note on page iv.</i>	<i>Figures omitted. See note on page iv.</i>
Operating costs						
Depreciation						
Shared services						
Central costs						
Operating profit						
Operating margin (%)						

Source: BUPA.

	1997	1998	1999
Revenue growth (%)	[20]	[20]	[20]

3.75. BUPA PMS comprises the four companies which own and manage its 36 hospitals the UK.¹ Its revenue has been increasing yearly. The [20] per cent increase in 1998 was due in part to the addition of six hospitals following the acquisition of Goldsborough. BUPA's 1999 Annual Report also reported growth in the self-pay market (following a television advertising campaign) and in day-case and out-patient procedures. BUPA told us that in 1999 it spent £7.1 million (plus VAT) on television advertising to raise general brand awareness. BUPA PMS was allocated 30 per cent of the costs.

3.76. BUPA told us that it did not allocate the bulk of the hospital costs to individual procedures. Operating costs (excluding depreciation) remained stable at between [20] and [20] per cent of revenue between 1997 and 1999. Staff and direct costs (drugs and consumables) were the two largest cost categories incurred by BUPA PMS, together accounting for about [20] per cent of revenue.

3.77. Allocated costs comprising shared services and central overheads fluctuated between [20] and [20] per cent of total revenue over the years 1997 to 1999 and depreciation accounted for a further [20] to [20] per cent of revenue. Allocated costs in 1999 totalled £[20] million and represented [20] per cent of BUPA's overall allocated costs. The allocation was based on measures determined by BUPA, reflecting its assessment of the resources used by each division.

3.78. Despite the increase in total revenue, the profitability of BUPA PMS decreased from £[20] million in 1997 to £[20] million in 1999. This reflected a decline in its operating margin from [20] per cent in 1997 to [20] per cent in 1999. Part of this was owing to BUPA PMS being allocated higher central and shared costs, [20] per cent of revenue in 1997 compared with [20] per cent in 1999.

3.79. The operating margin quoted excludes the interest costs associated with financing the business. BUPA told us that, historically, interest payable had not been charged to the divisions as they were set targets only at the pre-interest level.

Care Services

3.80. Care Services is the division within BUPA responsible for its nursing homes. It made three acquisitions in 1997 including Care First Group Plc in December 1997 for £410 million. As a result,

¹BUPA PMS also manages a part-owned hospital in Ireland (see paragraph 3.58).

revenue had increased from £67 million in 1997 to £364 million in 1999 and profit before interest and tax had increased from £9 million in 1997 to £31 million in 1999. But operating margins had fallen from 14 per cent in 1997 to 9 per cent in 1999. BUPA told us that the decrease in margin reflected expansion into homes predominantly funded by local authorities which operated on lower margins.

Investment activities

3.81. Table 3.6 summarizes BUPA's net investment income for the five years 1995 to 1999. In this period it declined from £65 million in 1995 to a net expense of £0.1 million in 1999.

TABLE 3.6 **BUPA: analysis of net investment income**

	<i>£ million</i>				
	1995	1996	1997	1998	1999
Investment income	59.9	53.4	53.8	45.3	39.9
Investment expenses	<u>-6.1</u>	<u>-6.4</u>	<u>-7.2</u>	<u>-6.0</u>	<u>-3.1</u>
	53.8	47.0	46.6	39.3	36.8
Realized gains/losses	29.7	19.4	16.1	41.0	8.1
Unrealized gains/losses	<u>14.8</u>	<u>1.5</u>	<u>-12.6</u>	<u>-18.9</u>	<u>10.6</u>
	44.5	20.9	3.5	22.1	18.7
Investment return	98.3	67.9	50.1	61.4	55.5
Interest payable	<u>-33.2</u>	<u>-32.1</u>	<u>-38.7</u>	<u>-61.0</u>	<u>-55.6</u>
Net investment income	65.1	35.8	11.4	0.4	-0.1

Source: BUPA.

3.82. As will be seen from Table 3.6, investment income (after investment expenses) declined by £17 million and gains on investments by £26 million whilst interest payable increased by £22 million. BUPA told us that its annual operating surplus (see Appendix 3.10) had moved from being heavily dependent on its net investment income in 1995 to greater reliance on its trading activities (see paragraph 3.61).

BUPA PMI—trends

3.83. The management accounts of BUPA PMI show a decline in subscriber numbers of close to 6 per cent over the last four years. In 1999, the number of subscribers totalled 1.29 million (representing 2.35 million individuals covered).

3.84. BUPA PMI's customers fall into three segments: personal, company (small organizations) and corporate (larger organizations). BUPA PMI refers to the company and corporate segments, when combined, as 'company paid'. In 1999, 63 per cent of its customers were company paid and 37 per cent were personal. Over the last four years, there has been a trend of declining subscriber numbers in both personal and company customer segments offset by increasing numbers in the corporate segment. This trend is consistent with the UK PMI market as a whole. The ending of tax relief on premiums for the over-60s in 1997 and the imposition of IPT have contributed to the reduction in personal subscriber numbers.

3.85. BUPA told us that its current network product was introduced in 1996 in an attempt to control costs. It was able to negotiate discounted prices with selected hospitals on the basis that they would be included in its network and could receive more patients. Network products offer subscribers lower premiums by restricting the subscriber's choice of hospitals to those included as part of the network. Network products are discussed in detail in paragraphs 4.108 to 4.121.

3.86. The shift of BUPA's subscribers to network products is summarized in Table 3.7. It is most marked in the company and corporate segments, where registrations respectively increased from 9 to

47 per cent and from 2 to 37 per cent between 1996 and 1999. Penetration of network products in the personal segment has remained relatively unchanged over the four years to 1999.

TABLE 3.7 **BUPA: number and percentage of registrations on network schemes, 1996 to 1999**

	1996	1997	1998	1999
Personal	164,700	179,600	176,200	167,000
Company	26,100	48,900	104,400	119,700
Corporate	11,500	17,600	78,600	207,100
	<i>per cent</i>			
Personal	31	36	35	35
Company	9	18	41	47
Corporate	2	4	15	37
Total	15	20	28	38

Source: BUPA.

BUPA PMI—profitability

3.87. Table 3.8 provides an analysis of contributions by customer segments to the profitability of BUPA PMI.

3.88. [

Details omitted. See note on page iv.

].

3.89. BUPA told us that the corporate segment on average both claims and pays less per subscriber (in value terms) than the other segments.

3.90. The corporate segment within BUPA PMI was the least profitable not because it pays less but rather because it claims more as a percentage of its premium paid (defined as loss ratio). [

Details omitted. See note on page iv.

] This trend of lower profits from the corporate segment is consistent with the UK PMI market. BUPA told us that the average age profile of its customers in the company and corporate segments were significantly lower than that of its customers in the personal segment.

BUPA PMS—revenue analysis of BUPA Hospitals Limited

3.91. The results of 30 of BUPA PMS's 36 hospitals are included in the accounts of BUPA Hospitals Limited (BUPA Hospitals). The results of the six Goldsborough hospitals are accounted for separately. BUPA PMS derives its revenue from four sources: PMI providers (on behalf of their subscribers), the subscribers themselves, self-paying patients and the NHS. Table 3.9 shows BUPA Hospitals' revenue for 1998 and 1999 by type of patient.

TABLE 3.8 **BUPA PMI: analysis of contributions by customer segment, 1997 to 1999**

	1997				1998				1999			
	Personal	Company	Corporate	Total	Personal	Company	Corporate	Total	Personal	Company	Corporate	Total
Subscriptions earned	<i>Figures omitted. See note on page iv.</i>											
Claims incurred												
Contribution												
Key performance indicators	<i>Figures omitted. See note on page iv.</i>											
Loss ratio (%)												
Exposures												
Percentage of total (%)												

Source: BUPA.

TABLE 3.9 BUPA Hospitals' revenue analysis by type of patient, 1998 to 1999*

	1998		1999		
	£m	%	£m	%	
PMI providers	(<i>Figures omitted. See note on page iv.</i>			
Self-pay					
NHS/GP fund					
Other					

Source: BUPA.

*Relates to 30 of BUPA's hospitals, as data are not yet recorded in this form for the six acquired Goldsbrough hospitals.

3.92. As shown in Table 3.9, BUPA Hospitals' main source of revenue is from PMI providers. In 1999 total revenue increased by [8%] per cent, with self-pay growing at a faster rate. According to BUPA's 1999 Annual Report, the rise in self-pay was in part owing to BUPA's television campaign.

3.93. Table 3.10 provides an analysis of the revenue of BUPA Hospitals for 1998 and 1999 by insurer.

TABLE 3.10 BUPA Hospitals' PMI provider revenue analysis, 1998 and 1999

	1998		1999		
	£m	%	£m	%	
BUPA PMI	(<i>Figures omitted. See note on page iv.</i>			
PPP					
Norwich Union					
Prime Health/Standard Life					
Sedgwick Noble Lowndes/Medisure*					
WPA					
ORION/Guardian					
RSA					
Others					
Total PMI providers					

Source: BUPA.

*Medisure is not a PMI provider but a TPA.

3.94. As Table 3.10 shows, in 1999 BUPA PMI and PPP (including ORION/Guardian) accounted for [8%] per cent of the total income received from PMI providers by BUPA Hospitals. BUPA PMI contributed between [8%] and [8%] per cent in both years, [*Details omitted. See note on page iv.*]. PPP (including Orion/Guardian) contributed about [8%] per cent in both years, [*Details omitted. See note on page iv.*].

3.95. Table 3.11 analyses the total revenue of BUPA Hospitals by the type of service provided.

TABLE 3.11 BUPA Hospitals' revenue analysis by type of service, 1998 and 1999

	per cent	
	1998	1999
Inpatient revenue	(8%
Day-case revenue		
Outpatient revenue		
Other		
Discounts (off the rack rate)		
Net revenue (after discounts)		

Source: BUPA.

3.96. BUPA categorizes its types of services into inpatient, day-case and outpatient. Inpatient and day-case procedure revenue is derived mainly from charges to customers for the use of theatres and wards, while outpatient procedure revenue is mainly derived from x-ray and pathology services. Third party evidence suggests that outpatient treatment is becoming an increasingly large source of revenue to private hospitals. This trend is evident in BUPA's revenue mix as shown in Table 3.11, with the proportion of revenue attributable to outpatient treatment increasing.

BUPA PMS—key performance indicators

3.97. BUPA told us that its hospitals were set several individual performance indicators. These included operating return on revenue (OROR), staff turnover and customer complaints resolved at local level. OROR is the main performance indicator used by BUPA to monitor the performance of its 36 hospitals. Operating return was defined as revenue less operating costs (excluding depreciation) and took into account only the costs that could be controlled at a local level. The average OROR in 1999 for all hospitals was [] per cent in the range of [] per cent to [] per cent.

Internal procedures to segregate PMI and PMS activities

3.98. BUPA told us that it did not consider itself to be a vertically integrated company. It said that its PMI and PMS businesses were operated at arm's length from each other and were subject to a strict code of conduct. BUPA believed that this was the best way to optimize the competitive performance of both its PMI and PMS businesses. BUPA also said it was in its best interest to ensure that these arrangements were in place as it was dependent on other PMI and PMS providers. However, many third parties told us that they doubted the effectiveness of these arrangements.

3.99. In particular, concerns were expressed about (a) the extent to which business units had access to funds generated by other units; (b) the extent to which business units shared support functions; (c) the possible flow of information between the business units; and (d) the movement of key staff between the business units.

3.100. As reported in paragraph 3.60, BUPA told us that it was entirely normal in its arrangements; in other diversified companies other business units commonly had access to funds generated in other parts of the business. However, we note that BUPA had a policy of not allocating investment income or interest expense to the divisions (see paragraphs 3.73 and 3.79). This issue was discussed in the 1990 report (see paragraph 3.27), which said that 'it may be that it would be to BUPA's own benefit to amend its organisation in certain respects: the separate and efficient management of BUPA Hospitals might be strengthened if there was to be an actual charge for the cost of any funds provided'. The OFT told us that it had been concerned about the degree of BUPA's vertical integration since that time.

3.101. We noted that it was not until 1995 that BUPA began to centralize its IT, finance, treasury, human resources and marketing functions. The costs of the support functions were shared between the business units on a number of bases.

Strategic outlook

3.102. BUPA told us that it expected its operating surplus (before tax) for the group to [] from £47 million in 1999, [

Details omitted. See note on page iv.

].

3.103. [

Details omitted. See note on page iv.

]

[

Details omitted. See note on page iv.

]

3.104. BUPA PMS was projected to deliver profits of £[200] million (2000) increasing to £[250] million (2003). Actual profits reported in 1999 were £[200] million (see paragraph 3.78). Forecast profits and losses were calculated after the allocation of central costs but excluded the allocation of interest expense. Hospital revenue excluding the merger with CHG was projected to grow from £[200] million in 1999 to [250] million in 2003, which equated to a cumulative annual average growth rate of [20%] per cent. The revenue growth was expected to be achieved from a combination of price increases and market share growth. Operating efficiencies were projected to be achieved from further centralization of certain hospital activities and enhancement of electronic methods of communication and activity, resulting in the operating margin improving from [20%] per cent in 1999 to [25%] per cent in 2003.

CHG

History of the group

3.105. CHG was established by several major UK institutions in 1981 as an investment vehicle for independent hospital projects. In 1983, the CHG board decided that CHG would take over the management and operation of the hospitals in which it had invested. In 1986, CHG diversified into the care of the elderly and started nursing homes, followed in the 1990s by home care and assisted living businesses. CHG floated on the London Stock Exchange in May 1989. In February 1991, a successful rights issue funded further expansion opportunities. The market capitalization of CHG on 27 October 2000 was £188.3 million.

3.106. In the autumn of 1996, following a detailed strategic review of the CHG Group, the decision was taken to concentrate on acute care services. In 1997, CHG implemented the first phase of its strategy, selling 14 nursing homes and its homecare business and closing one nursing home. The nursing homes were acquired by BUPA.

3.107. The CHG group acquired New Hall Hospital, Salisbury, in September 1997 and IBH in January 1998. IBH had previously been partially owned by Goldsborough. BUPA sold its stake in IBH as a condition of its acquisition of Goldsborough (see paragraph 3.28). IBH owned and managed 11 hospitals in areas complementary to those already owned by CHG. One of the IBH hospitals was subsequently sold. In addition, IBH also brought to the CHG group an occupational health business (Company Health Limited) and close-care units at Euxton Hall.

Principal activities

3.108. CHG currently owns and operates 21 hospitals with 843 registered beds, and (measured by bed capacity) is the fourth largest PMS provider which operates on a national basis in the UK. Measured by revenue it is the fifth largest. The average size of most hospitals within CHG is 40 beds, with two operating theatres and a full range of consulting, diagnostic and treatment facilities along with associated support services. All hospitals have 24-hour cover by resident medical officers. Most services are of a general elective nature, but CHG has developed a catheterization suite and intensive care unit, and introduced cardiac surgery, at its Yorkshire Clinic.

3.109. CHG has contracted to operate the Kettering PPU and provides management services to Gloucester Royal PPU.

Financial information

3.110. Appendix 3.12 summarizes CHG's balance sheet over the six years to 30 June 2000. The main changes in it reflect (a) its decision in autumn 1996 to concentrate on private hospitals and sell its care services, and (b) the revaluation of its assets in 2000.

3.111. In the 1997 financial year CHG sold 14 of its 16 nursing homes and closed one, and in the 1998 financial year it acquired New Hall Hospital in Salisbury and IBH. The impact on CHG's balance sheet is that tangible assets and borrowings fell in 1997 owing to the sale of 14 nursing homes and rose in 1998 owing to the acquisitions of IBH and New Hall Hospital. CHG ultimately paid £34.5 million (with goodwill arising of £1.3 million) for IBH and in addition assumed debt of £29.9 million and £8.3 million (with goodwill arising of £0.5 million) for New Hall Hospital. Consequently, CHG's debt-to-equity ratio decreased in 1997 and increased in 1998.

3.112. The five-yearly valuation of CHG's properties on 30 June 2000 increased the value of tangible fixed assets by £78 million from £171 million in 1998/99 to £249 million in 1999/2000 (as stated in the balance sheet). As a result of the revaluation, CHG's debt-to-equity ratio decreased in 1999/2000 to 27 per cent.

3.113. Over the last five years, CHG's ROCE increased from 11 per cent in 1994/95 to 16 per cent in 1996/97, but declined to 13 per cent in 1998/99 and to 9 per cent in 1999/2000. The ROCE calculated on 2000 performance is lower owing to the increase in CHG's property revaluation reserve (see paragraph 3.112).

3.114. Appendix 3.13 summarizes CHG's profit and loss statement over the six years to 30 June 2000. On a year-by-year basis the figures are not directly comparable because revenue and costs associated with nursing homes are included in the figures for the 1995 to 1997 financial years. The majority of the nursing homes were disposed of in 1997. The revenue and costs associated with IBH and New Hall Hospital were included in the figures for 1998. However, 1999 was the first year that included the full year effect of IBH and New Hall Hospital. Appendix 3.14 summarizes CHG's cash flow statement for the six years to 30 June 2000.

3.115. For the financial year ended 30 June 2000, CHG reported turnover of £124 million (an increase of 9 per cent) owing to growth in both the self-pay and PMI business. Operating margins declined to 18 per cent (1999: 19 per cent) mainly owing to additional labour costs.

3.116. Table 3.12 separates the profitability of CHG hospitals into two categories, those acquired before 1997 and those acquired in 1997 and 1998 (which include New Hall and IBH).

TABLE 3.12 CHG: hospitals' profitability

	£ million		
	Year ended 30 June 1999		
	<i>Hospitals acquired before 1997</i>	<i>Hospitals acquired in 1997 and 1998</i>	<i>Total</i>
Gross revenue	<div style="font-size: 4em; line-height: 1;">(</div> <p style="text-align: center;"><i>Figures omitted. See note on page iv.</i></p> <div style="font-size: 4em; line-height: 1;">)</div>		
Discounts			
Net revenue*			
Direct costs			
Gross profit			
Allocated overheads			
Fixed overheads			
Depreciation			
Unit operating profit†			
<i>Key performance indicators</i>			
Gross margin			
Unit operating margin			

Source: CHG.

*The total net revenue of CHG comprises net revenue from hospitals and from its other activities (£[] million) equating to a total £[] million.

†Unit operating profit is before exceptional items and central overheads. In 1999 CHG's operating profit after exceptional items and central overheads was £21.6 million.

3.117. CHG has reported that the acquired hospitals tend to operate on a lower gross margin and unit operating margin than the existing CHG hospitals. This has contributed to the small decline in CHG's overall operating margin in the 1999 financial year. CHG's 2000 Annual Report stated that opportunities for profit improvements continued to exist in the acquired hospitals and the management team was focused on achieving the efficiencies identified.

CHG hospitals—revenue analysis

3.118. Services by hospitals to PMI patients are often paid for directly from the PMI provider to the hospital. As is the case with BUPA PMS, CHG hospitals receive their revenue from PMI providers (on behalf of subscribers receiving the service), subscribers themselves, self-pay and the NHS. Table 3.13 analyses the revenue of CHG hospitals for 1998, 1999 and 2000 by type of patient.

TABLE 3.13 CHG: hospital revenue analysis by revenue source, 1998 to 2000

	Years ended 30 June					
	1998		1999		2000	
	£m	%	£m	%	£m	%
PMI providers	[<i>Figures omitted. See note on page iv.</i>]					
Self-pay						
NHS						
Total						

Source: CHG.

3.119. As Table 3.13 shows, CHG's main source of revenue was from PMI providers. Since 1998, the proportion of revenue from self-pay has been increasing and reached [38] per cent in the financial year ended 30 June 2000. (The increasing importance of self-pay to private hospitals is also seen in the revenue mix of BUPA PMS (see paragraph 3.92: the self-pay contribution level in 1999 for BUPA Hospitals was [38] per cent.) In 1999 CHG launched Fixed Cost Care in all hospitals to target the self-pay market. NHS-funded patients contributed [38] per cent of total revenue in 2000. CHG believed there were opportunities to expand this business.

3.120. Table 3.14 provides an analysis of CHG's revenue for 1999 by PMI provider (for inpatient and day-cases only).

TABLE 3.14 CHG: PMI provider revenue analysis (for inpatient and day-cases only), 1999

	£m	%
BUPA PMI	[<i>Details omitted. See note on page iv.</i>]	
PPP (including Guardian)		
Norwich Union		
Prime Health/Standard Life		
RSA		
WPA		
Others		
Total PMI providers	38	

Source: CHG.

3.121. Table 3.14 shows that in 1999 BUPA PMI and PPP (including Guardian) accounted for [38] per cent of inpatient and day-case income received from PMI providers by CHG. BUPA PMI contributed [38] per cent, [*Details omitted. See note on page iv.*], whilst PPP (including Guardian) contributed [*Details omitted. See note on page iv.*].

3.122. CHG has agreements with BUPA and PPP (which together account for about 70 per cent of the PMI market). CHG has a three-year agreement with BUPA, ending 31 December 2001, which provides for 18 of its 21 hospitals to participate in BUPA's network of hospitals. The remaining three CHG

hospitals are the Berkshire, in Reading; North Downs, near Gatwick; and Oaklands, in the Manchester area. All three are former IBH hospitals and CHG told us that all competed directly or indirectly with BUPA-owned hospitals. However, all CHG hospitals are available to patients who have chosen other BUPA products that are not restricted to the BUPA network of hospitals.

3.123. CHG has eight of its hospitals in the PPP network whilst the remainder are covered by a three-year pricing agreement. All CHG hospitals apart from the hospital located in Stafford are available to PPP-insured patients.

3.124. Table 3.15 analyses CHG hospital revenue by type of service provided to patients. As was the case with BUPA PMS, CHG categorizes its services into three broad groups: inpatient, day-case and outpatient.

TABLE 3.15 CHG: revenue analysis by type of service, 1998 to 2000

	<i>per cent</i>		
	<i>Years ended 30 June</i>		
	<i>1998</i>	<i>1999</i>	<i>2000</i>
Inpatient	60	57	56
Outpatient and day-case	<u>40</u>	<u>43</u>	<u>44</u>
Total revenue	100	100	100

Source: CHG.

3.125. As Table 3.15 shows, outpatient and day-case treatments are becoming an increasingly large source of CHG's revenue.

CHG hospitals—key performance indicators

3.126. CHG assesses its hospitals on a variety of performance measures, but the key financial indicators are gross margins and operating margins. Gross margin is defined as net revenue less direct costs and operating margin is net revenue less operating costs [

Details omitted. See note on page iv.

].

Strategic outlook

3.127. [

Details omitted. See note on page iv.

]

Comparison of BUPA's profitability with that of its competitors

PMI

3.128. At the time of our inquiry nearly all the large PMI providers (PPP, Norwich Union, Standard Life and RSA) were part of larger groups of companies so their accounts were not reported separately. Most of the large PMI providers told us that they were making underwriting losses and the largest costs facing them were the cost of claims incurred. Underwriting losses were offset by the returns made on the investment of subscribers' premiums. BUPA differed (as discussed in paragraph 3.73) in that it did not allocate investment income separately to BUPA PMI, in either the management or statutory accounts.

PMS

3.129. The four national PMS providers (measured by bed capacity) in the UK are GHG, BUPA, Nuffield and CHG. Each is discussed below.

3.130. GHG was formed in December 1997 by Cinven Ltd (a venture capital group) from the merger of Amicus Healthcare Group and the UK healthcare division of Générale des Eaux. In September 2000, GHG was sold to funds controlled by BC Partners, another venture capital group (see paragraph 3.158). GHG comprises three divisions, BMI Healthcare, Partnerships in Care and BMI Health Services. GHG is the largest PMS provider in the UK, owning (through BMI Healthcare) 42 acute hospitals and, with one under management, providing over 2,100 beds. Annual turnover of BMI Healthcare in 1999 was £352 million, or 81 per cent of GHG's total turnover.

3.131. Nuffield Hospitals is a company limited by guarantee with charitable status and does not have a share capital. It operates 41 hospitals including the newly acquired St Mary's of Bristol and a small Care of the Elderly business.

3.132. Table 3.16 summarizes the financial results of the four national PMS providers for 1998 and 1999.

TABLE 3.16 Financial comparison of the four national PMS providers, 1998 and 1999

	1998				1999				£ million
	BUPA*	CHG	Nuffield	GHG†	BUPA*	CHG	Nuffield	GHG†	
<i>Profit and loss</i>									
Operating revenue	260	86	196	396	277	114	215	436	
Personnel costs	-96	-27	-75	-146	-101	-37	-83	-169	
Other operating costs	-103	-34	-81	-138	-113	-45	-92	-140	
Operating profit	61	24	40	111	63	31	40	126	
Depreciation/amortization/leases	-34	-7	-17	-19	-30	-10	-21	-19	
Profit before interest and tax	27	17	24	92	34	22	20	107	
Interest expenses (net)	-23	-2	-3	-84	-34	-4	-3	-84	
Profit before tax	4	15	21	9	-1	18	16	23	
<i>Balance sheet</i>									
Capital employed	428	153	248	359	547	163	269	365	
<i>Ratios</i>									
Personnel costs as percentage of operating revenue	37	32	38	37	37	33	39	39	
Other operating costs as percentage of operating revenue	40	39	41	35	41	40	43	32	
Operating profit as percentage of operating revenue	23	28	20	28	23	28	19	29	
Depreciation as percentage of operating revenue	13	8	8	5	11	9	10	4	
<i>Key performance indicators</i>									
Operating margin	11	20	12	‡	12	19	9	‡	
ROCE	6	11	10	‡	6	13	7	‡	

Source: 1998: *The Fitzhugh Directory Independent Healthcare and Long Term Care 1999-2000*; 1999: Annual Reports; GHG 1998 and 1999: GHG Annual Reports.

*The BUPA results are taken from the statutory accounts of BUPA Hospitals and include only 30 of the 36 BUPA hospitals. The six ex-Goldsborough hospitals and Blackrock are not included. Therefore the results differ from the management accounts of BUPA PMS as reported in Table 3.5.

†GHG results represent the results of the group of which PMS accounts for 81 per cent of turnover.

‡GHG reports its fixed assets at cost (and not at market value) and operating margin and ROCE calculated are not fully comparable.

3.133. As shown in Table 3.16, in 1998 and 1999 both CHG and GHG reported operating profit before depreciation (as a percentage of operating revenue) of between 28 and 29 per cent. These profits compared with 23 per cent reported by BUPA Hospitals and between 19 and 20 per cent reported by Nuffield in both years. On this measure CHG and GHG are more profitable than both BUPA and Nuffield.

3.134. BUPA Hospitals said that its operating profit before depreciation (as a percentage of operating revenue) was 23 per cent in 1998 and 1999, in comparison with CHG's reported 28 per cent. But this was not related to efficiency: it reflected differences in case mix (some cases being more labour intensive than others and requiring more qualified staff). BUPA Hospitals believed it employed proportionately more qualified nursing and paramedic staff than CHG so that its staff costs were higher. BUPA told us that GHG, which had a similar case mix in its hospitals, had similar personnel costs as a percentage of operating revenue. As will be seen from Table 3.16, BUPA Hospitals reported personnel costs as a percentage of operating revenue of 37 per cent in both 1998 and 1999 and GHG reported 37 per cent in 1998 and 39 per cent in 1999. However, GHG had markedly lower 'other operating costs as a percentage of operating revenue' compared with BUPA Hospitals. As a result, GHG in 1998 and 1999 reported an operating profit before depreciation (as a percentage of operating revenue) of between 28 and 29 per cent whereas BUPA Hospitals reported 23 per cent.

3.135. BUPA Hospitals also reported a lower ROCE in comparison with CHG. In 1998 and 1999 BUPA Hospitals reported ROCE of 6 per cent and CHG reported ROCE of between 11 and 13 per cent.

Reasons for the proposed merger

The CHG board's reasons for recommending the proposed merger with BUPA

3.136. The CHG board believed that, despite the profitability and cash generative nature of CHG's operations, its performance had been poorly reflected in its share price. To maximize shareholder value, CHG had sought to expand its operations and enhance earnings growth through the acquisition of high-quality healthcare assets. It had actively pursued the acquisition of two substantial healthcare groups, but in both cases was outbid by other companies.

3.137. The failure to secure acquisition targets at realistic prices coincided with several approaches from private healthcare groups to acquire CHG and led the board to conclude that shareholder value could be best enhanced by the sale of CHG.

3.138. The CHG board reviewed several offers and, having considered the competition issues arising from each, concluded that it would unanimously recommend the BUPA offer of 650p. On 20 April 2000, prior to BUPA's announcement that it intended to make a bid for CHG, CHG shares were quoted at 308.5p and its market capitalization was £109 million.

Business case for BUPA's proposed acquisition of CHG

3.139. BUPA told us that it believed the PMS market was mature and offered limited opportunities for growth through the development of new hospitals. Even where planning permission was available, most local catchment areas large enough to support a private hospital already had sufficient provision to meet the level of demand. Therefore the only opportunity to expand BUPA's hospital portfolio was through acquisition. The merger with CHG would enable BUPA to gain access to new local markets, which could not have sustained entry by an additional provider, and would enhance its overall hospital portfolio.

3.140. [

Details omitted. See note on page iv.

]

3.141. [

Details omitted. See note on page iv.

]

3.142. [

Details omitted. See note on page iv.

]

BUPA's valuation of CHG

3.143. We sought to evaluate the price offered by BUPA for CHG. It had been put to us by third parties that a substantial premium was included in this price.

3.144. BUPA offered CHG shareholders 650p in cash (or a loan notes alternative) for each ordinary share held. This valued the equity of CHG at about £230 million. In addition to the purchase of equity, BUPA would also acquire £3.7 million in share options, £53 million in debt and incur an estimated £5 million in fees (including those incurred by CHG). So the maximum amount of cash required by BUPA to finance the acquisition of CHG was £292 million. This would be reduced pound for pound to the extent that CHG shareholders opted for the loan notes alternative.

3.145. BUPA said that in making the offer for CHG it had to ensure that the goodwill paid would not reduce its solvency margin below the FSA's comfort level of 35 per cent (see paragraph 3.42). Goodwill was an inadmissible asset according to FSA guidelines.

3.146. BUPA told us that it did not believe its offer price for CHG was unduly high. The BUPA board used discounted cash-flow methodology to calculate the appropriate offer price for each CHG share. BUPA provided us with their investment appraisals based on different sets of assumptions. The appraisals forecast returns of between [8%] and [12%] per cent. The appraisals assuming 6 per cent sales growth with (a) synergies and (b) no synergies are at Appendices 3.15 and 3.16. [

Details omitted. See note on page iv.

] BUPA assumed that growth in CHG's profits (excluding synergies) would be mainly from improvements in its operating margin (see paragraph 3.151). CHG told us it was unlikely that BUPA would be able to increase the operating margins in CHG hospitals by improved operational performance.

3.147. It appears that for the acquisition of CHG to achieve the level of returns forecast by BUPA, it would have to achieve a combination of revenue growth and improvement in CHG's operating margin. Revenue would have to grow at levels greater than the [8%] to [12%] per cent currently assumed by BUPA and growth would be achieved by a combination of price and volume increases. We note that for the year ended 30 June 2000, CHG's revenue grew 9 per cent (see paragraph 3.115) whilst its operating margin declined from 19 to 18 per cent.

Sale of a portion of CHG

3.148. In all versions of the discounted cash-flow models BUPA assumed the sale of several CHG hospitals for an estimated £[80] million. During our inquiry BUPA told us that it had yet to determine the combination of hospitals that would be sold. BUPA said that the final combination of hospitals to be disposed of would be those necessary to meet competition concerns together with [80] (see paragraph 3.141). Table 3.17 compares CHG's projected results for 2000 and 2001.

TABLE 3.17 BUPA's post merger valuation assumptions—(1) following sale of portion of CHG

	£ million		
	A	B	A+B
	2000*	2001*	2001*
	CHG	Portion sold	Remainder†
	Total CHG		
Turnover	[Figures omitted. See note on page iv.]		
Earnings before interest and tax (EBIT)			
EBIT margin (%)			
Valuation			

Source: BUPA.

*Estimated.

†Assumes [8%] per cent sales growth.

3.149. As Table 3.17 shows, BUPA assumed that in 2001 the portion of CHG hospitals sold would generate operating margins of [8%] per cent whilst the CHG hospitals remaining in BUPA's portfolio would generate operating margins of [8%] per cent. In 2000 CHG hospitals in total generated operating margins of [8%] per cent.

Margin and capital expenditure assumptions

3.150. Table 3.18 sets out the revenue growth and profit assumptions used by BUPA in its valuation of CHG.

TABLE 3.18 BUPA's post merger valuation assumptions—(2) revenue growth and profit

Scenarios (no synergies)	Revenue growth %	Operating margin (%)						Capital expenditure shortfall per year £m
		2000 %	2001 %	2002 %	2003 %	2004 %	2005 %	
One	[Figures omitted. See note on page iv.]							
Two								
Three								

Source: BUPA.

3.151. [

Details omitted. See note on page iv.

] CHG's accounts show that its operating margins have remained relatively stable, ranging between 18 and 20 per cent over the last six years (see Appendix 3.13).

3.152. [

Details omitted. See note on page iv.

] CHG told us that excluding synergies (discussed in paragraph 3.156) it was unlikely that BUPA would be able to increase the margins in CHG hospitals by improved operational performance.

3.153. In Table 3.17, the remaining CHG hospitals represented about [8%] per cent of total turnover of CHG hospitals. Table 3.19 summarizes (a) CHG's actual capital expenditure from 1995 to 2000 and its forecast capital expenditure in 2001, and (b) BUPA's forecast capital expenditure for CHG from 2001 to 2005.

TABLE 3.19 **CHG actual and forecast capital expenditure, 1995 to 2001; and BUPA forecast capital expenditure for CHG, 2001 to 2005**

	CHG (actual)	BUPA (forecast for the remaining CHG hospitals)
1995	£5m	2001 £
1996	£9m	2002 £
1997	£7m	2003 £
1998	£5m	2004 £
1999	£15m	2005 £
2000	£11m	
2001 (forecast by CHG)	£[]m	

Source: CHG, BUPA.

3.154. [

Details omitted. See note on page iv.

]

3.155. [

Details omitted. See note on page iv.

] BUPA told us that, in its experience, hospitals tended to have less annual capital expenditure than depreciation largely because the asset lives used for accounting depreciation were shorter than the effective lives. BUPA explained that this difference related to the depreciation on buildings which had a long life.

Synergies

3.156. [

Details omitted. See note on page iv.

]

3.157. These savings of £[] million were included in the discounted cash-flow models (with synergies) given at Appendix 3.16, [*Details omitted. See note on page iv.*].

Other valuation methods

3.158. We have further sought to evaluate the price offered by BUPA for CHG by comparing it with the price recently paid for GHG by BC Partners.

3.159. It was announced on 2 September 2000 that Cinven (a venture capital group) had sold GHG to BC Partners (another venture capital group) for a total of £1.28 billion. Table 3.20 provides a comparison of CHG and GHG and the prices proposed or paid for each company.

TABLE 3.20 Comparison of financial aspects of the sale of GHG with those of the proposed acquisition of CHG by BUPA

	GHG	CHG
	Years ended	
	31 December 1999 £m	30 June 1999 £m
Operating revenue	436	114
Personnel costs	-169	-37
Other operating costs	-140	-45
Operating profit (EBITDA*)	126	31
Total acquisition costs (£m)	1,280	292
Operating profit (EBITDA) Multiple	10	9

Source: CC.

*Earnings before interest, tax, depreciation and amortization.

3.160. The EBITDA multiple of 9 proposed by BUPA for CHG is in line with the multiple of 10 paid by BC Partners for GHG.

3.161. BUPA also provided evidence that, if the offer price for CHG were expressed in cost per bed terms, it would not be out of line with recent hospital transactions. Evidence provided by third parties to us suggested limitations on the use of the valuations per bed calculation because of the growth in day-case and outpatient activities.

Financing the acquisition

3.162. The maximum amount of cash that would be required by BUPA to fund the acquisition of CHG is £292 million. BUPA told us (assuming the entire CHG business was acquired and ignoring the initial disposals) that it had a 364-day loan facility of £[200] million agreed with HSBC Bank Plc at [200] basis points (bps) over the London Inter-Bank Offered Rate (LIBOR) as interim funds and an agreement in principle that National Westminster Bank Plc would continue to provide a £[200] million facility to CHG on BUPA's more favourable terms ([200] bps over LIBOR in comparison with 125 bps currently being paid by CHG). The balance of about £[200] million would be financed in the short term out of BUPA's existing cash resources. BUPA was also in a negotiation with a German bank to fund about £[200] million of this by way of a repurchase agreement.

3.163. BUPA's strategy is to replace short- and medium-term borrowings with longer-term borrowings, secured against long-term assets. This strategy enables it to borrow more cheaply with reduced capital repayment strain.

3.164. BUPA told us that the group's expected cash flow from its trading activities was expected to fund capital repayments of the term loan. Operating cash flow before the CHG acquisition and financing charges were forecast to be positive: £[200] *Details omitted. See note on page iv.*