

5 The views of the main parties

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BUPA

Introduction

5.1. BUPA said that its principal activities were the operation of healthcare funds and the provision of health and care facilities and services including ownership and management of hospitals, care homes, home care, health screening and occupational health services. BUPA operated in six business units or divisions, each of which was separately managed.

5.2. It was the UK's largest private health insurer with nearly 1.4 million UK registrations at the end of 1999 providing insurance cover for nearly 2.6 million people. It operated in three principal markets in the UK: PMI, PMS and care services.

The proposed merger

5.3. BUPA said that the market in which BUPA PMS operated was a mature one, offering limited opportunities for growth through the development of new hospitals. Opportunities to expand BUPA PMS's portfolio therefore arose primarily through acquisition. Opportunities to acquire good-quality hospitals in appropriate locations were rare. BUPA had a strong strategic rationale for wanting to acquire CHG. It was an attractive portfolio of high-quality hospitals which would allow BUPA PMS to rationalize its portfolio to focus on medium- to large-size hospitals and in so doing to dispose of some of the smaller hospitals. In this way it would be better able to meet the needs of its customers and to provide superior levels of care with the highest clinical standards and outstanding facilities. The majority of CHG hospitals operated in small self-contained markets to which BUPA would not otherwise have been able to gain access. In addition, their current standards of quality (including external accreditation) meant that they could be assimilated reasonably easily into BUPA PMS's operations. The objective was not simply to acquire hospitals but rather to develop a portfolio of hospitals appropriate to the needs and expectations of its customers.

5.4. By reducing central and other infrastructure costs BUPA PMS would be able to improve the financial performance of all its hospitals. Increasing regulation and the demands of clinical initiatives would in the future place further demands on private hospital operators, particularly as regards investment in new technology, and the enlarged group would be in a better position to respond to these demands in a cost-effective manner.

5.5. BUPA said that it had applied its standard methodology to the valuation of CHG. That reflected an appropriate hurdle rate of return on capital and conservative assumptions on revenue and sales growth. The valuation took no account of future cost savings; nor was it assumed that CHG's prices would rise in real terms. The approach to the valuation of CHG was the same as had been followed in previous bids for hospitals. In all cases where BUPA had acquired hospitals the forecast rate of return on capital from the investment had been achieved. The fact that it had been outbid by venture capitalists on recent occasions suggested that its methodology did not lead to unduly high valuations. BUPA also noted that the sale of GHG on 1 September 2000 for a reported £1.28 billion represented a price of between nine and ten times forecast earnings (EBITDA) which exceeded its offer for CHG.

5.6. BUPA said that at the time its interest in acquiring CHG first became public it had received informal approaches from six different parties interested in acquiring hospitals that might be disposed of following the merger whether for regulatory or commercial reasons. Since the reference to us, BUPA had had more detailed discussions and negotiations with two of these parties, in both cases covered by legally binding confidentiality agreements. BUPA believed that these approaches supported its view that it had not overvalued CHG. In both cases the discussions were terminated in August without agreement being reached. If BUPA were allowed to rebid for CHG it envisaged that these discussions might be resumed. CHG had taken no part in them.

5.7. Based on 1998 published accounts BUPA PMS achieved an operating margin of 23.4 per cent and CHG 28.5 per cent. BUPA saw CHG as an efficient business, hence its attraction, but it nevertheless expected to improve CHG's margins by centralizing certain functions and providing a better management and facility mix. The difference identified in operating margins was, BUPA believed, explained by the difference in case mix, in particular surgery necessitating labour-intensive care. BUPA PMS employed proportionately more qualified nursing and paramedic staff than CHG and so its staff costs were higher. The margins on these procedures were also lower than average because of the high costs involved. The difference in operating margins did not therefore necessarily reflect a difference in the efficiency of the two businesses.

The bid process

5.8. BUPA gave an undertaking to the Secretary of State regarding its acquisition of Goldsborough in 1997. That was to divest the minority stake held by Goldsborough in IBH, not to reacquire any interest in IBH and 'not to participate in the formulation or making of, or influence or attempt to influence, the

policy of IBH'. Since IBH was at a later date acquired by CHG the undertaking by its terms continued to apply to CHG, even though the former IBH hospitals constituted only a small part of the value of the CHG chain. But for the IBH undertaking, BUPA would have been free to acquire a stake in CHG directly, as is commonly done in public bid situations.

5.9. BUPA said that it was first approached on 10 April 2000 by the Chairman of CHG inviting offers for the business. [

Details omitted. See note on page iv.

] The SBUKE facility was put in place on 5 May and was used for the acquisition of CHG shares the same day.

5.10. BUPA's financial adviser was JHS, an indirect sister company of SBUKE. The two companies were part of SSSB and shared a common indirect parent in SIL.

5.11. In explaining the speed at which the SBUKE facility was put in place and used, BUPA recalled that JHS's advice after having spoken to institutional investors and CHG was that there was another party interested in acquiring CHG and prepared to match the BUPA offer of £6.20 a share, so a competing bid was expected.

5.12. BUPA said that JHS had advised it on the launch of its bid, but had not advised it on the loan agreement. BUPA was advised on this by its legal advisers, Slaughter and May, and had sought the opinion of counsel. The arrangement had been devised because BUPA could not buy a stake in CHG without breaching its Goldsborough undertaking. Its legal advisers had put the idea of the loan agreement to JHS. It was a straightforward loan facility, allowing SBUKE to acquire CHG shares as principal, not as agent. Not all the loan facility had been used and £8 million had been repaid to BUPA. BUPA Finance, the company making the loan, did not have any control over the shares or voting rights. BUPA accepted that in making the loan facility it was hoping that SBUKE would act in its interest. It would have been upset had SBUKE sold its CHG shareholding elsewhere on a price rise.

5.13. The BUPA board was fully apprised of the risks involved with the loan agreement, but was keen to go ahead. [*Details omitted. See note on page iv.*]

5.14. Assuming the merger were approved, BUPA would simply relaunch its bid, and it would be for SBUKE to decide whether or not to accept BUPA's offer. If SBUKE did not accept BUPA's offer it could hold the shares indefinitely. The loan agreement had no termination date. All the risks as well as the benefits rested with BUPA. BUPA accepted that if the merger were prohibited it would have no way of protecting its position with SBUKE.

5.15. At the time the arrangement with SBUKE was entered into, BUPA had expected that a competing bidder might emerge. It did not expect its own bid to be referred to us, but thought that undertakings in lieu would be appropriate. This was the context in which BUPA decided to enter into the arrangement with SBUKE.

The possible existing mergers

5.16. BUPA said that as a matter of construction of section 65(3) of the Fair Trading Act 1973 BUPA and SIL/SBUKE were not to be regarded as forming a 'group of persons able, directly or indirectly, to control or materially influence' CHG. In its view section 65(3) should be construed by reference to section 137(2). The special condition referred to by section 65(3) as necessary to be fulfilled by each person in the 'group' was the ability 'directly or indirectly, to control or materially influence' the business in question, ie CHG.

5.17. BUPA said that, regardless of whether SIL/SBUKE had the ability materially to influence CHG, it was clear from the terms of the loan facility between BUPA and SBUKE that BUPA did not have that ability directly or indirectly. The arrangements between BUPA and SBUKE were designed so as to preclude any possibility of BUPA having the ability as a result of these arrangements, directly or indirectly, to exercise influence over CHG's commercial policy.

5.18. Consequently the loan facility provided that SBUKE should be the legal and beneficial owner of the CHG shares and be free to deal with them at its absolute discretion; the facility further provided

that BUPA should have no interest in the shares nor any ability to exercise or control the exercise of any rights in respect of the shares. BUPA had obtained the opinion of leading counsel that the arrangements with SBUKE did not constitute a breach of the IBH undertakings. BUPA would contest vigorously any suggestion to the contrary. Since BUPA had no ability to influence CHG's commercial policy directly or indirectly it could not be part of a group of persons having the ability materially to influence CHG's commercial policy for the purposes of section 65(3).

5.19. BUPA said it had financed the purchase of the CHG shareholding. It was, however, no part of the arrangement that SBUKE should secure 'control' of CHG. There was no basis for concluding that BUPA had any direct or indirect control over CHG as a consequence of the arrangement. BUPA did not believe it should be regarded as an 'associated person' within the meaning of section 77. The arrangements between BUPA and SBUKE were implemented in order to assist a possible future acquisition of control of CHG by BUPA at such time as the IBH undertaking was released thereby enabling BUPA to acquire control of CHG; that was to be distinguished from arrangements whereby persons acted together to 'secure control'.

5.20. BUPA and SBUKE were not associated persons. BUPA patently did not have ability to influence CHG through SBUKE's holding which in itself appeared to raise no public interest concerns. Even if, hypothetically, the inquiry resulted in a prohibition on BUPA proceeding with the merger that would have no implications for the acceptability in public interest terms of the SBUKE shareholding in CHG. SBUKE remained entirely free to do as it wished with the shares and BUPA could neither procure nor prevent disposal of the shares.

5.21. On the question of BUPA's intentions with regard to the loan facility if its proposed full acquisition of CHG did not go ahead, BUPA said that the two matters were unrelated. If BUPA was cleared to offer for CHG and did so, SBUKE would have to decide, as would other shareholders, whether or not to accept the offer. If BUPA was prohibited from proceeding, that had no implications for the arrangement with SBUKE save that, under the terms of the facility, SBUKE's obligation to repay the loan to BUPA was restricted to payment out of funds realized on a disposal of the shares.

5.22. BUPA said it had not in any way sought to influence the policy of CHG. Nor would it seek to influence any vote to be exercised by SBUKE or its representative at a shareholders' meeting or, if appropriate, at a board meeting of CHG.

5.23. On the question of whether BUPA might wish to consider holding a stake in CHG if the full merger was not allowed to go ahead, BUPA said that the envisaged benefits of the merger, notably the opportunity it represented for portfolio rationalization, flowed from assembling a combination of the BUPA and CHG hospital portfolios. A stake in CHG would not enable these benefits to be achieved.

Corporate governance

5.24. BUPA said that although some aspects of its constitutional structure were unusual, it was a private company incorporated under the Companies Acts 1929 to 1985 and in many ways was no different from an ordinary private company. Non-executive board members outnumbered executive board members by about 2:1, were entirely independent and brought with them a considerable range of experience.

5.25. BUPA's provident status was neither an excuse for nor an inhibition on the commercial disciplines that were applied. BUPA aimed to perform just as commercially as a publicly quoted company. Each of the group's six divisions operated as separately managed profit centres and prepared their own operating and business plans to meet the financial and other targets set for them by the board. Their performance was rigorously monitored. Returns on capital were measured against the returns achieved by large public companies, both for the group as a whole and for the individual BUPA businesses, and over time they matched the returns achieved elsewhere. There was no cross-subsidization of one BUPA business by another. The group did not have a credit rating with Moodys or Standard and Poor, but had been given a triple A rating by two leading credit rating agencies when a long-term loan facility had recently been sought. BUPA took the same disciplined approach to capital as a publicly quoted company, although the time frame over which it evaluated risk tended to be longer. BUPA regarded the reserves it had accumulated over time as equivalent to its equity.

5.26. The position of Association Members of BUPA was broadly analogous to that of shareholders in a private company. They kept an eye on the board and attended the AGM. BUPA had over 100 Association Members and about 50 or 60 of them attended the AGM. These were people of independent interests from a wide range of backgrounds chosen by invitation of the board and who were required to retire at 70. In common with most private companies, BUPA did not have constitutional requirements that the approval of Association Members was sought for significant acquisitions. It was for the board to decide whether the Association Members should be consulted on any issue. The AGM provided an opportunity for close and possibly critical questioning of the board. The Association Members could, if so inclined, pass a vote of no confidence in the board, or decline to re-elect individual directors. Also by special resolution they could amend BUPA's Articles of Association.

5.27. The contracts of two of the three executive directors each provided for annual performance-related bonuses. These rewards were driven by the financial results of the group as a whole. The managing directors of the six business divisions were also eligible for performance bonuses linked both to the achievement of the targets set for their individual businesses and to the performance of the group as a whole.

5.28. BUPA had commissioned research in August 1999 which showed that some 6 per cent of people were aware that BUPA was a provident association. When provident association status was explained to them, 43 per cent said that it made them feel more favourably disposed towards BUPA. Provident status allowed BUPA to take a long-term view, in contrast to quoted companies which were often driven by short-term considerations. As far as public opinion was concerned, healthcare seemed to fit well with provident status. There were, however, two disadvantages of provident status: first, that there were no shareholders, analysts or institutional investors to inject a sense of urgency into the business, so this had to be done by the board and senior management; and second, BUPA had no access to equity funding.

Chinese walls

5.29. BUPA said that it had in place a detailed and rigorous set of rules governing all data flows and interactions between its Insurance and Hospitals businesses. These rules (BUPA Confidentiality Policy and Guidelines) are at Appendix 5.1. The two businesses were operated wholly independently of each other and had been run at arm's length since before the 1990 report. In essence BUPA PMI's relationship with BUPA PMS was no different from its relationship with other hospital groups, and BUPA PMI negotiated with BUPA PMS just as it did with any other hospital group. BUPA PMS was expected to complete the same documentation and meet the same quality criteria as other hospitals. BUPA could not understand why its PMI and PMS businesses were perceived by outsiders as being integrated in any way. It was proposing to seek to correct this misunderstanding by giving a much higher profile to the Confidentiality Guidelines that governed the relationship between the two businesses. These had been developed and refined since 1990 to take account both of the recommendations of the 1990 report and the views of the OFT. The Guidelines were seen not as a constraint on the PMI and PMS businesses but as the embodiment of their optimum business strategy. For BUPA PMI and BUPA PMS to favour each other in any way would not assist either of them to achieve the financial targets they had been set. BUPA rejected the idea that no penalty would attach to any failure on the part of the two businesses to observe the Chinese walls. On the contrary, it would lead to widespread customer criticism and concern and the adverse publicity would have very damaging effects for the group as a whole, for example it would be quite possible for a PMI provider to exclude BUPA PMS from its network. The Company Secretary added that he had never received an external complaint that the Confidentiality Guidelines had been breached.

5.30. BUPA had taken steps to ensure that confidentiality was preserved in providing input to the present inquiry. The two businesses were not integrated in any way and this position would not be changed as a consequence of the proposed merger. In its marketing BUPA sought to project values such as reliability, trustworthiness and quality which applied right across the group. In promoting brand awareness it was seeking to convey the message that BUPA was much more than a PMI provider. But this did not suggest an integrated approach to healthcare and was not inconsistent with its divisions being run as separately accountable businesses. Brand awareness was high as far as insurance was concerned but much less so for hospitals where people tended not to distinguish between those that were BUPA PMS-owned and other private hospitals where BUPA PMI paid for treatment. In one survey only 22 per cent of people had been aware that BUPA actually owned hospitals. The brand name did not drive people

into BUPA PMS-owned hospitals. On the insurance side, brand impact was strong with private subscribers but carried no particular weight in the corporate market.

5.31. BUPA said that funds from its various businesses were pooled and that its published accounts gave no indication of the way investment income and interest were attributed between the operational divisions. It emphasized, however, that its published accounts were produced exactly in the form laid down for insurance company accounts and complied fully with existing accounting standards. The management accounts looked at the way the individual businesses performed by reference to the cost of capital employed and the return on capital achieved. Changes to the group's financial and corporate structures had been put in hand some 18 months ago as a response to the requirements of the FSA and as a result of these changes there would be a new structure in which BUPA PMI would have its own permanent board separate from the main group board while BUPA PMS would continue to have its own separate management team. There would be two non-executive members on the PMI board, one of whom would be a member of the main group board. Separate statutory and management accounts were already prepared for each business. Only main board members and appropriate support staff in the group head office would receive performance and operational reports from both businesses.

5.32. Under its present structure all BUPA's investment income was the responsibility of the central treasury function which was treated as a profit centre with its own performance target. BUPA conceded that under this arrangement it was not possible to identify any cross-subsidization between divisions, but pointed out that there would be no benefit in doing so. BUPA's aim was to make the best use of all its funds and this was achieved by the pooled approach. Under the new arrangements the treasury function would continue to be managed centrally but debt would be allocated to the individual divisions. The PMI subsidiary would also be kept fully capitalized.

5.33. Although certain functions such as IT were administered centrally, this did not breach the Chinese walls approach. Training, except for the senior management development programme, was run separately, the respective IT systems were distinct, the personnel functions were separate and the PMI and PMS divisions were largely in different buildings. Cross-postings were extremely rare, and in practice the greater concern was with recruitment by competitors than whether the person in question had past experience on the other side of BUPA's business.

PMS market

5.34. Competitive pressures operated in an unusual manner in the PMS market. This was the result of several factors including:

- (a) the influence on the market of public healthcare provision through the NHS, which was free at the point of use;
- (b) the presence of the NHS in the private sector through low entry cost PPU's;
- (c) the provision of state-paid and privately-paid healthcare in public and private hospitals by the same body of consultants; and
- (d) the disconnection of the usual customer functions inasmuch as the consultant chose the hospital based on clinical and personal preference, the PMI provider paid for the treatment and the patient was largely indifferent as to price. The customers of private hospitals thus comprised three distinct groups: patients, consultants and insurers.

5.35. BUPA said that the PMS market was not a concentrated one. There were four major players and a host of smaller ones. There was not a single PMS market reflecting the influence of PMI providers' networks and bargaining at the national level. Since the introduction of network hospitals there had been no change in the patient discharge data.

5.36. PMS markets were extremely localized. The local PMS catchment areas within which BUPA PMS-owned hospitals operated were, as the MMC found in its 1990 report, in large part constrained by the pattern of referrals seen in the NHS and were restricted to a rather smaller area than a 20-mile radius. BUPA PMS's data indicated that on average patients were prepared to drive up to 30 minutes to reach a private hospital. Geographical and transport factors were relevant, but the most significant factor in setting the boundaries of an individual hospital's catchment was the referral practice of GPs who tended not

to distinguish between private and NHS referrals. Accordingly the private referral pattern generally followed the pattern of NHS referrals, which was based on HA areas. This was reinforced by the fact that private hospitals tended, because they were in the main using the same consultants as the NHS hospitals, to be located conveniently for the combination of an NHS and a private practice. There were very early signs of regional catchments where hospitals specialized in certain complex procedures, for example cardiac surgery, but apart from this it was not realistic to talk in terms of regional markets in any sense.

5.37. BUPA said that in its view London should not be considered to be a distinct market and that independent market analysts had never previously drawn such a distinction. Regional factors were not a consideration in the analysis of competition and the factors pointing to the local nature of PMS markets applied just as much to London as elsewhere. Individual PMS markets within the UK had their own local characteristics, and this was as true of London as elsewhere. London had major NHS teaching hospitals, strong specialist PUs and its private acute hospitals attracted self-paying patients from overseas in much greater numbers than such hospitals outside London. However, these factors did not affect the role of the consultant in determining which hospital a patient used, and the influence of consultants in local markets within London was just as important as it was in the rest of the country.

5.38. Running a hospital was about attracting consultants to use it. Their importance in the private hospitals market could not be overstated. They were the key determinant of hospital choice and PMI providers represented the only real constraint on their charges. Self-pay and NHS-funded treatment represented around 22 per cent of the business transacted by BUPA PMS-owned hospitals. BUPA PMS needed this custom as well as that provided by other PMI providers in order to make an acceptable return and had to provide good value to them all. The consultants and their staff in effect acted as informal brokers for self-pay patients. The choice of hospital was rarely determined by the patient, but by the consultant who was concerned about clinical standards and convenience. There was considerable pressure on hospitals to keep clinical quality up and charges down. BUPA PMS said that it was not practicable for its hospitals to provide preferential treatment for BUPA PMI patients even if they were minded to do so.

5.39. Construction costs for a new hospital represented a substantial barrier to entry to the PMS market. A typical hospital of 52 beds with two operating theatres would cost around £8 million to build, with the cost of land and special equipment adding a further £3 to £4 million. The entry cost of a PU was, however, quite different at around £750,000 to £1 million, which explained the rapid growth of PUs since 1992. This represented annual growth of between 9 and 16 per cent for the last five years compared with 4 to 8 per cent year on year growth for private hospitals. PUs also had the advantage of low exit costs as they could easily be converted back into Trust facilities. Planning permission to build a new hospital or convert an existing one could also be a problem, and another prerequisite was the backing of consultants prepared to bring work to it. Theatre capacity was also a key factor.

5.40. Capacity was difficult to measure, but excess capacity could in some circumstances be a barrier to entry. Midnight bed count was a simplistic measure of capacity which took no account of day-case work, but using this measure it was impossible to run at 100 per cent capacity because consultants did not usually work on Sundays and public holidays. 75 per cent capacity represented the maximum that could realistically be achieved. This necessitated 100 per cent capacity for much of the working week. Capacity was essentially a local market consideration and there were some hospitals, for example BUPA Leeds, BUPA Leicester and BUPA Roding, where BUPA PMS had recognized the need to create additional capacity. Taking the PMS market as a whole, nobody was running at full capacity. That was why BUPA PMS and other hospital groups were keen to get more people into their hospitals, with their efforts addressed to self-payers, PMI providers and the NHS. It was not commercially viable for any hospital or hospital group to rely exclusively on business from a single PMI provider. At the same time the hospitals were under great pressure from the PMI providers to reduce or contain costs.

5.41. On the quality of independent hospitals generally, BUPA said that some were very attractive, high-quality, competitive hospitals, while others were less so. Some hospitals were very good for particular specialisms. One problem for the industry was how to measure and improve quality. BUPA PMI was seeking to do this through the quality requirements for its network hospitals and also by the development of rigorous criteria relating to particular procedures. This latter approach had been started with breast care. If the criteria were met a hospital was granted special blue plaque status as a BUPA Approved Breast Care unit. The recognition related both to the hospital facility and specific consultants. There were 36 such units at present. Not all BUPA PMS hospitals had been awarded the plaque status, and 7 of the 20 that had applied for it had not been recognized although two had subsequently been provisionally accredited. The acceptance rate for BUPA PMS and CHG hospitals was below that of BMI and Nuffield hospitals which were 88 per cent and 90 per cent respectively. This was further evidence of

BUPA's two businesses being operated separately. BUPA PMI was currently engaged in extending this approach to colo-rectal cancer.

5.42. BUPA PMS did not agree that its charges for self-pay patients were generally lower than for insured patients, though it accepted that guidance had been issued to individual hospitals the effect of which could be to raise charges to self-pay patients. Charges for insured patients were determined through negotiations which were conducted centrally and generally speaking for each insurer a price was agreed for the same procedure regardless of hospital. In contrast, the prices charged to self-pay patients were determined by the hospital concerned and each individual patient was quoted an individually assessed price reflecting the procedure to be undertaken and the patient's medical condition. This meant that there was a range of prices at BUPA PMS hospitals for self-pay patients for any particular procedure, but the average episode price for self-payers correlated with the price paid by an insurer with similar volume. An insurer with small volume, ie less than the self-pay volume, was likely to be charged more than the average self-pay price and vice versa. But overall the prices were broadly similar.

5.43. To a great extent self-pay prices did reflect local circumstances. When, for example, a self-pay patient could be added to an existing operating list, the procedure could be costed on a marginal basis.

5.44. One problem in setting self-pay prices was the difficulty of accurately costing individual procedures because of the high fixed-cost element involved. Guidance was given from the centre but this was quite broad and there was no standard procedure for determining the price a hospital charged for a particular procedure.

5.45. Hospitals did use self-pay to try and stimulate the local market so prices were perhaps keener where there was a fair amount of local competition. The picture was, however, not straightforward because BUPA PMS hospitals also dealt with NHS waiting list work as well as cosmetic operations such as breast enlargements and facelifts.

PMI market

5.46. BUPA said that the relevant geographic PMI market was national, defined by national boundaries. The PMI market could be divided into company-paid and personal. The company-paid market could be further divided into corporate (essentially large companies) and company (smaller organizations) business. About 80 per cent of corporate clients purchased their PMI through a broker.

5.47. BUPA said that the PMI market encompassed a wide range of products offering different levels of benefit. The PMI market had seen large-scale entry over more than a decade and BUPA PMI's share had declined from about 70 per cent at the end of the 1970s to just over 50 per cent ten years later and to around 40 per cent in 1999. This reflected the competitiveness of the market. BUPA PMI was fighting hard in a flat market in which there were a large number of competitors. For much of the last decade average premium increases had gone up faster than the RPI and many customers had left the market. Price was increasing faster than the RPI primarily because the cost of claims as well as the incidence of claims had been increasing.

5.48. Until the mid-1990s BUPA's standard PMI product had been the traditional comprehensive policy offering full cover on an indemnity basis. More recently BUPA PMI, along with other insurers, developed a range of network products. Its non-network scheme offered cover for a wide range of recognized hospitals, including virtually all private hospitals and NHS hospital pay-beds in the UK. Its network scheme offered an economic alternative while maintaining comprehensive cover. By accepting cover that was limited to the hospitals in the BUPA PMI network, an individual was able to obtain a substantial reduction in premium. BUPA PMI said that its network product was popular with customers and since its introduction in 1996 the proportion of customers selecting the network product had increased every quarter. However, there was no pressure on customers to take the network product. The non-network product provided the widest choice of hospital to consumers, while the level of quality reviews made the network product attractive to them. It was a question of customer choice. The non-network product was the most expensive and yielded a slightly higher margin. Customers were free to switch between the network and non-network product at each annual renewal without penalty. Also, in common with other PMI providers, BUPA PMI offered economy schemes to further reduce the cost of premiums for subscribers, for example high excesses, restrictions on the procedures covered, and no outpatient

cover. The same range of excesses was available on both network and non-network policies. Network policies represented a minority of the policies sold in the PMI market.

5.49. Network policies were more popular with personal customers than corporate customers. Personal take-up of network policies seemed to be steady at about [30] per cent and [30] new personal business was now for non-network products.

5.50. BUPA PMI had no access to confidential data held by either BUPA-owned or non-BUPA-owned hospitals other than that available to BUPA subscribers. BUPA PMI had neither the ability nor the desire to exercise any influence over the commercial policy of these hospitals. Networks were operated by several PMI providers and in no case was exclusivity a feature. Hospitals, including those of BUPA PMS, typically featured in more than one network.

5.51. BUPA said that a large proportion of its business came through intermediaries. It relied on their integrity to advise clients on the most suitable PMI to meet their needs. Its air miles scheme was not an incentive to intermediaries to sell BUPA PMI schemes. It was aimed to raise awareness of the wide range of BUPA products on offer (including PMI, critical illness, PHI, long-term care and cash plan) and to reward those intermediaries which sold BUPA PMI products. The air miles scheme complied fully with the Code of Conduct of the ABI.

The BUPA PMI network

5.52. BUPA PMI was committed to offering its subscribers the best possible value and the widest possible choice of product, and to seeking to drive up healthcare standards generally. Network policies had opened up a new front of competition involving both PMI and PMS providers. In this connection BUPA drew particular attention to the conclusions of the OFT's 1999 inquiry (see Appendix 4.2).

5.53. BUPA denied that non-BUPA hospitals were less likely to be selected for inclusion in the BUPA PMI network if there was a BUPA PMS-owned hospital in the same area. There were examples of BUPA and non-BUPA hospitals in keen competition that were both included in the BUPA PMI network, for example in the Cambridge and Brentwood areas. Where non-BUPA hospitals in competition with BUPA-owned hospitals were excluded from the network, there were valid reasons for it. Thus the three CHG hospitals that were excluded from the BUPA PMI network were ex-IBH hospitals that had originally not met the required quality criteria. BUPA told us that it had been unable to agree terms with IBH as owner of the hospitals in 1996 when the network was assembled and that, since CHG's acquisition of these hospitals, BUPA had no need of additional facilities in the areas concerned. It said that the three hospitals were not excluded because of their proximity to BUPA-owned hospitals. BUPA PMI's aim was to give customers as much choice as possible even though they had selected a network product. BUPA denied that it was its policy that all BUPA-owned hospitals should be included in the BUPA PMI network. The fact that they were all in the network was a reflection of the high level of quality at these hospitals and the policy of seeking full national coverage by quality hospitals at a realistic price.

5.54. When the current BUPA PMI network product was put together in May 1996 the major chains had provided the central spine of the network and independents had tended to be included in areas not covered by them. The network had contained all the GHG and Nuffield hospitals. All the GHG hospitals were still in the network as were all the Nuffield hospitals bar one which was a hospital that Nuffield had acquired subsequently and which did not compete with a BUPA hospital.

5.55. Hospital recognition, whether for the full list of hospitals or the network list, was something BUPA PMI took very seriously. All hospitals went through a rigorous quality check before acceptance. BUPA PMI's network eligibility criteria are set out at Appendix 5.2 and the quality assessment documentation that is required to be completed by all hospitals is discussed in paragraphs 4.46, 4.47 and 4.49. The criteria for the network hospitals were even higher than those for non-network hospitals, as the emphasis was on a closer relationship, as evidenced by efforts to get network hospitals to bill electronically and to link the payments to the hospitals to BUPA's pre-verification procedures. In addition to clinical quality, servicing, price and value all had to be right. Ownership was not taken into account in this assessment. BUPA PMI's initial attempt at a network in 1992 had contained only 67 hospitals and at that time the selection criteria were weighted more to price than quality, but since then the importance of ensuring high quality and choice had been increasingly recognized, and the network had been extended to provide better geographic reach while offering value for money. The network was regularly reviewed

and updated, normally on a three-year basis, to ensure that quality and reach were maintained. BUPA rejected the idea that its network had been put together in an aggressive way and that it had caused the participating hospitals to modify their revenue expectations, and that as a result of the high discounts that were given to BUPA PMI, the hospitals concerned had to make disproportionate increases in the charges to other insurers and self-payers. BUPA said that it had never sought up-front cash payments from independent hospitals as a condition of their becoming part of the BUPA PMI network or that very short period contracts had been negotiated with a view to putting pressure on them.

5.56. In putting together its network BUPA PMI had sought to strike a balance between the interests of customers who wanted the greatest possible number of hospitals included in the network and the hospitals which once included in the network were not keen to see additional hospitals brought in.

5.57. There were three Goldsborough hospitals that had not been in the BUPA PMI network at the time of the BUPA acquisition in August 1997. Following acquisition BUPA PMS had undertaken a £6 million investment programme to improve the quality of the Goldsborough hospitals and £3.5 million of this was spent on the three non-network hospitals. BUPA PMI had undertaken an inspection and had been satisfied that the improvement in the quality of these hospitals justified their inclusion in the network which was effected on 31 January 1998.

5.58. BUPA PMI said that the OFT had called for greater transparency in the way its network had been put together and for the publication of the relevant criteria but the OFT had not objected to its general approach to the selection of hospitals. BUPA PMI was content to see its network eligibility criteria made public (see Appendix 5.2) and intended to undertake a consultation exercise with interested parties and in the light of comments received consider suitable amendments to the criteria. In the interests of transparency the network criteria would be available on BUPA's web site. BUPA considered, however, that the nature of the network product made it inappropriate to think in terms of security of tenure for hospitals meeting the quality criteria or for an automatic right of inclusion in the network for any hospital meeting them. A key element was the pressure exerted on hospitals to improve standards and provide better value, while from the hospitals' point of view it was open to them to decide not to continue in the network. BUPA saw itself as the market leader committed to driving up standards. Security of tenure by hospitals would remove the spur to greater efficiency. Realistic security of tenure was provided by BUPA's approach of offering three- or four-year term contracts with 12 months' notice of termination. BUPA PMI did not consider it appropriate to make public its network selection procedure, ie to explain how the eligibility criteria were applied. It was essential to its ability to negotiate the best network for its customers that this was not the case.

5.59. BUPA PMI said that PPP's network was built up on a tendering process in contrast to its own which was based on a process of selection and negotiation. The other insurers with networks, Norwich Union and Standard Life, followed BUPA PMI's approach. BUPA PMI had initially attempted to put together a network by tender, but the lessons that had been learned had caused it to move to its present approach. All insurers sought additional discounts from hospitals for their network products in order to keep costs down. BUPA PMI believed that on balance its judgement on building networks this way had been vindicated—customers could now choose a network product and over 1 million had done so, making material savings as a consequence. BUPA believed that networks had also helped to drive up standards.

5.60. On the relationship between inclusion in the network and the volume of customers, BUPA PMI said that both the insurer and the hospitals were taking some risk. Although giving the customer better value for money, it did not follow that the hospital would benefit from a greater number of customers. For the insurer margins were tight and although the network products attracted a higher level of discount from the hospital this was fed back to the customer in the sale price of the policy. BUPA PMI said that hospitals did get some benefit from greater volume though this increase had been slower than both parties had originally expected. BUPA PMI did not give hospitals any guarantee of volume for the discount price, nor did they propose to do so.

5.61. In addition to volume growth, BUPA PMI said that recent published research indicated the possibility of a consultant drag effect associated with network products. Consultants treated network patients at network hospitals and tended also to get patients with non-network products to attend network hospitals. The evidence was not, however, conclusive.

Pre-verification and pre-authorization

5.62. BUPA PMI said that pre-verification was a customer service initiative designed to ensure that patients understood exactly what they were covered for before entering hospital. It was a care management function carried out by clinically knowledgeable staff. There was no obligation on customers to use the service although they were encouraged to do so. The aim was to sort out any problems before admission; it was not the intention to interfere with clinical judgements in any way. People wanted to be sure they were fully covered. The procedure involved going through their insurance cover eligibility, checking that the consultant was recognized by BUPA and that the hospital concerned was included in the member's plan. First, the aim was to ensure that the customer was eligible for the proposed procedure. Sometimes a customer with a network product was intending to go to a non-network hospital. Sometimes a network patient needed to go to a non-network hospital, for example for specialist surgery, and in such cases the use of a non-network hospital was approved.

5.63. The second series of questions which related to only a few procedures was designed to make sure that the customer had exercised an informed consent regarding the procedure to be undertaken, if necessary involving a second opinion. For over a year BUPA PMI had tried to respond to the evidence from the Royal College of Obstetricians and Gynaecologists that a large number of hysterectomies were performed with insufficient clinical justification. If the patient still wished to proceed BUPA would pay for the procedure.

5.64. The same approach had been extended to wisdom tooth extraction last December. It had also been BUPA PMI's original intention to extend it to two common ENT procedures, tonsillectomy and adenoidectomy and insertion of grommets, but after discussions with ENT specialists it had been decided not to do so because new guidelines had been produced by one of the intercollegiate bodies which had itself triggered a reduction in the number of inappropriate ENT procedures carried out.

5.65. A problem could arise where a consultant's fee fell outside the maximum that BUPA PMI was prepared to reimburse. It was this problem and in particular the fact that some insured customers were faced with charges that they themselves were required to meet that had led BUPA PMI to introduce its CPS. This scheme encouraged consultants to bill within BUPA's Benefit Maxima. If they did so, at the end of a 12-month period they received an additional reward payment. Underlying the scheme was the aim of protecting consumers by ensuring that the reimbursement to the customer fully covered the consultant's fee. Analysis of bills showed that consultants in the scheme were much more likely to bill within the Benefit Maxima than were consultants outside the scheme.

5.66. BUPA PMI denied that the CPS had the effect of steering consultants towards BUPA PMS-owned hospitals. The initial version of the scheme had been linked with the use of BUPA network hospitals but that linkage had been removed after discussion with the OFT.

5.67. BUPA PMI denied that consultants who did not join the scheme were disadvantaged. In spite of opposition from the BMA some 6,250 consultants had signed up to the CPS, but insured customers were free to use any other approved consultant. Some consultants deliberately stayed outside the scheme and positioned themselves as a premium product in the market by charging markedly above the BUPA Benefit Maxima. BUPA PMI did not agree that the Benefit Maxima acted as a powerful price control on consultants. The CPA provided the only overall increase in remuneration that consultants had received since 1994.

5.68. An important aspect of the scheme was that it provided more effective billing arrangements. The scheme involved a commitment to move towards electronic billing. This would improve BUPA PMI's administrative efficiency and that of the other PMI operators by getting away from the host of handwritten invoices from consultants it currently handled.

5.69. BUPA said that there was no directional selling ie deliberately directing BUPA PMI insured patients to BUPA PMS-owned hospitals. In support of this BUPA said that its percentage share of the PMI market was greater than the percentage share of the total PMI business that BUPA PMS received that came from BUPA PMI.

5.70. BUPA PMI said that the lists used by its helpline staff were not an aid to directional selling. The system always listed the three nearest hospitals to the customer to the nearest mile based on post-code.

5.71. BUPA said that information on its web site was not used for directional selling. There were two sorts of information on the BUPA web site. First, there was corporate information about BUPA itself, which obviously could not list hospitals it did not own. Here were listed details of all BUPA PMS-owned hospitals and care homes. There was a separate and distinct BUPA PMI web site which listed hospitals by category in terms of the BUPA PMI product to which they related. In seeking information customers could select BUPA PMS-owned hospitals, all network hospitals or all recognized hospitals. If the patient asked for information on the nearest network hospital that would be given, irrespective of ownership.

5.72. BUPA PMI said that pre-verification did not involve directing BUPA-insured patients towards BUPA PMS hospitals. Nor was there any obligation on non-BUPA hospitals to ensure that BUPA PMI's pre-verification procedures were complied with before admission. No part of the pre-verification process steered a patient or a consultant towards a particular hospital. Either the treatment was covered or it was not.

Benefits of the proposed merger

5.73. BUPA said that the proposed merger was in the public interest. As a provident association, it had been committed since its inception to improving quality and service to its customers and the merger would allow it to further this objective.

5.74. From the beginning of the BUPA PMS business over 30 years ago it had been a leader in the healthcare industry, and it was committed to championing the interests of the consumer both through investment to upgrade facilities and improve services and by measures to contain costs and so provide better value for money. The merger would allow BUPA to carry forward these objectives. The acquisition of the CHG hospitals would allow it to rationalize its portfolio which would make it better able to meet the demands for higher standards and increased investment in the years ahead.

5.75. Over the last five years, BUPA PMS had invested £100 million in its hospital facilities and advanced diagnostic equipment. It had also invested heavily in patient-focused IT systems, electronic billing and pre-authorization in conjunction with other PMI providers, all in the interests of offering better services to its patients and customers. The merger would add momentum to these developments.

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

Effects of the proposed merger

5.77. BUPA did not regard it as significant that as a result of the proposed merger it would be the largest provider in both the PMI and PMS markets. Its combined share of the two markets over the period 1989 to 1997 had been comparable without there being any distortion of those markets or any evidence of anti-competitive behaviour.

5.78. In answer to the concern raised by third parties that BUPA's increased share of the private acute hospitals market would allow it to achieve either a marked degree of vertical integration or, as a minimum, would allow it to use its strong position in one market to leverage its position in the other, BUPA said that such allegations, though commonly levelled at it, were unfounded. The principal concern in vertical mergers was the potential harm to competitors either through forcing up their costs or causing them to exit from the market. But the private healthcare industry had important characteristics which meant that this standard analysis did not apply. Specifically BUPA would continue to deal with third parties in both markets. Given the role of the consultant in determining the choice of hospital, commercial considerations and the need to provide comprehensive geographic cover would impel BUPA PMI to deal with other PMS providers. There was a strong commercial incentive for the PMI provider to be able to offer patients access to the private hospital of their choice, and this choice was driven not by the PMI provider but by the location of the patient and the patient's consultant. Any action by a PMI provider to reduce its range of hospitals would operate to its disadvantage. These commercial pressures would be undiminished as a result of BUPA acquiring CHG.

5.79. BUPA said that it negotiated hard with hospitals to keep costs down and secure the best possible deal for its members. It was able to secure greater discounts from PMS providers than could smaller competitors. None of its present agreements with PMS providers contained best price clauses. It said, however, that in the recent past it had sought letters to this effect from various hospitals that it could show on a confidential basis to corporate clients.

5.80. At the same time there was a strong commercial incentive for hospitals to deal with the full range of PMI providers so that all patients on a consultant's list were able to attend the consultant's chosen hospital. Given the fixed-cost nature of running a hospital and the current oversupply of private hospital beds, BUPA PMS relied on the referrals of consultants of private patients insured by rival PMI providers. Of BUPA PMS's PMI-funded patients, around 36 per cent had BUPA PMI policies. This reflected BUPA PMI's share of the market. The largest part of the business of BUPA PMS was funded by other PMI providers. When self-pay business was added, BUPA PMI reflected 26 per cent of BUPA PMS revenue.

5.81. BUPA did not believe that any consequences adverse to the public interest would arise from the proposed merger. In relation to the PMS market, the local nature of competition meant that with a few exceptions where there were BUPA and CHG hospitals with overlapping local catchments, the effect of the merger meant no more than a change of ownership of the PMS provider. However, patients and consultants in those local markets would benefit from the investment BUPA PMS would be able to make in these hospitals, both in terms of capital resources to improve facilities and equipment and also in the development of high standards of management, training and care. BUPA PMS believed it would be able to make good hospitals even better.

5.82. The OFT had noted, with regard to the possibility that networks might lead to disadvantage for smaller PMI providers, that any increase in the level of vertical integration of BUPA's businesses would need to be carefully considered. BUPA said that there had been no such integration and that the proposed merger would not lead to any. The strict confidentiality arrangements (see Appendix 5.1) and the arm's length trading relationship (see paragraphs 5.29 to 5.33) would continue to apply.

5.83. BUPA said that CHG had no presence in PMI, so that the proposed merger could affect this market only if the increased size of BUPA PMS meant that BUPA would be in a position to use its power in the PMS market to leverage its position in the PMI market, or vice versa, or both. BUPA did not believe that the CHG acquisition would have any effect on the PMI market. Even if all the CHG hospitals were retained, BUPA PMS would have only 57 hospitals compared with 181 hospitals in the BUPA PMI network and there would still be large densely-populated areas of the country without coverage by BUPA PMS-owned hospitals, most notably in London. The balance of power in neither the PMS nor the PMI market would be affected by the acquisition.

5.84. BUPA said that the merger would increase its share of the PMS market from 15 to 22 per cent, but BUPA PMS would continue to face strong competition from other hospital providers such as GHG with 18 per cent of the market and Nuffield with 13 per cent. There would be no marked effect on competition at the national level although there were overlaps in local markets that would need to be addressed at Reading, Gatwick and Manchester. There would still be hospitals owned by non-BUPA PMS providers that would have to be included in the BUPA PMI network.

5.85. BUPA PMS said that the acquisition would not put it into such a position of power by virtue of ownership of certain hospitals that it could become an obligatory trading partner for other PMI providers. BUPA did not believe that its presence in either the PMI or PMS market had any distorting effect on those markets. It noted that Standard Life had recently formed a network and in so doing had completely excluded GHG which arguably included some flagship hospitals. This exclusion was notable because GHG's market strength in local markets was comparable to that of the proposed BUPA/CHG combination.

5.86. BUPA said that the merger would not weaken the independent hospitals. All of them were on BUPA PMI's recognized list to which 60 per cent of its customers had access and some were on its current network to which all of its customers had access. There was no evidence of BUPA PMI's network products weakening particular independent hospitals.

5.87. The proposed merger did not change the network position. BUPA PMS hospitals were in the network, as were most CHG hospitals. The three CHG hospitals not in the network were in locations where there was a local market overlap. There would be increased market power in these areas which it

was expected would be addressed by divestment. There would be no effect on the position of self-pay patients. The market for self-payers' custom was very competitive with BUPA PMS and other owned by other PMS providers competing head to head. PPU's also competed strongly for self-payers' business.

5.88. BUPA said that its increased local market power would give it no greater opportunity to use price discrimination in the self-pay market strategically against competitor hospitals. There was no evidence to suggest that predatory pricing had ever taken place. The strategy of pricing below cost for self-payers was as much available now as it would be post-merger but formed no part of BUPA PMS's approach. The merger would have no impact on the pricing of self-pay in local markets.

5.89. BUPA said that a potential concern we appeared to have was of BUPA PMS earning less from BUPA PMI patients than from those of other PMI providers (ie hospital charges would be set at levels below those that would have been achieved from competitive arm's length negotiations). BUPA noted that, given the competitive nature of the PMI market, such a strategy, if adopted, would be equivalent to a price cut in the PMI market. Lower hospital charges could result in lower PMI premiums (as the introduction of network products had clearly demonstrated) and as such should be welcomed in any event as being pro-competitive. However, BUPA said that both its PMS and PMI businesses had full economic incentives to negotiate the best possible terms from each other, as they did in their dealings with all other PMI and PMS suppliers. It was not possible for BUPA PMS to know whether its charges to BUPA PMI were high or low relative to what other hospital groups charged, although like all hospital groups it would compare its charges to BUPA PMI to the charges made to other PMI providers to ensure that they were competitive. This only served to prove the point why BUPA maintained the arms' length relationship between the two parts of the business. In the absence of a benchmark against which BUPA PMS could compare charges across hospital groups, running the two businesses on a commercial arm's length basis and conducting negotiations on an arm's length basis allowed BUPA PMS to be confident that the level of charges set was appropriate given prevailing market conditions. The strict enforcement of the internal Confidentiality Guidelines ensured that this separation was achieved at all levels of the organization.

NHS relationships

5.90. On greater involvement with NHS Trusts, BUPA said that it had no experience of managing PPUs. BUPA said that there needed to be much closer co-operation between the private and public sectors. At the moment the NHS generally used private hospitals as a last resort. The concordat suggested a more substantial relationship, but BUPA had no explicit views or proposals on how this might work.

Remedies

5.91. BUPA said that it would be very disappointed if the merger were prohibited for, in its view, prohibition was a totally disproportionate remedy that would signal to the market that the regulatory view was that it should be capped at 15 per cent of the PMS market. This would mean that it would be unable to grow other than by building new hospitals, which was slow and expensive. Those competition issues that did arise were local in character. A blanket national remedy was therefore entirely inappropriate. Such a remedy should be contemplated only if no behavioural or divestment remedies could meet the competition concerns that were raised. This was not the case with the proposed merger. BUPA noted that HCA's acquisition of St Martin's Healthcare in August 2000, which was not referred to us, gave the combined group at least a 40 per cent share of the London PMS market.

5.92. BUPA said that its reaction to possible divestments would depend more on the size and location of the hospitals identified for divestment than on their number. Its aim was to improve its hospital portfolio in line with the strategic objectives of growth and achieving economies of scale. It accepted that competition issues arose in three areas and that there were some other areas where the proximity of BUPA and CHG hospitals needed to be carefully considered. [

Details omitted. See note on page iv.

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5.93. BUPA would not wish to proceed with the CHG merger if it was conditional upon its PMI and PMS businesses being demerged. This too was a disproportionate remedy and was at odds with the group's overall strategy. It had been in both markets for 30 years and had no incentive to leave either of them. Important synergies arose within the group from its wide range of activities, particularly with regard to its finance, treasury and marketing activities. The US healthcare scene, where the trend was away from combinations of PMI and PMS providers, was completely different from that in the UK and should not be taken as the example to follow.

5.94. BUPA said that to address any concerns that there might be about its confidentiality arrangements and the operation of its PMI and PMS businesses at arm's length, it might be appropriate for the competition authorities to seek various behavioural undertakings from BUPA. Such undertakings might include the following:

- (a) reissuing its Confidentiality Guidelines on relationships between its PMI and PMS businesses as a binding obligation on all staff, with breaches subject to disciplinary proceedings. Staff would attend internal seminars to ensure that the rules and procedures were understood and would be required to sign that they had read and understood them. The Guidelines would be published on the group's web site. It would also be possible to develop a monitoring procedure with the Head of Information Protection being required to include details on compliance in a report to the Board's Audit Committee;
- (b) formalizing the separation of the PMI and PMS businesses with regard to their managing directors, finance functions, executive management committees, reporting lines and business plans as proposed in paragraph 5.31; and
- (c) publishing BUPA PMI's network eligibility criteria (see paragraph 5.58 and Appendix 5.2).

5.95. In response to possible remedies affecting pricing procedures that might be applied, BUPA said that:

- (a) Any attempt to enforce transparency in its pricing in any form would completely undermine its ability to undertake commercial negotiations.
- (b) Any attempt to force it to abandon centralized price negotiations would severely disadvantage it, and failed to recognize the advantages to PMI insurers and PMS providers alike.

5.96. As regards any divestment remedy that might be proposed, BUPA argued that:

- (a) It would be unjustified to cap its share of the PMS market at any particular level as this would be a limitation on its ability to act commercially.
- (b) It would be wrong to adopt either a national or regional approach to divestment as the relevant markets were entirely local in character.
- (c) In addressing local competition concerns, specific pairs of target hospitals should be identified.
- (d) It would be wrong to insist that any divestments were agreed with third party purchasers prior to the proposed merger taking effect. Such a requirement would operate unfairly on BUPA. The undertakings normally sought by the OFT in such circumstances would be entirely sufficient to avoid any degradation of the assets concerned.
- (e) A realistic period for the disposal process would be nine months.

5.97. Regarding the CHG/SIL and BUPA/CHG/SIL merger situations, BUPA said that it could see no grounds for concluding that SBUKE's holding of CHG shares operated against the public interest, so it would be inappropriate to require SBUKE to sell the shares. Requiring SBUKE to sell its shares could only possibly be justified if we found that BUPA was associated with SBUKE and that the BUPA/CHG merger should be prohibited.

CHG

Introduction

5.98. CHG was the fourth largest owner (measured by bed capacity) and operator of independent hospitals in the UK with 21 hospitals and 864 registered beds. A typical CHG hospital had 40 beds, two operating theatres and a full range of consulting, diagnostic and treatment facilities along with associated support services. While most services were of a general elective, ie non-emergency, nature, CHG had developed a specialist cardiac unit at its Yorkshire clinic including intensive care. CHG operated one PPU and managed the private patient services at another NHS hospital. It also owned two close-care housing complexes and a nursing home.

The proposed merger

5.99. On 28 April 2000 the boards of CHG and BUPA announced the terms of a recommended cash offer to be made by SSSB on behalf of BUPA Finance, a wholly-owned subsidiary of BUPA, for all the issued share capital of CHG.

5.100. CHG said that its basic strategy had been to seek to expand its operations in order to maximize shareholder value. It had sought to acquire two healthcare groups within the last 12 months in furtherance of this policy but in each case had been outbid. This coincided with several informal approaches to CHG from other private healthcare groups. It was recognized that the rate of earnings growth had been slowing over the last few years, having dropped from 17 per cent three years ago to 15 per cent two years ago to 12 per cent last year, reflecting the maturity of the market. Shareholders' expectations were for growth of the order of 15 per cent a year which could not be achieved without expanding the business. The problems associated with its share price had become particularly acute towards the end of 1999 and the board had reached the conclusion that shareholder value could best be enhanced by looking for a merger acquisition partner. Certain offers were received and that from BUPA was recommended to shareholders. BUPA's offer was conditional upon the proposed acquisition not being referred to us. Accordingly BUPA's offer lapsed with the referral on 12 June 2000.

5.101. CHG did not consider that the proposed acquisition would have any adverse effects on the public interest. On the contrary, it would enable BUPA to expand its portfolio, reduce central office and infrastructure costs and achieve economies of scale. As a direct consequence BUPA would be able to gain access to new markets and be able to expand the range and quality of its services.

5.102. The offer from BUPA was the culmination of an informal tender process managed by CHG's investment banker Granville Baird in which all the major players in the industry were approached. It had been started early in 2000. BUPA had emerged the outright winner. Several other companies and organizations had submitted bids. Some proceeded to the later stages of the tender process, while others had dropped out early on.

5.103. In the tender process GHG had been the last remaining bidder against BUPA. Other participants were various venture capitalists attracted by the earnings growth and prepared for higher gearing than CHG would contemplate and a proposed management buyout attempt.

5.104. CHG did not regard BUPA's final offer price as overly generous. There were clear and substantial economies of scale in the purchasing of consumables and in combining head offices. Another attraction was that CHG's margins were higher than those being achieved in BUPA hospitals, so BUPA would gain an insight into how its own margins could be improved which would generate more profit.

5.105. [*Details omitted. See note on page iv.*] Over the last two days of the tender process the two bidders had both been in direct contact with major shareholders of CHG. The information pack that was prepared by CHG went to all participants and contained only material that was in the public domain, apart from a breakdown of group operating profit.

5.106. CHG thought that BUPA and GHG had been able to outbid the venture capital-led buyers because their large presence in the market afforded opportunities for economies of scale.

5.107. CHG pointed out that its last published margins were 18.6 per cent before interest and tax. Its margins had been relatively stable over the last few years in the 18 to 19 per cent range.

5.108. CHG did not think that BUPA would be able to increase margins in the CHG hospitals by improved operational performance. Apart from rationalizing certain functions, this could only be done by improving the revenue side of the equation. Closing some of the hospitals was not a viable option.

5.109. In the final stages the regulatory position with regard to BUPA's IBH undertakings was one of the major considerations of its board. The CHG board had reviewed very carefully the conclusions of the OFT in December last year and listened to the views of competition lawyers from both BUPA and GHG. CHG was surprised when the bid was referred to us.

The possible existing merger

5.110. CHG said it would be unrealistic to assume that BUPA would have loaned SBUKE the money to purchase its shares without there being any intention or understanding that SBUKE would vote on the shares or otherwise act in any way other than in accordance with BUPA's interests and strategy.

5.111. BUPA's Company Secretary had telephoned the Chairman of CHG to tell him that BUPA's advisers had gone into the market with a view to acquiring approximately 25 per cent of CHG's shares. This was further evidence of the relationship between BUPA and SBUKE and in CHG's opinion clearly indicated that the shares were acquired on BUPA's behalf. If the merger were allowed to proceed, CHG would expect SBUKE to transfer its shares to BUPA.

5.112. CHG said that SBUKE's 26.8 per cent shareholding in CHG had conferred on SBUKE the ability materially to influence the policy of CHG. SBUKE had full voting rights on the shares which allowed it to block special resolutions at general meetings. This was not, however, an immediate problem for CHG as no special resolutions were currently contemplated. But the SBUKE shareholding was four times as large as that of the next largest shareholder. At least seven other shareholders would need to vote together to block a special resolution.

5.113. In CHG's view BUPA would make the decision on how the stake was voted. It represented a substantial blocking stake in the company, not only in terms of the Companies Act but also with regard to other shareholders. This would inevitably have an effect on the share price.

5.114. Although its agreement with SBUKE did not give BUPA direct or even indirect control over CHG, the arrangement had been entered into to assist the acquisition process.

5.115. BUPA would influence SBUKE, notwithstanding the way their agreement was drafted, because SBUKE had acted at the request of BUPA. SBUKE had acquired the shares only to support BUPA's bid. Subsequently as BUPA's adviser it would act on BUPA's instructions.

5.116. CHG said that other CHG shareholders holding 17 per cent of its shares had some interest in the PMI market but that there was no evidence that this had had any effect on the business.

5.117. On the danger of SBUKE simply dumping the shares on the market and the fact that SBUKE could sell them at any time, CHG said that this possibility had not been discussed by its board. This scenario was unlikely because BUPA would not want the CHG share price to fall.

5.118. CHG did not believe that SBUKE, SIL and BUPA should be regarded as a group of persons having the ability materially to influence the policy of CHG. In CHG's view the phrase 'group of persons' in section 65(3) of the Act was a reference to interconnected bodies corporate, ie a parent and its subsidiary or to joint control. On this basis, SBUKE and SIL could be treated as a group of persons, but not SBUKE, SIL and BUPA. CHG did not believe that the existence of a loan agreement between BUPA and SIL/SBUKE was sufficient to constitute a 'group of persons' for the purposes of section 65(3).

5.119. CHG accepted that it was no part of the agreement between SBUKE and BUPA that SBUKE should secure control of CHG. Even so, SBUKE, SIL and BUPA should be regarded as persons acting together to secure control of CHG. It had to be assumed that SBUKE would not have purchased the shares in CHG without the proposal being supported by BUPA, as was shown by the loan from BUPA. BUPA would not have lent the money to SBUKE unless BUPA intended to acquire some control of CHG and that SBUKE would vote on the shares at a general meeting in such a way as not to conflict with BUPA's interests.

5.120. CHG noted that section 77(1)(b) of the Act stated that associated persons should be treated as one person for the purposes of determining under section 65 whether any two enterprises had been brought under common ownership or common control. On that basis, SBUKE, SIL and BUPA were to be treated as one person and since SBUKE had the ability materially to influence CHG's policy, then all three companies should be treated as having that ability.

NHS relationships

5.121. CHG had no major plans to expand its involvement in the PPU sector. The two arrangements it had with the NHS worked well, but this work did not represent a huge commercial opportunity.

5.122. As to the future of the NHS, CHG would await developments. It already treated patients from NHS waiting lists and prices for NHS work were negotiated locally.

5.123. CHG saw relationships between the NHS and private hospitals as being determined by local needs and varying from area to area.

PMS market

5.124. CHG had contractual arrangements with most PMI insurers. Together they provided around 80 per cent of admissions to CHG hospitals. Its contract with BUPA PMI, a three-year agreement signed in January 1999, covered all services for BUPA-insured patients in CHG hospitals. The same agreement provided for 18 CHG hospitals to participate in the BUPA PMI network.

5.125. BUPA PMI got the lowest prices of all the insurance companies. CHG's agreement with BUPA PMI provided for different prices for network and non-network patients. CHG had increased volume expectations from the network but these were not written into the agreement. There had been some volume growth from membership of the BUPA PMI network but overall not as much as expected. Currently BUPA PMI network patients represented about 40 per cent of all BUPA patients treated in CHG hospitals. Dropping out of the BUPA PMI network would be a major decision for any hospital.

5.126. CHG said that BUPA PMI had asked for a guarantee of best price about three years ago but had been refused. BUPA PMI's CPS had initially included an element of directionality to the BUPA PMI network hospitals, but that was no longer so. The CPS basically established a series of practices, which were in BUPA PMI's interests but also in the interests of its patients in that they included best medical practice with new rules on hysterectomies and wisdom tooth extraction. The CPS was also a step along the way in simplifying billing and claiming procedures. Since the directionality element had been removed, the number of consultants signing up to the CPS had increased. The scheduled fees for consultants had not gone up for a number of years.

5.127. CHG said that, in defining the PMS market, both private acute hospitals and comparable services in PPUs should be included but NHS pay-beds should be excluded. There were CHG hospitals where serious competition was provided by local PPUs. But NHS pay-beds provided little competition for private hospitals and their occupancy levels were low. Consultants' services were a complementary but separate market. Hospitals had no control over where consultants practised or the prices they charged.

5.128. CHG saw the PMS market as mature and operating essentially as a series of local markets, with hospitals attracting local consultants and local people by providing a service for the local community. Competition was local with choice residing with consultants and patients. The services of the four national PMS providers were broadly similar. All sought to ensure that consultants had the full range of equipment and facilities they needed. CHG's own hospitals continued to achieve excellent ratings in patient satisfaction surveys and were the subject of a continuous investment programme to provide further refurbishment, modernization and upgrading, essentially by making better use of available space and providing more operating theatres and outpatient facilities.

5.129. On local catchment areas, CHG said that the HA area was the relevant market rather than any specific distance, such as a 20-mile radius. CHG patient data were based on postcodes related to HA boundaries and 80 per cent of patients came from within the primary catchment area established in this way.

5.130. There were four CHG hospitals that had no competition within a 25-mile radius. But the ownership of flagship or solus hospitals did not add significantly to the owners' market strength. Flagship hospitals were really a consequence of regional specialization in the NHS. It was not possible to create a flagship hospital.

5.131. CHG said that increased specialization was beginning to override local markets. Specialisms in the NHS were regionally based and where this occurred the private hospital market tended to be regional as well. An example was plastic surgery where there was a regional NHS centre in Salisbury. The CHG hospital in Salisbury also specialized in plastic surgery and drew consultants from the whole of Wessex.

5.132. Although prices with insurers were set nationally, the self-pay market was locally priced and self-pay prices were in some instances lower than the prices charged to insurers. PPU's tended to price below commercial levels in order to attract business, and so provided real local competition. [

Details omitted. See note on page iv.

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5.133. Insurers' networks had introduced a whole new dimension to the PMS market. From the hospital's point of view the key issue was whether the discount level that was given to the insurer was justified by increased volume. Hospitals had to decide whether it was in their best interests or not to be inside the insurers' networks. The risk in being outside the networks was substantial. In its negotiations with insurers CHG looked at the average episode cost for each insurer and broadly attempted to match the discounts it offered to expected volume. National pricing was more convenient from an organizational point of view, but in general pricing agreements with insurers carried no guarantee of volume. [

Details omitted. See note on page iv.

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5.134. In contrasting the BUPA PMI negotiating process with PPP's approach, CHG said that PPP had put eight locations forward in a tendering process, and CHG had been successful in seven of them. PPP did not seek tenders in areas where it knew it would have to include a particular hospital and 13 other CHG hospitals had been included in the PPP network on this basis. The single CHG hospital not included in the PPP network had been beaten at tender by a PPU.

5.135. There were some areas where PPP had not carried out a tendering process even though there were no solus hospitals in them. This meant that there were some areas where there were competing hospitals within the PPP network.

5.136. CHG said that initially there had been leakage out of the network product with consultants taking patients elsewhere. That had now stopped and a trend was building in the opposite direction. Consultants treated network patients in network hospitals and also took non-network patients there as well to complete their lists.

5.137. CHG said that BUPA PMS was not in a position to exercise a great deal of market power. It would be possible for a PMI provider to establish a network product without involving access to BUPA PMS hospitals. As an example of a network being established without the inclusion of the hospitals of a major hospital group it quoted the example of Standard Life, which had initially established its network without recourse to any GHG hospitals.

5.138. CHG regarded the barriers to entry to the PMS market as high. It estimated the new build cost for a 50-bed hospital at around £10 million. It achieved better returns from its bigger hospitals although its smallest hospital of 15 to 16 beds still made a worthwhile return.

5.139. Planning permission was also a barrier to entry. However, the biggest barrier to entry was that the PMI market was static and showed no signs of growth. Getting consultants to bring work to a new hospital could also be a problem. On this it was probably necessary to take a long-term view with the expectation that consultants would come over one by one. Operating theatre capacity was also a factor. The way space within hospitals was being utilized was changing. Patients stayed in hospital for shorter periods so bed numbers were being reduced while outpatient facilities and theatre capacity needed to be increased. Growth by acquisition was the easiest route into the market and there were still a large number of hospitals that could be acquired.

5.140. On capacity, CHG thought that midnight occupancy was not a reliable guide. Availability of operating theatres was the major capacity constraint.

5.141. CHG said that GHG was probably the price leader in the PMS market with BUPA and CHG close behind, and with CHG's prices slightly below those of BUPA, although it had no firm evidence.

PMI market

5.142. CHG said that the PMI and PMS markets were complementary but separate. In defining the PMI market, CHG thought that self-payers and cash funds should be excluded but that TPAs should be included. Most TPAs were of a type where organizations had chosen the TPA route but could equally have chosen a PMI product.

5.143. There were checks and balances in the working of the markets, principally because the aims of the PMI and PMS providers were completely different. The former wanted the minimum outlay on claims while the latter wanted to provide as much service as possible. An equilibrium position was reached in the pricing agreements between them. CHG's prices overall reflected average episode costs, but within that the bigger insurers got the lower prices and the smaller insurers the higher ones.

5.144. CHG's surveys of patient satisfaction showed a favourable reaction to the care patients received and to the hospital environment generally, but they suggested that claims, billing and claims-related matters like excesses and pre-existing conditions could be a problem. Some people with insurance cover were not sure what they were covered for. Pre-authorization had been introduced to address this.

5.145. CHG said that pre-authorization was not a particular cause of friction between insurers and consultants. Nor did it have concerns about BUPA being seen as a generic brand. It was not an issue as far as local competition was concerned.

5.146. On whether non-BUPA hospitals were less likely than BUPA hospitals to be selected for the BUPA PMI network, CHG said that initially in establishing its network BUPA PMI had approached the national PMS providers. Their support had been conditional upon BUPA PMI filling out its network with other hospitals.

5.147. All CHG hospitals apart from three were in the BUPA PMI network. These three were in competition with BUPA PMS hospitals. BUPA PMI had refused to take CHG hospitals that directly competed with BUPA PMS hospitals into its network. CHG did not think that these hospitals would necessarily be brought into the BUPA PMI network if the merger went ahead and they remained in BUPA PMS's ownership.

5.148. CHG said that it had been aware of various concerns expressed in the industry about the possibility of the BUPA PMI helpline being used in such a way as to direct patients towards BUPA PMS hospitals. However, CHG had no firm evidence that this had ever occurred and thought that if there had been problems in this regard they would have been brought to its attention, particularly by the consultants who practised at its hospitals who were independently-minded people.

Effects of the proposed merger

5.149. CHG did not think that the proposed merger would weaken other hospital groups or the smaller independents. The BUPA PMI network needed these hospitals. Prices were negotiated nationally and local market power did not result in any increase in that price. CHG said that it had not sought to exploit its monopoly in Cornwall; nor was it aware that BUPA PMS had sought to do so with its Norwich hospital. In negotiations with insurers hospitals did, however, need to have regard to the cost of upgrading, refurbishment and the provision of new equipment. As most of the CHG hospitals were already in the BUPA PMI network there would be no significant change in patient flows or volumes as a result of the merger. BUPA PMS hospitals would continue to need the business of other insurers.

5.150. CHG did not think there was any possibility of BUPA PMI dropping hospitals from its network in two or three years' time. BUPA PMI needed national coverage and this meant maintaining relationships with other hospitals and hospital groups. Nor did CHG think there was a likelihood of directional influence being exerted so that more BUPA PMI patients were treated in BUPA PMS hospitals. The key fact was that patients wanted to be treated locally.

5.151. CHG said that 18 of its hospitals were situated within a 20-mile radius of a BUPA PMS hospital which suggested that the effects of the merger would need to be considered on the basis of the data for each of these local markets. In its view the three CHG hospitals that were not part of the BUPA PMI network were all in direct competition with BUPA PMS-owned hospitals. These were at Caterham, Reading and Manchester. There were other areas where BUPA and CHG hospitals were situated close to each other but the catchment areas were discrete and patient discharge data revealed no or very little overlap. This was the case in the Blackpool/Preston, Brentwood/Chelmsford and Leeds/Bradford areas. The position was complicated and there were certain areas where what appeared to be the effect of a secondary or outer catchment area come into play. An example of this was the Hitchin/Harpندن area. In general, however, CHG did not regard this secondary catchment effect as significant.

Remedies

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

- (a) SBUKE to be required to assent to any offer to CHG shareholders recommended by its board;
- (b) to have a right of veto over the sale of the SBUKE shares to prevent any dumping of the shares;
- (c) to be allowed to have a positive role in seeking a purchaser for the SBUKE shares; and
- (d) to be allowed to buy back all or part of the SBUKE shareholding.

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

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

SBUKE

Background

5.155. SSSB said that JHS, previously a subsidiary of Schroders plc, had acted as BUPA's financial adviser on mergers and acquisitions for several years. JHS was retained by BUPA on 19 April 2000 to advise on a possible offer by BUPA for CHG. Under this mandate JHS was to receive a fee based on the successful conclusion of the offer. As a result of the acquisition of certain investment banking and equity businesses of Schroders plc by the SSSB unit of Citigroup, JHS became a sister company of SBUKE on 1 May 2000.

5.156. In connection with BUPA's 1997 acquisition of Goldsbrough, BUPA gave certain undertakings to the Secretary of State. These prohibited BUPA from acquiring any shares or an interest in shares in IBH. IBH was subsequently acquired by CHG. In the light of the Goldsbrough undertakings, neither BUPA nor any of its subsidiaries could acquire shares or an interest in shares in CHG. BUPA had applied to the OFT to have the Goldsbrough undertakings lifted, but no decision had been made by the Secretary of State when BUPA's bid for CHG was announced on 28 April 2000. BUPA's bid was conditional on a decision by the Secretary of State not to refer it to us.

The acquisition of CHG shares

5.157. SSSB said that, following the announcement of BUPA's recommended bid, JHS came to the view that there was a material risk of a counter-bidder acquiring shares in, and possibly 50 per cent or more of, CHG at a price equal to or less than BUPA's offer price of 650p per CHG share before BUPA could secure OFT clearance and before any decision could be taken by the Secretary of State on whether or not to lift the Goldsbrough undertakings.

5.158. Given this risk of a counter-bid and BUPA's inability to guard against it by purchasing CHG shares itself because of the Goldsbrough undertakings, BUPA and its financial adviser, JHS, considered alternative means of addressing the risk without breaching the Goldsbrough undertakings. It was accordingly proposed that SBUKE should seek to purchase a stake in CHG, with BUPA providing funding and assuming all economic risk and with SBUKE retaining full discretion over any CHG shares acquired. Although no commitments or understandings were given by SBUKE to BUPA and SBUKE would retain full discretion over any CHG shares acquired, SSSB's general expectation was that, if it entered the arrangement and in the absence of unforeseen developments, it would probably hold any CHG shares acquired until BUPA's anti-trust position was clear.

5.159. Upon the agreement of SBUKE management to a possible acquisition of the stake in CHG, on 5 May 2000 SBUKE entered into an agreement with BUPA Finance under which BUPA Finance made available a loan facility to SBUKE of up to £70 million to be utilized by SBUKE in acquiring CHG shares and in paying the expenses of such acquisitions and any subsequent disposals, including regulatory capital costs to SBUKE in connection with the holding of the position. The loan was interest free and repayable solely by the payment by SBUKE to BUPA Finance of the total net proceeds of the disposal of any CHG shares acquired, ie the agreement was structured on a no-profit, no-loss basis for SBUKE such that, if SBUKE purchased any CHG shares, BUPA Finance bore all economic risk on and received all economic benefit from the shares. In view of the Goldsbrough undertakings, the agreement gave BUPA Finance no interest in or control over any CHG shares purchased; SBUKE was to be the beneficial owner and was to retain complete discretion over the exercise of all rights attaching to the shares including complete discretion over their disposal. The proposed arrangements between SBUKE and BUPA Finance were reviewed by leading counsel to ensure compliance with the Goldsbrough undertakings, and were discussed with the OFT and other relevant authorities including the Takeover Panel prior to being entered into. Although it would have been possible for BUPA to enter into such an agreement with another finance house, there were several reasons why the agreement was concluded with an SSSB company. These were the need for speed and confidentiality and the fact that under the Takeover Code Rules anyone entering into this kind of agreement is not permitted to profit from it, so no third party would have been willing to undertake it.

5.160. Shortly after entering into the agreement with BUPA Finance on 5 May 2000 SBUKE acquired 9,500,000 CHG shares (approximately 26.8 per cent of CHG's issued share capital) in the market at a total cost of some £62 million, ie at approximately 650p per CHG share. [

Details omitted. See notes on page iv.

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5.161. As SSSB's dealer and market maker in UK equities and related contractual products, SBUKE dealt actively in the shares of many listed companies, including those which were actual or prospective takeover targets. SSSB said that it was, however, most unlikely that SBUKE would have acquired, with its own funds, a shareholding in CHG as large as the present shareholding. The terms of the arrangements under which SBUKE acquired the CHG shareholding were negotiated at arm's length between BUPA Finance and SBUKE, were fully contained in the agreement between SBUKE and BUPA Finance and were considered, taken as a whole, to be in the interests of SBUKE.

Material influence

5.162. SSSB said it recognized that a shareholding of more than 25 per cent would ordinarily be regarded as conferring the ability to exercise material influence over policy, on the ground that it enabled the shareholder concerned to block a special resolution. On this basis, SBUKE accepted that its 26.8 per cent shareholding in CHG might in theory confer the ability materially to influence the policy of CHG, though in practice it was unlikely to have this effect.

5.163. SSSB said that SBUKE acquired its stake in CHG with a view to protecting BUPA's offer for CHG until BUPA could secure the necessary anti-trust clearances. It was always envisaged as a short-term investment and was made in circumstances where BUPA itself was prevented from acquiring an interest in shares in CHG by virtue of the Goldsborough undertakings. If BUPA's proposed acquisition of CHG were permitted to proceed and BUPA rebid, SBUKE would expect, other things being equal, to assent its shares to BUPA's offer, although no decision on this had yet been taken; conversely, if BUPA were not permitted to proceed with its bid, SBUKE would expect to dispose of its shareholding in an appropriate manner and within a reasonable period, although again no decision on this had yet been taken. Although SBUKE had, by virtue of its shareholding, the theoretical ability to block special resolutions, in practice it was unlikely to have any opportunity to exercise that ability during the anticipated life of its holding in CHG. SBUKE has not sought board representation on CHG, and it was not envisaged that it would seek to do so in the future.

5.164. SSSB said that in considering whether SBUKE's stake of 26.8 per cent conferred the ability to exercise material influence over policy, it was necessary to consider not simply the theoretical ability to block special resolutions, but the likelihood of CHG needing to propose special resolutions during the anticipated period of ownership of SBUKE's stake. SBUKE considered it unlikely that CHG would need to propose special resolutions during the expected lifetime of SBUKE's holding in CHG, other than on matters of a purely routine nature, for example the annual disapplication of pre-emption rights sought by most listed companies at their AGMs.

De facto control

5.165. SSSB did not consider that SBUKE had the ability to control the policy of CHG by virtue of its shareholding. The concept of de facto control under the Act was not clearly defined; however, in SSSB's view, it was similar to the concept of decisive influence under the EC Merger Regulation. It was designed to cover situations in which a minority shareholder might in practice have control as a result of its ability to carry a majority of votes at shareholders' meetings. A shareholder who had this degree of control would also have the ability in practice to control the composition of the board. In policy terms, it clearly made sense for such a shareholder to be treated as having control and for the relationship to be treated as a merger. In the absence of any demonstrated ability to carry a majority of the votes at shareholders' meetings, however, there was no basis for concluding that a shareholder had de facto control. In the case of CHG, eight institutional shareholders between them accounted for approximately 29.5 per cent of the equity. In these circumstances, it must be regarded as highly unlikely that SBUKE would be able to carry a majority of votes at shareholders' meetings.

Control under section 65(3) of the Act

5.166. SSSB said that even if SBUKE were regarded as having the ability to exercise material influence over CHG's policy, it did not follow that SBUKE and its parent company, SIL, should be regarded as having control of CHG. Section 65(3) of the Act gave us a discretion to treat, or not to treat, a person who had the ability materially to influence the policy of a body corporate (but without having a controlling interest) as having control of it for the purpose of section 65(1) and (2). In the present case, it was no part of SBUKE's plan to seek to exercise control over CHG and accordingly SSSB considered that we should exercise our discretion to treat it and SIL as not having control of CHG. Whilst it was conceivable that SBUKE might vote against an ordinary resolution, for example if a sale of CHG's entire business to a third party during the period of the present inquiry were to be proposed, SSSB submitted that this possibility, of itself, was insufficient to support a finding of control, given that SBUKE could easily be outvoted by other shareholders.

5.167. SSSB said that SBUKE should not be regarded as a 'group of persons', along with SIL and BUPA, having the ability materially to influence or to control the policy of CHG. The concept of a 'group of persons' in section 65 of the Act was defined in section 137(2) in the following terms:

'group' (where the reference is to a group of persons fulfilling specified conditions, other than the condition of being interconnected bodies corporate) means any two or more persons fulfilling those conditions, whether apart from fulfilling them they would be regarded as constituting a group or not.

This definition did not appear to have been considered in detail in previous CC or MMC reports. It seemed clear, however, that in order for two or more persons to be treated as a group of persons having the ability materially to influence or control the policy of an enterprise, each of those persons individually must have that ability. In the present case, even if SBUKE were to be regarded as having the ability materially to influence the policy of CHG, it was clear that BUPA did not have that ability. SSSB understood that BUPA had only a nominal holding of CHG shares (1,250 shares held by BUPA Investments Limited and 100 shares held by Goldsbrough Limited) and was not represented on CHG's board.

5.168. SSSB said that, similarly, there was no basis on which it could be suggested that BUPA had the ability materially to influence or control the policy of SBUKE. BUPA had no shareholding in, or board representation on, SBUKE (which was an indirect subsidiary of SIL); nor were there any other agreements or arrangements in place which could be regarded as giving BUPA the ability to exercise material influence or control over SBUKE's policy. Whilst BUPA was a client of JHS, a sister company of SBUKE, this was not sufficient to support a finding of material influence or control over the policy of JHS or its affiliates. Indeed, it would be unworkable if the existence of an advisory relationship between two companies were regarded as sufficient to justify a finding of material influence, since this would suggest that potentially all JHS's clients might have material influence or control over its policy.

5.169. SBUKE did not believe a fortiori that its shareholding in CHG conferred de facto control. Even if we were to conclude otherwise, SSSB submitted that, in the particular circumstances of this case, neither SBUKE nor SIL should be regarded as having control of CHG.

5.170. SSSB accepted that SBUKE/SIL and BUPA could be regarded as having acted together in formulating arrangements, under which SBUKE purchased shares in CHG, but it was clear from the terms of the loan agreement between BUPA Finance and SBUKE that there was no continuing cooperation between them in relation to the manner in which voting rights attaching to those shares were to be exercised. This was made explicit in clause 4 of the loan agreement which provided as follows:

[BUPA Finance] acknowledges that it has no interest in the Shares, including any entitlement to exercise any right, or to control the exercise of any right, in respect of the Shares. SBUKE, as the legal and beneficial owner of the Shares, shall be free to deal with (including, without limitation, to dispose of) the Shares and/or to exercise any right in respect thereof as it may in its absolute discretion determine.

5.171. SSSB said that it might have been fair to characterize SBUKE/SIL and BUPA as associated persons at the time that SBUKE acquired its stake in CHG, but it did not follow that they should continue to be regarded as associated persons following that acquisition. Given that there was no continuing

arrangement between SBUKE/SIL on the one hand and BUPA on the other hand as regards the voting rights attaching to the shares in CHG, SSSB could see no basis on which we could properly conclude that SBUKE/SIL and BUPA should be regarded as persons acting together to exercise control of CHG.

5.172. The fact that, for the purposes of the City Code on Takeovers and Mergers, SBUKE and BUPA were concert parties was irrelevant to the question of whether they were associated persons for the purposes of the Act. The Code definition of persons acting in concert referred to a situation where persons, pursuant to an agreement or undertaking (whether formal or informal), actively cooperated, through the acquisition by any of them of shares in a company, to obtain or consolidate control of that company. Certain persons (including a financial adviser or stockbroker and its client in respect of the shareholdings of the adviser and persons controlling the adviser) were presumed automatically to be acting in concert.

5.173. SBUKE and BUPA fell within the Code definition of concert parties because of the advisory relationship between JHS, a sister company of SBUKE, and BUPA and because the acquisition of shares in CHG by SBUKE was intended to protect BUPA's offer for CHG. However, this had no bearing on the question of whether, for the purposes of the Act, SBUKE and BUPA should be treated as associated persons. SSSB accepted that SBUKE might have been associated with BUPA when it made the acquisition, but it could not accept that SBUKE was acting together with BUPA 'for the purposes of exercising control' of CHG, within the meaning of section 77(4)(d) of the Act.

Future courses of action

5.174. SSSB said that SBUKE had no immediate plans to sell its shareholding in CHG. In the event that BUPA's proposed acquisition of CHG were allowed to proceed and BUPA rebid, SSSB would expect SBUKE, other things being equal, to assent its shares to such an offer or sell its shares to BUPA, but no decision on this had yet been taken by SSSB, nor were there any plans or understandings to this effect.

5.175. Whatever the outcome of our inquiry, SSSB would not expect SBUKE to retain the CHG shareholding beyond the relatively short term. SBUKE was economically indifferent to the sale price achieved for its CHG shares since it neither benefited from any gain nor bore the burden of any loss on their sale.

5.176. SSSB said that if BUPA's merger was allowed to proceed and SBUKE assented its CHG shares to a renewed BUPA offer, such a sale would by definition occur at BUPA's final offer price, 650p per CHG share or above (because any new offer made by BUPA for CHG prior to 5 May 2001 had to be at not less than 650p per CHG share under Rule 11.1 of the Takeover Code). If, instead of accepting a renewed BUPA offer, SSSB sold its CHG shares to BUPA directly, for example because this achieved certainty of realization for SBUKE, SSSB would expect such a sale to be made either at BUPA's then offer price (650p or above) or at SBUKE's 650p original acquisition cost.

5.177. If BUPA's merger with CHG were prohibited or if BUPA did not renew its offer, SSSB would expect SBUKE, other things being equal, to sell its shares in an appropriate manner and within a reasonable period for the best price reasonably obtainable in circumstances providing the greatest certainty of realization. Although no approaches had been made to any prospective purchasers of the stake, nor had any approaches been received, SSSB believed that certain parties (including at least one competitor of BUPA) would be interested in purchasing the shareholding. Given SBUKE's clear desire not to be a long-term shareholder, it would certainly be willing in principle to sell to a competitor of BUPA, if that person were offering an appropriate price and provided certainty of realization.

5.178. SSSB said that the board of directors of SBUKE, in deciding how to act in relation to the CHG shareholding, would have regard to the interests of SBUKE and of SSSB as a whole. SBUKE's principal concern would be to safeguard the group's reputation as a leading international financial services business, acting and being seen to act in accordance with applicable laws and regulations and to the highest standards. Subject to that, while BUPA's interests or perceived interests were technically of no concern, SBUKE would naturally not wish to acquire a reputation for acting in a manner wholly at variance (or perceived to be wholly at variance) with the interests of a client of another member of the SSSB group.

5.179. SSSB said that if SBUKE were, for some unforeseen reason, to retain the shareholding, then there was no reason why the future operations of CHG or the interests of CHG shareholders should be harmed. SBUKE would not intend to concern itself with the operations of CHG and would remain willing, in principle, to discuss potential proposals for the disposal of its shareholding with all parties, including the directors of CHG and other CHG shareholders.

5.180. As an investment firm it was not normally part of SBUKE's strategy to seek representation on the boards of companies in which it held shares. Such a course of action was inappropriate in relation to its CHG shareholding which was a short-term investment. Furthermore there was no commercial incentive for SBUKE to do so.

5.181. SSSB said that, with the exception of the formal notification by SBUKE under the Companies Acts of its shareholding in CHG, there had been no contact between SBUKE and CHG. No need for SBUKE to make representations to the CHG board had yet arisen. If SBUKE did wish to engage in discussions with the CHG board, however, it was likely that the initial approach would be made through JHS which, in its role as BUPA's financial adviser, had had contact with CHG and CHG's financial advisers. This would therefore be the natural channel, at present, through which to initiate any such consultations. The most likely circumstance in which SBUKE might wish to engage in discussions with the CHG board (and in which the CHG board might itself wish to engage in discussions with SBUKE) would be in relation to the future of the SBUKE stake and the arrangements necessary to bring about its sale, in the event that BUPA were not to be allowed to acquire CHG.

Exercise of voting rights

5.182. SSSB said that SBUKE would be in a position to block a special resolution proposed at a general meeting of CHG, because the CHG shareholding represented more than 25 per cent of the voting rights exercisable at general meetings. Whether SBUKE would do so would depend upon the nature of the resolution proposed and the circumstances pertaining at the time. [

Details omitted. See note on page iv.

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5.183. In relation to an ordinary resolution, SBUKE's votes alone would be insufficient to block the resolution, as this would require a simple majority of votes cast. Whether SBUKE would vote in favour of or against such a resolution or abstain from voting altogether would depend upon the circumstances. In general, for ordinary as for special resolutions, SSSB would expect SBUKE to adopt a purely passive stance, in line with its position as a short-term CHG shareholder and its lack of economic exposure. If, however, a proposal fundamental to CHG's future were put forward, SBUKE would consider it carefully and act as it saw fit, without consultation with BUPA.

5.184. SSSB said that BUPA had not in any way sought to influence the manner in which SBUKE exercised the voting rights attaching to the CHG shares. SBUKE had absolute discretion to vote the shares as it chose. To date, no resolutions requiring votes had arisen and the question was therefore hypothetical. In the event that a vote were to arise, any decision as to whether voting rights should be exercised (and, if so, how) would be taken by the board of directors of SBUKE, which comprised the two Co-Chief Executive Officers of SSSB and the Head of European Equities. [

Details omitted. See note on page iv.

] Having regard to the Goldsborough undertakings, however, any consultation with BUPA would be inappropriate. SSSB said that SBUKE would not feel constrained to act in the interests of BUPA in deciding how to vote its shares in CHG. Any decision would be taken having regard to the best interests of SSSB.

The public interest

5.185. SSSB said that neither SIL nor SBUKE had made any detailed study of, or had any interest in, the PMI and PMS markets in the UK apart from positions held as part of SBUKE's market making or hedging activity. Accordingly SSSB had no views about the public interest issues raised in relation to the proposed BUPA/CHG merger.

5.186. If there were found to be a merger in being between SBUKE and CHG, SSSB said that SBUKE's acquisition of CHG shares had no adverse effect on the public interest. Nor could there be any future adverse effect since no company within Citigroup (it being the ultimate holding company of SBUKE, JHS and SIL) had any presence in the PMI and PMS markets in the UK other than possible trading positions. The CHG shareholding could have no adverse effect on competition. SBUKE had not sought to influence the conduct of the affairs of CHG and there was no reason to expect it to do so while it retained its CHG shareholding. If the merger were cleared, it could be expected that SBUKE would not retain the CHG shareholding, but would sell it to BUPA. If, however, the merger were not cleared, it could be expected to dispose of its shareholding to a willing purchaser or purchasers unconnected to BUPA.

Remedies

5.187. SSSB said that there were no comments it could usefully make on the proposed BUPA/CHG merger. If the BUPA/CHG merger were found to operate against the public interest and was prohibited, it would not be necessary or appropriate to impose a remedy on SBUKE. A forced sale should not be imposed on SBUKE as it would depress the sale price. SBUKE would not suffer any loss because of the terms of its agreement with BUPA, but such an outcome could reflect badly on the reputation of the SSSB, so SBUKE would seek to ensure that the best possible price was obtained for the shares. There would be no question of SBUKE dumping the shares. The best way of proceeding would be by auction. The auction approach might still be possible with a forced sale, but the bidders would know that SBUKE had no alternative but to sell and this would inevitably mean that bidders were restrained. In view of CHG's small size and the illiquid nature of the market in its shares, practical problems would ensue, bringing the risk of a heavy fall in the market value of CHG shares to the detriment of all CHG shareholders if it were suggested that the SBUKE shareholding should be split between a minimum number of purchasers or that no purchaser should be offered more than a certain proportion of the holding. SSSB suggested that if a forced sale were proposed, a period of 12 months should be allowed. Realistically it could take up to six months to find a purchaser, and if DGFT approval were a pre-condition to sale, a further two months would be needed, with the prospect of a further period of, say, four months if the original proposed purchaser were not acceptable to the DGFT. Generally any requirement to obtain DGFT consent before completion of a sale would create uncertainty and serve to depress the sale price.

5.188. SSSB said that if a forced sale was proposed it should not be necessary to require divestment below a 15 per cent holding. At 15 per cent it was inconceivable that any public interest detriments concerning the exercise of voting rights could arise. SBUKE had no intention of holding its CHG shares for any length of time. A forced sale of part of the stake would be likely to achieve a better price than a forced sale of the whole.

5.189. SSSB said that if we were to impose a divestment requirement no further remedy would be necessary. Alternatively if a behavioural remedy was sought regarding the voting rights attaching to the CHG shares, no divestment order should be imposed. If our concern was BUPA's possible influence, then any remedies that were thought appropriate in relation to BUPA could be imposed upon BUPA. Prohibition on voting was in effect disenfranchising a key stakeholder in CHG. To do so could disadvantage all shareholders in CHG by reducing CHG's and its shareholders' ability to provide advance certainty about the outcome of any resolution to, for example, a prospective purchaser of a substantial part of CHG's business, which would be necessary to consummate the transaction. It would also mean that SBUKE would be disadvantaged in dealing appropriately with any proposals tabled at a general meeting of the shareholders of CHG which would be to its detriment but to the benefit of other shareholders, or conversely would be unable to initiate or support proposals that were to its benefit.