

Completed acquisition by BUPA Finance plc of Clinovia Group Limited

The OFT's decision on reference under section 22(1) given on 9 May 2007. Full text of decision published 22 May 2007.

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

**PARTIES**

1. **BUPA Finance plc** is a direct subsidiary of **British United Provident Association Limited (BUPA)**, a global health and care organisation. BUPA has three principal divisions in the UK: BUPA Hospitals (BUPA PMS) which owns 25 private hospitals; BUPA Insurance (BUPA PMI); and, BUPA Care Homes. BUPA is a private company limited by guarantee. As such it has no shareholders and all surpluses are reinvested back into the business.
2. **Clinovia Group Limited (Clinovia)** is a provider of healthcare and related services in a home (non-hospital) environment. It has three business areas: Contracted Care (dealing with the compounding and delivery of nutritional and other drugs to patients at home); Medicines Management (dealing with the dispensing, delivery and coordination of prescribed high cost medication to patients at home); and, Complex Care (providing integrated care packages for patients with higher levels of dependency who have typically been in hospital for long periods of time, including social, medical and educational support). Clinovia's UK turnover for the year ended September 2006 was £103 million.

## **TRANSACTION**

3. BUPA Finance plc acquired 100 per cent of the shareholding in Clinovia following an open auction process. The completion date was 1 December 2006. The extended statutory deadline, which expires before the administrative deadline, is 9 May 2007.
4. BUPA gave initial 'hold separate' undertakings to the OFT under section 71 of the Enterprise Act 2002 (the Act) on 2 April 2007.

## **JURISDICTION**

5. As a result of this transaction BUPA and Clinovia have ceased to be distinct. The UK turnover of Clinovia exceeds £70 million, so the turnover test in section 23(1)(b) of the Act is satisfied. The OFT therefore believes that it is or may be the case that a relevant merger situation has been created.

## **BACKGROUND**

6. The main rationale for the merger as stated in BUPA's internal documents is to take advantage of the large growth in demand which is projected to occur in the home healthcare sector in the near future, largely through increased demand from national health service customers throughout the UK (referred to here for convenience as 'the NHS'). The OFT has been provided with evidence corroborating the identification of home healthcare as an important part of the Government's future healthcare plans, including by the NHS which is currently the main recipient of such services, and the encouragement of more independent sector involvement.<sup>1</sup>

## **MARKET DEFINITION**

7. Under the Act, in order to refer a merger to the CC the OFT must have a reasonable belief objectively justified by relevant facts that there is a realistic prospect of a substantial lessening of competition in a market or

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<sup>1</sup> For example, as contained in the Department of Health's White Paper (*'Our health, our care, our say: a new direction for community services'*) issued on 30 January 2006.

markets in the UK resulting from that merger<sup>2</sup>. For this test to be met there must have been some pre-merger scope for competitive interaction between the merging parties, primarily either horizontally within the same sector or vertically between sectors at different levels to be reduced substantially as a result of the merger.

8. Given that BUPA has never supplied home healthcare services itself, there is no obvious horizontal overlap between the activities of the parties. However, there are vertical links between them in relation to the interaction between BUPA's pre-existing operations in private medical insurance (PMI) and private medical services (PMS), and Clinovia's activities in home healthcare services. The OFT has therefore considered various candidate relevant product and geographic markets relating to these separate areas of activity in turn below.

#### **PMI**

9. PMI policies provide indemnity cover against the costs of private medical treatment. The main policy features relate to the comprehensiveness of the treatment covered and whether the policyholder's choice of hospital is unrestricted, or alternatively limited to a specified network of hospitals or preferred providers.
10. The Competition Commission ('CC') previously considered this sector in *BUPA/CHG*<sup>3</sup> and concluded that personal and corporate PMI policies form part of the same economic market due to a high degree of substitutability on the supply-side (although other forms of insurance products such as cash plans, income protection and critical illness policies were regarded as complementary to PMI rather than as substitutes). In relation to geographic scope, the CC concluded that the PMI sector was UK-wide. The OFT has not found any evidence suggesting a departure from this approach in the current case is necessary. The OFT considers that the candidate relevant market in which to consider BUPA's medical insurance activities in this case is, therefore, the supply of PMI in the UK.

#### **PMS**

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<sup>2</sup> OFT Guidance note of October 2004 revising paragraph 3.2 of '*OFT 516 Mergers – Substantive Assessment Guidance*'.

<sup>3</sup> *Report by the CC: British United Provident Association Limited and Community Hospitals Group Plc* (November 2000).

11. PMS refers to private hospitals which admit patients (including insured and non-insured) for surgical and other treatments. PMI companies negotiate rates with and pay private hospitals (PMS providers) for the use of their facilities by their insured patients. Private hospitals, in turn, are serviced by hospital consultants, most of which are mainly contracted to NHS hospitals but also undertake private patient treatment. Consultants make referral suggestions to patients on where private treatment takes place, which can be accepted or rejected according to patient wishes, and within any relevant insurance policy, which may limit the choice of hospital available.
12. In *BUPA/CHG* the CC considered the PMS sector to include 'private acute hospitals and the services they provide', including the admission of patients covered by health insurance and non-insured ('self-pay') patients.<sup>4</sup> It also considered the geographic scope of PMS to be national, although regional and local aspects were also considered.<sup>5</sup> No issues were raised during the course of the OFT's investigation suggesting a departure from the CC's approach.

## Homecare

13. Home healthcare, or homecare, is provided to a patient in their home and involves the delivery of drugs, helping patients to self-administer drugs, and the provision of more complex care packages to meet patient needs. Homecare can be further sub-divided into low-tech or high-tech, with the latter typically including intravenous therapy, other injectable therapy and oral therapy that require significant support.<sup>6</sup> The OFT's competitive analysis focuses solely on high-tech homecare as this is the area within which Clinovia is primarily active.
14. One third party suggested that high-tech homecare and PMS form part of the same relevant product market. Although there may be some similarities

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<sup>4</sup> The CC excluded from its scope other, more specialised, private hospitals and clinics, such as those dealing with pregnancy termination, cosmetic surgery and psychiatry. The CC considered that Private Patient Units (PPUs) within NHS hospitals operated broadly within the same market, but excluded NHS pay-beds on normal NHS wards.

<sup>5</sup> These included certain issues dealing with different market conditions pertaining in London compared with other areas of the UK.

<sup>6</sup> Low-tech healthcare typically refers to medical treatment such as oral medication, external preparations and non-intravenous injectable treatments that require no significant patient support.

between the homecare treatments provided to private patients, and the equivalent treatments offered for the same condition on a day-patient basis by private hospitals, evidence provided to the OFT suggests that a fundamental characteristic of homecare is its 'out-of-hospital' delivery basis requiring a very different set of assets and infrastructure. On the basis of the evidence provided to it, the OFT also believes that there is limited demand-side substitutability between PMS and homecare. For example, third parties consulted during the OFT's investigation generally did not view homecare as a strong substitute for PMS; several rather described it as complementary. Although there may be some limited overlap at the margins, the OFT therefore considers that PMS and homecare are more properly regarded as neighbouring or related services in separate candidate product markets.

15. A third party submitted to the OFT that the relevant product market in relation to high-tech homecare should be confined in this case to the provision of services to private patients alone (both insured and self-pay). It was submitted that a distinction between private and NHS patient groups is justified on the basis of differences in the medical services provided and infrastructure required, with the former limited to patients with acute conditions<sup>7</sup> and the latter focused on patients with chronic conditions (treatment for which is not usually covered by PMI providers)<sup>8</sup>.
16. Although there was a broad consensus by other third parties that responded to the OFT's investigation that PMI-funded homecare necessarily focuses on post-hospital treatment of the acute procedures covered by PMI,<sup>9</sup> they did not in general support the assertion that services offered to privately-funded and NHS patients form separate product markets. Evidence obtained by the OFT indicates that homecare providers operate in

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<sup>7</sup> These are treatments that are likely to result in a full recovery, such as chemotherapy, intravenous antibiotics/antivirals, blood transfusions and immunoglobulins.

<sup>8</sup> These are conditions that are on-going and not typically resulting in a full recovery, such as haemophilia and HIV.

<sup>9</sup> The *Laing & Buisson Report (Domiciliary Care 2007)* supports the notion that provision of homecare to private patients for acute conditions is a growing part of the overall homecare market, albeit that the NHS remains the principal purchaser of such services. For example, it states that, '*The relocation of treatment from hospital to GP, and from hospital to home, is part of the movement down the 'care ladder' apparent in most aspects of health and social care in the UK and elsewhere. The potential economic and patient benefits are driving the provision of NHS medical treatment at home rather than in hospital...The private medical insurers have started to encourage its development, for although they do not cover chronic illness, they are becoming more involved in the management of their policyholders' treatments, and high tech home healthcare for acute conditions can save them money.*'

a range of overlapping segments in the homecare sector and it would be relatively easy for a provider to move from one service area to another as the same resources (such as nursing staff) and infrastructure can be used. Further, several homecare providers serve both the NHS and the private sector and did not draw a distinction between the services provided to each. On the basis of this evidence, therefore, the OFT believes that there are no defining characteristics which distinguish the nature of homecare services provided to NHS and private patients and that the appropriate candidate product market is, therefore, high-tech homecare including both types of patient. However, in the interests of comprehensively dealing with vertical issues raised during its investigation, the OFT has also considered a narrower approach in the competitive analysis that follows.

## **VERTICAL ISSUES**

### **Introduction**

17. The OFT received concerns from various third parties that the merger may result in three types of foreclosure at differing levels of the supply chain.<sup>10</sup> Each of these is dealt with in turn below.
18. Where a vertically integrated entity possesses market power at one level of the supply chain, consideration must be given as to whether a merger results in an enhancement of the ability and incentive of the entity to exploit that market power. Therefore, in assessing whether the merger could have vertical foreclosure effects, in each case the OFT has considered whether either the ability of BUPA to foreclose or any incentive for BUPA to adopt a foreclosure strategy is created or strengthened by the merger.
19. In order to make such an assessment, it is necessary to consider the competitive situation, including the degree to which BUPA had the ability or incentive to foreclose, absent the merger (referred to as the counterfactual). The OFT's substantive guidance suggests that the best guide to the appropriate counterfactual will generally be the prevailing

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<sup>10</sup> Foreclosure does not mean simply that a vertically integrated firm is expected to exclude a non-vertically integrated firm from a market but may include a range of behaviours including a refusal to deal, raising barriers to entry and raising rivals' costs (see paragraph 5.2 of '*OFT 516 Mergers - substantive assessment guidance*').

conditions of competition pre-merger.<sup>11</sup> For the purposes of its vertical assessment, the OFT has focused particular attention on two aspects of prevailing conditions of competition.

- First, Clinovia currently has an extremely limited presence in the supply of high-tech homecare to privately insured patients, with the NHS as its principal customer.<sup>12</sup> Therefore, PMI providers currently source virtually all their homecare from providers other than Clinovia.
- Second, BUPA PMI is currently provided with high-tech homecare services under an exclusive three-year agreement with the homecare provider, Healthcare at Home (HaH), terminable by either party with a year's notice to expire at the earliest after 31 March 2008. To the extent the merger would create an exclusive arrangement between BUPA and Clinovia, this would not represent a substantial change relative to the near-term situation absent the merger, under which HaH (the largest overall provider of homecare services to NHS and private patients) is the sole supplier to BUPA PMI.

20. Further, in examining the robustness of the allegation of BUPA's incentive to foreclose in respect of all three theories alleged, internal documents provided by BUPA were reviewed by the OFT but no evidence was found suggesting that any business strategies based on foreclosure have been contemplated or implemented. On request by the OFT, concerned third parties were unable to provide documentary evidence supporting their concerns (as may be expected if the change of ownership of Clinovia would have a potentially substantial impact on their competitiveness). These points relating to documentary evidence reinforce the OFT's analysis on BUPA's ability and/or incentive to foreclose based on economic considerations detailed below.

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<sup>11</sup> See paragraph 3.24 of '*OFT 516 Mergers - substantive assessment guidance*'.

<sup>12</sup> BUPA has informed the OFT that Clinovia has only [ ]. Other than this, it has provided homecare services to a small number of PMI-funded patients and private self-paying patients on a case-by-case basis. However, revenues generated by such services are minimal, for example approximately [ ].

## Potential for high-tech homecare foreclosure

21. A number of third parties were concerned about the risk of the merger resulting in foreclosure of the high-tech homecare sector. In particular, it was submitted that BUPA would have both the ability and the incentive to move to a situation of self-supply for high-tech homecare and foreclose access of Clinovia's homecare rivals to BUPA PMI (an important set of insured patients).<sup>13</sup>
22. As noted, absent the merger HaH would have continued to supply BUPA PMI with homecare services on an exclusive basis, at least for the foreseeable near-term. This exclusive contract already prevents day-to-day access by rival homecare suppliers to BUPA's PMI customer base, even though there may have been competition for that contract in the past. Therefore, even if BUPA PMI were to exclusively contract with Clinovia as a result of the merger, this would not differ essentially from the current situation of exclusivity and in this sense would not result in a substantially less competitive position than that which already exists.
23. However, the most compelling reason for dismissing this theory relates to BUPA's small share of relevant demand. If Clinovia were to be granted preferred or exclusive high-tech homecare provider status to BUPA PMI post-merger,<sup>14</sup> the ability of the merged entity to carry out a foreclosure strategy depends on BUPA representing a substantial proportion of relevant demand. If BUPA accounted for a large share of such demand, the denial of access to such a large customer might weaken rivals relative to Clinovia by denying them scale economies and thus raising their costs; this in turn could relax competitive pressure on the merged firm at the homecare services level and inflate prices. However, the evidence available suggests that it would be misleading to define such demand narrowly simply in terms of privately-funded (excluding NHS-funded) high-tech homecare services. As discussed under market definition, the OFT fails to see material distinctions for these purposes between homecare services provided to privately-funded versus NHS-funded patients: the clinical

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<sup>13</sup> Alternatively, it was submitted that BUPA has close links with consultants that create a source of opportunity for it to direct insured patients to Clinovia rather than an alternative homecare provider.

<sup>14</sup> BUPA informed the OFT that it intends to give notice to terminate its exclusive arrangement with HaH and thereafter transition its purchasing of high-tech homecare services to Clinovia. However, BUPA also stated that it is not necessarily the case that it will cease to use third party homecare providers entirely over the short to medium term.

needs, deployment of nursing staff and equipment does not appear to differ based on the underlying financing of the service.

24. By properly taking into account NHS homecare demand, BUPA's purchasing position is dwarfed in scale by the NHS, and the potential customer foreclosure theory is easily dismissed. (The OFT has not found any evidence to suggest that BUPA accounts for any more than a maximum of 5 per cent of total demand for the high-tech home healthcare sector, including both privately-funded and NHS patients). This is particularly true of the incumbent supplier to BUPA, HaH, which is the predominant supplier to the much larger NHS segment.
25. For completeness, the OFT has also considered the narrower lens of privately-funded homecare. In this segment, BUPA PMI accounts for a significant purchasing proportion of PMI-funded homecare<sup>15</sup> and PMI demand requirements of other PMI providers (accounting for almost 60 per cent of PMI) would remain accessible to other homecare suppliers even if BUPA demand were met exclusively by Clinovia. In addition, the volume of homecare demanded by all PMI customers appears to be growing rapidly and can be expected to continue to do so, making the volume of current demand 'tied up' in any exclusive arrangement between BUPA and Clinovia even less significant than at current total demand.
26. BUPA has also confirmed that neither it nor Clinovia has exclusive arrangements with drug manufacturers for the supply of certain drugs which would give the merged entity the ability to refuse other homecare providers access to them.
27. Finally, it should be noted that Clinovia's rivals other than HaH do not currently have access to BUPA demand, which is served exclusively under contract by HaH, the largest provider of homecare services across NHS and private patients. To the extent the merger results in a transfer of the BUPA contract from HaH to Clinovia, the merger is actually deconcentrative in the homecare sector, by transferring volume to a smaller rival.
28. For the reasons given above, the OFT is able confidently to dismiss foreclosure concerns before considering competitive constraints arising

from expansion or entry. For completeness, however, potential barriers to entry and expansion identified by third parties in relation to homecare include the need to establish a 'track record' of service delivery, and reputation for staff expertise. As discussed above, demand from both the NHS and from PMI providers for homecare services is expected to continue to display strong growth. Other things being equal, this would tend to facilitate entry and/or expansion since it will be relatively easier for an entrant to achieve a viable scale. Some third parties specifically noted that high market growth and corresponding demand served to ease the entry of new players. As noted, the OFT does not need to draw conclusions on these points.

### **Potential for PMI foreclosure**

29. Several concerned third parties submitted that post-merger BUPA would be able to dampen competition from PMI rivals either by refusing to allow them access to Clinovia's services, or worsening the (price or other) terms of supply to make the PMI rival less (price) competitive.<sup>16</sup>
30. The OFT does not consider that BUPA has the ability to foreclose PMI rivals as they will not lack access to homecare alternatives to Clinovia to serve their future needs. Clinovia currently has an extremely limited presence in the supply of homecare to privately-insured patients so the OFT considers that any restriction in access to it will not have a significant impact. The PMI sector currently sources virtually all of its homecare requirements from providers other than Clinovia (in particular, from HaH which is the largest player in the homecare sector and active on a national basis). There can be no vertical theory of harm giving rise to a realistic prospect of a substantial lessening of competition if the merged firm lacks market power in respect of Clinovia's services, and therefore the ability to foreclose rivals by denying them, or raising the costs of, access to Clinovia. Accordingly, no competition concerns arise in respect of allegations of foreclosure of PMI services in the UK.

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<sup>15</sup> BUPA is the largest player in the provision of PMI in the UK with an estimated national share of supply of around 42 per cent based on revenue (*Laing's Healthcare Market Review 2006-2007*, page 197).

<sup>16</sup> Some PMI providers' concerns seemed based upon an expectation that Clinovia will significantly expand its supply of homecare to insured private patients, on the back of in-house BUPA demand.

## Potential for PMS foreclosure

31. A third party concern was submitted to the OFT that post-merger BUPA could have the potential ability and incentive to foreclose rival providers of PMS services (by driving patients from non-BUPA hospitals to homecare) by several means. First, BUPA could allegedly exploit its PMI strength (with a large share of the PMI sector) as a purchaser of PMS to try to reduce the period in which insured patients qualify for hospital treatment so that they can be transferred out of non-BUPA hospital care to Clinovia (to the extent that homecare is an alternative). Second, BUPA's close links with consultants or its ownership of a network of private hospitals allegedly created opportunities for BUPA to influence the direction of insured patients out of non-BUPA hospitals to Clinovia. It was also suggested that BUPA would be able to adopt a discriminatory policy in targeting its influence over directions of patients by focusing on areas where it does not have PMS hospital capability and avoiding areas where it does.
  
32. On the basis of the evidence before it, the OFT does not believe that as a result of the merger BUPA has the ability or incentive to carry out such a foreclosure strategy. As discussed in the above market definition section, homecare is largely complementary to private hospital treatment, rather than a competitive substitute. For example, in the context of this case, the OFT received no evidence that Clinovia is currently a significant substitute for (and therefore a competitive constraint) upon BUPA's PMS business, taking into account the views of PMI providers who are potential customers of both parties.<sup>17</sup> Further, even if this were the case, the OFT has not been provided with any evidence during its investigation to support a counterintuitive belief that the merger would provide BUPA with the ability to influence the direction of patients away from private hospital care to Clinovia (either through BUPA PMI restrictions or otherwise) such as to result in foreclosure. In particular, prevailing drivers of treatment referrals by consultants are clinical ones dependant on the type of condition being treated, specific patient requirement and cost. In other words, if a patient's clinical needs dictate that further stay in (private) hospital is required,

clinicians are unlikely to be persuaded, through BUPA's alleged influence or otherwise, to transfer them to homecare. Where patient needs do not dictate otherwise, to the extent a patient can be transferred from expensive hospital care to cheaper homecare, there are already strong cost imperatives to do so. BUPA's acquisition of Clinovia will not essentially affect these considerations. This is supported by the fact that the majority of PMS hospital groups responding to the OFT did not perceive themselves to be at risk of foreclosure (including the specific regional discrimination concerns mentioned above) as an issue arising from this transaction.

## **Conclusion**

33. In summary, a number of vertical foreclosure concerns were raised by third parties but the OFT does not believe on the basis of evidence provided to it that the merged entity would have the ability or the incentive to carry such strategies through.

## **ASSESSMENT**

34. There is no direct horizontal overlap between the parties. However, there are vertical links between them in relation to the interaction between BUPA's pre-existing operations in private medical insurance (PMI) and private medical services (PMS), and Clinovia's activities in high-tech home healthcare services.
35. A number of third party concerns relating to potential vertical foreclosure which could result from the merger at different levels of the supply chain were received by the OFT. The OFT therefore considered it necessary to assess these issues further to determine whether the merger has created or increased both the ability and incentive for BUPA to undertake foreclosure strategies, and thereby ultimately could harm consumers.
36. The prime concern that BUPA would have the ability and incentive to foreclose rivals of Clinovia in high-tech homecare provision fails simply because BUPA accounts for such a small share of relevant homecare demand that any exclusion of rival suppliers from its business would not

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<sup>17</sup> Accordingly, the OFT does not believe any horizontal competition concerns, relating to a loss of direct competition between the merging parties compared to the pre-merger situation, arise in this case.

foreclose a substantial part of the relevant market. The overwhelming size of NHS demand, and the majority of private demand, a growing sector, demonstrates that rivals would not be materially weakened and competition would not be harmed. Indeed, Clinovia's rivals other than HaH do not currently have access to BUPA demand, which is served exclusively by HaH, the largest provider of homecare services across NHS and private patients. To the extent the merger results in a transfer of the BUPA contract from HaH to Clinovia, the merger is actually deconcentrative in the homecare sector, by transferring volume from the largest player to a smaller rival.

37. A second concern was that rival PMI providers of BUPA could be restricted or discriminated against in their access to Clinovia. Taking into account that the PMI sector currently sources nearly its entire homecare requirements from providers other than Clinovia (in particular, HaH which has an established reputation as the leading homecare provider to private patients), the OFT believes that this concern is without merit.
38. A final allegation was that the private hospital (PMS) sector could be foreclosed as BUPA could, through a variety of means, influence the direction of patients from (non-BUPA) hospitals into homecare and even adopt a discriminatory policy by targeting this strategy in areas where BUPA does not have PMS capability and avoiding areas where it does. The OFT has found no evidence that Clinovia's business directly competes, as opposed to being largely complementary, with private hospital treatment. Neither was any evidence provided to support a belief by the OFT that BUPA could override the direction of homecare provision over clinical factors, including the nature of the conditions being treated and patient requirements. The lack of concern from the majority of PMS hospital groups reinforced the OFT's analysis dismissing this allegation.
39. In summary, on the basis of evidence provided in the course of its investigation, the OFT does not believe that BUPA has the ability to foreclose supply at any level of the private medical supply chain as a result of the merger. The OFT does not therefore hold a positive belief, objectively justified by relevant facts, that the merger give rise to realistic prospect of a substantial lessening of competition by means of foreclosure effects in one or more of homecare services, PMS or PMI in the UK.

40. Consequently, the OFT does not believe that it is or may be the case that the merger has resulted or may be expected to result in a substantial lessening of competition within a market or markets in the United Kingdom.

## **DECISION**

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