Bulletin

FEBRUARY 2014

Growing pains

EVALUATING THE BENEFITS OF HOSPITAL MERGERS

In October 2013, the UK Competition Commission (CC) issued a landmark decision to block a proposed merger between two hospital trusts in the south of England. This has brought into sharp focus the tensions between – on the one hand – the push to promote patient choice and provider competition and – on the other – the financial and clinical pressures driving trusts together. This bulletin explains the new challenges for providers considering mergers, as well as for the new Competition and Markets Authority (CMA), when asked to evaluate their benefits.*

Competition policy has been making waves in England's National Health Service. With the introduction of the Health and Social Care Act 2012 (HSCA), NHS hospital trusts in England that were looking to merge might be required to go through the same merger control process as is applied to businesses in the private sector. In 2013, the NHS got its first taste of what this could mean, with the

landmark decision by the CC to block a proposed merger between two trusts in Bournemouth and Poole, on England's south coast.

Competition in the NHS does not work quite like competition in other sectors. To start with, there is a disconnect between the those who pay for the service (taxpayers), and those who use it (patients) And there is little scope for price competition, with many tariffs being set centrally by Monitor, the sector regulator. Nevertheless, hospitals are increasingly paid on the basis of the number of patients they treat or number of contracts they win: giving patients or commissioners a choice of provider will, so the theory goes, further motivate hospital executives to provide a high quality of service. If they fail to keep up with the standards offered elsewhere, they risk losing their patients, their revenues and – ultimately – their jobs.

However, this push for choice and competition is running into opposing forces driving NHS trusts ever closer together. According to official figures released in January 2014, almost one in three NHS trusts in England is now forecasting they will end the financial year in deficit, and some have been eying up mergers as a way of saving cost. There may also be clinical benefits from operating on a greater scale. For example, the Royal College of Surgeons has recommended that the catchment population for an acute general hospital should, for preference, not be below 450,000–500,000.

STORM CLOUDS AT THE SEASIDE

These tensions between the perceived benefits of competition and scale were very much present in the CC's investigation into the proposed merger between the Royal Bournemouth and Poole Hospital Foundation Trusts. As the figure below shows, the trusts are located in the same built-up area, which is surrounded by a large rural hinterland.

Figure 1. 30-minute drive time isochrones for Bournemouth and Poole hospitals

Source: Frontier Economics, using MapInfo and Bing Maps

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The CC was concerned that patients in the area would have no local choice of provider if the merger went ahead. But the trusts argued that they were not close competitors. The services they offered were, in the main, complementary – one specialised in emergency care, paediatrics and cancer treatment, the other in elective care in areas such as orthopaedics, as well as in specialist cardiac treatment. Moreover, trusts argued that without the merger they would face considerable financial difficulties – and that Poole in particular risked becoming financially unviable as a standalone organisation.

Nevertheless the CC found that the merger would give rise to a substantial lessening of competition for a number of elective clinical specialties, as well as for maternity care. With regard to the financial challenges facing Poole, it argued that – in practice – trusts are only put into special administration in "exceptional circumstances", and may avoid this outcome even after running up large deficits for several years. For this reason, it contended, both trusts would likely remain as standalone organisations absent the merger.

DOUBLE VISION

The next question was whether the merger would give rise to any benefits capable of offsetting such a loss of competition. The trusts argued that the transaction would unlock significant clinical benefits that would be unachievable without a merger. It would, they argued, release capital to fund the construction of a new maternity unit at Poole (to replace a decrepit existing building). And amalgamating staff rotas would facilitate more out-of-hours consultant coverage.

While accepting that such changes would improve care, the CC took the view that the trusts could achieve many of these service improvements without merging. So far as the rest of the benefits were concerned, it was unconvinced that they would be achieved within a "reasonable" time period even if the merger went ahead.

In reaching these conclusions, the CC was applying essentially the same analytical framework that it has used to evaluate the claimed merger benefits in other sectors. The outcome of the Bournemouth-Poole investigation suggests that this framework makes it very difficult for competition authorities to accept the clinical benefits of mergers involving NHS trusts, because they will find it hard to leap the following hurdles:

- **Demonstrating commitment to deliver the benefits.** Most merger cases involve private firms whose guiding objective is to maximise profits. In these cases, the task for the merging parties is to show that they will have a financial incentive to cut prices or improve service quality after the merger. But this pure market approach will not work for not-for-profit NHS trusts. Paradoxically, given their patient-centred objectives, it was harder for Bournemouth and Poole to convince the CC that they would follow through and deliver clinical benefits, even though they had publicly stated that these

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benefits were the primary purpose of the merger. In other sectors, it may be possible to pre-commit to delivering specific benefits as a condition of clearance. However, pre-commitment is difficult in NHS mergers, where any major service reconfiguration needs to clear a number of regulatory hurdles.

- **Getting an expert opinion.** The HSCA introduced a role for Monitor to advise on the benefits of proposed mergers – which makes a lot of sense, given its experience in evaluating the reconfiguration plans of NHS trusts. However, the Act limited Monitor's role to advising the Office of Fair Trading during its preliminary assessment. At this stage of merger investigations, the focus was usually on establishing whether or not competition is likely to be reduced, rather than on any counterbalancing benefits. Under the CMA, there will still be a two-stage process, so it remains to be seen whether this weakness is corrected.

- **Quantifying the benefits.** For mergers in markets where the primary dynamic is price competition, the CC had an established framework for evaluating whether upward pressure on prices resulting from a loss in competition will outweigh any downward pressure on prices resulting from efficiency savings. No such framework yet exists for weighing up costs and benefits of hospital mergers when they both revolve around quality of care. Nor can care quality always be demonstrated by the use of simple quantifiable measures like mortality or morbidity. In the Bournemouth-Poole case the CC acknowledged that a new maternity unit would benefit mothers. But quantifying the effect on care wasn't easy – and in the end, having decided there was no certainty that any merger-specific benefits would take place on a reasonable timescale, the CC made no assessment.

IN THE WAITING ROOM

The CC's decision in the case of Bournemouth and Poole does provide some helpful hints on what an acceptable benefits case might need to contain – worth studying by any trust considering a merger in the future. Monitor has also published proposals on how it plans to help trusts evaluate their overall case, including benefits, early in the process. Alongside this, it has promised "continued dialogue" with the sector on how to weigh the benefits of merger against the costs of any reduction in competition – a discussion the CMA can be expected to contribute to. Until then, providers contemplating a merger that may lessen competition in the health sector face hurdles whose height is not easy to assess.

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