

Agenda

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For better, for worse? NHS mergers after Bournemouth and Poole

In October 2013 the UK Competition Commission (CC) published its final decision on the proposed merger of two hospital Foundation Trusts. This is the first such merger to be referred to the CC since the enactment of the Health and Social Care Act 2012

The CC has determined that the proposed merger between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust would be expected to result in a substantial lessening of competition (SLC) in the provision of a large number of services.¹ None of the merger benefits proposed by the Foundation Trusts (FTs) was considered to represent relevant customer benefits (RCBs), as defined by the Enterprise Act 2002. The CC also concluded that there are no remedies that would be effective in counteracting the SLC, and therefore decided to prohibit the merger.

At the same time as the decision on the Bournemouth and Poole merger, the CC, the UK Office of Fair Trading and the healthcare regulator, Monitor, published guidance on the merger review process.² With substantial policy and regulatory reforms ongoing in the health sector, the topic of mergers and reconfigurations of NHS services, and how they interact with competition authorities, has just got even hotter.

The CC report on this particular merger is critical of the merging parties' approach to presenting the effects of the merger, especially in relation to the benefits to patients and/or commissioners.³ For example, the CC states its hope that:⁴

in future, merging NHS hospitals will ensure that they are able to provide us with timely, accurate and consistent information regarding their activities and proposals, and that they will carefully consider the rationale for the merger and their post-merger reconfiguration plans from the perspective of patients.

The CC rejected the evidence about the RCBs that the parties claimed would arise from the merger:⁵

we did not find that the merger would give rise to any RCBs

For the parties to be unable to demonstrate to the CC any patient benefits as a result of the merger suggests that something has gone wrong in how the parties had presented the merger, or in the way the CC has evaluated it, or simply that there is a misunderstanding between the stakeholders.

If the CC's conclusions hold for other FT mergers that it assesses, this suggests that reconfiguration may answer very few of the NHS's problems going forward. However, if the merging parties are right that the merger is necessary to ensure the continued provision of high-quality NHS services, the current mode of interaction between the parties, Monitor, the Office of Fair Trading and the CC is not in patients' interests. This is because the alternative according to the parties (i.e. the counterfactual) is not attractive for patients as it involves a loss of choice due to failing trusts or reduced quality. Either way, there are important issues at stake. The CC wisely addresses mergers on a case-by-case basis and provides an opportunity for other merging trusts to argue that reconfigurations can be in patients' interests.

The simultaneous production of the joint statement on mergers and the decision on the proposed Bournemouth and Poole FT merger suggests that the relevant authorities are concerned that the problem could be one of understanding and differences in the stakeholders' frames of reference, rather than the premise that reconfigurations will not deliver patient benefits. If communication of the costs and benefits to patients of proposed mergers continues to be unclear, there is a risk that a merger that is actually beneficial to patients might be rejected.

The Competition Commission's findings

The CC's methodology and findings relating to the test for an SLC changed very little from its earlier provisional findings,⁶ with the most substantial difference being an analysis of the merger's benefits and potential remedies.

The CC found that the parties overlapped in the provision of inpatient services in 19 elective specialties and 21 non-elective specialties, and in the provision of outpatient services in 36 specialties. It estimated that the overlapping specialties account for a significant proportion of total clinical revenues for both FTs (in the region of 61–70%).

As in the provisional findings, the CC concluded that some of these overlaps constitute an SLC:

- for **elective** services, the parties have incentives to compete for patients, and this competition is likely to be stronger in the future absent the merger;
- for **non-elective** services, patients have little choice of provider and there are limited incentives for the FTs to compete for patients;
- patients can choose between **maternity services**, and the parties have incentives to increase patient numbers;
- the parties face outside competition for the majority of their overlapping private services, with the exception of inpatient private cardiology services;
- there would be no unilateral effects in community services or where there is competition 'for the market' in elective, non-elective, community and specialised services.

The CC therefore found that the proposed merger could be expected to result in an SLC for:

- 19 elective inpatient services;
- 34 outpatient services;
- maternity services;
- private inpatient cardiology services.

The specialties where an SLC was expected account for 20–30% of the total clinical income of each of the providers. The CC has concluded that these unilateral effects of the merger are unlikely to be mitigated by countervailing buyer power or entry. The parties did not put forward any arguments relating to efficiencies.

The key area of analysis that was absent from the CC's provisional findings was the potential for the merger to give rise to RCBs. The FTs proposed that the merger would result in RCBs in five clinical areas: maternity, cardiology, haematology, accident and emergency, and emergency surgery. The CC has now also considered the potential for:

- other clinical benefits;
- financial savings;
- merger-avoided costs;
- merger-enabled investments;
- a balanced portfolio of services;
- cost savings to commissioners.

The proposed benefits were assessed against the statutory

test for RCBs. To be regarded as an RCB under the Enterprise Act 2002 requires that the proposed benefit:⁷

- is passed through to customers (i.e. patients) in the form of lower prices, higher quality, greater choice, or greater innovation;
- will be accrued within a reasonable period as a result of the merger;
- is merger-specific (i.e. cannot be achieved other than through the merger of the two parties).

The CC considered that, as presented, none of the benefits proposed by the merging parties meets all three of these conditions, and thus that none of them constitutes an RCB.

In its advice to the Office of Fair Trading, Monitor found that a reconfiguration of maternity services would be likely to be a benefit.⁸ However, the FTs subsequently removed this benefit proposal. This in itself is important, as it shows that Monitor believes that there can be material benefits from FT mergers if they are evidenced and presented correctly.

Decision on remedies

The parties proposed a behavioural remedy based on the 'friends and family test' introduced in April 2013, which requires FTs to ask patients whether they would recommend the care they received to their friends and family. The parties argued that the remedy would require them to take action if the score from the test was not sufficiently high.

The CC considered that this would not provide an effective remedy to the SLCs identified, as the damage to the quality of care provided would already have occurred by the time the parties were aware of the test results. It also considered that a minimum quality standard would not incentivise further improvements in quality above that threshold. It therefore decided to prohibit the merger.

Implications for future Foundation Trust mergers

The process of this proposed merger will not have been cheap. To reach a conclusion that there are no benefits, after both FTs have spent considerable sums on preparing the proposal, is, in itself, not particularly efficient. One implication of the CC report is, therefore, that the merging parties and regulator/competition authorities have to find a way of understanding each other in relation to patient benefits.

Currently, the merging parties are arguing that the rationale for the merger is to deliver better services to patients, while the authorities are saying there are no benefits, or at least not as they are currently evidenced. If the merging parties are correct then the communication and presentation of those benefits to the authorities needs to be improved. The authorities' advice that potential merging parties should discuss the issues (and especially patient benefits) early on

in the process will clearly help in future such cases.

Notwithstanding the hundreds of pages of analysis (and thousands of redactions that make it even less comprehensible), there are still many unanswered questions about how the findings of SLC are reached and what an SLC for patients actually constitutes. The maps of catchment areas in the CC report may look pretty, but do they really illuminate the complex dynamic between choice and quality and their effect on consumer welfare? In this analysis, the CC was spared the problem of weighing up the costs and benefits of the 55 SLCs found:⁹

As we did not find that the merger would be likely to give rise to RCBs there was no need to measure such benefits against the adverse effects of the SLCs we identified.

However, one would expect there to be benefits to patients from most FT mergers that get as far as the CC, and deciding how to weigh up increased quality of care to patients in cardiology against a loss in choice and competition in maternity, for example, will be challenging. If the benefits to patients of a merger outweigh the costs, it is in nobody's interest for the merger to be blocked.

The maps in the CC report suggest that patients in the areas surrounding Bournemouth and Poole already have

significantly less opportunity for choice than patients elsewhere in the country because they do not live in an area where two hospitals are similar distances away. These hospitals therefore already face a demand pattern that would apply if the merger had gone ahead. This raises challenging questions for commissioners, such as whether the provision of services in these areas should be split and another hospital built so that patient choice is increased.

The arguments around how to optimise the spatial distribution of health service delivery are not going to vanish just because competition authorities are now involved. Indeed, the arguments are likely to get more, rather than less, vocal, at least in the short term.

There is much at stake here. Providers and regulators/competition authorities need to understand each other and be able to communicate effectively so that real patient benefits can be delivered—either by allowing mergers when they deliver net patient benefits, or prohibiting them when the impact on patients from an SLC outweighs any benefit from that reconfiguration. The conclusions of the CC should not be seen as putting an end to all NHS hospital mergers; rather, the door appears to have been left open for future mergers where patient benefits can be seen to arise.

¹ Competition Commission (2013), 'The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust', 17 October.

² Office of Fair Trading, Monitor and Competition Commission (2013), 'Ensuring that patients' interests are at the heart of assessing public hospital mergers', Joint statement, 17 October.

³ Commissioners are responsible for commissioning most healthcare services on behalf of patients in their locality.

⁴ Competition Commission (2013), 'The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust', 17 October, para. 6.

⁵ Competition Commission (2013), 'The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust', 17 October, para. 9.155.

⁶ Competition Commission (2013), 'The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Merger Inquiry. Provisional findings report', 11 July.

⁷ Office of Fair Trading and Competition Commission (2010), 'Merger Assessment Guidelines', September, para. 5.7.4.

⁸ Monitor (2013), 'Anticipated merger of Poole Hospital NHS Foundation Trust and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust: Monitor's advice to the Office of Fair Trading under section 79(5) of the Health and Social Care Act 2012', 11 February, p. 12.

⁹ Competition Commission (2013), 'The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust', 17 October, para. 9.157.