

# CMA Guidance on the review of NHS mergers

## FRONTIER ECONOMICS' RESPONSE TO THE CMA CONSULTATION

Frontier welcomes the CMA guidance which it believes clarifies the application of CMA's merger review rules to the healthcare sector. We have already had a number of conversations with people who value the guidance and the increased clarity it provides.

In what follows, we offer a few suggestions of how the guidance could be further improved. Our suggestions are based on our past and present involvement in NHS provider mergers. Over the past number of years, we have provided formal and informal advice to a large number of trusts in their proceedings with the CMA, its predecessors, OFT and CC and the CCP, as well as in their pre-merger deliberations.

We hope that the CMA will find our comments helpful. We would be happy to provide further clarification on any of the points we raise in our submission below. For further comments, please contact Matthew Bell ([matthew.bell@frontier-economics.com](mailto:matthew.bell@frontier-economics.com)) or Alena Kozakova ([alena.kozakova@frontier-economics.com](mailto:alena.kozakova@frontier-economics.com)).

### Monitor's and CMA's informal guidance to trusts

In paragraphs 3.10 to 3.12, the CMA guidance explains that the CMA is ultimately responsible for deciding on NHS mergers and, if in doubt whether a merger falls under its jurisdiction or might lead to competition concerns, trusts should approach CMA for informal guidance. In paragraphs 4.1 to 4.11, the CMA explains how this informal guidance should be sought and what a trust can expect from the CMA.

We note that in May 2014, Monitor published its own guidance<sup>1</sup> on informal advice it is prepared to give to trusts considering a merger including on the competition impact of their contemplated merger.

We realise that both sets of advice are intended to be helpful to trusts and that both authorities go beyond the level of assistance that other, non-NHS merging parties would normally receive. However, the dual role does create some confusion and risk of mixed messages (despite, as the CMA notes, the two

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<sup>1</sup> Our new approach to transaction: consultation responses and next steps, Monitor, May 2014.

organisations working closely together). The types of questions we are often asked are:

- “Who should I approach first – Monitor or CMA?”
- “Should I speak to both organisations in parallel, or would it be better to get an initial view from one before approaching the other?”
- “What material/thinking should I bring with me to that first conversation?”

The more the guidance can be explicit about these types of questions the more helpful it will be to the sector and how trusts should work within a process where two regulatory bodies clearly have important roles.

### Monitor’s formal advice to the CMA

Paragraph 3.13 specifies that Monitor is under a duty to provide the CMA with advice on patient benefits arising from the merger and other matters that it considers appropriate. It would be helpful to clarify further the ‘other matters’ that Monitor can be called to advise on.

We believe that Monitor is particularly well placed to comment on two such other areas. Firstly, Monitor is well placed to comment on the merger rationale. This would be helpful in the cases when the parties decide not to submit a formal benefits case but the CMA would like to understand the background for the transaction including the planned improvements for patients. While we understand that Monitor’s opinion on the merger rationale would not carry the same evidentiary weight as a formal advice on relevant patient benefits, it could provide valuable information for the CMA.

Secondly, Monitor is well placed to comment on the relevant counterfactual in particular when the parties are claiming that one of them is weakening. Monitor scrutinises foundation trust finances and clinical performance and can therefore provide a view on whether a trust is likely to be a strong competitor in the near future.

### Disclosure

The CMA rightly comments on the issue of publication and confidentiality (paragraphs 4.27 to 4.29) as trusts are often very sensitive to how their information is handled by regulators. We believe that the CMA does not do justice to the complexity of the issue and the considerations that it makes when determining which information to share and which not. We believe parties would

benefit from a more detailed guidance drawing in particular on paragraphs 4.17 to 4.34 of the referenced CMA draft guidance on disclosure<sup>2</sup>.

### Definition of ‘enterprise’

In paragraph 5.5, the CMA discusses what can be considered an ‘enterprise’ for the purposes of UK merger control. The wording of this paragraph (“what is necessary to operate the relevant services or clinical specialty”) would suggest that a specialty is the smallest part of a trust’s activity that will be considered an ‘enterprise’ and therefore a merger of any two services might trigger a CMA appraisal. If this is the case, it would be helpful to state this clearly.

### Service level agreements

In paragraph 5.11, the CMA explains that the Enterprise Act will apply to “situations of ‘shared’ control by several providers over one another”. It is not clear from the drafting whether the Act would apply to service level agreements (SLAs). It is important to clarify this given the prevalence of these agreements across the NHS.

In our experience, SLAs are akin to non-full-function joint ventures as they do not transfer control over a service to a joint enterprise and often retain an element of competition between the parties. We would recommend excluding SLAs explicitly from the application of the Act.

We understand that the CMA could still be interested in these agreements for the purposes of establishing the relevant counterfactual and Monitor want to consider their potentially anti-competitive impact. We therefore do not suggest excluding them from competition assessment altogether, just from a consideration as a relevant merger situation.

### Potential competition

In paragraph 6.12, the CMA considers the loss of a potential entrant as an example of alternative counterfactuals. We were surprised to see potential competition discussed in the section dedicated to the relevant counterfactual rather than on its own. It would be useful to give this issue more prominence and potentially include more information about how the CMA would consider whether the loss of a potential entrant might negatively impact on competition and what type of evidence the CMA would be looking for to establish whether this is likely to occur.

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<sup>2</sup> Transparency and disclosure: Statement of the CMA’s policy and approach (CMA06), January 2014.

## Exiting provider

In paragraphs 6.21 to 6.26, the CMA discusses “the three limbs” of the exiting provider scenario. It is, however, not clear from the text what these three limbs are. Only ‘two limbs’ seem to be reasonably clearly signposted, (i) the inevitability (Phase I)/likelihood (Phase II) of the relevant entity being dissolved and (ii) the absence of a less anticompetitive alternative acquirer. Given that this area has been in the past contentious with trusts, it would benefit from further clarification.

## Non-elective care

In paragraph 6.36, the CMA states that “the provision of elective activities may be constrained to some extent by non-elective providers”. We believe that this statement requires clarification. In our experience, all ‘non-elective providers’ are also ‘elective providers’, even if not for exactly the same specialties.

Assuming that the CMA meant that non-elective care in a given specialty may constrain elective care in the same specialty (it is worth clarifying the wording if that is the case), we still believe that this statement would benefit from further explanation. In general, the choices that a patient makes when a procedure is carried out electively, is not the same as when the same procedure is carried out non-electively. In the former case, a patient exercises a choice, in the latter, the patient is taken to the nearest trust able to handle their condition.

We assume that what is meant is that a provider of non-elective care in a particular specialty can more easily develop an elective service and compete for elective activity in that same specialty (or sub-specialty). In that respect there exists a potential competitor (see our comments above about potential competitors) that provides some services non-electively but not electively. Furthermore, it is more difficult for that same mechanism to work in reverse: it is harder for a trust that provides a service electively to start competing for contracts to provide that service non-electively.

There are other ways in which elective and non-elective care constrain each other. For example, non-elective care might constrain elective care where there is unusually high demand for non-elective care and that affects capacity available for elective procedures (e.g. waiting times might increase for elective care in that area). Separately, there are potentially issues about how training is provided to junior doctors and their availability on non-elective and elective rosters (e.g. staff used for care in the different areas might be different at different times). However, these constraints are physical rather than competitive in their nature.

Given these different interpretations of the current wording (“elective activities may be constrained to some extent by non-elective providers”), it would be useful to clarify what is meant in the guidance.

## Competition to attract patients

In paragraph 6.51, the CMA states that “[w]hen assessing closeness of competition, the CMA’s starting point will be to consider referral patterns and the overlaps between the catchment areas of the merging providers together with those of any other local providers.” We consider this general approach to be sensible. However, we think this statement is worth clarifying further given CMA’s past interest in particular overlap geographies and the difference the nuances in this assessment will make to merging trusts’ understanding of their competition risk.

We believe that the importance of geography should be seen on the whole, i.e. a trust will be constrained in different geographies more or less strongly by different trusts based on the location of those trusts and the quality of the service they are offering. Given that many elements of quality are set at a trust level, the CMA should, as the first and most important step, investigate the impact of the transaction on the sum of the geographic competitive constraints on each trust.

With respect to a residual concern in a particular locality, the CMA needs to spell out the degree of concern that will trigger a reference to Phase II or prohibition in Phase II. This is because many mergers will be taking place between trusts with some geographic overlap and therefore there will almost always be a locality where choice, if not necessarily competition, will be reduced. It is also likely that in most cases there will be at least some GPs in a some specialties for whom the merging trusts will be the most popular choices. Despite this, we would not expect the CMA to prohibit all of these mergers (even in the absence of a proven case of relevant benefits). Further clarification of this issue will make a considerable difference to trusts’ self-assessment.

## Coordinated effects

In paragraphs 6.57 to 6.61, the CMA explains that it could be concerned about coordinated effects following from NHS mergers. While theoretically possible, it would be useful to clarify whether and if so how these concerns can arise in the context of the NHS. This section paraphrases the general guidance on application of merger control to coordinated effects, a document that the CMA itself references in paragraph 6.60.

In our view, the geographic nature of competition makes coordination difficult. When trusts compete with each other ‘in the market’, they often do not compete over their entire catchment, but compete to a varying degree across the more or less competitive parts of the catchment. Given that trusts set many of their quality features at a trust level (and for the entire population they serve, rather than particular sub-populations), it is the overall balance of constraints that will influence whether or not a trust can afford to reduce competition. Each trust also has a slightly different set of constraints and therefore different ability and incentives to relax competition. It is difficult to understand how trusts could

achieve a common understanding and align their incentives in such a complicated web of constraints. We also cannot see how any of these concerns would be different from first order and second order unilateral effects.

It is more plausible that coordinated effects could occur in the case of tendering where the same trusts are able and willing to bid for the same set of contracts. Again, we find it difficult to see how these markets would be transformed by a hospital merger and why we should expect any SLC over and above the unilateral effects of the reviewed transaction.

Finally, in a market as complex as the provision of healthcare, with regulated prices and quality, it is difficult to see how providers could reach a common agreement and therefore the first of the CMA's tests could be met.

In sum, this section would benefit from articulating the specific NHS concerns when it comes to the application of the general CMA guidance in this area.

### Vertical and conglomerate mergers

In paragraph 6.63, the CMA suggests that “vertical mergers may occasionally damage competition if the merged provider restricts downstream competitors access to a key input or restricts upstream competitors from a key ‘route to market’”. The CMA further suggests that such a “merger may distort the pattern of onward referrals from one merger provider to the other at the expense of other providers of the same set of services who might compete on quality for referrals absent the merger.”

Given that vertical and conglomerate merger concerns are rare in most markets and such relationships also lead to efficiencies, we would have expected to see a greater guidance on how the CMA may approach application of this provision.

It would be helpful to explain how the CMA will appraise this potential harm. In our view, a change in referral patterns is not automatically negative. A loss of volume by a third trust as a result of the merger is unlikely to make it drop its quality as this trust will still be competing for other activity.

It would be helpful to explain in which circumstances the CMA is expecting vertical concerns to arise. In our view, there are two common circumstances where vertical relationships exist: (i) a merger of community care with secondary care and (ii) a merger of secondary care with tertiary care. In both cases, parts of this ‘vertical chain’ are tendered (community care locally and specialist care nationally), which make any merger reversible. We recognise there may be other mergers (or agreements that qualify as mergers) between primary care and other parts of the system which could raise different types of concerns.

Finally, there are often significant benefits of integrated patient pathways which allow better care to be delivered. It would help trusts if the CMA were to explain how it is going to assess these efficiencies and offset them against the potential harm. For instance, integrated pathways are considered an increasingly important

tool to approach the challenges posed by the aging population.<sup>3</sup> An integrated pathway will also allow a seriously ill patient a smoother access to tertiary care.

### The power of GPs

In paragraph 6.77, the CMA suggests that individual GPs are unlikely to exercise countervailing buyer power while in paragraph 6.78 it suggests that the Commissioners might be able to exercise such power, or at least that the CMA would consider this option. It is worth remembering that the Commissioners are local GPs. Dissatisfied GPs can therefore make their voice heard. In a recent case we were involved in, the CMA heard from trusts about changes made to local healthcare provision following the initiative of local GPs who communicated their wishes directly to the trusts and indirectly through the Commissioners. Considering GPs entirely without countervailing power is, in our view, inappropriate.

### A right to submit a benefits case

In paragraphs 7.4 to 7.6, the CMA explains that Monitor has an obligation to advise the CMA on benefits in Phase I of the CMA's investigation. It further explains the value of this advice and urges parties to engage with the CMA regarding their benefits case at the pre-notification phase.

It would be helpful to clarify the drafting of these paragraphs to make it plain that it is the trusts' right, not their obligation, to submit a patient benefits case. From our experience, this is not always clear to trusts. They also often worry that their case would be considered less favourably if they do not prepare a benefits case. An explanation of when a benefits case would be useful and a further clarification that it is not trusts' obligation to submit one, even though Monitor has to report to the CMA, would be welcome.

Finally, it would also be worth clarifying the role of Monitor with respect to benefits at Phase II. We are often asked by trusts whether they could submit a benefits case at Phase II even if they choose not to do so at Phase I and, if they do, how that case would be assessed by the CMA.

### What constitutes a patient benefit

In paragraphs 7.11 the CMA presents the types of benefits that have been previously submitted by trusts to the CMA or the former CCP. In paragraph 7.12, the CMA explains that it will assess those benefits on a case by case basis.

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<sup>3</sup> "Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders", NHS England, February 2014. <http://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf>

The drafting of the text suggests that all the benefits in paragraph 7.11 are admissible if well-argued and substantiated. While this may be theoretically true, the past practice suggests that some benefits will be very difficult to substantiate and trusts would do better focussing their efforts on other areas. Financial savings are one such area where the authorities have shown very little sympathy in the past. It would be helpful to clarify this and set the trusts' expectations at the right level.

### Merger specificity of patient benefits

In paragraph 7.13 the CMA explains that it would only accept as relevant patient benefits those benefits which are unlikely to accrue without the merger. In paragraph 7.15 it further explains that it would consider whether the merging providers would be able and willing to achieve these benefits independently or through other means than a merger.

We understand this test and it is reasonable from a theoretical perspective. Before this guidance was issued, the trusts were aware of the merger specificity requirement. The core of the problem, and the one that we hoped to see developed further in the guidance, is how this test is going to be applied.

The CMA should be aware that in the NHS, some service reconfigurations that trusts will claim as relevant patient benefits can, in theory, be achieved by other means than a full merger. However, this does not mean that they would actually be likely to occur absent the merger. The CMA guidance is helpful in that it already uses the term "unlikely to accrue" which suggests that a more reasoned analysis of the likelihood of the claimed benefits will be carried out. However, it would be helpful if the CMA could provide more detailed guidance beyond stating its assessment test. For instance, it could provide an example of the type of considerations it would make when appraising a particular benefit.

Paragraph 7.11 suggests that the CMA would investigate a "candidate list" of benefits, ticking and crossing off each of them in turn. While this approach is no doubt correct when the CMA is trying to understand the nature of the benefits, it misses an important point of benefit interdependence and transaction costs. For instance, even if all claimed benefits were possible individually absent the merger, the transaction cost in terms of management time and trust coordination could be such that only one or two would actually be likely to occur absent the merger. Some non-merger specific benefits can also enable other merger specific benefits but would not, on their own, be on the trusts' priority list absent the merger.

It would be helpful if the CMA could articulate in more detail how it will consider the subtlety of these issues (or, at a minimum, state that it understands that these issues may arise) and provide more concrete guidance on how it will weigh the arguments for merger specificity in its guidance.



## Weighing patient benefits against the SLC

In paragraphs 7.22 to 7.25, the CMA is attempting to describe the factors it will take into account when weighing the costs of the SLC against the claimed patient benefits. This section is most welcome as there had been a vacuum on how this analysis would be done.

We agree with the general approach of understanding the breadth and depth of benefits against the breadth and depth of the identified SLC. In our view, the CMA is stronger in explaining the former than the latter. The preceding section discussing patient benefits, notwithstanding our comments discussed above, gives some indication of the type of patient improvements that the CMA would expect to see.

The section discussing the SLC and how it could manifest itself is less detailed and draws a lot on established economic theory. This creates an uneven burden of proof for the CMA and the trusts. On the one hand, the CMA can rely on economic theory suggesting that, for instance, the removal of the closest competitor is “bad” for competition without having to explain how “bad” this is going to be. On the other hand, the CMA expects a very precise definition of benefits in terms of patient outcomes from the merging parties.

For instance, reduced opening hours at an outpatient clinic in a key overlap catchment area is unlikely to be commensurate with increased consultant cover at an A&E, the former causing inconvenience, the latter saving lives. It is unclear from the current precedent that any of the SLC concerns that the CMA raised with trusts would have qualified as more than an inconvenience, while some of the claimed benefits and merger rationales had a very tangible impact on patient outcomes.

This comment should not be read as our dismissal of the potential negative impact of the SLC on patient outcomes. Rather, that the impact of the SLC in terms of patient outcomes needs to be measured to understand its size relative to the benefits. The Guidance would be much improved if it included more detail on how the CMA proposes to do this (e.g. in other, non-NHS mergers, where it, for instance, applies econometric techniques to estimate the impact of the merger).