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## PUBLIC HOSPITAL MERGERS: A CASE FOR BROADER CONSIDERATIONS THAN COMPETITION LAW?

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*Market definition; Merger control; NHS foundation trusts; NHS trusts*

This article addresses the question of whether public hospital mergers should only be decided upon by a competition authority on competition principles, or whether it would be better that the ultimate decision is taken by the Government on the basis of broader considerations. In addressing this question the focus, by way of example, is the situation in the United Kingdom.

This article is prompted by the change that occurred from April 2013 in UK law as it applies to public hospital mergers, that the second merger to be investigated under the new regime has been subjected to a second phase investigation,<sup>1</sup> and much criticism has resulted. An indication of this criticism is that at the July 2, 2013 meeting of the UK Parliament's Health Committee, in response to a question the Secretary of State for Health stated that:

*"It is a concern to me ... I want to make sure that they [the OFT] properly consider the benefits and also that it doesn't take too long".*

In responding to a question about consideration of amended legislation, he said: "If we thought there was a serious problem in terms of the structures...then we would consider it, yes."

Part I of this article describes the UK law and procedures, both currently and before they underwent a material change in April 2013, as well as applicable EU law. Part II deals with the

unique aspects of public hospital mergers. Part III deals with market definition. Part IV addresses the reasons for merger and the measurements that are identified as relevant in assessing a merger. Finally, Part V describes why it might be better that the ultimate decision on a public hospital merger is taken by the government, rather than only by a competition authority. A suggestion for the United Kingdom is made.

### I: UK law and procedures

*Prior to April 1, 2013*

As a vocabulary introduction, the National Health Service (NHS) refers to the publicly funded healthcare systems within the United Kingdom. The systems are primarily funded through general taxation rather than requiring private insurance payments. The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for residents of the United Kingdom. An NHS Trust is a body corporate and refers to a wide range of NHS health trusts managing NHS hospital care in England, including community care and mental health services. They may also act as commissioners when sub-contracting patient care services to other providers of health care. An NHS Foundation Trust is a type of NHS Trust which is an organisation that is a not-for-profit, public benefit corporation. They were created to devolve decision making from central government to local organisations and communities. To provide some context, NHS



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## PUBLIC HOSPITAL MERGERS: A CASE FOR BROADER CONSIDERATIONS THAN COMPETITION LAW?

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Foundation Trusts (NHS FTs) provide over half of all NHS hospital, mental health and ambulance services. The distinction between NHS FTs and NHS Trusts is, from a competition law point of view, important even if temporarily so because the Health and Social Care Act 2012 (HSC Act 2012) states that all NHS Trusts will be required to become NHS FTs (or become part of a foundation trust) as soon as clinically feasible, with a clear target of April 2014. Monitor, which is a body corporate, is the sector regulator for health, with a primary duty to protect and promote the interests of people who use health services.

Prior to April 1, 2013 public (that is, state-owned) hospitals that were the subject of a contemplated merger were subject to specific regulation outside of the normal competition regime. Under this regulatory regime the Cooperation and Competition Panel (CCP), an advisory panel established by the Department of Health on January 29, 2009, provided advice on the mergers of NHS organisations that it reviewed to the relevant decision makers who would make the final decision in relation to these transactions. These decision makers were the Secretary of State for Health (or any person or organisation acting under delegated authority from the Secretary of State) and, in relation to NHS FTs, Monitor. The CCP undertook its review with reference to the Principles and Rules for Cooperation and Competition (Principles and Rules) produced by the Department of Health, that were first published in 2007 and most recently revised in 2010.

The CCP would review all mergers that fell within its remit, but technically it was a voluntary regime in that the merging parties were at liberty to complete the merger prior to such review and the decision of the relevant decision maker.<sup>3</sup>

Mergers that fell within the CCP's remit were mergers, acquisitions, joint ventures and other transactions between NHS service providers that resulted in two previously independent

organisations (or parts of organisations or of an organisation's activities) coming under common management or control. In addition, the revenue of the combined entity in the financial year prior to the merger had to exceed applicable thresholds, namely:

- £70 million in the case of acute and mental health trusts;
- £35 million in the case of community service providers;
- £15 million in the case of primary care providers; or
- £15 million in the case of providers from the different sectors identified above.

Under the CCP process, mergers that raised no (or no material) issues would receive CCP's advice within 10 working days (fast-track) or 40 working days (Phase 1) respectively. Where issues did arise the CCP would take up to a further 80 working days (Phase II) to deliver its report, that is 120 working days in total. When reviewing a merger under the Principles and Rules, the CCP carried out a cost-benefit analysis. On the cost side, the CCP considered possible adverse effects on patients and taxpayers (including both financial and non-financial impacts) arising from any loss of patient choice or competition stemming from the merger. On the benefit side, the CCP considered how the merger will benefit patients and taxpayers through, for example, improved clinical outcomes, better services and greater efficiency.

A review of a merger by the CCP under the Principles and Rules did not preclude the possibility of the OFT reviewing the same transaction under the Enterprise Act 2002. As a result, the CCP had agreed Working Arrangements with the United Kingdom's Office of Fair Trading (OFT) to ensure appropriate co-ordination between the CCP and the OFT in relation to those mergers (and other matters) that may be brought to the attention of both organisations. The practical effect of the Working Arrangements was that

## PUBLIC HOSPITAL MERGERS: A CASE FOR BROADER CONSIDERATIONS THAN COMPETITION LAW?

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mergers involving NHS Trusts were examined by the CCP and mergers between independent sector providers (private hospitals) and between independent sector provider of services to the NHS were examined by the OFT.

### From April 1, 2013

Under the normal competition regime for mergers in the United Kingdom pursuant to the Enterprise Act 2002 (EA 2002) certain mergers between enterprises are reviewed by the OFT and, if it holds a reasonable belief that there is likely to be a material adverse effect on competition, then it is investigated and decided upon by the Competition Commission (CC). Mergers investigated are transactions that result in two or more enterprises coming under common ownership or control, or where one enterprise becomes subject to the material influence of another, and where at least one of two thresholds is met; either the merging parties increase their share of supply (or purchase) of a good or service to at least 25 per cent of the total supply (or purchase) of the good/service in at least a substantial part of the United Kingdom, or the UK revenues of the target in the previous financial year was at least £70 million.<sup>4</sup>

On March 22, 2013, the OFT announced that it was of the view that the EA 2002 applies to mergers between NHS FTs and between NHS FTs and NHS Trusts. The share of supply or financial threshold tests would apply. In any event, the OFT's role in the mergers of NHS hospitals was set-out in the HSC Act 2012 s.79. The OFT is to investigate mergers between two or more NHS FTs (s.79(2)) and between one or more NHS FTs and one or more businesses.

Consequently, from April 1, 2013, in relation to a merger over which the OFT has jurisdiction namely, mergers between NHS FTs and between NHS FTs and NHS Trusts and which it investigates, the OFT is obliged to inform Monitor, which must respond by providing its advice on whether customer benefits arise and

any other matters appropriate—HSC Act 2012 s.79(4) and (5). As at the time of writing this article, Monitor had just completed its public consultation on guidance that it would publish in relation to mergers. The CCP has changed its name to the Cooperation and Competition Directorate (CCD) and is a part of Monitor, but functionally is unchanged. The CCD undertakes the review described above and delivers its report to the OFT. If the OFT decides to refer a merger to the CC, the CC will independently investigate the matter. Whilst the CC will have the benefit of the OFT's decision and the CCD's report, neither the CCD nor Monitor has a role in the CC's investigation, and the CC will take a decision on the basis of the statutory test. Namely, the CC will decide whether or not the merger resulted or may be expected to result in a substantial lessening of competition within any market or markets in the United Kingdom for goods or services. If the CC decides there is such an anticompetitive outcome of a merger, then it must remedy, mitigate or prevent such outcome from occurring. Typically this means the merger will be blocked (if it has not already completed) or the purchaser will be required to divest the target (if it has completed).

Mergers between two or more NHS trusts only will be subject to review by Monitor. Monitor will provide advice to the NHS Trust Development Authority (NHS TDA)<sup>5</sup> on the effect of the merger on choice and competition. This assessment will be undertaken for mergers involving all types of NHS trusts, including acute, mental health, ambulance and community services trusts. The NHS TDA will take account of Monitor's view. However, the NHS TDA may decide that there are material factors which override the adverse impact on choice and competition identified by Monitor, and so allows the merger to proceed because it is in the wider public interest. Where this is the case, the NHS TDA will publish its decision explaining what these reasons are and why the merger is in the interests of patients. It should be recalled that

## PUBLIC HOSPITAL MERGERS: A CASE FOR BROADER CONSIDERATIONS THAN COMPETITION LAW?

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under the HSC Act 2012 it is foreseen that all NHS Trusts will become or become part of a NHS FT. In this context the particular procedure and decision making process applied to mergers between NHS Trusts is appropriate because where a NHS Trust cannot achieve sustainability as a NHS FT in its current form, a range of transactions can be considered to achieve sustainability.

### UK and EU law

Prefiguring Part II of this article which addresses the unique aspects of public hospital mergers, a question that must be raised is the legal reasoning for applying competition law to public hospital mergers.

As noted earlier, the OFT under the EA 2002 has jurisdiction over mergers between “enterprises”—s.23(1)(a) EA 2002. Under the EA 2002 an enterprise means the activities, or part of the activities, of a business. A business

*“includes a professional practice and includes any other undertaking which is carried on for gain or reward or which is an undertaking in the course of which goods or services are supplied otherwise than free of charge”.*

Earlier in this article it was identified that both the OFT and the Government agree that an NHS FT is an enterprise. It also follows that the OFT considers an NHS Trust to be an enterprise, given that it will investigate the merger of an NHS FT and a NHS Trust. It is curious, however, that the OFT does not consider it has jurisdiction over a merger between two or more NHS Trusts.

This curiosity is underlined by the United Kingdom’s Competition Appeal Tribunal (CAT) 2002 ruling in the Bettercare case ([2002] CAT 7), that the activities of North & West Trust (a NHS Trust in Northern Ireland) in running its statutory residential homes and engaging in the contracting out of social care to independent providers are, for the purposes of the Competition Act 1998 (CA 1998), to be

regarded as economic activities for the purpose of deciding whether North & West Trust is an “undertaking” within the meaning of s.18(1) of the Act.<sup>6</sup> Correctly, much of the CAT’s consideration was over the need to ensure that its ruling on whether or not North & West Trust was an undertaking was, pursuant to s.60 of the CA 1998, consistent with EU law. The Bettercare ruling suggests that the OFT would need to examine every merger with or between NHS Trusts on its own facts, seeking to determine whether it was a merger between undertakings.

There would seem to be some legal reasoning to the OFT not seeking jurisdiction over a merger between two NHS Trusts. First, art.106(2) of the Treaty on the Functioning of the European Union (TFEU), which states that:

*“Undertakings entrusted with the operation of services of general economic interest or having the character of a revenue-producing monopoly shall be subject to the rules contained in the Treaties, in particular to the rules on competition, in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them. The development of trade must not be affected to such an extent as would be contrary to the interests of the Union”.*

Perhaps the view held by the OFT is that applying competition law to the merger of two or more NHS Trusts would obstruct the performance of the tasks of the NHS Trusts. Secondly, there would be a potential conflict in government objectives. A merger of two or more NHS Trusts may be necessary to achieve sustainability and put the combined entity into a fit state to become an NHS FT. There is a process for reviewing this, as identified above, but to have the OFT in addition investigating such a merger solely on the basis of competition issues might lead to a referral and ultimately a decision to block the merger, an

## PUBLIC HOSPITAL MERGERS: A CASE FOR BROADER CONSIDERATIONS THAN COMPETITION LAW?

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outcome that would frustrate the current objective of the reorganisation of the NHS.

### II: Unique aspects of public hospital mergers

Hospital mergers have particularities that make analysis complex. First, there tends to be few market players and typically the market(s) of relevance are oligopolistic and for certain services, and in certain areas may be monopolistic. Further, entry and exit are costly and, as a highly regulated market, it may in particular areas be impracticable or simply not allowed by the regulator/government.

Most problematically, hospital services are credence goods. A credence good is a good whose utility impact is difficult or impossible for the consumer to ascertain. In contrast to experience goods, the utility gain or loss of credence goods is difficult to measure both before and after consumption. However, the seller of the good knows the utility impact of the good, creating a situation of asymmetric information. Examples of credence goods include vitamin supplements, education and car repairs. One example of how this may create market effects is that the least expensive products might be avoided in order to avoid suspected fraud and poor quality. So a restaurant customer may avoid the cheapest wine on the menu, and instead purchase something slightly more expensive. However, even after drinking it the buyer is unable to evaluate its relative value compared to all the wines they have not tried (unless they are a wine expert). This course of action—buying the second cheapest option—is observable by the restaurateur, who can manipulate the pricing on the menu to maximise their margin, i.e. ensuring that the second cheapest wine is actually the least good value.

Dealing with this information asymmetry has led some, and this is the case in the United Kingdom, to focus on customer choice. This means both ensuring there is in fact a choice

and improving the information and information delivery mechanisms to enable customers to make informed choices. Such choices tend only to be relevant for elective care (that is a health service that is chosen by the patient or doctor, in contrast to accident and emergency services).

Another important particularity of hospital services is integrated care, namely, the need for multi-disciplinary teams both across specific health services and between health and social care. Integrated care is a requirement of patients and thus a concern of the regulator/government. Integrated care thus needs to be a part of the market offering and so may require hospitals to co-operate in the provision of patient care. For example, in England many hospitals have formed networks for the treatment of cancer which allow them to share best practice, to transfer patient records effectively between organisations and to ensure that patients requiring specialist treatment receive care in the specialist hospitals best placed to provide that care. A hospital merger would need to be considered in the context that co-operation is not adversely affected, nor become themselves anti-competitive structures.

Finally, the sector is in economic terms significant. For example, in total it is estimated that expenditure in England on publicly provided elective hospital services was around £12 billion in 2012. The sector also raises emotions in the customer (patient, and often their relatives) and stakeholders (for example, doctors). Consequently the sector is politically significant and careful consideration of the outcomes of applying competition law to this sector is required.

### III. Market definition

#### *Product market*

Product market definition has two main complexities for public hospital mergers. First, there is a multitude of different hospital

## PUBLIC HOSPITAL MERGERS: A CASE FOR BROADER CONSIDERATIONS THAN COMPETITION LAW?

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services. The International Statistical Classification of Diseases and Related Health Problems (ICD), is the United Nations-sponsored World Health Organization's standard diagnostic tool for epidemiology, health management and clinical purposes. It might be considered the health equivalent of the NACE codes,<sup>7</sup> although there are other nomenclatures. There are currently 14,400 different ICD codes, and some countries have felt the need to supplement the ICD through introducing codes dealing with medical procedures, and/or use their own codes. In the United Kingdom, there is a tendency to use the Office of Population Censuses and Surveys Classification of Interventions and Procedures (OPCS-4), which is a procedural classification for the coding of operations, procedures and interventions performed during in-patient stays, day case surgery and some out-patient attendances in the NHS.

Secondly, there are different participants in the market, with different demand and supply factors, leading to blurring of the market definition. For example, the patient has an illness. The doctor in a hospital and thus the hospital will have a speciality. The hospital will typically offer a multitude of different yet inter-related services. The payer (government or, in the case of the United Kingdom, increasingly in the first instance a set of purchasers that are autonomous from government) faces a multiplicity of different costs: diagnostic tests, drugs, medical devices, ancillaries, room and board etc. none of which are of concern to the patient. A patient may well need different services and given the issue of integrated care identified above, these component services may be offered by different (competing) hospitals.

Seeking to facilitate analysis, hospital services can be clustered based on similar medical resource requirements (primary, secondary and tertiary care services), similar duration (inpatient and outpatient services), or on similar complexity and volume. In relation to

the latter, market commentators have offered different suggestions. For example, Zwanziger Service Categories, based on a paper by Zwanziger, Melnick and Eyre (1994), creates "diagnostic related groups" (DRGs) and identifies 48 service categories, where the emphasis of the definition is on the doctor as the key input into hospital treatments. Such analysis can lead to opposite problems. Thus, statistics at the cluster level that do not appear problematic may mask issues in underlying categories, whilst issues in underlying categories can complicate a case that looks non-problematic at the cluster level.

As mentioned above (see fn.1), the United Kingdom's CC at the time of writing this article is for the first time investigating a public hospital merger. The summary of its conclusion on product market definition in its provisional findings indicate the complexities involved:

- (a) Each specialty constitutes a separate market. There may be a degree of differentiation within specialties and any constraint at sub-specialty level will be taken into account, when relevant, in our competitive effects assessment.
- (b) Within each specialty: (i) We treat outpatient and inpatient as separate markets and we note that there is an asymmetric constraint between inpatient and outpatient, with inpatient providers capable of readily supply-side substituting into outpatient services but not vice versa. We considered day-cases as part of the relevant inpatient market. (ii) Outpatient services should not be further separated according to whether or not the services can be provided in community settings, but certain services are provided only in the community and should be viewed as separate markets. (iii) Non-elective and elective activities are separate markets, although the provision of elective activities may be constrained to some extent by non-elective providers".<sup>8</sup>

## PUBLIC HOSPITAL MERGERS: A CASE FOR BROADER CONSIDERATIONS THAN COMPETITION LAW?

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### Geographic market

If anything this is a more complex subject than product market definition. Local market analysis techniques are critical and the case experience of local market mergers in other markets offers some insight. Thus isochrones analysis (determining the geographic market by reference to the locality bounded by a travel time, for example, 20 minutes journey time by car) is a technique that can be relevant.<sup>9</sup> Diversion ratio analysis (surveying where customers would go if a particular site was temporarily closed), may also provide insight, as could the more complicated related technique of critical loss analysis (measuring when the lost “business” reaches a level such that it does not make sense for the hypothetical monopolist to raise prices). Overlaying these techniques it is necessary to consider the particularities of hospital services. For example, in many countries in Europe emergency services are obliged to take accident and emergency patients to the hospital nearest to where the emergency service has picked-up the patient. For elective care, the degree of choice and information asymmetry is important. Many patients will be directed to a hospital by the General Practitioner, or will naturally go to the hospital of choice of the specialist doctor they are seeing (who may have to choose that hospital because the specialist doctor has a working relationship with it).

Analysis of geographic market definition is particularly important given the experience of hospital mergers in the United States. Between 1993 and 2000 there were more than 1,000 hospital mergers. The antitrust agencies (Department of Justice and Federal Trade Commission) challenged only seven of these mergers yet lost in each case. As a result of that setback, until very recently the two agencies did not challenge any hospital mergers. A full retrospective review by the agencies as to the actual effect on the market of past mergers led the agencies to conclude, in relation to geographic market analysis, that the methods

used by the courts to define geographic markets in past hospital merger challenges lead to markets that are overly broad, mistakenly implying that some anticompetitive hospital mergers are innocuous. In the hospital merger challenges of the 1980s and 1990s, courts relied on the Elzinga-Hogarty (EH) test to establish the boundaries of hospital geographic markets. The EH test posits that a relevant antitrust geographic market can be defined as an area for which the product flows into and out of the area are sufficiently small. In the context of hospital mergers, the first step of implementing the EH test is to designate a circle or group of zip codes that contain both of the merging hospitals. If most of the patients treated at the hospitals in this area also reside in this area (i.e. the inflows are small) and most of the patients residing in this area seek treatment at hospitals in the area (i.e. the outflows are low), then the area is an EH market. The thresholds used by the courts to define flows that are sufficiently small range from 10–25 per cent. If either the inflows or outflows exceed the threshold, the market is expanded (usually by adding adjacent zip codes) and the inflows and outflows are recalculated until an area is obtained with inflows and outflows both below the threshold. Some economists have long argued that the use of the EH test in hospital merger cases is inappropriate and leads to geographic markets that are too broad, especially in and around urban areas where the inflows are typically large, as rural and suburban patients seek care at the larger hospitals in the city. Courts using the EH test in hospital merger cases have, in some cases, defined geographic markets that are over 100 miles in diameter.<sup>10</sup>

It is perhaps not surprising that the OFT commissioned a report into market definition.<sup>11</sup> Whilst the report addresses private healthcare services (PH), its consideration is also relevant to geographic market definition in relation to public hospital mergers. As the reviewers noted: “Techniques for geographic market definition in PH have been examined in

## PUBLIC HOSPITAL MERGERS: A CASE FOR BROADER CONSIDERATIONS THAN COMPETITION LAW?

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great detail in the academic literature, as well as in government reports, competition investigations and court cases. The majority of the literature differentiates between the traditional, simpler techniques developed in the 1980s and 1990s, and the more complex and recent approaches. Overall, these techniques represent a broad spectrum of approaches that are characterised by different degrees of theoretical soundness, hospital mergers in the United Kingdom between 1997 and 2004. It focused on short term general (referred to as “acute” in the United Kingdom) hospitals. During the period studied, about half of the short term general hospitals in the United Kingdom merged. The study examined the impact of mergers on a large set of outcomes including financial performance, productivity, waiting times and clinical quality. The conclusion in the paper is that “such mergers often produce little benefit” and that “the findings suggest that further merger activity may not be the appropriate way of dealing with poorly performing hospitals”.

From the standpoint of management consultants, a<sup>13</sup> complexity, data requirements and the extent to which they have been tested empirically or have established precedent.”

For the United Kingdom, the reviewers’ opinion was that the simpler techniques (isochrones or fixed-radii) were likely to be more relevant, principally because of the paucity of data available. However, a multi-layered approach to geographic market definition is suggested, depending upon the health services in consideration and the type of hospital. For example, A&E services are likely to have smaller catchment areas compared to elective cosmetic surgery, whilst a large teaching (or university) hospital is likely to have a larger catchment area than a limited service community hospital.

### IV: Reasons for public hospital mergers

One of the UK Government’s policies is that it wants the NHS to become more efficient to free up funds for treating patients and keeping up with new treatments. On July 2, 2013, at the meeting of the UK Parliament’s Health Committee, the Secretary of State for Health said that “mergers between NHS providers were important to improving efficiency...”. This is consistent with and an expression of the UK Government’s emphasis on competition, which has been an important part of the UK Government’s NHS policy since 2000, and has antecedents in changes made since 1997.

The rationale for hospital mergers are to: improve or sustain clinical quality, reduce operating expenses, increase revenue, reconfigure service delivery, acquire new skills or technologies more rapidly, improve access to capital, be able to afford to provide new services that were otherwise prohibitive for either hospital to acquire on its own.

Given the above, it is perhaps surprising that the vast majority of commentators’ views, generally and not just in the United Kingdom, is that hospital mergers produce little benefit. A paper published in 2012<sup>12</sup> examined

*“Many hospital mergers fail. But when a merger is supported by both a compelling strategic rationale and strong pre- and post-deal management, the impact achieved is impressive”.*

In a follow-on article published in the United Kingdom’s Health Service Journal the authors confirm the general view when stating that

*“unfortunately, examination of the evidence from previous hospital mergers suggests very few have delivered significant improvements in clinical quality or financial performance”.*



## PUBLIC HOSPITAL MERGERS: A CASE FOR BROADER CONSIDERATIONS THAN COMPETITION LAW?

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The authors add that

*“our research — an examination of more than 700 mergers around the world, combined with surveys, interviews and literature review — suggested the primary reason was the absence of substantial changes in service delivery”.*

In aggregate, studies consider a large set of metrics in considering hospital performance, for example, mortality rate, teaching status, staff per bed, complication rates, high tech services, overall reputation, newspaper ranking, number of hospitals within X drive time, standard deviation of distance to nearest four hospitals, elective predictive patient flows, total admissions, length of stay, total income, income deprivation index for catchment population, prevalence of private hospitals, deaths after surgery, hip-replacement readmissions. These clearly make the potential for a complicated and difficult analysis. It is perhaps for this reason that despite the general view held by commentators that hospital mergers do not bring benefits, some commentators are more nuanced. For example, in a paper published in November 2012 by the Centre for Health Economics at the University of York<sup>14</sup> the theoretical and empirical literature on competition and quality is reviewed. The authors' conclusion following a review of the theoretical literature is that there are gaps in the theory and further modelling work should be undertaken.

### V: Perhaps a broader government view on mergers would be better?

In Part I it is identified that prior to April 1, 2013 consideration of and the decision concerning public hospital mergers were taken by the UK Government, or an organ of government that was directly accountable to the Department of Health. From this date the United Kingdom has placed mergers of most public hospitals into the competition mainstream. This might result

in competition law applying to activities that under EU law are able to be exempted from competition law oversight because the public hospitals, at least in part, are entrusted with the operation of services of general economic interest, per art.106 of the TFEU.

In Part II it is identified that the particular characteristics of public hospitals means that careful consideration should be given to the outcomes of applying only competition law to public hospital mergers. Most notably, that hospital services are credence goods, have significant political and economic weight, and the different interests of the many participants suggests that competition law and the authorities that implement them are not able to address all the public policy and societal goals that should be addressed.

In Part III it is identified that product market and geographic market definitions are fraught with difficulties. Generally expressed, this is not a new challenge for competition authorities, nor one that they cannot meet. However, at least in the context of the UK regime, it might be unrealistic to consider that the OFT would have the time or resources to address the complexities, and this concern might even apply to the CC.<sup>15</sup> Probably, with experience, the analysis of hospital mergers by the OFT or CC would become more efficient. The test that the CC must consider—the SLC test—and so whether or not there is an anti-competitive outcome, allows the CC to consider any actions it proposes to take on customer benefits—s.35(5) EA 2002. Despite this reference to customers (patients), it may be doubted that the CC could through this provision alone have regard to broader societal effects of a merger.

In Part IV it is identified that public hospital mergers are being encouraged through public policy and the introduction of competition into the NHS. This is despite the general record indicating that mergers do not bring benefits. Moreover, there are a host of potential benefits that merging parties seek although apparently

## PUBLIC HOSPITAL MERGERS: A CASE FOR BROADER CONSIDERATIONS THAN COMPETITION LAW?

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not usually profit maximisation. These non-pecuniary benefits could still be assessed in terms of the economic unit of utility. However, such analysis is arguably at best on the edge of the experience and perhaps capability of most competition authorities. The private utility benefits of the merging parties needs to be measured together with the effect on the utility of other stakeholders (for example, individual doctors or the government which is the ultimate funder in the United Kingdom). That does not seem a task for which competition authorities are suited.

This raises the thought that perhaps a broader government view on public hospital mergers would be better than the regime of the decision on a merger being taken by a competition authority on the basis of competition law and principles. In the case of the United Kingdom, the suggestion of changing the regime might seem hasty, given that the new regime entered into effect on April 1, 2013 and that at the date of this article only two public hospital mergers have been investigated (with one provisional finding of an anti-competitive outcome). Against this argument might be laid the significant difficulty the competition agencies in the United States have had, and by implication therefore also the courts, in analysing hospital mergers.

In relation to the United Kingdom, one possibility of allowing government to take the ultimate decision on the basis of broader considerations, without having radically to alter the new regime and maintain competition principles as a key pillar for assessment, is to allow the Secretary of State to issue a “public interest notice” under the EA 2002, effectively allowing the Secretary of State (SoS) to be the ultimate decision maker.

The SoS may, prior to the OFT deciding to refer or not to refer a merger to the CC, issue a public interest notice.<sup>16</sup> The SoS issues a public interest notice if he believes that a “public interest consideration” may be relevant to the merger.<sup>17</sup> A public interest consideration is a

consideration listed in s.58 of the EA 2002. The list of public interest considerations may be amended, removed or extend by order of the Secretary of State.<sup>18</sup>

Whilst no health subjects are currently listed, they could be relatively easily inserted, as an order of the SoS through a relatively simple and fast procedure. Indeed, the SoS can simultaneously issue a public interest notice and commence the procedure to have a new subject determined to be a public interest consideration.

The SoS receives the report of the OFT (which identifies whether or not there is a substantial lessening of competition, and may address the public interest considerations identified in the notice). The SoS then may make a reference to the CC if he believes a public interest consideration is relevant, and can do so in cases where the OFT has determined there is a SLC or where it has determined there is not a SLC.<sup>19</sup> The CC will report both on the question of whether there is a SLC and on whether or not the identified public interest considerations are relevant, and conclude whether or not the merger is adverse to the public interest. A merger will always be adverse to the public interest if there is an anti-competitive outcome unless justified by a public interest consideration.<sup>20</sup>

Upon receipt of the CC’s report, the SoS must decide, within 30 days, either to make an adverse public interest finding or no such finding. A decision that there is no such finding will be because the SoS concludes that no public interest consideration is relevant to the merger. Where there is no such finding, the CC will pursue the case in the normal course. In deciding an adverse public interest finding, the SoS is bound in relation to the competition authorities’ findings in relation to an SLC. Thus, if the OFT<sup>21</sup> reports that there is no SLC, the SoS’s decision that there is an adverse public interest finding is based solely on the conclusion that a public interest consideration is relevant to the merger.

# PUBLIC HOSPITAL MERGERS: A CASE FOR BROADER CONSIDERATIONS THAN COMPETITION LAW?

There are various potential outcomes from the above, but in short it allows the SoS to block a public hospital merger that otherwise would have been permitted on competition grounds, or to allow a public hospital merger that otherwise would have been blocked on competition grounds.

## Concluding remark

In order properly to assess the balance of all interests, the merger of public hospitals arguably should address issues beyond those that are normally and potentially able to be addressed by competition authorities. On that premise, whilst keeping competition law and principles as a key element in the analysis, there seems to be justification for government to take the ultimate decision, based on broader considerations than competition law.

## Footnotes

- 1 As at the date of this article, the anticipated merger between the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust was subject to investigation by the UK's Competition Commission, the deadline for that investigation, having been twice extended, was October 21, 2013.
- 2 OFT means Office of Fair Trading, the first level competition authority in the UK in relation to mergers.
- 3 No merger that was subject to the CCP review was completed prior to obtaining the relevant decision.
- 4 Under the Enterprise and Regulatory Reform Act 2013 changes will be made that affect process but do not otherwise impact on the subject of this article.
- 5 The NHS TDA is a Special Health Authority of the Department of Health in the UK. Its formation came as a result of reorganisation of the NHS in England outlined in the HSC Act 2012.
- 6 The CA 1998 mainly deals with the UK equivalent of arts 101 and 102 TFEU.
- 7 NACE means Nomenclature des Activités Économiques dans la Communauté Européenne.
- 8 Provisional Findings, para.5.48, p.137: The provisional findings are available at: [http://www.competition-commission.org.uk/assets/competitioncommission/docs/2013/royal-bournemouth-and-christchurch-poole/130711\\_rבח\\_merger\\_pfsreport\\_excised.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2013/royal-bournemouth-and-christchurch-poole/130711_rבח_merger_pfsreport_excised.pdf) [Accessed October 2, 2013].
- 9 Please refer to article of this author "Isochrones: Analysis of Local Geographic Markets", available at: [http://www.mayerbrown.com/files/Publication/7633e871-05b8-428f-bbcd-cf6d9163bab8/Presentation/PublicationAttachment/c7b45b1f-d4f4-413c-b5aa-b0579c87049f/Isochrones-Desai\\_Iss2\\_1108.pdf](http://www.mayerbrown.com/files/Publication/7633e871-05b8-428f-bbcd-cf6d9163bab8/Presentation/PublicationAttachment/c7b45b1f-d4f4-413c-b5aa-b0579c87049f/Isochrones-Desai_Iss2_1108.pdf) [Accessed October 2, 2013].
- 10 OECD, Policy Roundtables, Competition in Hospital Services, 2012, DAF/COMP(2012)9.
- 11 Techniques for defining markets for private healthcare in the UK, Literature review, Prepared for Office of Fair Trading, November 2011. Although the report was supposed to address product and geographic definition, the literature review in the report did not discuss product market definition in PH in detail because the reviewers opinion is that "the product market definition will often draw on clinical expertise and judgement, and may also depend on the particular attributes of the competition case being considered." As a result the report focuses on the techniques for geographic market definition.
- 12 Martine Gaynor, Mauro Laudicella and Carol Propper, "Can governments do it better? Merger mania and hospital outcomes in the English NHS" (2012) 31 Journal of Health Economics 528.
- 13 Penelope Dash, David Meredith and Paul White, Marry in haste, repent at leisure: when do hospital mergers make strategic sense?, 2012, McKinsey & Company available at: [http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CDOQFjAA&url=http%3A%2F%2Fwww.mckinsey.com%2F%2Fmedia%2FMcKinsey%2520Offices%2FUnited%2520Kingdom%2FPDFs%2FWhen\\_hospital\\_mergers\\_make\\_strategic\\_sense\\_.ashx&ei=rwsWUrqBqqkoQXXl4CoCw&usq=AFQjCNF54QcbHXgGxUNO1m2riSzwb5VNMQ&sig2=QsELCCqQEZ\\_3H9mvNCweDA&bvm=bv.51156542,d.dzk](http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CDOQFjAA&url=http%3A%2F%2Fwww.mckinsey.com%2F%2Fmedia%2FMcKinsey%2520Offices%2FUnited%2520Kingdom%2FPDFs%2FWhen_hospital_mergers_make_strategic_sense_.ashx&ei=rwsWUrqBqqkoQXXl4CoCw&usq=AFQjCNF54QcbHXgGxUNO1m2riSzwb5VNMQ&sig2=QsELCCqQEZ_3H9mvNCweDA&bvm=bv.51156542,d.dzk) [Accessed October 2, 2013].
- 14 Hospital Quality Competition Under Fixed Prices, The University of York, Centre for Health Economics, CHE Research Paper 80, November 2012, available at: [http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP80\\_hospital\\_quality\\_competition\\_fixedprices.pdf](http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP80_hospital_quality_competition_fixedprices.pdf) [Accessed October 2, 2013].
- 15 While the reasons are not clear from the public record, it can be noted that for the first public hospital merger investigated by the CC—see fn.1 above—very unusually two notices extending the period of the investigation have been issued, so extending this investigation from the statutory limit of 24 weeks (approximately 6 months) to approximately 10 months.
- 16 EA 2002 s.42(1).
- 17 EA 2002 s.42(2).
- 18 EA 2002 s.58(3).
- 19 If the SoS does not refer the merger to the CC, then the case will proceed in the normal course, namely, if no SLC finding by the OFT, then that is the end of the regulatory investigation. If there is an SLC finding then the merger will be referred to the CC unless undertakings in lieu of the referral are offered and accepted.
- 20 EA 2002 s.45(6).
- 21 This situation arises when the terms of reference to the CC are such that there would not be a substantial lessening of competition but taking account only of the relevant public interest consideration or considerations concerned, the creation of the relevant merger situation may be expected to operate against the public interest. EA 2002 s.45(3) and (5).

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