SUBMISSION TO THE ASHFORD ST PETER'S NHS FOUNDATION TRUST AND ROYAL SURREY COUNY NHS FOUNDATION TRUST MERGER INQUIRY

ABOUT THE HEALTH FOUNDATION

The Health Foundation carries out research and in-depth policy analysis, funds improvement programmes to put ideas into practice in the NHS, supports and develops leaders and shares evidence to encourage wider change. Over the past 15 years we have invested over £120m to help improve the quality of care in the NHS.

We want the UK to have a health care system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable.

We work to influence health care policy to help create an environment that supports and enables health services to improve the quality of care they deliver, using appropriate improvement methods and interventions. We are also working to understand more fully how successful health care improvement interventions can be spread more widely across the NHS.

The Health Foundation is an independent charity working to improve the quality of health and health care in the UK. We are grateful for the opportunity to submit evidence to the inquiry team and would welcome the opportunity to discuss this submission further.

ABOUT THIS RESPONSE

This submission does not comment on the specifics of the Ashford St Peter's NHS Foundation Trust and Royal Surrey Country NHS Foundation Trust Merger inquiry but instead seeks to give a broad overview of some of the broader challenges that currently face the NHS and highlights the lack of evidence on the use and impact of different policy levers including the role of competition.

This submission is split into three main parts:

- **Part 1:** The challenges currently facing the NHS.
- **Part 2:** How different system levers including competition can help the NHS to meet its core objectives.
- **Part 3:** The effectiveness of competition as a lever to improve the quality of health care.

We think it is right that there is some external scrutiny of merger decisions and accept that assessment of the impact on competition should be part of that process. However, we are concerned that:

- the underlying basic assumption used by the Competition and Markets Authority(CMA) in its assessment of merger proposals, that competition for clinical care results in net patient benefit (and that therefore its removal risks reducing the quality of care), is not sufficiently supported as yet by the empirical evidence in health care;
- empirical and theoretical evidence from other sectors on the impact of competition for consumers may not be a strong guide to help make decisions in health care;
- a wide range of factors influence patient benefit in health care and many are likely to have more impact than competition. While the evidence for other policy approaches can be limited, these approaches or interventions need to be fully taken into account in merger decisions;
- the future health needs of the population, and sustainability of the NHS, will demand new models of care to develop based on networked collaboration between providers. This is an international trend and should be considered in analysis by the CMA; and
- health care is complex and those with key roles in deciding on merger decisions concerning the NHS may not have enough health sector experience to fully appraise the relative merits of competition versus other interventions such as integrated care or quality regulation.

These concerns are explained in more detail in parts 1-3 of the document.

PART 1: CHALLENGES CURRENTLY FACING THE NHS

There is consensus that over the next five years the NHS in England needs to focus on three aims:

- Achieving financial balance;
- Transforming the way care is delivered for the future;
- Maintaining and improving the quality of care and health.

Failing to meet any one of them would have serious consequences for the NHS and the care patients receive.

Achieving financial balance

The NHS in England faces the huge challenge of meeting rising demand in a period of sustained financial pressure. NHS trusts and foundation trusts have reported a deficit of £822m for the 2014/15 financial year[1,2], despite £250m additional Treasury funding and an extra £650m from transferred planned capital investment.

The NHS Five Year Forward View confirms that it expects funding pressures to increase by £30 bn by the end of the parliament. It examines three options for productivity growth – 0.8% (the very long-run average), 1.5% and a phased step in productivity of 2% initially, then rising to 3% a year over the parliament. This last assumption is predicated on the NHS being supported to deliver the changes to the model of care set out in the Forward View. These three scenarios result in a funding gap after productivity improvements of £21 bn, £16 bn or around £8 bn in 2020/21 compared to flat real resourcing. [3]

The Conservative Party manifesto committed to allocating at least an additional £8bn by 2020 over and above inflation to fund and support the NHS Five Year Forward View. [4] This is predicated on the 2-3% productivity gains set out by NHS England in the Forward View. However, our analysis shows that NHS hospitals have only improved efficiency at an average rate of 0.4% a year over this parliament. This is substantially below previous estimates.[5] There is therefore a big challenge in improving the productivity of existing services.

Transforming care for the future

It is widely recognised that just improving the productivity of existing care is unlikely to be enough to deliver overall productivity growth of a minimum of 2-3%. Last year the NHS Five Year Forward View set out a comprehensive vision for the NHS, its main theme being the development of new models of care. A clear driver of the strategy is the objective of dissolving the classic divide between family doctors and hospitals, between physical and mental health, between health and social care, and between prevention and treatment. The Forward View set out the need to:

- Manage systems or networks of care and not just single organisations;
- Integrate services around the needs of patients;
- Learn much faster about best practice from within the UK and internationally;
- Increase the focus on out-of-hospital care. [6]

The Forward View set out a number of new care models as outlined in Table 1 below.

Table 1: New Care Models set out in the NHS Five Year Forward View	
Multispecialty community providers (MCPs)	Extended group GP practices as federations, networks or single organisations taking on a wider range of functions or professionals with the aim of shifting outpatient and ambulatory care out of hospital settings. These practices could potentially take over the running of local community hospitals.
Primary and Acute Care Systems (PACS)	Vertical integration between primary care and acute care systems. For example by enabling single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services. Acute trusts may be allowed to open their own GP practice or mature MCPs might take over the running of their district general hospital. At their most radical, PACs could take on the accountability for the whole health needs of a registered list of patients under a delegated capitated budget.
Urgent and emergency care networks	A range of interventions including the development of networks of linked hospitals that ensure patients with the most serious needs have better access to specialist emergency centres. This would involve strengthening clinical triage across the network.
Viable smaller hospitals	Develop new models for smaller acute hospitals for example by: • sharing management functions (either of the whole institution or of 'back-office') with similar hospitals; • 'outsourcing' more specialised services to another provider who would work on the site of the smaller hospital; • Forming a PAC with its local primary and community services.
Specialised care	Consolidation of some services where the evidence between patient volume and quality is strong.
Modern maternity services	Commission a review of future models for maternity units and make it easier for groups of midwives to set up their own NHS-funded midwifery services (with appropriate quality control).
Enhanced health in care homes	Work with the NHS and care home sector to develop new shared models of in-reach support including medical reviews and rehabilitation services in care homes with the aim of avoiding unnecessary hospital admissions.

On 10 March 2015, 29 'Vanguard' sites were chosen to lead on the development of the new care models outlined above. One of the 29 Vanguard sites is Salford. The Salford Together Partnership intends to create an integrated care organisation giving Salford Royal NHS Foundation Trust the lead responsibility for meeting the health and social care needs of the population through both direct provision and contracts with other local providers. Other organisations involved in the Partnership include Salford City Council, Greater Manchester West Mental Health NHS Foundation Trust as well as NHS Salford Clinical Commissioning Group.

A strong theme throughout the Forward View is the importance of improved coordination and integration of care. This follows previous initiatives in recent years including the Integrated Care Pilots[7] and the integrated care pioneers. [8] The rationale for these initiatives is that the health care needs of the population are changing, with much greater need from individuals with complex long-term conditions in the second half of life. This population group needs less planned and episodic 'curative care' in a hospital setting, but instead requires more ongoing maintenance of health across a range of providers over a long period of time (with an

objective to reduce dependence on the health system). To meet this objective, care will need to be coordinated much better between collaborating providers, and long relationships built up between the patient and a set of providers. This is an international trend.

While it will take time to roll out the new models of care at scale, there may be implications for the competition authorities and it is important to be aware of the context in which the NHS is operating. For example, MCPs by their nature will require greater collaboration across individual GP practices and may in some circumstances generate sufficient financial turnover to meet CMA thresholds for investigation in a merger situation. Further, acute foundation trusts and trusts will face additional competition from MCPs for some outpatient care. The plans in Salford to move towards an integrated care organisation model may have implications for the current system whereby there is a clear split between commissioners and acute providers.

Further, on 20 May 2015, Simon Stevens, Chief Executive of NHS England announced that NHS England was inviting bids to particulate in a fourth Vanguard programme – new models of acute care collaboration. Providers are increasingly looking to explore the benefits of 'horizontal' collaboration between different acute providers as well as vertical integration with primary care services.

The programme is not intended to support the implementation of traditional merger or acute reconfiguration programmes but the focus in on the development of new organisational arrangements that support productivity and quality improvements in acute services. Potential models include:

- Accountable clinical networks such as joint NHS-led vehicles;
- NHS service franchises;
- NHS management groups or chains of multiple organisations.[9]

Maintaining or improving quality

There are multiple definitions of quality. Within the NHS quality is commonly defined as:

- Care that is clinically effective;
- Care that is safe;
- Care that provides as positive an experience for patients as possible. [10]

Other definitions are broader focusing on the following dimensions:

- **Safe** – *avoiding harm to patients;*
- **Effective –** *providing services based on scientific knowledge and which produce a clear benefit;*
- **Person-centred-** *providing care that is respectful or responsive to individuals' needs and values;*
- **Timely -** *reducing waits and sometimes harmful delays;*
- **Efficient –** *avoiding waste;*
- **Equitable –** *providing care that does not vary in quality because of a person's characteristics.*[11]

Measuring the quality of health care and thus benefits to patients is complex and measurement is often partial. There are many different sources of information about the quality of care in the health sector but there are significant blind spots.

This is not a new challenge. In 2008 the Next Stage Review emphasised the role of measurement and national data in improving quality [12] and in 2010 the National Quality Board highlighted major gaps in nationally-collected quality data, setting out that: *'by 2015, the vision is to ensure that patients and professionals have ready access to meaningful information about the full range of services that the NHS provides, supported by high quality underpinning data'*.

It is difficult to argue that this vision has been achieved. For example, we know very little about community care and we still cannot measure how well the NHS puts people at the centre of their care. This lack of availability of data reduces the ability of staff to improve care, allows unwarranted variation to flourish, restricts commissioners' ability to understand the quality of the services they are commissioning and limits the ability of patients to make informed choices. This is relevant when considering the way in which consumer choice and competition operates within the NHS.

We have argued that there needs to be progress over the next Parliament in giving resource and priority to the development of a wide range of national indicators, support for local organisations to build their own analytical capacity and addressing data gaps through a comprehensive strategy for quality improvement for the NHS in England. [13]

Broadly speaking:

- progress continues to be made in tackling some key harms in hospitals, but we still know very little about safety in other settings. While evidence suggests more incidents are being reported in hospitals, it is likely there is significant under-reporting in primary care;
- access to care is better than it was before the introduction of targets but in recent months, waiting times have increased in some areas. As demand for services has increased, both performance against a range of waiting time targets and patient-reported access to primary care have deteriorated, but most people continue to be seen within target times; and
- since 2000, successive governments have made commitments to person-centred care, but we lack coherent and consistent indicators across all areas of care. [14]

Our joint Quality Watch programme with the Nuffield Trust monitors how the quality of health and social care is changing over time by analysing over 270 health care quality indicators. The NHS has done well to maintain or improve quality in some areas despite financial pressures (although the relationship between financing and quality is a complex one). However, the system is starting to feel the strain and the significant advances in quality of care that the NHS has experienced in recent years is starting to stall in some areas.

In summary, the future health needs of the population, and sustainability of the NHS, will demand new models of care to develop based on networked collaboration between providers. This is an international trend and should be considered in analysis by the CMA.

PART 2: HOW DIFFERENT SYSTEM LEVERS INLCUDING COMPETITION HELP THE NHS MEET ITS THREE OBJECTIVES

As set out above, the NHS is being asked to achieve financial balance, transform the way care is delivered for the future while maintaining and improving care quality. The Forward View has galvanised the system and there is support and consensus as to what changes are needed. However, one of the more challenging questions is 'how' system leaders can support the NHS to transform services at the scale and pace required. There are a range of approaches or interventions that national policy makers adopt and in our report *Constructive Comfort: accelerating change in the NHS*, we categorise some of these policy levers:

- **Type 1: 'prodding' -** *initiatives to change provider behaviour such as setting targets, issuing guidance, performance management, competition, regulation, contracting, commissioning and setting payment incentives.*

- **Type 2: 'proactive support'** *– initiatives that directly or indirectly support providers and commissioners from within to improve performance. This approach is reliant upon the intrinsic motivation of staff to make the right changes.*

- **Type 3: 'People-focused'** *this approach includes both prods and proactive support, targeting NHS staff rather than organisations, as well as actions to inspire, engage and involve staff. Approaches include using policy mechanisms such as education and training, national contracts, professional regulation and clinical standards.*[15]

Generally, policy-makers focus on 'prod' interventions aimed at influencing behaviour at the organisational level through management controls. These are traditional levers within the policy-maker's toolbox but often occur without a clear theory of change or understanding of the potential unintended consequences. However, we still know very little about the relationship between different levers such as regulation or competition within the 'type 1' category, nor do we know what the best blend of interventions may be in order to achieve a specific outcome. There has never been a coherent strategy on 'type 2' *'pro-active support'* initiatives but there is significant potential to accelerate change if there is much more thinking about action in this space than there has been to date.

To make progress on quality of care and productivity, the NHS will need to focus on achieving a better blend of *'type1'* interventions (of which competition is included). But a higher priority in our view is to work towards providing more system support and interventions targeted predominately at staff rather than organisations. We believe that there are four interconnected areas that warrant greater national focus in transforming our health system.

- Realising productivity gains necessary for a financially sustainable health system;
- Developing an effective accountability framework for finance and quality of care;
- Improving the availability and use of information within the NHS;
- Supporting improvement and local change.

With regards the role of competition, in 2014, the Office of Fair Trading (OFT) published an analysis of the theoretical and empirical literature on the impact of competition on quality. The review noted that the empirical literature is *'recent and still relatively sparse'* and '*it is probably too early to draw any general lessons from this'*. However, the report also stated that for health care, empirical studies suggest that competition leads to improvements in some measures of quality when prices are regulated.[16] The review did not consider the impact of competition relative to a full range of extrinsic incentives that can affect quality in

the NHS, such as targets, regulation, commissioning and payment mechanisms, or intrinsic incentives (for example, boosted by better availability of data on performance), nor whether the relationship between competition and quality outcomes in the literature was causative or merely associative.

As the Competition Commission noted in its final report into the proposed merger of Poole Hospital NHS Foundation Trust and the Royal Bournemouth and Christchurch hospitals NHS Foundation Trust there are a number of factors that influence quality and patient benefit within an acute hospital environment including the role of commissioners and the role of quality regulation (including the Care Quality Commission (CQC), Royal Colleges, NICE etc).[17]

We are concerned that in the assessment of the case for and against mergers in health care, competition is too strongly assumed to result in benefits to patients - this assumption is not supported irrefutably by the empirical evidence currently available in health care, as evidenced by OFT for example. We are also concerned that too much weight is put on the empirical and theoretical impact of competition in other sectors very different to health care, and note the apparent lack of specific health sector experience on the inquiry group for the Ashford St Peter's NHS Foundation Trust and Royal Surrey Country NHS Foundation Trust Merger inquiry. Furthermore the relative impact of competition on benefits to patients compared to other extrinsic 'type 1' factors such as regulation, publication of ratings or other comparative information, payment incentives, performance management, commissioning and different contract types is relatively unexamined.

For example, how does competition affect provider behaviour relative to quality regulation? The role of the Care Quality Commission (CQC) has been significantly strengthened in recent years. From 2013 onwards, it developed and adopted a new approach to its inspection regime alongside the introduction of improved surveillance mechanisms to identify risks and the adoption of publicly available ratings for providers. [18] Initial evaluation of CQC's amended model found that it was seen as transformative in comparison with the forms of regulation it replaced. It was regarded as much more credible, authoritative, rigorous and in-depth and much less likely to miss any issues of significant concern. More specifically, the evaluation suggested that staff were able to leverage inspection reports to influence actions and drive change within their organisation. Further, in the run-up to inspection; NHS trusts prepared and took some important actions to bring about improvement. [19]

We believe further research is needed to understand better the interplay within and between the three types of intervention and hope to commission additional research in this area.

In summary, a wide range of factors influence patient benefit in health care and many are likely to have more impact than competition. While the evidence for other policy approaches can be limited, these approaches or interventions need to be fully taken into account in merger decisions. Fully assessing the relative impact of competition versus other policy approaches is a complex task and we are concerned that while the Inquiry Group is made up of senior experts in their field, specific health sector expertise appears to be more limited.

PART 3: HOW EFFECTIVE IS COMPETITION AS A LEVER TO IMPROVE THE QUALITY OF HEALTH CARE?

Introduction

In many industries, it is accepted that competition is good for consumers. The rationale for this is that where it works, competition provides greater choice, better quality products and services and lower prices.[20] However, the picture is more challenging in health care, where it is well known that specific factors contribute to the need to intervene in the market, such as:

- an imbalance of knowledge and information between consumers and health professionals;
- the risk that some patients will use more services than they need to if they don't pay directly for them (moral hazard);
- the possibility that care providers or insurers driven by profit may select healthier patients with lower predicted costs ('cream skimming');
- the fact that health care can be a distressed purchase for example emergency health care.

A significant challenge in relation to competition in health care is the ability of patients and users of health services to make truly informed decisions when choosing providers. While competition for clinical care has existed within the NHS for some time, public awareness of a patient's right to choose is somewhat limited. A number of studies have shown that the role of the GP is critical in this decision-making process.[21,22] A survey conducted by Monitor in 2014 suggested that of those who had seen a GP in the last 12 months and had been referred for an outpatient appointment:

- **51**% were aware of their right to choose a hospital or clinic for an outpatient appointment before visiting the GP;
- **53**% had discussed where to have their treatment; and
- **38**% were offered a choice of hospital or clinic.[23]

Research suggests that patients do want to be offered a choice of provider, as well as choice of treatment. However, we know more about the impact of shared decision making[1] on patients' experience and outcomes than we do about the impact of choice of provider.[24]

Gravelle et al 2012 reviewed 12 studies focused on the influence of quality on patient choice of hospital. Most of the studies found that there is a positive association between demand for care and quality after controlling for other factors, including distance and waiting times. Three of the 12 papers focused on the English NHS. All three considered mortality rates as a measure of quality with one using a range of measures including ratings by the Care Quality Commission and infection rates.[25]

Challenges in measuring the effects of competition

Prior to the published analysis by OFT referred to above, Bevan and Skellern produced a helpful summary for the British Medical Journal on whether competition between hospitals improves quality of care for patients. Their paper argues that the market conditions introduced under the Labour government of the early 2000s resulted in a better market

[1] A collaborative process that allows patients and their providers to make health care decisions together.

structure than the Conservatives' internal market in the 1990s due to the elimination of price competition, and the provision of greater quality information and stronger incentives to increase market share. The article concludes that the impact of patient choice on outcomes in *elective surgery* remains an open question and the exact role of patient choice as a policy lever remains unclear.[26] It also summarises some of the methodological challenges in estimating the causal effects of competition on outcomes (see table 2).[27]

Table 2: Methodological limitations in measuring the effects of competition on outcomes according to Bevan and Skellern, 2011

Issue	Limitations
Measuring the intensity of competition and defining the size of a hospital's market	However it is measured, market structure is not necessarily a good proxy measure for the intensity of competition.
Measuring quality	Hospital mortality rates after acute myocardial infarction (AMI-heart attack) have been used as a proxy for the quality of clinical care across organisations. However, patients do not choose hospitals on the basis of quality when they are having a heart attack – they are generally taken to the nearest hospital. The implicit assumption is that quality for emergency patients is highly correlated with quality for non-emergency patients. '*All cause'* mortality measures are also used but deaths from elective surgery are rare and additional measures of quality such as outcome measures are needed.
Estimating the effect of competition between providers on quality	Econometricians need to show that variation in the intensity of competition is independent of hospital quality. If this is the case, changes in quality could be attributed to competition through correlation. Effectively, the intensity of competition should affect quality, but not be affected by changes in quality. However, high quality organisations might attract patients from wider catchment areas, making quality a factor in determining the intensity of competition.

Source: Bevan G, Skellern M. Does competition between hospitals improve clinical quality? A review of evidence from two eras of competition in the English NHS. *British Medical Journal*; 2011;343: d6470.

Competition on quality (where prices are regulated)

Within the NHS context, competition is based on quality and not on price. A number of studies have suggested that where prices are regulated, competition could have a positive impact on quality. For example, Cooper et al 2011 investigated whether the expansion of patient choice in the NHS in England in 2006 led to a change in hospital quality, using acute myocardial infarction (AMI) mortality data. The researchers found that, after the reforms were implemented, higher levels of competition were associated with a faster decrease in 30-day AMI mortality (within hospitals only).[28] Similarly, over the same period, Gaynor et al 2013

found that competition saved lives without raising costs. A rise in competition measured as a 10% decrease in the Herfindahl–Hirschman Index (HHI, a measure of market concentration) was associated with a fall of 2.91% in the 30-day AMI mortality rate.[29]

Bloom et al 2014 analysed the causal impact of competition on managerial quality and hospital performance using political marginality (that is, areas that are marginal parliamentary seats) as a variable for the number of hospitals in an area. The authors suggest that UK politicians rarely allow hospitals to close in marginal seats therefore leading to higher numbers of hospitals and higher rates of competition. They found that higher competition resulted in a higher quality of management and improved hospital performance. Adding a rival hospital was associated with increased management quality (based on survey data) by 0.4 standard deviations and increased 28-day survival rates after emergency AMI by 1.5 percentage points (9.7%).[30]

A paper from the Centre for Health Economics at the University of York examined the effects of hospital market structure on the risk of mortality among hip fracture and stroke patients, in addition to AMI, between 2002/03 and 2010/11. The researchers also considered whether this effect changed after the introduction of the right for NHS patients to be offered a choice of at least four providers from 1 January 2006 onwards.

The study found that for AMI and hip fracture, hospitals with more rivals had higher mortality at the start of the period, but the effect became smaller over time, which is consistent with previous studies. In the post-Choice period, the detrimental effect of rivals was smaller and statistically significant only for hip fracture. However, the decline in the apparently harmful effect of market structure seemed to pre-date the introduction of choice in 2006. The authors suggest that this decline in apparently harmful effects may have been prompted by improved medical knowledge and also the introduction of 'payment by results' which increased a provider's income according to the number of patients that were treated. Market structure did not appear to have any effect on stroke mortality.[31]

A recent study of the association between market concentration of hospitals and patient-reported gains used patient-reported outcome measures data, linked to NHS Hospital Episode Statistics in England 2011/12 after elective primary hip replacement surgery. It concluded that using hospital market concentration as a proxy for competition appears to show no significant association between competition and the outcome of elective primary hip replacement, but these findings cannot necessarily be broadly applied due to the limited nature of the data.[32]

One of the arguments in favour of introducing provider diversity is that private or voluntary sector providers might be more efficient. A World Health Organization (WHO) report suggests that the literature on the relative efficiency levels between private and public delivery of health care shows inconclusive evidence, and that the factors that could affect efficiency, such as demand, lack of resources or decision making powers, and payment mechanisms can cut across all types of provider ownership.[33] A study more specifically related to the NHS context observed that while competition between public providers promoted improvements in efficiency (measured using average length of stay for patients undergoing elective surgery), competition from private hospitals left incumbent public providers with a more costly case mix of patients with increased post-surgical lengths of stay.[34]

The Office of Health Economics' 2012 report on competition in the NHS suggests that competition is feasible across a range of clinical services, but that the nature of the 'customer' (ie whether the customer is a patient or a commissioner of care) can affect some

dimensions of competition (including demand factors, ease of acquiring information, short-term supply factors, political or institutional factors and cost factors). The customer could be individual patients (with or without access to a GP), a GP acting on behalf of their patient or a commissioner. The report again emphasised that competition based on quality and not price can be beneficial, but recognised that competition is not desirable or feasible for all NHS services in all locations.[35]

While the introduction of patient choice has been broadly positive it is still limited in practice. Bevan and Skellern 2011 ultimately conclude that: *'there are strong grounds for introducing patient choice into the NHS as an end in itself, given its potential to empower patients and give them greater control over the conditions of their care. Gaynor et al show that, when patients were offered choice, they exercised it, and hence provide evidence of the desirability of patient choice as part of the policy mix on these grounds. Nevertheless, how patient choice has affected outcomes in elective surgery remains an open question; the exact role it should play in the policy mix is therefore unclear.'*[36]

More broadly, we suggest that the empirical evidence on a causal link between competition and quality of clinical care is still weak. More evidence is needed before a definitive, objective conclusion is possible of the impact of competition on patient care and on the performance of existing NHS providers over the long-term. The evidence on competition, such as it is, is that its effect is small. It only really applies to elective care rather than non-elective care.

We recognise that merger is not a panacea and NHS organisations have a responsibility to articulate a strong case for why merger is an effective solution to financial or clinical challenges when merger has a poor track record of delivering intended benefits. For example, Gaynor et al 2012 looked at the impact of the 112 NHS hospital mergers which occurred between 1997 and 2006 but found little evidence that mergers achieved gains other than a reduction in activity.[37] However, there is a clear need for providers to improve productivity and quality across the totality of care and it is important to be clear about the magnitude of the effect of a loss of competition across an institution compared to potential positive effects of relevant customer benefits.

The NHS lacks robust real-time compatible data on the cost, volumes and quality of care. Without these data we simply cannot know if competition is improving productivity and quality or whether in difficult financial times competition could have unintended consequences. This data challenge is not limited to competition and the system requires better access to information on the effectiveness of different interventions more generally.

In summary, the underlying basic assumption used by the CMA in its assessment of merger proposals, that competition for clinical care results in net patient benefit (and therefore its removal risks reducing the quality of care), is not sufficiently supported as yet by the empirical evidence in health care. Further, empirical and theoretical evidence from other sectors on the impact of competition for consumers should not be a strong guide to help make decisions in health care.

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