**Cooperation and Competition Panel**

# Draft interim guidance on Merger Inquiries

**January 2009**

# 1. Introduction

1.1. There has been extensive Government investment in the NHS since 2000. During the same period, the NHS has moved from a system model based on control of the means of provision, towards a more open system with a defined division of roles between commissioners and service providers. The catalyst for change was the desire to make patient needs the main focus of the NHS.

1.2. For elective care services, patients now have the right to choose[1] any willing and registered provider of these services regardless of the physical proximity or type of provider.[2] The NHS is also moving towards a more competitive (or contestable[3]) model in the procurement of health services as well as through patient choice. Competition, including through service contestability, encourages innovation, quality and responsiveness to patient needs.

1.3. Competition and choice are powerful levers to drive up service quality, deliver better value and reduce inequalities. Yet they can only be effective if there are clear, enforceable rules guiding and governing behaviour within the healthcare system.

1.4. To address this need, the Department of Health published the *Principles and Rules of Cooperation and Competition* as part of the *NHS Operating Framework 2008/09 – 2010/11*.[4] Their purpose is to ensure fair and transparent cooperation and competition so as to make the best use of resources, enable innovation, and provide essential safeguards for the interests of patients, taxpayers, and the reputation of the NHS.

1.5. The Cooperation and Competition Panel (the Panel) helps ensure that the *Principles and Rules for Cooperation and Competition*[5] (Principles and Rules) in the provision of NHS-funded services support the delivery of high quality care for patients and value for money for taxpayers. It investigates potential breaches of the Principles and Rules, and makes independent recommendations to Strategic Health Authorities (SHAs), the Department of Health and Monitor (the Department of Health and Monitor together, Sponsors) on how such breaches should be resolved. It also reviews proposed mergers, and advises on the wider development of cooperation and competition within the NHS. In carrying out its responsibilities, the Panel works with all parts of the NHS, the independent sector and others to drive improvements in service delivery.

1.6. These guidelines deal specifically with the Panel's responsibilities in relation to proposed mergers, acquisitions and joint ventures. More detail on the Panel's wider responsibilities are provided on the Panel's website at www.ccpanel.org.uk.

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[1]Choice is exercised at the point at which a patient requires a referral for his/her first, consultant-led outpatient appointment.
[2]This right has now been enshrined within the NHS Constitution (Department of Health, January 2009).
[3] In economics a contestable market is one in which an incumbent faces strong competitive constraints from potential competitors because low barriers to entry and exit constrain an incumbent's ability to take advantage of their position. In the context of this document, however, we use the term "contestability" to refer more generally to services where a commissioner may have the option of contracting with alternative service providers..
[4] For more information, please see the *Operating Framework for the NHS in England 2008/09* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094
[5]The Principles and Rules are available at www.ccpanel.org.uk.

1.7. Mergers have an important role in the NHS in delivering high quality care for all through improving clinical standards or cost efficiencies, for example, or as a possible solution for unsustainable providers and for NHS Trusts that are unable to meet the requirements to be authorised as Foundation Trusts. However, where patient choice and competition are reduced mergers may have an adverse effect on patients and/or taxpayers. The Panel will provide advice to SHAs, the Department of Health and, in relation to Foundation Trusts, Monitor on whether proposed mergers comply with the Principles and Rules. Decisions by the relevant Sponsor regarding proposed mergers will take into account the Panel's advice as well as other factors unrelated to the Principles and Rules, such as financial sustainability.

1.8. It is expected that the merger guidelines will be reviewed as required and that they will need to be reviewed following any review of the Principles and Rules. The guidelines have introduced new concepts and processes in relation to NHS-funded health services. The review will allow the Panel to consider the effectiveness of the current provisions in the guidelines and to incorporate the learning acquired through the initial merger cases that it will investigate.

**Role of the Panel in advising on proposed mergers, acquisitions and joint ventures**

1.9. The role of the Panel in considering mergers is to advise SHAs, the Department of Health, and, in relation to Foundation Trusts, Monitor, on whether the proposed transaction is consistent with the relevant provisions of the Principles and Rules. This will involve assessing the impact of the proposed merger on the interests of patients and taxpayers taking into account both any adverse effects that may arise from the impact of the merger on choice, competition or service contestability as well as the benefits to patients and taxpayers that may arise from, for example, improvements in clinical care, more efficient service delivery and reduction in costs.

1.10. In reviewing proposed mergers, the Panel will also advise, where appropriate, on whether a merger should be referred by the merging parties to the Office of Fair Trading (OFT). It is worth noting that a merger between two independent sector service providers would fall within the remit of the OFT rather than the Panel. However, in some instances there may be specific contractual or other provisions that require commissioner approval of such a transaction and, where a PCT or SHA has concerns about the impact of such a transaction on patients or taxpayers, the PCT, SHA or a Sponsor may seek informal advice from the Panel regarding the proposed transaction. In its advice, the Panel may recommend to bring such a merger to the attention of the OFT for further investigation.

1.11. The Panel's merger guidelines supplement the Rules of Procedure in relation to the Panel's consideration of mergers and are designed to provide information and advice to NHS Trusts, PCTs and Foundation Trusts and their advisers on the procedures and the analysis that the Panel will use in conducting merger inquiries. In the event of any conflict between the Rules of Procedure and the merger guidelines, the Rules of Procedure will take precedence.

1.12. The remainder of this document is set out as follows:

- Section 2 sets out the policy framework for the Panel's merger inquiries;

- Section 3 sets out the acceptance criteria that must be met before the Panel can review a proposed merger;
- Section 4 describes the administrative processes the Panel will use in undertaking merger inquiries;
- Section 5 sets out the analytical framework that will be used by the Panel to assess the expected impact on patients and taxpayers of proposed mergers;
- Section 6 discusses the types of recommendations that the Panel may make once it has assessed a merger; and
- Section 7 provides guidance to merging parties on the content of submissions to be made to the Panel.

## 2. The policy framework

2.1. This section sets out the policy framework for the Panel's consideration of mergers, including first, the rationale for choice and competition in the NHS and the associated need for merger regulation and second, the broader administrative framework for taking forwards mergers between NHS-funded healthcare providers and how the Panel fits within this framework.

2.2. Choice and competition are key components of the government's strategy for reforming the NHS and delivering improved quality and more personalised care.[6] For routine elective services patients now have freedom of choice between providers. This means that patients can choose any willing and registered provider of these services at the point of referral – regardless of physical proximity or type of provider. Providers may include, for example, NHS Trusts, Foundation Trusts and non-government healthcare providers. Patient choice is being expanded into additional areas. For example, choice of provider, treatment and setting is beginning to be offered to patients with long-term conditions. Patients' ability to choose between competing providers is supported by the provision of comparable information about providers through the NHS Choices website.[7] Providers are also able to advertise or otherwise promote their services consistent with the NHS Code of Promotion.

2.3. For other services, Primary Care Trusts (PCTs) are under an obligation to commission services from the providers who are best placed to deliver the needs of their patients and population. While choice for patients may be more limited for these services, competition between providers will play an important role in ensuring that PCTs obtain the best possible offer of services for their patients.

2.4. In general terms, competition can be expected to have numerous beneficial effects: costs are driven down, and innovation and productivity increase, so increasing the quality and, more generally, the diversity of choice available as service providers respond to the preferences of their patients. As set out in the Framework for Managing Choice and Competition[8], choice and competition in the NHS can be expected to:

- improve quality and safety in service provision;
- improve health and wellbeing;
- improve standards and reduce inequalities in access and outcomes;
- lead to better informed patients;
- generate greater confidence in the NHS; and
- provide better value for money.

2.5. The benefits of competition for patients and taxpayers will only be realised, however, where there is effective competition between service providers for patients or contracts to provide services to patients (i.e. service contestability). Where the process of competition is dampened, or otherwise hindered, by a

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[6] See, for example, the interim report of The NHS Next Stage Review (*Our NHS, Our Future*). The government has also recently announced the NHS Constitution.
[7] See http://www.nhs.uk/ServiceDirectories/Pages/ServiceSearchTreatmentAtoZ.aspx
[8] For more information, please see the Framework for Managing Choice and Competition http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084779

merger, the benefits to patients and taxpayers from choice, competition and service contestability may be weakened or lost. As a result, there is a need for the oversight of merger activity between NHS-funded healthcare providers to ensure that patients and taxpayers continue to receive the benefits of choice, competition and service contestability.

### Administrative framework for consideration of mergers by the Panel

2.6. The Panel will receive referrals of proposed mergers involving NHS Trusts, PCTs or Foundation Trusts and advise SHAs, the Secretary of State, and in relation to Foundation Trusts, Monitor, as to whether a proposed merger would breach the relevant provisions of the Principles and Rules . Where a proposed merger would breach the relevant provisions of the Principles and Rules, the Panel will make recommendations as to how such a breach could be remedied.

2.7. A merger between two independent sector service providers would fall within the remit of the OFT rather than the Panel. However, in some instances there may be specific contractual or other provisions that require commissioner approval of such a transaction and, where a PCT or SHA has concerns about the impact of such a transaction on patients or taxpayers, the PCT, SHA or a Sponsor may seek informal advice from the Panel regarding the proposed transaction. In its advice, the Panel may recommend bringing such a merger to the attention of the OFT for further investigation. Obtaining advice from the Panel will not prevent a PCT from, where appropriate, reviewing its procurement of services from the merged entity.

2.8. The relevant provisions of the Principles and Rules[9] are set out in Table 2.1 below. Section 5 of these guidelines sets out the Panel's approach to analysing whether a merger would breach these provisions.

**Table 2.1: Principles and Rules for Cooperation and Competition in relation to mergers**

| No. | Principle | Rules |
|---|---|---|
| 9 | Mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible when demonstrated to be in the patients' and[/or] taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money. | 1. When considering a corporate transaction providers must adhere to standard NHS Contract clause 49 (Change in Control).<br>2. NHS Trusts must obtain consent from Secretary of State for joint ventures, mergers and acquisitions.<br>3. Foundation Trusts must comply with Monitor's REID guidelines for acquisitions and joint ventures and obtain Monitor's approval for mergers.<br>4. Providers, where they are acting as 'enterprises' must adhere to the Enterprise Act 2002, and consider self referral to the Office of Fair Trading. |
| 10 | Vertical integration is permissible when demonstrated to be in patient and taxpayers' best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money. | 1. Commissioners should not contract directly with secondary providers seeking to own, manage or control general medical list based services that would result in referrals to their own secondary provision function, without having agreed robust and proportionate safeguards and with the express agreement of the DH.<br>2. Providers must obtain prior written consent from the co-ordinating commissioner before exercising a change in control (NHS Contract clause 49).<br>3. Parties to the contract must declare conflicts of interest (NHS Contract, clause 53).<br>4. All referring clinicians (such as general practitioners and |

[9] The full version of the Principles and Rules is available at www.ccpanel.org.uk.

| | | hospital consultants) must tell their patients about any financial or commercial interest in (or are employed by) an organisation to which they plan to refer a patient for treatment or investigation. When treating NHS patients they must also tell the commissioner (GMC Good Medical Practice 2006, paras 74-76). This interest will also be declared on NHS Choices. |
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2.9. In connection with a proposed merger as part of the process of providing approval for a proposed transaction by either the Secretary of State or Monitor, the Secretary of State or Monitor will seek a formal merger assessment from the Panel where the combined turnover of the merging parties exceeds (i) £70 million in the case of acute and mental health trusts; (ii) £35 million in the case of community service providers; or (iii) £15 million in the case of primary care providers.[10] To enable this, the merging parties[11] should submit a notification to the Panel.

2.10. Further details of the requirements of the Department of Health and Monitor in relation to proposed mergers involving NHS Trusts/PCTs and Foundation Trusts, respectively, are contained in the Transactions Manual and Monitor's REID guidelines for acquisitions and joint ventures.

2.11. A merger between healthcare providers may also require approval by the Office of Fair Trading (and potentially the Competition Commission) under the Enterprise Act 2002 or the European Commission under the EC Merger Regulation. Where this is the case, the Secretary of State or Monitor may decide that a formal assessment of the proposed merger by the Panel is not required.

**Panel merger process in the context of wider DH and Monitor processes**

2.12. The Panel's merger review process forms part of a wider DH or Monitor process associated with a proposed merger. Merging parties need to ensure that the advice of the Panel is sought at the appropriate stage in these wider processes.

2.13. Process maps that place the Panel merger review process in the context of the wider DH approval processes for mergers involving NHS Trusts or PCTs will be published separately on the Panel's website. Further guidance to merging parties on DH approval processes is contained in the Transactions Manual.

2.14. Process maps that place the Panel merger review process in the context of the wider Monitor approval processes for mergers involving Foundation Trusts will be published separately on the Panel's website.

[10]In the case of mergers between healthcare service providers in different sectors, the lowest applicable threshold will apply. For example, in a merger between a community service provider and a primary care provider, the £15 million threshold will apply.
[11] In the case on an acquisition, the acquiring party.

## 3. Acceptance Criteria

3.1. Before the Panel will consider undertaking a merger inquiry under the Principles and Rules, the following acceptance criteria must be met:[12]

(i) The subject matter of the complaint comes within the ambit of the Principles and Rules;

(ii) The Panel is the most appropriate body to consider or resolve the issue (i.e. over other bodies or regulators including the Office of Fair Trading (OFT) and the Advertising Standards Authority (ASA)); and

(iii) All relevant parties involved make available all relevant and applicable information on the case to the Panel, including that outlined below under Guidance on Content.[13] This does not preclude the Panel from asking for further information as it requires.

[12] This acceptance criteria does not apply to the provision of informal merger advice as described in Section 4.
[13] See Section 7 of this document.

# 4. Merger Inquiry Process

4.1. The Panel may consider proposed mergers under the following processes:

- informal advice on a proposed merger; and
- a formal assessment of a proposed merger as part of the process by which merger parties gain approval from the Secretary of State or, for Foundation Trusts, Monitor.[14]

**Informal merger advice**

4.2. The Panel is willing to provide informal merger advice to parties as to the likely competition issues arising out of a prospective merger. The purpose of providing informal advice is to assist in the planning and consideration of prospective mergers. Informal advice by the Panel is not, however, binding on the Panel and does not replace the Panel's formal assessment of a merger.

4.3. Informal merger advice will generally be given orally and will represent the view of Panel staff, usually given by the Director of the Panel or other senior members of staff. The advice will be based on information provided by the parties. To ensure that Panel resources are used effectively as well as respecting the confidentiality of any proposed transaction, the Panel will not consider hypothetical transactions and will not seek information or evidence from third parties.

4.4. To provide informal merger advice, the Panel will need information about the merging parties, the proposed transaction, the services and geographic areas involved and the potential effects of the merger, as described in Section 7 of these guidelines. Although submissions are not expected to be extensive, the quality and accuracy of the Panel's advice will, to a large extent, reflect the quality of the information provided. The Panel recommends parties provide clear, full and accurate information when preparing submissions for informal advice.

4.5. There is no administrative timetable for the provision of informal merger advice, but the Panel will endeavour to accommodate parties' timeframes as much as possible. The Panel will expect submissions to be provided at least 5 working days prior to the Panel providing its informal advice.

4.6. Given that informal advice is aimed at assisting the merging parties to identify potential competition concerns during the formulation of a transaction, and the Panel will not have tested the information provided by the parties externally, informal merger advice should be kept confidential (although not from the relevant Sponsor) and in no way be used by the merging parties as advice on which third parties can rely. In this respect it should be noted that informal advice is not binding on the Panel and the Panel will subsequently undertake a formal merger assessment where this is needed as part of the process for obtaining approval from the Secretary of State or Monitor for the proposed transaction.

4.7. In the first instance, parties seeking informal advice (or simply wishing to discuss whether to request informal advice) should contact the Panel on the details provided on its website at www.ccpanel.org.uk.

[14] In cases where the proposed merger meets the notification threshold requirements.

**Formal merger assessments**

*Notification thresholds*

4.8. In connection with a proposed merger, as part of the process of providing approval for a proposed transaction by either the Secretary of State or Monitor, the Secretary of State or Monitor will seek a formal merger assessment from the Panel. To ensure that only those mergers that are likely to be material in terms of their overall impact on patients and taxpayers are considered by the Panel, the Panel has three turnover thresholds that determine which mergers will be considered by the Panel. Accordingly, the merging parties[15] should submit a formal merger notification to the Panel where the turnover of the combined entity exceeds:

(i) £70 million in the case of acute and mental health trusts;

(ii) £35 million in the case of community service providers; or

(iii) £15 million in the case of primary care providers. [16]

4.9. Where the merging parties are unclear as to whether their proposal meets the Panel's acceptance criteria for carrying out a formal merger assessment (including the notification thresholds), it is good practice to refer the matter to the Panel so as to avoid the risk of delay should the merger be subsequently referred to the Panel for formal assessment. For the avoidance of doubt, the Secretary of State or Monitor will require a formal merger assessment by the Panel where there is a notifiable merger[17] and the parties have previously sought informal advice.

*Pre-notification discussions*

4.10. Prior to a formal assessment of a proposed merger being sought from the Panel, the Panel is willing to hold discussions to explore the types of information that the Panel would be looking for in a particular case. Parties are encouraged to provide a draft submission (e.g. based on the draft outline business case) which can then be used to help identify the additional information needed to provide a complete submission and assist in accelerating the Panel's merger review process.

*Information requirements*

4.11. Submissions must include a full and frank disclosure of all relevant and applicable information in order to be accepted by the Panel and for the merger timetable to commence. NHS Trusts and PCTs may wish to address the Panel's information requirements in developing their business case documentation for approval so as to avoid unnecessary duplication of effort. Where information material to a merger investigation is missing from a submission or business case, the Panel will inform the merging parties at the earliest opportunity and not commence the timetable until it is satisfied with the submission.

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[15]In the case on an acquisition, the acquiring party.

[16]In the case of mergers between healthcare service providers in different sectors, the lowest applicable threshold will apply. For example, in a merger between a community service provider and a primary care provider, the £15 million threshold will apply.

[17]A notifiable merger is one where there is the intention to go ahead with a proposed merger and the merger meets the notification thresholds.

4.12. On receipt of a complete submission, the Panel will publish a Notice of Acceptance on its website and the timetable for the merger inquiry will commence on the working day following such publication. At this time the Panel will nominate a case officer to lead the merger inquiry and act as the point of contact at the Panel for the merging parties.

4.13. During a merger inquiry the Panel may need additional, or more comprehensive, information than is provided in the initial merger submission or business case. The Panel will ask for such additional data, information or documents as soon as it is clear they are necessary. Requests for such information will normally allow a short deadline for response such that the Panel can comply with the merger inquiry timetable. If that deadline cannot be met, it may be necessary to suspend the timetable until the requested information is provided.

4.14. It is important that merger parties in receipt of a request for information discuss at an early stage their likely timetable for responding, the extent to which the requested material is available and the form in which it is available.

*Third parties*

4.15. The Panel will invite comments from relevant PCTs, as commissioners, and SHAs (as system managers) and other third parties during a merger inquiry by means of an invitation to comment published on the Panel's website at www.ccpanel.org.uk. The Panel may also actively seek information and submissions from patient representatives, competitors, suppliers, relevant government agencies and industry bodies.

4.16. The purpose of third party inquiries is to: seek input from commissioners, SHAs and other relevant stakeholders on the possible implications of the proposed merger; confirm and clarify the information provided by merger parties; and identify any additional issues. Where the submissions of third parties raise significant concerns as to whether a merger is consistent with the Principles and Rules, the parties proposing the merger will be given an opportunity to respond to those concerns. Similarly, where the Panel's own analysis raises significant concerns as to whether a merger is consistent with the Principles and Rules the parties proposing the merger will be given an opportunity to respond to those concerns.

4.17. Although the Panel may seek the assistance of SHAs, the Department of Health or, in relation to Foundation Trusts, Monitor, during the merger inquiry process, the Panel shall provide its advice on the basis of its own analysis pursuant to these guidelines and independently of any views expressed by SHAs, the Department of Health or Monitor.

*Publishing and confidentiality*

4.18. The Panel will publish on its website non-confidential versions of submissions by the merging parties and others, as well as its advice and recommendations. It will also publish summaries of any hearings held with the merging and third parties.

4.19. Before any such publication, the relevant parties will be offered the opportunity to request the excision of business secrets or other confidential information from the public version of the documents. The Panel may publish information

where it is compelled by law or the Courts or where it is reasonably necessary to facilitate the Panel in the exercise of its functions and to allow transparency.

4.20. To the extent that the Panel's reasoning in any decision relies on confidential information, the Panel will make this information available to the relevant Sponsor, subject to the Sponsor confirming that it shall treat such information as confidential and that it shall use the relevant information only for the purposes of its decision.

*Decision making process*

4.21. After receiving a request for a formal merger assessment and satisfying itself that the proposed merger meets the Panel's acceptance criteria, including the provision of sufficient information by the merging parties in the form of a merger notification, the Panel will publish a Notice of Acceptance and details of the case on its website within 10 working days. The Panel will also write to the parties, copying the relevant Sponsor, notifying them of the process and timescales that it intends to follow. In the event that the proposed transaction does not meet the acceptance criteria, the Panel will write to the party, copying the relevant Sponsor, setting out the reasons for refusal to accept jurisdiction.

4.22. The Panel will adopt a two-phase approach to assessing mergers. The purpose of this two phase approach is to facilitate the efficient assessment of mergers, and in particular, allow those mergers that do not raise any significant concerns to be dealt with promptly, while providing sufficient time for the Panel to consider more complex cases in a second phase where this is required.

4.23. In Phase One, the Panel will undertake an initial assessment of the proposed merger to assess whether it is potentially inconsistent with the Principles and Rules. This may involve the collection and evaluation of further data and information from the merging parties as well as information from third parties and the Sponsors. Throughout Phase One, the Panel will generally consult with interested parties including via its website. During this phase, the Panel may request meetings or hearings with relevant parties.

4.24. Where the merger does not raise potential concerns under the Principles and Rules, the Panel will recommend to the relevant Sponsor that the merger proposal be allowed to proceed. In cases where the merger raises potential concerns, the Panel will set these out in a letter to the parties drawing upon the relevant evidence. Following the merging parties' response to that letter, the Panel will consider whether there is a realistic prospect that the merger will breach the Principles and Rules. If the Panel considers there is a realistic prospect that this is the case, it will proceed to a Phase Two assessment.[18] The Phase One assessment will be completed within 40 working days.

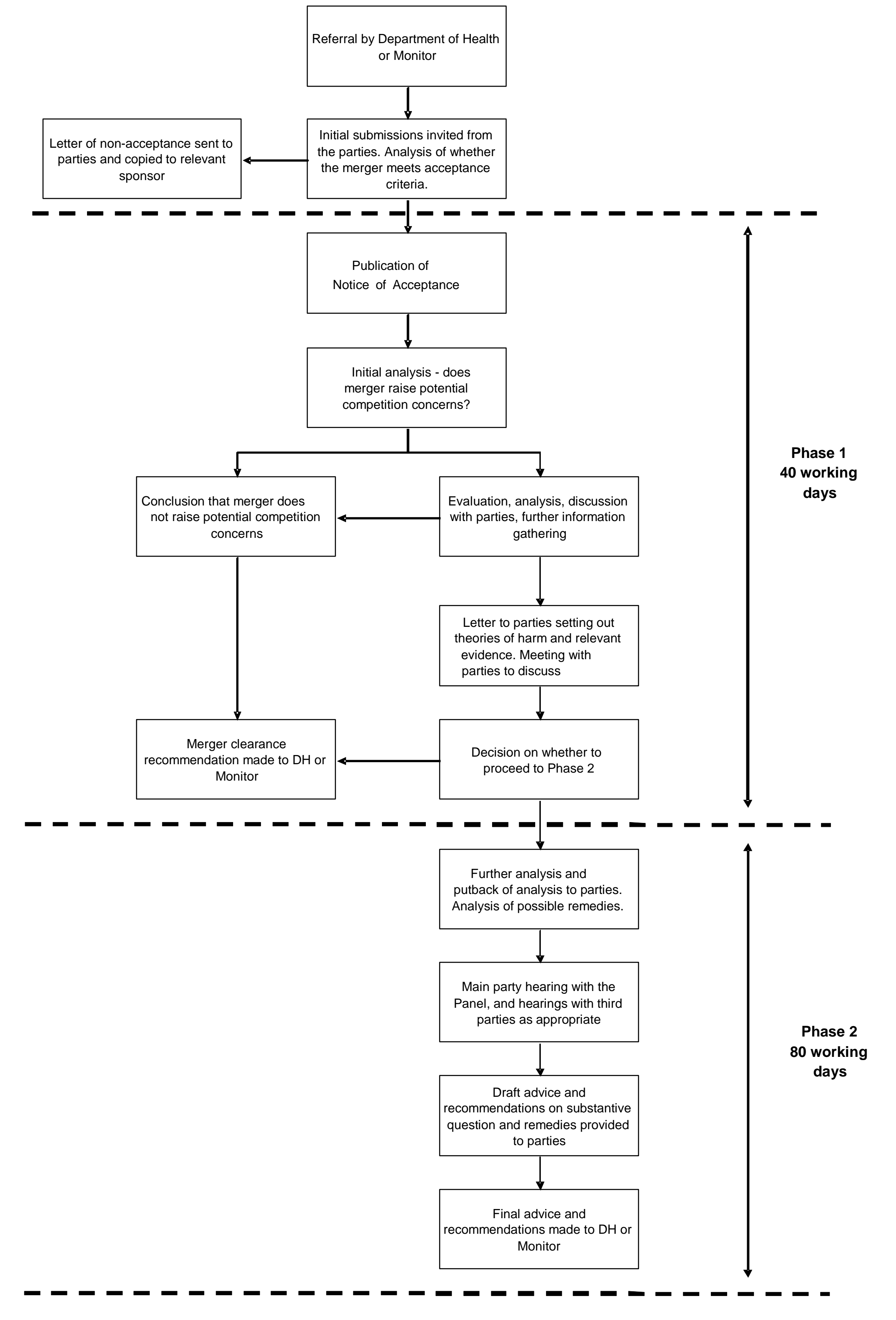
4.25. During a Phase Two assessment, the Panel will undertake further analysis based on data, information and submissions provided by the merging parties, commissioners, relevant SHAs, other third parties and Sponsors, and may request additional information to be provided by these parties. The Panel's analysis will be provided to the merging parties for comment. A hearing will be held with the merging parties to provide the Panel with the opportunity to ask questions and discuss the case with the merging parties. The Panel may also hold hearings with third parties during this second phase. Subsequent to the

[18] A 'realistic prospect' means not only a prospect that has more than a 50 per cent chance of occurring, but also a prospect that is not fanciful but has less than a 50 per cent chance of occurring.

hearing(s), draft advice and recommendations will be provided to the parties for any final comments. Final advice and recommendations will then be provided to the relevant Sponsor. The Phase Two assessment will be completed within 80 working days subject to any extension that might be granted by the relevant Sponsor.

4.26. The Panel will publish on its website the text of its advice and recommendations, subject to the excision of business secrets and other confidential information.

## Panel decision making processes on Mergers



# 5. Assessment of the effects of a merger

5.1. The Panel, in advising on a merger, is required to assess whether a proposed merger is consistent with the Principles and Rules in relation to mergers. As set out in Section 2, these principles are that:

- Mergers, acquisitions and joint ventures are acceptable and permissible when demonstrated to be in patient and taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money; and

- Vertical integration is permissible when demonstrated to be in patient and taxpayers' best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money.

In assessing the effect of a proposed merger on current and future patients, the Panel will consider the impact on service quality and choice as a result of reduced competition and balance any adverse effects against the clinical or other benefits to current and future patients that may arise from the merger

5.2. In addition, there are a number of rules associated with each of these principles that place certain obligations on the merging parties (see Table 2.1). In assessing the likely effects of a proposed merger and its consistency with the Principles and Rules, the Panel will draw to the attention of the relevant Sponsor cases where it considers that the merging parties may not have complied with these rules.

In assessing the effect of a proposed merger on current and future taxpayers, the Panel will consider the impact on commissioners, as purchasers of these services. In assessing the effect on taxpayers it will consider the impact on the price paid by commissioners and balance any adverse effects arising from reduced competition against other benefits to current and future taxpayers

5.3. In summary, in assessing a merger the Panel will apply a two part test that first assesses the impact of the merger on patients, and second, assesses the impact of the merger on taxpayers. Analysis relevant to assessing the impact of the merger on patients will also be relevant to assessing the impact on taxpayers. The remainder of this section sets out in turn how the Panel will undertake each of these assessments, and how it will refine these into an overall set of advice and recommendations, particularly where there is a conflict between these two assessments.

### Assessing the impact of a proposed merger on patients

5.4. In assessing whether a proposed merger is in patients' best interests and there remains sufficient choice and competition following the merger to ensure high quality standards of care, the Panel will consider two related issues.

- First, the services supplied to patients by the merging service providers and for each of those services the set of alternative suppliers, or potential suppliers, of those services (or substitute services) in the relevant geographic area(s). In competition analysis outside the healthcare sector, this exercise is referred to as defining the relevant market, and for the sake of simplicity the term 'market definition' is retained below.

- Second, whether the merger would, in those markets, reduce competition between service providers such that the reduction in patients' (and/or commissioners') ability to choose between alternative service providers would mean that the incentive for the merging parties to provide high quality services to current and/or future patients would be reduced.[19] We refer to this below as assessing the 'competitive effects' of the merger.

5.5. Where the Panel concludes that a merger would result in a lessening in the provision of high quality services to current and/or future patients, it will consider that the merger is not in the best interests of patients and could be expected to give rise to an adverse effect on patients (AEP).

5.6. When reaching a view on whether a merger might be expected to give rise to an AEP, it will not be sufficient for the Panel to believe that an AEP is possible: for the Panel to reach an adverse decision the Panel must expect such a result. The Panel will reach such an expectation if it considers that it is more likely than not that the AEP will result.

5.7. The remainder of this section sets out the Panel's intended approach to market definition and competitive effects.[20]

**Market definition**

5.8. In defining the market(s) in which merging service providers operate, the Panel will identify the set of alternative suppliers, or potential suppliers, of those services (or substitute services) for patients (and commissioners) in the relevant geographic area.

5.9. Defining these markets is not an end in itself, but rather is a framework within which to analyse the effects of a merger. The purpose of market definition is to define the relevant market. That is, the set of services and geographic areas to which the services of the merging parties belong. These are the set of services and geographic areas that might create competitive constraints to the merging parties.

> Few NHS-funded healthcare service providers have a profit maximisation objective. But, service providers generally need to earn enough revenue to cover their costs. Losing patients to other service providers will affect their ability to cover their costs. This increases their incentive to provide patients with high quality services and thus ensure that they are amongst the service providers of choice for current and future patients.

[19] This, in essence, is the same test as that used by the Office of Fair Trading (OFT) and the Competition Commission (CC) in their consumer-focused assessments of mergers under the Enterprise Act.

[20] In assessing market definition and competitive effects of mergers, the Panel will use in large part the same methodology as that used by the OFT and the CC with adjustments for the specific circumstances of the health sector. The starting point for the drafting of this section has been Parts 2 and 3 of the CC Guidelines for Merger References (Competition Commission, Merger References: Competition Commission Guidelines, CC2, June 2003 available at www.competition-commission.org.uk). Readers may find it helpful to refer to these guidelines for further elaboration on some of the issues discussed below. However, it should be noted that in the event of any conflict between the two documents, the Panel's own guidelines take precedence. The Panel notes that joint guidelines on the assessment of mergers are currently being developed by the OFT and the CC. It is the Panel's intention to refer to these guidelines, when they are completed, as the starting point for its own analysis of mergers. Where this would result in a revised version of the Panel's own guidelines this would be the subject of a public consultation process.

5.10. There are two dimensions to the definition of a market: a product dimension (which may correspond to a service or a provider, for example) and a geographic dimension. The services that should be included in a relevant market, and the geographic boundaries of that market, are determined by the extent to which patients or commissioners can and will readily switch between substitute services, or suppliers can and will readily switch their facilities between the supply of alternative services. That is, the key to market definition is patient choice (and substitutability more generally).

> Applying the hypothetical monopolist test to NHS-funded services needs to take into account the way in which 'prices' are set in the NHS. First, and foremost, provision of NHS-funded healthcare services to patients is free to the patient. The 'price' for these services is paid by the commissioner, in most cases a Primary Care Trust. For routine elective services, there is a uniform national tariff for each procedure. For other services, the 'price' that is paid by a Primary Care Trust may be determined through an annual negotiation or through a competitive tender.

5.11. The generally accepted conceptual approach to market definition is the hypothetical monopolist test. The Panel will use this approach, which is explained further below, wherever feasible. However, in doing so, the Panel recognises the limitations that may arise from, for example, variations in the availability of relevant data across different parts of the healthcare sector. It will also take account of the way in which prices are set for NHS-funded services and the extent to which different services are opened up to competition.

*Product market*

5.12. Under the hypothetical monopolist test, where there is price competition an assessment is made whether a hypothetical monopolist of a certain service, or set of services could profitably impose a small but significant non-transitory increase in price (SSNIP). This price increase is generally assumed to be between 5 and 10 per cent. The principle behind the test is that a market is defined as a service, or collection of services, the supply of which can, hypothetically, be monopolised profitably.[21]

5.13. Healthcare service providers' ability to set prices for their services in the NHS is often limited, and as a result, it is more difficult in both conceptual and practical terms to consider a hypothetical monopolist of these services that is able to increase prices. Nevertheless, in each merger there may be some price-based evidence that can be used for the purposes of the hypothetical monopolist test, and the Panel will take such evidence into account.

5.14. In the context of NHS-funded services, where ability to set prices is often limited, the Panel is likely also to consider whether a hypothetical monopolist of a certain service, or set of services, could profitably deteriorate the quality of a service or set of services[22] (as opposed to increasing the price of the service). For example, in acute services where there can be both tariff and non-tariff services the Panel may consider both non-price and price evidence.

[21] The Panel recognises that most providers of healthcare services do not have a profit maximisation objective although they will wish to ensure that their revenues are sufficient to cover their costs. The Panel considers that this is sufficient for the hypothetical monopolist test to be used for the purposes of market definition.
[22] In this context quality is defined widely to include factors such as access times, length of stay, risk of readmission, risk of infection, survival rate and cleanliness.

5.15. The application of the hypothetical monopolist test is an iterative process that typically starts by considering each service (narrowly defined) provided by each of the merging parties. The following question is then asked: if there were only one supplier of the service (a hypothetical monopolist) would it be able to sustain a SSNIP profitably? If the price rise, or deterioration in service quality, is unprofitable because patients would switch to other services, then the closest substitute services are added to the service group and the procedure is repeated. The relevant product market is normally defined as the smallest group of services for which a hypothetical monopolist could sustain a SSNIP profitably.

5.16. Assessing whether the hypothetical monopolist test is met for a service, or collection of services, depends on the net effect of three factors:

- first, the decline in the quantity of a service that is provided following any price increase, or quality decrease, as patients switch to other services (or commissioners switch to other service providers);
- second, any change in costs for the service provider as patients and/or commissioners shift to other service providers; and
- finally, the difference between revenue and cost (or margin) for each patient procedure.

> The extent to which NHS-funded services have been opened up to competition varies between service areas and geographies. Depending on commissioning strategies, certain services in some locations may face very limited competition, if any.

5.17. The first effect, generally known as substitution, is often the key focus of analysis. Substitution can have two components. These are demand-side substitution, where patients or commissioners switch to substitute services[23] and supply-side substitution, where service providers commence or increase the supply of the services affected by the merger as a result of the merger.[24]

5.18. The ability of patients to engage in demand-side substitution, in service terms, is likely to be limited. Patients needing, for example, a hip replacement will have limited options in terms of alternative treatments. Nevertheless, there may be instances of some services where alternative treatments, or treatments in alternative settings (e.g. in a community rather than acute setting), are feasible and the Panel will consider these situations where they arise. In practice, though, it is likely that much of the market definition exercise in any merger assessment will focus on the geographic, rather than the product, scope of the relevant market(s).

*Geographic market*

5.19. In principle, the geographic market for a healthcare service may be international, national, regional or limited to certain localities.

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[23]Evidence on emerging trends in demand-side substitution is likely to be relevant to the assessment, as well as evidence regarding current behaviour. It is also worth noting that the choices made by current patients are likely to inform the decisions of future patients.

[24]In some cases, new service providers might be considered as new entry rather than supply-side substitution. The distinction between new entry and supply-side substitution will be affected by the timescale over which new supply takes place.

5.20. As with the product market, the hypothetical monopolist test can be used to assess the geographic boundaries of the market. In doing so, the test assesses whether a hypothetical monopolist could profitably monopolise services in a narrowly defined geographic region. If it would not be profitable, for instance because patients would switch to services in neighbouring areas, then these areas would be included in the geographic market. The relevant geographic market is defined as the set of services in the smallest area that could, hypothetically be monopolised profitably.

5.21. Information that may be used to identify the relevant geographic market would include:

- information on the availability of different services in the area surrounding the merging parties;
- evidence on patients' use of different service providers across the area surrounding the merging parties;
- evidence on patients' willingness to travel to alternative service providers and how this might change in the future; and
- any costs to patients of switching to services in other geographic areas.

> Competition between service providers may take the form of direct competition for patients under the Any Willing Provider model or other models of patient choice. It may alternatively, or additionally, take the form of competition between service providers for contracts let by Primary Care Trusts or other commissioners. Both types of competition, where present, will need to be taken into account in considering the effect on patients of a proposed merger between healthcare service providers.

*Data limitations and market definition*

5.22. Data limitations mean that it is rarely possible to apply the hypothetical monopolist test in a direct sense in any industry (i.e. to actually predict with precision the impact of the price increase across the services concerned on demand and profits). It is usually necessary to infer, from whatever information is available or can be collected, what the likely outcome would be.

5.23. The Panel recognises that it is likely that in some healthcare sectors more data will be available than in others. As a result, the Panel will use the hypothetical monopolist test as a framework for assessing evidence rather than as some kind of mechanical test.

5.24. The Panel also recognises that patient choice has been introduced only recently into healthcare services. Evidence of past or current patient behaviour may not therefore necessarily be a good indicator of future behaviour in relation to their choice of service provider. As a result, the Panel will pay close attention to evidence of changes in patient behaviour and how patient behaviour may develop in the future in relation to choice of service provider.

**Assessment of the effect of a merger on competition between service providers**

5.25. This section considers a merger's impact on the extent of competition between service providers for patients. It deals with intra-market competition and competition-enhancing efficiencies before considering the possible effects of horizontal mergers on competition. It then considers other constraints on service providers, such as the potential for entry and expansion and

countervailing buyer or supplier power. Finally, it considers the impact on its assessment of proposed mergers involving 'challenged'[25] or unsustainable service providers, vertical mergers and other types of mergers.

*Intra-market competition*

5.26. In its analysis of the effect of a merger, the Panel will consider the effects that the structural changes brought about by the merger are expected to have on the competitive constraints on service providers. When assessing the degree of competition in the relevant market, the Panel will consider a range of structural and behavioural factors and measures, including:

- *Market shares and concentration measures*: market shares of service providers, both in absolute terms and relative to each other, can give an indication of the potential extent of their market power. For instance, a service provider with a large market share relative to other service providers in the same market may have the ability to deteriorate its service to patients independently of other service providers, at least to some extent. There is no particular market share threshold that will denote the likelihood of the Panel deciding that the merger has resulted in or is expected to result in an AEP. However, a combined market share of 25 per cent or more would in many economic sectors normally be sufficient to raise potential concerns regarding the effect of the merger on competition. Although, depending on how the market operates, mergers which result in a combined market share below this threshold may also raise competition concerns. This will be assessed on a case-by-case basis. The Panel will also look at measures of the degree of concentration in a market, which can indicate the ability of the leading service providers in the market to exercise market power.

- *Switching costs*: switching costs represent the cost to patients of switching between service providers. These may take many forms including inconvenience, monetary costs, administrative hurdles or lack of information about the services of alternative service providers.

- *Information asymmetries*: the balance of information held by patients and service providers may also affect the nature and degree of intra-market competition. The competitive process can be significantly affected where service providers have more information than patients, particularly regarding the quality of services where lack of good information may deter patients from seeking out alternatives.

- *Conduct of service providers*: markets with a similar structure can display different degrees of intra-market competition as a result of many factors, such as the different ability of, and capacity for, service providers to innovate. Other examples might include the objectives and culture of the service providers, the profitability of their services, their views on the future development of the market and the appropriate strategies to meet these developments.

**Competition-enhancing efficiencies**

5.27. Another factor that the Panel will consider is whether any efficiency gains result from the merger. If such efficiencies will arise as a direct result of the merger, they may have a positive effect on competition in the market, such that there

[25]The concept of 'challenged' service providers was introduced in *Developing the NHS Performance Regime* (Department of Health, June 2008), and was followed up in *Consultation on a regime for unsustainable providers* (Department of Health, September 2008).

may be no reduction in competition despite the combination of erstwhile competitors. The focus is therefore on whether the efficiencies will enhance competition among the remaining service providers. For example, a merger of two of the smaller service providers in a market resulting in efficiency gains might allow the merged entity to compete more effectively with the larger service providers.

5.28. Claimed efficiency gains may not arise. If they are to be taken into account in applying the AEP test, the Panel will need to form an expectation that the claimed efficiencies will:

- result within a short period of time;
- result as a direct consequence of the merger; and
- increase competition among the remaining service providers in the market.

**Horizontal mergers**

5.29. Horizontal mergers involve the merger of service providers that provide similar services to similar groups of patients. For example, it may be a merger between two providers of acute care, or two providers of primary care. The main effect of a horizontal merger is to remove an independent alternative provider of services to patients. The Panel will need to consider the likely effect of the removal of this service provider. In doing so, the Panel will evaluate the competitive constraints on service providers with the merger compared to the situation that would be expected without the merger.

5.30. The situation that would have been expected to prevail without the merger is known as the ‘counterfactual’. The counterfactual will be that situation that the Panel expects to arise in the absence of the merger under consideration and will, in many cases, relate to the existing, pre-merger, competitive conditions. However, in certain circumstances the Panel may need to take account of other factors, such as the expected changes in the structure of the market or alternative developments that may be expected in the absence of the merger. This is in order to reflect as accurately as possible the Panel’s expectation of the competition that will occur in the absence of the merger.

*Unilateral effects*

5.31. Unilateral effects occur when a merger enhances the ability of the merged service provider to exercise market power independently, without the need to second-guess the strategies of other service providers in the market. Where unilateral effects are likely, the Panel will need to assess whether the increment of market power resulting from the merger is significant enough to constitute an AEP.

5.32. Unilateral effects may arise in markets:

- where the merger results in a service provider with a large market share. In general, the larger the market share of the merged service provider, the greater is the potential for market power, though as already explained, market power is not assessed on the basis of market share alone;
- where no single service provider, or group of service providers, would be likely to apply sufficient competitive pressure on the merged service provider to prevent it exerting market power. Where existing service providers are

sufficiently competitive, however, this may reduce or prevent such an outcome even though the merger results in a high market share;

- where the merger itself eliminates an important competitive force in the market. For example, the merger may involve a recent (or potential) entrant or a service provider that provides a significant competitive threat to other service providers in the market. In such instances, by absorbing a major source of competition, the merger itself may increase the potential for unilateral effects;

- where patients or commissioners have little option of switching to alternative services. This may be due to the low number of alternative suppliers or burdensome switching costs, for example;

- where services are very similar (homogeneous services) and competitors of the merging service providers are capacity constrained. If competitors are unable to increase supply substantially, a reduction in quality initiated by the merged parties might be profitable; however, substantial excess capacity elsewhere in the market will tend to inhibit this;

- where the potential for entry and expansion is limited. The existence of significant barriers to exit, for example, may act as a deterrent to entry, increasing the potential for unilateral effects to arise within a market;

- where there is no, or limited, countervailing buyer, or supplier, power.

5.33. Not all of the factors outlined above need be present for unilateral effects to arise. However, information on the extent to which any of the above situations exists will be useful in assessing the potential for unilateral effects as a result of a merger.

*Coordinated effects*

5.34. Where markets are sufficiently concentrated, the actions of individual service providers can have identifiable effects on their competitors, such that service providers recognise their interdependence. This interdependence and the potential for such interdependence to increase as a result of the merger will be taken into account in the Panel's analysis of the effects of a merger.

5.35. The interdependence of oligopolistic service providers may lead them to anticipate competitors' responses to their own actions and take this into account in their own decisions. If, as will often be the case, this interdependence persists through time in such markets, the repeated nature of such decisions can have significant effects on competition. In particular, under certain conditions it might become rational for a service provider to refrain from engaging in improving their service to patients, which would be unavoidable in more competitive circumstances. This type of behaviour in competition analysis outside the healthcare sector is sometimes referred to as 'coordinated effects' or 'tacit collusion' and the potential for such behaviour to increase as a result of the merger will be considered in the Panel's analysis of the effects of a merger.

5.36. The conditions which facilitate coordinated effects include, but are not limited to:

- a high level of concentration in a market;
- the existence and significance of entry barriers;

- evidence of a long-term commitment to the market by service providers;
- a high degree of homogeneity of the service providers' services and the service providers themselves (for example, with respect to their size, market share and cost structures);
- a high degree of market transparency; and
- the existence of institutions and practices that may aid coordination (for example, information sharing agreements, trade associations and regulations).

5.37. Not all of the factors outlined above need be present for coordinated effects to arise – nor will the existence of such factors necessarily equate to the presence of such coordinated conduct. However, information on the extent to which any of the above situations exists will be useful to the Panel in assessing the potential for coordinated effects as a result of a merger.

**Vertical mergers**

5.38. Vertical mergers involve the mergers between service providers that service patients at different stages. For example, a merger between an acute trust and a provider of community services. Providers in vertically related markets do not normally compete directly with one another. However, competition concerns may arise from a merger if there is a vertical relationship between the merging parties such that they provide services to patients along the patient pathway, or more generally if one provider supplies inputs to providers operating at the other stage. Generally, a vertical merger will only raise competition concerns when the service providers involved are able to exercise a substantial level of market power in one or more markets. The Panel will seek to assess whether a vertical merger will strengthen the position of the merged service provider in any of the markets in which it operates and whether this would lead to an AEP in any of these markets.

5.39. In some cases, because of a vertical merger, the market power of a service provider in one market may be used to create or strengthen market power in the vertically related market. A merger between a supplier of an essential input and a downstream service provider, for example, might lead to a rival service provider downstream not being supplied (known as 'foreclosure' of supply).

5.40. The Principles and Rules specifically require the Panel to take this into account through the requirement that when considering vertical mergers the primacy of the GP gatekeeper function be preserved. The Panel interprets this to mean that in considering vertical mergers involving GPs, it should be particularly concerned to consider the effects that such a merger may have on the incentives for GPs to refer patients to related service providers as opposed to other service providers and the possibility of 'foreclosure'.

**Other competitive constraints**

5.41. It is necessary to consider possible competitive constraints that could reduce the likelihood of an AEP. These include the threat of entry and/or expansion, countervailing buyer power and supplier power.

*Entry and expansion*

5.42. The threat of entry or expansion can act as a constraint, preventing the merged entity from exercising market power. Alternatively, were prices to rise or quality to reduce post-merger, subsequent entry may be sufficient to reduce prices or improve quality to pre-merger levels or lower. Therefore, an AEP is unlikely to occur in circumstances where entry or expansion is easy, provided it is sustainable and likely to have an impact on the potential for existing service providers to exercise market power.

5.43. The distinction between entry and expansion is not always clear but is largely determined by the extent of the need for investment in production assets and the speed with which production can commence.

5.44. Factors the Panel is likely to consider when determining the likelihood of entry or expansion include:

- the history of past entry or expansion and evidence of planned entry or expansion;
- the extent to which past entrants have successfully gained market share and, more generally, the cost of gaining a significant share of the relevant market;
- direct observations, or statistical information, on barriers to entry, expansion and exit;
- the costs involved in entry or expansion and in operating at the minimum efficient scale necessary to achieve a reasonably competitive level of costs;
- the likelihood of entry or expansion within such a timescale that it bears on the incentives and decisions of the existing service providers in the market;
- the cost of exiting the market – if this is high it may deter entry by raising the cost of failure for new service providers;
- the potential effect of technological change and innovation on barriers to entry or expansion;
- the likely response to entry or expansion by incumbent service providers; and
- barriers to entry including regulatory barriers; reputational barriers established by brand names or otherwise; technical and other advantages enjoyed by well-established incumbents; sunk costs of entry and the history of anti-competitive behaviour in the market.

5.45. When looking at past behaviour, the Panel will also take into account the likelihood of behavioural change on the part of service providers as a result of the introduction of significant changes in the provision of healthcare services in England, including the introduction of Foundation Trusts, Payment by Results, patient choice and other recent changes.

*Countervailing buyer power on the part of commissioners*

5.46. The Panel may consider whether buyers (i.e. commissioners), either because of their size or commercial significance to their service providers or because of their ability to self-supply or sponsor entry, have the ability to prevent the exercise of market power by service providers. The size of the commissioner alone does not necessarily denote the existence of countervailing buyer power.

Factors that will affect the ability of commissioners to constrain service providers include:

- the commissioners' ability to find alternative service providers in the case of a price rise or deterioration in service quality;
- the ease with which commissioners can switch between service providers; and
- the extent to which commissioners can credibly threaten to stop purchasing other services sourced from the service provider.

**Unsustainable service providers**

5.47. In merger regulation outside the health sector, it can be the case that without the merger one of the parties would fail and no longer be able to provide services. In these instances, the merger may not result in any significant difference to the extent of competition because with or without the merger one of the parties would cease to exist. In these cases, mergers can be approved under the 'failing firm' defence.

5.48. For this defence to be accepted, three factors generally need to be considered, namely:

- whether the service provider is genuinely facing financial failure;
- whether any parties, other than the other merger party, might acquire the merging party that is on the brink of financial failure, its business or any of its assets (or wish to do so); and
- how the patients of the merging party that is on the brink of financial failure, should it exit the market, are likely to redistribute among remaining service providers. If, without the merger, patients are likely to be split across a number of other service providers, then the merger, by transferring most or all of the patients to the acquirer, may well have a significant impact on competition in the market.

5.49. In the health sector, the circumstances surrounding failing service providers are different to those in the wider economy. Service providers may not necessarily be expected to exit service provision in the same way. This is particularly the case in the acute sector. Both Monitor and the Department of Health either have, or will soon have, arrangements to oversee the restructuring of service providers where such organisations are no longer sustainable in their current form. Mergers may play an important role in enabling higher standards of quality for organisations that are 'challenged' or 'unsustainable'.

5.50. In assessing a merger involving a service provider that is designed to address 'challenged' or unsustainable service providers, the Panel would analyse the proposed merger according to those principles set out in paragraph 5.45, taking into account the differences in service provision exit noted in paragraph 5.46. More specifically, the Panel would be likely to regard organisations in such circumstances as genuinely facing financial failure, and it would focus its assessment on whether there are alternative credible acquirers of the failing service provider that would lead to a more competitive outcome than that being put to the Panel for its consideration.

**Relevant patient benefits arising from a merger**

5.51. In assessing whether a proposed merger could be expected to give rise to an AEP, the Panel will have regard to any benefits to patients arising from the merger ('relevant patient benefits'). These benefits may take the form of higher quality services, a greater choice of services or greater innovation in relation to such services. Such benefits must be expected to accrue within a reasonable period from the merger and be unlikely to accrue without the merger.

5.52. In considering relevant patient benefits that might arise from a merger, the Panel will have particular regard to evidence regarding clinical improvements that could be expected to arise from the increased scale of the merged entity.

5.53. Where the Panel identifies relevant patient benefits arising from a merger, the Panel will consider whether these are sufficient to offset any adverse impact on patients that might arise from a loss of choice or competition between service providers. The treatment of relevant patient benefits by the Panel in its advice and recommendations is discussed further in Section 6.

**Assessing the impact of a proposed merger on taxpayers**

5.54. As set out in paragraph 5.4, in addition to assessing whether a merger is in patients' best interests, the Panel must also assess whether a merger is in the best interests of taxpayers. In considering the effect of a merger on taxpayers, the Panel will, primarily, consider the impact on the price paid by commissioners for services from the merged entity.[26]

5.55. Where the Panel concludes that a merger would result in service providers having the ability to increase the price paid by commissioners for services, it will consider that the merger is not in the best interests of taxpayers and could be expected to give rise to an adverse effect on taxpayers (AET).

5.56. When reaching a view on whether a merger might be expected to give rise to an AET, it will not be sufficient for the Panel to believe that an AET is possible: for the Panel to reach an adverse decision the Panel must expect such a result. The Panel will reach such an expectation if it considers that it is more likely than not that the AET will result.

5.57. Analysis relevant to the assessment of whether a merger would give rise to an AEP will also be relevant to the assessment of whether the merger would give rise to an AET. This includes the definition of the relevant market, the extent of intra-market competition, the potential for entry and expansion and countervailing buyer power on the part of commissioners.

5.58. In assessing whether a proposed merger could be expected to give rise to an AET, the Panel will have regard to any benefits to taxpayers arising from the merger in the form of cost reductions or other efficiencies that would be passed on to taxpayers in the form of lower prices for services. These benefits must be expected to accrue within a reasonable period from the merger and be unlikely to accrue without the merger.

[26] This is not to say that taxpayers or commissioners are only interested in price. Clearly, they will also have an interest in service quality. However, we capture impacts on service quality in our analysis of the effects of a merger on patients.

5.59. Where the merging parties consider that the merger gives rise to taxpayer benefits, they will be expected to provide evidence regarding the nature and scale of these benefits and to show that they would be unlikely to accrue without the merger. The Panel will, to the extent possible, seek to verify these claims, and where it has doubts about the extent of the claimed benefits arising from the merger will include this in its advice to sponsors.

5.60. The Panel, in assessing submissions relating to the benefits to taxpayers arising from a merger will, however, pay particular attention to the extent of competition following the merger and its impact on the extent to which any efficiencies or cost reductions are likely to be passed on to taxpayers in the form of lower prices to commissioners.[27]

[27] The Panel recognises that there may be benefits to taxpayers arising from mergers between healthcare service providers, where these are taxpayer financed organisations, even when these are not realised in the form of lower prices to commissioners. However, the Panel considers that the assessment of such potential benefits fall outside the competition remit of the Panel.

# 6. Panel advice and recommendations to the relevant Sponsor

6.1. Following an assessment of the likely impact of a proposed merger on patients' and taxpayers' interests, the Panel must provide advice and recommendations to the relevant Sponsor. In summary, the Panel may recommend that a merger:

- not be allowed to proceed;
- be allowed to proceed; or
- be allowed to proceed under certain conditions.

6.2. The Panel will recommend that a merger be allowed to proceed where it is consistent with the Principles and Rules. That is, it is in the best interests of both patients and taxpayers and no AEP or AET finding has been made by the Panel. Where the Panel's finding that the merger may not be expected to give rise to an AEP or AET is based on the presence of relevant patient or taxpayer benefits, the Panel may include in its advice and recommendations such measures as it considers to be necessary to ensure that such benefits to patients or taxpayers will be realised. In providing advice to sponsors the Panel will explain clearly the evidence and reasoning it has relied upon in reaching its decision.

6.3. Where a merger gives rise to an AEP, an AET or both, the Panel will consider whether the merger should not be allowed to proceed or should only be allowed to proceed under certain conditions. In doing so, the Panel will identify all remedies, including prohibition, that are effective in addressing the AEP and/or AET. The Panel will then identify the least costly remedy (or set of remedies) that it considers to be effective in addressing the AEP and/or AET. The Panel may modify or change its choice of remedy to ensure the retention of any relevant patient or taxpayer benefits that have been identified. For the avoidance of doubt, the Panel's advice on remedies is not binding on the Sponsors.

6.4. The remainder of this section discusses the identification of effective remedies, and the assessment of the costs and proportionality of different remedies.

### Effectiveness of recommended remedies

6.5. Assessing the effectiveness of a remedy will involve several distinct dimensions:

*(a) Impact on AEP/AET.* Competition is a dynamic process of rivalry between service providers seeking to win patients' or commissioners' business over time. Remedies that preserve the structure of the market expected in the absence of the merger (so-called structural remedies) should be expected to address the adverse effects at source. Such remedies are normally preferable to measures that seek to regulate the ongoing behaviour of a merged entity (so-called behavioural remedies) as these are unlikely to deal with an AEP/AET as comprehensively as structural remedies and may result in distortions compared with a competitive market outcome.

*(b) Appropriate duration and timing.* Remedies need to address the AEP/AET effectively throughout its expected duration. Remedies that act quickly in addressing competitive concerns are preferable to remedies that are expected to have an effect only in the long term or where the timing of the

effect is uncertain. The effect of a remedy should also be sustained for the likely duration of the AEP/AET.

*(c) Practicality.* A practical remedy should be capable of effective implementation, monitoring and enforcement. To enable this to occur, the operation and implications of the remedy need to be clear to the merger parties and other affected parties. The practicality of any remedy is likely to be reduced if elaborate and intrusive monitoring and compliance programmes are required. Remedies regulating ongoing behaviour are generally subject to the disadvantage of requiring ongoing monitoring and compliance activity.

*(d) Acceptable risk profile.* The effect of any remedy is always likely to be uncertain to some degree. In evaluating the effectiveness of remedies, the Panel will seek remedies that have a high degree of certainty of achieving their intended effect. Patients, commissioners or suppliers of merger parties should not bear significant risks that the recommended remedies will not have the requisite impact on the AEP/AET.

**Cost of remedies and proportionality**

6.6. Having identified the set of effective remedies, the Panel will consider the costs of these remedies. If the Panel is choosing between two remedies which it considers will be equally effective, it will recommend the remedy that imposes the least cost or that is least restrictive.

6.7. The costs of a remedy may be incurred by a variety of parties including the merging parties, third parties, and others. The Panel will generally attribute less significance to the costs of a remedy that will be incurred by the parties to the merger than costs that will be imposed by a remedy on third parties.

6.8. The costs of a remedy may arise in various forms. Remedies may result in costs through distortions in market outcomes. This is more likely to be the case where behavioural remedies are used which intervene directly in market outcomes, especially over a long period. Remedies may also result in significant ongoing compliance costs. The Panel will endeavour to minimise such costs, subject to the effectiveness of the remedy not being reduced.

6.9. In exceptional circumstances, even the least costly but effective remedy might be expected to incur costs that are disproportionate to the scale of the AEP/AET (for instance if the costs incurred by the remedy on third parties are likely to be greater than the likely scale of adverse effects). The Panel will seek to ensure that no remedy is disproportionate in relation to the AEP/AET and therefore, in these exceptional circumstances, the Panel would not pursue the remedy in question.

6.10. It may be possible that all feasible remedies will only be partially effective in remedying an AEP/AET. In such cases, in making a recommendation to the relevant Sponsor, the Panel will select the most effective remedy or package of remedies that is available provided that the costs of this remedy are not disproportionate (as described above) in relation to the AEP/AET.

# 7. Guidance on content of submissions by merging parties to the Panel

7.1. The following paragraphs are intended to assist merging parties and their advisers in compiling a merger notification to the Panel. While the information set out below is neither prescriptive nor exhaustive, it will assist the Panel if the headings and ordering set out in the following sections are adopted in making a submission.

7.2. Nevertheless, it should be appreciated that the requirements set out here are for general information and advice only and may not apply exactly in every case. The types of information needed by the Panel are set out in two categories: general background information and information relevant to the substantive assessment of a proposed merger.

7.3. When the initial merger notification is submitted to the Panel, the notifying part/parties should submit at least two hard copies of each document and, where possible, electronic copies.

**General background**

*The parties*

7.4. Submissions should provide:

- the full legal name of the merging parties;
- relevant contact details in the UK for each merging party (and their legal/financial advisers) including its headquarters' address, telephone, facsimile, email and website address;
- a named contact, whether a representative of the notifying party/parties or a legal/financial adviser, with telephone number, fax number and email address;
- a description of the services provided by each merging party, including products and services that both parties supply and any areas of geographic overlap;
- maps setting out the location of the merging parties' activities as well as those of their main competitors;
- details of all related companies of each merging party and the relevant party's position within that group;
- any parts of the acquiring group, other than the acquiring party, that carry on business which overlaps with that of the target or which have a vertical relationship with that business;
- each merging party's turnover in England in the latest financial year, including its operating and pre-tax profits or losses; and
- the value and nature of the consideration provided for the proposed merger;
- the rationale for the merger.

*Supporting documentation*

7.5. Provide two copies of the most recent Annual Report and Accounts of the merging parties and, where relevant, copies of any agreements or other similar

documents between the parties, any market studies prepared in connection with the prospective merger and any press releases or newspaper cuttings. Any other information which helps the Panel's understanding of the transaction is always welcome.

*Third Parties*

7.6. Please provide names and contact details for at least the five principal competitors and, where relevant, service commissioners for each merging party in each area of overlap, providing a named contact, his/her title, phone number, fax number and email address where available.

*Timing*

7.7. In general, the Panel works to the timetable set out in Section 4. While the Panel will take into consideration requests for more expedient decisions, these will be accommodated only to the extent that they do not disadvantage the case under consideration and can be accommodated within the Panel's overall workload. If a quick decision is needed, the submission should clearly state why the case is urgent. In such instances, the Panel would expect merging parties to be alert particularly to the importance of a complete and accurate merger submission.

**Substantive assessment**

7.8. Set out below is a summary of the broad analytical elements that the Panel will review in seeking to identify mergers that may be expected to give rise to adverse effects and the type of information that the Panel would be looking for from the merging parties.

*Market definition*

7.9. As a starting point in the competitive assessment, the Panel will consider the scope of the market or markets in which the merging service providers compete. The submission should contain information about three specific matters.

- **Demand-side substitutability.** Are there services that are close substitutes for those made or sold by both the merging parties, in the sense that patients could switch easily to those alternatives in response to [an increase in prices or] a reduction in quality in the overlapping services?
- **Supply-side substitutability.** Are there other service providers that might be considered to be in the same market as the merging parties, even if they do not currently supply the same services? This would be the case, for example, if the other service providers could begin to supply the same services quickly and without significant extra cost by switching production, given the stimulus of an increase in price or a reduction in quality of those services.
- **The geographic market.** The area within which current buyers of the service (and close substitutes) could readily buy from other suppliers usually defines the geographic boundaries of a particular market. Please indicate the effective radius of the market (x miles from the hospital, for example) and provide appropriate supporting information. A map will invariably be helpful.

*Nature and extent of competition in the market*

7.10. The nature and extent of pre- and post-merger competition in the identified relevant markets may indicate concerns about a possible loss of competition as a result of the merger, particularly where the parties may be each other's closest competitors.

7.11. To assist the assessment of the effect of any horizontal overlaps between the merging parties, the Panel will require for each of the relevant markets an estimate of the size of the total market as well as market shares for each of the merging parties and their largest competitors. The figures supplied should normally be those for the most recent year for which they are available. If market shares vary significantly from year to year however, information for several years may be more useful.

7.12. Where the Panel may be concerned about the effects of vertical links, merging parties should explain the nature of any such effects. The Panel would not normally ask for more detailed information if none of the merging parties has a share of 10 per cent or more in an 'upstream' or 'downstream' market. In other cases, the Panel may ask for details of the market shares of the merging parties in relevant markets, the shares held by competitors in those markets and the extent to which the merging businesses supply to, or acquire from, competitors.

*Entry barriers*

7.13. Where a merger gives rise to possible competition concerns, entry by new competitors or expansion by existing competitors may be sufficient in scope, timeliness and likelihood to deter or defeat any attempt by service providers to capitalise on the loss of competition by exploiting patients.

7.14. Where there are no horizontal overlaps nor any issues associated with vertical links, or where the combined shares of the parties in the relevant market are 10 per cent or less, the Panel does not normally require any information about barriers to entry. For other cases, however, any information that can be supplied is likely to speed the Panel's assessment. In general terms, the higher the initial market share and the larger the increment, the more information it is helpful to have in this area. What constitutes a 'barrier to entry' can vary but may include:

- technical and other advantages enjoyed by a well-established service provider;
- regulatory barriers;
- reputational barriers established by brand names;
- a history of anti-competitive behaviour in the market, such as discriminatory dealings, which might constitute an entry barrier, and/or
- the 'sunk' costs of entry, such as research and development costs, the cost of creating a distribution or servicing network, or high advertising costs.

7.15. When the Panel assesses such barriers it may be helpful to know whether the market is growing or contracting and the history of entry and exit (new entrants and those leaving the market in the last five to ten years).

*Buyer power*

7.16. The ability of a merged entity to raise prices or reduce quality may be constrained by the countervailing power of commissioners. In assessing whether buyer power exists, it would be helpful to include in the submission evidence of the proportion of the merging parties' sales accounted for by their main commissioners.

*Patient and taxpayer benefits*

7.17. Notwithstanding the loss of an independent market participant through the merger, competition within the market as a whole might be increased through the efficiency gains enjoyed by the merged entity. If it is believed that the merger may deliver relevant benefits to patients and taxpayers it is worth making this clear, drawing attention to any matters that may be relevant and offering a detailed evaluation of the expected effects. Evidence of efficiencies that would outweigh a possibly anticompetitive merger will need to be compelling.

*Other background information*

7.18. The merging parties may, of course, offer any other information they think relevant. For example, references to earlier Panel reports dealing with the same markets, and to contacts with other government departments or regulators about the merger. The merging parties are also welcome to give their own views on the competition implications or any other effects of the merger.