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RECONFIGURING SERVICES : TESTING THE BENEFITS OF NHS TRUST MERGERS

Service reconfigurations are high on the agenda of most health authorities, boards and trusts. Pressures on costs, clinical staffing, accreditation and clinical quality, are encouraging many trusts, health authorities and boards to consider significant changes to patterns of service delivery. Trust mergers can play an important part in this process, both delivering direct benefits through creating fewer, larger organisations and as a way of facilitating the desired service reconfiguration. Such outcomes from mergers are highly attractive, but are by no means guaranteed. Trust mergers may also lead, at least in the shorter term, to increased costs and, in the longer term, may inhibit rather than encourage beneficial service reconfiguration. There may also be alternatives to trust mergers which could deliver similar or better outcomes faster and with more certainty. Without an element of caution there is a danger that easily encouraged and enforced trust mergers will become an alternative, and indeed a barrier, to the more difficult but more important reconfiguration of services. To this end this paper sets out a brief analytical framework - a test - to be applied to proposed mergers aimed at demonstrating their potential benefits.

THE ATTRACTION OF MERGERS

For many communities and their local health authorities and boards, the arguments in favour of a substantial reconfiguration of services are increasingly becoming irrefutable. Health authorities, boards and trusts are commonly faced with:

- *Cost and cash pressures*
- *Local duplication of services and assets*
- *Concerns over clinical quality*
- *Staffing problems, not least increasing difficulties in recruiting both hospital doctors and GPs.*

Despite continuing real growth in resources over a number of years and substantial improvements in productivity, a significant number of health authorities, boards and trusts continue to operate at a deficit. "Cuts" in spending are commonplace, whilst money for growth and development is increasingly scarce.

At the same time there is evidence of significant surplus capacity in services and assets within the health system as a whole, as well as of local

duplication. The diseconomies resulting from this dispersed surplus capacity, is one of the key reasons why health authorities are unable to pay for all the needed services, even as resources - clinicians and buildings - stand under-utilised.

The fragmented and unco-ordinated distribution of services also gives rise to concerns over clinical quality and effectiveness. Not only is the present structure expensive but has, at best, variable quality. Finally, the present structure is perhaps fatally challenged by a lack of trained personnel. For both the hospital and primary care services a severe shortage of doctors threatens.

The current pattern of service delivery therefore seems increasingly unsustainable - it may be impossible to staff, it looks expensive and some of the services delivered may be ineffective or inappropriate. Tackling these issues has, however, proved very difficult. Both local and professional interests are resistant to change; and whilst the introduction of the purchaser/provider split may have thrown some of the issues into starker relief, it has not made action any easier. Indeed the creation of nearly 500 independent local trusts has arguably made changing the system more difficult.



Whilst the creation of trusts has brought benefits - a return to local management and improved local efficiency within the trusts - the price may have been too high; an increase in overall costs, particularly in management and administration and for the system as a whole, a reduction in its capacity for strategic or significant change. This is, perhaps, not surprising given that the process of creating trusts was largely haphazard. The resulting pattern of trusts is neither consistent nor based on any strong rationale, either in service mix or in size. At different stages of the trust development process, different configurations were favoured with little supporting evidence as to their practical benefits. The apparent attractions of merging trusts are, therefore, manifest. The potential benefits of trust mergers are arguably fourfold:

1. Local management and administrative costs could be reduced if there were fewer trusts.
2. The existence of independent trusts, particularly within the same local community, encourages costly and unhelpful competitive behaviour.
3. Some trusts are simply too small to achieve beneficial economies of scale.
4. The merger process and the creation of fewer, larger trusts will encourage a process of service improvement.

The evidence that these benefits will be delivered is, however, more questionable.

Reducing Management Costs

The most obvious and immediate potential benefit from merging trusts is a reduction in management and administration costs. Independent existence brings with it a relatively fixed cost, of perhaps £750k a trust, coupled with a range of costs that will be semi-variable with the scale and nature of its activities. There is also some evidence that management and administration costs fall as a percentage of total trust costs as the size of the trust rises. Merging trusts could, therefore, be expected to reduce direct management and support costs, conceivably by only 1 or 2% of total income.

However, in the short term, such savings are likely to be offset by immediate increases in costs. There may be substantial direct costs associated with

bringing about the merger - for example, a reasonable communications and consultative process, legal costs and the costs of the necessary business planning exercises. In addition, there will be the inevitable cost of redundancies.

Furthermore, it cannot be assumed that reducing management and administration cost will have no impact on the rest of the trust. Bringing management and administration costs down by 20-40% may have implications for the operation of the trust as a whole. Indeed even a relatively small fall in the efficiency of clinical services, as a consequence of a reduction in management attention or effectiveness, would more than offset any cost savings so achieved.

Almost certainly in the short term the diversion of effort and emotion, inevitable to some degree in a merger process however "friendly", may result in a reduction in operational efficiency. Managers and clinical staff, concerned with their own and their organisation's survival, may be less effective in running day-to-day affairs.

On balance, merging trusts simply to reduce direct management and administration costs does not look very attractive. In the short term the costs are likely to exceed the benefits, particularly given the consistent track record of trusts reducing their management and administration costs, largely without incurring the disbenefits associated with mergers.

Reducing the Costs of Competitive Behaviour

The creation of autonomous trusts brought with it a period of explicit competitive behaviour, the costs and benefits of which are unclear. Reducing the number of trusts through mergers, should reduce some of those costs, but may also reduce some of the benefits.

Arguably, for competition to have a beneficial impact in driving down costs, there needs to be a degree of surplus capacity and some duplication of services. Competition requires patients (or at least their purchasers) to have choices and choices require some, even if temporary, inefficient use of assets and staff. Such inefficiencies can be tolerated, it is argued, if as a result the system as a whole is made more cost effective. The extent of the resulting duplication of services, specifically arising from inter-trust, competitive behaviour is not, however, known.



However, the extent of competitive behaviour between trusts has been highly variable and usually pretty marginal. Only in very rare cases has competitive - market - behaviour driven a trust out of business and thereby brought about a local restructuring. Whilst inter-trust competition may have contributed to the improvement of performance delivered by most trusts over the last few years, there is no sound evidence as to the relative contribution of competition to that improvement, as against the process of creating the trusts themselves, the development of the purchaser/provider split, the introduction of explicit performance measures or the impact of GP Fundholders. It is possible that limited competition may have encouraged duplication of service without applying any sanctions for the resulting inefficiencies.

Merging trusts may allow service duplication to be tackled and could reduce the amount of management time and costs diverted into competitive behaviour. Given that the costs of competitive behaviour are not known, the economic benefits of reducing such behaviour are equally unknown. Moreover, reducing what competitive pressures there are, may curtail the pressures on trusts to improve their own performance. Replacing competitive behaviour by co-operative behaviour, reflecting the commonality of interest amongst all the stakeholders in the NHS, may offer similar benefits with lower costs, though this is equally unproven.

Achieving Economies of Scale

The diversity in size and nature of trusts is not surprising given the relatively haphazard process of trust creation, which in many cases took little notice of the strategic or service context of the proposed trust. As a result, many may be the "wrong" size, failing to achieve the most desirable or optimum size or shape. Such arguments can apply to all aspects of trusts, both support services and core clinical services. Common observation suggests that many trusts are operating sub-optimally and, therefore, mergers should be encouraged to achieve economies of scale, delivering both cost and, possibly, quality benefits.

The available evidence is, however, far from conclusive. Reviewing recent studies undertaken by the King's Fund, the University of York and ourselves suggests that:

- *Productivity and unit costs may increase with unit size before declining again, for example, for acute hospitals the "optimum size" appears to be about the equivalent of 300 in-patient beds*
- *Optimum sizes almost certainly vary by activity and specialty, making it very difficult to predict economies of scale for trusts - as against hospitals or units*
- *Economies of scale, where they exist, can only really be achieved through horizontal mergers and are unlikely to be delivered through vertical integration.*

Some trusts may, therefore, be too small but, equally, some may already be too large. Furthermore, the size and scale of the trust itself may be a secondary factor by comparison to the configuration and scale of its constituent activities or units. Such conclusions reflect the heterogeneous nature of healthcare providers, which are largely a function of historical accident and lasting tradition. It is, therefore, not possible at this stage to make generic statements about trust economies of scale - every case needs to be considered separately.

Finally, there is the rather unfashionable question of management. Perhaps the explanation of why some trusts - despite great differences in scale, assets and environment - seem to perform better on a wide range of measures than their neighbours, is that they are just better managed. Merging trusts is no guarantee of good management; indeed it may result in allowing poor managers to make a mess of even bigger operations.

Facilitating Change

Trust boundaries often seem to be major barriers to bringing about changes that benefit the wider community and the NHS as a whole. The independent, autonomous, local nature of trusts, does seem to encourage parochial and perhaps unco-operative behaviour. Merging trusts may, therefore, remove barriers to bringing about beneficial changes. If the primary concern is significant service development, trust mergers may facilitate the required changes.

The assumption that mergers facilitate change - whilst delivering direct cost benefits - is appealing. However, the evidence is less clear. As is so common in the NHS, there do not appear to be any evaluation studies available on the mergers that have occurred. Direct experience of some trust



mergers suggests that two separate organisations in two separate trusts have been replaced by two organisations operating within the same trust. Furthermore, the merger process, if successful, is likely to encourage greater change *within* a trust but not necessarily for the system as a whole. Perversely, straightforward horizontal mergers, simply by creating larger trusts, may inhibit or discourage desirable changes involving other trusts or healthcare providers. Vertical mergers may result in greater integration of existing services, whilst inhibiting the development of new patterns of care from new providers.

DO MERGERS WORK?

Whenever an industry comes under stress and pressure, its constituent organisations and their managers discover an enthusiasm for mergers. In some cases this may be founded on a well worked out analysis and strategy but sometimes it appears to be no more than an end in itself; a diversion from tackling fundamental, underlying problems. Certainly in the private sector the evidence on mergers is mixed, not surprisingly suggesting that some mergers are very successful but that others bring few benefits.

The evidence from the public sector is far less complete. Reshaping organisational boundaries has been a favoured policy in recent years, not only in health but also in local government. The benefits of redrawing these organisational boundaries have rarely been predicted before the event or evaluated after it. For the NHS, trust mergers may be useful but it will depend on specific local circumstances. Furthermore, mergers are not without costs and the benefits they deliver might equally be delivered in a number of other ways.

THE ALTERNATIVES

Merging two organisations is a policy intended to bring about a series of performance benefits, predominantly lower costs and service development. But a merger may not be the only way to bring about these improvements. This is true even in the private sector, where the organisations coming together invariably have different shareholders and stakeholders, so that action can only be achieved by removing the

boundaries that divide them. In the NHS, the shareholders and stakeholders are overwhelmingly the same and, consequently, the barriers to be removed through mergers are, or should be, somewhat artificial. Alternative approaches would stress the potential for co-operative behaviour between organisations with common goals whilst remaining autonomous.

Rationalising Service Portfolios

The current distribution of clinical services may be inefficient and sometimes ineffective. Not only do many trusts fall short of a desirable scale and mix of services but their difficulties are likely to be compounded by problems over staffing and accreditation. To make progress, service portfolios may need to be rationalised over a number of trusts and sites. Rationalising service portfolios, through a partnership involving purchasers, GPs and trusts offers a far more radical and comprehensive approach than could ever be available through mergers. Mergers may be one of the consequences of this process but are not themselves the alternative.

Co-operative Cost Reductions

In many areas trusts have more in common with one another than they have differences. Yet many trusts still operate independent, sub-optimal activities in areas such as clinical and non-clinical support services. The potential for making major savings through co-operative initiatives across a range of services remains very great. Indeed, mergers may not deliver anything like the same scale of savings that could be achieved by a number of trusts acting together. The levers for bringing about such changes already exist; benchmark costs can be established and purchasers can decide not to pay for any service above the benchmark price.

System Transformation

Healthcare is an extremely complex business and becoming more so as the comfortable divisions

