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'Great companies can make ill-fated acquisitions'

By Lia Novotny | January 24, 2017

In a 2014 survey by The Advisory Group, the vast majority of healthcare executives said they planned to pursue M&A activities in the coming year. They weren't lying. A historic merger wave that began around 2010 has gripped the industry since, with few signs of abating.

But are leaders approaching those deals with the right mindset and capabilities? Len Schlesinger, the Baker Foundation Professor at Harvard Business School, a former chief operating officer at both Limited Brands and Au Bon Pain, has studied M&A as both an academic and a practitioner — and understands the pitfalls of growth without intentional design. athenaInsight spoke with Schlesinger about why mergers are a challenge, and how to do them right.

Q The academic literature in support of M&A as a source of value creation across a variety of industries is generally disappointing, yet M&A activities continue unabated. Healthcare is the new hotspot. What explains the disconnect?

A Leaders look at M&A from the front end, going in, and all they see is potential. Academics look at the back end, at outcomes. Even if executives are aware of M&A's poor track record, they often fall victim to that great myth: "This time is different." They convince themselves that their ability to spot value is extraordinary, their integration will be above average, and so on. The history of M&A is littered with inorganic growth attempts that are rooted in untested, emotionally-laden assumptions about what the world will be like post-merger that never turn out to be quite true.

Q Still, the economic advantages of scale in healthcare — particularly pricing and purchasing power — are real and can be profound. So is it possible that healthcare actually is different than other industries?

A The challenge is that economies of scale often take a back seat to the challenges of integration. I've been working with athenahealth to examine the financial data of its client base. We've found evidence of clear operational diseconomies of size in areas of productivity, patient loyalty, and collections. For example, athenahealth's larger clients often have a lower same-store organic growth rate — a strong indication that growth is not creating economic value for them at the operating unit level.

I've also seen outside research by my HBS colleague Leemore Dafny that says there is absolutely not a shred of evidence that healthcare systems that have grown through mergers achieved improved financial performance. This doesn't mean that inorganic growth always has negative financial consequences. But it does suggest that growth, if it's going to pay off, has to come with planning and intention.

Q What about the clinical side? Some studies have suggested that with scale and consolidation we will also see improved care. Aren't there advantages to scale there, especially as we move to population health?

A Yes. Larger systems can standardize care, ensure specialists and surgeons have enough volume, and make other clinical improvements. But the dirty secret is that healthcare leaders don't always lay the groundwork for these changes when negotiating deals. After all, it doesn't create a lot of good will with the seller to focus on how acquirers are going to control and standardize after the deal is signed. I still remember I spoke with one healthcare executive who said candidly, "We're buying up every poorly run little practice that we can find within our geography, and a critical part of the negotiation of buying them is to promise them autonomy." That's clearly not a recipe for success.

Q You sound pessimistic.

A Look, even great companies can make ill-fated acquisitions. I've studied Southwest Airlines extensively. Every one of their operational capabilities aligned with their strategy of being a high-quality, low-fare airline. They standardized their aircraft so their flight crews became interchangeable and maintenance less expensive; they increased utilization of their aircraft through quick turnarounds at the gate; they favored short-haul, point-to-point flights over the hub and spoke model. It was a lean, mean operation that delivered revolutionary profits and customer satisfaction at a time when the rest of the industry struggled.

And then, in 2010, they went and bought AirTran. On paper the deal made sense because the Atlanta-based carrier was also a low-cost airline. But AirTran had different planes. They flew long-haul in addition to short-haul. Their culture was different. Suddenly Southwest came under enormous pressure due to the incremental costs associated with Airtran's operational activities. The result was Southwest Airlines no longer had "very low" ticket prices. They had "low" ticket prices. Last year, Southwest acknowledged that it took them five years after the acquisition to recover.

Q How about the companies that have done M&A well? What can we learn from them?

A One is to be much more deliberate and careful about operational and cultural fit. The second is to be crystal clear about the methodologies and processes for bringing new practices and entities on board. Unfortunately, during this current transaction frenzy, you have a lot of executives saying, "let's buy it for scale and clout, and then we'll figure out how to put it together later."

In healthcare, successful acquirers will be very clear about their capabilities and their approaches, and should be very willing to lay all that out upfront as part of the process of acquisition. They're not going to overlook the cultural differences with the target.

There have been organizations in the private sector that are notoriously good acquirers. Cisco for years was the place everybody went to learn about M&A integration. They had the process nailed. They understood where they were going to leave people alone, and where there should be no opportunities for local discretion and variation. This is a leadership capability — setting a principled approach to growth.

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