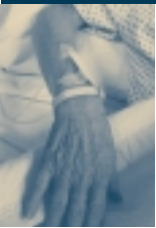


Mythbusters

A series of essays giving the research evidence
behind Canadian healthcare debates



Myth: Bigger is always better when it comes to hospital mergers.

More efficiency. Less duplication. Better safety. Many claims are made about the benefits of hospital mergers. Supporters say larger institutions can reduce management and administration costs while maintaining or even increasing service levels. They also argue that patients at larger hospitals have better outcomes, and merged hospitals do a better job of attracting and keeping staff.

To achieve these goals, governments and health authorities from Victoria to St. John's have been consolidating hospitals. Between 1990 and 1999 — the peak of “merger madness” — the number of Canadian hospitals declined from 1,231 to 929, a drop of almost 25 percentⁱ (though mergers were certainly not the only factor contributing to this change). This urge to merge is not just a Canadian phenomenon — in the U.K., some 99 trust mergers have taken place since 1997, 14 in London alone.ⁱⁱ

But the popularity of mergers doesn't mean that research shows they are a good idea. While evidence of greater efficiency can sometimes be found when smaller facilities merge, research shows this is more difficult in larger facilities.ⁱⁱⁱ Better patient safety hasn't been proven either, and mergers may have surprising and unintended consequences when it comes to staff morale.

The dollars

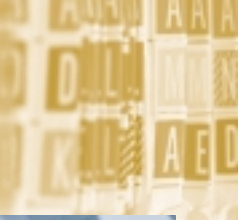
In Canada, the evidence on cost savings from mergers is largely anecdotal and inconclusive. For example, one report suggests that Canadian hospitals would save four percent of operating costs through mergers, but provides no evidence.^{iv} And managers in Victoria, B.C.



reported their staffing requirements dropped significantly following amalgamation, but without comparing it to similar hospitals that didn't merge, it is difficult to know whether this would have happened anyway.^v

In other cases, the literature on the subject is mixed. The 1979 merger of Chedoke-McMaster Hospitals in Ontario is reported to have saved an estimated \$1 million in operating costs,^{vi} but a hypothetical merger of St. Joseph's General Hospital and Peterborough Civic Hospital showed neither savings nor losses.^{vii}

Some research has found that there is actually an optimal size for a hospital, and it's not a mega-facility. Studies in many countries have shown that the best size for acute hospitals is actually between 200 and 400 beds — above that, management and administration costs tend to increase.ⁱⁱⁱ Studies in the U.S. have also shown mega-mergers can drive costs up. And in the U.K., a study of four newly-merged National Health Service trusts found that, two years after the mergers, the new institutions had not achieved the predicted management cost savings.ⁱⁱ



The sense

Though mergers in Canada were primarily a response to the financial crunch of the 1990s, proponents also claim they are better for patients and staff. Not so, according to research.

Few empirical studies have been done on the effect of mergers on quality of service. However, some research suggests larger bureaucracies create certain disadvantages, such as less responsiveness to the patient.^{viii} Other studies found mergers can disrupt services and absorb more management attention during the transition period than expected, thus affecting patient care.ⁱⁱ As well, one study showed that people with low incomes are less likely to travel extra distances for certain types of healthcare.ⁱⁱⁱ

We do know a positive link exists between volume and quality in some specialized units,^{ix} and that having a group of surgeons perform more complicated surgeries can mean fewer complications.^x But these factors do not support a broader argument that larger institutions produce better patient outcomes and while some research papers may appear to demonstrate such a link, they often fail to adjust sufficiently for differences in the groups of patients being treated, or the severity of their illness.ⁱⁱⁱ Other times, perceptions of improvements are broadly described and evaluation methods are weak or nonexistent.^{viii}

Research neither supports nor refutes claims of more efficient use of employees following mergers. In addition, no empirical evidence has been found to conclude that mergers lead to improved recruitment or retention of caregivers or management.ⁱⁱ Some researchers note the more impersonal nature of larger institutions could lead to higher staff turnover,^{xi xii} and in some cases, managers have taken jobs elsewhere to avoid organizational disruption.ⁱⁱ One study suggests the educational experience at teaching hospitals may be diluted due to the need to travel between institutions, and that curriculum planning is more complicated.^{xiii}

The changes involved with mergers can also have a devastating effect on staff morale, and this can affect quality of care. One study examining the effects of restructuring in a large Canadian teaching hospital found that morale and trust in the institution plummeted as the changes took effect.^{xiv}

There's also the challenge of managing a massive culture shift. Many of the Canadian hospitals that have been amalgamated are more than 100 years old, with deeply entrenched institutional cultures.

Yet, in a merger, old cultures must be retired and a new one forged — a lengthy, delicate and challenging process, but key to a hospital's success and the performance of its staff.^{xv}

Curb the urge

While the intuitive appeal of “bigger is better” in hospital mergers is powerful, it's clear the empirical evidence is weak and the potential for negative outcomes significant. The urge to merge is an astounding, run-away phenomenon given the weak research base to support it, and those who champion mergers should be called upon to prove their case.

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