Look Before You Leap

A Brief Review of the Plans and Evidence Regarding the Scarborough-West Durham Proposed Hospital Merger

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Introduction

Despite the fact that Ontario ranks extremely low in health care funding compared to the rest of Canada, the Ontario government has adopted a fiscal plan that aims curb health spending by $3 billion.[1] Hospitals have taken the brunt of the curtailment in funding, but since Ontario's hospitals have already been restructured for decades, there is a deep consensus among policy makers and hospital leadership that there are few "efficiencies" to be found without cuts to needed services. In this context, a new wave of hospital mergers is moving across Ontario.

In Scarborough and West Durham, facing a projected funding shortfall of $28.4 million,[2] the Scarborough Hospital and Rouge Valley Health System have proposed to merge. The final report, *Leading for Patients*, created by the Integration Leadership Committee (ILC) of the two hospitals, was submitted to the Central East Local Health Integration Network (LHIN) in November 2013. In January, the hospitals submitted plans for capital redevelopment (hospital building and renovation plans). In this paper, we have analyzed the *Leading for Patients* report, the capital planning submissions made by the hospitals to the CE LHIN and, more broadly, the direction and strategy of the Scarborough and West Durham hospitals in their restructuring plans.

Our findings have important implications for the future of access to hospital care in Scarborough and West Durham, affecting 1.5 million people who live in the catchment areas of the four existing hospital sites.[3] According to the hospitals' own projections, the proposed merger will cost $30 million. It will take more than a decade to pay off the high costs of merging, after which there are no clear projected savings anyway. Thus, any future savings that would be found in the newly merged hospital would have to come from cuts to health care services – service cuts about which no details have been released. Moreover, despite well-publicized promises to the communities that vital health services would not be cut and emergency departments would not be closed, in fact, the capital planning submission document sets out two options for Scarborough which include plans to close all three existing hospitals (and emergency departments) in Scarborough and replace them with either one hospital or two hospitals. The number of hospital beds in "Option 1" of the plan for Scarborough is fewer than currently exist.[4] The bottom line, based on the hospitals' own projections of bed needs, the first proposed option in its capital planning submission would close three hospitals and replace them with one hospital that is smaller (in terms of beds) than the current hospitals. The planned new hospital would cost more than $1.5 billion and have almost 600 too few beds to meet population need 25 years from now.

[1] "The Auditor General's Review of the 2011 Pre-Election Report on Ontario's Finances," Office of the Auditor General of Ontario. 28 June 2011.
[2] "Scarborough Cluster Hospitals Facilitated Integration." Central East Local Health Integration Network Board of Directors. 24 June 2013.
[3] RVHS and TSH Preferred Integration Plan – Final Report "Pre-Capital Submission Form" January 21, 2014, page 5.
[4] The number of beds in Option 2 of the plan is unclear. More details on page 10 of this report.

The results of the proposed merger plans in Scarborough-West Durham are not surprising. The international and Canadian evidence does not support the contention that mergers will result in savings. Instead, the evidence indicates that mergers lead to a host of new and higher costs, workforce problems, and service cuts/consolidations and reduced patient access. For this particular merger, the hospitals' own costing shows that there are tens of millions of dollars in new costs required just to restructure, and that those costs are not offset by savings for at least a decade, if not longer.

The impetus for mergers, regardless of evidence or sound planning, has not come from the local hospitals. In fact, across Ontario, hospitals are dealing with the combined implications of budget freezes and real-dollar cuts, a new hospital funding formula and a budget accountability regime. Combined, these forces are promoting hospital mergers and significant cuts to services. Overall, Ontario hospitals are forced to make planning decisions in a context in which hospital funding levels are arbitrary; they are not based on any assessment of capacity or need. In fact, Ontario funds our hospitals at the lowest rate in Canada per capita.[5] Currently, these planning and funding imperatives are propelling hospital restructuring in Scarborough and West Durham.

The fundamental function of our public health system should be to measure and plan to meet population need for health care services. However, an actual assessment of population need and a plan for a configuration of hospital services to meet that need is totally absent from the plans to merge the Scarborough and West Durham Hospitals. Not only do the plans reveal that the merger will cost tens of millions of dollars and yield few if any savings, they also show that very significant cuts to hospital beds and centralization of key hospital services into fewer sites are in the offing. Yet there has been no appropriate public disclosure of these plans and no measurement of the impact on patients.

[5] "OHC Austerity Index Volume 2: Health Care Cuts and Deficits across Ontario." 25 February 2013. P.8.

The Push to Cut, Offload and Consolidate Hospital Services

The Ontario government has imposed a number of policies to force hospitals to restructure. Hospital restructuring includes: service cuts; offloading of hospital services and patients to other entities usually with lesser service levels and more user fees; centralization of hospital services into fewer hospital sites forcing patients to travel further; delisting; and workforce changes. It is being accomplished primarily through:

- An ideology in the Ministry of Health that supports super-specialization, mergers and consolidations, rather than comprehensive community hospitals;
- Constraining hospital global budgets to less than the rate of inflation;
- Changes to the hospital funding formula;
- An aggressive enforcement regime requiring hospitals to eliminate deficits even at the expense of patient care.

Ontario's health reform program has centred on a restricting hospital funding to force shorter patient length of stay in hospitals, closing hospital outpatient services, consolidating hospital services into fewer sites, merging hospital corporations, and instituting competition for hospital funding between hospitals and private clinics. The Integration Leadership Committee (ILC) of the Rouge Valley Health System and the Scarborough Hospital notes that "HSFR [Health System Funding Reform] being rolled out by the provincial government is creating an increasingly competitive environment between hospitals for patients, funding, capital and health human resources."[6]

Since 2006, provincial budgets have held hospital funding increases below the rate of inflation forcing hospital service cuts. In the 2013/2014 Ontario Budget, the government completely froze hospital funding, which is akin to millions of dollars in cuts. As a result, hospitals have been unable to keep up even with the rate of inflation, let alone the demands of increasing populations and aging infrastructure. The planned underfunding of hospitals is forcing service cuts and consolidations. It is also forcing hospitals into making restructuring plans, simply to "play the game" set up through the government's process, whether or not those restructuring plans actually save any money.

Prior to the current round of hospital funding reform, hospitals were given global budgets and democratic local hospital boards determined what services would be provided locally. In 2012, the Ontario government made public its plans to change hospital funding. These changes are significant in that they exert more centralized control over what services hospitals provide and they force the centralization of a number of services into fewer hospitals, cutting those services in communities that cannot or choose not to compete on a price x volume basis for those procedures. The government's health system funding reform means that 70% of hospital funding will be done in a new manner. Of this, 40% will be allocated based on the Health-Based Allocation Model (a weighted per capita funding model that will replace and modernize existing

[6] "Leading for Patients." Rouge Valley Health System and the Scarborough Hospital Facilitated Integration Process, Preferred Integration Plan Final Report. P.10

global funding) and 30% is to be allocated based on a fee-for-service funding model, wherein hospitals receive a set amount of money for specified volumes of procedures. See chart below. Some of the procedures allocated under this new fee-for-service method include cataracts, joints and chronic kidney disease. This new funding system, which favours hospitals that can perform higher volume procedures, is driving a wave of hospital service consolidation into fewer hospital sites across Ontario. At the same time, the government has kept hospital global funding to less than the rate of inflation, further forcing hospitals to shrink the range of services they provide. Though the public expects our local hospitals to provide a relatively comprehensive array of services we need close to home, the planning and funding regime for hospitals in Ontario is now set up to force hospitals to narrow their range of services, specialize and centralize services into fewer hospital sites across larger regions.

Changes to the Hospital Funding Formula

Type of Funding	**April 2011**	**Phase I** **April 2012**	**Phase II** **April 2013**	**Phase III** **April 2014**
Fee-for-Service Procedures	0%	6%	15%	30%
Health-Based Allocation Model (HBAM)	1.5%	40%	40%	40%
Global Budgets	98.5%	54%	45%	30%

Source: Ontario Ministry of Health and Long-Term Care

These changes in hospital funding are a substantial part of the restructuring efforts of the Ministry of Health and Long Term Care, and hospital cuts that have resulted from changes in the funding formula and constraints on hospital global budgets are a deliberate strategy, according to Health Minister Deb Matthews.[7] But as services are consolidated into fewer hospital sites patients have to travel further to access care. There is no policy or requirement by the provincial government to protect local access to care in this restructuring. Indeed, the plan is to restrict care to fewer hospital sites.

Hospitals have not only been impacted by the new funding formula but also by the accountability agreements they must sign with the Local Health Integration Networks. Hospitals are required to follow the Ministry of Health's annual Hospital Accountability Planning Submission Guidelines in developing an operating plan for each year. It is these HAPS

[7] Theresa Boyle, "Ontario budget will see more hospital downsizing and community upsizing, health minister says." The Toronto Star. 2 May 2013.

Guidelines which make up the policy framework that has been pushing a new round of hospital mergers across Ontario including the proposal in Scarborough-West Durham. If a hospital is in deficit they are required to develop a plan to eradicate the deficit as it is unlawful for hospitals to run deficits regardless of population need for services. In fact, in the HAPS Guidelines, the Ministry of Health and Long Term Care provides a *Framework for Making Choices*, which guides the hospital and LHIN in planning how to deal with underfunding and where to identify cuts.

Hospitals in deficit are instructed to follow several steps to eliminate deficits. First they must optimize operational "efficiencies," which can include increasing new, self-generated revenue (increase parking and cafeteria fees). Next, hospitals are instructed to cut and offload services and amalgamate departments. Through the HAPS Guidelines, the Ministry makes it clear that the LHINs must explore mergers, explaining that there are limited opportunities to achieve further efficiencies in current hospital operations.[8] Ultimately, hospitals are required to progress towards service cuts as they are not, under any circumstances, permitted to request increased funding through the HAPS regardless of community needs.

Thus, funding for hospitals and even planning of hospital governance has become completely divorced from any assessment of need, social and demographic patterns, history and community. While hospitals are continuously being forced to cut services, the LHINs are required to continue to push for mergers, despite that the evidence shows that mergers can be costly and do not improve hospital performance.

[8] "Leading for Patients." Rouge Valley Health System and the Scarborough Hospital Facilitated Integration Process, Preferred Integration Plan Final Report. P. 4.

Recent Evidence on the Cost of Mergers

The evidence from recent studies internationally and in Canada revealed that mergers cost more and lead to deleterious service impacts. These studies raise serious questions as to why the Ministry of Health and Long Term Care would undertake such aggressive efforts to "integrate" (merge) hospitals in Ontario.

In 2012, a major study on mergers and their effects in England compared the performance of hospitals that merged with those that did not. The study looked at a range of measures of performance including activity per staff member, financial performance, wait times for elective surgeries and a range of measures of clinical performance. According to this research by the Centre for Market and Public Organisation, the wave of hospital consolidation in England in the late 1990s and early 2000s brought few benefits. According to the Centre, "Poor financial performance typically continued, with hospitals that merged recording larger deficits post-merger than pre-merger. What's more, the length of time people had to wait for elective treatment rose after the mergers. There was also no increase in activity per staff member employed in merged hospitals, and few indications of improvements in clinical quality."[9]

According to Kurt R Brekke, a professor of economics at the Norwegian School of Economics, there is growing concern in the U.K. about reduced competition brought on by hospital mergers. According to Brekke's recent study, merging hospitals have an incentive to reduce quality as competition goes down. "By reducing quality, the merging hospitals save costs and increase their revenues and profits."[10] Subsequently, the quality at other hospitals in the local area is also likely to drop as competitive pressure is lower after the merger.

In the 2010 edition of the Journal of Health Services Research and Policy, retired consultant Thomas Weil argued that, "almost all studies suggest that hospital consolidations raise costs of care by at least two per cent and in the U.S., sometimes significantly more."[11] Weil outlines a study of seven Norwegian hospital mergers between 1992 and 2000, in which authors Kjekshus and Hogen conclude that that the seven mergers demonstrated no significant effect on technical efficiency and a significant negative effect of 2.0% to 2.8% on cost efficiency.[12] While the appeal of 'bigger is better' in hospital mergers is powerful in Canada, Weil argues that the empirical evidence is weak and the potential for negative outcomes is significant. Furthermore, the only opportunity to realize cost savings from a merger, is when hospitals physically merge

[9] Martin Gaynor, Mauro Laudicella and Carol Propper, "Can governments do it better? Merger mania and hospital outcomes in the English NHS." Working Paper No. 12/281. Centre for Market and Public Organisation. Bristol Institute of Public Affairs, Bristol University. January 2012.
[10] Kurt R Brekke, "Merging hospitals and services may reduce quality of NHS care." The Conversation. 28 June 2013.
[11] Thomas Weil, "Hospital mergers: a panacea?" *Journal of Health Services Research and Policy. October 2010 15: 251-253*
[12] Ibid.

operations and shut one or more facilities since acute care facilities have high fixed and low variable costs.[13]

Another examination of 11 studies on restructuring and mergers from the US and Canada concludes that, "many of these studies have examined the effects of restructuring and mergers on cost, staff nurses, and patient outcomes. In the aggregate, restructuring and mergers did not achieve the desired reductions in cost."[14] More specifically, the study finds that often radical changes in restructuring proceeded with little evidence to guide them. Despite enormous organizational turmoil, very little progress was made that addressed quality and cost concerns in a meaningful way.

In 1996, the Mike Harris Conservative government pursued a vigorous campaign of hospital restructuring which saw the closure and mergers of dozens of Ontario hospitals. Despite promises of more efficient and seamless care as well as savings, the hospital restructuring of the mid 1990s did not save any money at all. In 1999 and 2001, the report of the Ontario Auditor General revealed the costs of the restructuring under the Harris government. The Auditor revealed that costs had escalated to $3.9 billion (up from the government's projected $2.1 billion) an increase of $1.8 billion over expectations.[15] Thus, billions of dollars were spent cutting beds, forcing mergers, closing hospitals and laying off staff, after which hundreds of millions were spent re-opening needed beds and recruiting staff to restore stability. The high costs of restructuring and merging were never recouped, and ultimately all of the funding that was cut from hospitals was returned.

Even reports and government-supported research that comes to the question of mergers from a point of view of looking for evidence to support more mergers and consolidations are very tepid in their conclusions. For example, according to the Canadian Health Services Research Foundation, "in Canada, the evidence on cost savings from mergers is largely anecdotal and inconclusive."[16]

As evidenced in the literature internationally and in Canada, hospital mergers do not save money. In fact, hospital mergers tend to increase the cost of care, decrease quality, and cause enormous organizational turmoil. Ontario has been down the painful road of restructuring under the Harris government of the 1990s, at which time billions of dollars were spent with no evaluation of the impacts. Regardless of the immense costs associated with this type of restructuring and the lack of evidence to suggest positive outcomes regarding access and quality of care, a new "merger mania" has taken over the health policy elites in Ontario; and now Scarborough and West Durham are under its spell.

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[13] Ibid.

[14] Bonnie M. Jennings, "Chapter 24. Restructuring and Mergers." Patient Safety and Quality: Am Evidence-Based Handbook for Nurses.

[15] Provincial Auditor's 2001 report. P. 315.

[16] "Mythbusters –Myth: Bigger is always better when it comes to hospital mergers," Canadian Health Services Research Foundation. 2002.

Scarborough-West Durham Hospital Merger to cost $30 million

In the ILC Report, the Scarborough Hospital and Rouge Valley Health System recommend moving ahead with a merger of the two hospital corporations. The genesis of this merger is a $28 million projected funding shortfall for the two hospitals by 2014/2015 (as projected by the hospitals' leadership themselves) and the Ministry of Health's policy requiring hospitals to look at mergers. However, upon further inspection of the ILC's own numbers outlined in their report *Leading for Patients*, it becomes evident that the merger itself will cost tens of millions of dollars and yield no savings at all for more than a decade.

In Table 5 of the ILC report, which outlines the summary of estimated operating cost savings, incremental costs and one time investments as a result of the merger, the estimated costs of the merger (estimated one-time investments) are $29.5 million. Thus, the merger is projected to cost approximately $30 million. The increased annual operating costs (incremental operating costs) are $5.4 million per year. So the merger is estimated to cost $5.4 million per year more on top of $30 million in one-time costs. But yet, the total estimated savings for the first three year comes to between $13 and $15 million, equalling $4.3 million to $5 million per year. This means that the total savings each year for the first three years is to $2.5 - $3.2 million (total cumulative savings minus estimated incremental operating costs). These savings are offset by the $30 million in one-time costs to merge. Therefore, according to the hospitals' own projections, it would take anywhere from 9.2 to 11.7 years to realize any savings at all through the merger. It should be noted that any projections that are as far away as ten years out are so inaccurate as to be meaningless, but even after 10 years of paying off the costs of the merger, according to the hospitals' own figures, projected savings are totally unclear.

Since the merger itself is not projected to yield any savings, any projected "savings" would have to come from services cuts. Thus, the merger is the means to set up cuts to and consolidations of hospital services across West Durham and Scarborough into fewer sites.

Table 5: Summary of Estimated Operating Cost Savings, Incremental Costs and One Time Investments

Opportunity Category	Cumulative savings for the first three years ($000's)	Estimated Incremental Operating Costs ($000's)	Estimated One-Time Investments ($000's)
Economies of scale*	$5,000 to $7,000		
Operating efficiencies**	$8,000		
Transition costs			($2,500)
Workforce restructuring			($5,000)
Workforce harmonization		($5,400)	
Information system integration requirements			($12,000)
Transformation management			($10,000)
Total	$13,000 to $15,000	($5,400)	($29,500)

**Total estimated Economies of Scale savings increases to $25 million with facility renewal*
***Total estimated Operating Efficiencies savings increases to $16 million with facility renewal*

Source: this chart is copied and pasted from the ILC report page 24.

Capital Plan Proposes to Close Scarborough Hospital Sites & Reduce Hospital Beds

In January, THS and RVHS submitted capital development plans to the CE LHIN. These documents reveal major plans to close hospital sites and reconfigure services in Scarborough. According to the capital planning submission, there are two options laid out for Scarborough Hospital redevelopment:

Option 1 – build a single hospital with 800 beds, and the potential revitalization of one or more of the existing facilities for one or two urgent care/ambulatory (outpatient) care facilities with short stay beds.

Option 2 – build two new full service hospitals– one north and one south of the 401with 600 – 650 beds. [Not clear if this means 600 beds each or 600 beds total.]

According to the submission from the hospitals: "Both options assume further development of areas of specialization and elimination of unnecessary duplication."[17]

According to the hospitals' own data, the current number of beds in the three hospital sites in Scarborough is 814. The projected need for beds 25 years from now (based on 90% occupancy, taking into account population growth) is 1,393. But the first option proposed for redevelopment would include only 800 hospital beds – 600 short of projected need. This chart is replicated from the hospitals' capital planning document (page 12):

Scarborough Cluster beds	**2011**	**5 years (2016)**	**10 years (2021)**	**15 years (2026)**	**20 Years (2031)**	**25 Years (2036)**
Acute	648	736	843	967	1089	1123
Post Acute (CCC/Rehab)	66	79	91	108	124	136
Mental Health	100	107	114	121	128	134
Total	**814**	**922**	**1047**	**1195**	**1340**	**1393**

Note the plans for Ajax-Pickering are quite different: The capital redevelopment proposal submitted by the hospitals to the CE LHIN for the Ajax-Pickering site lays out two options:

- to redevelop the hospital to expand the surgical suite increase beds to 330, sufficient to meet projected population growth over the next 25 years; or
- to rebuild the hospital in north east Pickering with 330 beds, sufficient to meet projected population growth over the next 25 years.[18]

[17] RVHS and TSH Preferred Integration Plan – Final Report, "Pre-Capital Submission" page 12.
[18] RVHS and TSH Preferred Integration Plan – Final Report, "Pre-Capital Submission" [Ajax-Pickering site] page 11.

No Consideration of Population Need in Final Report

In addition to the fact that the proposed merger will not save any money, the merger proposal set out in the *Leading for Patients* report does not flow from a service plan that has taken population need into consideration. Similarly, the hospital capital plan does not include an assessment of population need, a plan for services or a plan for needed configuration of services.

In the Preferred Integration Plan Final Report, facilitated by the Central East Local Health Integration Network (LHIN), the Integration Leadership Committee (ILC) outlines its interest in creating, "an integrated system of health care services that meets the needs of the people in our community, provides appropriate access to care, delivers an outstanding experience for patients and their caregivers, and uses our resources efficiently so that these services are sustainable in the future."[19] While the ILC pays lip service to meeting the needs of the people in the community, they have not provided any framework to accomplish this. The ILC plan sets up a situation in which budget cuts will have to come from service cuts and consolidation. In fact, the ILC report is completely divorced from any semblance of a plan to meet population need for hospital services.

Under the "Benefits and Risks" section of the ILC Report, the authors claim that at every point in the engagement process, discussion around the benefits of a merger was always balanced by the consideration of the risks, including the benefits and risks around accessibility. However, there is no mention of any effort to measure patient need and there is not a single proposal to address accessibility of care when the inevitable service reductions in the newly merged hospitals occur. Where concerns were raised around access to services post-merger, the report simply outlines the need to "explore possible options to improve access to services."[20] Furthermore, there are no guaranteed service levels nor any attempt to address existing service gaps. There is no benchmarking on the actual number of beds that will be needed based on the needs of the growing communities of Scarborough and West Durham. There is no concrete plan to measure and mitigate the risks to patients of closing and moving services further away from their home communities beyond the rhetoric of "exploring options." There is no funding to improve services, address service gaps or address problems in access in the plan.

With no consideration of patient need, a growing demand to cut services and merge entities (which the evidence suggests will cost more than it will save) there are likely going to be major implications for access and quality of health care services in Scarborough and West Durham, despite the rhetoric of the final report. The report outlines that, "by combining expertise to create critical mass, growing existing programs and developing new, more specialized services, a stronger hospital system could be created with the advanced capacity to meet the needs of

[19] "Leading for Patients." Rouge Valley Health System and The Scarborough Hospital Facilitated Integration Process, Preferred Integration Plan Final Report

[20] "Leading for Patients." Rouge Valley Health System and the Scarborough Hospital Facilitated Integration Process, Preferred Integration Plan Final Report. P. 18.

the Scarborough and west Durham population *in their community*."[21] But, in addition to the fact that the evidence does not support such a rosy view of mergers, the report fails to recognize that Scarborough and West Durham are not one community. They are multiple communities without an integrated public transportation system, featuring some of the worst car transportation gridlock in the country. There is an incredible level of diversity in these areas, including diversity of income, age and culture. Community services are not integrated across that region. The patterns of social development and population demographics across this region do not support this notion of one single community and the dangerous implications that hospital services can be consolidated into fewer sites. The Health Coalitions are particularly concerned about seniors who may require a variety of health care services, and persons of low socio-economic status who face more barriers to accessing care.

[21] "Leading for Patients." Rouge Valley Health System and the Scarborough Hospital Facilitated Integration Process, Preferred Integration Plan Final Report. P. 17.

Conclusion

In conclusion, the evidence shows that the merger plan for Scarborough and West Durham will of itself not save any money. This is ironic in the least since the reason for creating the plan is, at its core, an attempt by the provincial government to cut hospital funding. But more importantly, the fact that the hospitals' own ILC report shows that the restructuring costs of the merger are so high as to offset any potential savings for a decade or more, means that these hospitals which have already faced very severe service cuts in recent years will again be hit with major cuts. Moreover, the capital planning submission for the three hospital sites in Scarborough shows plans for hospital bed cuts and closures of entire hospital sites without ever measuring population need for services or attempting to mitigate patient risk and access concerns.

This is not something that can be solved at the local level. The government of Ontario has set hospital funding too low to meet population need, particularly in dense and high-growth regions like Scarborough and West Durham. That there has been no effort to measure patient need and no guaranteed service levels for the post-merger hospital corporation is a failure of policy at the provincial level, of oversight at the LHIN level and of process at the hospital level. We are extremely concerned, based on the international and Canadian evidence as well as the hospitals' own costing, that the likely outcome of the merger will include further service cuts and greater costs to patients as they are forced to travel greater distances and pay increasing user fees in private clinics.