Ontario Health Coalition

Briefing Note

June 1, 2018

Windsor Hospital Amalgamation/New Build

New Hospital is Instead of – Not in Addition to – the Existing Windsor Hospitals

It appears that a significant proportion of Windsor residents have been confused by the public relations messaging regarding the hospital. The new Windsor hospital is not planned *in addition to* the existing hospitals. It is *instead of* them: it is not an "add on"; it is a take away. Windsor will go down from its two remaining hospitals to one. Despite the rhetoric of "mega" hospital used by the hospital CEO and PR people, the hospital is planning to open no additional bed capacity with the opening of the new hospital and already this number of beds is too few to meet the community's need. Please note: the body of evidence from across Ontario is that new hospitals always have fewer beds than projected, so we are deeply concerned that the so called mega hospital will in fact be smaller, in terms of patient capacity, than the existing hospitals.

To be clear, the plan for a new Windsor Hospital includes a plan to close down both existing hospitals in the city. All emergency services and almost all acute care services serving approximately 400,000 people would be moved onto one green-field site out of the city, past the airport. The only services left in the core of the city would be an urgent care centre with uncertain hours, some daytime outpatient mental health, addiction and chronic disease services, and inpatient mental health services moved out to the city's west side.

It must further be noted clearly that an urgent care centre is a form of walk-in clinic. There is no standard of care in legislation, regulation or policy for an "urgent care centre". It is simply the trend that walk in clinics have started to call themselves urgent care centres. The language appears to be chosen in this case to make the services sound closer to those of an emergency department. This is deceptive. An urgent care centre does not receive ambulances, it can have a range of basic services but it does not and cannot provide specialized emergency services.

A flawed process

The public has not been fully informed about these plans, there has not been any meaningful public input into the decision to close and consolidate the hospitals, and the concerns about access to care for the lower-income communities in the city, the environment, cost to municipal services and EMS, and others have never been addressed.

The government announced the approval of the Phase I & II plans in the provincial budget without having undertaken the proper public consultation process that is required in the legislation for their own government-appointed regional health care planning group (called the LHIN*). In our own high-level meetings with government officials, they too expressed serious reservations about the single-site proposal and the plan to close down all the hospital services in the established city area. Despite repeated attempts to get the LHIN – the regional health planning body of the government – to meet with us and to engage in meaningful public consultation, they have refused to do so.

The planning process has been backwards, with the government announcing its approval of the mergers before any functional and financial plans were created. These approvals have been rubber

stamped without any normal planning and financial accountability, without public notice and without any real opportunity for public input. The public relations messaging that has been given to the community and staff has been incomplete and misleading.

The plans were set without any analysis of population need for hospital services, without any evidence to support them, and without any proper policy process to support mega-merger and service consolidation. One would be excused for expecting that such a radical plan would at the very least involve a detailing of the new risks resulting from the consolidation and that there would be a mitigation plan for these risks, particularly those associated with patient care, access, outcomes, and quality of care. There is not a single proposal to deal with the costs of the mergers or the increased transportation burden on patients as a result of service. In fact, much of the planning regarding the mergers has eschewed evidence and sound health care planning and instead has been focused on controlling the message given to the public throughout the process. The process for public input has been heavily controlled with almost no proper public record and very poor publicity.

Furthermore, there are regional impacts that must be considered. The positioning of the new hospital has raised concern that the plan is to posture Windsor's new hospital as a regional hospital since it is being moved to within 45 kilometres of Leamington, potentially risking services in Leamington and the southern part of the county. In other parts of Ontario (such as Niagara) the building of a new hospital outside of the city has threatened the existence of the other hospitals in the region. The affected communities in the county have never been given full information and have not been consulted about this but the choice of site for the new Windsor hospital certainly makes it look like the hospital leadership would like to position themselves to be the one regional hospital as a priority and shows less concern about serving the city and other parts of the county well.

More than 330,000 People Should Not Have to Compete for One Hospital

Across Ontario there are 145 public hospital corporations. In many communities there are hospitals that serve much smaller populations than the existing Windsor hospital sites and those have not been forced into amalgamations onto one site. There has been no public policy process, no debate in the Ontario Legislature, and no evidence supporting the mega-mergers of hospitals in this way. It is not usual, nor should it be accepted that 330,000 people across a geographic area of 1,850 square kilometres would have to compete with each other over the siting of one hospital. The county is in need of properly accessible hospital services and so is the city. The plan for Windsor is a poor precedent for all of Ontario.

Bigger is Not Better: The Evidence on Hospital Mergers

The body of evidence regarding the costs and quality-of-care consequences for mergers and consolidations of this type is substantial and stretches across two-and-a-half decades and the track record is not positive.

After the Harris mergers in the late 1990s, the Canadian Health Services Research Foundation published a 2002 essay in 2002 taking issue with the myth that bigger is better. They found that during the 1990s the number of Canadian hospitals declined from 1,231 to 929 – a drop of 25 per cent, largely due to mergers. The CHSRF said evidence on cost savings from mergers is largely anecdotal and inconclusive, noting that mergers involving hospitals with more than 400 beds tend to increase the cost of management and administration. They reported that that larger hospital mergers tend to be less responsive to the patient, disadvantage low income patients, do not necessarily improve recruitment and retention and often lead to issues around staff morale and trust. The essay concluded that "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."

In fact, 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 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."[1]

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."[2] 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."[3] 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.[4] 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 operations and shut one or more facilities since acute care facilities have high fixed and low variable costs.[5]

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

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[1] 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.

[2] Kurt R Brekke, "Merging hospitals and services may reduce quality of NHS care." *The Conversation*. 28 June 2013.

[3] Thomas Weil, "Hospital mergers: a panacea?" *Journal of Health Services Research and Policy. October 2010 15*: *251-253*

[4] Ibid.

[5] Thomas Weil, "Hospital mergers: a panacea?" *Journal of Health Services Research and Policy. October 2010 15*: *251-253*

nurses, and patient outcomes. In the aggregate, restructuring and mergers did not achieve the desired reductions in cost."[6] 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.[7] 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.

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.

P3 Privatization

When the hospital CEO for The Scarborough Hospital sent in his planning submission for a new build and mega-consolidation to replace 3-4 existing hospital sites in Scarborough (notably, these are plans that the Minister of Health did not approve) he included a 30 percent extra cost for the building the hospital as a privatized P3 hospital.[8] This is a conservative estimate of the higher costs entailed by building new hospitals through the privatized P3 model. This model was introduced by the Harris government and then followed by the Liberal McGuinty and now Wynne government in which a multinational private consortium builds the new hospital and leases it back to the local hospital board for 30-years or the economic life of the facility. It has been deeply controversial. In fact, highway 407 with its out-of -control tolls is a privatized P3 project. So too was the cancelled Oakville gas plant.

In fact, the Ontario Auditor General recently released a scathing report about the privatized P3 program in Ontario. In it, the Auditor General reports that $8 billion could have been saved if the privatized P3 projects covered in the audit (the hospitals built by the Wynne/McGuinty government and 2 court houses) used traditional public finance and sound management rather than P3s. Today, P3 hospitals are so expensive that 2 or 3 or more hospitals are closed down to build one single new site, too small to meet the needs of local communities for the next generation. As a result billions have been taken away from care and local access.

Windsor's new hospital development and any renovations should be done through public finance, not P3 privatization, and the savings plowed into establishing more services both in the city and the county for residents' use rather than siphoning off public health care funding to excess profiteering by multinational consortia, consultants and the like.

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

[7] Ontario Auditor General , *2001 Audit Report*: page. 315.

[8] Rick Ganderton CEO Rouge Valley Health System and Robert Biron CEO The Scarborough Hospital, *Pre-Capital Planning Submission* January 21, 2014: page 17.

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