

**The Costs and Consequences of Mega-Mergers:
An Analysis of the Hospital Restructuring Plans for
Scarborough and Durham**

Ontario and Durham Health Coalitions

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Introduction

On October 14, 2016, Ontario's Minister of Health issued an "integration order" in a bid to force through two large-scale hospital mergers in Scarborough and Durham. Under this order, if it is finalized, the Rouge Valley Health System which covers two hospitals – the Centenary site in Scarborough and the Ajax-Pickering site in Ajax – would be split. In Scarborough, a new hospital corporation would be formed to include the Scarborough Grace (Birchmount site), Scarborough General and Centenary hospitals. The Ajax-Pickering hospital would be taken over by Lakeridge Health, which currently includes the hospital sites in Port Perry, Oshawa and Bowmanville. All of the assets of the Ajax-Pickering hospital would be transferred to Lakeridge Health. All of the assets of the Centenary hospital would be transferred to the new Scarborough Hospital Corporation.

The Minister's plan would create two mega-mergers out of three already very large hospital corporations that are themselves the product of an earlier round of mergers and restructuring. The communities affected include a population of more than a million people. In every impacted community, thousands of residents have spent decades fundraising and volunteering to build their local hospitals and provide services closer to home. Despite this, and despite the fact that these are public hospitals that are funded by Ontarians and should be accountable to the public, there remain serious issues raised by concerned community members that have, to date, been almost entirely ignored by government planners.

In this report, we review the process by which the mergers are being forced through, their costs, the implications for local hospital services in the affected communities, and the evidence showing the poor track record of hospital mergers across Canada and internationally.

What we have found warrants a much more thoughtful and substantive response from the government than has occurred to date. The mergers are not based on any hospital service plan to meet population need. None of the planning documents provide any evidence to support the merger plans. The decision to force through the hospital mergers by order of the Minister bears no resemblance to the input that was given by community members in the poorly-publicized and extremely controlled "community engagement" processes conducted by the government appointees and hospitals. The costs of the mergers are very high, amounting to almost \$50 million and the government has refused to commit to paying for the costs of the restructuring it has ordered. This means that costs will have to come out of the operational budgets of the local hospitals. The hospital service implications of the mergers have been downplayed by government and hospital spokespeople, but under current government policies and budgeting processes, the mergers would undoubtedly mean more centralization of hospital care as the newly merged hospitals rationalize services across a wider geography.

Costs and Consequences

The total cost of the two mega-mergers has now climbed to almost \$50 million. While the price tag is enormous, there are few projected savings. To date, the Ministry of Health has refused to pay for these restructuring costs. This means that tens of millions of dollars to pay for the costs of mergers will have to come out of operational budgets for the hospitals.

According to the documents filed by the hospitals with the government's appointed regional health planning body – the Central East Local Health Integration Network (CE LHIN) -- the costs of the mergers are as follows:

Lakeridge/Ajax-Pickering merger cost:	\$18.2 million
Scarborough/Centenary merger cost:	\$29.6 million
Total cost to date:	\$47.8 million

There is no financial rationale for the mergers. In none of the documents supporting the mergers by the government's appointed panel, the Local Health Integration Network, the Ministry of Health and the hospitals is there any cost-benefit analysis of these restructuring proposals. Not only is this poor process, it is also indisputable that the immediate consequence of the mergers is the redirection of \$50 million away from patient care. Using the hospitals' own figures, we can calculate that the mergers will take decades to pay off, if ever. In the meantime, the funding for the mergers will reduce the money available for actual care and services for patients.

Lakeridge – Ajax Pickering hospital Merger cost \$18.2 million. Projected savings \$300 thousand per year. **It will take more than 62 years to pay off the cost of this merger.**

Scarborough- Centenary hospitals Cost \$29.6 million. Projected savings \$1 - \$1.8 million per year. **It will take 15 – 30 years to pay off the cost of this merger.**

According to hospital documents, for the Scarborough merger, "The net financial impact of the RVHS TSH Integration is estimated to be between \$1.0M to \$1.8M in annual savings/increased revenue. However, the Integration also requires \$25.1M in one-time investments.¹ Since July, that cost has increased from \$25.1 million to more than \$29.6 million."²

The hospitals' proposal goes on to state:

"There are minimal operating efficiencies that will result from integration....There is no material effect on the funding formulas through the Health Based Allocation Methodology (HBAM) and Quality Based Procedures (QBPs) as a result of integration."³

¹ Rouge Valley Health System and The Scarborough Hospital, *Integration Proposal* submitted to the Central East Local Health Integration Network, July 2016: page 2.

² The Scarborough Hospital, Rouge Valley Health System, Lakeridge Health, *Integration Update* slidedeck presented to CE LHIN Board of Directors, September 28, 2016: page 16.

³³ Rouge Valley Health System and the Scarborough Hospital, page 2.

The costs for this merger, according to the hospital's planning document, include:

- \$4.3 million over three years, for a transition management team
- \$15.6 million in first year, to merge telecommunications, email, information and technology
- \$1.2 million in the first few months of the merger for legal and PR
- \$5.4 million to lay off staff and harmonize wages.⁴
- A new cost projection was reported to the CE LHIN in September, showing a \$4.52 million increase in the projected price for merging telecommunications, email, and information and technology systems, to total \$20.17 million.⁵

According to hospital documents for the Durham merger, "The net financial impact of the LH RVHS Integration is estimated to be between - \$0.3M and \$0.3M in savings. However, the Integration also requires \$18.8M in one-time investments."⁶

As in the Scarborough merger documents, the hospitals' proposal for Durham goes on to state:

"There are minimal operating efficiencies that will result from integration...There is no material effect on the funding formulas through the Health Based Allocation Methodology (HBAM) and Quality Based Procedure (QBPs) as a result of integration."⁷

The projected costs for the Durham merger, according to the hospitals' plans include:

- \$1.9 million over three years for an integration management team
- \$13.6 million over 12 – 18 months to merge telecommunications, email, information and technology. (This projected cost was later lowered by \$570 thousand to approximately \$13 million.)
- \$1.1 million in legal and PR costs
- \$2.5 million in costs to lay off staff and harmonize wages.⁸

These projections do not include the costs of the Minister's appointed "facilitator", a consultant with KPMG appointed in April to ease the passage of the merger, nor do the projected costs listed here include additional "transaction" (legal and PR costs) for the CE LHIN. These costs have already added millions to the total bill for the mergers to be paid by Ontario residents.

⁴⁴ Ibid.

⁵ The Scarborough Hospital, Rouge Valley Health System, Lakeridge Health, *Integration Update* slidedeck presented to CE LHIN Board of Directors, September 28, 2016: page 16.

⁶ Lakeridge Health and Rouge Valley Health System, *Integration Proposal* submitted to the Central East Local Health Integration Network, July 2016: page 2.

⁷ Ibid: pages 2 – 3.

⁸ Ibid.

Impact of Costs on Hospital Services

What would \$50 million taken out of hospital operating budgets mean for services? We looked at the most recent round of cuts in the region to put these numbers into context.

In 2013, The Scarborough Hospital was forced to cut \$17 million from its operating budget due to funding shortfalls from the provincial government. As a result, the hospital conducted two rounds of cuts across 22 hospital departments including surgical, medical, geriatrics, maternal and child care, nutrition, cleaning, rehabilitation and occupational therapy, outpatient services and many others. Twenty surgical beds and two operating rooms were closed. Emergency department stretchers were cut. Outpatient services were cut and the rheumatology (arthritis) clinic which saw 2,000 patient visits per year was closed. The hospital was forced to create a deficit elimination plan to cut 200 nurses, health professionals and support staff, equalling a loss of more than 345,000 hours per year of patient care, therapy and hospital support.

The \$17 million in cuts in Scarborough in 2013 were unquestionably damaging to patient care and access to needed hospital services. These cuts amounted to approximately 1/3 of the costs of the mergers now being proposed. But to date, hospital executives and the government have claimed that \$50 million in merger costs to be taken out of local hospital budgets for patient care will have no negative impact. This claim is not supported by the evidence.

A Merger without a Mandate

As outlined in the previous section, there is no financial rationale for the merger proposals. There is also no concrete proposal to improve services. In fact, a review of all the documents recommending and proposing the mergers reveals that in no way are the merger plans linked to any normal population health planning analyses and methods used in other jurisdictions to make such decisions. Moreover, at no time is there any evidence that the government considered alternative options or conducted a comparative evaluation of the costs and consequences of all of these options.

In the two integration proposals totalling 107 pages filed with the CE LHIN by the hospitals at the behest of the Minister of Health, there is not a single concrete proposal to improve patient care.⁹ In the 48-page report of the Minister's panel, there is no analysis showing how the creation of two hospital corporations from three will improve patient care.¹⁰ In none of the documents is there any analysis of population need for hospital services in each of the affected communities.

There is a perfunctory mention of overall population growth and aging statistics and population growth projections for less than five hospital services in the panel's report. These are in no way tied to the proposal to change the structure of the hospital corporations.

The list of what is missing, compared to similar planning documents in other jurisdictions is lengthy. There is no analysis of community demographics, socioeconomic indicators or other data that is usually analysed in hospital strategic planning documents in other jurisdictions. There is no analysis of where different types of hospital services are most needed. There is no site-by-site analysis of hospital service utilization data or health outcomes. There is no analysis of transportation options and costs. There is no analysis of risks for patients as a result of the restructuring and no plan to mitigate these. There is no analysis by any of the planners comparing the costs and services of the current formation of public hospital corporations in the region to the optional alternative models.

The rationale for creating two hospital corporations is that this will create two hospital hubs. But there is no analysis as to what this means for patient care. There is no rationale given as to why the proposal is for the region is split into two hubs, as opposed to three or more. In summary, the papers and documents created in support of the mergers repeatedly tout the virtue of a "bigger is better" ideology without any supporting evidence. Yet, as the following sections of the paper will outline, the evidence on hospital mergers does not support this contention.

Across Ontario there are 145 public hospital corporations. In many communities, hospitals that serve much smaller populations than the Ajax-Pickering hospital site are not amalgamated into other cities' hospitals. There has been no public policy process, no debate in the Ontario Legislature, and no evidence supporting the mega-mergers of hospitals in different cities that serve populations of the size impacted in Durham and Scarborough (each large hospital serves more than 100,000 residents).

The structure of the amalgamations is also a contentious issue for local residents. In November 2015 government's appointed panel recommended two mergers to create two new hospital corporations,¹¹ one in Scarborough and one in Durham. But as the mergers have progressed, the plan has changed so

⁹ See Lakeridge Health and Rouge Valley Health System, *Integration Proposal* submitted to the Central East Local Health Integration Network, July 2016 and Rouge Valley Health System and The Scarborough Hospital, *Integration Proposal* submitted to the Central East Local Health Integration Network, July 2016.

¹⁰ See *Report of the Scarborough/West Durham Panel*, November 2, 2015

¹¹ *Ibid*: page 6 – 7.

that a new hospital corporation would be created in Scarborough but not in Durham. In Durham, the Ajax-Pickering site is to be taken over by Lakeridge without the formation of a new hospital corporation. There has been no explanation as to why this proposal changed. For the population of 200,000 people served by the Ajax-Pickering hospital, there are serious concerns that local control over there hospital will be lost.

A Flawed Process

In 2013, a proposal was made to merge the Rouge Valley Health System with the Scarborough Hospital corporation. That merger was slated to cost \$30 million and was abandoned due to lack of support from the Rouge Valley Health System leadership and concerns of the community over the costs, potential loss of services, and loss of local control.

Nevertheless, it has re-emerged as the new plan that would dismantle the Rouge Valley Health System and split its component hospitals between Scarborough and Lakeridge Health. This time, the process has been much more controlled, culminating in the October 14, order by the Minister of Health that would see the mergers forced through by fiat over the objections of the communities impacted. Ontarians should be very concerned about the precedent set by the Minister's order, and the flawed process that has been used to try to force the mergers through.

The planning process has been backwards from the beginning, with the Minister announcing his approval of the mergers before any functional and financial plans were created. Subsequent approvals at the hospital and LHIN level - which should have preceded the Minister's approval - 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, since at least last summer, cast the mergers as "done deals" even while there remains no plan to pay the tens of millions of dollars resulting from in the plans.

The fact that 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-mergers has been covered in detail in the previous section. In fact, significant portions of the hospitals' merger proposal documents contain lists of "risks" and plans to mitigate these. One would be excused for thinking that these risks were related to patient care, access, outcomes, and quality of care. In fact, they are lists of risks associated to public opposition. The mitigation strategies relate to communications and public relations only. 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 consolidations across the merged sites. 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. In the process leading to the government-appointed panel's recommendations in 2015, with the exception of two small public meetings, the panel held invitation-only meetings prior to coming up with its recommendation to the Minister. From our experience of these meetings, the final recommendation of the panel bore no relation to the input given, even as flawed as that process was.

The hospitals made the merger proposals in the middle of the summer (July 2016). There was no attempt to ensure that the public were informed. Indeed, from the beginning, the public relations strategy from the hospital leadership appears to be a plan to repeatedly state that the mergers would be concluded by an arbitrary deadline that they set for November 1, making it seem as though there was no opportunity for the public to impact the proposals.

From the time they submitted their merger plans in July, the hospitals were required by the CE LHIN to conduct "community engagement" processes on the proposals. But it was quickly evident that there was no real expectation or plan for meaningful public input. The hospitals' engagement plans were only

brought to the LHIN in September, though the mergers were supposed to be completed by November 1. The last-minute "community engagement" process was so poorly publicized as to be virtually non-existent. All input was "off-the-record". There were no proper public hearings as has been the case in previous restructuring processes in Ontario and is the case elsewhere. Public input meetings have been by invitation only and extremely poorly attended. Two tele-town halls were held but residents complained that they could not get on the line though they had pre-registered, and virtually none of the public's questions were taken to be answered. The entire tele-town hall process was strictly controlled.

On October 20 the Rouge Valley Health System planned to hold a general meeting of its membership to vote on the transfer of the corporation's assets and the amalgamation. That meeting was set to be located in Scarborough during the workday at 4 p.m., ensuring that residents in West Durham would face substantial barriers if they wanted to attend. That meeting was never publicized in local newspapers with two-weeks notice as is required by the hospital's by laws. It was then cancelled and the Minister announced he was ordering the mergers thereby circumventing any possible vote against the mergers by the membership of the Rouge Valley Health System corporation.

Poor notice of meetings has been the practice throughout the merger process. In another egregious example, on Wednesday October 12 the CE LHIN posted a notice at 11:44 a.m. on their website for a Board meeting to be held in Scarborough at 2:30 p.m. that same day to vote on a motion to send advice to the Minister endorsing the merger proposals. Even if the public could possibly have found out about the meeting, there is no way that they could attend, make submissions or have any influence.

Since the Minister made the order for the mergers, the government has been forced to follow the minimal public notice provisions set out in the LHIN legislation. The public was given 30-days to give written input. There have been no public hearings. Since the Minister announced that he intends the mergers to be completed by December 1 at the same time as he announced the 30-day notice period, there is little point to this consultation process.

Bigger is Not Better: The Evidence on Hospital Mergers

The body of evidence regarding the costs and quality-of-care consequences for mergers 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.”¹²

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.”¹³ 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

¹² 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.

¹³ Kurt R Brekke, “Merging hospitals and services may reduce quality of NHS care.” *The Conversation*. 28 June 2013.

two per cent and in the U.S., sometimes significantly more.”¹⁴ 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.¹⁵ 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.¹⁶

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.”¹⁷ 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.¹⁸ 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.

¹⁴ Thomas Weil, “Hospital mergers: a panacea?” *Journal of Health Services Research and Policy*. October 2010 15: 251-253

¹⁵ Ibid.

¹⁶ Thomas Weil, “Hospital mergers: a panacea?” *Journal of Health Services Research and Policy*. October 2010 15: 251-253

¹⁷ Bonnie M. Jennings, “Chapter 24. Restructuring and Mergers.” *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*.

¹⁸ Ontario Auditor General, *2001 Audit Report*: page. 315.

Conclusion

We are deeply concerned that the proposed mega-mergers in Scarborough and Durham will result in loss of hospital services in local communities. The merger plans are not founded in evidence. In fact, the evidence is that mergers lead to higher costs and poorer quality. The documents supporting the proposals and recommendations do not contain any health service planning proposals that would see improved patient care. In fact, they are not linked to patient care through any analysis, evidence or planning methodology. The costs of the proposed mergers are very high, and will redirect almost \$50 million away from the hospitals' operational budgets for patient care needlessly. These cuts are coming at the end of a decade of real-dollar budget cuts to Ontario's public hospitals' budgets.

Starting decades ago, mergers were touted as a way to streamline administrative costs and redirect funds to care. This promise has never been realized. In fact, smaller communities have suffered devastating loss of hospital services. As the government's planned funding constraints for hospitals have bitten ever deeper, policy has morphed to embrace the current concept of "one hospital" spread across multiple sites. In amalgamated hospitals, hospital sites are not supposed to house "duplicate" services. The notion of the community hospital with a relatively comprehensive range of services close to home has been abandoned by our government and hospital executives. A new language has emerged to paint these cuts as though they are service improvements – "Centres of Excellence", "integration" and other positive-sounding phrases are now the public relations lexicon. But the bottom line for patients is that planners now expect hospitals to specialize in fewer services. Patients are required to travel from site to site to access care. In a mega-merger, the population will need to travel from site to site across a wider geography to access services.

The plans for the mega-mergers in Scarborough and Durham entail significant implications for local hospital services across the region. The public has a right to know about these implications and to have real input. Our local hospitals do not need more cuts. They do not need enormous energies and entire management teams dedicated to restructuring on top of restructuring. It is time now that our local public hospitals be given the significant reinvestment needed to restore services, deal with overcrowding and long waits, bring services closer to home, and restore local governance and accountability.