Sounding Board

The Folly of Teaching-Hospital Mergers

TEACHING hospitals from Boston to San Francisco are merging and transforming themselves into so-called integrated health care systems. Massachusetts General Hospital and Brigham and Women's Hospital, both affiliated with Harvard, have merged into a new entity, Partners Healthcare System. In July, despite opposition from labor unions and the vocal dissent of some of its own members, the board of regents of the University of California approved the governance structure of a new nonprofit corporation resulting from the merger of Stanford Health Services, a private institution that includes Stanford University Hospital, with the hospitals of the University of California at San Francisco (UCSF).[1] And in November, the board of regents of the University of California and the trustees of Stanford University approved the merger itself, which, barring legal complications, will take effect next summer. Teaching hospitals in Minnesota, New York, Pennsylvania, and elsewhere are pursuing "strategic alliances" of various types to preserve their research and educational agendas.

The proponents of these mergers hope the institutions they are creating will achieve economies of scale by reducing administrative costs and sharing equipment, personnel, and facilities. This should be enough to improve their negotiating position with insurance companies and managed-care organizations, secure bases of patients adequate to conduct medical education, and preserve their critical roles in community service and research.

For the past 18 months I have been tracking the nationwide wave of mergers and consolidations involving teaching hospitals. The nature of the institutions and the types of arrangements vary. But they have enough characteristics in common to permit some tentative conclusions.

Mergers are complicated arrangements. The functions of medical schools may be put at risk if medical schools are separated from the support they now receive from teaching hospitals and clinic operations. In the past, the hospitals have provided financial support for medical education through fees paid by patients, Medicare and Medicaid reimbursements, and federal grants to cover the indirect costs of research. Studies show that these hidden subsidies, the result of decades of negotiations between medical schools and hospitals, are extremely difficult to identify, measure, interpret, and change.[2]

Insurance companies and managed-care plans seek to provide health care as cheaply as possible, however. They do not see why they should subsidize teaching and research, or even pay for expensive high-technology medicine that they would prefer their subscribers did not use. When funds from these sources disappear, medical schools will be forced to look elsewhere for money to cover medical education and research.

By placing their hospitals under a separate, independent corporate umbrella, Stanford and UCSF have relinquished their control of education and clinical research. A new corporation now decides about levels of staffing, terms of employment of clinicians and staff members, and the functions of the various departments. If that corporation overemphasizes financial considerations, education and research could become a distraction rather than the central focus of the institution's mission. Members of academic faculties already complain that they are being forced to spend more time in medical practice and less time in research and teaching. Faculty clinicians are depended on to transfer the newest medical discoveries from the laboratory to the bedside. Like basic scientists, such clinicians need to be among the top 10 percent of researchers in their fields or specialties to compete successfully for grants from the National Institutes of Health. If they do research two days a week, treat enough patients, and also teach, they will probably still fail to compete successfully with researchers doing full-time research or with private practitioners who only see patients.

Some faculty members may abandon research, and those who remain interested in research and teaching may leave for other jobs. Some researchers have moved from Boston to medical centers in Kansas, Colorado, and the South, where there is less managed care and where money for clinical research is more available. Although such an exodus is not yet considered catastrophic, Dr. David G. Nathan, the president of the Dana–Farber Cancer Institute in Boston, has spoken out as one leader who thinks clinical research is seriously threatened.[3] The consolidations in Boston and New York are "prompting anxieties" among research scientists, whose concern revolves around possible job loss and questions of funding, as institutions that were formerly competitive, and sometimes had grants for similar research projects, become one.[4] Senator Daniel Patrick Moynihan (D-N.Y.) has warned that unless Congress acts to fund medical education through taxes on insurance premiums and transfers from Medicaid and Medicare trust funds, New York will no longer be a mecca of medical innovation.[5]

Hospitals owned by universities or affiliated with them are staffed by faculty members who are rightfully proud of their technological innovations. Academic centers rely in part on such accomplishments

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for the success of their mergers, because innovative techniques allow them to provide services that other hospitals cannot offer. Still, of the mix of services that academic centers deliver to patients, only about 5 percent are unique. Another 15 to 25 percent consist of complex types of care that the centers probably provide more effectively than other hospitals. In most urban areas, the remaining services are available elsewhere at lower cost.

Teaching institutions that are planning mergers generally rely on the same pool of consultants, who are narrowly focused on the bottom line. Thus, the merger arrangements are strikingly similar, raising the question of whether the decisions to combine are in the best interests of patients and education. After mergers occur, deans and faculties are at the mercy of hospital bureaucrats and boards that tend to avoid their responsibility to spend money on medical education and research. Some worry that fewer poor people will have access to care and that valuable care givers, from nurses to technicians, will be replaced with less competent personnel.[6]

There is considerable disagreement about whether teaching hospitals can be consolidated in a beneficial way. For-profit institutions can operate hospitals very efficiently, often by sacrificing comprehensiveness and quality, but academic medical centers have always thrived on a sense of values and of mission to the community, and they are reluctant to lower the quality of their care or reduce their programs and services.[7] There is no evidence that mergers work in saturated hospital markets. Consolidating clinical programs such as those performing bone marrow or organ transplantation, for example, may not be enough to make a difference financially, even if there were corporate decisions to increase prices, which might constitute a violation of antitrust law.

The experience of investor-owned hospitals, which goes back 10 years or more, is the best yardstick we have for predicting how teaching hospitals may fare after a merger. The only approach that has succeeded is for an organization to move into a community, buy three hospitals, close two, and have one strong money maker.[8] Studies of mergers involving investor-owned hospitals also show that no substantial savings are passed on to consumers.[9]

The corporations resulting from the merger of New York Hospital–Cornell Medical Center with Columbia–Presbyterian Medical Center, as well as from the merger of the hospitals at UCSF and Stanford and other mergers elsewhere, intend to continue operating the separate facilities of each hospital after the mergers — a plan that makes "economies of scale" doubtful. More than three years after their merger, Massachusetts General Hospital and Brigham and Women's Hospital have not reduced the scope or size of their mammoth facilities. Charges in each hospital remain high, and there is little progress toward the elimination of overlapping clinical services.[10] Indeed, Massachusetts General Hospital opened an obstetrical service after the merger was announced.

Five years ago, the UCSF hospitals merged with Mount Zion Medical Center, also in San Francisco. This led to budget cutting, program shuffling, and the elimination of duplication.[11] But the patient census at Mount Zion did not increase, and UCSF lost patients. Paradoxically, the medical school at Stanford — UCSF's new partner — was never intended to become part of a health care empire. In 1959, it was relocated from San Francisco to Palo Alto, about 45 miles away. Stanford's small faculty devoted its energies almost exclusively to research and education. As much as possible, it was protected from the distractions of a large clinical practice, which was left, appropriately, to community physicians. Combining the school with the rest of the university extended and integrated knowledge in medicine and biological sciences and focused research on a better understanding of health and disease. That emphasis attracted talented students and differentiated Stanford from other medical schools. In the mid-1980s, fund-raising for a needed modernization of the hospital led the Stanford trustees to reorganize the hospital as a separate corporation with an independent board. The change, however, eroded the authority of the dean and faculty in hospital affairs and made the school an appendage of the hospital. Although this arrangement might have worked out differently elsewhere, at Stanford it had the unintended effect of transforming the school's original mission — fostering research and education — into a byproduct of the medical-practice business.[12]

The relations between university hospitals and medical schools are often fraught with controversy, even under favorable circumstances. Depending on whether an issue is examined by the dean, the chief executive officer of the hospital, or the faculty, perceptions vary. At Stanford, separating the hospital from the medical school led to a kind of organizational anarchy. The questions that should have been asked before the reorganization were fundamental ones: What is the purpose of the medical center? What should it be? It doesn't take an accountant to see that in the absence of clear answers, fixed costs would go up. The separation of the hospital, implemented with no critical assessment of the goals of faculty members, contributed to bad decisions, micromanagement by trustees, long-term administrative instability, and the lack of a clear, consistent plan to ensure the survival of the academic medical center.

Stanford Health Services was formed three years ago to address this disunity and provide a better framework for the university's clinical operations. In this merger, Stanford Health Services, which includes Packard Children's Hospital and the Stanford hospi-

tal and clinics, was combined with three local group practices providing primary care. Nonetheless, these joint ventures, together with a 49 percent increase in the number of clinicians on the faculty over the past nine years, have only marginally affected clinic visits and hospital admissions.

The sale of the University of Minnesota Hospital to Fairview Health Care Services in Minneapolis, which university officials preferred to describe publicly as a merger, was intended to remove the university from the hospital business. The transaction was approved in August 1996 by the university's board of regents after being repeatedly put on hold because of labor-union opposition, faculty objections, and disagreement over the structure of governance. Eventually, the university won the right to appoint the majority of the members of the new board, as well as a commitment from University of Minnesota–Fairview to provide ongoing support for academic programs. A week after the regents' action, however, HealthPartners, Inc., one of the largest managed-care organizations in Minnesota, announced that most of the patients it had been sending to Fairview Riverside Hospital would instead be sent to Methodist Hospital.[13] Although the University of Minnesota–Fairview consolidation will go forward, the announcement by HealthPartners came as a major setback, because in 1995 HealthPartners accounted for 39 percent of Fairview Riverside's 28,000 inpatient admissions and 25 percent of its revenues. The decision to take the HealthPartners business elsewhere may reflect unique circumstances, but it clearly challenges the notion that combining institutions to increase their market share is a guarantee of success.

Some academic medical centers are simply so big that further enlargement makes them unmanageable. Expansion through mergers and other arrangements could increase the tendency of managed-care organizations to avoid these institutions. When the 1996 merger of New York Hospital–Cornell Medical Center with Columbia–Presbyterian Medical Center was announced, Dr. William Speck, the chief executive officer of Columbia–Presbyterian, likened it to "merging Coke and Pepsi."[14] The comparison is not valid, however. Medical leaders need better cognitive maps of both their institutions and themselves. They must acknowledge that the merger practices used by commercial enterprises will not, by any standard of scientific objectivity, work well in academic medicine. The critical question they need to ask is not "Can we afford not to merge?" but "Does merging make sense for us?"

The jury is still out on hospital mergers, but it is increasingly clear that these consolidations cannot be relied on to solve the funding problems of academic medical centers. In addition to the demands made by purchasers of care and the growth of managed-care systems, the problems include the surplus of physicians, overspecialization, and the reluctance of the public to pay for education and medical innovation. The merger between New York University and Mount Sinai Health System and that in Philadelphia between the Medical College of Pennsylvania and Hahnemann University are notable exceptions, but generally medical schools, whose programs are chiefly responsible for high hospital costs, are left out of the merger deals.

In a series of reports starting in 1992, the Pew Health Professions Commission has recommended changes in medical education that include closing 20 percent of the medical schools in the United States and cutting back the training of new doctors, nurses, and pharmacists. The idea is to match medical education to the needs of the "emerging health system" of the 21st century.[15] This new system will require academic centers to tailor their appetite for programs — involving more than just their hospitals — to follow their bank accounts more closely. In most instances, institutions should be able to change their enterprises effectively on their own, without superimposing expensive new bureaucracies to do it for them.

Such an approach will require that often-overlooked middle managers, departmental chairpersons included, have new skills and a new willingness to make decisions. The issue of modifying or ending the tenure system, by which medical schools are obligated to retain all their faculty members until retirement, regardless of performance, must be faced head on. Because the current level of support from faculty-practice plans is diminishing and is not likely to be sustained under managed care, restructuring the financing of medical schools must be given a high priority. Some research laboratories may need to shrink, and their administrative-support services may need to be bundled together. Researchers using similar techniques could share laboratory space and expensive equipment. Classes in medical schools, expanded in the 1970s to address a predicted shortage of physicians, and slots in graduate training programs should be cut back. The construction of new buildings, typically financed through private philanthropy, should be matched to the needs of rescaled academic programs. Many centers that are merging plan multimillion-dollar construction projects. If their leaders really believe they face a financial crisis, they could alleviate it in part by declaring a moratorium on construction.

Academic leaders in universities that own their own hospitals must rethink the hallowed practice of keeping clinical operations separate from academic control. Management structures that tie the hospital, medical school, and university together more closely than ever before may improve operations. Johns Hopkins University did just that recently by

merging its medical school with its hospital. If academic centers want to stop competing with one another and to cooperate on patient care and research, they can exchange letters of understanding. Collaboration can already be seen in research on AIDS, heart disease, and cancer.

The strategists of mega-mergers that involve teaching hospitals ignore the part academic medicine has played in the escalation of health care costs. They wish to avoid paying for medical education and dodge the issue of tailoring medicine to the needs of society. They offer no leadership, only the preservation of the status quo. Moreover, by adopting the tactics of the health care marketplace, they cause academic medical centers to risk losing public support and the privileges they have enjoyed as nonprofit organizations. In a capitalist society, nonprofit status carries a halo of probity. One imagines the gentle administrators and trustees of nonprofit academic medical centers spending their time engaged in good works that benefit patients, rather than calculating new ways to beat the competition.[16]

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