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Academic Medical Centres & Mergers: Consolidation Leads to Increased Competitiveness

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Concerns over rising healthcare costs have motivated hospitals to seek ways to increase efficiency, decrease costs and improve quality. Hospitals have recognised that consolidation might accomplish these goals.Academic medical centres are especially vulnerable to a changing economic environment, as their teaching and research responsibilities increase the cost of their services and many found that re-organisation and consolidation put them in a more competitive position.This article examines the background, causes, benefits, and pitfalls of hospital mergers.We also analyse related managerial and organisational challenges.

In the US in the 1970s, both federal and state governments enacted various regulations and laws resulting in a shift from expansion to cost control. This altered the incentive for lengthy inpatient admissions and created a decline in demand for inpatient services. Also, the changing environment in healthcare delivery and reimbursement in the late 1980s and '90s sparked a major overhaul in the organisational structure of healthcare institutions, emphasising primary care physicians over specialists and introducing price competition into the marketplace. Factors that influenced this change were:

• Medicare moved from a cost-based to prospective, fixed-price payment system;

• Technological advances enabled more treatment to be provided in a lower-cost outpatient setting;

• Increases in managed care and selective contracting restrained reimbursement rates, enabling close monitoring of service necessity.

Academic Medical Centres Adapt to Market Demands

Academic medical centres faced enormous challenges in this new economic environment. Due to the high cost of the service delivered by them, referrals to academic medical centres from community physicians and hospitals began to decline. As volumes dropped, so did clinical revenues. As the clinical subsidies that supported teaching and research missions declined, the financial structure that supported the whole academic medical system was threatened. Moreover, academic medical centres also faced reductions in Medicare spending in the mid-to-late 1990s.

The academic medical community investigated a number of strategies to overcome the challenges it faced. In this regard, Harrison et al reported three alternatives:

1. “Do it alone” by creating a self-contained integrated delivery system;

2. Consolidate by forming networks or mergers;

3. Separate the college of medicine from the teaching hospital by selling the hospital to a for-profit company.

Perhaps the most hyped merger strategy was consolidation of highly specialised, high-cost programmes and equipment to result in significant savings, enhanced bargaining power to further reduce costs and the pooling of the patient base and increased referrals or market share to support operations.

Three Elements for Success

Three key elements play a critical role in achieving successful merger of health institutions: the consensus of fundamental goals and direction of merger by key leaders, agreement of governance structure and cultural resolution.

The first element crystallises the need for senior administrators from both institutions to reach consensus on the goals and pathways needed to achieve a viable merger. Both strategic direction and day-to-day operations of large organisations like hospitals depend on the skills, visions and team abilities of senior executives. Thus, once corporate-level issues are resolved, departmental leaders can act as liaisons in these discussions to facilitate communication between institutional leaders and clinical departments.

A second element is governance structure. The parties involved need to agree on the level of involvement or autonomy between them. The purpose of a central governance body of a nonprofit organisation is to provide strategic guidance and support but requires constant and proactive communication. In mergers where communication is a priority, more thorough and timely consolidation between departments is achieved.

A third key element to mergers is cultural resolution. Institutional leaders need to reach a consensus regarding cultural merger between two entities. Will they facilitate merger between two institutions by creating a new culture, where the perceptions of “us” versus “them” are minimised or will they retain former cultural practices? When entities retain an “us” versus “them” mentality, a destructive tendency against successful merger between the two departments emerges.

Radiology Departments and Mergers

There are several advantages for radiology departments to merge early during the process. Firstly, radiology is a procedure-based specialty and largely patient independent and therefore may have less departmental idiosyncrasies. Secondly, there are a sizeable number of radiological exams that are location independent, due to ease of electronic imaging relay systems. In addition, there is considerable investment in the property and equipment of radiology, making it extremely capital and space intensive, enabling departments to enjoy the benefits of economic scale. Finally, the level of advanced technology also has a significant impact on the clinical and educational components of academic medical centres.

Partners HealthCare System, Inc.

Brigham and Women’s Hospital and Massachussett’s General Hospital were among the first academic medical centres to merge in the US. Both are teaching hospitals of Harvard Medical School and were interested in establishing a holding company while preserving their names and identities. A neutral name was selected for the new organisation: Partners HealthCare System, Inc., (PHS). The ultimate power to decide policy for the corporation was given to Partners’ Board of Trustees.

Accomplishments of the new corporation include:

• The formation of Partners Community Healthcare Inc., (PCHI), a subsidiary corporation that established a network of over 1,000 primary care physicians to serve practices and conduct negotiations with insurers;

• Partners and Dana Farber Cancer Institute to form Partners/Dana Farber Cancer Care for joint clinical, research, and educational programmes in oncology;

• Partners’ joint continuing medical education programmes and research projects;

• Merging of half of the residency programmes and one-third of the fellowship programmes into single training programmes across both institutions. Executives of Partners are housed in Boston, MA, midway between both hospitals, and manage a consolidated administrative structure that includes finance, budgeting, information systems, investments, legal issues, marketing, etc.

Avoiding Staff & Patient Loss

Elements that typically lead to the failure of a merger include:

• Allowing anxiety of downsizing or demotion to permeate throughout both hospitals and departments leading to staff departures;

• Retaining separate financial records, information systems, billing systems, and marketing services;

• Merging with an entity geographically far from your institution.

An overwhelming number of mergers do result in layoffs of both managers and rank-and-file staff, so many employees have good cause to feel uneasy in times of change. To many employees, an impending merger spells an uncertain situation with implicit risks. Even if the merger does not eliminate their positions, it will change the way they perform their jobs. A simple memo indicating the will of the leadership to accomplish the merger with as little impact on employment as possible can be helpful.

Particularly for patient referral, the location of an institution is often a critical factor. Consequently, the consolidation of services in another location may result in loss of a significant percentage of patients than were anticipated, to support the operation.

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