

HOSPITAL MERGERS

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OUTLINE

- My own merger journey
- The persistent urge to merge
- How to merge
- Culture trumps all

OUTLINE

- Merger successes and failures
- MDs and Mergers
- Record of mergers
- Mergers – get use to it

OBJECTIVES

- List reasons why hospitals and laboratory leadership consistently pursue mergers. Name some situations in terms of the development of hospitals and labs where mergers are often seen as a solution.
- What are the steps that usually are necessary to effect a hospital merger.

OBJECTIVES

- What factors lead to a successful or unsuccessful merger
- Describe in general terms the record of mergers in North America over the past 50 years.
- What is the outlook for mergers in the future?

MY OWN MERGER JOURNEY

- Fellowship in 1990
- City of 400,000 with complete merger of labs to one site at University
- Experienced merger and divorce of 2 hospitals and labs in Toronto 2000-2006

[Joy Malbon]: The province says there's more to come with even more hospitals under review in Ontario. But healthcare workers say the battle isn't over yet. Some are looking at appeals, even lawsuits in a last ditch effort to keep their hospitals alive. Joy Malbon, CTV News, Toronto.

MALBON: So the Ontario government's commission on health restructuring is recommending some tough medicine. Pulling the plug on ten Toronto hospitals. The big names - Women's College Hospital, around since the turn of the century, and the Wellesley. Two other hospitals will be cut back to clinics and several health programs like dialysis and burn units will merge into existing hospitals. Total savings - 430 million dollars a year. What the report did not include is the human cost. How many healthcare workers will lose their jobs?

WOMEN'S COLLEGE HOSPITAL





MY OWN MERGER JOURNEY

- Experience failed merger of lab only to largest lab in country 2009-2016
- Entered MD initiated Lab Collaborative as Chief in 2013 until present.
- Chief of 2 autonomous hospitals 2014-16

MOTIVATORS FOR MERGERS

- Financial

eg high debt load and inability to compete for patients or “talent”

- “merge or sell” - particularly if outlived mission

Growth – especially to adjust to technologic changes/disease changes/population changes

Increase market share

MOTIVATORS FOR MERGERS

- Mission preservation – religious, academic, community ownership and not distant ownership
- Defence imperative

HOW TO MERGE.

- SWOT analysis of own institution
- Information composed by management but decision is solely for the Board
- Specific objectives essential to success

4CS OF MERGER- EVALUATING PARTNERS

- Capability – clinical strength, culture
- Capital – financial strength and access to capital dollars
- Clout – negotiating clout with payers
- Computers – technologic advances and functionality

USUAL CRITERIA

- Geography- sometimes distant best sometimes closer best
- Type of organization – religious, community, academic
- Size of partner including breadth of services

ONCE A PARTNER IS CHOSEN

- Merger committee – management, board, doctors, university, community, patients
- Hire the lawyers “pay me now or pay me later”
- Sign confidentiality agreements
- Most mergers cost in 7 figures to negotiate in US
- Develop communication plan

ONCE A PARTNER IS CHOSEN

- Sign MOU – like getting engaged
- Commence due diligence
- Sign final agreement
- If problems not resolved merger will fail

CULTURE TRUMPS ALL

- “the way we do things around here”

Business realities

Values

Heroes

History

Rites and rituals

Personal networks

CULTURE TRUMPS ALL

- A key component in pre- merger evaluation
- Culture is the shadow of the CEO
- Focus on shared values and shared behaviours to bring cultures together.
 - winning hearts and minds
 - Shared culture that makes business and clinical sense

CULTURE TRUMPS ALL

- Faith based are a step ahead with this
- Can be community, academic or quality based

CULTURE TRUMPS ALL

- Autonomy vs control
- Unity in essentials, Liberty in non-essentials, Respect in all things

TLC PRINCIPLES

- Consultation and second opinion are an essential part of Pathology practice. No one medical practitioner has all the answers.
- Informs our belief that no one institution has all solutions to all problems at all sites

TLC PRINCIPLES

- Share manpower and resources only where and when it serves the purpose of strengthening our group and member hospitals
- Always with regards to fiscal responsibility

TLC PRINCIPLES

- Utilize existing technologies in IT – cGTA and remote networks – faster, cheaper, easier.
- “ground up” philosophy- consider work exchanges and financial exchanges.

TLC PRINCIPLES

- Recognize role and value of all institutions
- Recognize corporate and medical “cultural wisdom” of onsite leaders and employees

A SUCCESSFUL MERGER

- Sound business rationale
- Long term commitment
- Excellent leadership skills
- Sound business plan to effect objectives

AN UNSUCCESSFUL MERGER

- Lack of business rationale
- CEO not sure merger is good for him or her personally
- SLT is ambivalent
- Board too trusting of SLT

AN UNSUCCESSFUL MERGER

- Commitment is superficial
- Merger only done for financial reasons
- Completely defensive mergers
- Merger is a reaction not a strategy
- Merger completely based on personal relationships
- Assuming cultural differences will resolve

AN UNSUCCESSFUL MERGER

- Merger of 2 financially weak organizations
- Merger based on money coming from merged authority but institutions all retaining autonomy
- Co CEOs

AN UNSUCCESSFUL MERGER

- Merger of medical staffs without a good reason
- Merging of Foundations and alienation of donors

AN UNSUCCESSFUL MERGER

- Complete asset mergers usually more successful
- Too many out clauses
- Unused space not reconfigured immediately
- “burn the life rafts”







Wellesley Central Place



MDS IN MERGERS

- Key problem for CEO
- Is the MD a competitor, a customer, a consumer, an employee, a partner?

RECORD OF MERGERS

- Weil J Health Sciences Research 2010

Almost all studies indicated that hospital consolidation raises costs by at least 2% in the US

Where there is less competition the cost of health care rises

RECORD OF MERGERS

- Only cost savings come from closing buildings
- Most robust studies, but not all, claim that quality of care will suffer due to less competition

RECORD OF MERGERS

- “those in leadership positions lack the necessary understanding and appreciation of the differences in culture, values and goals”
- Tendency to overlook medical staff issues such as referral patterns and joint leadership issues

MERGERS -GET USE TO IT

- Number of acute care beds in US decreased from 4.6 to 2.7 per 1000 persons between 1981-2008 with shift to ambulatory care
- Current period similar to 90s very challenging business environment
- 18 mergers in Minnesota in 90s and only 3 between 1999-2008

MN RECORD OF MERGERS

- Examined employment patterns in Labs in the Twin Cities area every 5 years from 1970-1995
- In 1970 30 hospitals with 10000 beds 2 blood banks and 4 clinical labs 1300 employees
- In 1995 18 hospitals, 7000 beds, 11 blood banks, clinics, reference labs and HMOs including 3 independent labs – 2900 employees

THE URGE TO MERGE

- Over 2/3 of US hospitals representing 80% of beds are now part of larger organization

MERGERS – GET USE TO IT

- New challenges – IT costs and competition, new organisms, overseas competition
- Closures, acquisitions and divestures rather than mergers