Research says hospital consolidation isn't a cure-all for health care

February 23 2015, by Tim Vogus

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In his new book, America's Bitter Pill, Steven Brill dives deep into the history of the Affordable Care Act (ACA) and how it was passed. He concludes that, although providing more Americans with health insurance is worthy of praise, the ACA does far too little to address the costs of health care.

And he makes his own proposal for bringing costs down: consolidation. As hospital systems expand and eye ways to grow even more, Brill proposes that these systems start to insure patients as well as treating them. If the hospital system is the insurer, he reasons, it has an incentive to keep costs down. And these new integrated systems would treat all their patients' needs from primary care, to surgery and more. In short – treating the whole patient.

Economists and other researchers have been looking at what consolidation, big integrated systems and dwindling competition mean for health care. And so far, it looks like consolidation isn't a cure for high costs or a way to improve care. In fact, it might make it harder for hospitals to deliver care well.

Consolidation is already happening

Hospital consolidation is either "horizontal," like buying a hospital and reducing the number in the market, for instance, or "vertical," like buying clinics and physician practices.

The truth is that hospitals are already a long way down this road. Both kinds of consolidation are happening and in recent years there has been unprecedented consolidation, with more planned for 2015.

And the ACA creates an incentive for organization to consolidate and offer insurance by encouraging the development of Accountable Care Organizations (ACOs). These are networks of doctors, hospitals and other care providers that coordinate care for patients. The idea is that they save money by increasing efficiency because they care for all of the patients health needs. That means everything from primary care to specialists, hospital services and more. ACOs are especially prominent in Medicare, but the Department of Health and Human Services (HHS) is pushing for more of this quality- and value-based contracting over

traditional fee-for-service.

Some critics say that consolidation in general means that hospital systems have a tremendous amount of market power – something that isn't known for keeping costs down. But Brill argues that any concerns about the market power these systems would hold can be overcome by simple regulations to ensure minimum competition.

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So in other words, both Brill and the ACA would push health care delivery toward large integrated entities that would manage the entire spectrum of patient needs from insurance to primary care checkups to cancer treatment to managing chronic disease. But research shows that consolidation has a poor track record of keeping costs down and that

very large organizations have trouble delivering care and working efficiently.

Consolidation doesn't have a track record of keeping costs down

Earlier attempts to control costs through consolidation did not succeed. In the 1990s integrated delivery networks attempted to lower costs, but failed due to financial losses from purchasing physicians practice, difficulties with integration and managing risk. Researchers argue that new attempts to control costs through consolidation are likely to experience similar disappointing results.

Martin Gaynor of Carnegie Mellon and Robert Town of the University of Pennsylvania's Wharton School summarize recent research indicating that increases in consolidation – and the resulting lack of competition – lead to higher health care costs. And these increases are especially high in consolidated markets with few hospitals.

Beyond higher costs, consolidation can also reduce the quality of care provided. Research from outside the US suggests that increases in consolidation can have a negative impact on survival from heart attack. Concentrated markets also mean less choice for patients when it comes to choosing hospitals or doctors, and research indicates that more choice can lead to better health outcomes for procedures like coronary artery bypass graft surgery.

Bigger systems don't always make for better care

Brill also ignores another major problem: integrating and operating a very large or consolidated health system is hard.

In research at a large, academic medical center, Brian Hilligoss and I found even simple, everyday care transactions and decisions are fraught with problems. Different units, like general medicine and emergency, have different workplace cultures and different ways of operating, which can make integration difficult. Units might be interdependent, but their administration is separated. And the physical size of these organizations matters too. The hospital we studied occupied over 6 million square feet putting a lot of physical distance between units and between doctors and patients. In our study we found that these factors led to a heavy reliance on technology to coordinate care rather than direct communication.

In another study Hilligoss found that this poor integration between different units in the hospital means that doctors rely on an elaborate process of "selling patients" to other departments in order to transfer them. One department has to make a case for the patient to be transferred to another department, even if that is where they objectively need to be. And inpatient services have the right to refuse transfers.

We found that physicians have to consistently engage in elaborate workarounds to carry out their work. And nurses face similar challenges in complex organizations. Anita Tucker of Brandeis University documents how, like doctors, they frequently encounter operational failures like missing materials and information that require workarounds.

Mergers don't always mean coordinated care

The consolidation encouraged by Brill exacerbates all the challenges identified in this research. For example, in her book Code Green, Dana Beth Weinberg documents how the merger of Beth Israel and Deaconess hospitals in Boston had profound effects on the way care was delivered at the bedside. The merger prioritized cost reductions through higher patient loads for each nurse which undermined Beth Israel's comprehensive and influential primary nursing model. In practice that

meant shifting critical patient care tasks away from highly skilled registered nurses to less skilled aides which compromised care quality.

And early evidence from Accountable Care Organizations suggest that is difficult for different organizations to integrate their cultures. Sara Kreindler of the University of Manitoba and colleagues examined early Accountable Care Organizations and found that in no case did these organizations see themselves as integrating different groups into one whole. In fact, the organizations studied painstakingly avoided the idea of integration.

While Brill's work offers a compelling personal narrative and a provocative and thorough recounting of the development and passage of the ACA, it has substantially less to offer as guidebook for change. He fails to sufficiently grapple with existing economic research, earlier attempts to achieve similar aims, and the real difficulties posed by consolidation for those doing the hard work at the point of care delivery.

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