Commentary

Public not served by merger of MGH, Brigham

Most reaction to the proposed merger between the Massachusetts General and Brigham & Women's hospitals has been surprisingly reverent and unjustifiably unquestioning. Discussing such academic medical centers, a former Boston hospital executive recently wrote that "self-interest . . . is something they perceive with clarity and to which they are always ready to respond." This merger promises considerable private benefits to the hospitals, principally from reduced price competition between them, but few public benefits.


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As the state's two biggest hospitals, each is large enough already to win almost all available administrative and clinical economies of scale. Staffing needs in most administrative departments would not change because they reflect the volume of paperwork that stems (in our fragmented health care financing system) from the volume of patients treated. And adding administrators to coordinate the merged units could mean costly new diseconomies of scale.

The hospitals could gain at best marginal efficiencies if they combine departmental operations, perhaps only for a few esoteric services such as transplants. But in 1985, these hospitals promised that a consortium with two other hospitals could limit costs and maintain quality of care sufficiently to warrant the state allowing all four hospitals—instead of only one—to do heart transplants. MGH and three other hospitals established a similar consortium for liver transplants. If such collaborations can actually save money, no merger is necessary. If the consortia have not saved money, these hospitals misled us or deceived themselves. So why should we believe their claims now?

Those who promise that the merger will bring big savings need to show specifically which programs or jobs will be cut. And why couldn't each hospital cut them on its own? MGH's reported decision to open its planned but unnecessary obstetrics service confirms that this is largely a formal merger to reduce price competition, one that does little to reduce costly duplication or to increase efficiency.

Further, this merger will in no way work against the main source of high costs in Boston medicine, the elaborate and expensive patterns of diagnosis and treatment that have given our region and state the world's costliest hospitals.

This merger actually may increase the cost of care. Combined, the two hospitals will have tremendous market power. Brigham and MGH have one-third of the acute hospital beds in Boston today, and serve one out of every 12 hospitalized Massachusetts residents. Most insurers would seek to use an institution commanding such a large share of the area's hospital resources, particularly in specialty care, so the merged hospital would have great ability to resist payers' demands for discounts.

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If necessary, with its enormous financial reserves of $700 million, this behemoth could subsidize temporary price cuts to bid insurance contracts and therefore patients away from other hospitals, some of which might have to close or perhaps merge on disadvantageous terms with the new Brigham-MGH entity. As the number of hospital beds falls further, occupancy rates will increase. Then surviving hospitals will be free to raise prices again in a sellers' market—where the merged Brigham-MGH will wield unparalleled clout.

The huge new hospital may also be less responsive to unmet health needs of Boston residents, since its community will be so broad and undefined.

Two years ago, our Project warned that deregulating hospital payments would bring market competition in the short term but market consolidation soon after. We pointed to the consequences of competitive pressures in Minneapolis-St. Paul, where observers indicated that boosting bargaining power, rather than increasing efficiency, had been the priority for hospitals, as well as for HMOs, insurers, doctors, and employers. Care-giver monopolies were emerging, facilitating resistance to pressure for price cuts.

The Brigham-MGH merger is the latest and loudest warning that competition among hospitals is but a transient phenomenon. It will be followed either by private market oligopoly power for surviving hospitals or by public reregulation in the public interest. The choice is clear: We must begin to plan now for the sorts of simple and fair controls on hospital behavior that have been demonstrated to contain cost while assuring universal coverage in all other industrial democracies.

We urge the state to deny approval for this proposed merger for three reasons. First, the proposed merger offers no demonstrated public benefits. Second, the two hospitals can reduce duplication and consolidate services without a merger and its accompanying problems. At a minimum, the merger should be put on hold until MGH and Brigham & Women's demonstrate that they can cut existing fat, a task which could be even harder in a bigger organization.

Third, although we doubt that hospital competition will succeed in controlling costs or improving quality and access, Massachusetts has adopted a policy of promoting competition, so state government should discourage reductions in the number of competitors. Competition needs competitors—the more the better—if it is to hold down prices. The Brigham-MGH merger may not violate today's ineffective antitrust barriers, but it would help drive competitors out of business, and the antitrust laws will do nothing to prevent such bankruptcies.

The merger could thus endanger other needed hospitals. And such closings are unlikely to reduce our costs. One-third of Massachusetts hospitals have closed since 1970, and our bed-to-population ratio is below the national average. Yet hospitals' per capita costs in this state have remained 35 percent to 40 percent above the nation's.

One final point: the hospital merger trend should give pause to those pondering a future in which managed competition is adopted to reform health care. Insurer and HMO mergers to boost market share would diminish the number of competing plans, reducing consumer choice. Because it is almost as hard to start a new HMO as to start a new hospital, there is good reason to fear that health care would increasingly be dominated by a few major insurance company-owned for-profit HMOs, with many of today's better nonprofit HMOs left on the margins of the market. The dominant insurers would then have little need to be responsive to the public interest in access to care, quality, and cost control.

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