David, Goliath and Asset-Heavy Health Systems

By David Johnson, Managing Director and Sector Head Non-Profit Healthcare & Higher Education

When Goliath challenged the Israelites, his considerable strengths (size, armament, weaponry) worked against him. As Malcolm Gladwell describes in David and Goliath, there's more to the story than underdog David defeating his towering foe. Incumbents often fall to more nimble competitors in surprising ways. David's battle with Goliath is a powerful metaphor for large health systems confronting nimble competitors seeking to exploit their inefficiencies. Under market pressure to reduce prices for acute services, health systems remain dependent on unsustainable high-margin fee-for-service payments. Centralized, expensive and complex, hospitals have been health systems' crown jewels and principal revenue generators. However, hospital-centric business models are not well-adapted to meet market demands for efficient consumer-friendly healthcare. To avoid Goliath's fate, health systems must reconfigure their asset-heavy operating models, share asset-ownership risk and experiment with consumerism.

Goliath Never Had a Chance

Under King Saul, the Israelites fought the Philistines to a standstill at the Elah Valley southwest of Jerusalem. Twice a day for forty days, Goliath marched into the valley and challenged an Israelite to decide the battle's outcome by engaging him in mortal combat. No warrior accepted Goliath's challenge until the shepherd boy David stepped forward. Refusing Saul's armor, David confronted Goliath with only his staff and a slingshot. A one-sided battle? Yes, in David's favor. Slingers regularly defeated infantry in ancient combat. Skilled "slingers" like David easily killed flying birds with rocks traveling 150 miles per hour. Expecting hand-to-hand combat, wearing heavy armor and carrying three weapons, Goliath lacked the agility to avoid the incoming rock. David grabbed Goliath's sword, cut off his head and declared Israelite victory. Goliath's imagination failed him. He expected one kind of battle and was unprepared for the battle that killed him.

Excess Acute Capacity: Too Much Armor?

The standard hospital capacity measure is the number of inpatient beds per thousand of population. The U.S. average is 2.6 beds per thousand and ranges from 1.7 beds in the State of Washington to 4.6 beds in North Dakota.[1] Like many healthcare performance measures, "beds per thousand" incorporates significant variation and doesn't capture market dynamics. Care has shifted dramatically to outpatient centers. Inpatient admissions will continue their decline with fewer elective procedures, less "overtreatment" and reduced readmissions.

To increase market share and profitable surgical volume, many hospitals have overinvested in acute care treatment facilities and locked-in high, inflexible cost structures. The "build and they will come" facility investment strategy that has worked for years no longer applies. In overbuilt markets, hospitals compete by offering amenities that include private rooms, concierge services and even private bathrooms in emergency rooms. Many health systems are continuing to pursue high-cost facility investment to attract patients. Stanford Medical Center has just broken ground on a new 400-bed facility whose cost will exceed $2 billion or $5 million per bed. Generating adequate future revenues to recover expansive facility investment costs will be difficult for all but the most successful health systems.

Embedded surgical overcapacity is a hidden danger. Surgeries are hospitals' principal revenue and profit generators. By definition surgery requires expensive operating rooms ("ORs"); yet, most acute facilities run their ORs only one shift per day four or five days per week. No other industry employs capital-intensive assets in such a limited manner. As pressure mounts to increase value (i.e. better care at lower costs), expect aggressive health systems to reduce per-unit surgical costs by extending surgical hours. True measures of market capacity must include the potential for more intensive OR utilization. Hospitals with under-utilized ORs will have less ability to adjust their cost structures to compete against nimble, David-like, competitors.

More Disruptive "Davids"

"Asset-light" companies emphasize primary care, excel in population health and manage utilization aggressively. HealthCare Partners in the west, Health Partners in the Twin Cities and Village Practice Management in Houston exemplify this breed of competitor. Expect their ranks to grow. They exploit excess acute care capacity by building narrow networks with efficient, lower-cost providers. Health systems will respond to this disruptive threat in predictable ways. Enlightened systems will adapt

their business models and develop population health/care management capabilities by themselves and/or with partners. Many will lower per-unit costs and price routine hospital services aggressively (most for-profit systems are employing this strategy). A few select institutions will have the brand strength and results-driven expertise to receive premium prices for complex care. Other health systems will use market leverage to maintain artificially high prices. Others still will seek legislative relief through higher governmental payments and/or favorable regulatory rulings. The last two approaches are self-defeating because they seek sustainability without creating value.

Strategy and Capital Formation Implications

Disruptive competition requires health systems to be strategically aggressive and expand approaches to capital formation. Expect to see the following as the market evolves:

- Less acute facility investment;
- More hospital consolidation to increase operating efficiency;
- Pro-active reduction in acute care facilities/capacity;
- Longer, more intensive OR scheduling;
- "Load-shifting" – moving routine procedures from inconvenient, high-cost facilities to lower-cost, patient-friendly settings;
- More for-profit facilities/business units to accommodate taxable partnerships and local governmental demands for tax revenues;
- More partnerships to gain comparative advantage and distribute investment, operating and ownership risks;
- Collaboration with asset-light companies. Banner's partnership with HealthCare Partners in the Phoenix market reflects this trend;
- Experimentation with risk-based payment and operating models;
- Engagement with REITs and other equity-based capital sources;
- Expansion of taxable debt issuance due to its competitive cost, flexibility, ease of access and avoidance of burdensome regulatory documentation;
- More creative use of investment funds to support health system growth; and/or
- Participation in venture capital investment to stimulate innovation, improve operating efficiency and generate equity-like returns.

Kodak Moments

In a sobering fireside chat at the Health Management Academy's spring CFO Forum, former Kodak executive Bill Zollars described the iconic company's downfall. At its peak, Kodak had $16 billion in revenues, 250,000 employees and the world's third most valuable brand. When it filed for bankruptcy in 2013, the company had $3 billion in revenues, 8,000 employees and become synonymous with failure. While Kodak confronted disruptive digital competitors, the company was a pioneer in digital technology and owned 1100 digital patents. It was Kodak's human failure to adapt its business model to emerging market realities that caused its collapse. Leadership failure, an insular "group think" culture, comfort with the status quo and limited accountability prevented Kodak from exploiting its digital expertise and made it vulnerable to multiple nimble competitors.

Zollars drew parallels between Kodak's "addiction" to its high-margin film business to hospitals' over-reliance on high-margin fee-for-service contracts. Confronting disruptive competition is difficult but essential to long-term survival. Depressingly, Zollars believes Kodak's last chance at survivability was in the mid-1980s, so Kodak was essentially a "zombie" company for its last 25 years – still functioning but already dead. He ended his talk by asking the assembled health system executives if they are confronting equally frightening "Kodak Moments". For the Goliaths of American healthcare, avoiding David's slingshot will require inspired leadership that disrupts in-bred cultures and status-quo business models.

[1] The Kaiser Family Foundation *kff.org/other/state-indicator/beds/*