# Consolidation in the Commercial Banking and Hospital Industries: Parallels and Contradictions

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Banking and hospital companies represent great threats to our economic vitality—at least that's how they are characterized in the daily press.

Banks have become so large that many critics view them as unmanageable, too large for government bailout, or too big to fail. Alternatively, the highly fragmented hospital industry is accused of contributing to the excessive cost and mediocre effectiveness of the healthcare services industry. This article considers the disparate approaches taken to industry consolidation by commercial banking and hospital companies over recent decades with an eye toward aiding future decision making by hospital boards.

We focus here on the business segment of the non-profit hospital industry (the "hospital business"; i.e., exclusive of Veterans Administration and government-owned safety-net hospitals). Non-profit hospitals represent approximately 85 percent of the total industry, and consist of 501(c)(3) community-sponsored hospitals (50 percent of the hospital business), religious-sponsored hospitals (mostly Catholic and 15 percent of the hospital business), and government-owned hospitals (20 percent of the hospital business); investor-owned companies represent the remaining 15 percent. We believe the impact of structural change is likely to be felt most prominently by 501(c)(3) community-sponsored companies; much of our review centers on these.

Banking has consolidated dramatically over the past 30 years. Many familiar names have disappeared via business combinations over this period (e.g., Manufacturers Hanover in the East, BankOne in the Midwest, and Security Pacific in the West). There were more than 30,000 independent banks in the United States in the early 1930s; only 6,500 banking companies remain today. The 10 largest bank holding companies now account for over 50 percent of all banking assets and the 50 largest bank holding companies hold over 70 percent of all bank assets.

The Patient Protection and Affordable Care Act (ACA) has generated the widespread expectation of increased business concentration in the hospital industry. This industry remains extraordinarily fragmented and consists of over 2,700 very small to moderate-sized companies and a dizzying array of ownership types. The 50 largest hospital systems generate only 25 percent of all hospital industry revenue, and the largest hospital companies have market shares of only 2 percent to 4 percent each. No other major industry in the U.S. is nearly as fragmented.

## Parallels between the Industries

A comparative review of the commercial, social, regulatory, governance, and ownership characteristics of these two industries reveals much about the potential for change in the structure of the hospital business. Many hospital board members have experienced industry consolidation as bank executives or customers and might view banking mergers as a corollary to hospital mergers.

### Commercial

Banks and hospitals operate in similar economic settings. Both are service providers in capital-intensive and highly regulated industries that are commercially and technologically complex. Both provide services locally, in the presence of customers. Both are capital intensive; hospitals require enormous and recurring investments in the plant, equipment, and technology, and banks require significant capital bases to support loan portfolios. The demands for capital are increasing in both industries. Healthcare reform is causing hospitals to invest more heavily in information technology and the employment of physicians, and banks are facing increased capital requirements from regulators.

### Social

Historically, firms in both industries were independent and locally based. Both were heavily immersed in their communities as visible and influential institutions. Many community leaders who served on local bank boards were also found on the boards of local hospitals. The local bank president was often a member of the hospital

board, and the hospital president sat on the local bank board. Many community organizations still receive funding, volunteer support, and leadership from local banks and hospitals. Both continue to be large employers and local officials are often concerned with the potential for reduction in employment subsequent to the acquisition of a bank or hospital. Strong parallels also exist at the customer level. Banks and hospitals elicit greater emotional responses than many industries because consumers are sensitive to their health and money.

**Regulatory**

Both are amongst the most heavily regulated major industries and are subject to significant oversight at state and federal levels. Both have a "gorilla" regulator that can greatly impact their ability to be successful. Banks cannot function without Federal Deposit Insurance Corporation insurance, and hospitals cannot function without CMS approval (via a recognized accreditation agency). Regulators also have a significant impact on pricing in both industries. In banking, the Federal Reserve influences interest rates; CMS sets the prices on more than 50 percent of the hospital industry's revenue base.

## Contradictions between the Industries

In addition to the similarities noted above, a few significant differences exist.

**Ownership**

The nature and role of ownership represents the greatest difference between the two industries. As investor-owned businesses, banks have clear and conventional ownership features, regardless of whether they are publicly or privately held. Board

decisions, economic incentives for change, and other elements of governance are generally made with this clear understanding. However, many believe that no one owns a non-profit corporation. As a result, most non-profit boards and executives are confused regarding the meaning of ownership as it relates to the hospital.

**Governance**

Like most investor-owned businesses, banks are generally governed by professional boards that are elected by shareholders, small in number, and include members from multiple locations. Conversely, non-profit hospital directors are volunteers who are not elected by the community (but are self-perpetuating), larger in number, and usually consist entirely of persons from the local community. These board features exacerbate the differences in the influence of ownership. For all practical purposes, legal control over hospitals rests with a board that is neither elected by, nor formally accountable to, the community.

This also results in hospital management having a greater influence over governance matters than in investor-owned companies. Understandably, voluntary boards rely more heavily on management input regarding the efficacy of business combinations and other major corporate events. Investor-owned businesses rely on management input regarding operating decisions, but are less beholden to management's guidance regarding major corporate matters. As a result, it is extremely rare for hospital boards to consider becoming part of a larger hospital company without management's concurrence.

**Commercial**

There are several notable commercial distinctions between these two industries. First, banks have relatively broad access to capital markets and are able to raise equity, either privately or publicly. Hospitals have narrow access to capital, primarily the tax-exempt debt market. This presents a serious challenge for independent hospitals given their capital intensity and the increased demands for capital associated with healthcare reform.

The two industries experience markedly different pricing mechanisms. Hospitals have highly concentrated sources of revenues. Collectively, the 10 largest managed care companies and the U.S. government account for over 85 percent of total hospital revenues. Bank revenues, on the other hand, originate from many millions of customers. As a result, few banks sell to many customers, and many hospitals sell to few payers.

The two industries also have dissimilar diversification opportunities. Over the past 30 years, the banking industry has attempted to enhance its low-margin commercial banking base through the addition of higher-margin investment banking and wealth management products, often via acquisitions. Few opportunities of this sort exist in the hospital industry. Acute-care activities represent the highest margin business available in healthcare services, and healthcare reform will force many hospital companies to secure capabilities in rehabilitation, skilled nursing, outpatient services, and other lower-margin product lines.

## Banking Consolidation Lessons Learned

The experiences of the banking industry hold several possible insights into future hospital consolidation transactions and subsequent integration. These center on the role of standardization, timing, and community relationships.

**Integration, Standardization, and Centralization**

Economies of scale can be realized through standardization and centralization of activities; this was one of the central tenets of the Industrial Revolution. Increased standardization can increase quality but can also lead to challenges in meeting unique needs of certain communities. Similarly, centralization can reduce costs and make standardization easier to accomplish but often eliminates local jobs and strains community relations. The banking industry wrestled with the proper degree of standardization and centralization for the past three decades. In the hospital industry, numerous industry experts and research studies have emphasized the significant benefits that result from evidence-based medicine and the increased use of standardized methods and protocols. The Institute of Medicine found that the United States wastes $130 billion per year on inefficiently delivered services that could be eliminated through standardization. Healthcare merger integration strategy needs to include a focus on standardization of care in order to increase clinical quality and reduce costs.

Certainly, there will be a role for independent and specialized hospitals that are able to provide unique value propositions that cannot be provided by large systems. However, hospitals should carefully consider the experiences of many small banks (i.e., simply being local will likely not be adequate in providing a unique value with which to combat large, well-run systems with more resources). Early in banking consolidation, large companies struggled with integration and execution was poor. Eventually, large banks improved service quality, making it much more difficult for small banks to differentiate themselves. Hospital board members should be wary of a strategy that relies solely on being "more local."

**Timing Matters**

Change in the number and size of companies in a given industry often results from the interplay of three forces: economies of scale, customer preferences, and regulation. These forces can act as catalysts that reward scale and efficiency and penalize poorly positioned industry participants. Classically, organizations that are impacted, but cannot adapt to these forces, fail to remain independent. In order to achieve optimal timing, sellers need to consider these forces.

For distressed sellers, one obvious lesson from the banking industry is to sell early rather than late. While all executive teams are trained to be optimistic and seem to be genetically predisposed to exert herculean efforts to turn faltering institutions around, the risk of continued deterioration is high. For both hospitals and banks, it is better to sell a slightly stressed operation than to wait until reaching full financial crisis to sell. This is a very difficult judgment call, particularly for non-profit hospital boards working without the clarity of ownership.

Merging early, before becoming severely distressed, requires a difficult and candid discussion of the probability of success. The standard should not be survival, but ability to thrive in the future. This is the largest issue confronting hospitals today. Of note, the quality of a hospital's market and the stability of its market share are the most important factors in assessing value. Once either the quality of the market or market share declines, whether financial distress is being experienced or not, value is declining. A healthy institution in a strong market can control its destiny; however, such institutions must be mindful of those partners that might provide the best merger terms or acquisition fit. Should their best partner join the hospital across the street, or shift corporate strategy, even a great hospital can find itself eventually merging with a less optimal partner.

**Community Relations**

Because banks and hospitals are important institutions in their communities, emotions regarding mergers and acquisitions often run high, particularly in the view of board members. There are many lessons in this area that hospital executives and boards can learn from the experience of the banking industry. First, be prepared for emotional responses, especially from elected officials, and implement reasonable tactics to address these concerns. Even more so than banking, elected officials view hospitals as a quasi-public organization similar to the institutions they control (e.g., schools, parks, and libraries). Professional public relations advice has become essential for hospitals considering mergers. Second, in time, patients and physicians will refocus on what matters most: clinical outcomes and patient satisfaction. If a merger improves these two primary factors, eventually these concerns will dissipate. In the end, patients, employees, and physicians are most concerned about good healthcare, not the hospital's name or sponsorship of the local parade.

## Conclusion

Hospitals and banks share many commercial, regulatory, and social features, and yet they find themselves at opposite extremes in terms of company size and industry concentration. Most hospital leaders forecast a need for consolidation into larger companies. Healthcare reform and the parallels between the two industries, particularly complexity and capital intensity, support this view. The fragmented state of the hospital industry is even more paradoxical when one considers the commercial contradictions between the two industries. As noted, hospitals have poorer access to capital, fewer diversification opportunities, and a less advantageous pricing mechanism than banks—all of these further underscore the need for consolidation.

Boards of community hospitals are confronted with a rapidly changing business environment. Considering these challenges in the context of the banking industry's experience might help. Certain lessons from banking consolidation should be considered, including timing, standardization, and community relations. More fundamentally, future decisions concerning business combinations might benefit from a realistic assessment of the hospital's ownership and governance circumstance. Recognizing the unique and challenging roles played by management, boards, and owners of hospital companies could add clarity to decision making. These anomalies have left many well-intended hospital boards clinging to local control without context, deep understanding, or accountability.

Despite predictions of rapid consolidation in the hospital business, we believe change will occur over many years and in a halting and painful manner. Much value and opportunity for improvement will be lost in the process. As a beginning, awareness of these issues might enable boards to be cognizant of the uniqueness of governance and ownership in hospitals and the related impact on board decision making.

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