

A Question of Scale: Insights from Agriculture to Inform Hospital Strategy

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In both farming and healthcare, the question of scale is not simply about efficiency—it often determines whether an organization can thrive.

A small farm considering the purchase of a combine harvester faces a decision much like that of a community hospital debating an investment in an MRI, a CT scanner, an electronic medical record system, or a new AI-driven clinical decision support tool. All are large capital commitments that require adequate volume to justify. Balancing those costs with utilization separates sustainable operations from those that slowly erode under financial pressure.

This comparison is more than a metaphor. It also frames a governance question for hospital boards: **when is it prudent to remain independent, and when does the scale imperative make partnership a fiduciary responsibility?**

Farming: Survival and Size

In agriculture, combine harvesters and other equipment are indispensable but expensive. A single combine can cost \$500,000 or more, and its value depends entirely on how much land it covers during harvest. For most operators, the economics work only at around 2,000 acres or more, where fixed costs can be spread across enough volume to make the investment pay off.

Smaller farms often cannot keep combines running long enough to justify the expense. Idle equipment raises the cost per acre and puts smaller operators at a disadvantage compared to larger competitors. Many turn to sharing equipment, joining cooperatives, or outsourcing. These

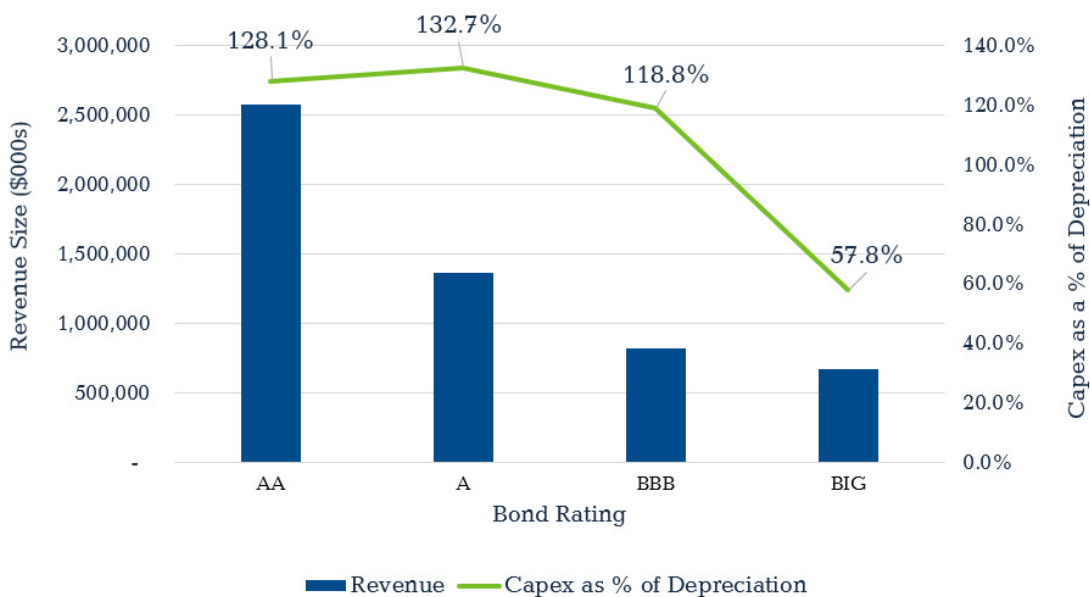
steps help preserve autonomy while still gaining access to the scale benefits necessary to compete.

Hospitals: Parallel Pressures from Capital Intensity

Hospitals face remarkably similar economics, and in healthcare we have a lot of “combines.” For example, advanced diagnostic equipment like MRIs and CT scanners are essential to modern care but costly. Beyond the initial purchase, hospitals must also fund installation, annual maintenance, and appropriate staffing. These same fixed-cost dynamics apply to less visible infrastructure too, such as information technology, analytics, cybersecurity, and care-management capabilities, which are all increasingly required for both quality and reimbursement.

Like farms, hospitals with size and scale are generally better positioned to achieve operating margins to fund capital reinvestment for the future. Management teams should assess capital needs on an ongoing basis to ensure they are keeping up. Analysts and rating agencies often evaluate this through capital expenditures relative to depreciation expense. Sustained levels below 100 percent can indicate underinvestment over time. Larger organizations with debt capacity and strong reserves can more nimbly address capital requirements than smaller organizations with tight cash positions and relatively high leverage. In fact, there is a direct correlation between a hospital’s revenue size, capital spending levels, and bond ratings as shown below:

Scale Correlates with Ability to Reinvest



Scale is a fundamental characteristic of well-capitalized hospitals. These organizations not only have the internal ability to reinvest in their physical assets, but by virtue of their bond ratings, also have access to external capital sources at a lower cost.

Small or rural hospitals rarely reach that threshold. The result is predictable: less robust systems, higher costs for services, thinner margins, and tighter budgets. Underutilized technology can drag on financial performance in the same way an underused combine does for a small farm. But unlike agricultural equipment, hospital technology cannot simply be parked until volume materializes. Clinical expectations, regulatory standards, and quality metrics require these assets to remain fully operational for care regardless of utilization.

Integration, Quality, and Reimbursement

The financial pressures around equipment are part of a broader trend. Hospitals are increasingly expected to integrate clinically, coordinate across service lines, and manage population health under value-based reimbursement models. Large systems tend to have the centralized resources to do this well—standardized electronic records, coordinated care teams, and fewer redundancies.

Independent hospitals often lack that capacity. Analyses from the American Hospital Association (AHA) highlight consistent structural pressures for rural hospitals, including low patient volume, workforce shortages, and reimbursement constraints. These factors make it harder for smaller facilities to cover fixed costs. Without the ability to maintain state-of-the-art clinical services, patients may choose to leave the community for care, only causing further financial erosion.

Governance and the Board's Fiduciary Imperative

For hospital boards, the scale challenge is fundamentally a governance issue. Board members are fiduciaries, responsible for ensuring the long-term stability of their institutions. That duty extends far beyond balancing this year's budget. It involves evaluating whether the organization can remain viable under shifting reimbursement, workforce, and capital conditions.

Sound governance requires directors to test the assumption that independence is synonymous with strength. Boards must regularly assess whether their hospitals have the volume, integration, and capital access needed to sustain mission and quality. Failing to do so risks breaching the duty of care, which includes overseeing strategy and anticipating material risks.

**Key Governance
Insight:
Maintaining
independence
is not a strategy.
Boards must
determine whether
independence
supports mission or
places it at risk.**

Critical Questions for Boards:

- Are we large enough to sustain the capital reinvestment necessary for modern care?
- Does our current scale allow us to meet future clinical, technology, and workforce expectations?
- What partnership models should we proactively evaluate before urgency limits our options?

Proactive boards examine partnership models and explore the potential benefits and trade-offs of affiliations before urgency limits their options. Periodically exploring partnership options does not represent giving up on local control; it is an exercise in stewardship. By initiating strategic evaluations early, boards maintain leverage to negotiate from a position of strength, preserving core values while securing a durable future.

Well before making big investments, boards should thoughtfully assess their competitive position to ensure their hospital will be there for the community over the long run.

Key Board Takeaways

- **Ensure capital budgeting aligns with strategic realities.** Boards should confirm that major capital allocation decisions are grounded in accurate projections of future volume, reimbursement, and workforce capacity.
- **Act early.** Boards that confront scale, integration, and partnership questions before financial pressure escalates uphold their governance responsibilities, protect community access to care, and position their organizations to thrive in a consolidated environment.
- **Evaluate a range of structural options.** Shared-service models, clinical affiliations, and regional partnerships can deliver scale benefits—shared technology, group purchasing, and specialized staffing—without requiring ownership transfer. Boards should balance relationships to keep future options open.
- **Reassess independence as part of fiduciary duty.** Governance responsibility includes determining whether independence remains in the community's best interest. The duty of care requires assessing strategic options, ensuring mission continuity, and anticipating market and regulatory shifts before they create crisis conditions.

TGI thanks Chris Benson, Managing Director, and Adam Davis, Executive Director, Juniper Advisory, for contributing this article. They can be reached at cbenson@juniperadvisory.com and adavis@juniperadvisory.com.

