Bridging Health Inequity through Health System Partnerships

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As hospitals and health systems emerge from the COVID-19 pandemic, they are confronting a new medical and economic world order. With government relief mostly ending, leaders are confronting a challenging set of circumstances—both new and old. Headwinds exist across the industry but are particularly acute for sub-scale providers, which most define as companies with less than $1 billion in patient net revenue.

This article explores the most pressing issues confronting boards today: 1) patient access to complex care delivery systems, 2) cost structure inflation, and 3) clinical quality issues. We describe how these factors, and others, have contributed to runaway disparities and inequities in the health of certain populations.[1] Lastly, we illustrate how some health systems, notably public hospitals sponsored by local-government entities, are using strategic partnerships or mergers and acquisitions as a tool to narrow the divide between the haves and the have-nots.

1. Patient Access to Complex Care Delivery Systems

"The U.S. healthcare market is the least customer-centric of any customer service industry…we are so numb to the pain that we rarely object or complain," said Bill Gurley of Benchmark.[2] In fact, across the U.S. economy, it is hard to find any business that compares to the malaise patients feel in the medical system—adrift from point of entry through recovery and payment.

One culprit may be the fragmented ownership structure of America's uniquely individualistic approach to care delivery and coordination. Reinventing or duplicating overhead in thousands of smaller communities, each attempting to individually raise capital, recruit and retain providers, and harness the power of complex health information technologies is, in aggregate, ineffective.

This fragmentation and inefficiency contribute to general patient confusion and uncertainty around care navigation and opaque billing practices. Obtaining care at the right place and right time through this fog is difficult for educated and insured patients. For vulnerable populations, preventive care for chronic disease may be an unreachable ideal, and the system may only be accessed at inappropriate settings like the emergency room where costs to the local system are high and individual care coordination and integration are not available.

These factors place stress on many local systems as patient expectations, fully met in other retail or service settings (i.e., Amazon or Trader Joe's), are not met. Dissatisfaction with the status quo is one of the leading reasons behind the growth in concierge medicine, which, in turn, perpetuates inequality.

Another trend, work-from-home employment, has enabled many to relocate from high-cost, high-tax urban centers to more lifestyle-oriented geographies—often rural, on water or in mountains. Patients accustomed to receiving care at academic trauma centers and who expect an EPIC record to seamlessly follow them are placing higher demands on local hospital leadership. Local hospitals are expected to have fellowship-trained specialists practicing in modern facilities with the most advanced technologies, and the reality is that costly upgrades and recruitment of specialists is difficult, if not impossible, for many community hospitals to provide on their own.

2. Cost Structure Inflation

Inflation, supply chain disruptions, and higher costs of staff and employees is a common refrain from the many health systems we visit. Specifically, these systems, both large and small, have had their cost structure upended by the trend of traveling employees, especially nurses.[3] In some cases, the cost structure of the organization has risen by around 20 percent. The impact is not just financial; it will result in less cash flow available for necessary routine infrastructure investments and technology upgrades.

Rating agencies, with a bias towards scale, recognize that larger-scale organizations are generally better able to implement discipline and performance improvement initiatives across the whole system. Smaller organizations may react by discontinuing services or restricting access in ways that disproportionately impact vulnerable populations.

3. Clinical Quality

The reputation, sustainability, and even reimbursement of a local health system are integrally reliant upon the organizational clinical quality. The above referenced development regarding hospitals being forced to hire traveling staff in order to maintain services is not just having an impact on expenses but is also having a significant adverse impact on clinical quality and safety. These temporary staff are often working in unfamiliar departments, with new equipment, and without the muscle memory on a team. As with sports (and most things in life—think 9th grade Algebra), repetition produces better outcomes. Safety and errors have long been correlated with volume. Current research goes further to suggest: "higher-volume hospitals may be better able to create clinical environments that improve the safety of surgical care…such as critical care expertise, as well as technologically

Key Board Takeaways

- Take into consideration the community needs of all stakeholders, including segments that may be subject to health inequities.
- Focus on partnerships that improve access, patient experience, and clinical quality for all communities served.
- Arm directors with an understanding of the full range of strategic alternatives available to meet the organizational mission.
- Consider spearheading broader solutions that address social determinants that are exacerbating health inequities.
- Challenge historic biases against change.

1 Selwyn Vickers, "Medical Students Need to Learn about Health Disparities to Combat Future Pandemics," AAMC, April 30, 2020.
2 As presented by Tandice Urban, Co-Founder of The Landby, at the All-In Summit in Miami, Florida on June 1, 2022.
3 Lauren Hilgers, "Nurses Have Finally Learned What They're Worth," The New York Times, February 15, 2022.

sophisticated diagnostic and treatment services."[4]

Further, economic inequality today can be seen directly impacting patient access to high-quality, affordable medical care. Netflix's "Operation Varsity Blues" that investigates the college admissions scandal calls this "opportunity hoarding." The breadth and availability of specialty services is commonly (and sadly) tied to the strength of regional demographics.

What Is the Proper Board Response?

Local governments that contain both affluent and poor communities are at a crossroads. Officials are confronted with how best to configure care *for all* constituencies. Many are choosing to explore the merits of partnerships to form more integrated delivery networks across diverse populations to better serve communities in need.

In response to these forces, a unique and interesting trend has emerged in health system mergers and acquisitions recently. Across the country, local government-sponsored health systems are stepping in to aid struggling private hospitals within or adjacent to their market. A principal aim of these business combination transactions is to maintain access, better coordinate population health, and thereby bridge health inequities.

Two recent examples stand out: Monterey County in California and Indian River Health District in Florida. Monterey County contains Carmel and Pebble Beach, with a median home value of $3,900,000. It also includes inland communities like Salinas with a base of largely migrant, undocumented agriculture workers earning a median annual income of $25,200.

A similar story exists in Vero Beach, Florida, whose exclusive John's Island is dominated by well-to-do retirees occupying homes with a median value of $1,300,000. A short distance inland, and within the same district, is the hub of the U.S. citrus industry where workers earn a median income of $28,002. Civic leaders sought to bridge the gap in care opportunities by coordinating under a shared ownership model. Indian River did this through a long-term lease with the Cleveland Clinic. Funds created by the transaction are being used to support educational programming, indigent care, scholarships, primary care development, and research regarding social determinants of health.

As readers undoubtedly feel, inequality is at all-time highs. The Economic Policy Institute measures the CEO-to-worker pay ratio, which shows no sign of narrowing.[5] While the California and Florida examples cited are extreme, they illustrate the ways in which inequality is tricklingly down to primary care and how hospitals are responding by partnering with others in their market.

There are several municipalities whose hospital systems have evaluated partnerships, such as Grant County, New Mexico; Indian River County, Florida; Branch County, Michigan; Hardin County, Kentucky; Hanford, California; Gregg County, Texas; and others. Some had elected officials directly overseeing hospital operations. Others had self-perpetuating 501(c)3 boards overseeing hospital operations separately from the government agency. We believe this is an important theme to monitor in 2022 and beyond.

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4 Shenae Samuels, et al., "Association of Hospital Characteristics with Outcomes for Pediatric Neurosurgical Trauma Patients," *Journal of Neurosurgery,* June 2021.
5 Economic Policy Institute CEO Compensation Report, August 2019.