New Partnership Models for a Post-Pandemic World

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How We Got Here: A Timeline of U.S. Healthcare

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The 19th Century: Professionalization

- Latter half of the 19th century is marked by professionalization of healthcare practices and emergence of a competitive market for healthcare services.
- The American Medical Association is established in 1847.
- Hospitals grow as sites for medical and surgical care after the Civil War.

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Early 20th Century — Hospitals Take Hold

- In 1904, the American Hospital Association (then the Association of Hospital Superintendents) forms its first committee to take on a hospital-based issue (a uniform hospital accounting system).
- The Catholic Health Association is officially established in 1915 (then known as the Catholic Hospital Association).
- Many hospitals begin receiving public support; in 1910, more than 45% received public appropriations.
- In 1929, Baylor Hospital introduces a pre-paid hospital insurance plan for teachers (forerunner to Blue Cross plans).

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World War II — Employer-Sponsored Insurance

- The War Labor Board rules that wartime wage freezes do not apply to fringe benefits. Companies use employer-sponsored insurance to recruit and retain talent.
- The Hill-Burton Act (1947) provides funds for the construction and expansion of public hospitals; hospitals are required to provide "reasonable volume" of charitable care.

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1950s and 1960s — The Government Steps In

- The NIH expands, providing more money for academic medical research.
- New technologies and procedures are introduced (polio vaccine, first successful organ transplant). The price of hospital care doubles over the 1950s.
- Medicare and Medicaid are established in 1965.
- From 1960 to 1970, the number of community hospital beds grows by 32.7%. Community hospitals become "one-stop shops" for healthcare needs.

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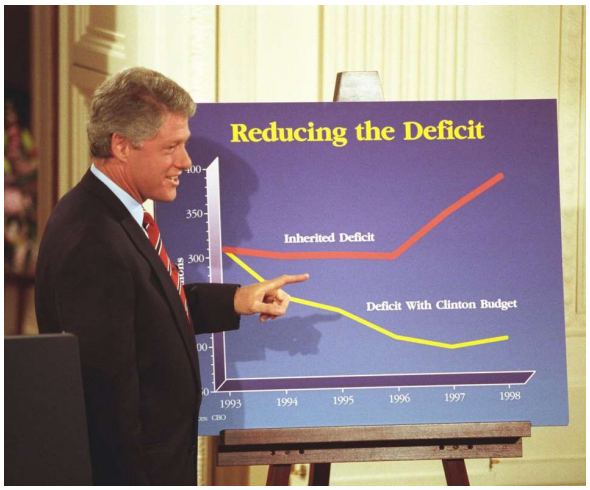
1970s to 1990s — Cost Containment and Scale

- Commercial insurers promote HMOs and managed care to contain healthcare costs.
- In 1983, Medicare introduces the prospective payment system and diagnosis-related group (DRG) payments, forcing attention on efficiency.
- The Balanced Budget Act (1997) decreases Medicare payments to hospitals by $115 billion over 5 years.
- The first major hospital consolidation wave in the 1980s and 1990s responds to the need for cost containment.



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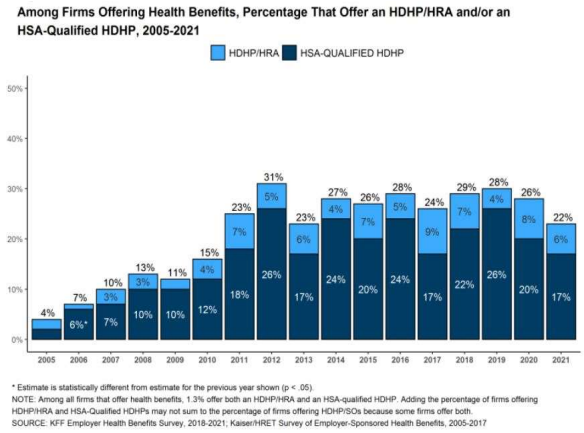
2000s — Rise of Consumerism and 'Value'



- 2003's Medicare Prescription Drug Improvement and Modernization Act allows the set aside of pre-tax dollars in health savings accounts when used in conjunction with high-deductible health plans. Consumers have more "skin in the game."
- Following an FDA policy change in 1997, direct-to-consumer advertising of prescription pharmaceuticals takes off, rising from $1.3B in 1998 to $3.3B in 2005.
- Healthcare access and costs are a major issue in the 2008 presidential campaign. The decade closes with passage of the Affordable Care Act (ACA) in 2010.

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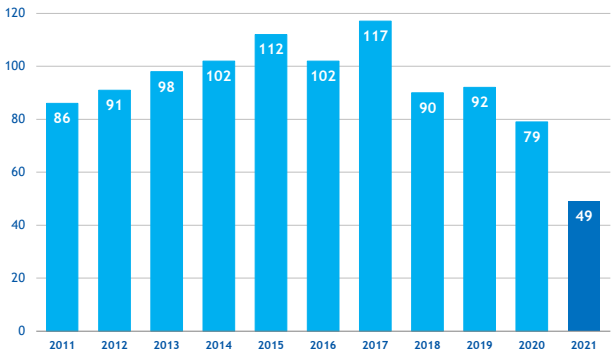
2010s — Disruption and Segmentation

- The ACA's emphasis on integrated care delivery, accountable care organizations, and other risk-based care delivery models spurs another wave of consolidation. Health systems seek scale to increase efficiencies and absorb risk.
- Care accelerates its migration from inpatient to outpatient settings. By 2019, Kaufman Hall data indicates that outpatient services accounted for more than 50% of average health system revenues.
- The lower cost of care in ambulatory and outpatient settings opens the way for new competitors who do not need to carry the high costs of acute inpatient beds.
- By 2019, two-thirds of community hospitals are in a health system.

Number of Announced Transactions, 2011-2021



Source: Kaufman, Hall & Associates, LLC

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2020's — Post-Pandemic, Competitive Differentiation

- Major disruption of hospitals' and health systems' core operations, first through shutdowns of elective services and then COVID surges that overwhelm EDs and ICUs.
- Labor shortages and wage growth threaten long-term pressure on operating margins.
- Growing demand for high-touch specialty services, including behavioral health and home health.

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Implications to Competitive Strategy

	GROWTH & SATURATION		MATURATION		TRANSFORMATION	
	Prior to 1900	1900-1945	1945-1969	1970-1999	2000-2019	2020 & *Beyond*
Market Focus	Informing & Meeting Demand		Sustaining/Expanding Demand		"Buyer" Preference	
Competitive Advantage	Existence and Presence		Broader Service Offering and Payer Relationships		Scale ➔ Value ➔ Innovation	
Nature of Growth	Rapid & Largely Unchallenged		Service Expansion & Clinical Efficiency		Holistic/Optimized Service Offering and Platform	
Success Factors	Size and Availability of Market		Capital, Sites & Technology		Better, Cheaper and/or Faster	

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Where We Need to Go: New Partnership Strategies

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The Evolution of Partnership Strategies

	MATURATION		TRANSFORMATION	
	1945-1969	1970-1999	2000-2019	2020 & *Beyond*
Strategic Rationale	Tactical, driven by distress or need		Aggregate to Achieve Scale ➔ Position and Transform for Value	
Commercial Principles	Combining Forces, Maximizing Operating Leverage, and Pursuing Diversification		Pursuing Capabilities, New Channels, Novel Expertise, and Intellectual Capital	
"Seller"/Smaller System Drivers	Access to Capital, Infrastructure Base, and Market Influence		Value-Based Models, Population Health Initiatives, Clinical & Business Intelligence	
"Buyer"/ Larger System Drivers	Extending Operating Leverage and Economies of Scale		Platform for New Markets and Convener of Best-in-Class Service and Delivery	

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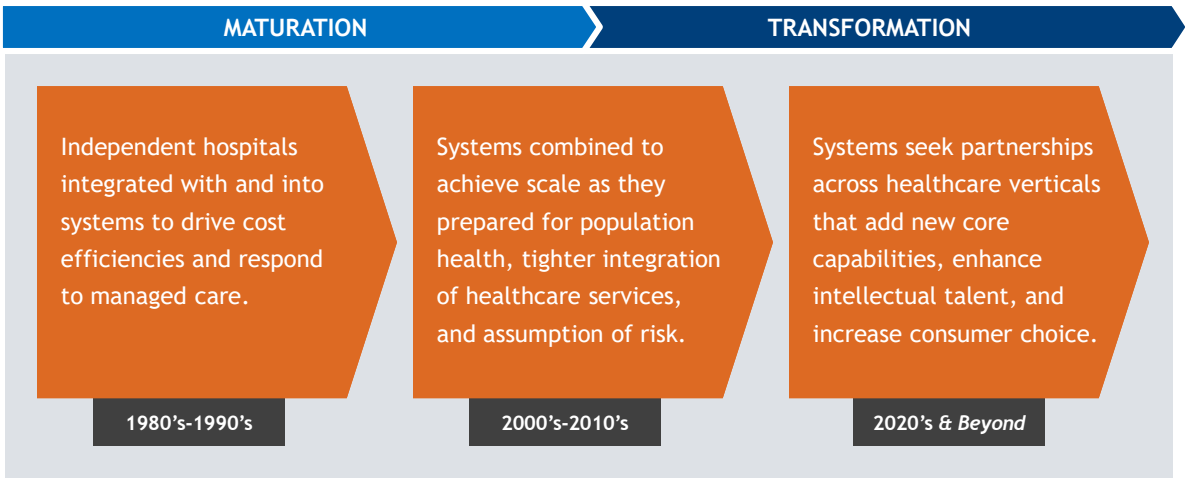
Timeline of Prevailing Partnership Strategies



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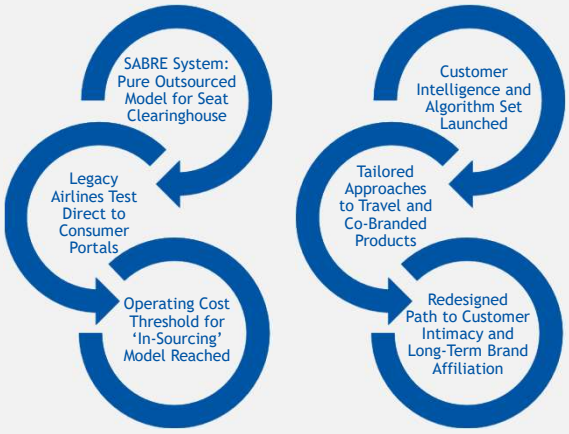
Rethinking Preference and Competitive Advantage

- **Airlines and Healthcare**
  - Low-margin core business (transporting people on flights)
  - High degree of price fragmentation (low and high fare passengers)
- **Profits driven from additional services**
  - Fees (checked baggage, seat upgrades, etc.)
  - Club memberships
  - Co-Branding (e.g., with banks for credit cards that build frequent flier miles and customer loyalty)
- **Different business models promote consumer choice**

From Cost Containment to Customer Intimacy



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Establishing Brand and Market Essentiality

- **Retail and Healthcare**
  - Low-margin core business
  - Highly competitive industry, subject to disruption
  - Significant real estate investment
- **Partnership rationale**
  - Partner with the consummate disruptor (Amazon)
  - Maximize 'scale' benefits on core national product offering
  - Customize local or market specific offerings through partnerships with local companies, to maintain competitive differentiation

Achieving Better, Cheaper, AND Faster

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The Distinction Between Forms of Market Consolidation

	AGGREGATION	TRANSFORMATION
Strategic Focus	Leveraging economies of scale for increasing marginal profits	Use of innovation to materially change/overcome industry dynamics
Revenue Strategy	"Buy low, sell high" approach to acquiring revenue	Pursuit of high "quality of revenue" strategic pursuits
Expense Strategy	Intense focus on fixed cost to maximize operating leverage	Total cost evaluation, attacking all sources of waste/excess
Capital Strategy	Driven by capacity, specialization/ distribution, and throughput	Frequently aimed at entirely new channels, markets, or access points
Market Posture	Market share, reliant on sheer size and barriers to entry	Market expansion, driven by alignment and collaboration

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Recent Takeaways from Lessons from the Pandemic

- **Realize the imperatives of scale**
  - Larger systems were better able to deploy resources, segregate facilities for infected/non-infected patients, and weather financial impacts that hit different facilities and markets at different times.
- **Focus on core markets and services**
  - Operational disruptions and financial pressures made non-core assets or assets in non-core markets less attractive, prompting divestiture or monetization of these assets.
- **Seek partnerships to add capabilities and meet consumer demand for new or enhanced services**
  - A new trend toward "coopetition" brings together organizations that are both potential competitors and partners to offer access to new services or enhance delivery of existing services that require specialized skillsets. Partnerships allow health systems to focus on their core business *and* enhance or expand service offerings.

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Rethinking Partnerships: Questions for Health Systems

- What is our core business?
- For what services is there strong consumer need/demand?
- Are there potential partners who can provide these services better than we can?
- What do we offer to potential partners?
- What degree of control do we need/want in the partnership?
- What is the optimal structure for the partnership (e.g., ownership, branding, financial commitment, governance, clinical decision-making)?

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Questions?

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