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Getting Serious about Costs, Revisited

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With the end of the Cold War, the U.S. Department of Defense faced a new geo-political reality. The Berlin Wall came down. The Soviet Union was dismantled. Communist regimes fell out of power in many parts of Eastern Europe. The Iron Curtain was lifted.

As promising as this new reality was for global politics, it was a problem for the U.S. military. For almost five decades, the military had been structured to provide defense based on the global structure of a Cold War world. Military personnel, capabilities, weaponry, and installations all were informed by the reality of the Cold War. Now that the reality had changed, the U.S. military was structured for a geo-political map that no longer existed.

At the broadest level, this structural mismatch resulted in three serious problems. First, the U.S. was not ready for potential new defense needs. Second, the outdated structure was highly inefficient, spending huge amounts of resources on assets that were no longer required. Third, this waste meant that funds were not available to invest in post-Cold War defense.

The most significant source of waste was the outdated physical structure of the military—installations that were located in areas that no longer needed military bases, or that needed different types of military facilities.

To realign the military's physical presence with the new reality, the U.S. Department of Defense began a process of base closures that continues today. The process involves a systematic and continuous comparison of military needs with the military's physical presence, and engages the many groups affected by these decisions. The result has been new rounds of recommended base closures or repurposing initiatives every several years.

Recently, a healthcare executive I have worked with for many years pointed out to me how apt base-closure is as an analogy for the situation faced by hospital-based health systems, and as a way to make difficult but positive changes.

Over the past 10 years, we have seen a major migration in healthcare demand from inpatient to outpatient settings. Surgeries that 10 years ago were almost exclusively inpatient-based are now routinely performed in outpatient settings. The length of inpatient stays for other procedures and conditions has dramatically reduced. Payment rules increasingly create incentives for care to be performed in outpatient rather than inpatient settings. And advances in telehealth are moving care encounters out of healthcare facilities altogether, and into patients' homes.

Over the past 10 years, MedPAC reports a 43 percent growth in outpatient visits, compared with a 20 percent decline in inpatient discharges. The American Hospital Association reports that inpatient and outpatient revenue for hospitals is nearly equal, whereas in 1995, inpatient revenue made up 70 percent of total operating revenue.

Hospitals' traditional facility footprint simply is no longer aligned with the realities of how healthcare is being delivered today, or how it will be delivered in the future.

This misalignment has a similar effect on the U.S. healthcare system as the post-Cold War military base misalignment had on U.S. defense. An enormous amount of healthcare spending goes to facilities that are underused or mis-matched to community healthcare needs, and that waste prevents investment in healthcare resources that can advance the quality, efficiency, and experience of healthcare for a new era.

As I wrote last year in the blog post "Getting Serious about Costs," hospitals have long struggled to manage their high fixed and operating costs. Traditionally, hospitals have focused their cost-reduction efforts on labor and supplies—high-cost areas that continue to warrant attention.

However, the basic mismatch between U.S. healthcare facilities and healthcare needs, and the unsustainability of healthcare spending to the U.S. economy, requires that legacy hospitals and health systems take on costs at a greater magnitude and with more permanence. That means taking a very hard look at the value being provided by each asset of the facility portfolio. Where assets are not contributing sufficiently to the healthcare needs of the community, and not meeting the strategic or financial needs of the organization, some very tough decisions are in order.

Repurposing or closing a hospital is one of the most difficult decisions healthcare leaders can make. The decision involves a major change to a trusted community presence. It can bring

community outcry, political scrutiny, and unfavorable press. At the least, it involves helping community members transition to a new approach to care.

Yet, in an environment that is rapidly transitioning from an inpatient to outpatient focus, some hospitals are no longer serving a relevant purpose in the U.S. healthcare system. A 2018 study identified 13 states in which average hospital occupancy rates for urban hospitals were 50 to 60 percent, and 28 states in which average occupancy rates for rural hospitals were 40 percent or less. These averages mask even greater variation from facility to facility within smaller areas.

Dealing with hospitals and other high-cost assets that no longer provide necessary value in the healthcare system of today is among the toughest and most important steps in managing healthcare costs.

Today, hospitals are at a "base closing" moment. In order to be competitive and relevant, hospitals will need a structured, continuous process that results in informed decisions about their facility and real estate portfolios. These decisions may be challenging in the short term. However, in the long term, a base-closure approach can improve care, improve the viability of healthcare organizations, and create a healthcare system that is more sustainable, more cost effective, and better able to meet the health needs of our nation.

Thanks to Peter McCanna, President, Baylor Scott & White Health, for important ideas that went into this blog post.

Your comments are welcome. I can be reached at kkaufman@kaufmanhall.com.