

# The smarter scale equation

Given today's realities, health systems must look beyond the traditional economies of scale if they want to reap the full benefits of M&A. They must consider other economies that M&A can offer, commit themselves fully to the effort, and execute flawlessly.

During times of upheaval (regulatory, economic, or both), a knee-jerk reaction in many industries is to pursue mergers and acquisitions (M&A) in hope of achieving economies of scale through asset consolidation. Historically, the hospital industry has been no different. In 2011 alone, US health systems completed 90 deals involving more than 150 facilities; the total transaction value exceeded \$8 billion (in comparison, there were 52 deals involving 80 facilities in 2009).<sup>1</sup> The consolidation appears to signal providers' quest to achieve scale benefits, especially in the context of a recent decrease in their ability to drive pricing—the lever the industry has used for most of its growth in the past decade.

During that time, providers were able to realize value primarily through increased contracting leverage with payors. Today, this leverage is disappearing, in part because the Federal Trade Commission is scrutinizing deals more frequently and closely, and blocking some on the basis of their potential impact on price. Now that their ability to create “quick-win” value through M&A deals is limited, providers must find and exploit other economies to create value through those deals. The other economies may require greater up-front investment, however.

Thus, we believe that the current wave of M&A is fundamentally different from prior ones because the “traditional scale equation” no

longer applies. This is not to say that M&A should be avoided—it will still be the right answer in many situations. However, a smarter, more sophisticated scale equation should be used today to evaluate potential value creation. Before health system leaders rush to pursue deals, they should outline what they hope to achieve through scale and carefully weigh the risks and benefits of various strategies. In particular, they should take care to avoid overestimating the potential value creation that can be gained through M&A and underestimating the investments (in funding, leadership bandwidth, other resources, etc.) that will be required to realize value. In addition, they should expand their thinking to consider strategies other than M&A that might enable them to achieve their scale goals, because some of those strategies could entail less overall risk and require less investment than M&A.

## The resurgence in hospital M&A

The US hospital industry bears all the hallmarks of a sector in which scale should drive performance. Inherent scale advantages are usually present when a sector is fragmented and has heavy capital requirements, overcapacity in many markets, differences in execution ability that drive highly variable operating performance, and major differences in balance sheet health (rich, deep pockets

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<sup>1</sup>*Health Care Services Acquisition Report*, 17th edition. Norwalk, CT: Irving Levin Publishers; 2012.

may be found down the street from institutions on the brink of bankruptcy).

Under these conditions, financial or regulatory disruptions in any sector often lead to industry consolidation; this is particularly true when an economic downturn and regulatory changes collide. In the European banking industry, for example, M&A activity has increased recently as governments have sought to divest equity stakes acquired in bailouts, banks have tried to raise additional capital in response to regulatory changes, and distressed assets have become available at attractive prices.

The US hospital industry has proved to be no exception. The past 25 years have seen several spikes in M&A activity following periods of economic downturn, regulatory changes, or both. In recent years, hospital M&A resurged as the recession, healthcare reform, and other trends (including population aging) converged to place multiple financial pressures on US hospitals. For example, population aging has been causing Medicare ranks to swell, and the elderly's higher utilization rates are significantly altering the mix of patients and having a disproportionate impact on hospital economics. Planned cuts in Medicare growth rates and proposed cuts in Medicaid growth rates are likely to intensify pressure on provider economics, requiring them to become more efficient and productive. Our research suggests that, on average, US hospitals that do not improve their operating cost structure could face an average EBITDA loss of more than \$1,500 to \$1,600 per Medicare admission by 2019.<sup>2</sup>

In addition, the recession expedited the ongoing erosion in employer-sponsored insurance (ESI) coverage. The share of the under-65

population covered by ESI decreased to 58.3 percent in 2011, falling for the eleventh year in a row (from 69.2 percent in 2000).<sup>3</sup> ESI erosion is forcing consumers to shoulder an increasing portion of each healthcare dollar, which is leading to greater price sensitivity and, often, to lower provider volumes.

However, the mix of patients hospitals see is also likely to shift away from the uninsured and those with ESI toward those with individual insurance, Medicaid, or Medicare.<sup>4</sup> We believe that this shift will, in the aggregate, put downward pressure on hospital margins; by our estimate, the shift could negatively affect hospital EBITDA by \$15 billion to \$25 billion annually by 2019.<sup>2</sup>

The pressures just described arose following years of strong commercial pricing growth for hospitals, which allowed many health systems to put minimal emphasis on operating cost discipline. Many providers were therefore unprepared for the downturn and became M&A targets. Smaller systems and community hospitals, for example, often found that their financial positions became untenable—they lacked a strong balance sheet, treated a disproportionate share of government-subsidized or uninsured patients, and were unable to cross-subsidize with higher-paying commercial volumes or a broader portfolio of care facilities. Similarly, many not-for-profit hospitals found themselves in untenable financial positions because of their dependence on endowments and philanthropy, both of which were adversely affected by the downturn.

## The traditional argument for M&A

M&A and the scale economies it can bring have often been viewed as a panacea for rising

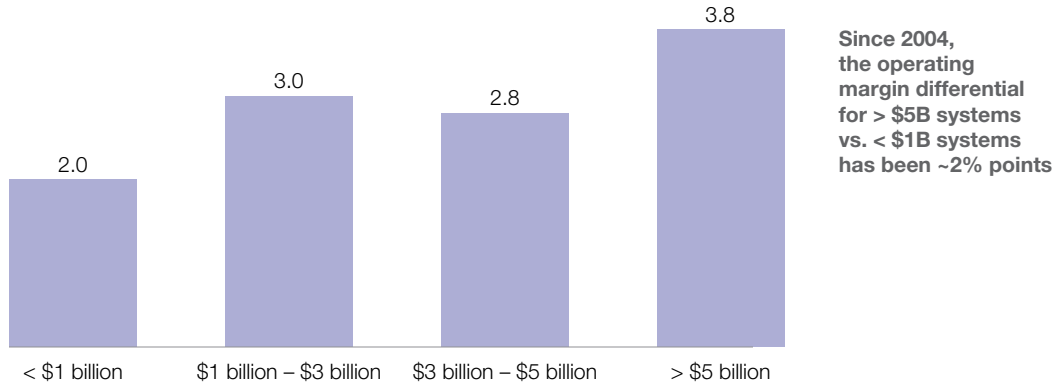
<sup>2</sup>McKinsey Provider Reform Impact and Stress-test Model, Center for US Health Reform.

<sup>3</sup>Gould E. Employer-sponsored health insurance continues to decline in a new decade. Economic Policy Institute Briefing Paper No. 353. December 5, 2012.

<sup>4</sup>For a closer look at how healthcare reform should affect patient volumes, see "The impact of coverage shifts on hospital utilization" on p. 73.

## EXHIBIT 1 Operating margin by health system scale<sup>1</sup>

Annual revenues (% , 2010)



<sup>1</sup>Historical data based on ~245 reporting systems; comparative data from Citi Growth Study. Health system data reflects the average for that category of revenues.

Source: Citi Healthcare Investment Banking Group presentation to the Healthcare Financial Management Association (January 19, 2012)

economic pressures. Indeed, evidence suggests that scale does influence a health system's operating margins (Exhibit 1).

Once the recession began, a number of industry observers, analysts, and banks (including Moody's Investors Service, HealthLeaders Media, Noblis Center for Health Innovation, JP Morgan, and BMO Capital Markets) predicted that hospital M&A activity would increase. Several of them advocated the benefits of asset consolidation to capture scale economies. Moody's, for example, described scale as an important driver of financial success; it said that health systems earning more than \$3 billion in annual revenues experience fewer ratings downgrades than smaller systems do—and more than three times fewer downgrades than systems with less than \$500 million in annual revenues receive (Exhibit 2).<sup>5</sup> Moody's also noted that the average cost of debt is consistently lower for systems with over \$5 billion in revenues than for systems with under \$1 billion in revenues.

However, the argument for hospital M&A has focused primarily on the value that can be captured through traditional scale levers, such as additional pricing leverage, better access to capital, and classic cost economies. Historically, this rationale for asset consolidation held up well. A report by the Robert Wood Johnson Foundation, for example, found that during the consolidation wave of the 1990s, hospital mergers raised inpatient prices by at least 5 percent and by up to 40 percent when the merging hospitals were closely located.<sup>6</sup>

## Updating the traditional M&A scale equation

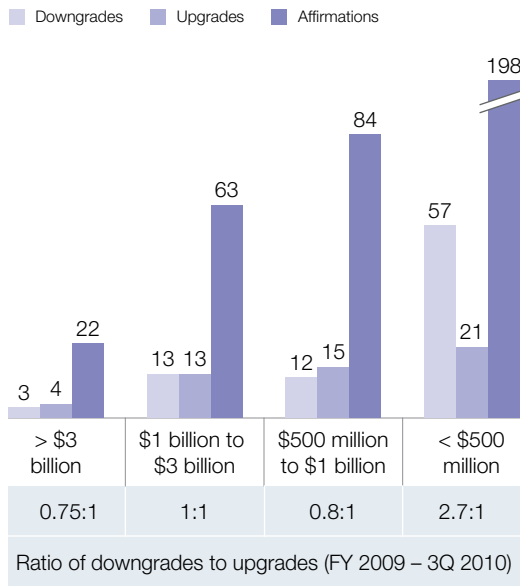
The emphasis on using asset consolidation to achieve the benefits of scale—which we call the traditional scale equation—ignores an important reality: M&A is fraught with value-creation challenges. A McKinsey analysis of healthcare M&A transactions (including pharmaceutical and medical device companies) shows that the deals created just 7-percent

<sup>5</sup>Moody's Investors Service, as cited in a Citi Healthcare Investment Banking Group presentation to the Center for Corporate Innovation (November 30, 2010).

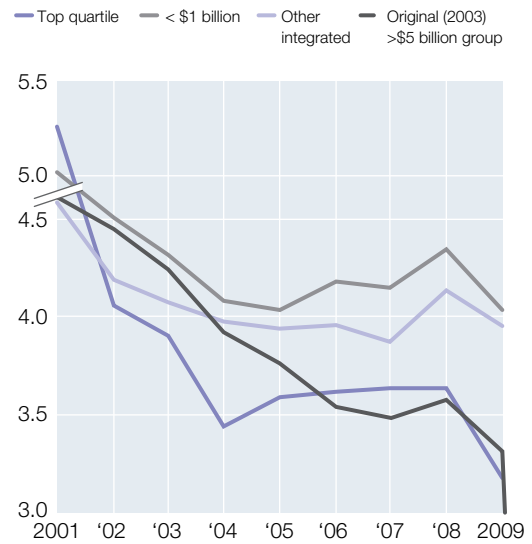
<sup>6</sup>Vogt WB, Town R. How has hospital consolidation affected the price and quality of care? Robert Wood Johnson Foundation, Research Synthesis Report No. 9. 2006.

**EXHIBIT 2 Ratings agencies agree that scale is an important determinant of success**

Number of health systems<sup>1</sup>



Average cost of debt<sup>2</sup> (%)



<sup>1</sup>In the event of an upgrade/downgrade rating action and affirmation rating action within the same year, Moody's accounted for the rating action as an upgrade/downgrade.

<sup>2</sup>Historical data based on ~245 reporting systems; comparative data from Citi Growth Study. Health system data reflects the average for that category of revenues.

Source: Moody's Investors Service; Citi Healthcare Investment Banking Group presentation to the Center for Corporate Innovation (November 30, 2010)

average added value globally over the past 15 years. In addition, the acquirer may have overpaid in about 60 percent of healthcare deals.<sup>7</sup>

The challenges to value creation are many. In any industry, pursuing M&A activity can consume the lion's share of management attention—not only during the transaction phase but also during the integration planning and implementation phases. Pursuing M&A activity also guarantees certain types of value destruction, as illustrated in Exhibit 3. In our experience, health systems often underestimate the cost of both pursuing an acquisition and managing the post-merger integration.

Analysis of the recent provider M&A environment confirms that acquisitions require substantial up-front investment. Transaction values have averaged 0.76 times revenues in recent years; EBITDA multiples have averaged 9.5.<sup>8</sup> On a per-bed basis, transaction values have averaged almost \$450,000.

Furthermore, given today's environment, providers face two other significant challenges if they pursue M&A on the basis of the traditional scale equation. First, many of the traditional scale levers, especially pricing and referral volume, are unlikely to continue to serve as strong sources of value creation. Greater consumer

<sup>7</sup>McKinsey M&A Transaction Practice. Deal value added is defined as the combined (acquirer and target) change in market capitalization, adjusted for market movements, from two days before to two days after the deal's announcement, as a percentage of the transaction's value.

<sup>8</sup>Health Care Services Acquisition Report, 17th edition. Norwalk, CT: Irving Levin Publishers; 2012.

and employer price sensitivity, increased scrutiny on industry profits, and regulatory concerns about hospital mergers are limiting health systems' ability to leverage pricing. Similarly, the increased patient volume that typically follows M&A because of larger referral networks will not be generated as easily going forward. If health systems want to generate value through greater volume, they will instead have to consider clinical network rationalization and strategies to combine service lines.

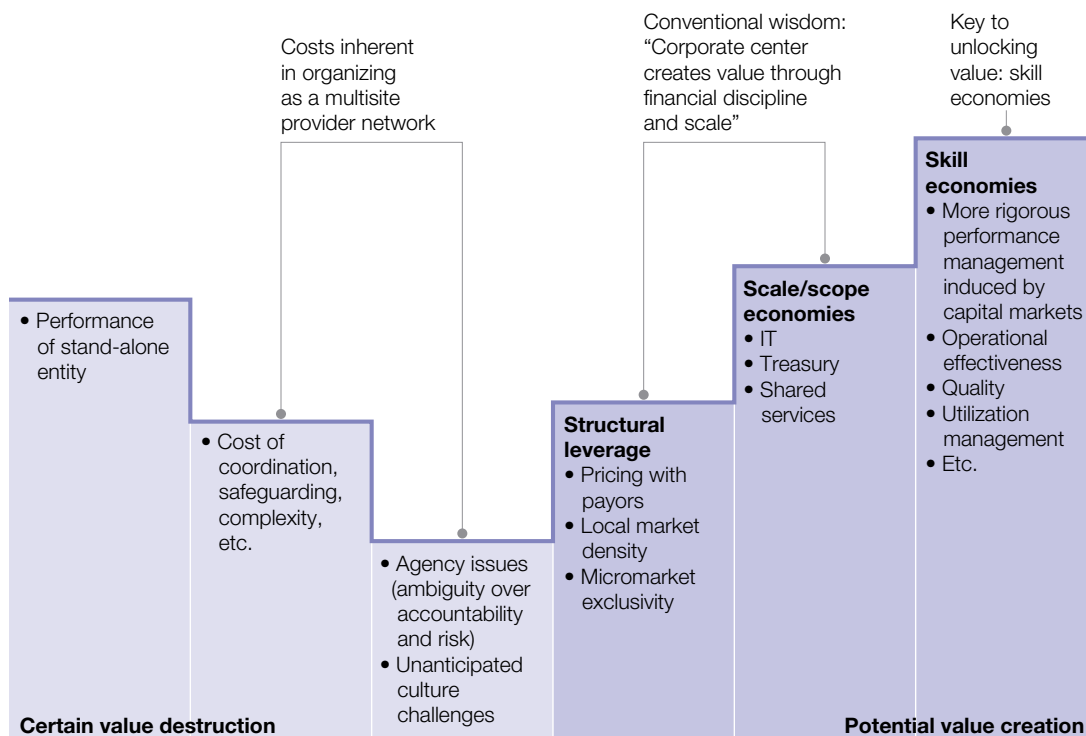
Second, scale per se is becoming less important as a source of value creation than is a disciplined operational focus applied through scale. Simply put, greater value can be created

when a system with a strongly disciplined approach to operations shares this skill with another system than when the operations of two moderately disciplined systems are merged. In the transition from volume-based to value-based reimbursement, hospitals and health systems will have to learn to operate as efficiently as possible. Simultaneously, they will have to align behaviorally with physicians to avoid waste and implement emerging care and payment models (e.g., narrow networks, medical homes, accountable care organizations, and bundled payments). Without a strongly disciplined approach to operations, health systems are unlikely to be able to achieve these aims.



**EXHIBIT 3 Building scale through M&A almost always destroys some value, and opportunities for value creation are not guaranteed**

Impact of M&A on value



## EXHIBIT 4 Shifting the scale equation

### The traditional scale equation

Asset consolidation = Pricing + Cost savings + Volume + Capital

### A smarter scale equation

Asset consolidation =  $-$  Costs of coordination, complexity, agency issues  $+$   $\frac{1}{X}$  Potential Pricing + Savings + Volume + Capital + Skills

Most health systems underestimate the costs and difficulty of successful asset consolidation

Value capture is typically less than expected, but skill economies are likely to be the most important for the future

As the sources of value creation shift from traditional scale levers (including pricing) to more complex economies, hospitals and health systems will need more than just asset consolidation. They will require true integration. However, integration in the hospital industry is especially complicated, with many unique challenges relative to other sectors. For example, key change agents—particularly physicians—are often not directly controlled by the health system. Many hospitals, especially not-for-profits, have close community ties that limit decision rights. Service delivery is typically a local game, whereas consolidation often occurs across geographies. The limited accuracy of most hospitals' cost accounting systems complicates the establishment of robust baselines (which are necessary to precisely estimate, capture, and monitor the value created).

Despite these challenges, M&A will still make sense in many situations. However, health systems must go in with eyes wide open. Asset consolidation is not a panacea that will solve the hospital industry's growing financial pressures. Furthermore, M&A may not be the only answer available to them.

Health system leaders considering M&A should therefore ask themselves: will the potential value capture from consolidation exceed the certain value destruction? Answering this question requires them to shift their thinking away from the traditional scale equation toward a more complex but smarter scale equation that recognizes the risks and costs of hospital integration, as well as the difficulty of actually capturing the potential upside value—both of which must be estimated within the context of a health system's scale goals (Exhibit 4).

## Consider alternative scale models

Given the challenges to successful M&A execution, health system leaders should consider a broader range of models for capturing scale efficiencies. Before they can choose a model, however, they first need to decide which type(s) of efficiency they want to go after. The efficiencies fall into four groups, each of which has different benefits, costs, and risks (Exhibit 5):

- **Classic economies of scale** focus on lowering the cost base per unit of care delivered (e.g., by spreading fixed costs across a larger

volume of patients and/or by enabling a provider to negotiate lower prices for major cost categories).

- **Economies of scope** can permit providers to leverage their scale to develop nontraditional revenue streams (e.g., direct-to-employer offerings).
- **Economies of structure** can permit providers to gain access to capital at lower cost and to leverage a stronger negotiating position with partners. However, they can also permit providers to take advantage of a broader footprint across the care continuum and to take on risk pooling for population health management.

- **Economies of skill** can enable providers to improve their capabilities and performance by allowing them to share or build best practices at comparatively low cost.

Which one (or ones) of these economies makes the most sense for a health system to pursue will depend on a candid self-assessment of the system’s objectives, strengths, and weaknesses. In many cases, providers may decide that it is skill economies that will best enable them to unlock value in the next few years. However, this is not always guaranteed, which is why a candid—and careful—self-assessment is so important.



**EXHIBIT 5 To understand potential value creation, identify the full range of possible benefits from scale**

	Benefits	Examples
<b>Economies of scale</b>	Administrative/overhead costs	<ul style="list-style-type: none"> <li>• Fixed costs spread across larger volume</li> <li>• Consolidation of functions</li> </ul>
	Supply procurement	<ul style="list-style-type: none"> <li>• Consolidation of purchasing organization</li> <li>• Development of internal PSM excellence programs</li> </ul>
<b>Economies of scope</b>	New revenue streams	<ul style="list-style-type: none"> <li>• Development of nontraditional sources of revenue</li> </ul>
<b>Economies of structure</b>	Care continuum	<ul style="list-style-type: none"> <li>• Rationalization of clinical network</li> <li>• Reduction in physician administrative costs</li> <li>• Brand recognition and customer loyalty</li> </ul>
	Capital efficiency	<ul style="list-style-type: none"> <li>• Stronger credit ratings and lower capital costs</li> <li>• More attractive return on invested capital</li> </ul>
	Partner relations	<ul style="list-style-type: none"> <li>• Fair share of new value created when engaging with payors</li> <li>• Size to assume risk for population health management</li> </ul>
<b>Economies of skill</b>	Clinical operations effectiveness	<ul style="list-style-type: none"> <li>• EHR accessible across the care continuum</li> <li>• Improved care quality, including protocols and standardization</li> </ul>
	Performance management	<ul style="list-style-type: none"> <li>• Size warrants skills specialization (e.g., reimbursement function by payor)</li> </ul>

EHR, electronic health records; PSM, purchasing and supply chain management.

Once a provider has determined which economies it wants to pursue, it can then decide which approach is best for capturing scale. At least 11 different models can be used, as detailed in Exhibit 6. These models fall into four general types:

**Inorganic scale** can be purchased through a traditional asset consolidation transaction involving the merger of two hospitals operating in the same region, the absorption of a hospital or multiple facilities into a larger health system, or the merger of two systems on a regional or national scale. Although some of these deals have been described as “mergers of equals” to protect fragile egos, the reality is that they are usually out-and-out acquisitions of small fry by larger fish.

**Virtual hospital integration** can enable a provider to capture certain benefits of scale without requiring it to directly control another organization or to commit to a long-term relationship. This type of deal may involve the co-provision or outsourcing of shared services or the joint creation of knowledge and innovation.

**Horizontal organic scale** develops when a provider extends its footprint across the care continuum (e.g., into physician practices and outpatient facilities). The extended footprint can then drive growth in the hospital setting.

**Vertical organic scale** requires a provider to build direct relationships with payors, employers, or both to enable it to capture

## EXHIBIT 6 A broad range of models can be used to build scale

### Inorganic scale

- 1 M&A with in-region hospital
- 2 M&A with in-region health system
- 3 M&A with out-of-region health system

● Traditional scale models of asset consolidation offer high economies of scale and skill, but at a high cost and with significant implementation risk

### Virtual hospital integration

- 4 Knowledge-sharing with other providers
- 5 Shared services with other providers
- 6 Outsourced services

● These options offer some economies of scale and/or skill, without high up-front investment or risks associated with M&A

### Horizontal organic scale

- 7 Expanded physician practices (PCP and specialty)
- 8 Expanded OP facilities

● These options strengthen a provider’s community footprint, facilitate referral growth, and pave the way toward population health management, but offer limited economies of scale

### Vertical organic scale

- 9 Payor partnership – narrow networks
- 10 Payor partnership – risk sharing
- 11 Direct-to-employer strategies

● These options can potentially create high value by enhancing a provider’s structural position, with potential for growth and innovation; however, they are challenging to implement because there is no established model



greater patient volume. This approach can be pursued in parallel with horizontal expansion, particularly when the payor-provider collaboration aims to establish new care or payment methods with a care management focus.

When deciding which model for capturing scale they want to use, a health system leader should consider two major questions: First, how much potential value creation is available with each model—and at what cost? Second, does the proposed model complement the system’s strengths, weaknesses, and objectives?

**What is the typical value capture potential?**


The value that any particular health system can capture will depend on its specific circumstances. Nevertheless, our experience suggests that there is a range of typical financial impact for each of the scale economies discussed earlier. In the case of administrative synergies and procurement benefits, for example, the potential financial impact increases in line with the size of the health system (Exhibit 7). McKinsey’s hospital consolidation model suggests that health systems with less than \$2 billion in revenues



**EXHIBIT 7 Potential value from certain levers can vary, based on the degree of scale achieved**

	Benefits	Savings from scale and health system integration (examples)
<b>Economies of scale</b>	Administrative/overhead costs	<ul style="list-style-type: none"> <li>• Best-practice benchmarks are typically 11–13% of NR (down to 9% for systems &gt;\$9 billion, up to 14% for systems &lt;\$2 billion), yet many health systems spend up to 20% of NR on administrative/overhead costs</li> <li>• Overall administrative cost savings of 10–40%                             <ul style="list-style-type: none"> <li>— Typically, 10–20% in savings available from removal of duplicate functions across two health systems</li> <li>— In addition, 10–25% savings from transformation to a shared service model: lean process improvements, demand management, optimized organization (e.g., centralization and consolidation into a single SSC)</li> </ul> </li> </ul>
	Supply procurement	
<b>Economies of scope</b>	New revenue streams	
<b>Economies of structure</b>	Care continuum	
	Capital efficiency	
	Partner relations	
<b>Economies of skill</b>	Clinical operations effectiveness	<ul style="list-style-type: none"> <li>• Cath lab example: minimum efficient scale of 200–400 PCI procedures per year to assure quality</li> </ul>
	Performance management	

AA, adjusted admission; NR, net revenue; SSC, shared service center; PCI, percutaneous coronary intervention; PSM, purchasing and supply chain management.



may be able to reduce total administrative and overhead costs to 14 percent of net revenues, whereas systems with revenues exceeding \$9 billion can reduce these costs to just 9 percent of net revenues. Similarly, systems with at least \$2 billion in revenues can achieve significant unit-cost purchasing savings, and those with \$5 billion or more in revenues may have additional opportunities to reduce supply spending.

The benchmark figures included in Exhibit 7 can help health system leaders assess the potential upside of each of the 11 models for capturing scale. That estimate can then be compared with the capital requirements (e.g., the acquisition price) and integration costs associated with each model. In most cases, a clear trade-off will emerge between the potential upside and the costs of implementation.

To illustrate the types of trade-offs that must be considered, we again used McKinsey's hospital consolidation model to evaluate the approximate value that a hypothetical health system could capture from six different scale models (Exhibit 8). In this example, we assumed that the health system had \$1 billion to \$2 billion in annual revenues and had merged with another hospital five years previously.

The consolidation model showed us, for example, that acquiring a local hospital would likely give the health system an additional \$400 million to \$600 million in revenues and create between \$22 million and \$30 million in run-rate value capture. However, it would also require more than \$150 million in up-front capital and an additional \$10 million to \$15 million in integration costs.

In contrast, merging with a large, out-of-region health system would likely add \$4 billion to \$9 billion in revenues. Although the up-front capital costs of such a merger would be minimal, there would likely be substantial integration costs (\$60 million to \$75 million). And while the deal would create significant value (\$50 million to \$80 million), the local system would probably lose considerable control of how that value would be allocated back to its community.

Expanding horizontally across the care continuum (e.g., by increasing the size of the employed physician base) would likely add \$100 million to \$200 million in revenues, require an initial outlay of at least \$170 million, and create \$30 million to \$40 million in value. Integrating vertically (e.g., through virtual partnerships with payors) could add anywhere from \$100 million to \$500 million in new revenues, depending on the market landscape and payor dynamics. This move would probably cost \$20 million to \$30 million to set up (assuming that the partnerships were long-term and had moderate complexity) and would generate \$35 million to \$45 million in value (e.g., by partnering with payors to capture greater care efficiencies).

In evaluating these numbers, the leaders of the hypothetical health system would also have to consider what capabilities it would need in the future and how much management bandwidth they would have to oversee the various deals. (The previous merger had consumed a considerable amount of their time.) In this case, it seemed clear that their best move was to focus on partnerships with payors and physicians, rather than other health systems. These partnerships would help the system build the capabilities it needed and provide a better base for the future than hospital asset consolidation would.

### What type of scale would complement a system’s needs?

As the previous example makes clear, decisions about scale can only be made after a careful assessment of a health system’s position. What advantages does it have that would enable it to derive greater value from scale? Conversely, what weaknesses does it have that could be mitigated through greater scale? An accurate

appraisal of these variables is crucial, because optimal value is created when scale-driven partnerships are symbiotic—both sides should be able to capitalize on their advantages while compensating for their weaknesses. This type of appraisal can also help a health system negotiate from a position of strength and avoid being seen as a “value-disadvantaged” partner desperately in need of scale (Exhibit 9).

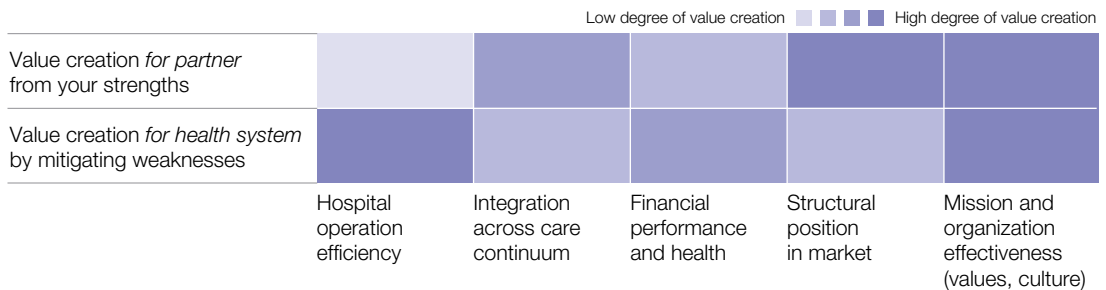


**EXHIBIT 8 Value capture (illustrative) for a small multihospital system with integrated physicians and out-of-hospital network**

	Additional scale \$ million net revenue	Value drivers	Value creation \$ million EBITDA run rate	Integration costs \$ million	Acquisition capital cost \$ million
<b>1 In-region acquisition: single hospital</b>	\$400 to \$600	<ul style="list-style-type: none"> <li>• Volume growth from referrals of 2–3%</li> <li><i>For target:</i></li> <li>• Reduced supply costs 10–12%</li> <li>• Pricing leverage of 2–3%</li> <li>• Reduced administrative expense 5–7%</li> <li>• Reduced cost of debt 5%</li> </ul>	\$22 to \$30	\$10 to \$15	\$150 to \$160
<b>2 In-region merger: health system</b>	\$1,400 to \$2,600	<ul style="list-style-type: none"> <li>• Volume growth of 3–5%</li> <li>• Reduced administrative costs 6–8%</li> <li>• Reduced supply costs 5–7%</li> <li>• Reduced clinical costs 0.2–0.3%</li> <li>• Reduced cost of debt 6–8%</li> </ul>	\$30 to \$45	\$30 to \$45	Not applicable
<b>3 Out-of-region large merger</b>	\$4,000 to \$9,000	<ul style="list-style-type: none"> <li>• Reduced administrative costs 18–22%</li> <li>• Reduced supply costs 7–9%</li> <li>• Reduced clinical costs 0.4–0.6%</li> <li>• Reduced cost of debt 20–25%</li> </ul>	\$50 to \$80	\$60 to \$75	Not applicable
<b>6 Virtual hospital integration</b>	No change	<ul style="list-style-type: none"> <li>• 15% overhead outsourced at 35–45% savings</li> <li>• 75% of labs and imaging outsourced at 35–45% savings</li> </ul>	\$15 to \$20	\$12 to \$18	Not applicable
<b>7/8 Horizontal expansion</b>	\$100 to \$200	<ul style="list-style-type: none"> <li>• Pricing increases of 13–17%</li> <li>• Reduced practice management costs 20–30%</li> </ul>	\$30 to \$40	\$10	\$170 to \$210
<b>10 Vertical relationships</b>	\$100 to \$500	<ul style="list-style-type: none"> <li>• Volume growth 6%</li> <li>• Reduced care costs 8–12%</li> <li>• 5% upside in quality bonuses</li> </ul>	\$35 to \$45	\$20 to \$30	Not applicable

## EXHIBIT 9 Value creation depends on whether the proposed scale partnership includes mutual complementarities

Each potential scale model should be evaluated based on mutual value creation



Objectives for a scale strategy should be defined by your strengths and weaknesses:

- Understand your strengths and how they can be leveraged to add value to your partner
- Understand your weaknesses/gaps and how they can be mitigated by your partner

Historically, small and midsize health systems have sought partners that could provide access to capital, payor contracting strengths, and physician alignment capabilities.<sup>9</sup> Although these factors will undoubtedly continue to be important, a new capability focused on healthcare value is likely to become top of mind for many health system leaders as the emphasis on total cost of care increases and payment models shift away from fee-for-service arrangements. All health system leaders should evaluate both their own healthcare value capabilities and those of any potential partners, and consider what sort of skill base they need to build as part of their scale strategy.



Growing financial pressures on consumers, employers, payors, and providers alike are encouraging a renewed focus on M&A as health systems seek to capture scale benefits.

Although the current trend toward consolidation is likely to continue, M&A is only one of several levers that can be used to capture the benefits of scale. Health system leaders should think through their scale goals carefully and then use a smarter scale equation to evaluate the full range of available models. This broader approach will enable them to achieve their desired outcomes at an appropriate risk and investment profile. ○

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<sup>9</sup>McKinsey interviews with CEOs of small hospital systems, midsize hospital systems, ambulatory surgery centers, physician groups, and specialty care centers.