Chapter 88
Coalitions:
The Future of Healthcare in Public Private Partnerships

Erinn N. Harris
Baltimore City Fire Department, USA

ABSTRACT

Demands in healthcare have placed a strain on healthcare providers trying to provide quality care while maintaining accreditations and planning for the possibility of expansion of resources as well as patients. Public Private Partnerships (PPPs) have been used to help ease this strain and increase the capabilities of healthcare systems all over the country. In an effort to "level the playing field," the federal government has recently decided to mandate the structure of these healthcare PPPs. That is, a new form of these partnerships (i.e. coalitions) has been designated the organizational model that healthcare PPPs must evolve into in order to receive certain types of federal grants. This chapter discusses these coalitions as well as challenges for PPPs that are just now in the process of forming. Also discussed is the increased effort required to form coalitions from PPPs that have already been in existence for any length of time.

INTRODUCTION

Public private partnerships have existed in the United States for hundreds of years (Cellucci, 2010) and have been used for endless types of projects branching from infrastructure to housing to tourism. Another area that has had high use of public private partnerships is healthcare. With the Baby Boomer Generation putting more demand on the healthcare industry in the form of number of physicians, medications and treatments to new healthcare legislation, the price of healthcare is steadily increasing. This cost increase is not only affecting the people requiring these services, but it is also increasing the cost of doing business within the healthcare industry itself. The American Heart Association estimates that by the year 2030, the number of people over the age of 65 will have doubled, increasing the number to more than 70 million Americans. Of all these people, more than one out of every six baby boomers will be managing more than one chronic condition. That is an estimated 37 million Americans. For all populations, the American Heart Association predicts that the number of physician's visits will double by the year 2030. This is slightly over 1.3 trillion visits to a doctor.

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Hospitals, emergency medical service providers and health departments are all struggling to find funds for continuing to provide the best and latest services as quickly and safely as possible. These costs come from several areas. For patient related costs, there is diagnostic testing such as x-rays, blood work, specimen collection, etc. Treatment costs include not only the people needed for the procedure, but the equipment and supplies also needed. Overhead is included in the form of bed a patient needs (admitted into a specialty area, kept in the ER, bariatric beds) and for how long they need to occupy that space. Not only are there costs of helping to physically repair the patient, but there are mental care issues as well. Was the patient injured in an isolated incident, or do they need to talk to social services? Do they need to enter a detox program for drugs or alcohol? Are there ongoing care issues where the patient would not be able to return home but needs to be evaluated for entry into a rehabilitation facility? While admission into a hospital was mentioned, most if not all of the issues that were listed can be handled within the Emergency Department of a hospital. The Center for Medicare and Medicaid released a statement in the Federal Register in 2002 that at least half of all emergency services go uncompensated.

Patient costs are not the only costs generated by the hospital. There are also the costs of becoming accredited to provide as many services as they are able. The process for becoming recognized as a cardiac catheter center, a primary stroke center, a trauma center, or even a location that pre-hospital services can consult with a physician at is a long one that has many loopholes to jump through. This means that aside from treatments, hospitals for example must also have a required number of training hours, assemble different types of response plans and be integrated with other aspects of the community in which they are located (for example the local health department). All of these things cost money. So the healthcare industry has turned to public private partnerships to try and offset any direct costs they might incur. One can see this in the number of hospital conglomerations that have been increasing in the past 5 years. Take for example MedStar Health in the Baltimore/ Washington DC area. It consists of 10 hospitals, and has its own research institute and medical education program through Georgetown University. (MedStar Health, 2014) MedStar Health generates 4.2 billion dollars annually and in 2013 listed a total of 551,292 emergency room visits in their hospitals. It is proving to be much easier to expand and generate money with a group of healthcare entities, who each can focus on a small group of specialties, than a single hospital trying to offer everything itself. While this type of public private partnership has proven to be beneficial, within the past five years there has been an attempt by government agencies to modify these partnerships into a mold so that they are all operating under the same rules and guidelines. MedStar Health is a non-profit organization. (MedStar Health, 2014) While there are certain advantages to being labeled this way and they have listed sizeable yearly revenue, what was not accounted for was how much of the revenue goes into the training, maintenance of current facilities and expansion projects that MedStar is undertaking. Billing for their services alone would not bring in enough to cover all of this organization's expenses. For this reason, most hospitals also need assistance from the government in the form of grants. The main supplier of these grants on the federal level is the Department of Health and Human Services (DHHS). Since there are so many forms hospitals and their partnerships can assume, it is difficult for DHHS to designate appropriate amounts of funds annually so that everyone has what they need. It is for this reason that DHHS is guiding healthcare public private partnerships to reorganize themselves into "coalitions." If public private partnerships would like to receive the same funding they have been getting in the future, or really any type of funding at all, then they need to transform into "coalitions" and operate under certain regulations.