HEALTH CARE COUNCIL
of Chicago

Beyond a "Call to Action"

Chicago's safety net is on the verge of collapse. Conservatively, a cohort of nine safety net hospitals in Chicago are projected to produce a $2.46 billion in cumulative loss from 2025 through 2030.

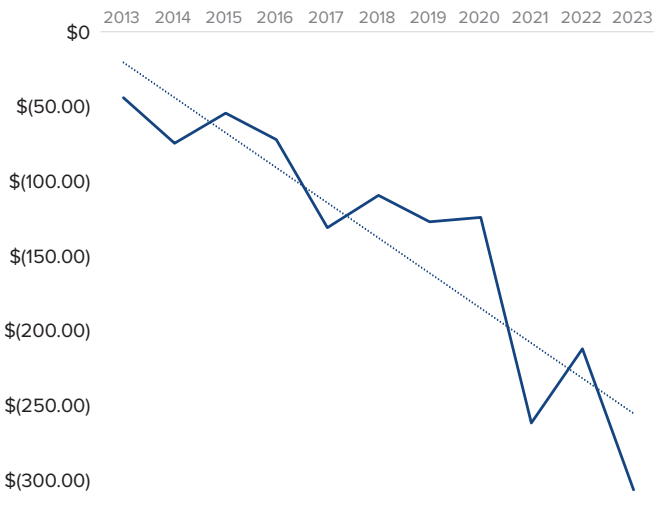
The State alone cannot fix the safety net system. And the way forward is highly complex, requiring a commitment from a myriad of stakeholders to build a more efficient system of care. The city needs a system that incorporates diverse funding streams, integrated care delivery, coordinated care, increased efficiency in the managed care – provider relationship, and capital to revitalize its crumbling infrastructure.

It's cliché to say this analysis is a "call to action." Instead, our objective is to resoundingly declare a five-alarm level of emergency to all market leaders, policymakers, philanthropists, businesses, insurance companies, and Illinois and Chicago health systems. Without prompt action, a serious structural change will reshape how many underserved Chicagoans access everything from emergency to primary care.

Inaction will cost jobs. Inaction will cost opportunities for the improved health that correlates to increased productivity and wealth creation.

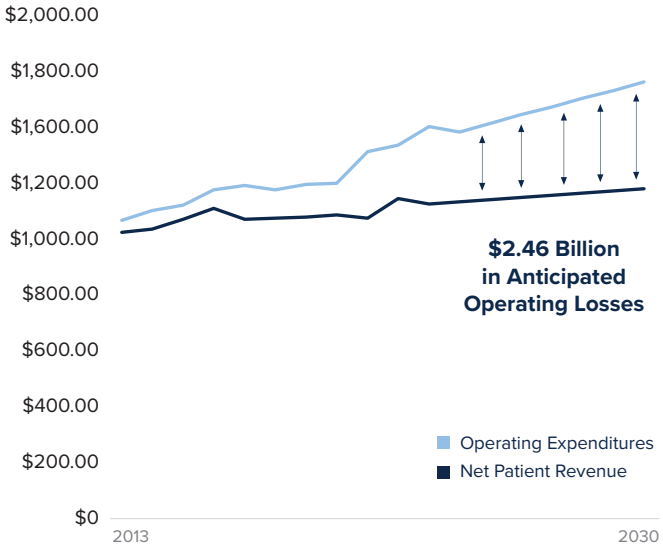
But most important of all, inaction will cost lives.

Net Income (2013 – 2023)



Chicago's safety net hospitals have seen a steady and sustained decrease in patient revenue while medical cost inflation and overall costs continue to climb.

Net Patient Revenue and Operating Expenditures Forecast (2013 – 20230)



The growing delta between expenses and revenues create an expected operating loss of $2.46 billion by 2030

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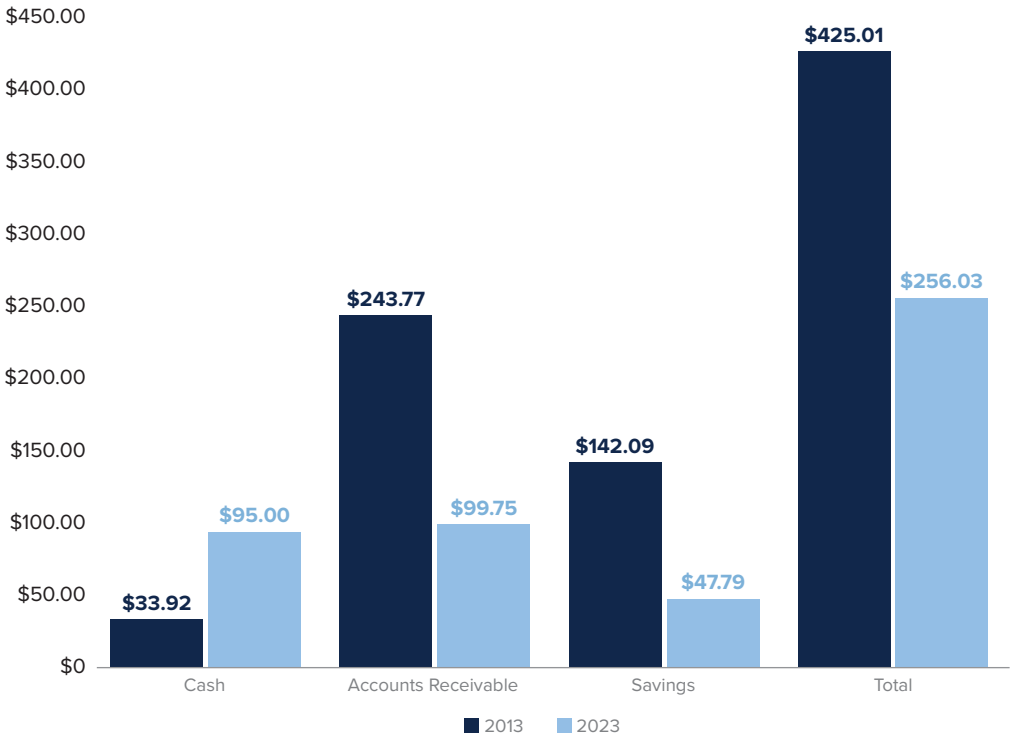
Current Asset Comparisons (2013 & 2023)



The asset base has declined by 40 percent over the last 10 years.

Current assets are only sufficient to cover ~16 percent of the total unfunded operating loss liability.

1. **Consolidate** safety net hospitals into an integrated health system and evenly balance clinical assets.

2. **Re-capitalize** hospitals and build infrastructure (i.e. imaging, stand-alone clinical services) to complement primary care capacity.

3. Develop 2-3 ubiquitous **value-based payment structures** that all MCOs use in safety net provider contracts.

4. Integrate **emergent AI** and consumer-facing digital tools in service of patient care inside and outside of clinical facilities.

5. Develop a s**pecialty medical group** that uniquely serves the safety net.

6. Require **high efficiency networks** that beneficiaries can select

7. Address **crippling medical malpractice** provisions in state law.