

# Taking the Pulse

THE STATE OF  
America's Hospitals



American Hospital  
Association

# Executive Summary

Every day hospitals confront many challenges that make it harder to keep the promise of caring and curing. The continually changing environment for hospitals at the local, state and federal levels makes it critically important to continuously assess the ability of hospitals to meet the health care needs of their communities.

*The State of America's Hospitals: Taking the Pulse*, a survey of our nation's community hospitals, illustrates hospitals' daily challenges:

- Continued high vacancy rates for health care professionals are affecting patient access to services. Hospitals reported that it has become even more difficult in the past year to recruit nurses (40%), pharmacists (38%), imaging (33%) and lab (31%) technicians.
- Sixty-nine percent of urban hospitals and 33 percent of rural hospitals report that emergency departments (EDs) are "at" or "over" capacity.
- A majority of urban hospitals (70%) and teaching hospitals (74%) experienced periods of ED diversion in the past year. Nearly one in six urban hospitals responding experienced diversion more than 20 percent of the time.

- The number one reason cited for ED diversion was lack of critical care capacity (44%) followed by ED overcrowding (23%) and lack of general acute care beds (13%).
- Forty-one percent of hospitals report that they have lost specialty coverage for a period of time in the last 24 months, and cite uncompensated care and liability concerns as their top reasons.
- The professional liability insurance crisis continues — 30 percent of hospitals in the American Medical Association-designated crisis states reported increases in liability insurance costs of 50 percent or more.
- Hospitals experienced double-digit increases in expenses for pharmaceutical products, and a seven to nine percent increase for medical supplies and devices.
- Of responding hospitals, 30 percent reported physician-owned limited-service hospitals operating in their area.

These and other problems facing hospitals must be addressed now to protect access to health care for future generations.

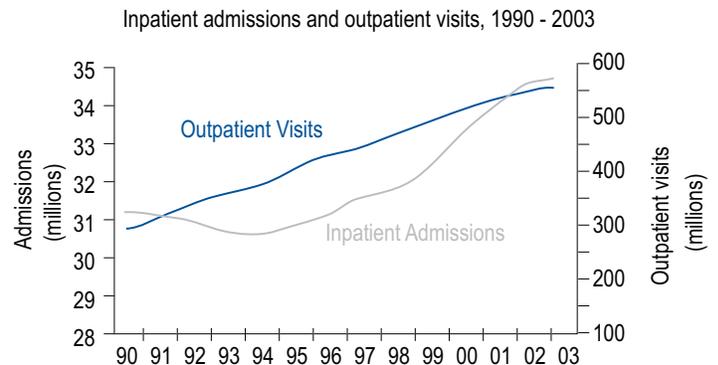
# Background and Survey Methodology

## Background

Hospitals are the cornerstone of our health care system – a system that has contributed to longer and better lives for Americans. Studies show that a person born in 2000 can expect to live more than three years longer than one born in 1980. But these advances have increased the demand for hospital care and the costs to provide that care.

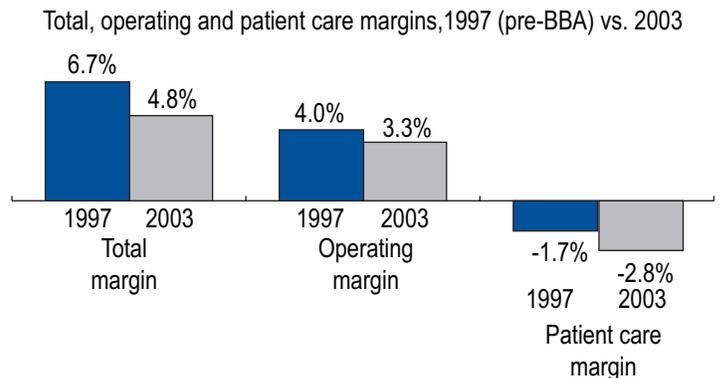
Since the Balanced Budget Act of 1997, the financial status of hospitals has declined. In 2003, nearly one-third of hospitals lost money overall and nearly 60 percent lost money caring for Medicare and Medicaid patients. With more than 45 million Americans lacking health insurance coverage, hospitals provided nearly \$25 billion of uncompensated care in 2003. Hospitals and other health care providers, however, remain a prime target for policy-makers looking for ways to cut the federal deficit, projected at \$331 billion in 2005.<sup>1</sup> And Medicare and Medicaid already pay substantially less than the cost of caring for patients they cover, and the shortfall is growing.

## The demand for hospital care is rising.



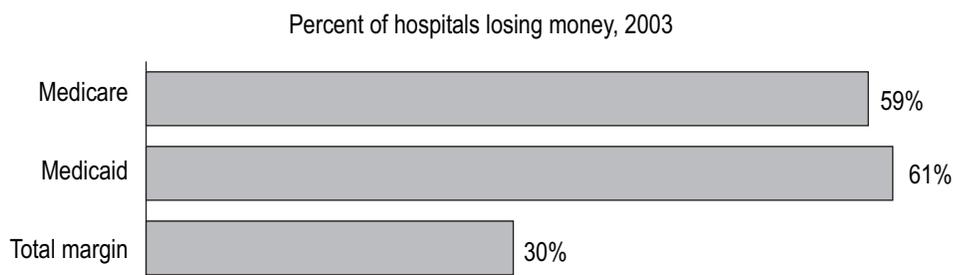
Source: 2003 AHA Annual Survey

## Hospital total margins are down 34 percent from pre-Balanced Budget Act levels.



Source: 2003 AHA Annual Survey

## The majority of hospitals lose money serving Medicare and Medicaid patients, while nearly a third lose money overall.



Source: 2003 AHA Annual Survey

But rising demand and fragile finances are only part of the picture. The following report documents other challenges that go much deeper:

- Hospitals face workforce shortages that are projected to reach crisis proportions in the coming decades.
- Our nation's overcrowded EDs provide evidence that rising demand comes at a time of constrained capacity.
- Specialty coverage in hospital EDs is a growing concern as physicians face reimbursement pressures and have increased opportunities to practice in other settings, without the responsibilities of ED on-call duty.

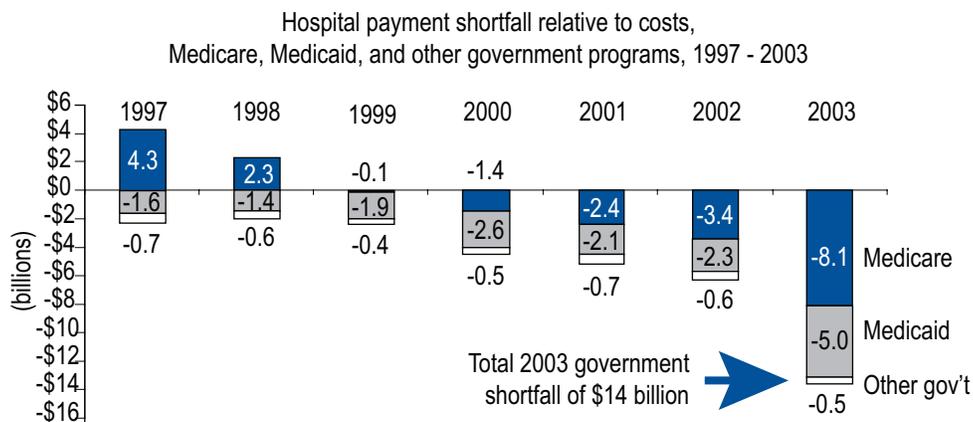
- The costs to hospitals for professional liability insurance, pharmaceuticals and other supplies continue to skyrocket.

- Physician-owned limited-service hospitals raise conflict of interest concerns and threaten the stability of the health care system.

### Survey Methodology

This report is based on Telling the Hospital Story, a 2005 Survey of Hospital Leaders sent to approximately 4,800 community hospital CEOs via e-mail and fax in February 2005. Unless otherwise specified, data is reflective of this time period. 700 responses were received.

## Growing government shortfalls put the financial health of hospitals at risk.



Source: 2003 AHA Annual Survey

## SURVEY FINDINGS

### I. Workforce

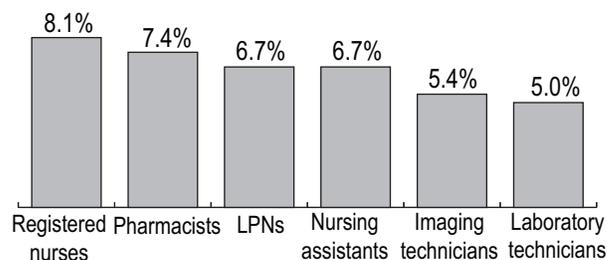
Health care is about people taking care of people. But the supply of hospital caregivers and other workers is not keeping pace with the demand for hospital care. As of January 2005, hospitals had an estimated 109,000 vacant positions for registered nurses (RN).<sup>2</sup> That is, 8.1 percent of RN positions, both full-time and part time, were vacant in December 2004 (Chart 1). Many hospitals report that it has become even more difficult in the past year to recruit nurses (40%), pharmacists (38%), imaging (33%) and lab (31%) technicians (Chart 2). Staff shortages can have a negative impact on access to health care services (Chart 3).

Rising unemployment in other sectors has led some to return to hospitals for employment, temporarily easing the shortage for some types of workers. But those re-entering the hospital workforce tend to be older and closer to retirement, making the long-term projections still look grim.

The health care workforce – particularly the RN population – is aging and retiring. Enrollment in health education programs has been declining as people – especially women – face an expanded range of employment options. The Health Resources and Services Administration now projects a shortage of one million RNs by 2020. This suggests that only 64 percent of the projected demand will be met.<sup>3</sup>

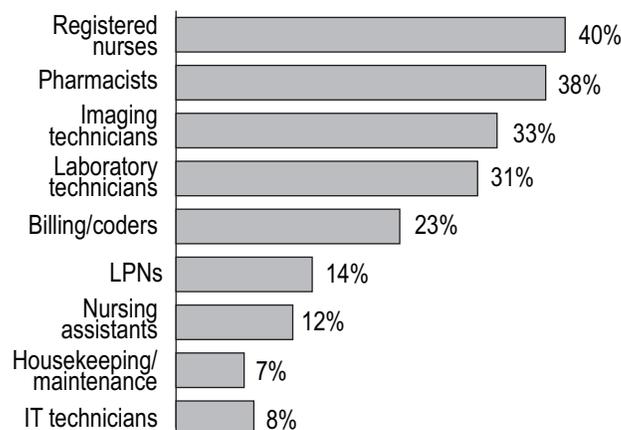
### Hospitals face workforce shortages in key caregiving professions...

Chart 1: Vacancy rates for selected hospital personnel, December 2004



### ... and recruitment efforts are increasingly difficult.

Chart 2: Percent of hospitals reporting recruitment more difficult in 2004 vs. 2003



### Staffing shortages are affecting patient care.

Chart 3: Percent of hospitals reporting service impacts of workforce shortage, 2004



## SURVEY FINDINGS

# II. Hospital Emergency Department Diversions and Physician Specialty Coverage

The hospital ED is the entry point for care not only for those with more immediate acute conditions like heart attacks, strokes and injury, but also for those with nowhere else to turn for any level of care – from ear infections to major trauma. In 2003, community hospitals responded to more than 111 million ED visits.<sup>4</sup>

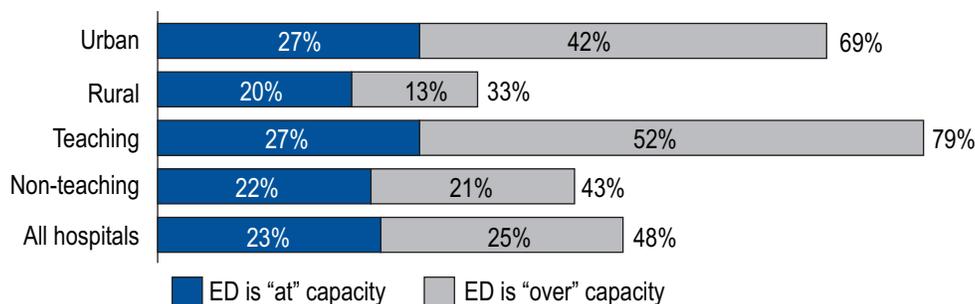
From 1993 to 2003 demand for ED care rose by 20 percent, while the number of EDs declined by 9 per-

cent.<sup>5</sup> This trend led to a 31 percent increase in visits per ED.<sup>6</sup> In 2005 nearly half of hospitals reported that they were “at” or “over” capacity (Chart 4).

The problem of ED overcrowding and diversion is most evident in our nation’s urban and teaching hospitals (Chart 5). Diversion, however, is not an option for many rural hospitals that may be the only access point for care in their communities.

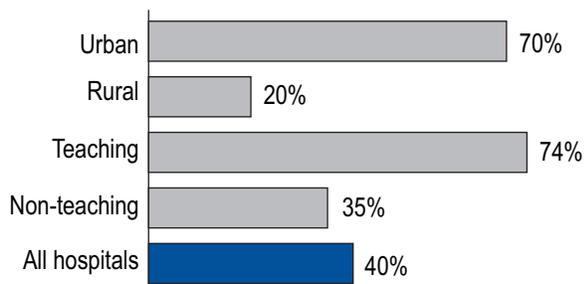
### Most EDs are “at” or “over” capacity...

Chart 4: Percent of hospitals reporting ED capacity issues by type of hospital



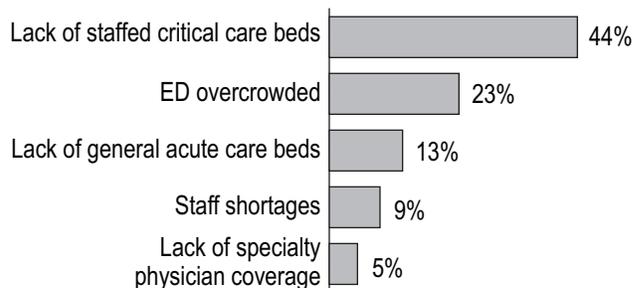
... and a majority of urban and teaching hospitals experience time on ED diversion...

Chart 5: Percent of hospitals reporting periods of ED diversion in last 12 months



... most often caused by a lack of staffed critical care beds.

Chart 6: Percent of hospitals citing factor as number one reason for ambulance diversion, January 2005



Lack of critical and acute care beds, ED overcrowding and staff shortages are most often cited as the number one reason for ambulance diversion (Chart 6).

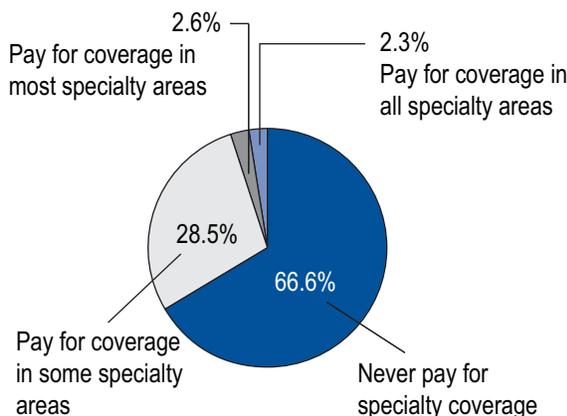
In January 2005, nine percent of urban hospitals reported being on diversion more than 20 percent of the time, and for 46 percent of hospitals the problem has deteriorated since 2002 (Chart 7).

In addition to overcrowding and ambulance diversion, hospitals are experiencing difficulties in obtaining specialty coverage for the ED. Forty-one percent of hospitals reported that they lost specialty coverage for a period of time over the last two years. For hospitals that lost specialty coverage, the most often cited reasons were uncompensated care, liability concerns, and physicians who retired or left the community (Chart 8).

To retain ED coverage, hospitals increasingly must pay specialists to be on-call. Thirty-three percent of hospitals reported that they are paying for “some” to “all” specialty coverage (Chart 9).

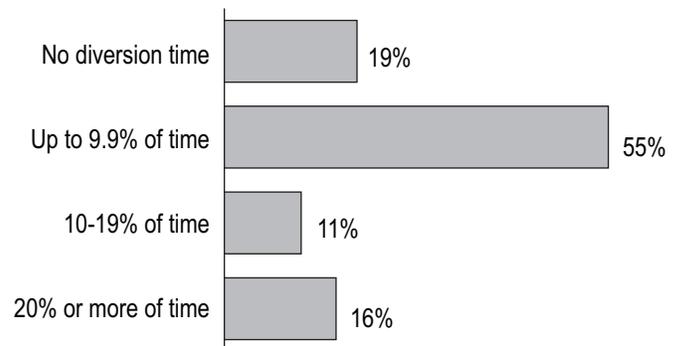
### Nearly a third of hospitals now pay some physicians for specialty coverage.

Chart 9: Frequency of paying for specialty coverage in ED



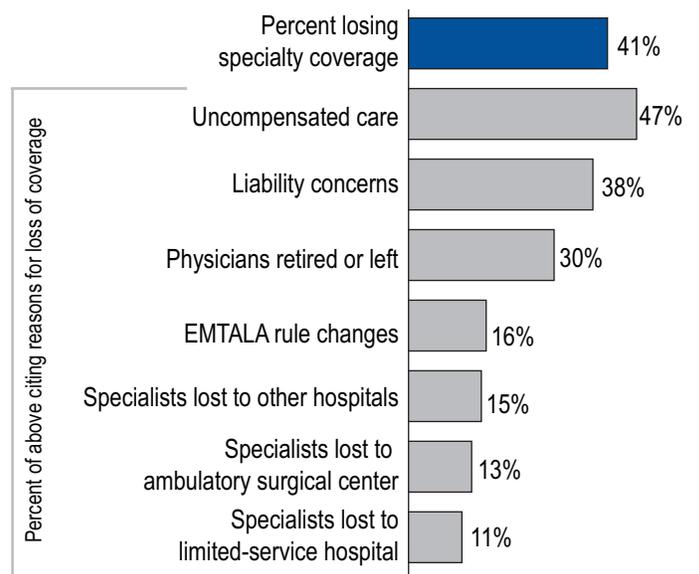
### Nearly one in six urban hospitals experienced diversion more than 20 percent of the time.

Chart 7: Percent of time on diversion, urban hospitals in January 2005



### 41 percent of community hospitals have lost specialty coverage in the emergency department for a period of time.

Chart 8: Percent of hospitals losing specialty coverage for any period of time in the last 24 months and reasons cited



## SURVEY FINDINGS

# III. Professional Liability Coverage

Finding affordable professional liability coverage is a growing concern for health care providers. Hospitals in American Medical Association-designated “crisis” states are seeing the largest increases in premiums for liability insurance. Nineteen percent of hospitals responding from crisis states reported increases between 50 and 99 percent in the last two years while more than 11 percent said they have seen an increase of double or more (Chart 10).

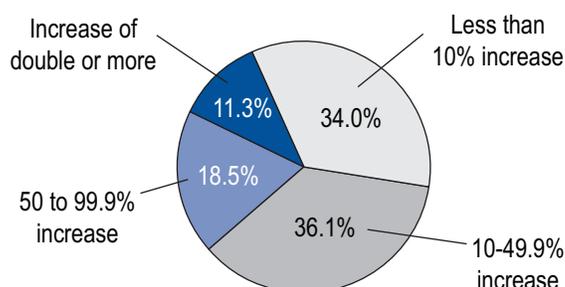
Physicians in high-risk specialties like obstetrics/gynecology and neurosurgery are most affected. In response to rising premiums for liability insurance, some physicians are curtailing services (e.g. not providing emergency call coverage or no longer delivering babies), while others are retiring early, moving to states with professional liability reform or simply abandoning their practices all together (Chart 11).

For hospitals, this can have a negative impact on their ability to provide health care services to patients. Survey respondents cited obstetrics (57%), neurosurgery (35%), and emergency care (32%) as the services most at risk (Chart 12).

In addition, efforts to reduce professional liability insurance costs have led nearly all hospitals in crisis states to take on more risk in the form of higher deductibles, reduced coverage, self-insurance, or, in rare cases, “going bare.”

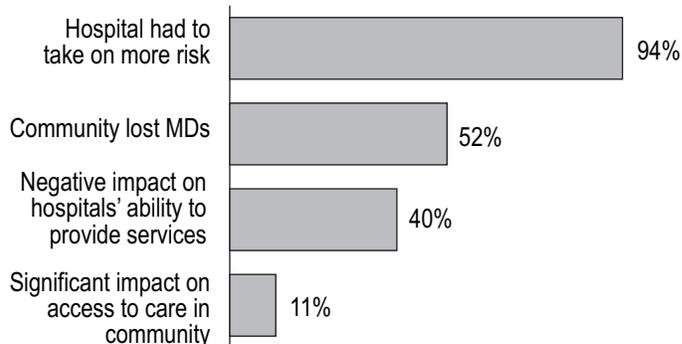
## Hospitals face skyrocketing costs for medical liability coverage...

Chart 10: Percent of hospitals in crisis states\* by rate of growth in professional liability expense over past two years



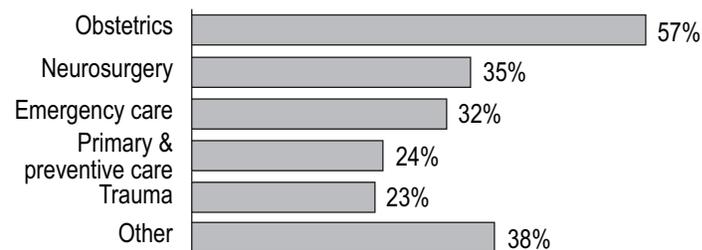
## ... affecting hospitals and the patients they serve...

Chart 11: Percent of hospitals in crisis states\* reporting specific effects of increased professional liability expenses



## ... with the greatest impact on care delivery for obstetrics, neurosurgery and emergency services.

Chart 12: Percent of hospitals in crisis states\* reporting negative impact on ability to provide specific services



\* Crisis states identified by the American Medical Association as of March 2004 include: PA, WV, NV, MS, WA, OR, TX, AR, MO, GA, FL, IL, NC, KY, CT, NJ, WY. Some of these states recently passed legislative reforms that have not been tested in the courts.

## SURVEY FINDINGS

# IV. Pharmaceutical and Supply Costs

America's health care system continually offers new possibilities to meet the health care needs of our aging patients and growing population. But the rapid pace of innovation is accompanied by rising costs for pharmaceuticals, medical devices and other supplies.

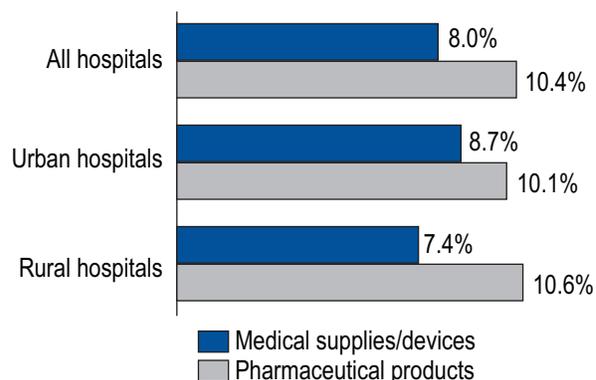
Each year, newly introduced products add billions to the cost of caring. U.S. sales of Boston Scientific's Taxus Drug Eluting Stent – one new technology – are expected to hit \$1.9 billion in 2005. The projected annual costs of implantable cardiac defibrillators for prophylactic use, just approved by Medicare for coverage this year, are \$1 to \$3 billion for the Medicare program alone.<sup>7</sup>

The substitution of new and more expensive products, rising prices for existing products, and more per patient use of drugs and supplies all have contributed to double-digit increases in costs to hospitals for phar-

maceuticals and an increase of seven to nine percent for medical supplies and devices (Charts 13 and 14).

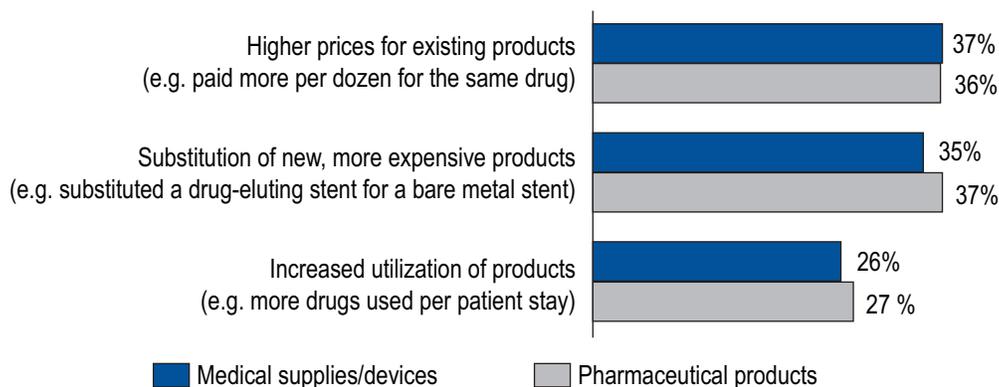
## Hospitals face significant increases in the costs of pharmaceuticals and medical supplies...

Chart 13: Percent change in hospital expenses for pharmaceuticals and medical supplies/devices, 2003 to 2004



## ... with new products and rising prices being more important drivers than increased utilization.

Chart 14: Percent of hospitals reporting their number one reason for increases in costs for pharmaceutical products and medical supplies/devices



## SURVEY FINDINGS

# V. Physician-owned Limited-service Hospitals

Physician-owned limited-service hospitals are a growing trend, raising concerns about conflict of interest and the impact that these facilities have on the health care system as a whole. Thirty percent of hospital leaders reported the presence of a physician-owned limited-service hospital in their area. In addition, nearly 20 percent noted that at least one was currently in development in their area (Chart 15).

Research has shown that the economic incentives created by self-referral influence physician behavior. These behaviors include:

- Steering patients to the hospital in which the physician has an ownership interest;
- Cherry-picking well-paid services, better reimbursed patients, and less sick patients; and

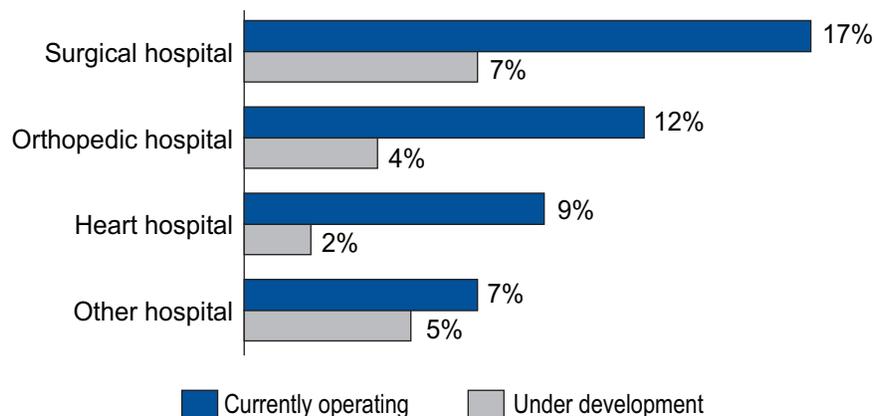
- Increasing the number of referrals and driving up health care costs.

The hope that “competition” from these facilities would lead to greater efficiency and better quality has not been supported by the research. In fact, the Medicare Payment Advisory Commission found that physician-owned limited-service hospitals actually had higher costs.

Meanwhile, these facilities have drained critical resources from community hospitals, leading to cut-backs in patient services. In some communities, physician-owners have reduced or eliminated on-call coverage at the community hospital. Since the majority of physician-owned limited-service hospitals do not offer emergency services, this practice has jeopardized access to care for affected specialties for the community at large.

### Many hospital leaders report that physician-owned limited-service hospitals are currently operating in their area and more are under development.

Chart 15: Percent of hospitals reporting limited-service hospitals operating or under development in their area



Source: 2005 AHA Survey of Hospital Leaders

## Conclusion

The state of America's hospitals is fragile. They face rising demand, constrained capacity and pressures from inadequate reimbursement. Our nation's health care system provides great promise to those who can access it, but current pressures put that promise at risk.

- **Worker shortages** will reach crisis proportions in the coming decades without action now.
- **Rising demand and constrained capacity** are causing emergency department overcrowding and ambulance diversion.
- **A medical liability crisis** threatens access to specialty care, especially in our nation's emergency departments.
- **Rapidly rising costs and payment shortfalls** threaten the financial stability of hospitals.
- **The tactics of physician-owned limited-service hospitals** strip critical resources from full-service hospitals and threaten access to care for the community at large.
- **Growing numbers of uninsured people** lack access to timely and appropriate care and strain the financial resources of the hospitals and others that care for them.
- **Payment shortfalls for Medicare and Medicaid** – government programs that support half of the care hospitals provide but pay less than the costs of caring – threaten financial stability.

These challenges must be addressed now to protect access to hospital care for future generations.

## Endnotes

- <sup>1</sup> Congressional Budget Office, *Monthly Budget Review*, August 4, 2005.
- <sup>2</sup> AHA estimate based on total number of full and part-time RNs and current vacancy rate.
- <sup>3</sup> Biviano M., Fritz M., Spencer W., What is behind HRSA's projected supply, demand and shortage of registered nurses?, National Center for Health Workforce Analysis, Bureau of Health Professions, HRSA and Dall T. The Lewin Group. September 2004.
- <sup>4</sup> AHA 2005 Hospital Statistics
- <sup>5</sup> AHA Trendwatch Chartbook 2005. [www.aha.org](http://www.aha.org)
- <sup>6</sup> Ibid.
- <sup>7</sup> Neumann PJ. Medicare National Coverage Decisions: How is CMS Doing? Presented at National Health Policy Conference. February 2005.



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