Cracks in the Foundation: Averting a Crisis in America's Hospitals
AMERICA'S HOSPITALS ARE THE FOUNDATION OF OUR NATION'S HEALTH CARE SYSTEM

A FOUNDATION BUILT WITH

PEOPLE taking care of people 24/7—doctors, nurses, other health care professionals, support staff, as well as executive and volunteer leaders—working together to support an essential public service.

TECHNOLOGY AND SUPPLIES available 24/7 to provide services from basic diagnostics to advanced life support—when a child is sick in the middle of the night or when disaster strikes a community.

FACILITIES with doors open to all people 24/7, even when there is no place else to turn.

FINANCIAL RESOURCES required 24/7 to pay the PEOPLE, purchase the TECHNOLOGY AND SUPPLIES, and maintain and improve the FACILITIES—financial resources from government and private payers—needed to support this essential foundation for health care.

UPDATED: August 2002
Worker shortages that will reach crisis proportions in the coming decades without action now.

Rising demand and constrained capacity that cause emergency department overcrowding and ambulance diversion.

Regulatory burden that takes caregivers away from the bedside and diverts financial resources away from patient care.

Rapidly rising costs that, if not matched with increases in payment, threaten the financial stability of hospitals.

Growing number of uninsured people which threatens access to timely and appropriate care for more than 40 million Americans and strains the financial resources of the hospitals who care for these individuals.

Decreased access to capital—capital that’s required to meet rising demand, keep up with advances in technology, and maintain facilities.

Payment shortfalls for Medicare and Medicaid, government programs that support half of the care hospitals provide but often pay less than the costs of caring for these patients.

These cracks must be addressed now or the foundation that supports our health care system—our nation’s hospitals—will continue to erode.
Health care is about people caring for people, but we face a severe shortage of caregivers and other workers. Without help, this shortage will reach crisis proportions in the coming decades.

Hospitals face severe workforce shortages...

Vacancy Rates for Selected Hospital Personnel, 2001

<table>
<thead>
<tr>
<th>Vacancy Rate</th>
<th>Imaging Technicians</th>
<th>Registered Nurses</th>
<th>LPNs</th>
<th>Pharmacists</th>
<th>Nursing Assistants</th>
<th>Laboratory Technicians</th>
<th>Bills/Claims</th>
<th>IT Technologists</th>
<th>Housekeeping/Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.3%</td>
<td>13.0%</td>
<td>12.9%</td>
<td>12.7%</td>
<td>12.0%</td>
<td>9.5%</td>
<td>8.5%</td>
<td>5.7%</td>
<td>5.3%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

Source: The Healthcare Workforce Shortage and Its Implications for America's Hospitals, First Consulting Group, Fall 2001

...that are affecting patient care...

Percent of Hospitals Reporting Service Impacts of Workforce Shortage

- ED Overcrowding: 38%
- Diverted ED Patients: 25%
- Reduced Number of Staffed Beds: 23%
- Increased Wait Times to Surgery: 19%
- Discontinued Programs/Reduced Service Hours: 17%
- Delayed Discharge/Increased Length of Stay: 12%
- Cancelled Surgeries: 10%
- Curtailed Acquisition of New Technology: 8%
- Curtailed Plans for Facility Expansion: 7%

Source: The Healthcare Workforce Shortage and Its Implications for America's Hospitals, First Consulting Group, Fall 2001
Today hospitals face an immediate need for caregivers and support staff, if we are to continue our tradition of providing the best medical care in the world. An estimated 168,000 positions are currently unfilled—and about three-quarters of these are for registered nurses (RNs). Without help, this shortage will reach crisis proportions in the coming decades, because:

- Demand for hospital services is soaring, especially as the “baby boom” generation begins to age.
- The health care workforce—particularly the registered nurse population—is aging and retiring as well. Enrollment in health education programs has been declining as people, especially women, face an expanded range of employment options. Between 1983 and 1998, registered nurses under age 30 dropped from 30 to 12 percent of the overall nursing workforce.
- By 2020, demand for registered nurses will exceed supply — by more than 800,000 RNs, a significant increase over previous estimates.
Today there are over 900 fewer hospitals than there were in 1980. Over the past 20 years, declining inpatient utilization and pressures to increase efficiency led to hospital closures and consolidation. But now demand for hospital services is rising, and the remaining hospitals are struggling to keep up.

Nowhere is this trend more evident than in our nation’s emergency departments (EDs). EDs represent an essential access point to care, not only treating victims of heart attacks, strokes and injury, but also serving as the safety-net for those with nowhere else to turn for any level of care—from ear infections to major trauma. But our EDs are overcrowded and many frequently must divert ambulances to other facilities because they lack the staff and space to care for additional patients.

A recent survey found:
- 62 percent of all hospitals—and 79 percent of urban hospitals—are “at” or “over” ED capacity.
- More than half of urban hospitals reported time on “ED diversion,” when the hospital is unable to accept patients by ambulance.
- One in eight urban hospitals are on diversion more than 20 percent of the time.
- A critical factor driving ED diversions is the nursing shortage, meaning staffed, critical care beds are not always available for ED patients.

ED overload is a critical warning sign of an overburdened health care system.

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

Percent of Hospitals Reporting ED Capacity Issues by Type of Hospital

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

Percent of Urban Hospitals Reporting Time on Diversion in November 2001

Hospitals face rising demand and constrained capacity, as evidenced by our nation's overburdened emergency departments.

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

Percent of Hospitals Citing Factor as Number One Reason for Ambulance Diversion

- Lack of Critical Care Beds: 43%
- ED Overcrowded: 24%
- Lack of General Acute Care Beds: 14%

Pressures will mount as ED volume continues to rise.

Number of ED Visits in Community Hospitals (in millions) 1990-2001

Source: The Lewin Group analysis of AHA ED and Hospital Capacity Survey 2002

Confusing, contradictory and cumbersome regulations force caregivers to spend more time on paperwork and less on patient care.

Government regulation of health care is complex and confusing...
In an era of serious health care worker shortages, caregivers’ time must be used as efficiently as possible. But, paperwork requires at least 30 minutes—often as much as an hour—for every hour of patient care provided. The burden is too heavy—at the expense of patient care. Excessive paperwork not only shortchanges the patient, it also makes the job of the health care professional less rewarding—a key issue in making the health care field attractive to future workers.

…creating a paperwork burden that takes caregivers away from the bedside.

### Care Setting
- Emergency Department Care
- Surgery and Inpatient Acute Care
- Skilled Nursing Care
- Home Health Care

### Every Hour of Patient Care Requires:
- 1 Hour of Paperwork
- 36 Minutes of Paperwork
- 30 Minutes of Paperwork
- 48 Minutes of Paperwork

Hospitals face rapid increases in costs:

- **Labor:** While hospitals confront the growing workforce shortage, their labor costs—which account for over half of a hospital’s expenses—are rising more than 50 percent faster than other service industries.

- **Drugs and Biologics:** The cost of pharmaceuticals continues to skyrocket with an increase of 17.3 percent in 2000 alone, while in 2001, the cost of a pint of blood increased an average of 31 percent.

- **Professional Liability Coverage:** Health care liability premiums are skyrocketing, drastically reducing access to care in many communities. Increasingly, insurance carriers are discontinuing health care liability insurance or becoming insolvent, resulting in fewer carriers, less competition, and higher premiums. In a recent American Hospital Association/American Society for Healthcare Risk Management (AHA/ASHRM) survey, one third of hospitals reported that premiums increased by 100 percent or more.

- **Disaster Readiness:** As frontline responders in the event of disasters, hospitals must help defend the homefront by upgrading their capacity to respond to nuclear, biological and chemical attacks—requiring an investment of more than $11 billion to ensure that every hospital has a minimum capacity to respond to such emergencies.

Hospitals face labor cost increases over 50 percent higher than service industries as a whole...

Percent Change in Employment Cost Index for Private Service Industries, 12 Months Ending March 2002

- **All Service Industries:** 3.9%
- **All Health Services:** 5.2%
- **Hospitals:** 6.1%

Source: Bureau of Labor Statistics, data released April 25, 2002
The costs of providing high quality health care are rising so quickly that America's hospitals and health systems cannot keep pace.

...and skyrocketing professional liability premiums.

Growth in Total Prescription Drug Spending as a Percentage of Total Growth in National Health Expenditures, 1981-2000

Source: Centers for Medicare & Medicaid Services, Office of the Actuary

Percent of Hospitals with a 10% or Greater Increase in Professional Liability Premiums, 2000-2002

Source: AHA/ASHRM Survey of Hospital Experience with Professional Liability Insurance
Hospitals serve as the safety net for America’s 40 million uninsured people.

Many fear recent progress in reducing the number of uninsured...

...has been erased as the unemployment rate climbs sharply after hitting a low in 2000.

Number and Percent Uninsured, 1985-2000

December Unemployment Rate, 1992-2001
Meanwhile, the cost of uncompensated care provided by hospitals is rising.

Aggregate Hospital Uncompensated Care Costs (in billions) 1997-2000

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost (in billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>$18.5</td>
</tr>
<tr>
<td>1998</td>
<td>$19.0</td>
</tr>
<tr>
<td>1999</td>
<td>$20.7</td>
</tr>
<tr>
<td>2000</td>
<td>$21.6</td>
</tr>
</tbody>
</table>

Source: AHA Annual Survey

A part of their mission—and as mandated by federal law—hospitals serve as the safety net for America's 40 million uninsured people, and in 2000, provided $21.6 billion of uncompensated care. The nation appears to have made modest gains in reducing the number of uninsured during the recent economic expansion as unemployment rates approached what many economists called "full employment" and State Children's Health Insurance Programs and other state programs expanded coverage for low-income people. Many fear, however, that these gains are quickly being erased as unemployment climbs and state budget deficits threaten recent coverage expansions.

Hospitals receive support for providing care to low-income populations through Medicaid, and from subsidies from state and local governments. This support, however, falls substantially below need. In 2000, hospitals received 82 cents for every dollar spent caring for Medicaid and charity care patients.
Hospitals continually need capital to maintain and update their physical plant, retool facilities to meet changing patient demand, and invest in new technology. The nature of health care delivery is changing. Hospitals not only need to meet rising outpatient demand, but also need to expand critical care capacity to serve older and sicker patient populations that remain in inpatient beds. The rapid infusion of new technologies is steadily improving care, but the investment requirements to keep pace are staggering. While a traditional X-ray machine costs $175,000, a more advanced CAT Scanner—now standard in most hospitals—costs $1 million, and the next round of technology, the PET scanner costs $2.3 million.

But hospitals are finding it difficult to access the capital essential to ensure that our health care system can continue to provide the same high quality of care upon which our patients depend.

"Access to capital markets for most hospitals remains very expensive, and spending for capital improvements is a fraction of what it was before 1997... hospital balance sheets remain weak... they will need sustained profitability before access to capital can return to 1997 levels. In order to achieve sustained profitability, more of the cuts should be restored and Medicare payment updates should at least account for inflation."

— MBIA Insurance Corporation, January 2002 letter to MedPAC

Hospitals facilities are aging...

Median Average Age of Plant in Years

![Graph showing the median average age of hospital plant facilities from 1990 to 2009.](image)

Source: CHPS: The 1994 Almanac of Hospital Financial & Operating Indicators; The 1995-97 Almanac of Hospital Financial & Operating Indicators; and The 2001 Almanac of Hospital Financial & Operating Indicators
Hospitals are facing difficulty accessing the capital needed to meet growing demand, replace aging facilities, and update technology.

...and the cost to keep up with advanced technology is staggering...

<table>
<thead>
<tr>
<th>&quot;Traditional&quot; Technology</th>
<th>Contemporary Technology</th>
<th>Next Round Technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-Ray Machine</td>
<td>CAT Scanner</td>
<td>CT Functional Imaging with PET</td>
</tr>
<tr>
<td>$175,000</td>
<td>$1,000,000</td>
<td>$2,300,000</td>
</tr>
<tr>
<td>Open Surgery Instrument Set</td>
<td>Laparoscopic Surgery Set</td>
<td>Robotic Surgical Device</td>
</tr>
<tr>
<td>$10,000</td>
<td>$15,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Cardiac Balloon Catheter</td>
<td>Stent</td>
<td>Treated Stent</td>
</tr>
<tr>
<td>$500</td>
<td>$2,300</td>
<td>$5,000</td>
</tr>
<tr>
<td>Scalpel</td>
<td>Electrocautery</td>
<td>Harmonic Scalpel</td>
</tr>
<tr>
<td>$20</td>
<td>$12,000</td>
<td>$30,000</td>
</tr>
</tbody>
</table>

"... continued market forces such as increased labor, pharmaceutical, and supply expenses, and growing liability insurance costs present obstacles to sustained advancement."

— Fitch Ratings, January 2002 Hospital Outlook

...but with more bond downgrades than upgrades, hospitals are finding access to capital difficult.

Number of Bond Rating Upgrades and Downgrades
Non-profit Hospitals, 1993 - 2001

Source: ©2002 University Health System Consortium

Source: Standard & Poor's Commentary "Hospital Stabilization Expected to Continue in 2002 — But for How Long?" January 11, 2002
Payment shortfalls from Medicare and Medicaid make it difficult for hospitals to meet current challenges.

Hospitals have received Medicare payment updates less than inflation for 13 of the last 15 years...

...resulting in a 21 percent payment gap.


Source: Centers for Medicare & Medicaid Services, Center for Medicare Management, 1998-1995
Update as a Percent of Market Basket uses the large urban payment update

Source: Update factors as presented in CMS, Health Care Industry Market Update, Acute Care Hospitals; uses large urban payment update
A hospitals strive to meet the challenges of workforce shortages, increased demand, regulatory burden, and the rising costs of providing care, the federal government—as the payer for half of hospital volume—plays a critical role.

Each year the Centers for Medicare & Medicaid Services calculates the rate of inflation for the goods and services hospitals need to buy in order to deliver inpatient services. At the inception of the Medicare inpatient prospective payment system, hospital inpatient payment rates were to be updated by this market basket rate each year. But hospitals have rarely received a payment update equal to inflation. In fact, large urban hospitals have received payment updates less than inflation for 13 of the last 15 years. The cumulative impact of this payment shortfall relative to inflation is over 21 percent.

In order to maintain financial viability as Medicare payments were falling in real terms, hospitals have had to cut costs dramatically. Hospitals have reduced length of stay and eliminated excess capacity. But after 15 years of belt-tightening, it is becoming apparent that there is little fat left in the system. The decline in length of stay has flattened out, an increasingly stressful hospital work environment is contributing to the workforce shortage, and rising rates of ambulance diversion indicate that capacity has become constrained in many parts of the country.

By 2005, 65 percent of hospitals are projected to lose money serving Medicare patients.

The federal government must not continue to cut resources from our nation’s hospitals—resources needed to ensure the foundation of our health care system remains sound.
Over 54 million people live in areas served by about 2,200 rural hospitals. Because of their small size—an average of 58 beds compared to 186 for urban hospitals—rural hospitals have had great difficulty absorbing the impact of policy and market changes. In the last decade, 186 rural hospitals have closed, and today more than a third of those remaining are losing money.

Rural hospitals face challenges common to all hospitals, but their unique characteristics increase their vulnerability.

- The workforce shortage is felt by all hospitals, but the geographic isolation of rural hospitals and lower wages make it even harder to fill vacant positions. Fewer professionals per job class mean that overtime often is not a realistic option to fill gaps and temporary workers are less available.

- Despite a smaller patient base, rural hospitals still have to maintain a broad range of services to meet the health care needs of their communities. But with fewer patients over which to spread these high fixed costs, costs per case tend to be higher.

- The older population of rural areas leads to a higher Medicare patient mix, exacerbating the impact of recent policy changes.

- Nearly half of gross revenues for rural hospitals come from outpatient care compared to only a third for urban hospitals. Often the only health care resource in a community, a greater percentage of rural hospitals offer home health and skilled nursing services. Medicare margins for outpatient care, hospital-based home health and skilled nursing services tend to be significantly below costs and were hit harder by the Balanced Budget Act of 1997 even after subsequent refinements.

Not surprisingly, many rural hospitals lose money serving Medicare patients and the situation is getting worse.

Just in the last decade,

186 rural hospitals have closed.

Rural Hospital Closures, 1990-1999

Source: U.S. Department of Health and Human Services, Office of the Inspector General

As rural hospitals provide more and more outpatient care...

Outpatient Revenue as a Percent of Total Gross Revenue
Rural and Urban Community Hospitals, 1980-2000

Source: AHA Annual Survey
Unique characteristics make rural hospitals particularly vulnerable to these current challenges. Losses from non-inpatient services have become an increasing concern... and are contributing to a downward trend in overall Medicare margins.

Inpatient
Outpatient
Home Health
SNF

Medicare Margin by Service for Rural Hospitals 1997 and 1999

Total Medicare Margins for Rural Hospitals, 1996-2000

Source: MedPAC

Payment reductions jeopardize the critical and multi-faceted role teaching hospitals play in our health care system.

Teaching hospitals face significant Medicare cuts... as they strive to maintain their academic missions...

Projected Total Medicare Payments to Teaching Hospitals (in billions), 1998-2005

Distribution of Mission-Related Costs for All Teaching Hospitals, 1998


Source: The Lewin Group analysis of the cost of teaching hospitals’ multiple missions, funded by The Commonwealth Fund. Excludes the costs of uncompensated care.
Our nation’s 1,100 teaching hospitals:

- provide training to over 75,000 medical and dental residents each year;
- house much of our nation’s capacity for highly specialized services and advanced technology, and stand ready to respond to the most critically ill and injured patients;
- care for a large portion of the nation’s poor and uninsured people; and
- conduct clinical research into new procedures, technology and medications to support treatment breakthroughs in medicine.

Teaching hospitals rely on revenues from public and private payers to help fund mission-related activities, but pressures from both sides are making it more difficult for teaching hospitals to maintain their missions. Medicare payments are declining relative to inflation, Medicaid pays less than the cost of care, and the private sector is less and less willing to make up the difference.
These cracks threaten the foundation of our nation’s health care system—our community hospitals:

- Worker shortages
- Growing number of uninsured people
- Rising demand and constrained capacity
- Decreased access to capital
- Regulatory burden
- Payment shortfalls for Medicare and Medicaid
- Rapidly increasing costs
We must take action now to:

... make sure payments are sufficient to cover rising costs and support financial stability;

... build a health care workforce that can meet the rising demands of our aging population;

... ensure caregiver time goes to patients, not to paperwork;

... improve access to care for uninsured populations;

... provide hospitals with access to capital to build and maintain facilities and keep pace with technological change; and

... address the growing crisis in the medical liability insurance market.