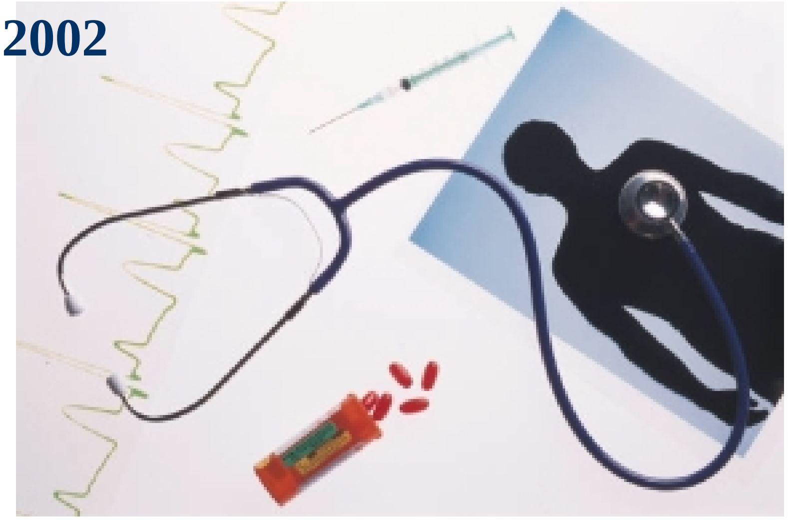
Healthcare Strategic Environmental Scan - 2003

Strategy Development Department

October 2002



CATHOLIC HEALTH EAST

Introduction

This Strategic Environmental Scan presents information on the economic impact of health care in society, the attitudes and demographic trends shaping the future, and the interplay of disease and new pharmaceutical treatment. It also examines the struggle of health care providers to improve patient care and cope with a growing shortage of qualified clinical workers. Information technology holds promise to transform health care as it is accepted by consumers and physicians and will be discussed as well. Finally, important to Catholic health providers are several issues including the growing uninsured population in light of the increasing financial demands facing health plans, employers, the government and consumers; the effect of the Church's recent scandal, especially on fund-raising; various state legislative issues in reproductive health and health benefits; and the development of new forms of sponsorship.

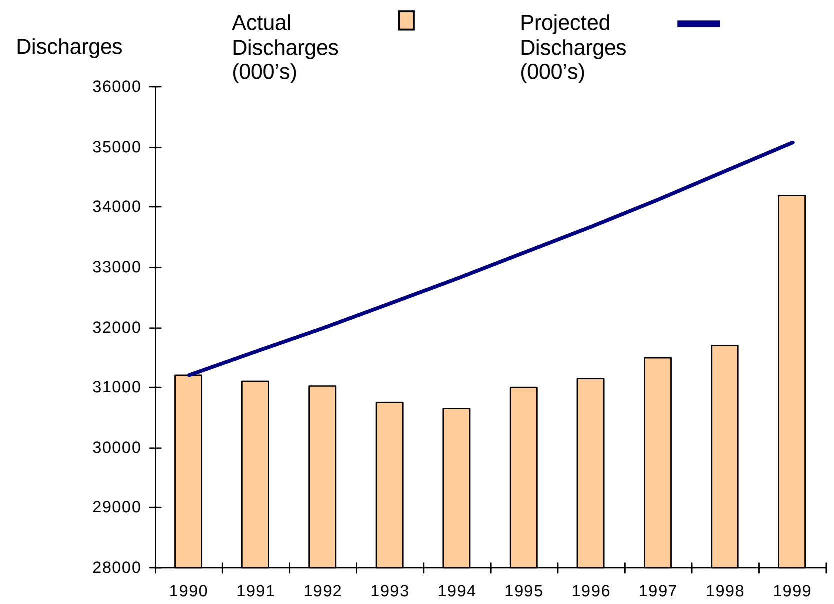
Historical Perspective

Over the past decade, two factors significantly impacted hospital utilization – managed care growth (in particular Health Maintenance Organizations – HMOs) and the movement of diagnostic and therapeutic modalities to outpatient settings.

In the 1980's, hospitals built capacity to handle an anticipated increase in inpatient demand. But a faltering economy and skyrocketing health costs (both health insurance premium costs in the private sector and the cost of providing Medicare services in the government sector) forced employers and the federal government to demand lower-priced alternatives. Hence, the birth of managed care – which controlled utilization of inpatient health care services and thus could be offered at a lower price to employers and the government. The effectiveness of managed care in controlling inpatient utilization is shown in Chart 1. By the early 1990's, hospitals faced excess capacity and higher operating costs than reimbursements covered.

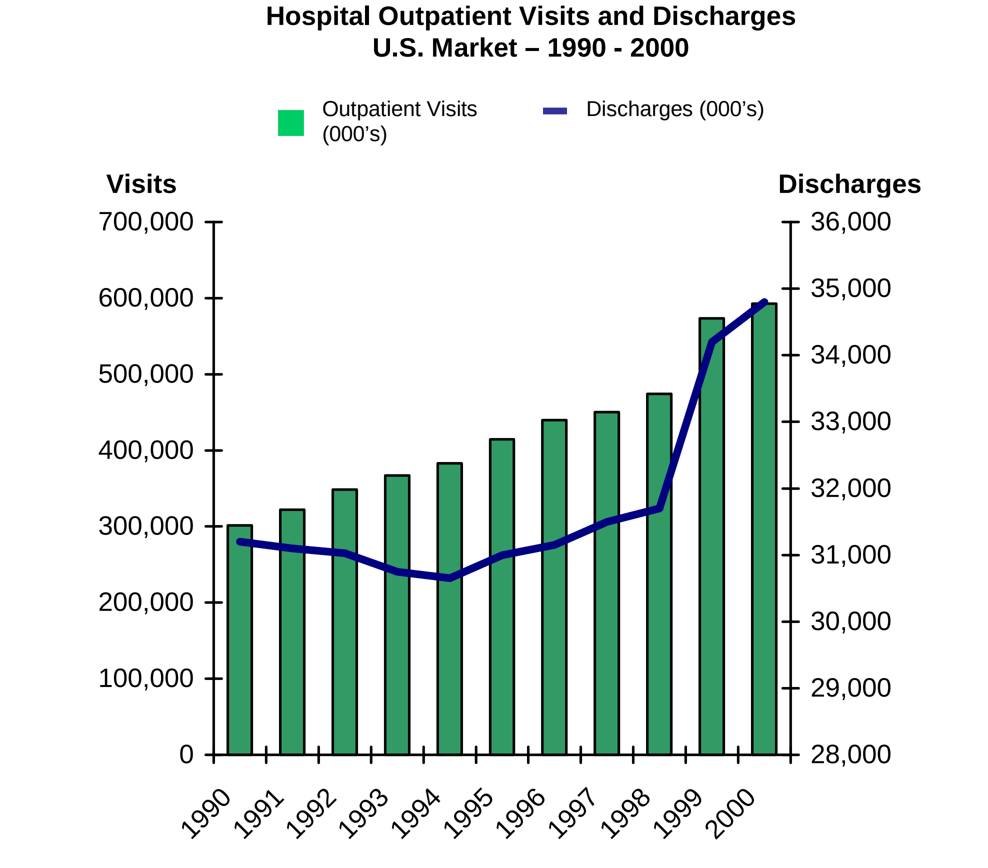
In 1997, the federal government passed the Balanced Budget Act, which further negatively impacted Medicare reimbursement rates, compounding hospitals' financial woes. From 1992

Chart 1. Inpatient Hospital Discharges U.S. Market, 1990-1999



Sources: Hospital Statistics, AHA (reprinted by Modern Healthcare December 2001); U.S. Census Bureau (*) Based on a population-based extrapolation derived from actual (1990 – 1999) U.S. Census Bureau population data through 2000, the number of staffed hospital beds fell 11.5% from 1.3 million to 1.15 million.[i] Between 1988 and 2001, 684 hospitals in the United States closed.[ii] In an effort to find economies of scale and enhanced operating efficiencies, 3,937 hospitals were involved in merger activities between 1995 and 2001.[iii]

Chart 2.



Source: Hospital Statistics, AHA (reprinted in Modern Healthcare, December 2001)

Managed care had minimal impact on the utilization of outpatient services. In fact, outpatient visits grew nearly 100% over the decade, and paralleled the population growth (see Chart 2.) In the late 1990's, consumers began to resist the controls that Health Maintenance Organizations (HMOs) placed on the care they were receiving. The economy was growing and unemployment was at a historic low. In combination, these factors helped to drive the movement of health plan enrollees to Preferred Provider Organization (PPO) health plans, which have fewer (if any) restrictions on health care services, and in turn, come at a higher price.

In 1998 and 1999, the utilization of inpatient hospital services rebounded. The trend of growing inpatient hospitalization has continued into the new millennium.

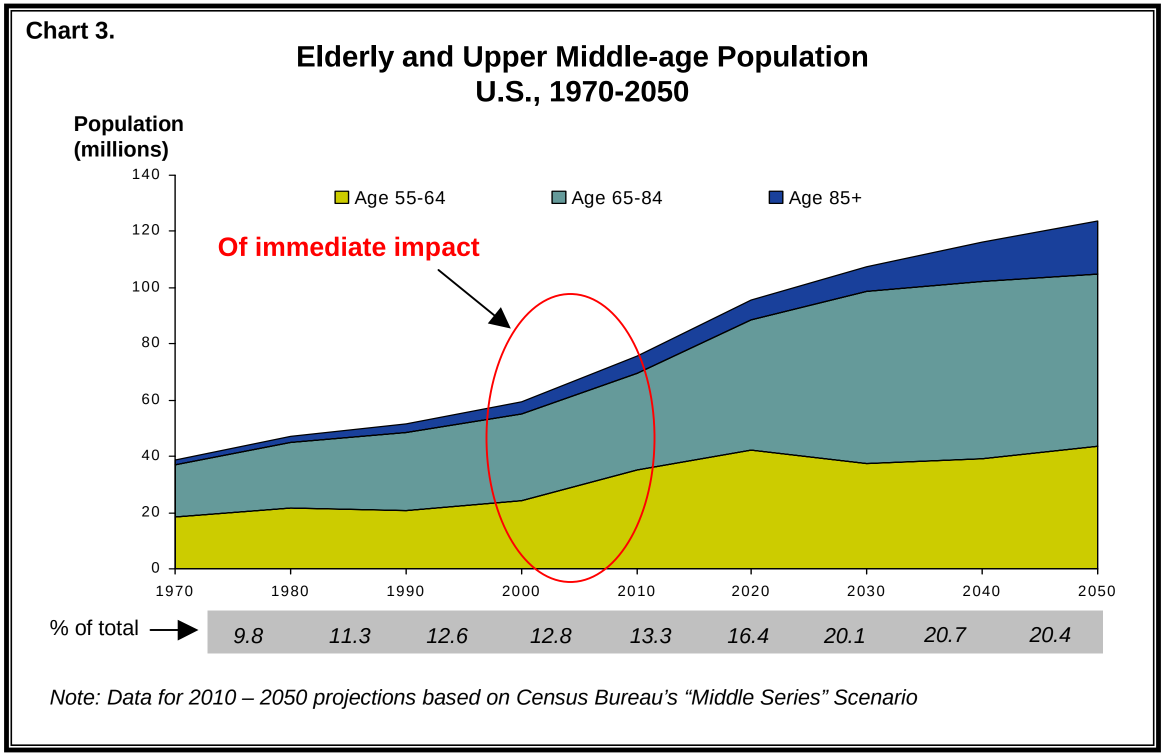
As health care providers look to the future, the landscape contains a multitude of forces that are shaping the demand for health care services – the trilogy of rising costs, demand for services and customer dissatisfaction are characterizing this decade and will impact the roles of the patients, the providers and the payers. One example of this impact already is the Leapfrog Group, a coalition of major U.S. employers that is drawing attention to the quality of care and patient safety issues.

Impact of Demographic Changes

In the remainder of the decade, two demographic factors will impact demand for health services - the swelling of the elderly and upper-middle age population and the anticipated international immigration.

By 2010, the baby boomers will be clogging the health care system and government resources will be stretched thin. In the U.S., health care spending is expected to consume 17% of the Gross Domestic Product, up from 8.9% in 1980, 12.2% in 1990 and 13.1% in 2000.[iv]

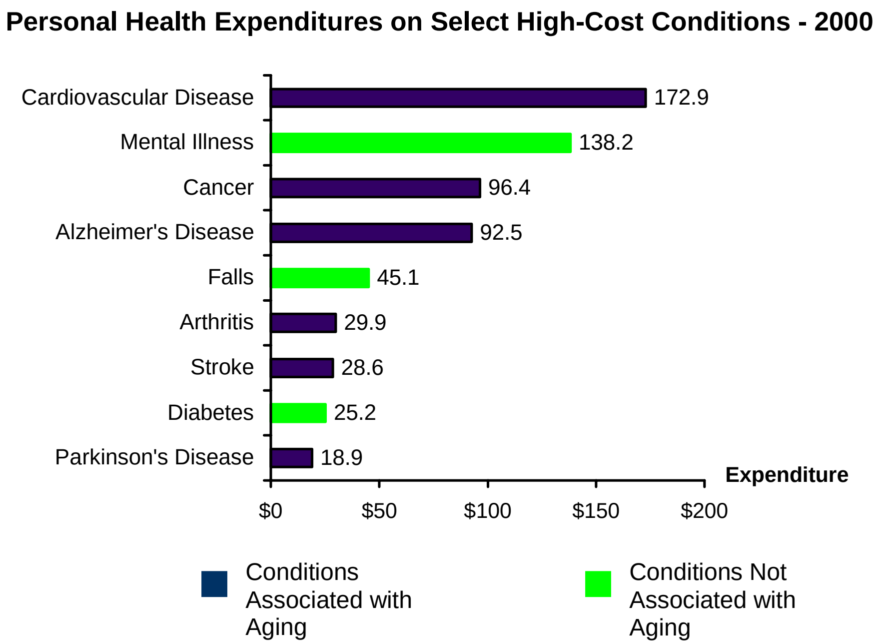
An aging population will drive resource use for key conditions (please refer to Chart 4 on the next page), and strain the acute and long term care provider system's ability to care for the increased demand.



Chronic conditions are the major cause of illness, disability and death in the U.S. today. In 2000, medical costs for people with chronic conditions totaled $774 billion (75% of total health care spending), a figure projected to rise to $1.07 trillion by 2020 (80% of total health care spending). Although Medicare was designed to cover acute care, it has essentially become a chronic care coverage program, as 80% of Medicare recipients have a chronic condition – and in 1999, accounted for 99% of total program spending.[v]

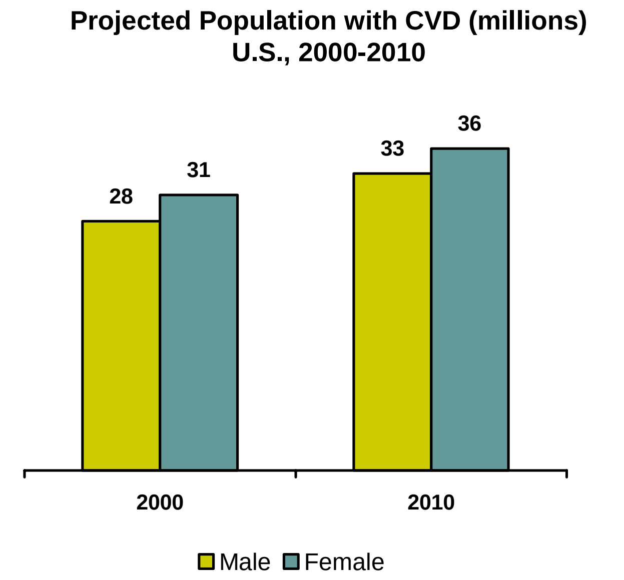
Cardiovascular disease and stroke combined were estimated to cost $298.2 billion in 2001 (direct and indirect costs).[vi] Cardiovascular disease is expected to grow 18% over the next decade and will accelerate between 2010 and 2020 as the baby boomers reach 65+ (please refer to Chart 5 on the next page.)

Chart 4.



Source: Duke University Center for Health Policy, Law and Management, "Cost of Illness by Disease"

Chart 5.



Sources: American Heart Association, 2001 Heart and Stroke Update; U.S. Census Bureau

Cancer prevalence will increase at an even faster rate, the result of an aging population ***and*** improving cancer survival:

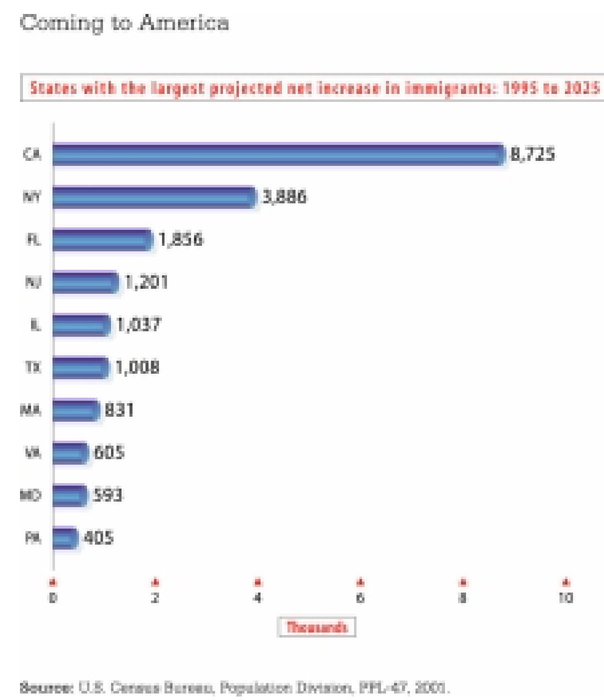
	2001	2010 (est.)	Growth
Breast	2.5 million	4.0 million	59%
Colorectal	1.5 million	2.2 million	47%
Prostate	1.7 million	3.9 million	136%
Bladder	0.7 million	1.1 million	51%
Uterus	0.6 million	0.9 million	39%
Melanoma	0.6 million	1.0 million	70%
Lung	0.5 million	0.6 million	35%

Source: SEER Database; U.S. Census Bureau; SG-2 Analysis

The nation's population is expected to grow by nearly 10% (~25 million people) due to the influx of international immigrants. Five of Catholic Health East's (CHE) states are among the top ten states expected to be the destinations of these immigrants (see Chart 6). This immigration has an impact on the diversity of the communities we serve, our patient populations and the potential workforce we are able to access. Each ethnic population has a different propensity for certain health conditions; the demand for services in a given market will be impacted by its ethnic make up. Health care providers will face the necessity of providing multi-lingual care responsive to the needs of many diverse cultures.

In summary, the key forces – the aging of the population with its higher utilization rates coupled with the increasing rates of coronary artery disease, stroke and cancer - point to an increasing demand for services and greater inpatient volume demand. An understanding of the ethnic make up a community's population is essential in estimating demand for services and developing service delivery modalities that are responsive to and consistent with the needs of those populations.

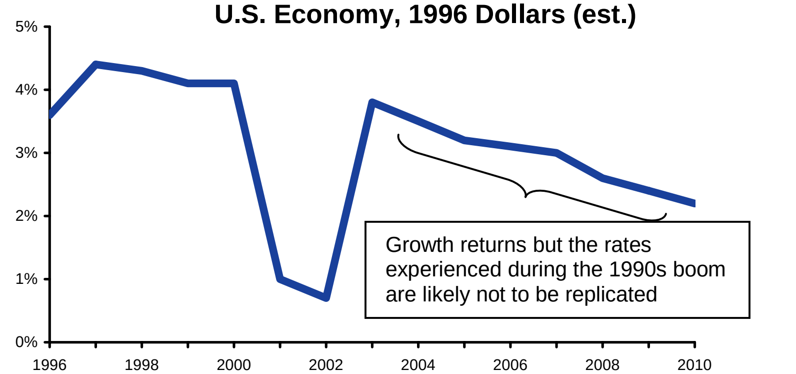
Chart 6.



Economic Impact

Chart 7.

Annual Growth in Real Gross Domestic Product (GDP) U.S. Economy, 1996 Dollars (est.)

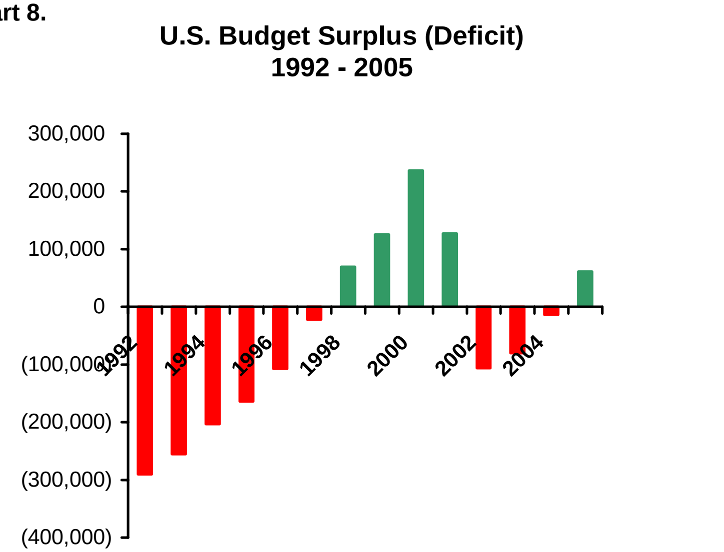


Source: Bureau of Economic Analysis, National Accounts Data, 2001 Annual Revision

The U.S. gross domestic product increased from $8.3 trillion in 1997 to more than $9.9 trillion in 2000. The percentage increase overall was less than the percentage increase in medical care expenses. The medical care CPI in 2000 was 260.8 compared to 167.3 for all other items excluding medical care.[vii]

The latest indicators (August 1)[viii] suggest that the economic recovery that seemed to be picking up steam in the first quarter slowed during the second quarter and economists warn of a "double-dip" recession, especially if consumer spending starts to wane.

Chart 8.



Source: OMB, Fiscal Year 2003 Budget, Historical Tables

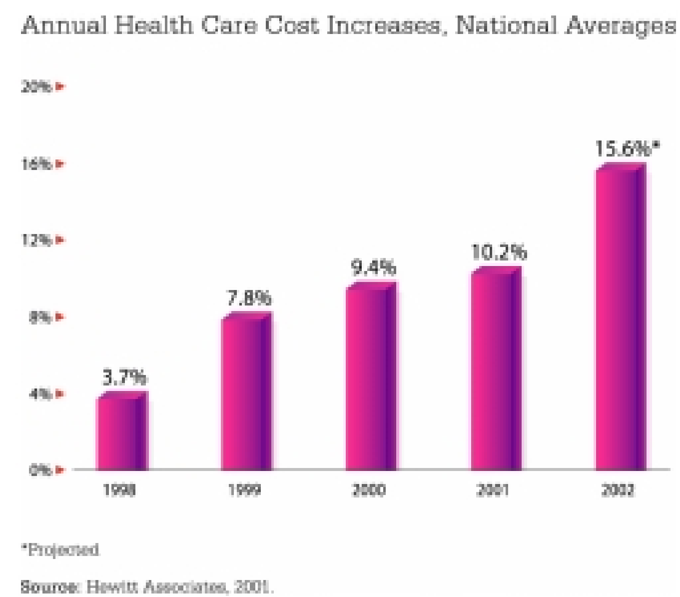
Anticipated federal budget surpluses have disappeared. Components of the $3 trillion reduction in the anticipated 2001-2010 surplus include:

Tax cut -	$ 1.5 trillion
Recession -	.7 trillion
War/security -	0.3 trillion
Ongoing programs -	0.3 trillion
Economic stimulus -	0.2 trillion

Many state budgets are stretched thin and it is expected that there will be a Medicaid funding crisis in many states with providers fighting for limited funds.

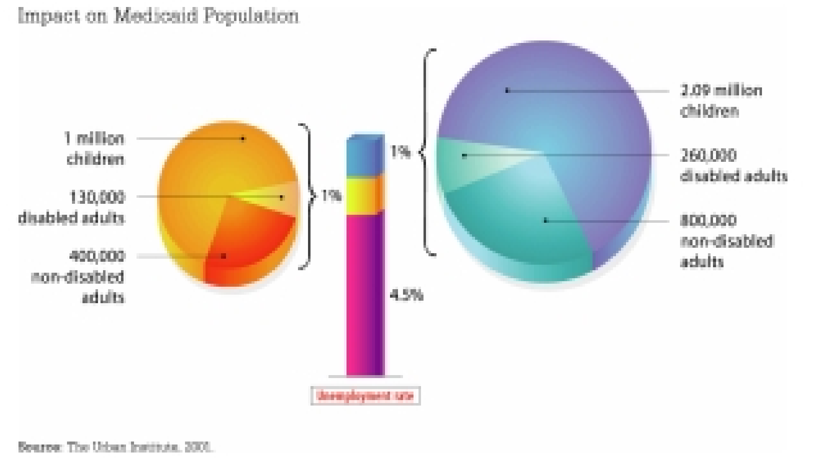
Health care cost inflation is at a ten-year high. Employers and the U.S. government have borne the brunt of rising health care costs. Studies indicate that health insurance premiums continue to rise at a faster rate than medical costs, with almost a 4.5% gap in 2000.[ix] Overall, employers reported average premium increases from 2000 to 2001 of approximately 10.2% and between 2001 and 2002 of 15.6%[x]. Caught between shrinking margins and rising health care costs, employers will once again accelerate the adoption of higher cost-sharing benefit plans.

Chart 9.



A slowing economy increases unemployment, which then leaves more people without health care coverage, which in turn increases the number of people eligible for Medicaid, and enrollment levels soon rise. Urban Institute researchers developed an estimate of the link between unemployment and increased Medicaid enrollment and found that a percentage point increase in the unemployment rate would increase the number of non-disabled adult enrollees by 400,000, children by 1,000,000 and the disabled by 130,000. The total number of beneficiaries would rise by 3.3 million if the unemployment rate jumped two percentage points. For every 1% rise in unemployment, the spending on Medicaid increases $2.7 billion – 56% of that paid for by the federal government and 44% of it paid for by state governments.

Chart 10.



While the number of uninsured declined in the late '90's, this trend has reversed and the number of uninsured rose in 2001 to 41.2 million or approximately 14.6% of the population[xi]. One in four uninsured Americans with chronic care cannot get the care they need.[xii] In past economic downturns, the number of uninsured has risen dramatically. There is no reason to believe that this economic cycle will be different in this regard. Those CHE states with the greatest number of uninsured include Florida at 17.5% and Georgia at 16.6%, ranking seventh and eighth highest in the U.S. in 2001[xiii].

The financial condition of hospitals has continued a pattern established over the past two years – weak balance sheets that have resulted in more credit downgrades than upgrades from the bond rating agencies, although the most recent data suggests that the pace of downgrades is slowing and a brighter future is predicted[xiv]. A cash crunch, expanding capital requirements and increasing costs have contributed to a challenging financial environment for hospitals. During the late 1990's hospitals subsidized operating losses with investment income. If Wall Street's bear market continues, this investment income will shrink further, having a devastating effect on hospitals' financial condition. The situation is expected to remain difficult.

In the past, health care has been considered "recession-proof"; in fact, in times of recession, utilization of services has actually increased, primarily for those conditions that are stress-induced. Some counter-balancing of the anticipated increase in services will occur because consumers (employees) will be sharing in a larger proportion of the costs due to different health plan designs.

Socio-cultural Factors

In the new millennium, many socio-cultural factors are at play in health care delivery, more so than in any previous "cycle" of the health care industry.

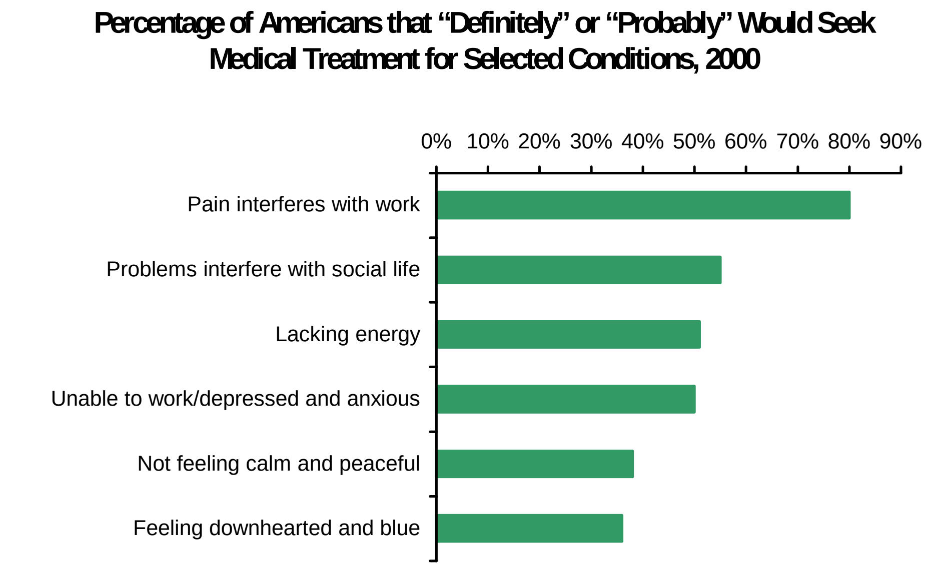
Socio-cultural Trend		Business Impact
▪ "Get it right or someone will pay"	→	▪ Increased malpractice premiums
▪ Increasing calorie and fat consumption	→	▪ Increased rate of coronary artery disease
▪ Expectations for health condition relief ▪ erectile dysfunction ▪ acid reflux ▪ allergies	→	▪ "New" demand for treatments ▪ Viagra ▪ Prilosec ▪ Claritin
▪ Improving exercise habits	→	▪ Reduced rate of congestive heart failure
▪ Access to the Internet	→	▪ Demand for specific treatment modalities

From 1997 to 2000, the public's perception of hospitals fell drastically. Hospitals' ratings fell from 77% (doing a good job) to 67%.[xv] The change in ratings was influenced by consumers' negative personal experiences, word of mouth, media coverage, and increasing out-of-pocket costs.

40% of Americans say they have personally suffered from a medical mistake – wrong diagnosis, wrong procedure, or an incorrect prescription or dosage from pharmacist. Almost half research their conditions in books and 31% use the Internet to follow up on a doctors' diagnosis or treatment recommendation.[xvi] Concurrently, the litigious nature of our society has skyrocketed. Physicians' malpractice premiums increased between 6 and 50% in 2001, depending on the state. Increases in Pennsylvania, Connecticut, New Jersey, New York and Florida jumped 10 – 40% in 2002, forcing physicians to practice defensive (more costly) medicine, lay off staff, defer equipment purchases, relocate their practices or quit practicing altogether.[xvii] Not only is affordability an issue, but accessibility is as well. One of the largest malpractice insurance providers, St. Paul, will cease this line of insurance effective January 1, 2003. According to an American Medical Association (AMA) report released in June 2002, five of CHE's states are in "crisis" – Florida, Georgia, Pennsylvania, New Jersey and New York.

Physicians aren't the only health care providers feeling the pinch of higher liability premiums – they are going up across the board. Hospitals are seeing increases between 25% and 300%, averaging 100% and long term care facilities are experiencing increases between 25% and 75%.[xviii]

Chart 11.



Source: *The Roper Center for Public Opinion Research, University of Connecticut*

Direct-to-consumer marketing by pharmaceutical and device manufacturers has increased significantly - 33% between 1999 and 2000 alone. In 2000, pharmaceutical companies spent $2.5 billion in direct-to-consumer advertising. The top five selling drugs in 2001 were Lipitor (treatment of high cholesterol), Prilosec and Prevacid (both treating stomach acid), Zocor (treatment of high cholesterol) and Celebrex (treatment of arthritis).[xix] Two effects are occurring with the direct-to-consumer advertising – Americans are not altering their lifestyle consumption habits (because they believe a drug can correct the situation) and they are demanding that their physicians prescribe the medications.

Consumers' expectations for what health care can "fix" are rising. Antidepressants are the top-selling category of drug - with $12.5 billion in retail sales, up 20.5% between 2000 and 2001.[xx]

In summary, the increase in obesity and high-fat diets, the increasing expectations of consumers for what health care can "fix", and the lower stigma associated with seeking behavioral health care and "lifestyle" care will cause the demand for health care (and its cost) to increase slightly.

Many not-for-profit health care providers have only recently begun to tap their fund development potential. It is uncertain how the recent child-abuse scandal that has caused the Catholic Church to reel may impact the ability of Catholic health providers to raise funds for key projects and charitable purposes.

Impact of Changes in Health Plan Design

A combination of forces is currently driving health plan premium levels upward – rising occupancy rates, hospital consolidation, the squeeze on hospital and physician profits, strong health plan profits, and consumer demand for the broadest networks of providers and most inclusive and comprehensive health plan coverage. Employers will be forced to build higher cost sharing into benefits. Consumer-directed plans will take many forms:

- Slice MSA-style offerings by niche players (*Lumenos*, *Definity*)
- Integrated, portfolio-style offerings by mainstream health plans (*FlexScape*, *SmartSuite*)
- Inpatient hospital (and ultimately physician office visit) copay tiering
- More cost-sensitive employee premium contribution strategies
- Models yet to be invented!

Common Themes

- *Broader consumer choices*
- *Alignment of cost-sharing incentives with consumer choices*
- *Consumer decision support*

In the past, higher cost sharing with consumers has proven to reduce the use of services. The paradox is that it reduces the use of both unnecessary *and* necessary health services.

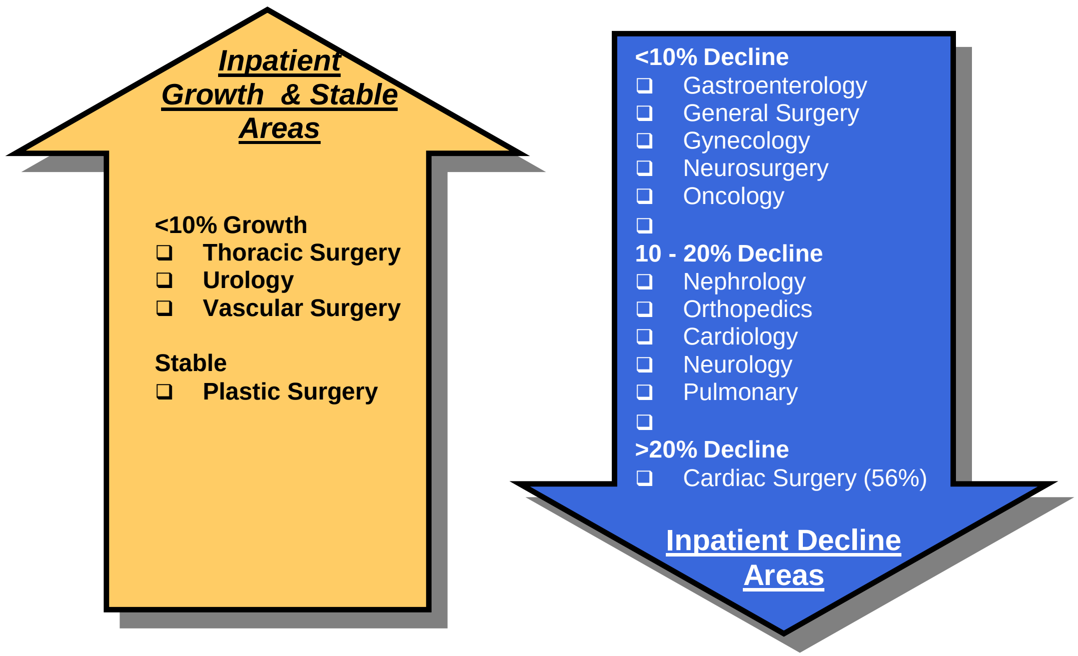
In the United States, we are in the "tail-end" of a rebound from managed care. By the mid-2000's, it is expected that the balance of power will shift back towards health plans. Consumer-directed health plans and increased consumer cost sharing will suppress demand for bed capacity and increase the demand for diagnostic tests and pharmaceuticals.

In addition, several state legislatures are debating whether health plans must include contraceptive coverage. For Catholic employers, this is in direct conflict with Catholic teaching. The impact of these legislative mandates is yet to be determined.

Impact of Technology

Several technological innovations will impact health care service delivery including minimally invasive surgery, immune modulation, imaging developments, targeted drug therapies, implantable devices, genetic engineering and medical informatics. Depending on the technology, its effect will be to increase *or* decrease utilization, shift utilization to another modality or setting, and to create demand. In addition, the timing of the adoption of these new technologies will have a significant impact on hospital volumes.

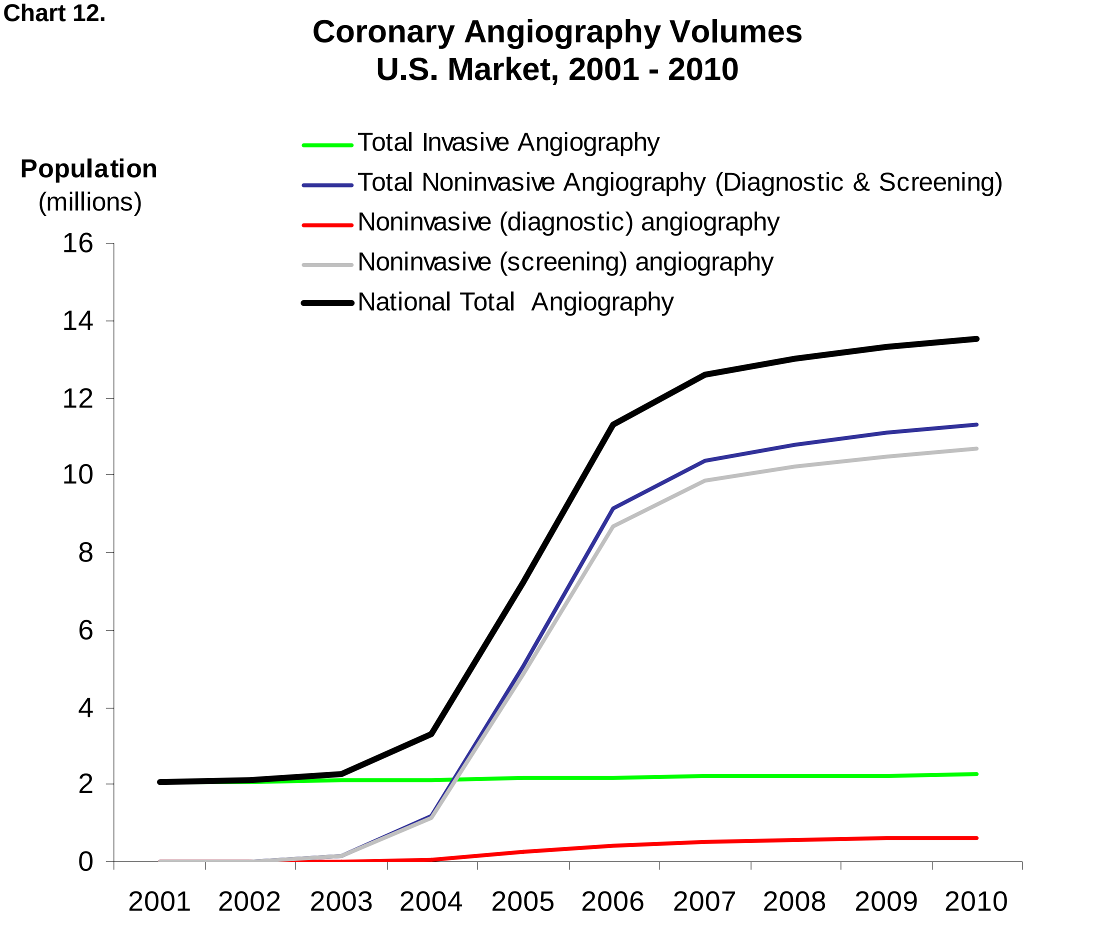
One newly formed consulting group that is looking at the impact of technology and innovation on demand for inpatient services is SG-2 out of Chicago. They have created a database (Impact of Change or IoC™) that contains all DRGs and >180 factors that will affect future demand/volume. Their cadre of clinical experts, researchers and statisticians has estimated the cumulative impact of these technologic developments on inpatient services through this decade as follows:



Source: SG-2 Analysis, 2002; IoC™ Database
Note: Total technology-driven volume change (including technology-driven outpatient shift) 2000 - 2010

Non-invasive angiography will increase and shift utilization as well as create new demand. Organizations will need to choose whether or not to invest in Cardiac Catheterization Labs or Multi-Slice CT suites.

Chart 12.



Sources: Diagnostic Imaging.com; Philips Medical Systems interviews; Imatron, Inc. interviews; SG-2 Analysis, 2002; IoC™ Database

The adoption rate of new technology will affect the shift in utilization. One recent example is the development of stent technology. Stents were approved in 1997 and the volume rose from a baseline of 200,000+ cases per year to over 800,000 cases per year in two years. Coronary Artery Bypass Grafts (CABG) began to decline the same year that stents were approved. There were nearly 1/3 fewer CABG performed in 2000 than in 1997.

It is anticipated that multiple factors will contribute to a precipitous decline in future CABG volumes by as much as 50%; however, drug-eluting stents, minimally invasive and off-pump procedures will attenuate this decline later in the decade; cardiac surgery will become increasingly reliant on valve procedures. In the future, patients and physicians will have a choice – cardiovascular surgery or cardiac cath.[xxi]

There are other significant developments on the near-term horizon:

- ☑ Imaging advances, including the 16-slice CT and integration of functional and anatomical images (PET/CT). An illustration of the application of this technology is shown in the pictures to the right.

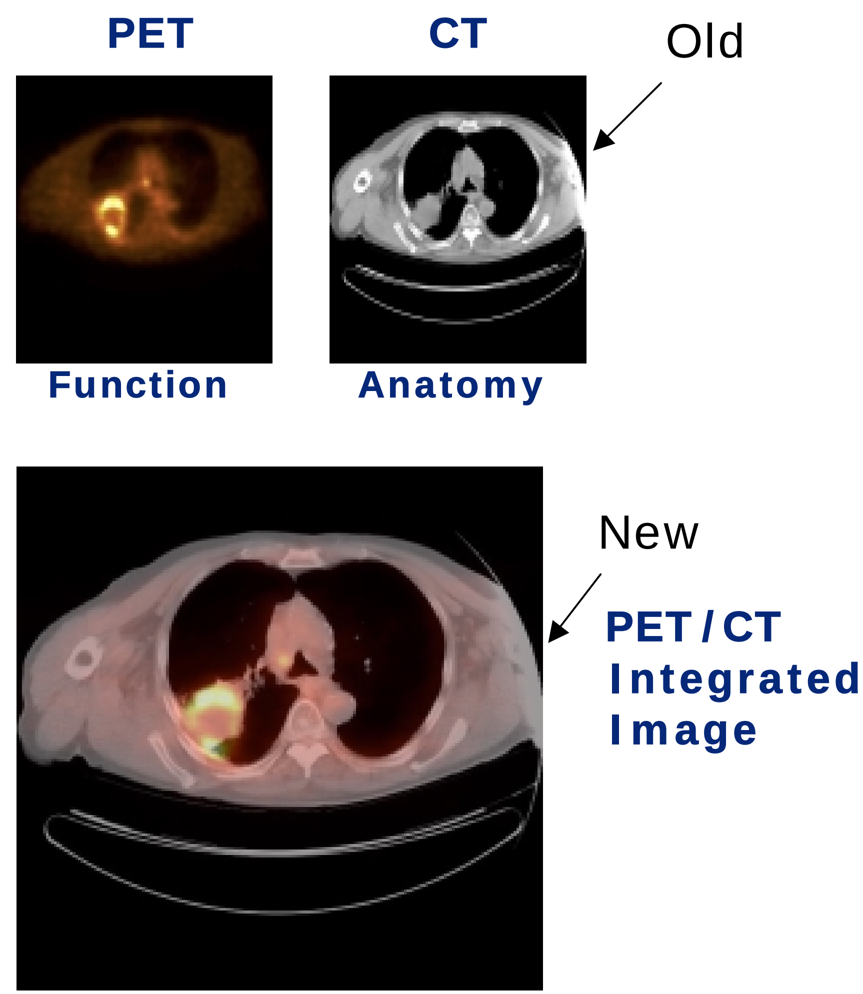
- ☑ Virtual colonography - which will reduce colonoscopy volumes by 2/3 over the next decade and screen an additional 3 million people who would not otherwise have undergone colonoscopy (anticipated to begin in 2003).

- ☑ Targeted drug therapies that will reduce inpatient admissions, especially in cardiovascular and oncology care.

- ☑ Minimally invasive surgery which will reduce inpatient procedures and lengths of stay for those that remain inpatient:

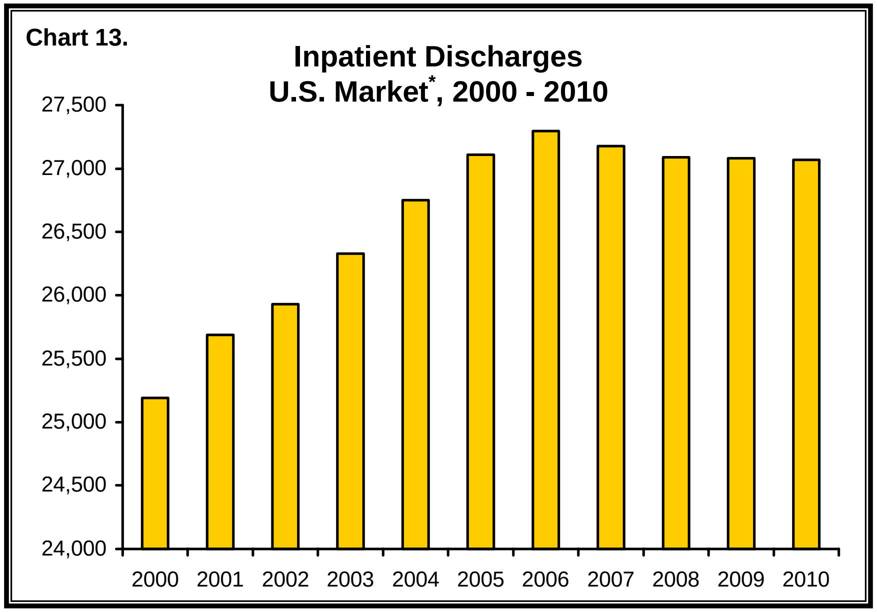
  Orthopedics – (26%)
  Urology – (16%)
  Neurosurgery – (14%)
  Cardiac Surgery – (12%)
  General Surgery – (9%)

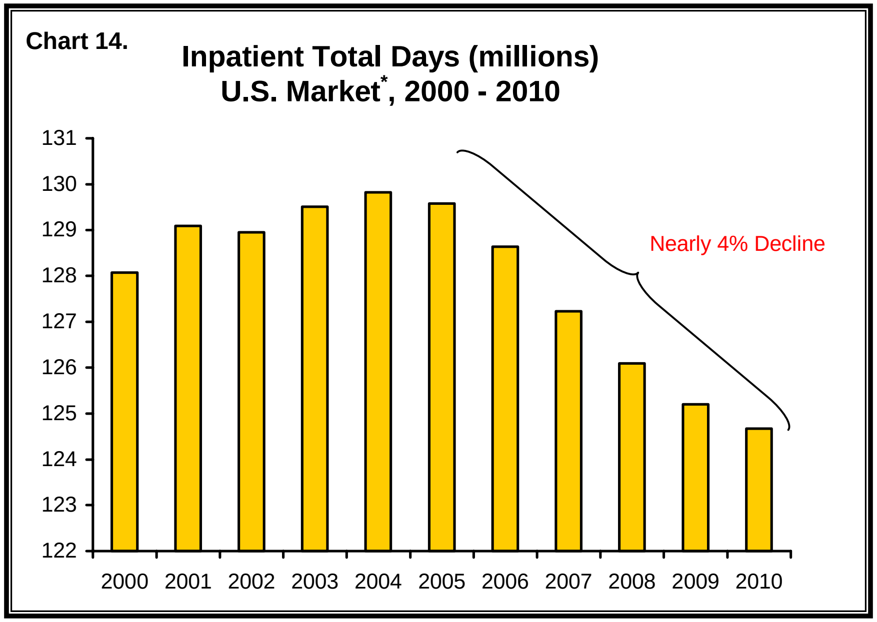
Comparison of Imaging Modalities



Surgery will continue its evolution to shorter patient stays – from an average length of stay of 5.7 days in 2000 to 4.7 days by 2010. Overall, surgery will expand due to minimally invasive techniques taking hold, but these shifts will result in more outpatient procedures, resulting in fewer inpatient admissions for surgical procedures.

While on the surface, it would seem that the increasing demands of the aging population coupled with the population growth due to immigration would create increased inpatient volume (both in days and discharges), overall the cumulative effect of technological developments will offset these increasing demands - inpatient admission rates will continue to rise until 2006, at which time they will begin to fall. It is anticipated that patient days will peak in 2004 and then begin to drop rapidly, a result of both flattening discharge rates and decreasing length of stay.

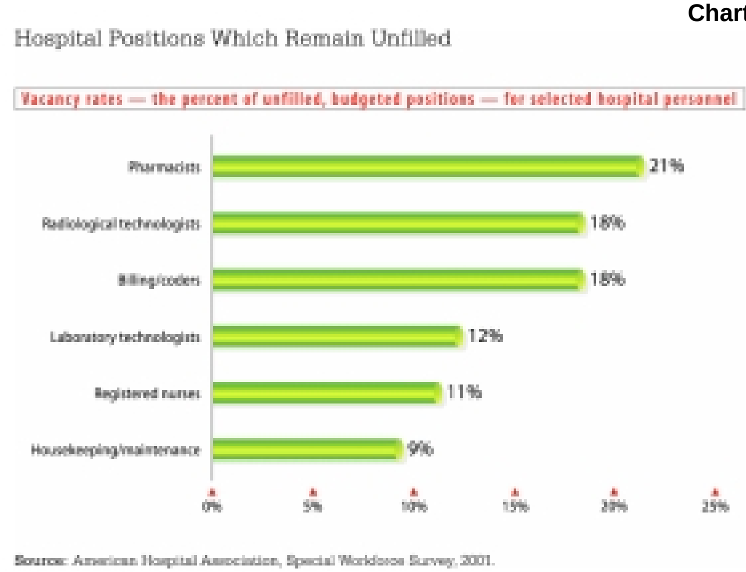




(*) Does not include Obstetrical, Normal Newborn, Neonate or Psychiatric utilization
Sources: National Center for Health Statistics; National Hospital Discharge Survey (NHDS), 2000; SG-2 Analysis, 2002; IoC™ Database

Other Forces – Workforce Shortage

Chart 15.



According to the American Hospital Association's recent workforce survey, the health care workforce shortage is growing across both urban and rural America. Although registered nursing positions represent 126,000 of the 168,000 unfilled positions, there is a growing need for other qualified staff. The situation is especially acute for pharmacists and radiology technicians. With the increase in paperwork required by third-party payers and the government, administrative employees such as billing/coding staff are also in short supply.[xxii]

As the number of people requiring health care increases with each year, hospitals and continuing care facilities are having difficulty recruiting specific types of workers. The difficulty in finding skilled workers causes many problems, from delays in care delivery to a reduction in inpatient and outpatient capacity. The battle to find, recruit and retain qualified workers will continue. Every year since 1996, the number of nursing school graduates has decreased, with a total decline of 20% between 1996 and 2000.[xxiii] The demand for nursing assistants in long term care is expected to increase more than 25% this decade. Turnover rates in nursing homes average about 45%.[xxiv] The biggest factor contributing to this is the low value placed on these occupations by society – which translates into wages paid.

Exacerbating the situation caused by the decline in numbers of new nursing graduates, the current RN workforce, on average is aging and will continue to get older, at least through 2010. The greatest growth will be in nurses in their 50's, the group that is nearing retirement and will soon exit the workforce. After 2010, the population of nurses in their 20's and 30's is expected to increase, lowering the average age of the nursing workforce.

Health care providers are developing innovative ways to attract and retain professional staff. More traditional ways (signing bonuses, enhanced benefits, etc.) have proven to be costly and ineffective in the long term. Organizations that are adopting service excellence programs, enhancing employee relations and developing life-stage benefit structures are having the most success. As the populations in our communities become more diverse, so does our potential workforce. Creating a culture of inclusivity is one aspect to successfully recruiting and retaining these individuals.

A different approach to the workforce shortage is to evaluate and re-design care processes, utilizing different skill mixes than are in place today. Better employment of information technology tools for enhanced productivity may help alleviate some of the shortage as well.

While most of the focus has been on the work force employed by hospitals and long term care providers, there is a growing awareness that the United States faces a looming shortage of physicians. Several factors contribute to this including the aging of the physician workforce itself, the increasing medical needs of an aging population, and the increasing proportion of women enrolled in medical schools (who, because of child-bearing and family responsibilities work fewer hours per year).[xxv] The medical malpractice crisis (as described earlier) is also contributing to the decline of physicians in the workforce.

In the near term, the impact on health care provider organizations will be one of increasing costs – signing bonuses, higher wage rates, more overtime and agency costs, and enhanced benefit structures – all in an effort to recruit and retain enough nursing and professional staff to keep the beds adequately staffed.

Other Forces – Information Technology

Advances in the use of Information Technology have proven to bring advantages to multi-provider systems. Centralized billing and electronic claims processing have expedited reimbursements and reduced costs. Physician order entry systems have been proven to reduce errors and improve patient safety.

According to a recent report, health care information technology spending has increased every year since 1993 (see Chart 16). The rate of spending slowed between 1998 and 2001 when on average it rose only 7.8% per year compared to the double-digit increases earlier in the decade. From 2001 to 2004 it is expected to increase 28% or just over 8% per year.[xxvi]

Chart 16.

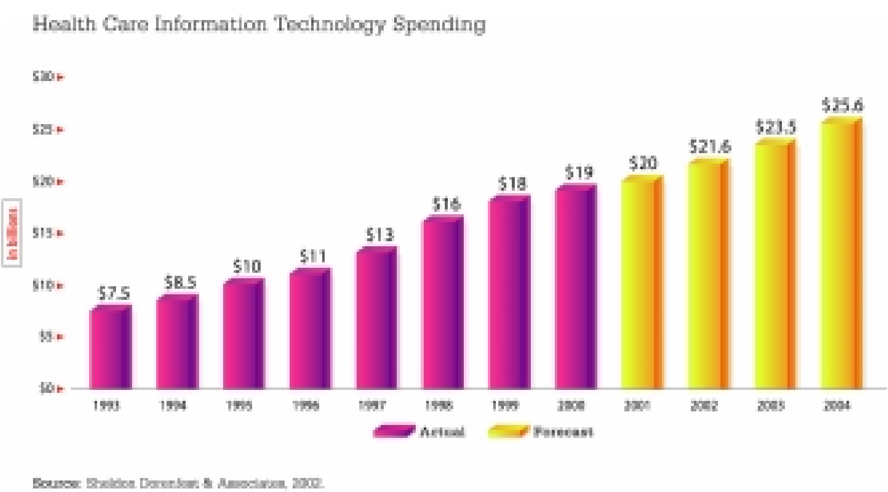
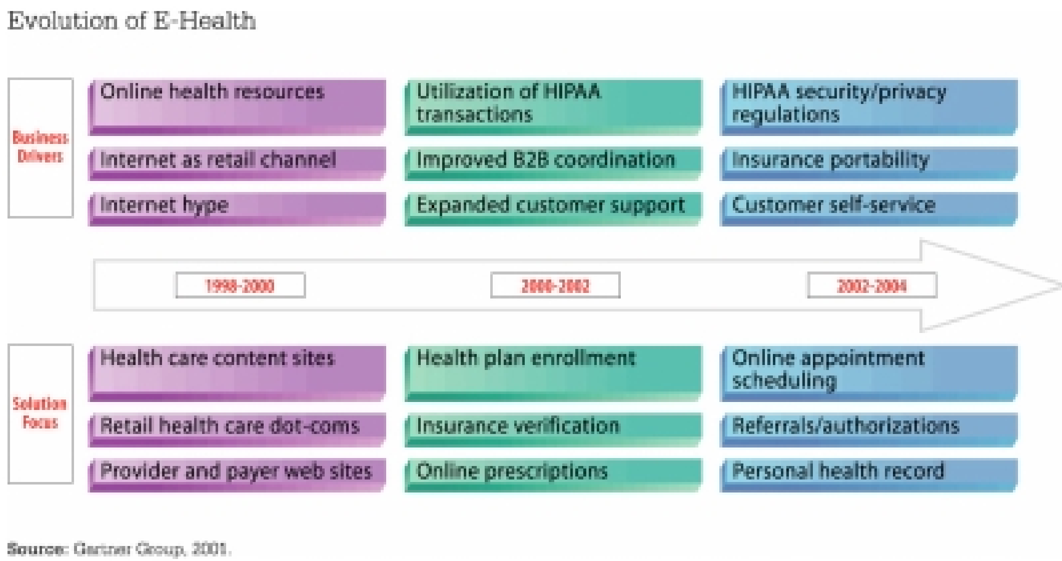


Chart 17.



E-health is an evolving market that will bring profound changes in the interactions between patients, providers, pharmacies and payers over the next few years. A general trend of rising consumerism (consumer demand for improved customer service and convenience in managing health care) is at the forefront of e-health and will drive the adoption of particular technologies.

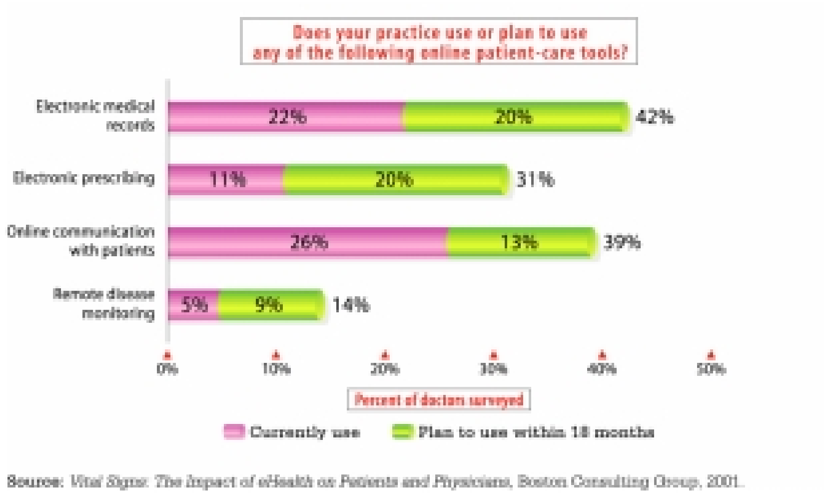
Underlying the technology developments for improved customer service through the Internet will be HIPAA security and privacy regulations. Some have estimated that the cost of HIPAA compliance will exceed that of Y2K.

Reports such as those released by the Institute of Medicine (IOM), the Center for Medicare and Medicaid Services (CMS) and other non-government agencies across the continuum of care will facilitate getting data on quality of care into the hands of consumers, facilitated by on-line technologies. This proliferation of information will help create greater accountability amongst health providers and alter the balance of physicians as the primary source of clinical information for patients.

Over the past few years, physician use of the Internet in the clinical work area, in their offices, and in their homes has grown, such that only 7% of physicians are not online anywhere.[xxvii] 89% of physicians report spending at least 3 hours per week online researching clinical treatment information and obtaining the latest medical news.

Chart 18.

About 1/3 of doctors use/plan to use online patient care tools…



As the benefits and efficacy of Internet communications become more pronounced, the new technologies will become more tightly integrated into medical practices and alter or replace less efficient technologies. About 1/3 of physicians are using or plan to use electronic patient care tools in their practices (see Chart 18).

The Internet has the potential to erase one of the biggest handicaps of the health care industry – relay speed. It can slash the time it takes to make referrals, get test results, get paid, find patients for clinical trials, disseminate best practices and share cost information. It will quicken the pace for the adoption of new ideas, new therapies and new measurements. E-business can improve business performance through connectivity. Health care organizations will need to have access to and commit the capital necessary to build the framework to keep them competitive.

In addition, the Internet has the potential to widen the gap in access for the underserved.

Other Forces – Physician Economics

The physician marketplace and the relationship between physicians and hospitals are tumultuous and in transition. The substantial and often symbiotic relationship between hospitals and physicians is being eroded by economic forces – shrinking reimbursement from all payer types, exploding malpractice premiums and rising support staff costs. Increasingly, physicians are becoming more independent and are moving patient care out of hospitals and pursuing competitive initiatives (such as imaging centers and ambulatory surgery centers). The challenge for hospitals and systems is how to redefine the role of the medical staff to help address many complex issues and foster collaboration between hospitals and physicians rather than competition.

Other Forces – Aging Physical Plants

In the 1990's, hospitals were discouraged from building additional capacity or making physical plant improvements. Hospitals are decaying beneath the surface – out-of-date chillers and boilers, asbestos in walls, outdated signage that cannot be read by aging or non-English speaking patients. Between 1994 and 1998, the average age of plant grew 8%, according to the Center for Health Industry Performance Studies (CHIPS).

Many hospitals are experiencing an Emergency Department crisis. The American Hospital Association surveyed 1,501 hospitals in the fall of 2001 (which represents 36% of all hospitals with EDs) and found that 62% of them are "at or over" operating capacity. One-third of the hospitals surveyed are on ED diversion, and 15% are on diversion 20% or more of the time. While increased volume is one cause (ED volumes are up 5% from 2000 to 2001), a lack of available critical care beds was the #1 reason cited for the diversion[xxviii].

This decade is expected to be one of booming construction for hospitals. Because expansion and construction take years to plan and complete, hospitals must look today at how their buildings should support their visions of tomorrow. It is critical to take into account the projected shifts in demand for services that have historically been high users of inpatient capacity, the changing expectations of consumers for convenience and efficiency, and the need to create an environment that maximizes the advantages of new clinical and information technology while designing facilities that are the most functionally-efficient as possible.

Cash reserves and investment income have suffered over the last two years because of the poor performance of the equity market. The demand for new capital will increase into the future, putting pressure on operating performance and margins. Providers and health systems in weak financial positions may not be able to make the physical plant changes or acquire new technology essential to their future viability.

Wildcard

The terrorist efforts of 9-11 have placed an unknown possibility before every sector of the American economy. A major escalation of military efforts could impact health care with a diversion of funding. Experts have noted for years that the United States was vulnerable to terrorism and the possible use of chemical and biological weapons. Community hospitals are being called upon to partner with the public health service to develop disaster preparedness plans. Prior to 9-11 an American Hospital Association study cited that only about 25% of U.S. hospitals were in some state of readiness for a chemical or biological incident. By February 2002, two-thirds had built a bio-terrorism response into their disaster plans and 76% had incorporated a chemical terrorism response[xxix]. Heightened disaster prepared efforts will divert resources from other initiatives health care providers should pursue.

2003 and Beyond

In light of the dramatic events of the past year, today's health care leaders face an even more challenging future. The current environment presents a great opportunity to address many of the challenges head on:

- With emerging forms of sponsorship and increased responsibility for lay colleagues, Catholic-sponsored healthcare providers must continue to develop leaders who live our core values.
- A common language must be developed to enhance the ability to communicate with one another, maximize synergies, and transfer knowledge.
- Providers must focus on the core business (taking care of people and patients) and creating value in order to strengthen their operational performance.
- A culture of inclusivity and service excellence must be created in order to better serve our patients, our employees and our physicians.
- An increased emphasis on quality and patient safety will be necessary to meet the requirements of regulators, accreditation bodies, independent rating agencies and consumers.
- Adequate funding must be generated through enhanced philanthropy and improved financial performance to sustain the Mission. Modification/elimination of services not core to the ministry must be evaluated.

Building on the heritage of religious sponsors, leaders in Catholic-sponsored health care must be willing to take risks to sustain and grow their Sponsors' Mission.

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