

Financial Challenges for California Hospitals

SEPTEMBER 2001

Background

When it comes to hospital systems, the state of California is a behemoth. California contains more hospital beds that generate more net patient revenue and expense than any other state in the nation. In 1999 the state's 409 acute care hospitals employed more than 300,000 people, discharged more than 3 million patients, recorded more than 23 million adjusted patient days, had an available bed capacity of more than 80,000, and generated more than \$35 billion in total revenue.

California hospitals also operate in one of the most competitive health care markets in the nation. This unique, heavily managed-care marketplace has resulted in a hospital system with relatively low cost, low utilization, and competitive costs to payers for hospital services. However, the very characteristics that have contributed to California's health care success also have helped create a serious and growing financial vulnerability among the state's hospitals.

When compared to hospitals across the nation, California hospitals function in a marketplace that poses a more formidable challenge to financial health. They operate in a highly competitive pricing environment for commercial patients, and federal budget reductions on Medicare payments have further exacerbated revenue pressures.

On the expense side of the equation, California hospitals confront a challenging climate relative to other hospitals in the nation. They have a higher patient acuity than the national average, due to the impacts of managed care on patient treatment patterns; higher wages for hospital employees; a growing nursing shortage; and the third-largest uninsured population in the nation.

In addition, state and federal regulatory measures on such issues as seismic retrofitting of hospital facilities, new data security rules on patient information, minimum nurse staffing ratios, and medication error reduction have increased financial pressures on the state's hospital industry.

Collectively, these market forces have caused a substantive weakening of operating margins among California's hospitals, with more than half losing money from operations in 1999. This weakening has not affected all hospitals equally, but rather has widened the historical gap between "have" and "have-not" hospitals. The highly vulnerable "have-not" hospitals are not only losing money, but are finding it increasingly difficult to obtain debt financing for the necessary and/or mandatory capital and information systems investments required to survive.

CHCF Issue Brief

Any single factor or a combination of forces has the potential to accelerate the weakening of the financial health of California's hospitals. Extended or worsening operating losses, coupled with legislative requirements that contain potentially adverse financial consequences, could create a cumulative set of impacts that would cause hospital closures throughout California.

The Methodology

This study was conducted by Shattuck Hammond Partners, and was commissioned by the California HealthCare Foundation. The study examined hospital financial performance for 1995 through 1999; it is exhaustive in scope, analyzing data for all 409 hospitals in California that submitted disclosure reports in those years to state and federal agencies. It sought to raise important questions facing health care industry leaders and policymakers:

- What is the current financial health of California's hospitals?
- What are the recent trends in financial performance, in terms of margins, revenues, expenses, and capital?
- Are the trends in financial performance consistent across various typologies of hospitals?
- How large is the gap between strong and weak hospitals?
- What are the public policy implications of the financial health of California's hospitals?

The study analyzed hospitals by size, location (both geographic and urban/rural), type of control, and patient mix, as well as by the following characteristics:

- Small (150 or fewer available beds)
- Medium-small (151–250 available beds)
- Medium-large (251–350 available beds)
- Large (more than 350 available beds)

- Rural
- Urban
- Northern/southern
- Investor-owned
- Nonprofit
- District-owned
- City- or county-owned
- Member of a health care system
- Non-member of a health care system
- Academic medical center
- Seismic Zone Status
- Disproportionate Share Hospitals

The study used these main data sources for its analyses:

- *Selected Hospital Financial Data* from California's Office of Statewide Health Planning and Development (OSHPD)
- *The Comparative Performance of U.S. Hospitals: The Sourcebook* from HCIA-Sachs and Deloitte & Touche
- *Hospital Statistics* and the *AHA Guide to the Health Care Field* from the American Hospital Association
- *The Almanac of Hospital Financials and Operating Indicators* from the Center for Healthcare Industry Performance Studies

In addition Shattuck Hammond Partners conducted a "MegaTrends Survey," which polled leaders of 13 leading hospital and health system organizations in California on issues raised by the study. This research will help policymakers, health care professionals, and the public better understand the issues contributing to the serious financial predicament looming before California's hospital industry.

The California HealthCare Foundation has funded additional research to further identify the specific characteristics that distinguish the state's profitable from the financially vulnerable hospitals.

Major Findings from the Study

The years 1995 through 1999 were indisputably a period of weakening financial health for California's hospitals. The deteriorating financial condition of California's hospitals is a legitimate and growing concern for California residents, planners, and policymakers. The potential for a significant portion of California's hospitals to face closure is now greater than ever. Due to the diversity of the state's hospitals, it is likely there will be few communities that are spared the fall-out of this potential scenario.

It should be noted that this study covers the years 1995 through 1999. There is anecdotal evidence to suggest an improvement in the financial position of a portion of California hospitals since 1999, making their fiscal status less precarious than during the years covered by the study. These improvements, however, may not have major impacts on the overall findings or conclusions of the study.

The California Market

California is a highly competitive market for hospitals in terms of revenues. This environment is the result of a particularly aggressive combination of the following factors.

- Strong business and purchasing alliances, such as CalPERS and Pacific Business Group on Health, maintain a high degree of premium pricing pressure on payers.
- High managed care market penetration—54 percent of HMO penetration, compared to 34 percent nationwide—combined with a high concentration of managed care patients among relatively few payers. In 1999, 85 percent of HMO enrollment was concentrated among five HMOs: Kaiser Foundation Health Plan, Blue Cross of California, PacifiCare of California, HealthNet, and Blue Shield of California. This consolidated payer purchasing power for hospital services.
- Competition for premium revenues not only with other hospitals but also with large, sophisticated medical group organizations.
- California hospital patients have a higher severity of illness as measured by the Health Care Financing Administration (HCFA) case mix index (CMI): 1.34 versus 1.22 nationwide in 1999.
- A higher median salary per full-time hospital employee: \$40,984 versus \$32,893 nationwide in 1999.
- A nursing shortage in which California has the lowest number of nurses per capita in the nation.
- A larger uninsured population than the national average: 21 percent versus 16 percent nationwide.

Expense Issues

The study found that operating expenses per unit of service have trended at levels below medical inflation rates over the last several years in spite of some rapidly rising components, such as pharmacy expenses. Moreover, utilization has been managed, with median adjusted acute average length of stay (ALOS) falling.

The data in Table 1 show risk-adjusted revenue, expense, utilization, and discharge statistics to illustrate the competing trends that drive operating margins.

The difference between revenue and expense, both in the per-day and per-discharge categories, eroded substantially for the average California hospital between 1995 and 1999. Remarkably, operating expenses in both the per-day and per-discharge categories were generally stable over that time period, with per-day expenses actually showing a slight decline. The compound annual rate of growth for both per-day and per-discharge expenses were significantly below the rate of inflation for the study period.

TABLE 1. CALIFORNIA HOSPITAL AVERAGE REVENUE, EXPENSE, AND UTILIZATION TRENDS, 1995 AND 1999

	1995	1999	Compound Annual Growth Rate
Daily operating revenue, per day	\$ 1,222	\$ 1,189	-0.67%
Daily operating expenses, per day	\$ 1,219	\$ 1,212	-0.14%
Difference	\$ 3	\$ (23)	NA
Operating revenue per discharge	\$ 7,347	\$ 7,638	0.98%
Operating expenses per discharge	\$ 7,523	\$ 8,077	1.79%
Difference	\$ (176)	\$ (439)	25.64%
Acute average length of stay	4.55	4.24	-1.74%
Acute days as % of total inpatient days	72.6%	70.4%	-0.75%
Acute inpatient discharges as % of total inpatient discharges	89.8%	88.3%	-0.41%

Source: Shattuck Hammond Partners. *The Financial Health of California's Hospitals*. July 2001.

Notwithstanding hospitals' success in managing expenses in the past, there is grave concern about the future. The majority of respondents to the MegaTrends survey indicated a fear that operating margins will continue to decline as a result of rapidly rising expenses, particularly pharmacy and labor costs. OSHPD data for 1995 through 1999 suggests that the overall rate of expense growth has been largely controlled. Median salaries and wages per adjusted patient day in California actually declined slightly in that time, from \$458 per day to \$446 per day, a drop of 0.69 percent.

Despite these positive trends, expense projections show some adverse signs. Salary and wage expenses, which have been contained by staffing reductions and changes in skill mix, may be poised for an increase. The combined factors of unionization, the minimum nurse staffing ratio legislation of state Assembly Bill 394 (AB 394), and general shortages of skilled patient care and information technology workers are creating

expectations for increasing wage expenses, the largest single component of hospital operating expenses.

California hospitals also incur expenses that are complex and, at times, difficult to control. For example, if new, more expensive cardiovascular technology allows cardiologists to implant stents into arteries to prevent occlusion, and this procedure is safer and more effective than the angioplasties that had been performed in the past, the procedure likely would be implemented. The majority of payment structures in place for California hospitals would not provide additional revenue to the hospital to offset such increases in expense, because hospitals are typically paid either a fixed per-diem rate or a fixed per-case rate, regardless of resources consumed. Any additional reimbursement from health plans would have to be negotiated at the time the hospital's current contract expires. Revenue increases from public programs may also not be responsive to current trends.

Information technology comprises another expected area of steep cost increases. Hospitals are faced with needed upgrades to information systems technology, which will allow them to better manage patient care and expenses. Although some of these technology investment requirements have both capital and operating cost implications, many have a direct operating cost impact.

While expenses trended at a rate well below the rate of medical price inflation, revenues trended at an even lower rate, leading to an erosion of operating margin. This finding reinforces the notion that competitive and regulatory forces have been very successful at containing California hospital pricing. Further, although the California hospital industry has kept per-unit cost trends well below the rate of inflation, it has not been successful enough in reducing those costs so as to maintain or improve operating margins.

Regulatory Mandates

State and federal regulatory measures have imposed substantial revenue drains and capital demands on the industry:

- The federal Balanced Budget Act of 1997 contains mandated Medicare payment reductions that by 2002 will cut net Medicare payments to California hospitals by a projected \$4.9 billion.
- California Senate Bill 1953 (SB 1953), enacted in 1994, requires all hospitals in California to meet stringent guidelines for structural resilience to earthquakes, with graduated levels of conformance required in 2008 and 2030. Costs could include retrofitting, business interruption and, in some cases, complete hospital replacement. Failure to meet these deadlines can mean the loss of acute hospital licensure. The California Healthcare Association has estimated the cost to the state's hospitals at \$24 billion.

- The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires providers to adopt electronic transaction standards, data security protocols, and privacy measures to protect confidential patient information that is stored or transmitted electronically. The American Hospital Association estimates an average annual cost per hospital of approximately \$4.6 million for the first five years of program implementation.
- Medi-Cal (California's Medicaid program) instituted managed care programs in 20 California counties by 1999, which generally resulted in reduced reimbursement to hospitals for Medi-Cal services.
- California Senate Bill 1875 (SB 1875), enacted in 2000, requires most hospitals to create technology-based systems to reduce medication errors by January 2005.

Deteriorating Operating Margins

A financially healthy organization is one that produces an operating margin sufficient to finance the current and future capital that is required for the maintenance and growth of its business. For most California hospitals, this capital comes from two primary sources: operating cash flow and debt financing.

Operating margin is an “early warning” indicator of financial health because it provides access to the capital required to sustain and/or grow a business in the future. Particularly in the capital-intensive hospital industry, access to capital, or lack thereof, determines future viability.

Although generalizing about healthy levels of operating margin may be misleading in some circumstances, an industry rule of thumb is that an operating margin of 3 percent to 5 percent would be considered healthy.

Given the pricing and expense environment of California hospitals relative to the nation, it is

not surprising to find that median California hospital operating margins are well below national figures (see Table 2). In 1999, California hospitals were reporting a negative median operating margin, at -0.33 percent; more than half of California's hospitals were losing money from operations that year. Nationally, the median operating margin was 0.4 percent. The most precipitous decline occurred from 1996 to 1997, with a decline of 1.5 percent of the 2 percent total drop over the entire five-year period.

Hospital Types: The Haves versus the Have-nots

Another potential risk factor facing California's hospitals is the differential financial health of its hospitals. Analysis of hospital types found that California possesses a highly vulnerable group of hospitals at the "have-not" end of the spectrum—a group that includes 25 percent or more of the state's hospitals. California also possesses a group of "have" hospitals, which are strong financially and are in a position to dominate the highly competitive private marketplace for hospital services.

The operating margin disparity between the top and bottom performing hospitals widened significantly from 1995 to 1999 for both California and the nation as a whole, as illustrated in Table 3.

It is troubling that the bottom quartile of California's hospitals had an operating margin of -7.76 percent in 1999. These most vulnerable hospitals had a deteriorating credit profile that in 1999 reached levels that would likely preclude them from accessing capital through debt financing in the public markets.

For these hospitals, any one or a combination of adverse financial developments could result in insolvency and possible closure. Given that the bottom quartile of California's hospitals handled 17 percent of the state's hospital discharges, this group is large enough to create a serious hospital access problem in California, if large numbers of them fail to survive. Furthermore, hospitals in other operating margin performance quartiles may be vulnerable to the same risk factors.

In a significant finding of this study, analysis of California's diverse array of hospital types yielded some patterns of over-representation in the lowest quartile of operating margin based on typology. Most evident was the state's rural hospitals. An analysis of rural versus urban hospitals revealed a widening gap in performance between 1995 and 1999, with rural hospitals showing a consistently negative and worsening median operating margin. Quartile distribution showed that rural hospitals are under-represented in the top quartile, comprising only 7 percent of the top quartile hospitals versus 18 percent of all hospitals, and are largely distributed below the median, with their highest representation, 26 percent, in the lowest quartile.

TABLE 2. MEDIAN OPERATING MARGINS, CALIFORNIA VERSUS THE NATION, 1995–1999

	1995	1996	1997	1998	1999	Change 1995–1999
California hospitals	1.65%	1.59%	0.09%	0.10%	-0.33%	-1.98%
National hospitals	2.8%	2.6%	2.8%	1.2%	0.4%	-2.4%

Source: Shattuck Hammond Partners. *The Financial Health of California's Hospitals*. July 2001.

TABLE 3. OPERATING MARGIN QUANTILES, CALIFORNIA VERSUS THE NATION, 1995 AND 1999

Quartile	California			National		
	1995	1999	Change	1995	1999	Change
75th percentile	6.84%	5.72%	-1.12%	7.0%	5.0%	-2.0%
Median	1.65%	-0.33%	-1.98%	2.7%	0.4%	-2.3%
25th percentile	-3.96%	-7.76%	-3.80%	-1.5%	-5.1%	-3.6%
75th minus 25th percentile	10.82%	13.48%		8.5%	10.1%	

Source: Shattuck Hammond Partners. *The Financial Health of California's Hospitals*. July 2001.

Other categories of hospitals that were over-represented among the bottom quartile hospitals occurred within the following groups:

- Small
- District-owned
- City- or county-owned
- Rural
- Disproportionate Share Hospitals
- Non-members of a health care system

Over-representation among the top quartile hospitals occurred within the following groups:

- Medium-large
- Medium-small
- Investor-owned
- Urban
- Members of a health care system

Notably, all hospital types have significant representation between both the top and bottom operating margin quartile hospitals, with the exception that city/county, district, and rural hospitals comprise an insignificant share of the top quartile.

Other observations include:

- Investor-owned hospitals had the highest median operating margin among all

categories between 1995 and 1999, but were not immune to the overall trend of declines in operating margin. While this was the strongest group in terms of type of control, the median operating margin decline of 2.26 percent exceeded the 1.98 percent median decline for all hospitals in this time period.

- Statewide, 18 of the 19 hospitals that were closed or had their licenses suspended from 1997 to 1999 had fewer than 200 beds, suggesting that small size had an influence on viability.
- While small and medium-small hospitals showed weaker operating margin trends, these two types also comprised 72 percent of all California hospitals in 1999, as well as 69 percent of top quartile hospitals and 79 percent of bottom quartile hospitals.
- Between 1995 and 1999, the proportion of medium-large and large hospitals above the median grew from 27 percent to 32 percent. In four of the five years studied, median operating margins for medium-large hospitals exceeded the median operating margins for all other size categories (i.e., small, small-medium, and large).
- Southern California hospitals' operating margins showed that in 1995 and 1999,

58 percent of its hospitals were below the statewide median operating margin. The region's hospitals could be modestly characterized as "have-nots."

- System member hospitals had much higher median operating margins between 1995 and 1999, and experienced a smaller decline in median operating margin during that time frame than non-system members. System hospitals' median operating margin went from 4.37 percent in 1995 to 1.77 percent in 1999; non-system margins slipped from -0.27 percent to -4 percent.
- Some hospital migration was observed among operating margin quartiles between 1995 and 1999. Of the hospitals that were in the worst-performing quartile in 1995, 53 percent remained in the same quartile in 1999, while 70 percent remained in one of the two bottom quartiles in 1999. Of the hospitals in the best-performing quartile in 1995, 53 percent remained in the top quartile in 1999 and 78 percent remained in one of the two top quartiles in 1999.
- In 1999 California's top quartile hospitals out-performed the nation's top quartile—a reversal from the 1995 relationship.
- From 1995 to 1999, California's bottom quartile hospitals fared worse than the nation's bottom quartile hospitals, experiencing a median operating margin decline of 3.8 percent, compared to a decline of 3.6 percent nationally.
- The gap between California's top and bottom quartile grew from 10.82 percent in 1995 to 13.48 percent in 1999.

Capital Access Woes Threaten Hospitals' Future

Capital for maintenance, replacement, and new technology is a critical need for hospitals in

California. The industry is particularly dependent on capital because its ability to provide quality service and produce operating revenue is heavily dependent on tangible assets such as land, facilities, medical equipment and, increasingly, information technology.

California hospitals rely heavily on debt financing as a source of capital. In 1999 California's median and weighted average hospital debt ratio statistics showed that its hospitals financed approximately 44 percent of their total capital with debt.

Table 4 shows financial ratios data for California hospitals, calculated from OSHPD data. These ratios, which lenders use to evaluate a hospital's creditworthiness, are compared to Moody's national median ratios for "Baa" credit ratings, which are the lowest investment grade rating the agency offers. A rating below "Baa" moves a borrower into "junk bond" territory, where debt financing is often very expensive and difficult to obtain.

Liquidity/Days Cash is a ratio that measures the number of days of operating expense that could be funded by a hospital's liquid reserves. A hospital's investment reserves not only provide it with a direct source of capital, but also influence the amount of debt financing a hospital can obtain. Lenders look to this ratio as a "comfort factor" in assuring timely debt repayment; low liquid reserves can limit a hospital's access to capital.

Debt Service Coverage is a ratio that measures the hospital's cash flow, divided by its existing annual debt service payments. It shows debt-financing levels at a given hospital; higher ratios create greater comfort for lenders.

Debt to Capital is a ratio that examines a hospital's debt in comparison to its total assets or capital. A hospital's access to debt financing is often limited by its ratio of debt to capital.

While the credit ratio data does not appear to evidence significant change in debt service coverage and debt to capital ratios, liquidity shows a

TABLE 4. CALIFORNIA HOSPITAL CREDIT RATIOS, 1995 AND 1999

Ratio		OSHPD DATA		Moody's "Baa" Median 1999
		1995	1999	
Liquidity/Days Cash	System	119.5	108.2	92.7
	Median	81.1	50.9	
Debt Service Coverage	System	2.52	2.21	2.62
	Median	2.34	2.43	
Debt to Capital	System	43%	43%	44%
	Median	47%	44%	

Source: Shattuck Hammond Partners. *The Financial Health of California's Hospitals*. July 2001.

weakening trend. Liquidity decline is an alarm for investors and credit analysts, which indicates an unsustainable combination of financial performance and capital investment.

Based on this data, California's hospital system as a whole would likely receive a weak "Baa" rating based on liquidity, coverage, and leverage ratios.

The strong link between operating margin and access to debt capital is readily apparent in observing California hospital trends. By 1999 the credit quality of California's hospitals had fallen dramatically:

- Moody's Investors Service (Moody's) and Standard & Poor's Corporation (S&P), two national credit rating agencies, had ratios of downgrades to upgrades for California hospitals of 4 to 1 and 11 to 1, respectively, for the period of 1997 to 1999.
- In financial profiles of California hospitals, 38 percent of Moody's and 30 percent of S&P's reports carried a qualifier of "negative outlook."

With the exception of a minority of California hospitals, California's hospital system overall has

experienced and will likely continue to experience significant credit deterioration, putting many hospitals in the position of being challenged to fund current much less future mandated capital expenditures.

Capital funding issues present the highest risk factor in accelerating a financial crisis among California hospitals. Study findings indicated significant credit erosion of California hospitals' overall financial profile. Furthermore, the rating agencies observed a deferral of capital spending among many rated California hospitals—an indication of capital inadequacy. If unchanged, this fragile state of capital access will likely lead to an increasing prevalence of hospital failures.

Primary among the risk factors facing California's hospitals are the seismic upgrade requirements of SB 1953. Although public, hospital-specific SB 1953 data is not available yet, it is the conclusion of this study that a significant portion of California's hospitals may not possess sufficient capital access to fund SB 1953 requirements. SB 1953 has great potential to accelerate potential financial non-viability for California's hospitals.

Virtually all MegaTrends survey participants believed that California's hospitals, on a systemwide

basis, could not afford to meet the requirements of SB 1953. Respondents anticipated increased debt levels and reduced liquidity from the combination of increasing capital needs and financial performance pressures, and overwhelmingly predicted an increase in the rate of closure of California hospitals in the future. Participants also ranked information technology first in priority and patient care facilities last, which is not surprising, given the pressures on the hospital industry to become more productive. Ironically, patient care facilities are ranked first in expected future magnitude of capital expenditures, due to SB 1953.

Policy Implications of California Hospitals' Financial Challenge

One Chinese translation for the word “crisis” is “dangerous opportunity.” This translation aptly describes the broader historical perspective on California’s hospitals in light of the current environment. California has led the nation in the constructive adaptation of its health care system. It has also led to a highly competitive managed care market, making much of hospital revenue subject to tough negotiation. The results have yielded a highly competitive hospital infrastructure that provides quality care and at the same time has seen hospital expenses remain at levels below the rate of inflation.

What threatens to alter the success of California’s hospitals is not necessarily competition alone, but rather the explosive confluence of competition and new governmental mandates. Historically, a quasi-public good like health care has been influenced by government, which has sought to achieve greater efficiency and the benefits of market-based adaptation through competition, while protecting the public and achieving social policy goals through regulation. Indeed, the “invisible hand” of health care policy, in tandem with market competition, has shaped the evolution of California’s health care environment.

Given the current financial situation among California hospitals, the marketplace has the potential to spark needed reforms in the structures and service delivery methods of the state’s hospital system, or to introduce serious dislocations and disruptions into that system.

Numerous studies have concluded that California has more hospital beds than are necessary for its current and future health care needs. The hospital beds currently in place in California are more appropriate, both in terms of geography and facility type, to the financial and health care needs of 30 years ago. The medical practices and technologies available today require significantly fewer inpatient beds, as well as different types of facilities. The ongoing redevelopment and modernization of inpatient services is likely to result in consolidation of services and closure or relocation of some hospitals, regardless of SB 1953’s seismic retrofit mandates.

In addition to these changes to inpatient services delivery, there also has been an historical under-investment in new or upgraded hospital buildings in California. This has made for an obsolescence problem among the state’s hospital facilities that also is unrelated to the seismic retrofit issue, particularly in rural areas.

Given the aging inventory of inpatient buildings and the need to comply with modern seismic standards, there is a golden opportunity to recast the distribution of inpatient services in a way that more closely matches California’s current and projected needs, and the changing approaches to health care delivery.

However, this is where the danger in “dangerous opportunity” could come into play. As the study has shown, many if not most of California’s hospitals do not have the resources to finance their own modernization. Should the health care marketplace be allowed to proceed in unfettered fashion, there could be a series of closures and consolidations that could benefit the state’s healthy hospital systems, but which have the risk of creating serious gaps in hospital access among

communities served by financially vulnerable hospitals.

In this situation, the market could tend to reward those hospitals in areas with the greatest potential for return on investment, while denying investment in the health care needs of potentially underserved communities. In addition to the potential for disruption from closures and relocation, consequences could include the continued use of obsolete or seismically unsafe facilities, and more consolidated control of hospital services, thanks to the absorption of vulnerable hospitals into enlarging systems.

Hospital closures could create regional capacity shortages. The MegaTrends survey suggests that many hospitals already are encountering capacity shortages in critical care units. While the overall hospital occupancy rate for California hospitals rose to 59 percent in 1999, this occupancy is not evenly distributed on a facility-by-facility or regional basis. Therefore, the potential for wide geographic distribution of vulnerable hospitals could result in similarly widespread hospital supply dislocations.

In addition, while there are a variety of viewpoints on how to ensure that the state's hospital system provides all Californians with high-quality medical care and appropriate access to services—and does so in cost-effective fashion—there is currently no systematic process in place to provide objective information, develop standards, or help resolve conflicts about the type and number of hospital facilities and services needed by each community.

Finally, communities tend to be very loyal to their existing hospitals. Reconfiguration, closure, and resizing of hospitals are significant political issues, and can prompt substantial public resistance to such proposals, even if experts agree that such steps are needed.

The fundamental policy questions that emerge from the study revolve around whether there is a need to seek preventive solutions to this

challenge facing the state's hospitals, or whether California's market forces should be allowed to shape the system's future. Considerations include:

- Should the public bear any or all of the responsibility for covering the costs of physical facility upgrades to California's hospitals, through such methods as state grants to hospitals or state underwriting of hospital construction bonds?
- If the state provides fiscal relief to the state's hospitals, what should taxpayers receive in return as a public benefit?
- Should consideration be given to providing financial support to hospitals in areas where closure or consolidation would result in significant gaps in service?
- Should financial assistance for modernization include criteria for support for projects other than seismic upgrades?
- Should delays be granted to hospitals for implementation of the seismic standards under SB 1953? If so, what conditions should be attached to such delays?
- Should facilities that fail to meet SB 1953 seismic standards be closed, or allowed to remain open?
- Should the state develop standards for acceptable access and appropriate sizing of inpatient facilities statewide and, if so, which agencies should develop and administer them?
- How would local communities and the general public be included in this decision-making process?

This substantial challenge to the state's hospital industry calls for the coordinated review and analysis of legislative requirements, in the context of the current highly competitive market environment. Such a review could allow California to convert its pending hospital challenge into an opportunity.

For More Information

Contact:

Cecilia Montalvo

Mark Harrison

Shattuck Hammond Partners

601 California Street

San Francisco, CA 94108

(415) 788-6900

To receive the full report by Shattuck Hammond Partners, and for additional copies of this issue brief and other publications, contact the California HealthCare Foundation's publications line at 1-888-430-2423 or visit us online (www.chcf.org).

CALIFORNIA HEALTHCARE FOUNDATION

476 Ninth Street

Oakland, California 94607

Tel: (510) 238-1040

Fax: (510) 238-1388

www.chcf.org

Mission

The California HealthCare Foundation, a private philanthropy based in Oakland, California, focuses on critical issues confronting a changing health care marketplace by supporting innovative research, developing model programs, and initiating meaningful policy recommendations.