HOSPITAL CONSOLIDATION TRENDS IN TODAY'S HEALTHCARE ENVIRONMENT

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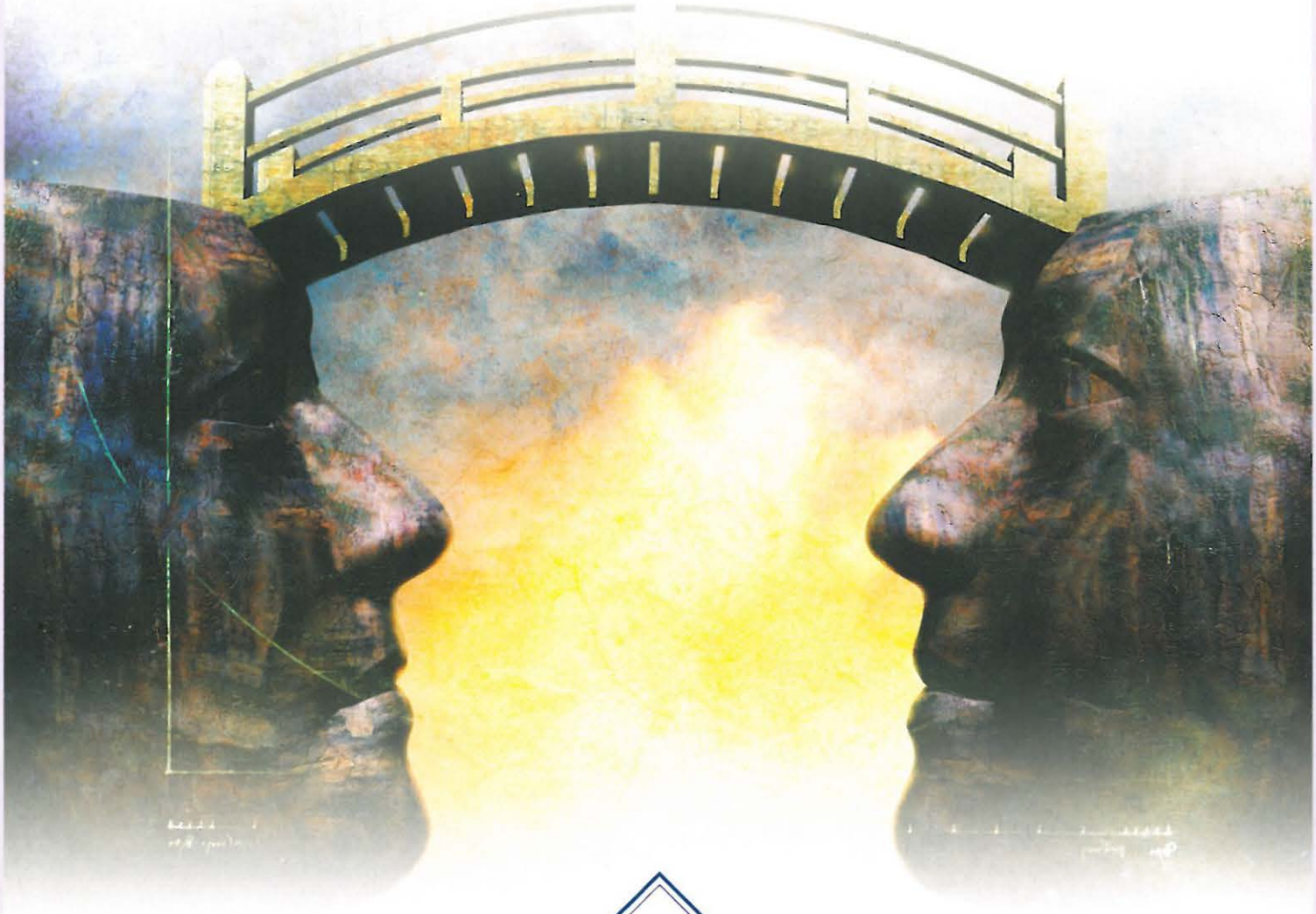

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Introduction

Economic and health policy experts seem to agree that healthcare delivery is a "market failure." The U.S. spends much more on healthcare than countries with similar economies—16 percent of the gross domestic product. This puts U.S. businesses at a competitive disadvantage in the global marketplace and acts as a drag on the economy.

Despite spending twice as much as most major industrialized countries on healthcare, the outcomes associated with these expenditures are mixed. We trail other countries in most measures of health quality (e.g., infant mortality, life expectancy, and disease prevention). This is not new; many of the same issues and concerns have been discussed over the past twenty years. Healthcare executives and leaders have been calling for the creation of larger hospital "systems" for at least a decade.

This white paper seeks to develop a framework in which to consider the likely impact of the Patient Protection and Affordable Care Act and the Healthcare and Education Reconciliation Act of 2010 (collectively referred to herein as healthcare reform) on hospital consolidation and, specifically, how this might occur and what hurdles are likely to be encountered. (For the purposes of this white paper, consolidation refers to horizontal combinations of ownership and control between hospitals, rather than the creation of vertically arranged businesses through combinations.) We do not attempt to review the *need* for scale and larger companies; this topic has been well covered by others. Rather, we take this as a given and attempt to develop a framework for recommendations as to how management teams and boards might best prepare for responding to healthcare reform. In order to do this, we explore the sources of the hospital industry's historical resistance to change, review the current structure and development of the industry, and develop a view regarding those industry participants who are best positioned to lead this change.

Despite some consolidation in the past two decades, the hospital industry remains fragmented and populated by many relatively small companies. Healthcare reform has the potential to dramatically alter the hospital business and accelerate consolidation.

Healthcare reform is expected to profoundly affect consolidation between hospitals. Not only is it expected to increase the number and size of mergers, but the underlying motivations are also expected to change. Until the present, microeconomic factors have driven hospitals to consider business combinations. We believe that this will likely change so that the formation of larger companies will become a "top-down" macroeconomic requirement. This is because healthcare reform will impose lower prices and enforce reimbursement models that create powerful incentives for hospitals to form large systems of care, including bundled payments, payments for quality, and accountable care organizations.

The hospital industry is highly regulated, capital and labor intensive, and technologically and commercially complex. And yet, the overall structure of the industry appears to be a mixture of cottage industry with a heavy dose of altruism, rather than the large sophisticated industry it needs to be. One could argue that reform, effectively, results in the federal government telling the healthcare delivery industry: "the cost of healthcare delivery is unsustainable. We are going to fix this by driving down prices; you, the providers, figure-out how to make this work."

Despite the significant level of discussion regarding business combinations occurring at the present time, significant hospital consolidation and creation of large companies seem far-off. Why is this? What is it about the hospital industry that causes it to have an incredibly fragmented structure and to be so resistant to change? While there are some obvious and understandable reasons for this structural anomaly, this white paper attempts to explore the reasons behind the now-antiquated structure of the hospital industry, and considers how it can evolve in the immediate future.

In preparing this white paper, we sought input regarding the factors influencing the rate of consolidation from independent and multi-hospital systems, located in both urban and non-urban areas. We then gathered available data illustrating the consolidation trends that have occurred over the past two decades. To this, we added our own experience in advising non-profit boards on business combination transactions. We hope that this will provide Governance Institute members with greater awareness and insight into this complex topic as they prepare to respond to healthcare reform.

A Note from the Authors

In researching and preparing this white paper for The Governance Institute, we recognize that this topic exposes a number of potentially difficult and unpleasant issues for many readers. In our interviews, we heard a call for change. However, we also recognize that this topic fosters controversy. The type of change described herein is likely to result in movement away from a past in which glorious traditions and deeply held convictions were developed and maintained for a long period of time. We attempted to use data, the opinions of experts, the results of our interviews with 25 CEOs, and our accumulated experience over the past 25 years in advising on business combinations to shed a realistic light on this issue.

Chapter 1. Consolidation: Change Is Coming

There has never been a time when the subject of market concentration in the hospital industry has been more important. Ironically, as national attention is being paid to the "too-big-to-fail" structure of the banking industry, the hospital industry appears to have the opposite problem—the small size of its companies and market fragmentation suggest that it might be characterized as "too-small-to-succeed." Furthering this paradox, U.S. banks are not being broken up, largely because of concern over their subsequent ability to compete in a global economy against huge foreign banks. At the same time, hospital companies must become larger for a similar reason—remaining competitive in a global marketplace makes it necessary for the U.S. economy to reduce its overall expenditures on healthcare. Larger, more efficient, hospital companies are part of the solution.

The hospital industry, uniquely, has evolved from a complex and interrelated set of mission and commercial objectives, but the determinants of success have changed enormously. In the past, the hospital industry's local approach and fragmented structure fitted the needs of the market and were consistent with its commercial and reimbursement characteristics. Since the 1980s, however, the industry has gradually shifted from community, religious, and government missions to a commercial orientation. Today, even religious-sponsored hospitals exhibit market behavior that does not meaningfully differ from publicly held, for-profit corporations.

Most industry leaders believe hospital companies must standardize medical care and integrate with physicians in order to respond to the external pressure of healthcare reform. Many of these same industry leaders have, for at least a decade, felt that hospital businesses must become larger in order to respond to internal issues—namely, to offset cost inflation, deal with concentrated managed care payers, and implement standardization. As the intensity of change appears likely to increase in the near future, it is interesting to compare the business factors that contributed to the modest consolidation that has been experienced over the past two decades with those that are likely to result in greater consolidation in the future. The data regarding industry structure over the past two decades in reviewed in the next section.

Historical Causes of Consolidation

Over the past two decades, business combination transactions between hospitals have been, broadly, the result of two very different factors. During the 1990s, most were in response to the advent of managed care; this was a pervasive *external* issue. Large numbers of transactions were completed as non-profit and for-profit companies entered into business combinations in an effort to position themselves to secure managed care contracts. Primarily, this involved the creation of regional systems of hospitals.

Industry leaders believe hospital companies must standardize medical care and integrate with physicians in order to respond to healthcare reform.

In the 2000s, however, business combinations have largely been the result of a set of *internal* issues, most notably operating problems that led to difficulty in raising capital. Far fewer transactions were completed during this period. The main issues faced during the first eight years of the 2000s centered on the following:

- **Access to capital:** maintaining access to adequate amounts of external capital has been a major concern in the past decade for non-profit hospitals. Capital investment needs have been outpacing resources; aging facilities, expensive information technologies, and physician employment demands have drained cash reserves and reduced credit quality. With the credit markets still suffering lingering effects of the 2008 and 2009 financial market collapse, many hospitals have limited or impaired access to the capital markets.
- **Business complexity:** the hospital business has become more complex, both commercially and technically. The ability to arbitrage operating skills within a system of hospitals has proven to be one of the key strengths of the most successful and multi-hospital companies, whether non-profit or for-profit. Larger systems are better equipped to address the heightened business complexity of the hospital industry.
- **Scale:** larger companies have smaller fixed expenses in relation to larger revenue bases. Currently, scale is a requisite for success for many hospital businesses. We are also told that scale equates to political influence over government regulations passed at the state level.

Healthcare Reform's Impact on Consolidation

We expect healthcare reform to have a substantial impact on consolidation between hospitals. By and large, most leaders we interviewed felt that it would greatly accelerate market consolidation. Not only is it expected to increase the number and size of mergers, but also the underlying motivations are expected to change. Essentially, until now, microeconomic factors drove certain hospitals to consider business combinations. We believe this will likely shift so that the formation of larger companies will be in response to macroeconomic mandates of

the federal government. The following are expected to be key issues in the near future:

- **Cost:** because healthcare services, including hospitals, act as a drain on the economy, it is critical for hospitals to focus on creating value. As more patient satisfaction, pricing, and other data are released, the market will drive reform in the payment system, and those providers that are not efficient will be forced to merge or exit. Bundling of services and containing costs is going to become necessary.

  Under the current payment system, physicians are incentivized to provide more services with little regard to best practices or cost sensitivity. A bundled payment might address this dilemma since it will provide one payment that encompasses the entire continuum of care for a given medical condition. Many leaders we interviewed believe that bundled payments could provide further incentive to form large hospital systems and focus on efficient operations. One physician we spoke with saw no way to contain costs to fix this until physicians are integrated with hospitals and incentives are aligned.
- **Quality:** larger organizations can devote time, resources, and capital to improve delivery, hopefully translating into better health outcomes. For example, nearly all physicians in the Netherlands, the U.K., and Germany use electronic medical records. Standardization will allow for better data for comparison, creating more efficient procedures that will reduce cost and increase quality.
- **Branding and marketing:** healthcare consumers are becoming more sophisticated and looking for recognizable brands. Along with name recognition, this will be even more important when systems release performance data to consumers. "Image association," as one interviewee told us, "will be critical once consumers have the opportunity to review performance data under healthcare reform."
- **Standardization:** this is not a newfound idea or concept. As Dartmouth Professor John Wennberg first observed in 1967, evidence-based medicine, where best practices are shared, standardized, and broken-down for others doctors to repeat, yields far better outcomes and is much more cost-effective.

Slow Pace of Consolidation

Despite these historical and prospective reasons for consolidation, the rate of change has been slow, as is detailed in the paragraphs below. In order to identify the underlying causes of this resistance, we interviewed 25 CEOs of non-profit health systems during the winter and spring of 2010. Given that the community-sponsored, 501(c)(3) hospital group is the largest segment of the non-profit industry, we concentrated our interviews on this group. We also drew upon our own experiences in advising non-profit boards on business combinations over a 20-year period.

Tax-Exempt Status: Unintended Consequences?

We heard that reticence to consolidate is, in many cases, an unintended consequence of legitimate efforts to remain tax exempt. The *propensity* to sell could be inhibited by tax-exempt status; there is no evidence that this impedes the *ability* to sell. The IRS grants tax-exempt status to 501(c)(3) organizations on the basis of meeting certain charity care thresholds (e.g., the "community benefit standard"). This fosters strong underpinnings of local control, usually resulting in boards that are, understandably, made up entirely of local volunteers. The pervasive focus on local issues often compromises the ability of boards to deal with the larger issues confronting the hospital industry.

Costs are out of control, in part, because every community in the country wants what it believes to be best. This has led to incredible redundancy and inefficiency.

Community Benefit, Local Business

Responding to healthcare reform is a challenge for the hospital industry at the national level. However, hospitals are governed, by and large, on a local basis. There is a pervasive and long-held view that local issues and exclusivity should be considered in governing a hospital. Every community, it seems, wants a hospital that fits the preferences of its locally populated board. The cumulative effect of "every community getting what it wants" is one of the most dramatic features of hospitals in the U.S.

This orientation and method of allocating capital is partially responsible for excessive costs in the healthcare delivery system. One CEO we interviewed in Colorado alluded to an ongoing saga regarding the city-owned hospital system in Colorado Springs. The issue in question is whether this two-hospital system should remain local and independent, by transferring to a 501(c)(3), or become part of a system. One commentator in a local blog summed-up local thinking thusly, "when you forfeit local control, you allow folks in another city or state to determine what Colorado Springs receives and what programs are important. The factors in those decisions ... could dramatically change what Memorial provides."[1] Well, might this sort of approach, in which every community in the country gets what it "wants," be a large part of the problem with our healthcare system? Costs are out of control, in part, because every community in the country wants what it believes to be best. This has led to incredible redundancy and inefficiency.

Capital Markets

The municipal bond market has played a significant role in the development of the non-profit industry. This market's willingness to provide debt capital to many relatively small businesses in a very fragmented industry is sharply different from the experience of companies in most taxable industries. This willingness has, essentially, "enabled" the non-profit hospital industry to consist of a very large number of small businesses.

1 Brian Newsome, "The Future of Health Care in the Pikes Peak Region" (blog entry), June 17, 2010, http://thefutureofhealthcare.com.

The U.S. municipal bond market is one of the largest and most stable capital markets in the world. Despite its enormous size, this market, itself, is very fragmented in that it has no central oversight and no central clearing function; this is quite different from the corporate bond market, which is overseen by the Securities and Exchange Commission. This has contributed to the municipal market's willingness to purchase the bonds of independent hospitals, despite their small size and lack of risk diversification. The municipal market is also unique in that other parts of the industrialized world do not have a comparable market.

Boards that allow management to play an overbearing role in merger discussions are forsaking important fiduciary responsibilities.

The municipal bond market has been the most common source of external financing for hospitals since the 1930s. Bondholders purchase these securities in direct response to an issuer's creditworthiness, which is gauged largely by ratings assigned by one or more of the major credit rating agencies. These agencies assign ratings based on a number of financial and business criteria, including liquidity as measured by the "days cash on hand" ratio. Because their access to external sources of capital is largely defined by their debt rating, hospitals are incentivized to build liquidity, rather than invest in capital projects or acquisition opportunities.

In contrast, equity capital seeks growth. For-profit managers and boards are incentivized to pursue business combinations and other means of growth in order to generate a return on equity. The sharp differences between the objectives of debt and equity investors heavily impact business decisions of for-profit and non-profit hospitals and have a great deal to do with the differences between the two.

Looking forward, non-profit hospitals should be concerned that this market might not continue to be available to smaller, independent, non-profit hospitals. It is possible that this market will gravitate towards larger systems, which are better positioned to thrive under healthcare reform. This change has already begun; it is becoming more difficult to accomplish small debt offerings and higher rating thresholds are being applied for access to this market. Terry Mieling of Bank of America and Merrill Lynch points out that "there has been a significant widening of spreads between A and BBB issues, and issuers below BBB now have to provide investors with the security of mortgages on real property along with debt service funds and tight debt to capital constraints." All of this translates to ever increasing difficulty for smaller non-profit hospital companies in raising capital.

Management Control and Incentive

Many of the board members we interviewed expressed concern about management's power relative to the volunteer board, and the dynamics this sometimes produces. One such board member felt that his CEO's ego drove most of the strategic directions at the hospital, as he put it, "like Sherman through Georgia." One CEO was very blunt with us in saying, "why would I want to pursue a business combination? I would put myself out of a job. I have three kids in high school, my wife and I have lived here for a long-time, and I don't want to put that in jeopardy." Broadly, many of these situations likely reveal that certain boards are not doing a good job of clarifying management's role *vis à vis* the board's control. Often, boards that allow management to play an overbearing role in merger discussions are forsaking important fiduciary responsibilities. The board should be governing, and ultimately it can remove the CEO if necessary. Obviously, this is a difficult subject and, unfortunately, it is likely to be a source of additional concern as a result of post-healthcare reform considerations.

Operating versus Financial Returns

It has been suggested that hospitals operated in an artificially buoyant environment over the last decade as a result of non-operating factors. Through much of the 2000s, hospitals benefited from bull-market investment portfolio returns and financing activities that occurred at extraordinarily low and, ultimately, unsustainable, interest rates through the creation of auction-rate debt securities. An overreliance on foundation income could mask underlying operating issues. This is unique to the non-profit hospital business as it alone categorizes endowment earnings as part of operating results. Strong equity market performance also kept the cost of funding or terminating pension plans artificially low. Liquidity pressures associated with investment portfolio losses, pension funding shortfalls, and interest rate swap mark-to-market accounting changes are straining "operating performance." Once all three of these ceased to exist following the collapse of Lehman Brothers in the fall of 2008, many hospitals felt intense operating pressures, which forced some to reevaluate their ownership status.

Service Providers

The very large number of relatively small companies that make-up the non-profit hospital business has resulted in a very large "industry" of external service providers. In more mature industries, self-sufficient companies perform most of these functions themselves. On a relative basis, this group of service providers dwarfs anything that exists in traditional industries. Because of their small size, hospital companies find it more efficient to outsource general corporate functions rather than perform them in-house. Some of those we interviewed suggested a belief that consolidation opportunities were inhibited by the presence of such a large group of providers who relied on the *status quo* and were not objective about change. Obviously, were there to be fewer, larger companies in the industry, the need for much of this "industry" could shrink dramatically. Our own experience tells us that this group is significantly larger than that found in conventional industries. While it likely adds some "stickiness" to change, we are not sure, however, about the extent to which this is the case. Still, this is something non-profits should consider in the future.

Certain services we heard about represent functions that do not exist in the corporate word, for example:

- **Financial advisors:** large advisory firms have been built, often by people with municipal finance backgrounds, to assist hospitals in raising debt. They are an intermediary between the issuer and underwriter. This role does not exist in the corporate world. With fewer but larger hospital companies, the need for these external services would shrink.
- **Interim management companies:** these operate hospitals under contract for small non-profits. Again, this industry function does not exist in mature industries.

Additionally, certain service providers that exist in the corporate world often play larger roles in the hospital industry as very small companies cannot afford to provide these functions themselves, including:

- **Lawyers:** some law firms act, effectively, as "in-house" counsel to non-profit hospitals, many of which are too small to retain in-house counsel for routine needs. This reliance on outside counsel for routine needs, while understandable, is extremely expensive and inefficient.
- **Turnaround experts:** these abound in the hospital industry. They certainly exist in the corporate world (recently at General Motors), but their intrusiveness into hospitals, as measured by length of stay, greatly exceeds what occurs in the corporate world.
- **Operational consultants:** this function exists in most industries, however, one aspect of this service is unique to non-profit hospitals, and it is troubling. Many non-profit bond documents call for the use of "consultants" should issuers "trip" maintenance covenants (i.e., the maintenance of certain minimum ratios regarding leverage, liquidity, and operating performance). This means a firm will provide help regarding operating problems, but in our experience, this is often to the exclusion of addressing market competition and other systemic issues. As a result, these broader issues can go undetected by boards while these consultants spend a great deal of time (sometimes years) addressing operating issues. To the extent that market and structural issues were central, then, money and time are wasted.

Federal Trade Commission

The Federal Trade Commission's antitrust review of potential combinations represents a major issue in the future for consolidation. This is particularly true in towns with declining populations and in which local hospitals need to consolidate so as to survive.

"Affiliation"

Many CEOs of larger hospital systems believe that contractual attempts at "systemness" have delayed true business consolidation. Such forms include partnerships, affiliation agreements, and joint operating agreements. These contractual relationships focus more on governance oversight than centralized ownership and control. They strike us as well-intended efforts that fail in practice; with ownership remaining unchanged it is not possible to make the difficult decision necessary to create systems of care. To this point, one CEO we interviewed contrasted "affiliations" with the "regionalized systems" in Canada, which are afforded the authority to rationalize services across a region to consolidate care, specialize in order to improve outcomes, and minimize duplicate services.

Chapter 2. Industry Structure

This chapter describes the hospital industry's structure in relation to horizontal concentration. We review the ownership forms present, the trends in horizontal consolidation, and the size of companies that comprise the hospital industry. In considering the likely impact of healthcare reform on business combinations in the hospital industry, it is important to first understand the changes in the structure and ownership forms of the industry that have occurred over the past two decades.

In order to accomplish this, we review trends related to the number and type of hospital *facilities*, the development of hospital *systems*, or *companies*, and the size and nature of these *companies*. The data on hospital *facilities* provide basic information on the number of individual hospitals, over time, and their ownership forms. The data related to the development of hospital *systems* provide further insight into the overall ownership and control of the industry. This also provides useful information regarding the forms of ownership that appear to be leading the consolidation of the industry. The data on hospital *companies*, themselves, attempt to describe the formation of business entities in the industry, how extensive their access to capital is, and how large, in absolute and relative terms, these companies are.

Several features of the American Hospital Association (AHA) database we used were inconsistent with these objectives and necessitated adjustment:

- The AHA tracks *facilities* and systems, and makes no reference to *business entities*. We attempted to determine the number of businesses so as to be able to form judgments about the level of fragmentation in the industry.
- Certain facilities included in the AHA data (categorized as "other") have business characteristics that differ from general acute-care hospitals. These include long-term acute care, psychiatric, and Veterans Affairs hospitals; in 2008, there were 592 such facilities. We eliminated these from the data in the charts below so as to restrict our review to the general acute-care hospital industry only. We believe this provides a much more accurate picture of the hospital business.
- Similarly, the AHA data concerning for-profit facilities include long-term acute-care, psychiatric, behavioral health, and specialty hospitals; for the same reason as above, we excluded these from the data. Also, based on our working knowledge, we believe that the number of for-profit, acute-care facilities approximates the number of for-profit, acute-care facilities in systems (i.e., there are very few standalone, for-profit hospitals). Finally, we excluded those for-profit hospitals where physicians own the majority of the equity because these tend to provide more specialized services than general acute-care hospitals.
- The AHA groups academic, local-government, and 501(c)(3) systems into one "non-profit" category. We believe the majority of these are 501(c)(3) community hospitals (hereafter referred to as "community" hospitals). This is because most local government-owned systems, by their nature, are single hospitals, and most academic systems are free-standing facilities as a result of their research and teaching orientation.
- Religious-sponsored facilities tend to be part of systems; we believe the number of standalone facilities is insignificant.

The total number of hospitals declined by 10 percent from 1995 to 2008, with most of the decrease occurring in the late 1990s.

Hospital Facilities

Table 1 reflects changes in the number of general acute-care hospitals over time and by ownership type. It also indicates the proportion of all hospitals held by each ownership group. We make the following observations regarding the data on hospital facilities:

- The total number of hospitals declined by 10 percent from 1995 to 2008, with most of the decrease occurring in the late 1990s.
- Predictably, local government-owned hospitals experienced the greatest decline. This group's proportion of the total also declined.
- The number of religious-sponsored hospitals increased in the late 1990s but remained flat through the 2000's.
- The number of for-profit, general acute-care hospitals actually declined slightly during the 1995–2008 period. This decline occurred in the late 1990s as for-profit companies engaged in intra-sector mergers. The reader should assume a small margin for error in the for-profit data due to the assumptions we had to make in order to remove those facilities that are not general acute-care hospitals.
- The proportion of all hospitals that are non-profit or for-profit remains unchanged during the entire period.

Table 1. Hospital Facilities

	1995	2000	2005	2008
501(c)(3) and academic non-profit hospitals	2,507	2,341	2,295	2,265
Proportion of total hospitals	50%	50%	50%	50%
Local government (% of total)	1,350	1,163	1,110	1,105
Proportion of total hospitals	27%	25%	24%	24%
Religious-sponsored	585	662	663	658
Proportion of total hospitals	12%	14%	15%	15%
Total number of non-profit hospitals	**4,442**	**4,166**	**4,068**	**4,028**
Proportion of total hospitals	88%	89%	89%	89%
Total number of for-profit hospitals	**589**	**514**	**514**	**513**
Proportion of total hospitals	12%	11%	11%	11%
Total number of acute-care hospitals	**5,031**	**4,680**	**4,582**	**4,541**

Sources: American Hospital Association, 2010; Juniper estimates.

Table 2 describes the *source of change* in the number of hospital facilities. The following observations highlight the key points in this data:

- Consistent with a decline in the number of facilities in the 1990s, the number of hospitals involved in merger and acquisition (M&A) transactions was considerably greater in the late 1990s than in the 2000s. During just five years between 1996 and 2000, 1,214 hospitals were involved in M&A transactions—nearly 13 percent more hospitals than the 1,075 hospitals involved in M&A transactions during the eight years between 2001 and 2008. We believe this is due to the source of change driving the M&A markets in the 1990s *versus* the 2000s. In the 1990s, business combinations resulted from the *external* pressure associated with the onset of managed care. In the 2000s, business combinations resulted from the *internal* pressure associated with difficulty in accessing capital.
- The size of transactions, measured by the number of hospitals involved, was consistently small over the entire period, averaging between just one and two hospitals per transaction. The only exceptions occurred in 2004 and 2006 when the average number of hospitals per transaction was four or more. However, the data in these two years were impacted by several large transactions that were more akin to investments and financial engineering. For example, in 2004, Iasis was "acquired" by Texas Pacific (a private equity firm), and Blackstone (another private equity firm) "invested" in Vanguard; and, in 2006, HCA entered into a leveraged buyout. These transactions, obviously, did not result in any industry consolidation.
- The small number and size of these transactions are indicative of a developing, relatively immature industry in which only a modest amount of consolidation is occurring.
- Net hospital closures have not played a significant role in consolidation as they were less than 1 percent of the total number of hospitals in any given year.

Table 2. Change in Hospital Facilities

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total number of hospitals	5,031	4,964	4,849	4,833	4,798	4,680	4,673	4,692	4,660	4,684	4,582	4,573	4,543	4,541
M&A market														
Number of transactions	128	163	197	139	110	86	83	58	38	59	50	57	58	60
Average number of hospitals per transaction	N/A	1.9	1.6	2.1	1.6	1.5	1.4	1.7	1.5	4.0	1.8	4.4	2.6	1.3
Total hospitals involved	N/A	312	308	287	175	132	118	101	56	236	88	249	149	78
Net hospital closures	32	32	35	29	42	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	44

Notes:

1. The data on M&A transactions includes long-term acute care and specialty hospitals. This is challenging to adjust since hospital names may not be listed explicitly. Juniper does not believe these facilities had a major impact on consolidation trends in the past 15 years and so we did not adjust this information.
2. AHA did not track closure data for years 2000–2007.

Sources: Irving Levin; American Hospital Association, 2010; Juniper estimates.

Development of Hospital Systems

Table 3 reviews the development of multi-hospital systems, including both non-profit and for-profit, general acute-care systems. This is the first set of data that can be used to assess the overall level of *business concentration* in the industry as measured by the proportion of hospitals that are part of systems. The following observations can be made about the system development data:

- There has been some consolidation in the hospital industry—the proportion of hospitals that are part of systems increased from 40 percent in 1995 to 55 percent in 2008. The majority of this concentration occurred in the mid-1990s.
- By the mid-2000s, slightly more than half of all hospitals were part of multi-hospital systems.
- The business entities, themselves, have not become larger. The number of hospitals per system actually declined from 8.1 hospitals per system in 1995 to 7.5 hospitals per system in 2008.
- As a result, there were more multi-hospital systems in 2008 than 1995, and more hospitals were part of multi-hospital systems. However, the systems themselves have become slightly smaller.

Table 3. System Development Overall

	1995	2000	2005	2008
Total acute-care hospitals	5,031	4,680	4,582	4,541
Hospital systems, total	253	266	314	330
Total hospitals in systems	2,040	2,291	2,387	2,488
Hospitals per system	8.1	8.6	7.6	7.5
Proportion of hospitals in systems	40%	49%	52%	55%
Independent hospitals—*not* in a system	2,991	2,389	2,195	2,053
Proportion of hospitals not in systems	60%	51%	48%	45%

Sources: American Hospital Association, 2010; Juniper estimates.

In continuing to assess the development of multi-hospital systems, we next attempt to consider which types of non-profit hospitals have been most inclined to consolidate (i.e., either by forming or becoming part of multi-hospital systems). **Table 4** describes the development of multi-hospital systems by ownership type. Please note:

- Over the total period, the number of community hospital systems grew 63 percent.
- The number of Catholic-sponsored systems actually shrank by 32 percent, primarily as a result of large intra-Catholic mergers in the late 1980s and 1990s. These resulted in fewer, but larger Catholic systems.
- The number of for-profit companies also declined, primarily as a result of intra-sector mergers in the 1990s.

Table 4. Types of Systems Being Developed

	1995	2000	2005	2008
Non-profit systems				
Community 501(c)(3)-sponsored	162	195	244	264
Religious-sponsored	71	56	55	51
Catholic	57	45	42	39
Other	14	11	13	12
Total non-profit systems	233	251	299	315
Total for-profit companies	20	15	15	15
Total for-profit and non-profit systems	253	266	314	330

Sources: American Hospital Association 2010; Juniper estimates.

Tables 5–9 describe the *development of multi-hospital systems by ownership type.* **Table 5** describes the development of community systems since 1995. Please note:

- Community hospitals are joining systems at a faster rate than the other groups. The number of systems and the proportion of all hospitals that are part of community systems have grown meaningfully.
- By 2008, 53 percent of hospitals that were in systems were part of community systems.
- However, the size of these community systems, measured by the number of hospitals per system, is small and does not appear to be growing.
- We estimate that the average revenue per community system is approximately $1.4 billion, approximately $230 million per hospital. By comparison, across all systems, the average revenue per system is $2.0 billion and the average revenue per hospital is $175 million. This means that, on average, community systems have fewer, but larger, hospitals than other types of systems.

Table 5. Community Systems

	1995	2000	2005	2008
Number of community systems	162	195	244	264
Hospitals in community systems	866	1,115	1,210	1,317
Hospitals per community system	5.3	5.7	5.0	5.0
Proportion of all systems that are community systems	43%	49%	51%	53%
Proportion of all acute-care hospitals in community systems	17%	24%	26%	29%

Sources: American Hospital Association, 2010; Modern Healthcare; Juniper estimates.

Next we consider the development of Catholic-sponsored systems since 1995. Non-Catholic religious systems are not a significant group from a national point of view, so we focus on Catholic systems. Please note:

- Smaller Catholic systems merged into large systems in the late 1980s and 1990s; however, there has been very little consolidation since then.
- The proportion of total systems that are Catholic declined in the 2000s as community systems were more actively involved in mergers.
- The proportion of total hospitals sponsored by the Catholic Church increased slightly in the late 1990s (as others closed hospitals), but did not change during the past decade.
- The size of Catholic systems, as measured by numbers of hospitals continued to increase over the entire period as the largest of the Catholic systems acquired smaller Catholic systems.

Table 6. Catholic Systems

	1995	2000	2005	2008
Number of Catholic systems	57	45	42	39
Hospitals in Catholic systems	488	560	555	556
Hospitals per Catholic system	8.6	12.4	13.2	14.3
Proportion of all systems that are Catholic systems	24%	24%	23%	22%
Proportion of all acute-care hospitals in Catholic systems	10%	12%	12%	12%

Sources: American Hospital Association, 2010; Modern Healthcare; Juniper estimates.

Summing up the development of *all non-profit systems* since 1995, as shown in **Table 7**:

- The number of all non-profit systems increased by nearly 35 percent over the period, as did the number of hospitals that were part of these systems.
- The proportion of all hospitals that are part of a non-profit system increased from 29 percent to 44 percent.
- It should be reiterated, however, that as of 2008, 45 percent of all hospitals remained independent.

Table 7. All Non-Profit Systems

	1995	2000	2005	2008
Number of non-profit systems	233	251	292	315
Hospitals in non-profit systems	1,451	1,777	1,873	1,975
Hospitals per system	6.2	7.1	6.3	6.3
Proportion of all systems that are non-profit systems	71%	78%	79%	79%
Proportion of all acute-care hospitals in non-profit systems	29%	38%	41%	44%

Sources: American Hospital Association, 2010; Modern Healthcare; Juniper estimates.

Table 8 reviews the development of *for-profit systems* since 1995:

- The for-profit sector has shown no overall growth. This is important to note because if one considers the data as reported by the AHA, i.e., inclusive of specialty hospitals, the for-profit sector appears quite a bit larger, close to 20 percent of the total hospital industry, and exhibits greater consolidation.
- For-profit companies, are, however, much larger (measured by number of hospitals) than any of the non-profit system groupings. The for-profit companies average 34.2 hospitals per system versus 6.3 hospitals per system for all non-profits.

Table 8. For-Profit Companies

	1995	2000	2005	2008
Number of for-profit companies	20	15	15	15
Hospitals in for-profit companies	589	514	514	513
Hospitals per for-profit company	29.5	34.3	34.3	34.2
Hospitals in top 10 for-profit companies	882	514	616	513
Proportion of all systems that are for-profit	29%	22%	22%	21%
Proportion of all acute-care hospitals in for-profit companies	12%	11%	11%	11%

Sources: American Hospital Association, 2010; Modern Healthcare; Juniper estimates.

Table 9 reviews the development of *all systems*, both non-profit and for-profit, since 1995. Please note:

- The total number of systems and their proportion of all hospitals have increased since the late 1990s.
- However, the number of hospitals per system is stagnant, indicating that hospital systems, on average, remain relatively small businesses.

Table 9. All Systems Combined

	1995	2000	2005	2008
Total number of hospital systems	253	266	314	330
Total number of hospitals in systems	2,040	2,291	2,387	2,488
Hospitals per system	8.1	8.6	7.6	7.5
Proportion of all acute-care hospitals in all systems	41%	49%	52%	55%

Sources: American Hospital Association, 2010; Modern Healthcare; Juniper estimates.

It is obvious from the analysis above that the community systems have been the primary participants and drivers of horizontal consolidation of the past two decades. This trend, in our view, is likely to be a predictor of future activity.

Hospital Companies

In order to better understand the extent to which control has become more centralized, we next attempt to consider the number of business entities or "companies" in the hospital industry. In order to do this, we combined the number of independent hospitals with the total number of systems to approximate the number of businesses. Our estimate shows the number of companies has declined through consolidation, but there are still over *2,300 separate business entities* making up the general acute-care industry.

Table 10. Business Entities

	1995	2000	2005	2008
Hospital systems	253	266	314	330
Independent hospitals	2,991	2,389	2,195	2,053
Acute-care hospital "companies"—systems plus independents	**3,244**	**2,655**	**2,509**	**2,383**

Sources: American Hospital Association, 2010; Modern Healthcare; Juniper estimates.

By any measure of comparability, this is a staggering amount of fragmentation. There are more than 2,300 CEOs and boards of directors, each trying to "go it alone." Similarly sized and more conventionally structured industries (e.g., insurance, airlines, banks, food, beverage and tobacco) have dramatically fewer companies. Despite some overall consolidation, the largest systems are relatively small in terms of their absolute size and share of the market. No other industry, particularly one so vital to the broader economy, even closely approaches this level of fragmentation. As we heard repeatedly from hospital executives, this would make it very difficult to operate hospitals profitably, especially post-healthcare reform. By way of comparison, **Table 11** highlights the level of concentration, as measured by the share of revenues held by the 50 largest companies, in several industries.

Table 11. Concentration of Industries
($ in billions)

Industry	Companies	Combined annual revenue	50 largest companies
Hospital	2,400	$700.0	25% of industry revenue
Managed care	1,000	$465.0	75% of industry revenue
Airline	500	$130.0	80% of industry revenue
Food, beverage, and tobacco	1,900	$1,300.0	75% of industry revenue

Sources: First Research 2010; Juniper estimates.

There are more than 2,300 CEOs and boards of directors, each trying to "go it alone." Similarly sized and more conventionally structured industries (e.g., insurance, airlines, banks, food, beverage and tobacco) have dramatically fewer companies.

It is also relevant to consider the *size* of companies in the hospital industry, particularly as one considers the demands likely to be placed on hospital businesses by healthcare reform. Compared to other major industries, the hospital industry has few companies that appear to be "market leaders." Frequently, more than half of the top 10 competitors in any given industry are of relatively comparable size. However, Ascension, HCA's largest competitor, is only one-half the size of HCA in terms of revenues. Historically, such comparisons have been viewed to be less important in the hospital industry due to local and regional, rather than national market characteristics, and lack of international markets. As illustrated in **Table 12**, the hospital industry has one "market leader" in terms of size, which commands only 4 percent of industry revenue. By comparison, the leaders in the airline and banking industries occupy 22 percent and 23 percent of their industries, respectively.

Table 12. Largest Hospital Systems

($ in billions, 2009)

FP = for-profit, NP = non-profit

	Revenues	Market Share	Tax Status	Debt Rating
Ten largest hospital systems (for-profit and non-profit)				
HCA	$30.1	4.3%	FP	B2
Ascension Health	$14.3	2.0%	NP	Aa1
Community Health Systems	$12.1	1.7%	FP	B1
Catholic Health Initiatives	$9.6	1.4%	NP	Aa2
Catholic Healthcare West	$9.3	1.3%	NP	A2
NY Presbyterian Healthcare System	$9.2	1.3%	NP	N/A
Tenet	$9.0	1.3%	FP	B3
Sutter Health	$8.3	1.2%	NP	Aa3
University of Pittsburgh Medical Center	$7.7	1.1%	NP	Aa3
Mayo Clinic	$7.2	1.0%	NP	Aa2
Total	**$116.8**	**16.7%**	-	-
Hospital industry (aggregate)	$700.0			
Top 10 companies' total share of industry	16.7%		7 NP : 3 FP	Aa3 median

Sources: Company Web sites; Moody's; Juniper estimates.

Also, market leaders of most major industries have access to capital that is significantly better than that experienced by the leading hospital companies. In most mature major industries, the leading companies have excellent access to both equity *and* debt markets. Access to equity is characterized by publicly held shares, which are actively followed by equity analysts and institutional shareholders. Access to debt is characterized by strong investment grade ratings, the ability to issue debt in most of the major global markets, and the ability to issue commercial paper and medium-term notes.

There are no hospital companies, non-profit or for-profit, with this sort of access to capital. Approximately 40 percent of non-profits have strong credit ratings and good access to debt, although limited to the bank and municipal bond market. None, of course, have access to equity. Currently, *no* for-profit companies have investment-grade ratings, and only five have access to public equity markets.

To emphasize the point regarding maturity and access to capital, it is instructive to consider the largest company in the industry, HCA. Currently, HCA has 166 hospitals and its access to debt capital is limited to the bank and high-yield markets. It is owned by a group of private equity sponsors; however, it is in registration to become public again. By contrast, in the early 1980s, HCA had approximately 350 hospitals, good access to public equity (as a seasoned company with institutional sponsorship and research following), and broad access to debt markets—commercial paper, medium-term notes, Eurobonds, and domestic bond market. From a capital access point of view, this has been a real a step backwards.

Summary

Taken as a whole, the data in this section suggest that the hospital industry is unique, fragmented, and immature. There are over 2,300 separate businesses and the leading companies are small compared to their peers in other industries. No hospital company has full access to the capital markets. As discussed in the next chapter, many believe that healthcare reform represents a need for greater business scale, and that the overall direction of the hospital industry will be to become less fragmented.

Chapter 3. Industry Direction in Response to Healthcare Reform

The hospital CEOs we interviewed believe healthcare reform creates an urgent case for greater business scale, and that consolidation of ownership between hospitals is necessary. Since the data illustrates that the hospital industry is still fragmented and immature, our sense is that healthcare reform could be viewed as the final element in a two-decade-long build-up of pressure for industry consolidation. In this final chapter, we discuss which groups in the hospital industry are likely to lead this consolidation and maturation process. We also offer suggestions to management teams and boards regarding their response to healthcare reform.

Nearly all of the CEOs whom we interviewed suggested that resistance to change has long existed in the hospital industry. As reviewed earlier, consolidation has been slow to occur, particularly during the past decade. There has been some consolidation in the community hospital sector; however, the hospital industry still consists of relatively small companies with only limited, or partial, access to capital. Given this, is real change likely and how should boards approach the future?

Despite resistance, we agree with the experts—there will be significantly greater horizontal consolidation of ownership between hospitals. The healthcare delivery system in the U.S. has reached a critical point; its cost to the national economy is not sustainable. The 1990s represented the only period of meaningful consolidation in recent decades and it was the result of an external factor: managed care. We see a strong parallel between the 1990s and the overarching external issue confronting the industry over the next decade—healthcare reform and its imposition of lower prices and new reimbursement models.

Current Merger Market

Since the recent passage of healthcare reform, non-profits have demonstrated much more interest in achieving scale. Also, a large number of freestanding hospitals and small hospital systems are questioning whether they can thrive, post-healthcare reform, without becoming part of a large system. There appear to be three groups and approaches emerging: consolidators, mergers-of-equals, and "consolidatees."

We have been surprised at the acquisition interest shown by potential non-profit suitors in recent transactions. During the past decade, non-profits exhibited very tepid, at best, interest in acquisitions. Recently, however, a number of well-known non-profits have been indicating interest in expanding and building greater scale, and they are demonstrating a willingness to consider acquisitions even in new markets. Previously, these same companies were concerned only with their local market, operations, and debt ratings.

However, these likely consolidators continue to struggle with the tactics and approaches necessary to successfully compete for transactions. Competitive for-sale processes have become the norm, but most non-profits have a great deal of difficulty navigating through them. Non-profits tend to be uncomfortable with these processes; they spend too much time negotiating changes to confidentiality agreements, and they over-think operating issues and other details during the early stages of these processes. Experienced purchasers, by contrast, focus initially, on strategic rationale and the broad outline of their acquisition interest. As a result, non-profit suitors often provide proposals that are short on financial details and long on rhetoric—these rarely succeed in capturing the interest of the seller's board.

Since the recent passage of healthcare reform, non-profits have demonstrated much more interest in achieving scale.

Also, quite a few non-profit consolidators seem to be operating under a striking sense of *noblesse oblige*. We have recently observed a number of non-profit consolidators who have no intention of providing any "consideration" to the seller (e.g., purchase price or capital expenditure commitment). They seem to believe that target hospitals should be content with simply becoming part of their system (i.e., that these systems will, effectively, "give" themselves to the consolidator). We have been amazed that a few non-profit boards have actually agreed to these sorts of "no-consideration" sale transactions. Legally, these transactions have been structured as mergers or membership substitutions. However, they clearly are not mergers-of-equals, but rather acquisitions without consideration.

We asked Michael Peregrine of McDermott, Will & Emery whether attorneys general might begin to challenge these "no-consideration" transactions, despite the fact that they are "transfers." He indicated that there was no applicable "Revlon Standard," meaning a narrowing of the board's fiduciary obligation to maximize shareholder value when a sale is inevitable, for these transactions. As a result, attorneys general will likely not interfere in these sorts of transactions until local donors challenge them on "charitable trust" grounds.

Separately, there are a number of mid-sized systems seeking to build large businesses through mergers-of-equals. To date, these have been very hard to achieve, likely as a result of the difficulty associated with reaching agreement on business combinations with more than two partners, especially regarding post-transaction management and governance issues. Our suspicion is that very few, if any, of these will materialize. These companies will have to become consolidators or consolidatees, most likely the latter.

Consolidatees represent a group that has made the difficult decision that they are not in a financial position to lead the consolidation of a particular region. To us, the most startling development in this group, in many cases, is the inclination to surrender their hospital to a large partner without financial consideration. Usually, this is not at all necessary, and these hospitals often have significant value. Board confusion regarding fiduciary duty, whether it is to the corporation or the community, clearly, plays a role in this.

It will be a major challenge for community hospitals to move away from the "locality" of their strategic thinking.

Large Systems of the Future

Given the need for larger hospital companies, which ownership types are likely to lead the way? We anticipate that two groups will be the primary consolidators of the industry and will be the source of tomorrow's larger, more integrated companies. Community non-profits are likely to form very large regional systems, and certain for-profits will form large national companies as this sector matures.

Community Hospitals

We believe leadership in consolidation is most likely to come from the community hospital sector. Strong regional systems, either single or multi-state, could be developed by this group of non-profits. These will vary in size depending upon market characteristics; most experts believe they need to be between $2 billion and $5 billion in net patient revenues. In the aggregate, this is the largest group, and these systems have the regional prestige and financial strength to accomplish this. As described earlier, community systems, on average, have fewer, but larger hospitals than the industry overall. In this regard, it will be a major challenge for this group to move away from the "locality" of their strategic thinking.

For-Profit Companies

As reflected in the data, for-profit companies have not done a particularly good job of leading industry consolidation over the past two decades. While they are skilled and reliable in their approach towards acquisitions, they have not increased their share of the general acute-care hospital industry. In our view, this is largely due to the amount of capital and energy expended in financial engineering transactions. The result of this, along with the nature of the business creation process, is a for-profit sector that has no companies with investment grade debt ratings, and only five publicly held companies. There are only a few large, national for-profit companies, and, as discussed earlier, the largest company, HCA, is considerably smaller and has less access to capital than it did 25 years ago. For this sector to be a leader in industry consolidation, as we believe it will, it must accelerate its acquisition of non-profits, greatly expand the number of publicly held companies, and develop companies with investment grade credit profiles.

The near-term ability of for-profits to grow, and foster consolidation, will be heavily influenced by private equity's commitment to the industry. Currently, ten of the fifteen major companies are backed by private equity funds. During and after the recent financial crisis, several of these reduced their commitment to portfolio hospital companies. However, the pending transactions in Detroit and Boston (as of this writing) have the potential to represent a dramatic shift in the nature of for-profit hospital companies and the ownership structure of the industry. In both cases, for-profits have agreed to buy struggling, urban non-profit hospitals. Vanguard, backed by the Blackstone Group, has agreed to buy Detroit Medical Center, which, ironically, is located in a town in which Ascension has been closing hospitals. Cerberus, another large private equity firm, has agreed to purchase Caritas Christi Health Care, a Catholic-sponsored system serving the Boston area. Caritas had been unable to convince any Catholic system to acquire it or to provide financial support.

Local Government-Owned Hospitals

We believe the persistent decline in numbers of local government-owned hospitals is likely to continue, or even accelerate. These hospitals will have the greatest difficulty in succeeding in the post-HCR environment. These are typically one- or two-hospital companies and they are much too small to thrive. They are burdened with troublesome governance structures. Some will convert to 501(c)(3) and become independent non-profits; however, most will become part of larger systems. Change is likely to come very slowly given political pressure and martinet-like adherence to "community control" objectives. However, a number of these hospitals have enlightened managements and boards with a good understanding of the need for change in ownership. In fewer cases, it is possible that financial pressures felt by local governments will cause them to initiate change.

Religious-Sponsored Hospitals

This group does not seem to be well positioned to lead consolidation or to participate in it meaningfully. Non-Catholic religious system are few in number and do not seem destined to have a meaningful presence in the future. While a sizeable minority of all systems, Catholic hospital systems have challenging and changing governance and sponsorship issues, along with the conflict and contradiction inherent in their mix of mission, faith, and financial objectives. Fundamentally, they face a huge issue as sponsoring Sisters decline. More are becoming *public juridic persons*, which only adds to the confusion regarding their purpose. They tend to be focused on financial measures and Church bureaucracy rather than strategic objectives. Also, Catholic systems tend to be very slow to sell non-strategic hospitals. As a result, they often end-up closing hospitals, rather than selling them. Their financial orientation and lack of strategic purpose leads us to believe that they will participate mainly in intra-Church transactions.

Considerations for Boards and Management Teams

What conclusions can be reached from the data reviewed above and the input we received from the interviews? If the community hospital sector is to be a leader in the development of larger systems of care, boards and management teams need to *proactively* consider their circumstances. Rather than simply reacting to operating issues, boards should consider their strategic position in the context of their regional market. The best outcomes, historically, have accrued for those who were "ahead of the curve" in making these kinds of choices. We sense there is considerably more proactive thinking occurring at present than has been the case in the past. Along with understanding the need for change, it is important to determine whether one is in a position to lead in the development of a regional system, or whether one would be best served by becoming part of another system. That is, whether your organization is likely to be a consolidator or consolidatee.

The following are general suggestions for improving management and governance constructs for non-profits, and particularly community hospitals, in the post-healthcare reform era. These reflect input received during our interviews:

- Consider adding a non-local individual with specific knowledge of the hospital and healthcare industries to join the board. This has proven to be very fruitful in several examples that we are aware of and we believe this will be much more common in the future. A knowledgeable, outside perspective might be additive to local input, particularly in the post-healthcare reform era.
- Develop compensation schemes that reward change. Several interviewees indicated that compensation plans provide incentives that caused companies not to consider logical divestitures and, in other circumstances, not to complete attractive acquisitions.
- Consider CEO candidates who have experience in both non-profit and for-profit hospital companies. Also, we believe that it is likely that executives with experience outside of the hospital could begin to appear at large hospital companies. This has recently occurred in the auto industry.
- Reconsider whether the hospital business is entirely "local." We recognize that this is almost a mantra; however, with electronic medical records and standardization of medical practices on the near-term horizon, perhaps the industry should think beyond this, at least partially.
- Rethink antiquated mission statements, which often act as an anchor to accepting change. Consider developing a business that provides systems of care for a region.

Consolidators

Should a board reach the view that a particular community system be a consolidator, we further recommend the following:

- Regarding potential acquisitions, develop an organization that seeks success, rather than the common situation in which too many people are involved and most are looking for a reason not to make a strong proposal. Become comfortable with what is commercially reasonable in confidentiality agreements, and other procedural aspects of acquisitions. Focus on strategic interest first, and worry about detailed investigations during the formal due diligence period.
- Overcome a sense of *noblesse oblige* and complete risk aversion. Recognize that boards of target hospitals have significant fiduciary obligations, particularly to consider alternatives and enter into financially "fair" transactions. Commercially reasonable transactions with fair apportionment of risk between buyer and seller are, ultimately, going to be the norm.
- Consider converting to for-profit status. Several leading non-profits are considering this in light of challenges to community benefit and executive compensation. Weigh the potential benefits of greater access to capital, greater operating flexibility, better focus on business objectives, with higher cost of debt capital and payment of property taxes.
- If at all possible, do not assign the corporate development function to your CFO. Consider creating a separate development department and, perhaps, hire experienced staff from the for-profit hospital sector.
- Consider being "A" rated rather than "AA." In the future it will be more important to grow and thrive commercially rather than conforming to financial characteristics, especially regarding cash, in order to achieve "AA" credit stature. For-profit corporations in major industries have considered this perspective for decades.

Consolidatees

Should the conclusion be reached that a particular community hospital or system is not well positioned to lead regional consolidation, serious and early consideration should be given to overtly seeking a partner or buyer. In this circumstance, we recommend the following:

- The board has a duty to the corporation and should seek fair consideration in a transaction. This can be either purchase price or commitment to capital projects, or both. Hospitals tend to be quite valuable and one should resist the temptation to "give away" their hospital for the sake of the community.
- Learn more about the for-profit industry and have an open mind. Boards should listen to management and advisers, but also meet for-profit companies, visit their hospitals, and make up their own minds. We are constantly amazed at inaccurate information that is offered, even by otherwise sophisticated parties, to non-profit boards regarding for-profits.

Conclusion

The leaders of today's community hospitals and health systems have much to consider for the future viability of their organizations. It is a unique time in history when external forces are asking organizations to make decisions that may be for the better of the healthcare industry overall, but may not be for the benefit of each individual organization. It does seem to be a stark reality for some. However, there is much to be played out in the coming years as providers seek the ultimate task—to integrate care delivery systems, improve quality and efficiency, and reduce cost. Consolidation might be one way hospitals can get closer to the goal of making the U.S. healthcare industry sustainable. However, as with all complex industries, there will not be only one answer.

We hope this white paper provided a foundation for readers to consider industry trends, strategic responses, and unique market positions, in order to reach the best conclusion for their own communities and patients. We are optimistic that the success of the industry will encourage innovative thinking, and pave the way for strong organizations that can provide for the public in new and unique ways, regardless of ownership, location, size, or other factors addressed in this white paper.