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Stable condition: Healthcare reform will enable growth, but high labor costs will constrain profit

IBISWorld Industry Report 62211

Hospitals in the US

December 2012

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About this Industry

Industry Definition

The Hospitals industry includes firms licensed as general medical and surgical hospitals that provide surgical and nonsurgical diagnostic and medical treatment to inpatients with medical conditions. Hospitals maintain inpatient beds and usually provide other services such as outpatient services, operating room services and pharmacy services. The industry excludes psychiatric and other specialty hospitals.

Main Activities

The primary activities of this industry are

- Inpatient care
- Outpatient care
- Anatomical pathology services
- Diagnostic X-ray services
- Clinical laboratory services
- Operating room services

The major products and services in this industry are

- Childbirth
- Circulatory diseases
- Digestive diseases
- Injury and poisoning
- Outpatient care
- Respiratory diseases
- Other inpatient care
- Other

Similar Industries

62221 Psychiatric Hospitals in the US
This industry includes hospitals that provide diagnostic and treatment services for inpatients with psychiatric or substance abuse illnesses.

62311 Nursing Care Facilities in the US
Establishments in this industry are referred to as hospitals, but they primarily provide inpatient nursing and rehabilitative services to people requiring convalescence.

Additional Resources

For additional information on this industry

www.aha.org
American Hospital Association

www.cdc.gov
Centers for Disease Control and Prevention

www.cms.gov
Centers for Medicare & Medicaid Services

Industry at a Glance

Hospitals in 2012

Key Statistics Snapshot

Revenue	Annual Growth 07-12	Annual Growth 12-17
$785.7bn	3.1%	4.0%
Profit	**Wages**	**Businesses**
$20.4bn	$302.3bn	3,013

Market Share

HCA Inc. 4.5%

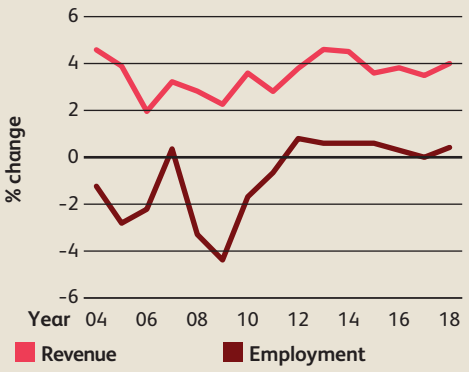
p. 31

Key External Drivers

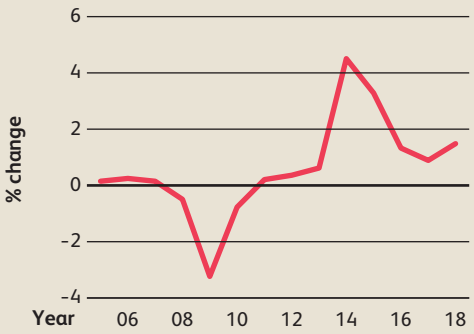
- Federal funding for Medicare and Medicaid
- Number of people with private health insurance
- Number of adults aged 65 and older
- Per capita disposable income

p. 4

Revenue vs. employment growth

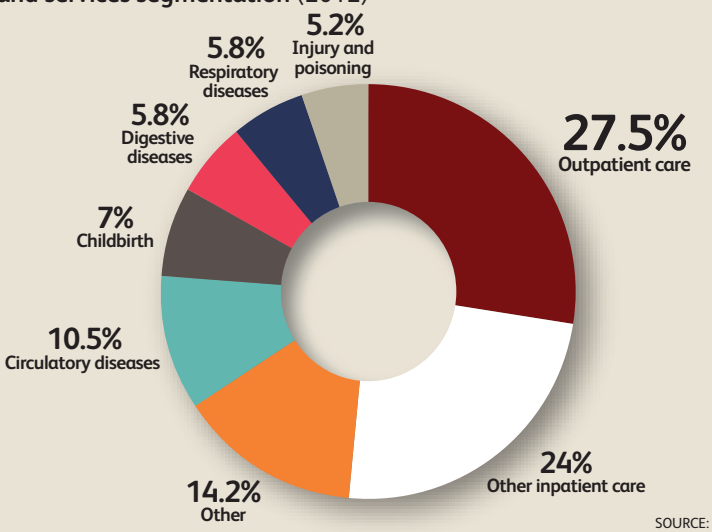


Number of people with private health insurance



SOURCE: WWW.IBISWORLD.COM

Products and services segmentation (2012)



SOURCE: WWW.IBISWORLD.COM

Industry Structure

Life Cycle Stage	Growth	Regulation Level	Heavy
Revenue Volatility	Low	Technology Change	Medium
Capital Intensity	Medium	Barriers to Entry	High
Industry Assistance	High	Industry Globalization	Low
Concentration Level	Low	Competition Level	Low

FOR ADDITIONAL STATISTICS AND TIME SERIES SEE THE APPENDIX ON PAGE 43

Industry Performance

Executive Summary

Hospitals are at the forefront of healthcare for individuals. The $785.7 billion industry has had a longstanding presence in the United States and revenue continues to grow. From 2007 to 2012, revenue is expected to increase 3.1% per year on average. Revenue is also forecast to increase an average of 4.0% annually in the five years to 2017, reaching $955.9 billion that year. The poor economic environment in 2008 and 2009 only moderately dampened industry sales. During the recession, fewer people with health insurance coverage caused overall demand to soften, so hospitals treated more uninsured and Medicaid patients in emergency rooms (ERs). The number of insured patients in hospital rooms shrank, contributing to declining profit margins since 2007.

As more individuals gain health insurance, hospitals will benefit from increasing revenue

Hospital administrators also face nurse and physician shortages. Hospitals struggle to recruit and retain qualified personnel for several reasons, including insufficient and costly education programs. As a result, wages as a percentage of revenue have risen, as hospitals attempt to fill these positions. This trend in wages is forecast to continue and possibly become more severe during the next five years.

In response to lower government-program reimbursements and consolidation among managed-care organizations, hospitals are consolidating. During the five years to 2012, the number of operators is expected to decline at an average annual rate of 2.4% to 3,013. Healthcare reform passed in 2010 is expected to slow consolidation somewhat, but it will not keep operator numbers from declining 0.9% per year on average through 2017.

The Patient Protection and Affordable Care Act of 2010 will likely benefit the industry as more individuals gain health insurance coverage. This factor will reduce the number of uninsured patients that hospitals treat, decreasing uncollectible payments and boosting revenue an estimated 3.8% in 2012. As hospitals anticipate a growing customer base, fewer nonprofit hospitals will close. Still, reimbursement from Medicaid and Medicare will be strained, as the government seeks to finance healthcare reform and states deal with budget deficits, dampening profitability. The electronic health record incentive and cost cutting efforts will buoy operating profit during the five years to 2017, raising profitability to about 3.1% of revenue.

Key External Drivers

Federal funding for Medicare and Medicaid

It is costly for hospitals to administer oversight to government policies surrounding Medicare and Medicaid. Federal and state funding of Medicare and Medicaid, together with the government-determined terms of access to these reimbursement programs, affect demand for healthcare services and the prices charged for those services. Government reimbursement programs increasingly challenge prices paid for healthcare services. This driver is expected to increase during 2013; however, ongoing uncertainty about the future of reimbursement rates continue to pose a threat to the industry.

Number of people with private health insurance

People covered by private health

Industry Performance

Key External Drivers continued

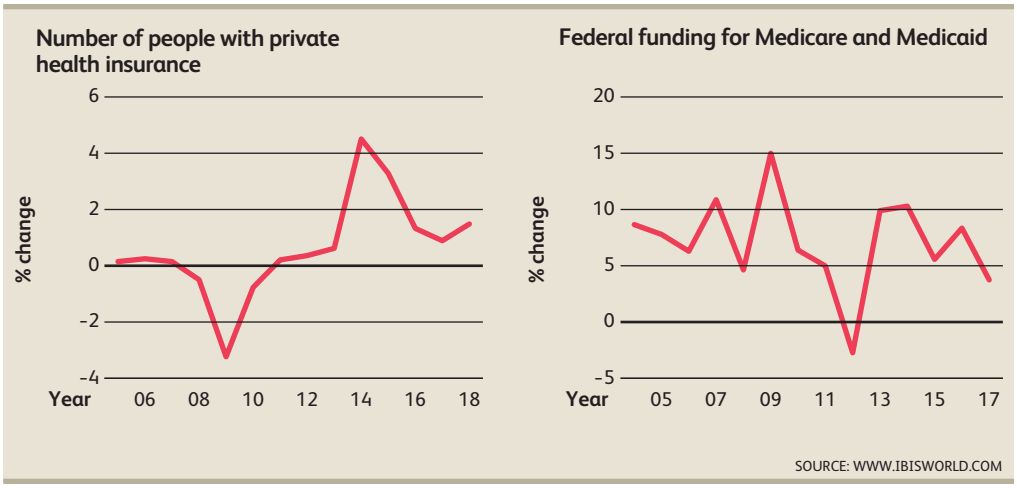
insurance typically use healthcare services more frequently. Private health insurers often pay more for a hospital procedure relative to public insurers, so the extent to which private health insurance covers the US population affects demand for and spending on healthcare services. This driver is expected to increase slowly during 2013, reflecting a potential opportunity for the industry.

Number of adults aged 65 and older

An increasing number of elderly Americans positively affects hospitals because people older than 65 generally need more medical care. The per-capita healthcare spending in this age group is three to five times higher than for people under 65, according to major companies' annual reports. This driver is expected to increase during 2013.

Per capita disposable income

People with higher incomes typically spend more on healthcare (including hospital services) and are more likely to have private health insurance that provides coverage for hospital services, boosting industry demand. Furthermore, people with higher disposable incomes are more likely to pay their hospital bills. This driver is expected to increase slowly during 2013.



SOURCE: WWW.IBISWORLD.COM

Current Performance

The Hospitals industry is expected to grow at an annualized rate of 3.1% during the five years to 2012. Nevertheless, hospitals have been challenged to provide quality patient care, while dealing with rising costs and strong competition for patients.

In 2012, moderate improvements in the economy are expected to help boost revenue 3.8% to $785.7 billion; however, changes in reimbursement rates and a shortage of qualified personnel continue to be obstacles for hospitals.

Industry Performance

Profitability under pressure

Advances in healthcare have helped people live longer, healthier lives. In 2007, American life expectancy at birth reached 77.9 years, according to the Centers for Disease Control. This progress has been accompanied by increases in healthcare spending that many view as unsustainable. Hospital care as a percentage of total spending on healthcare services and supplies has actually declined from 43.0% in 1980 to 33.0% in 2009 (latest data available), according to the American Hospital Association, even as health spending continues to rise. Still, hospital care remains the single largest category of healthcare spending, making the industry a prime target for cost reductions.

Lower reimbursement and mounting costs are pressuring operating profit margins down. In 2012, profitability is expected to fall to 2.6% of revenue, down from 6.0% in 2007. Caps on government reimbursements for Medicare and Medicaid patients have restricted hospitals' abilities to raise prices in response to mounting costs. The US government limits the amount that hospitals are reimbursed for treating Medicare and Medicaid patients. This limitation effectively puts a ceiling on the prices that hospitals can charge for services it provides to these patients. These limits directly affect revenue because 30.0% to more than 40.0% of a typical hospital's patients are in Medicaid and Medicare programs. As the number of patients using Medicare and Medicaid grew in recent years, stretching federal resources, the government further reduced caps for these programs. The lower caps can have two effects on hospitals: reducing the amount that a hospital gets reimbursed, and reducing the amount of services a patient can receive each year. Each has the ultimate consequence of lowering the number of patients. In 2011, the Centers for Medicare and Medicaid Services (CMS) reduced the amount hospitals could charge the federal government by 2.9%. However, for 2012, CMS payments to general acute care hospitals for operating expenses are expected to increase 1.1%, which will benefit the industry's operating profit.

Low reimbursement levels and mounting costs have placed downward pressure on profit

Hospitals have had lower revenue and higher administrative costs during the five years to 2012. In an effort to rein in costs, in 2012, the Centers for Medicare and Medicaid Services will perform an audit before paying for certain cardiology and orthopedic procedures in key states. This policy is expected to cause reimbursement for numerous procedures to decrease during the year and raise administrative costs associated with getting payments from CMS. While costs rise, hospitals still need to take care of all patients who request care. Even as the economy began to recover, already-high numbers of uninsured patients climbed further in 2010 and 2011 because unemployment remained high (employers are often the source of consumers' private health insurance). The reform law, which expands coverage to 32.0 million Americans, will not go into effect until 2014.

The Medicare electronic health record (EHR) incentive program is one positive aspect of reimbursement. This program will provide incentive payments to eligible hospitals that demonstrate meaningful use of certified EHR technology. In May 2011, CMS issued its first round of payments, totaling $75.0 million, to providers that signed up in the first two weeks of the program. Also in May 2011, CMS issued a proposed rule

Industry Performance

Profitability under pressure continued

for Medicare's electronic prescribing incentive program. The rule allows hospitals that meet meaningful use requirements to apply for a waiver from the 1.0% e-prescribing penalty that will take effect on January 1, 2012. Therefore, for 2012, hospitals that are not successful will receive 99.0% of the Physician Fee Schedule amount that would otherwise apply to their covered charges.

Consolidation continues

Hospitals are consolidating to reduce costs through better negotiating power with suppliers and payers. Also, operators are closing underperforming hospitals. During the five years to 2012, hospital locations are expected to decline at an average rate of 2.5% per year to 4,794. Reimbursement from government programs has grown at a slow pace, and the industry's ability to obtain favorable contracts with nongovernment payers, including health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other managed-care plans has fallen. These factors have negatively affected revenue and profitability. Revenue derived from these entities and other insurers accounted for about 60.0% of patient revenue in 2012. Nongovernment payers, including managed-care payers, continue to demand discounted fee structures. The trend toward consolidation among nongovernment payers tends to increase their bargaining power over fee structures. Since 2007, operator numbers have declined at an average annual rate of 2.4% to 3,013.

Consolidation is occurring in response to heightened competition from other healthcare facilities

Consolidation is also occurring in response to heightened competition from other providers. Historically, the Hospitals industry has faced low competition, since most communities are home to only a few hospitals. However, during the five years to 2012, the number of new facilities that deliver healthcare services, such as physician-run outpatient surgery centers, specialty hospitals and diagnostic centers, has grown rapidly. Independent competitors often have lower costs because of their smaller size and simpler infrastructure. Hospitals use the income provided by high-margin operations to finance certain unprofitable services and procedures. Increased competition can reduce the number of more profitable operations performed in hospitals, significantly diminishing profit.

Healthcare reform takes effect

Healthcare reform has already started to make big waves in the Hospitals industry. While the industry consolidated prior to the legislation, operators that anticipate tougher times once healthcare reform takes full effect are pursuing mergers and partnerships on a broader basis. After the economic downturn of 2008 and 2009, many not-for-profit hospitals (typically owned by counties, municipalities, religious orders or foundations) continue to struggle financially. Some of these hospitals have concluded that partnering with other hospitals is prudent given the uncertainties to come. Others have chosen to consolidate to meet the reform's initiatives for cost-

Industry Performance

Healthcare reform takes effect continued

control measures and regional cooperation among facilities.

Some hospitals are merging with corporate hospital operators. Furthermore, some centers are teaming up with nearby providers to reduce expenses in areas like data management, medical system upgrades and supply procurement and billing functions. Changes in insurance and Medicaid and Medicare reimbursement, such as lower or higher reimbursement rates on certain products and services, are further incentives to consolidate. Pharmaceutical and medical device manufacturers also have a direct role in how hospitals must adjust to regulatory changes. For instance, in late 2010, manufacturers of drugs that treat rare diseases informed children's hospitals that they would no longer qualify for certain discounts under new healthcare laws.

The cost-control measures that fuel healthcare reform are intended to benefit hospitals in a variety of ways, particularly by reducing the number of uninsured "charity" patients and providing government grants to fund quality improvements. Nonetheless, several areas could potentially cut operating profit, particularly for smaller players. Ultimately, hospitals have innovated to reduce their operating expenses, so that they can continue to provide quality healthcare while maintaining profitability. In the present environment, the most logical option for many providers is to band together.

Uninsured patients burden the industry

Historically, hospitals have been able to collect only 10.0% of the total billed to uninsured patients. Since hospitals are required by law to provide emergency care to all patients, the number of uninsured patients and bad-debt expenses has been rising and pressuring profit margin. A growing need for acute care has caused US healthcare costs to rise, despite a decline in the number of facilities that provide this care in emergency rooms (ERs). The increase in uninsured or underinsured patients who are unable to pay for services has resulted in this mismatch. Patients often turn to emergency departments for their primary care needs. That trend has resulted in overcrowding, making it difficult to focus adequate resources on patients who present true emergencies.

The number of people with health insurance in the United States dropped for the first time in 23 years in 2009, with 253.6 million insured people, according to the US Census Bureau, down from 255.1 million the previous year. The number of people covered by private health insurance is decreasing, while the number with government coverage like Medicare and Medicaid is increasing.

The uninsured are filling ERs, and people with Medicaid or other government insurance also make up a large share of increased ER traffic, according to the latest federal numbers released in 2010. Medicaid patients are going to ERs because they are unable to get appointments with physicians. When patients get sick but are unable to see a physician, they often wait until an illness has worsened to the point that they need care in an emergency department. Many doctors say Medicaid reimbursement is so low that they lose money on each patient. The number of physician offices that accept Medicaid and the volume of patients that each can take are decreasing. Nationally, about 69.0% of offices accept Medicaid in 2012, according to data from the Centers for Disease Control. By contrast, more than 80.0% of physician offices accept Medicare.

Industry Performance

Physician and nurse shortage

To increase or maintain the breadth of specialized services available to its patients, hospitals must hire qualified physicians and nurses. This factor has become an industry-wide challenge since the nation faces a shortage of both professionals. The economic downturn led to an easing of the shortage in many parts of the country. Nonetheless, the shortage has caused wages as a percentage of revenue to increase in order to recruit and retain qualified medical personnel or hire more expensive temporary or contract personnel. In 2012, wages are expected to inch up to about 38.5% of revenue versus 38.2% in 2007.

The nursing and physician shortage has occurred for various reasons, including a scarcity of education programs. US nursing schools turned away 54,991 qualified applicants from baccalaureate and graduate nursing programs in 2009 due to insufficient faculty, clinical sites, classroom space, clinical preceptors and budget constraints, according to a report from the American Association of Colleges of Nursing. Also, American physicians are getting older. In the past 20 years, the percentage of doctors older than 55 has risen from 27.0% to 34.0%, meaning that many of them will retire in the coming years. The shortage is especially acute in specialties like cardiology, family practice, general surgery, internal medicine, oncology, orthopedic surgery, psychiatry and urology. In rural areas, where fewer than 10,000 of 212,000 physicians are surgeons, specialists are even scarcer. Rural doctors generally receive smaller salaries than their urban counterparts, adding to the challenges that rural hospital chains face in recruiting for many of their locations.

Industry Outlook

Healthcare reform, reimbursement trends, electronic records and nursing shortages are the top concerns that operators in the Hospitals industry face. Healthcare reform will likely increase the number of insured patients, thereby boosting revenue. Other factors, such as the aging population, will contribute to revenue growth over the next five years. IBISWorld projects that industry revenue will increase at an average annual rate of 4.0% to $955.9 billion during the five years to 2017. In 2013, revenue is forecast to grow 4.6%. Profitability will remain pressured as labor costs increase due to a nursing shortage; however, the industry's profit margin will get a boost from the increasing number of people who have health insurance.

Industry Performance

Healthcare reform's effects to take shape

Hospitals are refining their strategies because of changes in market competition and the introduction of new medical technologies. The advent of major healthcare reform via the Patient Protection and Affordable Care Act (PPACA) will drive dramatic changes in the industry through 2017.

At its core, healthcare reform promises health insurance coverage for a vast number of the uninsured population (estimated to be more than 32 million Americans). Its adoption will increase the number of patients that hospitals serve. Coverage has already started growing – parents can now cover their young adult children up to age 26 – and the PPACA prohibits insurance companies from denying insurance to children because of their health status. Adults cannot have their coverage dropped when they get sick, and people who are denied insurance because of their health conditions will be eligible for improved high-risk insurance. These measures will likely reduce the number of patients who are unable to pay their healthcare bills, bolstering industry revenue and profitability.

Almost 50.0% of the $938.0 billion legislation is scheduled to come from cost savings garnered by reducing payments to hospitals, insurers and other healthcare providers that participate in Medicare. In 2014, Medicaid expansion and the individual mandate to purchase insurance will take effect. Coverage purchased in the health insurance exchanges must meet minimum benefit standards, and this requirement will improve the situation. Nevertheless, hospitals will not benefit from getting more Medicaid patients unless these programs increase their reimbursement, which is often less than the cost of providing care. Unfortunately, this will not likely occur unless the economy turns around and states' budget deficits shrink.

Healthcare reform will increase the number of patients served by hospitals

Even in that case, Medicaid may not pay higher reimbursements. Hospitals will have a harder time bridging the gap between the cost of providing care and the reimbursement payments received from Medicaid and Medicare, even though Medicare and Medicaid services represent about 40.0% of total revenue.

Because most states must operate with balanced budgets and the Medicaid program is often their largest program, states will likely adopt legislation designed to reduce Medicaid expenditures. The economic downturn has increased budgetary pressures, resulting in decreased spending for Medicaid programs in many states. Many have adopted or are considering legislation designed to reduce coverage and program eligibility. They have also adopted or considered enrolling Medicaid recipients in managed-care programs or imposing additional taxes on hospitals to help finance or expand states' Medicaid systems. Finally, about $36.0 billion in cuts to the Medicare and Medicaid disproportionate share hospital (DSH) payments are planned to begin in 2014. DSH payments provide additional compensation to providers (via states); they were created to offset the burden of treating a "disproportionate" number of uninsured patients. For many of these providers, DSH payments are essential to remaining in operation.

A growing insured population, a declining number of nonprofit operators and a difficult reimbursement environment will lead to a moderate increase in profit margin to about 3.1% of industry revenue in 2017, versus 2.6% in 2012.

Industry Performance

Electronic health records

While Medicare cuts are forecast to decrease, technology costs are going up. For example, state and federal governments will institute new requirements for keeping electronic medical records. The Health Information Technology Economic and Clinical Health Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA), includes billions of dollars in Medicare and Medicaid incentive payments to providers and hospitals for the "meaningful use" of certified health information technology (IT) products. The ARRA calls for hospitals to create an electronic health record (EHR) for every American by 2014. The funding is expected to range between $9.7 billion and $27.4 billion and will be distributed over 10 years, according to the CMS. Hospitals that fail to comply by 2015 stand to lose up to 1.0% of their Medicare reimbursements.

The government will provide some assistance for electronic recordkeeping conversion

Nearly $20.0 million in new technical support assistance provided by the federal government will help critical access and rural hospital facilities convert from paper-based medical records to certified EHR technology. Critical access hospitals (CAHs) are located in rural areas more than 35 miles from any other hospital. Additionally, CAHs maintain fewer than 25 inpatient beds and are required to provide 24-hour emergency care services. More than 1,600 critical access and rural hospitals stand to benefit from this assistance, which can help each of them qualify for substantial EHR incentive payments from Medicare and Medicaid.

Ongoing personnel shortage

Unfilled faculty positions at nursing colleges, resignations and retirements in the workforce, and the shortage of students being prepared to be faculty will pose a threat to the nursing education workforce during the next five years. In light of healthcare reform and the subsequent demand for nursing services, the slowing production of nurses will adversely affect the industry.

Hospitals will likely enhance wages and benefits to recruit and retain nurses and other medical support personnel. Alternatively, they may hire more expensive temporary or contract personnel. In addition, many states are expected to adopt mandatory nurse-staffing ratios or reduce mandatory nurse-staffing ratios already in place. State-mandated nurse-staffing ratios negatively affect labor costs and adversely influence revenue because they require operators to limit patient admissions to meet the required ratios. As a result, industry labor costs are projected to increase to 38.8% of revenue by 2017, versus 38.5% in 2012.

Decline in number of nonprofits

Cash-poor nonprofit hospitals, which are unable to borrow money for needed improvements in facilities and equipment, will seek for-profit suitors. Concurrently, for-profit hospital companies and investment firms (with the improving economy and the expected influx of more insured Americans) will look to the nonprofit sector for opportunities.

Industry Performance

Decline in number of nonprofits continued

Not-for-profit operators will face new challenges due to healthcare reform; Section 9007 of the PPACA has made it more difficult to be a charitable hospital. Specifically, the legislation adds requirements for charitable hospitals that are exempt from federal taxation. These requirements include performance of periodic community needs assessments and financial assistance policy requirements for patients. These changes will trigger further consolidation between not-for-profit and for-profit operators in the industry, which normally results in a higher average operating profit. However, a challenging reimbursement environment will counteract this factor and limit profit growth.

More acquisitions of nonprofits are forecast to occur during the five years to 2017, reducing the number of industry operators an average of 0.9% per year to 2,884. Still, the acquisition trend will likely be smaller than in the late 1990s and early 2000s, when for-profit companies such as Columbia/HCA (now the Hospital Corporation of America) and Tenet Healthcare acquired several nonprofit hospitals. About 70.0% of the 4,794 hospitals in the United States are nonprofit, 11.5% are for-profit, and the rest are government run. The percentage of nonprofits in the industry is forecast to decline to about 65.0% by 2017.

As capital costs rise, cash-poor nonprofit hospitals will seek for-profit suitors

Healthcare reform addresses the uncompensated care problem, making urban hospitals more attractive acquisition targets. Since these hospitals will have a higher population of insured patients due to the PPACA, fewer locations are set to close during the acquisition process. Consequently, the number of locations is forecast to decline more moderately, at an average annual rate of 0.5% to 4,666 by 2017.

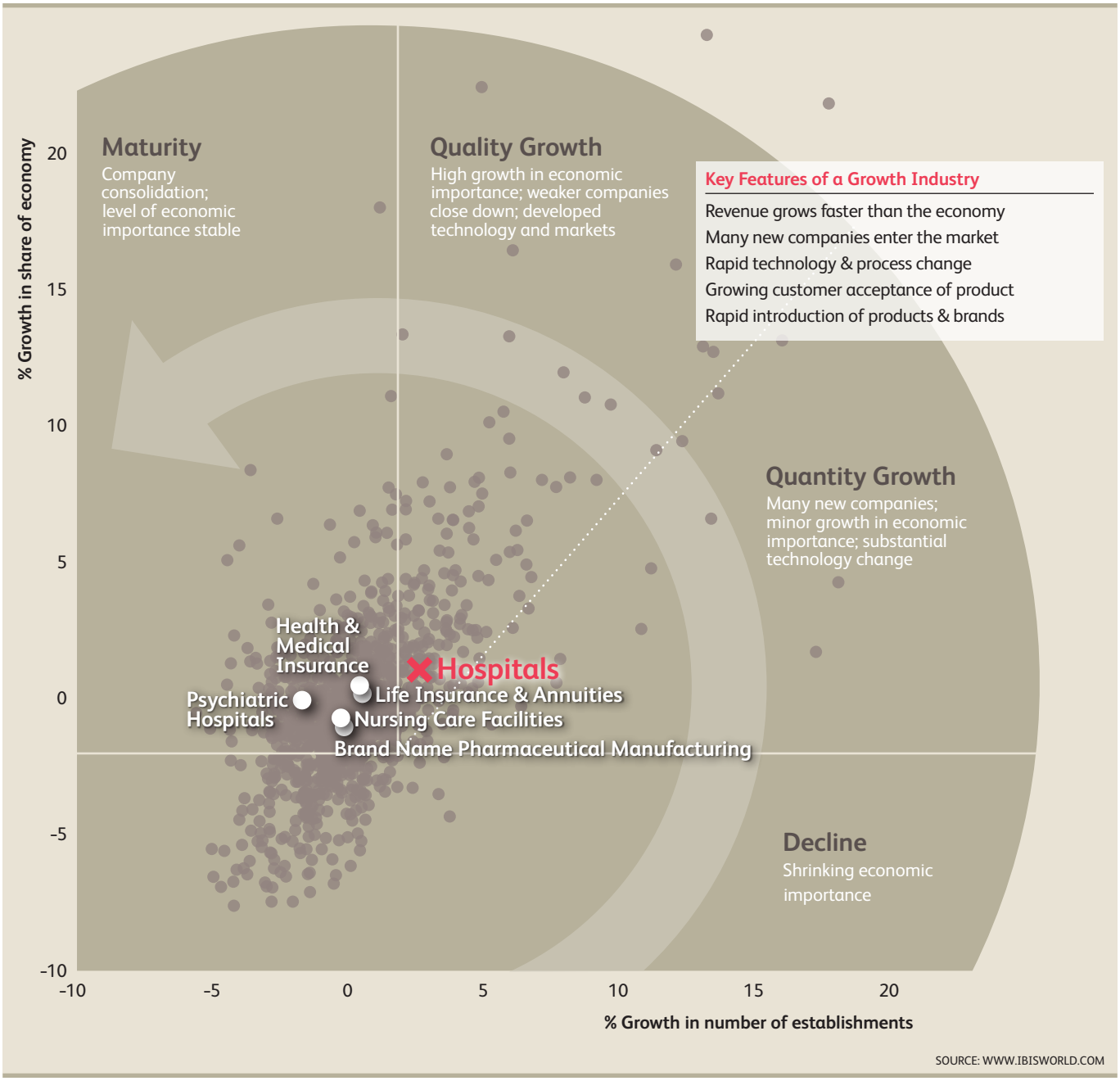
Industry Performance

Life Cycle Stage

The value that the industry adds to the US economy is growing faster than GDP

New technologies are expanding the array of services and increase capital expenditure

A projected increase in the number of insured individuals is partly driving consolidation



SOURCE: WWW.IBISWORLD.COM

Industry Performance

Industry Life Cycle

This industry is **Growing**

Despite the industry's longstanding presence in America, the Hospitals industry is in the growth phase of its life cycle. Growth in the value that the industry adds to the overall US economy is forecast to average 2.8% annually during the 10 years to 2017. This increase is faster than the projected average annual growth of US GDP during the same period (1.8%).

The industry will be bolstered by investments in technology, specifically in electronic health records. This will cause capital expenditure to increase. Additionally, the aging US population will contribute to growing demand for hospital services, and the healthcare reform of 2010 will increase the number of people with health insurance. However, Medicaid, the program under which most of the newly insured will be covered, typically pays hospitals less than the actual cost of care.

While new technologies will expand the array of services that hospitals offer, these innovations can also cause the average length of stay to decline. This trend may slightly restrain industry revenue growth and result in a shift toward outpatient services that are delivered from other healthcare providers. Governments have also made efforts to reduce costs, including in health, and this factor will somewhat stifle profitability. Managed care organizations will attempt to reduce growth in benefits paid for hospital services. These payers are consolidating and growing in size. In response, industry operators will likely consolidate to maintain bargaining power for prices charged for services. However, consolidation is also occurring in response to growth opportunities; more for-profit operators will likely acquire nonprofit hospitals in response to the projected increase in the number of insured individuals due to healthcare reform.

Products & Markets

Supply Chain | Products & Services | Demand Determinants
Major Markets | International Trade | Business Locations

Supply Chain

KEY BUYING INDUSTRIES

52411a **Life Insurance & Annuities in the US**
Life insurers provide coverage for hospital services.

52411b **Health & Medical Insurance in the US**
Health and medical insurers provide coverage for hospital services.

52512 **Health & Welfare Funds in the US**
Health and welfare funds provide hospital services and other benefits exclusively for the sponsor's employees and members.

KEY SELLING INDUSTRIES

32541a **Brand Name Pharmaceutical Manufacturing in the US**
Pharmaceuticals and medicines are used to treat and care for hospital patients.

33911a **Medical Instrument & Supply Manufacturing in the US**
Surgical and medical instruments and appliances are used to treat and care for hospital patients.

42345 **Medical Supplies Wholesaling in the US**
Medical and hospital equipment are used to treat and care for hospital patients.

56171 **Pest Control in the US**
Janitorial services provide hospital cleaning services.

56211 **Waste Collection Services in the US**
Waste collection companies remove hospital waste.

62111a **Primary Care Doctors in the US**
Primary care doctors refer patients to hospitals and can provide services within hospitals.

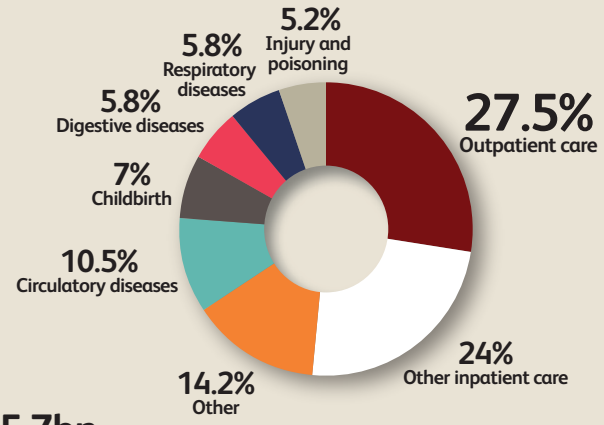
62111b **Specialist Doctors in the US**
Specialist doctors refer patients to hospitals and can provide services within hospitals.

62133 **Psychologists, Social Workers & Marriage Counselors in the US**
Therapists provide services in hospitals.

62151 **Diagnostic & Medical Laboratories in the US**
Pathology and diagnostic imaging companies provide services to, and within, hospitals.

Products & Services

Products and services segmentation (2012)



Total $785.7bn

SOURCE: WWW.IBISWORLD.COM

Products & Markets

Products & Services continued

Three basic types of hospitals exist in the United States: proprietary (for-profit) hospitals; nonprofit hospitals; and charity- or government-supported hospitals. The services within these institutions vary considerably, but they are usually organized around the basic missions or objectives of the institution. For-profit hospitals include general and specialized hospitals, usually as part of a healthcare network (i.e. HCA Inc.), which may be corporately owned. Proprietary hospitals aim to make a profit from the services provided.

Nonprofit teaching or community hospitals serve several purposes: they provide patients for the training or research of interns and residents; they also offer services to patients who cannot pay for services, while attempting to maintain profitability in order to maintain and update facilities. Nonprofit centers like the University of California at San Francisco and the Mayo Clinics combine service, teaching, and profitability without being owned by a corporation or private owner.

Government-supported hospitals include tax-supported hospitals for counties, communities and cities, with voluntary hospitals (community or charity hospitals) run by a board of citizen administrators who serve without pay. This type of hospital's main objective is to provide healthcare for a community or geographic region.

Nonprofit hospitals have historically and currently dominate the industry; however, ownership of hospital beds in the United States has been trending away from nonprofit or government ownership and towards increased for-profit ownership over the five years to 2012. This trend has been persisting since at least the 1990s based on data from the American Hospital Association. For-profit hospitals are also growing in size relative to nonprofits.

Types of healthcare

Hospitals typically offer acute care services, operating and recovery rooms, radiology services, respiratory therapy services and clinical laboratories and pharmacies. In addition, most hospitals offer intensive care, critical care or coronary care units, physical therapy, and orthopedic, oncology and outpatient services. A number of industry operators also provide tertiary care services such as open-heart surgery, neonatal intensive care and neuroscience. Some general hospitals have the facilities to provide complex resource-intensive procedural services. Smaller community-based hospitals are more numerous and tend to be located closer to the population. These smaller hospitals manage less-complex cases, referring complex cases to the centralized tertiary hospitals.

Hospitals have continued to expand the scope of services they offer during the five years to 2012. New technologies, such as robotic surgery and positron emission tomography (PET) scan services, are among those that have grown most rapidly. Core hospital services (e.g. trauma care, cardiac services and oncology) are also been offered by more hospitals in 2012 than in 2007 based on data from the Centers for Medicare and Medicaid Services. Post-acute care is a rare area in which the share of hospitals offering a type of service is expected to decline during the five year period. Rural hospitals tend to offer fewer high-tech services but have been expanding their imaging and orthopedic surgery offerings.

Inpatient versus outpatient

Most hospitals offer both inpatient and outpatient care, depending upon the needs of the people. Outpatient care refers to any type of service that does not involve an overnight stay in a medical facility. The typical visit to a doctor's

Products & Markets

Products & Services continued

office is outpatient, but so is a surgery in a hospital where the patient returns home the same day. Blood tests, lab work, x-rays, mammograms and the like are usually outpatient and may take a few hours to perform. However, these tests may also be performed on those who are hospitalized. Similarly, a same day surgery can become inpatient if complications arise and the person must be hospitalized overnight.

During the five years to 2012, the number of outpatient and alternative healthcare delivery services for less acutely ill patients has increased. This growth has mainly occurred because of regulatory and technological changes, a shift toward outpatient treatment and an increasing supply of out-of-hospital physicians. For example, it used to be standard to hospitalize people for conditions like pneumonia. However, improved drug treatments mean that fewer people need to actually stay in the hospital unless they have aggressive pneumonia or other serious conditions. Similarly, many surgical procedures, such as pacemaker implantation, that were once performed solely as an inpatient service are now often done in an outpatient setting. Also, the quality of rest and care is often better at home than in hospital settings. Other refinements in medicine, like improved surgical techniques and anesthesiology, have also led to a reduction in the types of surgeries that require overnight care in a hospital.

Increased outpatient services have also been driven by cost; it costs much more to hospitalize patients overnight or for several nights than it does to send them home. When it is safe for a patient to recover at home, it greatly reduces the cost of medical care. An additional benefit to decreased inpatient care is that it helps to save room in already crowded hospitals for people who do require more extensive care. Major payers like Medicare, Medicaid and managed care companies also face higher pressure to reduce admission rates and length of stays and to maximize outpatient and alternative healthcare delivery for less acutely ill patients.

Types of diagnoses

The US Center for Disease Control conducts an annual survey that details diagnostic categories of short-stay hospitals. Some of the major diagnostic categories include circulatory system diseases (accounting for about 18.0% of all discharges), of which, about 67.7% are heart diseases. Other categories include childbirth (about 12.0% of discharges from all conditions); digestive system diseases (about 10.0% of all discharges); respiratory system diseases (about 10.0% of all discharges) and injury and poisoning (about 9.0% of all discharges). Diagnostic categories of short-stay hospitals also include mental disorders (about 7.0% of all discharges); musculoskeletal system and connective tissue diseases (about 6.0% of all discharges); genitourinary system diseases (about 6.0% of all discharges); endocrine system, nutritional and metabolic disease, and immunity disorders (about 5.0% of all discharges); and neoplasms (about 5.0% of all discharges).

Cardiovascular disease (CVD) is the leading cause of death and a major cause of disability worldwide. In the United States, heart disease and stroke – the principal components of CVD – rank first and third, respectively, among the leading causes of death. CVD is also a major cause of health disparities and rising healthcare costs. The aging population, obesity epidemic, underuse of prevention strategies and suboptimal control of risk factors could exacerbate the future CVD burden. Increased adherence to clinical and community-level guidelines and renewed emphasis

Products & Markets

Products & Services continued

on policy, environmental, and lifestyle changes will be crucial for its effective prevention and control.

In economic and social terms, hospitalizations related to childbirth are an important part of the US healthcare sector. During a woman's hospital stay for childbirth, several hospital procedures may be performed. The two most frequent procedures related to childbirth are those that assist with delivery of infants and Cesarean sections (C-sections). Other high-volume childbirth-related procedures included repair of current obstetric laceration and fetal monitoring. The high frequency of obstetric procedures is especially evident in the 18 to 44 age group. The dramatic changes in utilization of certain obstetric procedures, such as C-sections, have drawn recent media attention given patient safety and cost concerns.

Demand Determinants

The general health of the population, demographic trends, healthcare technologies, and the cost, affordability and availability of hospital care affect industry demand. Public and privately funded programs can increase the overall level of health by promoting healthy lifestyles (relating to diet, exercise and drug taking), and by increasing safety on the road, in the workplace and in other areas. New drugs may avert or reduce the need for hospitalization. The size, growth, natural increase and age distribution of the population also influence demand for hospital services. Older adults tend to be major users of hospital services, as are women in the childbearing age group.

New technologies can increase the range of treatments available in hospitals (increasing demand) and in other settings (reducing demand). They can also reduce the length of stay in hospitals (diminishing demand). New technologies allow people to be treated on an outpatient basis (e.g. day surgery), which is usually cheaper compared with inpatient care, leading payers to demand a shift to ambulatory or outpatient care wherever possible. People on higher incomes tend to spend more on healthcare, and they often have private health insurance. Therefore, the demand for hospital services tends to rise in response to growth in incomes in the community.

People with health insurance coverage (2008)*

	No. of people ('000)	% of total population
Total covered	255,143	84.7
Private	200,992	66.7
Employment-based	176,332	58.5
Government	87,411	29.0
Medicare	43,029	14.3
Medicaid	42,641	14.1
Military	11,560	3.8
Not covered	46,340	15.4

*Latest information available

SOURCE: US CENSUS BUREAU

Private and public health insurance can reduce the direct cost to patients of hospital care, and higher rates of insurance coverage can promote overall demand. In recent years, a weak economy, reduced Medicaid budgets, an increase in the number of individuals and employers without insurance, and an increase in co-payments and deductibles contributed to a rise in uninsured and under-insured patients (who are often less able to pay). This trend has increased the likelihood of individuals deferring hospitalization.

Several other factors affect demand for industry services. For example, the extent to which hospital procedures are conducted in general medical and

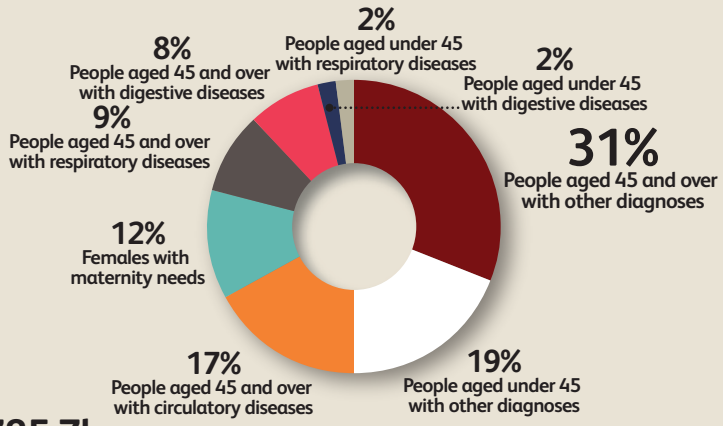
Products & Markets

Demand Determinants continued

surgical hospitals, relative to specialist hospitals influences demand. Also, the range of services provided and demanded within general medical and surgical hospitals affect demand. Additional services within hospitals can include radiology, pharmacy, physiotherapy and laboratory procedures. Hospital revenue is also affected by ancillary services and therapy programs that are ordered by physicians and provided to patients.

Major Markets

Major market segmentation (2012)



Total $785.7bn

SOURCE: WWW.IBISWORLD.COM

The market for hospital care can be segmented by patient age, gender, admission reasons and payment methods, among other characteristics like household income, ethnicity and insurance status.

Consumers aged 65 and older account for about 37.0% of the total discharges from short hospital stays, according to data from the National Center for Health Statistics. This age group accounts for only about 12.5% of the US population. The aging of the US population has resulted in people older than 45 years old representing a growing share of total discharges from US hospitals. The proportion of routine discharges or patients discharged to their homes declines with age, from 91.0% for inpatients aged younger than 45 to 41.0% for those aged 85 and older.

Patients are also getting sicker, based on the top four Medicare classifications of diagnoses. These classifications include circulatory system diseases, respiratory system diseases, digestive system diseases and childbirth. Within these categories, the top 10 most common diagnoses for hospitals are hypertension, chest pain, lower back pain, atrial fibrillation, abdominal pain, pain in limb, diabetes mellitus, cough, malignant neoplasm of prostate and anemia, according to the American Hospital Directory's analysis of data from the 2010 Medicare Outpatient Prospective Payment System (latest data available). In general, the case-mix index, which reflects a hospital's overall Medicare DRG patient caseload, from 2006 to 2010 increased from 1.33 to 1.39, illustrating that hospitals are treating sicker patients.

Revenue sources

Hospital revenue depends upon inpatient occupancy levels, the medical and

Products & Markets

Major Markets continued

ancillary services ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or payment rates for these services. Charges and reimbursement rates for inpatient services vary significantly depending on the type of payer, the type of service (e.g. medical or surgical, intensive care or psychiatric) and the hospital's geographic location. Inpatient occupancy levels fluctuate for various reasons, including demographic trends and the intensity of the flu season.

Hospitals receive payment for patient services from the federal government under the Medicare program, state governments under Medicaid or similar programs, managed care plans, private insurers and directly from patients. Medicare is a federal program that provides certain hospital and medical insurance benefits to people aged 65 and older, some disabled people, people with end-stage renal disease and people with Lou Gehrig's Disease. Medicaid is a federal-state program, administered by the states, which provides hospital and medical benefits to qualifying individuals who cannot afford healthcare. Amounts received under Medicare and Medicaid programs are significantly less than established hospital gross charges for the services provided. Medicare payments make up about 27.0% of revenue, Medicaid accounts for about 10.0%, managed care and other insurers make up about 58.0%, and payments directly from uninsured patients account for about 5.0%.

Hospitals typically offer discounts to certain group purchasers of healthcare services, including private insurance companies, employers, health maintenance organizations (HMOs), preferred provider organization (PPOs) and other managed care plans. These discount programs generally limit the ability to increase revenue in response to increasing costs. Patients are usually not responsible for the total difference between established hospital gross charges and amounts reimbursed for these services under Medicare, Medicaid, HMOs or PPOs and other managed care plans. However, they are responsible to the extent of any exclusions, deductibles or coinsurance features of their coverage. The amount of such exclusions, deductibles and coinsurance is expected to continue to increase during the five years to 2012. Payment collection from individuals is typically more difficult than from governmental or third-party payers. Hospitals also usually provide discounts to uninsured patients who do not qualify for Medicaid or charity care under a hospital's charity care policy. These discounts are similar to those provided to many local managed care plans.

Many industry operators are nonprofit. Based on data from the Census Bureau's "Service Annual Survey," for-profit firms only account for 11.5% of industry revenue. The proportion of for-profit firms has increased during the five years to 2012; in 2007, for-profit firms accounted for only 10.5% of industry sales. Government owned and controlled hospitals account for an estimated 18.5% of all operators, and other tax-exempt firms account for about 70.0%.

Products & Markets

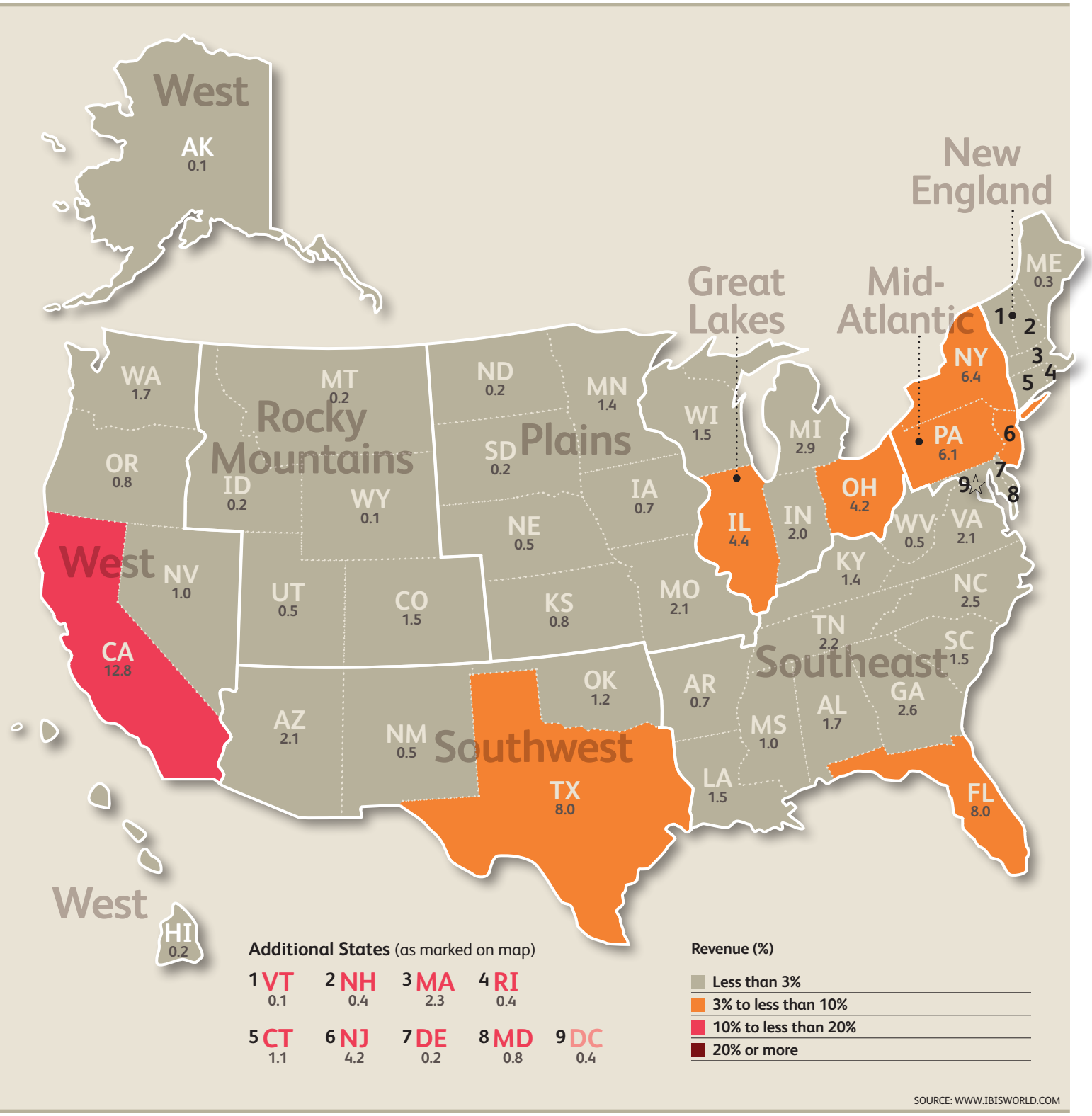
International Trade

Treating foreign patients in US hospitals is a growing trend that helps increase revenue and utilization of expensive high technology equipment. Therefore, this practice reduces service costs per patient. Foreign patients are usually wealthy and do not have access to health insurance that covers services rendered in the United States. They are attracted by the skills, expertise and technology applied by US medical practitioners. Many healthcare practitioners are world-renowned and attract patients from around the world. These patients are usually prepared to pay high fees for treatment of life-threatening illnesses or conditions.

US citizens are increasingly traveling overseas to be treated for health conditions. US citizens may seek treatment overseas when physicians have a particular expertise or where treatment costs are relatively cheap. Some countries, such as India and Singapore, have developed an export-focused hospital industry and offer tourist-related healthcare packages. According to an article in *the Economist* magazine ("Importing Competition," August 14, 2008), the number of people who will travel for care is set to increase from just under one million to 10 million by 2012, depriving US hospitals of $160.0 billion of annual business. Some insurance plans offer surgery abroad.

Products & Markets

Business Locations 2012



SOURCE: WWW.IBISWORLD.COM

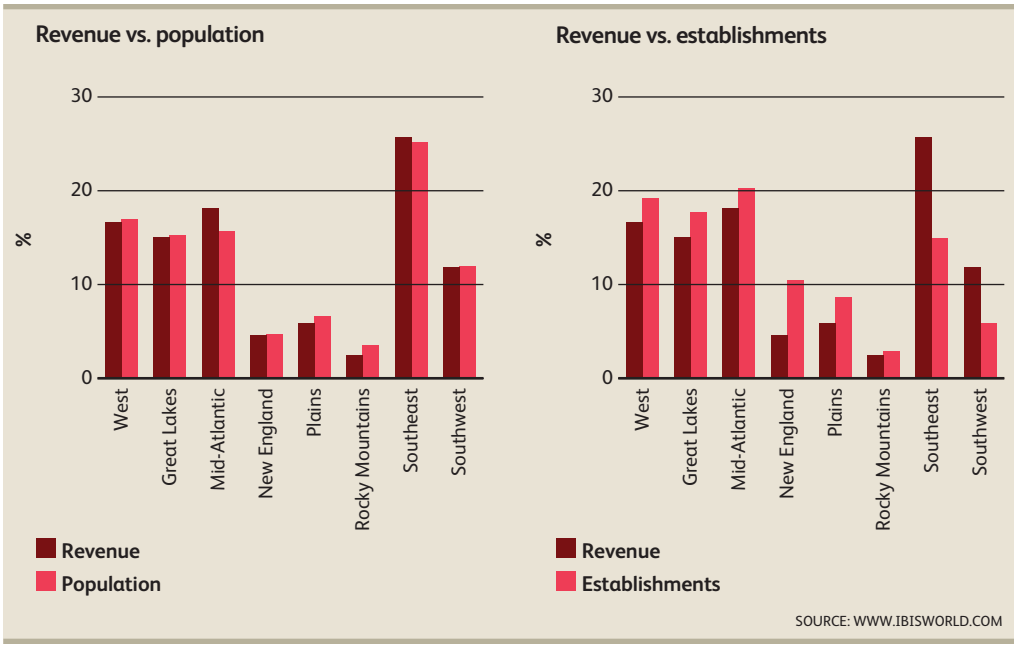
Products & Markets

Business Locations

The location of hospitals in the United States largely reflects the distribution of the population and each region's geographic size. Other factors include the age distribution of the population, birthrates, household incomes and the extent to which other substitute services are provided. The regions accounting for the largest share of industry activity include the Mid-Atlantic, West and Great Lakes. The largest states in terms of industry establishments and employment are California, New York, Texas and Florida.

The southwest and southeast regions generate disproportionately large amounts of revenue compared to the number of hospitals located in these regions. One potential cause for this variation in revenue is hospital ownership and the resultant differences in product mix. Medicare reimbursements vary only slightly for a given service, so the variation across regions is likely caused by differences in the types and quantities of services being provided. These differences in product mix are observed across the three main hospital ownership styles in the United States: for-profit ownership, nonprofit ownership and government ownership.

Hospitals are less inclined to locate in rural areas in the United States. Rural hospitals typically serve more uninsured or low-income patients. Additionally, urban and more prosperous areas are disproportionately home to the countries' skilled healthcare work force. According to a 2008 study by the University of California, San Francisco, rural hospitals tend to perform worse than their urban counterparts. Consequently, patients living in rural areas may struggle to have convenient access to quality care at hospitals. For this reason, the federal critical access hospitals (CAH) program was designed to improve rural healthcare access and reduce hospital closures. CAHs are small, rural hospitals that provide limited services and meet federally mandated criteria that enable the hospitals to receive cost-based reimbursement for Medicare services.



Competitive Landscape

Market Share Concentration | Key Success Factors | Cost Structure Benchmarks
Basis of Competition | Barriers to Entry | Industry Globalization

Market Share Concentration

Level
Concentration in this industry is **Low**

The Hospitals industry is fragmented, with hundreds of providers of various sizes spread throughout the country. No player accounts for more than 5.0% of industry revenue, and the four largest companies are expected to make up 9.7% of total industry sales in 2012. Despite some consolidation during the five years to 2012, the industry remains fragmented. The number of mergers and acquisitions per year has been increasing since 2007, but the record 139 deals set in 1998 has not been surpassed, based on data from the American Hospital Association.

The healthcare reform of 2010 has the potential to alter the hospital business and accelerate consolidation. Healthcare reform is expected to increase the number and size of mergers. Furthermore, it will likely change the underlying motivations, since it will impose lower prices and enforce reimbursement models that create powerful incentives for hospitals to form large systems of care. These incentives include bundled payments, payments for quality, and accountable care organizations.

Concentration varies between geographic markets. For example, HCA holds 20.0% to 40.0% market share in most of the geographies in which it operates, and the company has a geographic concentration in Florida and Texas. Universal Health Services (UHS) aims to seek market leadership in growth markets, and concentrates on medium-size cities with populations of up to 500,000. UHS prefers not to compete in large cities where there are many competitors. Community Health Systems and LifePoint Hospitals have focused on markets outside metropolitan areas, and a large proportion of their hospitals are in markets where there are no competitors.

Key Success Factors

IBISWorld identifies 250 Key Success Factors for a business. The most important for this industry are:

Access to highly skilled workforce

The ability to attract and retain quality medical, nursing and administrative staff is important, since the staff need to provide quality service and effectively manage hospital operations.

Proximity to key markets

It is important to be located in a highly populated area, close to other health service providers and nursing homes.

Having a good reputation

Patients and their referrers often seek out hospitals with a reputation for procedural expertise, good facilities and good patient outcomes. Some hospitals specialize in areas that can raise their reputation and barriers to entry.

Understanding government policies and their implications

Hospitals must have a good understanding of regulations, costs and the effect of the proportions of different diagnoses treated on costs and funding.

Economies of scale

Larger hospitals can accrue cost savings and other efficiencies.

Optimum capacity utilization

Maximizing occupancy rates can promote revenue and profitability.

Competitive Landscape

Cost Structure Benchmarks

Profit

Hospital profit margins are expected to decrease in the five years to 2012, despite increases in the prices charged for hospital care. Input costs have increased as occupancy fell and uncompensated care rose. Hospitals generated losses by caring for Medicaid patients because Medicaid reimbursement does not fully cover the cost of care, and Medicaid enrollment is increasing due to higher unemployment rates.

During the past five years, the number of for-profit firms has increased as a percentage of total firms in the industry, while the number of nonprofit and government-run firms has moderately decreased. This aspect has helped buoy profit during the economic recession. Nonetheless, in 2008, operating profit margins fell to 2.6% of revenue, down from 6.9% in the previous year. In 2012, profit margins are expected to remain suppressed at about 2.6% of revenue due to low reimbursement from federal programs and mounting wage costs. Profitability is expected to benefit moderately from the government's electronic health record incentive payments and slightly higher Medicare and Medicaid reimbursement rates.

Various steps to control costs have sustained hospital bottom lines in 2012; however, many institutions continue to have financial problems. Nearly 34.0% of hospitals in the United States are estimated to have a negative operating margin in 2012, according to data from the American Hospital Association. Healthcare expenditures are usually slow to dip in a downturn, so the full effect of the recession may not yet be realized.

In the next five years, profit margins will likely improve to about 3.1% of revenue. An increase in the number of insured patients, restraints on money spent on new technologies, and improvements in hospital investment portfolios will result in this growth. Many institutions have already improved their efficiency: Lengths of stays have gotten shorter, and more revenue is being earned per patient discharge.

Labor costs

Wages as a percentage of revenue are about 38.5% in 2012, slightly up from 2007. This percentage varies by hospital type. During the economic recession, many hospitals reduced staff in administrative functions; however, hospitals have struggled to employ more physicians and nurses. Labor shortages and greater use of relatively expensive agency staff and other contracted labor have driven up wage expenses.

In some markets, the availability of nurses and medical support personnel has become a significant operating issue. To address this challenge, industry operators have implemented initiatives to improve retention, recruiting, compensation and productivity. The industry will likely continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel or hire more expensive temporary or contract personnel. As a result, labor costs are forecast to increase during the five years to 2017.

Labor unions often represent hospital employees. Proposed changes in federal labor laws, including the Employee Free Choice Act, may increase the likelihood of employee unionization attempts. If a significant portion of the industry employee base unionizes, wage costs would increase materially. In addition, several states will likely adopt mandatory nurse-staffing ratios or reduce mandatory nurse-staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and negatively affect revenue if hospitals need to limit patient admissions to meet the required ratios.

Competitive Landscape

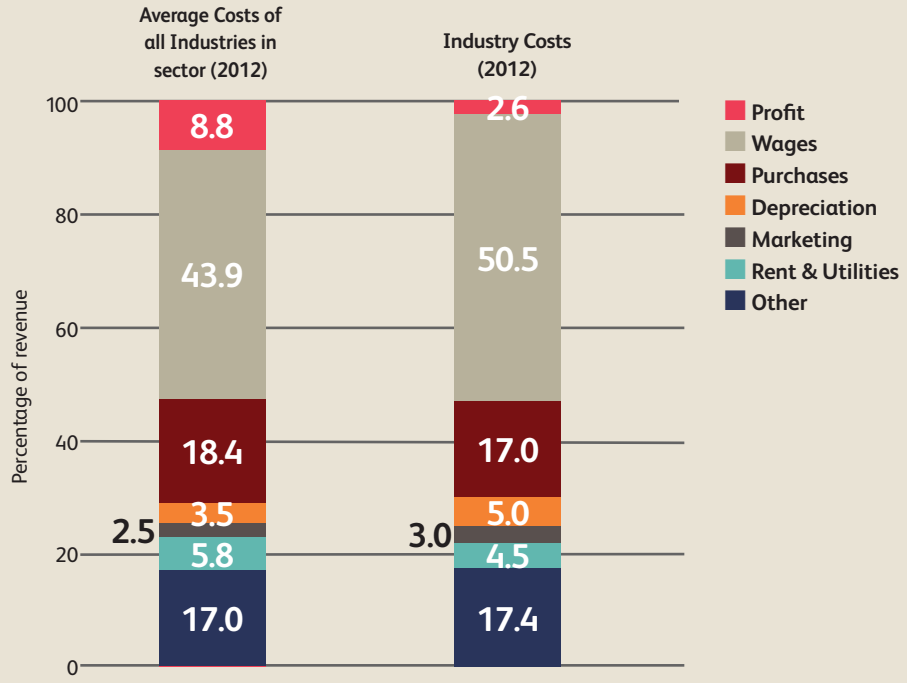
Cost Structure Benchmarks continued

Provision for doubtful accounts

The collection of payments from Medicare, managed care payers, other third-party payers and patients make up the main source of industry revenue. The primary collection risks relate to uninsured patient accounts, including patient accounts for which the primary insurance carrier has paid the amounts covered by the agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. Provision for doubtful debts can represent more than 10.0% of revenue for some companies (though the percentage can change from year-to-year and from company-to-company, depending on payer profiles, management policies and bad and doubtful debt estimates). Trends that can make it difficult to reduce doubtful debts as a percentage of revenue include payer mix shifts to managed care (with greater patient co-payments and deductibles), and an increase in the volume of services provided to uninsured and under-insured patients. Any increase in unemployment can also contribute to growth in doubtful account provisions.

The provision for doubtful accounts and the allowance for doubtful accounts relate primarily to amounts due directly from patients. Operators record an estimated allowance for doubtful accounts for all uninsured accounts. Accounts are written off when all reasonable internal and external collection efforts have been performed. The total provision for doubtful accounts is based on a company's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal, state and private employer healthcare coverage and other collection indicators.

Sector vs. Industry Costs



SOURCE: WWW.IBISWORLD.COM

Competitive Landscape

Cost Structure Benchmarks continued

Other costs

Other major expenses include supplies (e.g. medical equipment and devices and pharmaceutical supplies), which account for an estimated 17.4% of industry revenue. They also include asset depreciation and amortization (mainly buildings and medical equipment), accounting for an estimated 5.0% of revenue. Other expenses include repair and maintenance, consulting, malpractice and information systems.

Basis of Competition

Level & Trend
Competition in this industry is **Low** and the trend is **Steady**

Internal competition

Hospitals compete on the basis of many factors. These include quality of care and the ability to attract and retain quality physicians, skilled clinical personnel and other healthcare professionals. Furthermore, other bases of competition include location, breadth of services, technology offered and prices charged. Industry operators increasingly focus on operating outpatient services with improved accessibility and more convenient services for patients, and improved predictability and efficiency for physicians. Geographic constraints limit competition, since there are rarely more than a few hospitals in one geographic area.

Two significant factors that affect a hospital's competitive position are the number and quality of physicians affiliated with the hospital. Physicians from other hospitals and specialty healthcare providers refer patients to a hospital based on the quality and scope of services it renders to patients and physicians, the quality of physicians on the medical staff, the location of the hospital and the quality of the hospital's facilities, equipment and employees.

CMS publishes performance data related to quality measures and data on patient satisfaction surveys that hospitals submit in connection with their Medicare reimbursement. Federal law provides for the future expansion of the number of quality measures that must be reported. Additional quality measures and future trends toward clinical transparency will likely escalate the competitive importance of quality for operators.

Another major factor in the competitive position of a hospital is the ability to negotiate service contracts with group healthcare service purchasers. Managed care plans attempt to direct and control the use of hospital services and obtain discounts from hospitals. In addition, employers and traditional health insurers attempt to contain costs through negotiations with hospitals for managed care programs and discounts from established gross charges. Generally, hospitals compete for service contracts with group healthcare services purchasers on the basis of price, market reputation, geographic location, quality and range of services, quality of the medical staff and convenience.

Healthcare providers compete to enter into managed care contracts or negotiate increases in reimbursement and other favorable terms and conditions. For example, some hospitals or specialty care providers may negotiate exclusive provisions with managed care plans or otherwise restrict the ability of managed care companies to contract other hospitals. The trend toward consolidation among non-government payers tends to increase their bargaining power over fee structures. The importance of obtaining contracts with managed care organizations varies from community to community, depending on the market strength of these organizations.

External competition

During the five years to 2012, the number of freestanding specialty hospitals, surgery

Competitive Landscape

Basis of Competition continued

centers and diagnostic and imaging centers is expected to increase. Specialty hospitals owned by physicians are one of the fastest-growing segments in healthcare. Such facilities focus on one area of care, such as cardiac, orthopedic, or general surgical services. The emphasis on cost containment coupled with service delivery innovation during the past decade has created opportunities for freestanding ambulatory surgery centers (ASC). These centers are limited-service alternatives that treat surgery patients who do not need to stay overnight.

ASCs have a unique competitive advantage. ASCs do not offer inpatient services, so they typically service patients who have a low likelihood of complications arising from surgery. If ASCs systematically treat relatively low-severity patients, then ASC competition may increase the average severity of hospital-based patients. Therefore, the industry's average cost per patient treated will likely increase. This rise in average severity negatively influences hospital profit margins because such a rise in severity, while having real cost consequences for the hospitals, is not accounted for under payment reimbursement mechanisms, including those used by Medicare.

General hospitals have various strategies to maintain profit. One tactic is to increase revenue through other channels, such as shifting the patient mix toward privately insured or self-paying patients, or changing the service mix. Hospitals are also expected to attempt to offset revenue declines with cost reductions. The industry will likely allocate managerial effort toward cost-containment initiatives. These initiatives include cutting staff, reducing uncompensated care, or otherwise limiting expenses. Hospitals are also augmenting offerings in specialty areas in direct response to mounting competition, most notably in cardiac catheterization and angioplasty services, according to data from the American Hospital Association (AHA).

Barriers to Entry

Level & Trend
Barriers to Entry in this industry are **High** and **Steady**

Barriers to entry in the Hospitals industry are high, due to the significant regulatory requirements and the experience and strength of incumbents.

Licensure, accreditation and regulation

Medical licensure creates a barrier to entry in the healthcare sector. Operators must meet extensive federal, state and local government laws and regulations when establishing and operating hospitals. These regulations relate to the adequacy of medical care, equipment, personnel, operating policies and procedures. Regulations also involve maintaining adequate records, preventing fires, rate-setting and complying with building codes and environmental protection laws. These regulations make it difficult and costly to enter the industry. The technological specifications for modern hospital buildings, including wide corridors and doorways, large elevators, strongly supported flooring and extensive plumbing require an estimated four to nine years of planning and construction time. The relatively large investment in infrastructure represents a cost that may discourage new hospitals from entering the industry.

State certificate of need (CON) laws, which place limitations on a hospital's ability to expand hospital services and facilities, make capital expenditures and otherwise make changes in operations, have the effect of restricting competition in the industry. Before issuing a CON, states consider the need for additional or expanded healthcare facilities or services.

Competitive Landscape

Barriers to Entry continued

In states that have no CON laws or set relatively high levels of expenditures before they become reviewable by state authorities, competition in the form of new services, facilities and capital spending is more prevalent.

Other barriers

In addition to licensure and regulation, other conditions serve as barriers to entry. In particular, economies of scale, learning curve effects and system affiliation can make it prohibitively costly for new firms to enter the industry. While hospitals benefit from size to some degree, considerably large hospitals can experience size burdens. Large hospitals may find it difficult to control costs and reach optimum occupancy. Nonetheless, appropriately sized hospitals benefit from supply purchase discounts and negotiating power with payers, such as managed care organizations.

To a small degree, incumbent hospitals may have lower costs and better patient outcomes because they have physicians and other staff members that have learned from each other and are therefore more efficient than an incoming hospital might be. Learning by watching imparts productivity or quality improvements that occur over time regardless of an increase in the number of services provided; therefore, the cost advantages do not depend on scale. Learning by watching arises from knowledge or technological change that can be easily transferred across hospitals.

Systems, as defined by the American Hospital Association, are multihospitals or diversified single hospital systems. A multihospital system is two or more hospitals that a central organization owns, leases, sponsors or contract manages. Single, freestanding hospitals may be categorized as a system by bringing into membership three or more, and at least 25.0%, of their owned or leased non-hospital pre-acute or post-acute healthcare organizations. Hospitals that have system affiliation benefit from referrals from other physicians and contracts and negotiating power with payers.

Barriers to Entry checklist	Level
Competition	Low
Concentration	Low
Life Cycle Stage	Growth
Capital Intensity	Medium
Technology Change	Medium
Regulation & Policy	Heavy
Industry Assistance	High

SOURCE: WWW.IBISWORLD.COM

Industry Globalization

Level & Trend
Globalization in this industry is **Low** and the trend is **Decreasing**

This industry has a low level of globalization, partly because of the presence of US-based government and not-for-profit hospitals, which account for nearly 90.0% of industry revenue. US-based companies predominantly, if not entirely, control for-profit private hospital groups. This factor is due to significant regulatory requirements relating to the healthcare sector and the relatively low profitability of the sector.

Additionally, US-based private hospital groups have concentrated on the US market, with only small investments in overseas-based hospitals. Many groups have divested overseas operations in recent years. HCA sold its two Switzerland hospitals in 2007, and Universal Health Services sold its hospital interests in France in 2005. Tenet Healthcare Corporation sold its only foreign operation, a hospital in Spain, in 2004.

Telemedicine has allowed hospitals to use professional services (such as diagnostic imaging) outside the United

Competitive Landscape

Industry Globalization continued

States, sometimes from providers that offer low prices compared with domestic providers. CMS has proposed rules that set out new credentialing and privileging processes for physicians and other healthcare professionals who provide telemedicine services. Current CMS regulations require all hospitals, including those certified as critical-access hospitals, to privilege each physician who provides telemedicine services to a hospital's patients as if the physician were on-site. The proposed regulations allow the governing body of a hospital whose patients receive telemedicine services to grant privileges based on recommendations from its medical staff. In turn, the medical staff would rely on information provided by the distant-site hospital. The CMS proposal allows for the advancement of telemedicine worldwide, while it still protects the health and safety of patients.

Major Companies

HCA Inc. | Other Companies

Player Performance

HCA Inc.
Market share: 4.5 %

Hospital Corporation of America (HCA) is one of the largest operators of hospitals and health systems in the United States. HCA facilities provide nearly 5.0% of all inpatient care delivered in the country. HCA operates 163 hospitals, composed of 157 general, acute care hospitals, five psychiatric hospitals and one rehabilitation hospital. The 163 hospitals include eight hospitals (seven general acute care hospitals and one rehabilitation hospital) owned by joint ventures in which an affiliate of HCA is a partner. The company also operates 106 freestanding surgery centers, eight of which are owned by joint ventures in which an affiliate of HCA is a partner. The company has facilities in 20 states and employs 190,000 employees. In October 2011, HCA purchased The Colorado Health Foundation's interest in the HCA-HealthONE LLC joint venture. HealthONE facilities specialize in a more acute patient base, and as such, it carries significantly higher margins than core HCA facilities. In December 2011, it sold Palmyra Medical Center in Albany, GA.

HCA provides comprehensive healthcare services. The general acute care hospitals typically provide medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic services and emergency services. Its general acute care hospitals also provide outpatient services such as surgery, respiratory therapy, and physical therapy. HCA hospitals do not typically engage in extensive medical research and education programs. However, some hospitals are affiliated with medical schools and may participate in the clinical rotation of medical interns and residents and other education programs.

Financial performance

Through its facilities located in high-growth urban areas, HCA has recorded consistent growth. The company's wide presence helps it reach a larger number of customers and boost its revenue-generating capabilities. Growth in patient volumes is expected to remain favorable through 2012, particularly in emergency visits and surgical volumes. The patient volume growth reflects strategic facility locations in areas with favorable growth dynamics and the company's operating strategy that seeks to improve accessibility of services and the efficiency and effectiveness with which it services patients through the system.

During the five years to 2012, HCA's revenue is expected to grow 4.1% annually on average to $32.8 billion. Expected growth of 1.0% in 2012 will mainly be due to higher patient volume. Revenue has been rising across all classes of patients, led by Medicare and managed care providers, and in all geographies, led by the Southwest region. Both of these trends reflect demographic changes in the United States and are consequently forecast to continue in the future. Moreover, the effects of a higher population of insured individuals (due to healthcare reform) will start to benefit the company during the next five years.

HCA's operating profit margin has

Major Companies

Player Performance continued

hovered between about 11.0% and 14.0% during the past five years. Growth in recent years reflects improvements in operational efficiencies and volume increases. In 2012, the company's operating profit will benefit from HITECH payments (federal government incentive payments for the implementation of qualified electronic health records). Additionally, the company will receive a 1.1% increase from Medicare in 2012. The company attributes consistent revenue growth to its diversified portfolio of assets and services, combined with improvements in operating efficiencies.

Despite HCA's strong market position, use of the company's hospitals has stagnated in recent years. A comparatively lower occupancy rate, a dwindling number of inpatient surgeries and slow admissions growth reflect lower hospital use. Open-heart surgeries have also been declining; this trend is significant because open-heart surgeries generate high amounts of revenue per procedure and a decline in these operations squeezes HCA's revenue per equivalent admission. At 53.0%, the company's occupancy rate (proportion of licensed beds occupied by patients) is low compared with that of its competitors, such as Kindred Healthcare, which has an occupancy rate of nearly 65.0%. To improve future profitability, HCA plans to manage its facilities more effectively.

HCA Inc. – financial performance

Year	Revenue ($ million)	(% change)	Operating Income ($ million)	(% change)
2007	26,858	5.4	3,610	28.1
2008	28,374	5.6	3,191	-11.6
2009	30,052	5.9	3,989	25.0
2010	30,683	2.1	4,328	8.5
2011	32,506	5.9	4,596	6.2
2012*	32,843	1.0	4,875	6.1

*Estimate

SOURCE: ANNUAL REPORT AND IBISWORLD

Other Companies

Ascension Health

Estimated market share: 2.0%

Ascension Health, the nation's largest Catholic and nonprofit health system, formed in 1999 with the merger of the Daughters of Charity National Health System and the Sisters of St. Joseph Health System. Its facilities are primarily located in the Southern, Midwestern, and Northeastern areas of the United States. In 2003, Ascension Health merged with Carondelet Health System.

Ascension Health's hospital network consists of 67 general acute care, four long-term acute care, three rehabilitation, and four psychiatric facilities. Ascension Health also operates community clinics and other healthcare facilities. Its facilities have a total of 16,515 available hospital beds. Ascension Health's revenue is expected to reach $16.0 billion in 2012. Profitability is expected to benefit from the company's formation of a wholly-owned group purchasing organization (GPO). The

Major Companies

Other Companies continued

GPO will represent a number of the company's organizations, act as the contracting agent for all its participants, and leverage the combined volume of purchases to secure lower prices in areas ranging from supplies and professional services to utilities.

Ascension Health was an innovator in patient experience work in 2006 when it was among the first healthcare providers in the nation to adopt the net promoter score (NPS) as its key measure of patient satisfaction and loyalty. In 2011, the Health Ministries of Ascension Health achieved a Systemwide NPS of 68.3, representing a 17.0% improvement from its 2007 baseline performance.

Community Health Systems Inc.

Estimated market share: 1.9%

Community Health Systems Inc. (CHS), headquartered in Nashville, TN, is the largest non-urban provider of general hospital services in the United States in terms of facilities and revenue. The company's general care hospitals offer a range of inpatient and outpatient medical and surgical services, such as general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric, and rehabilitation services. It also provides outpatient services at urgent care centers, occupational medicine clinics, imaging centers, cancer centers, ambulatory surgery centers, and home health and hospice agencies. In addition, the company offers management and consulting services to non-affiliated general acute care hospitals. CHS owns, leases or operates 135 hospitals in 29 states, with 20,000 licensed beds. The company was founded in 1985 and is headquartered in Franklin, TN.

CHS has been acquisitive over the past decade, growing from 57 owned hospitals in 2002 to 131 in 2012. This trend has promoted growth in the company's revenue. During 2010, the company acquired five hospitals. The company closed its acquisition of Mercy Health in mid-2011, and on October 1, 2011, the company acquired Tomball Regional Medical Center in Tomball, TX. In 2012, the company has acquired Moses Taylor Health Care System, a Scranton, PA-based hospital and a York, PA-based hospital. These acquisitions will help to bring 2012 revenue to $14.5 billion, or about 1.9% of industry revenue.

Tenet Healthcare Corporation

Estimated market share: 1.2%

Tenet Healthcare Corporation (Tenet) is an investor-owned healthcare service company, which principally operates general hospitals and related healthcare businesses. Tenet's subsidiaries operate 50 general hospitals and a critical access hospital, with a total of 13,453 beds, serving urban and rural communities in 11 states. Of those general hospitals, 45 are owned by Tenet's subsidiaries and five are owned by third parties and leased by Tenet's subsidiaries. Its subsidiaries also operate various healthcare facilities, including a long-term acute care hospital, outpatient surgery centers, diagnostic imaging centers, occupational and rural healthcare clinics, and a number of medical office buildings. Tenet was founded in 1967 and is headquartered in Dallas, TX.

Tenet has sought to improve its portfolio of hospitals through acquisitions, divestments and closures, and it concentrates on markets where it has a strong presence. The company is planning to sell its stake in the Creighton University Medical Center (CUMC) to Alegent Health in mid-2012. This strategy has resulted in the company's revenue and market share declining. Tenet's revenue is expected to reach $9.8

Major Companies

Other Companies continued

billion in 2012. The company has had an uptick in elective procedures and has continued to have strong inpatient and outpatient admission trends during the past five years.

Health Management Associates Inc.

Estimated market share: 0.8 %

Health Management Associates Inc. (HMA) provides a broad range of general acute care health services to non-urban communities. HMA was founded in 1977 and is based in Naples, FL. The company operates 66 general acute care hospitals, with a total of 10,330 licensed beds and 33,700 employees. More than half of the company's hospitals are located in Florida and Mississippi. HMA has pursued a strategy of selectively acquiring additional 100- to 300-bed acute care hospitals located in nonurban communities in market areas of 30,000 to 400,000 people primarily in the southeastern and southwestern United States. HMA has moderated its acquisition activity in recent years.

During the past five years, the company has also divested or closed several underperforming hospitals. On August 28, 2008, HMA completed the sale of Southwest Regional Medical Center. On June 1, 2008, the company closed the Woman's Center at Dallas Regional Medical Center (the Center). On January 1, 2008, HMA closed Gulf Coast Medical Center (GCMC). In July 2010, the company acquired a 60.0% controlling interest in three Shands HealthCare hospitals, Shands Lake Shore located in Lake City, FL, Shands Live Oak, located in Live Oak, FL, and Shands Starke, located in Starke, FL. In 2012, HMA is expected to generate $6.5 billion in revenue. Growth during the year is expected to be driven by the company's patient-centered operating strategy, its focus on emergency room operations, physician recruitment and market service development.

Universal Health Service

Estimated market share: 0.5 %

Universal Health Services (UHS) owns, operates or is constructing 25 acute care hospitals (excluding one new replacement facility under construction) and 102 behavioral health centers in 32 states, Washington DC and Puerto Rico. The company also manages or owns outright, or in partnership with physicians, nine surgery hospitals and surgery and radiation oncology centers located in five states and Puerto Rico. In 2012, the company's hospital revenue is expected to reach $4.2 billion.

UHS was founded in 1978 and has about 39,900 employees. The company has successfully anticipated the trend toward outpatient services and managed care growth. As reimbursement policies have favored shorter hospital stays, UHS has increased its portfolio of outpatient facilities, which include radiation oncology centers and ambulatory surgical centers. The company's behavioral health facilities also offer many services to patients on an outpatient basis.

LifePoint Hospitals Inc.

Estimated market share: 0.5 %

LifePoint Hospitals Inc. (LifePoint) operates general acute care hospitals in nonurban communities. The company operates 52 hospital campuses in 17 states, having a total of 5,915 licensed beds. On January 31, 2011, LifePoint announced the formation of DLP Healthcare LLC (DLP), a joint venture between the company and Duke University Health System. Effective September 1, 2010, the company completed the acquisition of HighPoint Health Systems (HighPoint), formerly Sumner Regional Health Systems. In 2010, the company acquired Clark Regional Medical Center (Clark).

LifePoint's revenue in 2012 is expected to reach $4.0 billion. The company is focused on several initiatives

Major Companies

Other Companies continued

to position the company for future growth. These initiatives include recruiting high quality physicians and specialists; investing in new and upgrading developed lines to meet demand in its markets; and acquisitions.

Other nonprofit hospital operators

Some higher education institutions are major hospital operators, including John Hopkins University and the University of Pennsylvania. Catholic Health Initiatives (CHI) is an amalgamation of four Roman Catholic healthcare systems (Catholic Health Corporation of Omaha; Franciscan Health System of Aston, PA; Sisters of Charity Health Care Systems of Cincinnati; and Sisters of Charity of Nazareth Health Care System of Bardstown, KY). CHI's faith-based system operates in 19 states and includes 75 hospitals, 40 long-term care, assisted-living, and residential facilities, and two community health organizations. About 12 different congregations sponsor the organization. In addition, through its QHR subsidiary, the company provides hospital management, consulting and advisory services to more than 200 independent community hospitals and health systems in 43 states.

SSM Health Care, headquartered in St Louis, is a nonprofit Catholic organization sponsored by the Franciscan Sisters of Mary. SSM Health Care operates in four Midwestern states with 21 hospitals, three nursing homes, 5,000 affiliated physicians and 23,000 employees.

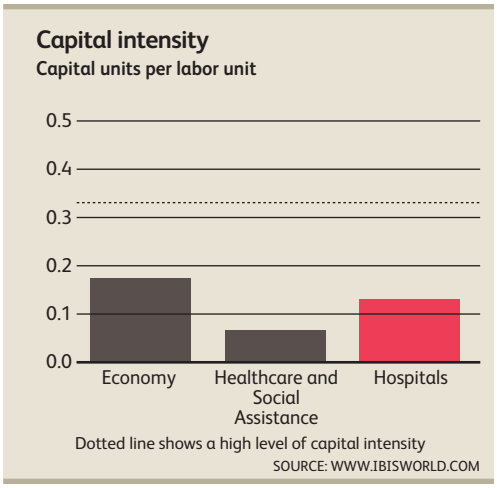
Operating Conditions

Capital Intensity | Technology & Systems | Revenue Volatility
Regulation & Policy | Industry Assistance

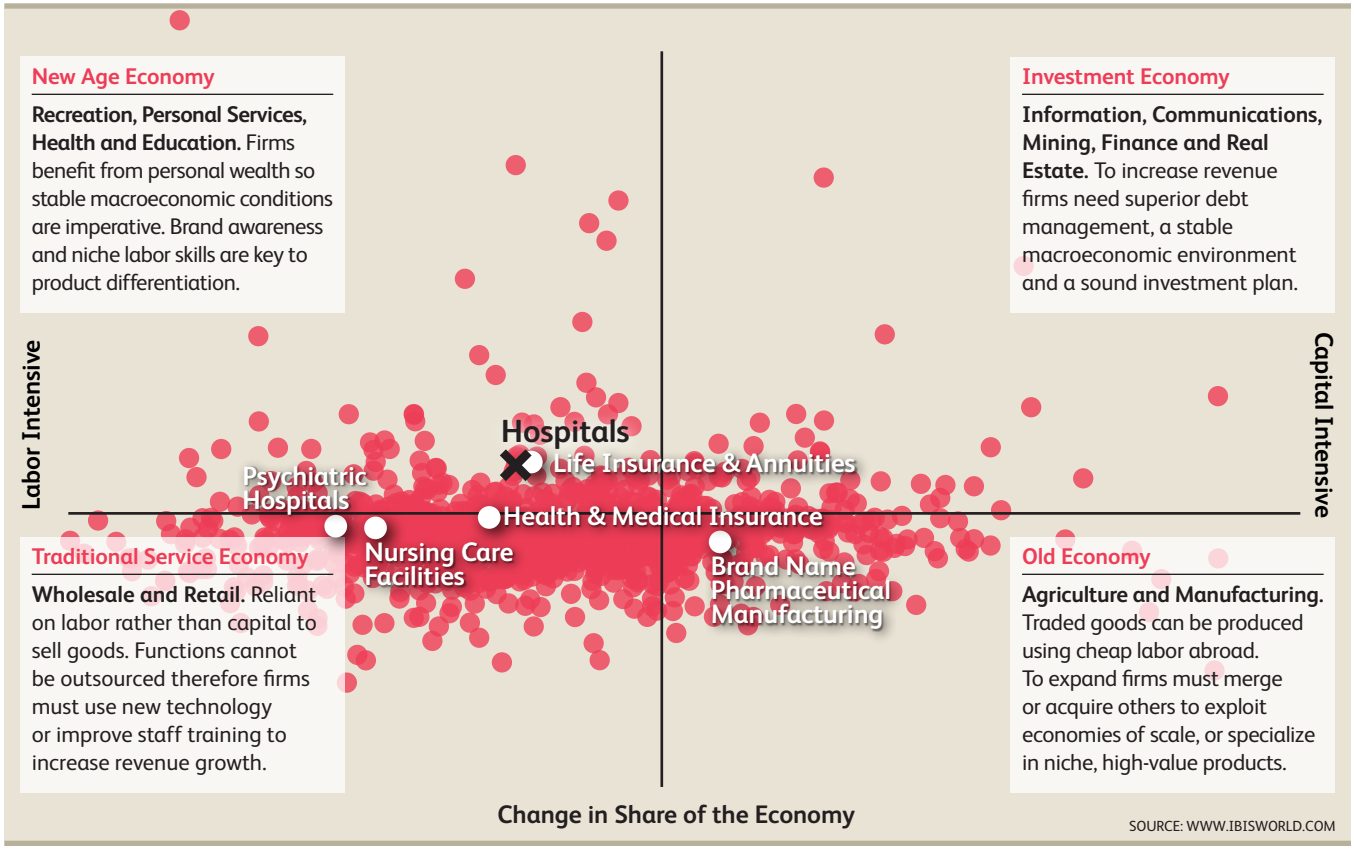
Capital Intensity

Level
The level of capital intensity is **Medium**

Capital intensity in the Hospitals industry is medium. The average firm requires about $0.13 worth of capital for every $1.00 of labor. Labor-related costs (including contracted services) are estimated to account for nearly 50.0% of total hospital revenue. Hospitals provide a high level of personal care. The safety and quality of patient care in hospitals is influenced by the size and experience of the physician and nursing work force. Inpatient conditions have deteriorated in some facilities because hospitals have not kept up with the rising demand for nurses. This situation has motivated some state legislatures to enact or consider regulatory measures to assure adequate staffing. Wages will likely increase during the five years to 2017, further reducing capital intensity in the industry.



Tools of the Trade: Growth Strategies for Success



Operating Conditions

Capital Intensity continued

Depreciation and amortization expenses represent about 5.0% of total revenue. Hospitals have reduced capital expenditures during the five years to 2012, mainly due to low profitability and a lack of access to capital (particularly among the not-for-profit organizations) during the recession. In 2008 and 2009, patient volume and ability to pay was a major concern. Lower patient volumes and patients falling out of healthcare coverage and receiving government benefits weighed down on hospitals. Healthcare reform also created angst in the industry. With hospitals on the hook for roughly $155.0 billion in savings over 10 years, reimbursement and cost pressures caused hospitals to postpone major purchases.

After three years of reduced equipment purchases from 2008 through 2010, hospitals will likely increase capital expenditure during the five years to 2017. In order to stay competitive, operators will be pressured to invest in new technologies. Capital expenditures can include expenditures on new hospital buildings and equipment; expenditures on extensions to, or redevelopments of, existing hospitals; and expenditures on information systems. While capital expenditures will recover during the coming years, wages will grow at a faster pace due to the personalized nature of healthcare and the shortage of physicians and nurses.

Technology & Systems

Level
The level of Technology Change is **Medium**

Technological developments influence hospital efficiency. For example, computerized systems help with patient management and record keeping, and an extensive range of medical equipment enable tests to be performed quickly and treatment to be delivered more accurately. Specialized surgical equipment and devices increase the speed and success of surgical procedures. Furthermore, the continuing release of new drugs, equipment and medical procedures and systems can increase efficiency and reduce the cost involved with hospital separation (i.e. when a patient leaves a hospital due to discharge, transfer or death). New technologies and medical procedures will also lead to new services, which will boost demand for some hospital services.

While most advances in technology generally increase demand for hospital services, hospitals are expensive to build and operate. This factor encourages government and private initiatives to promote less costly out-of-hospital services (e.g. telemedicine and home-based care). As a result, demand for hospital care may shrink in the longer term. These initiatives will decrease the length of stay in hospitals and demand for some services. Telemedicine is a rapidly developing application of clinical medicine wherein medical information is transferred through interactive audiovisual media for the purpose of consulting and sometimes for remote medical procedures or examinations.

Electronic health records

In general, technology advances allow the industry to streamline care, reduced fraud and reduce medical errors. Specifically, electronic health records (EHRs), systems that integrate electronically originated and maintained patient-level clinical health information, have been a major and ongoing development in the industry. EHRs can combine information derived from multiple sources into one point of access. An EHR can replace the paper medical record as the primary source of patient information. The use of EHRs is growing, albeit as a slow pace. A survey from the American Hospital Association found

Operating Conditions

Technology & Systems continued

that 69.0% of reporting hospitals have either fully or partly implemented an EHR. Larger hospitals, those in urban areas and teaching hospitals are more likely to be among those with implemented EHRs.

Hospitals can register and receive information technology incentive payments under the Medicare and Medicaid programs. In 2011, hospitals scrambled to implement and meaningfully use EHRs to qualify for Stage 1 federal clinical information technology incentive payments under the American Recovery and Reinvestment Act. The Act will provide $27.0 billion in payments over the life of the multiyear information technology incentive program. The share of hospitals with a basic or a comprehensive EHR was 11.9%in 2009, but only 2.0% reported having EHR systems that allowed them to meet the federal government's meaningful-use criteria, according to research published in August in the policy journal Health Affairs. The researchers also found a widening IT divide opening between the digital haves and have-nots in this country.

On October 1, 2010, the clock started on the Medicare and Medicaid portions of the IT incentive program. To get paid federal incentives, hospitals have until September 30, 2011 to illustrate 90 consecutive days of meaningful use of an EHR system under the Medicare program. Hospitals can adopt, implement or upgrade a system under Medicaid.

Simultaneously, the federal government will operate a host of programs to boost the use of health information technology, including IT work force development programs at the junior college, undergraduate and graduate levels; funding and policy support for state-level health information exchanges; a Beacon communities program to push cutting-edge practical applications of health IT; and a system of regional health IT extension centers to assist providers in selecting and adopting EHR systems.

Also, computerized physician order-entry systems allow physicians to electronically order medications, tests and consultations. They also provide advice on best practices and alerts to the possible adverse consequences of a therapy. A survey of hospitals by the American Hospital Association found that at least some physicians routinely order medications electronically in 27.0% of hospitals.

Revenue Volatility

Level
The level of Volatility is **Low**

Revenue for the Hospitals industry exhibits low volatility. During the five years to 2012, revenue is expected to increase each year. Moreover, during this period, revenue is expected to fluctuate by an average of 0.8% annually. Hospital services are essential for treatment of many diagnoses, and health needs do not vary significantly over the short to medium term, thereby reducing volatility. Within any given year, hospitals are subject to certain seasonal fluctuations, including decreases in patient utilization during holiday periods and increases in the cold weather months.

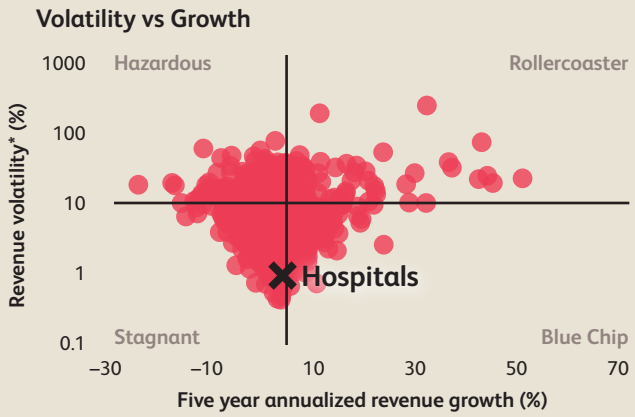
Government reimbursement of hospital services also moderates volatility by reducing out-of-pocket costs and increasing accessibility to hospital services. Similarly, the availability of health insurance, which reduces the out-of-pocket cost of hospital care, also reduces volatility. On the other hand, while Medicare and Medicaid funding acts to reduce volatility, changes to Medicare and Medicaid policies and reimbursements can increase volatility.

Operating Conditions

Revenue Volatility continued

A higher level of revenue volatility implies greater industry risk. Volatility can negatively affect long-term strategic decisions, such as the time frame for capital investment.

When a firm makes poor investment decisions it may face underutilized capacity if demand suddenly falls, or capacity constraints if it rises quickly.



* Axis is in logarithmic scale

SOURCE: WWW.IBISWORLD.COM

Regulation & Policy

Level & Trend
The level of Regulation is **Heavy** and the trend is **Steady**

Hospitals must comply with the conditions of participation and licensing requirements of federal, state and local health agencies. They must also observe municipal building codes, health codes and local fire department standards. In granting and renewing licenses, a department of health considers the physical buildings and equipment, the qualifications of administrative and nursing staff, the quality of care and continuing compliance with the laws and regulations relating to the operation of facilities. State licensing of facilities are a prerequisite of certification under the Medicare and Medicaid programs. Various licenses and permits are also required to dispense narcotics, operate pharmacies, handle radioactive materials and operate certain equipment. The US Health Insurance and Portability Act of 1996 requires hospitals and insurance payers to adopt standard code sets for financial and clinical electronic data interchange.

Staffing

Many states have passed legislation or regulations attempting to address nurse staffing. In 1999, California enacted legislation that called for the same unit specific nurse-to-patient ratios to be utilized in all nursing units in all California hospitals. Currently, a few states now require specific ratios in specialty areas such as intensive care and labor and delivery units, but none require ratios in every patient care unit in every hospital as required in the California regulations.

Medicare and Medicaid

The federal government makes payments to participating hospitals under its Medicare program based on various formulas. Federal, state and local governments also make payments under the Medicaid program. Federal law contains provisions that ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards. These provisions also aim to ensure that the services are medically necessary and that claims for reimbursement are properly filed. Federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who comes

Operating Conditions

Regulation & Policy continued

to the hospital's ER for treatment. If the patient is suffering from an emergency medical condition, the hospital must stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. Federal regulations provide that admissions and utilization of facilities by Medicare and Medicaid patients must be reviewed to insure efficient utilization of facilities and services.

The federal self-referral and payment prohibitions (codified in 42 USC Section 1395nn, Section 1877 of the US Social Security Act) generally forbid, except where qualifying for one of the exemptions, a physician from making referrals for the furnishing of any designated health services, for which payment may be made under the Medicare or Medicaid programs, to any entity with which the physician (or immediate family member) has a "financial relationship," which includes any direct or indirect compensation. Some states, including Texas, have passed laws to seek to apply for a waiver from current Medicaid regulations to allow the state to require that Medicaid participants be serviced through managed care providers.

Healthcare reform

Healthcare is one of the largest sectors in the United States and continues to attract much legislative interest and public attention. National healthcare reform is an ongoing focus at the federal level. In 2010, the Obama administration passed the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act. The reforms aim to provide insurance coverage for an additional 32.0 million to 34.0 million Americans by 2019 (through a Medicaid expansion that begins in 2014 and private health insurance reforms that occur from 2010 through 2014). Additionally, the Acts make a number of changes to the government healthcare programs. For those with private insurance, lifetime caps on coverage will end, and children will be able to stay on parents' policies until age 26. Furthermore, insurers will not be able to cancel coverage except in the case of fraud.

The healthcare reform legislation provides for Medicare, Medicaid and other federal healthcare program spending reductions between 2010 and 2019. Other reforms will also significantly affect hospitals. In federal fiscal year 2013, the US Department of Health & Human Services (HHS) is set to implement a value-based purchasing program for inpatient hospital services. This program will reward hospitals that meet certain quality performance standards established by HHS. Beginning in the same year, inpatient payments will be reduced if a hospital experiences "excessive readmissions" within a 30−day period of discharge for heart attack, heart failure, pneumonia or other conditions designated by HHS. Reimbursement will decline based on a facility's hospital acquired condition (HAC) rates. Beginning no later than January 1, 2012, a Medicare Shared Savings Program will promote accountability and coordination of care through the creation of accountable care organizations (ACOs), which can include hospitals (if an ACO produces savings in the Medicare program, some of these savings may be shared between ACO participants). In addition, HHS will establish a five-year, voluntary national bundled payment pilot program for Medicare services beginning no later than January 1, 2013. Under the bundled payment program, providers agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care.

Operating Conditions

Industry Assistance

Level & Trend
The level of Industry Assistance is **High** and the trend is **Steady**

Lower reimbursements

In addition to lower Medicare reimbursements in 2011, hospitals may face more cuts in the future as the federal government redoubles efforts to reduce spending. For 2011, CMS implemented a 2.9% reduction in the market basket update for hospitals. CMS asserts that hospitals were overpaid in 2008 and 2009 due to changes in hospital coding practices that do not reflect increases in patients' severity of illness.

Cash-strapped states are also expected to further cut Medicaid spending; however, hospitals must still take care of any patient. The degree of the problem varies by state, and the healthcare reform law requires states to maintain a minimum level of eligibility. Also, many states have used enhanced funding for non-healthcare activities.

Medicare and Medicaid

Medicare's Hospital Insurance Trust Fund (Part A) provides funding to cover the medical bills of people who are enrolled in the Medicare program (mainly people aged 65 and older and people with disabilities). Acute care hospitals are reimbursed primarily based on established rates by a diagnosis related group (DRG). Medicare's Supplemental Medical Insurance Program (Part B) pays 80.0% of the approved amount for physician services, home health and outpatient hospital services after the payment of a deductible amount.

The federal government makes payments to participating hospitals under its Medicare program based on various formulas. General acute care hospitals are subject to a prospective payment system (PPS). For inpatient services, PPS pays hospitals a predetermined amount per DRG based on a hospital's location and the patient's diagnosis. Beginning August 1, 2000, under a new outpatient prospective payment system (OPPS) mandated by the US Balanced Budget Act of 1997, general acute and behavioral health hospitals' outpatient services are paid a predetermined amount per ambulatory payment classification, based on a hospital's location and the procedures performed.

Medicare has special payment provisions for "sole community hospitals," and these hospitals can receive higher reimbursement rates. Federal, state and local governments also make payments under the Medicaid and TRICARE programs. All hospitals participating in the Medicare, Medicaid and TRICARE programs must meet certain financial reporting requirements.

Critical access hospitals

A critical access hospital (CAH) is a hospital that is certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby reduce hospital closures. Each hospital must review its own situation to determine if a CAH status would be advantageous. CAHs are certified under a set of Medicare Conditions of Participation that are more flexible than the acute care hospital's conditions. The CAH program was designed to improve rural healthcare access and reduce hospital closures. Medicare reimburses CAHs on a "reasonable cost basis" for services provided to Medicare patients.

Acute care hospitals

Acute care is a branch of healthcare that provides necessary treatment of a disease for only a short period of time. Acute care hospitals treat patient for brief but severe illnesses. Many acute care facilities aim to discharge the patient as soon as the patient is deemed healthy and stable, with appropriate discharge instructions. The term is generally associated with

Operating Conditions

Industry Assistance continued

care rendered in an emergency department, ambulatory care clinic or other short-term stay facility. The final version of the Medicare inpatient prospective payment system (IPPS) for 2011 anticipates a $440.0 million drop in operating payments to acute care hospitals. The net loss results from a formula that increases reimbursements to account for inflation. However, that gain is more than erased by a documentation and coding adjustment that recoups certain overpayments from fiscal 2008 and 2009.

Electronic health records

Federal funding for "meaningful use" of electronic health records (EHRs), which started in May 2011, may be a strong incentive for hospitals to make the investment. About $30.0 to $40.0 billion will be distributed to hospitals, physicians and other providers, with each hospital receiving as much as $11.0 million and physicians' offices getting as much as $44,000 to $64,000 per physician.

The Medicare and Medicaid EHR incentive programs are based on a number of factors, beginning with a $2.0 million base payment. There are three types of eligible hospitals for the EHR incentive program: Subsection (d) hospitals in the 50 states or the District of Columbia that are paid under the hospital inpatient prospective payment system; critical access hospitals; and Medicare advantage (MA) hospitals. Hospitals will qualify for incentive payments if they demonstrate meaningful use of certified EHR technology.

Medicare hospitals that adopt a certified EHR system and are meaningful users can receive incentive payments through 2015. Hospitals can receive payments in any year from through 2015, but the incentive payment will decrease for hospitals that start receiving payments in 2014 and later. Hospitals that are not meaningful users of certified EHR technology beginning in 2015 will be subject to payment adjustments. Acute care hospitals (including CAHs) with at least 10.0% Medicaid patient volume and children's hospitals (no Medicaid volume requirements) may be eligible for Medicaid EHR incentive payments.

Industry organizations

The American Hospital Association (AHA) is a national organization that represents and serves all types of hospitals, healthcare networks and their patients and communities. The AHA has 5,000 institutional members, 600 associate members and 5,000 personal members. The AHA advocates and lobbies members' perspectives.

Key Statistics

Industry Data

	Revenue ($m)	Industry Value Added ($m)	Establish-ments	Enterprises	Employment	Exports	Imports	Wages ($m)	Domestic Demand	Number of Physician Visits (Milion)
2003	591,153.2	284,110.3	6,557	3,984	5,727,249	--	--	226,177.1	N/A	1,079
2004	618,248.1	296,640.2	6,468	3,965	5,656,464	--	--	233,579.9	N/A	1,055
2005	642,300.4	302,958.1	6,037	3,806	5,497,527	--	--	236,799.9	N/A	1,080
2006	654,862.8	315,710.7	5,773	3,536	5,375,823	--	--	243,672.0	N/A	979
2007	675,960.2	338,850.4	5,440	3,401	5,395,018	--	--	258,407.7	N/A	977
2008	695,032.4	327,262.8	5,413	3,187	5,217,488	--	--	274,439.7	N/A	967
2009	710,738.8	329,211.4	5,475	3,227	4,989,044	--	--	265,907.2	N/A	971
2010	736,270.9	353,525.6	4,969	3,155	4,904,956	--	--	276,833.6	N/A	980
2011	756,960.4	391,885.7	4,833	3,000	4,872,706	--	--	290,947.0	N/A	988
2012	**785,675.3**	**456,477.3**	**4,794**	**3,013**	**4,911,687**	**--**	**--**	**302,347.2**	**N/A**	**1,014**
2013	821,816.2	429,311.1	4,791	2,985	4,941,157	--	--	316,675.5	N/A	1,039
2014	858,880.6	444,820.4	4,751	2,982	4,970,804	--	--	329,322.9	N/A	1,089
2015	889,749.3	422,408.6	4,744	2,942	5,000,629	--	--	344,333.0	N/A	1,111
2016	923,711.3	432,671.2	4,716	2,917	5,015,631	--	--	357,930.7	N/A	1,115
2017	955,941.1	445,404.5	4,666	2,884	5,015,631	--	--	371,017.1	N/A	1,142
Sector Rank	**1/59**	**1/59**	**40/59**	**40/59**	**1/59**	**N/A**	**N/A**	**1/59**	**N/A**	**N/A**
Economy Rank	**5/1142**	**3/1142**	**438/1141**	**460/1141**	**4/1142**	**N/A**	**N/A**	**2/1142**	**N/A**	**N/A**

Annual Change

	Revenue (%)	Industry Value Added (%)	Establish-ments (%)	Enterprises (%)	Employment (%)	Exports (%)	Imports (%)	Wages (%)	Domestic Demand (%)	Number of Physician Visits (%)
2004	4.6	4.4	-1.4	-0.5	-1.2	N/A	N/A	3.3	N/A	-2.2
2005	3.9	2.1	-6.7	-4.0	-2.8	N/A	N/A	1.4	N/A	2.4
2006	2.0	4.2	-4.4	-7.1	-2.2	N/A	N/A	2.9	N/A	-9.4
2007	3.2	7.3	-5.8	-3.8	0.4	N/A	N/A	6.0	N/A	-0.2
2008	2.8	-3.4	-0.5	-6.3	-3.3	N/A	N/A	6.2	N/A	-1.0
2009	2.3	0.6	1.1	1.3	-4.4	N/A	N/A	-3.1	N/A	0.4
2010	3.6	7.4	-9.2	-2.2	-1.7	N/A	N/A	4.1	N/A	0.9
2011	2.8	10.9	-2.7	-4.9	-0.7	N/A	N/A	5.1	N/A	0.8
2012	**3.8**	**16.5**	**-0.8**	**0.4**	**0.8**	**N/A**	**N/A**	**3.9**	**N/A**	**2.6**
2013	4.6	-6.0	-0.1	-0.9	0.6	N/A	N/A	4.7	N/A	2.5
2014	4.5	3.6	-0.8	-0.1	0.6	N/A	N/A	4.0	N/A	4.8
2015	3.6	-5.0	-0.1	-1.3	0.6	N/A	N/A	4.6	N/A	2.0
2016	3.8	2.4	-0.6	-0.8	0.3	N/A	N/A	3.9	N/A	0.4
2017	3.5	2.9	-1.1	-1.1	0.0	N/A	N/A	3.7	N/A	2.4
Sector Rank	**26/59**	**2/59**	**51/59**	**37/59**	**47/59**	**N/A**	**N/A**	**26/59**	**N/A**	**N/A**
Economy Rank	**409/1142**	**34/1142**	**904/1141**	**636/1141**	**735/1142**	**N/A**	**N/A**	**290/1142**	**N/A**	**N/A**

Key Ratios

	IVA/Revenue (%)	Imports/ Demand (%)	Exports/Revenue (%)	Revenue per Employee ($'000)	Wages/Revenue (%)	Employees per Est.	Average Wage ($)	Share of the Economy (%)
2003	48.06	N/A	N/A	103.22	38.26	873.46	39,491.40	2.40
2004	47.98	N/A	N/A	109.30	37.78	874.53	41,294.33	2.42
2005	47.17	N/A	N/A	116.83	36.87	910.64	43,073.89	2.40
2006	48.21	N/A	N/A	121.82	37.21	931.20	45,327.39	2.44
2007	50.13	N/A	N/A	125.29	38.23	991.73	47,897.47	2.57
2008	47.09	N/A	N/A	133.21	39.49	963.88	52,599.97	2.49
2009	46.32	N/A	N/A	142.46	37.41	911.24	53,298.23	2.58
2010	48.02	N/A	N/A	150.11	37.60	987.11	56,439.57	2.71
2011	51.77	N/A	N/A	155.35	38.44	1,008.22	59,709.53	2.95
2012	**58.10**	**N/A**	**N/A**	**159.96**	**38.48**	**1,024.55**	**61,556.69**	**3.36**
2013	52.24	N/A	N/A	166.32	38.53	1,031.34	64,089.34	3.11
2014	51.79	N/A	N/A	172.79	38.34	1,046.26	66,251.44	3.13
2015	47.48	N/A	N/A	177.93	38.70	1,054.10	68,857.94	2.87
2016	46.84	N/A	N/A	184.17	38.75	1,063.53	71,363.04	2.83
2017	46.59	N/A	N/A	190.59	38.81	1,074.93	73,972.17	2.82
Sector Rank	**18/59**	**N/A**	**N/A**	**19/59**	**31/59**	**1/59**	**14/59**	**1/59**
Economy Rank	**135/1142**	**N/A**	**N/A**	**771/1142**	**153/1142**	**4/1141**	**294/1142**	**3/1142**

Figures are inflation-adjusted 2012 dollars. Rank refers to 2012 data.

SOURCE: WWW.IBISWORLD.COM

Jargon & Glossary

Industry Jargon

CIRCULATORY SYSTEM The system that moves blood throughout the body, including the heart, arteries, capillaries and veins.

CRITICAL ACCESS HOSPITAL (CAH) A small facility that gives limited outpatient and inpatient hospital services to people in rural areas. CAHs must meet Medicare requirements.

INPATIENT Admitted patients who stay overnight or longer.

OUTPATIENT A patient admitted to a hospital, clinic or associated facility for diagnosis or treatment and released the same day.

TEACHING HOSPITAL Instruction for medical students combined with assistance to patients and often linked to a medical school.

TELEMEDICINE An application of clinical medicine whereby medical information is transferred through interactive audiovisual media for the purpose of consulting and remote medical procedures or examinations.

IBISWorld Glossary

BARRIERS TO ENTRY High barriers to entry mean that new companies struggle to enter an industry, while low barriers mean it is easy for new companies to enter an industry.

CAPITAL INTENSITY Compares the amount of money spent on capital (plant, machinery and equipment) with that spent on labor. IBISWorld uses the ratio of depreciation to wages as a proxy for capital intensity. High capital intensity is more than $0.333 of capital to $1 of labor; medium is $0.125 to $0.333 of capital to $1 of labor; low is less than $0.125 of capital for every $1 of labor.

CONSTANT PRICES The dollar figures in the Key Statistics table, including forecasts, are adjusted for inflation using the current year (i.e. year published) as the base year. This removes the impact of changes in the purchasing power of the dollar, leaving only the "real" growth or decline in industry metrics. The inflation adjustments in IBISWorld's reports are made using the US Bureau of Economic Analysis' implicit GDP price deflator.

DOMESTIC DEMAND Spending on industry goods and services within the United States, regardless of their country of origin. It is derived by adding imports to industry revenue, and then subtracting exports.

EMPLOYMENT The number of permanent, part-time, temporary and seasonal employees, working proprietors, partners, managers and executives within the industry.

ENTERPRISE A division that is separately managed and keeps management accounts. Each enterprise consists of one or more establishments that are under common ownership or control.

ESTABLISHMENT The smallest type of accounting unit within an enterprise, an establishment is a single physical location where business is conducted or where services or industrial operations are performed. Multiple establishments under common control make up an enterprise.

EXPORTS Total value of industry goods and services sold by US companies to customers abroad.

IMPORTS Total value of industry goods and services brought in from foreign countries to be sold in the United States.

INDUSTRY CONCENTRATION An indicator of the dominance of the top four players in an industry. Concentration is considered high if the top players account for more than 70% of industry revenue. Medium is 40% to 70% of industry revenue. Low is less than 40%.

INDUSTRY REVENUE The total sales of industry goods and services (exclusive of excise and sales tax); subsidies on production; all other operating income from outside the firm (such as commission income, repair and service income, and rent, leasing and hiring income); and capital work done by rental or lease. Receipts from interest royalties, dividends and the sale of fixed tangible assets are excluded.

INDUSTRY VALUE ADDED (IVA) The market value of goods and services produced by the industry minus the cost of goods and services used in production. IVA is also described as the industry's contribution to GDP, or profit plus wages and depreciation.

INTERNATIONAL TRADE The level of international trade is determined by ratios of exports to revenue and imports to domestic demand. For exports/revenue: low is less than 5%, medium is 5% to 20%, and high is more than 20%. Imports/domestic demand: low is less than 5%, medium is 5% to 35%, and high is more than 35%.

LIFE CYCLE All industries go through periods of growth, maturity and decline. IBISWorld determines an industry's life cycle by considering its growth rate (measured by IVA) compared with GDP; the growth rate of the number of establishments; the amount of change the industry's products are undergoing; the rate of technological change; and the level of customer acceptance of industry products and services.

NONEMPLOYING ESTABLISHMENT Businesses with no paid employment or payroll, also known as nonemployers. These are mostly set up by self-employed individuals.

Jargon & Glossary

IBISWorld Glossary continued

PROFIT IBISWorld uses earnings before interest and tax (EBIT) as an indicator of a company's profitability. It is calculated as revenue minus expenses, excluding interest and tax.

VOLATILITY The level of volatility is determined by averaging the absolute change in revenue in each of the past five years. Volatility levels: very high is more than ±20 %; high volatility is ±10 % to ±20 %; moderate volatility is ±3 % to ±10 %; and low volatility is less than ±3 %.

WAGES The gross total wages and salaries of all employees in the industry. The cost of benefits is also included in this figure.