

FEWER HOSPITALS CLOSE IN THE 1990s: RURAL HOSPITALS MIRROR THIS TREND

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BACKGROUND

Throughout the 1980s and into the early 1990s there was a prevailing sense among policymakers that many rural hospitals were struggling to stay open—the number of hospitals that closed reached a post-WWII high during the 1980s—and there was concern that more closings would cause the loss of major sources of care in rural communities. Policymakers feared that the Medicare Prospective Payment System might be causing undue financial distress among small rural hospitals, so they developed and implemented several special hospital payment programs such as the Sole Community Hospital (SCH), Medicare Dependent Hospital (MDH), and most recently the Critical Access Hospital (CAH) Programs. Facilities that qualify for one of these programs are entitled to enhanced Medicare payments. The high level of participation in these programs suggests that they offer meaningful financial benefits and that participating hospitals should now be operating under less financial distress. While this evidence is encouraging, it is still essential to understand trends in hospital closures and to identify unresolved or emerging problems for rural health care systems. This findings brief attempts to illustrate some of those trends by describing patterns of hospital closures during the 1990s.

The process of identifying and tracking hospital closures is challenging. There are over 5,000 acute care short-term general hospitals operating in the U.S., and hospitals have a tendency to reorganize, restructure, and merge as well as open and close. Several factors make tracking difficult - perhaps the greatest impediment to a regular inventory is the lack of a common definition for a closed hospital. In addition, state agency documentation of hospital closures and other changes in status is inconsistent, and some states do not track hospital closures at all.

The US Department of Health and Human Services Office of the Inspector General (OIG) has developed a system to navigate these obstacles. It tracks hospital closures and publishes them annually. These reports are limited in their application to policy-making, however, since there is considerable delay in their release and only one year of closures is generally reported. Academic researchers and organizations such as the American Hospital Association (AHA) have aggregated data from the OIG's annual reports, occasionally augmenting data with information collected independently, and produced reports showing trends in hospital closures. This study attempts to update research describing hospital closures during the 1980s and early 1990s by illustrating trends observed between 1990 and 2000.

METHODS

Information about closed hospitals drawn from existing hospital closure reports served as the foundation for a dataset of hospital closures. Annual reports on hospital closures published by the OIG were the primary source of information for our dataset; additional reports released by the AHA, the Centers for Medicare and Medicaid Services (CMS-formerly HCFA) and academic researchers supplemented

the data. To verify closures reported by these sources, we contacted every state's hospital association or licensure agency and requested information regarding our list of closures. Our contacts reviewed our information and corrected inaccuracies in data—most frequently, the incorrect report of a closure or the date of closure. New information about recent closures or details about facilities that had closed but recently reopened was also gathered.

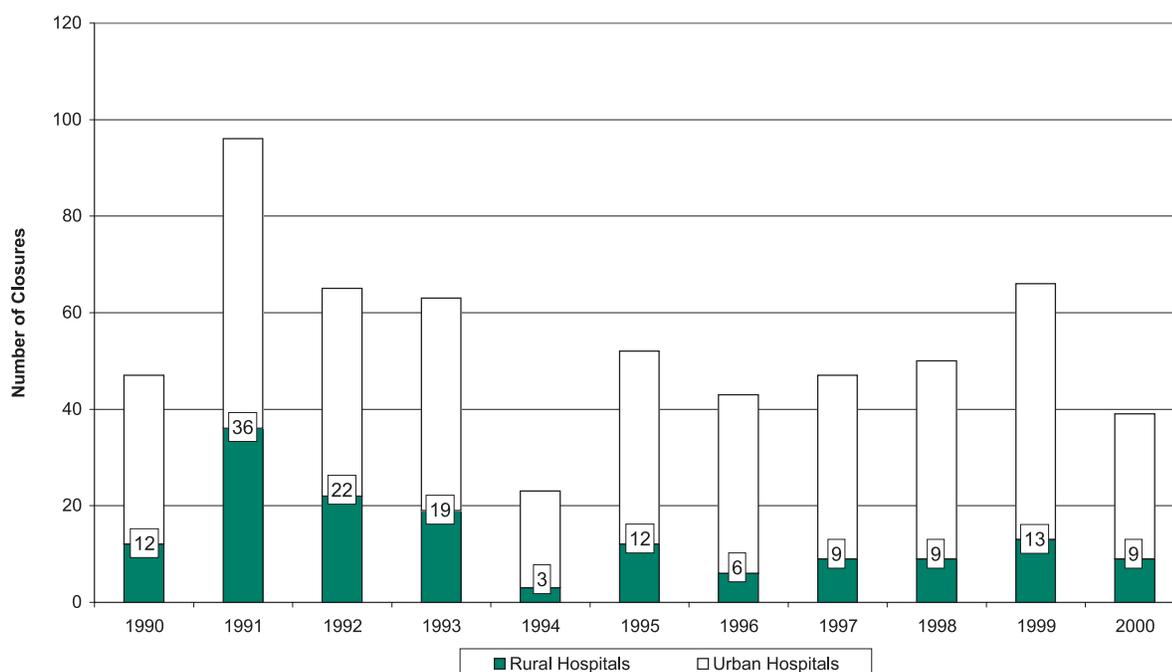
For the purpose of this analysis, a hospital was considered closed if it stopped providing short-term inpatient services. Hospitals that converted to outpatient clinics or centers for rehabilitation, substance abuse, or urgent care were considered closed; facilities that simply changed licensure status for reimbursement purposes, for example, converted to Critical Access Hospitals, were not considered closed. Hospitals that closed for a period of time but later reopened are discussed separately from the facilities that remain closed. A hospital was considered rural if it was located in a nonmetropolitan county as defined by 1999 MSA (Metropolitan Statistical Area) classifications published by the US Office of Management and Budget.

FINDINGS

During the 1990s, a total of 460 general hospitals across the United States closed; of these, 35% were located in rural areas. An AHA¹ report documenting hospital closures found a much higher rate of hospital closure from 1980-1989, with a significantly higher rate of closure in rural areas. During the 1990s, an average of 42 facilities closed each year; the AHA report shows that the rate of closure during the second half of the 1980s was twice as high. Data reported by the AHA show that the rate of hospital closure began to decline in 1989; our data indicate that this trend continued into the early 1990s, with the exception of an increase in 1991. By 1994, the rate of hospital closures in both urban and rural areas was as low as it had been in at least 15 years. After 1994, the rate of closure began to rise slowly, but with a more pronounced increase in urban areas. For the first time since 1983, rural hospital closures represented less than one-third of all US hospital closures (Figure 1).

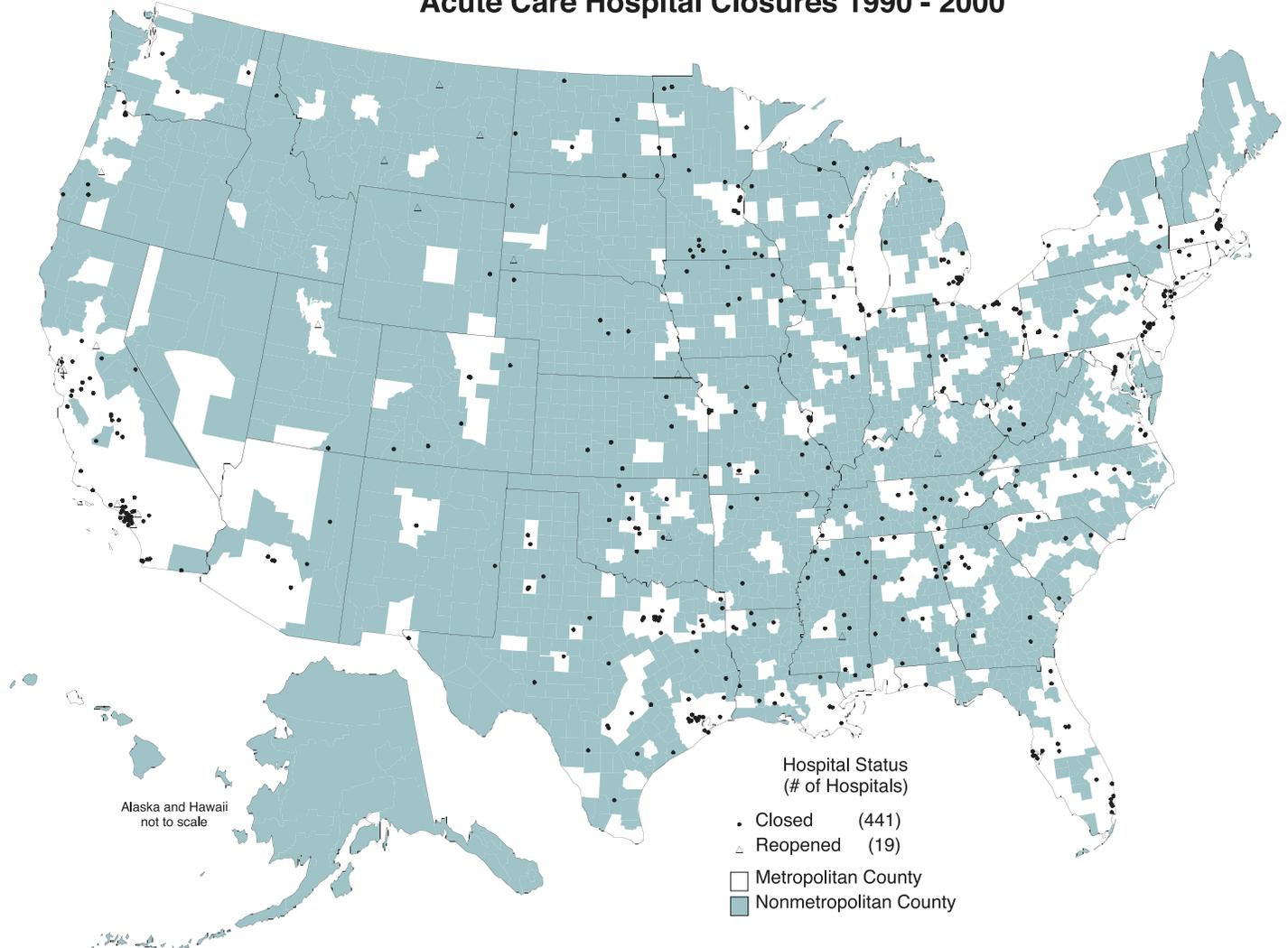
The majority of closures occurred in the Southeast and Central regions of the US (Figure 2). Not surprisingly, states with large numbers of hospitals, such as California and Texas, experienced the most closures; however, the majority of closures in these states happened in urban areas. The closure of rural hospitals was most common in Missouri, Minnesota, Mississippi

Figure 1: Short-term Acute Care Hospital Closures 1990-2000



Source: North Carolina Rural Health Research and Policy Analysis Center, UNC-CH. 2001.

Figure 2: Geographic Distribution of Short-term Acute Care Hospital Closures 1990 - 2000



Sources: North Carolina Rural Health Research Program, Cecil G. Sheps
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and North Dakota. By 2000, many states had less than 90% of the rural hospitals they started the 1990s with.

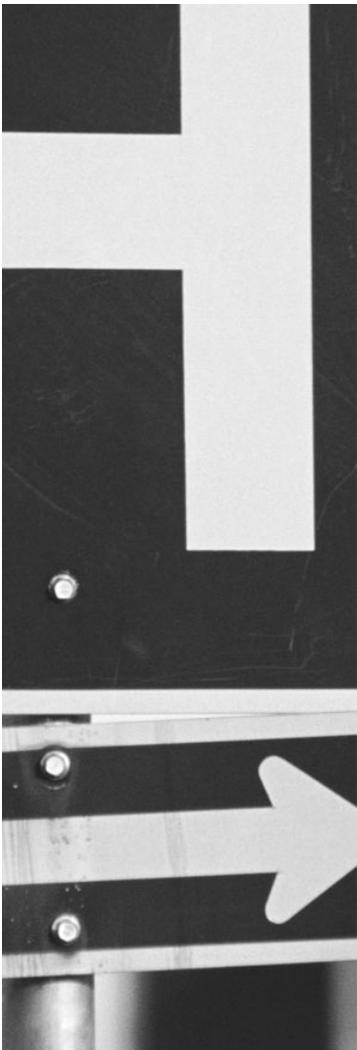
Of the 460 hospitals that closed between 1990 and 2000, 19 reopened as acute care hospitals by the end of the decade. Eleven of the facilities that reopened did so as Critical Access Hospitals; 10 of these are located in nonmetropolitan counties. (The CAH program was designed to allow facilities that closed within the last 10 years to reopen as a CAH under the restrictions of the program. Officials managing the CAH program report that other facilities will reopen as CAHs in the coming years.*)

SUMMARY AND CONCLUSIONS

In the early 1990s, the rate of rural hospital closings slowed considerably from the previous decade, but by 1995, the rate of closures began to slowly increase. The overall decline in closures may signal a trend of improving conditions for rural health care systems, but the results must be interpreted cautiously, since hospital closure is only one indicator of market stress.

There is evidence that many of the nation's rural hospitals may still be operating under financial distress. A study by Dalton et al.,² examined Medicare Cost Report data, and identified

* For more information on the Critical Access Hospital Program see the Tracking Website at <http://www.rupri.org/rhfp-track/>



Hospital closing continued...

hundreds of rural hospitals that exhibit signs of stress based on a set of risk indicators constructed by the authors. Existing federal initiatives, such as the CAH, SCH, and MDH programs, may help some of these facilities, but some hospitals are unlikely to qualify for these programs because of restrictive eligibility criteria. Though it does appear that many hospitals are faring better than in years past, policymakers should continue to explore ways to assist them, and should not interpret the recent trend of declining rural hospital closings as evidence that all of the problems facing rural hospitals have been solved.

References:

1. Health Care Information Resources Group for the American Hospital Association. (March 1994). Hospital Closures 1980-1993: A Statistical Profile. Chicago, IL.
2. Dalton, K.; Slifkin, R.T.; Howard, H.A.. (February 2000). "At-Risk Hospitals": The role of CAH status in mitigating the effects of the new prospective payment systems under Medicare. Working Paper No.67. North Carolina Rural Health Research and Policy Analysis Center, UNC-CH.

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