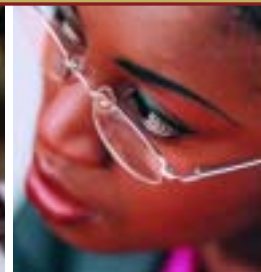


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GE Healthcare Financial Services

How Are Hospitals Financing the Future?

The Future of Capital Spending

**Financing the Future Report 3:
How Are Hospitals Financing the Future?
The Future of Capital Spending**

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Research conducted by HFMA and
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Table of Contents

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Report 3:

How Are Hospitals Financing the Future? The Future of Capital Spending

Key Findings	ii
1. Setting the Scene	1
2. What Will Influence the Need for Capital?	2
Condition of Infrastructure	2
Future Population Growth Rate	3
Future Health Status	4
Physician Demand Growth Rate	4
Historical Capital Spending	5
3. Where Will Capital Need Be Most Acute?	6
4. How Will Hospitals Allocate Their Capital?	8
Technology	8
Expanding Capacity	9
5. How Much Will Capital Spending Increase?	11
Spending by Type of Hospital	11
Drivers of Increased Spending	12
Impact on the Industry	13
6. Looking toward the Future	14
Matching Need and Spending	14
Steps toward the Future	15
The Next <i>Financing the Future</i> Report	15
Appendix A: Measuring Your Own Future Capital Needs	16
Appendix B: Selected States' Potential Capital Needs	17
Appendix C: Methodology	19

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Report 3:

How Are Hospitals Financing the Future? The Future of Capital Spending

Key Findings

- Seventy-two percent of CFOs surveyed said they expected their hospitals' capital spending to increase in the next five years.
- The increase in capital spending expected was 14 percent, compared with average annual increases in capital spending of 1 percent between 1997 and 2001.
- Not-for-profit hospitals are more likely to increase capital spending than for-profit hospitals.
- The hospital industry is concerned about its ability to address its current and future capital needs. Nearly half of hospital CFOs say they're not able to keep up with deteriorating plants.
- Drivers of increased capital spending will be most intense in Idaho, Georgia, Florida, California, Tennessee, Alaska, Texas, Rhode Island, Arkansas, Arizona, Utah, and Delaware. Drivers of increased capital spending will be least intense in Louisiana, Ohio, Iowa, Maine, Montana, Nebraska, Wyoming, Hawaii, and South Dakota.
- The three most commonly cited future capital projects all focused on technology: digital radiology systems, computerized physician order entry systems, and other major information technology. Many hospitals cited capital projects to build capacity. Furthermore, among states with the highest projected population growth, plans for increased capacity had a relatively higher priority than in all states combined.

1. Setting the Scene

Hospitals have a responsibility to reinvest in their plants and equipment every year. Yet the rate at which they do so is highly variable, depending on their own profits, growth rate, prior investments, and other spending priorities. As any car owner knows, a lack of investment in maintenance can be devastating, but the implications are even more traumatic if you're driving a two-seater and you add twins to your family. Businesses that provide a service to the general public, such as schools, utilities, and hospitals, must not only maintain their facilities but also keep one step ahead of the growth rate to ensure continued quality of service.

The average annual increase in hospital capital spending between 1997 and 2001 was just 1 percent, and during that period the capital spending of 41 percent of hospitals was not keeping up with depreciation, according to *Capital Spending in Health Care Today* (January 2004), the most recent report of *Financing the Future*. (*Financing the Future* is a year-long project led by HFMA in partnership with GE Healthcare Financial Services. The project is based on research conducted by HFMA and PricewaterhouseCoopers.)

Exacerbating the situation, the deteriorating financial situation of hospitals is making capital access a more significant challenge and is polarizing the industry into the “have’s” and the “have-not’s,” as reported in *Capital Access in Health Care Today* (November 2003), the first *Financing the Future* report.

Now we turn to the future, and our findings suggest that the industry is in for a sea change with regard to capital spending.

Seventy-two percent of hospital CFOs surveyed predict that capital spending will increase. CFOs surveyed plan to increase spending by an average of 14 percent annually, compared with the 1 percent annual increase of recent years.¹

An increase of this size begs a number of significant questions:

- What will influence the need for capital in the future?
- In which geographic areas will capital need be most acute?
- How will hospitals allocate their capital among competing needs?
- How much will capital spending increase, and what effect will this increase have on the industry?

The purpose of this report is to answer these questions. Future reports will answer the equally pressing questions of how hospitals will access needed capital and how they can improve their capital planning in an environment of increasing capital needs and tight financial constraints.

This report is based on the following research conducted by HFMA and PricewaterhouseCoopers:

- Comparison of capital-need challenges in various states based on factors that influence capital demand. This analysis uses a “Cap X Scorecard” developed by PricewaterhouseCoopers. (*See Appendix C for methodology.*)
- A survey of hospital CFOs at 460 hospitals and health systems conducted by HFMA.
- Interviews with hospital executives and industry leaders.

¹ The average is weighted based on current capital spending. The median response of CFOs surveyed was a 15 percent increase in capital spending. The figure of 1 percent annual increase in spending is based on analysis of 1997-2001 Solucient data.

2. What Will Influence the Need for Capital?

The future need for capital is largely influenced by projected demand for services and past capital investments. Simply put, sharply growing demand and lack of past capital investment are a recipe for high capital spending in the future. This section assesses how our nation's hospitals will be affected by the key factors influencing capital need:

- Condition of infrastructure
- Future population growth rate
- Future health status
- Physician demand growth rate
- Historical capital spending

A look at each of these factors, and how each is likely to change over the next five years, reveals that hospitals' capital needs are likely to increase dramatically, with certain regions most commonly affected by certain factors.

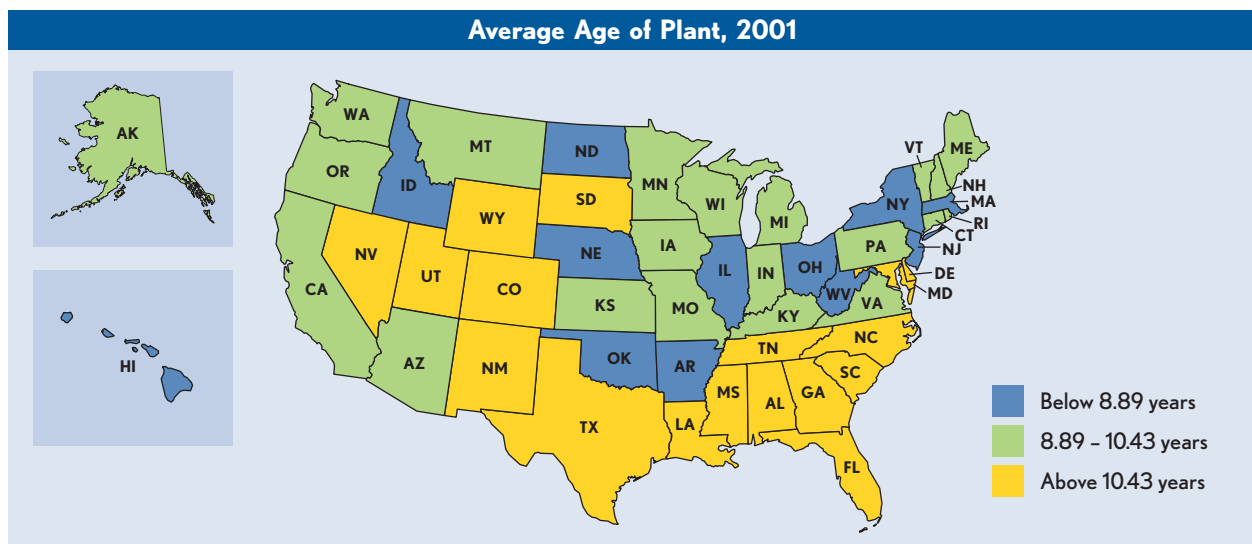
Each of these factors affects each hospital uniquely based on a hospital's specific location; the particular way the factor is manifested locally can dramatically influence the need for capital spending. Although a

review of these factors in each metropolitan statistical area is beyond the scope of this project, we do illuminate the regional distinctions by analyzing them on a state-by-state basis using a uniform scoring method. (See Appendix C for a full description of the scoring method.) Section 3 of this report consolidates scores for all of these factors to depict relative nationwide capital need.

Condition of Infrastructure

Hospital CFOs appear to be of two minds about the state of their infrastructures. Although only about one-third of CFOs surveyed believe their hospitals have fallen behind in maintaining their infrastructures during the past 10 years, almost half believe their infrastructures are deteriorating faster than they can make capital improvements, with greatest concern among teaching hospitals. For hospitals in general, age of plants is rising, most notably in the north. These findings suggest that deteriorating plants are likely to demand significant capital investment in the next five years.

Exhibit 1



Source: Ingenix, Almanac of Hospital Financial and Operating Indicators, 2003

The median age of plant in 2001 was 9.5 years, up from 9.2 years in 1997, according to Ingenix data. This increase continues the trend of age of plant rising over the past dozen years. In 2001, 16 percent of hospital plants were more than 15 years old, according to analysis of Solucient data. Among states, average age of plant ranges between seven and 15 years. In general, northern states tend to have older plants than southern states (see Exhibit 1). Hospitals with older plants may need more capital in the future for routine maintenance and adapting to information technology requirements.

Teaching hospitals led the list of hospital segments for which CFOs were worried about being able to making enough capital improvements. Teaching hospitals that haven't spent much on capital improvements in recent years could be facing major needs going forward.

For example, take the case of Princeton (N.J.) Healthcare System, where CEO Barry Rabner said management is considering a \$200-million replacement facility. The current teaching hospital is physically landlocked. Employees have to be bussed in because of a lack of parking, operating suites are too small, and executives are worried about competitors taking market share because of Princeton's inability to grow. "It's tough to balance the demands for capital today in an existing facility while knowing that you are going to build a new one," Rabner noted.

Other groups of hospitals in which more than half of respondents voiced worries about deteriorating infrastructure were critical-access hospitals and urban hospitals.

Sister Geraldine Hoyler, CFO of Catholic Health Initiatives, summarizes the need to invest capital in rehabbing or replacing aging facilities. "There are Hill-Burton hospitals that are 55 years old," she noted. "A lot of these places haven't done much [plant improvement]. These inefficient plants become untenable."

Future Population Growth Rate

America's population is growing at a rate of about 1 percent a year. However, the growth is far from uniform, creating potentially large capital needs in some areas, and potentially very low capital needs in others (see Exhibit 2.)

It's also important for hospitals to consider growth in the over-65 demographic because this group is the highest user of hospital services. Americans between the ages of 65 and 74 average 1.3 inpatient days annually compared with less than one-half day for Americans under age 65.²

Four states—Nevada, Arizona, Colorado, and Florida—are projected to lead the nation in growth rate of both overall population and population over age 65 between 2002 and 2007. In absolute numbers,

Exhibit 2



Source: Solucient, 2003

² National Hospital Discharge Survey, Centers for Disease Control and Prevention, 1998.

the states that will see the biggest swells in population are California, Texas, Florida, and Georgia.

Lee Memorial Hospital, located in the high-growth state of Florida, is preparing for the future with a 10-year, \$500-million capital plan. “We’re in a growth community,” said John Wiest, the hospital’s CFO. “We were told 15 years ago that we were overbedded and that managed care was going to take care of utilization. Most people pulled in their horns and said don’t build any capacity.” Now, Lee Memorial is “right-sizing,” moving 122 beds from its main campus to a new one called Health Park.

Future Health Status

As the nation that spends more on health care per capita than any other in the world, you’d think that Americans would be quite healthy. Yet our health status is worsening in a number of areas, which in turn will place a burden on hospitals to invest the capital necessary to cope with increased demand for services and a higher acuity of services.

Generally, health status is measured through two types of benchmarks: risk factors that lead to future health problems and outcomes. For example, one risk factor is lack of health insurance. An estimated 15.2 percent of Americans were uninsured as of 2002, up from 14.2 percent in 2000.³ The uninsured

generally have less access to health care and poorer health status than those with health insurance. They tend to postpone medical care, which can lead to more serious illness and avoidable health problems, such as infant mortality.

Exhibit 3 portrays the 2003 health status rankings by United Health Foundation. The rankings consider 17 risk factors and outcomes, including smoking prevalence, motor vehicle deaths, obesity rates, prenatal care, lack of health insurance, infant mortality, premature death, and limited activity days. The results show that the population’s health status in several Southern states is worse than that in most Northern states. The risk factors that these low-health-status states have in common include lower percentage of high school graduates, higher risk of heart disease, and more children living in poverty. The outcomes they share include higher premature death, high infant mortality, and limited activity.

Physician Demand Growth Rate

Physicians are significant drivers of capital need. Areas that have more physicians have higher utilization of healthcare services and more capital needs. The projected growth rate for physicians between 2002 and 2007 is 5.9 percent nationally, according to analysis of Solucient data.

Exhibit 3



* Health status ranking according to various risk factors and outcomes, including smoking prevalence, motor vehicle deaths, obesity rates, prenatal care, lack of health insurance, infant mortality, premature death, and limited-activity days.

Source: 2003 rankings, United Health Foundation

States with the highest projected physician demand growth rate are Nevada, Arizona, and Colorado. States with the lowest projected physician demand growth rate are North Dakota, West Virginia, and Nebraska. The growth rate for physicians hinges on population growth and utilization, which vary widely in different geographical areas.

Teaching hospitals are especially attuned to the connection between capital needs and physician retention and recruitment. “The need is now. If we put off this investment, we risk slowing or stopping the momentum we have generated in recruiting world-class faculty,” said Ron King, CFO of the University of California Irvine Medical Center, where a new hospital is under development. “The inability to invest hampers our recruitment of physicians.”

Historical Capital Spending

A simple truth: hospitals that have spent less on capital investments in the past are more likely to spend more on capital investments in the future. Hospital CFOs who said they expected their hospitals’ annual capital spending to increase by 15 percent or more a year were spending, on average, \$34,653 per bed. On the other hand, those who expected to decrease their hospitals’ capital spending were spending, on average, \$46,726 per bed—35 percent more.

It only makes sense that hospitals that haven’t spent much in the past would be expected to spend more in the future. Those that spent heavily in the past may not need as much in capital improvements, or they may have tapped out their debt capacity.

Stanford Hospital and Clinics in Palo Alto, Calif., spent only about \$20 million on capital during the last couple of years. “During the 1990s, there was an over-supply of beds in the market,” said Roy Santarella, Stanford’s CFO. “Until the market shook itself out, we

were reluctant to deploy our capital. After the managed care players shook out, we were willing to look at what the needs were.” Stanford will ramp up capital spending to between \$50 and \$60 million a year in 2005 through 2007, Santarella said. It will be even higher in 2004, when Stanford is opening a \$150 million cancer center. Taken on a state-by-state basis, Hawaii, Alaska, North Dakota, and New York had the lowest average capital expenditure growth rate, indicating that they will have higher capital needs in the future. States including Louisiana, Georgia, and Michigan had a higher capital expenditure growth rate, indicating they wouldn’t need as much capital in the future.

Another wrinkle to capital expenditure growth rate is IT investment. The median IT investment by hospitals as a percent of budget was 2.5 percent in 2001 and 2.2 percent in 2002.⁴ A low investment rate would indicate that hospitals needed to catch up in their IT spending. States in which hospitals had a low investment rate were Wyoming, Arkansas, South and North Dakota, Idaho, and Vermont. States in which hospitals had a higher IT investment rate included Arizona, North Carolina, Washington, and New Jersey.

Like other capital spending, IT spending can be lumpy. Hospitals may make huge investments one year followed by smaller ones later on. For example, Adventist Health, a 3,100-bed system based in Roseville, Calif., is replacing the clinical IT system in all 20 of its hospitals at a cost of \$75 million over the next three years. IT as a percent of overall capital is about 14 percent, said Brett Spenst, the system’s chief information officer. However, it will drop to about 4 percent in future years.

Investing in IT is critical to quality, safety, and productivity, which Spenst says will differentiate hospitals from each other going forward. “I believe the smaller facilities won’t be able to compete with the larger urban ones if they don’t have the technology,” he said.

⁴ *Modern Healthcare* / PricewaterhouseCoopers Annual Survey of Information System Trends

3. Where Will Capital Need Be Most Acute?

The previous section explains how individual factors that influence capital need are affecting different parts of the country. For example, Sunbelt and southern states in general are predicted to experience population growth and diminishing health status based on several indicators, while the Rust belt and northern states tend to have older infrastructure that will need to be replaced or upgraded. By consolidating findings for all of these factors, we can present a picture of the relative acuity of capital need in each state of the country. This is done using what we call the Cap X Scorecard, developed by PricewaterhouseCoopers. The scorecard considers seven indicators. (See Appendix C for a description of how each indicator is measured and scored.)

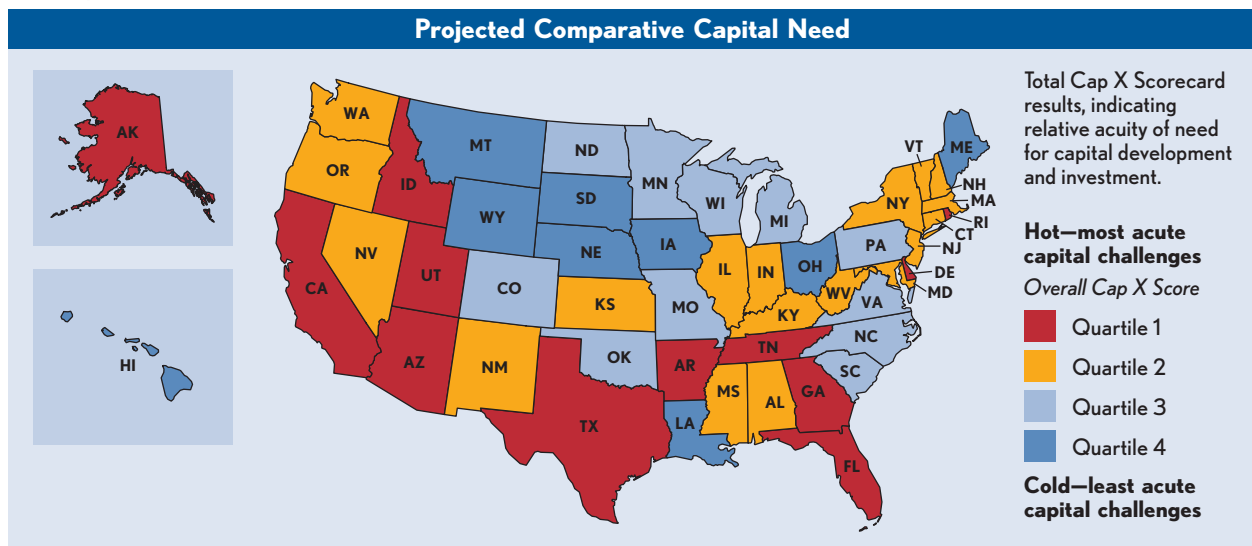
- Demographic factors
 - Percentage growth in overall population
 - Percentage growth in over-65 population

- Historical capital spending
 - Growth in capital spending
 - IT spending
 - Average age of plant
- Clinical demographic factors
 - Health status
 - Physician demand growth

Combining these factors yields a picture of which states are likely to have the most and the least acute need for effective capital planning and development in the next five years. States with the highest score on the Cap X Scorecard are projected to experience the most population growth, currently have the oldest infrastructure and lowest capital spending, and are ranked low on health indicators. All of these circumstances can result in an acute need for capital.

Note that states identified as having acute need for capital development are not necessarily the states that

Exhibit 4



Source: PricewaterhouseCoopers analysis, 2004.

will invest the most capital in terms of absolute dollars. A state with a large population and a large number of hospitals inevitably will invest more capital than a state with a small population and a small number of hospitals, no matter their Cap X Scorecard ranking. The purpose of the scorecard is to identify states that, *in relative terms*, will face the greatest challenges in capital planning and development.

As shown in Exhibit 4, states likely to face the *most* acute need for capital planning and development include (starting with the state facing the most need) Idaho, Georgia, Florida, California, Tennessee, Alaska, Texas, Rhode Island, Arkansas, Arizona, Utah, and Delaware. These states' Cap X Scorecard scores were in the top quartile, meaning they had a combination of the highest projected rate of population growth, lowest comparative historical capital spending, lowest health status, and highest comparative physician demand. States with Cap X Scorecard scores in the lowest quartile—meaning they are likely to face the least acute need for capital planning and development—are (starting with the state facing the least need) Louisiana, Ohio, Iowa, Maine, Montana, Nebraska, Wyoming, Hawaii, and South Dakota. Appendix B provides more detail about the scorecard findings for the highest and lowest scoring states.

Exactly how the Cap X Score will apply to capital allocation and spending will vary depending on local circumstances. Take age of plant as an example. As

any baby-boomer can attest, age is relative. Although northern hospitals are older than southern hospitals, northern hospitals won't necessarily be replaced as quickly as southern ones. "The Northeast and New England are slow to change; they have a tendency to look at the older buildings as acceptable," said D. Kirk Hamilton, principal of Watkins Hamilton Ross Architects, Houston, Texas.

Northeastern hospitals may choose to spend their capital on equipment or IT rather than plant improvements. When asked to prioritize capital needs, Bob Glenning, CFO of Kaleida Health System in Buffalo, N.Y., put information systems, radiology equipment, and cardiology equipment at the top of the list. "Bricks and mortar are last on the list," he said. "IT is our largest single capital expense, making up to half of our capital budget. We are seeing a trend toward the convergence of IT and clinical equipment such that we expect there to be little to no differentiation in the future between these two categories of spending."

Meanwhile, younger plants in California will need capital soon for seismic retrofitting. In California, the average age of plant is 9.2 years, which is slightly less than the national average. Yet a state law mandates earthquake-proofing hospitals at a possible cost of nearly \$42 billion.⁵

Appendix A offers guidance on how hospitals can adapt the Cap X Scorecard method to help measure local capital needs.

⁵ Meade, C., Kulick J., Hillestad, R., *Estimating the Compliance Costs for California SB 1953*, RAND Corporation, April 2002.

4. How Will Hospitals Allocate their Capital?

The planned capital projects most frequently cited by CFOs surveyed pertained to technology. However, construction—especially expansion of capacity—featured prominently in the next 10 most frequently cited planned projects, with 23 percent of CFOs saying they plan to build a new hospital within the next five years (see Exhibit 5).

Technology

The three most frequently cited capital projects hospitals intend to fund in the next five years all are technology acquisitions:

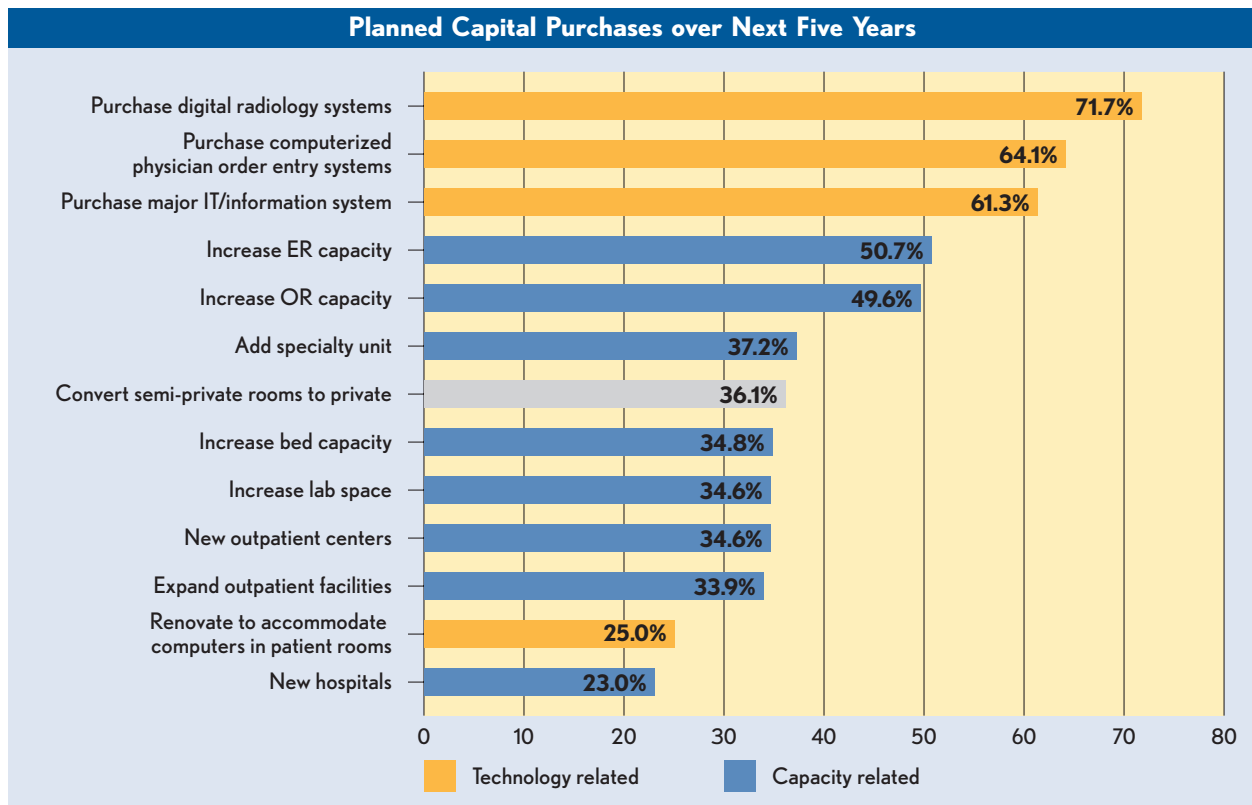
- Digital radiology systems (cited by 72 percent of respondents)
- Computerized physician order entry (CPOE) systems (cited by 64 percent of respondents)
- Major information technology systems (cited by 61 percent of respondents)

- Major information technology systems (cited by 61 percent of respondents)

Further analysis suggests the types of organizations planning to make these investments and the purpose of the investments.

Digital radiology systems. Larger hospitals (300+ beds) and not-for-profit religious, teaching, and sole-community-provider hospitals were the most likely to purchase digital radiology systems. The return on investment for picture archiving and communications systems (PACS)—which store, retrieve, distribute, and display medical images in a digital format—has been so strong that most hospitals of over 400 beds already have some type of PACS, according to research by Frost & Sullivan.⁶ Frost & Sullivan predicts that the North American PACS market will grow by about 11 percent

Exhibit 5



Source: Financing the Future Survey

⁶ Garcia, Antonio, Frost & Sullivan Inc., San Antonio, Tex., as cited in Baldwin, Fred D., "Traveling in PACS: Web-based Systems Make Images Accessible at Multiple Locations," *Healthcare Informatics*, November 2003.

per year through 2008, with much of that growth in small and medium-size hospitals. Indeed, CFOs at more than 70 percent of hospitals between 51 and 300 beds in our survey said they expected to purchase digital radiology systems in the next five years.

Computerized physician order entry. Larger hospitals (300+ beds) and not-for-profit, religious, and teaching hospitals were those most frequently planning to purchase CPOE systems. This finding, too, is supported in the marketplace, where academic medical centers are leading adopters, in part because they can mandate that their faculty use such systems. Some medium-sized and smaller community hospitals have cited the potential for physician resistance as a reason for not purchasing a CPOE system; also, hospitals may be implementing less expensive patient-safety solutions immediately and planning to implement more expensive solutions such as CPOE later.

Major IT systems. Larger hospitals and teaching hospitals were leading the way in planned major IT system purchases. CFOs at for-profit hospitals said their hospitals were less likely to purchase IT systems, but those answers may reflect that such purchases are made at a system level. Nick Bonvino, CIO of Triad Hospitals, a for-profit chain of 57 hospitals based in Plano, Texas, said IT is currently a high priority for Triad. He noted that there is always competition for capital within a large hospital system and that IT projects typically can't post the same return on investment as other capital projects. Even so, IT is getting the nod because "certain things are done just because it's the right thing to do. They can affect adverse drug events and improve quality; it's hard to put a price tag on that."

Expanding Capacity

Although the three most frequently cited planned capital projects were technology acquisitions, eight of the next 10 most frequently cited projects involve expanding capacity:

- Increase emergency-department capacity (51 percent)
- Increase operating-room capacity (50 percent)
- Add a specialty unit (38 percent)
- Increase laboratory capacity (35 percent)
- Increase bed capacity (35 percent)

- Add a new outpatient center (35 percent)
- Expand outpatient facilities (34 percent)
- Build a new hospital (23 percent)

Why is this expansion being contemplated, and how much will it cost?

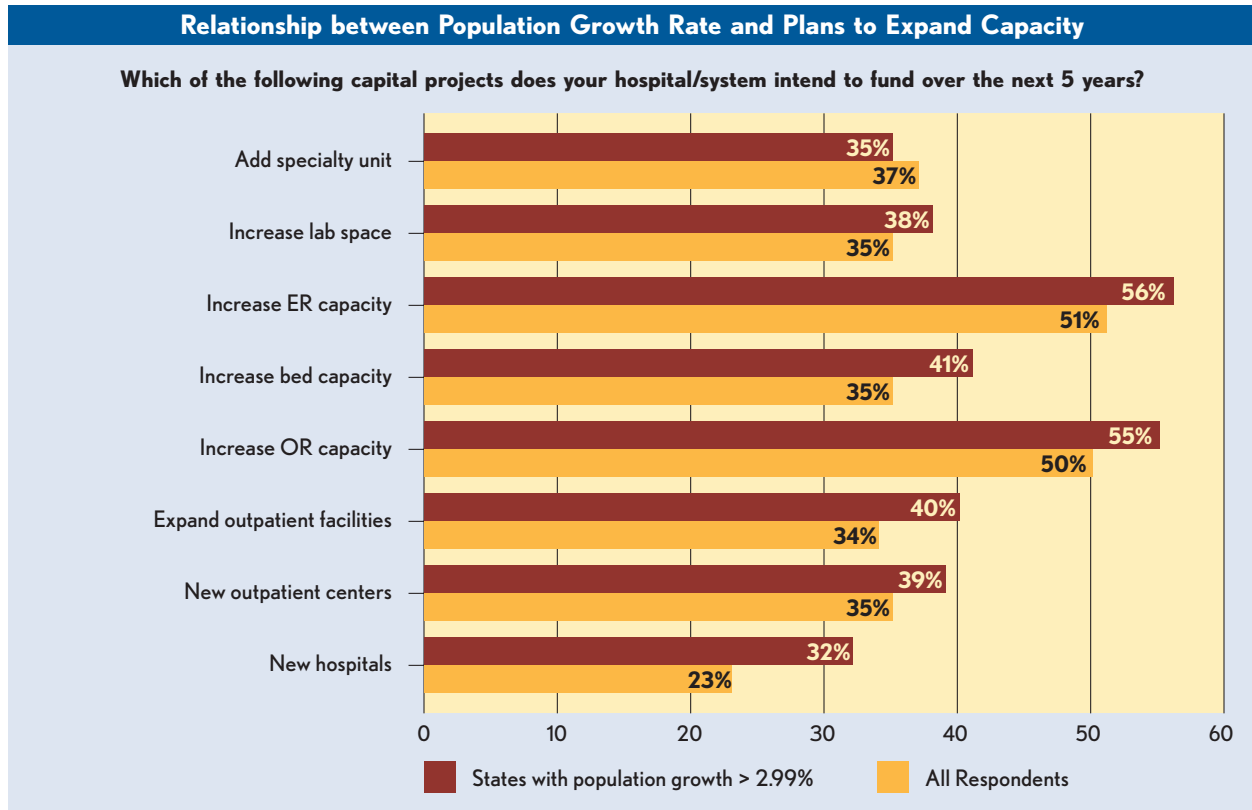
Population growth and expanding capacity. Our survey results show a strong correlation between state population growth and plans to expand capacity (see *Exhibit 6*). Hospitals in states with high population growth (3 percent or more between 2002 and 2007) were more likely than hospitals in general to be adding capacity in beds, ER and OR space, labs, and outpatient centers. Perhaps most striking is that although 23 percent of all respondents said they plan to fund a new hospital, 32 percent of respondents in high-population-growth states were planning new hospitals. The only category in which high-population-growth states did not demonstrate more interest in expansion than respondents as a whole was creation of new specialty units.

Outpatient expansion. Survey findings show a clear interest in enhancing outpatient services. CMS predicts that between 2002 and 2008 the largest increases in spending will be in hospital outpatient departments (12.1 percent) followed by ambulatory surgery centers (11.2 percent).⁷ The spending growth of inpatient services is forecast to be relatively modest at 6.2 percent. The increase in outpatient utilization and the intent to expand outpatient capacity signal that hospital executives view outpatient services as more than just an adjunct to the "real" business of inpatient care.

Inpatient expansion. So, what about beds? Thirty-five percent of the survey respondents said they expect to increase bed capacity, which is a relatively small percentage, but it could still have a big impact depending on where and how many beds. New hospital beds are being built in dozens of cities, yet about 70 percent of survey respondents said they weren't worried about hospitals in their communities adding too much capacity. However, urban hospitals were much more likely than rural ones to be concerned about overcapacity in their markets.

After the Hill-Burton building years, the number of hospital beds in the United States consistently dropped—until 2001. According to the American

⁷ MedPac, June 2003 Databook.



Hospital Association, 2001 was the first year since the late 1960s that the total number of hospital beds increased.⁸ Although the increase was a scant 0.3 percent, many believe this may be the start of a trend resulting from increased utilization by an aging population. Solucient has predicted that demand will necessitate an increase in hospital beds of about 1 percent annually through 2012.⁹

A 1 percent annual increase would mean a total addition of 72,000 beds between 2002 and 2012. The capital spending required for such an expansion is considerable. Using an estimate of \$750,000 per bed (based on a list of pending construction projects compiled by PricewaterhouseCoopers), such new construction would amount to \$54 billion in new capital costs over the 10-year period. And capital costs are not the only costs associated with additional hospital beds. For example, measured on a per-bed basis, inpatient hospital spending has been increasing rapidly. In fact,

inpatient spending per bed increased faster than overall spending on hospital services between 1997 and 2000; in 2001, overall spending on hospital services increased faster.¹⁰

(The change in this pattern in 2001 is probably connected to the increase in beds in 2001 and the continued boom in outpatient procedures and services. Other research on hospital spending by the private sector has documented that outpatient hospital spending is fueling the overall rise.¹¹)

Much of the increase in hospital spending results from higher acuity patients and the additional resources—labor, supplies, and technology—required per patient. The highest acuity beds in a hospital are in intensive care, and the number of those beds is increasing. That increase raises not only the hospital’s operational costs, but also its capital costs. Intensive-care units—whether neonatal, pediatric, or medical-surgical—cost more to build than acute-care units.

⁸ AHA Hospital Statistics, 2003 edition.

⁹ National and Local Impact of Long-Term Demographic Change on Inpatient Acute Care, Solucient, November 2002.

¹⁰ AHA and CMS. Percentages were calculated using the National Healthcare Expenditures figures for total hospital spending. Percent of inpatient spending was calculated based on AHA outpatient and inpatient revenues. Then that percentage was multiplied by overall hospital spending to reach inpatient spending, which was divided by total number of beds reported by AHA.

¹¹ Strunk, Bradley C., Ginsberg, Paul B., and Gabel, Jon R., “Tracking Health Care Costs: Growth Accelerates Again in 2001,” *Health Affairs*, September 25, 2002.

5. How Much Will Capital Spending Increase?

Almost three-fourths of the CFOs surveyed said that capital spending in their hospital or hospital system would increase during the next five years (see Exhibit 7). The annual expected increase was 14 percent.¹²

This proposed rate of increase stands in stark contrast to the 1 percent average increase in capital spending in the five-year period between 1997 and 2001.

In this section we will first explain which types of hospitals plan to spend more and which plan to spend less. We then look at what research shows about increased spending among the major drivers of capital spending: expansion, technology, and replacement and routine maintenance. And finally, we explore whether such proposed capital spending increases are feasible and what effect such increases would have on the healthcare industry.

Spending by Type of Hospital

Although survey findings show planned increases in capital spending across a variety of hospital types, the most significant findings are the aggressive plans for capital spending among small and rural hospitals when compared with large urban hospitals, along with the aggressive plans for capital spending among not-for-profit hospitals when compared with for-profit hospitals.

Small/rural versus large/urban. Smaller hospitals tended to be more aggressive in their projections about capital spending than larger hospitals. Sixty percent of hospitals with fewer than 50 beds expected spending to increase by 15 percent or more annually, compared with 52 percent in the 51 to 100 bed range, 55 percent in the 101 to 200 bed range, 49 percent in the 201 to 300 bed range, and 47 percent in the greater than 300 bed range. In all of the bed ranges, only between 3 percent and 5 percent of respondents said they expected capital spending to decrease (see Exhibit 8).

Exhibit 7

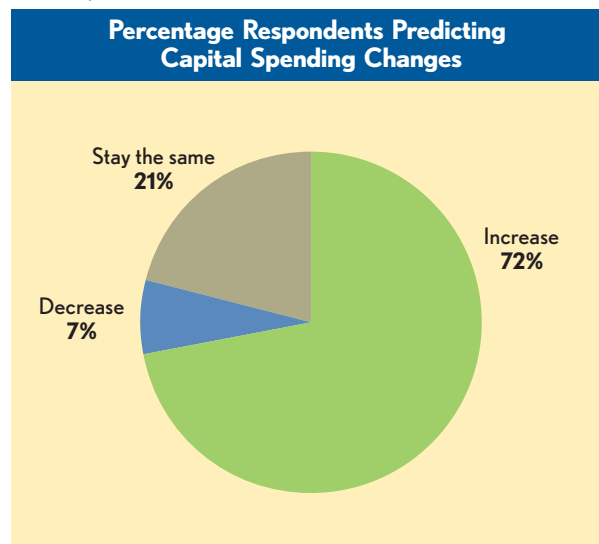
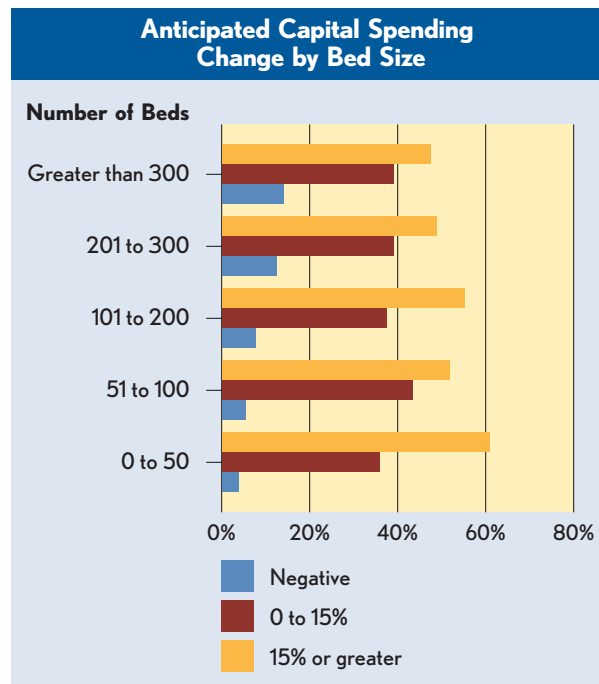


Exhibit 8



¹²Weighted average based on current spending.

In terms of location, 56 percent of rural hospitals expected spending to be 15 percent or greater, compared with 52 percent of urban hospitals.

The planned increase in capital spending among small and rural hospitals is tied to better reimbursement in recent years. The best example is critical-access hospitals, which have reverted to cost-based reimbursement. Those hospitals already have been increasing their capital spending.

For-profit versus not-for-profit. Those who said that they would increase capital spending were overwhelmingly at not-for-profit hospitals. CFOs from for-profit hospitals were the only group in which the majority did not expect to increase capital spending by 15 percent or more. Forty-eight percent expected to see annual spending increases of less than 15 percent, and 14 percent expected to see decreases in capital spending. Only 38 percent said they expected to see a 15 percent or greater increase in annual capital spending, compared with a robust 50 percent plus among all of the other ownership categories, including government and private not-for-profit.

This finding is substantiated by the nation's largest for-profit chain, HCA. In 2003, HCA spent \$2 billion on capital investments on existing hospitals, up from \$1.7 billion the previous year. However, HCA is predicting decreases in capital investments in 2004 and 2005. The moderation "is prudent based upon recent volume softness and the fact we have recapitalized most of our markets over the past four or five years, spending approximately \$7 billion," noted Vic Campbell, HCA's senior vice president. In 2003, HCA spent \$48,100 per bed in capital expenditures, which was more than any other for-profit hospital chain, according to UBS Warburg.¹³

Drivers of Increased Spending

Research into capital spending in the recent past and projections about spending in the future suggest significant increases among the primary drivers of capital spending: bed capacity, technology, and replacement and routine maintenance.

Bed capacity. Different sources offer various predictions about the amount of growth in bed capacity expected in the industry over the coming years. According to Solucient, bed demand will grow at about 1 percent between 2002 and 2012, resulting in an increase of 72,000 beds by 2012. Solucient goes on to predict that over the next 25 years, bed demand will increase by 46 percent, resulting in an increase from the current 519,000 beds to more than 756,000 beds.¹⁴

At the other end of the spectrum, The Advisory Board's most conservative scenario, based on 2001 research, calls for almost double the amount of beds predicted by Solucient—an increase of 179,000 by 2011.¹⁵

These projected increases compare with a decline in total beds between 1997 and 2001 from 5.05 million to 4.9 million.

The Center for Studying Health System Change cautions healthcare organizations against unnecessarily aggressive bed growth, saying that based on studies of 12 nationally representative communities, "additional capacity might be needed in some markets, [but] better management of existing resources could be a more effective solution."¹⁶

Technology. Most industry studies predict steady growth in information-technology spending. For example, Forrester projects 9 percent annual growth in IT spending over the next three years,¹⁷ while McKinsey indicates overall IT spending will increase 6 to 7 percent annually over that same period.¹⁸ An example of the increase in spending on medical technology is the average 11 percent annual increase in spending on MRI scanners between 1994 and 2002, according to Frost and Sullivan.¹⁹

Replacement/routine maintenance. The most notable indicator that replacement and routine maintenance will be driving future capital spending is the continuing aging of hospital plants. In addition, our survey suggests that almost half of hospital CFOs believe their infrastructures are deteriorating faster than they can make capital improvements.

¹³ Capital Spending in the Hospital Sector, Understanding the Supply Side of the Supply/Demand Equation, UBS Warburg, May 14, 2003.

¹⁴ "National and Local Impact of Long-Term Demographic Change on Inpatient Acute Care—A Solucient White Paper." Solucient, 2002.

¹⁵ *The New Economics of Care*, Washington, D.C., Health Care Advisory Board, 2001, pp 152-153.

¹⁶ Bazzoli, Gloria J., Brewster, Linda R., Liu, Gigi, and Kuo, Sylvia, "Does U.S. Hospital Capacity Need To Be Expanded?" *Health Affairs*, November/December 2003.

Impact on the Industry

Is this level of spending increase feasible? Is it sustainable? Will it result in economic hardship for some hospitals?

Industry analysts suggest that this level of increase may not be sustained, especially if utilization does not grow as rapidly as it has in recent years. Further, analysts believe that the need for a significant increase in capital spending will further polarize the industry, with the “have’s” housed in state-of-the-art facilities, while the “have-not’s” increasingly struggle to maintain plants and equipment.

The planned 14 percent annual increase in capital spending may not be sustained over time, according to Paul B. Ginsburg, Ph.D., president, Center for Studying Health System Change. Ginsburg comments, “The pattern of 1 percent per year increases over the 1997-2001 period, followed by a period of 14 percent increases, reflects the inevitable lags as hospitals adjust to changing demands for care and changes in their ability to pass higher costs on to payers. The period of flat capital spending follows a time when hospital utilization declined and hospitals were squeezed on pricing. What is happening today reflects the sharp increases in utilization that began in the late 1990s and more pricing power. The 14 percent rate will not be sustained as utilization trends return to more normal rates.”

Even if this rate of capital spending growth is not sustained, it will create a “revolution” between financially healthy and financially struggling hospitals, according to Uwe Reinhardt, James Madison Professor of Political Economy at Princeton University. Reinhardt says, “There are always about 25 percent of hospitals that are really struggling, and there are quite a few others that are really rolling in cash. There’s quite a distribution in operating cash-flow earnings and cash on hand. If a hospital has a good cash flow—not-for-profit or for-

What’s in the Pipeline

An assessment of capital projects currently under way suggests the future direction of capital spending. An inventory of construction projects of \$1 million or more that were announced, begun, or completed in 2003 comprises 535 projects, including:

- At least \$16 billion in new hospitals and outpatient facilities, consisting of nearly 12,000 beds
- At least 44 replacement facilities
- Another \$1.3 billion in expansion projects of \$1 million or more, which include 1,000 new beds

The list cannot be considered comprehensive because a majority of the projects do not yet include costs. However, it gives an idea of the magnitude of hospital capital expenditure projects in the pipeline.

profit—it can raise money at the moment with bonds or, if it’s for-profit, with stocks. Today’s environment is really favorable to recapitalization. Three years down the road, you will have these new hospitals with new beds—some new, some replaced—and with brand-new equipment. Some of the new physical plants are stunning. Those hospitals are at a distinct advantage. And that, of course, is what is going to drive the hospitals that cannot rebuild into even more desperation. So there will be a gradual increase in beds, but in that increase, you will probably have a revolution, where new beds crowd out old beds—unless those old beds are in areas where the patients have no choice.”

¹⁷ Greeley, Michael, “Nothing Ventured...Six-Million-Dollar Questions,” *Bio-IT World*, June 15, 2003 (<http://www.idgventures.com/boston/news/2003-06-15.html>).

¹⁸ Tufts Healthcare Institute, *Quality and Clinical Decision-Support Systems*, Online White Paper, May/ June 2002 (http://www.tnci.org/other_resources/topic56_02.htm)

¹⁹ “By the Numbers,” a supplement to *Modern Healthcare*, December 22, 2003 (<http://www.modernhealthcare.com/docs/bythenumbers03web.pdf>)

6. Looking toward the Future

Given the scarcity of resources in health care today, it is worth returning to an idea alluded to in the previous section—that future capital spending will be driven both by *need* and by *desire*. The definition of need related to capital spending will always be debatable. What are the criteria of need? Current demand? Future demand? Is a capital expenditure designed to respond to competitive pressure or vocal consumers a true need, or is it really a desire—a capital expenditure that might be avoided without harming the hospital or the community?

As hospitals confront a growing—and more expensive—capital wish list in the years to come, hospital executives will need to ensure that their strategic planning is farsighted enough, objective enough, and savvy enough to identify true capital needs. And capital planning will need to accurately match these needs to capital development and spending. Healthcare futurist Jeff Goldsmith comments, “The challenge is in setting the mix of capital expenditure between facilities, high-tech equipment, and information technology. Even wealthy institutions do not have enough capital to meet all three needs simultaneously. Managing the tradeoffs between function and efficiency, support of safe clinical care, and modernization of diagnostic services is a complex and highly political process. Moreover, while it must be informed by calculations of return on the institution’s capital, it must also be sensitive to market realities.”

Matching Need and Spending

Hospitals that have not spent as much on capital as have other hospitals are starting to recognize the need to increase spending. That’s especially true among rural hospitals, where spending has been low. For example, 56 percent of critical-access-hospital CFOs

said their plants were deteriorating, yet 56 percent expect to increase spending by 15 percent or more. Critical-access hospitals were spending only \$24,500 per bed on capital, according to the survey.

CFOs at teaching hospitals, the group of hospitals most concerned about deteriorating plants, also expect to increase capital spending significantly. Fifty percent said they expect to increase spending by 15 percent or more.

At government hospitals, capital spending per bed was \$36,693, and 47 percent said their plants were deteriorating. Sixty-three percent said they expect to increase capital spending by 15 percent or more.

Yet matching capital need and spending is a complex equation, full of assumptions that can be wrong as often as they’re right and, in 26 states, subject to Certificate of Need (CON) regulations.²⁰ It’s also affected by managed care contracting issues, which can direct patients to specific providers, and specialty hospitals, which can quickly take away higher-margin patients.

Yet being too optimistic about future needs could be an expensive mistake as well. “Demand may soften with increased out-of-pocket costs for consumers,” said Preston Gee, senior vice president of strategic planning for St. David’s Health Partnership, Austin, Texas. “All of these expenditures may be based on growth trends of 2001 and 2002, and we may be aiming for artificial targets. If that’s the case, you’re going to see an overcapacity situation.”

Unless there’s a catastrophic occurrence in the funding system, hospitals will continue to regularly spend on renovation, expansion, and technology. The challenge for each hospital’s executives will be to identify both the true needs—the capital initiatives required for the hospital to stay viable—and the capital projects that will benefit the hospital in its competitive strategy.

Steps Toward the Future

Capital projects are legacies for future generations. Determining which projects to fund can be contentious and emotional as participants are ensnared in the debate over needs versus competitive positioning. The following steps can help ensure you're approaching the subject in the most objective manner possible.

1. **Assess your current state, and be realistic.** What is your hospital's market share? What are its strengths? Is the medical staff stable? Which service lines are profitable and which aren't?
2. **Assess your future state if you maintain the status quo.** What does the future look like for your hospital or system if you don't change anything? Assume no new programs or growth. Sometimes you have to invest to protect what you have. What kinds of investments will you have to make just to stay status quo?
3. **Determine where you need to go or want to go.** Set an objective. It may be financial—achieve a 10 percent EBITDA. It may be volume oriented—increase admissions by 5 percent. Many hospitals want to improve their bond rating to lower borrowing costs. Another objective for hospitals may be achieving magnet status for nurses, which helps in recruitment and retention. Pick one constant—yes, just one. You may have heard the truism, “You can have as many strategic goals as you want, as long as it's no more than one.”

4. **Lay out a plan to get to the objective you've selected.** Do a gap analysis and set out what the action steps would be. If the objective is to increase admissions, determine where the admissions gains will be, how many physicians must be recruited to achieve the gain, and whether the current capacity is enough or whether you need to build additional capacity. If you want to improve your bond rating, it may involve increasing your days cash on hand. That may mean limiting capital expenditures. When you lay out the action steps, set realistic goals and metrics.
5. **Assess whether the plan is realistic.** Is the plan overly dependent on one individual or department? Is it contingent on things you can actually control? Is its time frame feasible?

The Next *Financing the Future* Report

The next *Financing the Future* report, to be issued in May 2004, will address the issue of capital planning by assessing the future state of capital access. The report will explore the likely sources of capital, the relative amounts available from those sources, and the non-traditional sources that might be tapped as capital need grows and ease of access to traditional sources diminishes.

Appendix A: Measuring Your Own Future Capital Needs

Predicting capital need may seem more like art than science. However, several indicators that can be used illuminate likely future needs. Those indicators pertain to demand for services and to state of infrastructure. Combining the findings for such indicators helps illuminate potential future capital spending needs.

This appendix offers some guidelines on how to develop your own local scorecard for potential capital needs.

Select Indicators to Measure Capital Need

Decide which indicators are the best proxy for projected capital need. For the analysis in this report, we analyzed three separate types of projected capital need indicators: 1) demographic (population growth, over-65 population growth), 2) infrastructure (average

age of plant, capital expenditure growth rate, IT expenditures), and 3) clinical demographic (health status, projected physician demand).

Projections. Demographic demand projections are most easily obtained from U.S. Census data. These data can be divided into the areas to be examined—by zip code or metropolitan statistical area (MSA). Specific detail should be obtained and analyzed for high-use cohorts (over 65, female 18-44) and should be analyzed at appropriate time intervals (five to 10 years).

Assessing the current state of infrastructure.

Assess the current state of infrastructure by collecting common capital expenditure benchmarks for the hospitals located within the study area. Although average age of plant is the most common proxy for capital expenditures, it should not be used as the sole indicator.

Exhibit 9

Sample Scorecard for Determining Potential Capital Needs							
	5-Year Population Growth Rate	5-Year Population Growth Rate (over 65)	Average Age of Plant	Projected Capital Expenditure Growth Rate	Health Ranking (top % of its market)	Past IT Investment	Physician Demand Growth
Medians for Sample MSA	10.10%	12.20%	8.70	8%	33%	3.78%	11.42%
First Community Hospital	8%	9%	10	5%	12%	2%	10%
Scoring for First Community	1	2	3	1	1	3	1

First Community Hospital, a fictional hospital, could compile its own Cap X Scorecard to compare its capital need to that of competitors by gathering population statistics about its market and the surrounding metropolitan statistical area (MSA), average age of plant, projected capital expenditure growth rate, health status ranking, past IT investment, and physician demand growth rate. Some of these values may have to be estimated using market intelligence or various databases. First Community's planners could add in other indicators that may impact capital need, such as occupancy rate or lack of outpatient facilities. The scoring is fairly simple, using a median of 2—for each indicator that First Community rates higher, it would receive a 1, for each value at or near the median, it would receive a 2, for each indicator below the median, a 3. In this example, First Community's score is 1.7, showing that its capital need is less than that of others in its MSA. Or, First Community's scores could be compared to national, state, or regional ones. The scoring could be more complex by weighing certain indicators more than others.

In the second *Financing the Future* paper (published in January 2004), we suggested another way to measure whether hospitals' capital spending is keeping up with need—specifically, aging facilities and equipment—by comparing the acquisition of fixed assets to ongoing depreciation expense.¹ We will call this the future investment index. If the index is less than 1.0, average age of plant increases over time, and if the index is greater than 1.0, average age of plant decreases. In other words, hospitals with an index of greater than 1 are more likely to have newer plants and equipment and not need as much capital investment in the future. Be sure to integrate other useful measures such as capital expenditure growth rates and IT investment rates. In addition, because these indicators vary widely on an annual basis, include multiple years of data to avoid skewing your analysis based on atypical data.

Developing clinical demand indicators. Clinical demand indicators are used as a proxy for measuring the projected change in healthcare utilization (i.e., will the area be demanding more services per capita).

Useful indicators can include health status, use rates, and/or current and projected physician demand. Again, be sure to analyze multiple years of data to avoid skewing your results.

Develop a Scoring Methodology

Using a national and/or state benchmarking database, formulate median ranges for each indicator used. Because you will analyze each indicator with respect to its position within a median range of values, develop a methodology to score median values, positive outliers, and negative outliers. For example, all areas within the median range of values are scored a 2, all values falling on the positive side of the median range are scored a 1, and all values falling on the negative side of the median range are scored a 3.

You will then sum the score for all indicators. This scoring methodology can be used to rank individual areas based on capital need.

See Exhibit 9 for an example of such a scorecard.

Appendix B: Selected States' Potential Capital Needs

This appendix presents state-specific information about potential capital need—specifically, findings related to specific demographic, health, and clinical demographic indicators associated with capital need. The appendix covers two sets of states: states anticipated to have most acute capital challenges and states anticipated to have the least acute capital challenges, based on these findings.

Five States with the Most Acute Future Capital Challenges

Idaho

By 2007 there will be almost 8.5 percent more people living in Idaho than there were in 2002, and the health-care-resource-intensive over-65 set will actually grow

at a higher rate of just over 8.6 percent between 2002 and 2007. However, Idaho's infrastructure is not well positioned to meet this growth. Idaho's average age of plant is 10.6 years—one of the oldest in the United States—and the state's average capital expenditure growth rate was an anemic 5.7 percent between 1997 and 2001, while IT investment was only 1.3 percent in 2002. Coupled with a strong projected physician demand (9.7 percent), Idaho's demographic indicators are poised for substantial need.

Georgia

As in Idaho, Georgia's capital needs are driven by strong demographic growth (a 9.2 percent projected population increase between 2002 and 2007) and a strong physician demand. Georgia's infrastructure

¹ The index was calculated as new spending on buildings, fixtures, and major moveable equipment as a percent of reported depreciation and amortization expense from Medicare cost report data through the Solucient database for the period 1997-2001. The analysis used an average five-year amount to account for non-reporting facilities and to smooth out the effect of years of large capital spending versus years of limited capital spending. The data were also culled to remove obvious reporting errors.

falls within the median, but to meet large population increases, the state may require increased spending. Georgia's low health ranking may also be a big driver of projected capital need, as it ranks 41st in the nation.

Florida

Florida's primary drivers are based on *more*: more people, more people over 65, and more physicians (9.8 percent total growth and 8.8 percent over 65 growth by 2007; 10.7 percent physician demand growth). Florida's infrastructure is mixed, with a low average age of plant (6.7 years) and capital expenditure growth rate and IT investment rate squarely in the median. Florida's health ranking of 42 may be an additional driver for capital need, as population health needs often track capital needs.

California

Sunny California's population growth and physician demand growth are the key drivers for projected capital need. The California healthcare infrastructure is average, but average may not be enough to manage immense demographic changes. In addition, our ranking does not take into account regulatory drivers such as California's seismic retrofitting and nurse-patient ratio laws that may compound the state's capital need.

Tennessee

Tennessee falls into the median in most categories—population and physician demand growth are in the median (3.8 percent total, 3.8 percent over 65, 4.9 percent between 2002-2007), and the capital expenditure growth rate is also in the median (6.6 percent). The state's paltry 1.7 percent IT investment rate and its low health ranking of 46 suggest plenty of potential capital needs.

Five States with the Least Acute Future Capital Challenges

Louisiana

Demographic indications show the Bayou state growing very slowly and physician demand growth creeping along as well (0.75 percent overall, 1.2 percent over 65, and 1.9 percent physician demand). Louisiana's healthcare infrastructure is in relatively good shape

with a low average age of plant (8.4 years), a high average capital expenditure average growth rate (7.7 percent between 1997-2001), and a relatively high average IT investment rate of (2.4 percent). Louisiana only bucks its low capital need standing in one category—it ranks 49 out of the 50 states in health status.

Ohio

By 2007, Ohio's population will have increased less than 1 percent—refuting the adage that “if you build it they will come.” Ohio's current assets remain in the median (average age of plant 9.4 years, capital expenditure growth rate 7.4 percent, and IT investment 3.4 percent). The state's health ranking and physician demand are also squarely in the median, indicating that Ohio is a state with a low projected capital need.

Iowa

As in Ohio, there is not a lot of projected demographic growth in Iowa to drive capital needs. If you don't have people pushing capital need, then the next driver to examine are the current assets, and Iowa's are in the median (average age of plant 10.4 years, capital expenditure growth rate 5.9 percent, and IT investment rate 1.7 percent). Furthermore, health will not be a big driver of capital needs, because the Hawkeyes are a healthy bunch with a state ranking of 7.

Maine

Maine is a state that spends money on its assets. While the average age of plant is 9.7 years, the state's capital expenditure growth rate is 8.4 percent and the IT investment rate is 3 percent—both very strong rates. Results for all the demographic indicators for population and physician growth fall in the median range (total population 3.2 percent, over-65 population 3.6 percent, and physician demand 4.5 percent between 2002 and 2007). Maine is the eighth healthiest in the state rankings.

Montana

A rural state with slow population growth, Montana's average age of plant is 9.3 years. The state's capital expenditure growth rate averaged 8.6 percent between 1997 and 2001—a very strong rate. The rest of the indicators fall in the median.

Appendix C: Methodology

This report is based in part on research comparing capital-need challenges in various states based on factors that influence capital demand. This analysis uses a “Cap X Scorecard” developed by PricewaterhouseCoopers, in which the states were divided into two buckets according to the individual states’ median values for each key indicator: those

greater than or equal to the median and those less than or equal to the median. The Scorecard median range was established by calculating the median value for each of the individual buckets. The positive and negative values were determined to be those values above or below the established Scorecard median range.

Key Indicators	Methodology	Source
Population growth	The sample for this analysis included the rate of growth of the overall population between 2002 and 2007 for each of the 50 states and Washington, D.C. Values below the Scorecard median range were assumed to drive lower levels of future capital need.	Solucient, 2003
Age cohorts	The sample for this analysis included the rate of growth of the population age 65 or greater between 2002 and 2007 for each of the 50 states and Washington, D.C. Values below the Scorecard median range were assumed to drive lower levels of future capital need.	Solucient, 2003
Capital expenditure spending growth	The sample for this analysis included the average median capital expenditure growth rate from 1997 to 2001 for each of the 50 states and Washington, D.C. The capital expenditure growth rate is defined as the percentage of overall fixed assets added in a given year. Values above the Scorecard median range were assumed to drive lower levels of future capital need.	Ingenix: <i>Almanac of Hospital Financial and Operating Indicators</i> , 2003
Average age of plant	The sample for this analysis included the average age of plant for 2001 for each of the 50 states and Washington, D.C. Average age of plant is defined as the average age of fixed assets and calculated by dividing accumulated depreciation by the current depreciation expense for a given year. Values below the Scorecard median range were assumed to drive lower levels of future capital need.	Ingenix: <i>Almanac of Hospital Financial and Operating Indicators</i> , 2003
State health rankings	The sample for this analysis included the overall health ranking (from 1 to 50) for each of the fifty states. Values below the Scorecard median range were assumed to drive lower levels of future capital need. The ranking is based on various risk factors and outcomes, including smoking prevalence, motor vehicle deaths, obesity rates, prenatal care, lack of health insurance, infant mortality, premature death, and limited-activity days.	United Health Foundation: <i>America’s Health: State Health Rankings</i> , 2003 Edition
IT investment	The sample for this analysis included the percentage of total hospital operating budget consumed by IT expenditures for each of the 50 states. Percentage of IT expenditures is calculated as IT expenditures divided by total hospital operating budget. Values above the Scorecard median range were assumed to drive lower levels of future capital need.	2001 and 2002 PricewaterhouseCoopers/Modern Healthcare Survey
Physician demand growth	The sample for this analysis included the rate of growth in demand for physicians based on the 50th percentile productivity level (low to moderate) for each of the 50 states and Washington, D.C. Values below the Scorecard median range were assumed to drive lower levels of future capital need.	Solucient, 2003

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