Hospitals have long been a central figure in the civic, economic, and health care environments of communities around the nation. In an era characterized by rapid changes in the way Americans receive and pay for health care, hospitals are facing unprecedented pressures to keep up the pace or be left behind. Increased cost-consciousness of health care purchasers has spurred the movement toward managed care, which has shaken health care financing and delivery to its very core. As a result, hospitals are struggling to rethink and reorganize what they do, why they do it, how quickly they do it, who does it, and how it all is financed.

In this paper I present a picture of hospitals in fifteen communities across the country that were part of The Robert Wood Johnson Foundation’s (RWJF’s) Community Snapshots study. This study, part of RWJF’s larger Health Tracking initiative, endeavored to capture the process of change in fifteen localities nationwide, with particular emphasis on the impact of change on the people who live in those localities.  

Three teams of researchers participating in the Community Snapshots study conducted case studies of fifteen diverse communities, using site visits and literature reviews to better understand those communities’ health care systems as they existed during the study period of mid-1995. Researchers met with a range of leaders from the health care provider, insurer, purchaser, consumer, and government sectors. Persons interviewed typically included the chief executive officer (CEO) and key staff members of three or four of the most prominent hospitals in each community.

The fifteen communities were selected to maximize diversity of population size, geographic location, and stage of market development. The study sites are especially diverse in the size of their hospital sectors. The most populous study community, south Florida, has twelve times as many hospital beds and nearly seventeen times as many hospitals as Wilmington has (Exhibit 1). At the same time, broad similarities emerged across the communities’ hospital sectors. For example, bed capacity was always reported to

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Exhibit 1
Number Of Hospital Beds And Hospitals In Community Snapshot Sites

<table>
<thead>
<tr>
<th>Sites</th>
<th>Total beds</th>
<th>Total hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wilmington, DE</td>
<td>1,481</td>
<td>4</td>
</tr>
<tr>
<td>Columbia, SC</td>
<td>1,564</td>
<td>6</td>
</tr>
<tr>
<td>Albuquerque, NM</td>
<td>1,860</td>
<td>11</td>
</tr>
<tr>
<td>North central FL</td>
<td>2,528</td>
<td>18</td>
</tr>
<tr>
<td>Fargo, ND/west central MN</td>
<td>2,742</td>
<td>24</td>
</tr>
<tr>
<td>Des Moines, IA</td>
<td>2,914</td>
<td>16</td>
</tr>
<tr>
<td>Portland, OR/Vancouver, WA</td>
<td>3,796</td>
<td>18</td>
</tr>
<tr>
<td>Indianapolis, IN</td>
<td>5,336</td>
<td>17</td>
</tr>
<tr>
<td>San Diego, CA</td>
<td>5,992</td>
<td>25</td>
</tr>
<tr>
<td>Orange County, CA</td>
<td>6,553</td>
<td>36</td>
</tr>
<tr>
<td>Minneapolis/St. Paul, MN</td>
<td>6,786</td>
<td>24</td>
</tr>
<tr>
<td>St. Louis, MO</td>
<td>11,995</td>
<td>41</td>
</tr>
<tr>
<td>Houston, TX</td>
<td>12,669</td>
<td>47</td>
</tr>
<tr>
<td>Boston, MA</td>
<td>14,888</td>
<td>65</td>
</tr>
<tr>
<td>South FL</td>
<td>17,714</td>
<td>67</td>
</tr>
</tbody>
</table>

Source: Data were obtained from Quality Resource Systems, Bureau of Health Professions’ Area Resource File (ARF) (Fairfax, Va.: QRS, Inc., February 1995). ARF figures are 1992 data.

be too high. From Wilmington to Portland/Vancouver to south Florida, hospitals also are seeing expanding market boundaries, severe pressure on their revenues, and a weakened negotiating position with the other major stakeholders in their local health care systems. In response, hospitals are scrambling to chop their costs, develop new relationships with other hospitals, and strengthen and create new relationships with individual physicians and medical groups.

In this paper I discuss the broad similarities seen among hospitals in the study sites, drawing on specific site examples to illustrate these points and to offer some local flavor to the commonalities. After discussing the forces affecting local hospitals, I move to observations on hospitals' resistance to change, then touch on the most important changes reported from the study communities: horizontal integration with other hospitals and vertical integration with other providers, particularly physicians.

Forces Affecting U.S. Hospitals

The new economics of managed care. The primary force affecting hospitals is the new economics of managed care. Under capitation, payment is based on the number of persons enrolled with a health provider or system, regardless of what is actually spent on those persons’ medical care. Physicians, clinics, and hospitals operating under these new economics are
transformed from revenue generators to cost centers. For providers that represent the highest share of costs, this transformation is especially wrenching.

In most of the communities studied, a rapidly growing portion of the privately and publicly insured populations receives health care paid by capitated reimbursement. In Albuquerque, for example, health maintenance organization (HMO) enrollment increased by one-third from 1990 to 1993. Even in rural north central Florida, HMO penetration has doubled in the past year, so that it is now reported to represent roughly 20 percent of the population. All of the study communities are seeing their Medicaid populations move into capitated health plans. Ten of the sites are in states with mandatory Medicaid managed care programs, while the other five have voluntary programs. As for Medicare risk HMOs, the four communities located in California and Florida are in states with the largest number of enrollees (1.1 million and 441,000, respectively), but Texas’s 1995 enrollment level of 130,000 also is significant because it represents more than a 2,000 percent increase over 1987 enrollment.

Despite the pervasiveness of the observed moves toward capitated and managed care, different markets are moving at their own speed and in their own way. In Houston the powerful state medical association has provided some counterforce to the pressures of managed care. Wilmington’s move toward managed care was precipitated by a surprise announcement by its dominant employer, DuPont, which continues to exert great influence on the actions of major health plans and hospitals in that community. Orange County is home to a fragmented hospital sector, some highly visible medical groups, and a high-profile county bankruptcy.

**Loss of market power.** Hospital executives in all study sites described a significant loss of their market power to health plans and insurers. This shift requires two elements: the presence of other hospitals, and sufficiently low occupancy rates to allow hospitals to accept additional patients.

**Presence of other hospitals.** For hospitals in the study sites, there is an expanding number of “other” hospitals-and possibly other health care providers-competing with the local hospitals. This expansion comes not from the establishment of new hospitals within an existing market area, but from a changing health care system that has the effect of expanding the geographic field of competition. The expansion was especially evident in a small health care market with clear, long-established boundaries. In Wilmington consumers have long considered the area to be entirely self-contained; they simply did not use the hospitals in nearby Philadelphia or Baltimore. New financial incentives in many Wilmington patients’ managed care plans have pushed them out of their local hospital area for at least one procedure, coronary artery bypass surgery. This shift has prompted
consumer complaints and even state legislative proposals; it also has prompted the major local hospital to reduce its charges for this procedure by 40 percent. Observers expect out-of-state hospitals to become competitors with Wilmington hospitals for even more types of tertiary care, perhaps even for lower levels of care.

**Low occupancy rates.** The second element seen in the shift of market power away from hospitals is low occupancy rates. Exhibit 2 shows the wide variation among communities’ hospital sectors in inpatient utilization rates, beds per capita, and occupancy rates. Especially striking is the three-fold difference between inpatient utilization rates for the West Coast communities (Orange County, San Diego, and Portland/Vancouver) and for the community with highest utilization, the rural area of Fargo/west central Minnesota. Even urban communities such as St. Louis and Boston have inpatient rates more than twice those of the West Coast communities.

For local hospital observers, questions of hospital utilization and occupancy rates are typically framed as an issue of excess bed capacity. In Fargo/west central Minnesota some observers believe that the community needs only one hospital system instead of the two that exist there. Even in study communities with low inpatient utilization rates such as Portland/Vancouver and Orange County, observers report that substantial excess capacity still exists among the hospitals, with perhaps half of their beds

---

**Exhibit 2**

<table>
<thead>
<tr>
<th>Sites</th>
<th>Inpatient days per thousand</th>
<th>Beds per 100,000</th>
<th>Occupancy rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orange County, CA</td>
<td>488</td>
<td>264</td>
<td>50.7%</td>
</tr>
<tr>
<td>Portland, OR/Vancouver, WA</td>
<td>538</td>
<td>254</td>
<td>58.1</td>
</tr>
<tr>
<td>San Diego, CA</td>
<td>542</td>
<td>230</td>
<td>64.5</td>
</tr>
<tr>
<td>Minneapolis/St. Paul, MN</td>
<td>710</td>
<td>288</td>
<td>67.5</td>
</tr>
<tr>
<td>North central FL</td>
<td>723</td>
<td>314</td>
<td>63.0</td>
</tr>
<tr>
<td>Albuquerque, NM</td>
<td>796</td>
<td>373</td>
<td>58.5</td>
</tr>
<tr>
<td>Houston, TX</td>
<td>860</td>
<td>426</td>
<td>55.3</td>
</tr>
<tr>
<td>Wilmington, DE</td>
<td>864</td>
<td>325</td>
<td>72.7</td>
</tr>
<tr>
<td>Columbia, SC</td>
<td>865</td>
<td>296</td>
<td>80.0</td>
</tr>
<tr>
<td>South FL</td>
<td>980</td>
<td>421</td>
<td>63.8</td>
</tr>
<tr>
<td>Indianapolis, IN</td>
<td>1,020</td>
<td>413</td>
<td>67.7</td>
</tr>
<tr>
<td>Boston, MA</td>
<td>1,054</td>
<td>396</td>
<td>73.0</td>
</tr>
<tr>
<td>Des Moines, IA</td>
<td>1,136</td>
<td>469</td>
<td>66.4</td>
</tr>
<tr>
<td>St. Louis, MO</td>
<td>1,146</td>
<td>492</td>
<td>63.9</td>
</tr>
<tr>
<td>Fargo, ND/west central MN</td>
<td>1,481</td>
<td>577</td>
<td>70.4</td>
</tr>
</tbody>
</table>

**Source:** Data were obtained from Quality Resource Systems. Bureau of Health Professions’ *Area Resource File* (ARF) (Fairfax, Va.: QRS, Inc., February; 1995). ARF figures are 1992 data.
unnecessary and presumed to disappear sometime in the future. Hospital executives are well aware of the important role played by excess capacity in the shift of health care market power from hospitals to health plans. One Orange County hospital CEO suggested that a philanthropic foundation could make a valuable contribution to local health care by reducing excess capacity through buying and then closing selected hospitals.

Imbalance of size and resources. In response to an increasingly hostile operating environment, the hospital sector is moving away from being a cottage industry of individual, freestanding, and primarily nonprofit hospitals. Data from the study communities suggest that this change is the result of local hospitals’ responding to the size and resource advantages of much larger purchasers, insurers, and, increasingly, hospital corporations. Hospitals in four communities are increasingly affected by the activities of proactive purchasing coalitions in their states that represent a powerful alliance of public employees and large employers: Minnesota’s Buyers’ Health Care Action Group (BHCAG) and California’s Pacific Business Group on Health (PBGH). Health care providers report that the HMO and preferred provider organization (PPO) plans with which they contract pass through to them the price reductions negotiated by the purchasing coalitions.

At the same time that purchasers are becoming a more proactive and united force in the health care market, local hospitals also find themselves negotiating with insurance companies and competing with some hospital systems that often are larger and have more resources at their disposal. The best example of this involves Columbia/HCA, a Tennessee-based hospital chain with $4.6 billion in annual revenues. This rapidly growing company is the nation’s largest hospital system, with current ownership of 338 hospitals throughout the country, 143 of them acquired during 1995. Columbia/HCA is reportedly considering joint ventures with insurance companies to further increase its market share in certain regions.

Local observers in all of the study communities consistently cited Columbia/HCA’s actual, expected, or rumored entry into their community as a major influence on the actions of local hospitals. Columbia/HCA has an especially strong presence in south Florida, where it owns twelve of the sixty-seven hospitals, and in Houston, where it owns fifteen of the forty-seven hospitals. It also has a presence in north central Florida, San Diego, and Boston. An intriguing example of the new role played by this major hospital system is seen in Columbia, South Carolina, where one of the largest hospitals is part of a joint venture between a Catholic hospital system and Columbia/HCA. Under terms approved by the church in late 1995, Providence Hospital and three others from the Sisters of Charity of St. Augustine will enter a joint venture with Columbia/HCA. This is the first partnership between Columbia/HCA and a Catholic hospital system.
Resistance to downsizing and managed care change. Despite reports of major financial difficulties, few hospitals in the study communities have closed in recent years. Although published analyses have documented many hospitals’ ability to remain open even during periods of financial distress, the continued operation of such facilities was a source of surprise and sometimes obvious dismay for local observers interviewed in the study communities.” In Orange County, the community with the lowest overall occupancy rates, even individual hospitals with occupancy rates in the 20 percent range are still operating, reportedly “living off their balance sheets.”

The general correlation seen in Exhibit 2 between lower inpatient utilization rates and lower hospital occupancy rates suggests that even a downsizing of bed capacity—which falls far short of hospital closure—is neither a prompt nor a prevalent response to low utilization rates.

Why are many hospitals willing and able to continue operating despite low utilization rates and the resultant financial pressures? Part of the answer lies in the institutional inertia created by hospitals’ long-standing ties to their local communities and their importance as a local employer, community presence, and high-prestige institution. Wilmington illustrates hospitals’ importance as an employer; here the largest hospital is the second-largest private employer. Health care is the major industry in Fargo/west central Minnesota, an area with communities small enough for one or two persons to take effective action. In one community there, one energetic couple (he the sole physician, she the hospital administrator) prevented closure of the local hospital. These communities will go to great lengths to ensure the continued operation of a major source of local employment.

Local hospitals often have close organizational ties with leading community employers, elected officials, and other local agencies. These ties are formalized via numerous governing and advisory boards, particularly for nonprofit hospitals. A 1994 study in St. Louis revealed that representatives of its largest fifty-nine companies were directors on a board of at least one health insurer or hospital. The chairman of the board for Wilmington’s dominant hospital traditionally has been a high-level executive from DuPont, that community’s largest and most influential employer. Even in larger markets such as Des Moines, one hospital CEO insisted that the hospitals there, which are all nonprofit, are expected to avoid changes that would hurt their local community: “If you are working for a proprietary hospital, what you would do [after a hospital merger] is shut down one hospital and take the physicians. You do not do that kind of thing here in Des Moines; that does not fit well here. Things are very community focused, people focused.”

In addition to a general resistance to closure, some hospitals have been able to use their high prestige within the community to resist major
changes. In St. Louis 80 percent of the area’s practicing physicians were trained in that community’s two medical schools. The influence of these teaching facilities appears to have helped to fend off rapid health system change there until the mid-1990s. One example of their influence is the number of St. Louis hospitals that historically have refused admitting privileges to primary care providers. In Houston the eight general hospitals and six specialized hospitals within the world-famous Texas Medical Center (TMC) have been much more resistant to managed care change than the less prestigious, less financially endowed hospitals outside TMC. One TMC hospital executive reported that it was very profitable for that hospital to continue under the old high-cost system for as long as possible. The largest and most prestigious of the TMC hospitals signed its first managed care contract in January 1994, only after seeing its patients enrolled in PPO plans move to other hospitals. Like the TMC hospitals in Houston, Scripps Health in San Diego is a higher-cost system than its competitors. It has been the slowest of the major San Diego systems to build its capitated enrollment, relying on its reputation for high-quality care and its $200 million endowment to dominate the dwindling noncapitated market.

### Hospitals’ Responses To Change

Despite historical resistance to change, hospital executives now are responding more proactively to turbulence in the health care system. In every community hospitals reported engaging in many types of cost-cutting activities, mergers with other hospitals, closer relationships with physicians, purchase or closer affiliation with other types of health care providers, and sometimes movement toward insurers’ traditional functions. I focus here on hospitals’ efforts to merge and then integrate themselves with other health care providers or insurers.

**Horizontal integration.** Hospitals’ joining with Columbia/HCA is only one example of mergers in the study communities. The more typical examples follow Stephen Shortell’s first stage of hospital system formation: development of new systems with a smaller number of local hospitals in each system. Hospitals creating these local partnerships have similar missions and similar but not necessarily identical religious affiliations.

The merger activities of hospitals in some of the study communities echo previous reports that executives in leading hospital systems feel that their most important challenge is “survival” and that most hospitals and not a few hospital systems “have been running scared.” In St. Louis, Boston, and Columbia some hospital mergers appear to be a hasty reaction to intense fears more than to the actual pressures of purchasers or insurers. Whatever the reasons, examples abound of hospitals’ coming together to form new
alliances or partnerships. Hospitals’ reasons for pursuing this kind of horizontal integration appear to follow strategies to improve participants’ competitive advantage through a more cooperative structure. More specifically, this strategy seeks to reduce a hospital’s direct acute care competition and expand its acute care networks.

Recent activities of Indianapolis hospitals illustrate several types of “first-stage” hospital mergers. Ten suburban hospitals there have combined to negotiate with insurers and compete with larger, urban hospitals. As the major urban hospitals move to consolidate with hospitals outside the urban core, members of this suburban alliance are under pressure to split the alliance and affiliate with one of the two emerging health care systems. At the same time the “big five” hospitals in the Indianapolis metropolitan region are moving together into two large systems. One alliance that already has taken place integrates services, administration, and information systems of its five member hospitals, but not finances or medical staff. The Department of Justice is examining the possibility of another hospital’s joining this alliance, which would then control 45 percent of the county’s acute care market.

The study communities also provide examples of a preference for hospitals with religious affiliations to join with hospitals of similar religious affiliation. In one of the merger discussions involving St. Francis Hospital and Methodist Hospital in Indianapolis, the Catholic cardinal in Chicago is reported to have instructed St. Francis Hospital to cease these discussions and work instead with another local Catholic hospital. St. Louis hospitals provide a more complicated example of the influence of religious affiliation. In this community more than three-quarters of the hospital market is controlled by three networks, each involving more than 2,000 beds and $800 million in annual revenues. One of these systems is BJC, whose components include Barnes Hospital, Jewish Hospital, and Christian Hospital. Observers report that BJC came together to avoid encroachment by strong Catholic hospitals, which represent four of the nation’s ten largest Catholic hospital systems. In response to the BJC merger, two local systems were created by the merger of various Catholic hospitals (also including an Episcopalian system). These new networks are under considerable external pressure to join forces as that community’s “Catholic network,” although this has not happened to date. Meanwhile, the component hospitals of BJC are governed by five separate boards and guided by different philosophies, yet they report that they are working to achieve “cultural consolidation.”

Moving beyond local systems. The growing phenomenon of hospitals’ joining with Columbia/HCA and other regional or national hospital systems is part of a larger trend of centralization and consolidation of decision-making control among some hospitals in the study communities. This
development corresponds roughly to Shortell’s “smaller wave” of hospital system growth predicted to follow the first, more local stage, although it appears to be occurring among some hospitals in the study communities simultaneously to the “first-stage” developments for other hospitals. As individual hospitals move to respond to imbalance between their size and resources and those of larger purchasers, insurers, and hospital systems, they see movement of decision making and planning from a local to a regional or even national level. Two of the three for-profit hospital systems in Orange County that together control nearly 25 percent of the hospital market have local strategies that appear to be incidental to their national growth strategies in markets elsewhere. Kaiser Foundation Hospital and the Permanente Medical Group is the largest health care provider in San Diego, where the actions of this hospital/physician organization are dictated by the larger strategies of its California parent organization. Wilmington provides a dramatic example of the movement of one hospital’s local decision-making control toward its system’s parent organization. Here, the president and CEO of St. Francis Hospital resigned during the study period, taking with him a majority of the hospital’s board members. Local media reports indicate that this was the most visible development in a sometimes tense relationship between the parent of a system of thirteen hospitals and seven nursing homes and its Wilmington flagship hospital. Although St. Francis leads its major local competitor in development of a primary care provider network and other indicators of change, its former CEO was reportedly balking at pressure from the parent organization to join a system-wide capitated contract with a large, for-profit HMO. The parent system, also negotiating a merger with two other Catholic health systems, did not want the objections of one member hospital to endanger the contract.

Assessing degrees of horizontal integration. Much work is needed to truly integrate hospitals. Hospital activities reported in the study communities touch on two of the criteria that can be used to assess the degree of “systemness” with which a group of hospitals operates. These are (1) the degree of commitment to a common culture and underlying mission, and (2) the degree of systemwide financial planning and budget control. Little information was gathered on other assessment criteria, which include degree of systemwide decision and information systems, degree of systemwide quality assurance, and degree of systemwide human resource planning.

One finding was that local observers often used words intended to convey varying degrees of horizontal integration but did not always do so with clarity or consistency. Reports of new hospital relationships used phrases such as “mutually beneficial cooperative arrangements that are not mergers” to describe relationships later referred to as “affiliations.” Of course, most observers cannot be expected to know all of the legal, finan-
cial, and organizational details necessary to choose the best way to describe emerging schemes for horizontal hospital integration. In fact, when the discussion expands to vertical integration, even expert commentators are scrambling to describe and label the various entities now emerging.

**Vertical integration.** Foremost among hospitals’ vertical integration efforts are closer relationships with physicians, particularly primary care practices or clinics. There are different reasons for hospitals to seek closer relationships with nonhospital components of a health care system. By purchasing, “partnering” with, or otherwise affiliating with primary care physicians, the hospital protects and possibly broadens its physician referral base. Strengthening ties between hospital and physicians is an important part of hospitals’ strategy of competing with health plans, which also seek to control primary care physicians. Finally, hospitals may want to start building a provider network that can be used for full-risk capitation from a health plan or direct contracting with health care purchasers.

New physician/hospital arrangements include physician/hospital organizations (PHOs), management services organizations, and the foundation model. The most commonly reported of these was the PHO, although many hospitals also reported buying the practices of physicians outright.

In St. Louis hospital systems seek to control patient bases and resources by strengthening ties with physicians, particularly those providing primary care. They are organizing PHOs, employing primary care physicians, and investing in multisite primary care group practices. Similarly, in Portland/Vancouver all of the major hospital systems are contracting with or buying primary care groups or setting up PHOs. Many hospitals in the south Florida area have developed and capitalized PHOs, including a “super-PHO” for the one major hospital system comprising nonprofit hospitals. Nearly all of the hospitals in north central Florida are in early stages of developing their own physician networks by either establishing a PHO or acquiring primary care practices.

Each of the three major hospital systems in Minneapolis/St. Paul has developed varying methods of affiliating with physicians. The Fairview system has created a PHO with staff physicians, plus an autonomous, integrated practice network. HealthSystem Minnesota contracts with 400 physicians in nineteen metro area locations through Park Nicollet Clinic. Through its primary physician network, it also has contracts with thirty primary care providers. In Albuquerque one of the four major health systems employs thirty physicians and also owns a physician practice management company that provides services to fifty physicians in numerous specialties. Primary care providers in this community have a full range of affiliating options with hospitals—from management services contracts to risk-sharing agreements—depending on the physicians’ needs and willing
ness to accept risk. Some examples of physician/hospital relationships with an urban/rural flavor come from Des Moines, where both of the two dominant hospital systems are building stronger relationships with primary care physicians in the city and surrounding communities. One system includes two major physician practice groups and has been building clinics in small towns. These clinics are staffed by salaried physicians who receive administrative support and financial incentives to increase their patient loads. The other dominant system has purchased eleven primary care practices within the past six months and has partnered with a physician organization formed by its medical staff to create SecureCare, a provider organization licensed under the state’s new category, “organized delivery systems.”

Of all of the communities studied, Houston hospitals appear to have had the least success—or perhaps the least interest—in organizing and managing physicians. A few hospitals are buying primary care providers’ practices, and many hospitals are considering developing PHOs. It is outsider physician management firms that have acquired the two largest individual practice associations (IPAs) plus one of the two multispecialty groups.

Moving toward insurance components. Although all of the hospitals studied are moving toward greater integration with local physicians, some larger ones also are taking steps toward creating an organized delivery system by adding an insurance component. One method of doing so is for a hospital to buy an existing health plan, as in Minneapolis/St. Paul, St. Louis, and San Diego, and to a lesser extent in several others. A different strategy is for the hospital to create its own insurance components after building a provider network.

What appears to be the biggest step for physician/hospital provider groups is movement toward direct contracting with purchasers. This step was clearly seen in Des Moines, where the newest managed care plan was formed recently by one of the major hospital systems and its medical staff. The plan, which is the only one licensed under a new state category for provider networks, has recently been offered by the large employers’ purchasing group. In Minneapolis/St. Paul insurers that are worried about the growth of direct contracting are trying to discourage this by developing “aligned” financial incentives for providers (not necessarily capitation) and forming strategic alliances with hospital or physician groups.

Discussion

A “snapshot” case study of fifteen communities provides information on health system change that is taken at one point in time, is highly current, and is intended to reflect specific characteristics and dynamics of those communities. This case study generated information on hospitals that is
broadly consistent with other published studies, as well as being generally consistent across the fifteen sites of this study. Hospitals in every community are anxious and unhappy about major health system changes and are trying to respond to these changes. They are moving away from an acute care focus and pursuing a variety of strategies to achieve this.

This study also reported many areas of local and regional differences that deserve further study. Does the variation reported in this snapshot reflect local communities caught in different stages of the same change process? Does it, alternatively, reflect persistent cultural or economic differences among different geographic regions of the country? For example, the inpatient utilization data presented here suggest regional differences in consumer attitudes toward the organization of health care markets, particularly differences between California/West Coast hospitals and eastern region hospitals. Another example involves the extent and type of influence exerted by religious affiliation in some hospitals’ pursuit of mergers and integration. Why does the affiliation seem to matter more in some mergers or markets than in others? How separate are these questions from the implications of the hospital sector’s movement away from independent, nonprofit entities? These questions all deserve further study as hospitals attempt to respond to the tidal wave of health system change by transforming themselves into new organizations providing new systems of care.

The author acknowledges the contributions of her colleagues in the RWJF Community Snapshots project, particularly those who wrote the site visit reports that provided much of the information for this paper. Special thanks are due to Paul Ginsburg, Harold Luft, Gloria Bazzoli, and two anonymous reviewers for helpful comments on an earlier version.

NOTES

1. For more detail on the Community Snapshots study, see P.B. Ginsburg, “The RWJF Community Snapshots Study: Introduction and Overview,” Health Affairs (Summer 1996): 7-20. The fifteen communities were Albuquerque, New Mexico; Boston, Massachusetts; Columbia, South Carolina; Des Moines, Iowa; Fargo, North Dakota/ west central Minnesota; Houston, Texas; Indianapolis, Indiana; Minneapolis/St. Paul, Minnesota; north central Florida; Orange County, California; Portland, Oregon/ Vancouver, Washington; St. Louis, Missouri; San Diego, California; south Florida; and Wilmington, Delaware.


3. Ibid., for more complete description of the study’s methods.


8. Efforts to reduce excess capacity can quickly run afoul of legal restraints on anticompetitive behavior such as the Sherman Antitrust Act, U.S. Code, vol. 15, sec. 1 et seq.; the Clayton Act, U.S. Code, vol. 15, sec. 13a et seq.; and state antitrust laws. In Fargo/west central Minnesota the Federal Trade Commission looked into possible antitrust violations of local hospitals when they consolidated into two major systems. The federal agency reportedly concluded that having only two systems did not threaten fair competition.


15. Ibid.


17. Observers sometimes mentioned constraints of antitrust law, but this topic was not pursued in this study. See R.J. Bogue et al., “Hospital Reorganization after Merger,” Medical Care 33, no. 7 (1995): 676-686; and Zuckerman and D’Aunno, “Hospital Alliances.”


19. Ibid.

20. Physician/hospital organizations (PHOs) tend to be organized and financed by hospitals, prompting one Florida observer to describe a local PHO as “heavy on the H, light on the P.”
