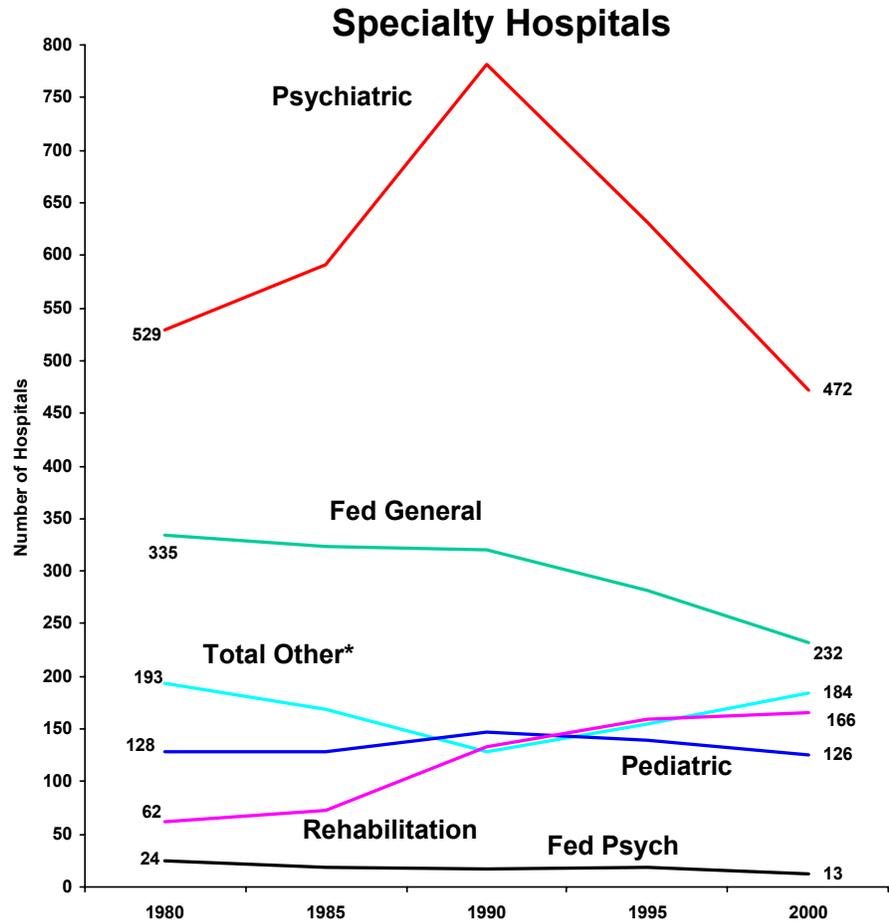
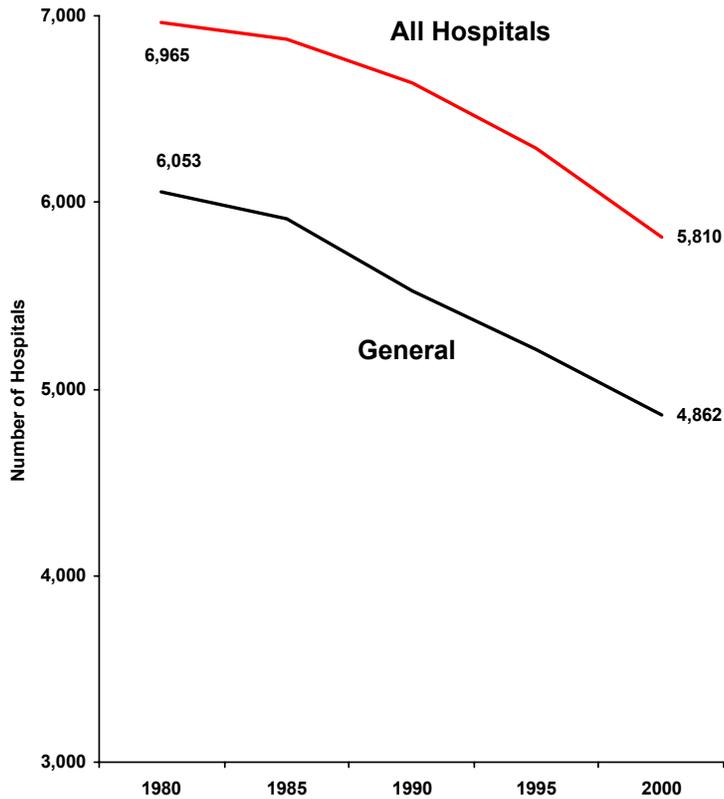


Table 2.1 Number of Hospitals by Type, 1980-2000

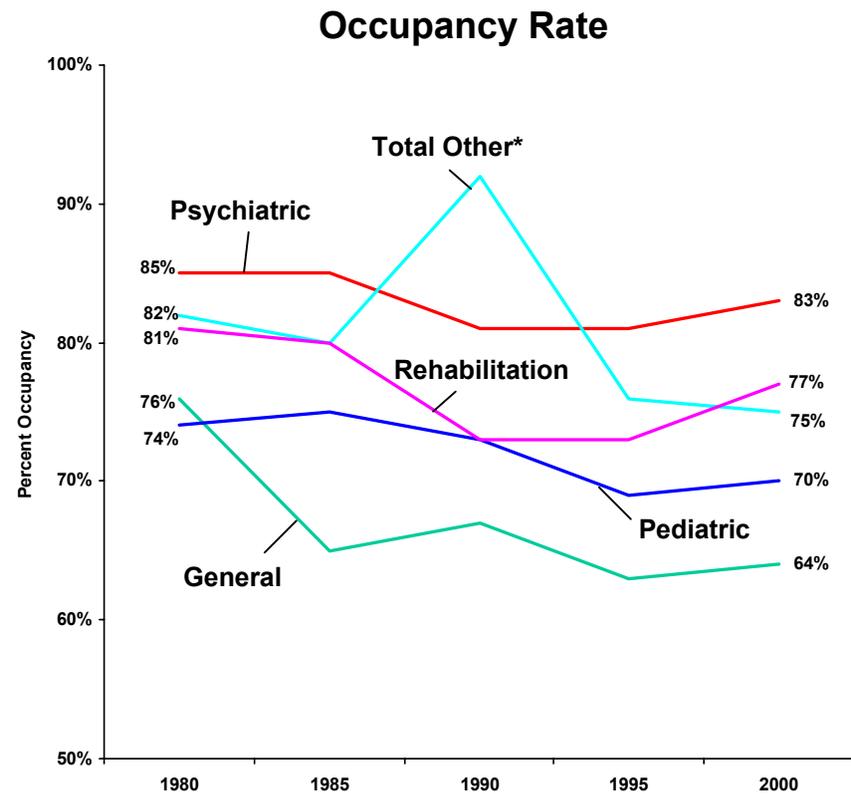
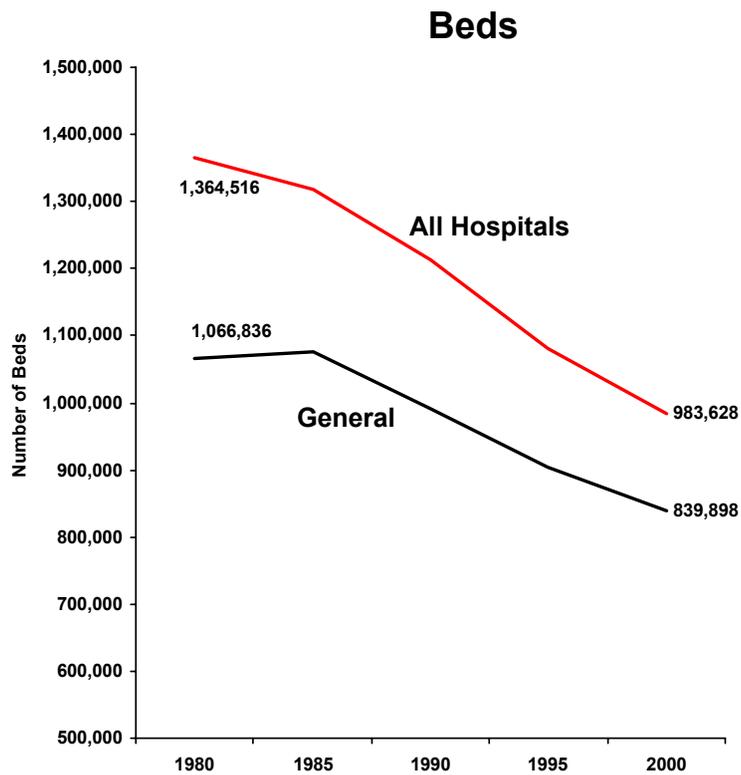


*Includes specialty hospitals such as TB, Ob-Gyn; eye, ear, nose and throat; orthopedic and chronic disease.

Source: American Hospital Association, personal communication.

Table 2.2 Number of Hospital Beds and Occupancy Rates by Hospital Type, 1980-2000

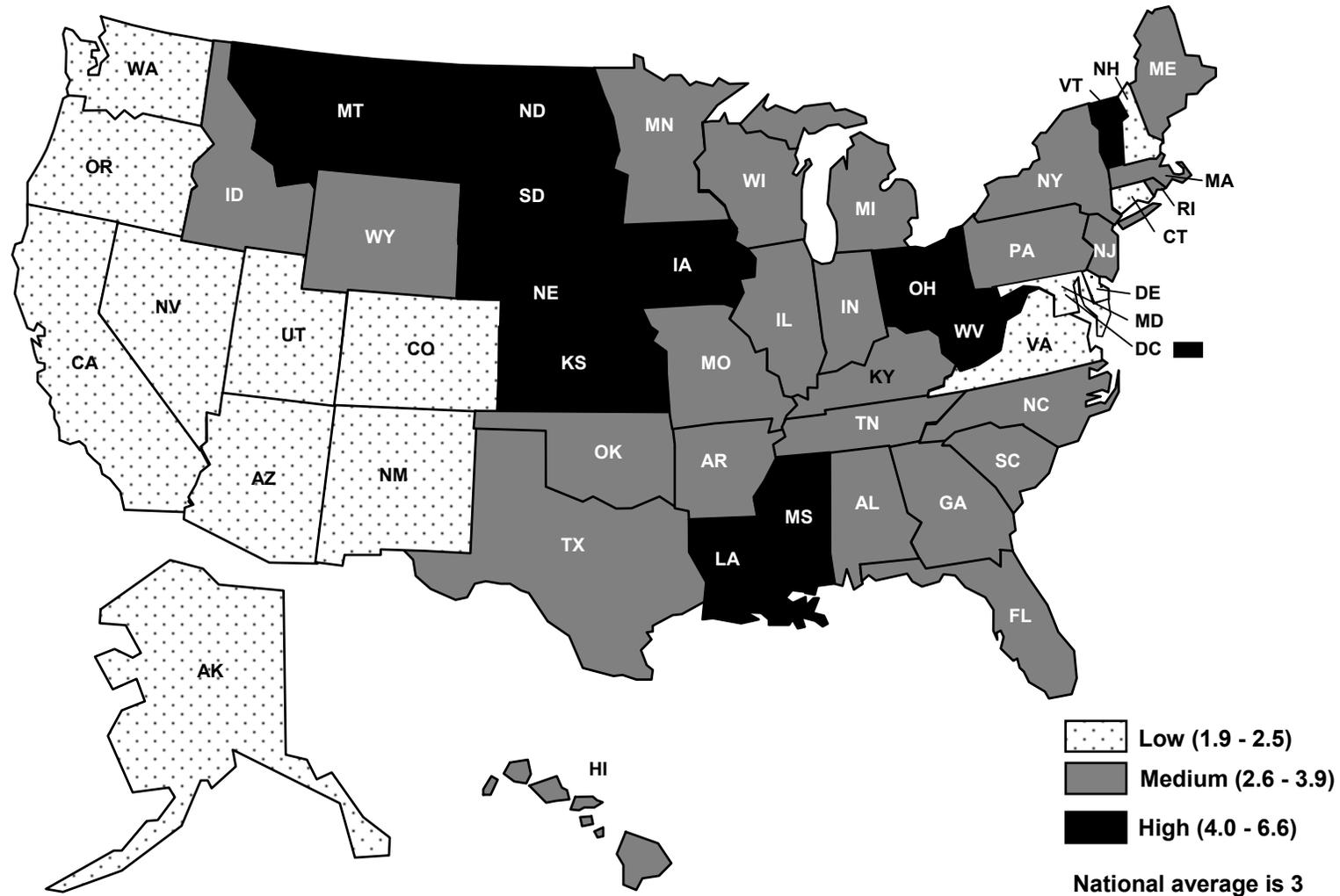
Decline in the total number of hospital beds has not kept up with declines in occupancy.



*Includes specialty hospitals such as TB, Ob-Gyn; eye, ear, nose and throat; orthopedic and chronic disease.

Source: American Hospital Association, personal communication.

Table 2.3
Number of Hospital Beds per 1,000 Persons by State, 2000

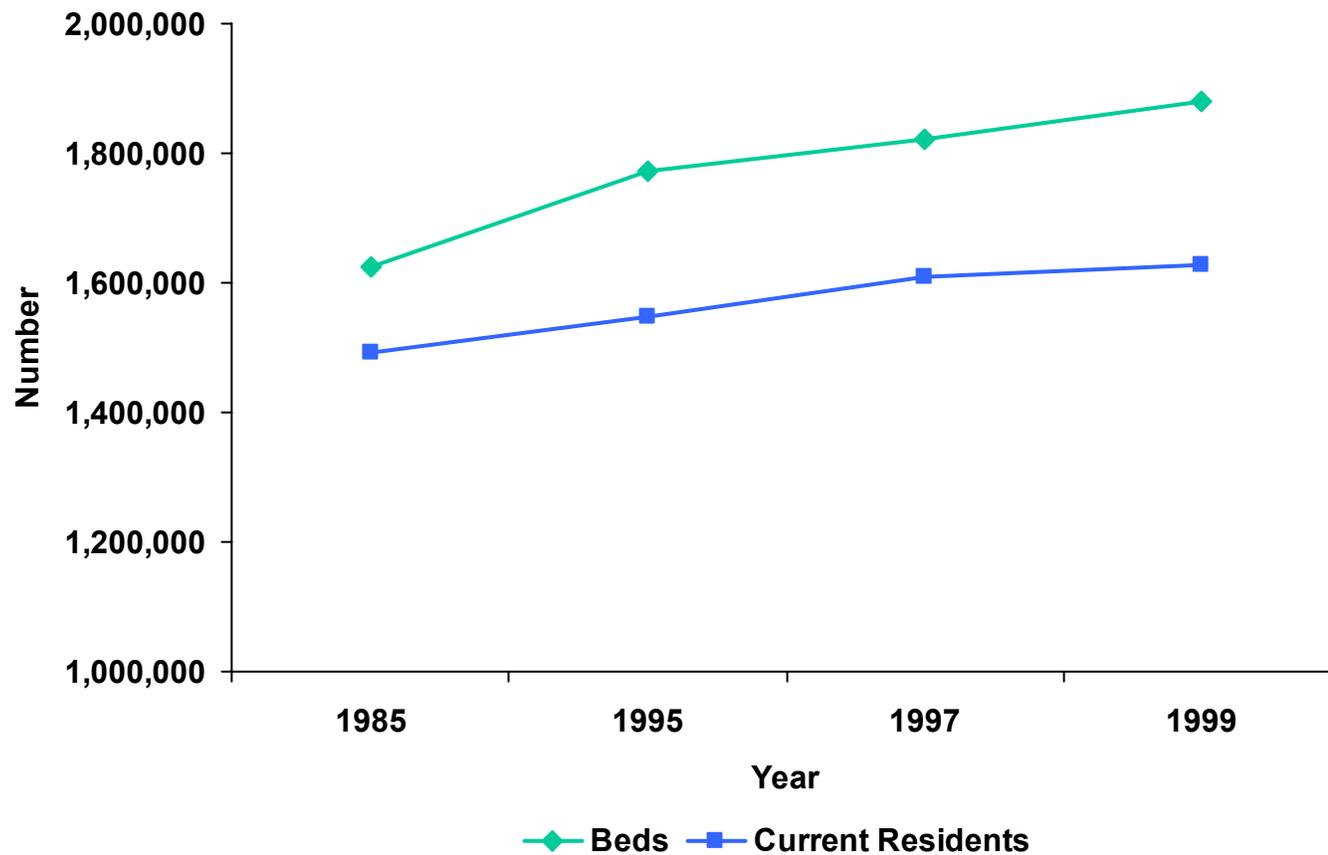


Note: Per 1,000 population.

Source: 2000 AHA Annual Survey. Kaiser Family Foundation State Health Facts Online.

Table 2.4 Number of Nursing Home Beds and Residents, 1985-1999

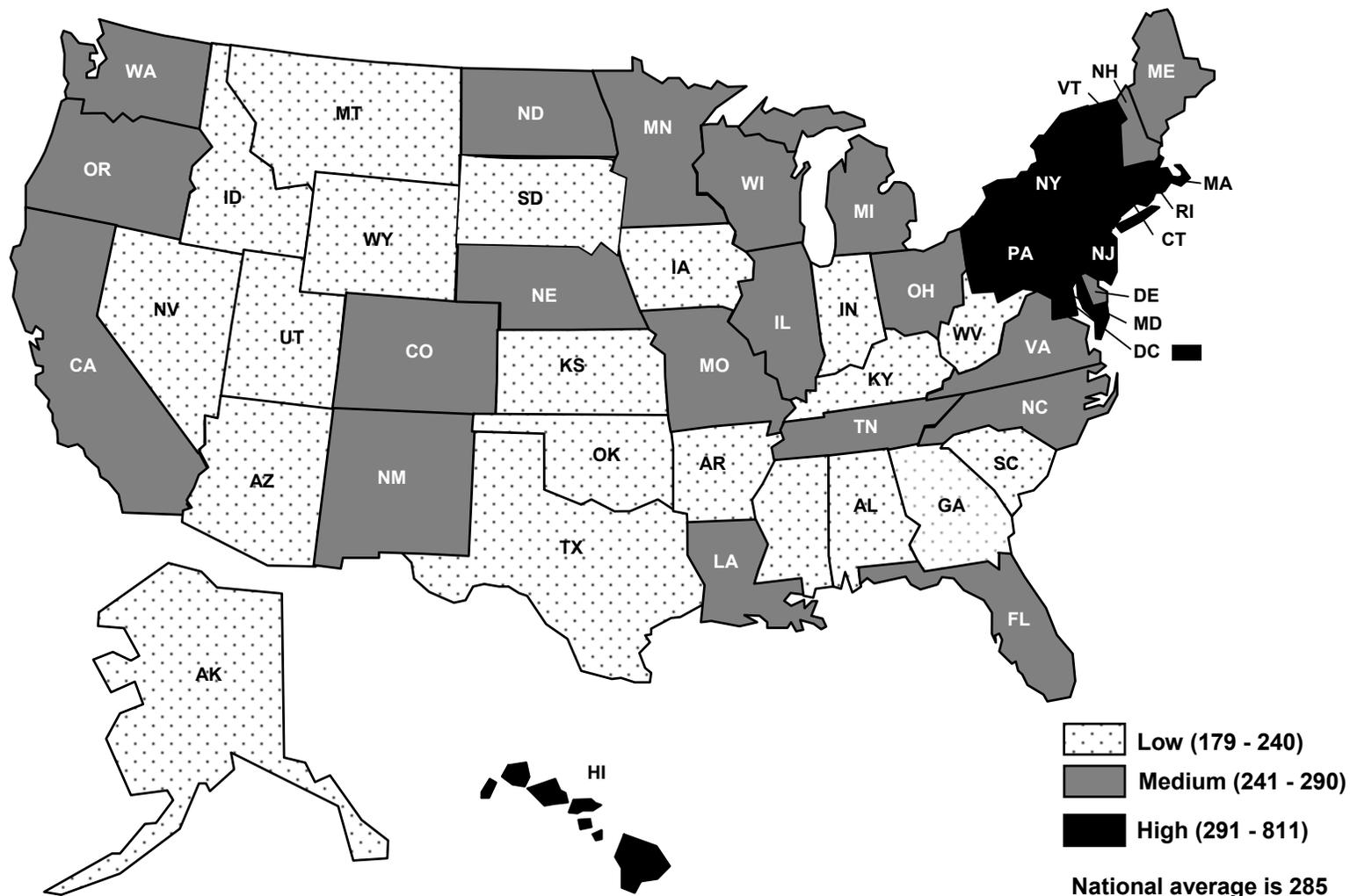
The growth in beds outpaces the growth in residents.



Source: *Health, United States, 2001*, National Center for Health Statistics.

Table 2.5 Number of Physicians per 100,000 Persons by State, 1999

Availability of Physicians varies substantially by state.



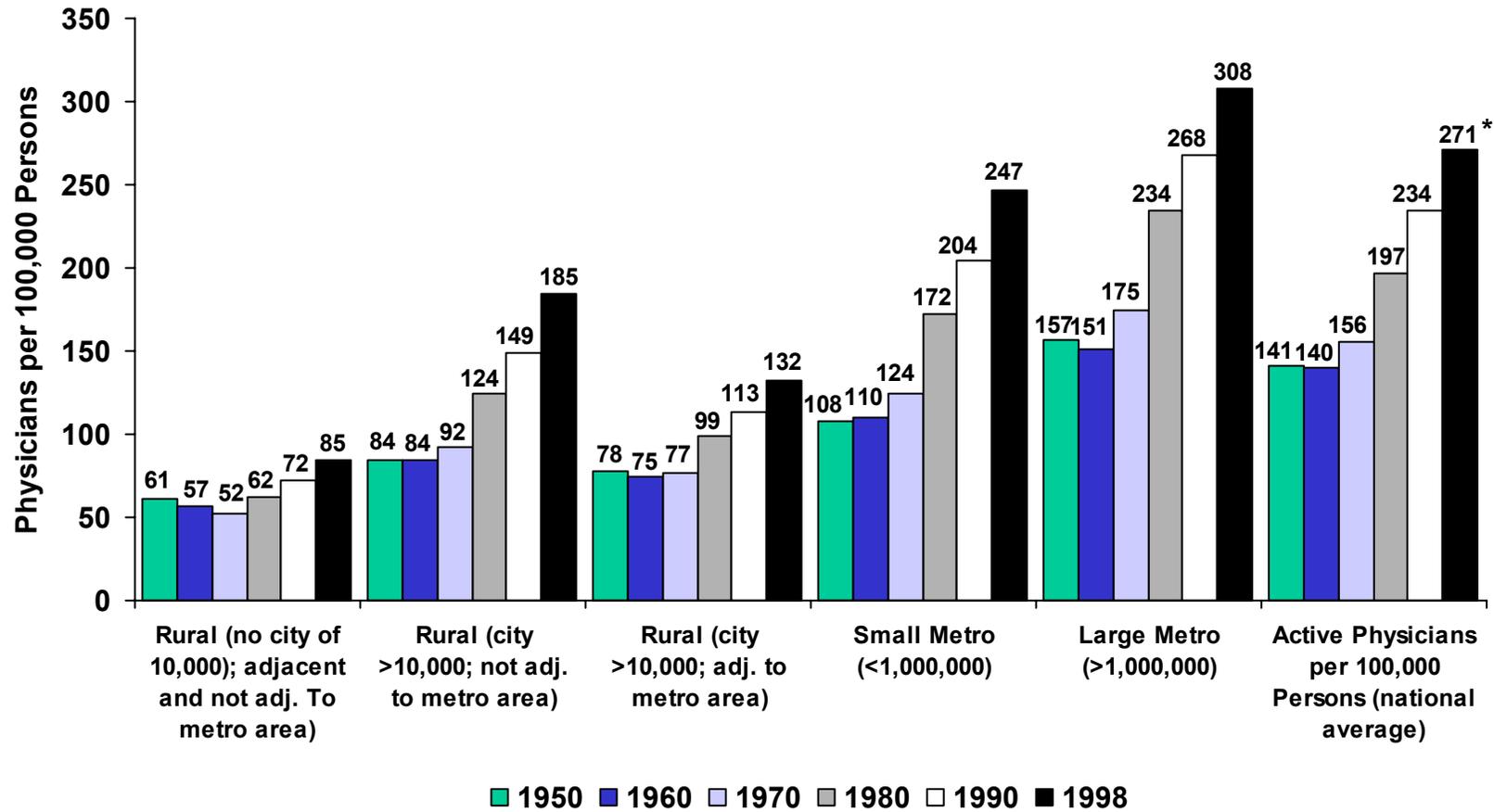
Note: Includes non-federal physicians only.

Source: Physician Characteristics and Distribution in the U.S. 2001-2002. American Medical Association. Kaiser Family Foundation State Health Facts Online.

Table 2.6

Active Physicians per 100,000 Persons by Location, 1950-1998

Since 1950, urban areas have seen much more rapid growth in physicians than rural areas.



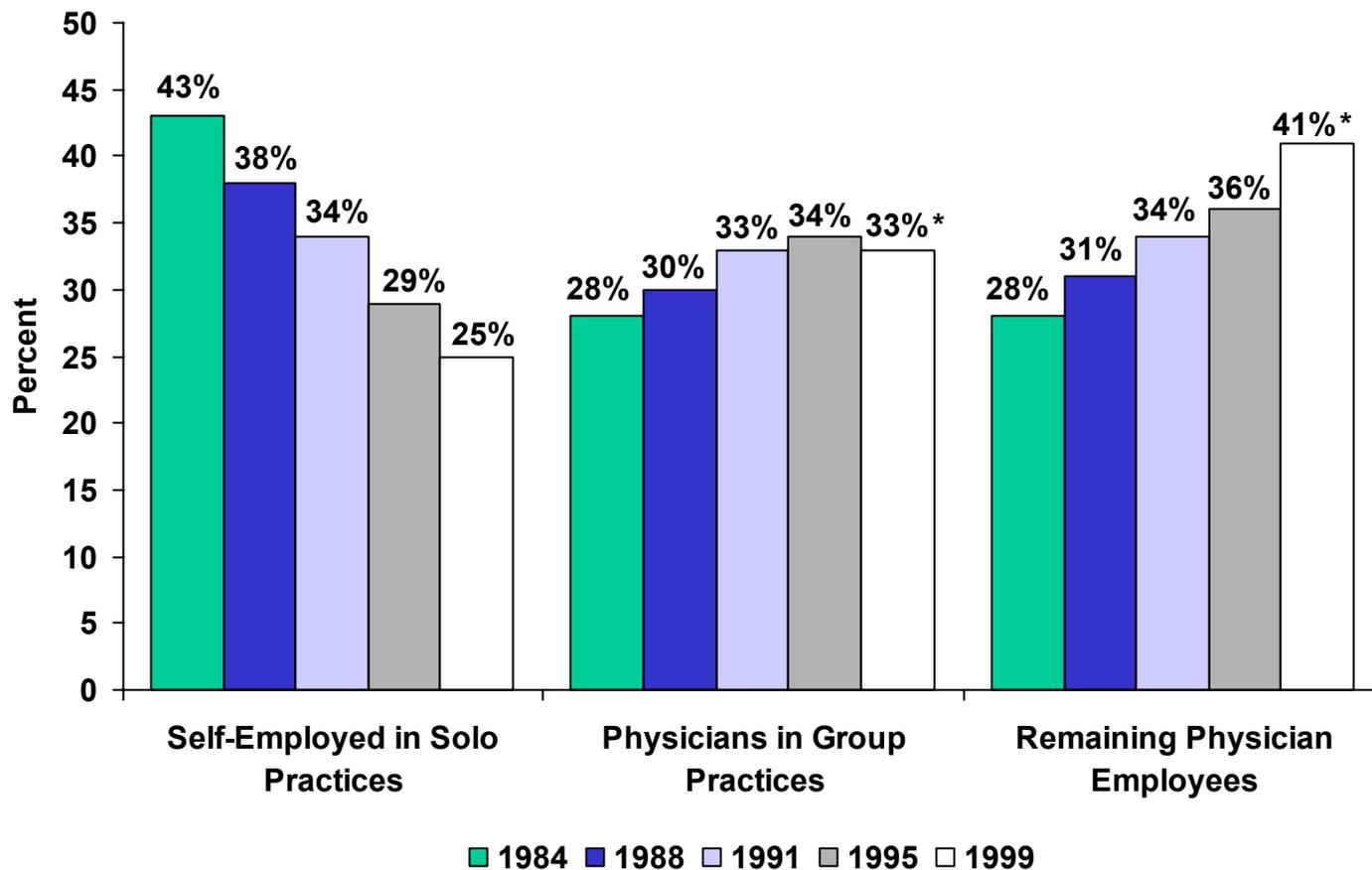
*Projection for 2000.

Note: Includes all active physicians.

Source: AMA data from the Bureau of Health Professions and Health, United States, 1993.

Table 2.7
The Percentage of Physicians in Differing Practice Arrangements, 1984-1999

Declines in solo practice physicians are offset by increases in salaried physicians.

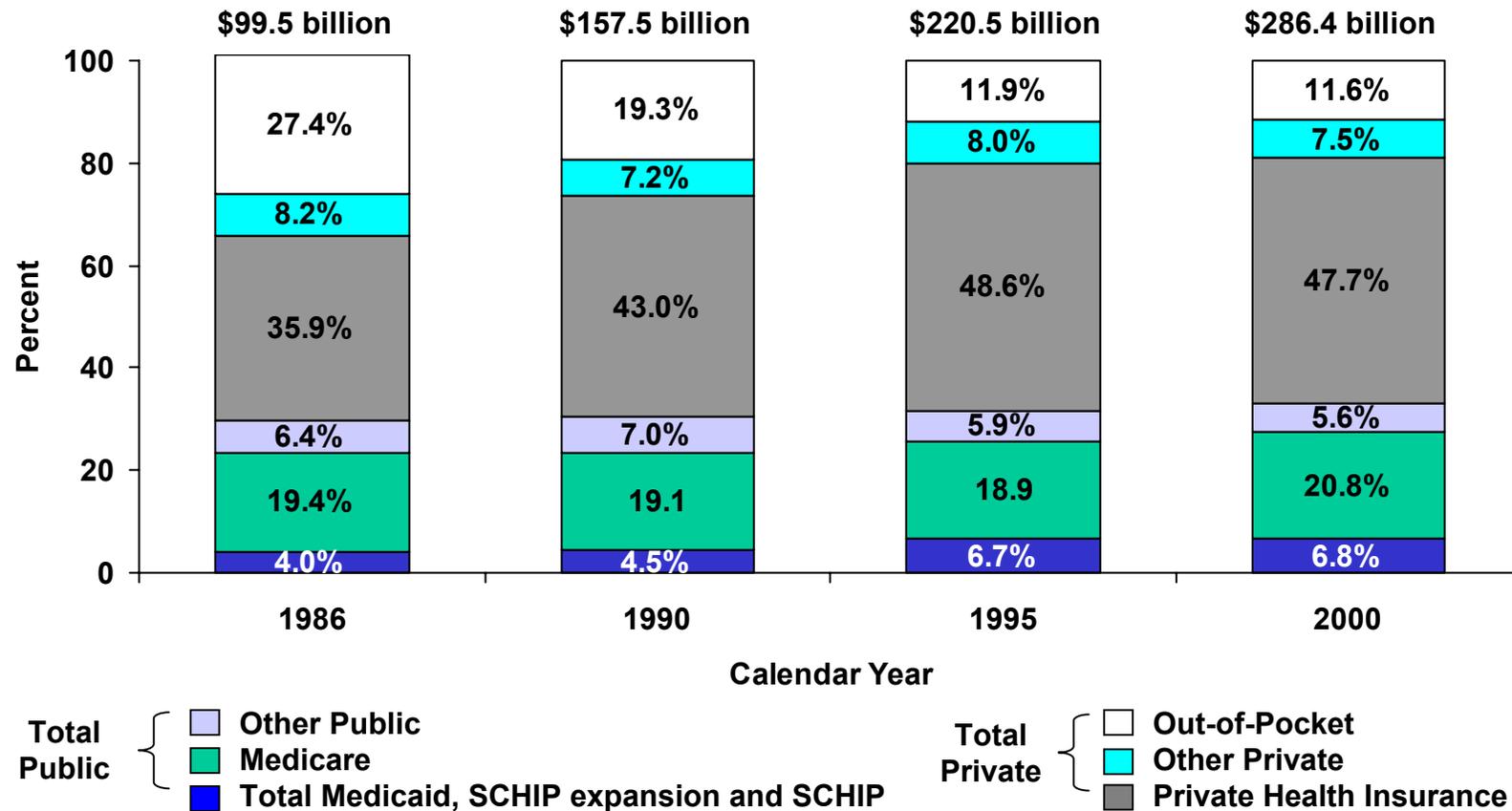


*The 1999 data do not include group practice employees in the group practice data, and instead include them in the physician employee column.

Source: AMA Socioeconomic Monitoring System and AMA Physician Masterfile.

Table 2.8 Physician Revenue by Payer, 1986-2000

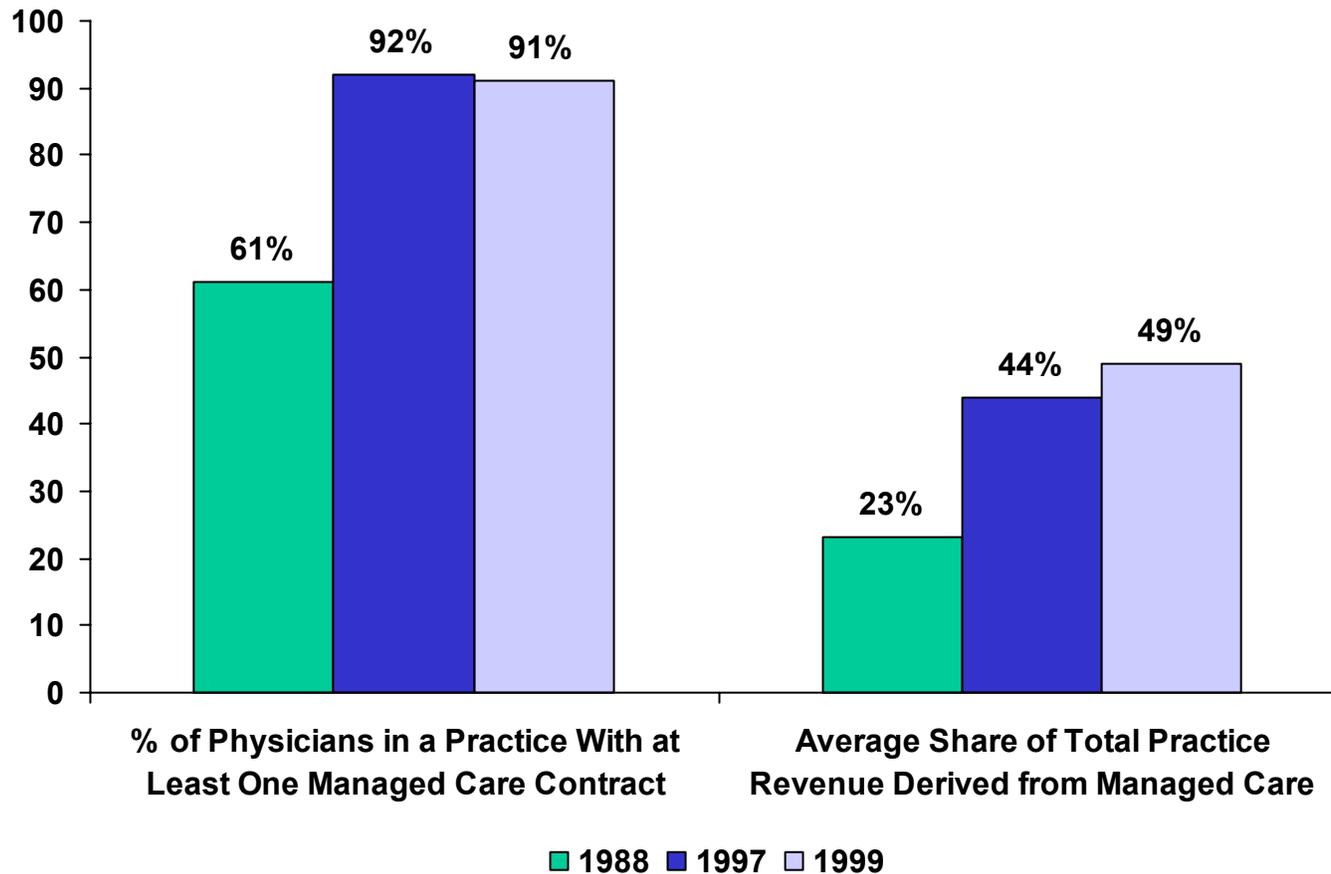
The share of physician and clinical services revenue paid by patients out-of-pocket has declined substantially since 1986. Private health insurance continues as the largest source of physician and clinical services revenue.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Table 2.9 Physician Participation in Managed Care, 1988-1999

There have been large increases in the percentage of physicians participating in managed care contracts as well as the share of practice revenue derived from such contracts.

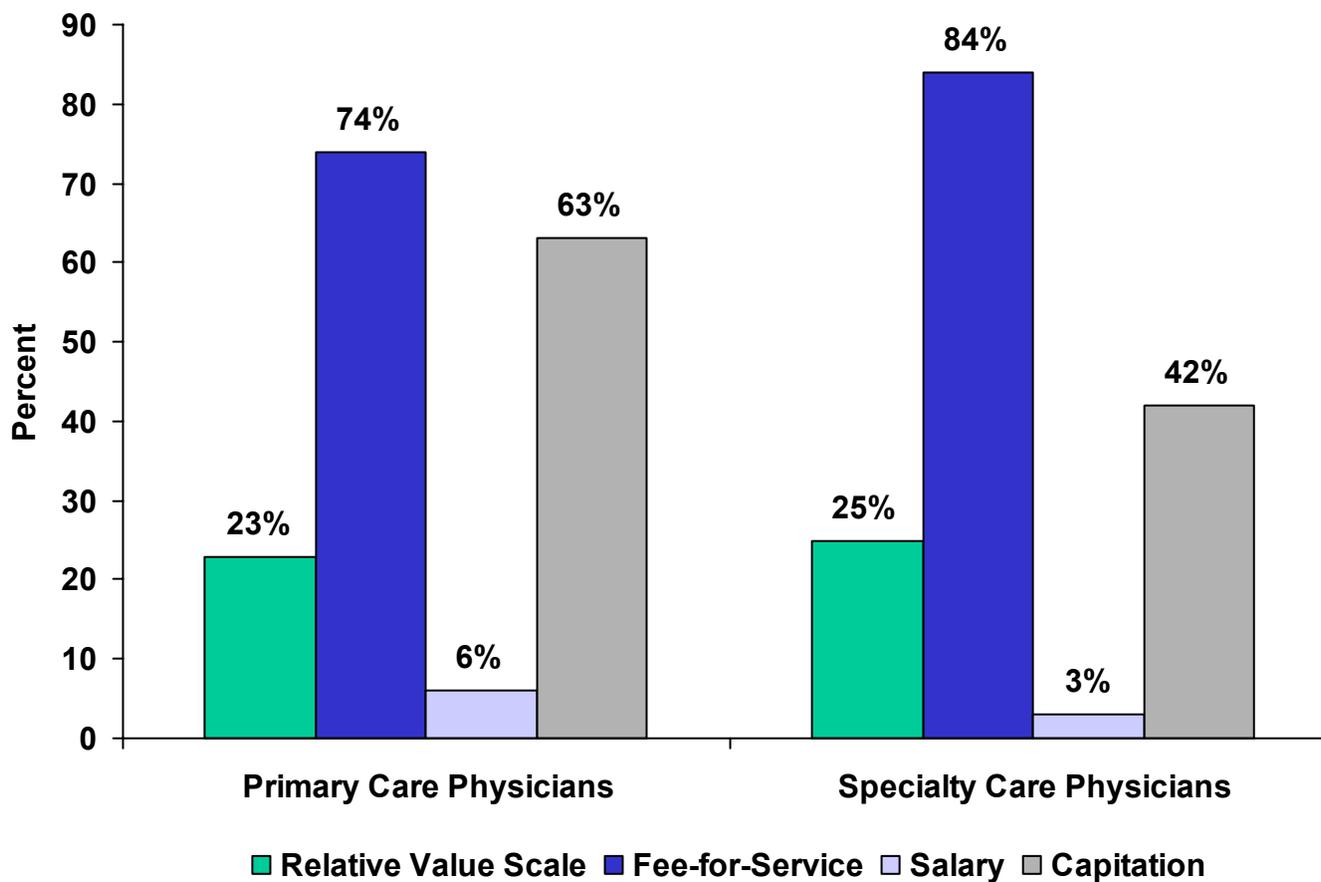


Note: Managed care contracts include HMOs, IPA, and PPOs. Data from the American Medical Association.

Source: Trends and Indicators in the Changing Health Care Marketplace, 2002, Kaiser Family Foundation.

Table 2.10 Physician Managed Care Payment Arrangements, 2000

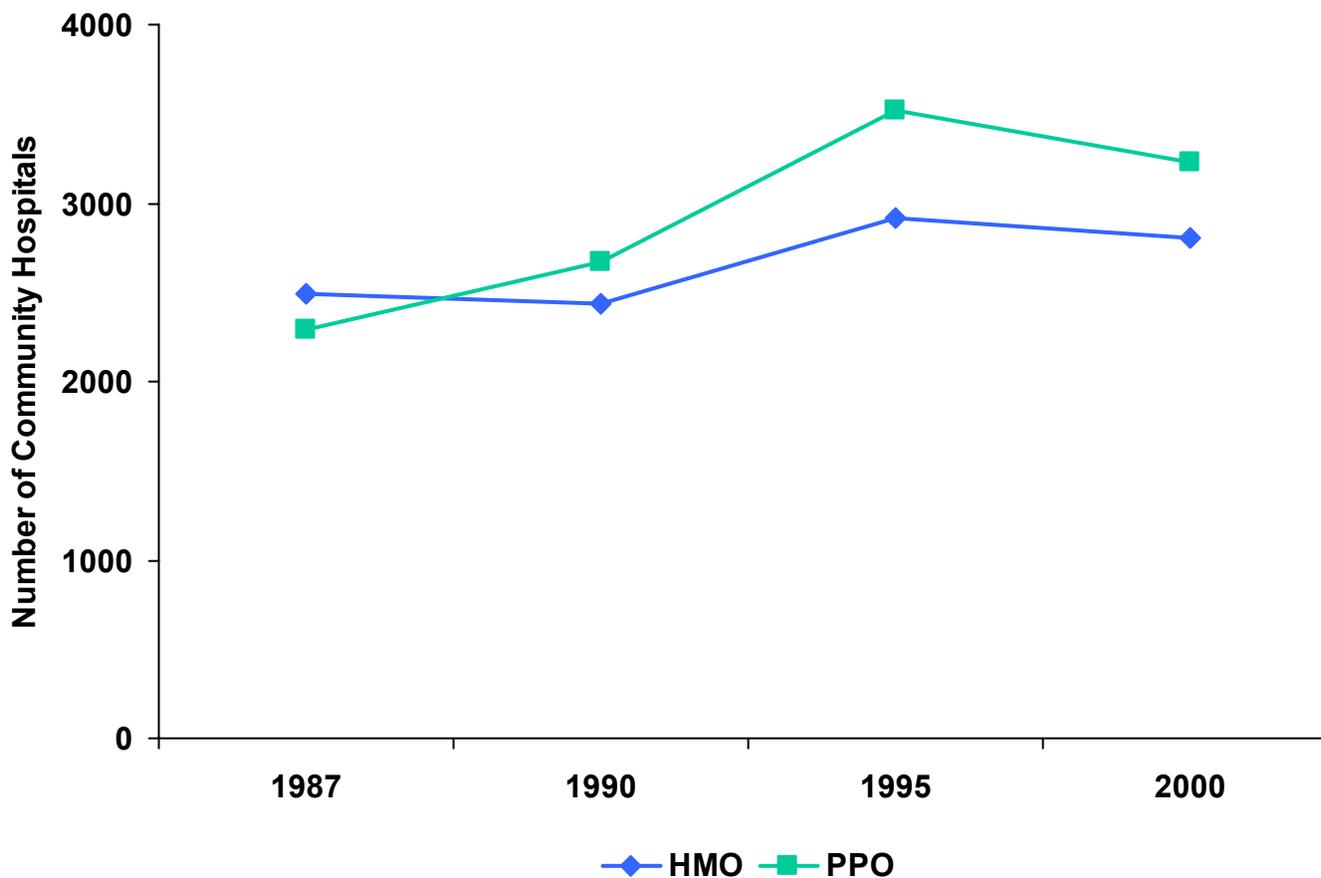
Fee-for-Service occupies a larger percentage of specialty care physician pay while capitation is more prevalent among primary care physicians.



Source: Trends and Indicators in the Changing Health Care Marketplace, 2002, Kaiser Family Foundation.

Table 2.11 Hospital Participation in HMOs and PPOs, 1987-2000

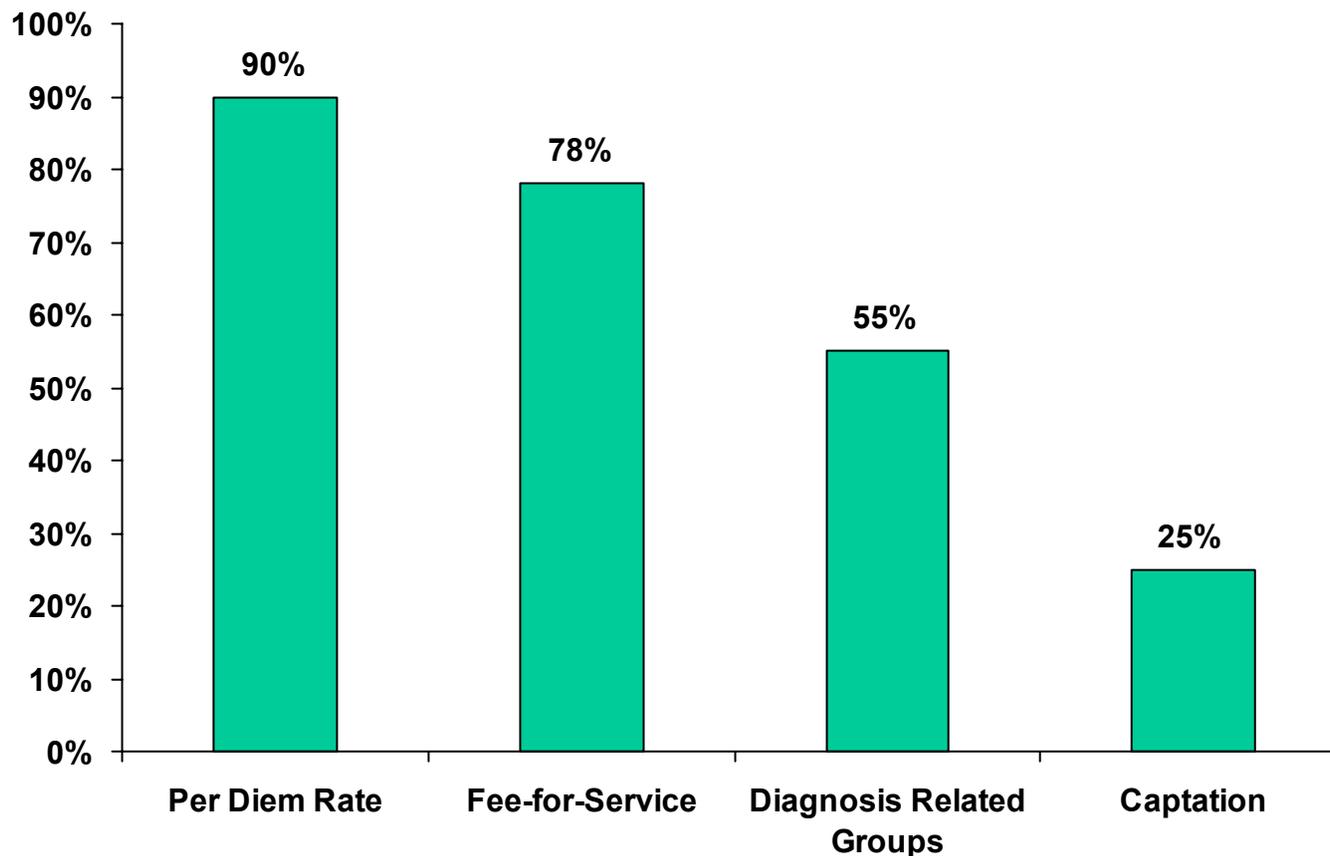
There has been a steady rise in the number of hospitals participating in both Health Maintenance and Preferred Provider Organizations.



Source: American Hospital Association, personal communication.

Table 2.12 Hospital Managed Care Payment Arrangements, 2000

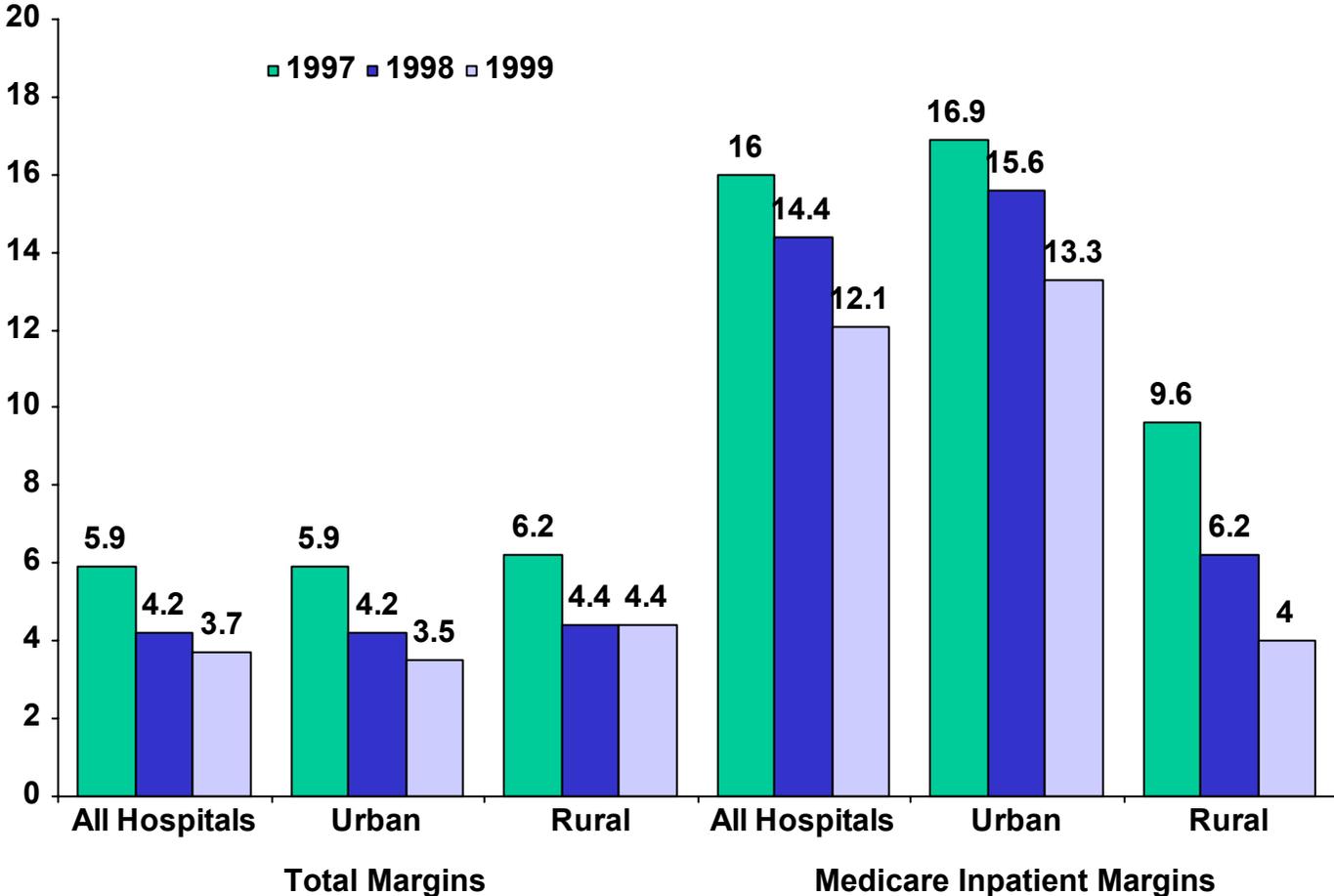
Most hospitals receive per diem and fee-for-service payments, a much smaller number also receive capitated payments.



Source: Trends and Indicators in the Changing Health Care Marketplace, 2002, Kaiser Family Foundation.

Table 2.13 Hospital Profit Margins for All Payers and Medicare, 1997-1999

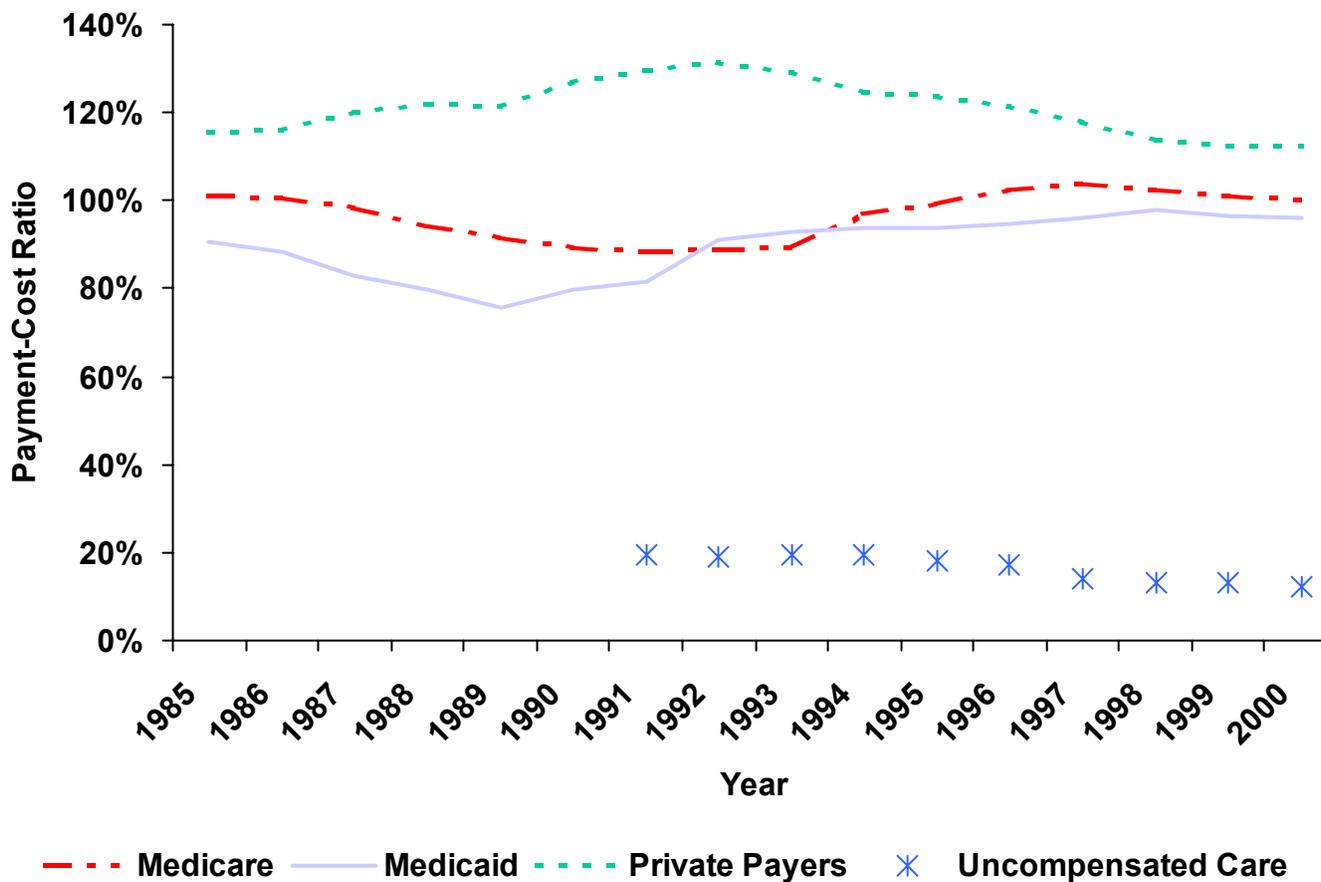
For both rural and urban hospitals, overall and Medicare inpatient hospital profit margins have declined.



Source: CMS, Office of the Actuary. Medicare cost report data.

Table 2.14 Hospital Payment to Cost Ratios for Medicare, Medicaid, and Private Payers, 1985-2000

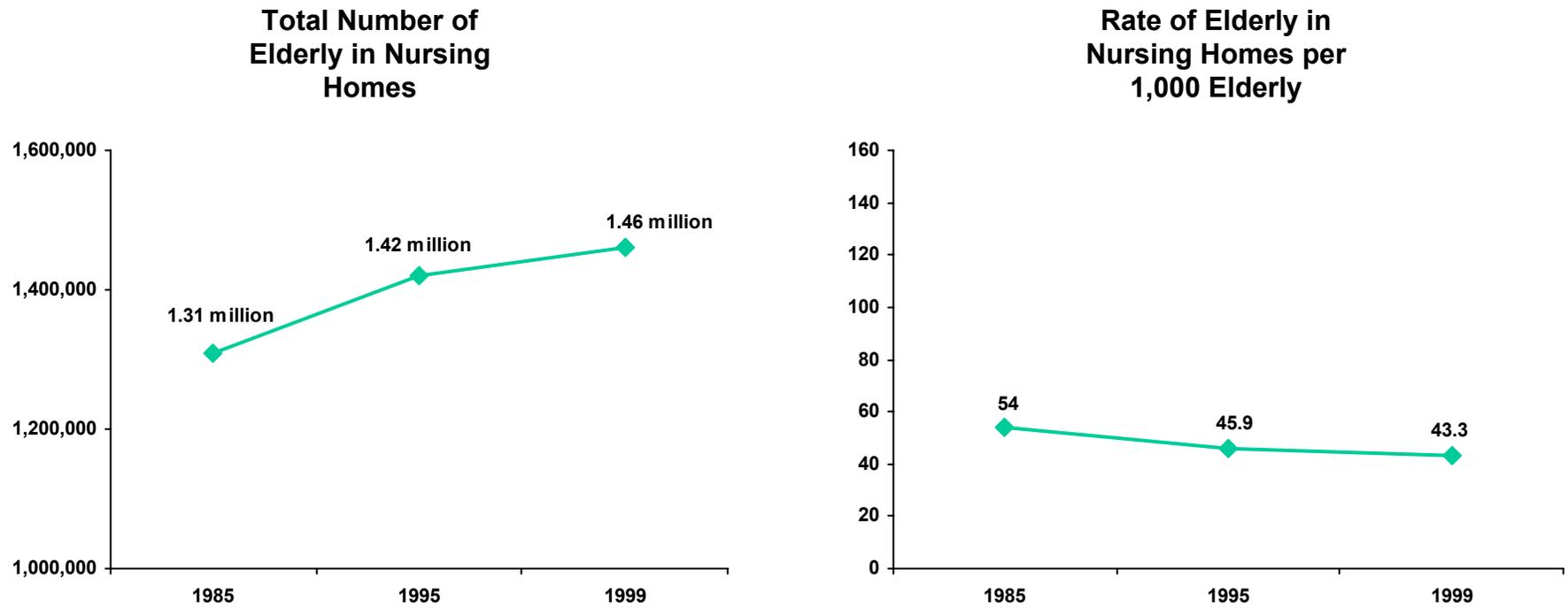
Despite rises in cost ratios for private payers and declines for Medicare and Medicaid payers throughout the early and mid nineties, ratios have recently returned to mid eighties' levels.



Source: Propac/Medpac analysis of data from the American Hospital Association Annual Survey of Hospitals.

Table 2.15 Change in Nursing Home Institutionalization Rate for the Elderly, 1985-1999

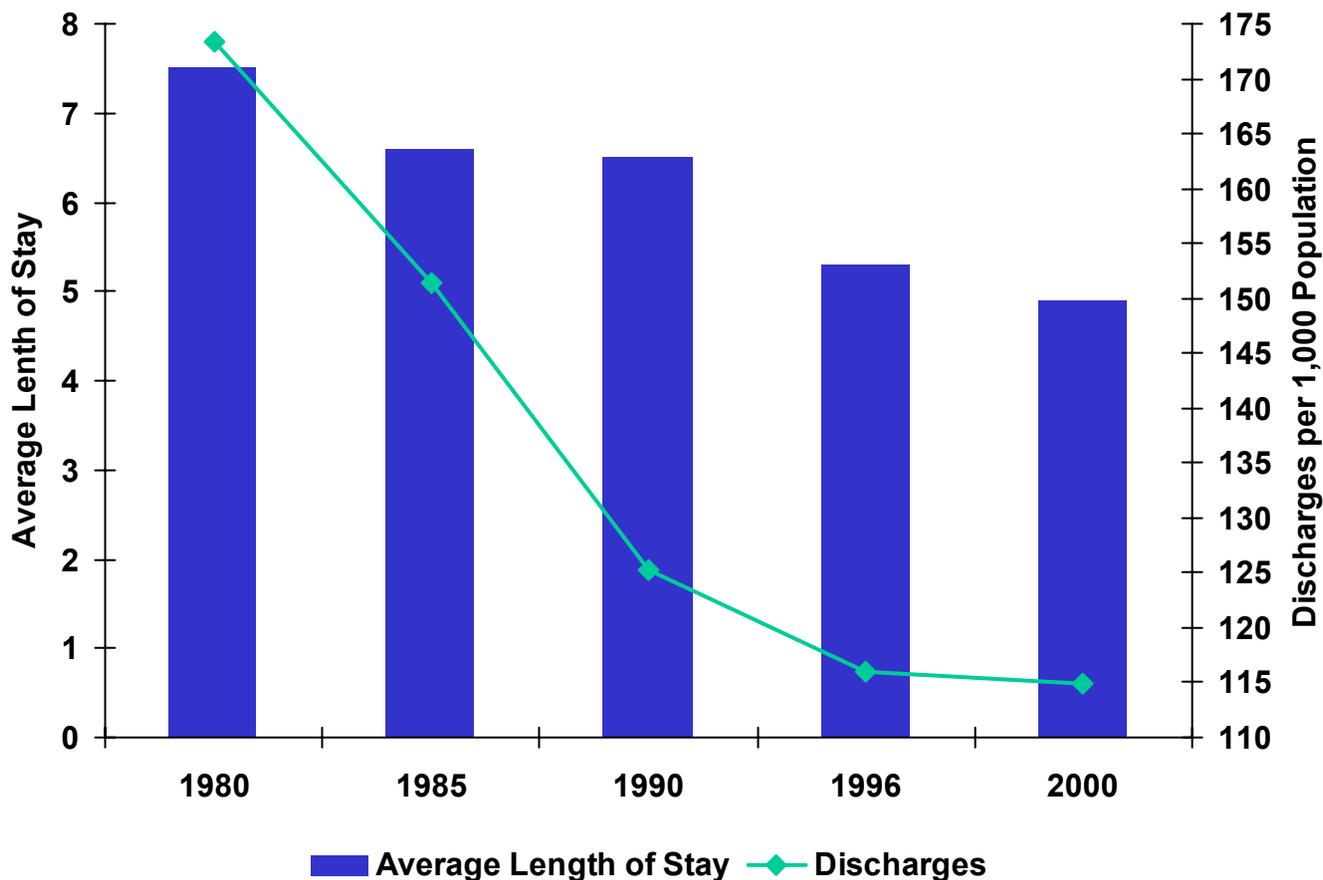
While the absolute number of elderly in nursing homes continues to rise, the number of residents per 1,000 elderly has declined.



Source: Health, United States, 2001, National Center for Health Statistics.

Table 2.17 Number of Hospital Discharges and Average Length of Stay, 1980-2000

Hospital discharges and length of stay have declined over the last two decades.

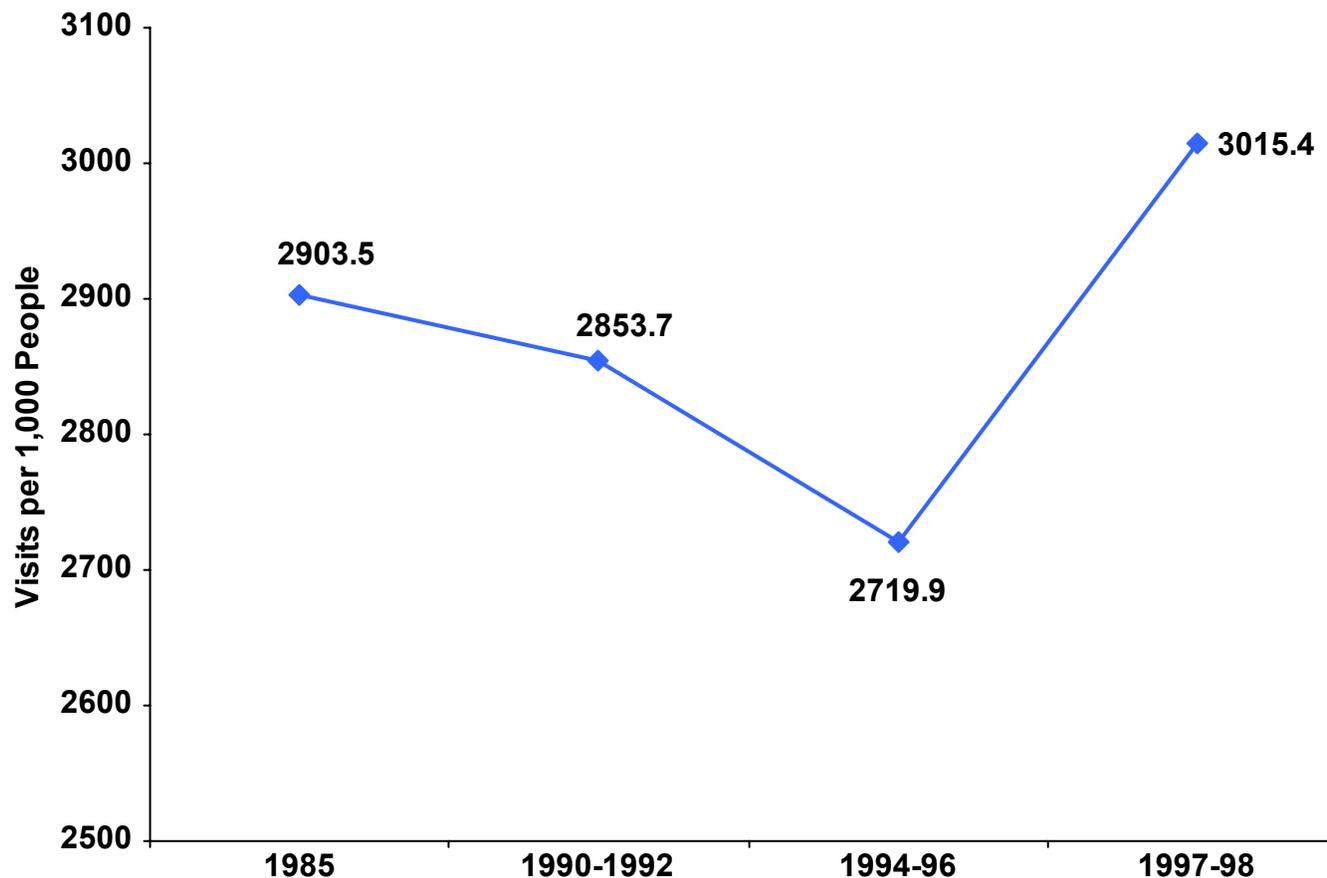


Note: Non-Federal short-stay hospitals.

Source: *Health, United States, 2002*, National Center for Health Statistics. Table 91.

Table 2.18 Number of Physician Visits per 1,000 Population, 1985-1998

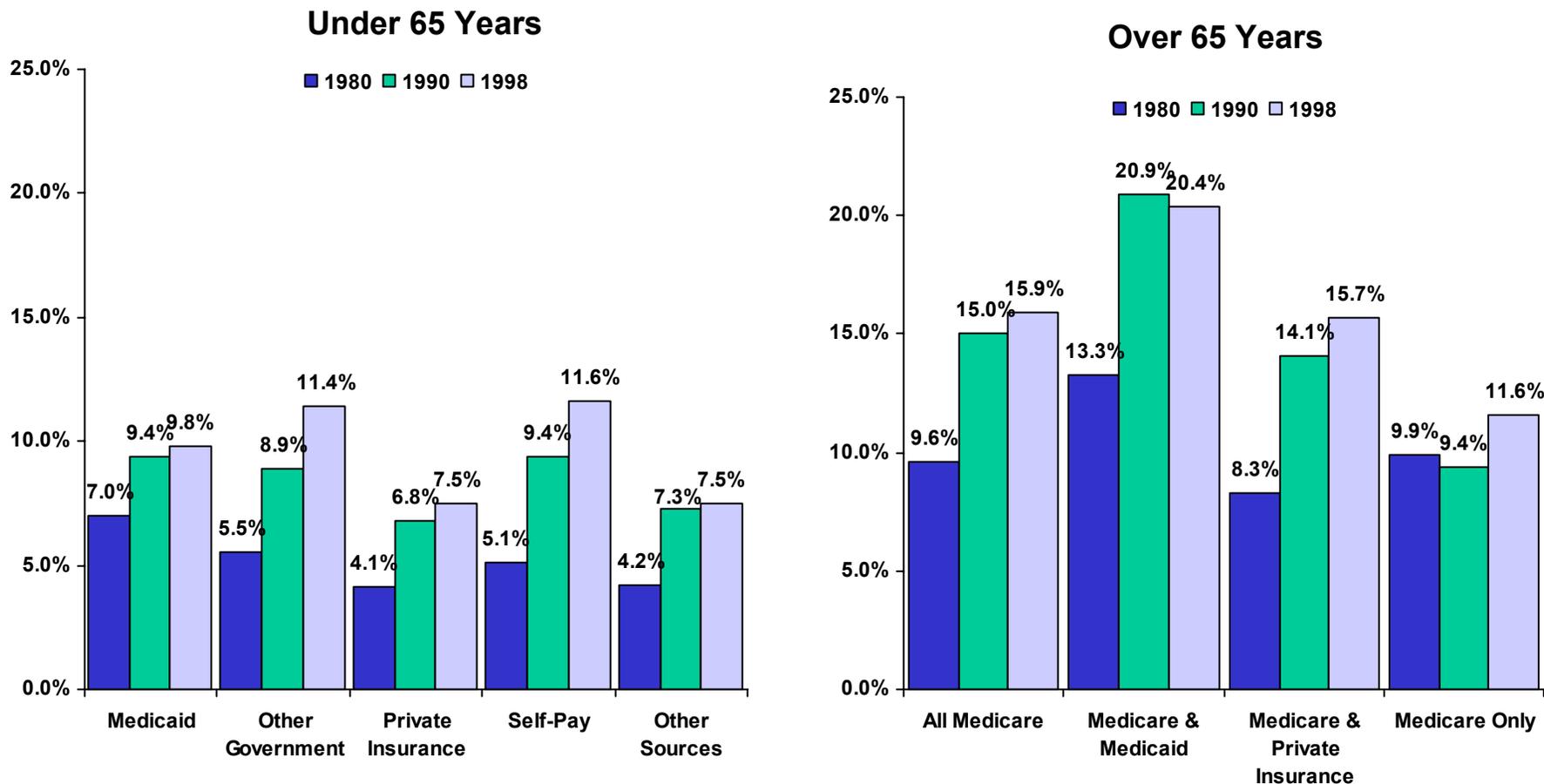
While there was a drop in the overall number of physician visits during the early nineties, by 1997-98, levels were higher than those in 1985.



Source: Bernstein AB, Hing E, Burt CW, et al. Trend Data on Medical Encounters: Tracking A Moving Target. Health Affairs 20(3): 58-72. Mar/Apr. 2001.

Table 2.19 Avoidable Hospitalizations by Insurance Type by Age, 1980-1998

Avoidable hospitalizations show steady growth across insurance types.*



*Note: Avoidable hospitalizations are defined as hospitalizations that could have been prevented with timely and appropriate ambulatory care.

Source: Kozak LJ, Hall MJ, Owings MF. Trends in Avoidable Hospitalizations, 1980-1998. Health Affairs 20(2): 225-32. Mar/Apr 2001.