STRATUM HEALTH ADVISORS

CASE STUDY N° 10 · DECISION ANALYSIS

When Closing a Service Line Is the Strategy

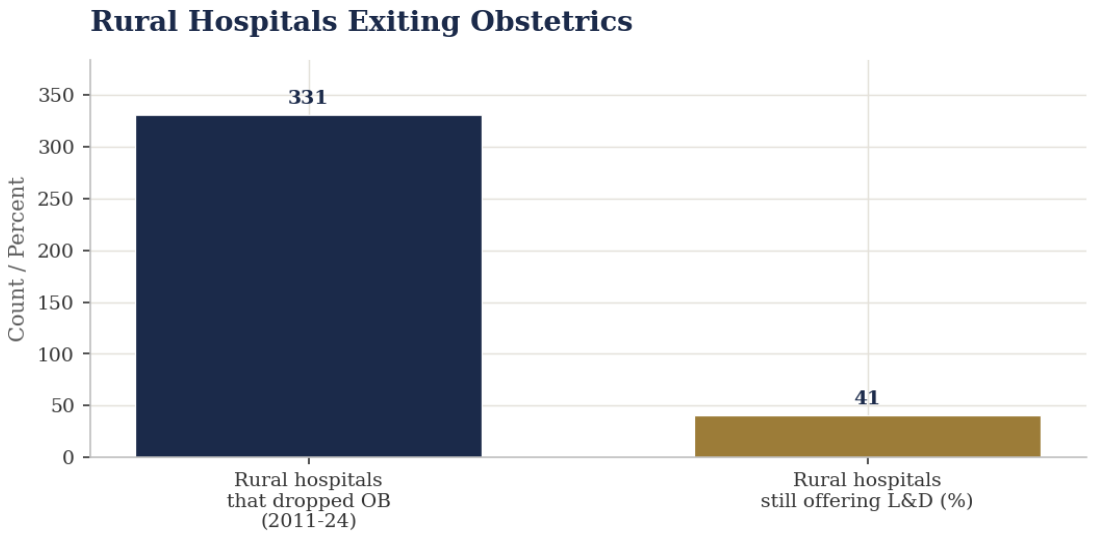
Why hundreds of rural hospitals have exited obstetrics — and how to make a service-line closure a deliberate strategic decision rather than a slow bleed. A regional and rural health-system decision analysis.

1. The Fork

A regional hospital runs a service line — obstetrics is the recurring example — that loses money every year, serves a real community need, and is part of the institution's identity. Volumes have declined, recruiting the required specialists has become nearly impossible, and the losses drag on the whole system. The board faces a decision it hates: keep subsidizing the line from other margins, or exit it and redirect scarce capital and staff toward services the system can sustain. Hundreds of rural hospitals have now made this exact decision on maternity care, which makes it one of the most documented service-line-exit situations in American healthcare. This is an analysis of that fork, framed for any regional system deciding whether, and how, to exit a beloved but unsustainable service.

2. The Landscape Before the Decision

The scale of the exit is striking. Between 2011 and 2024, 331 rural hospitals stopped offering obstetric services — more than one in four rural hospitals — and by 2022 a majority of rural hospitals (52%) no longer had any maternity ward[1]. Less than 42% of rural hospitals still offer labor and delivery.



Mixed units, labeled | Source: National Rural Health Assn (2026); CHQPR. Left = count; right = % still offering.

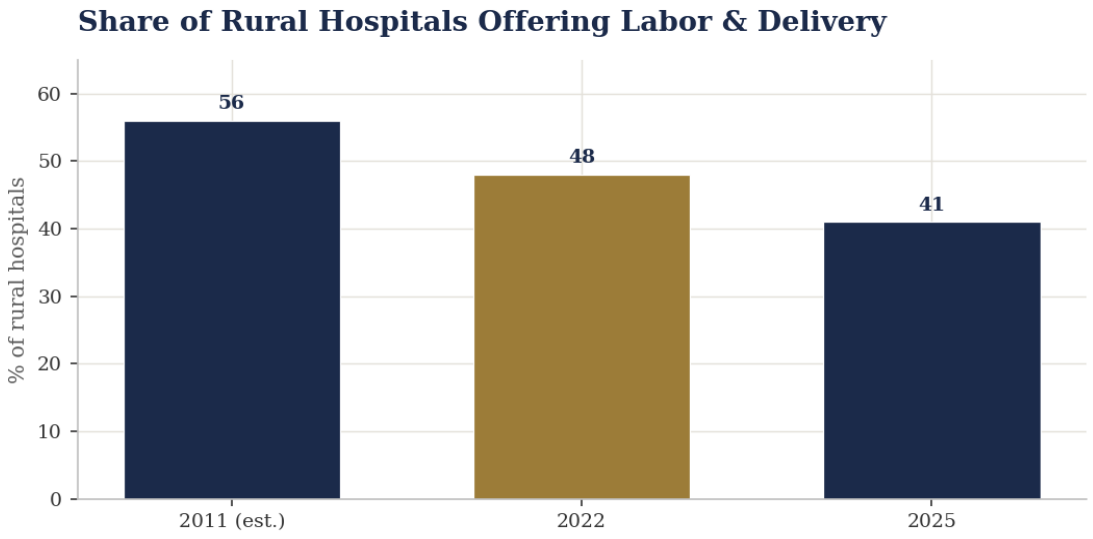
The financial logic driving it is consistent: declining local birth volumes, severe difficulty recruiting obstetricians and anesthesiologists, chronic underpayment from Medicaid (which covers a large share of rural births), and rising staffing and supply costs[2]. Rural hospital operating margins have hovered near or below zero — one state analysis found an average operating margin of roughly negative 0.5% across its hospitals in 2024. A low-volume, high-fixed-cost, poorly-reimbursed service line is precisely the one that breaks a thin margin.

3. The Decision Logic — Steelmanned

Exiting is defensible, and the strongest version of the case is not merely financial. A low-volume obstetrics unit that cannot reliably staff anesthesia or maintain clinical proficiency is a patient-safety concern, not just a cost center — consolidating deliveries into a higher-volume regional site can produce better outcomes even as it reduces access. For a system whose survival is genuinely at stake, subsidizing a chronically money-losing line can threaten the solvency that keeps its emergency department, primary care, and every other service open. Exiting one line to protect the whole institution is a rational act of triage. The board that closes obstetrics to keep the hospital's doors open is making a hard, defensible choice about the greatest good the institution can still deliver.

4. The Landscape After

The chart below illustrates the decline: the share of rural hospitals still offering labor and delivery has fallen steadily as exits accumulated[1]. But the aftermath reveals a trap that makes service-line exits far more consequential than they look on a P&L. Eliminating obstetrics sets off a cascade: obstetricians and the anesthesiologists and surgeons who supported them often leave, denting revenue in other lines; Medicaid patient volumes drop; and the hospital can lose 340B drug-discount eligibility and supplemental payments. Service-line reductions are documented as one of the precursors to full hospital closure, not a stabilizing retreat from it.[3]



Illustrative | Source: CHQPR; Univ. of Minnesota (2022: 52% had none, i.e. ~48% offered). 2011 & 2025 approx.

The discipline that separates a good exit from a bad one is deliberate reallocation: the hospitals that exited obstetrics well treated it as a planned strategic transition — arranging patient transfers to a partner system, retaining the OB-GYNs for gynecologic and primary care, protecting 340B where possible, and communicating a coherent plan [4]. The hospitals that exited badly simply stopped the service and absorbed the cascade unmanaged. Same decision; opposite executions; very different survival odds.

5. The Strategic Read — For Any Regional System

A service-line exit is not a subtraction; it is a strategic reallocation that either strengthens or destabilizes the whole institution depending on how the second-order effects are managed. The tradeoff space:

DIMENSION	KEEP SUBSIDIZING THE LINE	EXIT DELIBERATELY
Near-term cash	Continued drain on system margin	Relief — if the cascade is managed
Community access	Preserved	Reduced — requires a transfer plan
Second-order revenue	Stable	At risk — specialists, Medicaid, 340B
The failure mode	Subsidizing until the whole system fails	Stopping the service without managing the cascade

6. The Stratum Outlook

IN PLAIN TERMS

Strip away the mechanics and it is this: a lot of rural hospitals kept a money-losing baby-delivery unit open out of loyalty until the losses threatened the entire hospital — and a lot of others closed it and accidentally triggered a chain reaction that pushed the whole hospital toward closing anyway. Closing a service line is not just crossing out one loss on a spreadsheet. When obstetrics goes, the surgeons and anesthesiologists can follow, Medicaid patients go elsewhere, and special payment protections can disappear. The lesson is that the exit itself is not the risk — the

> unmanaged aftermath is. If you are going to close a line, close it on purpose: line up where the patients go, keep the staff you can redeploy, protect your payment status, and tell everyone the plan. A deliberate exit can save the hospital. A passive one can end it.

7. Where Stratum Fits

A regional system weighing a service-line exit needs the full second-order picture quantified before the board votes: the true all-in cost of the line, the cascade risk to specialists, Medicaid volume, and 340B status, and the transition plan that turns a closure into a reallocation rather than a bleed. Stratum builds that analysis independently. Start a conversation at stratumhealthadvisors.com.

References

All figures in this analysis are drawn from the following public sources, current as of publication (July 2026).

[1] The 19th / National Rural Health Association, July 2026 (331 rural hospitals exited OB 2011–2024); University of Minnesota study via U.S. News, Dec 2024 (52% of rural hospitals without a maternity ward by 2022). ruralhospitals.chqpr.org (<42% still offer L&D).

[2] Center for Healthcare Quality and Payment Reform, “Stopping the Loss of Rural Maternity Care.” ruralhospitals.chqpr.org; Oregon Capital Chronicle / InvestigateWest, Sept 2025 (~ -0.5% average operating margin, 2024).

[3] Modern Healthcare / Chartis Center for Rural Health, “Rural hospitals cut maternity, oncology care.” 2023. (Cascading financial impact: specialist departures, Medicaid volume, 340B eligibility.)

[4] Becker's Hospital Review, “Maternity service closures” and “32 hospitals closing departments or ending services,” 2025–2026. beckershospitalreview.com. (Examples of managed consolidations and transfer partnerships: St. Mary's, Merrimack Health, Delta Health.)

Figures reflect the most recent public sources available and may change as ownership and market conditions evolve. This reference list is provided for transparency and does not constitute an endorsement by the cited parties.