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Private Supply, Public Benefit

Reduce wait times with specialty hospitals.

In the Thursday, March 15, 2007 issue of the Toronto *Globe and Mail* it was reported[1] that the Ontario Ministry of Health was considering contracting with a private hospital in Ontario to perform knee replacement surgery. As the *Globe* article put it:

> *"The Ontario government is reviewing a proposal that would pay a private hospital to perform 1,500 knee replacement operations -- a move that comes as the province struggles to reduce lengthy queues where some patients wait as long as one year for surgery.*
>
> *If the pitch by Don Mills Surgical Unit Ltd. goes through, Ontario would join other provincial governments that have learned that sometimes, the best way to reduce ballooning waiting times in the public health-care system is by going private."*

Members of the Canadian Health Care Consensus Group (CHCCG) have come together to provide a platform for bold, reasoned and practical plans for genuine reform of the health system and to demonstrate that there is an emerging consensus among reform-minded observers about the direction that real reform must take. The CHCCG, coordinated by the Atlantic Institute for Market Studies (www.aims.ca), includes medical practitioners, former health ministers, past presidents of the Canadian Medical Association and provincial medical and hospital associations, academics, and health care policy experts, all of whom are signatories to the Statement of Principles.

This paper is one of a series of discussion papers prepared for the CHCCG, which are intended to contribute to that new debate. These papers do not represent official positions of the Consensus Group, and are not themselves consensus documents, but rather are intended to act as starting points for debate, some of which will occur on the Consensus Group's website (www.consensusgroup.ca). The first few papers will deal with aspects of the "public" versus "private" debate, while later ones will consider other issues which were raised in the Consensus Group's Statement of Principles.

The next day, Friday, March 16, 2007 the *Globe* reported[2] that the province of Ontario would not be making use of the Don Mills Surgical Unit's services:

> *"Ontario Health Minister George Smitherman said the government will not consider contracting out knee-replacement operations to a private Toronto hospital. …….. "This Ministry of Health gives you and all Ontarians the complete assurance, I will never support the outsourcing of those knee surgeries to any private, for-profit-motivated organization," Mr. Smitherman said. "Our government fundamentally believes that the public health-care system, the not-for-profit public health-care system is the best expression of Canadian values."*

Preliminary reports on the pilot project suggested a reduction from 47 weeks to 5 weeks between first orthopedic consult and surgery.

Sadly, Mr. Smitherman doesn't seem willing to give Ontarians the chance to decide for themselves whether adhering to the ideology of non-profit provision is more important than reducing their own waiting times. For all the claims that the self-styled defenders of Medicare make about the damage private supply of care would do to Canada's health care system, the international evidence is that expanded private supply would only benefit the system.

The issue of private provision of care isn't a new one, of course. There was, during the 2006 federal election campaign, an interesting unscripted political moment when NDP leader Jack Layton, a staunch opponent of private health care, discovered that Toronto's Shouldice Hospital, at which he'd once had a hernia operation, was in fact a private hospital. Mr. Layton's response was that his doctor had sent him to Shouldice, that Shouldice was where everyone went for that procedure, and that he had no way of knowing that it was a private facility. Mr. Layton's statement made the news because, earlier in the campaign, he had said that he would never use a private clinic for health care.[3]

The argument was also made, in Mr. Layton's defence, that Shouldice is a not-for-profit clinic, but on this there seems to be some confusion. Most sources list Shouldice as a for-profit operation, although with a limited number of residual profit takers - any profits it makes from, say, increasing the efficiency with which it provides care go to two members of the Shouldice family and the Government of Ontario. The fact that the government is a major shareholder has led some commentators to suggest that Shouldice[4] is effectively a non-profit, but on that argument provincial alcohol monopolies, which pay all of their apparently quite considerable surpluses to provincial governments, would also be classed as non-profits. Looking at the prices in some provincial liquor stores, that's not really a convincing argument.

There was another news story recently in which for-profit health care should have played a bigger role than it actually did. Back at the end of 2005 it was announced that a pilot project in Alberta had achieved significant reductions in wait times for hip and knee replacement surgery.[5] Preliminary reports on the pilot project suggested a reduction from 47 weeks to 5 weeks between first orthopaedic consult and surgery. The result was widely hailed as proof of what publicly run health care

could accomplish through centralization and reorganization (and nobody seemed to raise the question of why it hadn't been done before waiting times for joint replacements became a serious problem).

Less often mentioned in those stories was the fact that part of the reason the Alberta project was a success was that it contracted many of those joint replacement operations to a private, for-profit clinic, Calgary's Health Resource Centre (HRC). The HRC is an investor-funded, for profit facility which had already been providing surgical services to the Calgary Health Region (presumably in a satisfactory manner, since the Calgary Region has recently renewed its contract with HRC) and had also been supplying non-insured hip and joint replacement surgery. Its capacity was right there when it was needed. British Columbia is moving ahead with a similar scheme for improving joint replacement waiting times, but since it apparently lacks a similar private facility to draw on, and seems unwilling to let private entrepreneurs establish one, that will have to wait until the provincial government builds one.

Private, specialty facilities like Shouldice and HRC are the bogeymen of the moment in the Canadian health care policy debate. Shouldice itself is pretty much untouchable, if only because so many influential people have had hernia surgery there, and because of its outstanding record, not only in terms of efficiency but also in terms of quality of care. Detractors are left having to make the rather feeble argument that just because Shouldice is a first class, world renowned clinic doesn't mean that other for-profit specialty clinics would also be efficient, high quality clinics, but the success of investor-financed operations like HRC are a threat to the whole argument that private for-profit care is necessarily bad.

Specialty clinics are on something of a roll in the United States at the moment. Cardiac surgery clinics, orthopaedic clinics, women's hospitals and more general surgical clinics have been appearing at a rate which has started to alarm the people running traditional hospitals, leading to major PR efforts aimed at blocking the specialty clinics. We'll talk about the Texas Hospital Association's efforts a bit later on.

The most common arguments against specialty hospitals is that they're profit driven and will sacrifice quality of patient care for the sake of maximizing profits. It's an extension of the old argument that for-profit care is necessarily bad and that physician ownership of clinics creates a conflict of interest which would lead to the physician putting his own financial interests ahead of the interests of his patients.

There have been enough concerns raised that a number of bodies have looked into the role of specialty hospitals (in addition to the outpouring of journal articles on their place in the US health care system). Most widely noted are probably those by MedPAC (the Medicare Payment Advisory Commission - the independent body responsible for advising Congress on issues affecting the Medicare program[6]) and the GAO (at the time of the report the General Accounting Office of the US government, now, with suitable alphabetic economy, the Government Accountability Office[7]).

The January/February 2006 issue of the journal *Health Affairs* included a series of articles on the specialty hospital issue, including one by Stuart Guterman,[8] which reviewed the findings of the MedPAC and GAO reports.

The Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services also produced a report, using data from a small sample of physician-owned specialty hospitals.[9]

Practice makes perfect and that focusing on a limited number of activities is a more efficient mode of production than trying to do everything.

The arguments made by proponents of specialty hospitals are very straightforward. Specialty hospitals are more efficient. The efficiency comes from their specialization - it's as much a truism in medicine as in any other field that practice makes perfect and that focusing on a limited number of activities is a more efficient mode of production than trying to do everything. A clinic which specializes in a limited range of procedures will not only have experienced staff, it will be able to design its facilities with only a handful of activities in mind, rather than the wide range of activities a general hospital has to be able to undertake. Beyond that, though, is efficiency of organization. According to testimony given before a Senate Subcommittee by Mark Miller, the Executive Director of MedPAC,[10] the major attractions of specialty hospitals for physicians are: fewer disruptions to the operating room (OR) schedule, less down time between surgeries, ability to work between two operating rooms during a block of OR time, and more direct control over OR staff. Doctors working in specialty hospitals can use their time more efficiently and more efficient use of time translates into greater productivity.

There's plenty of evidence on this point. In 2005, the British press[11] was full of reports on an Italian orthopaedic surgeon, John Petri, who moved to the UK after spending most of his career in France, and was somewhat taken aback by the inefficiency of the NHS surgical system, notably the amount of surgeon downtime. By making more efficient use of the operating room resources available in his hospital he was reportedly able to double his workrate and eliminate his waiting list. He had, he reports, the agreement of anaesthetists and OR staff to make the changes, which simply involved getting a second patient ready in a second operating room while Petri was operating on his first patient, which allowed him to move immediately on to the second patient when he was finished operating on the first. (He also increased his operating room sessions from 3.5 hours to five hours at a time.) His fellow surgeons were less enthusiastic about the changes, but reforms to the NHS in recent years have given hospital managers much more scope to innovate than they once had and the management of his hospital supported him - according to the chief executive of the hospital, a small increase in cost has bought a large increase in output. That's essentially what those American specialty hospitals do and, according to John Petri, it's also the way the French hospital system works.

What about the criticisms of the American specialty hospitals?[12] For many people, the most serious criticism is that they are private, for-profit institutions. There's a general assumption that doctors who have ownership positions in these hospitals will put their financial interests as investors ahead of their patients well-being, cut corners to save costs and induce unnecessary surgeries. The GAO, CMS MedPAC reports all considered the question of whether physician ownership distorted physician behaviour, and none found any evidence of it.

They did, however, produce some interesting evidence on the pattern of ownership of specialty hospitals. According to the GAO, for example, some thirty percent of specialty clinics had no physician ownership. Of the remainder, at half the hospitals with physician ownership, the average individual physician's share was about 2%. It turned out, too, that over 70% of physicians with admitting privileges at specialty hospitals had no ownership share in them. And, interestingly enough, while local hospitals often objected to the establishment of specialty hospitals in their catchment areas, in quite a few cases the local community hospital actually had an investment position in a specialty hospital. While there were some differences in admitting patterns between owners and non-owners, the evidence did not support the view that doctors were putting their own financial interests first.

The evidence does tend to support the view that specialty hospitals tend to admit less severe cases, although this is not universal, especially in the case of cardiac surgery hospitals. American critics, making an argument which could not apply to Canada under our present hospital funding mechanisms,[13] argue that this threatens the financial stability of American community hospitals, because it reduces their capacity to use the revenue from low cost cases to cross-subsidize high cost cases.

This argument stems from the way American hospitals get their funding from Medicare (and to a degree from private insurers as well). The U.S. Medicare system pays hospitals using DRGs, Diagnosis Related Groups. Essentially, a DRG refers to a medical condition, broadly defined. The idea, when DRGs were first introduced,[14] was that for any case that fell in a particular DRG category hospitals would be paid a fee equal to the average cost of treating all cases (averaged over all degrees of severity) in that DRG grouping. Some cases would be simple ones, costing less than the DRG to treat, while others would be more costly than the DRG fee would cover, so hospitals were expected to use the excess of revenue over cost from the less complicated cases to cover the excess costs of the more severe cases. This was cross-subsidization. The idea was that, on average, within each diagnosis related group, revenues would equal costs. It never worked all that well, for two reasons - first, some hospitals just happened to get more severe case loads and so lost money on the deal, and second, some hospitals (including non-profit ones) became pretty good at screening the severity of potential cases and weighting their admissions towards the less severe cases in each DRG. More severe cases tended to wind up at the doors of government hospitals, whose funding was often not adjusted to compensate.

The complaint against the specialty hospitals is that they take the sorting process a step further, with doctors who have an ownership position in a specialty hospital and who also have admitting privileges at the local community hospital admitting the less severe cases to their own institutions and the more severe ones to the community hospitals.

As we noted, there is some evidence that specialty hospitals do admit less severe cases. This is not, however, necessarily a bad thing. The index of severity of a particular case could depend on the severity of the primary diagnosis or it could depend on the number of other, complicating health problems (co-morbidities) the patient has. A patient whose case is severe because of co-morbidities is better off in a general hospital where there is a range of specialists available for consultation.

The major complaint here is actually the financial one - community hospitals losing the potential for cross-subsidization. This is a weak complaint. Cross-subsidization is a singularly inefficient way of financing anything.[15] It has persisted in part because the American system has been slow to introduce more severity adjustments into DRGs (although that is happening now). One part of the problem has been the difficulty of classifying cases within individual DRGs into severity categories.[16] The spread of specialty hospitals makes the matching exercise easier - if it is true that specialty hospitals tend to admit less severely ill cases, the appropriate response would be for Medicare to adjust fees downward for cases admitted into specialty hospitals, and upward for cases admitted into community hospitals in areas in which specialty clinics operate.

This is an unusual criticism, to say the least - specialty hospitals are to be rejected because their care is of the same quality as that provided by existing hospitals.

It is worth remembering, though, that it is not necessarily a bad thing that specialty hospitals are taking less severe cases out of community hospitals, since this makes resources in those community hospitals available for the treatment of more severe cases, although taking full advantage of this opportunity would mean having to discard the cross-subsidization approach and designate certain hospitals as complex case units, funding them accordingly. The real problem here is not the presence of specialty hospitals, it's the singularly awkward approach the US uses to funding its hospitals. Other countries have learned that even non-profit hospitals respond to economic incentives; it's surprising that the American system hasn't taken that on board.

The other big complaint about specialty hospitals deals with the quality of the care they provide. At first, the argument was that they would provide lower quality medical care than community hospitals, but none of the reports on these hospitals support that result. More recently, critics of specialty hospitals have fallen back on complaining that the care they provide is of no higher quality than that provided by community hospitals. This is an unusual criticism, to say the least - specialty hospitals are to be rejected because their care is of the same quality as that provided by existing hospitals. But it gets stranger, because there's a twist to the argument. This is an argument which has been made by both Canadian and American opponents of specialty hospitals, but it's set out nicely in a press release from the Texas Hospital Association,[17] headed "Do doctor-owned health facilities provide better care? New Study says NO." The THA release quotes a paper by Peter Cram et. al., from the *New England Journal of Medicine*,[18] as saying that "[O]ur study provides no definitive evidence that cardiac specialty hospitals provide better or more efficient care than general hospitals with similar procedural volumes."

The Cram study has been quite widely cited by opponents of specialty hospitals, so it's worth quoting the conclusion from its abstract here: "Conclusions: The lower unadjusted mortality rate after cardiac revascularization in specialty cardiac hospitals is accounted for by their healthier patients and higher procedural volumes."

This means that the raw mortality figures for cardiac specialty hospitals are lower than those for community hospitals. What Cram et. al. did next was adjust the mortality rates for differences in complexity of cases. This is reasonable, since specialty hospitals often focus on a less complex case mix, which would tend to

reduce their mortality rate. The twist is that even after adjusting for case mix differences, specialty hospitals have lower mortality rates. Most of the remaining difference was explained by the simple fact that specialty hospitals specialize - they have lower mortality rates in those areas in which they specialize precisely because specialization tends to produce better quality outcomes.

Critics of specialty hospitals tend to interpret this as meaning that specialty hospitals aren't inherently higher quality than community hospitals, and that if community hospitals provided the same number of the same services, their mortality rates would also be lower. That, however, rather begs the question. A patient of a certain level of severity faces a lower risk of mortality if he has his procedure performed in a specialty cardiac hospital than if he has it done in a general hospital. The fact that the outcome is better because the hospital specializes isn't grounds for criticizing the hospital - the argument made by supporters of specialty hospitals is that specialization improves quality of care. It does so at Shouldice and it turns out that it also does so in cardiac specialty hospitals. It's easy enough to say that community hospitals could reduce their risk-adjusted mortality rates to the levels shown by specialty hospitals if they performed more of certain types of procedures, but people who want to make that argument have a responsibility to explain why those community hospitals haven't already done it.

It's also sometimes said that private surgical hospitals do not, in fact, have lower costs per case than general hospitals. This is quite probably true, if only because those hospitals tend to have higher nurse-patient ratios than have most community hospitals (the CMS report cited numbers like 3 to 4 patients per nurse as compared with 10 to 12 in community hospitals). That's part of the reason specialty hospitals tend to do well in patient satisfaction surveys like the one described in the CMS report. If specialty hospitals can produce higher satisfaction and better patient outcomes (even if only as a result of specialization) while being paid standard Medicare and private insurance rates the argument against them seems weak.

One more apparently major criticism often aimed at specialty hospitals in the US is that they don't have emergency departments. That's a misleading statement - orthopaedic specialty hospitals generally don't have ERs, but the majority of cardiac surgery hospitals do, and cardiac specialty hospitals tend to be well-staffed round the clock. On reflection, it really wouldn't make a lot of sense for an orthopaedic hospital, whose staff was highly specialized in a limited number of areas of medicine, to try and run a general emergency facility.[19] It actually would make much more sense to fund certain facilities to supply general emergency services than to tack them onto whatever facility happened to be around.

In fact, while many of the American criticisms of specialty hospitals are imported directly into Canadian debate, for the most part the problems arise not from the existence of the specialty hospitals but from the peculiarly inefficient way the Americans fund their system. To take one simple example, the argument about private hospitals doing damage to the financial position of general hospitals by siphoning away low cost cases has no force in a system where general hospitals are paid block budgets. Removing simple cases from general hospitals frees up budget resources to be devoted to the treatment of more complicated cases. Cross-subsidisation is an American issue, not a Canadian one.

Of course, non-Shouldice specialty hospitals aren't a uniquely American phenomenon. The Coxa hospital[20] in Finland is reported[21] to have had tremendous success in improving the quality of joint surgery. Coxa is partly owned by the local hospital district, but is also partly owned by a German private hospital company and is expected to operate on a commercial basis. And Australia's large private hospital sector tends to specialize in surgical procedures. In most countries, in fact, specialty hospitals are becoming important, if small, parts of the health care system, and in none of those countries which have well-managed publicly funded systems are they doing any damage to those systems. Their growth may be forcing the people managing some parts of the system to change their ways, but that's not automatically a bad thing.

The idea that private specialty hospitals would be a threat to the Canadian health care system simply doesn't hold up when you go beyond ideology and look at the international evidence.

The idea that private specialty hospitals would be a threat to the Canadian health care system simply doesn't hold up when you go beyond ideology and look at the international evidence. Integrating them into the system wouldn't necessarily be without hitches, but there's so much evidence from the rest of the world as to how they can fit that Canada is in a good position to learn from the experience of others.

The advantages of allowing private clinics (hospitals or ambulatory surgical clinics) are many. They're highly efficient, by dint of their ability to specialize, and while it's often said that they'll draw physicians and nurses away from general hospitals, they'll also draw patients away, and, if they are permitted to take full advantage of the efficiencies which come from specialization, the increased productivity will amount to a more than proportional increase in surgical capacity. If there are adjustment problems for community hospitals, the answer is not to ban specialty hospitals and lose the benefits of specialization, it is to recognize that general hospitals will increasingly be the places where more complicated treatments are concentrated, and to fund and equip them accordingly.

Specialty hospitals don't have to be private hospitals, of course. Provincial governments could perfectly well establish specialty units, and some are apparently moving in that direction. Very slowly. When critics of private specialty hospitals make the point that government could establish specialty hospitals which could be every bit as efficient as private ones, the obvious question is, why haven't they already done it?

This brings us to another of the advantages of permitting specialty hospitals to enter at will, rather than when government decides to establish them - they bring start-up financing with them. No group, even a non-profit doctors group, will be able to get private financing to start up a clinic in a region where the demand does not warrant it, but if the demand is there, private funds will support the start-up. As it stands, publicly funded clinics would come into being only if their capital costs could be fit into this year's government's capital budget. Private clinics, paid out of Medicare and workers compensation fees, would, if they were established in areas which could be shown to be underserved in certain regards (orthopaedic surgical clinics being the best example at the moment), bring in the start-up capital funding and pay it off over time out of fees from the public health care system. That, of course, is exactly the way a new GP operates when he sets up practice in a new area - he borrows from the bank to set up his practice and pays the loan off out of his medicare revenues. Multi-specialty group practices are all the rage, at least as a theoretical concept, among health planners - presumably those practices are going

to have some treatment facilities on site (otherwise they become no more than doctors' office buildings), and presumably they will be expected to achieve some efficiencies. Allowing such groups, whether multi- or single specialty to go to the banking sector for their capital funding just makes it easier for them to be established.

Contrary to the "sky will fall" claims of some critics, specialty surgical hospitals (or women's hospitals or whatever) will never threaten the publicly funded system, if only because their numbers will never be that large. They will only arise in specializations where there are efficiencies to be realized (the degree to which increased volume improves quality varies across procedures) and in which there is sufficient unmet demand that physician time is being used inefficiently in the current hospital system. They will not result in poorer quality care, judging from the international experience, and in any event can be monitored as carefully as any general hospital - more carefully, in fact, since the range of services they will be producing will be less, and therefore easier to assess. And they will never be the profit mills some of their critics claim if only because their owners will have to pay the full labour and capital costs of any procedures performed there, whereas in the public system as it stands, all of those inputs are provided free courtesy of the public purse. It's difficult to argue that private clinics will be more profitable when setting one up requires agreeing to pay out of the clinic's revenues all of the costs which are paid for by the public in community hospitals.

In short, specialty hospitals will be established where (in both the geographic and medical sense) there is significant unmet demand, where there are people willing to put up the start-up capital, where the efficiencies to be gained from specialization (and from avoiding the diseconomies of scale which appear when a community hospital gets past a certain size and takes on some of the aspects of a badly run zoo) are large enough to outweigh the need to pay nurses out of the clinic's revenues, and where doctors are sufficiently frustrated by the inefficient way their own time is used in general hospitals that they're willing to run their own surgical facilities.

On the whole, if all of those conditions are satisfied, there seems no basis for opposing specialty hospitals other than pure ideological stubbornness.

Endnotes

[1] Ontario mulls private knee operations One-stop shopping proposal under review LISA PRIEST on line at http://www.theglobeandmail.com/servlet/story/LAC.20070315.PRIVATE15/TPStory/specialScienceandHealth

[2] Smitherman won't outsource knee operations LISA PRIEST on line at http://www.theglobeandmail.com/servlet/story/RTGAM.20070316.wxknees16/BNStory/specialScienceandHealth/home

3.Private clinic operation 'no secret', says Layton CBC News Thu, 12 Jan 2006 21:04:26 EST http://www.cbc.ca/story/news/national/2006/01/12/layton-surgery060112.html

[4] Shouldice was grandfathered under Ontario's Private Hospital Act, allowing it to continue to function as a for-profit institution under Medicare. According to the Globe piece cited above, two other hospitals were also grandfathered, one of which was the Don Mills Surgical Unit, which the Minister of Health decided not to use to help reduce Ontario's wait times

[5] Government of Alberta, Dec. 20, 2005, Wait times reduced for knee and hip replacements http://www.gov.ab.ca/home/index.cfm?Page=1306

[6] MedPAC's home page can be found at http://www.medpac.gov/ . The cited report is Report to the Congress: Physician-Owned Specialty Hospitals March 2005 http://www.medpac.gov/publications/congressional_reports/Mar05_SpecHospitals.pdf

[7] The GAO's home page can be found at http://www.gao.gov/ . The cited reports are Specialty Hospitals: Information on National Market Share, Physicians Ownership and Patients Served, (2003) http://www.gao.gov/new.items/d03683r.pdf and Specialty Hospitals: Geographic Locations, Services Provided and Financial Performance (2003) http://www.gao.gov/new.items/d04167.pdf

[8] Stuart Guterman (2006): "Specialty Hospitals: A Problem Or A Symptom?" Health Affairs, 25, no. 1 (2006): 95-105

[9] Centers for Medicare and Medicaid Services (n.d.) Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement and Modernization act of 2003 on-line at http://www.cms.hhs.gov/reports/downloads/RTCPhysSpecHosp.pdf

[10] Mark Miller, Physician-owned specialty hospitals, Testimony before the Subcommittee on Federal Financial Management, Government Information and International Security, Committee on Homeland Security and Government Affairs, U.S. Senate, May 24, 2005

[11] The Sunday Times, for example, on October 23, 2005 ran a piece entitled: "'French factory' surgeon cuts NHS queues", available at http://www.timesonline.co.uk/article/0,,2087-1838871,00.html

[12] For one summary of some of the most commonly raised criticisms, see Laura A. Dummit (2005): Specialty Hospitals: Can General Hospitals Compete? Issue Brief No. 804, July 13, National Health Policy Forum, the George Washington University, on line at http://www.nhpf.org/pdfs_ib/IB804_SpHospitals_07-13-05.pdf . Another good general discussion of concerns about the role and nature of specialty hospitals can be found in Improving Health care: a Dose of Competition US Department of Justice and Federal Trade Commission, July 2004, on line at http://www.usdoj.gov/atr/public/health_care/204694.htm

[13] The argument relates to cross-subsidization, which isn't possible in a system where hospitals are given global budgets.

[14] Prior to the introduction of the DRG system, Medicare, and private insurers, basically paid whatever individual hospitals chose to bill them. That was, understandably, a major reason US health care costs rose inexorably over the years. In the pre-DRG era, running a non-profit teaching hospital could be an extremely lucrative business. Other countries, notably Australia, are making use of the DRG system, which essentially puts part of a hospital's funding on a fee-for-service footing, but in designing their own systems have learned from the mistakes made in the early years of the US DRG system.

[15] The need to use long distance rates to cross-subsidize local phone service was, for a long time, the argument against admitting competition into the long distance telephone market.

[16] Software is now available to do this, and as severity categories are introduced into DRGs, hospitals are using the software to ensure that they classify cases in a Medicare-revenue maximizing manner. This is part of the explanation for what is known as DRG creep.

[17] THA Hospital Health Bulletin Issue #3, undated.
http://www.thaonline.org/PressRoom/Bulletin3.pdf

[18] Cram, Peter; Rosenthal, Gary E.; Vaugh-Sarrazin, Mary S. (2005): "Cardiac Revascularization in Specialty and General Hospitals" New England Journal of Medicine 352(14), 7 April, 1454-1462

[19] Apparently all that would actually be required in some areas for a hospital to be classified as having an ER would be for it to have a single treatment bay and a single bed.

[20] http://www.coxa.fi/englanniksi.html

[21] See the Health Affairs article by David Shactman (Vol. 24 No. 3, 2005) "Specialty Hospitals, Ambulatory Surgical Centers and General Hospitals: Charting a Wise Public Policy Course" on-line at http://content.healthaffairs.org/cgi/content/full/24/3/868 , and the detailed proceedings of the Sept 2004 Fall Conference of the Council on Health care Economics and Policy of the same title, on-line at http://council.brandeis.edu/pubs/Specialty%20Hospitals/Sept10CONFNUM.pdf

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