AAOS American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Position Statement

Specialty Hospitals

This Position Statement was developed as an educational tool based on the opinion of the authors. It is not a product of a systematic review. Readers are encouraged to consider the information presented and reach their own conclusions.

Introduction

Adoption of lean production, flexible specialization, and focused factories in U.S. industry in the latter half of the 20th century led to many business establishments becoming less diverse and more specialized. The U.S. hospital industry appears to be following a similar path, evident in the growth of free-standing ambulatory surgery centers, specialty hospitals, and specialized units within general hospitals.[1]

Specialty hospitals offer focused services to treat medical conditions that require a particular subset of skills and technology. Specialty hospitals are not a new phenomenon. They have existed in various forms for many years as children's hospitals, psychiatric hospitals, rehabilitation hospitals, eye and ear hospitals, arthritis hospitals, and others. More recently, specialty hospitals have begun focusing on cardiovascular surgery, orthopaedic surgery, general surgery, and women's health.

Specialty Hospitals (SH) versus General Hospitals (GH)

Proponents of SH argue that these organizations can set a new competitive benchmark for hospital services by taking advantage of the associated economies of scale and scope, potentially lowering the cost of health care and possibly enhancing the quality of care by concentrating the expertise associated with increased specialization augmenting patient choices.[2]

Opponents of SH claim that physician ownership presents a potential conflict of interest and engenders unfair competition by targeting patient referrals, offering services that encourage over-utilization, focusing on the most profitable patients and limiting the ability of full-service community hospitals to cross-subsidize unprofitable services.

Demand for specialized inpatient and outpatient services has been growing. Analogous to non-health care industries, the hospital industry has been the subject of renewed emphasis on quality of care and consumer satisfaction and in response, both general and specialized hospitals alike have developed consumer-oriented centers of care.[1] From the perspective of the insured consumer in situations where choice is feasible (elective care), observable amenities like larger private rooms, more convenient locations, and higher nurse-to-patient ratios, perceptions of higher quality are likely to attract consumers.

The health care system in the United States has been dominated by general not-for-profit (NFP) hospitals.[3] NFP hospitals benefit from property, sales, and income tax exemptions, low-interest-rate bond financing, and other financial advantages. Questions have arisen regarding whether for-profit SH and GH and ambulatory surgical centers (ASC) hinder the NFP hospital's ability to subsidize unprofitable hospital services and to provide uncompensated care. It has been argued that for-profit hospitals positively affect society through taxes they pay and the beneficial aspects of the competition they provide to NFP.[4]

The Federal Trade Commission (FTC) has stated that competition in health care results in increased quality. Preliminary studies from the Medicare Payment Advisory Commission (MedPAC) on the financial and other effects of SH on local community GH note little financial impact. Independent research has shown that SH have a minimal impact on the operations and financial performance of GH and a minimal impact on Medicare expenditures in the areas with SH.[1, 5, 6]

MedPAC data also indicate that community GH remain profitable despite the competition from SH. The MedPAC preliminary report found that the competition from SH prompts positive changes in community GH in-patient services, such as extending patient hours, improving scheduling, and upgrading equipment.[7]

A recent study commissioned by the Centers for Medicare and Medicaid Services (CMS) found that SH exhibited higher levels of patient satisfaction compared with GH in the same market.[8] SH report nurse-to-patient ratios higher than the national average which managers believed to be critical to achieving high-quality patient outcomes. In a comparative cost analysis of SH versus GH, SH were found to have significantly higher levels of cost inefficiency than their GH competitors.[9] In a systematic review of the effects of physician-owned SH, it was concluded that there was no compelling evidence demonstrating the added value in terms of quality or cost of the delivered care.[10] In fact, orthopaedic SH costs have been shown to be 20 to 30% higher than GH.[11]

Safety advantages in favor of SH supported the volume-safety relationships (treating higher volumes of cases can improve safety of care), but these relationships disappeared when the outcomes were adjusted for patient characteristics and procedural volume (effect explained by advantageous patient characteristics and larger procedural volumes).[10]

Specialty hospitals have an important role for treating patients who need musculoskeletal care offering high quality care and safety and enhancing access. These facilities complement other sites of patient care, including acute care hospitals, academic medical centers, and ASCs. Further, SH are well-positioned to meet the CMS definition of a Center of Excellence (COE) as an important high-quality and cost- effective site for patient care.

The efficiencies of SH are likely attainable by either SH or specialized service units within GH. It has not been shown that SH enjoy a comparative advantage over GH in capturing these efficiencies.

Physician Ownership

Approximately 70% of SH have at least some level of physician ownership. In 2008, there were approximately 175 physician-owned SHs across the country, representing 4% of all hospitals.[12]

Most of these facilities are located in states without certificate-of-need programs, which restrict market entry by regulating the construction and augmentation of health care facilities.

Physicians' knowledge of their particular specialty can provide valuable guidance to enhance the patient experience and improve outcomes. The most significant criticism of SH is that physician ownership may lead to an overuse of services, which increases health care costs. As owners of the hospital, the concern is that physicians may have financial incentives to "induce demand" for services to the patient. A study that examined the effects of the entry of physician-owned SH on the treatment of back/spine disorders found substantial increases in the market utilization rates for outpatient epidurals, MRIs, and physical therapy as well as inpatient complex spine surgery on Medicare beneficiaries.[13] (ref JMM 2007) During the same time period, these changes were not observed in regions without physician-owned SH. In another study, physician owners were 129% more likely to perform carpal tunnel release and 76% more likely to perform rotator cuff repairs on a similar patient population than were non-owners.[14] (ref JMM 2010) Although it cannot be concluded this represents inappropriate treatment, the findings warrant further study and prospective monitoring.

The value of physician leadership and collaboration in hospital design, management, and operations to improve quality and efficiency needs to be recognized, but equally as important is the recognition of financial conflict of interest when SH are physician-owned. Physicians must take an active role in the leadership of both SH and GH. Physician-owners should be required to disclose ownership and oversight should be provided to ensure ethical conduct.

The American Association of Orthopaedic Surgeons (AAOS) supports the rights of all patients to receive safe, high-quality, and efficient care in the facility that best addresses the patient's needs. The AAOS also supports the development of specialty care hospitals that provide a valuable role by promoting decentralization of the health care industry which, through competition, can lead to improved care and lowered costs. Several ownership models exist, and the AAOS supports physician and non-physician investment in facilities that deliver high-quality and cost-effective health care.

The AAOS believes the provision of services to the patient should not be based on provider financial incentives and that physicians should always prioritize the needs of patients when determining at which facility care is provided. The AAOS recommends that physicians should divulge to a patient any ownership interest in health care facilities, including specialty hospitals. The patient should be fully informed of his/her choices and be allowed to make the final determination as to where to receive diagnostic testing and care The AAOS maintains that physicians with ownership interests in health care facilities should continue to adhere to the highest standards of quality and appropriateness of care without overutilization for financial gain.

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