# Ethics should drive health policy reform, especially with physician-owned specialty hospitals

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The ethical principles that have for centuries shaped the relationship between patient and physician should also guide legislators, regulators -- and justices of the highest court -- charged with crafting U.S. health care policies that demarcate the boundaries of a physician's business practice, an Indiana University professor argues.

This is all the more pressing with the "creeping commercialization" that now characterizes medicine in the form of physician-owned specialty hospitals, according to an analysis published in the June issue of the *American Business Law Journal*.

Some of the clearest examples of these ethical considerations are the reforms to the physician-owned specialty-hospital industry enacted in the Patient Protection and Affordable Care Act, argues legal scholar and ethicist Joshua Perry, assistant professor of business law and ethics at the IU Kelley School of Business.

Perry argues the PPACA legislation could have gone further and completely banned physician-owned hospitals. Short of that, his article provides justification for the aggressive regulation of physician-owned hospitals contained in the PPACA.

"Ethics are the bedrock of health care, the root of total trust between physician and patient and what makes health care unique among

economic enterprises," Perry said. "But rising tides of commercialization have eroded longstanding, ethics-based self-regulation and internal constraints. As systemic complexities related to cost, quality and access are debated, ethics deserve a seat at the table where policies are being argued."

The PPACA legislation prohibits new or expanded physician-owned specialty hospitals from filing Medicare claims if a financial relationship exists between the referring physician and the hospital receiving the government reimbursement, among other regulations designed to promote transparency, fair competition and patient safety. However, no such restrictions were placed on existing entities, allowing for a gradual exploitation of a legislative loophole.

"A more prudent, ethically driven course would have been complete closure of existing loopholes that gave rise to physician-owned facilities and the retroactive removal of Medicare certification from those currently operating," Perry said.

Physician-owned specialty hospitals are either partially or fully owned by physician-investors, with services limited to cardiac, orthopedic or other surgical procedures.

Limiting practices to services deemed "high-profit" has led to successful medical businesses, providing tens of thousands of jobs, millions of dollars in state and federal tax revenues (which nonprofit hospitals do not pay) and hundreds of millions of dollars in cumulative payroll, according to Perry's research. Physician-owned specialty hospitals tripled between 1990 and 2003 to approximately 265 currently in operation.

However, Perry found that specialty hospitals treat a lower percentage of severely ill patients than general hospitals, suggesting that physician-

owned specialty centers "either intentionally skim the cream off the top of the patient population or limit treatment to the healthiest and least costly patients."

At the same time, due to staffing levels, employee compensation and the use of single-occupancy rooms, physician-owned facilities have higher costs than general hospitals and result in higher utilization rates and greater requests for Medicare reimbursement.

Still, Perry observed that for physician owners whose personal incomes have declined over the past decade, these investments offer an environment where they can practice what they love while controlling decisions about patient care and earning opportunities -- without interference.

"One could conclude that the emergence of physician-owned specialty hospitals is directly linked to disagreements among health care providers, administrators and government bureaucrats, all of whom have failed to recognize the necessity of an interconnected health care community," Perry said.

For more than a decade, arguments for a free and largely unregulated market for health care have proliferated. But an unregulated market in medicine fails to address issues of relational trust and patient vulnerability, according to Perry, and neglects to resolve social inequities that arise when unfettered health care markets fail to provide access to the uninsured or under-insured.

Some measure of government regulation becomes essential, Perry said -- and such governmental interference must be informed by ethical principles.

"If the health care market were left to operate solely based on principles

of profit maximization, many physicians -- trained at government expense and subsidized by Medicare or Medicaid programs -- would have little incentive beyond a commitment to professional or moral duty to treat those who are often the sickest and without private payment sources," Perry said.

With the Supreme Court ruling expected shortly on the PPACA, Perry urges the justices to consider the ethical dynamics of the PPACA law and the consequences that result when the health care business becomes more about business and less about care.

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