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Introduction by Annals of Health Law[*]

I. INTRODUCTION

David L. Woodrum holds a Masters of Business Administration with a major in Health Care Administration from the George Washington University in Washington, D.C. He is a partner in Woodrum/Ambulatory Systems Development LLC, a national ambulatory surgery and ambulatory care company, as well as a partner and Chairman of the Board of ReSurge Hospitals, a specialty hospital company. He is also President of Woodrum, Inc., a national hospital turn-around and transitional management company.

Mr. Woodrum has served as a health systems administrator and has extensive experience in the planning, management, and marketing of ambulatory surgery centers, free-standing ambulatory projects such as cardiac catheterization laboratories, urgent care centers, free-standing emergency centers, and imaging and oncology centers. He has served as president of hospitals in West Virginia, Texas, and Saudi Arabia, as Corporate Secretary of the National Resident Matching Program, and as a chairman officer of health care organizations. Mr. Woodrum is a diplomat in health care administration and a certified healthcare consultant. He writes and speaks extensively on a broad spectrum of health care administration, management, and revitalization issues.

This introduction expands upon Mr. Woodrum's presentation at Loyola University Chicago School of Law's Annual Health Law and Policy Colloquium, where he discussed the impact of rising health care costs from the perspective of hospital administration and also discussed the collaborative responses to these increases by doctors and hospitals.

II. OVERVIEW

Health care costs have risen substantially over the past decade and

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continue to climb annually.[1] Estimated health care costs for 2005 exceed $1.9 trillion, a 48% increase over the $1.3 trillion spent in 2000.[2] These costs are nearly 4.3 times higher than our national defense spending[3] and have been rising at least 50% faster than the rate of inflation.[4] Further, inpatient hospital costs have increased almost 50% in the last decade,[5] illustrating a need to apply cost containment strategies in hospitals themselves. Despite the fact that the onset of managed care has tamed some of these high costs of care, hospitals are, generally, not-for-profit and service-focused.[6]

Mr. Woodrum addresses three strategies for cost containment from his perspective as a hospital administrator. First, hospitals can reduce costs through continuous, incremental changes while still keeping up with technological advancement and standardizing their practices. Second, hospitals and doctors can diversify their revenue by staking joint ventures and trying new systems. Finally, health care providers can increase efficiency using the same resources. For example, some health care costs have been alleviated with the advent of specialty hospitals, imaging centers, and ambulatory care facilities.

III. COST CONTAINMENT THROUGH STANDARDIZATION

Part of the increase in health care costs is a result of the increase in new, innovative drugs, many of which prevent the need for expensive medical procedures requiring surgery and an inpatient stay.[7] This has led to a reduction in traditional, acute care hospitals - with more than 1200 having closed in the twenty year period between 1980 and 2000.[8] Such dramatic reductions were further exacerbated by the competition of managed care organizations - HMOs and PPOs - which resulted in more than 700 hospitals closing their doors between 1986 and 1996.[9] Many hospitals

1. CALIFORNIA HEALTHCARE FOUNDATION, SNAPSHOT: HEALTHCARE COSTS 101, at 2 (2005), http://www.chcf.org/documents/insurance/HCCosts10105.pdf.

2. *Id.*

3. *Id.*

4. Brief for the State of Ohio as Amicus Curiae Supporting Petitioners, Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982) (No. 80-419), 1981 WL 390408.

5. Fred Hyde, *The Hidden World of Health Care: Organization, Structure, and Function of the American Health Care Delivery System: What Trial Lawyers Should Know*, 401 ATLA-CLE (2002).

6. *Id.*

7. *Id.*.

8. *Id.*

9. Leonard A. Hagen, *Physician Credentialing: Economic Criteria Compete with the Hippocratic Oath*, 31 GONZ. L. REV. 427, 445 (1995/1996).

continue to experience serious financial hardship.[10] Hospitals cannot withstand increased expansions without corresponding increases in revenue.[11] Philanthropy is often the only way to acquire new technology, build or expand facilities, or even offset operating deficits.[12] Standardization of physician and hospital rates may have some impact on this, with capitation being "the latest . . . cost-effectiveness technique for improving health care delivery."[13]

Capitation is defined as a predetermined per-patient flat fee paid by a health care plan to a physician without regard to the true cost of the services provided.[14] Because the provider bears the risk for costs that exceed the capitated amount, this incentive structure ensures that providers deliver health care more efficiently, since providers will be more likely to focus on cost-effectiveness when recommending treatment.[15] In addition, capitation is lauded by both providers and managed care organizations because physicians can prescribe treatment without feeling the yoke of budget micromanagement yet can still retain control over their own finances and medical decisions by determining which course of treatment is most cost-effective.[16] Further, insurers no longer manage provider decisions because treatment determinations are now wholly in the hands of the physicians themselves.[17] While capitation seems to be testing successfully among some large HMOs, such as Kaiser Permanente, there still remains the question of what the capitated payment should be to ensure that both cost and quality are in line.[18]

IV. JOINT VENTURES BETWEEN PHYSICIANS AND HOSPITALS

One way to increase collaboration across the medical community is through business partnerships between physicians and non-hospital facilities. This can include laboratories, surgery centers, outpatient centers, and even durable medical equipment companies.[19] Usually, the physician

10. Hyde, *supra* note 5.

11. *Id.*.

12. *Id.*

13. Frances H. Miller, *Capitation & Physician Autonomy. Master of the Universe or Just Another Prisoner's Dilemma? What Can Britain's National Health Service Experience Teach Us?* 6 HEALTH MATRIX 89, 90 (Winter 1996).

14. Hagen, *supra* note 9, at 443.

15. Miller, *supra* note 13, at 90.

16. *Id.* at 91.

17. *Id.*

18. *Id.* at 92-93.

19. Theodore N. McDowell, Jr., *Physician Self Referral Arrangements: Legitimate Business or Unethical "Entrepreneurialism"*, 15 AM. J. L. & MED. 61, 62 (1989).

owns stock or a partnership interest in a corporation or is a partner in a health care facility.[20] These agreements now include limited partnerships, where the physician has equity in the facility but has limited personal liability.[21]

The benefits to such arrangements include:

> The main reason for such ventures is that physicians largely control access to medical services, and can bring medical expertise to the joint venture.[22] There is some concern about physician self-referrals, which can lead to overutilization and ethical conflicts of interests.[23]

However, the benefits of a collaborative venture between physicians and hospitals can outweigh these concerns. Quality of care is improved because physicians are more likely to permanently commit to a facility when they have a financial stake in the venture.[24] Also, these co-ventures are often a result of specific responses to the health care needs of their communities, such as increasing access to health care in underserved areas.[25] Further, prohibiting physicians from entering these kinds of ventures means that an entire market is left untapped, the market that is most knowledgeable about the medical field.[26] Finally, physicians bring with them their experience in the field and their personal interest in keeping administrative costs low, thereby reducing overall costs.[27]

V. EFFICIENCY IN SPECIALTY HOSPITALS

Market pressure to reduce health care costs has resulted in creativity on the part of both hospitals and doctors.[28] In addition to joint ventures between physicians and hospitals, Mr. Woodrum discusses alternative integrated health care systems, such as imaging centers, ambulatory care, and other specialty hospitals and surgery centers. Gatekeeping, which requires patients to receive approval from their managed care plan before visiting specialists in hospitals, has led to an increase in the utilization of both primary care physicians for treatment and outpatient settings.[29] Due to

20. *Id.*
21. *Id.* at 63.
22. *Id.*
23. *Id.* at 65.
24. McDowell, *supra* note 19, at 71.
25. *Id.* at 72.
26. *Id.*
27. *Id.* at 72-73.
28. Hagen, *supra* note 9, at 429.
29. William M. Sage & James M. Jorling, *Vital Issues in National Health Care Reform: A World that Won't Stand Still: Enterprise Liability by Private Contract*, 43 DEPAUL L. REV.

new and innovative technology, ambulatory clinics and surgery centers are now able to offer procedures that were once available only in traditional hospital settings.[30] Improvements in information and medical technology have also forced hospitals to make significant overhauls,[31] but these may be easier to bear in smaller, newer clinics and ambulatory care units. As many hospitals cannot finance these expensive but necessary changes, more hospitals may be forced to close.[32]

VI. CONCLUSION

Health care in the United States is "the most costly in the developed world."[33] Considerable public and private debate focuses on how to improve quality and access to care, without sacrificing efficiency, and yet still taming rising costs. However, the impact that hospitals can make on rising health care costs is great. Mr. Woodrum illustrates the need for a collaborative effort between hospitals, physicians, and communities, which will continue to bring superior health care to Americans while reigning in costs.

1007, 1014 (Summer 1994).

30. Thomas R. Prince, *Information Technology and Hospital Closures,* 8 AM. BANKR. INST. L. REV. 115, 123 (Spring 2000).

31. *Id.*

32. *Id.*

33. Scott D. Litman, *Health Care Reform for the Twenty-First Century: The Need for a Federal and State Partnership,* 7 CORNELL J. L. & PUB. POL'Y 871, 873 (Spring 1998).