

Specialization and its Discontents

Professor Regina E. Herzlinger
Harvard Business School

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Americans enjoy the highest per capita GDP among large nations mainly because we have the highest rate of productivity gains^{1 2}. But, the U.S. Congress threatens to strangle an innovation that holds great promise for productivity gains in health care, with extension of the ban it imposed on specialty hospitals in the 2003 Medicare Prescription Drug Act. Congress felt that physician-owned specialty hospitals cherry-picked the most profitable procedures and induced over-utilization of hospital services.

The Congress could not have picked a worse cause. Our health care costs, at 14.9% of GDP, highest in the world, create major competitiveness problems, as does their rate of growth³. General Motors' financial woes were exacerbated by health care costs of \$1,500 per car that exceed that of steel. Hospitals are not only the largest component of health care costs but also the major reason for their growth⁴. The hospital sector sorely needs managerial innovations like specialty hospitals.

The Congressional moratorium is based on faulty diagnoses: specialty hospitals *do not* cause hospitals to lose their most profitable areas and physician ownership *does*

not induce overuse. Rather, these real problems are caused by the third-party payers for U.S. health care, the insurers and governments. They distort prices, so that some services are artificially profitable and others artificially low, and insulate users from costs, so they have no financial incentive to curb over-consumption.

The solution? Permit health service providers to quote the prices they want to charge. In a consumer-driven insurance system, users will choose those providers who give them the best value for the money. The resulting competition between all types of hospitals, including specialty hospitals, cannot help but control our health care costs.

Specialization in the U.S. Economy

Specialization is key for productivity growth elsewhere in the U.S. economy.

Consider the steel industry, for example, which Ken Iverson, a technology entrepreneur, almost single-handedly revived. Nucor, the steel-focused factory Iverson managed, differed from the everything-for-everybody steel behemoths of yore, like Bethlehem Steel, with its specialty steel products and relatively small mini-mills, as did his egalitarian, productivity-based management practices. Nucor paid its nonunionized

workers like owners, primarily with productivity-based incentives. In contrast, Bethlehem Steel's unionized workforce was paid wages, largely regardless of their productivity.

The results of focus and ownership? Nucor required 1 man-hour per ton of steel and Bethlehem 2.7; Nucor's workers earned \$60,000 (\$40,000 from bonuses), and Bethlehem's \$50,000; and Nucor was highly profitable, earning \$100 million in recessionary 2002, whereas Bethlehem lost \$2 billion.⁵

Nucor did good for its customers, employees, and the U.S. economy, and it did well for its shareholders, including Ken Iverson.

Sadly, were Iverson a doctor, he could not create the "do good—do well" health care-focused factory equivalent of Nucor.⁶ Rival everything-for-everybody hospitals would allege that he was robbing them of their most profitable business, leaving them with the money-losing dregs, while federal government regulations would inhibit his ownership.

Negative press and legislative prohibitions create daunting obstacles for productivity-minded entrepreneurial physicians. For example, MedCath, a partially

physician-owned heart hospital firm, spends up to \$200,000 to counter such complaints per project per year.⁷

Specialization in Health Care

Specialized health care facilities, partially owned by entrepreneurial physicians, present hope for a higher-quality and higher-productivity health care system. The specialization integrates care that consumers must now struggle to obtain from a system organized by separate providers, while ownership provides important additional incentives for physicians to provide the best value for the money.

Indeed, when it comes to specialization, the question is not whether to specialize but rather how to do it. Everyone agrees that the health care system should provide focused, integrated care—especially for the victims of chronic diseases and disability who account for 80% of costs.⁸ For example, Duke Medical Center's integrated, supportive program for congestive heart failure causes annual treatment costs declines of \$9,000, nearly 40%. Duke achieved these cost reductions by improving participants' health status—their hospital admission and lengths of stay dropped—and not by restricting access to needed care—visits to cardiologists increased nearly 6-fold.^{9,10}

The productivity impact of specialist-initiated and/or -owned programs is compelling, although sparse. For example, Dr. Denton Cooley's price for coronary artery bypass surgery at his focused Texas Heart Institute center was approximately 40% lower than the national average with a case mix whose severity was at least equal to the average.^{11,12} The reason is clear-cut: specialist physicians can readily understand other physicians' needs. Notes the CEO of an orthopaedic surgery practice: "Orthopaedists . . . in a hospital . . . work in the same operating room [as] general surgery and obstetrics. Orthopaedics is nuts-and-bolts equipment intensive. It drives them crazy to have a staff that's not familiar with a tray of multisize screws and nuts and bolts."¹³

Physician Ownership of Specialized Facilities

The paradigm for specialization currently favored, top-down care management, is typically initiated by insurers.^{14,15} Yet, the positive connection between corporate ownership and performance is a bulwark of our economy. Noted Adam Smith in 1776,

“The directors of . . . [joint-stock] companies, . . . being the managers rather of other people’s money than of their own, it cannot well be expected, that they should watch over it with the same anxious vigilance with which the partners in a private copartnery frequently watch over their own. Negligence and profusion, therefore, must always prevail, . . . in the management of the affairs of such a company.”¹⁶

Our robust economy provides compelling evidence of the positive relationship between ownership and productivity. The economy’s productivity growth bests that of all but smaller, newly developing economies, such as Ireland and Hungary—a result akin to a mature elephant’s outrunning a young cheetah.¹⁷ Small businesses, created by owner-entrepreneurs, are key: they are highly productive—some becoming titans such as Microsoft, Wal*Mart, or Dell because owners are motivated to create the balance between quality and efficiency that will increase their market share and profits through satisfied repeat customers.

The ambulatory surgery center (ASC) sector illustrates the importance of physician ownership. Two Phoenix, Arizona, physicians opened the first ASC in 1970, despite the unwillingness of insurers to pay for its services. Notes one government

analysis: “Physician investment of ASCs was . . . important . . . since many hospitals were reluctant to open or invest in ASCs that competed with their own outpatient and inpatient surgery departments.”¹⁸

Currently, approximately 90% of ASCs are owned and operated by physicians¹⁹ Most companies active in the development and operation of ASCs seek at least 49% physician ownership not only for the physicians’ capital but also for their entrepreneurial ideas about how to improve health care quality and costs. Small wonder that one analysis found that physician compensation based on net revenues—i.e. when physicians were paid like owners—was associated with lower costs whereas salary-based compensation was linked to higher costs.²⁰

Health Care Specialization and Its Discontents

Nevertheless, the objections raised to specialized, physician-owned systems of care are valid. For example, because cardiology accounts for 35% or more of a community hospital’s revenues, its absence will likely significantly damage the hospital’s financial status.²¹ Similarly, the overuse that characterized physician-owned imaging laboratories and physical therapy facilities appears genuine.²²

Yet, although the complaints are valid, the diagnoses of the causes and the resultant cures are misplaced. These problems occur because of the structure of our third-party health care system and not because of the existence of physician-owned specialty hospitals.

To sharpen these points, let us return to the steel industry analogy: why did integrated steel manufacturers not complain that Nucor was cherry-picking or act to restrict Iverson's ownership interests?

They could not complain that Nucor was stripping out their most profitable products because market-based steel pricing makes it impossible for firms to succeed simply because the price is excessively high: When prices are so high that existing firms earn excessive profits, new entrants cut them to gain market share. In a free market, suppliers succeed because they are productive, not because a third party technocrat has mistakenly set their prices too high. Similarly, steel buyers do not complain that manufacturers are foisting off unneeded steel on them. Because they pay directly for the product, they buy only what they need.

In contrast, in health care, some services are highly profitable primarily because the third-party payers that unilaterally set prices have reimbursed them at wrongly generous rates while other services lose money because prices are set too low. Further, because third-party insurers insulate users from the costs of their care, they are susceptible to over-utilization. When users pay, they are more sensitive to the value for the money. One careful analysis revealed a 16% decrease in volume for a 10% price increase in consumers' payment for health insurance. (Patients were also sensitive to quality measures. Providers who appeared to skimp on quality to control costs lost volume.²³)

Innovation, not Regulation

The solution for controlling the monumental costs of our health care system is to encourage entrepreneurial innovators, not to bind them in regulatory straightjackets.

Both the hospitals' and economy's problems could be solved if we allow the *market* to set prices and strip insurance bureaucrats of this power. It is not that they are incompetent or venal but rather that they are incapable of simulating market prices. As a result, they make costly errors. For example, a 2003 analysis showed that overly

generous prices for procedures in hospital-based outpatient departments cost \$1 billion more than the prices for the same procedures in free-standing surgery centers.²⁴

Similarly, the best way to achieve user sensitivity to the cost of services is to switch to a consumer-driven system in which users select from a wide array of insurance products offered at different prices.²⁵ The competition will also reward cost-effective health service providers. For example, the consumer-driven, universal-coverage Swiss health care system features many novel insurance policies.^{26 27} The resulting competition reduces the costs of the excellent Swiss health care system, as a percentage of GDP, to 10%, versus 15% for the United States.²⁸

Those who worry that health care consumers lack the expertise and clout of steel buyers should consider consumer-driven markets for complicated products such as cars and computers. Despite consumers' lack of expertise and group-purchasing clout, both have steadily improved in quality and decreased in costs. Buyers who do not know a piston from a valve can be effective buyers because of sources such as *Consumer Reports'* automobile buying guide and J. D. Power consumer quality rating.

The level competitive playing field that would reward or punish innovators requires market-based pricing of services and a consumer-driven insurance system. Fortunately, consumer-driven health care is becoming a reality with more than three million Americans already enrolled in consumer-driven insurance products,^{29 30} Yet, third-party buyers, most notably in the government's Medicare administration, inhibit innovation with their stranglehold on pricing.

Let us cure our health care woes the good, old-fashioned American way, not with a thicket of regulations, but, with a market of competitive suppliers—entrepreneurial physicians and other providers—and empowered consumers. The U.S. Congress can lead the way by rejecting suppression of competition as a solution and supporting consumer-driven health insurance and market-based pricing for provider services in the Medicare and Medicaid programs.

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Professor Regina E. Herzlinger is the Nancy R. McPherson Professor of Business Administration at Harvard Business School and Senior Fellow at the Manhattan Institute. Her latest book is *Consumer-Driven Health Care* (San Francisco, CA: Jossey-Bass, 2004).

Endnotes

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