Specialization and Its Discontents

The Pernicious Impact of Regulations Against Specialization and Physician Ownership on the US Healthcare System

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Ken Iverson, a technology entrepreneur, almost single-handedly revived the moribund US steel industry. His success contains important lessons for healthcare. 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 non-unionized 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 this revolution in focus and incentives? 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.1

Nucor did good for its customers, employees, and the US economy, and it did well for its shareholders, including Ken Iverson, currently hailed as the second Andrew Carnegie of the industry.

Sadly, were Iverson a cardiologist or cardiac surgeon, he could not create the “do good–do well” healthcare-focused factory equivalent of Nucor.2 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 doctors’ ownership stakes.3

The combination of negative press and legislative prohibitions creates daunting obstacles for productivity-minded entrepreneurial physicians. For example, MedCath, a partially physician-owned heart hospital firm, spends up to $200 000 to counter hospital complaints per project per year.4 Not surprisingly, relatively few focused healthcare facilities exist. A 2003 study found only 92 specialized hospitals, fewer than 2% of the market, and, more importantly, other physician-owned facilities that integrate care are sparse.5

These results are unfortunate: Specialized healthcare facilities, partially owned by entrepreneurial physicians, represent the best hope for a higher-quality and higher-productivity healthcare system. The specialization integrates care that consumers must now struggle to obtain from a system organized by separate providers. Along the way, it reduces costs. And ownership provides an important additional incentive for physicians to provide the best value for the money.

Specialization

When it comes to specialization, the question is not whether to specialize but rather how to do it. There is widespread agreement that the healthcare system should provide focused, integrated care—especially for the victims of chronic diseases and disabilities who account for the bulk of costs.6 Where it does, the results are impressive. For example, when Duke Medical Center offered an integrated, supportive program for congestive heart failure, annual treatment costs declined by $9000, nearly 40%. Duke’s new model achieved these cost reductions by improving participants’ health status—their hospital admissions and lengths of stay dropped,
Cardiology services are highly profitable primarily because the third-party payers that unilaterally set prices have reimbursed them at wrongly generous rates. Conversely, other services lose money because they set prices too low. The solution is to fix the pricing mechanism so that prices are neither excessively generous nor excessively stringent.

The only way to achieve such prices is to permit the market to set prices and to strip insurance and government 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.

Overutilization of services is caused by a system in which a third party, rather than the user, pays for them. Users who pay are more sensitive to the value for the money than are third parties. 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, however. Providers who appeared to skimp on quality to control costs lost patients.

The best way to achieve user sensitivity to the cost of services is to switch to a consumer-driven insurance system in which users select from a wide array of products offered at different costs. (Currently, in the United States, most large employers offer a limited number of policies with nearly identical features except for the cost and ease of reaching providers.) For example, in the consumer-driven Swiss healthcare system, one of the most popular insurance options is a high-deductible policy in which enrollees are frequently sent copies of their bills for the insured services they received. (The Swiss have universal insurance. The government either gives citizens who cannot afford health insurance funds or buys it for them.) The resulting transparency is likely one of the major reasons that the costs of the excellent Swiss healthcare system, as a percentage of GDP, are 10%, versus 14% for the United States.

To sharpen these points, let us return to the steel industry analogy to examine why integrated steel manufacturers did not complain that Nucor was cherry-picking or act to restrict Iverson’s ownership interests. They did not complain that Nucor was stripping out their most profitable products because prices were set by the market. Free-market pricing makes it impossible to succeed simply because the price is excessively high. For example, if the price is so high that existing firms earn excessive profits, new entrants will cut prices to gain market share and thus reduce prices. In a free market, suppliers succeed because they are productive, not because a third party technocrat has mistakenly set their prices too high.

Buyers of steel do not complain that manufacturers are foisting off unneeded steel. Because they pay directly for the product, they buy only what they need.
Some may contend that the users of healthcare services lack the expertise and clout of steel buyers. They should consider the consumer-driven markets for complicated products such as cars and computers. Despite consumers’ lack of expertise and group-purchasing clout, both products have steadily improved in quality and decreased in costs.

**Conclusion**

The right solution for our healthcare system is to encourage entrepreneurial physicians, not to bind them in regulatory straightjackets. Creating the level competitive playing field that would reward or punish them requires market-based pricing of their services and a consumer-driven insurance system.

Fortunately, both are becoming a reality. More than a million Americans already are enrolled in consumer-driven insurance products, and insurers such as United and Aetna are offering panels of providers selected for their excellence and competitive pricing.22–24

Let us cure our healthcare woes the good, old-fashioned American way, with a market of competitive suppliers—physicians and other providers—who know what they are doing and empowered consumers who know what they are buying and not with a thicket of regulations.

**References**
