Committee on Homeland Security and Government Affairs

Subcommittee on Federal Financial Management, Government Information and International Security
SD-562

May 24, 2005

Testimony by

Regina E. Herzlinger
Nancy R. McPherson Professor of Business Administration
Harvard Business School
Boston, MA

Ladies and Gentlemen, I am honored to be here to testify on an issue that is central to the future welfare of the U.S. economy.

Americans owe their prosperity to the country's productivity. We have the world's highest per capita GDP among large nations mainly because we have the highest rate of productivity gains[1]. From 1995 – 2003, the differential between U.S. and European growth rates reached a record high[2]. But, when it comes to health care, the U.S. Congress has inadvertently strangled an innovation that holds great promise for productivity gains, with the moratorium it imposed on specialty hospitals in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

The Congress could not have picked a worse area. As evidenced by General Motors' financial woes, our health care costs, at 14.9% of GDP, far higher than those of any other country, create major competitiveness problems, as does their rate of growth[3]. Hospitals not only are the primary component of our health care costs but are also the major reason for their growth[4]. The hospital sector sorely needs managerial innovations

[1] Central Intelligence Agency, *The World Factbook* (2004), www.odci.gov/cia/publications/factbook/rankorder/2004rank.html, accessed May 23, 2005.
[2] *OECD Economic Outlook*, Table 1, Growth Rate and Level of GDP per Hour Worked, U.S. vs. Europe, 1990-2003, December 2003.
[3] Davis, Karen and Barbara S. Cooper, "American Health Care: Why So Costly?" New York, NY: The Commonwealth Fund, 2004.
[4] Cowan, Cathy, Aaron Catlin, Cynthia Smith, and Arthur Sensenig, "National Health Expenditures, 2002," *Health Care Financing Review*, 25:4, Summer 2004.

like specialty hospitals. Further, the aging facilities of nonprofit hospitals[5] will soon require massive capital funds from U.S. taxpayers, a source of which investor-owned specialty hospitals will not require.

The 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 of hospital services. 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 is to permit health service providers to quote the prices they want to charge in a consumer-driven insurance system. Consumers 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

Specialty hospitals may well help to control both the magnitude and the growth of the hospital sector's costs. After all, specialization is key for productivity growth elsewhere in the economy.

Consider the steel industry, for example, which Ken Iverson, a technology entrepreneur, almost single-handedly revived. His success contains important lessons for health care. 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 this revolution in 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.[6]

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

Sadly, were Iverson a doctor, he could not create the "do good—do well" health care-focused factory equivalent of Nucor.[7] Rival everything-for-everybody hospitals

---

[5] Harrison, Jeffrey P. and Christopher Sexton, "The Paradox of the Non-for-profit Hospital," *The Health Care Manager*, 23:3: 192 – 200.
[6] Henry, K. Nucor sets pace for steelmakers. *The Hamilton Spectator*. May 13, 2002: D10.
[7] Herzlinger, Regina E., *Market-Driven Health Care*. Cambridge, MA: Perseus Books: 2000: 173-182.

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 its growth. 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.[8]

Specialization in Health Care

As elsewhere in our economy, 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 and typically reduces costs. And ownership provides an important additional incentive 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. There is widespread agreement that the health care system should provide focused, integrated care—especially for the victims of chronic diseases and disability who account for the bulk of costs.[9] 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 $9,000, nearly 40%. Duke's new model 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 or reducing providers' payments—visits to cardiologists increased nearly 6-fold.[10,11] (From 1995 to 1999, physicians' inflation-adjusted net income dropped, in part because of such strategies.[12]) In these ways, specialization helps both patients and physicians.

But the paradigm for specialization currently favored—top-down disease and/or care management, typically initiated by insurers—has demonstrated scant evidence of efficacy.[13,14] In contrast, the evidence of specialist-initiated and/or specialist-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. [15,16]

---

[8] Herzlinger, Regina E., *MedCath Corporation*. Boston, MA: Harvard Business School Publishing; 2003:4.
[9] Robert Wood Johnson Foundation and FAACT. "A Portrait of the Chronically Ill in America." Princeton, NJ, and Portland, OR: Robert Wood Johnson Foundation and FAACT; 2002.
[10] Snyderman, R. and Williams, R. W. "The new prevention," *Modern Healthcare*, 33:19 (2003).
[11] ------, "Congestive heart failure: comprehensive heart failure teams reduce health care costs," *Health & Medicine Week* (2000).
[12] "Behind the time: physician income 1995-99," *Medical Benefits*. 20:4 (2003).
[13] Ferguson, J. A. and Weinberger, M. "Case management programs in primary care," *Journal of General Internal Medicine*, 13 (1998): 123-126.
[14] Boult, C., Kane, R. L., Pacala, J. T., et al., "Innovative healthcare for chronically ill older persons: results of a national survey," *American Journal of Managed Care*, 5 (1999): 1162-1172.
[15] Edmonds, C. and Hallman, G. L. "CardioVascular Care Providers: a pioneer in hundled services, shared risk, and single payment," *Texas Heart Institute Journal*, 22 (1995): 72-76.

The reason is clear-cut: specialist physicians are in the best position to understand the needs of other physicians. 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."[17]

Physician Ownership of Specialized Facilities

The positive connection between corporate ownership and performance is a bulwark of our economy. As Adam Smith noted 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. Like the stewards of a rich man, they are apt to consider attention to small matters as not for their master's honour, and very easily give themselves a dispensation for having it. Negligence and profusion, therefore, must always prevail, more or less, in the management of the affairs of such a company."[18]

The robust U.S. 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.[19] Small businesses, created by owner-entrepreneurs, are key: they are highly productive—some becoming titans such as Microsoft, Wal*Mart, or General Electric (founded by Thomas Edison)—because owners are motivated to create the balance between quality and efficiency that will increase their market share and profits through satisfied repeat customers.

Free markets create appropriate ownership structures[20], while government meddling hampers them. This occurred in late 19th century France when the government forced the stock exchange to become essentially a government agency[21] and in "continental European social democracies [that] press managers to stabilize employment, to forego some profit-maximizing risks with the firm, and to use up capital in place rather

---

[16] Herzlinger, Regina E. "MedCath claims to have saved Medicare $800 per discharge in 2000," *MedCath Corporation*. Boston, MA: Harvard Business School Publishing (2003): 22.
[17] Hawryluk, M. "Congress eyes boutique hospital backers," *American Medical News*, May 12, 2003: 6.
[18] As cited by Jensen, Michael C. and Meckling, William H. "Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure," *Journal of Financial Economics*, 3:4 (October 1976): 305-360.
[19] Central Intelligence Agency, *The World Factbook* (2004), op. cit.
[20] Demsetz, Harold and Vilalonga, Belen. "Ownership Structure and Corporate Performance," Social Science Review Network.
[21] Coffee, John C., Jr. "The Rise of Dispersed Ownership: The Role of Law in the Separation of Ownership and Control," Columbia Law and Economics, Working Paper No. 182, December 2000.

than to downsize when markets no longer are aligned with the firm's production capabilities."[22]

Ownership incentives appear to work in health care. The ambulatory surgery center (ASC) sector illustrates the importance of physician ownership. First, it stimulates entrepreneurial ventures. Two Phoenix, Arizona, physicians opened the first ASC in 1970. Although no outside entity would insure it, they persisted. The Office of Inspector General noted: "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. Accordingly, many of the early ASCs were financed and owned by surgeons and other physicians who worked in them."[23]

Currently, approximately 90% of ASCs are owned and operated by physicians.[24] Most companies active in the development and operation of ASCs seek at least 49% physician ownership. They want not only the physicians' capital but also their entrepreneurial ideas about how to improve health care quality and costs. One analysis found that when physician compensation was based on net revenues it was associated with lower costs, whereas salary-based compensation was linked to higher costs.[25]

Health Care Specialization and Its Discontents

Nevertheless, despite the clear theoretical and practical benefits of specialized, physician-owned systems of care, the objections raised to them 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.[26] Similarly, the overuse that characterized physician-owned imaging laboratories and physical therapy facilities appears genuine and persuasive.[27]

Yet, although the complaints are valid, the diagnoses of the causes and the resultant cures are misplaced. These problems in hospital profitability and referral abuse occur because of the way our third-party health care system is structured and not because of the existence of physician-owned specialty hospitals.

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.

---

[22] Roe, Mark J. "Political Foundations for Separating Ownership from Corporate Control," *Stanford Law Review*, 53 (December 2000).
[23] 64 Federal Regulation 63537 (November 19, 1999).
[24] Federated Ambulatory Surgery Association (FASA), "Physician-Led Ambulatory Surgical Centers Vital to Meeting the Surgical Needs of Tomorrow," FASA: Alexandria, VA (January 2005): 5.
[25] Kralewski, J. E., Rich, E. C., Feldman, R., et al. "The effects of medical group practice and physician payment methods on costs of care," *Health Services Research*, 53 (2000): 591-613.
[26] Devers, K. J., Brewster, L. R., Ginsberg, P. B. "Specialty Hospitals: Focused Factories or Cream Skimmers?" Washington, DC: Center for Studying Health System Change, 62, April 2003.
[27] O'Sullivan, J. *Health Care: Physician Self-Referrals, "Stark I and II."* Washington, DC: Congressional Research Services 7-5EPW; December 6, 1996.

They did not complain that Nucor was stripping out their most profitable products because steel prices were set by the market. Free-market pricing makes it impossible for firms to succeed simply because the price is excessively high: 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. 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 they set prices too low. Further, because third-party payers insulate users from the costs of their care, they are susceptible to over-utilization. Users who pay 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, however. Providers who appeared to skimp on quality to control costs lost patients.[28])

One way to solve both the hospitals' and economy's problems is to allow 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.[29] 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. (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.) The competition will also reward cost-effective health service providers. The consumer-driven Swiss health care system features many novel insurance policies.[30] (The Swiss have universal insurance. The government either gives citizens who cannot afford health insurance funds or buys it for them.) 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.[31]

Some worry that health care consumers 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

---

[28] Harris, K., Feldman, R., and Schultz, J. "The buyers health care action group: consumer perceptions of quality differences," in Herzlinger, Regina E. *Consumer-Driven Health Care*, San Francisco, CA: Jossey-Bass (2004).

[29] Office of Inspector General (OIG). *Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers*, Washington, DC: OIG Report OEI-05-00-00340, January 2003.

[30] Herzlinger, Regina E., Parsa-Parsi, R. "Consumer-Driven Health Care: Lessons from Switzerland," *Journal of the American Medical Association*, 292:10 (September 8, 2004): 1231-1220.

[31] Ibid.

clout, both products have steadily improved in quality and decreased in costs. Consumers are assisted by readily-available, user friendly, excellent information. Thus, buyers who do not know a piston from a valve can be excellent buyers because of sources such as *Consumer Reports'* automobile buying guide and J. D. Power consumer quality rating.

Conclusions

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

The level competitive playing field that would reward or punish them requires market-based pricing of services and a consumer-driven insurance system. Fortunately, consumer-driven health care is becoming a reality. More than three million American already are enrolled in consumer-driven insurance products.[32] Yet, although insurers such as United and Aetna offer panels of providers selected for their excellence and competitive price,[33] third-party buyers continue to 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, instead with a market of competitive suppliers—entrepreneurial physicians and other providers—and empowered consumers. The U.S. Congress can lead the way by lifting this moratorium and supporting consumer-driven health insurance and market-based pricing for provider services in the Medicare and Medicaid programs.

This testimony is partially based on "Specialization and Its Discontents: The Pernicious Impact of Regulations Against Specialization and Physician Ownership on the U.S. Health Care System," *Circulation*, 109 (2004): 2376-2378.

[32] *Inside Consumer-Driven Health Care*, February 4, 2005.
[33] Innovative Products Offer Narrow Provider Networks Targeted to High Cost Diseases," *Managed Care Week*, 13:4 (2003).