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"Specialized healthcare facilities, partially owned by entrepreneurial physicians, represent the best hope for a higher-quality and higher-productivity healthcare system." That's how Harvard University Graduate School of Business Professor Regina Herzlinger, a specialty-hospital champion and a revered guru to many young conservative lawmakers on Capitol Hill, puts it in an essay in the May 25, 2004, issue of the journal *Circulation*.

"The specialization integrates care that consumers must now struggle to obtain from a system organized by separate providers," Herzlinger continues. "Along the way, it reduces costs. And ownership provides an important additional incentive for physicians to provide the best value for the money."

• ***In health care, it's all about unintended consequences.*** At a September 10 conference of the Council on Health Care Economics and Policy, where Herzlinger was the lead-off speaker, other analysts agreed that — at least up to a point — care-delivery systems focused on one procedure or on one disease or constellation of diseases can be more effective and efficient than what Herzlinger calls "everything-for-everybody hospitals"

Nevertheless, many analysts at the forum said they wouldn't follow that idea to its apparently logical conclusion: Free up entrepreneurial physicians to open all the specialty facilities they like and watch outcomes improve and health-care efficiency soar.

Qualms about the result of unleashing such untrammeled physician-entrepreneurship are numerous, but most seem to boil down to this: In some fundamental ways and for various reasons, including historical anomalies, we demand that health-care organizations function as part of an interconnected system.

Today that system is in delicate — perhaps even precarious — balance as tens of millions of Americans lack any source of care or coverage and rising costs alarm many. This raises the question whether every development that increases efficiency or improves care in one area should proceed if it threatens the stability of some other key part of the system.

If the low-income uninsured and the underserved were cared for, then "we'd all" be in favor of a focused-factory model for much of health care, suggested Council Chair Stuart Altman, professor of national health policy at the Brandeis University Heller Graduate School, September 10. But "literally billions of dollars" worth of medical care is provided each year to patients who can't pay for it, "and it is disproportionately provided by broad-based institutions that cross-subsidize" unpaid or poorly paid services with revenues from higher-paid services such as cardiology.

That fact leaves analysts seeking answers to these questions, among others: Would a flood of new specialty hospitals in fact drain money from the cross subsidies, or are full-service hospitals crying wolf to drive away competition? Could efficiencies created by a new focused-factory model of care delivery actually free up dollars to pay for expanding coverage?

• ***Specialty-hospital proponents see the problems, too.*** Herzlinger is sold on the potential of well run specialty hospitals to make care more efficient and effective. But, given the current reimbursement structure, even she is not sure whether this crop of specialty facilities live up to the model's potential.

Are the new breed of cardiac, orthopedic, and general-surgery hospitals focused factories achieving true efficiencies and clinical excellence, or are they engaged in economic games-playing, participants asked at the September 10 forum. "We'll never know until we get the pricing right," Herzingler's replied.

Some facts suggest that many physician-owned specialty hospitals were created mainly to grab some high reimbursements that are easily available rather than to improve earnings by creating a more efficient system of care delivery, she acknowledged.

For example, there is "very good evidence that there is overuse" of some kinds of care because of the rise of specialty facilities, said Herzlinger.

There is also "very good evidence" that specialty hospitals "cherry pick" certain lucrative kinds of care that otherwise would take place at general hospitals, she said. In addition, there is "credible evidence" that some specialty hospitals "cream skim" patients, directing to the specialty facility those whose cases would net the highest revenues.

Specialty-hospital backers like Herzlinger aren't on the same page as some other analysts and policymakers on the question of what to do about such abuses, however. Many analysts and lawmakers would end cream skimming, for example, by banning physician ownership in the facilities. Only physician-owners have an incentive to direct to specialty facilities the patients who are likely to net the hospital higher revenues, goes the argument. If physicians are not owners, then financial conditions will no longer drive where a given patient gets care.

But Herzlinger and other free-market theorists argue that such regulation of who owns what has bad effects in the long run.

"The right solution for our healthcare system is to encourage entrepreneurial physicians, not to bind them in regulatory straightjackets," she wrote in *Circulation*.

Nevertheless, "despite the obvious theoretical and practical benefits of specialized,