

physician-owned systems of care ... the objections raised to them are valid," she wrote. "Because cardiology accounts for 35 percent or more of a community hospital's revenues, its absence will likely significantly damage a hospital's financial status. Similarly, the overuse that characterized physician-owned imaging laboratories and physical therapy facilities appears genuine and pervasive."

The free-market solution: Allow physicians to invest as they like, but abandon administratively set prices and traditional kinds of third-party insurance that insulate patients from the actual costs of care. With patients bearing more of their own costs through consumer-directed health plans and patient demand setting prices in a free market, reimbursement levels will become more accurate, leaving many fewer medical-procedure cherries to pick or creamy patients to skim, the argument goes.

"What is essential is a change in the way providers are compensated," with higher risk-adjusted reimbursements rewarding those who care for sicker patients and payments made for rational "bundles" of care rather than service by service, Herzlinger said. If providers were compensated for the true costs and worth to patients of their care — as in a wholly free market — then there would be no pockets of over-rich payment that specialty facilities could skim away, she argued.

• ***Can the market set health-care prices accurately? Some economists aren't so sure.*** "Market-based prices would be nice, but I'm not sure they're possible," said Harvard economist Joe Newhouse. "For one thing, risk adjustment inherently has administered pricing in it."

Paying providers risk-adjusted rates implies that someone who is presumably more knowledgeable and disinterested than the individual patient-consumer determines what kinds of cases are actually more severe and difficult to treat and thus deserve higher pay. It generally also implies that someone other than the individual consumer — such as a pool of insured people or the government — picks up some of the cost of these more severe cases. To the extent that this is the case, risk adjustment looks like a double whammy against free-market principles, since it not only requires some administrative price setting but also insulates individuals from some of the cost of their care.

Newhouse argued that setting payments for episodes of care rather than service by service also would most likely be done by some third-party administrator, and thus would not be strictly market-based. University of Pittsburgh economist Judy Lave pointed out that Medicare's experiments with paying for episodes of care have generally sent providers running in the opposite direction.

Herzlinger responded that in the market system she envisions "providers could bundle their own care and offer it to insurers at prices they quote." But several analysts at the forum remained skeptical that full, accurate market-set pricing is possible. "At the end of the day, there will still be imperfections in the pricing system that will leave profitable and unprofitable opportunities," said Newhouse.

• ***Possible or not, on-the-nose pricing is not here today. Just ask the providers who've developed "focused factories" outside of cardiology and orthopedics.*** Herzlinger and other proponents of "focused factories" point to physician-owned specialty hospitals that have thrived in the current reimbursement system as key examples of effective delivery models health care practitioners would devise if they were free to innovate at will.

But Herzlinger also is a fan of another kind of focused factory — one that apparently cuts costs and works well for patients but suffers on the reimbursement front. This other sort of focused factory develops not around a set of medical procedures but around a certain medical condition for which the factory offers what she terms a "chain of care."

This breed of focused factory is not necessarily owned by physicians — more likely it is not — but it is developed by physicians with the entrepreneurial aim of making care more effective and efficient. Unlike specialty hospitals, the other sort of focused factory often is not a stand-alone facility.

A top example cited by Herzlinger in her *Circulation* essay is an integrated program for congestive heart failure pioneered at the Duke University Medical Center.

Unlike for physician-owned specialty hospitals, the evidence seems to be in on the effectiveness of such "chain of care" facilities: The Duke program, for example, saw stunning results, both in economics and clinical outcomes, said Herzlinger. **Annual treatment costs per CHF patient dropped by $9,000, or nearly 40 percent. Patients had improved health status and experienced a six-fold drop in visits to cardiologists along with reduced numbers of hospitalizations and shorter hospital lengths of stay.**

And how were the Duke innovators rewarded for this impressive success? Herzlinger asked the Council audience.

The answer came from the middle of the audience: "They lost money."

PEOPLE

Steve Lieberman retires from federal service September 30 to join the Virginia-based consulting firm The Moran Company. A long-time analyst with the Congressional Budget Office and, earlier, at the White House Office of Management and Budget, he most recently worked on rulemaking for the Medicare Modernization Act.