

# Medicine as a Business

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## Abstract

There is a growing debate over whether medicine should function like a business, guided, as businesses are, by concerns such as profits and customer satisfaction. Of course, for-profit businesses already permeate medicine, and those businesses are not confused about their priorities: providing high quality goods and services people want, at affordable prices. These companies know that they must do well in order to continue doing good.

Critics of the business model argue that the profit motive makes health care too expensive and that only by nationalizing the health care system can doctors provide high quality care at an affordable cost to society. However, a survey of journals and newspaper articles about the Canadian health care system, often cited as an anti-business model for U.S. reform, reveals that quality has suffered significantly under that system. Patients wait in long lines for health care, and sometimes cannot get help at all.

This paper argues that incentives in the U.S. health care system are complicated, and that health care needs to work more like a business—not less. Doctors don't know whom they are serving—patients, insurers, employers or the government—because it is usually someone other than the patient who is paying the bill. The way to get the incentives structured properly is to allow patients to control more of their health care dollars—perhaps through a system of Medical Savings Accounts. Following the business model is the only way to ensure that medicine provides high quality services at affordable prices—just like every other sector of the economy.

**Key Words:** Business model, Canada, single payer, rationing, incentives, medical savings accounts, managed care.

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WERE THIS COUNTRY beginning from scratch today, so that we had to consider separately each segment of the economic system and how it should work, many politicians and food policy experts surely would assert: Food is unique. And because it's unique, it could never be part of a free market system where consumers are free to make their own choices and vendors try to maximize profits.

Just consider, critics would assert, some of the problems that would arise if people could profit from the sale of food. We know that food is a necessity; everyone has to have it. Thus, consumers would be at the mercy of food producers, who could charge whatever they wanted to charge. Moreover, because there would be a financial incentive to keep costs as low as possible, food producers would constantly look for ways to cut quality. The result of these two

forces would surely mean that consumers would pay very high prices for very low quality. And, of course, since most people aren't trained in nutrition, there would need to be an army of trained nutritionists to help them make good decisions.

Social thinkers helping to organize this new food system would point out that since humans must have food, it should be a basic human right. As a result, people without enough money to pay for their food should nevertheless be allowed to walk into a grocery store and take anything available without paying for it. These planners also might be concerned that under a free market system, higher-income individuals would be able to buy not only more but higher-quality food than those with low incomes, thus creating a two-tiered system. Such a situation, they might argue, is unfair and unjust. Do we really want a country in which some people have steak, while most settle for ground beef?

Their solution: raise taxes and use the increased government revenue to create a national food system that would ensure that everyone has equal access to food. Fortunately, we are not creating a food system from scratch. The one that has served us well for centuries operates almost completely under the free mar-

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Adapted from a presentation at the Issues in Medical Ethics 2001 Conference on "Medicine, Money and Morals" at the Mount Sinai School of Medicine, New York, NY on November 2, 2001, and updated February 2004.

ket system, and the result has been that the quality of food is high, the prices are low, and there is more than enough to go around. So why is it that people say that “medicine is unique” and want to do to the health care system what our food policy analysts might have done to the food system?

### The Business of Medicine

For the past several years there has been a growing debate among philosophers, ethicists, health care professionals and public policy analysts over whether medicine should function like a business, guided, as businesses are, by such worldly concerns as profits and customer satisfaction (1). Surely, they say, a profession as old, as self-sacrificing and as dedicated to the end of suffering and the betterment of humanity as medicine should be guided by some nobler, more altruistic goal.

Of course, the truth is that business permeates medicine—and big business at that. Health insurance and managed care companies, and the pharmaceutical and medical device industries are irrevocably intertwined with the health care system. Even doctors’ practices are businesses; they pay rent, buy equipment, occasionally borrow money, meet payrolls and (usually) close out fiscal years with more income than outgo. Business is as important to medicine as new pharmaceuticals are to an effective physician: You just can’t have one without the other. And most of those businesses are not confused about their priorities. They are there to help people, but they know that unless they make a profit, they won’t be able to help people for long.

Some doctors, as well as some philosophers, health policy analysts and visionaries, see medicine as a social endeavor. Physicians were meant to heal, not degrade themselves over paying rent, balancing books, fighting off lawsuits, justifying their decisions to managed care companies, or trying to keep Congress from destroying the health care system.

Some physicians think medicine already looks too much like self-serving capitalism. Business is about taking care of yourself; medicine is about taking care of others. Business is guided by pragmatic decisions, medicine by ideals, and some physicians seek to take the business out of medicine so that the ideals can prevail. The idealists hope to do good without regard to doing well; the businesses in medicine strive to do well in order to continue doing good.

I will argue that, in contrast to such idealistic views, the problems facing the health care system result not from its being too business-like, but because the practice of medicine doesn’t act enough like a business. Business is guided by the very pragmatic goal of providing high quality goods and services to people, at affordable prices. Isn’t that also the goal of medicine? Even those who think the government should run the health care system believe that. And they usually argue that nationalizing the health care system, thereby minimizing or completely eliminating the business element, will keep health care costs affordable while freeing doctors to provide quality health care. But is that what actually happens when a health care system is nationalized?

### Do Single-Payer Systems Provide Quality Health Care?

Countries with national health care systems spend less on health care than does the U.S. For example, in 2001 the U.S. spent 13.9% of its gross domestic product (GDP), on health care, while Canada—a frequently cited “model” for U.S. reform—spent only about 9.7% of its GDP (2). But spending less on health care is not the only—and probably should not be the primary—goal. The challenge is to maintain a high-quality and responsive health care system while spending less money.

Has a country like Canada achieved that goal? The *New York Times* has revealed numerous problems all across Canada. According to one story (3):

- “[I]n Winnipeg, ‘hallway medicine’ has become so routine that hallway stretcher locations have permanent numbers. Patients recuperate more slowly in the drafty, noisy hallways, doctors report.”
- At Vancouver General Hospital on the West Coast, “Maureen Whyte, a hospital vice president, estimates that 20 percent of heart attack patients who should have treatment within 15 minutes now wait an hour or more.”
- Finally, “Last summer [i.e., in 1999], as waiting lists for chemotherapy treatments for breast and prostate cancer stretched to four months, Montreal doctors started to send patients 45 minutes down the highway to Champlain Valley Physicians’ Hospital in Plattsburgh, New York.”

As the *New York Times* points out, “Canada has moved informally to a two-tier, public-private system. Although private practice is limited to dentists and veterinarians, 90 percent of Canadians live within 100 miles of the United States, and many people are crossing the border for private care” (3).

### Case Study: A Flu Epidemic

A recent flu epidemic in Toronto expanded the waiting times to see a family physician to 5–6 weeks. Appointments were scheduled so far into the future that most patients would have recovered from their illness and would no longer have needed to see a doctor.

Unfortunately, many patients who needed to see a doctor immediately didn’t even have an emergency room option. In December of 1999 and January of 2000, Toronto emergency rooms were so full that they were turning away patients—regardless of how sick they were. According to a story in the *Toronto Star*, 24 of 25 emergency rooms were closed on Monday, December 27, 1999. By the next day, “21 of 25 emergency wards were refusing to accept any new patients, no matter how ill or critically injured they might have been, or were accepting only the most serious cases” (4). According to the authors, “Toronto Ambulance’s paramedics were working the phones like veteran travel agents, trying to find emergency room spots for their patients on a day when the demand was close to its peak.” Only three weeks later, an 18-year-old boy, Joshua Fleuelling, died of asthma because the emergency rooms were on “critical care bypass” and couldn’t accept him (5).

### Case Study: Waiting Lines

But it gets worse. In March of 2000, Canadian Health Minister Allan Rock told the House of Commons, “There are people who are waiting too long, waiting hours in the emergency ward, waiting months for referral to a specialist, waiting a year for a long-term bed, waiting what seems to be an eternity for someone to answer the call button in an understaffed hospital” (6). Rock is referring to the Canadian health care system—one in which, according to supporters, accessibility, efficiency and affordability are all supposed to converge.

Canadians often wait weeks and even months to see a specialist. According to the Vancouver, British Columbia-based Fraser In-

stitute’s annual survey of waiting times in Canada (7):

- The average total waiting time between referral from a general practitioner and treatment by a specialist rose from 13.3 weeks in 1998 to 14 weeks in 1999.
- Waiting times between specialist consultation and treatment (which does not include the time between seeing a general practitioner and getting to see a specialist) increased from 7.3 weeks in 1998 to 8.4 weeks in 1999.
- Waiting times for diagnostic tests also underwent some increases. For example, the median wait for a CT scan across Canada was five weeks in 1999, a 6.4% increase over 1998.

### Case Study: Canada’s Budget Debate

In 2000, Canada’s health care system reached a crisis over funding. In this case, however, the crisis wasn’t instigated by budget deficits, but by a budget surplus. Some Members of Parliament wanted to pass an income tax cut of at least 20%, which others opposed, claiming that the proposed budget only offered two cents in health care funding for every dollar in tax cuts (6).

Ralph Klein, premier of Alberta, who wants to bring a little of the “business mindset” back into Canadian medicine by letting for-profit clinics perform some of the procedures currently provided by Canadian hospitals, has offered one solution to the problem of waiting lines. The government health care program, known as Medicare, would reimburse the clinics for the care (8).

### Case Study: Limited Access to Technology

In a system where health care budgets are tight, bureaucrats and politicians tend to see new technology as too costly to justify the benefit they would provide. As a result, funds, if any, are provided only for the purchase of a limited amount of the newest technology. The decisions on what to buy and when to buy it are often arbitrary and guided more by good politics than good medicine.

Even more important, these arbitrary limits usually enshrine the medical knowledge and techniques current at a particular point in time. A central control system cannot afford new

medical discoveries and treatments, because they aren't in the budget and no funding or other resources is allocated for them. Thus, a single-payer system inherently tends to foster outdated medical techniques and resist new or innovative ones.

Although single-payer proponents cite Canada as a system that rivals the U.S. in the availability of new technology, the country lags behind many of the Organization for Economic Cooperation and Development (OECD) countries. While Canada ranks fifth in terms of total health care spending (as a percent of GDP), a recent study by the Fraser Institute, comparing OECD data, found that the country (9):

- Ranks 21 out of 28 in CT scanner availability;
- Is 19th out of 22 in lithotripter availability;
- Is 19th out of 27 for the availability of MRIs.

Stories abound of Canadians going to extreme measures in order to gain access to medical technology. For example, several years ago an enterprising hospital in Guelph, Ontario, decided to allow animals needing computed tomography (CT) scans to enter the hospital in the middle of the night—charging pet owners C\$300 apiece. There is nothing necessarily wrong with that action, except that thousands of people in Ontario were waiting up to three months for an appointment on the same machine (10).

"I'd go any time," said Greg Moulton, who was in the middle of a two-month wait to learn why he was having "excruciating" headaches (10). Because people are not allowed to pay out of pocket for medical procedures covered under the government-run plan, they have to wait. However, if you're a dog, you can get medical technology immediately.

When dogs get better treatment than people, then people will "become dogs." In December 1999, the *Washington Post* reported that waiting lines for magnetic resonance imaging (MRIs) in Ontario had grown so long that one Ontario resident "booked himself into a private veterinary clinic that happened to have one of the machines, listing himself as 'Fido'" (11).

### Case Study: Rationing

At a 1999 conference in England organized by the Institute for Public Policy Research, Alan Milburn, health secretary of England, said of the country's National Health Service (NHS), "The NHS—just like every other health system in the world, public or private—has

never, or will never, provide all the care it might theoretically be possible to provide.... So within our expanding health system there will always be choices to be made about the care to be provided" (12).

Thus the question is, "Who decides about who gets what?" In a single-payer system, the government makes the larger decisions about funding levels, leaving the doctors, hospitals and other health care providers to make the tougher individual decisions about whose care to limit. The targets of rationing are usually the marginal cases, and that often means the very young, the very old and the very sick. The patient is often simply told, "There's nothing more we can do for you," a statement that is true within the confines of the budget. The range of medical options is simply not discussed in these circumstances.

The *Canadian Medical Association Journal* (CMAJ) reported in May 1999 that during a 12-month period, 121 patients waiting for coronary bypass surgery were removed from the waiting list because their conditions had deteriorated to the point where they were unlikely to survive surgery. "In Quebec," according to Steven Pearlstein of *The Washington Post*, they've sent more than 250 cancer patients over the border to the United States this year (1999) to get treatment and still there are 350 who have waited more than four weeks for radiation or chemotherapy (waiting more than 4 weeks is considered medically risky)" (11). Such stories are not rarities, but commonplace, even in the best of single-payer systems, and Canada is one of the best. The fact is that health care rationing is pervasive when the government controls health care. And as health care costs rise and government budgets tighten, rationing expands.

Canada has been very explicit about its attempt to avoid using the business model in health care. And this has led to waiting lines, increased pain and suffering, needless deaths, lack of access to technology and rationing. Is this really the model the U.S. should follow for providing quality health care?

### The Need to Get Incentives Right

The primary problem with the doctor-patient relationship as it exists today is that the incentives are complicated. In a market system, providers of goods and services know who they are trying to please—the customer—and why. It is in the interest of those who provide goods or services to make sure that their clients and cus-

tomers are satisfied. A restaurant owner has an interest in making sure that those who come to his establishment enjoy their dining experience. An attorney has an interest in ensuring that her clients are satisfied with her services.

This is not simply about economic interests. Most vendors want to have a good reputation for producing and selling quality products. They want people to respect them for what they do and how they do it, not just for how much they make. Fortunately, those who develop a reputation for quality products or services usually get rewarded financially as well. When incentives are operating properly, everyone walks away from a transaction happy—the vendor because he sold a product or service and made some money, and the customer because she has a product she wanted for a price she was willing to pay.

But who is the doctor trying to please? The patient or the managed care company or the employer? Most professionals have a fiduciary responsibility to their clients to work for their best interests. But to whom does the doctor owe a fiduciary responsibility? Since the patient gets the care but the insurer pays the bill, it isn't clear exactly who the client/customer is.

The current medical system distorts all of the normal incentives. Doctors do not believe that they are serving patients, but rather the insurers, the employers, the government or the managed care companies that are paying the patients' bills. These managed care companies strive to disenroll those physicians who provide too much care. Patients aren't satisfied, because they feel that somebody is keeping them from getting the care they were promised and their employer paid for. And employers, insurers, state and federal governments, and managed care companies aren't happy, because they believe that doctors and patients are driving up health care spending and finding ways to sidestep or minimize the controls meant to keep health care costs low.

Consider just one of the perverse incentives common in the system. Under most circumstances, workers get paid more for doing more. But under a managed care capitation system, doctors get paid more for doing less. There is no way that this kind of incentive system will encourage satisfaction and confidence from either the patient or the physician.

### **Making Medicine Work More Like a Business**

The problems facing the health care system are not going to be resolved unless it begins to

operate more like a business. That means getting the incentives right once again. The reason businesses seek to offer a quality product at an affordable price is that customers want value for their money. That is, they weigh cost, quality, service, convenience and other factors before making a decision on what to purchase.

To a large extent, customers in the health care system—otherwise known as patients—don't seek value for their dollars, because in the vast majority of cases they are spending someone else's money (i.e., the insurer's, the managed care company's, the employer's or the government's).

This insulation from the cost of health care has created a number of problems. When people are insulated from the cost of their economic decisions, they will spend more than they otherwise would. And the medical establishment has exacerbated the problem by pushing for everyone to be covered for everything. That is a prescription for financial disaster.

In addition, the tax system provides a generous tax break to those who get their health insurance through their employer, but not to those who buy it themselves (13). Because most employees think that employer money spent on health insurance comes from the employer—although most economists believe it is actually paid for by the employee because it is part of the total compensation package—they want their employer to buy as comprehensive a policy as possible. That practice has also contributed to the problem of people being overinsured.

If people were to reduce some of that cost insulation—say, by choosing a high-deductible health insurance policy that covers them for a major accident or illness—they would begin to act more like consumers act in every other segment of the economy (14). If they were allowed to put the resulting savings in a tax-free account to pay for health care, they would be getting the same tax advantage they currently receive when the employer pays the health insurance bill. In fact, that is what flexible spending accounts (FSAs) and medical savings accounts (MSAs) are meant to do, but both plans are currently burdened by restrictions that have reduced their appeal (15).

Although it may seem radical, there is nothing new about this idea. Fifty years ago, health insurance was reserved almost exclusively for catastrophic medical events (13). It was even called "major medical." When patients visited a doctor, or the doctor came to their house, they paid those costs out of pocket. Of course, some

patients didn't have the money and doctors had to work something out with them, perhaps by accepting a reduced fee or even nothing at all (16). The medical community's drive to make sure everyone has comprehensive health insurance has not resolved that problem. Doctors still have to reduce their prices, only now it's the managed care companies that are demanding the discounts.

Just imagine how much different the office visit would be if patients had to pay the full cost of, say, Celebrex or Vioxx out of their own funds or an MSA. Most would be much more interested than they are today in getting the doctor's opinion about whether the name brand or a less-expensive, over-the-counter pain reliever would do. That is where value would come in. Once patients are concerned about value, and health care providers are concerned about ensuring that patients receive that value, the proper incentives will be in place—and the health care system will begin to look a lot more like a successful business (17).

### Conclusion

There is no escaping it: someone will determine who gets what in health care. The question is whether that someone will be the patient in consultation with a doctor or some company overseeing health care costs.

For years many people both inside and outside the medical community have argued that "medicine is unique." And because it is unique, neither doctors nor patients should have to weigh the costs of health care with the benefits. As a result, managed care companies, employers, insurers and the government have stepped in and weighed those costs and made those decisions.

The medical profession will probably never operate completely like a business. Health insurance—even with a high deductible—will continue to insulate people from the full cost of care. And doctors will continue to provide care even to those who cannot afford it. But medicine can learn from business, and even become more like it. That means adjusting the incentives so that they create a positive, rather than a negative, impact.

In becoming more business oriented, medicine doesn't have to give up its own unique values. Indeed, it is only by adopting the business model that medicine can embrace its values in providing a high level of quality for an affordable price—just as the food system and most other businesses do.

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