

The Health Care Blog

Everything you always wanted to know about the Health Care system. But were afraid to ask

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Health Care For Profit

Written by John Goodman

I've noticed at The Health Care Blog quite a few people are obsessed with the role of profit in the health care system. Many apparently believe that for-profit entities have no legitimate role in an ideal world and that all organizations should be nonprofit.

My own view, interestingly enough, is the exact opposite. Were I a Health Care Czar, I would remove the nonprofit status from almost all health care organizations and force them to be for-profit under tax law. I would be willing to consider some exceptions here and there, and in special cases allow for-profits to set up nonprofit subsidiaries. But the vast majority of all patients in my ideal world would be dealing with for-profits — in getting health insurance and in getting medical care. And in return they would get lower-cost, higher-quality care.

Why do we have such radically divergent views on this subject? As so often happens in public policy, much confusion is caused when people are not familiar with basic economic principles. In this case, the antiprofit folks are confused about (1) the economics of capital, (2) the economics of competition and (3) the economics of motivation in complex social systems.

Suppose the government builds a hospital and plans to have the entity be self-sustaining (all operating costs are to be paid from expected revenues). Following conventional public sector accounting, the cost of the capital needed to build the hospital will be treated as zero.

(Afterall, all we need is for the Treasury to write a check.) And even though the plan to cover costs with patient revenues is far from certain to pan out, the accountants will also ignore the cost of that risky decision.

This example is Exhibit A in my case for abolishing the nonprofit status of hospitals.

There is a real social cost of the capital used here. It is the social value of the next best use of those dollars. Because we build a hospital, we have to forgo the opportunity to build a school or a library or even an oil refinery. Note: This cost doesn't vanish just because accountants don't write it down on the financial statements. Making risky decisions is also costly, and the cost is implicitly borne by taxpayers. In the worst case, the hospital might never open its doors — in which case the taxpayers' entire capital investment would be lost. More optimistically, the hospital might operate, but incur large losses that will have to be covered with additional taxpayer assessments. Again, these costs don't vanish just because accountants don't record them. A better approach is to make these costs transparent. If the hospital has to raise money in the capital market, the cost of capital will be made explicit. If its plan is an especially risky one, the cost of that risk will be reflected in the extra premium the capital market will charge. Not only would a for-profit approach be more transparent, it would also be less costly. The reason? The social cost of raising money on Wall Street is a

lot lower than the social cost of collecting income taxes.

Like other for-profit entities, hospitals should have to report the cost of capital they make and they should have to report the “profit” they earn in order to cover the cost of that capital. (See the discussion following Linda Gorman’s post at the John Goodman Health Policy Blog.)

The second issue relates to the economics of competition. In my book, *Regulation of Medical Care* (Cato, 1980), I summarized organized medicine’s 20th century efforts to drive for-profit entities out of the market. In the early part of the century, for-profit medical schools were replaced with nonprofits. By midcentury, for-profit hospitals were almost completely driven from the market. After World War II, nonprofit health insurers (Blue Cross and Blue Shield) were established for the express purpose of completely changing the way doctors and hospitals would be paid. They tried to dominate the market and drive their for-profit rivals from the field. In the American Medical Association’s (AMA) ideal health care system, the only people earning a profit would be the doctors themselves!

We are still living with the vestiges of this history. But it would be a mistake to conclude that the real issue was profit vs. nonprofit. The AMA’s real goal was a medical marketplace in which all the entities were subservient to the interests and vision of organized medicine. The AMA assumed, probably correctly, that nonprofits operating in a not-very-competitive market would be easier to dominate and control. Today, no one thinks hospitals, health insurance companies and other entities should exist to serve the interests of doctors. And today everyone recognizes that nonprofits can compete for patients based on price and quality just as vigorously and successfully as for-profits can. In fact, in today’s environment the whole

distinction between for-profit and nonprofit is an irrelevant distraction.

The final issue is motivation. As Adam Smith discovered 200 years ago, as a producer in a competitive market, I cannot succeed without meeting other people’s needs. Of course, Smith realized that the butcher, the baker and the candlestick maker were not primarily motivated to help other people. They were self-interested. But they could not pursue their own interests without serving the interests of others. Now let’s suppose that Adam Smith was wrong about people’s motivations. Suppose that a lot of producers are actually completely altruistic. We can use modern economics to show that no matter what motivates the producer, he can’t survive in a competitive market without meeting other people’s needs the same way that all his selfishly motivated rivals are meeting them. Put differently, in competitive markets, the motivation of any particular producer really doesn’t matter very much.

More to the point, you and I cannot control other people’s motives. But we can control public policies. With that in mind, it is in our interest as patients to promote institutional environments in which providers of medical care find it in their economic self-interest to deliver low-cost, high-quality care. And this is true regardless of all the many and complex factors that make up the underlying motivations of the doctors and institutional administrators who provide that care.

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