

# ***PERSONALLY SPEAKING***

***Number 41***

***December 2007***

---

## **HEALTH CARE SPENDING AND PROFITS**

**Edward J. O'Boyle, Ph.D.**

**Mayo Research Institute**

---

The public discourse on the high and rising cost of health care at times triggers an attack on profit-making enterprises especially pharmaceutical companies. Critics assert that if we could only get profits out of the system, costs would be much lower. A review of U.S. health care expenditures may shed light on the part that profits play in health care costs.

National health expenditures in 2005 amounted to \$1.988 trillion.<sup>1</sup> Roughly 45 percent of those expenditures are funded from public sources principally Medicare and Medicaid. The largest single category of expense is hospital care at \$612 billion. Data for 2004 indicate that only 15 percent of all U.S. hospitals operate as for-profit institutions and taken together they account for just nine percent of all hospital care expenditures.

The nursing home business is largely in the hands of for-profit organizations but the number of homes has been declining since 1999. Though their numbers are quite large alongside the number of hospitals, on average they have fewer beds than hospitals and therefore expenditures at nursing homes – \$122 billion in 2005 – represent only six percent of national health expenditures. Monthly charges at for-profit nursing homes are lower than at other types of nursing homes.

The second largest category of health expenditures is physician and clinical services – \$421 billion in 2005. Mayo Research Institute found no national data on the extent to which physician and clinical service enterprises operate as for-profit businesses. However, two comments are relevant though presented without statistical support.

First, many physicians establish their practices as business enterprises in a way that allows them to draw a regular monthly salary and, after meeting their other financial obligations, to divide any surplus at the end of the year among the practice partners. Physicians who are employed in the practice but are not partners do not share in this distribution. This surplus does not represent profit in that it originates in the services provided by the physicians. It and their regular salaries are properly considered compensation for services rendered.

Second, due to severe problems with reimbursement from private and public health insurers physicians – many are paid 50 percent or less of what they charge for their

---

<sup>1</sup> Throughout we employ the most recently available data.

services – increasingly are closing their office-based practices and are finding paid employment with hospitals where they are designated “hospitalists.”

After hospital care and physician/clinical services, the third largest category is prescription drugs that added \$201 billion (10.1 percent) to national health expenditures in 2005. Most of these funds no doubt went to for-profit pharmaceutical companies, and critics assert that caps imposed on prescription drug prices would do much to reduce the cost of health care. The opportunities for earning profits are considerable. So are the risks and the cost of developing new drugs. Tufts University Center for the Study of Drug Development stated in late 2006 that it takes eight years for the typical biotechnology product to move from the development stage through the regulatory phase and costs \$1.2 billion, with the cost about evenly split between the preclinical stage and the clinical stage. Sales that fall short of \$1.2 billion mean that the company takes a loss on a product even if it proves to be clinically safe and effective.

Further, many of the large pharmaceutical firms are investor owned. Market valuation toward the end of November 2007 for Johnson and Johnson, for instance, was \$191 billion, for Pfizer \$157 billion, and for Merck \$125 billion. Who will buy out the current stockholders if price caps also lead to a call for transforming these companies into nonprofit enterprises? As nonprofits would they be more successful in developing new products? Would they be more efficient and able to reduce the cost of product development below what it would have been had they remained profit-making companies? What would the public do if pharmaceuticals decided to halt the development of new drugs and switch to other product lines?

Critics also assert that it is unethical to profit from human suffering. Quite true. However, is there anything unethical in making a profit producing products and services that help relieve human suffering? Should we condemn Bayer for producing at a profit its hugely successful over-the-counter drug aspirin? Is General Electric to be condemned for the profits it makes in selling high-tech diagnostic equipment? Is for-profit IASIS Healthcare to be condemned for rescuing community-owned Glenwood Regional Medical Center in West Monroe, Louisiana that for years had been hemorrhaging cash to the point of almost forcing it to close its doors permanently?

Students of economics 101 learn that for any transaction to take place both parties must experience gain: what is gotten is more highly valued than what is given up. Remove that gain and the exchange collapses even for a nonprofit business unless it is subsidized to the point where its income (what is gotten) at least covers the cost of production (what is given up).

How, then, do we tackle the problem of rising health care expenditures which climbed from 5.2 percent of GDP in 1960 to 16 percent in 2004? Surely not by cutting reimbursement because over the long term cuts in reimbursement drive providers out of the health-care system: what is gotten is less highly valued than what is given up. Cutting reimbursement leads to cost shifting where paying patients are charged inflated prices to cover the cost of providing services to nonpaying patients. It also leads to a narrowing of access to physician care. In the extreme, cuts in reimbursement leave nothing in compensation for providers

who take seriously their duty to pay in full their own financial obligations to their employees, suppliers, and others. Certainly not by eliminating for-profit companies, especially in pharmaceuticals, though curbing *excess* profits – profits above what are necessary to retain them in the health care system – likely would bring down the cost of health care.

Since U.S. health care is governed by market forces, there are in general two options: the demand-side option and the supply-side option. On the demand side we have heard for years that more must be done to prevent the onset of disease and injury such as wearing seat belts, exercising, eating healthy foods, and cutting out cigarettes. The growing problems of obesity and sexually transmitted diseases, to name just two serious health disorders, indicate that the demand option is not working, at least not well enough to cut health expenditures. That leaves the supply side option. One possibility is to deny access to certain very expensive procedures. Insurers are doing that already and are facing great resistance from the persons they insure. Another possibility is to concentrate research and development on those products and clinical modalities that reduce the cost of treatment today without compromising quality of care or outcomes. We've done it successfully with cheaper and better computer hardware, with more fuel efficient and safer automobiles and aircraft, with lower-cost telecommunications, with inexpensive and lightning-fast online systems for selling equities, buying books, and trading second-hand goods, with energy-saving appliances and insulating materials, with wider use of reprocessed materials in new products such as flooring and counter tops. And many more.

It's time to try this alternative with renewed vigor in health care especially hospital care. Nanotechnology for one might contribute that kind of creative energy if it can transition from a basic to an applied science and then profitably to commercial products. It simply does not make sense to banish for-profit companies from health care when it has been firmly established for many years that the profit motive is one of the principal forces driving innovation.

Sources: U.S. Centers for Medicare/Medicaid Services <http://www.cms.hhs.gov/NationalHealthExpendData>; U.S. Census Bureau, *2007 Statistical Abstract of the United States*; Centers for Disease Control and Prevention, *The National Nursing Home Survey:1999 Summary; 2004 National Nursing Home Survey; Health, United States, 2006*.

---

*Edward J. O'Boyle is Senior Research Associate with Mayo Research Institute. Since completing his doctorate in economics from Saint Louis University more than 35 years ago, Dr. O'Boyle has specialized in economic research and analysis increasingly from the perspective of the human person engaged in everyday activities both as a unique individual and as a community member. In January 2004 the Association for Social Economics conferred on Dr. O'Boyle its prestigious Thomas Divine Award for lifetime contributions to social economics and the social economy. He taught economics at a state university in Louisiana for 30 years prior to his retirement in 2007.*

---

*Mayo Research Institute 1217 Dean Chapel Road West Monroe, Louisiana 71291  
318-396-5779 edoboyle@earthlink.net*