**The Price is wrong: Explaining the Lack of Entrepreneurial Behavior in Healthcare**

*“When we debate health care policy, we seem to jump right to the issue of who should pay the bills, blowing past what should be the first question: Why exactly are the bills so high?”*—Steven Brill[[1]](#footnote-1)

**Introduction**

Virtually every knowledgeable observer agrees that the United States healthcare system underperforms. When compared to peer countries, our quality is at best moderate, and our costs are the highest[[2]](#footnote-2). In a recent Harvard Business School survey, only 1% of market participants were strongly positive that the US could increase quality and lower costs to below general inflation, and 22% were strongly negative[[3]](#footnote-3). The United States spends about 18 percent of its gross domestic product on health care, nearly twice as much as most other developed countries.

Americans pay, on average, about four times as much for a hip replacement as patients in Europe and more than three times as much for a Caesarean section. The average price for Nasonex, is $108 in the United States compared with $21 in Spain. The costs of hospital stays in the US are roughly triple those in other developed countries, even though they last no longer[[4]](#footnote-4).

This is evidence of an ineffective system. Two salient questions must be asked: 1) Why is our healthcare system so ineffective? 2) What can be done to improve it? I am certainly not the first person to pose these questions. Certainly many causes of this inefficiency have been identified—inadequate coordination of care, bad production processes, ineffective insurance companies, patient litigiousness, government involvement, etc. In the same way, many nostrums have been suggested—single payer system, free market system, increased cost and pricing information, increased regulation on hospitals, etc.

All of these causes contribute to the problem and all of the solutions would likely help improve our system, at least to some extent. My solution is of the free-market variety. Many have commented that healthcare should be subjected to more to market forces, here I would like to take a more simple tack by singularly focusing on the lack of innovation and entrepreneurship among a key market participant--physicians. When we consider the lack of entrepreneurship among physicians there are many culprits, but chief among them are 1) a culture of extreme risk aversion among practitioners, 2) legal barriers, and 3) the lack of a free market price in healthcare. I will briefly discuss each below.

First, by virtue of the nature of their vocation and training, physicians are risk-averse. This risk-aversion in the practice of their craft is also manifested in the business side of their practices[[5]](#footnote-5). On average, it is simply not in a physician’s nature to take risks. Prudent risk-taking is part and parcel to entrepreneurial experience and without it, opportunities may be identified, but never exploited. This is likely further exacerbated by the fact that medical schools very seldom offer any sort of business training.

Related to the lack of risk-taking behavior is the presence of substantial legal implications (e.g. malpractice lawsuits) for physicians who seek to behave entrepreneurially. These implications encourage physicians to develop a defensive posture in their practices, which hamstrings the average physician’s willingness to exploit business opportunities[[6]](#footnote-6).

Finally, is the issue of price. I believe that the subtle power of price is often overlooked, particularly when discussing entrepreneurial behavior. Price is one reality underlying all of this—in virtually all instances, there are no “real prices” between buyers and sellers in this market. By “real”, it is meant market-based. Most of the complex solutions that have been suggested would be largely unnecessary if the market based prices were allowed to exist in this industry. Again, I am not the first person to state this, however what is often not appreciated is the role that price plays in motivating entrepreneurs to behave like entrepreneurs.

This point will be expounded upon in the sections below, but consider the implications of the absence of a true price. Specifically, consider the implication for perhaps the system’s most important participant—physicians. Many participants in this system could act as entrepreneurs, change agents, or innovators; but in this work, I maintain that physicians are—and should be—the primary source of entrepreneurship in healthcare and that their ability to behave entrepreneurially is being stifled. It is stifled by a tragic quasi-market, which contains as a chief weakness no ability to set a price. For entrepreneurs to do their job in an economy, this deficiency cannot be present and will eventually create a system that cannot bear the weight of its own inefficiency.

This work submits that physicians can be the “heroes” in this system, assuming that the system can be altered in a way that allows them to perform. This work takes no stance on the Affordable Care Act or any other devised system of healthcare distribution. And, it is not advocating for the demise of Medicare or Medicaid. It is however the goal here to draw attention to the impact that a centrally set price must have on the healthcare industry. To this end, I focus my arguments on the relation between entrepreneurial behavior and price in the healthcare environment.

**The Role of Price in Healthcare**

An important truism is that that, on average, humans will do what they are incentivized to do. When incentives are properly aligned, win-win situations are the norm—not the exception[[7]](#footnote-7). When incentives are misaligned, win-lose situations become the norm. This is case with regard to physicians in the healthcare system.

The role of price in an economy is critical and relatively straightforward. In brief, prices signal to buyers and sellers where shortages and surpluses might exist. With these signals, buyers and sellers will adjust their behavior to meet a changing market place. These behavior changes allow for efficient distribution of resources in a market.

Without these signals, buyers and sellers will not alter their behavior based on shortages and surpluses. Therefore, the system will contain many of these errors. For physicians, there are no prices; instead there are *reimbursements*. These reimbursements are set centrally by either insurance companies or the Centers for Medicaid and Medicare. Because price is set centrally (discussed in more detail below) and is not market based, entrepreneurs either cannot identify or cannot exploit opportunities as they exist in the marketplace—there are no signals. Until physicians can observe the opportunity and profit from altering their behavior, they are very unlikely to alter their behavior. They are, after all, human.

An unfortunate example of this playing out now is the shortage of general practitioners[[8]](#footnote-8). The prices (i.e. reimbursement rates) set for procedures performed by these physicians are much lower than those set by more focused specialists (e.g. orthopedic surgery). Even though an aging population is demanding more of these services, the price cannot rise because it is not market based. As an extended result, in medical schools, students are choosing specialties other than general practice. This does not make them immoral. It makes them human. They are responding to incentives—incentives that are misaligned. As Brill states:

“…we've squeezed the doctors who don't own their own clinics, don't work as drug or device consultants or don't otherwise game a system that is so gameable. And of course, we've squeezed everyone outside the system who gets stuck with the bills (p. 41).”

I would argue further that doctors are not gaming the system, but they are playing by the rules of the game, as they have been by policy makers. They are responding to the misaligned incentives that must exist in a gamed system.

There is also substantial evidence of surpluses. Over fifteen years ago Harvard’s Clayton Christensen recognized that some specialties are actually “overserving” patients. That is, patients are getting far more service than they actually need: “Our major health institutions—medical schools, groups of specialist physicians, general hospital, research organizations—have together overshot the level of care actually needed or used by the vast majority of patients”. This occurs because of the threat of malpractice, but also is likely occurring because physicians are incentivized to provide more procedures and products because they will be reimbursed more if they do. This is still the case today[[9]](#footnote-9).

I am not suggesting that doctors are routinely over-providing for profit, but I am stating that they have no motivation to provide the appropriate amount of service—all incentives and disincentives are encouraging them to error on the side of overserving, possibly by a lot. “With a relatively inelastic quantity, and prices that are invariant to quality, the incentives for providers to invest in more efficient care provision are very substantially blunted.” [[10]](#footnote-10)

This evidence of overserving is important, because it is one of the key drivers of frame-breaking innovation[[11]](#footnote-11). In a well-functioning market, when incumbents overserve customers, entrepreneurs enter to provide a more appropriate, cheaper, and simpler product. However, neither the shortage of GP’s nor the overserving of some patients can be corrected, because there is no market price, and therefore no way for entrepreneurs to make a profit, and therefore no reason for them to change behavior.

**Physicians as entrepreneurs**

Many definitions of entrepreneurs exist. Here we use the following definition slightly adapted from numerous scholarly definitions: One who discovers, evaluates, and exploits opportunities to introduce new goods and services.

Physicians (defined here as those who have attained MD or DO degrees) as the highly trained and informed line workers in health care are in the ideal position to introduce both incremental and frame-breaking innovations. Not only are they the most aware of effective products and services, but they deal with the end-user (the patient) many times every day. Moreover, many of these individuals are business owners—they own and manage their private practices. By almost any definition, a large percentage of physicians are entrepreneurs. Virtually no other industry has such highly trained individuals on the front line, yet the healthcare industry is one of the least entrepreneurial[[12]](#footnote-12). This clearly begs the question, why do these individuals not display more entrepreneurial behavior?

To find our answer, a brief review of two influential economists is in order. First, is Israel Kirzner. Kirzner states that an economy cannot successfully manage supply and demand without alert and enterprising individuals (i.e. entrepreneurs) taking action to reallocate resources in a way that moves an economy toward “equilibrium”—where supply and demand are balanced. These alert individuals are the ones who notice signals that others do not and take actions that others will not to balance supply and demand. When they do not, or cannot, act to fill unmet needs in the economy, then innovations do not get introduced.

Another influential economist is William Baumol. Baumol chooses to focus on the role of policy decisions in an economy. That is, the “rules of the game” that have been set by the government and other institutions. For Baumol, entrepreneurs are always present in any setting, but the “rules of the game” will direct their behavior towards productive, unproductive, or destructive entrepreneurship. If the reward structure (i.e. rules) is such that one can benefit from engaging in activities that are good for the economy and society, then enterprising and alert individuals will do just that. When there is no incentive for engaging in productive entrepreneurship, then no one will.

The point in reviewing these thought leaders in entrepreneurship is to make the assertion that in the current healthcare setting, alert medical doctors cannot take advantage of opportunities, because these entrepreneurs are denied true market based feedback. They cannot make sense of a given event because too many forceful non-market based mechanisms are in place. In both Baumol’s and Kirzner’s view, society wants entrepreneurs to be equilibrium agents, that is when excess demand is present; we want them to satisfy that demand with products and services at a price determined by the market.

Unfortunately, in health care the “rules of the game” are set by the government and right now they encourage a movement away from GP. If a given physician could set price, he or she would likely be able to charge a premium offering GP services, and patients desiring care would oblige. Additional GP’s would get into the market and equilibrium could be reached. Because there is no true market price, the market cannot move toward equilibrium, and thus physicians are necessarily responding to “command incentives” set centrally.

**Healthcare’s Major Players**

Figure 1 contains a general, high level depiction of how prices are set (and taken) in the U.S. healthcare system. At this level of analysis, there are three key players. First, the providers are principally made up of large hospitals. Second, the payers, are made up of two key participants—the Centers for Medicaid and Medicare (CMS) and the insurance companies. The third group is the patients. There are two broad types of patients: insured and uninsured. Theoretically, in the US (under the Affordable Care Act) all citizens should be insured, but some are not. The final group of interest in the model is the employer group, and they function as an intermediary between the insurance companies and some patients.

FIGURE 1 ABOUT HERE

The theoretical customer in this model is the patient, but the patient is not the actual customer. For a given transaction, they do not pay the full price of the care because they have the price reduced on account of their (and possibly their employers) premium payment to their insurance company—or because they are enrolled in Medicare/Medicaid. In fact, it is highly likely that the patient does not (and cannot) know the price of a given procedure before that procedure takes place.

The two dominant players in this model are the large hospitals and the Centers for Medicare and Medicaid. The insurance companies certainly matter, but they have less power in the industry vis-a-vis these two. The customers, then, are the CMS and the insurance companies. Price of care is set before any care is delivered and is determined in one of two ways: 1) Hospitals negotiate a price with the insurance companies; 2) hospitals are told by Medicare what to charge.

This a priori pricing issue deserves some attention. The payers negotiate prices with the providers months (possibly years) ahead of actual service provided, and the patient has no real way to know what these prices are. Though efforts at price transparency have improved, it is still a long way from true transparency[[13]](#footnote-13). Moreover, the patient has no real motivation to care about the price because they will pay the same (or similar) amount regardless—the payer will pay the rest. So the patient receives the service, but the bill is paid by the *third party* payer.

So, what is the problem? The problem is that under this scenario, no market based price can exist. Briefly, the general cause of the fake price scenario is two-pronged. First, the hospitals’ prices originate from a being called the *chargemaster*. The chargemaster is essentially software that compiles a lot of data (e.g. historical and future “prices”, historical and future costs, health trends, geographical information, etc.) and sets a price on every product and service. Market forces have very little impact on this price. In fact, the hospitals have every motivation to make this already fake price even “faker” by jacking it up. This motivation exists because they use the chargemaster price as a starting point for negotiations with the insurance companies. Brill states: “…the chargemasters are both the real and the metaphoric essence of the broken market. They are anything but irrelevant. They're the source of the poison coursing through the health care ecosystem”. (p. 40).

The second payer, CMS, has a similar cache of archival and predictive procedures for setting price. These procedures are similarly fake. The only difference is that CMS makes every attempt to push the price *down* as opposed to up. Moreover, CMS’ reimbursement formulas for these tests are regulated by Congress--it literally takes an act of congress to change “price”. This is hardly efficient. Though CMS has managed to contain costs somewhat, it still does not accomplish what a free functioning market could do. The starting point for CMS’ data—just like the chargemaster data—must be an artificial price. That is, some number that is not determined by a market exchange.

Logic dictates that the resultant prices must be fake. With very few exceptions, there has been no actual market exchange of healthcare services in the U.S. since private “insurers” took over as payers. Where would a true market prices originate? It is technically impossible for CMS or the hospitals to charge a true market price.

**Why Is There Not A Free Market Price?**

The current state of US healthcare today is the result of a hodgepodge of (mostly) well intended decisions by our political leaders, the American Medical Association, employers, and insurance companies. It is not the goal here to recount the entire history of healthcare in the US, but some—highly abbreviated—background is important[[14]](#footnote-14).

1. The American Medical Association, founded in 1847, led the charge to establish strict licensing requirements on who could practice medicine in the US. This had the obvious impact of reducing the number of physicians in the country. Before this, the practice of medicine in the US was largely unregulated. Physicians treated patients and patients payed the physicians.
2. In effort to increase access to healthcare and motivate students to enter into medical schools, in 1937 Blue Cross commission was formed. This would eventually, with support of AMA, firmly establish Blue Cross and Blue Shield. Blue Cross and Blue Shield were granted tax exempt status by the federal government. This made insurance much cheaper and made the medical profession far more lucrative. In response to wage freezes imposed because of World War II, employers began to offer health insurance as a fringe benefit—which were not frozen.
3. Shortly after this, health insurers (Blue Cross/Blue Shield) would evolve into third party payers—not technically insurance companies. This set into motion our current predicament regarding the absence of a true price. The third party payers were required to set fees ahead of time. Patients had very little input on these fees.
4. In 1965, Medicare was signed into law to cover those 65 and older who were no longer covered by their employers—and could not afford insurance. This is the set into motion the negotiated price (Figure 1) between CMS and hospitals. By the 1980’s, there was little trace of a true market price for services rendered in health care.

**Are there free market prices anywhere?**

When real prices can exist, inefficiencies should be wiped away by entrepreneurs. That is, when price signals that an opportunity is present, individuals will be motivated to exploit that opportunity. When the rules of the game are such that no such signal can be sent, the inefficiencies will remain.

Measuring innovation is tricky and inexact. As a result, here I simply look at cost to outcome comparisons. That is, I assume that industries which contain both high costs and poor outcomes (i.e. inefficiency) lack innovation. Certainly there are exciting and valuable innovations occurring in the broader healthcare industry. But, I argue, there is precious little of this at the level of the practicing physician—where the rubber meets the road. To address this more directly, let us take a look at healthcare markets where real prices can be set. We should see less inefficiency here. That is, either better outcomes, lower costs; or both.

Again, data and research are sparse, but when we look at industries like cosmetic surgery, LASIK, and concierge medicine; the theory based on free market price seems to hold. For example, in cosmetic surgery, where insurance companies and CMS are rarely involved we see positive results.

First, it appears that physicians behave differently in a free market setting. Physicians that practice both cosmetic surgery and other types of surgery provide more transparent pricing information to the market in their cosmetic surgery practices. Cosmetic surgeons, on average, provide prices up front to patients and patients can comparison shop[[15]](#footnote-15). These same physicians do not (and probably cannot) provide this information for insurance related procedures. Second, and possibly more importantly, price in cosmetic surgery is actually lower in real terms than it was 10 years, and considerable innovations have been made in this arena[[16]](#footnote-16). This quote from IBIS World, a non-partisan market research firm, is especially telling:

“Demand for plastic surgery has been on the rise. The aging population and an increasingly favorable public perception of plastic surgery have been driving forces behind the recent rise in industry demand. Furthermore, technological advances have helped bolster industry revenue as safer and cheaper procedures have become available for consumers. …the industry has been hampered by rising external **competition**….As competition heightens, operators have been forced to **reduce prices** on numerous procedures.” [Bold added] LASIK and concierge medicine show similar properties[[17]](#footnote-17).

Alternatively, consider a quote from the same source regarding primary care doctors:

“While healthcare reform has increased the number of insured individuals, it has also **exacerbated the shortage of primary care doctors**. Despite growth, the number of primary care doctors has not expanded enough to keep pace with demand. In an effort to address this shortage, a number of reforms have been implemented under the PPACA, including the provision of grants and contracts to support entry into primary care. Most importantly, the PPACA has increased **reimbursement rates** for primary care services through Medicare and Medicaid, aimed at bridging the substantial pay gap between primary care and specialist physicians in an effort to encourage more primary care doctors.” [Bold Added]

So, in one case, we have rising demand, increasing competition, technological advances, and decreasing prices. An appropriate result of the existence of a free market price. On the other hand, we have increasing demand, increasing prices, shortages, and increased government intervention. An appropriate result of the absence of a free market price.

**What should we do?**

My recommendation is admittedly ideological: change the rules of the game in healthcare to more closely resemble a market. THEN, set the safety net based on that pricing data—simply, put the horse back in front of the cart. In this way, those who cannot afford necessary health services can still be covered under Medicaid and the elderly can still be covered under Medicare, but a move in this direction would:

1. Make insurance companies act like insurance companies instead of payers. This payer dynamic has truly inhibited market forces. Dissolve the current insurance companies. They have become what Baumol would call “unproductive entrepreneurs”.
2. This would lead to a real price based on supply and demand. Some would never pay this price, but the baseline price data would far more indicative of what a patient would pay in a market.
3. Most importantly, this would allow and encourage our most well informed, well trained, and well-meaning individuals to behave like entrepreneurs.

Figure 1. Price Setting/Taking in Healthcare

**Providers**

**Patients**

**Payers**

Hospitals

-Not for profit

-Large physician groups

-For profit

Insurance companies

--HMO

--PPO

Negotiation

Negotiation

Employers

Price Setting

Negotiation

Price Taking

Price Setting

Insured

Patient

Medicare/Medicaid

Price Setting

Price Setting

Uninsured

Patient

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