

The Business of Healthcare

*Essential Lessons for
Emerging Healthcare Leaders*

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Preface

I have studied, practiced, and taught medicine, health law, and healthcare business for nearly 50 years. This includes attending three of the country's leading graduate schools, learning from world-class faculty, engaging with outstanding students, and working with leading practitioners and healthcare institutions across the United States.

The business of healthcare is incredibly complex. Medicine alone is too complicated for any single individual to master in a single lifetime. Healthcare is the most heavily regulated industry in the country, and health law is one of the most demanding specialties in the legal field. Then add to this the countless complexities of successfully operating a healthcare business in an industry that accounts for one in five dollars spent in the United States. Mastering the medicine, law, and business of healthcare is too much for one person. And yet, I have learned that the key lessons for success in healthcare business are not particularly complex and can be understood within a reasonable period by any sufficiently interested professional.

This book will provide essential business knowledge for healthcare leaders. It was written for physicians, nurses, allied healthcare practitioners, and individuals new to healthcare management and leadership. It may also serve as a valuable primer for politicians and concerned citizens seeking to understand and improve the U.S. healthcare system. By necessity, I have covered most topics in only the most superficial manner.

This book contains little original material. Any originality lies only in the selection, arrangement, and presentation of the contents. As it is not intended to be an academic textbook, I have avoided footnotes. You can quickly establish and expand on all statements with brief internet searches or AI inquiries. For those who want to dive deeper into any subject, I have ended each lesson with a list of a few outstanding written works, with additional resources in an appendix. These will guide you in your study of the content of each lesson in more detail.

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The Challenges Facing U.S. Healthcare

1.1 Introduction

In this lesson, we will identify the primary challenges confronting the United States healthcare system from a business perspective. An initial question might be whether healthcare is even a business. Historically, it was not always considered as such. We will briefly describe the size and complexity of the healthcare system and examine the primary challenges of quality, cost, and access. We will discuss the concept of value in healthcare and compare U.S. healthcare with systems in other nations.

1.2 Is Healthcare a Business?

A business can be thought of as a black box. At one end of this machine, resources are fed in. The black box does its work. At the other end, something of greater value emerges than the initial inputs. A business exists to create value. The primary measure of this value is in dollars. Any successful business takes some amount of wealth and turns it into greater wealth. In this way, a business is a money-making machine. In business school, you are typically taught that the primary, and often sole, reason for a business to exist is to make money.

Consider a refinery. At one end, raw petroleum products are put in. The refinery produces higher-value petroleum products. While refinery workers may be proud of the quality of the end products, the ultimate reason for the refinery's existence is to generate profit. A refinery that produced a high-quality product but lost money year after year would be shut down. The same is true of sandwich shops and lawn services. The primary concern for every business on this planet is how to create enough value—a product or service of sufficiently high quality at a reasonably low cost—that consumers will buy the product or service and allow the company, at

a minimum, to keep operating. We can think of this as the simple equation: $\text{Value} = \text{Quality} / \text{Cost}$.

Any business that wants to remain in operation must therefore be able to accurately measure the quality of its products or services and the cost of producing them. Only through these measurements can the business improve quality and reduce costs, thereby offering sufficient value to its customers.

Unlike most businesses, healthcare began not with the idea of making money, but with the idea of providing a charitable service. A classic charity relies on donations from individuals, which it allocates to other individuals. This is a very different model from a typical business. The charity exists to serve an essential or noble purpose. With this background, until very recently, you could readily find physicians and administrators who would argue that healthcare was not a business. The argument usually ran along the lines that every patient is unique, with a unique presentation of a disease or health issue. When treatment was provided, these patients responded in distinct ways. Some patients required extensive care, whereas others with the same disease required very little. There was no way you could measure quality because you could not compare one patient to another. Similarly, there was no way to estimate costs because each patient incurred a different amount to treat or cure their condition. In the absence of quality or cost measures, you could not treat healthcare as a business. Besides, healthcare existed primarily not to make money, but to serve one of the most noble causes of humankind—the care of another individual's health. That heritage persists: most U.S. hospitals remain nonprofit and treat profit as a secondary goal—the means to the mission rather than the mission itself (“no margin, no mission”)—even though every one of them must earn enough to keep operating.

1.3 Is There a United States Healthcare System?

The U.S. healthcare system is perhaps the most complex business ecosystem in the country. It involves many types of businesses with very different goals, operating principles, and legal structures. Think about national for-profit hospitals, regional nonprofit hospitals, county and federal government-run hospitals, volunteer organizations, pharmaceutical/medical technology/biopharmaceutical companies, insurers, physicians, nurses, allied health professionals, etc. It currently involves nearly 20% of GDP—one in five dollars spent in this country. And it employs roughly one in eight American workers. It is massive, complex,

and often dysfunctional. Complaints of poor quality, high cost, and unequal access typically characterize the dysfunction.

It is the dysfunctional nature of U.S. healthcare that leads some experts to say that there is no U.S. healthcare system—it is just an assemblage of poorly articulating parts. But a less-than-optimal system is still a system. The U.S. healthcare system comprises large, powerful enterprises and professions that interact and feed back on one another in highly complex ways.

1.4 Fundamental Unanswered Questions

One reason for the high costs and less-than-optimal healthcare outcomes in the United States is that, as a nation, we have not agreed on what we want our healthcare system to be. What is the mission of our healthcare system—to treat patients who are sick or to keep people well? The majority of hospitals and physicians are paid (and therefore motivated) for seeing sick people, with little or no incentive to keep us well.

Should the marketplace regulate quality, cost, and access in healthcare, or should we rely on the federal government to regulate the system? As we will see, unlike most industries, the healthcare marketplace has largely failed, which explains why it is the most regulated industry in the country.

Perhaps most critically, is healthcare considered a right (as in every other developed country) or a privilege (as it remains in the United States)? The United States has an overall uninsured rate of about 8% (2024); among people under 65, roughly 10% of Black Americans and 18% of Hispanic Americans are uninsured (KFF). Most of the 38 nations of the Organisation for Economic Co-operation and Development (OECD), a group of 38 mostly high-income countries, have uninsured rates of 0–1%. In OECD data on population coverage for a core set of services, the U.S. ranks below countries such as Portugal, Türkiye, Hungary, and Poland. In a groundbreaking 2002 review, the Institute of Medicine (IOM) estimated that 18,000 Americans died annually because they lacked health insurance. Later estimates ranged from roughly 26,000 (Families USA, 2012, using the IOM's approach) to about 45,000 deaths per year (Wilper and colleagues, 2009, using a different method). This report established the baseline argument that lack of insurance is deadly. It highlighted the reality that uninsured adults receive less preventive care and are diagnosed at more advanced stages of disease.

1.5 Size and Complexity

The healthcare sector is colossal, with national health spending reaching \$5.3 trillion in 2024—18% of U.S. GDP, dwarfing the arts, entertainment, and recreation industry, which accounts for 1.2%. Healthcare is the largest employment sector in the U.S., surpassing both the Retail Trade sector and the Federal Government. According to the Bureau of Labor Statistics (2024 estimates), there are 3.4 million registered nurses, 700,000 licensed practical/vocational nurses, 1.5 million nursing assistants, roughly 600,000 health services managers, 4.3 million home health and personal care aides, 200,000 health information technicians/coders, more than 1 million physicians (MD/DO), and 3–5 million allied health technicians. The Texas Medical Center in Houston, Texas comprises 21 hospitals dedicated to patient care, 15 schools, 18 support facilities, and staggering numbers, including 10 million patient encounters and 180,000 surgeries annually. It would rank as the 8th largest business district in the U.S., with an employee count exceeding 120,000.

The healthcare landscape encompasses roughly 20,000 approved drug products, more than 13,000 recognized diagnoses, thousands of laboratory tests, and some 70,000 diagnosis codes. A testament to the field's ever-evolving nature is the publication of 1.7 million biomedical articles annually. In 1950, medical knowledge was estimated to double every 50 years; by one widely cited 2011 projection (Peter Densen), it would be doubling every 73 days by 2020. An aspiring clinician trying to keep up with this literature would have to read more than 180 articles per hour, twenty-four hours a day, seven days a week, for a whole year to stay current.

1.6 Growth

The healthcare sector's growth is stunning. CMS projects U.S. healthcare spending to grow 5.4% per year on average over 2025–2034, with Medicare at 7.7% and Medicaid at 5.0%, outpacing projected GDP growth. Job opportunities within the sector are also projected to grow by 9%, twice the average growth rate for all other occupations. This growth is outpacing the capacity of the U.S. federal and state governments, as well as businesses, to fund healthcare. It is also challenging to find sufficient numbers of physicians, nurses, and allied healthcare professionals to staff our clinics and hospitals.

1.7 Data Explosion

When I entered medical school in 1981, we were collecting a relatively limited amount of data on patients—vital signs, handwritten history and physical exams, daily notes, and handwritten lab results on pieces of paper taped into medical charts, along with a few images on photographic film. All of this was filed away in manila folders on shelves.

Fast-forwarding from 1981 to the present, and we are now in the midst of a digital revolution in healthcare, encompassing everything from electronic medical records and electronic billing to sophisticated data tracking and AI-driven insights. Yet, with these data advancements come challenges. A 2013 study of a community hospital emergency department found that emergency physicians spent 43% of their work time on data entry (~28% on direct patient care), averaging nearly 4,000 mouse clicks during a busy 10-hour shift.

1.8 Regulation

The U.S. healthcare industry is the most heavily regulated in the country. Thousands of healthcare-related statutes and tens of thousands of related regulations exist. For context, the Affordable Care Act (ACA) alone ran to roughly 900 pages as enacted (more than 2,000 pages as a congressional bill) and has generated well over 10,000 pages of regulations and guidance.

1.9 Three Great Challenges Facing Healthcare Leaders

In 1981, it was sufficient to focus mainly on practicing medicine. Today, providers must focus not only on delivering increasingly complex care but also on becoming more financially efficient and navigating an increasingly labyrinthine legal landscape. The U.S. healthcare system, despite its massive scale and resources, faces tremendous challenges. Here, we will focus on the three most pressing challenges for healthcare leaders.

1.9.1 Quality

My students often find it difficult to accept that there is a problem with healthcare quality in the U.S. Most are quick to point out that the U.S. drives many of the world's leading advances in healthcare technology. This is true. But it is also true that the unique way we provide and pay for healthcare in this country—different from that of all other developed countries—results in inferior outcomes for our population. The Commonwealth Fund provides the most respected review of healthcare systems in

developed countries. Since it began ranking healthcare systems in 2004, it has ranked the U.S. last in comparing it to peer countries. In its 2024 Mirror, Mirror report comparing 10 high-income countries, the U.S. again ranked last overall. While the U.S. ranked second in care process, it ranked last in access to care, equity, and health outcomes, and ninth in administrative efficiency.

Another significant concern relates to patient safety and medical errors. The first comprehensive study on this subject in 1999, “To Err Is Human,” published by the Institute of Medicine, estimated that in the U.S., there are between 44,000 and 98,000 annual deaths from preventable medical errors. A 2016 study from Johns Hopkins, published in the *British Medical Journal*, identified preventable medical error as the third leading cause of death in the U.S. This study calculated a staggering 251,454 annual deaths from medical mistakes—equivalent to 689 deaths per day, or five fully loaded 737 aircraft crashing every day of the year (this is an unofficial estimate, as death certificates do not list “medical error” as a cause). The figure is a widely cited but contested extrapolation; later analyses put preventable in-hospital deaths far lower.

1.9.2 Cost

Healthcare costs in the U.S. have risen exponentially. From \$27 billion in 1960, the cost of care increased to \$4.1 trillion in 2020 and \$5.3 trillion by 2024. While the OECD average for healthcare hovers around 9% of GDP (about one in ten dollars spent on healthcare in their countries), the U.S. stands at almost twice that rate, at 17–18% of GDP (one in five dollars).

Areas of concern include the soaring paychecks of healthcare CEOs and the high prices of medications. A 2021 study from the University of Minnesota Medical School documented the escalating prices of standard-of-care medications over eight years. Examples include the cost of a drug used to treat hookworm rising from \$32.77 to \$1,660 and a pinworm drug’s price shooting up from \$14.81 to \$130. Healthcare insurers generate significant profits, and physicians, especially in high-end specialties, are among the highest-paid in the world.

Increasingly, U.S. patients are delaying routine healthcare visits because of cost. And the U.S. is the only developed country that routinely allows medical bankruptcies—citizens forced to declare bankruptcy because they cannot afford healthcare.

1.9.3 Access

Access, or the lack thereof, is the third primary concern. As of 2020, 31.6 million Americans (about 10%) lacked health insurance. Thanks to cover-

age expansions, the uninsured rate fell to 8.2% by 2024—roughly 27 million people, near the lowest level ever recorded, but still far higher than in other developed countries. That total included 3.7 million children (5% of all children) and 23 million working-age adults (nearly 12% of that group). That progress is now expected to reverse. The Congressional Budget Office projects that the 2025 budget reconciliation law (H.R. 1), together with the expiration of the enhanced ACA premium subsidies at the end of 2025, will add more than 14 million to the ranks of the uninsured by 2034.

Even those with insurance often find healthcare unaffordable. In one year, 40% of Americans skipped a recommended treatment or test due to cost, according to a 2018 study by the University of Chicago. Preventive care is another area in which the system lags, with only 8% of U.S. adults aged 35 and older receiving all the high-priority preventive services recommended for them. Overall, patient satisfaction remains low.

1.10 Market Failure

What emerges from these challenges is a picture of an expensive healthcare system operating suboptimally, with poor outcomes and insufficient accessibility for our most financially disadvantaged citizens. In the U.S., we have traditionally relied on the free market to address economic challenges of quality, cost, and access. In a genuine free market, prices for goods and services are determined by the open market. Information regarding quality and cost is readily available. And there is little or no interference from governments or monopolies.

The U.S. healthcare system illustrates all the signs of market failure. There are significant information asymmetries, a lack of competition in many geographic areas, incomplete markets in others, public-good and merit-good considerations, externalities, moral hazard, fraud, and equity issues. Ludwig von Mises, an eminent economist, once said, “The issue is always the same: the government or the market.” In the absence of a viable free market, the only other choice is enhanced governmental regulation. Since 1965, with the creation of Medicare and Medicaid, state and federal governments have increasingly sought to address issues of cost, quality, and access through an ever-expanding array of regulations.

1.11 Value in Healthcare

The value of any service or product is derived from what one receives in exchange for what one pays for. Taken as a whole, the U.S. healthcare system is failing to deliver on value. Value in healthcare (as in any business)

can be envisioned as the relationship between quality and cost. $\text{Value} = \text{Quality} / \text{Cost}$. We will examine quality and cost in some detail in subsequent lessons, with quality including access for all citizens to receive adequate care. But for now, we should realize that improving quality, cost, and access—all at the same time—is a daunting challenge. It has typically been described, following William Kissick, as the “iron triangle”: improvements in quality come with increased costs, cost reductions come at the expense of access or quality, and expanded access significantly increases costs. The Institute for Healthcare Improvement (IHI) has suggested a similar (but not identical) Triple Aim of improving population health, enhancing the patient experience, and reducing per capita healthcare expenses. Historically, this has seemed to be a zero-sum game.

In addressing value, experts typically begin theorizing about changing the healthcare system with new policy shifts—more regulation rather than less. However, given the current political realities in the United States, it is unlikely that there will be a significant overhaul of the U.S. healthcare system in the next decade. Besides the differences in political parties, there are massive, well-funded, and politically powerful entities—physicians, pharmaceutical companies, hospitals, healthcare insurers, and older adults (who vote in large numbers) who have little (short-term) incentive to change the current system.

This is not a policy book. In the following lessons, we will accept the U.S. healthcare system as it currently exists and address the challenges of quality, access, and cost as business problems. For years, the U.S. healthcare system has lagged behind other industries in quality initiatives, data analytics, human resource allocation, and other key management principles. This book provides an entry point into the fundamental business ideas necessary to lead and improve the U.S. healthcare system over the next decade.

1.12 Healthcare in Other Countries

Before we move on, we might take a brief tour of how other developed countries are delivering healthcare. On average, they are achieving better outcomes at half the cost. What are they doing differently? Healthcare systems in different countries generally follow one of three models: the Bismarck Model, the Beveridge Model, or the National Health Insurance Model.

1.12.1 Bismarck Model

Named after a German Chancellor and adopted by countries like Germany, Japan, Belgium, Switzerland, and parts of Latin America, this model operates with private healthcare providers and private payers. Private insurance plans, despite being funded through employer-employee payroll deductions, cover everyone, including the unemployed, and operate as nonprofits. The government tightly regulates services and costs.

1.12.2 Beveridge Model

Named after a British economist, this model is used in countries including the United Kingdom, Spain, Scandinavia, and Hong Kong. Healthcare providers (hospitals, clinics) are mostly governmental institutions, and most physicians, nurses, and allied health professionals are government employees. Healthcare is fully financed through taxation and administered by the government. The government plays a pivotal role in regulating medical practice and physician fees.

1.12.3 National Health Insurance Model

This model has been adopted by countries like Canada, Australia, Taiwan, and South Korea. The main payer is a government-operated insurance firm. Hospitals and physicians are usually private. The government receives funds through taxation and can control service provision and wait times.

1.12.4 Out-of-Pocket Model

In many low-income countries, healthcare is predominantly financed through out-of-pocket payments. The provision of care is directly proportional to patients' ability to pay. There is very little control over quality or cost.

1.12.5 The U.S. Model

The U.S. is unique because it has adopted all four basic models. For veterans and Native Americans, the Department of Veterans Affairs (VA) system and the Indian Health Service operate like the Beveridge Model, with the government both paying for and owning/employing all the hospitals and physicians. For Americans aged 65 and over, Medicare operates similarly to the National Health Insurance Model. For employees with employer-based healthcare insurance, healthcare operates like the Bismarck Model. For those without access to these types of insurance, care is provided out of pocket, as in Cambodia.

Additionally, even when the U.S. federal government is involved, it exerts little control relative to other governments. For example, until recently, Medicare could not negotiate drug prices. Because providers must seek payment not from a single payer but from dozens of negotiated agreements across all four models, the U.S. incurs much higher administrative costs in managing its healthcare financing. Finally, the U.S. is one of the only developed countries with for-profit healthcare insurance companies. These contribute to the complexity and cost of our system.

1.13 Summary

In this lesson, we argue that healthcare is not only a business but also a complex, massive, and often dysfunctional one. However, unlike the great majority of for-profit businesses, profit is typically a secondary goal, subordinate to the mission of providing high-quality patient care. The U.S. healthcare system is substantial, accounting for nearly 20% of GDP and employing roughly 1 in 8 American workers. The iron triangle of quality, cost, and access describes the primary challenges facing healthcare. We will be returning to the concept of increasing value, conceptualized as quality/cost, in the upcoming lessons. Compared with other countries with significant economic development, the U.S. healthcare system differs in adopting four distinct financing models and in avoiding granting the federal government considerable control over cost negotiations.

1.14 Executive Takeaways

The following points summarize the primary challenges and structural complexities of the U.S. healthcare system as discussed in the text:

1. **Healthcare as a Value-Creating Business.** Historically viewed as a charitable service, healthcare is fundamentally a business that creates value, which can be expressed by the equation: $\text{Value} = \text{Quality} / \text{Cost}$.
2. **Size and Economic Impact.** The U.S. healthcare sector is colossal, with \$5.3 trillion in annual spending, accounting for 18% of the nation's GDP. It is the largest employment sector in the country, employing roughly one in eight American workers.
3. **The “Iron Triangle” Challenge.** Healthcare leaders must navigate the “iron triangle” of quality, cost, and access. Historically, improving one often leads to a decline in another, such as significantly increasing access, which drives up costs.

4. **Inferior Outcomes Relative to Cost.** Despite spending roughly double the percentage of GDP on healthcare compared to other OECD nations, the U.S. consistently ranks last among top developed countries in terms of healthcare outcomes, access, and equity, and near the bottom in administrative efficiency.
5. **Evidence of Market Failure.** The U.S. healthcare system exhibits signs of market failure, including information asymmetries and a lack of competition, which helps explain why it is the most heavily regulated industry in the country.
6. **Medical Knowledge Explosion.** Medical knowledge is projected to double every 73 days, making it impossible for clinicians to stay current solely through traditional reading.
7. **The Crisis of Preventable Errors.** Preventable medical errors are a staggering concern; a 2016 study identified them as the third leading cause of death in the United States, causing approximately 251,454 annual deaths.
8. **The Burden of the Uninsured.** The U.S. has an approximate 8% uninsured rate as of 2024. Studies have estimated that lack of insurance is deadly, causing between 18,000 and 45,000 deaths per year.
9. **Unique Financing Model.** The U.S. is unique in that it utilizes a “patchwork” of four basic international healthcare models: the Bismarck Model (employer-based), the Beveridge Model (VA system), National Health Insurance (Medicare), and the Out-of-Pocket model.
10. **Unanswered Fundamental Questions.** A primary reason for the system’s dysfunction is a lack of national consensus on its mission: specifically, whether the goal is to treat the sick or keep people well, and whether healthcare is a right or a privilege.

1.15 Further Reading

The Health Care Handbook: A Clear and Concise Guide to the United States Health Care System, by Elisabeth T. Askin and Nathan Moore, published by Wolters Kluwer (3rd ed.), 2023, is the best short orientation to how the U.S. system is organized, financed, and regulated, written for clinicians who need the whole picture in an afternoon.

“It’s the Prices, Stupid: Why the United States Is So Different from Other Countries,” by Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, *Health Affairs*, 2003, showed that the United

States spends more than peer nations because of higher prices, not higher utilization.

The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care, by T. R. Reid, published by Penguin Books, 2010, tours the Bismarck, Beveridge, national health insurance, and out-of-pocket models country by country and explains why each delivers better outcomes at lower cost than ours.