Medicine as a Profession and a Business

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Lecture 1

The general subject of these lectures is the revolution in the medical care system that is sweeping this country, transforming the way we organize and finance the system, the way doctors work within it, and the way we think about health care. In particular I propose to discuss how the ethical values and assumptions upon which our medical system has long been based are now being challenged by new social, economic, and political realities.

In the first lecture, I will describe the health care revolution in broad terms, attempting to explain its origins and present direction. In the second lecture, I will focus on the changes occurring in the medical profession — a profession more troubled and less sure of itself than at any time in my memory. At the end, I hope to consider some of the public policy issues posed by these developments and speculate about the future options for the medical profession and for health care planners.

Underlying all of my discussion will be some basic questions. Is medical care a consumer good like any other, a commercial service provided by skilled vendors for consumers willing to pay the market price, or is there something fundamentally different about the relation between doctor and patient? Will American society be served best by treating medical care like commerce, by relying mainly on the market to solve the problems of allocation, access, cost control, and quality assurance, or should we regard medical care as a form of social service which our nation owes its citizens and which therefore ought to be provided in a more planned and regulated context? The tension between these two views of medicine — the economic and the social — is the leitmotif of these lectures, the theme around which I develop my interpretation of what is now happening to medical care in this country.

Let me begin by explaining what led up to the present economic troubles of our health care system. In essence two basic developments, one technological, the other political, worked synergistically to create an uncontrollable inflation. In the first place, there was a postwar scientific and technological explosion without parallel in history. Biomedical science was poised to expand just before World War II, and the resources poured into health care during and immediately after the war provided the impetus for a major national commitment to medical research and education, which led to a period of rapid growth. The establishment of the National Institutes of Health in Bethesda, Maryland, was followed by generous federal funding of research and training programs in the medical schools. Federal, state, and private philanthropic support for the construction of new or expanded medical schools and research institutions also played a role in fostering a vast postwar expansion of biomedical resources. New discoveries in basic and applied medical science, and new technology in almost every field, led to advances in diagnostic and therapeutic techniques, which produced new medical subspecialties. Meanwhile, the expanding medical schools were turning out new doctors in ever greater numbers, and about 70 percent of them became specialists rather than the primary-care practitioners who had up to then constituted the great majority of physicians.

The other seminal development was the expression of a liberal political consensus that more had to be done to increase the availability of medical services to all who needed them. The perception in the immediate postwar decades was that not only did we need more medical research, more medical schools, and more doctors but that we also needed to provide our citizens with more and better access to medical care. Construction of new hospitals was fostered through a federal program of grants and loans. State and local taxation as well as private philanthropy and bond issues also contributed to the expansion of hospital capacity. Many new programs extended medical services into the communities,

but the limiting factor in achieving access for all people was the relatively high cost of hospital care, which few could afford to pay for out-of-pocket. Most affluent citizens, as well as the self-employed middle class, had begun to depend on privately purchased hospital insurance plans to pay their major medical expenses. By the decade of the 1960s, hospital insurance had become a virtually universal component of the fringe benefit package offered by large employers to their workers. The cost of the premiums was a business expense which reduced corporate tax liability, but the value of the benefits to employees was not taxable as income, so work-related medical insurance became a tax-free bonus in the form of a nearly unlimited hospital credit card, paid for by the company and, of course, ultimately subsidized by the company's customers.

Widespread as these arrangements were, major gaps in coverage still remained and were not filled until 1966 with the advent of Medicare and Medicaid. This legislation extended limited hospital insurance protection to most of the elderly and many, but by no means all, of the poor.

The prevailing view during those days was that medical care was a right of all citizens, regardless of their insurance coverage or their ability to pay. There was general agreement that everyone was entitled not to every medical service they wanted but to whatever care they really needed, and this care ought to be in the mainstream, that is to say, through private physicians of one's own choice and in semiprivate hospital accommodations. Medicare and Medicaid patients were not to be treated any differently, although, of course, anyone was free to pay for extra private amenities if they wished to do so. Indeed, the federal government was very insistent that, since it was paying customary charges, the services to Medicare and Medicaid patients were to be the same as those provided to any other semiprivate patient.

With the passage of this legislation, our country took a large step toward equality in health care, but we were still far from that

goal. Most people sixty-five years of age or older qualified for Medicare coverage, regardless of financial need, but Medicare benefits in hospitals and nursing homes were limited. Medicaid benefits were more extensive, but to qualify, patients had to be virtually destitute. Even then, assistance was not assured, because state participation in the Medicaid program, which was intended to take care of the very poor and the disabled, was in fact highly variable. Many citizens unable to afford hospital or nursing-home services did not qualify for Medicaid benefits, with the result that even after the passage of the Medicare and Medicaid bills, some 10 to 12 percent of the population were without insurance and therefore largely excluded from mainstream health services.

For those without any insurance or other means to pay for their care, society's obligation to provide at least the necessary short-term hospital care was met in part by free services in the public tax-supported hospitals or in the voluntary, private not-for-profit hospitals. The public tax-supported hospitals devoted a much larger share of their income to free care than did the voluntary hospitals, but since there are many more of the voluntaries, the latter provided in aggregate nearly two-thirds of all the charity care in the country.

Of course, no medical care is free (except possibly to those who receive it). The marginal cost of charity services in the public hospitals was borne largely by local tax funds and in part by whatever surpluses could be generated from the income recovered from third-party payers. In the voluntary hospitals, some of the cost was paid by philanthropy, but most came from the surpluses generated from private paying patients and third-party payers. In other words, most voluntary hospitals paid for the poor with the profits they earned from their other sources of payment. In those days, Medicare and Medicaid, Blue Cross, and all the other third-party payers were quite willing to pay the customary hospital charges, even when these included the costs of taking care of the poor. Some critics quietly observed that, in effect, shifting costs in

this way was a hidden tax on those who paid for health care, levied without express legal authority. However, except for a few economic purists, no one publicly complained about this cross-subsidy. The private insurers seemed content to pay the bills as long as they could add the costs to their premiums, businesses accepted the rising premium costs for their employees as long as they could be passed along to customers and were tax deductible, and the federal government was willing to absorb its rising cost into the Medicare and Medicaid budgets because that was what the political climate allowed.

As for physicians, they had long been accustomed to providing discounted or free services to the poor as part of their professional obligation to a society which had subsidized their education, granted them a licensed monopoly, and vested them with unique power and authority. The Johnson administration's proposal for Medicare and Medicaid, which was intended to pay doctors as well as hospitals for taking care of the poor and elderly, was at first vigorously opposed by organized medicine's leaders because they feared government intrusion into the practice of medicine. But medical leaders were mollified when the government agreed to pay physicians and hospitals their customary and reasonable fees for Medicare and Medicaid patients and promised to leave the medical decisions entirely in the hands of the doctors. After the law passed, physicians began to be paid for providing services to the poor, which they had previously felt obligated to provide gratis as a condition for obtaining appointments to local hospital staffs. Revenues of doctors as well as hospitals rose rapidly, even as the poor and elderly benefited from new services.

I do not want to be misunderstood. My enthusiasm for the patchwork system we had achieved with the passage of Medicare and Medicaid is easily restrained. Although access of the poor and elderly to mainstream medical care was substantially improved, most of those with insurance still had only limited coverage which paid mostly for technical procedures and relatively

short hospital stays but rarely covered prolonged or chronic illnesses and offered little or no coverage of ambulatory care. Long-term nursing-home coverage was available only to those who qualified for Medicaid. With all its limitations, however, I believe the system was better than what appears to be replacing it now. But this is getting ahead of my story. Further discussion of this point should be deferred until I explain how the economy of the system began to destroy itself.

The seeds of a disastrous inflation were all there: a rapidly expanding technological base; a growing and increasingly specialized corps of medical professionals trained to practice high-technology medicine and reimbursed on a piecework basis; an insurance system based on payment of customary charges, which still excluded many patients and certain types of services but was virtually open-ended in its funding of those it did cover; and more than two decades of essentially unregulated proliferation of hospital facilities.

The inevitable result of this highly inflationary mixture was a runaway growth in national expenditures for personal health care, which ultimately became intolerable. In 1966, the year that Medicare and Medicaid were passed, we spent about $40 billion for personal health care; in 1984 the figure was $342 billion. Slightly more than three-quarters of this growth was due to general inflation of prices and the growth and aging of the population, but even after making these corrections the average rate of real growth during those eighteen years was about 6 percent per year. Perhaps the most meaningful way to look at growth in health care expenditures is to follow it as a percentage of the gross national product (GNP), which largely corrects for price inflation and reflects the fraction of the national economy devoted to health care. Expressed this way, expenditures for health care rose fairly steadily from 6 percent of the GNP in 1966 to nearly11 percent in 1984.

Health care has now become the second largest sector of our national economy. If it were the automobile industry or the com-

puter industry or any other domestic market, such rapid growth would have been hailed as an economic triumph. The jobs and general prosperity generated by this expansion would have been a source of great general rejoicing and numerous lyrical articles in the *Wall Street Journal* and *Business Week*. Why, then, has the growth of the health care sector been so widely regarded as a national disaster? The primary answer to that question, I think, is that those who are paying for most of the costs (i.e., the federal government and large businesses) are not the direct consumers and do not receive the health care benefits. They say they cannot afford to subsidize the system any longer.

Businesses devote an increasing fraction of their overhead to health benefits for their workers and retirees. In the automobile industry, for example, the major companies spend more on health benefits than on steel. The costs are passed along to consumers, of course, but in pushing automobile prices higher, they make American cars less competitive in world markets and threaten the industry's future. It is not surprising, therefore, that the large manufacturers are now firmly determined to reduce their health care expenditures.

The federal government spent over $100 billion in 1984 on Medicare and Medicaid alone and contributed about 29 percent of all the resources devoted to health care. State and local government funds contributed another 12 percent, making a total of 41 percent from government. Public financing of health care in this country has increased greatly since 1966, and the present contribution of government may seem large. However, in relative terms the United States lags far behind all other Western democracies in its governmental support of health care. Most of these countries pay for more than 60 percent of their total health care costs with public funds. Furthermore, during the past seven or eight years, the percentage of the public contribution to health care in this country has been slowly declining as all levels of government attempt to restrain such budgetary commitments. The

federal government has a particularly difficult task in this regard, inasmuch as it seeks to reduce its deficit while also cutting taxes and increasing its military expenditures. Medicare and Medicaid outlays have been major targets for cost cutting because they are so large, because they have recently been rising at a rate of 10–15 percent per year, and because a political backlash against cuts in health care programs has not yet become a major force. The Reagan administration has therefore been doggedly whittling away at its Medicare and Medicaid obligations. As one of the two major payers of health care, it is determined to reduce the federal contribution either by cutting or shifting costs. Together with large corporate employers, the federal government has become the major force in a developing revolt of third-party payers against the old system of hospital reimbursement.

What needs to be emphasized here is that the current cutback in Medicare and Medicaid programs does not reflect an explicit change in public opinion about access to health care. Most Americans still believe that it is government's responsibility to subsidize necessary medical services for those who are not insured and cannot afford to pay for themselves. However, the prevailing view is that Medicare and Medicaid, like many other government programs, are inefficient and too expensive and that adequate medical services for the poor, the disabled, and the elderly could be provided at substantially lower costs. In any case, economic pressure, rather than public rejection of the right to health care, seems to be the primary force behind the present retrenchment in government support of health care.

At this point, before any further discussion of the recent changes in health care financing, one other crucial element in our story must be introduced. I refer to the rise of investor-owned hospital businesses and the growth of the commercial ethic in health care.

Small, privately owned proprietary hospitals were common during most of the first half of this century, but they functioned mainly as workshops for the private practices of their physician

owners. Large, investor-owned hospital chains are a new and quite different phenomenon that first appeared in the mid-sixties, about the time of the introduction of Medicare and Medicaid. After the majority of people began to have health insurance that would pay hospital charges, groups of businessmen around the country soon began to recognize the attractive entrepreneurial opportunities afforded by the ownership of a chain of hospitals. To ensure a profit, all one had to do was to buy or build hospitals in relatively prosperous locations where the population was expanding and most people had insurance. The keys to financial success were: (a) a medical staff of busy, procedure-oriented specialists; (b) large price mark-ups on all supplies and technical services; (c) an efficient billing and collecting system; and (d) the meticulous avoidance of uninsured patients and those with "low-profit" illnesses, that is, patients with chronic problems requiring a heavy investment of human resources and few procedures or tests. Combining this winning formula with an aggressive acquisition policy, several large hospital chains have developed and prospered during the past fifteen years or so. Today about 15 percent of all nonfederal hospitals in this country are owned, leased, or managed by for-profit businesses. Their geographic distribution is not uniform. In some states, especially those in the Southeast, the Southwest, and California, investor-owned hospitals now have a large share of the market (e.g., over 40 percent in Florida and California), but in many other states they are virtually nonexistent.

The great majority of these hospitals, nearly eight hundred, are controlled by the five largest multihospital systems: Hospital Corporation of America, American Medical International, National Medical Enterprises, Humana, and the Republic Health Care Corporation. These firms have become large, diversified health care corporations, with revenues in the billions of dollars and business interests not only in acute-care hospitals but in a wide variety of other health facilities, services, and products. In addition to the giant hospital chains, there are scores — perhaps by

now even hundreds — of other large and small investor-owned companies, which operate psychiatric hospitals, nursing homes, diagnostic laboratories, free-standing radiologic centers, walk-in clinics, ambulatory surgery centers, home health care services, and health maintenance organizations (HMOs) all over the country. The majority of the private psychiatric hospitals and nursing homes in this country are now under for-profit ownership. A growing fraction, between a third and a half, of all HMOs are operated for profit, as are a majority of the new kinds of ambulatory-care facilities that appear to be springing up in almost every shopping mall. There are no accurate data, but I estimate that at least a quarter of all expenditures on personal health care is now going to for-profit business, and this new health care industry continues to grow at an annual compound rate of about 10 to 15 percent per year. The most recent development is the entrance of the giant hospital chains into the health insurance business. Together with their control of HMOs, this new move enables these corporations to direct patients to their own hospital facilities and further increase their market share.

As a growing sector of our medical care system comes under investor ownership, the public will want to know much more about the effect of this trend on the cost, quality, and availability of medical care. They will also want to look very carefully at the impact of investor-owned hospitals on the public and private institutions with which they will increasingly be competing. Does investor ownership offer any advantages to offset the loss of public or local community control of facilities that ought to be serving local community needs? This question was examined in a report recently issued by the Institute of Medicine of the National Academy of Sciences.[1] The authors of the study found that, before the recent change in hospital payment, for-profit hospitals charged

[1]B. H. Gray, ed., *For-Profit Enterprise in Health Care*, Report of the Committee on Implications of For-Profit Enterprise in Health Care, Institute of Medicine, National Academy of Sciences (Washington, D.C.: National Academy Press, 1986).

about 10 to 20 percent more than not-for-profit hospitals, had similar or slightly greater expenses, gave less free care, and did very little teaching or research. Quality of care could not be adequately assessed, but there were no obvious differences. The majority of the authors did not feel that present evidence warranted any major change of public policy toward investor-owned hospitals, but they said that the questions of quality and access will be particularly important if the health care system becomes increasingly competitive and investor ownership grows.

In any event, the whole system of paying for hospital care has now been turned upside-down by what one might call "the revolt of the payers." Instead of continuing their passive role and simply paying the bills, the federal and state governments and the large corporate employers have begun to impose their own financial arrangements on the system in an effort to contain costs.

Prospective or fixed-price payment has begun to replace reimbursement of charges as the financial basis of the system. Beginning in 1983, payment for the hospital care of Medicare patients has been gradually converted to the so-called diagnosis-related group (DRG) system, in which all diagnoses are grouped into a few hundred categories, each of which is assigned a fixed price. Hospitals are paid the price assigned to each patient's diagnostic group, regardless of the actual costs incurred. If the latter are greater than the DRG price, the hospital sustains a loss in taking care of the patient; if they are less, the hospital keeps the profit. If the price for each DRG category is set properly, the law of large numbers will ensure efficient hospitals an acceptable overall operating margin of profit. The system so far involves only Part A of Medicare, that is, the hospital services. To date, there has been no major change in Part B, the payments for physicians' services, but there is currently much discussion of this subject and it seems likely that some type of federal action will be taken before long, either to revise fee schedules or to begin folding some physician payments into the DRG system.

Another major new trend being pushed by the payers is a shift to HMOs, which combine an insurance function with the direct provision of health services. For a fixed price, per capita or per family, HMOs undertake to provide all needed medical care — ambulatory and in-hospital — except for certain specified services. HMOs either own hospitals, or more commonly, contract with community hospitals to provide the necessary in-patient care for their patients. They employ individual physicians on a salaried basis (the "staff-model" HMO) or they contract with a group of physicians (the "group-model" HMO) to provide professional services in the HMO's offices and in the hospital; or else they contract with individual private practitioners to provide services in the practitioners' own offices (the "IPA-model" HMO), HMOs are growing rapidly in numbers and in total enrollment. Today there are a few hundred HMOs, nearly 40 percent of which operate for profit. Total subscribers have reached almost 20 million, an increase of nearly 20 percent in the last year alone.

In addition to DRGs and HMOs, many other kinds of contracted arrangements with hospitals and doctors are being developed by governmental and private payers. States like California, for example, are contracting with hospitals to provide care for patients on Medicaid and other programs at discounted rates. Major employers, acting as their own health insurers, and private health insurance firms are striking deals with hospitals or doctors, which give the providers preferred access to large groups of insured patients in exchange for discounted charges or some type of capitation payment. Sometimes hospitals themselves are acting as insurers and offering such contracts to their own medical staffs. Hospitals or doctor groups that make such arrangements to provide care at special rates are known as PPOs (preferred provider organizations).

The net effect of all this has been to turn hospital economic incentives around by a full 180 degrees. Under the old system, the more services hospitals provided to each patient, the more they

would get paid and, if they were so inclined, the greater their opportunity for profit. Since insurance usually reimbursed only for hospital-based procedures, it was a system that encouraged hospitalization and the use of expensive technological tests and procedures.

Under the new system, ambulatory rather than hospital care is encouraged. Hospitals can prosper only by increasing their admissions and by reducing the average number of procedures per patient and the average length of stay. They have had to become much more cost conscious because they must compete with other hospitals in their community for contracts with insurers who are shopping for hospital services for their clients at the lowest possible price. The growth of hospital capacity over the past few decades has created a surplus of beds in many communities, which adds to the competitive economic pressures on hospital managers to keep their costs down and their beds filled. Suddenly, hospitals have become overpriced, underutilized businesses struggling to attract paying customers in a price-sensitive competitive market.

Among the first casualties in this cost-control crunch are the unreimbursed services hitherto provided by the not-for-profit community hospitals. In the new, competitive, price-sensitive hospital market, insurers are not interested in subsidizing the costs of services to patients other than their own beneficiaries. Thus, it becomes increasingly difficult for not-for-profit hospitals to cross-subsidize the care of the poor and uninsured or to support expensive teaching programs or to offer standby services and community programs that are costly and unprofitable.

The change in the health care climate in this country has been astonishing in its speed and scope. The growth of the for-profit sector has joined with the revolution in the financing of medical care to create a degree of commercialization quite unprecedented in my lifetime in medicine. Health care is now widely considered to be an economic product, and its delivery a business. Both for-profit and not-for-profit hospitals are encouraged to think of them-

selves as businesses, and their management is increasingly in the hands of MBAs whose concerns are primarily economic. Pick up any issue of the magazines hospital managers read these days and you read nothing but business talk. You read about "customers," "market share," "advertising and marketing," "joint ventures," "corporate restructuring," "cash flow problems," and "bottom line" results. You read much more about "products" than services, more about "competition" than collaboration, and more about identifying and satisfying consumer demands than meeting community health care needs. According to a recent survey, U.S. hospitals spent more than a billion dollars on marketing and advertising in 1985 and more than half again as much last year.

There is nothing wrong, and much that is sensible, about being concerned with economic efficiency. Our health care expenditures did get out of control, there is considerable slack and waste in the system, and much can be gained by more businesslike management of our hospitals. But that is quite different from turning control of hospitals over to investor-owned corporations and making the delivery of health care into a competitive commercial market, where services are provided according to ability to pay and profits become the prime consideration.

Spokesmen for the new health care industry often try to blur this distinction by arguing that profits are simply the cost of capital and that all economic enterprises must generate a profit to remain viable and accumulate the resources necessary for plant maintenance and renewal. According to this argument, even so-called not-for-profit hospitals — unless they can count on philanthropy or public funding — must operate at a profit (i.e., with a surplus of revenues over expenses) if they are to survive. Some go so far as to argue that the only significant distinction between not-for-profit and for-profit hospitals is that the latter pay taxes and have little access to tax-exempt financing. This point is given emphasis by the increasingly entrepreneurial behavior of not-for-profit hospitals in the new competitive climate of prospective payment.

Despite all this, I believe it denies the obvious to ignore the basic difference between the goals of the investor-owned for-profit hospital corporation and those of a not-only-for-profit community hospital. The latter tries to generate an operating surplus while meeting what it considers to be the health care needs of the community it serves. The investor-owned hospital is owned usually by a large corporation which seeks above all else to increase its revenues and market share so that it can generate dividends and capital gains for its investors.

An even more significant difference is to be found in the general philosophy of the leaders of the two kinds of institutions. Those who speak for the investor-owned health care corporations, as well as many economists and policymakers who advocate the new competitive marketplace, believe that health care is not basically different from other necessities like food, clothing, or shelter. All of the latter commodities are sold in a commercial market and defenders of the health care market profess to see no reason why medical care should not also be distributed that way. Indeed, many have argued that medicine is a business and that fee for-service physicians are private businessmen, interested in maximizing their income like others engaged in trade. Those who defend the voluntary sector usually look askance at this philosophy. While not denying that economic considerations have always played a role in private medical care, they would argue that there is something unique about medical care that places it apart from commerce and makes physicians basically different from skilled tradesmen.

I share the latter view. Medical care differs from most other essential commodities not only because it is often necessary for the protection of life and the quality of existence but because it can properly be provided only through the professional services of a trained and committed physician who must be trusted to choose the care that is needed. The patient or a surrogate gives consent but is rarely in a position to know what is needed. It is impossible to think of any commercial service or commodity that is as intimately

related to the well-being and integrity of the individual consumer and as dependent upon the skill and commitment of another person. Consumers of medical care are often totally dependent upon the physician: the sicker and more worried they are, the more they must rely upon the advice and ministrations of the doctor. This is not the relation between consumers and vendors in a commercial market. In trade, consumers are supposed to make their own choices among different but more or less standardized products or services, and in deciding what they want to buy and what they are willing to pay, consumers accept the principle of caveat emptor, buyer beware.

Medical care is different. Patients may choose their doctors, their hospitals, or the kind of insurance coverage they want, but when they need medical care, the physician acts as their agent in deciding what is needed. Of course this is usually done with the consent and cooperation of the patient, but it is the physician who bears the responsibility for the decision, and it is the patient who must trust the physician to do the right thing. I will have more to say about this in the next lecture.

This trust, which physicians are sworn to honor, is the essence of the relationship between doctor and patient. Their professional ethical code requires that physicians place their obligation to serve the patient's interest above any personal economic interests. Businessmen are expected to deal honorably with their customers and to offer good products, but beyond that, they have no obligation to determine what is really best for their customers or to put the customers' welfare ahead of their own economic interests. Maximization of profits within the bounds of the law is the accepted rule, and in pursuit of maximal gain commercial vendors usually try to persuade potential buyers to choose their goods or services. Indeed, it is generally assumed that when informed buyer and competitive-but-honest seller each seek their own economic interests, the free market will operate to their mutual advantage. Such assumptions are clearly inapplicable and inappropriate to medical care.

If market principles do not properly apply to the relation between doctor and patient, what happens when medical care becomes a business and when doctors are encouraged to act like entrepreneurs? In the next lecture, I will discuss how the medical profession has been affected by the new economic climate and will attempt to forecast where current trends are likely to lead.

Lecture 2

In the first lecture, I explained how the rising cost of medical care has led to a revolt of the third-party payers and a radical reorientation of the economics of the health care system. A new kind of commercialized competitive market has developed, emphasizing contractual prepaid group arrangements for patients, discounted prospective payment for hospitals, and ambulatory care as a substitute for in-patient care. Investor ownership, previously confined largely to hospitals and nursing homes, has now expanded into HMOs and other forms of out-patient care. Giant vertically integrated health care corporations have emerged, which not only own a wide variety of facilities but sell the insurance that will pay for their use. Both for-profit and not-for-profit hospitals are now competing for patients to fill their nearly half-empty beds, and in many parts of the country, they are reducing the number of beds or even closing their doors. The current wisdom seems to be that health care should be regarded as a business and that cost control can best be achieved through business competition, which will eliminate inefficient providers. Since there can be no business competition without profits and losses, investor ownership has been encouraged not only to stimulate the competitive process but to provide the venture capital to replace disappearing public funds. Health care, once considered largely a public and community responsibility, is now becoming privatized along with many other sectors of American society previously in the public domain.

In this lecture I propose to discuss the impact of this revolution on the medical profession. At the conclusion of that discussion I will consider some of the public policy issues posed by these developments and will speculate about future options for health policy in this country.

Any discussion of the current problems of the medical profession in the new economic climate should begin with a clear understanding of the central role of physicians in our health care system. At its core, the system revolves around the relations between doctors and their patients. The decisions and recommendations made by doctors largely determine the consumption of medical care resources. Doctors are paid only about nineteen or twenty cents of the medical care dollar, but their decisions and recommendations determine how most of the rest will be spent. In a very real sense, doctors are the purchasing agents for their patients. Therefore, no major change in the economics of the health care system is likely to occur without a change in the behavior of physicians. Expenditures for health care are not going to be reduced significantly unless, through one means or another, doctors modify their behavior or unless access to, or demand for, care decreases.

Medical care is much more than an economic transaction, however, and doctors are far more than purchasing agents for their patients. Doctors are entrusted with responsibility for the medical welfare of their patients, whose interests they are required by their professional oath to protect. Lawyers have somewhat similar responsibilities as trustees for their clients, but a patient's dependence on his physician, as I have argued in my first lecture, is relatively unique. It is a rare client whose very life depends on his lawyer's skill, but sick or injured patients often must rely on their physicians for the preservation of their life and the protection of the quality of their existence. To get the help they need, they expose their bodies to their physician and disclose intimate details of their personal life which they might not share with anyone else. Their dependence is further intensified by the vulnerability and

helplessness of ten accompanying serious illness or injury, which can undermine the sense of personhood and limit the capacity for independent thought and action.

This is not to say that adult patients when they need medical care must simply be passive, trusting children. Much of the medical consumerism movement is quite properly directed against this notion, advocating instead that patients take more responsibility for decisions about their own health care. But despite the rhetoric, there really is no basic conflict between this view and the concept of professional responsibility. Paternalism is an element in, but certainly not the essence of, the doctor-patient relation. Patients should be as fully informed and involved in their own care as they wish and are able to be. Doctors clearly have an obligation to encourage their patients' autonomy by explaining as much as patients want to know about their illness and the available options for diagnosis and treatment. Except in emergencies, doctors also have a duty to obtain their patients' informed consent before taking any course of action. However, given what Kenneth Arrow has termed "the informational inequality" between doctor and patient,[2] and given the limitations imposed by the patient's anxiety and physical incapacity, fully informed consent is more an ideal than an attainable goal. The reality is that the physician usually bears the major responsibility for most medical care decisions and has to be trusted to counsel or act in the patient's best interest.

Although the relation between doctor and patient is not in essence a marketplace transaction, it certainly can be influenced by economic considerations and by the financial and organizational arrangements through which medical care is provided. Until recently, the dominant arrangement was fee-for-service solo or small partnership private practice. Let us briefly consider how the economics of this system affected the doctor's professional responsibility to his or her patient.

[2]K. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* 53 (December 1963), pp. 941-69.

Fee-for-service private practice is based on the assumption that patients should be free to choose their physician and, except in emergencies, physicians should similarly be free to choose whom they wish to serve. However, after accepting professional responsibility for a patient, the physician is obligated to serve the interests of that patient to the best of his or her ability as long as there is a medical need. The relation can be terminated at the patient's request at any time; the physician can also withdraw-provided the patient's welfare is protected and adequate alternative arrangements are made.

Financial reward is not supposed to be the prime consideration in this arrangement (or in any other type of medical practice), but in fee-for-service practice, physicians expect to be fairly paid for each identifiable service they provide, and it is assumed that the patient (or the insurer) will be prepared to do so. Before the advent of insurance, it was also assumed that patients would pay to the extent they could afford. This necessitated that fees be reasonable and commensurate with the patient's ability to pay. When patients could not afford to pay anything, it was expected that physicians would provide their services gratis, usually at the local community hospital, where they rendered free care to ward and clinic patients in exchange for the privilege of a staff appointment.

Fee-for-service medical care, of course, has an inherent conflict of interest. In economic terms, fee-for-service physicians are suppliers who are able to determine the demand for their own services. They make the decision to use the medical services which they provide and for which they will be paid on a piecework basis. It is an arrangement with a built-in potential for abuse. Until the past few decades, however, this traditional system of delivering medical care was generally supported by the public and held to be reasonably satisfactory. There were some abuses, of course, but on the whole the medical profession was deemed to be acting as it should, putting patients ahead of economic self-interest.

The reasons for the success of fee-for-service medical care during the first four or five decades of this century are easy to understand, First of all, there was the restraining influence of a well-established and generally accepted ethical code of organized medicine, which clearly said that medical practice must be based on the doctor's commitment to the patient's interest. The code also said that doctors should do only those things they believed would support that commitment. Of course, the chance of a physician's doing anything unnecessary was not very great when there were not many things for a physician to do beyond examining, counseling, and comforting. Except for the relatively few surgical specialists, most doctors until nearly the middle of this century had mainly their time and advice to offer. Up to that time the great majority of physicians were primary-care givers, who had only a modest and inexpensive array of procedures and remedies. When specialists were used, or surgery contemplated, the referrals usually came from the primary-care physician, so self-referral by specialists was not a problem as it is now. The major ethical concern was fee-splitting between referring physician and specialist. But there were not that many specialists or primary practitioners who would risk the professional ostracism associated with "kickback" practices of that kind. Most fees were relatively modest because relatively few patients were insured. Primary-care physicians usually knew the patients for whom they acted as advisers. They knew the financial as well as medical impact of illness on their patients, and they therefore were restrained in their recommendation of special procedures, as they were in the setting of fees.

Furthermore, one of the most important protections against exploitation in conflict-of-interest situations is disclosure, and disclosure is built into the solo practice, fee-for-service arrangement. Patients understand that if they choose to follow their doctor's advice to have some test or procedures done, the doctor expects to receive a fee for that service. Patients who do not trust the integ-

rity and judgment of their doctor can consult someone else, but there can be no deception about the nature of the arrangement because the doctor's financial interest in the transaction is perfectly clear.

There is one final and very important reason why the fee-for-service system was not much abused. Until recently, most doctors had more patients than they could comfortably handle. They had no incentive to do more than was necessary for any patient because there were plenty of patients and much work to do. As long as physicians were in relatively short supply, there was no pressure on them to offer their patients more than the essential services.

However, all of these factors restraining the potential abuse of the solo practice, fee-for-service system began to disappear with the growth of technology and the extension of insurance coverage. The conversion of the medical profession from mainly low-technology generalists and primary-care practitioners to predominately high-technology specialists and the extension of open-ended, charge-reimbursing medical insurance to the majority of citizens raised physicians' incomes as well as their economic expectations. At the same time, the numbers of practicing physicians began to rise as a consequence of the government-supported expansion of medical schools which took place in the postwar decades. Between 1970 and 1986, the number of physicians per 100,000 population increased from 148 to 220, and the curve will continue to rise steeply unless there are sharp reductions in the size of medical school classes. More doctors per population means more competition for patients and more reason for professional behavior to be influenced by considerations of income and vulnerable to economic pressures.

With the advent of the cost-containment revolution in health care financing and the growing commercialization of health services, doctors suddenly find themselves in a drastically altered economic climate which is having a profound effect on their habits of practice. They are being pressured by HMOs, IPAs, PPOs, and

many insurers to control expenditures. Inasmuch as a growing fraction of patients have contractual, prospective payment arrangements with these cost-conscious organizations, physicians have little choice but to accede. Hospitals are urging limitation of expenditures on hospitalized patients, and these strictures are reinforced with particular respect to Medicare patients by professional review organizations (PROs) and in general by peer pressure from the medical staff organizations. The threat to professional income, independence, and direct access to patients has been clearly perceived, and many physicians have reacted by seeking to extend the range of services in which they have a financial interest and over which they can exert some professional control. At the same time, the increasingly competitive health care corporations (both for-profit and not-for-profit) have been seeking arrangements with physicians that will increase the corporation's market share and protect its capacity to control costs. These arrangements include the employment of physicians, as well as contracts and joint ventures.

Some physicians, particularly those who have not yet established their own practices, are full-time employees of HMOs and other types of corporations providing medical care. Others, in private practice, have contracted with corporations to provide specified medical services for prearranged fees or under various profit-sharing arrangements. Still other kinds of contracts between corporations and practitioners reward the doctor for practicing in the corporation's facilities or using its services or products. Also becoming increasingly common are so-called joint ventures between doctors and hospitals or other health care corporations, by means of which doctors buy an equity interest as a limited partner in a health care facility, often one to which the doctors will refer their patients. A few adventurous practitioners, reluctant to tie themselves to health corporations not entirely within their control, are competing with the corporations in local markets by establishing their own businesses.

A decade or two ago, most private practitioners earned their practice-related income entirely from fees paid by insurers or patients for the professional services rendered by the practitioner. A small fraction of physicians worked for a salary in group practices that also collected fees for services rendered. Today, a physician's income may depend on a wide variety of business deals, many of them hardly imaginable before the advent of the new medical market. A few specific examples may give a better sense of what has been happening:

- To encourage cost control in the management of hospitalized Medicare patients, some hospitals are sharing profits earned from DRG payments with the private physicians involved in the care of these patients.
- To stimulate use of their operating rooms, a for-profit hospital chain shares profits from its surgical suites with the private surgeons who use the facilities.
- To induce physicians to practice there, some hospitals (for-profit and not-for-profit) offer them rent-free office space near the hospital, low-interest loans to help them start their practices, free office equipment, and so forth, all of which are contingent upon the physicians' continued use of the hospital's facilities.
- To keep their costs down, some HMOs pay their staff physicians bonuses based on profits earned in the management of patients.
- In a somewhat similar arrangement, some "managed care" plans allow the primary-care physician who controls expenditures to keep a percentage of the unspent premium.
- Many ambulatory care facilities, such as "same-day" surgery centers, diagnostic imaging centers, and clinical chemistry laboratories offer equity interest opportunities to physicians who use the facilities. Sometimes a group of physicians will start their own facility.
- Wholesale distributors of prescription drugs market prepackaged drugs to office-based physicians who prescribe the drugs and then sell them to their patients at a profit.

Many more examples could be cited, but this list should suffice to show the variety and ingenuity of these business arrangements. They clearly serve the economic interests of physicians and owners. Whether they also serve the best interests of patients is not so clear. Some of them verge on the illegal. Federal law prohibits the payment of any remuneration for the referral of Medicare or Medicaid patients or for the purchase of supplies for these patients. Many lawyers nevertheless believe that with appropriate precautions these arrangements can be structured to avoid violation of federal law, although in some jurisdictions state law may create other impediments. In any case, what these legal concerns imply is that government recognizes the potential risk to the public interest when physicians make deals with businesses. So far, however, there is no sign that government is seriously concerned about the propriety of business selling health care for profit.

Even if they do not violate the law, these new business arrangements take physicians into uncharted waters, where conflicts of interest abound and the separation between business and professional aims is obscured. No longer are physicians the trustee solely for their patients' interests; they become in addition agents for a corporate enterprise which regards patients as customers. Economic incentives to withhold services, to overuse them, or to choose particular medical products are inconsistent with the duty of the physician to act as unselfish trustee and agent for the patient. Even though physicians may believe they are doing what is best for the patient, there will still be the appearance of conflicting interests with a resulting erosion of public confidence in the physician's motivation, a confidence that has already been weakened by a growing public opinion that doctors are too interested in money and charge too much. Since trust is vital to good care, these public perceptions could lead to a deterioration in the quality of care as well as a change in attitude toward the medical profession by the public. Most damaging of all would be a change in

the profession's view of itself, a change that could erode the sense of commitment which I have suggested is the essential core of medical practice.

What should the medical profession do, what can it do, to maintain its ethical standards in the new economic climate? I believe it must, first of all, be clear about its purposes and priorities. There should be more discussion of these matters in the forums of organized medicine and in the professional journals. Physicians have been too preoccupied with the incessant demands of practice to think much about the social role of their profession or its ethical foundations. But since these are public policy issues as well, and since many reforms will need public support or cannot legally be realized without government sanction, the discussion should be in public forums as well. The recent report entitled *For-Profit Enterprise in Health Care* released by the Institute of Medicine of the National Academy of Sciences has stimulated interest, but much more exposure is needed.

In the meantime, the profession could make an important start. It could demonstrate its priorities by dealing with the growing conflicts of interest between duty to patients and economic self-interest. This should begin with a resolve to limit practice income to fees or salaries earned from professional service personally provided or supervised. Medicine is a personal, caring profession, not a license to invest in health care businesses or sell medical goods. Physicians in private practice should avoid arrangements that reward them for using a particular facility, product, or service, or for withholding services from their patients. Furthermore, to protect their professional independence practitioners should avoid direct individual employment by a for-profit corporation. If they practice in any kind of for-profit setting they should either be self-employed or part of a self-managed and self-regulated medical group which contracts with the owners.

While endorsing the view that commitment to patients must be a physician's first priority, the American Medical Association

currently rejects the guidelines suggested above as unnecessary and discriminatory. Thus, in a recent letter to the *New England Journal of Medicine,* Dr. James Todd (Senior Deputy Executive Vice-President of AMA) declared:

> There is no self-interest, economic or otherwise, that ethical physicians allow to supersede their duty to their patients. Changes in the medical marketplace will neither make ethical physicians more ethical nor deter the unethical. However, in a period of shrinking resources, reducing the options available to patients or advocating withdrawal from entrepreneurial activities by physicians would be contrary to the current and popular move toward competition as a method of restraining the increasing cost of health care. . . . Such a restrictive policy would impose unnecessary and unfair discrimination against members of a respected and respectable profession.[3]

I agree that an ethical canon against conflicts of interest would not of itself make ethical physicians more ethical or deter the unethical. It would, however, be a beacon to guide the many physicians who are confused and uncertain about this question, and it would have a powerful salutary effect on the public's confidence in the medical profession. As for the desirability or necessity of physician entrepreneurship, some have argued that participation by physicians in health care businesses is required to ensure the preservation of quality and the protection of patients' interests. But that claim cannot be taken seriously because independently practicing physicians can always exercise control over quality as long as they have responsibility for the important medical care decisions and for the choice of facilities and services used by their patients. It is only when they give up their independence by working as employees of for-profit corporations, or compromise their freedom by making business deals with the corporations, that physicians jeopardize their effectiveness as advocates for their patients.

[3]*New England Journal of Medicine* 314 (Jan. 23, 1986), p. 250.

Although the recent Institute of Medicine report avoided definite policy recommendations on the future of for-profit health care businesses, it was very firm about the importance of physicians remaining uninvolved. The study committee, representing a wide spectrum of health care interests, was unanimous in recommending that doctors "be as free of economic conflict of interest as possible."[4] The committee pointed out that as business ownership and profit considerations exert increasing influence over health care facilities and services, it becomes even more essential that doctors be able to act as independent advocates for their patients and as unencumbered monitors of the quality of care. Enlightened leaders of the new health care industry should want to endorse that view, since it cannot be in their interests, or in the public's, to risk the abuses and the deterioration of quality in medical care that would surely occur in a system in which the independence of physicians had been compromised.

Beyond the need to reaffirm its ethical foundations, the medical profession has other major tasks before it. Together with government, it will have to address the many problems that have led to the cost-containment crisis and the present turmoil in our health care system. It should begin to confront the manpower problem. We will shortly be facing a surplus of physicians. We also have disproportionately too few primary-care physicians and too many subspecialists in several fields. Closely related to this problem is the current system of customary fees, which rewards technical procedures excessively and underpays primary care. Present federal antitrust policy prevents organized medicine from unilaterally taking on these problems, but with legislative sanction, cooperation between the medical profession and government should be possible.

Other initiatives need to be taken to expand the assessment of medical technology. As mentioned earlier, new technology has been a powerful impetus to cost inflation in health care. Efficient

[4]Gray, *For-Profit Enterprise in Health Care,* p. 164.

use of new tests and procedures requires detailed information about safety and effectiveness, which in most instances is inadequate or lacking. Only through greatly increased clinical studies will we acquire the necessary information, in the absence of which vast resources are apt to be wasted on useless, redundant, or unsafe procedures. The large funds needed for such studies should come from the third-party payers, who will benefit considerably from resulting savings. Organized medicine must push government and the insurance companies to provide the necessary support and should ensure that the new information is appropriately disseminated and employed in everyday practice.

Another way in which organized medicine can help improve the health care system is through the promotion of quality assurance and peer review. The quality and fitness of physicians need to be monitored, as well as the standards of everyday practice, in and out of the hospital. The mounting tide of medical malpractice claims reflects in part a diminishing public confidence in the medical profession. Physicians blame perverse incentives in the legal system, with, I believe, considerable justification, but other major causes of the chronic malpractice crisis we are suffering these days surely include a deterioration in the doctor-patient relation, and the profession's failure to monitor quality of physicians and services as rigorously as the public has a right to expect. Remedying these deficiencies would lower costs as well as improve the quality of medical services and would undoubtedly help protect the public against the abuses inherent in a market-driven health care system. Here again, although the medical profession must show the way, governmental sanction and support are essential. The Health Care Quality Improvement Act of 1986 is an excellent example of the way enlightened and timely federal legislation can help the profession meet its responsibilities for self-regulation and quality control. The tort reform bills recently enacted by many state legislatures in response to pressures from state medical societies are another manifestation of government

response to professional initiatives which are generally recognized to be in the public interest.

But the most pressing problem in our health care system today is its inequity. In the first lecture, I pointed out that the revolution in health care financing has left little room for cross-subsidization of the poor. Voluntary hospitals formerly provided nearly two-thirds of the care for the indigent and funded it with charity or the surpluses earned from charge or cost-paying patients. Charity has not kept pace with the inflation of medical costs, and profitable patients are being replaced by patients under prospective payment and contractual arrangements that allow no overhead for unreimbursed care. Furthermore, in some parts of the country voluntary and public hospitals have been partially replaced by investor-owned hospitals, which generally provide even less charity care than the voluntary hospitals. Public hospitals are more overburdened with indigent patients and less adequately funded than ever before, and federal and state support of health services of all kinds is being cut back. The number of uninsured or underinsured people is now estimated to be between 35 million and 40 million and still growing. Access to health care among the poor and elderly is decreasing, while evidence accumulates to suggest that their health is being adversely affected.

The market is an efficient mechanism for the distribution of economic goods and services according to ability to pay, but it has no interest in those who cannot pay. If we allow the market to be the major factor in the allocation of our health care services, which is the fashion these days, we can be sure that the poor will get far less than their proportional share and very probably less than they need. As a civilized and affluent society we cannot avoid responsibility for providing all our citizens with necessary care — and that means we must be prepared to pay for it.

Uniquely qualified to determine the need for care, as well as monitor its quality, effectiveness, and safety, the medical profession has a special public responsibility. Working with local, state,

and federal government and with consumer groups, organized medicine should be in the vanguard of a national movement to ensure adequate, efficient care for all at a price our society can afford to pay. To be effective, the profession must be trusted as the advocate of the public interest. That, as I have tried to suggest in these lectures, requires physicians to think about their moral obligations. In the new market-dominated climate of health care, they will have to decide whether they wish to take their stand firmly by the side of their patients or whether they will join the new army of medical entrepreneurs.