ABSTRACT. The ethical implications of the growth of for-profit health care institutions are complex. Two major moral criticisms of for-profit medicine are analyzed. The first claim is that for-profit health care institutions fail to fulfill their obligations to do their fair share in providing health care to the poor and so exacerbate the problem of access to health care. The second claim is that profit seeking in medicine will damage the physician-patient relationship, creating conflicts of interest that will diminish the quality of care and erode patients' trust in their physicians and the public's trust in the medical profession. The authors conclude that while the continued expansion of for-profit health care may exacerbate in some respects problems of access, trust and conflicts of interest, it is a mistake to consider these problems as unique to for-profit health care; they are problems for not-for-profit health care as well. Though these issues justify continuing moral concern, they do not at this time provide decisive grounds for substantially curbing or eliminating for-profit enterprise in health care.

Key Words: for-profit medicine, competition, access to health care, justice, patient-physician relationship.

The American health care system is undergoing a rapid socio-economic revolution. Within a general environment of heightening competition, the number of investor-owned for-profit hospitals has more than doubled in the past ten years. Although the increase in investor-owned hospitals has been most dramatic and publicized, a rise in investor-owned health care facilities of other types, from dialysis clinics to outpatient surgery and "urgent care" centers has also occurred. Investor-owned for-profit corporations are controlled ultimately...
by stockholders who appropriate surplus revenues either in the
form of stock dividends or increased stock values. Independent
proprietary institutions are for-profit entities owned by an indi-
vidual, a partnership, or a corporation, but which are not con-
trolled by stockholders. Nonprofit corporations are tax-exempt
and are controlled ultimately by boards of trustees who are
prohibited by law from appropriating surplus revenues after
expenses (including salaries) are paid.

The above definitions treat “for-profit” rather narrowly as a legal
status term referring to investor-owned and independent proprie-
tary institutions. However, much of the current concern over “for-
profit health care” has a wider, though much less clear, focus. It is
often said, for instance, that health care in America is being
transformed from a profession into a business like any other
because of the growing dominance of those types of motivation,
decisionmaking techniques, and organizational structures that are
characteristic of large-scale commercial enterprises.

A recent book published by the Institute of Medicine (1983)
bears the title *The New Health Care For Profit*, with the subtitle
*Doctors and Hospitals in a Competitive Environment*. The difference
in scope between the title and subtitle is but one example of a
widespread tendency of discussions of “for-profit health care” to
run together concerns about the effects of increasing competition
in health care, which affects both “for-profit” and “nonprofit”
institutions in the legal sense, and special concerns about the
growth of those health care institutions that have the distinctive
“for-profit” legal status.

This essay will focus primarily on the ethical implications of the
growth of for-profit health care institutions in the legal sense.
However, although the ethical problems we shall explore have
been brought to public attention by the rapid rise of for-profit
institutions (in the legal sense), it would be a mistake to assume
that they are all peculiar to institutions that have this legal form.
They are problems that stem from increasing competition and
cost-conscious management throughout the health care sector.

There has been a sharp polarization in the responses of
observers to this apparent trend toward increased profit-seeking
in medicine. Some view profit motives in any form and at any
place as wholly inappropriate for medicine. This has led in at
least two states to legislation or proposed legislation limiting
or banning for-profit health care institutions from operating in
The Profit Motive in Medicine

Opponents of for-profit medicine are a diverse group and include representatives of the medical profession seeking to preserve their professional autonomy, advocates concerned to prevent a worsening of access to health care for the poor and uninsured, those concerned about the impact of profit-seeking on quality of care, and many others. Proponents of the growth of for-profits are likewise diverse and include, among others, representatives of the investor-owned firms concerned to protect their economic interests as well as health policy analysts who look to the for-profits to introduce more competition into health care and to help contain rising health care costs.

The polarization of positions on the influx of profit-seeking in medicine has often generated more heat than light. Serious moral criticisms of for-profit health care have been voiced, but often in over-stated, rhetorical terms. Before they can be evaluated, these criticisms must be more carefully articulated than has usually been done. In this paper, we seek to clarify and evaluate two of the central ethical criticisms of profit-motivations and for-profit institutions in medicine: (1) for-profit health care institutions fail to fulfill their obligations to do their fair share in providing health care to the poor and so exacerbate the problem of access to health care; and (2) profit-seeking in medicine will damage the physician-patient relationship, creating conflicts of interest that will diminish the quality of care and erode patients' trust in their physicians and the public's trust in the medical profession.

I. FOR-PROFITS EXACERBATE THE PROBLEM OF ACCESS TO HEALTH CARE

Twenty-two to twenty-five million Americans have no health care coverage, either through private insurance or through government programs including Medicare, Medicaid, and the Veterans Administration. Another twenty million have coverage that is inadequate by any reasonable standards (President's Commission, pp. 92—101). The charge that for-profits are exacerbating this already serious problem takes at least two forms. First, it is said that for-profits contribute directly to the problem by not providing care for nonpaying patients. The data are not fully consistent on whether for-profit hospitals provide less or as much uncompensated care as do nonprofit hospitals; data from several states show that they provide less, but national data show minimal
Differences between for-profits and nonprofits, both of which do much less than publicly-owned hospitals. In any event, our concern here is to analyze the arguments that have been advanced regarding the issue of uncompensated care. In particular, we shall examine the assumption that if for-profit hospitals provide less indigent care, then they thereby fail to fulfill an important obligation and act unfairly.

Second, it is also alleged that for-profits worsen the problem of access to care in an indirect way because the competition they provide makes it more difficult for nonprofits to continue their long-standing practices of 'cross-subsidization'. Cross-subsidization is of two distinct types: nonprofits have traditionally financed some indigent care by inflating the prices they charge for paying patients, and they have subsidized more costly types of services by revenues from those that are less costly relative to the revenues they generate.

It is sometimes assumed that in general for-profits are more efficient in the sense of producing the same services at lower costs and that these production efficiencies will be reflected in lower prices. At present, however, there is insufficient empirical evidence to show that for-profits on the whole are providing significant price competition by offering the same services at lower prices, though this may change in the future. In fact, what little data there are at present indicate that costs, especially of ancillary services, tend to be higher, not lower, in the for-profits (Brown and Klosterman, 1986; Watt et al., 1986).

However, the argument that for-profits are making it more difficult for nonprofits to continue the practice of cross-subsidization does not depend upon the assumption that for-profits are successful price competitors in that sense. Instead, it is argued that for-profits 'skim the cream' in two distinct ways. First, they capture the most attractive segment of the patient population by locating in more affluent areas, leaving nonprofits with a correspondingly smaller proportion of paying patients from which to subsidize care for nonpaying patients. Second, by concentrating on those services that generate higher revenues relative to the costs of supplying them, for-profits can achieve greater revenue surpluses, which provide opportunities either for lower prices or for investment in higher quality or more attractive facilities, both of which may worsen the competitive position of nonprofits making it more difficult for them to cross-subsidize.
Critics of for-profits predict that access to care will suffer in two ways: fewer nonpaying patients will be able to get care and some paying patients, i.e., some who are covered by public or private insurance, will be unable to find providers who will treat them for certain ‘unprofitable’ conditions. Although these predictions have a certain a priori plausibility, they should be tempered by several important considerations. First, as already indicated, there is at present a dearth of supporting data concerning differences in the behavior of for-profits and nonprofits, and this is hardly surprising since the expansion of the for-profit sector has been so recent and rapid. However, preliminary data do support two hypotheses that tend to weaken the force of the criticism that for-profits are exeracerbating the problem of access to care by making it more difficult for nonprofits to continue cross-subsidization. One is that at present there seems to be no substantial difference in the proportion of nonpaying care rendered by for-profits and nonprofits (Committee Report, Ch. 5). The other is that at present the proportion of nonpaying care rendered by nonprofits is on average only about 4% of their total patient care expenditures (Committee Report, Ch. 5). Here again, however, it may be important to separate from the overall data for nonprofits the public hospitals in which the proportion of nonpaying care is both higher than in the for-profits and substantially in excess of 3% of overall total patient care expenditures (California Association of Public Hospitals, unpublished). If the public hospitals experience a decrease in their paying patients, their ability to carry out their mission of serving the indigent could be seriously jeopardized.

A third reason for viewing predictions about the effects of for-profits on access to care with caution is that there are other variables at work that may be having a much more serious impact. In particular, the advent of a prospective reimbursement system for Medicare hospital services (Diagnostic Related Groups [DRGs]) and other efforts for cost-containment of state and federal regulatory bodies and businesses, as well as the general increase in competition throughout the health care sector, are making it more difficult for any institution to cross-subsidize.

In addition, as defenders of for-profits have been quick to point out, in some cases for-profits have actually improved access to care not only by locating facilities in previously underserved areas thus making it more convenient for patients to use them, but also by making certain services more affordable to more people by
Dan W. Brock and Allen E. Buchanan

removing them from the more expensive hospital setting. The growth of outpatient surgical facilities in suburban areas, for example, has improved access to care in both respects. Indeed, there is some reason to believe that by making decisions on the basis of the preferences of their boards of trustees (which may be shaped more by their own particular tastes or considerations of prestige rather than by demands of sound medical practice or response to accurate perceptions of consumer demand), nonprofits have in some cases duplicated each other’s services and passed up opportunities for improving access by failing to expand into underserved areas.

This latter point drives home the complexity of the access issue and the need for careful distinctions. For-profits may improve access to care in the sense of better meeting some previously unmet demand for services by paying patients, while at the same time exacerbating the problem of access to care for nonpaying patients. However, there is clearly a sense in which the latter effect on access is of greater moral concern. We assume here that the members of a society as affluent as ours have a collective moral obligation to ensure that all have access to some ‘decent minimum’ or ‘adequate level’ of care, even if they are not able to pay for it themselves. Surely, providing basic care for those who lack any coverage whatsoever then should take priority over efforts to make access to care more convenient for those who already enjoy coverage and over efforts to reduce further the financial burdens of those who already have coverage by providing services for which they are already insured in less costly non-hospital settings.

So far we have examined the statement that ‘cream skimming’ by for-profits exacerbates the problem of access to care. Ultimately, this is largely an empirical question about which current data are inconclusive. There is another way in which the ‘cream skimming’ charge can be understood. Sometimes it is suggested that for-profits are acting irresponsibly or are not fulfilling their social obligations by failing to provide their ‘fair share’ of indigent care and unprofitable care, as well as making it more difficult for nonprofits to bear their fair share through cross-subsidization. To this allegation of unfairness, defenders of for-profits have a ready reply: “No one is entitled to the cream; so for-profits do no wrong when they skim it. Further, for-profits discharge their social obligations by paying taxes. Finally, since the surplus revenues
that nonprofits use to subsidize nonpaying or unprofitable care are themselves the result of over-charging — charging higher prices then would have existed in a genuinely competitive market — then it is all the more implausible to say that they are entitled to them."

While this reply is not a debate-stopper, it should give the critic of for-profits pause since it draws attention to the unstated — and controversial — premises underlying the contention that cream-skimming by for-profits is unfair because it constitutes a failure to bear a fair share of the costs of nonpaying or unprofitable patients. The most obvious of these is the assumption that in general nonprofits are (or have been) bearing their fair share.

To determine whether for-profits or nonprofits are discharging their obligations, we must distinguish between two different types of obligations — general and special. For-profit corporations, like individual citizens, can argue that they are discharging their general obligation to subsidize health care for the poor by paying taxes. To see this, assume that the fairness of the overall tax system is not in question, and in particular its taxation of corporate profits. For-profits can then reasonably claim that they are doing their fair share to support overall government expenditures by paying taxes. If the government is subsidizing health care for the poor as part of overall government expenditures, then for-profits would appear to be doing their fair share towards supporting subsidized health care for the poor. If the government is providing inadequate subsidization of health care for the poor, then the fair share funded by the for-profits' taxes will in turn be inadequate, but proportionately no more so than every other taxpayer's share is inadequate, and not unfair relative to the subsidization by other taxpayers. The responsibility for this inadequacy, in any case, would be the government's or society's, not the for-profit health care corporation's.

A for-profit hospital chain cannot say that if it is paying, for example, $30 million in taxes, it is providing $30 million towards funding health care for the poor. Its taxes, whether at the federal, state, or local level should be understood as a contribution to the overall array of tax-supported programs at those levels. But it can claim to be subsidizing health care for the poor with the portion of its taxes proportionate to the portion of overall government expenditures devoted to subsidizing health care for the poor.

On the other hand, those who raise the issue of fairness have
apparently assumed that health care institutions have special obligations to help care for indigents. Even if this assumption is accepted, however, it is not obvious that in general nonprofits have been discharging the alleged special obligation successfully for the reasons already indicated. First, even if cross-subsidization is widespread among nonprofits, the proportion of nonpaying and unprofitable care that is actually provided by many nonprofits appears not to be large. Second, some of the revenues from 'overcharging' paying patients apparently are not channeled into care for nonpaying patients or patients with unprofitable conditions.

It was noted earlier that while many publicly-owned nonprofit hospitals provide a substantial proportion of care for nonpaying patients, non-publicly owned nonprofits ("voluntaries") as a group do not provide significantly more uncompensated care than for-profits. One rationale for granting tax-exempt status is that this benefit is bestowed in exchange for the public service of providing care for the indigent. If it turns out that many nonprofit health care institutions are in fact not providing this public service at a level commensurate with the benefit they receive from being tax exempt, then this justification for granting them tax-exempt status is undermined.

It is also crucial to question the assumption that for-profit health care institutions have special obligations to help subsidize care for the needy over and above their general obligation as tax-payers. As the for-profits are quick to point out, supermarkets are not expected to provide free food to the hungry poor, real estate developers are not expected to let the poor live rent-free in their housing, and so forth. Yet food and housing, like health care, are basic necessities for even minimal subsistence. If there are basic human rights or welfare rights to some adequate level of health care, it is reasonable to think there are such rights to food and shelter as well as health care.

Whose obligation is it, then, to secure some basic health care for those unable to secure it for themselves? Assuming that private markets and charity leave some without access to whatever amount of health care that justice requires be available to all, there are several reasons to believe that the obligation ultimately rests with the federal government. First, the obligation to secure a just or fair overall distribution of benefits and burdens across society is usually understood to be a general societal obligation.
Second, the federal government is the institution society commonly employs to meet society-wide distributive requirements. The federal government has two sorts of powers generally lacking in other institutions, including state and local governments, that are necessary to meeting this obligation fairly. With its taxing power, it has the revenue-raising capacities to finance what would be a massively expensive program on any reasonable account for an adequate level of health care to be guaranteed to all. This taxing power also allows the burden of financing health care for the poor to be spread fairly across all members of society and not to depend on the vagaries of how wealthy or poor a state or local area happens to be. With its nationwide scope, it also has the power to coordinate programs guaranteeing access to health care for the poor across local and state boundaries. This is necessary both for reducing inefficiencies that allow substantial numbers of the poor to fall between the cracks of the patchwork of local and state programs, and for ensuring that there are not great differences in the minimum of health care guaranteed to all in different locales within our country.

If we are one society, a United States, then the level of health care required by justice for all citizens should not vary greatly in different locales because of political and economic contingencies of a particular locale. It is worth noting that food stamp programs and housing subsidies, also aimed at basic necessities, similarly are largely a federal, not a state or local, responsibility. These are reasons for the federal government having the obligation to guarantee access to health care for those unable to secure it for themselves. It might do this by directly providing the care itself, or by providing vouchers to be used by the poor in the health care marketplace. How access should be guaranteed and secured — and in particular, to what extent market mechanisms ought to be utilized — is a separate question.

Granted that the obligation to provide access to health care for the poor rests ultimately with the federal government, is there any reason to hold that for-profit health care institutions, such as hospitals, have any special obligations to provide such care? The usual reason offered is that health care institutions, whether nonprofit or for-profit, are heavily subsidized directly or indirectly by public expenditures for medical education and research and by Medicare and Medicaid reimbursement, which have created the enormous predictable demand for health care services that has
enabled health care institutions to flourish and expand so dramatically since the advent of these programs in 1965. However, we believe it is less clear than is commonly supposed that these subsidies redound to the benefit of the for-profit institution in such a way as to ground a special institutional obligation to subsidize health care for the poor.

The legal obligation of nonprofit hospitals to provide free care to the poor is principally derived from their receipt of Hill-Burton federal funds for hospital construction. However, the for-profit hospital chains secure capital for construction costs in private capital markets and do not rely on special federal subsidies. Even when they purchase hospitals that have in the past received Hill-Burton monies, they presumably now pay full market value for the hospitals. If there is a subsidy that has not been worked off in free care, that redounds to the nonprofit seller, not the for-profit purchaser. What of other subsidies?

There is heavy governmental subsidy of medical education; it is widely agreed that physicians do not pay the full costs of their medical education. Perhaps then they have a reciprocal duty later to pay back that subsidy, though it would need to be shown why the form that duty should take is to provide free care to the poor as opposed, for example, to reimbursing the government directly. However that may be, it is physicians and not the for-profit hospitals who are the beneficiaries of medical education subsidies. Physicians are the owners of these publicly subsidized capital investments in their skills and training, and are able to sell their subsidized skills at their full market value. Physicians, and not the owners of for-profit health care institutions in which they practice or are employed, are the beneficiaries of education subsidies and so are the ones who have any obligation there may be to return those subsidies by in turn subsidizing free care for the poor.

Another important area of public subsidy in the health care field is medical research. Much medical research has many of the features of a public good, providing good reason for it to be publicly supported and funded. (Where these reasons do not apply, as, for example, in drug research, the research is largely privately funded by the drug companies.) Medical research makes possible new forms of medical technology, knowledge, and treatment. Because it is publicly funded, and once developed is generally freely available for use by the medical profession, for-profit health care institutions are able to make use of the benefits
of that research in their delivery of health care without sharing in its cost. But who ultimately are the principal beneficiaries of this public subsidy of research? Not, we believe, the for-profits, but rather the patients who are the consumers of the new or improved treatments generated by medical research. It may or may not be true that for-profits will not bear the research costs of these treatments as part of their delivery costs. But if, as is increasingly the case, the for-profits operate in a competitive environment concerning health care costs or charges, they will be forced to pass on these subsidies to consumers or patients. (And if they operate in a largely noncompetitive environment, there will be a strong case for some form of regulation of their rates.) The price that patients pay for health care treatments whose research costs were subsidized by the government will not include those research costs and so will not reflect true costs. It is then consumers of health care, not the for-profits, who principally benefit from research subsidies, and any obligation arising from this subsidy presumably lies on them.

Finally, consider the large public subsidy represented by Medicare and Medicaid. These programs created a vast expansion in the market for health care that many for-profits serve and from which they benefit. This is new health care business that heretofore did not exist and on which they make a profit. Perhaps this benefit grounds a special obligation of for-profit institutions to provide subsidized care for the poor. The most obvious difficulty with such a view is that the subsidized health care consumers, not the deliverers of the health care, are by far the principal beneficiaries of Medicare and Medicaid. Any profit that the for-profits receive from serving Medicare and Medicaid patients is only a small proportion of the overall cost of their care.

It must be granted, nevertheless, that the for-profits do earn profits from these subsidized patients. But it is difficult to see how this fact by itself is sufficient to ground a special obligation of the for-profits to subsidize free care for the poor. In the first place, for-profits can again respond that they pay taxes on these profits, like other profit-making enterprises. Moreover, they can point out that in no other cases of government-generated business of for-profit enterprises is it held that merely earning a profit from such business grounds a special obligation similar to that claimed for for-profit health care enterprises. Virtually no one holds that defense contractors, supermarkets who sell to food stamp recipi-
ents, highway builders, and so forth have any analogous special obligation based on the fact that their business is created by government funds. Nor it is ever made clear why this fact should itself ground any special obligation of for-profits in health care to provide access to health care for the poor. Thus, we conclude that none of the current forms of public subsidy of health care will establish any significant special obligation of for-profits to provide free care, and so the claim cannot be sustained that for-profits do not do their fair share in providing access to health care for the poor. We emphasize that we believe there is an obligation to guarantee some adequate level of health care for all, but the obligation is society’s and ultimately the federal government’s and not a special obligation of for-profit health care institutions.

Even if there are insufficient grounds for the assumption that for-profit health care institutions, or health care institutions as such, have special obligations to provide a “fair share” of uncompensated care, it can be argued that a nation or a community, operating through a democratic process, can impose such a special obligation on the institutions in question as a condition of their being allowed to operate. According to this line of thinking, a community may, through its elected representatives, require that any hospital doing business in that community provide some specified amount of indigent care, either directly or by contributing to an indigent care fund through a special tax on health care institutions (so far as they are not legally exempt from taxes) or through a licensing fee.

Whether such an arrangement would be Constitutional or compatible with statutory law in various jurisdictions is not our concern here. One basic ethical issue is whether the imposition of such special obligations would unduly infringe on individuals’ occupational and economic freedoms. Although no attempt to examine this question will be made here, this much can be said: a community’s authority to impose a special obligation to contribute a portion of revenues (as opposed to an obligation to contribute services) for indigent care seems no more (or less) ethically problematic than its authority to levy taxes in general.

A second basic ethical issue is then whether such taxes, or requirements to provide uncompensated care as conditions of doing business for health care institutions, fairly distribute the costs of providing care to the indigent. That will depend on the details of the particular tax or requirement to provide uncom-
pensated care, but since any are likely to be ultimately a tax on the sick, it is doubtful that such provisions will be fairer than financing care for the indigent through general tax revenues.

There is, moreover, an additional difficulty with any claim that, by skimming the cream, for-profits fail to fulfill an existing special obligation to bear a fair share of the burden of providing at least some minimum level of care for all who need it but cannot afford it. This is the assumption that in the current U.S. health care system any determinate sense can be given to the notion of a 'fair share' of the burden of ensuring access to care (in the absence of specific legislation such as the Hill-Burton Act). Unless a rather specific content can be supplied for the notion of a fair share, the nature and extent of an institution's alleged special obligation will be correspondingly indeterminate. In particular, it will be difficult if not impossible to determine whether for-profits have met such a special obligation. But it will also be problematic to assert what some defenders of nonprofits imply, namely that nonprofits have in the past done their fair share through cross-subsidization.

The current U.S. health care system is a patchwork — or, less charitably, a crazy-quilt — of private insurance and public program entitlements. There is no generally accepted standard for a 'decent minimum' or 'adequate level' of care to be ensured for all, no system-wide plan for coordinating local, state, and federal programs, charity, and private insurance so as to achieve it, and no over-all plan for distributing the costs of providing care for those who are unable to afford it from their own resources. Absent all of this, no determinate sense can be given to the notion of an institution's special obligation to provide a 'fair share' of the burden of ensuring an 'adequate level' or 'decent minimum' of care for everyone.

Furthermore, even if it were possible at present to determine, if only in some rough and ready way, what an institution's 'fair share' is, this would still not be enough. Whether an institution has an obligation — a duty whose fulfillment society can require — will depend upon whether it can do so without unreasonable risks to its own financial well-being. But in a competitive environment, whether one institution's contributing its 'fair share' will be unreasonably risky for it will depend upon whether other institutions are doing their 'fair share.'

The establishment of a coordinated system-wide scheme in which institutions share the costs of providing some minimum
level of care for all is a ‘public good’ in the economist’s sense. Even if every governing board of every institution agrees that it is desirable or even imperative to ensure some level of care for all, so long as contribution to this good is strictly voluntary, each potential institutional contributor may attempt to take a free ride on the contribution of others with the result that the good will not be achieved.

It is important to understand that failure to produce the public good of a fair system for distributing the costs of care by voluntary efforts does not depend upon the assumption that potential contributors are crass egoists. Even if the potential contributor has no intention to take a free ride on the contributions of others, he may nonetheless be unwilling to contribute his fair share unless he has assurance that others will do their fair share. For unless he has this assurance, to expect him to contribute his fair share is to expect him to bear an unreasonable risk — a cost that might put him at a serious competitive disadvantage. In the absence of an enforced scheme for fairly distributing the costs of care for the needy, the current vogue for containing costs by increasing competition in health care will only exacerbate this free-rider and assurance problem. And unless an institution can shoulder its fair share without unreasonable risk to itself, it cannot be said that it has an obligation that it has failed to fulfill. Granted that this is so, what is needed is an effective mechanism for enforcing a coordinated scheme for distributing the costs of providing some minimal level of care for all without imposing unreasonable competitive disadvantages on particular institutions.

It is important not to overstate this point. Although the notion of unreasonable risk is not sharply defined, it is almost certainly true that many for-profit (and nonprofit) institutions could be spending more than they currently are for nonpaying or unprofitable patients without compromising their financial viability. So it is incorrect to conclude simply from this that in the current state of affairs institutions have no special obligations whatsoever. The point, rather, is that debates over which institutions are or are not fulfilling their obligation are of limited value and that the energy they consume could be more productively used to develop a system in which institutional obligations could be more concretely specified and in which society would be morally justified in holding those who control the institutions, whether governmental or private, accountable for the fulfillment of those obligations.
Moreover, there is at least one obligation that now can be justifiably imputed to for-profit (and nonprofit) health care institutions and that is the obligation to cooperate in developing a system in which determinate obligations (whether general or special) can be fairly assigned and enforced. It is much less plausible to argue that the initial efforts needed to develop a coordinated, enforced system would undermine an institution's competitive position, even if it is true that in the absence of such a system an institution's acting on a strictly voluntary basis to help fund indigent care would subject it to unreasonable risks.

Assuming that, as members of this society, we all share a collective obligation to ensure an 'adequate level' or 'decent minimum' of health care for the needy, those who control health care institutions, as individuals, have the same obligations the rest of us do. However, because of their special knowledge of the health care system and the disproportionate influence they can wield in health policy debates and decisions, health care professionals may indeed have an additional special obligation beyond the general obligations of ordinary citizens to help ensure that a just system of access to health care is established.

It can still be argued that whether or not they fail to fulfill their obligations, for-profits have at least contributed to the decline of cross-subsidization and that the cross-subsidization system has made some contribution toward coping with the problem of access to care. Whether this provides a good reason for social policy designed to restrain or modify the behavior of for-profits will depend upon the answer to two further questions: (1) Are cross-subsidization arrangements the best way of coping with the access problem? and, just as importantly, (2) Is it now feasible in an increasingly competitive environment to preserve cross-subsidization even if we wish to do so?

Objections to cross-subsidization are not hard to find. On the one hand, cross-subsidization can be viewed as an inefficient, uncoordinated welfare system hidden from public view and unaccountable to the public or to its representatives in government. Further, it can be argued that widespread cross-subsidization is incompatible with effective efforts to curb costs. Surely an effective solution to both the access and cost containment problems requires a more integrated, comprehensive, and publicly accountable approach. Consequently, the demise of cross-subsidization should be welcomed, not lamented.

This last conclusion, however, is simplistic. It assumes that an
explicit public policy designed to improve access for those not covered by private or public insurance is presently or in the foreseeable future politically feasible. Perhaps the strongest argument for cross-subsidization is the claim that it does — though admittedly in a haphazard and inefficient way — what is not likely to be done through more explicit social policies.

It might be tempting to protest that even if this is so, cross-subsidization ought to be rejected as an unauthorized welfare system since it did not come about through the democratic political process as a conscious social policy. However, if providing some minimum of care for the needy is a matter of right or enforceable societal obligation and not a matter of discretion, then the lack of a democratic pedigree may not be fatal, since rights and obligations place limitations on the scope of the democratic process.

Controversy over the ethical status of cross-subsidization may soon become moot if a point is reached where it is no longer feasible to shore up or rebuild an environment in which cross-subsidization is economically viable for health care institutions. So even if cross-subsidization has been the best feasible way of coping with the problem of access it does not follow that it will continue to be a viable option. Perhaps too much energy has already been wasted in policy debates defending or attacking cross-subsidization when the real issue is: How can we now best achieve the purpose that cross-subsidization was supposed to serve?

Our focus thus far has been on the charge that for-profit health care institutions fail to fulfill their obligations to provide care for the poor. We have seen that a close examination of this criticism of for-profit institutions raises more general issues about the relationship between self-interested institutional behavior — whether in for-profit or nonprofit institutions — and the access problem. One important conclusion reached was that it is incorrect to understand the access problems as the result of a failure to fulfill institutional obligations because at present there is no social mechanism that specifies, fairly distributes, and enforces such institutional obligations.

It seems likely that competition and cost-containment pressures will continue to lead to further increases in commercial or profit-maximizing motivation and behavior in all forms of health care institutions, for-profit and nonprofit as well. If this is the case,
then the crucial question is this: How can the pursuit of institutional self-interest be made to serve the social goal of improving access?

The preceding discussions of the free-rider and assurance problems suggest, respectively, two distinct approaches. The first, proceeding on the assumption that a sense of collective moral responsibility will not serve as a significant constraint on the pursuit of profit by institutions, is to change the incentive structure under which institutions operate so that they can best serve their own interests by serving the poor. This might be achieved by providing the poor with health-care vouchers at financial levels comparable to those of current insurance reimbursements or by expanding eligibility for Medicaid and increasing Medicaid reimbursement rates. A second, quite different, approach proceeds on the more charitable assumption that a collective sense of moral responsibility can serve as a significant constraint on an institution's pursuit of profit if the cost of acting morally, though not eliminated, is kept at acceptable levels. One important way of lowering the cost an institution incurs when it aids the poor is to provide it with assurance that competing institutions will reciprocate by bearing their fair share of the burden. To prevent the pursuit of profit by health care institutions from worsening an already shameful access problem, a combination of both types of approaches will probably be needed.

II. FOR-PROFITS DAMAGE THE PHYSICIAN-PATIENT RELATIONSHIP, ERODE TRUST, CREATE NEW CONFLICTS OF INTEREST, AND DIMINISH QUALITY OF CARE

The second broad concern about the growth of profit-seeking in medicine is that it will damage the physician-patient relationship, erode the trust necessary to that relationship, create new conflicts of interest and ultimately diminish the quality of care. Physicians have, of course, always sought to earn a living from the practice of medicine. The concern about increased profit-oriented behavior is commonly that new profit-oriented institutions, most commonly large for-profit hospital chains, will alter the behavior of physicians that work for or in them in ways to produce the bad effects noted above. We shall continue to use here for-profit hospitals as the paradigm of the rise in profit-seeking at the institutional level in exploring its potential effects on the behavior of individual physi-
cians and on the physician-patient relationship. It is undeniable that for-profit health care involves potential conflicts between the interests of providers (physicians, managers, administrators, and stock-holders) and those of patients. In the most general terms, the conflict is simply this: an institution with a strong, if not an overriding, commitment to maximizing profit may sometimes find that the best way to do this is not to act in its patients' best interests.

This fundamental potential conflict of interest is said to be of special concern in health care, not only because health care interests are so important, but also because the ‘consumer' of health care, unlike the consumer of most other goods and services provided by profit-seeking firms, is in an especially vulnerable position for two reasons. First, patients will often lack the special knowledge and expertise needed for judging whether a particular health service is necessary or would be beneficial, whether it is being rendered in an appropriate way, and even in some cases whether it has been successful. Second, because illness or injury can result in anxiety, dependence and loss of self-confidence, the patient may find it difficult to engage in the sort of self-protective bargaining behavior expressed in the admonition 'caveat emptor'.

Whether this conflict of interest will damage the physician/patient relationship will depend on the extent to which it already exists outside profit-seeking settings. And it is quite clear that a fundamental potential for conflict of interest is not peculiar to for-profit health care. A health care institution may exhibit a strong commitment to maximizing profit, and this commitment may result in practices that are not in patients' best interests, even if the institution is of nonprofit form. When we ask whether an institution's or an individual's pursuit of profits is prejudicial to the patient's interests, the appropriate sense of the phrase 'pursuit of profits' is quite broad, not the narrower legal sense in which nonprofit institutions do not by definition pursue profits. After all, the issue is whether the opportunities for attaining benefits for themselves provide incentives that influence behavior on the part of providers that is not in patients' best interest. Whatever form these incentives take and whatever kinds of benefits are pursued, they may all run counter to the patient's interests.

In any form of medical practice operating under a fee-for-service system, under any system of prepayment (as in Health Maintenance Organizations [HMOs]), and under any system of
capitation, where physicians are paid a salary determined by the number of patients they treat (as in Independent Practice Associations [IPAs]), a basic conflict of interest will exist, regardless of whether the organization is for-profit or nonprofit. In a fee-for-service system, the conflict is obvious: physicians have an incentive to overutilize services because their financial return will thereby be increased. The incentive for overutilization of services can conflict with the patient's interest in three distinct ways: it can lead physicians to (1) provide services whose medical costs to the patient outweigh their medical benefits (as in the case of surgery or x-rays which actually do more medical harm than good), (2) impose financial costs on the patient that exceed the medical benefits provided (greater out of pocket expenses for the patient), and (3) contribute to higher health care costs (including higher insurance premiums) for everyone, including the patient.

In prepayment or capitation systems, providers are subject to conflicts of interest because of incentives to underutilize care. In HMOs, providers have an incentive to limit care because the overall financial well-being of the organization requires it and because salary increases and year-end bonuses as well as new personnel, new equipment, and new services are all financed by these savings. In IPAs and other organizations that operate on a capitation system, conflicts of interest due to the incentive for underutilization are equally clear: spending less time and using fewer scarce resources enables physicians to handle a larger number of patients, and this results in a larger salary. Whether, or to what extent, these incentives actually result in reduced quality of care is an extremely difficult question. But what is clear is that they create conflicts of interest in both for-profit and nonprofit settings.

The nature of the concern about physicians acting to further their own economic interests will change as the settings in which they practice increasingly shift from fee-for-service with its incentives for over-utilization to various forms of capitation with their incentives for under-utilization. The most obvious harm to patients from overutilization is the financial waste of resources in comparison with other more beneficial uses. However, there are probably also serious and widespread health harms to patients from overutilization of treatments (for example, unnecessary coronary artery by-pass operations that have significant mortality rates), procedures (for example, overuse of x-rays and mammo-
grams linked to cancer), and hospitalization with its attendant risks including infection. The harm to patients from under-utilization, on the other hand, is principally to their health and well-being, or even life, when needed and potentially beneficial but unprofitable health care is withheld. Neither over nor under-utilization will be easily detectable by the patients who suffer them. Patients' consent is commonly needed for the additional treatment of over-utilization and so they will usually be aware of receiving the treatment, but they will commonly be in a poor position to evaluate for themselves their need for the care. Incentives for under-utilization may lead the physician never to mention possibly beneficial but unprofitable treatment, and so leave the patient unaware of it. Thus, shifting incentives from over- towards under-utilization will alter the likely effects and concerns about conflicts of interest, though we lack the data to say whether over-utilization or under-utilization is on balance a more serious problem.

Some analysts have recognized that the preceding sorts of conflicts of interest are unavoidable because they result from two features that will be found in any form of health care institution or organization: (1) the patient's special vulnerability and (2) the need to provide some form of incentive for providers that is related in some fashion to the amount and kind of services they provide. They have then gone on to argue that what makes conflicts of interest especially serious in for-profits is that for-profits provide physicians with opportunities for secondary income. This secondary income may come either from charges for services which they themselves do not provide but which they recommend or which are provided by others under their supervision, or from being a shareholder in the for-profit health care corporation.

Secondary income, however, and the conflict of interest it involves, is also neither a new phenomenon in health care nor peculiar to for-profits. While "fee-splitting" traditionally has been condemned by organized medicine, several forms of practice of physicians working in nonprofit settings essentially amount to fee-splitting. One of the most common is an arrangement whereby physicians receive a percentage of the fee charged for x-rays, laboratory tests, other diagnostic procedures, physical therapy, or drug or alcohol counseling that they recommend but which are performed by people they employ or supervise. In some cases, licensing and certification laws and reimbursement eligibility
requirements for Medicare, Medicaid, and private insurance require non-physician health care professionals to be supervised by a physician, thus creating a dependence which makes it possible for physicians to reap this secondary income. Physicians may also charge fees for interpreting diagnostic tests, such as electrocardiograms, that they recommend and which are performed by others even if they do not split the fee for the procedure itself.

It may still be the case that the opportunities for secondary income and other conflicts of interest tend to be greater in most for-profit institutions than in most nonprofit institutions. While there is some data suggesting higher usage rates for profitable ancillary services in for-profit hospitals, at present neither the extent of these differences, nor, more importantly, the extent to which they are taken advantage of in ways that reduce quality of care, increase costs, or otherwise compromise patients' interests is well-documented. It may also be the case that even though serious conflicts of interest, from secondary income and other sources, already exist in nonprofit health care, the continued growth of for-profits, both in their own activities and the influence they have on the behavior of nonprofits, will result in a significant worsening of the problem. The current paucity of data, however, makes it premature to predict that this will happen or when it will happen.

There is another form of the charge that profit-seeking health care institutions create new conflicts of interest or exacerbate old ones. Some fear that even if physicians' behavior toward patients is not distorted by incentives for secondary income or by equity ownership, physicians in profit-making institutions will be subject to greater control by management and that this control will make it more difficult for physicians to serve the patient's interests rather than the corporation's. There can be little doubt that American physicians are increasingly subject to control by others, especially by managers and administrators, many of whom are not physicians.

There are two major factors that have led to this loss of 'professional dominance' that are quite independent of the growth of profit-seeking institutions in health care (Starr, 1982). One is the institutionalization of medicine that itself arose from a variety of factors, including the proliferation of technologies and specializations that call for large scale social cooperation and
cannot be rendered efficiently, if they can be rendered at all, by independent practitioners. The other is the increased pressure for cost-containment in a more competitive environment, which has led to a greater reliance on professional management techniques within health care institutions and more extensive regulatory controls by government. At most, the growth of profit-seeking institutions may be accelerating this loss of professional dominance.

It should not simply be assumed, however, that diminished physician control will result in an overall lowering of the quality of care or a worsening of the problem of conflict of interests. Whether it will depends upon the answer to three difficult questions. To what extent will management or shareholders of for-profits exercise their control over physicians in the pursuit of profit and at the expense of patient interests, unrestrained by ethical considerations? To what extent will management and stockholders act on the belief that in the long-run profits will be maximized by serving patients’ interests? To what extent have physicians, in the physician dominated system that has existed up until recently, actually acted in the best interests of their patients? The answers to the first two questions await data not yet available.

The third question is especially difficult to answer because of an ambiguity in the notion of the ‘patient’s best interests’. In a fee-for-service, third party payment system in which physicians exercise a great deal of control in ordering treatments and procedures, a physician who makes decisions according to what is in the individual patient’s best medical interests will tend to order any treatment or test whose expected net medical benefit is greater than zero, no matter how small the net benefit may be. Under such a system, the traditional ethical principles of the medical profession, which require the physician to do what is best for the patient (or to minimize harm to him), and the principle of self-interest speak with one voice, at least so long as the patient’s interests are restricted to his medical interests. Indeed, even if the physician considers the patient’s overall interests — financial as well as medical — so long as a third party is picking up the major portion of the bill, the physician may still conclude that acting in the patient’s best interest requires doing anything that can be expected to yield a non-zero net medical benefit. Yet, as has often been noted, the cumulative result of large numbers of such
decisions, each of which may be in the best interest of the particular patient, is that health care is overutilized and a cost crisis results.

'Overutilization' here does not mean the use of medically unnecessary care, i.e., care that is of no net medical benefit, or that is positively harmful; instead what is meant is what one author has called 'non-costworthy care' — care that yields less benefit than some alternative use to which the same resources could be put, either for other health care services or for non-health care goods (Menzel, 1983 p. 17). Overutilization of health care in this sense, not just overutilization as non-beneficial care, is clearly contrary to everyone's interest. If continued professional dominance means perpetuation of this problem of overutilization, then even if a further loss of professional dominance will lead to medical decisions that are not, considered in isolation, in the individual patient's best interest, it may nevertheless result in the elimination of one important conflict of interest and one source of collective irrationality in the current system. This does not rule out the possibility, of course, that greater control by non-physicians will also lead to overutilization. If this occurs, then one system that works against everyone's best interest will merely have been replaced by another that does the same thing.

We have seen that in the fee-for-service, third-party payment system in nonprofit as well as for-profit settings the cumulative result of many physicians acting on the desire to do what is best for the individual patient can result in overutilization that is contrary to all patients' best interests. Some critics of for-profits suggest that we must either pay the price of this overutilization or cope with it by methods that do not undermine physicians' commitments to doing what is best for their individual patients. They then conclude that even if it could be shown that the growth of for-profits would restrain overutilization by introducing greater price competition into health care, the price would be too high to pay because the physician's all-important commitment to do his best for each patient would eventually be eroded by the increasing 'commercialization' of health care that is being accelerated if not caused by the growth of profit-seeking enterprise in medicine.

The force of this objection to for-profits depends, of course, not only upon the correctness of the prediction that the growth of for-profits will in fact contribute to a weakening of the physician's
commitment to do the best he can for each patient; it also depends upon the assumption that under the current system that commitment has been a dominant force in physician behavior. This last point may be cast in a slightly different way. How concerned we should be about the tendency for the behavior of physicians to become more like that of businessmen depends upon how great the difference in behavior of the two groups is and has been. If one assumes that as a group physicians have been significantly more altruistic than businessmen and if one also assumes that altruism is the only effective safeguard against exploitation of the patient's special vulnerability, then one will oppose any development, including the growth of for-profit health care, which can be expected to make physicians more like businessmen.

Many outside the medical profession and some within it greet the claim that physicians as a class are especially altruistic and committed to patient interests at the expense of their own with some skepticism. This attitude is not groundless. One of the difficulties of determining the strength of altruistic patient-centered motivation among physicians, as we have already noted, is that until very recently, the fee-for-service, third party payment system has produced a situation in which altruism and self-interest converge: doing what is best of the patient (pursuing all treatment that promises non-zero benefits) was often doing what was financially best for the physician. Nevertheless, critics of the thesis that physicians are especially altruistic can marshal a good deal of evidence to support their view, such as the profession's historical opposition to HMOs and to Medicare and Medicaid, each of which promised significant extensions of access to health care (Starr, 1982), its failure to overcome the chronic geographical maldistribution of physicians in this country, and its support of strict entry controls to the profession through medical licensure together with relatively weak oversight of the continuing competence of those already licensed, and the refusal of many physicians to treat Medicaid patients because Medicaid reimbursements are lower than those of private insurance. We can make no attempt to evaluate such evidence here, but the self-interest of the profession seems a better prima facie explanation for much of this behavior than does an altruistic concern for the ill. It is important to emphasize that explanations of these phenomena need not assume that self-interest here is exclusively or even primarily
financial self-interest. The profession’s resistance to Medicare, for example, was probably more an attempt to preserve physician autonomy, as well as to protect the physician-patient relationship from outside intrusion by government.

In assessing these question of conflict of interest and physician motivations we think it is helpful to distinguish the behavior of physicians acting as an organized profession addressing matters of health policy from the behavior of individual physicians toward individual patients. As we have noted above, much behavior of medicine as an organized profession (as reflected for example in the political role played by the American Medical Association [AMA]) in seeking to maintain physician dominance in the health care profession, to protect and enhance physician incomes, and so forth, has served the self-interest of physicians. Controversial is the extent to which the self-interested function of the motivation for supporting such practices as medical licensure is manifest or latent, explicit or implicit. In considering the conduct of professional trade associations such as the AMA, we believe that forwarding the economic and other interests of the members of the profession is often the explicit, conscious and indeed often legitimate intent of the representatives of the profession. To the extent that the profession has been successful in furthering its members’ interest, we would expect to find an institutional, organizational, and legal structure shaping the practice of medicine that serves the economic and other interests of members of the profession.

It would be hard to look back over the evolution in this century of the position and structure of the medical profession without concluding that the profession has in fact had considerable success in promoting its interests. It would be completely implausible to attribute a high level of altruism to the medical profession if that was interpreted to mean a high level of economic self-sacrifice in favor of the public’s health needs. The exceptionally high levels of physician incomes would belie that. Nor is it plausible to claim that the organized profession had led efforts to address some of the most serious moral deficiencies in our health care system, such as the continued lack of access to health care of large numbers of the poor. As we noted above, the history of the profession’s opposition to national health insurance and to Medicare and Medicaid belies any such role of altruism or moral leadership. Nor finally have many members of the profes-
sion acting as individuals been remarkably self-sacrificing or acted as moral leaders in addressing these problems. Occasional physicians have, of course, located in undesirable geographical areas to meet pressing health care needs or provided substantial unpaid care to the poor, but such behavior has not been sufficiently widespread to have a major impact on these problems.

Despite the extent that the profession has promoted its members' interests and that individual members have not been self-sacrificing in addressing the most serious deficiencies in the health care system, we believe it would be a serious mistake to conclude that the patient-centered ethic that has defined the traditional physician-patient relationship is mere sham and rhetoric, a thin guise overlaying the physician's self-interest.

An alternative, and we believe more plausible, interpretation is that in part just because the medical profession has been exceptionally successful in promoting and protecting an institutional and organizational setting that serves well physicians' economic and other interests, individual physicians have thereby been freed to follow the traditional patient-centered ethic in their relations with their individual patients. Put oversimply, a physician whose overall practice structure assures him a high income need not be so concerned to weight economic benefits to himself when considering treatment recommendations for his individual patients. As we have argued above, conflicts of interest between physicians and patients have long existed and are hardly a heretofore unknown consequence of for-profit health care institutions. As one commentator has argued, much of medicine can be viewed as a conflict for the physician between self-interest and altruism, requiring a balancing of these sometimes conflicting motivations (Jonson, 1983).

What we are suggesting is that the self-interested organized professional behavior and institutional structure of medicine may have helped protect the possibility of altruistic behavior on the part of the physician when guiding treatment with his individual patients. (This hypothesis, of course, requires careful qualification. In some cases the self-interested behavior of organized medicine has clearly had a negative impact on patient interests. For example, licensure and other forms of self-regulation by the profession have often failed to protect patients from chemically dependent or otherwise incompetent physicians and have exacerbated the problem of access by inhibiting the development of less
expensive forms of care utilizing non-physician providers such as midwives and nurse practitioners.)

One virtue of this more complex perspective is that it allows us to accommodate the elements of truth that exist in each of two otherwise seemingly incompatible perspectives, each of which taken only by itself appears extreme and incomplete. One perspective views the physician simply as an economically self-interested businessman in his dealings with patients. Those who support this perspective can point to the various ways in which the actions of the medical profession and the institutional and financing structure in which medicine is practiced serve the interests of physicians, as we have done above, but they often go on to deny any significant reality to physicians’ commitment to promoting their patients’ best interests. On the other hand, many defenders of physicians viewed as devoted professionals committed to the well-being of their patients seem also to feel it necessary to deny the extent to which medical practices and institutional structures serve physicians’ interests. Either perspective is by itself stubbornly one-sided in its view of physicians simply as self-interested economic accumulators or as devoted altruists. We favor a view which recognizes that these two perspectives are not incompatible and accepts the elements of truth in each of them.

One advantage of this more balanced perspective is that it permits the recognition of the reality and great importance of the traditional patient-centered ethic, without denying the conflicts of interest between physician and patient that we have discussed above or the important historical role played by economic interests of physicians. A perspective that encompasses a balance between self-interested and altruistic motivations on the part of physicians can help articulate the concern of many observers that the rise of for-profit medicine while not representing an entirely new phenomenon nevertheless does pose a danger to the traditional physician-patient relationship by shifting the traditional balance between self-interested and altruistic motivations and by bringing motivations of economic self-interest more directly and substantially into the physician’s relations with individual patients.

What, more specifically, is the worry about the erosion of the physician-patient relationship by the rise of for-profit health care institutions? We think that worry can be most pointedly brought
out by initially overstating the possible effect. The traditional account of the patient-centered ethic makes the physician the agent of the patient, whose “highest commitment is the patient (American College of Physicians, p. 17).” The physician is to seek to determine together with the patient that course of treatment that will best promote the patient’s well-being, setting aside effects on others, including effects on the physician, the patient’s family, or society. This commitment to the patient’s well-being responds to the various respects discussed above in which patients are in a very poor position to determine for themselves what health care, if any, they need. It is not just a function of more traditional paternalistic forms of physician-patient relations. Among the many increasingly common accounts of shared decisionmaking between physician and patient, the more plausible versions recognize that many of the inequalities in the physician-patient relation are probably to a significant extent ineliminable. Because many patients are and wish to be significantly dependent on their physicians, it is especially important to the success of this physician-patient partnership in the service of the patient’s well-being that the patient believe that the physician will be guided in his recommendation solely by the patient’s best interests. Patients have compelling reasons to want the physician-patient relationship to be one in which this trust is both warranted and fostered, quite apart from the putative therapeutic benefits of such trust.

Suppose the rise of for-profit health care so eroded this traditional relationship, and in its place substituted a commercial relationship, that patients came to view their physicians as they commonly now view used car salesmen. We emphasize that such a radical shift in view is not to be expected. We use this “worst-case” example of a caveat emptor commercial relationship only because it focuses most pointedly the worry about the effect on the physician-patient relationship of the increasing commercialization of health care. Many factors will inhibit such a shift from actually taking place in patients’ views of their physicians, including traditional codes of ethics in medicine, requirements of informed consent, fiduciary obligations of physicians, as well as powerful traditions of professionalism in medicine. Recognizing that the unsavory stereotype of the used car salesman substantially overstates what there is any reason to expect in medicine, nevertheless what would a shift in this direction do to the physician-patient relationship?
Most obviously and perhaps also most importantly, it would undermine the trust that many patients are prepared to place in their physicians' commitment to seek the patient's best interests. In general, there is no such trust of a used car salesman, but rather his claims and advice are commonly greeted with a cool skepticism. He is viewed as pursuing his own economic interests, with no commitment to the customer's welfare. It is the rare (and probably in the end sorry) consumer who places himself in the hands of the car salesman. Anything like the fiduciary relationship in which a patient trusts the physician's commitment to put the patient's interests first is quite absent with the used car salesman.

This is not to say that some additional consumer skepticism of physician recommendations and increased attempts by patients to become knowledgeable health care consumers would not be a good thing — they would. It is rather to say as already noted, that many of the various inequalities in the physician-patient relationship are sufficiently deep and difficult to eradicate that some substantial trust of the physician's commitment to the patient is likely to remain necessary and valuable. The commercial model of arms-length, caveat emptor bargaining is not well-suited to the physician-patient relation.

While historically there has been some deception of patients by physicians, it seems to have markedly decreased in recent decades, and this deception in medicine was justified as for the patient's own good (even if in fact if often was not). However, one does not expect the truth, the whole truth, and nothing but the truth from a used car salesman, nor that shadings of the truth are done for the customer's own good. We expect some concealment and distortion of information in order to make the sale, although this is not to say that some outright deception in commerce may not be fraudulent and immoral.

It is also commonly accepted that businessmen are in business to sell as much of their product as possible, however much the customer may not "need" the expensive car being pushed by the salesman. Businessmen respond to consumer wants, not needs, and will do their best to manufacture such wants where they do not already exist. Physicians, on the other hand, are expected not to encourage needless consumption. Commercialized medicine may respond increasingly to consumer wants for health care even if they are for frivolous amenities such as champagne breakfasts for obstetric patients and however unrelated they may be to the
patient’s true health care needs. Because health care consumers are commonly in a poor position to evaluate for themselves their own need for health care, their actual health care wants will often be both ill-informed and unusually vulnerable to influence and manipulation by health care professionals. However, not all increased responsiveness to consumer wants would constitute a shift from serving patients’ true health needs to serving their mere wants. To the extent that which treatment, if any, best promotes a patient’s well-being depends at least in part on that patient’s particular aims and values, increased responsiveness to consumer wants can make a genuine contribution to patient well-being.

A shift towards commercialization of health care could also be expected to result in increasing emphasis on marketing strategies to secure profitable segments of the market. Moreover, we expect no unprofitable products or service from a car salesman in response to consumer need. And most clearly, persons who lack the ability to pay for commercial goods and services simply do not receive them. We have argued that the moral obligation to ensure access to health care for the poor is ultimately the government’s, not an individual physician’s or hospital’s by way of cross-subsidization. Nevertheless, in the face of unmet need, some physicians and health care institutions do, and are often expected to, respond to that need by furnishing the needed care. Increasing commercialization of health care is likely to weaken this disposition of some physicians to respond to people’s health care needs without regard to their ability to pay.

Other norms important to the practice of medicine also have a weakened or non-existent role in most commercial transactions, such as the requirement of confidentiality concerning information about the patient. Like the commitment to put the patient’s interests first, the norm of confidentiality concerning patient information is both fragile and under increasing pressure from many forces, such as the growing specialization within health care, besides rising commercialism.

One must be careful not to overstate the contrast between medicine and commerce. It is certainly not the case that commerce takes place in the absence of any ethical constraints (or legal constraints, reflecting ethical norms) nor that the medical profession is never moved by self-interest. Our society does in fact expect, and in some cases enforces by the power of the law, significant restrictions on the pursuit of profit by ‘mere business-
men'. One would not want a physician who was motivated exclusively by financial reward, but then one would not want an electrician who was either. In fact, it can be argued that the moral obligations of businessmen to their customers are not significantly less demanding than those of physicians toward their patients when equally important interests are at stake. However, important interests may be more frequently potentially at stake in health care than in ordinary business transactions. And even if there is a tendency to overstate the contrast between ethical and legal constraints on business transactions and the physician-patient relationship, we typically do expect a somewhat higher standard of conduct from physicians.

We believe there is, moreover, a genuine and important difference in the ethos of the two enterprises that plays out in important differences in the physician-patient and businessman-consumer transaction. The ethos of medicine is one of commitment and service to others. While medicine has, of course, contained physicians primarily concerned with their own economic and other interests, they are viewed and condemned as deviants by that ethos. Not so, however, in commerce. Oversimplifying, it is commonly believed that in business transactions, individuals pursuing their own interests, though admittedly within some ethical and legal constraints, will best promote the overall social good. It is this view of the motivation of self-interest as ethically acceptable that quite reasonably worries many as medicine becomes increasingly commercialized.

Since physicians are, of course, human like the rest of us and quite naturally concerned with their own interests, it is reasonable to view their primary commitment to the patient's well-being as inevitably fragile and always in danger of being undermined. In that light, it is unnecessary to view for-profit institutions as introducing a qualitatively new dimension of commercialization and new set of conflicts of interest into health care. As we have argued, such a view is indefensible. Nor need it be expected that physicians' concern with their patients' well-being will just disappear as soon as they go on the payroll of a for-profit hospital or, more likely, establish other types of contractual relations with it. That view too would be indefensible, indeed downright silly.

The realistic worry, concerning which the data are not yet in, is rather that over time the increased importance of investor-owned for-profit institutions may permit considerations of economic
self-interest increasingly to invade the heretofore somewhat protected sphere of the physician-patient relationship, and thereby weaken the patient-centered ethic on which that relationship importantly depends. The difference would only be one of degree, but no less important for that. As we have noted above, there are other independent factors putting similar pressures on the relationship such as the expected oversupply of physicians. It would be a mistake to think that these possible adverse effects on the physician-patient relationship are uniquely due to the rise of for-profits. However, that is no reason to be unconcerned with these effects of for-profits, but only a reason not to focus solely on for-profits.

We emphasize that the traditional patient-centered ethic need not be incompatible with greater attention to costs in health care utilization decisions and practices. Utilization of health care should reflect the financial costs as well as benefits of care, but that will not be appropriately achieved by, nor need it inevitably lead to, physicians making utilization decisions solely according to their own economic self-interest. Whatever the right mix of incentives for reasonably limiting health care utilization and costs, simply making physicians fully subject to incentives of economic self-interest by breaking down the patient-centered ethic seems not the path to that mix. A physician weighing the true financial costs of care against its medical benefits to the patient is entirely different from one who simply weighs the economic consequences to himself of the patient utilizing care.

The most obvious worry, then, is that the increasing prominence of for-profits may contribute to a shift in physicians' patient-oriented behavior, which may in turn affect the patient trust important to a well-functioning physician-patient relationship. The test of that hypothesis would then be the extent to which physician behavior is actually different within for-profit settings. But it is important to realize that patient trust may be eroded, and so the physician-patient relationship adversely affected, even in the absence of any actual shift toward more self-interested behavior by physicians. Even if outward behavior does not change, a change in the motivations of the behavior, and in turn of perceptions by others of those motivations, may be important. If physicians are increasingly perceived by patients as motivated by self-interest rather than by a commitment to serving their patient, then even in the absence of a change in physicians'
behavior, it is reasonable to expect an erosion in patient trust that physicians will act for their patients' best interests. Part of what is important to patients in health care is the reassurance that the professional cares about them and their plight. (This is one respect in which other health care professionals, for example nurses, are often more important than physicians in patient care.) A change in physicians' motivations, or even simply in patient's perceptions of those motivations, may be enough to affect patients' beliefs about whether their physicians "really care" about them. This point should give pause to those who propose to test the effects of for-profits on the physician-patient relationship and on patient trust by looking only at changes in physician behavior.

III. CONCLUDING REMARKS

Any summary conclusion of our examination of two of the principal ethical issues in the growth of profit-seeking in health care will inevitably oversimplify. A continuing theme running through our analysis is that the moral objections commonly voiced against profit motives and for-profit institutions need to be both framed and evaluated more carefully than they usually are. At many places, these objections also rest on empirical claims for which the data are not yet available. We have been generally critical of the argument that for-profits fail to do their fair share in providing health care to poor or unprofitable patients. That argument assumes that for-profits have special obligations to care for these patients, that a determinate content can now be given to that obligation, and that the obligation can be discharged without unreasonable sacrifice on the part of the for-profit. These assumptions are all problematic. It is a mistake to focus on how for-profits exacerbate or ameliorate access. The debate could more profitably concentrate on the need for a coordinated societal response to the serious injustices in access to health care that now exist.

We believe that the potential adverse effects of the growth of for-profits on the physician-patient relationship and on the quality of care is of serious ethical concern. The potential conflicts of interest between patient and provider are not new. Indeed, they are fundamental to the physician-patient relationship in either for-profit or nonprofit settings. Moreover, the other powerful forces besides the growth of for-profits, in particular cost-containment
efforts and increased competition, are impinging on the physician-patient relationship. But the importance of the patient’s trust in his physician, and the fragile balance between the physician’s commitment to serve the patient and his natural concern with his own interests, give reason for serious continuing attention to this potential effect of increased profit seeking in health care.

NOTES

* This paper is drawn, with revisions, from our longer paper, ‘Ethical Issues in For-Profit Health Care’ (Brock and Buchanan, 1986).

1 While the number of investor-owned, as opposed to independent, for-profit hospitals has risen, hospital ownership, classified by broad categories — federal, state, and local government, non-profit and for-profit — has changed little in the past decade (Gray, 1984).

2 Investor-owned for-profit corporations are controlled ultimately by stockholders who appropriate surplus revenues either in the form of stock dividends or increased stock values. Non-profit corporations are tax-exempt and are controlled ultimately by boards of trustees who are prohibited by law from appropriating surplus revenues after expenses (including salaries) are paid.

3 At this writing, New York has legislation limiting the operation of for-profits in the state and the Rhode Island legislature is considering proposed legislation to ban their operation.

4 The argument in this and the next paragraph is drawn directly from the President’s Commission for the Study of Ethical Problems in Medicine report, Securing Access to Health Care (1983), which both the present authors helped to write.

REFERENCES


