PROFIT AND COMMERCIALISM

The practice of medicine is clearly a profession, as usually defined. In some senses it is also a business. However, the extent to which the professional behavior of physicians ought to be influenced by business considerations is a matter of debate (Veatch 1983). A more general but closely related question is the degree to which business values should control the health care system (Gray 1991).

Physicians in private practice must generate income to pay their costs and earn a livelihood. In this sense, profit (the excess of gross revenues over costs) is as economically important in the fee-for-service practice of medicine as it is in the conduct of a business. But some have carried the analogy further and have maintained that the payment of a fee is an essential part of the professional relation between physicians and patients because this relation is in effect a commercial contract between the supplier of a service (the physician) and the purchaser of a service (the patient). Although the service is professional, and therefore involves more constraints and responsibilities for the supplier than does an ordinary market transaction, this interpretation of medical practice effectively blurs most of the distinctions between medicine and business (Sade 1971). This argument further asserts that physicians may choose to offer their services to indigent patients gratis or at reduced rates, but their professional status does not require them to do so. Nor are physicians required to ignore or minimize their own economic interests when making professional decisions, provided their treatment is medically appropriate (Engelhardt and Rie 1988).

Opposed to this point of view is the perhaps more traditional interpretation that regards medical practice primarily as a ministering function—a commitment to serve the needs of patients without concern for self-interest (Relman 1992). According to this interpretation, profit may be an economic necessity in fee-for-service practice, in the aggregate if not in each individual case, but a de facto contract binding all physicians establishes an overriding obligation to serve those in need of medical care regardless of their ability to pay. Furthermore, fee for service is not considered to be a critical, or even an important, feature of professional practice. In this view, the contract between doctor and patient is basically ethical, not commercial, and is seen as part of a broader commitment that physicians make to society in exchange for licensure, authority, and the many other benefits bestowed on them by the state.

Although there has always been an uneasy tension between these two perspectives, until recently the traditional view of the ethical obligations of the medical profession generally prevailed. Most people considered medical care to be a social good, not an economic...
commodity, and most physicians and medical professional organizations acted as if they agreed. For example, the version of the American Medical Association’s (AMA’s) ethical code prevailing from 1957 to 1980 states: “The practice of medicine should not be commercialized nor treated as a commodity in trade” (AMA Judicial Council 1969, 28). Advertising was discouraged, and physicians were advised to limit the source of their professional incomes to services to patients rendered by them or under their supervision (AMA Judicial Council 1969).

A similar view of the role of hospitals as essentially not-for-profit social institutions was widely accepted. Although many small proprietary hospitals existed in the early part of the twentieth century, until fairly recently virtually all hospitals larger than seventy-five beds were public or private, not-for-profit institutions that considered their primary mission to be public service. Most of the private, not-for-profit (voluntary) hospitals admitted patients—particularly those who were acutely or seriously ill—without regard to income, and many accepted less than full payment from patients with limited means. They sometimes operated at a deficit and depended on philanthropy, public contributions, or other non-patient-derived income to continue operation. The public hospitals, of course, were tax supported and were not expected to meet their expenses from patient revenues.

Beginning in the late 1960s, however, a new commercial spirit began to permeate the health care system (Relman 1980; Gray 1991). It started with the hospitals but soon spread rapidly to virtually every other part of the system. In response to the growing opportunities for profit resulting from the expansion of government-supported health insurance through Medicare and Medicaid in the 1960s and employment-based private health insurance, large chains of investor-owned hospitals sprang up in many communities. Other types of for-profit medical facilities and services soon followed, attracted by the seemingly unlimited opportunities for financial gain. Today about 20 percent of all private general hospitals and the majority of private nursing homes, psychiatric hospitals, and free-standing ambulatory care and diagnostic facilities are owned by for-profit corporations. When the Clinton administration’s proposals for health insurance reform failed in 1993, for-profit companies selling managed care insurance quickly filled the breach. By the beginning of the twenty-first century, the great majority of private health insurance plans came from investor-owned companies. In 1980 I first called attention to this new “medical-industrial complex” and to the ethical issues it raised (Relman 1980). Together with the new and rapidly growing biotechnology companies and the traditional pharmaceutical and medical supplies and equipment industries, these for-profit businesses constitute a vast commercial network with a pervasive and powerful influence on the US health care system. In no other country is so much of the health care delivery and insurance system operated by investor-owned corporations, and in no other country does private business have so large a stake in health care policy.

Even the not-for-profit voluntary hospitals have become infused with the entrepreneurial spirit. Overexpansion of hospital capacity and competition from investor-owned health care facilities, both in-patient and ambulatory, forced voluntary hospitals to become more competitive. Private managed care insurance and federal insurance programs have pressured the not-for-profit hospitals to accept lower payments. As a result, their marketing and advertising efforts, and their preoccupation with the generation of revenue, are almost indistinguishable from those of their investor-owned competitors. Care of the indigent, once considered a prime responsibility of voluntary as well as public hospitals, has been increasingly shifted to public institutions. Pressures to control costs have led to reductions in hospital staff and shortened lengths of stay, which may adversely affect quality of care.

Practitioners first began to feel economic pressures in the decade of the 1980s, and these pressures have increased since then, forcing them, like the hospitals, into more entrepreneurial behavior. The numbers of competing specialists have grown rapidly, while available fee-for-service patients have become more scarce and insurance companies have shifted from unquestioning payment of the doctor’s bill to increasingly stringent efforts to control expenses through capitated and discounted payment and through managed care. Medicare fees are also being reduced. To protect their income, many physicians began to act like competing businesspeople, seeking more customers and more ways to deliver profitable services (Relman 1988). Physicians have also become interested in opportunities to increase their revenues through partnership in, or ownership of, health care facilities and through financial arrangements with companies supplying the drugs, devices, or diagnostic services they prescribe for their patients. In many parts of the United States, practicing physicians refer their patients to freestanding diagnostic or ambulatory surgery facilities in which the physicians hold financial interest—a practice called self-referral.

In 1975 the US Supreme Court declared that the reach of antitrust law extended to the professions (Goldfarb v. Virginia State Bar 1975), and shortly thereafter the AMA was legally enjoined from interfering with the advertising and marketing practices in which increasing numbers of physicians were engaged. In response to the growing view that health care was a competitive marketplace and physicians were essentially small independent entrepreneurs, the AMA retreated in the 1980s from its earlier proscriptions against commercialization.
Its 1982 revised ethical code says nothing about the distinction between medical practice and trade; instead, there is a statement that competition is “not only ethical but is encouraged” (AMA Judicial Council 1982, 22). Advertising was sanctioned provided it was not misleading, and the earlier restriction on sources of professional income was removed. Self-referral and other kinds of economic interests by physicians in the medical products they prescribe were said to be ethical, provided the financial interest was disclosed to patients and did not influence medical judgment. The most recent AMA position (1998, 121) puts additional restraints on self-referral, but does not prohibit it altogether.

Ethical issues aside, does the commercialization of the health care system bestow any special benefit on patients or on society in general? In most sectors of the economy, free market competition among suppliers of goods and services helps to control prices and encourages quality. Although suppliers promote consumption through marketing and advertising, the cost-conscious choices of consumers largely determine the number of units purchased and the total expenditures allotted to each product. Goods and services are distributed primarily according to consumers’ desires, their judgments about price and quality, and their ability to pay—all of which is believed to serve useful social purposes.

But the health care sector is quite different from most other parts of the economy, and the consequences of market competition are not the same. Consumers (patients) can make relatively few independent and informed purchasing decisions because they must rely so heavily on advice from their physicians. And because of third-party payment, neither the consumer nor the provider of services (the physician) is much constrained by cost. Physicians largely determine the distribution and use of services. Professional judgment of the patient’s medical needs is the primary consideration, but the economic benefits to the physician and the health care institution also play a role, particularly when the medical needs are optional or uncertain. Therefore, when health care that is paid on a fee-for-service basis becomes commercialized, competition serves not to limit but to increase expenditures because providers have greater economic incentives to offer their services to patients who are, for the most part, dependent and unresisting consumers. Profit motives thus intensify inflation in a health care system unless it has effective cost-control mechanisms.

On the other hand, when payment for medical services is made in advance, as in HMOs and other kinds of prepaid managed care, economic incentives tend to force physicians and hospitals to reduce, rather than increase, their allocation of elective services to patients. In such a system insurers and providers profit most when medical expenditures are kept to a minimum. Commercialization of managed care thus raises concerns about cutting corners and underserving patients’ needs, just as the commercialization of fee-for-service care raises concerns about excessive and unnecessary services. In both cases, there is the risk that the profit motive may influence professional judgment and make it more difficult for physicians to act in the best interests of their patients.

Furthermore, a commercialized health care system has little concern for the needs of the uninsured and the underinsured. Unless government intervenes, those without means to pay are denied access to all but emergency care. The steadily rising number of patients without insured access to health care testifies to the social indifference of a profit-oriented medical marketplace and to the inability of tax-supported institutions to accept the growing burden of the medically indigent. It is currently estimated that about 15 percent of the US population has no medical insurance and that at least as many are seriously underinsured. The Affordable Care Act of 2010 (ACA) proposes to expand insurance coverage by about 32 million with federal and state support, but as of this writing its political future is uncertain. Efforts by providers of medical care to remain economically viable may require them not only to restrict charity but also to promote profitable services, which may not be those most needed by the community.

Proponents of commercialization in health care argue that it rewards innovation and technological development. They say that one of the benefits of an expanding medical marketplace is stimulation of applied research and development, leading to the more rapid introduction and dissemination of useful new products. However, there is no reason to believe that the pace of worthwhile innovation would be significantly slowed in a system that encouraged research and development but allowed industry to market only properly tested new products, and restrained entrepreneurialism in the delivery of medical care. The current dominance of the United States in the development of new medical technology is probably the result more of substantial public support of medical research than of the commercialization of the health care system.

The growing crisis caused by the continuing increase in private and public health costs at a rate greater than the growth of the general economy led President Bill Clinton to propose major reforms in 1993, but these were never taken up by Congress. In 2010 President Barack Obama barely managed to get approval of his reform plans, as provided in the ACA (Relman 2010). The legislation is under serious political attack, but even if it survives, it has no provisions that ensure control of costs. The ACA depends on private insurance and a private, competitive market to cover most persons not in Medicare or

Profit and Commercialism

BIOETHICS, 4TH EDITION 2557
Medicaid, so additional legislation and further reforms will be needed to eliminate the effects of commercialism.

These reforms would require a major change in public opinion and the active support of most physicians, so early resolution of the problems of the US for-profit and commercially oriented system is unlikely. This issue has been hotly debated ever since the introduction of managed care. Those who believe that the era of the “corporate practice of medicine” has arrived assert that old-fashioned medical professionalism is becoming obsolete (Robinson 1999), but there are still influential voices defending the traditional ethical values (Freidson 2001).

It remains to be seen whether commercialism in medicine will continue to grow and ultimately dominate the US health care system. Those who believe medical care is a business like any other regard such an outcome as desirable and necessary for the achievement of optimal efficiency. On the other hand, those who believe medical care is primarily a social rather than an economic good hope that the present trend toward commercialism will be resisted and in the long run reversed. They believe the ultimate solution of the health care problems in the United States will be found through social action and community responsibility.

SEE ALSO Advertising and Marketing in Health Care; Commercialism in Scientific Research; Corporate Social Responsibility in Health; Economic Concepts in Health Care; Health Care Institutions; Health Insurance; Managed Care; Pharmaceutical Industry

BIBLIOGRAPHY


Professor Emeritus of Medicine and Social Medicine, Harvard Medical School

PSYCHIATRY, ABUSES OF

Abuse of psychiatry conjures up an image of a psychiatrist acting improperly, causing a patient to experience harm. The concept is more complex, however. This entry examines psychiatric abuse in an effort to determine its causes and meaning so that steps can be taken to prevent it.

HISTORICAL BACKGROUND

Evidence has accrued since the early 1970s of unethical practices such as the abuse of psychiatry for political purposes in the former Soviet Union (Bloch and Reddaway 1977, 1984), the deployment of psychiatric