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Ethical Issues in For-Profit Health Care

Dan W. Brock and Allen Buchanan

The American health care system is undergoing a rapid socioeconomic revolution. Within a general environment of heightening competition, the number of investor-owned for-profit hospitals has more than doubled in the past 10 years, while the number of independent proprietary. for-profit hospitals has declined by half[1] 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 individual, a partnership, or a corporation, but which are not controlled 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. 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.

The above definitions treat "for-profit" rather narrowly as a legal status term referring to investor-owned and independent proprietary 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, decision-making techniques, and organizational structures that are characteristic of large-scale commercial enterprises.

A recent book published by the Institute of Medicine 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 which 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.

In what follows, "for-profit" will be used only to denote a distinctive legal status and not as a vague reference to "commercial" motivation or decision making and organizational structure, or as a synonym for the equally nebulous concept of "competitive health care." We shall explore, however, some moral concerns about the rise of for-profit institutions in the legal sense that focus on the profit motivation, decision-making forms, and organizational structures common to those institutions.

Serious moral criticisms of for-profit health care have been voiced, both within and outside of the medical profession. Before they can be evaluated, these criticisms must be more carefully articulated than has usually been done. In each case, after clarifying the nature of the criticism, we shall try to answer two questions: (1) Is the criticism valid as a criticism of for-profit health care? (2) If the criticism is valid, is its validly- restricted to for-profit health care?

The most serious ethical criticisms of for-profit health care can be grouped under six headings. For-profit health care institutions are said to (1) exacerbate the problem of access to health care, (2) constitute unfair competition against nonprofit institutions, (3) treat health care as a commodity rather than a right, (4) include incentives and

organizational controls that adversely affect the physician-patient relationship, creating conflicts of interest that can diminish the quality of care and erode the patient's trust in his physician and the public's trust in the medical profession, (5) undermine medical education, and (6) constitute a "medical-industrial complex" that threatens to use its great economic power to exert undue influence on public policy concerning health care. Each of these criticisms will be examined in turn.

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 20 million have coverage that is inadequate by any reasonable standards.[2] 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. This is an empirical question to which the accompanying Institute of Medicine (IOM) report devotes a chapter. 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.

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.[3]

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, as noted earlier, 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 non-profits, 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 which tend to weaken the force of the criticism that for-profits are exacerbating 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 significant difference in the proportion of

nonpaying care rendered by for-profits and nonprofits.[4] The other is that at present the proportion of nonpaying care rendered by nonprofits is on average only about 3 percent of their total patient care expenditures.[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 percent of overall total patient care expenditures.[6] 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 and other efforts for cost-containment by 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 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 preferences or considerations of prestige 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 assumed that the members of a society as affluent as ours have a collective moral obligation to ensure that everyone has 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 nonhospital 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 overcharging—charging higher prices than 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 non-profits 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 nonprofitable care that is actually provided by many non-profits 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, nonpublicly 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 taxpayers. 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 a minimal subsistence existence. 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 meet 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 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 which many for-profits serve and from which they benefit. This is new health care business which 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 recipients, highway builders, and so forth have any analogous special obligation based on the fact that their business is created by government funds. Nor is it 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 or not 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 the individual's 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 uncompensated 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 non-profits 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 overall 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, determining whether one institution is 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 of taking 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 which 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 obligations 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 government or private, accountable for the fulfillment of those obligations.

Moreover, there is at least one obligation which *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 have. 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 important, (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?

For-Profits are Unfair Competition for Nonprofits

This criticism of for-profits can be interpreted in either of two different ways. The first understands it as a charge we have already examined in detail, that for-profits skim the cream and gain a competitive advantage over nonprofits by failing to discharge their institutional obligations to bear their fair share of the costs of providing care for indigents

and those with unprofitable diseases. But the metaphor of cream-skimming suggests another possible aspect of the charge of unfair competition that it is worth saying a. little more about. This is that besides not taking a fair share of the "bad" (unprofitable) patients, the for-profits also take more than their share of the "good" (profitable) patients.

As we noted above, if no one is *entitled* to the profitable patients, it is unclear why seek-hag to get as many as possible of them is unfair. Nor is it clear that the nonprofits do not also seek as many as possible of the profitable patients. If the for-profits get a disproportionate share of the profitable patients, which may be true at some places but not others, why would that be? Since paying patients have a choice about where and from whom they receive care, their choice of for-profits must in significant part reflect their view that for-profits offer a more attractive product: for example, more convenient location, more modern and higher quality facilities, additional amenities, cost-saving efficiencies, and so forth. It is difficult to see why getting a disproportionate share of the profitable patients simply because one offered a better product is unfair. Of course, when for-profits get more of the profitable patients because of factors such as tie-in arrangements with physicians, this may constitute unfair competition, but nonprofits may engage in such anticompetitive practices as well.

According to the second interpretation of the unfair competition charge, nonprofit health care institutions make a distinctive and valuable social contribution—one that is so important that they ought to be protected from the threat of extinction through competition with for-profits. Three main arguments can be given in favor of perpetuating the nonprofit legal status for health care institutions and, hence, for social policies that are designed to protect them from destructive competition from for-profits. First, nonprofit health care institutions are properly described as charitable institutions. As such they help nurture and perpetuate the virtue of charity among members of our otherwise highly self-interested society, and this virtue is of great value. The nonprofit legal form stimulates charity by exempting charitable institutions from taxes. Because it also ensures that those who administer charitable funds do not appropriate revenue surpluses, the nonprofit legal form encourages charity by providing potential donors with the assurance that they will not be taken advantage of and that their donations will be used for the purposes for which they were given. This assurance is especially vital in the case of donations for health care because donors usually lack the knowledge and expertise to determine whether the providers they support are using their resources properly.

Second, nonprofit health care institutions both function as and are perceived to be an important community resource, serving the entire community, rather than a commercial enterprise ultimately serving its shareholders and restricted to "paying customers." Like the virtue of charity, the sense of community, is an important though fragile value in modern American society, and institutions that contribute significantly to it should not be lightly discarded.

Third, nonprofit health care institutions nurture a professional ethos that is more likely to keep the patient's interest at center stage than do for-profit institutions, in which the commercial spirit is given freer rein. Hence nonprofits are valuable because they protect quality of care. The quality-of-care argument will be examined in detail later.

The first argument above assumes that most nonprofit health care institutions are properly described as charitable institutions in the sense that a substantial portion of their financial resources comes from donations. At present, however, most nonprofit hospitals are not charitable institutions in this sense; they are "commercial" rather than "donative" institutions insofar as the major portion of their resources comes from selling services rather than from donations.[7] The more closely nonprofit health care institutions approximate the purely "commercial" nondonative type, which is becoming the dominant form among nonprofit hospitals, the weaker the value of charity appears as a justification for perpetuating the nonprofit legal status. Nevertheless, even if only a small portion of most nonprofits' revenues comes from charitable donations and is in turn used for unpaid care, nonprofits may still be properly regarded as "charitable" *if* they do in fact serve as the provider of last resort for those who are unable to pay for their care and who are not covered by any insurance or government program to fund their care. Even if such care represents only a small portion of a hospital's overall revenues, it may still be perceived as an important charitable activity and thereby reinforce altruistic and charitable motivations.

It should be clear that the charity and community arguments are not unrelated. It is partly because nonprofits stand ready to provide unpaid health care to the poor (if they do) that they are seen to be a community resource available to the entire community. They can serve to symbolize a shared community commitment that no member of the community should be denied access to an adequate level of health care. This commitment is especially important in the mission of public hospitals. Moreover, control of nonprofits will commonly rest with a board of trustees composed of members of the local community, rather than with a board of directors of a large national or multinational chain. This effect of nonprofits on the sense of community as shared by members of the community is somewhat intangible and difficult to measure. It is also certainly true that nonprofit hospitals are not the only institutions supporting this sense of community, or even the only means of supporting it within health care, and that for-profit hospitals can often contribute to it as well. Nevertheless, we believe the nonprofits are in general more likely than the for-profits to promote this significant value of community.

For-Profits Treat Health Care as a Commodity to be Bought and Sold in the Marketplace Rather than as a Right of Every Citizen

This next collection of ethical concerns about the growth of for-profit health care is steeped in stirring rhetoric. We are told that "health care is not a commodity," that "health care ought not be left to the market," that "access to health care ought not depend on ability to pay," and that "everyone ought to have access to a single level of health care." And it is often said that the ethical acceptability of for-profit health care delivery systems depends on whether health care is properly viewed as a right or as a commodity.[8] In this section we attempt to sort out just what the implications of claims like these are for for-profit health care.

The slogan that health care is not a commodity is best understood as a normative, rather than a purely descriptive claim. As a descriptive claim, it is quite false: if a commodity is defined as something which has a market price or relative exchange value, then health care is a commodity since various treatments, tests, and services are assigned a market price in our society. (Until recently, of course, codes of professional ethics for physicians, backed up by the coercive power of legislation, have made it difficult for most consumers to learn the market price of most forms of health care; but this is a fact about the profession's success in restricting consumer information about health care, not a fact about the nature of health care.)

As a normative claim, the slogan that health care is not, that is, should not be treated as, a commodity implicitly depends on two sorts of assumptions: (1) empirical assumptions about what health care will be distributed to which persons if production and distribution of health care are carried out by for-profit institutions in a marketplace and (2) moral assumptions about what is a just distribution of health care, and what moral right, if any, there is to health care. With regard to the moral assumptions, we believe it is crucial to distinguish the claim that justice requires some level of access to health care for all from the claim that it requires equal access for all persons. We shall argue here that only the view that justice requires *equality* in access to health care, not merely that it implies a right to health care, is incompatible with for-profit provision of health care in a free marketplace.

If the goal is only to ensure that everyone is guaranteed access to some minimally adequate level of health care, why not leave its distribution to the market and so to for-profit institutions? The difficulties with doing so are well known and need not be rehearsed in detail here. Generally, a market system for the distribution of health care, like a market distribution of all other goods and services, will be influenced by the initial natural endowments and wealth that people bring to the market, rather than simply by their need for health care. The market distribution of health care, as with other goods, will only be just if the distribution of initial assets, including income and wealth, is just.

However, there are specific characteristics of health care, and of health care markets, which further ensure that a market distribution of health care will fail to satisfy, the demands of any theory. of justice requiring that some minimally adequate level of access to health care be guaranteed to all. Health care needs are highly unpredictable for any particular individual, vary greatly between different individuals (unlike other basic needs for food or shelter), and

in the context of modern health care are very expensive relative to most other goods and services. As a result, it is difficult if not impossible for any but the very richest to budget their health care expenditures.

The market solution to this situation, of course, is the development of a market in insurance, a device for *risk-sharing* that enables individuals to protect themselves from substantial unforeseen financial losses and to secure very expensive professional help in coping with disease or disability when it occurs. However, competition in the market for health care insurance will lead to differentiation of risk pools. Different insurance packages, with different premiums, will be developed for different groups of individuals with similar risks of sickness and disability with the result that those individuals who have the greatest risk of ill health—that is, those who need insurance the most—will find it prohibitively costly. Regulatory measures requiring community rating of insurance risks and unlimited access to insurance pools can be used to counter risk-pool differentiation, although a market proponent will view these as inefficient interferences in the operation of health care markets.

With either different risk pools or community rating, however, health care insurance will remain extremely expensive, and beyond the financial reach of substantial numbers of the poor in this country. This would be true even if access to health insurance were less closely tied to employment than it is in the United States today. Thus, even with health insurance the market will make access to even some minimally adequate level of health care depend upon ability to pay, an ability that many millions of Americans today lack (and would lack even under a system of perfectly competitive markets for the distribution of income).

On virtually any general theory of distributive justice, and in particular any theory of justice in health care other than a rather austere libertarian view, no one in a country as wealthy as ours ought to have to go without access to at least a minimally adequate level of health care. There is a general moral obligation of society to ensure that level of access for all, and we have argued that the obligation falls ultimately on the federal government. While general theories of rights are not well developed, nevertheless, we believe this obligation supports the claim that there is a moral right of all Americans to that level of health care. Market distribution systems employing for-profit health care delivery systems will fail to meet this obligation, or to secure the correlative right, and so will distribute health care in an unjust way.

To this extent, then, the rhetoric with which we began this section is correct: the distribution of health care ought not be left to the market and ought not depend on ability to pay. But this fact provides no reason for preferring for-profit health care to nonprofit health care, or for attempting to protect nonprofits or to stem the growth of for-profits. As noted earlier, until quite recently nonprofit institutions have dominated the health care system, but they did not solve the problem of access to care. The greatest extension of access to care to those who previously had virtually no access came from Medicare and Medicaid, not from the private insurance market working within a largely nonprofit system. Whether or not a predominantly nonprofit system, a predominantly for-profit system, or a more evenly mixed system will remedy the ethical deficiencies of a purely market distribution of health care will depend upon the specific arrangements for modifying the market distribution by subsidizing care for the worse off.

In a system in which virtually all health care institutions were of the for-profit form, the distributional inequities of the market might be avoided by the use of health insurance vouchers for the poor, financed by taxes, including taxes of health care institutions. Of course, if some health care markets are sufficiently noncompetitive so that supply problems still remain, for example in poor rural or inner-city ghetto areas, then supplementary, nonmarket direct provision programs such as the National Health Service Corps may be needed. The fundamental point, however, is that unjust gaps in access left by a market system of health care distribution require redistributive measures (probably by the government), whether the overall health care system is predominantly nonprofit or for-profit, and that redistributive means are available for either a nonprofit or for-profit system. So here, as with the charge that for-profits exacerbate the access problem, analysis of a criticism which at first appears to be directed only at for-profit health care leads us back to more fundamental issues of distributive justice—issues that would perhaps be just as urgent if for-profit health care had never appeared on the scene.

If acknowledgment of a right to health care is compatible with either a nonprofit or for-profit delivery system, both of which require redistributive measures to fund access for the poor, why is it so often thought that for-profits and markets are incompatible with that right? A principal explanation, we believe, is the confusion of a right of all persons to an *adequate* level of health care (the right we have appealed to above) with a right of all persons to the *same* level of health care. A right to an adequate level requires some minimal floor of health care access below which no one should be allowed to fall. That level does not, on the other hand, constitute a ceiling above which no one is permitted to rise, and so is compatible with individuals using their resources to purchase in the market more or better health care or health care insurance than the adequate level guarantees.

Without trying to specify what an "adequate level" would be, it also seems clear that it would be less than all medically beneficial care. A right to an adequate level of health care, then, is only minimally egalitarian in requiring an equal minimal level of access for all while permitting departures from equality in an upward direction from that minimum. A right of all persons to the same level of health care, on the other hand, is strongly egalitarian in not permitting departures from equality in either a downward or upward direction from the level specified by the right. If that level is something less than all medically beneficial health care, as we believe it inevitably would have to be, such a right would have the effect of prohibiting anyone from using his or her resources to purchase more or better health care than is guaranteed to all.

This strong egalitarian position regarding health care distribution is incompatible with the unconstrained purchase and sale of health care in a market, *whether the seller is a for-profit or nonprofit institution*. Limited market price competition among providers offering only a single level of care to all would be possible, and so equality in health care does not foreclose all use of market competition, though it is likely that such competition would spread to quality, and quantity of care, thereby undermining the single level of care for all. However, if markets for different amounts or quality of health care are allowed to exist alongside whatever system ensures the equal level to all, then any differences between persons in either income and wealth and/or preferences for health care as opposed to other goods and services will produce inequalities in the overall distribution of health care.

As several commentators have noted, the necessary prohibition of markets for health care to enforce this equality in health care, understood as requiring both a floor and ceiling, would have the effect of permitting persons to use their resources to purchase nonessential luxury goods like Mercedes Benz cars and Caribbean vacations while prohibiting their use for the basic and essential good of health care.[9] Without pursuing the matter further here, we believe this would require a stronger commitment to equality than is either plausible or widely accepted in American society, while at the same time conflicting with the freedom of individuals to decide for themselves how they will use their justly acquired resources.

There is another version of the concern that health care is a right whereas for-profits treat it as a commodity to be bought and sold in the marketplace. The important distinction here is between health care *needs* and market-expressed *wants* or preferences for health care. For-profits, it is argued, will respond 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. The right to health care, on the other hand, is to some level of health care adequate to meet the patient's objectively determined, basic health care needs. There are two versions of this concern with a health care system that responds to wants rather than needs that should be distinguished.

The first rejects the identification of patients' well-being or just claims to health care with the satisfaction of even their *fully informed* preferences or wants. This view depends implicitly on some objective account of human well-being that does not ultimately reduce to the satisfaction of fully informed wants, or on an account of individuals' just claims to health care that depends on some objective features or ranking of health care (for example, its effects on a person's range of opportunity as in Norman Daniels'[10] theory of justice in health care). To evaluate this version of the concern would require us to evaluate the underlying objective theories of human well-being or the nonpreference-based

theories of justice in health care. Most of these theories are not sufficiently well developed to permit their evaluation, and that task is in any case beyond the scope of this paper.

The second version of the concern about a health care system that responds to wants rather than needs is the more common one. It is that the actual expressed wants for health care of real patients in real conditions often deviate sharply from both their objective health care needs and what their fully informed preferences for health care would be.

As we have noted above and will discuss further, health care consumers are commonly in a poor position to evaluate for themselves their own need for health care. They lack information about the nature of their medical condition and of what alternative treatments might positively affect it in what ways. Moreover, in circumstances of serious illness, patients are often anxious, fearful, confused, and dependent in ways that further impair their capacities to assess for themselves their health care needs in an informed and rational fashion. Thus, their actual health care wants will often be both ill-informed and unusually vulnerable to influence and manipulation by health care professionals. It is these fundamental features of the setting in which decisions are made to utilize health care that support the importance both of the physician's commitment to act in the patient's best interests and of the patient's trust that the physician will do so.

One concern about the growth of for-profits is that they may contribute to strengthening physicians' motivations to act in their own economic interests and thereby weaken their commitment to their patients' well-being; we pursue this possible adverse impact on the physician/patient relationship later in this paper. The other potential effect of health care coming increasingly to be viewed as a commodity to be aggressively marketed is that physicians will cater to ill-informed patient wants at the expense of their true health needs or take advantage of patients' vulnerable positions to manipulate their wants. In either case, the result will be the delivery of health care that fails best to meet patients' true health needs. We believe this is a reasonable worry that warrants careful future monitoring, although the data do not yet exist to show to what extent, if any, the phenomenon has begun to occur.

However, not all increased responsiveness to consumer wants constitutes a shift from serving patients' health needs to serving their mere wants. Increased responsiveness to consumer wants makes a genuine contribution to patient well-being to the extent that which treatment, if any, best promotes a patient's well-being depends at least in part on the particular aims and values of that patient. If for-profits promote this form of responsiveness to patients they are to be commended, not condemned.

For-Profits Damage the Physician/Patient Relationship, Erode Trust, Create New Conflicts of Interest, and Diminish Quality of Care

It is undeniable that for-profit health care involves potential conflicts between the interests of providers (physicians, managers, administrators, and stockholders) 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, he 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 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 that it also exists outside for-profit settings. And it is quite clear that this 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 that 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.

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 enable 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.

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. Several forms of "fee splitting" are practiced by physicians working in nonprofit settings. One of the most common is an arrangement whereby a physician receives a percentage of the fee charged for X-rays, laboratory tests, other diagnostic procedures, physical therapy, or drug or alcohol counseling that he recommends but which are performed by people he employs or supervises. In some cases, licensing and certification laws and reimbursement eligibility requirements for Medicare, Medicaid, and private insurance require nonphysician 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. At present, however, 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 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. Our current lack 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 for-profit health care creates new conflicts of interest or exacerbates old ones. Some fear that even if the physician's behavior toward patients is not distorted by incentives for secondary income or by equity ownership, physicians in for-profits 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" which are quite independent of the growth of for-profits.[11] One is the institutionalization of medicine which itself arose from a variety of factors, including the proliferation of technologies and specializations which 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 for-profits may be accelerating the 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 or will their pursuit of profit be restrained 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 nonzero 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 having no net medical benefit or which is positively harmful; instead what is meant is what one author has called "noncostworthy care"—care which yields less benefit than some alternative use to which the same resources could be put, either for other health care services or for nonhealth care goods.[12] Overutilization of health care in this sense, not just overutilization as nonbeneficial care, is clearly contrary. to everyone's interest. If continued professional dominance means perpetuation of this problem of overutilization, then even if a continued loss of professional dominance will lead to medical

decisions that are not, considered in isolation, in the individual patient's best interest, it may result in the elimination of one important conflict of interest and collective irrationality in the current system.

This does not rule out the possibility, of course, that greater control by nonphysicians will also lead to overutilization. If this occurs, then one system which 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 re-suit in overutilization that is contrary to all patients' best interest. 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 for-profits.

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.

Those who make the first assumption tend to overlook two points which call it into question. First, 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 businessmen." 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.* Robert Veatch has observed that if a physician becomes aware that another physician is acting on misinformation or performing a procedure incorrectly, then the first physician is under an obligation to bring this to the attention of the second and perhaps to help him remedy the defect.[13]

Veatch then goes on to say that a businessman who learns that a competitor is acting on misinformation or using sloppy production techniques is under no obligation to point this out to the competitor. Veatch's contrast between the moral obligations of physicians and businessmen, however, is overdrawn if not outright mistaken. It is not clear that a physician has a moral obligation to inform another physician that he is misinformed or even that his technique is deficient unless significant patient interests are at stake. It may be true, however, that important interests are more frequently potentially at stake in health care than in ordinary business transactions.

Yet surely a businessman has a moral obligation to inform a competitor that he is unwittingly endangering people's lives even if in giving his competitor this information he prevents his competitor from ruining himself and, thereby, foregoes a chance to eliminate the competition. Moreover, if a businessman lies to or defrauds a customer, we conclude not only that he has done something illegal but that he has acted immorally. And even if he breaks no law, we may nonetheless condemn him morally as a cheat and a scoundrel. All of this is simply to emphasize a simple point that critics of the "commercialization" of health care sometimes overlook, namely, that we customarily do apply not only legal but also moral standards to the behavior of businessmen. One would not want a physician who was motivated exclusively by financial reward, but then one wouldn't want an electrician who was either. Nevertheless,

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.

Many outside the medical profession and some within it greet the claim that physicians as a class are especially altruistic with some skepticism. This attitude is not groundless. One of the difficulties of determining the strength of altruistic motivation among physicians 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 for the patient (pursuing all treatment that promises nonzero benefits) was often doing what was financially best for the physician. Nevertheless, critics of the thesis that physicians are especially altruistic can marshall 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,[14] 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. We can make no attempt to evaluate such evidence here, but the self-interest of the profession seems a better prima facie explanation of it than does an altruistic concern for the health of 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*.

In assessing these questions of conflict of interest, 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 the American Medical Association (AMA) has played 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 and conscious intent of the representatives of the profession. To the extent that the profession has been successful in forwarding its members' interests, 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. Moreover, 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 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 has 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 profession acting as individuals been remarkably self-sacrificing or acted as moral leaders in addressing these problems. Occasionally physicians have, of course, located in undesirable geographical areas to meet pressing health care needs or have 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 forwarded 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, perspective is that in part just because the medical profession has been exceptionally successful in promoting and protecting an institutional and organizational setting that well serves 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 weigh 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.[15]

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 nonphysician 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 end up denying any significant reality to the physician's commitment to promoting his 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 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 because it tends to bring 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."[16] The physician is to seek to determine together with the patient that course of treatment which 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. Because the patient is unusually

dependent on the physician, it is especially important to the success of their partnership in the service of the patient's well-being that the patient believe that the physician will be guided in his recommendations 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 warranted, 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 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 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 their (the patients') 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 first to the patient's interest 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 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 promising for the physician/patient relation.

While there has been deception of patients by physicians, it seems to have markedly decreased in recent decades, and in the past this deception in medicine was justified as for the patient's own good (even if in fact it 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 believed that businessmen are in business to sell as much of their product as possible, however much the consumer may not "need" the expensive car being pushed by the salesman, whereas physicians are expected not to encourage needless consumption. Businessmen respond to consumer wants, not needs, and will do their best to manufacture such wants where they do not already exist.

A shift towards commercialization of health care could be expected to result in increasing emphasis on marketing strategies to secure an increasing segment of the market. Moreover, we expect no unprofitable products or service from a car salesman in response to consumer need. 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, physicians and health care institutions often do, and are often expected to, respond to that need by furnishing the needed care. Other norms important to the practice of medicine have a weakened or nonexistent place in most commercial transactions, such as the requirement of confidentiality concerning information about the patient.

One must be careful not to overstate the contrast between medicine and commerce—we have already seen it is certainly not the case that commerce takes place in the absence of any ethical constraints (or legal constraints,

reflecting ethical norms) or that the medical profession is never moved by self-interest. However, we believe there is 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. 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 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 patient's 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 has traditionally depended. 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 that 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 not a reason to be unconcerned with these effects of for-profits, but only a reason not to focus one's concerns 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 a physician's motivations, or even in the patient's perceptions of those motivations, may be enough to affect the patient's belief about whether the physician "really cares" about him. 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.

For-Profits Undermine Medical Education

The charge that for-profits undermine medical education parallels the claim examined previously that for-profits exacerbate the problem of access to care. Medical education, like care for indigents, is in part funded through cross-subsidization, and for-profits are believed to be contributing to the demise of cross-subsidization. It is thought that not only will for-profits themselves refrain from providing medical education because to do so would not be profitable for them, but also that they will make it increasingly difficult for nonprofit institutions such as university hospitals to carry on medical education and still remain competitive.

Much of what was said regarding cross-subsidization of indigent care applies here as well. Even if the growth of for-profits is contributing to the crisis in funding for medical education it is difficult to estimate the magnitude of its contribution, and it is clear that other factors are at work as well. Faced with growing pressures for cost containment, nonprofit institutions would presumably have strong incentives to reduce all "unprofitable" activities, including medical education, even in the absence of competition from for-profits. And here, as in the case of cross-subsidization for indigent care, whether one laments these developments or welcomes them will depend upon one's views on the efficiency and ethical acceptability of a system which in effect disguised the true costs of medical education and upon whether one thinks that the political process is likely to produce a workable alternative system for funding medical education through explicit public policy choices.

Furthermore, before a convincing answer can be given to the question of what obligations institutions or individuals have to help support medical education, several basic ethical issues must be resolved which the cross-subsidization system has effectively kept out of the public view. Perhaps most importantly, to what extent should medical education be subsidized by public resources?

To the extent that physicians benefit from the skills which they sell at their full market value there is a presumptive case for making them bear the costs of their own training. However, there are several countervailing considerations which may overcome this presumption. First, it can be argued that if medical education is publicly subsidized we will all benefit from a higher level of skills than would be possible under a system in which individuals had to bear the full costs of their training. Second, public subsidization makes it possible for persons from lower socioeconomic groups to become physicians and this is desirable, not only because it promotes equality of opportunity, but also because there is some reason to believe that physicians from the same socioeconomic background as their patients may be better able to communicate with those patients and to serve them effectively.

Third, it may also be that a strong system of medical education, like medical research, has some of the features of a public good. Medical education does not simply build economic assets for physicians. At both the graduate and post-graduate levels it also sets, transmits, and improves standards and methods of sound medical practice. Because the average patient is in a poor position to evaluate for him- or herself the quality of care provided by a particular physician, all patients benefit from a high-quality system of medical education that provides some assurance of the high quality of training and skills of the physicians produced by that system. If public subsidization of medical education facilitates training geared more toward the quality, of patient care and less toward the economic value to physicians of the skills produced, that may be of benefit to patients, that is, the public.

While it would be unjustified to maintain that the growth of for-profits is a major source of the reported crisis in funding for medical education, it can perhaps be said that for-profits are one element in a complex array of changes which will test the strength of the public commitment to medical education and challenge the moral assumptions on which that commitment is based.

For-Profits and the Political Power of the Medical-Industrial Complex

The widespread view that the medical profession's dominance in the U.S. health care system is waning has already been noted. One important aspect of the weakening of professional dominance is said to be the decreasing effectiveness of organized medicine's lobbying efforts in recent years. Whether or not one greets this development with enthusiasm or regret will depend, of course, upon the extent to which one believes that these efforts to influence

public policy have promoted or impeded the public interest. However, both the supporters and the critics of professional dominance have voiced a concern that it may be replaced by the dominance of a few extremely wealthy —and politically powerful—giant health care corporations forming a medical-industrial complex.[17] The fear is that a handful of the largest corporations might "capture" the regulators, molding public policy to their own needs through lobbying, campaign contributions, and use of the media to sway the electorate.

The real concern here should be the political effects of highly concentrated *corporate* power in health care—not simply the power of *for-profit* health care corporations. While it is true that the hospital "industry" is becoming increasingly concentrated, it is important to point out that some of the largest hospital chains are owned or operated by large nonprofit corporations. Further, there is nothing to prevent large nonprofit corporations from using their wealth and power to influence public policy and little reason to believe that they will in general be less willing to do so than large for-profit corporations. At present, however, it is difficult to predict how concentrated the health care sector will become or to what extent the disparate interest groups within and across health care institutions can be welded together under corporate leadership to function as a unified influence on public policy.

The issue, then, is whether it may become necessary in the future to utilize regulation or some other form of societal control to neutralize or minimize the political effects of the economic power wielded by large health care corporations, whether nonprofit or for-profit. Some possible, even if not politically likely, controls include limitations on campaign contributions and on political advertisements in the media, special laws designed to disqualify, legislators or regulators with conflicts of interest, or limitations on the maximum size of corporations.

It has often been remarked that it is a hallmark of a profession to be self-regulating. In the case of the medical profession, the idea that the physician/patient relationship is fiduciary along with the belief that medicine is a service for healing and comfort rather than simply one commercial enterprise among others have buttressed the profession's claim that it can be trusted to regulate itself.

Until recently it was widely assumed not only that the medical profession should regulate itself, but that it should also be chiefly responsible for regulating health care in general. This position rested on three main premises: (1) physicians and only physicians have the technical training and knowledge needed for informed control of their own professional activities, (2) physicians' professional activities are largely autonomous from other activities in health care, (3) the activities of other health care professionals are almost exclusively dependent upon physicians' decision making. The recognition that some of the most perplexing decisions concerning the use of medical treatments require complex moral, social, and legal judgments has undermined the first premise. (Decisions to forgo life-sustaining treatments for terminally ill or comatose patients are only the most obvious cases where medical judgment is not sufficient for guiding the physicians' own professional activities. These decisions require moral judgments because they rest on assumptions about the nature of individuals' rights and the quality and value of life.) The second and third premises also become dubious once it is seen that physicians' professional activities are increasingly dependent, not only upon decisions of other types of health care professionals (such as biomedical engineers and laboratory and radiology technicians) who sometimes possess specialized knowledge which physicians lack, but also upon a complex web of institutional functions, including planning, investment, and allocation of resources.

Some of the same reasons that make it implausible to leave regulation of health care to physicians make it equally implausible to entrust it to corporations or groups of corporations. In particular, the vast commitment of public resources to health care grounds a legitimate public concern that the resources be used efficiently and fairly, and the growing list of ethical dilemmas concerning the uses of medical technology is no more amenable to the administrative expertise of the corporate manager than to the professional judgment of the physician. There is, however, one reason why the public is perhaps even less likely to tolerate self-regulation by health care corporations than by the medical profession. If health care is perceived to be controlled by corporations—whether for-profit or nonprofit—that are in many respects indistinguishable from other commercial enterprises, then the presumption in favor of self-regulation, which flourished under professional dominance, will erode. For if the key decision makers in health care are

perceived to be businessmen rather than fiduciaries committed to healing and comfort, an important barrier to societal regulation of all forms of health care will have fallen. Whether new forms of regulation will be needed to constrain the political influence of large health care corporations can only be determined after careful study not only of the impact that these organizations have on public policy, but also of the expected effectiveness of proposed regulations.

Conclusion

Any summary conclusion of our examination of the ethical issues in for-profit health care will inevitably oversimplify. The one continuing theme running through our analysis of the moral objections commonly voiced against for-profits is that those objections need to be both framed and evaluated more carefully than they usually are. In many instances 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 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 have also been skeptical of the claim that for-profits represent unfair competition for nonprofits, though for-profits may have possible adverse effects on charitable motivations and a sense of community. We have again been critical of a common objection to for-profits, that they wrongly treat health care as a commodity rather than a right. It is only the view that all persons should have one *sin gle* level of health care, not the recognition of a right to an adequate level of health care, that is incompatible with market provision of health care by for-profit institutions.

The arguments in each of the first three sections of the paper ultimately raise deeper issues of great importance about the just distribution of health care that go beyond the for-profit/nonprofit debate. We have argued that potential adverse effects on medical education, like those on access, may indeed be worrisome, but the data on them are at this point very limited and they probably arise more from other forces such as cost containment efforts than from for-profits. Similarly, although the possibility that a small number of large health care corporations may come to wield disproportionate influence on public policy is a serious matter for concern and vigilance, it would be a mistake to assume that the potential for political abuse of economic power exists only with for-profit corporations, rather than with large institutions generally.

We believe that perhaps the most serious ethical concern with the growth of for-profits is their potential adverse effects on the physician/patient relationship and on the quality of care. Here too, 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, 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 for-profits.

Footnotes

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, nonprofit and for-profit—has changed little in the past decade. Gray, B. H. (1984) Overview: origins and trends. Keynote address, Annual Health Conference, The New Entrepeneurialism in Health Care, held by the Committee on Medicine in Society of the New York Academy of Medicine, *Bulletin of The New York Academy of Medicine*, second series, Vol. 61, No. 1, pp. 7-22.

2. *Securing Access to Health Care* (1983) Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Washington, D.C.: U.S. Government Printing Office) Vol. 1, pp. 92-101.

3. This statement is based on a preliminary draft of the report of the Institute of Medicine Committee on For-Profit Health Care. Additional data may be included in the final report.

4. Ibid.

5. Ibid.

6. Brown, Kathryn J., and Richard E. Klosterman. Hospital acquisitions and their effects: Florida, 1979-1982. This volume.

7. Hansmann, Henry D. (1980) The role of nonprofit enterprise. *Yale Law Journal* 89(5):835-901.

8. Robert M. Veatch seems to take this position in Ethical dilemmas of for-profit enterprise in health care, *The New Health Care For Profit*, B. H. Gray, ed. (Washington, D.C.: National Academy Press, 1983), p. 143. Cf. also Outka, Gene, Social justice and equal access to health care in *Ethics and Health Policy*, R. Veatch and R. Branson, eds. Cambridge: Ballinger Publishing Co.

9. See, for example, Guttman, Amy (1983) For and against equal access to health care, and Brock, Dan W. Distribution of health care and individual liberty, both in *Securing Access to Health Care, Volume Two: Appendices. Sociocultural and Philosophical Studies*, Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Washington, D.C.: U.S. Government Printing Office).

10. Daniels, Norman (1985) *Just Health Care* (New York: Cambridge University Press).

11. Starr, P. (1982) *The Social Transformation of American Medicine* (New York: Basic Books).

12. Menzel, P. (1983) *Medical Costs, Moral Choices* (New Haven: Yale University Press) p. 17.

13. Veatch, R. (1983) Ethical dilemmas of for-profit enterprise in health care, B. H. Gray, ed., *The New Health Care for Profit* (Washington, D.C.: National Academy Press) pp. 145-146.

14. Starr, P. (1982) *The Social Transformation of American Medicine* (New York: Basic Books).

15. Jonson, A. (1983) Watching the doctor, Sounding Board, *New England Journal of Medicine*, 308(25): 1531-1535.

16. *American College of Physicians Ethics Manual* (1984) p. 7.

17. The term "medical-industrial complex" is borrowed from an article by Relman, A. (1980) The new medical-industrial complex, *The New England Journal of Medicine*, 303(17):963-970. Relman expresses a number of the concerns about for-profits analyzed in the present essay, including the fear that large for-profit corporations may exert undue influence on public policy.

Dr. Brock is professor and chairman of the Philosophy Department of Brown University. Dr. Buchanan is a professor with the Department of Philosophy at the University of Arizona as well as the Division of Social Perspectives in Medicine in the university's College of Medicine.

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