The business ethic vs. service ethic in U.S. health care: Which will prevail?

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Health care in the United States today is dominated by a large medical-industrial complex with corporate tentacles across a largely for-profit health care marketplace. This is a major cultural change over the last 60 years.

Like it or not, physicians and other health care professionals are immersed and to an extent held captive by this change.

Historical perspective

Four major elements have gone into the rapid rise of today's pervasive medical-industrial complex:

1. Corporatization;
2. Growth of investor-owned care;
3. A shift to for-profit health care; and
4. Privatization of public programs.

The battle over ethics during this transformation was engaged from the start. These two approaches could not have been farther apart. "Few trends could so thoroughly undermine the very foundations of our free society as the

acceptance by corporate officials of a social responsibility other than to make as much money for their shareholders as possible," explains Milton Friedman, PhD, Nobel Laureate in economics at the University of Chicago, author of Capitalism and Freedom, and leading advocate for free market economics.[1]

Edmund Pellegrino, MD, physician, ethicist, and moral philosopher, founder and director for many years of Georgetown University's Center for the Advanced Study of Ethics, said, "Medicine is at heart a moral enterprise and those who practice it are de facto members of a moral community. We can accept or repudiate that fact, but we cannot ignore it or absolve ourselves of the moral consequences of our choice. We are not a guild, trade union, or a political party. If the care of the sick is increasingly treated as a commodity, an investment opportunity, a bureaucrat's power trip, or a political trading chip, the profession bears part of the responsibility." [2]

Corporatization

The creation of Medicare and Medicaid as public programs in 1965 opened up new opportunities for corporate investment across much of the health care enterprise, ranging from hospitals and nursing homes to clinical laboratories. Blue Cross became involved by assuring hospitals that it would process hospitals' claims.[3]

In his 1982 Pullitzer Prize winning book, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*, Paul Starr, professor of sociology at Princeton University, noted the enormity of this change:

> The rise of the corporate ethos in medical care is already one of the most significant consequences of the changing structure of medical care. It permeates voluntary hospitals, government agencies, and academic thought, as well as profitmaking medical care organizations….The organizational structure of medicine used to be dominated by the ideals of professionalism and volunteerism, which softened the underlying acquisitive activity. The restraint exercised by those ideals now grows weaker.[4]

Today, we have huge corporations with vast political power and influence dedicated to profits, not service. David Cay Johnston, Pulitzer Prize-winning investigative journalist and author of *The Fine Print: How Big Companies Use "Plain English" to Rob You Blind*, observes how this came about. "Citizens United is to the expansion of corporate power what the big bang was to the beginning of the universe," he writes.[5]

Growth of investor-owned care

Following the enactment of Medicare, many corporations became investor-owned, with expanding corporate chains ranging from hospitals and nursing homes to dialysis centers and home care services. The term "medical-industrial complex" was coined in 1970 by John Ehrenreich (ΑΩΑ, University of Texas Medical Branch School of Medicine, 1994, Resident) and Barbara Ehrenreich in their book, *The American Empire: Power, Profits and Politics*,[6] harkening back to President Dwight D. Eisenhower's parallel use of the term, "military industrial complex," warning against its growing dangers in his farewell address upon leaving the White House in 1961.

In 1980, increasingly concerned about the impacts of the growing medical-industrial complex on patient care, Dr. Arnold Relman (ΑΩΑ, Columbia University Vagelos College of Physicians and Surgeons, 1945), nephrologist and long-time editor of *The New England Journal of Medicine* (1977 to 1991), called for action by the medical profession:

> If we are to live comfortably with the new medical-industrial complex we must put our priorities together: the need of patients and of society come first . . . How best to ensure that the medical-industrial complex serves the interests of patients first and of its stockholders second will have to be the responsibility of the medical profession and an informed public.[7]

By 1984, the eight largest investor-owned corporations owned and operated more than 400 acute care hospitals and 100 psychiatric hospitals, together with more than 270 long-term care units, 60 dialysis centers, and many ambulatory and home care services.[8]

As corporatization proceeded across the health care non-system, investors and investment firms increasingly subverted traditional goals of medicine to maximizing profits and revenues to shareholders. Matt Stoller, former senior advisor and budget analyst to the Senate Budget Committee, drew this conclusion in his 2019 book, *Goliath: The 100-Year War between Monopoly Power and Democracy*:

> By the end of the 1980s, Wall Street had permanently changed corporate America. A new type of business model existed. The leveraged buyout industry, stung with bad publicity, rebranded as "private equity."

While some private equity firms made productive investments, they were largely tools of floating capital

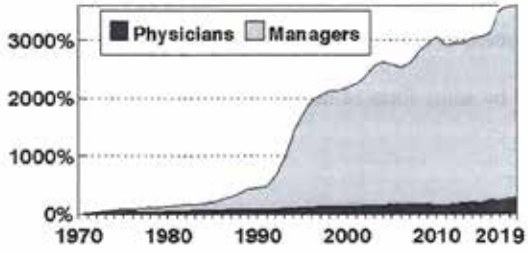
that sought to use the corporation for the purpose of the financier.[9]

Shift to for-profit health care

As economic transactions shifted to a corporatized marketplace, including the private health insurance industry, the numbers of administrators and managers exponentially exceeded the numbers of physicians. (Figure 1) That huge workforce was required for billing and tracking purposes for maximization of profits. In parallel, for profit ownership in 2016 had increased to the point where two-thirds of nursing homes and hospices are now for profit, as well as 90 percent of dialysis centers, 95 percent of Surgical Centers, and 100 percent of free-standing laboratory/imaging centers.[10]

Figure 1

Growth of physicians and administrators —1970-2019



Source: Bureau of Labor Statistics; NCHS; and Himmelstein/Woolhandler analysis of CPS. Note - Managers shown as moving average of current year and 2 previous years

Privatization of public programs

Privatization of Medicare and Medicaid has grown over the last 40 years with the false claim that they will be more efficient than their public counterparts. However, in both cases they have been gamed by profiteering corporate interests. Congress passed the Tax Equity and Fiscal Responsibility Act in 1982, which authorized Medicare to contract with private health maintenance organizations (HMOs) and pay them 95 percent of what traditional Medicare would pay for fee-for-service in beneficiaries' county of residence. Reimbursement levels soon went up, even to as high as 120 percent. Medicare Advantage insurers, including the giant United Health Group, have gamed the system for years by overstating the severity of patients' illnesses in order to gain higher reimbursements.[11]

Privatized Medicaid plans took root with the rapid growth of managed care in the 1990s which led to widespread corporate fraud that diverted capitation funds from actual care. Managed care soon became known as managed reimbursement instead of care, with many ways to increase revenues through such means as falsifying new enrollee registrations, disenrolling sicker patients, or embezzlement of capitation funds paid by the state.[12]

As HMOs consolidated through many mergers, the five largest national HMOs controlled 50 percent of market share by 1997.[13] By 2000, three-quarters of the U.S. population was covered by some form of managed care.[14]

Adverse impacts of the medical-industrial complex on patient care and medical practice

As a result of the fundamental transformation to the invisible hand of the corporatized marketplace in U.S. health care, these detrimental changes have been resistant to reversal:

- Price increases to what the traffic will bear;
- Uncontained costs;
- Decreased choice and access to care;
- Compromised quality of care with worse outcomes;
- Rampant profiteering and fraud; and
- Weak oversight by government with little accountability.

The business ethic and media misrepresentation

The market's business ethic threatens or trumps the professional service ethic. What serves corporate and shareholder interests (i.e., higher profits) is diametrically opposed to the interests, and sometimes even safety of patients and their families. Some examples that are reminding us of this ethical gap include:

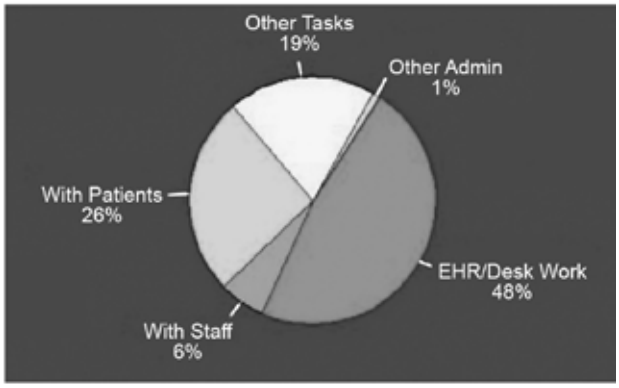
- Mass marketing of products, with hyped claims but without evidence of efficacy or safety (e.g., full-body screening of CT scans).
- Corrosion of research by such practices as suppression of unfavorable research results,[15] and paying physicians for lending their names to biased ghostwritten articles.[16]
- Supposedly not-for-profit hospitals merging through consolidation, then leveraging their market power to charge exorbitant prices, as occurred in northern California with Sutter Health's large hospital network's charges now 70 percent higher than for inpatient care in southern California.[17]
- The electronic health record (EHR) which became subverted as a billing instrument for hospitals and other employers of physicians. Employers then pressured physicians to up-code what was done (and not done!) in a patient visit, often leading to exorbitant and even

fraudulent bills.[18] Beyond billing excesses, the EHR has seriously impacted face-to-face time between physicians and patients.[19] (Figure 2)

- Medical information has become a growing industry rife with profiteering, even to the point of fraud as exemplified by Outcome Health, a digital provider of medical information and advertising for physicians' offices and pharmaceutical companies, which defrauded its clients by misrepresenting the quality and quantity of its advertising services.[20] Amazon and Google are also getting into health care, without clarity on what they will do with surveillance data or how they will profit therefrom.
- Physician-owned specialty hospitals that focus on well-reimbursed procedures, especially in orthopedic surgery and cardiovascular disease, cherry pick well insured patients, then triple dip by receiving payment from performing procedures, sharing in the facility's profit, and increasing the value of their investment in the business.[21]

Figure 2

Doctors spend twice as much time on EHR/desk work as with patients



Source: Sinsky, C, Tutty, M, Colligan, L. Allocation of physician time in ambulatory practice. *Ann Intern Med* 166 (9): 683-684, 2017

Profiteering by investor-owned private equity firms

The growth of PE firms, mostly below the radar for most, has become the ultimate way for corporate profiteering without regard for the success of their acquisitions, including hospitals, physician practices, or other health care providers. PE firms have established lucrative markets in recent years that range from emergency care and hospitals to nursing homes, mental health, and physician practices in a number of specialties, including dermatology,[22] obstetrics-gynecology,[23] and ophthalmology.[24]

Table 1

Investor-owned care vs. not-for-profit care	
Comparative examples	
Hospitals	Higher costs, fewer nurses, and higher death rates[29,30]
Emergency medical services	Higher prices, worse care with slower response times.[31]
HMOs	Worse scores on all 14 quality of care measures.[32]
Nursing homes	Often in corporate chains, have lower staffing levels, worse quality of care, and higher death rates.[33]
Mental health centers	Restrictive barriers and limits to care, such as premature discharge without adequate outpatient care.[34]
Dialysis centers	Mortality rates 19 percent to 24 percent higher;[35] 53 percent less likely to be put on a transplant waiting list.[36]
Assisted living facilities	Many critical incidents of physical, emotional, or sexual abuse of patients.[37]
Home health agencies	Higher costs, lower quality of care.[38]
Hospice	Missed visits and neglect of patients dying at home.[39]

Source: Geyman, JP. Profiteering, Corruption and Fraud in U.S. Health Care. Friday Harbor, WA. Copernicus Healthcare, 2020, p. 33.

In the case of hospitals, PE firms load excessive debt on facilities thereby raising the likelihood of default and bankruptcy as a profit-seeking strategy when they are forced to close.[25]

Nursing homes owned by PE firms have higher mortality for short-stay patients, less nurse availability, and decreased compliance with Medicare standards of care.[26] They also are subject to closure, with little advance notice to patients or staff, when PE or investment firms no longer find them sufficiently profitable.[27]

The overall track record of investor-owned care versus not-for-profit care is consistently poor, whether in terms

of costs, quality of care, or patient outcomes. This pattern is pervasive across the medical-industrial complex from hospitals to hospices.[28] (Table 1)

Role of government enabling corporate transformation of health care

Government has been an active party in enabling many of these changes. Some examples that have fostered this transformation of medical and health care are:

- Passage of Citizens United in 2010, which led to soaring federal campaign contributions by billionaires targeting legislators friendly to corporate and Wall Street interests.[40]
- Passage of legislation in 1993 that allowed Big Pharma to carry on direct-to-consumer advertising, banned in many other countries, often with deception and disinformation.[41]
- Allowing FDA review committees to accept and retain members with conflicts of interest with industries seeking approval of their products.
- FDA evaluation of medical devices only requires substantial equivalence to other devices instead of evidence of effectiveness and safety; one example of this problem is the delayed recall of Johnson & Johnson's defective all-metal hip replacement, with its high failure rate forcing some 80,000 patients to have them removed.[42]
- Lack of effective oversight, such as failure to monitor how large government subsidies were used to help physicians and other health professionals install EHR; software defects were concealed during mandatory reviews intended to ensure safety; major EHR vendors later made a multi-million-dollar settlement with the Department of Justice to close allegations that they had rigged the government's certification tests.[43]

Can the service ethic be re-established in U.S. health care?

There can be no question that medical practice and the profession's influence on the ethics of care have been transformed over the last 60 years, from physicians being mostly self-employed in small independent practices to today's environment where almost two-thirds of the nation's physicians are employed by large hospital systems or by private insurers. Moreover, since our largely corporatized deregulated health care markets have continued to prosper over these years, one might reasonably conclude that a transition back to a professional service ethic might be a bridge too far.

However, looking at the serious systemic problems of current U.S. health care, with long-standing barriers of access to affordable health care, failure of cost containment, unacceptable quality of care, and persistent disparities and inequities, it becomes clear that reform is urgently needed.

Before considering what can be done, there are four questions to answer:

- Who is the system for, profiteering corporate stakeholders, their shareholders and Wall Street investors, or patients, families and taxpayers?
- Is health care just another commodity for sale in a largely for-profit market-based system, or essential services based on medical necessity?
- Is health care a human right or a privilege based on ability to pay?
- What ethic should prevail in health care, a business ethic maximizing revenue to providers, or a service ethic based on needs of patients and their families?

Universal access to health care is the sine qua non underpinning for health care reform. If it was in place for all residents of the U.S., financed by a not-for-profit public financing system and progressive taxation, all four of these questions could be answered for the common good.

There are now four major reform alternatives:

1. Building on the Affordable Care Act (ACA);
2. Some kind of a public option;
3. Medicare Advantage for All; and
4. National health insurance through single-payer Medicare for All.[44]

Dr. Richard L. Byyny (ΑΩΑ, Keck School of Medicine of the University of Southern California, 1964), has proposed a variant of the fourth alternative—funding universal coverage through a National Health Reserve System (NHRS).[45]

The first three options, however, can never achieve universal access or cost containment, for they leave a profiteering private multi-payer financing system in place. Dr. Byyny's proposal, as a variant of eventual single-payer, is laudable for its goal of universal coverage. However, it seems to overlook the 30-plus years of progress toward straight-forward single-payer national health insurance by Physicians for a National Health Program (PNHP) and the bills that have been brought to Congress, including H.R. 1976 in the House today. It also would depend on continuation of employer-sponsored health insurance, privatized Medicare Advantage, and some multi-payer financing, the problems of which have been described elsewhere.[46,47]

The challenge to the medical profession is whether, how, and if it can play a leadership role in addressing systemic problems of health care for the common good, not its own self-interest. In his address to the New York Academy of Medicine in 1990, Dr. Pellegrino framed the central dilemma facing medicine as a choice between two opposing moral orders—"one based in the primacy of our ethical obligations to the sick, the other to the primacy of self-interest and the marketplace."[2]

Organized medicine to date has been largely missing in action and to an extent co-dependent with corporate health care controlled by the business ethic. In 2000, Pellegrino questioned whether medical professionalism could survive.[48] The profession does appear to be at a crossroads. Will it be de-professionalized into fragmented groups of well paid technicians with little influence on health policy, or will the profession pull together to rejuvenate its moral legacy of public service, and deal with conflicts of interest within its own ranks?

Some medical organizations are taking positions against the corporate takeover of health care. Notable recent examples are the withdrawal by the American Medical Association and the American College of Radiology from the Partnership for America's Health Care Future, an industry front group formed to combat coverage expansions like Medicare for All.[49]

Although most medical organizations in the U.S. have opposed national health insurance over the last century, a sea change is starting to happen with promising examples of leadership by the medical profession toward health care reform. The American College of Physicians endorsed Medicare for All in 2019,[50] soon followed by the Society of General Internal Medicine.[51] Physicians' support for Medicare for All is growing across the country, state medical associations in Vermont and Hawaii have already endorsed it.[52]

Physicians, regardless of their specialty, can call out excesses of corporatized health care when it poses a risk or harm to patients' well-being:

- Protest closure of facilities for investors' profits that limit access to necessary care in communities.
- Do not participate as consultants paid by industry to give promotional talks, disguised as marketing efforts by drug and medical device companies.
- Work with hospital systems and other employers to reveal and stop revenue-building efforts that harm patients.
- Promote and participate in rebuilding small group practices with increased clinical autonomy for physicians.
- Become informed about health policy and options for health care reform.
- Lead as individuals and as active members of one's medical organization toward federal legislation to provide universal access to health care.

A larger role of government in the public interest will be required to make needed reform of health care work and remain effective. Some of the approaches that make sense to that end include:

- Provide a system of universal coverage to health care through a not-for-profit single-payer financing system, i.e., Medicare for All.
- Establish an Office of Health Equity, as called for by HR 1976, to monitor and eliminate health disparities and inequities.
- Develop a physician workforce plan to address shortages in family medicine, other primary care specialties, geriatrics, and psychiatry.
- Support small, independent community-based primary care practices.
- Stabilize hospitals and other facilities, with an emphasis on serving rural and other underserved areas.
- Restore funding for public health and the Centers for Disease Control and Prevention.
- Fund and rebuild the Office of Technology Assessment, which was defunded and eliminated by former House Speaker Newt Gingrich in 1994.[53]
- Eliminate Citizens United.

Conclusion

Drs. Pellegrino and Relman brought us this important insight at the turn of this century:

> A reasonable compromise should be struck between the legitimate economic concerns of a professional facing an increasingly hostile workplace and the ethical obligations of a profession that wishes to be trusted and hopes to continue to hold a privileged place in U.S. society. These latter obligations should prevail. As a practical matter, medical associations should recognize that their power and influence in effecting almost any change in the health care system will increasingly depend on public trust and support, which, in turn, will depend on whether the associations are seen to be working for the public interest.[54]

Is it too late to make a difference? Can the moral compass of health care in this country be restored? The clock is ticking.

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