

## Why For-Profit Health Care Systems Are Not in the Best Interest of Patients or in the Best Interest of an Accountable and Altruistic Profession!

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I will begin by restating a position I have long held: I believe we should be seriously concerned about the introduction of investor-owned corporations into our medical care delivery system. There is a fundamental disjunction between the social purposes and values of the medical care system and the culture and financial imperatives of corporate for-profit businesses. This business culture, with its primarily economic view of medical care and its reliance on market forces to determine the price, distribution, and quality of medical services is a major contributor to the present unhappy condition of our health care system and our profession. I first raised this issue years ago. My concerns have been amply justified by developments since then, and are supported by many studies. With time, the problem has grown worse, and now, with the ascendancy of investor-owned managed care and the acquisition of voluntary teaching hospitals by large for-profit corporations, the situation has become even more serious than I had originally predicted.

### *Beliefs and Background*

Although managed care is a prime focus for physician discontent these days, I do not think we need be primarily concerned about it, at least in principle. In fact, I see managed care, properly organized, as the logical and inevitable next step in the evolution of our health care delivery system. Control by business management is the problem, not the principle of managed care, per se. We should worry instead about the investor-owned corporations that control most managed care plans, along with a growing fraction of our hospitals and ambulatory care facilities. Without more opposition than has been mobilized so far, these corporations will change our medical care system from a community-based, largely not-for-profit social service into a vast commercial market, in which physicians will be either employees, contractors or entrepreneurs and in which not-for-profit institutions and physician-managed groups will be marginalized. In an industrial model of health care, medical professionalism and professional values will command little respect and the distinction between profession and trade will become blurred.

The introduction of investor-owned hospital corporations into the medical care delivery system began soon after the passage of Medicare and Medicaid, in response to the financial

incentives offered by a "cost-plus" hospital reimbursement system financed through third-party indemnity insurance. A second major wave of investor initiatives, in the form of managed care companies, started near the end of the last decade, when employers were demanding control of the rising costs of health insurance. In both instances, the investors were responding to attractive financial opportunities created by inefficiencies or failures in the existing piecework payment system. In the 1960s and 1970s the hospital companies made huge profits by charging all the traffic would bear, in a wide-open system that encouraged irrational over-expansion and overuse. Those of us here who held administrative positions in teaching hospitals during that time—and I am one—bear some responsibility for not seeing the handwriting on the wall. In recent years the piecework payment system has led to a revolt of the employers and a demand for prepaid services. Huge profits can now be made by insurance companies that control costs through contracts with physicians and hospitals. In this way investor-owned managed care insurance plans have taken charge of a delivery system that could not, or would not, control itself, and an aggressively price-competitive market has replaced the comfortable old reimbursement system.

The result has been a reduction in hospital expenses and excess capacity, a rush to hospital mergers and a shift to ambulatory services. Employers have been pleased with the moderation in the rate of increase in their insurance premiums. The managed care companies have accomplished this while aggressively reducing payments to physicians and hospitals, thus retaining substantial fractions of the premium for their own profits and corporate expenses.

Advocates are proclaiming these results a triumph for market competition. They urge more of the same for the future, but leavened perhaps by a greater attention to quality and accountability. I take a more skeptical view. A fiercely price-competitive market may have temporarily controlled runaway inflation in one sector of the health care economy, but its likely long-term effects and its impact on the rest of the health care system seem horrendous to me. We now face a host of serious problems caused or exacerbated by the market revolution, and these problems clearly are not going to be solved by market forces. These include the large and growing number of uninsured and underinsured citizens, a neglect of community needs, a

weakening of support for education and research, and an undermining of professionalism and ethical standards. Without the resolution of these problems we face a deterioration in the fabric of our health care system and a loss of professional autonomy and integrity. The "corporate practice of medicine," once the bugaboo of conservative private practitioners who feared group practice, is returning to haunt us in the form of corporate managed care plans and investor-owned hospital chains that seek to control the attitudes and behavior of physicians in pursuit of cost control and profits.

### *Distinguishing the Differences*

Many supporters of for-profit health care argue that too much is made of the alleged distinction between "for-profit" and "not-for-profit" health care. They say that "profit" has always been a feature of the medical care system. Doctors in private fee-for-service practice have always managed their offices like small for-profit businesses, they say, and so-called not-for-profit hospitals have always had to generate net revenue (in effect, a "profit") if they wanted to survive. So nothing basically new in this respect has been added by the introduction of investor-owned firms. According to this argument there are only two significant differences between for-profit and not-for-profit health care firms:

- 1) The for-profits raise most of their capital in the stock market, while the not-for-profits raise it from charity or tax exempt bonds;
- 2) For-profits pay taxes and not-for-profits generally do not.

These purely financial distinctions are correct, but the important differences go much deeper than the proponents of investor-owned health care want to admit. These differences include: ownership, mission, commitment to local communities, compatibility with professional and ethical values, and the support of research and education.

Let me elaborate briefly on these points.

First with respect to *ownership*:

Stockholders and investors are the legal owners of for-profit health care institutions, and the managers of these institutions are legally bound to protect the financial interests of the owners. Not-for-profit institutions have no investors or stockholders, only trustees, and they are not the private property of anyone. Unlike the directors of an investor-owned corporation, the trustees of not-for-profit corporations are supposed to represent the community's interest in the charitable functions of the institution.

There is also a significant difference between the two kinds of institutions in the stability and local orientation of their ownership. Trustees of not-for-profit institutions usually reside in the community served by the institution and are committed to keeping the institution alive as long as its services are needed by the community. In contrast, for-profit health care facilities are usually part of large regional or national corporations, whose directors sit in distant board rooms and are charged with promoting the financial welfare of the entire corporation, not simply that of any particular local unit. Furthermore, the for-profit health care corporation is usually part of a ferociously competitive and volatile industry in which mergers, acquisitions, divestments and all kinds of financial deals are constantly changing the scene, and in which the continued existence or ownership of a particular local institution can never be assured.

Second, with respect to *mission*:

The primary mission of the for-profit health care corporation is to promote the economic interests of its owners by generating profits (that is what "for-profit" means!), while the primary mission of the not-for-profit corporation is to promote the charitable purposes for which it was granted tax-exempt status.

Another difference with respect to mission concerns the disposition of net revenue. Profits generated in the course of providing care in for-profit institutions are mostly taken out of the health care system and distributed to investors and senior management, while profits generated in not-for-profit institutions remain within the institution and are used largely to further the institution's mission. In addition, since for-profit providers are usually large national corporations, while non-profit providers are usually local organizations, the surplus generated by the not-for-profits is much more likely to remain in the local community.

Turning now to *professionalism and professional values*: I believe that, in general, not-for-profit health care organizations are more compatible with professional values and ethics than their investor-owned for-profit competitors. Big for-profit corporations depend on tight, centralized policy-making and firm managerial control. In investor-owned HMOs the independence of physicians gets in the way of that control, and must therefore be restricted. This is usually accomplished through utilization review, economic profiling and various kinds of contracts with individual physicians that reward clinical parsimony, and punish the more generous use of medical resources. Not-for-profit institutions, on the other hand, are less centralized (and perhaps therefore not as efficient) and they delegate more decision making to their physicians. Most of the

successful not-for-profit HMOs are controlled or owned by physicians and it is my impression from visiting several of them that professional values and opinions carry more weight in these institutions than in their for-profit competitors.

For-profit hospitals and ambulatory care centers also compromise professional autonomy and integrity, but in a different way. In an effort to attract business away from their competitors, they offer physicians who use their facilities equity interest in the firm. They also buy physicians' practices, or offer them favors, and thus use their financial strength to buy the loyalty of the doctors in their community. Not-for-profits, of course, also try to attract physicians but they are usually not as aggressive, and they do not offer the same financial rewards. When corporations buy physician loyalty in this way, particularly by making them limited partners in the for-profit facility, it is a form of kickback. It is clearly unethical and, in many instances, also illegal.

Last but not least is the difference between the two kinds of organizations in their commitment to what might be called the "medical commons." I use this term to refer to such things as charity care, unprofitable community health care services, and education and research. The larger not-for-profit hospitals usually shoulder considerable responsibility for these functions. Indeed most medical education takes place in these hospitals, and they provide most of the free care in their communities. The for-profit hospitals have always protested that they make essentially similar contributions to charity care, but all the objective data in the past have indicated otherwise—although there is a dearth of recent studies on this point. There is no doubt, however, about education and research. The for-profit hospitals simply do not consider education and research as part of their responsibility, even though they, like all other health care providers, benefit from these functions. They argue that the taxes they pay represent their fair contribution to the cost of maintaining the "medical commons," but this issue has never been objectively and systematically studied. In any case, we know that taxes paid by health care corporations, whatever they may amount to, are not going back into health care and therefore are not directly helping to support the "medical commons."

It is noteworthy that I have said nothing so far about how the "quality" of care compares in the two kinds of organizations. There is no systematic or credible evidence on this issue—only advertising and unsubstantiated claims. Much attention is currently being devoted to the development of reliable measures of quality and to the establishment of methods for the maintenance and improvement of quality. In my judgment these

efforts, although laudable, are still in their infancy. Responding to widely expressed concerns about the impact of price competition on the quality of medical care, it is often said that the judgments of consumers about the services they receive will force health care corporations to become quality-conscious, not simply cost-conscious. Further, it is alleged that the release of data on quality will force competing health care institutions (for-profit and not-for-profit alike) to be careful about compromising quality in pursuit of cutting costs. The market, it is said, will guarantee quality—provided that appropriate information is made available to the public.

Such arguments appeal to those who think of medical care as a commodity—a product with a market price and a measurable value and quality that can be evaluated and selected by consumers just like other products on the market. While I agree that the public should have more and better information about the processes and outcomes of the medical care they receive, there is a vast difference between medical care and standardized consumer products. The care of sick patients—and that is what uses most of the resources in our medical care system—is a highly individualized process that resists quantitative measurements of quality. Unlike the preventive care of well patients, it involves a large number of personal transactions between doctors and patients, the quality of which is best judged by other doctors. Outcome measures have been touted as a promising approach to the evaluation of the care of the sick, but such measures are fraught with confounding variables and cannot be used at present as a reliable test of quality. Patients, of course, know whether they are satisfied. That's important, but it isn't the same thing as getting good care. In short, I don't think we currently have reliable measures of the quality of care of sick patients by HMOs, although the care of well patients, is much easier to measure.

If objective measurements of "quality" are presently inadequate—and are likely to remain so for the near future—it seems clear to me that we must continue to rely upon the professional commitment of ethical and competent physicians to ensure that sick patients are well cared for. I see no substitute for the compassion and personal concern for patients upon which the doctor-patient relationship rests. But good doctors need to feel responsible for, and attached to, their patients, something that the corporate practice of medicine does not encourage or reward. So, if we need both managed care and personalized, truly professional care, it seems to me that the only long-term solution will be local not-for-profit managed care organizations run by physicians.

### Conclusions

If the ABIM is concerned with the professionalism and the ethics of medical trainees, and not simply with their technical knowledge and competence, then it must be concerned about these issues. That much seems clear. The more difficult question is: What should, and can, the Board do about it? Let me conclude with a few brief suggestions.

First, I believe the Board should do more to emphasize professional and ethical issues in its examinations, and in its recommendations to training program directors. I find an astonishing deficiency among students and residents in their understanding of the social and economic forces that are transforming the health care system today, and very little understanding of the current threat to professional values. Many young people never even think about the issues under discussion at this conference. They hardly react when health care is called an "industry" and medical practice a "business." We need more consciousness-raising on this score and more education about what it means to be a physician. Dissemination of forthright public statements on these issues might also be useful.

Second, I believe that this Board, in concert with others, should promote discussion among the various specialty societies on practical initiatives

to encourage the establishment of the local not-for-profit managed care organizations, which I described earlier. There are many ways to create such organizations and many hurdles to overcome, but I am convinced that strong, concerted action by physician groups could accomplish a great deal in redressing the current imbalance between business and professional control of health care. I do not suggest a new role of public advocacy for the Board, but rather that it should join with other specialty groups in focusing the profession's attention on this critical issue.

Investor-owned corporations have taken charge of our health care system without a legislative mandate and without much resistance from our profession. Now is the time for physicians to reaffirm their professional commitment, not by vainly struggling to bring a bankrupt fee-for-service system back to life, but by rejecting corporate control and organizing their own not-for-profit HMOs. Only physicians can legally practice medicine; business corporations can not. That ought to be the rock upon which such an effort can be based—and professional organizations that stand for quality of care, such as this one, ought to be a part of the campaign.

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