EDITORIAL

The conflict and paradox of medical practice and corporate medicine

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AMERICAN MEDICINE functions in an incongruous environment. The humanistic and intellectual challenges of a medical career have never been more stimulating, yet applications for admission to medical schools have been decreasing. Research activities are productive but financial support is reduced. Business and government impose competition and regulation on a profession whose purpose is to help the sick. The benefits of scientific and technical medicine are eagerly sought by the American people while the competence of doctors is challenged by a litigious society.

This dichotomy of a profession growing rapidly in capability while decreasing in autonomy is the outcome of major shifts in the cultural and economic value of health services to the American people in the past three decades. Fuchs¹ has described them well. The major force currently appears to be economic rather than cultural, with emphasis on competition and regulation. These changes and their causes are not new to economists and social theorists; but, only recently has the influence of these socioeconomic events begun to be evident to practicing doctors. The impact universally affects medical practice and bears directly on the concept of professional behavior. It continues at a rapid pace and with increasing strength. It is essential that physicians (1) recognize the socio-economic factors that shaped the health care marketplace, (2) understand the implications of the current transmutations in health care delivery, particularly as they apply to the private practitioner, and (3) protect their professional role in the new world of medical practice.

Socioeconomic factors that shaped the health care marketplace. Health care is the fourth largest area of our economy and in recent years has expanded more than any component of the Consumer Price Index.² It has increased from 4.4%³ of the Gross National Product in 1950 to 10.6%⁴ in 1984. Currently, that amounts to more than a billion dollars a day. Fuchs¹ explains this as the result of a progressing economy. It reflects an advancing society in which the major output of the employed population is in services rather than in agriculture, manufacturing, or commerce. Health care is the most highly valued of human services. The demand for that service became manifest with the rapid growth of health insurance as a tax exempt employee benefit since 1957. That was followed by the enactment of Medicare in 1965 and Medicaid in 1969. For currently active physicians who entered the practice of medicine about 1950, the changes in sources of payment for health care are striking. In 1950, private health insurance accounted for only 9% of personal health care expenditures and government supported programs paid 22%; the majority, 66%, was covered by out-of-pocket or direct payment (philanthropy covered the remainder).³ Currently, private health insurance pays 32% of the nation’s personal health care bill, and government, with the addition of Medicare, Medicaid, and other publicly supported programs, is responsible for 40%; now out-of-pocket payment accounts for only 25%.⁴

The driving force in the economic growth of health care has been the remarkable increase in the capability of medicine as a helping profession. Readers of this journal know best that among the most dramatic advances are those that have occurred in cardiology and cardiothoracic surgery. The increased competence of physicians is well received and heavily utilized by the public. Consequently, medical school capacities were expanded in the 1960s and the ratio of physicians to population increased 60%. It is estimated that there will be a surplus of about 70,000 physicians in the United States in 1990.⁵ Within those projections is included an excess of 7150 cardiologists (excluding pediatric cardiologists), a surplus almost equal to the number required. In spite of these projections, the number of medical school positions have been largely sustained, although the number of applicants per position in American and Canadian medical schools decreased by about 25% from 1974 to 1984.⁶ ⁷

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When these several factors affecting the growth of health care are interrelated, a clear message appears. To business people, medical care is an industry — a 400 billion dollar annual enterprise with a valued product, customers with ever increasing demand, money for payment, and finally, an oversupply of physician producers, i.e., potentially cheap labor.

**Implications of the current transmutation in health care delivery.** The delivery of health services is being drawn into the world of big business. Medical practice is caught in the onrushing tide of its own success and economic growth. Doctors are beginning to work in a new and different world. The entry into the medical care field of entrepreneurial business interests was encouraged by large employers who became increasingly resistant to paying the rising costs of their employees' health benefits. Employers are assuming that business control of the health care marketplace with its concomitant emphasis on competition will introduce efficiency and orderly management of doctors and hospitals, thereby yielding reduced costs. The current executive branch of the federal government shares this view and may seek to privatize Medicare. ⁸

Tarlov, in classifying public policy periods in medicine, ⁹ has labeled the years between 1975 and 1990 the "Period of Transition." Manifestly, the major guiding force of this period has been to exercise restraint on rapid increases in the costs of health care. For physicians, it is a time for associating themselves with a variety of new health delivery organizations to preserve their practice. These include independent practice associations (IPAs), health maintenance organizations (HMOs), which were first called prepaid group practices, and preferred provider organizations (PPOs). All these organizations grew out of the concept of prepaid group practice, which was first established 50 years ago as consumer or physician participatory methods of delivering health care. However, most of the newer organizations are owned and operated by subsidiaries of insurance companies or new kinds of health care companies. Some are described as health management companies or networks. These are for-profit enterprises and are moving toward what Tarlov has labeled the "Period of New or Social Capitalism," a time of change expected to begin about 1990 and that will extend into the 21st century. He forecasts that gradually private corporate ownership of the production component of medical care will occur. Since physicians rightfully consider themselves to be the central figures in the production component of health care, it can be stated that in the Period of New Capitalism, physicians' services will be under corporate control or ownership. Many hospitals are already under corporate ownership.

The control of physicians' services is being developed through the mechanism of third-party reimbursement. It is not a complex process. Rather than paying doctors directly for their professional services on a case-by-case basis, insurers contract with employers and their employees to provide comprehensive health care for a fixed premium. The rules for obtaining care are established as conditions of the contract. One of those rules is that subscribers to the plan can obtain health care only from doctors who also have contractual arrangements with the insurer or management company. These arrangements are now becoming familiar to many private practitioners as well as academicians.

The economic forces in play are obvious. Employers are receptive to the plans offered by the management companies because they are offered at rates competitive with conventional health insurance plans. The concept that employer costs for fringe benefits for health coverage can be reduced or, at least, contained governs this trend. With several health care companies eager to establish a position in the marketplace, employers believe they are likely to remain competitive. For employees, the attraction is low out-of-pocket costs. The low cost may be a sufficient attraction to lure them from other preexisting sources of health care. Physicians feel required to join the plans to maintain their availability to their established patients and to attract new ones. The net effect is that the health care company owns the contract with the patient to deliver his or her health care, and the physician as an individual, trying to maintain his practice, has little choice but to agree to the terms to provide professional services. Therefore the health care company has virtually complete authority to direct the range of services offered and who will deliver them — and for what payment. Hitherto, arrangements for patient care between patient and doctor were implied contracts, verbal, and with no formal structure; they could be terminated by the patient at any time or by the physician within limits of safety for the patient. Until either patient or doctor decided otherwise, the legal and professional commitment was between patient and physician. The contractual arrangement between insurance companies and patients preempts the ability of physicians to engage directly in agreements with their patients to provide professional care. IPAs, PPOs, and the like have taken possession of the doctors' marketplace. Health insurers own the patients' contracts and thereby determine the choices of both patients and doctors.
The most obvious changes in the shifting of control of health care from profession to corporation has been the imposition of financial risk on physicians. It is now commonplace to require doctors who contract with health insurers to assume personal financial responsibility to control costs. They are expected to do this as "case managers" by controlling the services they deliver as well as those they request of others. Physicians now find themselves serving in the inconsonant but simultaneous roles of case manager as well as patient advocate. Doctors, now more than ever, must weigh the costs of services against their value to the patient's care. It is an uncomfortable and conflicting role for physicians. It can be contradictory to the basic obligations of their profession because constraints imposed by nonmedical authority may restrict the exercise of their medical skills. Patients whose therapy formerly might have been constrained by limitations of knowledge are now informed that their treatment is limited by government restriction or health insurance coverage.

Now, from small communities to academic medical centers, physicians and hospitals as well as all the attendant ancillary providers are being drawn into the Period of New Capitalism. "Vertical integration," namely, the coordination and operation within one company of the full range of all professional, technical, and domiciliary services to provide unified comprehensive health care, is underway. Corporate ownership of the production component is underway. It is a time of confusion, and it is necessary to separate out the changes that affect health care positively from those that do not.

With the increasing complexity of health services, efforts such as the closer integration of medical practice and prudent allocation of health resources have a rational basis. There can be substantial benefit to patients and physicians alike from adopting a restructured organization for medical practice. New and different methods of payment to physicians also can have a rational basis. The objection to the changes currently underway in the Period of Transition is not that medical practice is being shaped into larger organizations of physicians who will be reimbursed through intermediaries. That is no longer an issue. That change is the inevitable consequence of the growth of medicine to a place of greater sociologic and economic importance in our culture. The issue is that the control of these new systems is moving into the wrong hands — the business corporations. Control of physician services will confer on the business community the power to encroach on professional authority. This raises serious questions that are vital to the medical profession as well as to the personal interests of physicians. They are of even greater significance to the American people.

The medical profession continues to react slowly to these developing problems. It is incongruous that the profession that has been extraordinarily competent in its research efforts and in adapting to the growth of medical technology has shown such ineptitude in its ability to organize and govern its status in response to the newly developing health care system of this country.

Protecting the professional role in the new world of medical practice. Physicians now have the special obligation to protect the role of their profession in what remains of the Period of Transition. To do so requires a considered evaluation of the status of the new world of medicine in modern society.

Physicians must acknowledge the reality that they are engaged in a profession that has become too complex and too vast an enterprise of social and economic importance for individual and idiosyncratic physician control. With few exceptions, the choice of an independent professional life is quite unlikely for those who choose medicine as a career. They will be working within more formally structured systems and in even closer professional relationships with each other then they do now, and that is to their advantage. They must work together. It is in the best interests of their profession and their patients, and in their own, that doctors work in close alliance and share responsibility to defend the principles of medical practice.

The essential precept by which physicians must act is that medicine, encompassing both science and art, is a profession. The rules of behavior of those who profess to be physicians taking care of the ill are prescribed by the profession. The special responsibility of doctors is to act on behalf of their patients' best interests, even when that action may be in conflict with their own self-interest. That includes ensuring the best treatment possible for their patients. It is on that professional principal that patients can place their trust in the physician to be the ultimate authority for their care. No one else in the vast and complex process of delivering health care possesses that competence or bears that responsibility. That is why the practice of medicine is the core of the delivery of health care in any system and why physicians must protect their professional prerogatives.

Physicians — and only physicians — must establish the criteria to define the presence of illness, the accuracy of its diagnosis, the range of therapeutic options, and the duration of treatment. To do that, physicians
must assume governance for the management of the systems in which they work, including strong and effective systems of utilization review and quality control. They must recognize also the requirement for cost containment in medical care. They must become involved in these activities themselves to remain authoritative in the validation of what is and what is not appropriate care. To surrender this authority would render physicians vulnerable to payment systems that conceivably could be used as implements to control directly their professional behavior. It would threaten the primacy of the obligation of physicians to their patients. To varying degrees, such a threat exists in all methods of payment. Hypothetically, the perfect system of health services delivery is one in which pressures for personal interest are entirely separated from those of professional responsibility. It is one in which physicians can do all they can do for the benefit of their patients and are rewarded for their professional care without regard to the number or kinds of services provided. Clearly, no such system exists. Several approximations with attendant flaws can be substituted. Onerous and potentially dangerous variations can also be envisioned. One such variation presenting a serious threat to the health care of Americans is the imposition of substantial financial risk directly on physicians for the cost of delivering health care to their patients, thereby requiring them to participate heavily in underwriting the insurance component of the health plan. There is also a potential hazard in the policies of companies that offer physicians incentives of substantial extra rewards for achieving extra economies — those that might incite borderline professional judgment with unnecessary risk to the patient. Thus, rather than removing their medical decisions further from physicians’ rewards, these systems of remuneration drive them even closer, hinging them directly to personal risk and gain. It is entirely opposite to the goals of correct professional behavior.

Whatever abuses or deficiencies may have existed in the fee-for-service system, there is no evidence to show nor reason to believe that these newly directed business interests outside the medical profession are more capable than physicians in managing health care delivery with lower cost or more efficiency, let alone quality. Not-for-profit organizations, mainly prepaid group practices, have demonstrated well the ability of physicians to attain cost containment, good management, and high-quality health care. Some have been successfully operational for 50 years. For-profit business ventures in the human service of health care are an unlikely way to arrive at the prudent use of dollars. There is no evidence to support the promise to employers that costs will be reduced. In fact, data are mounting to show that commercial enterprise in for-profit health care, at least in hospital management, is more expensive than not-for-profit. In for-profit ventures in patient care, the cost of extra management and the acquisition of profit will be at the expense of physicians’ incomes and hospital payment. A reduction of 20% of physician payment, a typical “discount” required of participating physicians in some plans, might well yield a savings of 4% in health care costs, since physicians consume 20% of health dollars. A 10% discount in hospital charges will save another 4%, since hospitals consume 40% of those health dollars. Together, these are the major areas where savings can be derived. Additional savings may occur, but there are also offsetting added costs for administration that can be substantial. Savings of 8% are not sufficient to provide both a satisfactory reduction in costs for the employer as well as a satisfactory return for the investor in the for-profit company. Both may well be disappointed, but physicians will be most vulnerable financially. They will have no control over the origin of their incomes, namely, the health insurance premiums that are set unilaterally by corporate managers who inevitably will be engaged in an intense competitive environment. With a surplus of physicians, the medical profession will have a fragile base on which to negotiate reasonable financial terms for doctors’ services.

The remuneration of physicians is an issue of greater sensitivity than it should be. Physicians have legitimate self-interests and have good reasons to expect to be paid well. They undergo a long period of rigorous and costly education and training, have a relatively short work life, assume great responsibility for the lives of others, and possess a skill that is — and should be — highly valued. If they work hard, and most do, they should expect to be well rewarded financially for all that has gone into their efforts. Whatever that reward is, it should be based on the value of the professional services of physicians as determined by broader social criteria than those of business executives whose major functions include, not inappropriately for business people, the control of costs in a competitive environment. Medicine is not a business. Physicians should not be under the control of laymen who consider health services to be a “product” to be sold for profit. At the same time, physicians must correct the excesses and inequities now existing in professional remuneration.

Appropriate and competitive remuneration for pro-
fessional services needs to be established within the medical community. That will mean a more equitable enhanced value for primary care physicians. The discrepancies between first-line physicians and their subspecialist consultants are too great, and if allowed to continue they will lead to pernicious internal dissenion.

The course of action for the medical profession seems clear. Physicians need to explore and to be receptive to innovative methods of health care delivery. They should be active and major participants in the management and operations of the organizations in which they work. Doctors collectively should be prepared to provide the finances for and thus acquire the ownership of the systems in which they work. Physicians, with the same enthusiasm they apply to scientific achievement, should engage in creative and exploratory activities in seeking new ways of practicing medicine that they will control. Most of all, physicians must become involved directly in the management of organizations of their own creation. With the projected surplus of manpower, a unique opportunity exists for doctors, particularly those who seek career change, to develop management skills to operate their own health systems. This already happens in some prepaid group practice organizations. Such doctors are very different from those hired to act first in the interest of corpora-

tions. The managers this profession requires are those who understand that maintaining the best possible, safe, economic health care system is first the obligation and responsibility of physicians. Those managers are available. They are called Doctors of Medicine.

References
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