Prologue: Over the last decade, the increasing presence of for-profit hospitals, nursing homes, and health maintenance organizations has generated considerable interest among policy analysts. The implications for public policy and, indeed, all of society as a consequence of this growing trend were examined closely by a prestigious committee at the National Academy of Sciences’ Institute of Medicine (IOM), which recently released its long-awaited report. A major dimension of the committee’s work dealt with an examination of the physician’s role in a more entrepreneurial environment. Simply put, is the physician a businessman who purveys services like any businessman (or woman) or does his professional credential mean he is a breed apart? Two of the most outspoken members of the IOM’s committee on this question were Arnold Relman, who has been editor of The New England Journal of Medicine for almost a decade, and Uwe Reinhardt, a professor of political economy at Princeton University. The exchange that follows, originally buried in the committee’s 550-page report, discusses in a provocative fashion the physician’s role in a changing medical care system. In its lead editorial June 12, The Wall Street Journal said: “If you read nothing else this year about the future of health care, you should read this exchange of salvos on the nature of American medical practice.” Ever since Relman wrote, in the fall of 1980, an essay entitled “The New Medical-Industrial Complex,” he has become the most outspoken critic of the increasing role that profitmaking has assumed in American medical care. Relman, with his thirty-year perspective as a nephrologist, medical educator, and clinical researcher, believes that medical practice has a crucial moral component: The commitment of the doctor to the patient, to place the patient’s interest above his own, and always to do what is in the patient’s best interest to the best of his ability. Reinhardt, on the other hand, asserts that physicians are not unlike “other purveyors of goods and services,” thus no more should be expected of them. A German by birth, a Canadian (and a strong advocate of its health insurance scheme) by upbringing, and now a naturalized American, Reinhardt has reached the top of the academic pecking order at a young age. He is known widely for his intellectual prowess and his wit as a speaker.
August 23, 1984

Professor Uwe E. Reinhardt
Woodrow Wilson School of Public
and International Affairs
Princeton University
Princeton, NJ 08544

Dear Uwe:

I have just read your entertaining piece in the July 23 issue of Medical Economics, debunking the “cost crisis” in health care, and I wanted to make a brief comment.

In general, I agree with your argument—which has the usual Reinhardt style and panache—that as a nation, we could spend much more on health care if we wanted to (particularly in the public sector). But it seems to me that you ignore the crisis caused by the maldistribution of the burden of the cost. We have a crisis in the private sector because employers can’t continue adding the rising costs of their employees’ health insurance to the price of their products without becoming noncompetitive in world markets. And we have a crisis in the public sector because the government, having made a commitment to provide care for the poor and the elderly, is no longer willing to pay the bills, and local taxpayers are unwilling to pick up the slack. So, I don’t think you help the public understanding of our dilemma by asserting that there is no “crisis.” The problem is that we want to have our cake and eat it too. We want more and better health care, but we don’t have a system of paying for it that distributes the cost equitably or assures equal access for all citizens. That is what I would call a real “crisis.”

Turning to another aspect of your article: I was puzzled by your comment about the economic behavior of “health care providers.” You say that the public shouldn’t be concerned about the “remuneration ranging from good to excellent” now being earned by people and institutions in the health care “industry.” ”Somehow they expect health care providers to behave differently from the purveyors of other goods and services.”

Why shouldn’t the public expect health care providers to be different from other “purveyors?” Do you really see no difference between physicians and hospitals on the one hand, and “purveyors of other goods and services” on the other? Do you regard the health care system as just another industry, and physicians as just another group of businessmen? Where does the professional commitment to service fit into your view of medical care? Do hospitals have no responsibility to serve the community, or do you reserve that obligation only for the public tax-supported hospitals?
It seems to me that this issue goes to the heart of the matter we have been discussing in the IOM committee [Institute of Medicine Committee on For-Profit Enterprise in Health Care]. As a physician, I believe the medical profession’s first responsibility is to serve as a trusted agent and adviser for patients. Physicians should be adequately compensated for their time and effort, but not as businessmen. Unfortunately, too many physicians nowadays are succumbing to the lure of easy profits and are becoming entrepreneurs. The investor-owned hospital corporations obviously are businesses and tend to think of health care as a business. It is also true that many voluntary hospitals are becoming more businesslike in their orientation towards sales, marketing, cost control, and so forth. But does this mean that the health care system really is fundamentally the same as any other business, or that we should encourage it to become so?

As an economist, you may not see any distinction between the practice of medicine and a business, but that point of view would be strongly contested by many people outside of economics, including the great majority of health professionals. It would also be contested by almost anyone who has had a major personal encounter with medical care. Sick or frightened patients do not regard their physicians as they would “purveyors of other goods and services,” nor do they think of the hospital where they go for treatment as simply another department store.

In any event, this is an issue that needs to be discussed in more depth at our committee meetings, and certainly deserves thoughtful consideration in our final report.

With kindest regards,

Sincerely yours,

Arnold S. Relman

September 6, 1984

Arnold S. Relman, M.D.
Editor
The New England Journal of Medicine
10 Shattuck Street
Boston, MA 02115

Dear Bud:

Many thanks for your letter of August 23rd concerning my recent piece in Medical Economics. For starters, let me mention that the piece was actually written by one of their editors, after an interview that, in turn, was based upon my paper entitled, “What Percentage of its GNP Should a Nation Spend on Health Care?”
Be that as it may, the thrust of the article is certainly mine, and I am willing to defend it. You register two criticisms against the piece: (a) that I mislead the public by arguing that cost is not the essence of our health care crisis, and (b) that I do not expect physicians’ behavior to be different from that of “purveyors of other goods and services.” Let me respond to both criticisms in turn, with emphasis on the second, because it bears on the matter before our IOM committee.

It is my sense that you misread the intent of my remarks on costs. Because you are an astute reader, other readers may have misread it as well. Thus, I plead *mea culpa* for inadequate communication.

Let me draw your attention to a sentence in the piece that really constitutes the heart of the argument:

All I’m saying is that we’re dodging the real issue when we pretend that God has spoken from on high and told us: “Sorry folks, you can’t spend any more on health care or you’ll be running around naked!” The real issue—and it’s tough enough—is how much we want to spend on health care, and how to apportion the cost [to individual members of society.]

I do not believe, as you apparently do, that premiums for employee health insurance have rendered American business noncompetitive. In Europe and (I believe) in Japan, the bulk of health care is typically payroll financed. Collectively, German and French business firms bear a larger share of the nation’s total health bill than do American firms. There are more compelling reasons why American business firms find it hard to compete abroad.

Nor do I believe that our public sector could not absorb additional expenditures on health care. Let me not dwell on the $400 hammers we have no difficulty buying from our defense contractors. In 1983, we spent $22 billion on farm support programs—expenditures designed to pay farmers not to grow food or to grow surplus food the government must store in its warehouses. A nation that can do this year after year has no case arguing that it cannot afford additional public health care expenditures.

In sum, I stand by the argument that references to the percent of GNP [gross national product] we spend on health care, to the plight of business or of David Stockman, or to physicians’ average income are smoke screens to hide the true dimension of the crisis before us: an apparent unwillingness of society’s well-to-do to pay for the economic and medical maintenance of the poor. It is not an externally imposed economic or cost crisis; it is a moral crisis. That is what I meant by the statement that “the real issue is how to apportion the cost of our health care to individual members of society.” And, as you mention, you agree.

Let me now come to the more important part of your letter. In it you argue that the American public should expect health care providers to
be different from the “purchasers of other goods and services,” and you
wonder why I think otherwise. Furthermore, you argue that this question
goes to the heart of the matter before our IOM committee.

In view of the central role you have played on the committee, I think
that it is only fair to take your question head-on. Unfortunately, I shall
not be able to attend the next two meetings. Permit me, therefore, to
respond to your question with a commentary that goes much beyond the
customary length of a letter. My ultimate objective will be to extract from
you: (a) a positive definition of the kind of health care system you would
find acceptable on ethical grounds, and (b) a statement explaining pre-
cisely in what sense American physicians differ from other “purchasers of
goods and services”—purchasers you do not seem to hold in high regard. I
shall proceed with a series of pointed questions.

Do I understand you to imply that you would like to see the U.S.
health care system converted to something akin to the Swedish system?
In Sweden, comprehensive health care is the responsibility of the county
governments. Most Swedish doctors are salaried employees of the coun-
ties, that is, they are truly not-for-profit providers of health care. Only 5
percent of Swedish physicians are private, for-profit practitioners on the
U.S. model. Are you not ultimately asking that such a system be intro-
duced in the United States as well? Of course, in such a system physi-
cians and others working in it would have to be paid the “good to
excellent” wages earned by other “purchasers” in the economy, because
the health sector must compete with other industries for the available
pool of manpower. The time is long past when as vast and technically
complex a sector as the health care sector could be run by missionaries
and candy strippers. It is a real industry now, whether we like it or not,
and it must pay wages competitive with other industries.

Actually, I have never heard you make that plea for the Swedish
system before our committee, nor have I seen you make it in print. Let
me therefore assume, in what follows, that you do not advocate the
Swedish model outright, but merely wish us to revert to the U.S. status
quo circa 1970, that is, to the world as it was before the for-profit institu-
tions appeared on the scene. It was a world in which physicians had the
right to organize their practice as private entrepreneurs on a for-profit or
for-income or for-honorarium of for-whatever-you-want-to-call-it basis,
and in which they were supported by nonprofit institutions that were
financed by someone else, but freely available to physicians as their
workshops. If this is the world to which you would have us return, then I
must confront you with yet another set of questions, some of which may
not be altogether tactful. These questions will center strictly on physi-
cians and not on other parts of the health care industry. I would like to
explore with you what role model your own profession has been to other
purchasers of health care.
Let me, then, turn your question around and ask: What, in the history of the American medical profession, aside from that profession’s own rhetoric, should lead a thoughtful person to expect from physicians a conduct significantly distinct from the conduct of other purveyors of goods and services? I do not deny that there have been grand and noble physicians among the lot, just as there have been grand and noble financiers, lawyers, and even economists. Rather, I am referring here to central tendencies, to the mainstream of American medicine as it has revealed itself through the ages to a paying public. What, then, in the conduct of mainstream American medicine should have led a thoughtful person to expect from physicians a conduct distinct from other ordinary mortals who sell their goods and services for a price? And what in the history of mainstream American medicine would you have serve as a role model for the emerging for-profit institutions delivering health services?

Surely you will agree that it has been one of American medicine’s more hallowed tenets that piece-rate compensation is the sine qua non of high-quality medical care. Think about this tenet, We have here a profession that openly professes that its members are unlikely to do their best unless they are rewarded in cold cash for every little ministration rendered their patients. If an economist made that assertion, one might write it off as one more of that profession’s kooky beliefs. But physicians are saying it!

Ordinary mortals, not blessed by professional courtesy, experience the application of this piece-rate principle whenever they pass the physician’s cashier on the way out; one is asked to pay, on the spot, with cash or valid check. Indeed, it is not uncommon that one makes a down payment or even a complete prepayment for obstetrical care or surgery—“cash on the barrelhead,” as lesser mortals would put it. Why would patients who undergo this routine not think of the physician as a regular business person? If you do not like the imagery, perhaps you object to fee-for-service compensation. Again, if you object to fee-for-service medicine, why have you not made this clear to our IOM committee?

You will recall that, for many decades, our nation has been plagued by a maldistribution of physicians. Careful empirical research has established scientifically what was known to any cab driver all along: physicians, like everyone else, like to locate in pleasant areas where there is money to be had. Thus, our favorite areas have been said to be vastly overdoctored, while other areas, notably the inner cities, have been sorely underserved. As a nation we have been able to solve this problem only through the importation of thousands of FMGs [foreign medical graduates]. (Let us thank them one and all!) Because I do not think ill of ordinary mortals, and because I think of physicians as ordinary mortals, I would not look down upon physicians for their locational preferences. They have simply behaved like certain Ivy League professors who lavish
their pedagogic skills on the offspring of America’s well-to-do instead of teaching students who really need them. But how does someone imputing a more lofty social role to physicians reconcile the physicians’ locational choices with the lofty ideal? Do you really believe that physicians are more civic in their behavior than the rest of us? Do you think they could come even close to members of the voluntary fire brigade? Let me put the question to you even more bluntly: Do you sincerely believe that our for-profit hospitals will leave in their wake as much neglect of uninsured, sick Americans as American physicians have, collectively, in the past and are likely to leave in the future?

You ask me whether hospitals have no responsibility to serve the community, and whether I reserve that obligation only for the public tax-supported hospitals. This question involves principles of law and principles of ethics, and I am neither a lawyer nor an ethicist—just a little country economist from rural New Jersey. But perhaps I can make some headway by seeking guidance in your own profession’s code of ethics. After all, the human capital of physicians (their training) has traditionally been largely tax-financed. Let us examine, then, what obligation for community service physicians believe they have shouldered in return for a largely tax-financed education. From that ethos we might derive some clues on the social obligation of a hospital that is wholly investor-financed and not tax-financed. Specifically, if physicians believe they owe no community service for their public subsidies, can we legitimately saddle investor-owned hospitals with such an obligation?

According to a recent article in Medical Economics (Jack E. Horsley, “Who Can Sue You for Not Rendering Care?” 20 August 1984), the AMA [American Medical Association] Principles of Medical Ethics include the following tenet: Physicians are free to choose whom they will serve. Further on in the piece the author opines that “an AMA legal analysis states that ‘a physician is not required to accept as patients all who apply to him for treatment. He may arbitrarily refuse to accept any person as patient, even though no other physician is available.’” (Italics added.) Finally, the author advises the reader, “You have a perfect right to refuse patients who are not insured or on welfare.” As we all know, many American physicians have acted on these ethical precepts. They have refused to accept Medicaid patients because they considered the cash yield for treating such patients inadequate. They have “skimmed the cream,” so to speak.

You and some of your colleagues seem troubled now by the thought that for-profit hospitals may “skim the cream” and refuse to treat uninsured, poor patients. You have made much of this point in our committee meetings. Here comes yet another question for you: Given that the medical profession, in its own code of ethics, actually has laid the moral and legal foundation for such refusals, have you at any time prior to the
emergence of for-profit hospitals ever railed against your own profession’s code of ethics? If so, I would love to see that literature. If not, why have you not?

You may have noted in our committee’s public hearing last fall that the representative of the AMA steadfastly refused to be goaded into saying something negative about for-profit hospitals, particularly on this issue. That was very appropriate, too, because people in glass houses should not throw stones, as the old saw goes.

My own thoughts on the matter, for what they are worth, are these. Society should not expect private physicians or private hospitals (for-profit or not) to absorb the cost of whatever social pathos washes onto their shores. We as a society have a moral duty to compensate the providers of health care for treating the poor. If providers do give some charity care, our thanks to them. Ultimately, however, it is the responsibility of the citizenry at large to pay for the economic and medical maintenance of their less fortunate peers.

It follows that I do not consider it sensible to nit-pick over how much charity care for-profit hospitals do or do not give. Our committee has wasted too much time on that irrelevant question. In any event, to the extent that they refuse to render such care, they can point to the medical code of ethics as a moral justification for their policy, and they can buttress their case by pointing to the neglect your profession has traditionally visited upon low-income Americans. Examine, if you will, the data presented in the attached exhibit. (See Exhibit 1.) Would you interpret the sudden upswing in the physician care received by America’s poor since the mid-1960s as: (a) a massive attack of unrequited noblesse oblige seizing members of your profession shortly after 1964, or (b) a sudden decrease in the health status of American’s hitherto unusually robust and healthy poor, or (c) the emergence of federal financing of physician care for America’s poor, many of whom were sick all along?

My money is on (c). If I am correct, the graph is not exactly a monument to the beneficence of American medicine, is it? And, if I am correct, other “purveyors” probably would have traced out similar graphs under similar circumstances, would you not agree? Real estate developers are one example that comes to mind; they have done much for the poor since federal funds began to pay them for it. If we pay the for-profit hospitals for treating the uninsured poor, they will treat them, too, as many American physicians (though not all) did in response to the onset of federal financing.

And what of the profits the investor-owned hospitals will reap in the process? You will recall that you and I have had quite a few exchanges on the level of these profits. As you probably know, economists decompose a physician’s income into at least three parts: (a) a rate of remuneration for hours of work, (b) a rate of return to the investment in fixed facilities
(the practice), and (c) a rate of return to the investment the physician has made in his or her own training. Research has shown the latter rate to be certainly on par with the rate of return to shareholders’ equity earned in industry, the hospital industry included.

Recently I read that over 70 percent of all cataract extractions in this country are covered by Medicare. If you look up the prevailing charges for that operation and relate these to the time it takes to perform a cataract extraction, you will arrive at a quite handsome hourly rate of physician remuneration for that kind of work. Properly viewed, it implies quite a handsome rate of return to the investments made by ophthalmologists in their training. My legendary inbred tact stops me from dwelling on the rates of return our nephrologists have been able to extract from taxpayers via the Medicare program. But let me raise the following question: If it is all right for physicians to earn a handsome rate of return on their investments, what is so evil about paying a handsome rate of return also to the non-M.D.s who have let their savings be used for the brick and mortar of health care facilities against nothing more than the piece of hope-and-prayer paper lawyers refer to as a “common stock certificate?” Do you think that, in its final report, our committee can fairly get into the issue of the rates of return earned by the shareholders of investor-owned hospitals without exploring also the rates of return physicians earn on
their investments? Might you not agree that we had best drop that entire issue as well?

So far, I have argued that, as individuals, American physicians have traditionally conducted themselves in a style that casts them into the role of a regular purveyor of a service. I do not judge it to be a style ordinary mortals need behold with awe. It is tempting to buttress the case further with reference to the activities of organized American medicine. I shall refrain from reciting that history, however, because Clark Havighurst of Duke University has already done so quite effectively before our committee. Suffice it to say that one would be hard put to distinguish organized American medicine from the trade association of any other group of purveyors of goods and services. Would you not agree with that as well?

In this connection, you may also wish to read Paul Feldstein's chapter “The Political Economy of Health Care” in his book Health Economics. In that chapter he demonstrates rather persuasively that the political activities of organized medicine are best explained with a simple model of economic self-interest. Feldstein asks, inter alia, why a profession that professes to be deeply concerned over the quality of health care has been opposed so long to strict, effective periodic relicensing on the model of, say, periodic relicensing of airline pilots, all the while invoking the issue of quality in the defense of restrictive licensure laws that exclude would-be competitors from the primary health care market. Economists are neither shocked nor surprised by such a posture nor, however, does it persuade them that physicians stand much apart from the rest of humanity.

You might argue that all I have said about American physicians is perfectly true, but beside the point you wish to make: that such things just should not be true. But then I must repeat my earlier question, to wit: Do you not really ask for a health system something like the Swedish one? I raise the issue again because nothing short of such a revolution will rid our health system of the conflicts of interest you seem to deplore. At a minimum, you should want our system to be converted totally to nonprofit HMOs [health maintenance organizations] that pay physicians a salary and do not—repeat, do not—distribute to physicians any year-end bonuses based on the HMO’s economic performance. Is that your plea?

You suggest that, when people are sick, they are often frightened and can, thus, be easily exploited by a for-profit provider. Is that true only when the provider is a for-profit institution, but not true when the provider is a fee-for-service (that is, for-profit) practitioner? Do you really believe that the executives of a for-profit hospital naturally lack the decency and integrity self-employed physicians naturally have? Let me ask you this question in yet another way. It is well known that the hourly remuneration physicians earn for inpatient physician services exceeds that for ambulatory physician care. Would you not agree that, given the
entrepreneurial practice setup American physicians have always preferred, and given the pressure on physician incomes likely to come from a physician surplus, this disparity in hourly remuneration may lead to needless testing, hospitalization, and length-of-stay, even if all hospitals in our country were not-for-profit?

I put to you the proposition that this question goes to the heart of our debate. Whatever the ownership of the hospitals in which American physicians work, the ethical standards by which our health care sector operates will ultimately be driven by the ethical standards of our physicians. To make the case you have sought to make to our committee—unconvincingly, in my view—you must present us at least with a testable theory according to which the ethical standards of essentially unsupervised, self-employed, fee-for-service physicians affiliated with nonprofit hospitals can withstand even the severest economic pressure (mortgage, kids in college, alimony, lovers with expensive tastes, and so on) in the face of ample opportunity to be venal. You must also show that the ethical standards of physicians affiliated with for-profit hospitals, or employed at a salary by the latter, will wilt at the mere suggestion by some corporate officer to set aside medical ethics for the sake of corporate profits that do not even go, dollar for allegedly corrupt dollar, to the allegedly corrupt M.D. Make that case convincingly, and you will walk away with our committee.

Until you do make that case convincingly, I shall continue to subscribe to the theory that, whatever erosion in medical ethics we shall observe in the future will be the product of excess capacity all around. When a nation decides to finance the operation of, say, only 90 percent of the human and material health care capacity it has put into place, there will be a scramble for the health care dollar among health care providers. In that scramble, medical ethics matters little if those who scramble for health care dollars define what they grab as “honoraria,” “income,” or “profits.” These are semantic differences of little practical import for, when faced with economic extinction, nonprofit enterprises are unlikely to fight nicely nor, I suspect, will unsupervised, self-employed, fee-for-service physicians.

Let me assure you that all of us on the committee appreciate and, indeed, share your concern over the quality of American health care. Unfortunately, you seem to be shooting at the wrong target. The AMIs, HCAs, and NMEs [American Medical International, Hospital Corporation of America, and National Medical Enterprise] of the world strike me as nothing other than the logical end product of a trend originally nutured by none other’ than this country’s medical profession. To be sure, it is a development which, from the profession’s perspective, went out of control. But your profession nourished it along; physicians served as the role models. For better or for worse, we must now expect the
for-profit corporations in health care to follow in your profession’s tracks.

Throughout this century, American medicine has prided itself on its rugged individualism. If one looked for die-hard champions of free enterprise and libertarian thought, one could always find them among our physicians. As Clark Havighurst remarked before our committee, American medicine fought valiantly to defend its right to entrepreneurship in health care, and it fought just as valiantly to deny almost everyone else that right. It was a seductive strategy, but, alas, a dangerous one. Somewhere along the way the profession’s erstwhile, tight control over the distribution of entrepreneurial rights in health care slipped out of its hands. My guess is that the tension between the profession’s claim for an exalted social position and its earthy fight for an exclusive entrepreneurial franchise ultimately strained the credulity and patience even of medicine’s friends. And, thus, the individual American physician finds him or herself today reduced somewhat in stature, though not in wealth, almost a mere peer among an ever-increasing number of profit-oriented purveyors of health care, each competing vigorously for the health care dollar.

If you deplore this outcome, you should have started writing eons ago. By now, as Paul Ellwood has put it, the targets you ought to want to hit are already much beyond our reach. We are left with the search for incentives that make our for-profit or for-income or for-honorarium providers of health care do good by doing well. It probably can be done, although I cannot guarantee it. We shall see.

David Rogers once told me that I seem to be one of the few social scientists who does not hate physicians. He is right. I really do not hate physicians, nor do I begrudge them their income. I like them and respect them just about as much as I do other Americans (business people included), most of whom are very decent folk. This has not always been so. During my student days at Yale I did develop a certain disdain for physicians, but I write that off as a lack of maturity. You see, until those days I had thought of physicians as people somehow apart and above the rest of us. Naively, I had accepted the imagery physicians like to project of themselves. It was the dissonance between this imagery and the empirical record all around me that pained me enough to lash out in anger at your profession. Now I have mellowed. Years of both casual and careful empiricism have persuaded me that physicians really are not very different from other “purveyors.” If one accepts them on that level, they come across as truly fine purveyors—expensive, to be sure—but truly fine, nevertheless. By and large, I like what they sell, and I like them, too.

Write me off as an economist or, alternatively, call me a realist. But it so happens that I am more comfortable dealing with a well-trained, competitive, self-professed professional entrepreneur who drives a Lincoln than I am with a well-trained, competitive, self-professed saint who insists on driving a Cadillac. Chacun a son gout, I suppose.
Until we meet again with my best wishes,

Sincerely,

Uwe E. Reinhardt

September 25, 1984

To: Uwe E. Reinhardt

Dear Uwe:

Thanks for taking the time to give such a detailed and thoughtful response to my letter.

For someone who declares that he really likes and respects physicians, you certainly have managed to roast the medical profession to a crisp. I shudder to contemplate the fate of a debating adversary you didn't like!

The questions I was trying to raise with you concern broad issues of public policy and social philosophy. Does the concept of a profession, as applied to physicians and other health care professionals, have any meaning in our society and, if so, does that meaning imply ethical obligations for health professionals that do not apply with equal force to businessmen? Are there differences between health care and other services that would justify different public expectations for the behavior of health care institutions and business firms?

My purpose in writing to you was simply to solicit your views on these questions, because I consider them to be at the very heart of the problem our IOM committee is wrestling with. Some members of the committee apparently believe that there basically is no difference between health care and other goods and services, or between physicians (as they are, or ought to be) and businessmen. It, therefore, would be logical for them to conclude that the investor-owned health industry is a pseudo-problem. Others, starting from the opposite assumption, think that it is self-evident there is a problem which needs looking into. Oddly enough, our committee has so far devoted virtually no attention to this matter, despite its crucial importance for our deliberations. That is why I was hoping you would respond directly to my questions and help generate some interest among our colleagues in giving further consideration to the issue.

Unfortunately, you have avoided a direct answer by inveighing against the moral hypocrisy of the medical profession. You seem to be saying that since there are so many profit-oriented entrepreneurial physicians out there, and since “the ethical standards by which our health care sector operates will ultimately be driven by the ethical standards of our physicians,” how can I, as a physician, even raise questions about the ethics and social value of selling health care in a commercial market?
Suppose I were not a physician and were asking the same questions about investor-owned health care. Would your response be the same? Would you say that physicians will have to discipline themselves more effectively, or change their economic modus operandi before we can even look into the for-profit industry?

You have also dodged my questions by asking a lot of your own. There isn’t time for me to deal here with all the questions you have raised about my personal views, even if they were germane to our committee agenda—which they are not. Perhaps we can continue the dialogue on another occasion. However, some of my opinions are already on record. I enclose a copy of an article I wrote in *Health Affairs* (“The Future of Medical Practice”) in case you haven’t seen it. It summarizes many of my views about the fee-for-service system and entrepreneurial health care, and it outlines some of the reforms I think physicians can and should institute. I haven’t yet written about my concept of the “ideal” health care system because I am not at all sure I know what that is. I do, however, have pretty definite and well-known views about the ethical obligations of physicians, whatever the economic environment.

I happen to believe that your description of physicians as “almost a mere peer among an ever-increasing number of profit-oriented purveyors of health care” is exaggerated. It has some truth, but it overlooks the basic element in our health care system, which is the relation between doctor and patient. That relation is based on trust by the patient and a commitment by the doctor to serve the patient’s interest first. The fact that most doctors are also interested in being well paid for their services, whether by salary or on a fee-for-service basis, doesn’t change the primacy of their ethical commitment to the patient. This commitment is unfortunately being more and more eroded by new economic forces, but it is still there, and it is one of the several reasons why health care is different from other economic goods and services. Other reasons include the virtually total dependence of the consumer on the advice of the physician, and the often intimate and immediate relation of health care to the quality and quantity of life. You will probably attribute such views to the hubris of doctors, but I believe they are correct. Do you challenge these statements? If so, I hope you will tell the committee why.

In my view, these ethical considerations ought to be part of our committee’s agenda. They boil down to the question of whether there is something special about health care which makes distribution of health services in a commercial marketplace problematic and inappropriate. A second issue (or set of issues) for our committee is whether there is in fact any empirical evidence of differences between not-for-profit and investor-owned health care in terms of process, product, or broader social consequences. In my opinion, it would be as serious an omission to avoid discussion of the first issue as it would be to assume, without objective
examination of all the available evidence, that we know the answers to the second.

With kindest regards,

Sincerely yours,
Arnold S. Relman

October 16, 1984

To: Arnold S. Relman

Dear Bud:

Many thanks for your letter of September 25 concerning the issues before the IOM Committee on For-Profit Health Care. Your letter, and especially your paper on “The Future of Medical Practice” from Health Affairs enclosed with that letter, finally put to us concisely the central question that appears to have troubled you all along, I take it to be the following question: What revisions in the medical profession’s code of ethics need to be made to minimize the conflicts of interest inherent in the transformation of health care from a labor-intensive to a more capital-intensive activity? This question is rather distinct from (although not totally unrelated to) the question we seem to have pursued during the past year, namely: Relative to health care delivered by not-for-profit institutions, what effect does the for-profit motive have on (a) the quality of care, (b) the cost of care, and (c) access by the poor to the care rendered by investor-owned institutions?

The second question is obviously interesting in its own right and thus worth pursuing. But it is at best tangential to the first question which you now declare to lie at the heart of our inquiry.

You seem to argue now that the primary focus of our inquiry should have been the physician and not the hospital. If that is so, then you surely bear a good part of the blame for our straying from the course. After all, you have rather consistently oriented the committee toward the for-profit hospital as the quintessential threat to the quality and fairness of American health care. In your comments and letters to the committee, you have drawn our attention to the relative markups for-profit and nonprofit hospitals charge on ancillary services, to the relative ratios of total charges to total costs, to relative profit rates, and to relative rates of charity care. None of these issues is really central to the issue you raise in your paper on “The Future of Medical Practice.” In that paper, the focus is squarely on the physician. It is not clear to me whether the committee will be able to shift so late in the game to zero in on the focus you now propose.
In your paper you speak of the “commercialization” of health care, just as Eli Ginzberg in his well-known paper speaks of the “monetarization” of health care. These phenomena are, of course, American adaptations to an underlying change in the technology of health care: the increasing reliance of modern medicine on sophisticated and expensive capital equipment. One need not be a confirmed Marxian economic determinist to believe that this underlying technological change lies at the heart of the changes you and Eli deplore.

The shift from labor-intensive to more capital-intensive medicine confronts society with two distinct questions: (1) Who should finance, own, and control the equipment and structures used in modern health care? (2) Should physicians ever be among the owners?

Some societies—for example, Canada and most European nations—appear to have decided that the capital used in health care should be financed and owned primarily by the public sector. In these societies, health care capital is rarely owned by private investors, and not even by physicians. West Germany furnishes the only major exception to this pattern. (Although hospital care in that country is given almost exclusively by salaried physicians, some physicians do own small hospitals. Furthermore, the physicians in ambulatory care fill their private offices with all sorts of laboratory and therapeutic equipment. Many of them earn money simply by blowing hot air on patients’ heads or by performing similarly weird capital-intensive procedures. More and more, West German physicians have become capitalists.)

In the United States, we have increasingly looked to private capital markets as sources of financing health care capital, and physicians rank prominently among the investors. We have answered both of the two questions raised above with a definite yes. Presumably, we believe that patients are competent enough to cope with whatever economic conflicts of interest physicians as capitalists face under this arrangement.

In your paper you take issue with premises underlying the emerging pattern of capitalist medical practice in this country. As I interpret your policy recommendation on pages 17-18, you argue that physicians should not enter joint ventures with other entities in the ownership of health care capital and, presumably, that they should not own expensive medical equipment as sole proprietors either. In making that recommendation you tacitly accept, do you not, that the physician’s professional ethics are apt to be malleable—that a physician who must worry about the break-even volume of an x-ray machine, laboratory, or treadmill exerciser is unlikely to be impervious to such economic pressures in composing treatments for patients. I am persuaded by that argument, particularly because I view physicians as regular-issue human beings. Perhaps other members of the committee will be persuaded as well. You should press the argument at the next meeting, if only to test the waters.
But suppose the committee agreed on the recommendation that, wherever it is technically feasible, physicians should minimize the conflict of interest they already face under fee-for-service compensation by avoiding direct or indirect ownership of health care capital. Would it necessarily follow from this recommendation that health care capital should then also not be owned by other private laypersons? If you are prepared to make that argument, you should develop your case carefully. At this time I am still of the view that investor-owned hospitals, for example, are quite compatible with the strict code of medical ethics you espouse. As long as physicians can keep their noses clean of economic conflicts of interest in their role as the patients’ agents, they should be able to act as their patients’ powerful ombudsmen in dealing with investor-owned institutions. That was the central thrust of the argument in my earlier letter of September 6. Do you have a problem with that line of reasoning? If so, voice it loudly and explicitly. It is my sense that our committee will arrive at some such proposition in its final report.

It is my sense that at least some of the for-profit hospitals might go along with the strict code of ethics you would impose on physicians. In a paper he prepared for last year’s Duke University Private Sector Conference on Health Care, for example, HCA chairman Don MacNaughton argued explicitly against joint cooperative economic arrangements between hospitals and physicians. Don seemed worried that, in the long run, such joint ventures might impair the image of the hospital industry. I think he is right. It may not be good for the patient’s fiscal and physical health to have both the physician’s and the hospital’s economic incentives aligned in the same direction, namely, against the patient. Of course, if one throws this argument against joint ventures between fee-for-service physicians and hospitals, one should be prepared also to lob it with equal force against HMOs. One unfortunate feature of an HMO is that, by “meshing” the physician’s and the HMO’s incentives in one direction, the physician may lose independence in his/her role as the patient’s ombudsman. That is precisely why the champions of the poor tend to be so alarmed whenever it is proposed to force the poor into HMOs. Profit-sharing or bonus-giving HMOs are joint ventures.

You mention in your letter that you have not yet developed your own conception of an ideal health care system—one that minimizes the economic conflict of interest faced by physicians. It is time that you work on the articulation of such a system, lest your commentary be written off as destructive criticism. Perhaps you might begin by listing all of the arrangements to which you object. By a process of elimination you might then arrive at the set of acceptable arrangements. That set may include only “salaried medical practice.” It might also include, however, the relatively more harmless fee-for-service system used in Canada in conjunction with essentially publicly owned or controlled hospitals. (Physicians
in Canada own little capital.) If you wish the committee to be responsive to your thinking, you cannot go on forever without offering more constructive criticism of our present system.

Let me now come to some of the other questions in your recent letter. Although you have chosen not to answer any of the pointed questions I put to you in my previous letter—which is a pity—I shall nevertheless try to answer yours. I am that nice of a guy.

You ask me again whether I truly see no differences between physicians and other purveyors of goods and services. Honestly, I don’t. Physicians are not the only purveyors whose work I am not technically competent to judge. The craftsmen who repair our cars and homes perform a similar agency role. Although we read of corrupt repairmen, just as we read about doctors who run Medicaid mills or push pills for profit, I have always been struck by the integrity of most of the craftsmen and businessmen in whose ethics I must necessarily trust. Physicians really should not be offended when one likens them to such “purveyors.”

You and Donald M. Nutter, in a recent piece in your journal, contrast the presumably venal “business ethic” with your profession’s presumably more lofty code of ethics. If you ever sat in on the board meetings of large corporations, you would be surprised to learn how often business people forgo easy profits for the sake of ethical standards. And you would be surprised to learn what they could get away with, if they were as venal as is implied in your use of the term “business ethic.” I honestly believe that a corporation has as much concern over the decency with which it treats its customers as physicians have over their patients. In short, I stand by the conception of physicians I expressed in my letter of September 6. They are as decent as other human beings, and just as frail under severe economic pressure.

Frankly, I remain a little puzzled by your own views on medical ethics. Sometimes you seem to suggest that physicians are endowed with a strong commitment to ethical conduct. If that is true, why do you worry so? At other times you lament the erosion of medical ethics in the face of capitalist medicine. If medical ethics erode so easily, what then does set physicians apart from “other purveyors?”

You ask me in your letter whether we (the IOM) shall have to wait for the medical profession to clean up its act before we can even look into the for-profit hospital industry. The answer is: No, we don’t have to wait, and we did not wait. After all, our committee is looking into the behavior of for-profit hospitals without even looking at the behavior of physicians. Unfortunately, no major policy recommendations are likely to emerge from such a study. Besides, our inquiry into this facet misses the central question you raise, for reasons indicated above.

Finally, you ask me whether there is something special about health care which makes it problematic to distribute it through the marketplace.
The answer to that question depends on two issues. First, what distributional ethics do we wish to impose on health care? And, second, quite aside from the distributional ethics, do the consumers of health care possess sufficient consumer sovereignty to fend for themselves in the market for health care?

The first of these questions involves social values. Most societies treat health care not as a consumer good, but as a community service that is to be distributed on an egalitarian basis, on the basis of medical need. While that lofty goal may not always be attained, it is at least espoused. It is my sense that Americans have now decided to treat health care as essentially a private consumer good of which the poor might be guaranteed a basic package, but which is otherwise to be distributed more and more on the basis of ability to pay. What I personally think about this ethic is uninteresting. In thinking about policy recommendations for the United States, I must take the prevailing ethic as a state of nature. For better or for worse, it now points to two-class medicine.

The second question is a purely empirical one. The champions of freemarkets in health care obviously are persuaded that individual patients can muster adequate countervailing power even against systems in which the physician’s and the hospital’s economic incentives are fully aligned against the patient. Paul Ellwood seems to be in this school of thought. Frankly, I harbor some doubts on this point. I am not aware of any conclusive empirical research on the ability of patients with different health status and from different socioeconomic and demographic groups to muster effective countervailing power in the health care market. In this area we seem to proceed on preconceived notions, as any debate on the subject in our committee is apt to reveal. We certainly should discuss the issue, if only to bare our preconceptions.

Until we meet again, Bud, keep on trucking. I salute you for having the courage to propose for your brethren a strict code of ethics on the ownership of health care capital. Unfortunately, you propose this code just at a time when your brethren have come increasingly to look upon the ownership of capital as a substitute source of income, in the face of declining patient-physician ratios. You propose to kill the goose expected to lay your brethren’s future golden eggs. It takes guts to go to their fiscal jugular in this fashion. As to the success of your campaign, I can only send you that old Navajo salute: Mazeltov!

With my best regards,

Cordially,

Uwe E. Reinhardt
To: Uwe E. Reinhardt

Dear Uwe:

I am afraid you misunderstood the point I was trying to make in my last (September 25th) letter. I never said, nor even implied, that the committee should abandon its analysis of investor-owned health care institutions in favor of a new focus on the ethics of the medical profession. All I proposed was that we include in our report some discussion of the underlying ethical and social questions (as they apply to both health care institutions and physicians). I believe that public policy choices depend at least as much on these underlying questions as on the empirical and historical questions to which we have devoted most of our attention so far.

Clearly, it is of the utmost importance for us to marshal and evaluate all the available evidence on the characteristics and behavior of for-profit hospitals and other investor-owned health care facilities. It is essential that we try to determine whether the type of ownership of health care services makes any difference to their cost, efficiency, quality, availability, and responsiveness to community need. We also should consider how the growing presence of for-profit facilities has affected, and will affect, the viability of public and voluntary facilities in the same community. These questions have been high on our committee’s agenda, as they should be, but I believe that our report should also recognize that there are other important considerations that the public and the government ought to be thinking about as they consider future policy on health care.

Is there something special about health care that makes it socially undesirable for facilities to be owned by private investors, or for physicians to be entrepreneurial businessmen? What will be the social consequences of the growing commercialization of our health care system? If we are to do a thorough job of evaluating the for-profit phenomenon, I believe we should discuss these kinds of questions along with the other topics we have been considering. I recognize that there may be no clearly right or wrong answers to such questions, and that we are not likely to get a committee consensus. Nevertheless, it would be a useful exercise to at least lay out the issues. Our report will be widely read and quoted, and it seems to me that we would do a public service by at least pointing out the questions that need to be addressed and the arguments pro and con. I suspect that many committee members, whatever their opinions about for-profit health care, would agree with me on this point, and I hope you will too. We still have several months in which to prepare the first draft of our report, and I see no reason why it shouldn’t be possible to include
some of this kind of analysis and still meet our deadline.

I now want to comment on some of the views you express in the remainder of your letter:

(1) You say that in the United States (as opposed to Canada and most European nations), we have decided that “private capital markets” and physicians should “own and control the equipment and structures used in modern health care.” I can’t agree. Certainly, it is true that much private capital has recently been invested in health care, and the trend is growing. That is what our report is all about. I see no evidence, however, that a political decision has been made to rely on this method of financing health care—or that the implications of such a decision have even been explored or publicly discussed. As I see it, our report is one of the first steps in the process of examining and debating public policy on this subject. The growth of the investor-owned health care industry, and the extent of any future involvement of the medical profession in this industry, will depend on decisions yet to be made. Our report could influence those decisions.

(2) Yes, you interpret me correctly. I do advocate that physicians should neither enter joint business ventures with health care facilities (for-profit or not-for-profit) nor hold any equity interest in health care businesses. You raise the interesting question of physician ownership of expensive medical equipment. Exactly where the line should be drawn between permissible, relatively inexpensive items of office equipment and impermissible, more expensive equipment in the office or elsewhere, is a difficult question that I cannot answer, but I recognize the problem. You may be interested to know that the Judicial Committee of the AMA is currently studying conflicts of interest in physician ownership of health care capital and will shortly offer some guidelines.

(3) You say that you believe physicians should avoid direct or indirect ownership of health care capital, but you do not believe this stricture needs to be extended to other private investors. You think that investor-owned hospitals are compatible with the strict code of medical ethics I espouse because “as long as physicians can keep their noses clean of economic conflicts of interest in their role as the patients’ agents, they should be able to act as their patients’ powerful ombudsman in dealing with institutions.”

I agree that physicians must avoid conflicts of interest if they are to represent their patients and protect them against exploitation by investor-owned health care businesses, and have urged this policy on many occasions. I am not convinced, however, that such a policy will be sufficient. Much depends upon how much authority and independence the medical profession will have in a system that may be increasingly dominated by for-profit corporations and by business managers who focus primarily on the bottom line. For example, how effectively will doctors be able to
represent their patients’ interests when the doctors are employed by for-profit institutions, or when a for-profit hospital chain is the only game in town?

Be that as it may, I find your position on this issue to be puzzling. You say that physicians need to be ombudsmen for their patients, and yet you also insist that there are “no differences between physicians and other purveyors of goods and services.” How could that be? Are salesmen and other commercial purveyors also supposed to be ombudsmen for their customers?

(4) In defending your claim of no difference between doctors and businessmen, you say that “physicians are not the only purveyors whose work I am not technically competent to judge. The craftsmen who repair our cars and homes perform a similar agency role.” And a little later, you say that businessmen and corporations deal with their customers just as ethically as physicians do with their patients.

I think you avoid the main issue here. Of course there are many services which, like medical care, consumers are technically incompetent to judge. And, of course, physicians are not inherently more virtuous or honest than business people, or maybe even than corporations. But I would maintain that there is something unique about the doctor-patient relation which clearly distinguishes it from the relation between a car mechanic, a home repairmen, or any other commercial purveyor and his customer.

It is not that there aren’t experts other than doctors on whom clients or customers have to depend for technical advice. It is simply that a sick patient is dependent upon his doctor in a peculiarly critical and intimate way that isn’t matched by any commercial relationship. Up to now, at least, society has recognized this special relation by surrounding it with a network of legal and ethical constraints on the behavior of physicians which make it very clear that physicians are not to be regarded simply as purveyors of expert services in a commercial market. The ethical obligations of a car mechanic or any other purveyor are to be honest in his business dealings, and to offer a good product or service, if the customer wants it enough to pay the price.

An ethical physician’s obligations to his patient go far beyond that. The sick patient must rely on the physician to ensure that he gets the services he needs, and to make choices for him, upon which the quality and quantity of his life may depend. Financial considerations are secondary. There are some superficial resemblances, but no one who has ever been really sick would take your analogy between a car mechanic and a physician very seriously. Some authors, in attempting to understand how medical services differ from those ordinarily provided in a commercial market? draw the distinction between needs and wants. This strikes me as a useful and illuminating insight. Markets are driven by customers’
wans; the medical care system is supposed to consider health needs.

Maybe in the future, society will want to change this special relationship between doctor and patient by “deregulation” of the practice of medicine, as Milton Friedman and other free market zealots suggest. I doubt that very much, however, because most people understand how dangerous to health that radical step would be.

(5) You suggest “Americans have now decided to treat health care as essentially a private consumer good of which the poor might be guaranteed a basic package, but which is otherwise to be distributed more and more on the basis of ability to pay.” I can’t agree. As with your earlier opinion about the role of private capital markets and physician entrepreneurial ownership of health care facilities, I believe the issue hasn’t been discussed or analyzed sufficiently to say what the American people really do believe. It is certainly true that we have been drifting towards a marketplace mechanism for distribution of health care, but the public hasn’t given its approval of that trend, and many people haven’t even thought about it.

There are strong egalitarian feelings about health care in this country. I doubt that a two-tier system, such as would inevitably develop with market-determined distribution of health care, would be politically acceptable. In any event, I believe the issue is still open. One of our responsibilities on this study is to discuss the probable effects of an expanding for-profit sector on the distribution of care, so that intelligent policy decisions can be made. Voluntarism and cross-subsidization in our not-for-profit institutions formerly accounted for a large share of free care. If we replace these institutions with investor-ownership we will either require much larger tax subsidies for the poor, or we will have to deny the poor access to services. Given the choice, the public may decide that new policies favoring the preservation of the voluntary system may be preferable to either of these outcomes. It is also conceivable that within five or ten years, perhaps in a new political climate, a tax-supported national health insurance system might be seen as a viable option again.

(6) Finally, I want to respond to your comments where you urge me to offer my own version of the “ideal” health care system, lest my objections to the marketplace approach be written off as simply destructive criticism. In the first place, I don’t see that the committee’s report needs to be concerned with my personal views—or with anyone else’s, for that matter. We are supposed to be analyzing the implications of investor-owned health care, not expressing any particular view of the “ideal” system. If there are cogent reasons to be concerned about the for-profit approach, as I believe there are, I don’t see why those criticisms should be set aside simply because they are not coupled with a blueprint for the solution to all our health care problems.

In criticizing the for-profit system, I fully recognize the limitations of the
system it seems to be replacing. And in decrying entrepreneurialism in investor-owned hospitals, I also decry similar behavior by voluntary hospitals and among physicians. I am frank to admit, however, that I am not sure what the best alternative would be. I do believe that we will need considerable reform in the present fee-for-service practice of medicine, and that we will also need more, not less, public regulation and subsidy of health care. But I still don’t have a clear idea of what the “ideal” system for the United States would look like. All I am sure about at the moment is that a commercial marketplace isn’t the answer.

I apologize for the length of this missive, but your last letter was so interesting that I couldn’t resist trying to set my own thoughts straight on the many provocative points you raised. I think that I have now said all that I should. If you choose to reply—as I hope you will—I promise I will not attempt another rebuttal. You can have the last word. I have learned a lot from this exchange and have enjoyed it enormously. Thanks for staying with it.

I will be looking forward to seeing you at one of our next committee meetings.

With best regards,

Sincerely yours,

Arnold S. Relman

June 9, 1986

To: Arnold S. Relman

Dear Bud:

Many moons have passed since you sent me your third in our series of by now infamous letters on for-profit medicine. Because these letters will be published, I accept belatedly your gracious invitation to give a final response to your letter.

I, too, have learned much from locking horns with you over the problems raised by the new health care market. Having been forced by your question to view the world through unfamiliar prisms, I have gained a much better appreciation of your concerns.

On first hearing you, I was inclined simply to write you off as one of those physicians who mourn the passing of your profession’s dominance over our health system. Few laymen, least of all economists, would offer your profession condolences over that loss.

After our many written and verbal exchanges, however, I judge my initial reaction to your concerns to have been unfair. Your seem to mourn much less the loss of professional dominance than the disintegration of a
social contract that, in your view, has served American society reasonably well and that is being replaced by a social contract whose ethical foundation you find seriously wanting. Furthermore, you see the emergence of investor-owned health care facilities as the central driving force in that transformation. Excision of these enterprises from our health system, you seem to believe, will lead to a restoration of the old social contract.

If my interpretation of your position is correct, I continue to differ with you on two counts. First, I believe the old social contract to have been less benign than you seem to suggest. That contract had been executed in a seller’s market, physicians and hospitals could write not only the clinical ticket in health care, but also the economic ticket. This market power enabled physicians and hospitals to finance with hidden cross-subsidies some reallocation of health resources toward the nation’s indigents. That reallocation aside, however, the bulk of our health care resources then as now tended to gravitate toward culturally and financially attractive geographic areas and to the moneyed classes within these areas. Worse still, such care as the poor were granted flowed to them in the form of unpredictable noblesse oblige on the part of providers. Surely it cannot be argued that, in the 1960s and 1970s, America had a one-tier health care system, and surely it cannot be argued that the system gave the poor much power and dignity in dealing with providers, Millions of our indigent were relegated to the status of health care beggars, as they remain to this day. Second, I do not believe that for-profit enterprises have been the central driving force in the transition from the old to the new social contract in health care. Rather, I see “for-profit” medicine as merely a peripheral phenomenon in the emergence of “for-income” medicine all around.

Even an economist can grant that health professionals pursue a variety of goals, among which income is but one. In a sellers’ market, these professionals can act as if income were a subordinated goal, because a shortage of providers assures everyone of an adequate income in any event. In a market characterized by a surplus of physicians and hospital beds, this subordination of pecuniary to other professional goals is a luxury providers can no longer afford. Merely to survive, they must raise income to a primary goal. When income has risen to a primary goal, however, we have what you decry as “commercialized health care.” We would have commercialized health care in this sense even if we outlawed investor-owned health care facilities altogether.

If the American public, and the politicians who represent it, really cared about the nation’s indigent, they ought to be able to exploit the emerging surplus of health care resources to the advantage of the poor. For example, it should now be possible to procure for the poor good quality health care through competitively bidding health maintenance
organizations at affordable and predictable prices. To be sure, that arrangement would deny the poor the freedom of choice among providers traditionally available to the middle- and upper-income classes. In that sense, the policy would reflect itself in a two- or multitiered health system.

In your last letter you judge such a system to be “politically unacceptable” because “there are strong egalitarian feelings about health care in this country.” But what in America’s history would ever suggest that notion to you, Bud? Unlike Canada, we are and always have been content to tolerate remarkable inequality in the distribution of human services. For example, no astute observer surrounded by Northeastern prep schools and Ivy League universities could possible conclude that we distribute educational opportunities on an egalitarian basis. These institutions claim to cater primarily to superior intellect. In fact, of course, in their admissions policies they have always treated family wealth and lineage as partial substitutes for the applicant’s innate ability. As a nation, too, we have tolerated and continue to tolerate astounding inequalities in the distribution of legal services and, indeed, of justice. Finally, as already noted throughout this correspondence, we have always tolerated remarkable inequality in the distribution of health care and health insurance. In the face of these inequalities all across the board, how can one possibly infer that ours is a nation with strong egalitarian feelings?

Part of the much vaunted American Dream, Bud, is incessant daydreaming about civic virtues we would like to have but which we are much too stingy to underwrite financially. With the singular exception of Japan, we are the least-taxed nation in the industrialized world. We have a surplus of health resources all around. We have some 30 million uninsured fellow citizens, and we are denying some of them acutely needed care in the face of idle resources. Tell me about this nation’s social ethics, Bud, and about its egalitarian stirrings!

Blame not the Hospital Corporation of America for the plight of our indigent. The fault lies with a disingenuous, daydreaming people that has now forced on its providers of health care a fast-paced game of financial musical chairs, but still looks to these providers for the proverbial free lunch—for the unrequited treatment of the poor whom that people as taxpayers would just as soon forget.

Let us hope that we shall soon awake from this disgraceful American Daydream. Let us awaken, too, from the silly and harmful daydream that ours is an egalitarian society. And, finally, let us stop daydreaming about a bygone era in American health care that probably was not so great in the first place and that cannot soon be recreated in any event. In the meantime, until we meet again, with my very best personal regards and, yes, with many thanks for engaging in this correspondence with me.

Cordially,

Uwe E. Reinhardt
NOTES

1. Reinhardt (23 August 1984): Incidentally, I am not saying that the medical profession departs from the celebrated Hippocratic Oath our medical graduates swear. As I read that oath, I see no reference in it to charity care. It is merely required that physicians do the utmost, without corruption, for patients whose house they do (choose to) enter. There is the added promise that "you will be loyal to the profession and just and generous to its members," and there is the wish that "prosperity and good repute be ever yours." I saw nothing explicit about charity care in the version I reviewed. Maybe there is a longer one that does make reference to it. If so, I stand to be enlightened.

2. Reinhardt (23 August 1984): I do not deny that even prior to Medicaid, some American physicians did treat some of our poor on a charity basis. It is also true that our for-profit hospitals now do treat some uninsured poor on a charity basis.


5. Reinhardt (16 October 1984): I realize that a physician may have to please the hospital to enjoy privileges there. But that applies with equal force to nonprofit hospitals as well.

6. Reinhardt (9 June 1986): I have sketched out such a system in “Economics, Ethics and the American Health Care System,” The New Physician (October 1985): 20-42; and in even more detail in “Should All Employers be Required by Law to Provide Basic Health Insurance Coverage for their Employees and Dependents” (Mimeographed, April 1986).

The first five letters in this exchange are reprinted from: Institute of Medicine, For-Profit Enterprise in Health Care (Washington, D.C.: National Academy Press, 1986).