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THE FUTURE OF THE MEDICAL PROFESSION BETWEEN BIOETHICS AND THE MARKET. A Final Comment

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SUMMARY

For a variety of historical and professional reasons the field of bioethics has paid little attention to the market. It has tended to treat the market with suspicion or hostility. Now, however, the market must be taken seriously. It has become a world-wide force in health care, and there is every reason to believe it will remain strong in the future. For that reason, it is wise to see what can be taken from the market, rather than simply dismiss it altogether. The market has various aspects: a theory of human nature, a view of human behavior, and an ideological aspect, with proponents stressing the necessary connection between political and market freedom. This article argues that only its view of human behavior should be accepted, particularly the possibility of using incentives, positive and negative, to change behavior. That can be helpful in health care, whereas the market's view of human nature should be rejected.

The economic market has been surprisingly neglected as a serious topic in bioethics. While a few people have written well and interestingly on various aspects of the market, few broad attempts have been made to assess its ethical significance for medicine. I suspect there are a number of reasons for this omission, some obvious, others less so. Among the more obvious reasons is the generally left-leaning, liberal tendency among most bioethicists, surely in the United States but in other places as

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well. The *market*, fairly or unfairly, is associated with conservative social and political views, of a kind with comparatively few supporters in academic bioethics. Indeed, since the 1980s in particular, the aggressive efforts of various groups to press the virtues of the market- and to be able to point to the collapose of Communism to help their case along- have led to some open struggles with those of a more liberal bent.

A no less obvious reason is that bioethicists are for the most part academics, with comparatively little exposure to, or interest in, the worlds of business, commerce, and finance. It is a world with different people, different perspectives, different languages and culture. And when those differences are combined with the ideological fervor of market proponents, a large chasm is created, one that discourages mutual understanding. Bioethicists have, by and large, been on one side of that chasm, with no bridges at hand that might allow a crossing in both directions.

Among the less obvious reasons are some that are important. In addition to its ideological and political supporters, the language and tools of the market are characteristically deployed by economists and policy analysts, the latter usually well-trained in economic techniques and perspectives. But neither the fields of economics or policy analysis have much love for, or room for, ethical analysis and considerations. While the great economist Adam Smith saw the importance of a background moral culture for the good of both economics and society, and while a few distinguished contemporary economists deplore the economic disinterest in ethics, the mainline forces in the field consider ethics irrelevant to their interests and professional concerns. Hence, there have been no efforts by economists to bring those in bioethics closer to their work; and it is not an easy world for the bioethicist to enter (far harder, say, than clinical medicine).

Economics prides itself on being a science, or a kind of a science, and one interested in questions of means rather than ends. It leaves ends and goals to religion, or politics, or culture; its focus is on exchange, efficiency, and human behavior in the face of scarcity. While there are professional moral standards in the field, they bear on the ethics of practice, not on the ethics of human behavior more generally. The fact that modern economics

is heavily quantitative, in its practice and even more in its aspirations, opens still another gaps. The methods of bioethics- philosophical, linguistic, qualitative, and normative in their styles- contrast sharply with those employed in economics and policy analysis.

I stress these background considerations not only as a way of speculating about why bioethics has paid so little attention to the market. But it is also important to understand them, and their continuing force, if some fruitful work is to be done. As has been the case with many physicians, the market is simply seen by most people in bioethics as a menace to traditional values and ways of thinking. It is believed to introduce wrong motives and purposes, to threaten the destruction of important medical and health care institutions, and in general to be an alien, foreign force. Moreover, since most people in bioethics appear to favor systems of universal health care, the market is seen as a major hazard there: it is the market, and privatization, that governments are turning in order to relieve their economic burdens in trying to provide universal health care.

While Great Britain has used *internal markets* as a way of strengthening its government-controlled British National Health Service, most other countries have turned to the market as an alternative to universal care. And since bioethics has for so long given problems of health care equity a high place, the market appears a direct and palpable threat to that value. The market has been celebrated for its maximization of free choice, for its efficiency, and for its indirect support of democratic political values. It has not been celebrated for its promotion of equity, even though many of it supporters would argue that its capacity to increase wealth promotes equity in the long run.

I want now to look at medicine and the market at two levels, to see if some kind of fruitful interchange between bioethics and the market can take place. I will distinguish between the institutional and the operational level. It is at the institutional level that the strongest contrast between medicine and the market appears. Historically, medicine as an institution has existed to minister to the health problems of human beings; it has in its root values been oriented to individual welfare. It has been in

that respect a fundamentally altruistic and philanthropic enterprise: it seeks a certain kind of good, that of health. The market, by contrast, is really not an institution at all, but may reasonably be likened to one: it embodies a set of values and a kind of culture. As an institution, it has no formal goals. It focuses on the exchange of goods and services in an impersonal, neutral way. A principal use of it as an institution is to promote income and affluence, by allowing people to freely work out attractive economic and other exchanges. It does not aim as such for individual or collective welfare, though its proponents believe that is what it achieves when let alone.

At the institutional level, then, medicine and the market represent sharply different values and aims. The opposition of many in medicine and in bioethics comes, I believe, by focusing on that contrast. Medicine is thought a good and worthy institution because of its philanthropic aim. The market is looked upon with suspicion because that is not its aim at all. Indeed, the market is thought to represent a fundamental threat to medicine because of its capacity to commercialize human relations, and to put a price tag on altruism itself. When patients are called consumers rather than patients, as they often are in the United States, that is taken as *prima facie* evidence of the presence of a fatal virus, turning medicine and health care into one more commodity, to be bought and sold in accordance with the impersonal rules of supply and demand. When physicians are urged, by for-profit health care organizations, to be sensitive to *bottom line* economic considerations, when pharmaceutical companies hawk their wares in the newspaper, and when the directors of managed care organizations make multi-million dollar salaries-then medicine is seen as a victim of the market, directly jeopardizing physician integrity and patient welfare.

Seen in this way, it is perfectly reasonable for those in medicine, and bioethics, to see the market in the worst possible light. It promises harm without any corresponding benefits for the mission of medicine. I want, however, to propose a different perspective, which I will call the operational. I do so for two reasons. One of them is simply a kind of *real politik*: the market is a powerful and growing force in medicine and health care, and

no amount of criticism, however valid, is going to do away with it. Thus in some way or other, medicine must accomodate its thinking, and some of its practice to it. The question is how much and in what what. The other reason is that it is in fact possible to look upon the market in a more benign way if various aspects of market thinking and practice are distinguished and disaggregated. If medicine must find a *modus vivendi* with the market, it need not do so with each and every element of the market. Some it can accept and others it can reject.

At the operational level, the market can be understood to comprise three main ingredients. One of those ingredients is a theory of human nature. Classically, going back to Adam Smith, the market has understood human nature to be oriented toward individual self-interest. People act for their own private good, not for the common good. Another ingredient is an understanding of actual behavior that is essentially behavioristic in its orientation: people respond to behavioral incentives, either negative or positive, economic or otherwise. The third ingredient is a political-cultural ideology: a free market is understood to be a necessary condition of a politically free society; they go hand in hand.

Given this background classification of the core ingredients of market thinking. I believe that medicine must reject the view that human nature is motivated solely by self-interest. That is neither an accurate description of the human nature nor is it compatible with medicine's historical institutional altruism. Medicine must also reject that ideology which sees some kind of holy alliance between free markets and free societies. Totalitarian China has a thriving free market, while some socialist-oriented countries, such as Sweden, have perfectly healthy democracies. More could be said about all this, but I want to move directly to an examination of the remaining ingredient of market thinking, that of the place of behavioral incentives and disincentives.

This is more promising territory for medicine. For it seems, on the one hand, true to say that people do respond to incentives in the choices they make and in the way they behave. Rewards and punishment, money, glory, and praise are all things that can induce people to behave in one way or another. This is not to say that such incentives are utterly deterministic. Once in awhile

people can resist flattery, turn down money, and risk punishment. This is why it is false to say that people act only out of self-interest (unless one defines self-interest in such a way that every human action is called self-interested by definition). But incentives work, particularly if they are well designed, with a sharp eye for what people consider helpful to maximize outcomes.

In the medical world-I hesitate to call it the *medical marketplace*- incentives can be brought to bear in a number of ways, some good and some bad. Small patient co-payments can help to hold down unnecessary office visits and elective procedures, as can deductibles. Some financial incentives may be able to change bad health behavior (for instance, some kind of financial rewards for good medical compliance), while some negative incentives can do the same (forcing smokers to pay a higher insurance premium). Financial incentives can also influence physician-behavior. Fee-for-service medicine can stimulate considerable diagnostic and therapeutic activity, sometimes more than is needed. Incentives can also influence physician behavior in the opposite direction, as when there is a financial benefit in providing less treatment (as is the case in some health maintenance organizations).

What I want to suggest here is two points. One of them is that the use of incentives is a standard way, in medicine and elsewhere, of inducing people to act in certain ways. The second point is that any moral judgment passed on incentives must be on a case-by-case basis. There is nothing wrong *per se* with the use of incentives (assuming people are not tricked or manipulated), but there can be many things wrong with particular kinds of incentives (for instance, financial incentives for physicians to under-treat their patients, withholding needed and beneficial care and being rewarded for doing so). In short, when medicine borrows from the market some of its behavioral techniques that may be both beneficial and morally justifiable. If the incentives, positive or negative, are used to promote higher standards of medical care, better attention to patient needs, then the good of medicine and its philanthropic goals are well served. The moral test of incentives is whether they are offered in such a way that they do not impinge upon patient (or physician) rights and dig-

nity in their means, and do not go counter to the legitimate ends of medicine in their goals.

But how far can we go here? What about the use of competition as a way of introducing incentives into medicine. Market proponents like competition because of its supposed power to promote an expansion of consumer (or patient) choice, to stimulate innovation (technological or managerial), and to enforce efficiency. In competitive markets there are winners and losers, a situation thought to benefit medicine just as it can benefit other institutions. Here the incentives are institutional rather than individual, but the same behavioristically oriented psychology is at work.

I believe competition needs to be looked at more warily. It is unclear, at least in medicine, that competition promotes better or more cost-effective health care. In some cases, it has just the opposite effect. No less important, institutional competition for economic ends more directly conflicts with the institutional goals of medicine. Just what is to be understood as the *bottom line* in competition: economic benefits or patient-welfare benefits? But, someone might ask, why not have both kinds of benefits as the ultimate goal, aiming to have them achieved in tandem? This is, I believe, impossible: there is no reason to believe that economic and patient benefits are perfectly compatible, even congenial goals. Only believers in some kind of *invisible hand* could expect the world to turn out that way. For if we know anything about the relationship between medical needs and economic costs, it is that needs will always exceed resources, particularly the kind of open-ended needs of modern medicine that have no final resting point. It would be a miracle if every conceivable benefit was given to patients and that turned out to produce a profit. Not in this or any other world.

Let me now face up to an important difficulty in the argument I have been advancing. Will it be possible to take out and use in isolation some aspects of market practice while putting aside others? I see no reason why that can not be done. Indeed, one of the appeals of the market over the years is that it has features that many find appealing, responding to some deeply held human values for instance, its celebration of choice and free-

dom. There is no reason why an effort can not be made to capitalize on its strengths while rejecting those features that represent values of doubtful validity (such as the notion that self-interest is the mark of all human action). The feature I am proposing to be used represents, in fact, an insight into human behavior that was around long before the concept of the market appeared, that of the human proclivity to respond to incentives.

The most important problem now is not whether to use or reject some market thinking, but in finding what can be used and in what useful way. The reality in most countries now is a mixture of market and government mechanisms; pure examples of either approach do not even exist any longer, even though a few countries (Canada and Norway, for instance) have almost purely government-dominated programs. What most countries now seek is some effective way to mix the two approaches: how much and what kind of health care should be left in government hands, and how much and what kind left to the mechanisms of the market? Even that formulation of the questions is too simple, since it is possible to introduce aspects of the market into government programs (the *internal markets* of the British National Health Service) and for government to regulate the private activities of the market.

At stake in finding the right balance are three issues. First, are there some aspects of health care that ought to remain in the hands of government or at least be closely monitored and regulated by government? My answer to that question would be yes, and it would be the protection and care of the poor that would be most important there. The market can not anywhere be depended to care for, much less reach out for, the poor: there is no economic incentive to do so. A second question is this: are there some aspects of health care that should be protected from market domination, even if the market is allowed some play? Again, I would answer yes: that of the professional integrity and discretion of physicians and other health care workers. It is vital to protect the good practice of medicine, a practice that can not honorably be sustained if its practitioners are too influenced by, or coerced by, financial considerations. Now in one sense money can never be ignored, and if there is a scarcity of resources, that

will and must influence medical practice. But the real point is not to use financial incentives in a way that would knowingly harm practice. That is why many would argue that, if there must be rationing, it should not be done by the doctor at the bedside. It should instead be established at the policy level, representing the collective agreement of all those who would be affected: doctors, patients, and those paying for the care. Financial incentives might well be used to induce good medical behavior. They should not be used to lure physicians into bad behavior.

The third question I would pose is the most complex. What kind of medical and health care goals are most likely to preserve medicine from a domination by market ideology? I ask this question with an assumption in mind. It is that contemporary medicine, with its drive for endless progress and technological innovation, has a set of goals that invite an eventual market takeover. By virtue of its open-ended war against all known causes of death and all known causes of illness, medicine is engaging in a struggle against biology that, in the end, it can not really win. However much progress medicine makes, there will always be further that it can go. But modern medicine has been unwilling to set any finite, realizable goals. Moreover, as should be clear by now, the chronic and degenerative diseases of advanced, aging societies have become increasingly difficult to combat. Lacking any available or potential cures, at least of a simple kind, they invite the use of expensive high-technology medicine to wrest small, mainly incremental gains, not clean victories.

In a forthcoming book, *Sustainable Medicine*, I argue that medicine must change some of its most basic and revered modern values, particularly those of unlimited progress and technological innovation as well as ridding itself of a dominating, manipulative stance toward nature. Medicine's modern values guarantee that it can not be economically sustainable. That situation is a most fertile ground for an introduction of the market. Government, for one thing, finds the cost of providing universal health care prohibitive; and it looks to the market and privatization to relieve its burden. At the same time, in modern, increasingly individualistic societies, the market beckons as a way of giving people greater choice in their medical care. At least the

affluent can gain greater choice, but often enough the price of this choice is that the poor get less choice. Choice costs money, money that the affluent have and which government does not.

An equitable, sustainable medicine can not be had with medicine's present values. Only a more modest, finite set of goals will make that possible. The power of market thinking and ideology is at an all-time high, strengthened by the failure of the Communist system in Eastern and Central Europe, by the drive of many governments to be relieved of heavy welfare burdens, and by a widespread belief that only the market is capable of imposing discipline and efficiency on health care systems. The contemporary ideals and values of scientific medicine, unsustainable in the long run, invite market intervention.

Bioethics has so far failed to take decent account of the rise and importance of market thinking. I have tried to suggest some reasons why. It is now time for it to change course. It will be useless in its response if it continues to adopt the pervasive hostility that has marked most of its recent attitudes. The market can not be stopped as a force, at least in the near future. Now it must be lived with and the most made of it. The market has many good things to offer medicine. The market also poses some great dangers to important medical goals and values. The problem before us is to learn how to distinguish the good from the bad-or, even more difficult, to know how to keep the bad under control while promoting the good. That will not be easy, but I see no other feasible choice.

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Recensioni/*Essay Reviews*

ABBA' Giuseppe, *Quale impostazione per la filosofia morale? Ricerche di filosofia morale.* Roma, LAS, 1996

La bioetica sta vivendo una stagione di particolare notorietà, anche in ragione del fatto che i mass-media danno quasi ogni giorno risalto a notizie che rientrano nel novero della disciplina stessa. E anche i medici, refrattari per certi versi ancor oggi a tematiche che non siano propriamente tecniche, cominciano ad avvicinarsi con curiosità alle problematiche di questa disciplina. Da quello che si sente e si legge spesso si ha l'impressione che i problemi siano piuttosto semplici, ma basta poco per rendersi invece subito conto che, non appena si comincia a considerare qualche problematica clinica o biologica dal punto di vista della morale, ecco che la situaziuone diviene complessa. Tanto più se non si ha la competenza etica per affrontare i problemi; tanto più se non si conosce il fatto che esistono più bioetiche, e non una sola; ne esistono tante quante sono le impostaziobni fondanti le argomentazioni che si cerca di dare come supporto alle azioni che vengono mosse dai giudizi, dalle regole, dai principi, dalle teorie etiche, dalle antropologie, dalle religioni, dalle visioni dell'uomo e del mondo, e così via. Spesso si ha l'impressione di naufragare in una confusione che incoraggia ad indietreggiare, oppure a prendere una posizione più emotiva che razionale. La verità è che i medici di questo ventesimo secolo hanno visto tolti dal loro curriculum formativo gli insegnamenti di filosofia teoretica e di filosofia pratica, presenti fino allo scorcio del secolo scorso. Questo ha comportato una disaffezione da problematiche etiche, che pur essendo state sempre importatnti per la professione medica, sono state relegate in virtù della deleteria pretesa di vedere il medico come scienziato neutrale. Ecco, invece, alla fine del secolo, tornare in auge la necessità oramai indilazionabile per i medici di recuperare un approccio all'uomo nella sua totalità. Questo comporta un ritorno all'approccio ed