

For-Profit Public Good: A Contradiction in Terms

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When President Clinton proposed ambitious expansion of health care services a few year ago we were warned that the result would be "socialized medicine." While we were worrying about that menace, someone overnight-somewhat like the move of the Baltimore Colts to Indianapolis-gave us *capitalized* medicine.

Something very important happened to our society while we were paying attention to other things. If we have in fact moved to a market-driven system of health care it is at least as dramatic a change as any of the radical social movements of recent decades. A for-profit health care system replaces not a system of socialized medicine but a system of *professional* medicine.

That's one focus of these remarks: the rise of *capitalized medicine*. Will the quality of health care improve or decline? Will the tradeoffs between cost and service favor cost to such an extent that service deteriorates? Is the quality of health care at risk? Is access to health care at risk?

A second focus of these remarks is not on organizations or institutions or the health care system but on the individuals now called "health care providers." The second issue is *the decline of the professional ideal*.

The third point follows from the first two: If health care provision is to shift from government to marketplace, and if the professional ideal is considered no longer viable, what alternative is there? The third issue is the urgent need for models of *public life based on an ethic of service*.

The competing values involved in the first two issues-the rise of capitalized medicine and the decline of the professional ideal-are those of self-interest and social responsibility. To

what extent is health care as a public good a matter of individual responsibility and to what extent is it a matter of social responsibility?

Health care providers presume to care for the health of others. Health care providers make the *professional* claim they are both *competent* and *trustworthy*. The label we attach to those who are considered to be "professionals" in health care creates expectations on the part of our patients and clients, and on society as a whole, that have strong moral obligations. Beyond the expectations held by those immediately involved, there is a larger *social* trust that the *system* of individuals and institutions providing health care services can be trusted to act for the public good.

In the simplest and yet most powerful terms, we of the general public have been encouraged to trust health care professionals to act in our best interest before attending to their own. On balance, we are told, such trustworthiness will serve the larger public good better than any alternative.

That is the professional ideal in health care. The public myth of the physician always on call, never knowingly or intentionally causing harm to his (and increasingly her) patients, is a long-popular theme of our culture. The heroic figure of Florence Nightingale is another widely-held public myth, a model of personal discipline and sacrifice for others. Professional nurses may feel uncomfortable about some aspects of their careers, but more recently Mother Teresa was seen as a model of compassionate care of the kind that characterizes nursing at its best. In much the same way, Albert Schweitzer offered a model that was problematic for some physicians but that personified the ethic of service for most of the general public.

Through the first half of this century, the public myth of the professional ideal prevailed and inspired countless thousands of young people to seek careers as doctors and nurses. Many of us who remember those days from personal experience can refer to people who personified those values in their work. We have actually been cared for by people who seemed to make the myth an honest story and not mere propaganda or sentimental fiction. A friend of mine passed away a few months ago having devoted four decades of

professional life to caring for children according to that ideal. My father-in-law, in general practice in a small Iowa river town for fifty years, was a generation older than my friend, but they marched to the same drummer. They put the patient's interest before their own private benefit and convenience. Neither of these men was poor; neither was rich. They cared for their families and they paid their bills.

There was evidence in the lives of those two physicians of the making of a tradition of professionalism, a set of teachings about the practice of medicine and health care based on values that went beyond what the law or profit required. I have been modestly involved as a volunteer with schools of medicine and nursing several times in my career. I know people in those institutions who by personal observation measure up to the ideal of professionalism.

I am not sure the successor generation of physicians and nurses is committed to sustain the professional ideal of health care. The rules of professional practice have changed and professional values may have changed as a result. The word "professional" may no longer mean what it seemed to mean fifty years ago. Some of the changes are clearly for the better-the professions are more open, for example-but some suggest an erosion of central values such as the ethic of service.

Although physicians offer the best known version of the ideal, nurses share in the expectations. As I understand the public view, nurses are thought to be less highly trained than physicians but in their version of the professional ideal nurses are, in special ways, considered better qualified than physicians to deal with many of the most important needs of patients and their families.

As the myth has eroded, physicians now appear to be less concerned with the patient and more concerned with their own well-being; at the same time, public sentiment toward nurses has improved. Nurses are thought to be compassionate as always but also to be more highly trained and competent. The perceived gap of competence between the two professions has narrowed.

The public myth of health care is that physicians and nurses work together, and subordinate their differences for the benefit of the patient. I have also lived long enough to know that such happy cooperation is not always the case. The *ideal*, however, is clear enough: physicians and nurses have an obligation to perform to the best of their ability and to subordinate their self-interest to the best interest of the patient. According to the *ideal*, hospitals are places where patient care is paramount; they have not been thought of, first and foremost, as for-profit business enterprises.

The same expectations of trustworthiness that grew up around physicians and nurses developed in public myths about hospitals. The professional ideal that encourages public trust in physicians and nurses and other health care providers is attributed to the hospitals where they work.

The care and repair of public myth, as one historian describes it, seems increasingly to be shaped in general by the marketplace and its values.

Under socialized medicine, the threat to the public good is that "bureaucrats" will define policy and procedure. The theory of bureaucracy is based on the assumption that the necessary guidelines for performance can be defined by legislation and administrative directive. Socialized medicine thus claims to eliminate favoritism and privilege and to offer the same quality of care to all. Rules and regulations rather than individual judgment determine what is done.

It is customary to scorn bureaucracy and bureaucrats, but we should be reminded of why they came into being in the first place. Prejudice, privilege, favoritism and special interest provided the public demand for the rules and regulations we now disdain.

Capitalized medicine promises something different. The first promise is that competition under capitalized medicine will reduce the cost of health care. The public is receptive to such claims, thanks to the high cost of even routine medical procedures. Skepticism arises from the widely-publicized income of some physicians (nurses are never mentioned). The common morality holds that health care professionals will be comfortable but not rich. A third concern is that hospitals have become notorious not

simply for rising costs but for widely-publicized abuses of insured health care programs. For-profit hospitals claim to reduce such costs, but people are skeptical that for-profit hospitals are as committed to quality health care as they are to making a profit. In addition to worrying about physicians and nurses and administrators, the public must now be concerned about the well-being of investors. Not only that: investors are said to have the first claim on assets, and therefore ultimate control of resources.

The marketplace falls short in two ways: on one hand it fails to provide support for the nonmaterial aspects of life, and on the other it seems indifferent to the larger public good in areas like health care and the environment.

If I were mean spirited, I would put it this way: Socialized medicine would make health care into a government bureaucracy, offering low quality at high cost; capitalized medicine would make health care both low-cost and of unreliable quality. Neither socialized medicine nor capitalized medicine would care much about me as a person. I consider that a weakness of those systems, not of me. Sooner or later, systems will be judged by their responsiveness to the complex and changing needs of the individuals they serve.

There is another variation, that of a mixed system of socialized and capitalized medicine, which is what we appear to have. For-profit hospitals compete for government funds to provide health care services to those whom the system of capitalized medicine tends to overlook and for whom socialized medicine seems unable to offer acceptable care. A recent discussion on National Public Radio (why is it that people never seem to shout at each other on National Public Radio?) caused me to think about the version of socialized medicine that is provided by the Veterans Administration. The principal allegation, not denied, was that physicians in Veterans Administration hospitals sometimes fell below acceptable professional standards. That is, the government hospital must compete in the marketplace for medical staff and medical staff are simply not available in sufficient number and quality among people willing to accept lower rates of compensation.

The response of the official on the NPR program was that reform of the Veterans Administration's hospitals and health care services now provides sharply increased compensation to attract better physicians. (Again, nurses are not mentioned.)

Privatizing care for veterans faces stubborn opposition from the veterans' lobby, but veterans are clearly suffering from a decline both in quality and extent of health care as both the expenditure and scope of care are reduced. There appears to be a veteran population that cannot afford the health care it needs, in some cases needs resulting from injuries and disease encountered in the course of military service. The central point of my own reflections is that there is an indispensable element missing from both socialized medicine and capitalized medicine. It is what my assigned title refers to as "the public good." The public good-what we seek in quality and scale, in excellence and access to health care as a system-is not adequately served by a socialized system dependent on regulation, nor is it adequately served by a capitalized system dependent on profit. Neither regulation nor profit, nor some clever combination of those, will provide us with a system of health care that is sufficiently advanced and at the same time sufficiently responsive to the needs of the people it serves.

The missing ingredient is *trust*, social trust in the professional physicians and nurses and trust in the hospitals where they work. Trust cannot be based on the power of government to legislate a health care system that is just and excellent, parsimonious in the use of resources, and generous in its concern for patients and families. Trust cannot be bought by economic performance in the marketplace. Trust can only arise from people who are trustworthy. In this case, that means doctors and nurses who can be trusted in the immediate case to put the best interest of the patient before their own.

Trust in health care as a public good is an urgent issue. That trust has declined sharply in recent decades, both because of the growing inefficiency and lack of responsiveness of government-designed health care programs, and because health care is not merely "a business like any other business." In health care the so-called consumer is at a profound technical disadvantage and psychologically vulnerable as well. The physician's trust in the patient to pay his bills is not equivalent to the patient's trust in the physician's

knowledge and skill. The physician can presumably always find another patient if this one dies; the option of finding another physician is not always open to the patient who may suffer terminal disappointment.

Health care problems are enormously complex, so complex and so technical, in fact, that many people simply drop out of the discussion. Yet the moral assumptions and actions of health care should be accessible to everyone.

You may find it useful, as I do, to make a distinction between morals and *ethics*: morals is about behavior; ethics is about thinking about behavior. That is, we can be moral and not ethical, ethical and not moral. But we become moral-or amoral or immoral-in how we behave; our behavior rather than what we say or even what we think is the best guide to our morality. A man suffered severe burns over fifty percent of his body in the course of rescuing two children from a burning house. He couldn't give reason; it was simply something he had to do. Our behavior defines our morals.

What are the morals of health care? Do we accept some limitations on the health care we receive in order to accommodate the needs of others? Do we as a society make special provision for the weak and poor? Do we entrust the vulnerable to government-to socialized medicine-and expect the strong and affluent to look after themselves? Do we deny medical treatment to those we consider unworthy? Do we deny care to strangers and refugees? Do we admit people to medical treatment only after they have satisfactorily demonstrated their ability to pay for it? Do we permit physicians and nurses to deny their services to people in critical need?

More to the point here: To what extent are life-and-death health care decisions made on financial rather than medical grounds?

I am not asking what *should* be the case; I am asking what actually goes on. What is the common morality of health care in America?

There is a long-established way to think about these problems. I will use the word *professionalism* as a label for it. Professionalism was on its way to becoming a tradition-

that is, a set of practices and values sustained over several generations-when it ran into its own failures, largely beginning three decades ago.

Professionalism is an ideal. It first emerged as an ideal in the work of the physician and the nurse. In this country it began to emerge about 150 years ago, as I understand it, when *some* physicians became determined to Insist upon a higher standard for all physicians than was then generally accepted. Two related criteria were affirmed: the first was a written code of ethics; the second was inclusion in that pledge of an ethic of service. Physicians were not only expected to adhere to certain standards of trustworthiness in their performance-their *moral* behavior-but to know why they should behave in some ways and not others-their *ethical* understanding.

About fifty years ago, the concept of professionalism was defined by five generally-accepted criteria: (1) competence based on advanced education and training; (2) membership in an association of peers; (3) commitment to a code of ethics; (4) an ethic of service; and (5) autonomy of judgment in practice. The criteria applied not only to physicians but to others in health care. The model attracted those in other fields who wished to identify themselves as adhering to a demanding standard of technical performance *and* personal integrity. Competence as measured by the extent of advanced education and training and specialized expertise lifted some physicians to the highest plane of occupational life in our society. Other participants in providing health care-nurses, especially-insisted that there were other health care values deserving of equal emphasis as well as equal recognition. The discussion was not merely about social status or even income; it also had to do with authority and control. Whatever the substance of the debate, priority was given to the public good of patients and not simply to the private good of health care providers. *Investors* were never mentioned.

Attacks on the professional ideal of the physician began in the 1960s and came largely from the Left of the ideological spectrum. Physicians were alleged to be using their power for their own economic benefit, using advanced training to justify rising incomes. Physicians also extended their control over the content of advanced education as well as

admission to medical school and the array of research opportunities. In the jargon of the critics of the Sixties, the medical profession was sexist, racist and generally exclusionist.

Being at the top of the heap, physicians were the first target of the critics, but only the first. More and more occupations claimed the status and privileges associated with the label of professional; "professional" was increasingly equated with "white collar" and little more. Meanwhile, critics increasingly attacked professionalism across the board as self-serving and unjust.

The health care system was accused of being dominated by the American Medical Association, which as the largest and most visible target was in turn accused of being a trade association concerned only about its members' economic advantage rather than a professional association committed to the public good.

The early critics of professionalism tended to support the expansion of government-funded health care to meet the needs of the poor. "One quality of health care for all," they argued, could only be assured by a system grounded in social justice and equal rights. The critique was political more than economic. The measures of success were not efficiency but access, not quality at all costs but equal quality at whatever cost.

In more recent decades the attacks on professionalism have come from the Right and coincided with attacks on government. Health care providers were accused of taking advantage of government-insured programs. They allegedly diverted resources that were intended to help patients to use them instead to ease their own lives and fatten their own incomes. Because government-funded programs underwrote costs, the cost-cutting disciplines of the marketplace were missing. The sins of government-supported health care were alleged to be incompetence, intrusiveness, inefficiency and corruption.

In this critique, health care providers who work for the government are expected to maintain the same standards that would be expected of them in private professional situations. It is a sobering reminder that in many societies in which health care is wholly government-provided, health care *professionals* as such don't exist; health care

bureaucrats do. Non-medical bureaucrats often make medical decisions and "professional" considerations are set aside or overruled.

The positive case from the Right praises the merits of competition. For-profit health care advocates claim that a well-managed clinic or hospital will show a profit—there will be enough patients to pay for the medical care they need and want and can afford.

Physicians and nurses will share in the financial benefits depending on their contribution to the financial bottom-line. The competition for patient as consumer will cause health care providers and their institutions to provide a steadily higher level of quality care.

Or such is the new public myth of for-profit health care as we are urged to accept it.

The language of health care has shifted from the language of professionalism and the public good to the language and values of the private marketplace. If health care is an economic activity first and foremost, then its economic self-interest must be served.

The values of the marketplace tend to be reduced to performance as measured by short-term financial results. For the layperson, the most telling argument against for-profit health care is that medical decisions will not rely on the autonomous judgments of physicians and nurses but on non-medical administrators or on medical personnel functioning as non-medical administrators. Those decision making processes provide the media's horror-stories that have the general public in a state of anxiety.

Neither socialized medicine nor capitalized medicine offer the promise of a health care system that is optimally excellent and accessible. Each one promises more than it can deliver.

Only the tradition of professionalism seems to get to the core of the problem: an ethical system based on *private* responsibility for the *public* good.

The trust that is given by-or exacted from-the patient relies on a high degree of trustworthiness. The health care provider accepts a responsibility commensurate with higher status and sometimes a higher quality of life. For the health care provider, at least

as I have known them, *self-respect* is an important governor. Self-respect, as people are eager to point out, is more important than self-esteem. Some professionals will find self-esteem in affluence; but in my opinion the true professional can find self-respect only in an ethic of service.

We have all known cultures of health care in which professional values permeate everything that goes on. But my sense is that such places are diminishing in number; that professionals themselves are diminishing in number and in influence. The professional ideal is at risk.

Health care is a public good, at least in aspiration. Societies seem always to fall short of making a high quality of care accessible to all. In our search for the best answer we turned to government provision and control. When that proved to be inadequate, we turned to the private marketplace. There seem to be deficiencies in that system, too, especially in providing health care for the poor and most vulnerable, but even in the norms of care for patients able to pay.

The third approach discussed here is the professional ideal: Health care is guided by physicians and nurses and their best judgment of what health care should provide and for whom. The professional ideal has fallen victim of its own weaknesses, attacked with stunning effect from both Left and Right. The stewards of the professional ideal-the professionals themselves-seem to have lost their sense of mission.

Two concluding thoughts occur to me. The first is to ask about the sources of social trust and how those sources might be replenished and renewed. There is no public good without social trust. A society like ours with an extensive reliance on voluntary action for the public good is likely to be a society with a large capacity for social trust.

The second thought is that we always need *models of public life*. The professional health care provider was such a model. The scientist has been another. The politician as public servant was another. These career models are held up to young people as models of public life because they are expected to serve the public good and not simply their own *private* good. We do not ask that of business people or ordinary citizens-we can confine

ourselves to our private lives and measure success by our private benefits. The argument here is that the concern with private benefit, whatever the great achievements of private enterprise, fails in important ways to serve the public good. *Some* among us must devote their lives to the public good. *Some* among us must serve as models of trustworthiness.

Philanthropy may provide some answers. Philanthropic giving may provide the marginal subsidy that makes the professional ideal sustainable over time. Philanthropy can support initiatives like the new center on health care ethics and professionalism that I've become associated with. Philanthropy can support conferences like this one, bringing health care professionals together in candid self-assessment.

Philanthropy can subsidize the education and training of young people drawn to the professional ideal as their model of public life. Philanthropy can support physicians and nurses whose values add a moral dimension to rules and regulations and to cost-benefit analysis. Philanthropy can subsidize professionals who wish to devote part of their time and energy to community service, like those in the so-called CATCH program of the American Academy of Pediatrics. Philanthropy can fund sabbaticals for physicians and nurses to advance their social knowledge and ethical understanding as well as their technical competence.

If we think of philanthropic giving and service as working at the margin to make health care better, rather than as a means of providing the economic and technological infrastructure, philanthropy should bring the moral and ethical voice to the discussion of health care.

"Voluntary action for the public good" links philanthropy to concepts like professionalism. It is in fact the *philanthropic* value of concern for the well-being of others that lifts professionals above their peers in the private marketplace. Philanthropy and professionalism, among other instruments of the public good, rest most fundamentally on moral rather than on economic or political values.

Like all ideals, philanthropy and professionalism are models of public life that fall short of the ideal in practice. Vice as well as virtue is evident in all human affairs, including the

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most noble. But if our models of public life, both individual and institutional, do not contain a strong moral discipline, we lose the framework that creates social trust. That's what the struggle is about.