
The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic

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ABSTRACT

Commodification of health care is a central tenet of managed care as it functions in the United States. As a result, price, cost, quality, availability, and distribution of health care are increasingly left to the workings of the competitive marketplace. This essay examines the conceptual, ethical, and practical implications of commodification, particularly as it affects the healing relationship between health professionals and their patients. It concludes that health care is not a commodity, that treating it as such is deleterious to the ethics of patient care, and that health is a human good that a good society has an obligation to protect from the market ethos.

Key words: commodification, economics, ethics, ethos, health care, human good, managed care, marketplace, physician-patient relationship, professional ethics.

INTRODUCTION

In Book I of the *Republic*, Socrates asks Thrasymachus, his pragmatic young interlocutor, this question:

But tell me, your physician in the precise sense of whom you were just speaking, is he a moneymaker, an earner of fees or a healer of the sick? And remember to speak of the physician who really is such...

– Plato (*Republic* 341C)

Even the cynical Thrasymachus, who denies the viability of justice in a world dominated by powerful people, admits that physicians are healers first.

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Were Socrates's question to be asked in today's health care environment, the answer would be different. We would be told that physicians should be encouraged — indeed, impelled — by financial incentives and disincentives to become money-makers for themselves and money-savers for their corporate employers or investors. Physicians, in short, are asked to be primarily purveyors of a commodity and not the healers Plato said they should be if they were to be *true* physicians.

In this essay, I wish to examine the ethical consequences of commodification of health and medical care on the relations of physicians with patients, with each other, and with society. I will do so by posing three questions and offering three conclusions.

The questions are these: (1) is health care a commodity like any other, subject to distribution by the operations of the competitive marketplace? (2) what is the ethical impact of commodification on professional ethics and the care of the sick? (3) does commodification work? (4) if health care is not a commodity, then what is it, and how should it be treated in a just society?

To each question, I shall reply, in turn, as follows: (1) health and medical care are not, cannot be, and should not be commodities; (2) the ethical consequences of commodification are ethically unsustainable and deleterious to patients, physicians, and society; (3) commodification does not fulfill its economic promises; and (4) health care is a universal human need and a common good that a good society should provide in some measure to its citizens.

IS HEALTH CARE A COMMODITY?

It is a fundamental dictum of managed care that health care should be treated like any other commodity, i.e., its cost, price, availability, and distribution should be left to the free workings of a free marketplace constrained by a minimum of governmental regulation (Hertzlinger, 1997; Enthoven, 1997). Through the usual mechanisms of competition a “quality product” should emerge since providers will compete with each other in quality, price, and satisfaction of consumers to keep their market-share and/or profits.

For their part, “consumers” and “purchasers” will be free to choose among providers selecting the best “buy” suited to their individual needs. Costs will decline, and quality will be maintained or will improve. More care will be accessible to more people on their terms, not the doctor's. The laws of competition will reduce waste, overuse, and error to everyone's

advantage. Medicine will be demystified, physicians will become employees, and physicians' decisions will be shaped to conserve society's resources.

In this view, these desirable ends can be facilitated by turning the physician's self-interests to the advantage of the competitive system. By controlling clinicians' expenditures, employing financial and other rewards and penalties, costs will be kept down, unnecessary care eliminated, and quality outcomes optimized. In this view, there is no objection to physicians being money-makers so long as this activity is confined to a managed environment and their "product" is traded on the open market. The fundamental question is a deeper one than we can examine here, namely, the issue of the proper relations of ethics to economics (Friedman, 1967; Piderit, 1993; Sen, 1987).

The underlying ethos of managed care is the theory of Adam Smith's *Wealth of Nations* (1909) and *Theory of Moral Sentiments* (1817). If, as Smith taught, everyone pursues his or her own interests, the interests of all will be served. The profit motive as adduced by Smith ultimately works to social benefit. But, for Smith, profit is not the primary end of the market ethos. Rather, it is the best means of attaining the primary end which is "...a plentiful revenue of subsistence for the people" (Worland, 1983, p. 8). As I shall note later in this essay, Smith also felt that some things could not be left to the fortuitous workings of the marketplace and could only be assured by government intervention (Worland, 1983, p.8). For some economists, this reservation would inhibit the liberty only an unrestrained market can provide (Friedman, 1967).

In its most aggressive form, managed care expresses the market ethos in tightly restrained risk selection, high-powered marketing and advertising, strict rules about denial or approval of care, competitive price-cutting, and putting substantial portions of the physician's income at risk. Reward and penalty for doctors depend negatively on the clinical costs they incur and positively on meeting marketing goals and patient satisfaction (Kuttner, 1998; Anders, 1996). Gaining the benefits of market competition for health care when treated as a commodity will, of necessity, lead to a loss of professionalism (McArthur and Moore, 1997).

Before discussing the ethical problems consequent on treating health care as a commodity, there is ample reason to question the validity of this line of reasoning even from the purely economic point of view. There is, today, an intense and growing reaction to managed care as it is now practiced. This is of sufficient proportions to cast doubt on the economic theory behind managed care. There is evidence that costs are again rising, services being reduced, young and healthy subscribers being favored over

old and sick ones, emergency rooms being closed, etc.(Kassirer, 1997; Smith, 1997; Flocke, 1997; Anders, 1996; Pear, 1998; Larson, 1996). Restrictive legislation is currently before the Congress (Patient Access and Responsibility Act, 1997), class action suits are beginning to surface, and legislation has been proposed to remove the protections of managed care organizations against liability provided by the Employee Retirement Security Act.

Economists, health care planners, governmental budget officers, industry investors, young and healthy persons who have not made use of the system, and entrepreneurial physicians, nurses, and administrators regard these as transient problems curable by fine-tuning the system. Their faith in democratic capitalism is not without reasonable foundation. After all, they argue, the free market concept has brought America to its position of preeminence and affluence among nations, it has contributed to the superiority of American medicine, and it accords with the spirit of enterprise, freedom, and self-determination Americans rightly cherish. Indeed, the dismal failure of government-operated enterprises and centrally regulated economies in Eastern Europe sharply underlines the superiority of free markets for most commodities.

Much more important than the economic short-comings of the managed care line of reasoning and operation are the ethical issues encompassed in the paradigm shift from a profession to a market ethic. Before examining these, it is necessary to see whether health and medical care are, in fact, commodities. If they are, then the managed care line of reasoning is essentially correct, and the present short-comings should yield to instrumental manipulation. But, if they are not commodities, then instrumental manipulation will not cure the present ills. Attention will have to turn to the ends and purposes of medicine, to healing as a special kind of human activity governed by an ethic that serves those ends and not the self-interests of physicians, insurance plans, or investors.

The legitimacy of the marketplace, competition, and democratic capitalism, therefore, are not at issue. Rather, the ethical question commodification raises is whether the marketplace is the proper instrument for the distribution of health care. Specifically, is health care sufficiently different from panty hose, ocean-front condominiums, or television sets to set it apart from other consumer goods? The answer to this question rests on what we mean by a "commodity" (Zoloth-Dorfman and Rubin, 1995; Anderson, 1990; Immersheim and Lestes, 1996; Reynolds, 1995; Anderson, 1996).

The *Oxford English Dictionary* gives a wide range of meanings to the word "commodity" (*OED* Vol. II, 1961, p. 687). The definition most relevant to this discussion is the way the word is used in commerce, i.e., a

thing produced for sale valued for its usefulness to the consumer or its satisfaction of his preferences. Implicit in this definition is the idea of fungibility, namely, that one health care encounter is like any other, just like any bag of beans of same weight and quality is like any other bag of beans. It follows also on this view that, providing they are equally competent, any physician is like any other, and any patient like any other. Hospitals, laboratories, and nursing homes are all interchangeable as well.

If health care is a commodity, then it is something we possess and can sell, trade, or give away at our free will. This implies that, like any commodity, ownership of medical knowledge upon which health care depends resides with health professionals or those who employ or invest in them (Nozick, 1974, p.160; Engelhardt, 1996, p.381). No one else can lay claim to their medical knowledge or skill unless they were acquired unjustly. In this view, there would be no duty of stewardship over medical knowledge which would require its use on behalf of those who need it but cannot pay for it. Nor can there be any valid moral claim by the sick on society for its allocation or distribution. Whether health care is a commodity in this sense will be discussed below as will the moral implications for the justice of moral claims in the allocation of resources.

The commodification question centers on "health care" not on the facilities, medications, instruments, dressings, and other disposable items used in or necessary to health care. These are, in one sense, commodities, since they can be owned, consumed, bought, traded, and donated. They are in a different category from commodities unrelated to health care. To a large extent, they must be subject to market forces. But in the interests of the common good, they become the subject of ethical and public concern when their scarcity threatens human well-being. The sale of body parts, kidneys, or blood is another instance of commodification with serious ethical implications (Titmuss, 1997; Brecher, 1991). Granted the importance of all the objects that are essential in health care, the central ethical issue is the quality and nature of personal relationships involved. The materials used are means to the end of healing and helping sick persons.

By "health care," therefore, I mean the provision of assistance to persons in need of care, cure, education, prevention, or help related to trauma, illness, disease, disability or dysfunction by other persons knowledgeable and skillful in providing such assistance. The central feature of health care is the personal relationship between a health professional and a person seeking help (Ray, 1987; Pellegrino and Thomasma, 1987). Commodities may be used in the process of providing care, but the totality of health care itself is not a commodity.

The most common assertion of those who see no objection against classifying health and medical care as commodities is that there is nothing unique about them as human activities. It is an assertion made usually by healthy people, the young and those who have not thought much about their own vulnerability and finitude. To be fair, there are undoubtedly a few people who steadfastly hold to this view despite everything, even when they themselves, or members of their families, become ill. Still, even they might reexamine that position at the moment when some dear family member is denied access to life-saving or life-enhancing treatments because of the fortuitous operations of the marketplace.

This is happening, today, in communities where hospitals are closing emergency rooms, burn units, premature baby care centers, and neonatal intensive care units to cut losses or to enhance profits (Kilborn, 1997). As a result, important care is not available or is so inconvenient or delayed that danger or death might occur. Acute care of this type is a need that may occur anywhere, anytime, and to anyone. If there is a first priority, this surely is one since other needs become insignificant until the emergency is over.

The same can be said for less dramatic medical and health care services. Human flourishing can and does occur in the presence of chronic illness, but it is certainly more easily attained when one is healthy. Chronic illness, pain, discomfort, or disability can constrain the most determined and best-adjusted person. For most people, it is difficult or impossible to do the things they want to do or enjoy when they are afflicted by illness. Health is a fundamental requirement for the fulfillment of the human potential and freedom to act and direct one's life. To lack health and to need treatment is to be in a diminished state of human existence — a state quite unlike other deprivations which can be borne if one is healthy.

Serious illness changes our perceptions of ourselves as persons. It forces us to confront the fragility of our own existence. Human finitude is no longer a distinct abstraction, but something illness forces us to confront as a possible present reality. Regardless of whether the illness is serious, if we wish to be treated, we are forced to seek help, to invite and authorize a stranger — the health professional — to probe the secret places of body, mind, and soul. Without this scrutiny, we cannot be helped. To be sure, lawyers are permitted access to some intimate secrets, tax advisors to others, and ministers to still others. But only the physician may need access to the widest range of secrets, since being ill is not confined to the body. It is a disturbance in the whole life-world of the patient.

What the sick person needs is healing, i.e., a restoration of what has been "lost," a reestablishment of the equilibrium that existed before the

onset of illness. This “restoration” is not just a return of biological equilibrium (Gadamer, 1996). It is rather a restructuring of our whole life world — one with its unique history, set of relationships, and social milieu. In that restoration, there is a meshing of the life and lived worlds of both the doctor and the patient (Pellegrino, in press). Healing is achieved by a combination of the physician’s biological interventions (drugs, surgery, manipulations) with the healing power of the patient’s own body. In the end, where self-healing and medical healing begin and end may be highly problematic, but in either case, the assistance of knowledgeable health professionals is indispensable.

Given the special nature of illness and healing, health care cannot be a commodity. Health care is not a product which the patient consumes and which the doctor produces out of materials of one kind or another. The sick person “consumes” medication and supplies, and expends money for them, but he does not consume health “care” as he would a bag of beans or a six-pack of beer. Health or amelioration of disease may be the end of medicine but health, itself, is not a weighable commodity.

In a commodity transaction, like buying bread, the persons who buy and who sell have no personal interest in each other beyond the transaction. They are focused on the object or product, on the commodity to be traded. Their relationship does not extend beyond the sale or the consumption of that commodity. The medical relationship, in contrast, is intensely personal. Confidence and trust are crucial as is a continuing relationship, at least in general medicine if not in the subspecialties.

There are other intimate professional relationships as well as medicine. But, even in such intimate services as legal or ministerial advice, the sheer totality of engagement with the biological as well as the psycho-social and spiritual, which occurs in medicine, is lacking. This is not to depreciate these other crucial human services. They, too, respond to fundamental human needs: the lawyer to the need for justice; the minister to the need for spiritual reconciliation. Those are human needs of such fundamental significance for human flourishing that they, too, cannot be classified as commodities. However, the universality, unpredictability, inevitability, and intimate nature of the assault of illness on our humanity, the impediments it generates to human flourishing, and the intimate and personal nature of healing give health care a special place even among the helping professions.

Another feature of a commodity is that it is proprietary. Commodities are produced by someone who makes something new out of preexisting materials. The seller herself, or her agent, owns the goods or commodities she offers for sale. For a price, she transfers ownership to the buyer who

consumes the product as he wishes. This is not, and cannot be, the nature of the case with medical or health care. Physicians, nurses, and other health professionals are not the sole owners of their medical knowledge for several good reasons.

For one thing, the physician's knowledge comes from many years — and in some cases, centuries — of clinical observations recorded by his or her predecessors. All health professionals have free access to that record across national boundaries. In addition, the most reliable, clinically pertinent medical knowledge comes from autopsies or controlled experiments on other human beings. A research “break-through” often results in response to previous work. The investigator uses instruments and methods discovered by others. No research exists in a vacuum. The fruits of research also result from the willingness of our fellow citizens to be research subjects so that others might benefit. Biomedical research is funded by public agencies or by private philanthropies to which all contribute by paying taxes or purchasing products from whose profits the funds for philanthropy derive.

Moreover, the doctor's education depends upon the acquisition of a kind of knowledge and experience which is ethically possible only with society's sanction (Pellegrino, 1995). In their first years, for example, medical students dissect human cadavers for which they would be criminally prosecuted without social sanction. Later, they are allowed to participate in the care of patients when they are incompletely trained, albeit under supervision of licensed practitioners. Students can only learn procedures and operations by “practice,” again, under supervision. They participate in clinical care when, clearly, their skills are rudimentary. They continue to enjoy this privilege in their post-graduate years as residents or fellows.

Society sanctions these practices because the only way future physicians can be trained properly is by “hands-on” experience. Physicians in practice continue to enjoy these privileges in continuing education which is designed to maintain their skills or teach them new procedures. Surgeons develop and maintain their skills by continuing “practice,” at first under supervision and, later, independently.

The argument has been made that medical knowledge is proprietary because it has been paid for by tuition and continuing education fees and by the many years of study and demanding work required for a thorough medical education (Sade, 1971). But even this cannot make medical knowledge proprietary. There is no fee that could buy the privileges or waive the legal penalties that would be imposed if medical students, residents, and fellows did not have social sanction for what they are allowed to do.

Moreover, these privileges are accorded not primarily so that doctors or nurses may have a means of livelihood or an “edge” in competing with their fellows. The privilege of medical and nursing education are permitted in exchange for the benefits society accrues from the assurance of a continuing supply of well-trained physicians and other health professionals.

As a result, when they accept the privilege of a medical education, medical and nursing students enter implicitly into a covenant with society to use their knowledge for the benefit of the sick. By entering this covenant, they become stewards rather than proprietors of the knowledge they acquire. Their fees and labor entitle them to charge for their personal services – not because they own the knowledge they employ, but because of the effort and time they invest and the danger they may incur in applying that knowledge to particular persons. They are entitled to compensation for their effort. But, to paraphrase Plato, they are *true* physicians when they are *healers* first, and *moneymakers* second (Plato, *Republic* 341c).

COMMODIFICATION, MARKET ETHICS, PROFESSIONAL ETHICS

Clearly, health and medical care do not fit the conceptual mode of commodities. They center too much on universal human needs which are much more fundamental to human flourishing than any commodity *per se*. They depend on highly intimate personal inter-relationships to be effective. They are not objects fashioned and owned by health professionals, nor are they consumed by patients like other commodities. Stewardship is a better metaphor than proprietorship for medical knowledge and skill.

All of this might be granted and still some might hold that, even if health and medical care are not commodities in the usual sense, they should be treated as such. In this view, the market is the best mechanism in a free society for the distribution of health care like all human goods. It is the best guarantor of those special aspects of health and medical care we have insisted must be preserved. When consumers are free to choose and providers compete, the interests of all will be better served, especially when costs are high, quality among providers is variable, and resources are scarce.

Let us examine the consequences of such assertions from the point of view of their ethical meaning for persons who are ill and for society in general.

The most immediate and urgent ethical consequences of commodification occur at the bedside at the moment of actual decision-making. Here

the major issues are divided loyalty, conflicts of interest, conflicts with the traditional ethic of medicine, and challenges to the personal integrity of physicians and nurses. These conflicts have been examined in some detail elsewhere (Pellegrino, 1997; Rodwin, 1995; Rodwin, 1996; and McArthur and Moore, 1997). The focus here will be on commodification and commercialization of the healing relationship and the supplanting of the traditional professional ethic by the ethic of the market and of business.

First of all, the commodification of health and medical care means that the transaction between physicians and patients has become a commercial relationship. That relationship, therefore, will be primarily or solely regulated by the rules of commerce and the laws of torts and contracts rather than the precepts of professional ethics. Profit-making and pursuit of self-interest will be legitimated. Inequalities in distribution of services and treatments are not the concerns of free markets. Denial of care for patients who could not pay were not unknown in the past. But they were not legitimated as they are in a free market system where patients are expected to suffer the consequences of a poor choice in health care plans, or a decision to go uninsured or to pay only for a plan with lesser levels of coverage. In this view, inequities are unfortunate but not unjust (Engelhardt, 1996). Some simply are losers in the natural and social lottery (Nozick, 1974). The market ethos does not *per se* foreclose altruism, but neither does it impose a moral duty to help, especially if helping impinges on the proprietary rights of others without their consent.

In a market-driven economy, commodities are fungible, i.e., any one of them can be substituted for any other similar commodity, provided quality and price are the same. In this view of health care, physicians and patients become commodities, too (Zoloth-Dorfman and Rubin, 1995; Greenberg *et al.*, 1989; Starr, 1982, p. 217). The identity of physicians, hospitals, clinic locations, and laboratories makes no difference unless a clear quality gap or danger is demonstrated. Patients, too, become fungible. They are "insured lives." They can be traded and bargained for, back and forth, in mergers, network formation, or sales of hospitals and clinics. They are "profit" or "loss" centers, assets when they stay well and pay premiums, and debits if they become ill and need too many services (Greenberg *et al.*, 1989). The "quality" of any group of patients is then measured by their profitability and this can be a "deal breaker" in mega-mergers, etc., when both doctor and patient become faceless counters in business mega-deals (Blecher, 1998).

When both doctors and patients are fungible, choice of physician has no ultimate weight despite repeated surveys showing it is the most important factor in the therapeutic relationship. Physicians no longer look on pa-

tients as “theirs” in the sense that they feel a continuing responsibility for a given patient’s welfare. Without this attachment of particular doctors to particular patients, it is easy to justify a strict 9-5 workday, signing out to another doctor on short notice, or being “unavailable” for all those personal concerns and worries that beset patients even with non-life-threatening illnesses. Even short-term continuity of care is difficult to come by and, in any case, reckoned as not essential for care to be “delivered” (Flocke *et al.*, 1997). Similarly, necessary communications between primary care physicians and specialists are hampered, further aggravating the discontinuity (Roulidis and Schulman, 1994).

To remedy this, patients are urged by the corporate ethos and the fungibility of physicians to regard the managed care organization as their “doctor.” The corporation will provide. The organization will deliver the commodity and make certain that “someone” is there to deliver it. Many physicians are already socialized into this corporate way of thinking. They place less emphasis on continuity, personal commitment, and personalized relationships with patients than in the past. Physicians who are corporate employees become encultured in an ethic alien to the professional (McArthur and Moore, 1997). The ethic of the marketplace and the ethic of the employee begin to displace the more demanding ethic of a profession. The ethic of individual patient welfare based on principles has moved towards greater dependence on the institutions providing care (Emanuel, 1995).

There is no room in a free market for the non-player, the person who can’t “buy in” — the poor, the uninsured, the uninsurable. The special needs of the chronically ill, the disabled, infirm, aged, and the emotionally distressed are no longer valid claims to special attention. Rather, they are the occasion for higher premiums, more deductibles, or exclusion from enrollment. There is no economic justification for the extra time required to explain, counsel, comfort, and educate these patients and their families since these cost more than they return in revenue.

Despite the boast about prevention under a managed care system, the time required for genuine behavioral change — the essential ingredient in true prevention — is not recompensed. To be sure, immunizations, diet sheets, smoking cessation clinics might be offered. They are not as costly nor as effective as the constant effort required for genuine behavior modification with reference to diet, exercise, stress control, and the like. Effective prevention requires education and counseling, and these are person-intensive and rarely profit-making.

The business ethos puts its emphasis on the bottom line, on profit, on an excess of revenue over expenses. The aim of business is to maximize

returns to investors (Friedman, 1970). For-profit organizations return those profits to investors, executives, and board members. The care they provide turns out to be more expensive as well (Woolhandler and Himmelstein, 1997). Non-profit organizations use profits to expand services or to “survive” the intense competition that characterizes the health care “industry” today. But in both for-profit and non-profit systems, health professionals who contribute to the bottom line are valued; those who do not are devalued or let go (Kuttner, 1998, pp.1562-1563).

In a commodity transaction, the ethics of business replaces professional ethics. Business ethics is not to be depreciated. Many businesspeople genuinely seek to be “ethical.” A whole literature and a whole new set of experts in business ethics give testimony to a genuine interest in ethical business conduct in general and in health care in particular (Bowie and Duska, 1990; Blair, 1995; Evans, 1988; Shortell *et al.*, 1996). Emphasis on worth creation rather than profit maximization and better representation of patient interest are promoted by ethically sensitive corporations.

The question, however, is not the validity of a business ethics, but whether it is appropriate for health and medical care. If there is any weight to the arguments for the special character of health care, then a business ethics is inappropriate and insufficient as a guide for health professionals. Revisions of business ethics are admirable, especially if they ameliorate some of the crasser aspects of for-profit plans. But the problems are of a more fundamental sort not susceptible to cure by changes in management ideology.

The contrasts between business and professional ethics are striking. Business ethics accepts health care as a commodity, its primary principle is non-maleficence, it is investor- or corporate-oriented, its attitude is pragmatic, and it legitimates self-interest, competitive edge, and unequal treatment based on unequal ability to pay. Professional ethics, on the other hand, sees health care not as a commodity but as a necessary human good, its primary principle is beneficence, and it is patient-oriented. It requires a certain degree of altruism and even effacement of self-interest.

When humans are at their most vulnerable and exploitable, they need much more secure protection than a business ethics can afford. Buying an automobile, for example, is a tricky business, to be sure. Much faith must be placed in the manufacturer and the salesperson (a slender reed, indeed). One hopes for an ethical dealer. But the vulnerability of the auto purchaser pales to insignificance when compared to entering an emergency room with a pain in the chest or a fractured skull.

The corrupting power of industrial and business metaphors has been commented upon elsewhere (Pellegrino, 1994). Suffice it to say that sub-

stituting words like “consumers” for patients, “providers” for physicians, “commodities” for healing relationships, or speaking of health care as an “industry,” or of “product-lines” or investment opportunities” inevitably distorts the nature of healing and helping. Euphemisms, if repeated often enough, eventually will shape behavior as though they were true renditions of real world events and states of affairs.

If we treat health care as a commodity, then we are prone to “sell it” like any other commodity — that is, by creating a demand among those who can pay. Getting the competitive edge via advertising is standard commercial practice. The first move in this direction came in 1982 when the Federal Trade Commission decided that the then-standing AMA ethical prohibition against advertising constituted a restraint of trade (Federal Trade Commission, 1982). The Commission treated medicine as a business and not a profession. In effect, the Commission ordered the AMA to set its ethical code aside in the interests of commerce. The implications of such an action for the ethical integrity of the profession have not been sufficiently appreciated.

Since the FTC order, the ethos of the advertising world, with its all-too-characteristic seductive promises and often-misleading inducements has dominated the promotion of health care in the media. In the name of competition, everything has become a “P.R.” problem and an exercise in spin-control. The claim that advertising provides information upon which consumers (patients) can base their choice of doctors or health plans is no less spurious than it is in the advertisement of cosmetics. Reliable, clear, unambiguous data on coverage and quality are hard to see through the camouflage and persiflage of marketing.

DOES COMMODIFICATION WORK?

Some might agree that treating health care as a commodity does, indeed, carry the ethical risks I have detailed above. However, they might insist that, commodity or not, health care is part of the economy, and it is best distributed in a free market. They can point effectively to the dismal failure of government-controlled markets in socialist economies of recent unhappy memory. They might argue that the benefits of a free market might outweigh the dangers. Three of these putative benefits are (1) cost savings which competition would effect, (2) the subscriber or “consumer’s” freedom to spend his or her money for health care as he or she wishes, and (3) the satisfaction the patient would enjoy as providers competed for his or her business. Let us examine these presumed benefits in

the light of the realities as they are unfolding in managed care, which does, indeed, make health care a commodity and seeks to improve its distribution and price while retaining its quality via the workings of the market.

It is a fact that rationing and limitations on physician decisions have kept costs from escalating. But there are already clear evidences of a reverse trend (Smith, 1997; Anders, 1996). Premiums are rising in many states and promise to do so elsewhere. Profits are dropping. Initial savings through mergers, reductions of personnel or acquisitions, and tightened controls on physician decisions are one-time savings. Mergers may be as much signs of weakness as strength. Treating medical and health care as a commodity subject to market forces must face certain inescapable clinical realities.

For one thing, subscribers cannot all be, and remain, young and healthy forever. As subscribers age, they need and demand more services. As time goes by, initial promises to contain costs or to return a profit become more difficult to keep. Subscribers either must be dropped, selected out at the outset, or corners must be cut and quality endangered. When profits drop, investors in for-profit plans will sell and move to better opportunities; non-profit organizations will face bankruptcy, and for-profit plans will tighten approval requirements for care or for inclusion in the plan. Every plan will scramble to enroll young, healthy people who have little need for care. The poor, the under-insured, and the genuinely sick will be pariahs to be avoided or dis-enrolled in some way.

The promise of freedom of choice is even more illusory (Enthoven, 1980; Hertzlinger, 1997). For the largest majority of those insured, their employers (who are the purchasers of the plans) make the first choice — selection of a plan with which to contract for services. This is done primarily on the basis of cost, not of quality. Indeed, neither the employer nor the employee is in a good position to judge outcomes and quality of care except in the grossest terms. The fragility of these choices is manifest in the employer's constant shifting from plan to plan for the "best" buy, which often translates into the cheapest buy. The employee has no choice but to go with the plan or go it alone and buy his or her own insurance.

Once in a plan, freedom is, again, limited — this time in choice of doctor. Yes, there is choice, as long as it is from the panel of approved physicians and a list of approved services. The same limitation on freedom prevails when it comes to choice of hospital, or specialist, or an MRI or lab facility. The advertisements proclaim "choice," but all have fine print that limit those choices.

Even more uncertain is the choice of how best to spend one's money in health care — whether to buy a plan with a high or low deductible, wheth-

er to go naked and use one's money for other things, and which of the complex and confusing array of "products" and "packages" best suits one's health needs at one time of life or another. This illusory freedom flies in the face of realities like the difficulty, even for educated people — even health professionals — of comprehending what the convoluted obscurantist language of the contract covers or the impossibility of predicting how much coverage one will, in fact, need, particularly to meet the uncertainty of an unexpected catastrophic illness. Should one buy limited coverage? Should one opt for a high or a low deductible? How are changing needs to be accommodated — like being married, divorced, having children, retiring, choosing a medical savings account, or unexpectedly picking up the care of elderly parents? What do hospitals, physicians, and society do when those who make bad choices appear for care?

Libertarians might regale in this richness of choices. Yet, even they would have to admit that bad choices can be made by the most educated people. The libertarian could reply that this is the price of freedom: "Better than someone else making the choice! After all, some people do not value health care above other goods. They may wish to run the risk in order to be able to spend their earnings on more immediate needs or pleasures." This is carrying *caveat emptor* to the extreme without resolving the question of what physicians do when the patient who made a poor choice presents himself or herself with a medical emergency or a serious illness.

In a market-driven ethos, theoretically at least, physicians would be justified in refusing care. They could argue that patients are responsible for their own health, that they must live with their choices, and that to provide care under those circumstances is to distribute other people's wealth without their consent. This is a stark but unavoidable conclusion of a strictly libertarian view of property rights, health care, and social governance. Whether this conclusion is consistent with the most minimal rudiments of professional ethics or with a good or just society is highly debatable.

Many managed care plans measure their success in terms of consumer satisfaction. But the relationship between satisfaction and quality is a tenuous one. Consumer satisfaction is not the whole of health care. The genuine difficulties of measuring quality outcomes are vastly under-rated by the satisfaction criterion. The young, those who have not needed the system, or those who make low demands might very well be satisfied with lower premiums and some of the advertising slogans. This is much less the case with the chronically ill, the aged, and those who make demands on the system. Data are appearing that show these patients have poorer out-

comes in managed care systems than in fee-for-service systems (Ware *et al.*, 1996). Others go through the “revolving door,” leaving their capitated plan for Medicare and Medicaid coverage when they really become ill.

IF NOT A COMMODITY, WHAT IS HEALTH CARE?

If, as I have argued, health care is not a commodity, if the consequences of treating it as such are morally unpalatable, and if it is a special kind of human activity derived from a universal need of all humans when they become ill, how should it be treated in a just society? Here we enter the complex, much-debated field of distributive justice, in general and in health care, and the very practical issues of health care reform and policy. These large subjects are well beyond the scope of this essay. But, by arguing against the commodity notion and the market ethic, I incur a certain obligation to point to the direction in which a morally tenable answer might lie.

Buchanan (1987) has summarized the major theories of justice associated with the distribution of health care. He has done so with care and with a fair appraisal of the strengths and weaknesses of each. In serial order, Buchanan examines the libertarian theories of Nozick (1974) and Engelhardt (1996), the contractarian views of Rawls (1971) and Daniels (1985), the egalitarianism of Veatch (1986) and Menzel (1983). These theories all depend on whether or not there is a right of the sick to health care, created by the unfortunate circumstance of illness. The limitation of rights and rights language in public life are receiving more attention (Glendon, 1991; Bellah *et al.*, 1991). Rights-language focuses too often on the negative rights of freedom from coercion and not enough on obligation and duties. Given the vulnerable and dependent state of sick persons, it is not intrusion on rights they fear, but abandonment to their fates by their fellow humans. As a result, there is a growing interest in communitarian and common good conceptions of justice.

Buchanan includes a non-rights-based approach which contends, instead, that there is a duty in beneficence to aid the needy and those in distress. In this view, health care is a “collective good.” Government enforcement is necessary to ensure that this collective good is provided even to those who may not have a discernable “right” to it. In this approach, beneficence is given at least equal weight with justice, and the collective good at least as much weight as the individual good (Buchanan 1997, p. 358).

Another challenge to commodification is to regard medical and health care in a societal context as a public work, that is, as an “...organized

medical response to illness in a social context and to the practice of caring in a community” (Jennings and Hanson, 1995, p. 8). This notion needs further fleshing out. While it intimates a connection with the idea of a common or civic good, it remains somewhat vague. Importantly, it does return our attention to the fundamental questions about the social ethics of health care.

I believe that the moves to a *prima facie* obligation of beneficence on behalf of the sick (Buchanan, 1997) or the practice of caring in a community (Jennings and Hanson, 1995) are in the right direction. For a morally defensible policy of health care distribution, however, the obligation to provide health care needs firmer grounding in a philosophy of medicine and of society. In a theory built on *prima facie* principles, social beneficence could be overridden for good reason by other principles like autonomy or a competing theory of justice like Engelhardt’s or Nozick’s. A firmer justification can be found in the origins of a moral claim in the phenomena of illness and healing and in the notion of health care as common good. Together these realities would establish health care as a moral obligation a good society owes to all its members.

This is because health, or at least freedom from acute or chronic pain, disability, or disease, is a condition of human flourishing. Human beings cannot attain their fullest potential without some significant measure of health. A good society is one in which each citizen is enabled to flourish, grow, and develop as a human being. A society becomes good if it provides those goods which are most closely linked to being human. Health care is surely one of the first of these goods. It is, to be sure, not the only human good (Aristotle, *Nicomachean Ethics*, 1178b30–34). But other goods, like happiness, wealth, friends, career, etc., are compromised or even impossible without health.

In addition to the claim that arises out of the obligation of a good society to enhance the flourishing of its members, there is the non-proprietary, non-commodity character of medical knowledge alluded to in sections I and II above. The nature of medical knowledge and the way in which it is acquired and transmitted to health professionals make it a collective good on which the members of a society have a substantive claim. Human beings across national boundaries also contribute to the body of knowledge required in health care today. With varying degrees of strength, all humans are linked in a world community which shares in the fruits of medical research.

Health care is both an individual and a social good. A good and well-functioning human society requires healthy members, and healthy members require a good and well-functioning society. This reciprocity of de-

pendence between individual and societal good implies a reciprocity of obligations as well. Aquinas puts the relationship between the individual and common good in this way:

He who pursues the common good thereby pursues his own good for two reasons. First, because the proper good of the individual cannot exist without the common good of the family or state or realm.... Second, since a person is a part of a household or state, he ought to esteem that good for him which provides for the benefit of the community (Aquinas, ST 2a2ae,q.10,2).

Any linkage of a social obligation to provide health care as a human good must engage the question of reciprocal responsibility of citizens to care for their own health. In a common good conception, the self-abuser, the person who refuses to buy insurance he or she can afford, or who refuses to take a genuine part in community life, imposes burdens on his fellow humans. Such persons weaken any claim they might have had to societal resources (Boyle, 1977). Plato warned about hypochondriac or aged members of society whom he believed should not receive care (Heyd, 1995).

This is a harsh judgment which a compassionate society could not impose strictly. It implies refusal to treat the self-abuser in the emergency room whose bleeding from esophageal varices are the result of alcoholic cirrhosis of the liver. Such retributive justice could not be consistent with the primary ethical obligation of physicians as healers. Perhaps a practical compromise is to discriminate against products like alcohol, tobacco, high-risk sports, etc. by taxation or higher premiums but not against persons who do not know how or do not care about their health (Evans, 1988). After all, where does one draw the line on irresponsibility? How much exercise, weight-, or stress-reduction is enough to qualify for participation in the societal good? Who has pursued health so sedulously as to be free of lapses for which he is responsible? Where do we draw the bright line?

The role of government here is not forcefully to redistribute wealth in general or to bring about total equality in all things but to assure that collective goods, or the satisfaction of a common claim on such goods, are justly distributed. This approach does not translate into an unlimited claim on all the health care possible. It is not an invitation to "blank check" medicine. Nor does it mean that health care takes priority at all times and in all places over all other societal goods. Nor does it swallow private property rights in central planning. It does mean that there is a moral obligation of a good society to relieve the sufferings of its citizens, to provide what is needed for the fabric of society to hold together, and to see

that the collective interest of society's members in health care is assured. This is, in effect, beneficent justice — justice ordered by the obligation to rescue, sustain, and nourish both society and the individual since each suffers if either is neglected or abused. This is a positive obligation that transcends the more negative or legalistic notion of "rights," but it is not an absolute obligation overriding all other obligations.

Treating health care as a common good implies a notion of the solidarity of humanity, i.e., the linkage of humans to each other as social beings. The common good is, however, more than economic good — necessary though this may be in an instrumental sense (Bellah, 1991; Glendon, 1991). It also implies the development of social and governmental institutions designed to promote justice and the well-being of the whole society in essential things like health, safety, environment, and education.

Nowhere does this conception militate against the protection of individual rights. It stands against the absolutization of the Marxian collective as well as the absolutization of Nozickian property rights. Rather, the morally defensible aim is a mixed economy: one in which private property and private enterprise are protected, but there is enough social control to assure justice, especially in those things that cannot be left to the fortuitous operations of the competitive marketplace (Ryan, 1916). These things must always be few and of such nature that a healthy and well-functioning society could not exist without them.

It is especially important to recognize that rejection of a marketplace ethics for the distribution of health care does not make the market an unethical instrument for the distribution of most other goods and services. As Worland has shown, Adam Smith himself recognized that the market was not the preferred device for providing certain public goods like defense, education, or a transportation infrastructure or for setting rates of interest, etc. (Worland, 1983, pp. 8–9). Smith had no difficulty reconciling liberty, private property, and government intervention when the rights of a few threatened to endanger the whole. In both *The Wealth of Nations* (1909) and *The Theory of Moral Sentiments* (1817), Smith saw a specific role for moral restraint on self-interest and of government's responsibility to prevent monopoly and to administer justice (Worland, 1983, p. 21).

In this view, the role of the government is both to protect personal liberty and attend to those common goods that liberty destroys when it becomes license. How this balance is to be achieved is a constant struggle of democratic societies and institutions. What is crucial in health care is that any policy must take cognizance of the common social good, the shared moral claim on medical knowledge, and the special nature of health care as a human activity.

What is equally crucial is that the physician remain truly a physician, concerned with healing and not money-making (Plato, *Republic* 342c and 342d). In any plan in the future, the physician ought not be the gatekeeper, microallocator, or rationer. Nor should she or he become provider, insurer, or risk-taker simultaneously (O'Reilly, 1998; Witten, 1997; Wang, 1996). The current move to establish the physician-provider organizations in which employers, hospitals, and corporations "buy" health care from groups of doctors are just as dubious morally as other capitated insurance plans. In addition, they deprive patients of their last advocate since the physician is the healer, the risk-taker, and the profit-maker simultaneously (Woolhandler and Himmelstein, 1995). The assumption that physicians as administrators are more likely to represent patient interests if they own or administer the system is dubious at best. If earlier studies of higher prices and overutilization of doctor-owned radiology and laboratory facilities are accurate, this assumption is likely to be a dangerous myth.

This is not the place to design a total system of health care, nor to fill in the content of precisely what services constitute a fair share of the common good of health care, nor to speak of the costs, modes of payment, and choices among other societal goods. Obviously, those are the questions most often at issue in policy debates. But, in the end, those are second-order questions. They can be answered properly only in light of the first-order questions: What is health care? What kind of good is it? What moral claim do members of a society have on this good? What are society's obligations, and what are the obligations of the health professional with reference to that good?

Understanding health care to be a commodity takes one down one arm of a bifurcating pathway to the ethic of the marketplace and instrumental resolution of injustices. Taking health care as a human good takes us down a divergent pathway to the resolution of injustice through a moral ordering of societal and individual priorities.

One thing is certain: if health care is a commodity, it is for sale, and the physician is, indeed, a money-maker; if it is a human good, it cannot be for sale and the physician is a healer. Plato's question admits of only one ethically defensible answer.

Can we deny, then, said I, that neither does any physician, insofar as he is a physician, seek to enjoin the advantage of the physician but that of the patient?

(Plato, *Republic* 342c)

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