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BOOK REVIEW

DOCTORS' CONFLICTS OF INTEREST (& ALTRUISM) IN THE UNITED STATES AND GREAT BRITAIN

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Review of Marc A. Rodwin, MEDICINE, MONEY & MORALS: PHYSICIANS' CONFLICTS OF INTEREST, Oxford University Press, New York (1993).

INTRODUCTION

Patients often react with anxiety, not to mention indignation, to the notion that physicians derive profits from the practice of medicine.[1] Could financial self-interest possibly sully their own doctors' advice? Professor Marc Rodwin's *Medicine, Money & Morals: Physicians' Conflicts of Interest*[2] answers that question in the affirmative, giving comprehensive chapter and verse to support his conclusion. When doctors have the dominant hand in directing spending for more than 14% of this nation's GNP, it would probably be naive to expect otherwise.[3] But whatever happened to the medical profession's traditional altruism and to its ethical obligation to avoid financial conflicts of interest?[4] And how much clinical judgment is distorted by

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1. The modern debate over the role of profit-making in medicine was stimulated by the publication of Dr. Arnold S. Relman's influential article, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963 (1980).

2. Oxford University Press (1993).

3. *See generally* E. Haavi Morreim, Ph.D., *Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care*, 12 J. LEGAL MED. 275 (1991).

4. The American Medical Association's Principles of Medical Ethics (1957) § 7, stated: "In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him . . . . His fee should be commensurate with the services rendered . . . . He should neither pay nor receive a commission for the referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient."

incentives for physicians to realize secondary economic gain[5] through their patients' medical problems?

Professor Rodwin's impressively documented and detailed book analyzes both of those important questions, and advocates statutory reform to minimize conflicts of financial interest between doctor and patient, conflicts he sees as inevitable given the competitive structure of the technology-intensive United States health industry.[6] But does our health system encourage more self-interested professional conduct than can be observed in other countries? Do other payment schemes promote less conflicted and more altruistic physician behavior? Is guaranteed payment itself the core of the problem, since most patients lack financial incentives to question their doctors' recommendations (or lack thereof) for testing and treatment? Or is the real culprit the expensive technological advance of the past four decades, which opened up previously undreamed-of opportunities for making money from medicine?

This Review will explore those questions in preliminary fashion, with direct comparison between abuses in the United States Professor Rodwin so graphically illustrates, and the recent introduction of competitive forces to the United Kingdom's National Health Service.[7] Over the past few decades, the professional ethos of physicians in the U.K. (which adopted national health insurance in 1948) has seemed more focused on public service than has that of the U.S. medical profession.[8] Indeed, one of the best-known analyses of the interplay between economics and patient welfare, Professor Richard Titmuss' *The Gift Relationship: From Human Blood to Social Policy*,[9] presented a scathing critique of American commercialism in medicine alongside a paean to British altruism.[10]

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5. Professor Rodwin's book focuses primarily on the conflicts engendered by opportunities for physicians to generate *secondary* income from their professional status. *See infra* text accompanying notes 23-27.

6. The weekly *AMA News*, for example, gives prominent and comprehensive coverage to issues affecting the economic well-being of its membership. For example, the front page headlines for the October 18, 1993, edition were: "Coming out of the blocks running: Mrs. Clinton starts legislative dash to reform"; "Employers aren't waiting; market clout forcing reform"; and "Beginning of the end for fee for service?" AM. MED. NEWS, Oct. 18, 1993, at 1.

7. *See generally* Patricia Day & Rudolf Klein, *Britain's Health Care Experiment*, 10 HEALTH AFFAIRS 39 (1991).

8. JOSEPH JACOB, DOCTORS AND RULES (1988) (doctors constitute a professional elite motivated by the morality of service rather than by economic reward).

9. RICHARD TITMUSS, THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY (1971).

10. Professor Titmuss compared the entrepreneurial U.S. approach to blood transfusion policy with the more altruistic British technique, in the pre-AIDS era. This landmark work documented that the U.S. practice of paying blood donors, either with money or with replacement transfusions, had corrosive effects on the quality and cost of blood for transfusion. In contrast, the U.K.'s blood collection policy depends almost solely on the willingness of donors to make "no-strings" gifts of blood. The book documented that British altruism generated a sufficient supply of higher quality blood, at far lower cost, than did the quid pro quo policy of U.S. collection

Perhaps the communitarian underpinnings of the budget-capped National Health Service (NHS) have been instrumental in generating less self-interested physician behavior. On the other hand, it may be that opportunities for U.K. doctors to advance personal over patient interests have simply been lacking because of payment mechanisms under socialized medicine. The recent British introduction of competition to the health sector provides a revealing account of physician behavior in response to changing economic incentives.[11]

Professor Rodwin begins *Medicine, Money and Morals* by defining the two major types of conflict of interest between physician and patient: those between the personal interests of doctor and patient, which are often financial (but need not be so[12]), and those which "divide a physician's loyalty between two or more patients or between a patient and a third party."[13] He also distinguishes mere conflicts from actual breaches of obligation.[14] Professor Rodwin then traces the U.S. medical profession's reaction to perceived conflicts over the course of the past century, demonstrating persuasively that organized medicine has concentrated as much on defending the economic well-being of physicians as it has on promoting the best interests of patients.[15]

The part of the book most troubling to those unfamiliar with modern conflicts of financial interest in American medicine is the section detailing current problems and institutional responses.[16] Professor Rodwin describes an astonishing array of incentives for United States doctors to advance their economic well-being by increasing or decreasing medical services. The dangers both types of incentives present for the quality of patient care are sobering.[17] Professor Rodwin then paints a disturbing picture about the inability of present law and policy to cope adequately with those dangers.

Medicine, Money & Morals could hardly be more timely in the mid-1990s, as the United States gropes determinedly for ways to control its exorbitant spending on medical services, to help finance universal access to health insurance. President Clinton obviously agrees with the regulatory thrust of the book; indeed, Professor Rodwin's work was instrumental in documenting the

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schemes. *Cf.*, Robert Solow, *Blood and Thunder*, 80 YALE L.J. 1696 (1971).

11. For background, *see generally* Frances H. Miller, *Competition Law and Anticompetitive Professional Behaviour Affecting Health Care*, 55 MOD. L. REV. 453 (1992).

12. Non-financial conflicts of interest abound in the physician-patient relationship. *See, e.g.*, A. Zuger & S.H. Miles, *Physicians, AIDS and Occupational Risk: Historic Traditions and Ethical Obligations*, 258 JAMA 1924 (1987).

13. RODWIN, *supra* note 2, at 9.

14. *Id.*

15. *Id.* at 19-52. *See* J. BERLANT, PROFESSION AND MONOPOLY (1975).

16. RODWIN, *supra* note 2, at 55-175.

17. "[P]atients need to know that virtually every major study indicates that physicians who make referrals to medical facilities that they either own or have a financial interest in, recommend more (or more expensive) medical tests and procedures than do physicians without a financial interest." *Id.* at 215 (footnotes omitted).

need for reform. The administration's 1993 budget legislation has already endorsed Professor Rodwin's views by extending the federal Medicare anti-kickback prohibitions to cover services rendered under Medicaid.[18] It has also expanded significantly the list of proscribed self-referral activities.[19]

Thus, in the brief period since this work was published, Congress has been instrumental in accomplishing some of Professor Rodwin's recommendations: that is, by "recasting social issues as legal ones . . . [as] a prelude to addressing them effectively."[20] *Medicine, Money and Morals* concludes that the medical profession is either incapable of policing conflicts of interest itself, or unwilling to tackle the problem as forcefully as circumstances demand. Professor Rodwin sees increased and more finely tuned regulation as not only desirable, but as essential.

The White House plan for health sector reform announced in the fall of 1993 takes Professor Rodwin's basic point about the detrimental potential of financial conflicts seriously, and proposes an all-payer health care fraud and abuse enforcement program as part of its strategy to enact universal health insurance coverage. The plan would punish "the payment or receipt of any item of value as an inducement for referral of any type of health care business . . . ."[21] The proposed reforms would also end medical self-referrals by prohibiting "[p]ayment to an entity for any item or service . . . in which the physician ordering services has a financial relationship . . . ."[22] The Clinton administration clearly considers minimizing the possibilities for doctors to generate income from anything but their own services to be a key element in controlling overall health care costs. Eliminating this economic incentive to prescribe unnecessary services has beneficial implications for the quality of health care as well. At the most simplistic level, unneeded medical procedures can harm patients, and the money saved by eliminating them frees up resources to provide care for those who might derive real benefit from it.[23]

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18. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312 (1993), to be codified as 42 U.S.C.A. § 1395 nn (1993).

19. These "designated health services" (for which referral is proscribed when the physician has a financial relationship with the entity furnishing them) now include clinical laboratory services; physical and occupational therapy services; radiology or other diagnostic services; radiation therapy services; durable medical equipment; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices; home health services; outpatient prescription drugs; and inpatient and outpatient services. *Id.* at 604.

20. RODWIN, *supra* note 2, at 246.

21. Health Security Act, Title V, subtitle E, §§ 5401-03; 5411.

22. Health Security Act, Title IV, subtitle A, Part S, § 4042.

23. Critics point out that the prohibitions could also sweep too broadly. In limited circumstances they might prevent doctors from prescribing needed care regardless of whether an actual conflict existed, simply because they stood to benefit financially. To deal with that possibility, the 1993 budget legislation makes an exception to its enumerated prohibitions for rural providers "if substantially all of the designated services . . . are furnished to individuals residing in such a rural area." 107 Stat. 312, at 598.

But is all this regulatory cat-and-mouse activity really necessary? Are conflicts of interest a peculiarly American problem, and does regulating perceived conflicts further undermine physicians' altruistic impulses? Could we structure our health care delivery system differently to make doctors less vulnerable to conflicts between their personal interests and the health needs of their dependent patients? A brief look at physician behavior under socialized medicine in the U.K., both before and after the 1991 introduction of competition to the National Health Service, may shed light on the answers to these questions.

I. WHY DO THINGS SEEM WORSE TODAY?

Until shortly before mid-twentieth century, physicians could provide surprisingly little in the way of effective medical treatment.[24] Ordinarily they could give their patients scarcely more than their own knowledge, skill and judgment, plus whatever compassion and empathy they could muster. Antibiotics and the modern wonder drugs were not yet available to curb surgical and other infections, so hospitals were sometimes extremely dangerous venues for sick people. The great technological advances which permit sophisticated diagnoses—and sometimes cures—in medicine were yet to be discovered.[25] Quite simply, there was not much physicians could *do* as healers that they did not do themselves. Scant opportunity existed for doctors to recommend medical tests or procedures which might generate an additional source of revenue for them. Most doctors' professional income was thus directly related to the services they actually performed. Moreover, many patients paid little for those services prior to the introduction of private health insurance during the depression era[26] and the more recent introduction of the Medicare and Medicaid programs.[27]

Even the simpler state of economic arrangements between doctor and patient that existed until well into this century was not entirely devoid of financial conflict of interest. Fee-for-service medicine, which was the overwhelmingly dominant mode of United States practice until the 1980s, entails inherent tension between a patient's legitimate medical needs and the physician's ability to increase income by delivering unnecessary medical

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24. *Cf.* THOMAS MCKEOWN, THE ROLE OF MEDICINE: DREAM, MIRAGE OR NEMESIS? (1979). In the Foreword to *Medicine, Money & Morals*, at p. ix, Dr. Arnold Relman describes the American medical care system as "formerly a community-based social service . . . ." Arnold Relman, *Foreword* to RODWIN, *supra* note 2, at ix.

25. *See generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE, ch. I (1982).

26. SYLVIA A. LAW, BLUE CROSS: WHAT WENT WRONG? (1974).

27. Medicare (42 U.S.C.A. § 1395 et seq. (West 1992 & Supp. 1993)) and Medicaid (42 U.S.C.A. § 1396 et seq. (West 1992 & Supp. 1993)) were enacted in 1965.

care.[28] The more often the patient sees the doctor, the more often the doctor gets paid.

Salaried medical practice, which has become much more prevalent in this country as pressures for managed care have increased, presents the opposite problem. Because income remains constant no matter what services physicians render, they can increase their effective rate of return by cutting back on patient treatment and maximizing their free time. Both financial reward structures tempt doctors to consider their own economic well-being in the context of ministering to their patients' medical needs. The personal financial reward is tied directly to the physician's own efforts.

Professor Rodwin acknowledges these conflicts associated with fee for service and salaried modes of practice. If doctors are to be compensated for their services at all, however, some form of economic conflict is inevitable.[29] Moreover, health insurers already utilize many managed care mechanisms[30] and other monitoring devices[31] to detect and discourage abuse arising from these basic compensation systems. Far more insidious, according to Rodwin, are the conflicts of interest engendered by opportunities for physicians to generate significant *secondary* profit from the diagnostic or therapeutic procedures they recommend their patients to undergo,[32] and by the divided loyalties created by some insurance arrangements.

The level of scientific uncertainty in medicine,[33] combined with the widespread availability of health insurance, has enhanced doctors' ability to dominate medical decision-making. Third party payment curtails patients' financial motivation to question medical advice, and information inequality between doctor and patient simply reinforces the passive patient role. Historically, third party payment has also encouraged doctors to disregard the

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28. The market share for indemnity health insurance, which reimburses patients primarily for the amounts they pay for fee-for-service medical expenses, dropped precipitously from 95% of all private health insurance sold in 1982, to 45% a mere decade later. Harris Meyer, *Beginning of the End for Fee For Service?*, Oct. 18, 1993, AM. MED. NEWS at 1, 33.

29. ALBERT R. JONSEN, THE NEW MEDICINE AND THE OLD ETHICS (1990).

30. Frances H. Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 LAW & CONTEMP. PROBS. 195, 199-207 (1988).

31. Timothy S. Jost, *Administrative Law Issues Involving the Medicare Utilization and Quality Control Peer Review Organization (PRO) Program: Analysis and Recommendations*, 50 OHIO ST. L.J. 1, 4-9 (1989).

32. For background, see Frances H. Miller, *Secondary Income from Recommended Treatment: Should Fiduciary Principles Constrain Physician Behavior? in* THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT 153 (Bradford H. Gray ed., 1983).

33. Greenfield, Nelson, Zubkoff, et al, *Variations in Resource Utilization Among Medical Specialties and Systems of Care: Results from the Medical Outcomes Study*, 267 JAMA 1624 (1992); Charles E. Ohelps, *The Methodologic Foundations of Studies of the Appropriateness of Medical Care*, 329 N. ENG. J. MED. 1241 (1993). *Cf.* LYNN PAYER, MEDICINE AND CULTURE (1988).

true costs of treatment, because the economic burden does not fall directly on either their patients or on them.[34] More recently, however, some have feared that the cost containment provisions of certain managed care systems may induce doctors to skimp on necessary treatment for their patients.[35]

Health insurance has generally diminished the necessity for physician altruism in delivering medical services, particularly since the 1965 introduction of Medicare and Medicaid, because insurance has pumped hundreds of billions of dollars into health care demand.[36] The societal need for doctors to deliver uncompensated care, or to cross-subsidize services for indigent patients with Robin Hood pricing, has thus been drastically reduced. Some contend that the guarantee of insurance payment may also have undermined the ethical norms of medicine, which once did a better job protecting patients from physicians' conflicts of financial interest.[37] If that general thesis is accurate, then the Clinton administration's proposed extension of coverage to all Americans will exacerbate conflict of interest difficulties, according to MEDICINE, MONEY & MORALS, unless comprehensive and well-crafted curbs on physician profiteering are enacted.

II. CONFLICTS OF PHYSICIAN INTEREST IN THE U.K.

The United Kingdom's health system provides a useful base of comparison for examining structural arrangements introducing new conflicts of financial interest to physician-patient relationships. Until well into the twentieth century, doctors in both the U.S. and the U.K. were compensated primarily on a fee-for-service basis, and professional practice and mores in the two countries were roughly similar.[38] As Professor Rodwin points out, when George Bernard Shaw was writing *The Doctor's Dilemma* in 1911,[39] he railed against what he considered the inherent folly of providing financial incentives for British doctors to perform individual medical acts: "That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make you despair of

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34. On the moral hazard problem in health insurance, see L. Frieberg & F.D. Scutchfield, *Insurance and the Demand for Hospital Care: An Examination of the Moral Hazard*, 13 INQUIRY 54 (1976).

35. Wickline v. State of California, 228 Cal. Rptr. 661 (Cal. Ct. App. 1986), *rev'd*, 727 P.2d 753 (Cal. 1986), *dismissed*, 741 P.2d 613 (Cal. 1987).

36. *See generally* THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT, *supra* note 32.

37. The American Medical Association's first Code of Ethics, adopted in 1847, suggests that economic conflict of interest issues concerned organized medicine more than a century ago. Ch. I, § 5.

38. *Cf.* Frances H. Miller, *The Doctor's Changing Role in Allocating U.S. and British Medical Services* (with Robert G. Lee), 18 LAW, MED. & HEALTH CARE, Nos. 1 & 2, at 69 (1990).

39. RODWIN, *supra* note 2, at 5.

political humanity."[40] Shaw championed government provision of medical services instead of private fee-for-service practice, which he found riddled with conflicts of interest for British physicians.

Since its inception in 1948, the U.K.'s National Health Service ("NHS") has constituted the world's most successful example of socialized medicine.[41] By every standard indicator of public health, the NHS has been spectacularly effective in providing good medical care for the entire population at a bargain price, notwithstanding perennial grousing about waiting lists for non-urgent services.[42] The NHS accomplishes this miracle with only 6.2% of GNP,[43] a fraction of what other western industrialized countries—most pointedly the United States—spend on the same endeavor.[44]

Approximately 32,000 general practitioners ("GPs") constitute the majority of NHS physicians, and they are independent contractors paid primarily on a capitation, rather than a fee-for-service, basis.[45] The NHS's more than 17,000 consultant-specialists are, by contrast, salaried, hospital-based doctors.[46] Until very recently, therefore, the major economic incentive created by either basic payment system was for NHS doctors to under-treat rather than to over-treat. Because the British government caps the total health service budget, neither GPs nor consultants had many opportunities to generate secondary income by ordering NHS patient care from third parties from whom they derived additional profits.[47] Thus a professional ethos oriented toward public service was consistent with economic reality.

In 1991 the National Health Service underwent radical re-structuring when the Conservative government created internal markets under the umbrella of socialized medicine.[48] Competitive forces were introduced to the NHS by

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40. GEORGE BERNARD SHAW, THE DOCTOR'S DILEMMA: A TRAGEDY 9 (Penguin Books 1987) (1911).

41. *See generally* RUDOLF KLEIN, THE POLITICS OF THE NATIONAL HEALTH SERVICE (1983).

42. *See, e.g.*, George J. Scheiber, Jean-Pierre Poullier & Leslie M. Greenwald, *U.S. Health Expenditure Performance: An International Comparison and Data Update*, 13 HEALTH CARE FIN. REV. No. 4, 1, 53, 55, 65, 67 (1992).

43. *Id.* at 4.

44. More than 14% of GNP is currently spent on the U.S. health sector. *Cf.* Uwe E. Reinhardt, Ph.D., *Regulated Fees or Regulated Competition? Implications for Young Physicians*, 269 JAMA 1709 (1993).

45. *See, e.g.*, U.K. Dep't of Health, TERMS OF SERVICE FOR DOCTORS IN GENERAL PRACTICE, paras 32-34 (Feb. 1991).

46. Karen Bloor & Alan Maynard, *Rewarding Excellence? Consultants' Distinction Awards and the Need for Reform*, UNIVERSITY OF YORK CENTRE FOR HEALTH ECON. HEALTH ECON. CONSORTIUM 100 (1992).

47. NHS physicians are, however, permitted to engage in private practice to a limited extent. Private practice is conducted primarily on a fee-for-service basis in the U.K. *See* Monopolies and Mergers Commission, *Private Medical Services Monopoly Inquiry*, App. C, Private Healthcare (July 1993).

48. National Health Service and Community Care Act, 1990, ch. 19.

separating the government's historic purchasing function from its role as provider of health care.[49] Two new categories of surrogate purchasers forced hospitals and their specialist consultants to compete for contracts to provide patient care, in an effort to stimulate more efficient delivery of NHS services.[50] These reforms presented an unusual opportunity to observe the extent to which changed economic incentives can influence physicians' actions. Most significantly for purposes of examining physician conflicts of interest, the reforms now permit those GPs having a critical mass of patients on their lists[51] to control substantial budgets for the non-urgent specialist care required by their charges.[52] These GP-fundholders in effect function as mini-HMOs, striking individualized bargains with hospitals and consultants for the sophisticated services their patients require, but the GPs themselves do not provide.

To induce these GPs to become active instruments of competition among hospitals and consultants, the government permits fundholders to plow back money "saved" from their budgets through astute contracting to improve the amenities and other services of their own practices. Fundholders cannot pocket the savings directly, but they are allowed to augment their economic status collaterally with the fruits of their bargaining for more sophisticated patient medical needs. Practices upgraded as a by-product of budgetary economies become more attractive to current and potential fundholder patients, who can usually gain access to specialist and hospital care only through gatekeeper-GPs.[53] Significant practice improvements, in addition to faster and higher quality service when that is the outcome of contracting, improve fundholders' competitive position vis-a-vis all other GPs, with whom they must vie for portions of the fixed capitation pie. These capitation payments comprise the primary source of income for all GPs, fundholding or not.

How did GP-fundholders react to these restructured economic incentives? In most cases, they responded in time-honored profit-maximizing fashion. Not

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49. For a more detailed description of the purchaser-provider split, *see* Miller, *supra* note 11, at 458-63.

50. District Health Authorities purchase specialist and non-urgent hospital care for the patients of non-fundholding general practitioners, while fundholding GPs purchase such care directly.

51. Those group practices serving at least 7,000 enrolled patients were permitted to become fundholders.

52. *See* Miller, *supra* note 11, at 460. Local District Health Authorities purchase hospital and consultant services for the patients of non-fundholding GPs.

53. The General Medical Council, which licenses U.K. physicians, states, "a specialist should not usually accept a patient without reference from the patient's general practitioner. If the specialist does decide to accept a patient without such a reference, the specialist has the duty immediately to inform the . . . [GP] of his findings and recommendations *before* embarking on treatment. . . ." [emphasis added] PROFESSIONAL CONDUCT AND DISCIPLINE: FITNESS TO PRACTICE 22 (1991). The British Medical Association strikes the same theme. *Philosophy and Practice of Medical Ethics* 13-14 (1988).

only did many of them raise the quality of patient care by driving bargains with hospitals for shorter waiting periods and more user-friendly service, but they innovated in other ways as well.[54] For example, some fundholders hired hospital-based NHS consultants directly—but in the consultants' private practice rather than their NHS capacity—to conduct specialty clinics on GP-fundholder premises.[55]

This relieved fundholder patients of the necessity to queue for NHS consultant appointments, often with the very same specialists who were now perfectly willing to see them more expeditiously while wearing private practice hats. These specialists thus responded to financial incentives permitted by the reforms exactly as economists would predict—in self-interested fashion—notwithstanding a more altruistic public articulation of professional duty. Moreover, fundholder patients requiring hospital services can now gain places on NHS waiting lists earlier, because a specialist examines them sooner than if they had to wait for a regular NHS consultant appointment.[56] Fundholders thus use NHS funds to purchase *private* consultant services for their NHS patients, who then get scheduled for NHS hospital treatment far more quickly than would have been possible without the intervening private consultation. The irony is that private market services have effectively improved the efficiency of publicly-financed health care.

Before long, some GP-fundholders latched onto the idea of forming private companies to supply ancillary services to their own practices, paid for from the fundholding budgets that they themselves controlled. Thus, some British GPs began to capitalize on the possibility of generating secondary income from the treatments they recommended for their patients by becoming shareholders in the companies furnishing those very services. In essence, these entrepreneurial fundholders responded to changed economic incentives by strategically altering their business arrangements to increase personal income; some of them are reported to have reaped a "windfall."[57] Little empirical data exists on whether patients were deprived of necessary care when these fundholder surpluses were generated, but preliminary evidence indicates that they were not. The government may simply have set fundholding budgets at too generous a level initially, in order to stimulate sufficient GP enthusiasm for fundholding to give the reforms momentum.

The British government responded to the clash of economic interest it had set in motion not by tinkering with the economic incentives, but by regulating

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54. *See generally* Howard Glennerster et al., *A Foothold for Fundholding*, 12 KING'S FUND INSTITUTE (1992).

55. P. Pallot, *GPs Hire Specialist Help*, THE DAILY TELEGRAPH, May 16, 1991, at 2.

56. John Willman, *The Doctors' Dilemma—John Willman Takes the Pulse of the Changing U.K. General Practitioner Service*, FINANCIAL TIMES (LONDON), Mar. 31, 1992, at 15.

57. Alan Pike, *Government May Curb Spread of GPs Companies*, FINANCIAL TIMES (London), Dec. 10, 1992, at 8.

the conflicts. In other words, having adopted competition principles as a successful stimulus to efficiency, at least preliminarily, the NHS then resorted to regulation to contain the conflicts fanned by the newly competitive environment. As of April 1, 1993, the NHS no longer approves contracts with private companies providing health care if GP-fundholders receive direct or indirect payments for treatment the company delivers to fundholder patients.[58] This sounds very much like the prohibitions on self-referral which President Clinton proposes for all payors in the context of current United States health sector reform.[59] It also signals that the market forces unleashed in the U.K. in 1991 have been seductive enough to undermine the allegedly higher service ethos of at least some British physicians.

III. CONCLUSION

What do we learn from this brief examination of comparative economic incentive systems in health care? What does it tell us about medicine, money and morals? First and foremost, it confirms what most of us instinctively suspect anyway: that Professor Rodwin's evidence and analysis are basically correct. *Medicine, Money & Morals*, and the impact of competitive forces introduced to the U.K.'s National Health Service in 1991, both illustrate dramatically that economic self-interest exerts a powerfully seductive influence on professional behavior. It would thus be unwise to rely on professional self-restraint to forestall abuse, regardless of the articulated professional ethos.

Health policy planners and legislators should therefore pay attention to what Professor Rodwin suggests. They should analyze the economic incentives generated by physician payment systems meticulously, particularly when those payment mechanisms are mandated by government. If we are to embrace the principle of universal health insurance coverage, yet avoid investing massive new resources in the health sector, reform must be structured to minimize the potential for excessive private gain at the expense of cost-effective medical care. Professor Rodwin reminds us that money talks to American physicians, as it does to their British counterparts. We must be very careful about the message it sends.

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58. HEALTH CARE DIRECTORATE, NAT'L HEALTH SERVICE, HSG(93)14, GP FUND-HOLDING PRACTICES: THE PROVISION OF SECONDARY CARE, Annex. A, 5 (1993).

59. *See supra* note 22 and accompanying text.