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FROM THE EDITOR

Medicine and the Market

Unlike in countries with nationalized or restrictively regulated health care systems, the United States' system is embedded in and based on a capitalist, market-based model. Market forces, including the profit motives of corporate interests such as insurance and pharmaceutical companies, have a significant role in shaping the provision of medicine in the United States. They have significant effects on individual practitioners—in their medical education years and in their practice years—and on patients—in their ability to access, afford, and choose care—as well as policy, through industry lobbying efforts. Our contributors examine and elucidate these effects in the August 2015 issue of the *AMA Journal of Ethics*.

Corporate interests begin shaping physicians' practice as soon as they begin their education. In a case commentary, Ashvini K. Reddy, MD, explores the effect of donated surgical equipment on the future business practices of medical students, who can form a lifelong preference for and loyalty to the systems they train on. Recognizing the early appearance of business issues in medicine, the Bander Center for Medical Business Ethics works to instill in students ethical business decision making. As Erin L. Bakanas, MD, and Tyler A. Zahrli explain, its most recent endeavor in that direction is its new casebook, available for free on the Bander Center website.

Once physicians get into practice, pharmaceutical companies vie for their business; though much of the wining, dining, and gifting that were once standard is now prohibited, companies still seek to pitch to and form relationships with physicians. David F. Essi, MA, contributes a piece on commonplace violations of Food and Drug Administration guidelines for pharmaceutical speaker programming at restaurants. In his case commentary, Shahram Ahmadi Nasab Emran, MD, MA, gives readers guidance about meeting with pharmaceutical company representatives and parsing the information they present.

Pharmaceutical companies affect not only physicians' prescribing practices, but also which drugs are developed, how much they cost, and their availability in ways influenced by financial motives. Taeho Greg Rhee, AM, gives an overview of the Orphan Drug Act's incentive for companies to develop treatments for rare diseases and what progress still needs to be made. I review a statement on the high and increasing prices of drugs for chronic myeloid leukemia, which the authors, experts in the field, strongly object to. Tobin Klusty explains the recent court case *State of New York v Actavis*, which determined that the practice of "product hopping," or introducing a new formulation of a patented

drug just before its patent expires, thereby restarting the patent “clock” and preventing generic competition, is anticompetitive.

Insurers, too, of course, have their own bottom lines to consider. The Affordable Care Act (ACA) has done much to curtail insurer business practices that harm patients. Sandy H. Ahn, JD, LLM, reviews the new regulations of insurer business practices that the ACA put in place to promote access to care, affordability, and adequate insurance coverage.

Concerns about the bottom line also affect what hospitals charge patients and their insurers and how they collect those fees. Erin C. Fuse Brown, JD, MPH, discusses the gaps in current legislation that fail to prevent for-profit hospitals from engaging in predatory billing and bill-collection practices; she suggests making the preventive restrictions apply not only to nonprofit hospitals but to all hospitals that participate in Medicare. In the podcast, interviewee Peter A. Ubel, MD, discusses factors contributing to the high cost of health care and the compatibility of cost containment and profit seeking.

Another way of protecting patients from unpayable hospital and health system prices is discussed by Gerard Anderson, PhD, and Bradley Herring, PhD: all-payer rate setting, in which all insurers pay the same price for each individual service or treatment, rather than each paying different rates. This would reduce costs by drastically reducing the complexity and administrative needs of the system, give insurers the bargaining power to keep prices lower, improve access to care, and make costs more transparent to patients.

Several situations in which physicians’ own bottom lines may create conflicts of interest—dispensing of products in the clinic and self-referral—are discussed in this month’s code excerpt. In his piece, Eli Y. Adashi, MD, MS, takes a big-picture look at the relationship between financial gain and healing throughout the ages.

The fact that our health care system is market based is the background against which all medical ethics issues play out in the United States. Too often this leads us to take market-based ethical problems for granted. We hope that this issue of the *AMA Journal of Ethics* will spur readers to consider them anew.

Hannah L. Kushnick, MA

Senior associate editor, the *AMA Journal of Ethics*
Chicago, IL

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