# Ethics in the Marketing of Medical Services

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## Abstract

This paper deals with the ethics of marketing medical services by physicians, medical groups, hospitals and other mainstream medical caregivers in the United States. It does not deal with pharmaceutical marketing, since that raises a number of special issues, some of them legal and some having to do with the unique culture of pharmaceutical marketing, which really ought to be dealt with separately. Nor does it touch on the little-explored field of marketing alternative and complementary medicine. It begins with a general description of what is included in "the marketing process." It then briefly tours some of the difficulties faced by those who would market medical services ethically, and ends with some comments on the relevance of professionalism to ethical marketing.


**Key Words:** Professionalism, medical marketing, market competition, health care, product, placement, price, promotion, ethics.

### Marketing 101: The Four P's

Most of us are apt to associate the idea of "marketing" with promotion and advertising. But in fact, "promotion" is only one of the famous "four P's of marketing" taught in most business schools.

The first step in any marketing plan is to determine the nature of the *Product* (or service) one wishes to sell. Next, one determines its *Placement*, the distribution channels through which the product or service can best be made available to the consumer. Then, one attempts to determine the *Price* at which the product or service will be both profitable to the seller and attractive to the target consumer—e.g., should this be sold cheaply, as a "loss-leader," or at a steep markup as a luxury item? Finally, one plans the *Promotion*—where and how to advertise. Each of the four P's raises its own characteristic set of ethical questions. *Product* raises questions about product safety and efficacy; *Placement*, about the use and abuse of power within distribution channels; *Price*, about fair pricing, consumer access to goods and services, and the relationship of price to quality; and *Promotion*, about honesty, deception and exploitation in advertising and sales.

### Product

There is cause for profound concern about certain "products"—the medical services—that mainstream medical caregivers sell. In spite of the writings of David Eddy (1) and Archie Cochrane (2) on evidence-based medicine, and decades after John Wennberg's initial demonstrations of small-area variations in medical practice (3), many medical services are still not adequately based on science. The first step in medicine's ethical marketing plan must be to continue and expand upon the current efforts to determine which medical services truly are effective. It is surely an ethics violation to sell a service, under false pretenses, to patients who would be better off without it.

On the other hand, there are a number of recent innovations in the "product" area that seem to be morally unproblematic and may even enhance the efficiency and efficacy of medical

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service provision. These involve bundling—or unbundling—of medical services. Hospitals and physicians have bundled services through physician-hospital organizations, in order to deliver more efficiently integrated packages of medical services to insurers and those whom they insure. Some physicians have formed large multi-specialty groups for the same reason. And other physicians have formed disease- or specialty-specific group practices, both in order to deliver their services more efficiently and in order to foster patient disease-management groups. In the last decade, hospitals have also been "unbundling" services that have traditionally been part of general inpatient care, and spinning them off into lower-cost entities (such as ambulatory surgical centers) or specialty hospitals.

The impetus for much of this bundling and unbundling has been economic; these innovations are designed to maximize payment and minimize costs associated with contracting for and delivering various services. But there can be genuine efficiency and quality gains from service-bundling. Specialty groups can gain experience and expertise, and provide coverage with relative ease. Physician-hospital organizations and multi-specialty practices can make intra-group referrals and consultations easy, and they can minimize the transaction costs of contracting with payors and patients. These are real gains.

## Placement

Placement refers to the "distribution channel" aspect of marketing: By what avenues will consumers gain access to the product or service? A certain amount of medical service placement is done by medical caregivers themselves, as when, for example, an urban hospital decides to set up a suburban outpost for the convenience of its patients, or when a physician group opens a walk-in clinic at the mall. But in the United States, the primary mechanisms of placement in health care are those tied to insurance coverage. Patients gain access to medical services through a number of distinct pathways dictated by the nature of their insurance coverage (4). The primary distinction here is between those who obtain their health care through private insurance and those who obtain it through government programs. There are subdivisions within each of these basic categories—and then there are the uninsured. This section gives a brief overview of the main distribution channels for health care, drawn largely from the work of James Robinson (4); it then explores the two major kinds of ethics problems connected with marketing through these distribution channels.

Among the insured, self-employed individuals and employees of small firms commonly seek health services through Blue Cross and Blue Shield (BCBS). To attract their wide variety of small customers, BCBS needs broad networks of physicians, health care institutions and allied health professionals, and substantial contacts with the insurance brokers through whom smaller insureds obtain their policies. BCBS also needs to supply brokers with marketing materials about the coverage they offer, and has to work with them to support existing contracts.

Larger employers sometimes use BCBS, but more often they insure their employees through indemnity plans, or use insurers to administer self-insured plans. (Public employees and unions, by contrast, often contract with HMOs.) Large single buyers have the purchasing power to create more exclusive, less diverse networks of health care providers, as well as the power to offer their employees quite limited network choices. This gives them the opportunity to make demands of providers regarding quality of care and to cost-control. (By contrast, BCBS can make fewer such demands, because their priority is on maintaining a large, open network for their diverse small-customer base.) Large employers also have no need of broker contacts, since their contracting and claim-servicing are conducted by in-house personnel departments.

The major distribution channel for medical services is Medicare. There is comparatively less need for marketing within the fee-for-service part of Medicare, since everyone over 65 is covered and almost all hospitals and physicians (at least among the relevant specialties) take Medicare patients. (There is room here, however, for promotion efforts to attract seniors to particular Medicare physicians; these are discussed below.) Such Medicare HMOs as can survive the relatively low governmental compensation rates compete with one another by offering extra services, especially to seniors who lack private Medigap insurance. Medicare HMOs market their services directly to seniors, through senior centers or in personal sessions.

State Medicaid and State Children's Health Insurance Programs (SCHIP) services are woefully ill-marketed. Perhaps because reimbursement is so low and costs to state budgets so

high, very little is done to draw eligible recipients into the benefits channel. Neither state Medicaid programs nor SCHIPs have succeeded in enrolling all the adults and children who are eligible for those programs. This leaves over a third of the poor uninsured (5).

The four major distribution channels for health care, then, are: small-group and individual insurance, dominated by brokers; large employer insurance, dominated by personnel departments; Medicare, where limited competition for placement takes place mostly in small meetings; and Medicaid, where special outreach programs enlist—or fail to enlist—eligible patients (4). These distribution channels raise two major kinds of ethics problems, problems of agency and problems of access.

Agents are generally obligated to act in the interests of their principals. Agency problems arise whenever an agent has personal interests that are not well-aligned with his principals', and which therefore threaten to lead him to act contrary to his obligation. In the above schema of health care distribution channels, the principals are the health insurance consumers. Brokers are their customers' agents for the purchase of health insurance, but they also have interests that run counter to their customers' interests. For example, brokers are interested in making a sale even if the products they sell do not fit well with the customer's needs, and they want to maintain a good reputation and relationship with large insurers even when those insurers treat customers badly, and so on.

The large-employer distribution channel has the most difficult-to-manage agency problems. Employers in this scheme serve as their employees' agents for the purchase of health care coverage and the selection of health care professionals. Often, however, employers' and employees' interests are only imperfectly aligned. In theory, employers should have every reason to desire high-quality health care for their employees. Such care reduces absenteeism, increases employee satisfaction, enhances recruiting ability, and reduces the amount of time spent by the personnel department in managing complaints. Similarly, employees should have strong interest in cost-control, since they would prefer to minimize the total percentage of their salary/benefits package that is earmarked exclusively for health care coverage—coverage for which they may not have much use. Nonetheless (perhaps because employees have personal experience relating to quality of care, while employers have better information about firmwide health care costs), employers often end up placing more emphasis on a provider's record of cost-control than on its quality, its communications skills, or its convenience for employees. In addition, in-house personnel departments have an interest in resolving problems swiftly and in using their employees' time efficiently. This can sometimes run counter to their obligation, as agent to pursue employees' claims disputes vigorously. Finally, employers have an interest in minimizing the transactions costs of shopping and contracting, and this may conflict with the interest of employees in transferring from a health plan with which they are dissatisfied.

There is no general solution to such agency-related ethics problems. These problems may be limited by the introduction of financial incentives to keep agents' interests aligned with principals', of monitoring and oversight measures to catch instances when agents act badly, and of bonding by agents to assure their fidelity to principals' interests. But the crucial factor here must be the agent's moral commitment to pursuing the interests of the principal even when it conflicts with his own.

Access issues are, of course, raised most dramatically in connection with the uninsured, who remain outside all of the main distribution channels for medical care. The broad social-justice problems of non-coverage are beyond the scope of this paper, but it is certainly appropriate to note here the ethical failure of marketing in the Medicaid/SCHIP channel. There has been widespread failure at the state level to engage in sufficient outreach, so that the eligible poor actually enroll in publicly supported programs. This has real health costs for those who remain uninsured. It also has long-term political costs, since it contributes to a misunderstanding of the finances of public health care and helps present a falsely reassuring picture of the availability of publicly funded health insurance to the poor.

## Price

The ethics of pricing in the market for medical services are decidedly complex. In thinking about medical service pricing, we must begin by noting that a very large proportion of all medical services supplied in the United States are supplied at prices that are set politically, through the Medicare and Medicaid programs. Over the last decade, competing spending priorities, revenue shortages, and the desire to force adoption of better cost-control measures have

all led governmental programs to place sharp limits on payment for medical services. The American Hospital Association notes that about 57% of hospitals lose money on Medicare inpatient services (6); the American Medical Association, using data drawn from government sources, estimates that physicians' Medicare reimbursement rates have slipped 14% against their costs of supplying services since 1991 (7). Such limited reimbursement is in fact to be expected from government programs. Given their very large market share, their budgetary interests are best served if, on average, they pay health care providers just enough to cover their fixed costs and overhead, but not enough to cover their full costs of providing services. Pricing at this level should assure that providers continue to take program patients (since seeing program patients, and covering only fixed costs, is less expensive than seeing no patients and covering none), but will also keep program costs to a minimum. This reimbursement scheme creates an instant fairness problem, since the shortfall on program patients has to be made up in the price set for non-program patients.

Most non-program patients are insured, either by their employers or by health insurance companies. Prices for the medical services they buy are commonly set by the market, in negotiations between insurers and health care providers, and between insurers and insureds. The intensity of price negotiation, and therefore of price competition between providers seeking contracts, has undoubtedly risen over the last several decades, first with the cost-cutting pressures of the 1980s and again with the managed care revolution of the mid-1990s. Though fierce price competition is normally considered beneficial for consumers, since it assures that goods and services are delivered to consumers at something close to their cost of production, there are a number of important grounds for worrying about possible ill effects of price competition in the health care sphere.

Here it is worth recalling that, until the early1980s, physicians' and hospitals' ethics rules imposed strong limits on advertising, and on price competition in particular (8). Advertising was widely considered degrading to the profession of medicine, and price-advertising was considered downright dangerous. (Similar norms obtained for the practice of law.) The application of federal antitrust laws to the medical profession abolished many of the formal ethics rules relating to price advertising (8), but a strong social norm against such advertising lives on. The cynical view of this history is that we are well rid of those so-called "ethical standards," since they were not based on ethics at all, but were rather a means of creating a cartel by limiting competition and facilitating price-fixing among medical service providers. But there is a non-cynical argument to be made in favor of such ethical restrictions. Let us turn from history to theory.

It is probably true that few of us really know whether the medical services we have received are of high or low quality. We can be more or less satisfied with a medical outcome, but we cannot dependably convert our satisfaction into a sound judgment about the quality of the service we received. Excellent care can result in poor outcomes, given our mortal nature and the unpredictability of illness. Poor care can result in fine outcomes, given the resilience of the body and the self-limiting nature of much disease. If high-quality care costs more to provide, and if quality is difficult or impossible for consumers to detect, then fierce price competition should have the tendency to drive out high-quality care. Neither insurers or insureds will be willing to pay extra for "quality" that they cannot observe.

Another important problem with price competition in health care is that, as a matter of social policy, we seem not to want what effective price competition normally gives us, namely, a wide range of quality available at different prices. Part of the function of price, in a competitive market, is to signal quality. We expect that $15 watches will not work as well, or last as long, as $200 watches. Yet we are happy to have both kinds of watches on the market. We are not, it would seem, similarly happy with the idea of having low-cost, low-quality health care available in the market, side by side with high-cost, high-quality health care. (There is no doubt that we do have such a cost/quality scale in our current medical system, but public and critical sentiment runs, for the most part, against it.) Fierce price competition drives down the margins of health care service provision, and one use of those margins, historically, has been to cross-subsidize medical care for the poor, allowing even those who cannot afford its actual cost to receive something approximating the highest quality care.

A final difficulty with price-competition in health care is that pervasive governmental and private health insurance virtually guarantees that prices are set at one or more removes from the actual patients who, in consultation with

their doctors, make the final decisions about which health care services to buy. Patients are seldom aware of the cost of the services they purchase, and neither in the public nor in the (tax-subsidized) employer-insurance systems do patients bear, via their premiums, the entire cost of their medical risks, let alone the entire cost of their actual purchases. The virtue of the market-competition mechanism is supposed to be that it allocates social resources to those who value them most. But price competition that takes place only in narrow portions of a market otherwise pervasively distorted by tax subsidy, lack of information, political price-setting, and the economics of insurance, cannot be delivering on that promise.

These three reasons (the threat of price competition to quality in markets where quality is difficult to perceive, the tendency of price competition to create multiple tiers of quality, and the inefficacy of isolated price competition in otherwise distorted markets) offer theoretical support for a professional reluctance to embrace price-competition. The difficulty here is that, at least for the privately insured portion of the health care market, price competition is favored by American public policy. Neither hospitals nor physicians can avoid it.

## Promotion

We turn, finally, to Promotion. The single most striking fact about advertising for medical services is that there seems to be very little of it. This is particularly surprising, given our evident willingness to spend a great deal on such services. It stands in marked contrast to the wealth of advertising for medical products (especially patented drugs), and for health-related products, from "nutriceuticals" to ab-flattening machines. Not surprisingly, the medical services which seem to attract the most advertising are elective procedures: hair transplants, liposuction, plastic surgery, laser surgery for vision. On one level, the reason for this is obvious. Demand for fuller lips can be created by advertising, while only cancer can create demand for oncological services. But, given the near-inevitability of serious illness for each of us, and the dependably high prevalence of at least certain kinds of illness in the population, one must still marvel at the paucity of advertising for medical services. The only explanation for it, I think, lies with continuing professional norms against advertising directly to patients (about which, more later).

Of course, a great deal of promotion takes place out of the public eye, between businesses within the health care system: group practices and hospitals promote themselves to insurers, health plans promote themselves to employers, and so on.

The business ethicist David Holley has argued that a sale, to be mutually beneficial to buyer and seller, must be based on a purchase decision that is well-informed, unforced and rational (9). Promotional tactics that interfere with any of these three decision-conditions are unethical. Thus, advertisements that are untruthful or deceptive are unethical because they induce consumers to make poorly informed decisions. Threats and the abuse of unequal bargaining power are unethical when they force people into purchases they do not want. And it is of course unethical to sell anything to someone who temporarily or permanently lacks the capacity for rational judgment.

(I note in passing the strong resemblance of Holley's "conditions for uncompelled exchange" to the Catholic moral tradition's description of human acts—those for which we are morally responsible. Human acts are those that are voluntary, knowing and free (10). A purchase by one temporarily incapacitated by grief would be involuntary; a forced sale would be unfree; a sale based on deception would be unknowing.)

In most cases of the "business-to-business" promotional activity briefly mentioned above, the ethical analysis will be straightforward. Following Holley, we may state that all such promotional efforts are ethical if they are truthful and non-deceptive, if they are not coercive, and if they are targeted at persons with full capacity.

Advertising becomes slightly more problematic when it is aimed directly at the proposed consumer of medical services. Here we face greater risks. Individual patients or their family members may need to make decisions about medical purchases when their capacity has been diminished by shock or fear or depression. Marketing tactics that take advantage of this vulnerability are clearly unethical. Patients may be subject to unethical coercion by providers who abuse their position of power, or by payors who force them to accept one treatment option over another. Yet, though these ethical dangers are real, the more analytically complex problems have to do not with rationality or coercion, but with information and the patient's state of knowledge.

At the level of institutional advertising for medical services, we need to consider the dis-

tinction between untruthful advertising and deceptive advertising—for an advertisement may be both entirely truthful and deceptive. Particularly in the health care arena, where accurate measures of quality are hard to come by, it turns out to be surprisingly difficult to say anything true, concrete and specific about the quality of care supplied by any given provider that is not also in some way deceptive. A provider can easily engage in stock "puffery"—"We deliver high-quality care at a reasonable price." But the difficulty arises when it attempts to recite actual facts to back that puffery. "We have the lowest death rate of any hospital in the city"—true, but deceptive, since the higher death rates may belong to more sophisticated hospitals that attract more intractable cases. "We conduct the finest cancer research of any facility in the world"—true, but deceptive, unless research somehow translates into quality of bedside care. "Our physicians are all board certified specialists"—true but arguably deceptive, since most listeners do not know what board certification involves, and board certification is in any case no guarantee of quality of care, bedside manner, and so on. The sheer complexity of medicine, and of the quality measures it has available, virtually guarantees that any statement about quality that can fit comfortably in a popular advertising format will be deceptive, because it can only be a partial truth.

In general, it is much harder to become an informed purchaser of medical services than it is to become an informed purchaser of a peach, an automobile, or even a house. Most of us are not frequent purchasers of serious medical services. Except in the case of elective procedures, there is commonly very little time in which to explore our options. There are few *Consumer-Reports*-like sources of unbiased, useful information about medical services. In many cases, we simply feel too ill to spend much energy on comparison shopping or information gathering. Any marketing behavior that takes advantage of this common lack of information, any pressure toward more remunerative treatment options, for example, is unethical.

The traditional solution to this problem of patient knowledge has been for the patient to depend upon a physician as his or her agent for the purchase of medical services. In the paradigm case, the primary care physician examines the patient and then makes a recommendation about what kinds of further medical care the patient ought to purchase. The recommendation may be for additional care or examination by the primary care physician himself, or for specialty care, or for a prescription drug, or for an inpatient stay. The patient relies upon her physician to make purchasing decisions in her best interests, thus cutting out much of the need for advertising to inform patients about available medical services.

This system creates obvious conflicts of interest. Because the physician is the patient's purchasing agent for services that the physician may, himself, profit from selling, he has a personal financial interest in recommending purchases that the patient does not really need. Alternatively, he may recommend services that will not profit him, but that will profit others whom he has an independent interest in pleasing: partners in a practice group, specialist friends, institutions with which he has a long-term affiliation. Some of these conflicts are alleviated by such devices as the second opinion, utilization review, regulations prohibiting physician referrals to facilities in which the physician has financial interests, and regulations prohibiting payments or kickbacks for referrals. But some of these conflicts may be more intractable.

## Professionalism: The Fifth P of Medical Marketing?

Medical marketing, then, is full of ethical pitfalls. There are ethics problems with the nature of the medical *product*; fairness and quality problems with the nature of *pricing*; agency and access problems with *placement*; and problems involving deception, lack of information and conflict-of-interest in *promotion*. Where can medicine turn for solutions to these pervasive problems? I believe, perhaps too idealistically, that medical *professionalism* can help—indeed, that *professionalism* should be the fifth P of medical marketing.

What is medical professionalism? As I have already described one version of the doctrine of medical professionalism in this journal and elsewhere (11, 12), I shall offer only a brief summary here. Importantly, the doctrine of professionalism is aspirational; it is a normative description of what medical professionals' motives ought to be, and of how they ought to act, rather than a positive description of how they or their professional institutions have in fact acted in the past. To say that physicians may have occasionally acted badly in the past is thus not to deny the truth of the doctrine of professionalism, but to accuse physicians of having sometimes failed to live up to it.

In short, medical professionals mediate between society and their individual patients, helping on the one hand to restore the sick to social usefulness and dignity, and on the other to advocate for individuals against social norms that are sometimes intolerant of illness. To sustain this mediating function between individuals and society, medical professionals must cultivate a particular set of motivations. The medical professional is motivated primarily not by the desire for wealth or power, but by the desire for public respect and trust, and for a reputation among his or her peers for excellence. (Wealth-motivation could lead to the "capture" of professionals by wealthy private interests; power-motivation could lead to their capture by society through politics; either of these would pull them from their proper mediating function.) The institutions of professionalism (schools, societies, publications, medical staffs, codes of ethics, etc.) are designed to cultivate and reinforce the appropriate motivations. They offer professionals venues in which to pursue, display and celebrate their learning and skills, and to reaffirm their values, both before one another and before the public whose trust and respect they seek to earn.

How might the fifth P address some of the problems of medical marketing? First, with regard to *product*, norms of professionalism can encourage the scientific improvement of medical services, and spur experimentation with different bundles of services; professional institutions should disseminate such improvements and celebrate the researchers who develop them. With regard to *price*, professionalism can serve to counter some of the pressures created by price competition. A professional who is primarily motivated by the desire for excellence rather than by the desire for wealth can (at some personal cost, and within limits set by economic realities) deliver high-quality care even when the price charged does not reflect that quality, and even when the buyer cannot detect it. Similarly, a strong professional ethic can minimize the tendency of price-competition to create different quality levels.

With regard to *placement*, medical professionalism can encourage the provision of free care to those outside the existing distribution channels. A successful professional association—one that has gained the public's trust and respect by being associated with excellence and professional values rather than with pocketbook issues or political struggles—could also engage in meaningful lobbying to improve the public's health, both through increased access to health care and by other means. Finally, with regard to *promotion*, a professionalism concerned with earning the public's trust would limit the use of deceptive-though-true advertising, and would, moreover, minimize the degree to which physicians take advantage of their patients in conflict-of-interest situations.

There are those who will dismiss this idea of "professionalism as the fifth P" as hopelessly naive and unrealistic, but such naysayers actually do not have a very persuasive set of arguments on their side. They can point to the many instances in which physicians, hospitals, and professional associations have failed to live up to the professional ideal, and have been manifestly motivated by greed or by the desire for political power—but that is an argument for reinvigorating professionalism, not for dismissing it. They may dismiss any number of professionals' laudable acts as mere superficial bids for respect or reputation—but such dismissal forgets the deeper truth that the surest way to gain respect is to earn it, and that the safest way to build a reputation for excellence is to be excellent. They may deny that professional institutions could ever affect the motivations and actions of persons so deeply as to counter the human desire for money and power—but here they replace the wisdom and experience of institutional conservatism with a simplistic economism.

Medical services need to be marketed. But they need to be marketed in a way that does not deliver unnecessary or harmful care; that does not leave people vulnerable because of their lack of medical information; that does not contribute to the unfairness in distribution of health care services; that does not sacrifice quality of care to the competitive fray. An ethic of professionalism can help.

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