The Medical Industrial Complex

Howard P. Rome, MD

The emergence of what is now called the medical industrial complex requires for its analysis a review of its historical origins rooted in the social institutionalization of hospitals. Hospitals themselves are latterday derivatives of ancient sites where purification ceremonies and healing rituals were performed. Thus, the very expectation of beneficence endowed these places with the aura of sacredness seen as an attribute of religio-magical, devinatory powers. In successive ages when progressive moves to secularization divested these places of the actual presence of other-worldly powers, they still retained the disembodied spiritual forces which were invoked in behalf of the persons who sought healing and succorance. Thereby, therapy became the human instrumentality of healing rituals and the process conferred its agents and agencies with curative powers as well. Physicians are its present-day legatees, their ministrations and medications that constitute their prescriptions vouchsafed their potency. The social institution of medicine in one or another of its many variant forms can be traced in every culture. Although its form takes many guises, its procedures reflect both the spiritual and substantive attributes of what is highly prized.

In our time, there are only totemistic remnants of this sacred heritage. Physicians, upon graduation, still swear by the oath of Hippocrates. Hospitals, as places of healing, once largely the tangible expression of religiously motivated acts of charity given in response to the biblical admonition to heal the sick and care for the suffering, have been gradually replaced by non-religious philanthropic foundations and more recently by community enterprises and, lately, commercially inspired for-profit institutions.

This is not to say that over this long stretch of time the caring humanitarianism, which was its sole motivation, has been entirely changed incidental to its successive reorganizations. Doctors and hospitals are still dedicated to serve their patients and the constituent communities which seek their help. Rather, the point is that all social institutions necessarily are structured in accordance with the requirements of the society of which they are an integral part. It is obvious that an important social institution such as medicine reflects in its structure and operations the prevailing economic and social attributes of the population which it serves.

Inherent in the very structure of the corporate practice of medicine is its potential industrialization. The aggregation of like forces with its increased efficiency of production and reliance on the advantage of division of labor, is clearly seen in the history of mercantilism. Its entrepreneurial manifestations in factory production of tangible products is comparable to cooperative alliances dedicated to facilitating service needs of progressively larger populations.

It was only a matter of time when the cost-benefit of this commercialization would be taken as a model to be applied to the last bastion of resistance to an outright adoption of an overt commercial posture.

There were many foreshadowings of this. The development of medical specialization reflected the advances of human biology as well as other aspects of the human condition. Increased information led to increased concentration and the inevitable compartmentalization of clinical services. In turn, it was an obvious next step to contrive an affiliation among physicians who saw the utility of sharing their compartmentalized expertise for the betterment of their collective service to their patients. This was group practice. Its development and increasing professionalization made necessary a comparable level of professionalization in its managerial services. At the same time, the hospital and its personnel as well as its physical organization were undergoing changes. These ranged the entire gamut of the needs of inpatients in the division of labor of nursing services and the allocation of specially designed physical units to better care for and treat the unique problems of medical, surgical and psychiatric patients.
The pros and cons of the dramatic change in the commercialization of the structure of medicine has led to heated debates.

The mushrooming growth of technology required the inclusion of specially trained non-medical experts in the delivery of total health services; in group practices as well as in primary, secondary and tertiary hospital facilities. In much the same way, the health insurance industry grew and expanded.

A significant role in this history of social institutional change is played by all echelons of government. Government’s paramount function is to superintend the potentially conflicting forces that arise in every organized society. Indeed, as far back as colonial times, governmental powers construed their social controls in a more extensive context. Thereby, its province was extended to the provision of those needs which would not only preserve but enhance the health and welfare of its citizens. These more extensive operations continued to proliferate, over a long period of time, from the initial regulations concerning the quarantine of the infectious diseases to current subsidy for basic research and clinical education. It is needless to further document the details of the ramified extrapolations of the welter of other domains that now encompass the seemingly endless expansion of those activities which constitute health care and services.

The growth of industrialization was dependent on the cooperation of its work force. The purpose of unions was and still remains, the protection of the worker’s rights. An essential part of management/worker benefits includes the cost of health services. This entitlement was extended from laws governing Workmen’s Compensation to postretirement health benefits. In 1935, the Federal Government’s role in these activities was incorporated in the new Social Security legislative enactments. These were further extended by the Medicare-Medicaid amendments and Social Security Acts in 1965.

As long as the economy appeared to afford medical care on a nationwide scale, we acted as if there was an infinite capacity to provide what was needed to better serve our collective health needs; the progressively increasing cost for this provision was taken to be a secondary consideration. However, economic stringencies necessitated drastic cutbacks in the funding of health and welfare services. In the past 4 years, the nation’s health enterprises have undergone draconian curtailments by the Federal Government. At the same time, philanthropic contributions have been sharply decreased. The result is that hospitals and clinics, as well as medical education and research, now confront serious budgetary deficits. These structural changes in the economics of health care culminated the growth of the newly emerging medical-industrial complex. The financial base of these operations, heretofore supported by governmental funds and philanthropic bequests, obviously required a new funding source. This need was seen as a potentially profitable commercial enterprise by expert managerial groups possessed of capital resources and technological know-how.

The pros and cons of this dramatic change in the commercialization of the structure of medicine has led to heated debates. The Editors of Psychiatric Annals are very pleased to offer in this issue documented evidence which presents empirical data on this controversial subject. Reasonable judgments can be made only when they are based on factual accounts of the issues that are explicit in this revolutionary change in medicine.