The NEW ENGLAND JOURNAL of MEDICINE

Perspective

AUGUST 7, 2025

THE CORPORATIZATION OF U.S. HEALTH CARE

A Gilded Age for Patients? The Broken Promises of Profit-Driven Medicine

Nancy Tomes, Ph.D.[1]

In mid-January 2025, J.P. Morgan held its annual health care conference for biomedical investors. Widely covered in the financial press, the conference conveyed optimism, highlighting great investment opportunities in gene and cell therapies, artificial intelligence (AI)–powered digital health solutions, and medical robotics. Attendee Juergen Eckhardt, who leads Bayer's impact investment unit, summarized: "It's clear the industry is at a pivotal moment — a golden age for patients, marked by unprecedented innovation."[1]

The previous month, UnitedHealthcare chief executive Brian Thompson had been murdered in what appeared to be an act of protest against the health insurance industry's denial-of-claims practices. Polls revealed that many Americans, while disapproving of the violence, also expressed frustrations with the insurance industry.[2] Commentary on Thompson's murder contrasted sharply with the "golden age" rhetoric of the financial pages, emphasizing the profit-driven U.S. health care system's market failures in distribution and access to health goods, which have brought poor health outcomes and declining life expectancies.

These apparently contradictory perspectives are two sides of the same set of historical developments. Between the 1920s and the 1960s, the American medical profession adopted a new doctor-controlled business model of care delivery, dependent on continual investment in new drugs, technologies, and procedures. That model created the profit opportunities that enticed corporate stakeholders to invest in health care in the 1970s and 1980s. But as the corporate presence increased, physicians lost control of their business model; the "tail" of financialization began wagging the "dog" of medical practice. That shift coincided with corporate cooptation of the language of consumerism to justify these changes as in patients' best interests. In the process, physicians and patients lost economic autonomy over health care choices.

Understanding today's corporatization requires seeing it from this historical perspective. Starting in the 1920s, the medical profession adopted a new business model that its leaders deemed better suited to the U.S. economy. But

unlike other dominant sectors, such as heavy industry and consumer goods, medicine modernized not by adopting a corporate structure but by convincing state legislatures to delegate control over medical education and licensure to its professional organizations, in particular state medical boards. This professional sovereignty, as Paul Starr termed it, facilitated increasing prestige and incomes for physicians.[3] (A list of supplemental readings on this historical time period is provided in the Supplementary Appendix, available at NEJM.org.)

While rejecting its reliance on shareholder investment, the profession borrowed elements of the interwar corporate order to improve medical practice. The engine of that transformation was modernization of the hospital as the "doctor's workshop." Hospitals had a corporatelike structure, with boards of managers and physician-dominated organizational hierarchies, which facilitated investments in new technologies and procedures. To sustain this technology-and-innovation model, hospitals had to function in a more efficient, businesslike fashion. That ethos spread to private practice as well. Modern physicians had to see themselves as investors, first in a high-quality medical education, then in a well-equipped office. To pay off those costs, doctors had to modernize their fee-setting and bill-collection practices, eschewing the old family doctor's lax financial habits.[4]

This financialization led to dynamics whose negative consequences persist to this day. The model gave young physicians little incentive to practice in poor urban neighborhoods or rural areas; instead, they preferred urban and suburban areas where middle-class patients could afford their rising fees. The model also favored specialization with its higher fee scales, triggering the slow decline of general practice. Long before the corporate era, two major weaknesses in U.S. health care — medical "deserts" in poor urban neighborhoods and a trend toward uncoordinated specialization — were well established.

Even the middle-class patients, who were expected to benefit most from medicine's new model, didn't accept it readily, finding the costs hard to budget for and the world of medical specialization difficult to navigate. The American Medical Association (AMA) and the American Hospital Association insisted that prudent consumer–patients could afford innovative, technology-driven care by giving up "luxury" items and saving for medical crises. Among the prospective patients who disagreed were other professionals (economists, engineers, lawyers) and union leaders, who questioned a model empowering doctors and hospitals to set their own fees. In the aftermath of the Great Depression, critics decried the AMA as a "medical monopoly."[4]

These discontents created the opening for new business partners: insurance companies, which in the late 1930s figured out how to profitably pool savings for unpredictable expenses. The success of Blue Cross and Blue Shield, organized as collective funds that employees and employers paid into, showed that the idea could work. Workplace-based insurance for medical calamities boomed in the 1940s and 1950s, as corporations competed for executive talent and labor unions bargained for insurance coverage.[4]

Insurance plans let doctors and hospitals set prices, facilitating more investment in the capital-intensive technologies equated with higher-quality care. But that dynamic also created an upward spiral of costs. Americans who lacked work-based insurance, or lost it when they retired, couldn't pay the rising prices. These problems led to a second transformative movement: the federal government's entry into the health insurance business, with the creation of Medicare and Medicaid, which also let doctors and hospitals set prices.

This insurance revolution aimed to relieve Americans of the duty of financing the medical system themselves, bringing in third parties to help. Enrollees in the new plans got more coverage but only on the terms set by those parties; uninsured people had to manage on their own. Meanwhile, the cycle of rising costs continued unabated. Yet even as physicians, politicians, and economists lamented its cost, the expansion of insurance coverage made investment in new products and procedures attractive to corporate investors. Some, such as pharmaceutical and medical technology companies, had established ties to medicine; others recruited external investors to invest in for-profit nursing homes, hospital chains, and "doc-in-a-box" clinics to compete with "old-fashioned" medical practitioners. Medical entrepreneurs believed that applying market discipline to health care would produce the right combination of innovation, efficiency, and cost–benefit balance to ensure better care for patients while profiting investors.

These strategies came to dominate for-profit and nonprofit health care enterprises alike, making it

harder to distinguish between the two by the turn of the 21st century.[4] In both public and private sectors, the corporate business model led to physicians losing control over their economic fates. Just as insurers exerted power over patients, determining when and how they could use their coverage, increased reliance on insurance reduced the independence of the medical profession, which had become accountable to corporate stakeholders and government bureaucrats.

Proponents of market-driven medicine presented themselves as agents of patients, demanding more and better medical care. The corporate embracing of this so-called consumerism led to a radical departure from past business practices. Before the 1970s, professionalism had discouraged ethical pharmaceutical companies, hospitals, and physicians from advertising services directly to the public. Starting in the late 1970s, in the name of serving "consumers," first the pharmaceutical industry then hospital chains and clinics began spending heavily on direct-to-consumer (DTC) advertising. Ironically, one unintended consequence of 1960s and 1970s patient activism seeking more unbiased information about drugs and fees was the legitimation of such advertising as protected "free speech."[4]

While adopting some consumer-industry practices, corporate health care players strove to avoid others, such as direct price competition. Policy efforts to rein in costs stressed the need for price transparency: consumer–patients needed to "shop" more critically for the cheapest care. In this spirit, political conservatives promoted "consumer-driven" health care. But such schemes foundered on the reality that many insurance plans gave patients little flexibility to price-shop for care.[4]

Instead, the "merger movement" in hospital and physician services enabled health care organizations to benefit from economies of scale while minimizing direct price competition. Hospitals and physician practices slowly fused into chains. Today, according to the U.S. Department of Health and Human Services, 81% of Medicare-enrolled hospitals are structured as corporations or limited liability companies. Nearly 70% of American physicians are employed by such corporate entities.

The extent to which DTC advertising and mergers have benefited patients is hotly debated. Systematization has probably encouraged improvements in patient-centered care, such as sharing of clinical records and monitoring of safety protocols. But it has also led to "consumer satisfaction" assessments that better serve economic goals than clinical ones. If a physician's employer gives her only 15 minutes to see a patient, how useful are data on that patient's satisfaction? If the employer doesn't invest adequately in emergency department and hospital resources, such that patients languish in EDs for hours, what do those patient satisfaction measures reflect?

Seeing patients as consumers has become essential to health care organizations' quest for greater economy, efficiency, and productivity. But neither physicians nor patients share this understanding of their interactions. A 2016 study of a for-profit hospital found that whereas administrators viewed patients as customers, physicians and patients did not. Asked who the hospital's customers were, patients pointed to physicians. "Most patients (60%) specifically rejected labeling themselves as customers, citing the high anxiety level, lack of understanding, and low decision-making power they experienced during the hospitalization process."[5]

Many powerful health care industry stakeholders still believe allowing corporate interests freer rein will produce that "golden age for patients." The health care economy's fragility suggests otherwise.

Although it may seem obvious that health care doesn't work like a restaurant chain, many powerful health care industry stakeholders still believe allowing corporate interests freer rein will produce that "golden age for patients." The health care economy's fragility suggests otherwise. For example, the Covid epidemic revealed hospitals' financial reliance on elective surgeries. When they pivoted from profitable surgeries to unprofitable Covid care, they needed massive infusions of government funding to survive.

Similarly, recent shortages of essential but low-profit drugs, including chemotherapy agents and insulin, reveal the limits of the pharmaceutical industry's profit-oriented approach to essential drug production. Meanwhile, the launch of new weight-loss drugs, widely advertised on television, has strained insurers' capacity to cover their expense.

One "cure" now hyped as a silver bullet for U.S. health care's problems is AI. Corporate players eyeing huge profits are striving to convince health care leaders that they can achieve greater efficiencies and higher customer satisfaction by replacing humans with AI — from chatbots for routine communication to robots for procedures. At the same time, AI is powering the algorithms insurance companies use to deny patient claims.

No market solution has arisen for the most critical determinant of poor health and health care outcomes in the United States: extreme income inequality. Countless studies indicate that poverty is the most important health risk factor that Americans face. Yet a market-driven health care system offers limited incentives to lower that risk; little profit can be made by preventing or treating poverty-induced illnesses.

An audio interview with Nancy Tomes is available at NEJM.org

U.S. health care needs a new business model. Many physicians resist the pressures to pursue economic goals at patients' expense, spending countless hours convincing pharmacy benefit managers and insurance companies to cover necessary care. But only more collective physician and patient action will help medicine find a more equitable, sustainable model.

Meanwhile, the Trump administration appears intent on blowing up our fragile health care system in the name of an unrestrained "free market" and corporate profiteering. Many people will suffer if the system collapses completely, but perhaps a more sustainable health care system can be built from the rubble.

The series editors are Atheendar S. Venkataramani, M.D., Ph.D., Lisa Rosenbaum, M.D., Debra Malina, Ph.D., Genevra Pittman, M.P.H., and Stephen Morrissey, Ph.D.

Disclosure forms provided by the author are available at NEJM.org.

[1]Department of History, Stony Brook University, Stony Brook, NY.

This article was published on August 2, 2025, at NEJM.org.

1. Eckhardt J. 5 insights from the 2025 JP Morgan healthcare conference. Forbes. January 16, 2025 (https://www.forbes.com/sites/juergeneckhardt/2025/01/16/5-insights-from-the-2025-jp-morgan-healthcare-conference/).
2. Sanders L, Murphy T, Thomson-DeVeaux A. Most Americans blame insurance profits and denials alongside the killer in UHC CEO death, poll finds. Associated Press. December 27, 2024 (https://apnews.com/article/luigi-mangione-unitedhealthcare-brian-thompson-shooting-b53fde08980d160ee93fd08b1664108d).
3. Starr P. The social transformation of American medicine. New York: Basic Books, 1982.
4. Tomes N. Remaking the American patient: how Madison Avenue and modern medicine turned patients into consumers. Chapel Hill, NC: University of North Carolina Press, 2016.
5. Mazurenko O, Zemke DM, Lefforge N. Who is a hospital's "customer"? J Healthc Manag 2016;61:319-33.

DOI: 10.1056/NEJMp2415751

Lead Contamination in Milwaukee Schools — The Latest Episode in an Ongoing Toxic Pandemic

Marty S. Kanarek, Ph.D., M.P.H.[1,2]

Lead contamination in the schools in Milwaukee, Wisconsin, recently became a subject of national news. Lead has long been a threat to children in Milwaukee, especially in its poorest neighborhoods: much of the city's housing stock was built in the 19th and early 20th centuries, when lead was a common additive in paint, before being banned in 1978.

The adverse effects of lead in children are well known. They can include a loss of brain volume, behavioral problems such as a propensity to commit crimes and violence, speech and hearing problems, kidney and cardiovascular effects, and lower scores on IQ and school achievement tests.[1] The effects can begin in utero from fetal exposure to lead in maternal plasma, and neurobehavioral deficits can persist into adulthood. Studies have established that chronic, low-level lead poisoning is a risk factor for cardiovascular disease in adults and cognitive deficits in children, even at levels that were previously thought to be safe. Indeed, no safe concentration of lead has been identified, and research has repeatedly shown that