

## PHARMACEUTICALS, MONEY, AND THE HEALTH CARE ORGANIZATIONAL FIELD

**Dr. Yagnamurthy Raja**

Assistant Professor, Masters in Business Administration,  
Presidency University, Bangalore, India,  
Email Id-narasimharaja@presidencyuniversity.in

---

### ABSTRACT

As the organization that develops, produces, and distributes the drugs and medical supplies necessary for patient care, the pharmaceutical business is crucial to the area of healthcare organizations. However, there are many other facets and a complicated link between drugs, money, and the healthcare system. The interaction between pharmaceutical firms, financial interests, and the healthcare organizational sector is examined in this chapter. An in-depth discussion of the financial elements of the pharmaceutical sector is provided in the chapter, including the expensive expenditures associated with medication research, marketing, and pricing. There may be conflicts between pharmaceutical firms' financial goals and the objective of making pharmaceuticals for patients inexpensive and accessible due to their pursuit of profit. The conflict between patient well-being and financial viability poses significant ethical and policy issues. The chapter also looks at how pharmaceutical firms affect clinical practice, clinical research, and healthcare policy. Drug approvals, formulary selections, and prescription practices may be impacted by the pharmaceutical industry's financial resources and lobbying influence, which have the capacity to influence healthcare policies and objectives. Such impact prompts questions about possible conflicts of interest and the need for open, impartial decision-making procedures. The effects of pharmaceutical marketing strategies on doctors' prescription habits and patient care are also explored in the chapter. Marketing initiatives may influence pharmaceutical decisions and lead to the overuse or improper use of medicines, such as direct-to-consumer advertising and promotional activities aimed at healthcare practitioners.

**KEYWORDS:** Healthcare, Organizational, Pharmaceutical, Sector, Social.

### INTRODUCTION

There are several approaches to conceptualize healthcare institutions and their social obligations. One perspective is that the provision of health care is primarily a social institution that is, an organisation that exists to serve collective goods. These are products that are produced and maintained by institutional role occupants who, in turn, have an institutionally derived right to the goods and are inherently desirable. These collective goods in the context of health care include those that ensure quality of life, those that ensure ontological security by restoring and maintaining fundamental physical and social functioning, and those that promote survival by extending lives that would otherwise be cut short. The institution of health care, like other social institutions, is normative in the sense that it creates social norms that correspond to institutional rights and obligations deontic characteristics. These, in turn, are attached to certain institutional functions and ethically limit the actions of those who hold those roles. The rights, obligations, and standards that define a social institution are articulated via, and exercise their influence through, the institution's logic that is, the taken-for-granted belief and meaning systems that are apparent in institutional patterns of behavior, speech, and policy [1], [2].

In its idealized state, healthcare professionals who follow a professional institutional logic rule the social institution of health care. Such a rationale would enable clinical practitioners to have a great deal of autonomy over their education, credentialing, quality control, and pricing, as well as the resources they need to practice from either governments or private insurers. In exchange, they are anticipated to act indifferently as others and give priority to the group's interests. have favored output above solely commercial factors. There are several further professional categories in the area of health care organisations, each of which follows a unique institutional logic or collection of logics. Health service administrators and health policymakers with their managerial, government/state, bureaucratic, or administrative logics are among these groups. These occupational groupings are likewise expected to place a higher priority on the communal goods they create than solely financial concerns, even if their rights, obligations, and standards are different from those of professionals providing direct patient care.

## **DISCUSSION**

The fact is that the logic of the health care organisational field is, and always has been, in part a market logic that is, a logic characterised by the promotion of free and unregulated competition and the use of financial metrics and consumer satisfaction to judge success. Many people think that the medical establishment is becoming more accepting of market norms, beliefs, and systems. This has been attributed to a number of factors, including the privatisation of health care services and the growing propensity of clinicians to emphasise their technical expertise as validated by the market and measured through metrics like cost effectiveness and consumer satisfaction. Similar patterns have been seen in academic settings, where biomedical researchers are rushing to commercialise their discoveries some of whom are now entrepreneurs and where government funding agencies and academic institutions are putting more emphasis on commercial measures of productivity.

Along with this marketization of clinical and academic institutions, the number and influence of several for profit sectors within the area of health care organisations have grown dramatically. These include the pharmaceutical, biotechnology, medical device, and diagnostics sectors as well as those involved in the manufacture of complementary and alternative medicines and health foods. With a focus on the pharmaceutical business and the organisational forms that pharmaceutical firms engage with, I shall map the current health care organisational landscape in the next sections of this chapter. Then I'll go into detail about the many ways that stakeholders have reacted to the growth of the pharmaceutical sector within the context of health care organisations. There will then be some recommendations. As to how players in the health care organisational sector may better accommodate conflicts between and among stakeholder groups, as well as how such tensions might be conceptualised. Without entirely reneging on their devotion to their professional, academic, or administrative principles and conventions, the pharmaceutical industry's presence [3], [4].

## **Mapping the Health Care Organizational Field**

When apothecaries started producing medications like morphine, quinine, and strychnine and dye and chemical industries started learning that their products had medicinal uses, many of the pharmaceutical corporations we know today had their start in the late 19th and early 20th centuries. At this period, a number of pharmaceutical corporations with names that are still used today were founded, including Merck, Schering, Roche, Smith Kline, Parke Davis,

Bayer, Ciba, Geigy, and Sandoz. Between 1930 and 1960, the modern pharmaceutical business flourished thanks to the creation of a wide range of ground-breaking medications, including immunosuppressants, antibiotics, antimalarials, synthetic vitamins, hormones, antihistamines, and anaesthetics. New methods for directing treatments against physiological processes made it possible to create, among other things, antihypertensive, cholesterol-lowering medications, tranquillizers, antidepressants, anti-inflammatory pharmaceuticals, contraceptives, and cancer therapies throughout the 1970s and 1980s. Further treatment innovations have been made possible since the 1980s thanks to advancements in molecular biology, genetics, biotechnology, and information technology. The pharmaceutical industry is currently dealing with a number of issues, such as declining productivity, rising R&D costs, increased competition from generic drug producers, threats to international intellectual property regimes, and growing demands from those who pay for medicines.

Companies prove not only the safety and effectiveness of new medicines but also true innovation and value for money. Pharmaceutical companies have started to adapt to these difficulties by outsourcing a large portion of their research, development, and manufacturing to nations like Brazil, Russia, India, and China by relying less on developing blockbuster drugs and more on creating personalized medicines through participating in numerous open innovation projects and research with other businesses and institutions. Development R&D partnerships by utilising the big data that can be produced and analysed through new biological, informational, and computational technologies and by adjusting their R&D to the requirements of customers, clinicians, and funding bodies. Despite the difficulties it confronts, the pharmaceutical sector is very strong and rich, with more than \$1 trillion in annual worldwide sales. It has been predicted that the global pharmaceutical business might be worth more than \$1.6 trillion by 2020 due to the increasing burden of infectious and chronic diseases throughout the world as well as trade liberalization. Therefore, it is expected that the area of health care organisations will continue to be heavily commercialized, and the pharmaceutical sector is likely to play a major role in this institutional tendency.

### **Organizational Forms that Interact with Pharmaceutical Companies**

The pharmaceutical industry's expansion has had a significant impact on other organisational structures in the sphere of health care organisations. In some instances, these organisational forms owe their creation or at least their prominence to the pharmaceutical industries, while in other instances, the pharmaceutical industry's presence has profoundly altered pre-existing organisational structures.

### **Organizations That Are Supported by the Pharmaceutical Industry**

Many organizational structures in the health care sector depend largely on the pharmaceutical industry to finance their main operations or to provide them other types of assistance. Academic scholars, medical professionals, biomedical publications, and patient advocacy groups are a few of them. Universities and funding agencies support academic basic scientists in their efforts to commercialize their discoveries, which frequently requires them to collaborate with pharmaceutical firms in various public-private partnerships. Similar to this, the pharmaceutical business currently finances practically all clinical studies worldwide. Clinical practitioners significantly depend on the pharmaceutical sector to not only create the drugs they recommend but also to educate them on these drugs. The majority of official programmers for continuing medical education are financed by for knowledge on new

medications, the pharmaceutical business and many doctors depend on pharmaceutical salespeople, or drug reps. For their conferences, journals, patient education materials, lobbying efforts, research grant programmers, and clinical practice recommendations, professional medical groups often depend on business financing as well [5], [6].

The publication of the findings of pivotal clinical trials contributes significantly to the reputation and impact factors of biomedical journals. Therefore, they depend on their connections to the authors of clinical studies supported by the pharmaceutical business to draw attention to these chapters. According to Hopkins, Gallagher, and Levine journals receive a significant portion of their funding from the pharmaceutical industry in the form of advertising, the purchase of article reprints which are valuable marketing tools for pharmaceutical companies, and sponsorship of special issues and supplements. Finally, the majority of patient advocacy groups get funding from pharmaceutical firms, who collaborate closely with them to promote access to medications that may otherwise not be approved for marketing or covered by public or private insurance programmers.

### **Medicines Policymaking Organizations**

Many organisations that influence drug policy owe their entire existence or at the very least, their prominence to the pharmaceutical sector. These include drug regulatory organisations that evaluate the safety and effectiveness of both new and old medications, such as the US Food and Drug Administration FDA and the European Medicines Agency EMA. Additionally, they include governmental and commercial organisations that decide how to allocate resources, perform health technology assessments of new medications, and create clinical practice recommendations. The firms that wish to get their drugs approved or subsidised may pay significant submission fees to these regulatory and financing organisations, which in certain circumstances serves as industry assistance [7], [8].

### **Related Commercial Organizations**

The contract research organisations CRO, a new commercial organizational structure, has developed as a direct consequence of the expansion of the pharmaceutical sector. Due to the rising costs and complexity of developing, regulating, financing, and marketing pharmaceuticals, several organisations have developed. The contract research organisations CRO, a new commercial organizational structure, has developed as a direct consequence of the expansion of the pharmaceutical sector. Due to the rising costs and complexity of developing, regulating, financing, and marketing pharmaceuticals, several organisations have developed.

### **Addressing Ambivalence**

Ambivalence towards pharmaceuticals is very unlikely to ever be dispelled. There will always be some friction in the connection between the pharmaceutical sector and society, as Santoro observes: Given the divergent ends of a for-profit industry and a product with immense public health implications. In other words, it appears improbable that a hybrid logic that can easily accept both professional and market logics and allow the pharmaceutical sector to peacefully coexist with the healthcare organizational field would ever be developed. This is not always a negative thing since persistent ambivalence makes sure that the appropriate checks and balances are constantly in place to prevent any one institutional logic from entirely dominating the organizational field. We wouldn't want critics to cease calling

out misbehavior in the sector. We also wouldn't want the sector to cease defending itself and informing us of all the ways it helps ensure our existence, safety, and prosperity.

Strong pro and anti-pharma stances essentially represent the opposing poles of a dialectic. This dialectic's presence is a reflection of the fact that, like other complex psycho-social realities, the health-care organizational field inherently consists of potentially divisive aspects. The best way to deal with these types of social realities is through dialectical forms of reasoning and debate, which challenge the notion that apparent contradictions about the nature of social reality are necessarily reflective of a lack of understanding of what is really going on and explicitly think in terms of contradictions. Dialectic offers a means of explaining these allegedly oppositional, and nondeductible components of psycho-social reality if individuals have seemingly divergent opinions about the nature of social reality. We would benefit from people having a better understanding of why there is such a great deal of conflict between stakeholder groups and why they might feel uncertain about their own stances, even though we do not want to and could not in any case eliminate ambivalence about the pharmaceutical industry. This would aid in reducing the cognitive dissonance that is so pervasive in the discourse surrounding the pharmaceutical business today and that probably hinders people's capacity for complex problem-solving.

People might benefit from learning that the pharmaceutical sector is a component of a social institution that strives to advance human happiness, survival, and security but may sometimes fall short in doing so. People may feel less compelled to take a strong pro- or anti-industry position as a result. A little less vitriolic ambivalence towards the pharmaceutical sector might also be beneficial. This is due, in part, to the fact that polemic of the kind depicted above has the potential to oversimplify issues, prevent exchange and cooperation between industry and government, and be a bitter pill for those who work within or collaborate with the pharmaceutical industry and do so with the best of intentions. Other parties involved and hide potentially original problem-solving approaches. Almost often, these innovative solutions must be multifaceted and include a blend of internal and external control, rewards, penalties, openness, and disengagement. The kind of the challenge will determine the best combination of techniques. For certain issues, it will be imperative to press for strict external control, required openness, and/or punitive action against offenders. For instance, there should be no tolerance for evident mistreatment of clinical trial participants, hiding of safety information, or buying off of decision-makers or physicians.

A softer and more cooperative attitude may be necessary in other situations. For instance, there are varying opinions on the advantages and disadvantages of off-label marketing, direct-to-consumer advertising, and the extension of treatable illness categories. These discussions might benefit from more interaction between those who criticize the business and those who work in it. Such communication and collaboration have started to get academic support Fisher, 2007. The application of moral principles by individuals working in the pharmaceutical sector is shown by empirical study to be quite comparable to that of doctors and researchers. Employees in the sector are concerned with doing well, preventing damage, and attaining justice, both for their employers and for the general public, much as doctors and researchers are at least those in medical and regulatory departments. Additionally, according to Lipworth, Montgomery, and Little, they have a range of sophisticated methods for achieving conflicting economic, medical, or scientific objectives. This implies that there may be opportunities for people who have concerns about the pharmaceutical sector to interact

more with workers at pharmaceutical firms. This cooperation should not, however, come at the price of a strong, outward dialogue that allows for the detection and correction of grave and unequivocal misconduct. For the reasons outlined above, none of these techniques can ever fully eliminate the conflicts between market and other logicalities in the area of health care organizational structure. The strategies described here, however, may assist in overcoming hostile interdependence and cognitive dissonance that unnerve participants in the area of increasingly for-profit health care organisations.

## **CONCLUSION**

Patient care, healthcare regulations, and the general efficiency of the healthcare system are all greatly impacted by the complex and dynamic interaction between drugs, money, and the organizational world of health care. We have looked at several facets of this connection in this essay, highlighting both its potential and difficulties the advancement of medical innovation and the provision of patients with necessary pharmaceuticals are both greatly aided by the pharmaceutical sector. The huge expenses incurred in drug research, marketing, and pricing, however, have prompted questions regarding the accessibility and affordability of pharmaceuticals. It is still difficult to strike an appropriate balance between the pharmaceutical industry's desire for financial stability and its commitment to provide universal access to inexpensive and fair healthcare. Pharmaceutical industry financial resources and lobbying influence may have an impact on clinical practices, research agendas, and healthcare policy. Important ethical questions are raised by this impact, notably those involving possible conflicts of interest and the need for open decision-making procedures. The integrity of healthcare regulations must be protected, and policymakers must make sure that patients' needs come before profits.

The prescription habits and patient care of healthcare professionals might be affected by pharmaceutical marketing strategies. However, in order to avoid excessive influence on medical choices and to support the ideal of evidence-based medicine, marketing activities must be regulated and scrutinized. This is true even if marketing initiatives may provide useful information about new treatments. In conclusion, it takes the combined efforts of many stakeholders to solve the complicated interaction between medications, money, and the organizational sector of healthcare. Together, policymakers, healthcare providers, pharmaceutical firms, and patient advocacy organisations must come up with solutions that put the needs of patients first while still fostering medical innovation and the pharmaceutical sector's financial sustainability. In this environment, transparency and accountability are essential for making choices that are evidence-based, objective, and in the patients' best interests. We can create a healthcare system that provides high-quality care to all people while upholding the integrity and sustainability of the pharmaceutical industry by fostering a culture of ethical decision-making, supporting fair pricing and access to medications, and encouraging innovative research. The ultimate objective is to achieve a balance between medicines, finances, and the organizational landscape of the health care sector that promotes medical advancement, enhances patient outcomes, and assures fair access to necessary drugs for everyone.

## **REFERENCES**

- [1] H. Sun, H. Zhang, E. L. Ang, en H. Zhao, Biocatalysis for the synthesis of pharmaceuticals and pharmaceutical intermediates, *Bioorganic and Medicinal*

- Chemistry*. 2018. doi: 10.1016/j.bmc.2017.06.043.
- [2] T. H. Miller, N. R. Bury, S. F. Owen, J. I. MacRae, en L. P. Barron, A review of the pharmaceutical exposome in aquatic fauna, *Environmental Pollution*. 2018. doi: 10.1016/j.envpol.2018.04.012.
- [3] A. Biancolillo en F. Marini, Chemometric methods for spectroscopy-based pharmaceutical analysis, *Frontiers in Chemistry*. 2018. doi: 10.3389/fchem.2018.00576.
- [4] S. Bungau *et al.*, Aspects regarding the pharmaceutical waste management in Romania, *Sustain.*, 2018, doi: 10.3390/su10082788.
- [5] S. Sultana en S. Mohammed, A Review on Stability Studies of Pharmaceutical Products, *Int. J. Pharm. Res. Sch.*, 2018, doi: 10.31638/ijprs.v7.i1.00003.
- [6] R. N. Patel, Biocatalysis for synthesis of pharmaceuticals, *Bioorganic and Medicinal Chemistry*. 2018. doi: 10.1016/j.bmc.2017.05.023.
- [7] F. Desbiolles, L. Malleret, C. Tiliacos, P. Wong-Wah-Chung, en I. Laffont-Schwob, Occurrence and ecotoxicological assessment of pharmaceuticals: Is there a risk for the Mediterranean aquatic environment?, *Science of the Total Environment*. 2018. doi: 10.1016/j.scitotenv.2018.04.351.
- [8] C. Moltó-Puigmartí, R. Vonk, G. van Ommeren, en I. Hegger, A logic model for pharmaceutical care, *J. Heal. Serv. Res. Policy*, 2018, doi: 10.1177/1355819618768343.