

## **Belief versus Reality in Reforming Health Care**

J Michael Wynne

*J Michael Wynne is a retired surgeon who has spent over 15 years following the changes from a predominantly not-for-profit to a for-profit health care system in the USA and Australia. This article explores how two conflicting patterns of thinking, for-profit and not-for-profit currently influence Australian health care. It describes the differences between these two patterns and how people resolve the conflict between them. The consequences of this conflict and the domination of for-profit thinking in health care are illustrated with examples from the USA.*

There are two fundamental precepts that throw light on developments in health care and provide pointers to future developments. Firstly, humans will try to achieve success in the situation in which they find themselves in whatever way success is defined. In most situations, a majority of individuals will do whatever it takes to be successful. They are likely to do so even when this is not in the best interests of others or of the social system itself. Secondly, humans as social beings live in a world of ideas and beliefs. These create the frames of understanding that are used to determine actions and justify behaviour to ourselves and others. These ideas and beliefs can develop within specific situations or can be brought to these situations from elsewhere.

People become uncomfortable when there is a conflict between different ideas and beliefs, and try to develop strategies to escape this conflict. Individuals and even whole societies adopt strategies that allow them to identify with dominant belief systems and ignore contradictions. Power and credibility have a far greater influence on the adoption of particular systems of thinking than logic or evidence.

When the dominant ideas conflict with the requirements of the situation, those whose personalities can most successfully accommodate the contradictions surrounding less savoury practices succeed and become leaders. This ability makes them more prone to overstep social and legal limits to feather their own nests, exploit the weakness of others and indulge in fraud.

The ideas that underpin successful lives are soon welded to individual and group identity. As a consequence they are durable, are strenuously defended, and on occasions, enthusiastically promoted as global solutions for all human endeavour — an ideology. These ideas are only abandoned when they fail to deliver successful outcomes for the establishment or when a sufficient number of citizens are so disadvantaged that they act. There have been many examples of severely dysfunctional regimes during the 20<sup>th</sup> century. More recently there have been examples of disturbing conduct in the market-place and health care.

### **Health Care**

Health care is at the cross roads with old and new patterns of "legitimate" thinking competing for allegiance. These two patterns are currently called not-for-profit and for-profit. This is quite different to the Australian terms "public" and "private". Until the 1980s, almost all private health care was provided within the not-for-profit frame. The contrasts between the pure forms of the two patterns are stark and confronting, and can be outlined in Table 1.

Table 1.

	Not-for-profit	For-profit
Origins	Developed over 2,000 years from the Hippocratic tradition and within the health care context as an expression of the reciprocal interaction between community and professional providers.	Originated in the market-place and during the latter part of the 20 <sup>th</sup> century. Moulded into a global belief system by economists, business schools and think tanks. Powerful forces have asserted its general applicability to all fields of endeavour.
Primary focus	Represented by words like altruistic, humanitarian and Samaritan. Its policy and practices follow the needs of the community and of those it serves.	Profit for impersonal others who have little interest in the welfare of those from whom the profits are developed. Its policy and practice is to follow the money.
Responsibility	Act for the community in its humanitarian role. They are primarily responsible to individuals and the community.	Act for and are primarily responsible to their owners, the institutional shareholders and to the bankers who lend them money. Their main interest in health care is in the profit generated for those whose money they handle.
The mode of operation	Primarily cooperative in pursuit of common goals.	Competitive in an attempt to secure a greater share of the money that government and insurers provide. Competitiveness is a core value and a conflict model of human activity is followed. Competitiveness is achieved by efficiency.
Motivation	Reflective and value-based. Outcome measures and rewards are related to the core ideals.	Economic and outcome-based. The focus is on self-interest with personal incentives and disincentives being linked directly to outcome measures that are primarily financial.
Rewards	Personal satisfaction in work and achievements in service. Personal wealth may be sacrificed in return for altruism, trust and reasonable financial security.	Predominantly financial with social benefits coming from the status enhancement acquired by generating wealth.
Equity	Reflected in "providing care according to need and paying according to means" and the establishment of universal Medicare-like funding systems.	Seen (but seldom expressed) as an equal right to compete in the market-place for the money to buy better care.
Failures	Have not met the urgent health care need for an integrated system, nor have they fully embraced technology for patient management.	The proposed benefits for patients have not been realised because the sort of integration and consolidation practised has been directed towards profit and market power instead of serving patients.

Both systems have their weaknesses. Not-for-profit's greatest weakness is its immediate dependence on community affirmation and support. It is consequently excessively vulnerable when the community adopts ideas and value systems that compete directly with its core values and its legitimacy. It is also prone to bureaucratic inertia, excessive individuality and community fragmentation. Not-for-profit has recognised its weakness in regard to human vulnerability and selfishness. It has attempted to control this through ethical structures.

For-profit's greatest weakness is the discordance that exists between its thinking and mode of operation on the one hand, and the requirements and the objectives of the health system on the other. Successful social outcomes depend on well-informed customers having the knowledge to effectively evaluate a complex product, and being willing, healthy enough and sufficiently emotionally controlled to shop around for the best. This does not exist in the majority of clinical encounters nor is it ultimately practicable.

At a more practical level, funding in health care is capped by government or insurer, paying for care and not for corporate profits. The corporations are competing for a limited resource. There are financial, manpower, and motivational overheads to the business of competition that must be diverted from care. Once profits have been taken the resources remaining for care are limited. Corporate logic dictates this is possible because the competitive system is so efficient. Efficiency has its limitations; it is increasingly clear that efficiency has become a rationalisation for reducing the services available to care for patients in order to increase profits (*New Mexico Business Journal* 1996a, 1996b; Wynne 2004a).

Despite its short-term weaknesses, not-for-profit thinking has been remarkably durable in the long-term. When prevailing ideologies have passed it has reclaimed its humanitarian tradition. For-profit thinking in health care is recent. It has been bolstered and supported by a strong establishment and by its spectacular economic successes. Its multiple social failures have been glossed over in publicly stated efforts to "put this behind us and move on". The tensions between it and our sense of community and our interpersonal responsibilities as represented by health care suggest it is not viable as a global all-encompassing vehicle for community activity and its durability can be questioned.

Not-for-profit thinking sees the exploitation of the weakness and misfortunes of others as a violation of the core values on which the Samaritan tradition depends. For-profit thinking perceives not-for-profit thinking as obsolete, collusive, self-serving, inefficient and resistant to change. Each of these assertions has validity within the ideas with which each has structured its world (Wynne 2004b, 2004c).

### **Coping with Discordance**

The divide between these two perspectives in health care is so wide that there is little room for concordance and compromise. Other coping strategies must be developed. The most common of these I will call split consciousness — one side for each perspective. A sharp dividing line is placed between them so that the conflicts are seldom confronted, conceptual harmony is maintained, and dissonance controlled.

Wider community sentiment and credibility still embrace the not-for-profit ideals and it is essential for health care providers to pay service to them. Power and personal financial reward reside with the for-profit ideal. The response is to place the public face and identity within the not-for-profit half, while the practical business of life is conducted in the for-profit. Both for-profit and not-for-profit groups and individuals employ this strategy and loudly maintain the illusion in order to persuade themselves. Those unable to successfully perform the mental gymnastics lie low, become ineffective, fail, or go elsewhere. Those who embrace them become corporate leaders and very wealthy. This divide is readily apparent when public statements and marketing are compared with reports and addresses given to shareholders.

## **The Consequences**

For-profit thinking has appropriated the word "reform" and placed the word "market" before it. This catch-phrase has enabled them to drive their agenda across the world and back it with little or no evidence (Wynne 2004c). However, there is now clear evidence that, when contrasted with not-for-profit, the for-profit system in the USA is much more expensive, extremely inefficient, wasteful of resources, and produces overall health outcomes inferior to most other developed countries. It has been ruthless, impersonal and uncaring in its dealings with individuals (Barlett & Steele 2004; Schiff 2000; Woolhandler et al. 2003; Woolhandler & Himmelstein 2004; Devereaux et al. 2004). A recent Royal Commission into the future of health care in Canada challenged for-profit interests to show this system had economic, social or quality advantages over the existing values-based system. They were unable to do so (Romanow 2002).

In the USA, aged care staff cuts and de-skilling of health care workers have resulted in higher incidences of preventable complications and earlier deaths. In other sectors, mounting evidence now affirms anecdotal suggestions of greater morbidity (Himmelstein et al. 1999; Wynne 2004e, 2004f). Meta-analysis indicates that this is reflected in higher death rates in for-profit services than in comparable not-for-profit (Devereaux et al. 2002a, 2002b).

The most vulnerable citizens have been deceived and exploited for profit. In the 1980s, several companies providing psychiatric care in the USA ran marketing campaigns, directed largely at children, urging people to come for free assessments, the purpose of which was to persuade them into hospital. Screening services were run across the community and in schools. Vast numbers of people, many of them normal children, were admitted to hospital and kept there for the full duration of their insurance. Here they were subjected to vast quantities of essentially ineffectual treatment each day in order to push up profits. These practices were justified internally on the basis that people had paid for their insurance so were entitled to stay in hospital for the full period to enjoy the benefits (Wynne 2004g).

Care has been denied, and at other times, provided needlessly simply because this was more profitable. An example of this occurred in Redding, California where a small hospital grew to become a regional cardiology centre — one of Tenet Healthcare's most profitable — as patient recruitment filled its beds. The bubble finally burst in October 2002 when a patient sought multiple second opinions, challenged the hospital and then went to the FBI. It transpired that hundreds of patients with normal hearts had undergone major cardiac operations (Wynne 2004g; 'Unhealthy Diagnosis' 2003).

Not-for-profit entities that have attempted to maintain their not-for-profit orientation have been unable to compete. As a consequence they have sold to for-profits, or formed joint ventures, or handed management to for-profits while maintaining the illusion of not-for-profit operation. Those who survived have embraced for-profit thinking and practices. This same trend is now apparent in Australia (Wynne 2004h).

In spite of these facts and the absence of common sense justification for market reform the establishment comprising businessmen, economists and politicians have maintained their divided consciousness. They continue to promote and impose for-profit thinking and practices in "reforming" health and aged care. There is no dispute that the not-for-profit system requires updating, reinvigoration and change to meet the challenges of modern medicine. The dominance of for-profit thinking, the impact this has had on the consciousness of health professionals, and the aggressive rhetoric served to paralyse effective not-for-profit thinking.

## **Australia and the USA**

As the failures of for-profit market medicine in the USA become more obvious the response has been to distance Australia from them by claiming that we are different and the US situation is not relevant. It is even claimed that the failures in the USA are because it is not sufficiently market-like (Samuel 2000).

It is wishful thinking to assert that our oversight and accreditation processes will contain any problems without explaining how these differ from the USA, where oversight and accreditation failure has been persistent and recurrent. There are already claims of failures in detecting Medicare fraud and a number of reports indicating accreditation failure in aged care in Australia (Scanlon 1998; 'Doctoring the Figures' 2004; Davies 2004; Thomson 2004).

The for-profit patterns of thought and their business practices in offering incentives linked to profitability are no different from those in the USA. The discordance between for-profit ideas and the health care context remains. Corporate directors and CEOs of local health care companies have enthusiastically adopted for-profit thinking. Economists and politicians identify with them and see them as the only solution to perceived problems in the current health system. Government bodies and decision making forums are dominated by the corporate sector.

For-profit thinking in health care has been credible and dominant in Australia for only 15 years. It took 30 years before the results of running health care as a for-profit business became a major public problem in the USA. This can be related to the eventual demise of a credible, active and effective not-for-profit establishment. When not-for-profit thinking became irrelevant individuals within the health system no longer had a secure and credible base from which to criticise and challenge corporate practices. Effective restraint was removed. That situation has not yet been reached in Australia.

### **How the Mental Gymnastics Work**

The following examples illustrate how the precepts operate and how individuals respond to the conflict between the discordant systems of thinking. They represent extremes of behaviour across the health care systems but illustrate the dynamics of the way the two precepts operate across the system and our vulnerability.

Doctors control admissions to hospital, deal directly with the patients, and order the investigations and treatment from which profits are generated. In for-profit health care, they are therefore a core element in the generation of profit for shareholders. Health care companies can gain control of doctors' income through allocating patients. In the USA, doctors who support the company's practices have been rewarded with patient referrals, lucrative appointments in the hospitals, free offices, secretarial assistance, and interest-free loans for their houses. Golden handshake agreements became golden handcuffs binding doctors to the corporate mission.

Doctors who did not comply were marginalised and their incomes threatened. Those who tried to blow the whistle were attacked, their credibility and careers destroyed. When doctors in a region banded together to resist corporate pressures some companies brought in questionable doctors from interstate, gave them appointments and directed the patients to them (Wynne 2004i).

All the corporations offer management incentives usually in the form of share options linked to profit achievements and this extends down through the ranks. These are normal business practices used throughout the market place. It is illegal to pay doctors for referrals or entice them with incentives. Instead companies now attempt to align doctors' financial interests with those of the company by making them shareholders or by involving them in joint commercial ventures. Both are legal. Joint ventures have proven very successful in aligning the profession with company practices (Wynne 2004i; Matterson 2004).

In 1998 Mayne and AXA jointly attempted to get specialists in Australian Mayne hospitals to enter into agreements relating to fees. Specialists were acutely aware of the consequences of managed care contracts in the USA. They saw these agreements as a threat to their autonomy and their ability to care for their patients. They refused to participate and were accused of greed and self-interest. In 2002, they felt able to make allegations of cherry picking — the selection of patients with profitable conditions and a refusal to admit those that were unprofitable. Doctors at the hospitals felt that changes

being implemented threatened their clinical autonomy and compromised standards of care. The company had no hold over them so doctors simply moved to competing hospitals and took their patients with them (Wynne 2004j).

What happened in Mayne is as much a reflection of corporate and political ineptitude in dealing with doctors as it is the doctors' dedication to their patients. In this instance the company had angered the doctors and fuelled their distrust. The interests of the doctors and their patients were aligned and the company had failed to bind them to the corporate mission.

### **Conclusion**

This analysis stresses the importance of a synergy between the patterns of thought used to justify actions and the concrete situation where these actions take place. The for-profit and not-for-profit systems vying for supremacy in health care illustrate the problems that arise particularly well. It appears that for-profit frames of understanding are not suited to the health care context. There is a rapidly growing body of evidence to affirm this. Dysfunctional practices are likely if the policy is continued.

This is not a plug for socialism or for government provided health care. Payment systems are not addressed. I suspect that a similar analysis of the public hospital system setting the primary objectives of politicians against the objectives of the health system would be revealing and help to explain under-funding. The message is that in planning and evaluating reform of the health systems the operating frames of reference used need to carefully set against the real life situation. If there is congruence they are more likely to work.

The difficulties in confronting ideological prescriptions are enormous. Not only must one generate a clear alternative, but the terminology and concepts to express it and expose the challenged prescriptions must be developed and clearly articulated so that they are easily understood by those whose support is needed. While ideas are important in building a power base the outcome will ultimately be determined by a balance of power rather than logical argument. At this time there is little to motivate a wealthy and complacent community to action.

The silver lining is that all-embracing ideologies ultimately flounder on the hard rocks of the real world and disintegrate, but this may take a long time. No one knows how to disentangle a corporate health care system without leaving a massive hole in services when this happens. This has become a key problem in the USA where the public are disenchanted and where credible individuals are at last seriously challenging the for-profit system in health care. Their hands are tied by their inability to promote a clear path away from corporate control.

### **References**

'Andy Turner wants the government out of health care, Period' 1996a, *New Mexico Business Journal*, Vol. 20, No 4, p. 10. Retrieved from [www.corpmeminfo.com/sun\\_the\\_fat.html](http://www.corpmeminfo.com/sun_the_fat.html)

Barlett, D. L. & Steele, J. B. 2004, *Critical Condition: How Health Care in America Became Big Business and Bad Medicine*, Doubleday, USA.

Davies, J. 2004, 'For the love of Alice: Special investigation aged care', *The Bulletin*, 17 August, p. 16.

Devereaux, P. J., Choi, P. T., Lacchetti, C., Weaver, B., Schunemann, H. J., Haines, T., et al. 2002a, 'A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals', *Canadian Medical Association Journal*, Vol. 166, No. 11, pp. 1399-1406.

Devereaux, P. J., Schunemann, H. J., Ravindran, N., Bhandari, M., Garg, A. X., Choi, P. T., et al. 2002b, 'Comparison of mortality between private for-profit and private not-for-profit hemodialysis centres: A systematic review and meta-analysis', *Journal of American Medical Association*, Vol. 288, No. 19, pp. 2449-2457.

Devereaux, P. J., Heels-Ansdell, D., Lacchetti, C., Haines, T., Burns, K. E. A., Cook, D. J., et al. 2004, 'Payments for care at private for-profit and private not-for-profit hospitals: A systematic review and meta-analysis', *Canadian Medical Association Journal*, Vol. 170, No. 12, pp. 1817-1824.

'Doctoring the Figures' 2004, ABC Television, *Four Corners*, 6 September.

Himmelstein, D. U., Woolhandler, S., Hellander, I. & Wolfe, S. M. 1999, 'Quality of care in investor-owned vs not-for-profit HMOs', *Journal of American Medical Association*, Vol. 282, pp. 159-163.

Matterson, H. 2004, 'Affinity deal just what doctors ordered', *The Australian*, 30 September.

Romanow, R. 2002, *Final Report: Building on Values: The Future of Health Care in Canada*. Retrieved from [www.hc-sc.gc.ca/english/care/romanow/hcc0086.html](http://www.hc-sc.gc.ca/english/care/romanow/hcc0086.html)

Samuel, G. 2000, *Introducing Competition in the Public Delivery of Health Care Services*, Address to the World Bank Human Development Week, Washington DC, USA. 29 February. Retrieved from [www.ncc.gov.au/](http://www.ncc.gov.au/)

Scanlon, W. J. 1998, *California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes With Serious Care Violations*, General Accounting Office (GAO) report by Director, Health Financing and Systems Issues, before the Senate Special Committee on Aging 28 July 28.

Schiff, G. 2000, 'Fatal distraction: Finance vs. vigilance in our nations' hospitals editorial', *Journal of General Internal Medicine*, Vol. 15, pp. 269-270.

Thomson, T. 2004, 'Aged care checks rorted', *Courier Mail*, 2 September.

'Unhealthy Diagnosis' 2003, US Television, *60 Minutes*, 2 February.

'Watch them grow, and grow' 1996b, *New Mexico Business Journal*, Vol. 20; No. 4; p. 15. Retrieved from [www.corpmedinfo.com/chain\\_policy.html](http://www.corpmedinfo.com/chain_policy.html)

Watt, A. & Green, G. 2005, 'Surgery priority lists based on hospital operating at a profit', *Courier Mail*, 25 June 23. (see also Bundaberg Hospital Commission of Inquiry retrieved from [www.bhci.qld.gov.au/](http://www.bhci.qld.gov.au/))

Woolhandler, S., Campbell, T., & Himmelstein, D. U. 2003, 'Costs of health care administration in the United States and Canada', *New England Journal of Medicine*, Vol. 349, pp. 768-775.

Woolhandler, S., & Himmelstein, D. U. 2004, 'The high costs of for-profit care', *Canadian Medical Association Journal*, Vol. 170, No. 12, pp. 1814 - 1815.

Wynne, J. M. 2004a, *Performance Of Corporate Groups*. Retrieved from [www.corpmedinfo.com/corp\\_perform.html](http://www.corpmedinfo.com/corp_perform.html)

Wynne, J. M. 2004b, *The Great Divide in Perceptions About the Corporate Market-place*. Retrieved from [www.corpmedinfo.com/divide.html](http://www.corpmedinfo.com/divide.html)

Wynne, J. M. 2004c, *Joseph Califano and the Market Revolution*. Retrieved from [www.corpmedinfo.com/califano.html](http://www.corpmedinfo.com/califano.html)

- Wynne, J. M. 2004d, *Globalisation of Managed Care*. Retrieved from [www.corpmedinfo.com/internat\\_man\\_care.html](http://www.corpmedinfo.com/internat_man_care.html)
- Wynne, J. M. 2004e, *The Market-place in the USA*. Retrieved from [www.corpmedinfo.com/corporate\\_overview.html](http://www.corpmedinfo.com/corporate_overview.html)
- Wynne, J. M. 2004f, *Aged Care and Nursing Homes*. Retrieved from [www.corpmedinfo.com/access\\_aged.html](http://www.corpmedinfo.com/access_aged.html)
- Wynne, J. M. 2004g, *Tenet Healthcare and National Medical Enterprises*. Retrieved from [www.corpmedinfo.com/entry\\_to\\_Tenet.html](http://www.corpmedinfo.com/entry_to_Tenet.html)
- Wynne, J. M. 2004h, *Tenet Healthcare PACMAN Activities: Mergers and Takeovers of Not-for-profit Hospitals*. Retrieved from [www.corpmedinfo.com/tenet\\_pacman.html](http://www.corpmedinfo.com/tenet_pacman.html)
- Wynne, J. M. 2004i, *The Impact of Financial Pressures on Clinical Care Lessons from Corporate Medicine*. Retrieved from [www.corpmedinfo.com/Corpmed.html](http://www.corpmedinfo.com/Corpmed.html)
- Wynne, J. M. 2004j, *Mayne Nickless and its Subsidiary Health Care of Australia*. Retrieved from [www.corpmedinfo.com/mayne.html](http://www.corpmedinfo.com/mayne.html)