Impact of For-Profit Enterprise on Health Care

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GUEST EDITORIAL

THE effects of profit-seeking enterprises in the field of health care can be viewed from a variety of perspectives. Mine are based on 30 years of experience as a private physician practicing general internal medicine in a local community in Chicago, an equal length of time on the faculty of the University of Illinois College of Medicine, ten years as Chairman of Medicine at Cook County Hospital, a long-term public involvement in many health care issues, and, since November, 1983, appointment as President-designate of the Chicago Board of Health.

An in-depth examination of for-profit trends is timely and of very great importance; there is no more paramount issue in the field of health. The speed and depth of penetration of major health care systems by investor-owned, profit-seeking enterprises has already had significant impact; they may well become the dominant factor in this vital sector.

I should like to examine the key issues in health and attempt to characterize the effects of a marketplace, profit mode on these matters.

Let me start with the overarching question of the day: the cost of medical care. I find the position of marketplace advocates to be marginally persuasive, limited to the benefits of improved management and, on occasion, economy of scale. I hasten to add, however, that the profits from these sources in no small part are simply distributed to the investor-owners, and it goes without saying that good managerial practice and economy of scale can be achieved outside of a profit mode.

More formidable is the undeniable superior access of publicly held corporations to capital, based upon investor optimism about high dividends and stock rises. The remarkable yields of the past decade justify the opti-

mism, but these surpluses pass out of the health system as gain to the investor. The spectre of a bust of these volatile booming stocks threatens a blow to health service of a new type.

On the other hand, many problems of cost are aggravated by this profit mode. It is the legitimate and ethical goal for the managers of such enterprises to seek maximum profit within the laws and regulations of our society. In contrast, the appropriate goal of the health care system as a whole is to enhance the health status of the American people. It seems to me that these two objectives are only occasionally congruent and in many critical instances contradictory. It is the goal of a prudent manager to reduce losses and to substitute higher profit activity for low yield. In the world of health care, uncompensated or low profit transactions, more often than not, are generated by patients with the greatest health care needs but few resources. Studies indicate that for-profit institutions are skilled in limiting or eliminating the underfunded patient. Similarly, high-overhead services of proven value and necessity to our communities may not be offered. The rationale for these investment-protecting decisions is that the profits of these businesses are subject to taxation and thereby they fulfill their proportionate civic responsibility for the omitted services.

To enhance profit, high-occupancy rates are artfully pursued. A pattern of high utilization of profitable ancillary services emerges and the patient mix is controlled to avoid losses. Each of these legitimate business practices can seriously aggravate the fiscal problems of our health system.

Closely linked to funding, of course, is the question of access. In an especially bad expression of exclusionary policies, the for-profits exacerbate a long-time practice in American health care delivery. I refer to "dumping." The public sector has traditionally been the place of arbitrary referral of the underfunded patient by the private sector. As government supports have contracted and unemployment-related loss of insurance has risen, "dumping" has increased. The obvious result is to burden, at times to the breaking point, already fiscally-tormented public hospitals. It is ironic that in this situation, for-profit hospital chains have negotiated scores of Faustian pacts with beleaguered county governments to relieve them of their deficit-plagued public hospitals. The attractive front-end purchase price paid for these hospitals conceals the fact that tax advantages pass the cost of this one-time bonanza back to the taxpayers and soon legitimize rises in the per diem charges based upon the high initial investment and the large debt service costs (which may be paid to a corporate satellite of the new for-profit owner). I view this opportunistic

erosion of our chronically undernourished public sector by investor-owned businesses as an unmitigated disaster.

To achieve significant enhancement of the people's health for the rest of this century and beyond, we will have to shift our vast health expenditures into different channels, away from high cost, high tech, late- or end-stage care and towards prevention, early detection, reduction of environmental and occupational hazards, and changes in disease-producing lifestyles; asymptomatic cancer and cardiovascular disease, faulty nutrition, alcohol and drug abuse, and physical unfitness must all receive attention if we want a rise in our health standards.

At this time less than 2% of our $360 billion annual health expenditure is dedicated to the preventive mode. Expanding the for-profit share of the market will thwart development of public policies which seek to take from the sector where these investments are concentrated and reallocate resources to programs based upon self-help, community organization, improved social conditions and cultural changes—places where profit achievement is very difficult and more risky.

The sudden accelerated rise in profit-seeking health services is not solely the product of physician wealth and wisdom coupled with entrepreneurial empire building. No, this florid growth found nurture in the historic failures of recognized guardians of the nation's health.

Organized medicine too often has acted as if physicians' interests were always congruent with the best health policy; they are not. Prosperous doctors have been in on the ground floor in the formation of major investor-owned health facilities: nursing homes, hospitals, health maintenance organizations, pharmacies, medical laboratories. The potential for conflict of interest and ethical dilemma has stimulated a large concern. At the same time corporate enterprise is rapidly transforming younger physicians into hired hands beholden to company goals.

The insurance industry, much too late, learned that its role had to progress from cash flow facilitator (and thereby the premier health care cost inflator) to innovator of cost-prudent efforts. The profit-seeking world has demonstrably superior skills in maximizing third-party payments.

Since the Second World War the academic medical establishment accepted billions in public largesse and produced a plethora of physicians, 80% of whom were specialized and subspecialized and heavily committed to high-tech solutions, the immediate source of the primary physician shortage.

The federal government by pragmatic and erratic increments assumed

open-ended financial burdens and spurned the responsibility accepted by the governments of most nations to deal with health care and health status as a public trust, a public utility. Forty-two percent of all health costs are now paid directly from public treasuries, and a good deal more is paid indirectly by tax exemptions. We have, in effect, nationalized payment for health services. At the same time we have not allowed the taxpaying public to decide upon allocation and reallocation. Our system places the center of gravity for health policy decisions with the providers.

This legacy of short-sighted and self-serving institutional and professional policies has created the environment wherein the profit-seeking conglomerates have prospered—not by reform but by exploitation of these exploitable policies. Thus, physicians are at once a prime source of venture capital and, increasingly, captive salaried minions. Thus, for-profit chains seek, again by purchase, to enter the world of academe. Thus, powerful profit-mode corporations acquire the faltering public and private not-for-profit institutions made vulnerable by cash-flow and capital-acquisition debilitation.

Finally, I want to note the problems of conglomeration and monopoly. Our automobile industry took nearly a century to contract from scores of producers to the big three, with their attendant financial vulnerabilities, inordinate control of national transportation policies, and imperviousness to the consumers' plea for a smaller, safer, cheaper vehicle. In less than two decades the for-profit hospital chains have combined and recombined into four to five giants. The possibility of local monopolies and the obvious dangers of abuse need no elaboration here. One might add that for all of their aggressive expansionism, the for-profit providers have been on good behavior these fifteen years. Once the stage is largely theirs, the monopoly behavior so odious to this nation could easily be the most serious new distortion of our vast health resources. The for-profit moves to add vertical consolidation (combining hospitals, psychiatric units, health maintenance organizations, home health care and even hospices) to the massive horizontal consolidation of the big chains are harbingers of a for-profit dominance in our system of health care from birth to the grave.

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