Corruption in the health care system: the circumstantial evidence

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Abstract

Health care systems are under intense scrutiny, and there is an increasing emphasis on patient safety and quality of care in general. Evidence continues to emerge demonstrating that health systems are performing at sub-optimal levels.

The evidence includes the under-use, over-use and mis-use of health care services; new standards asking for respect, dignity, honesty and transparency; the corporatisation of health; and the existing inequalities in power and health outcomes.

Recommendations for improving health care often refer to increasing the level of collaboration and consultation. These strategies are unlikely to remedy the root causes of our ailing health systems if we accept the circumstantial evidence that suggests the system is rotten.

Questioning our views about our health system

The health care system is under intense scrutiny throughout the world. There is an increasing emphasis on patient safety and improving the quality of care (President's Advisory Commission 1997, Kohn et al 1999, Corrigan et al 2001, NHS Department of Health 2000, Australian Council for Safety and Quality in Health Care 2000, Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary, 2001). Over the last thirty years the clinical research evidence has emerged demonstrating unequivocally that health systems throughout the developed world are performing at sub-optimal levels (Kohn et al 1999, Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary, 2001).

The many remedies proposed for a better health care system in the future often refer to the need for increasing the level of collaboration and consultation between the health funders, providers and patients. See for example President's Advisory Commission (1997), Kohn et al (1999), Corrigan et al (2001), NHS Department of Health (2000), Australian Council for Safety and Quality in Health Care (2000), and the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary (2001). Most people would correctly interpret these references to collaboration as meaning to 'work jointly' for the greater good. However, we should recall the Oxford dictionary definition includes a more sinister interpretation. The word collaborate also means to 'co-operate traitorously with the enemy' (Sykes 1982).

The enemy in this case is somewhat intangible. However, it can be conceptualised as the current health system, which has not delivered the desired health outcomes that are possible with current professional knowledge. Collaboration within this existing structure is unlikely to remedy the root causes of our ailing health systems. If we want progress, we need to re-examine the health care system by focusing on it as an organisation or corporation that has deviated from the core goal of delivering health.

This re-examination may lead a cynic to suggest that the cause of deviation from the core goal has occurred because the current health care system is corrupt, with collusion between the health funders and providers at the expense of the patient. This essay examines the issues in a deliberately provocative manner to stimulate a more diverse discussion about the current health care system.

Corruption in healthcare systems

Most health professionals would be insulted by the statement that they were part of a corrupt health system. This is understandable because of the long standing perceptions regarding altruism, ethical and moral standards of health care professionals and the low levels of corruption in developed countries. However, if we examine the situation in a dispassionate and an objective manner, health professionals in developed countries may accept the possibility there is a subtle form of corruption in the current health system.

The word corrupt literally means rotten, depraved, wicked. Corruption refers to decomposition, moral deterioration; perversion from its original state (Sykes 1982). No one would deny there are corrupt individuals in health care and many would readily cite the example of Shipman, a general practitioner in the United Kingdom who systematically murdered hundreds of his patients (Dyer 2001) and gained financially.

However, this does not prove system-wide corruption. As shown in Table 1, The World Bank typology for system wide corruption describes two different types: state capture and administrative corruption (The World Bank 2000). Where is the direct evidence of system wide corruption in health care? Clear examples are seen in the tobacco and pharmaceutical industries' funding of research and fraudulent insurance claims for health services that were not delivered.

The case we present is not about these obvious examples where there is a clear intention to distort practice and there is a financial gain. The case we wish to make is that despite our best intentions there is something rotten about the current health system.

Consider our case, which is based on circumstantial evidence from many different sources:

- evidence from clinical research trials that clearly demonstrate under-use, over-use and misuse of health care services (Chassin 1998)
- evidence from accreditation organisations that call for respect and honesty in the standards of practice
- evidence that the corporatisation of institutions potentially compromises their core goals and values
- evidence from examples of inequality in health that could be interpreted as collusion between stakeholders in the health care system.

First, evidence from clinical research trials that clearly demonstrates under-use, over-use and misuse in health care. Under-use refers to the failure to provide an effective service when it would have produced favourable outcomes (Chassin 1998).

Exhibit 1. Patients who suffer an acute myocardial infarction should receive treatment with aspirin unless there is a contraindication. Ellerbeck et al (1995) found that only 83% of the patients who were 'ideal' candidates for treatment received aspirin during hospitalisation.

Exhibit 2. Post-menopausal women with early-stage breast cancer that is positive oestrogen receptor status should receive hormonal therapy. Guadagnoli et al (1998) found that only 59 - 63% of eligible women received hormonal therapy.

Exhibit 3. The management of schizophrenia treatment. Young et al (1998) found that 70% of patients with significant psychotic symptoms received poor management of their symptoms. This is in a group of patients that had been treated at a clinic for at least 3 months and been in hospital for a stay of less than 21 days.

There are many more examples of under-use documented in the Institute of Medicine report titled 'Crossing the quality chasm: a new health system for the 21st Century' (Corrigan et al 2001).

In other words, the issue of under-use is the same as a shopper being continually short-changed at a supermarket, or as a retailer being told that their requested supplies of white goods have not all arrived because some items had fallen off the back of a truck.

Reasonable explanations for this level of under-use in health care include financial barriers. Moreover, the large volume and increasing complexity of medical research means it is no longer possible for the individual clinician to know all that is required for the practice of evidence-based medicine (Chassin 1998).

Overuse refers to the provision of a health service when its risk of harm exceeds its potential benefit (Chassin 1998).

Exhibit 4. Prescription of antibiotics for the common cold. Nyquist et al (1998) found antibiotics were prescribed at 44% of visits of patients with the common cold.

Exhibit 5. Elective hysterectomy for non-oncological indications. Bernstein et al (1993) found that 16% of hysterectomies were inappropriate, and 25% were for equivocal indications.

Exhibit 6. Coronary artery by-pass graft surgery. Leape et al (1996) suggests that 1.65% of surgery were inappropriate and 7% were for equivocal indications.

In other words, the issue of over-use is the same as a mechanic replacing your car engine when all that was needed was an oil change and tune-up.

Explanations suggested for overuse in health care include fee for service payment methods, clinician enthusiasm, the nature of referral to specialists, defensive medicine and an expectation that doctors should "do something" (Chassin 1998).

Misuse refers to the avoidable complications of appropriate health care (Chassin 1998).

Exhibit 7. The Harvard Medical Practice Study, based on practice during 1984 in New York hospitals documented a rate of adverse events of 3.7% per hospitalisation, of which 27.6% were "negligent" (Brennan et al 1991).

Exhibit 8. Quality in Australian Health Care Study based on practice during 1992 in two states of Australia documented a rate of adverse events of 16.6% per hospitalisation, of which 51% were 'preventable' (Wilson et al 1995).

Exhibit 9. The Utah Colorado Study based on practice during 1992 in 28 hospitals. This study documented the presence of 2.7% adverse events per hospitalisation, of which 32.6% (Utah) and 27.4% (Colorado) were "negligent" (Thomas et al 2000).

These negligent adverse events resulted in a significant number of deaths and permanent disabling injuries. Extrapolations from the study by Wilson et al (1995) are that there are 18000 preventable deaths each year in Australia.

The results of these studies are widely debated and have not been universally accepted because of significant methodological limitations. However, what is beyond contention is that a significant problem exists.

In other words, the issue of misuse is the same as a chef not washing their hands and the customer contracting Hepatitis A from eating the prepared meal.

Explanations for misuse relate to the complex nature and structure of the health care systems. Health care service delivery is dependent on idealised standards that require individuals to perform tasks at levels of perfection that are not humanly possible (Chassin 1998).

These examples demonstrate a certain degree of incompetence. If interpreted in light of the everyday comparisons, they would begin to raise questions about the health system being rotten and wicked. We would agree with it being called rotten but we do not believe it is wicked because these sub-optimal practices are not intentional and rarely present health professional with any financial gain.

The second type of evidence concerns the standards of care developed by accreditation organisations. Accreditation standards provide an insight into the industry's perceptions of the state of health care. The standards required for the accreditation of health care organisation include calls for respect and honesty in the delivery of health services. Consider the following examples.

Exhibit 10. In France the national accreditation system includes a standard which states;

"Standard 6: The patient's privacy, personal dignity and liberty are respected throughout their stay or consultation (ANAES 1999)".

Exhibit 11. A similar message is present in Australia. The ACHS criterion 1.5.3 states; the 'Rights and needs of patients/consumers are considered and respected by all staff (ACHS 1999)".

These are concepts are so fundamental that not only do we expect the health care system to adhere to them but these ideas are embedded in the social fabric of society. Why is it necessary for these concepts to be re-iterated in health care standards? Perhaps the presence of these statements suggests the health care system is failing to consistently deliver on these ideas.

The third piece of evidence is that the corporatisation of institutions potentially compromises their core goals and values. The recent action of Nottingham University, which is accused of being an accomplice in the tobacco epidemic, demonstrates this point (Cohen 2001). Nottingham University recently accepted £3.8m from British American Tobacco to establish a centre for corporate social responsibility. Some would call this ironic. The arguments for accepting money include the supremacy of academic freedom, the constant need for more funds, and the existence of ethical guidelines to protect research from undue influence (Campbell 2001).

It is even easier for health care organisations and health professional to use the very same arguments to justify their more questionable practices. The US Senate Committee on Finance has been investigating the practice of training doctors about coding and billing practices to teach doctors how to bill at a higher level (Charatan 2001). These seminars were a mandatory requirement for doctors employed at some medical centres. The practices of 'gaming', DRG creep, financial assistance from pharmaceutical and technology companies are often explained by health professionals in terms of being for the greater good of their patients and community. This introduces the possibility of collusion, and brings us to the fourth piece of evidence that suggests the current health system is corrupt.

Collusion

Collusion refers to fraudulent secret understanding especially between ostensible opponents (Sykes 1982). The fourth type of evidence is the existence of inequality in health and health care services. Consider these three examples of inequity: the health status of indigenous populations, the lack of stroke units, and the recent emphasis of a trial of labour among women with a prior cesarean delivery.

Exhibit 12. Health status of indigenous populations. The inequalities in health status between the indigenous population and rest of the Australian population have been well documented. The most dramatic example is the difference in life expectancy between these two groups. The indigenous population have life expectancy that is reduced by at least 8 years and up to 20 years (Australian Institute of Health and Welfare 1998). Significant inequalities also exist along socio-economic gradients.

Exhibit 13. Lack of stroke units. The provision of care in a dedicated stoke unit has been shown to save lives and in the UK only 18% of patients have a significant period of their hospital care in a stroke unit (Wolfe et al 2001). However, the debate about the need for specialist acute care for stroke remains because the resources and effort spent on the research and clinical care of patients with stroke is generally regarded as a poor relation to cardiovascular disease.

Exhibit 14. Management of labour among women with a prior cesarean delivery.

In the United States, the overall cesarean section rate peaked at 25% in the late 1980s. Initiatives to reduce the rate included encouraging a trial of labour among women with a prior cesarean delivery. These initiatives included quality improvement programs, changes to payment rebates by health insurers and the setting of a national goal of 15% through the Healthy People 2000 program.

Subsequent research has shown that women who undergo a trial of labor have a threefold increase in the rate of uterine rupture compared to women who have an elective repeated cesarean section (Lydon-Rochelle et al 2001). The major consequences of a uterine rupture include a tenfold increase in the risk of perinatal mortality.

Although the absolute rates of death are small (1 more perinatal death for every 417 trials of labor), if a women asks "what is the safest thing for my baby?" the answer is an elective repeat cesarean section (Green 2001).

What are the perceptions of the indigenous population, patients with stroke and women about the current health system? It is plausible that perceptions of collusion between and within health funders and health providers would arise as a possible explanation for these situations.

The alternative explanations for all these events are based on the unique complexity of health services. This arises from the difficulty of defining and measuring outputs. The work is highly variable and complex, with little tolerance for error and requiring extremely high degrees of specialisation and coordination between diverse professional groups (Shortell and Kaluzny 2000). These are reasonable explanations, although, perhaps distracting us from facing the reality of the situation, and maintaining the current power structures within health system.

Law 32 of The 48 Laws of Power (Greene 2000) states; "Play to people's fantasies. The truth is often avoided because it is ugly and unpleasant. Never appeal to truth and reality unless you are prepared for the anger that comes from disenchantment. Life is so harsh and distressing that people who can manufacture romance or conjure up fantasy are like oases in the desert."

If we accept the argument that there is something rotten in the current health system and that its main purpose has been perverted what can be done. General concepts are seen in the World Bank recommendations of a general strategy to combat corruption in countries undergoing economic transition, as summarised in Table 2 (The World Bank 2000).

More specific ideas can be obtained from the recommendations of the inquiry into the Bristol Royal Infirmary where 35 children died after undergoing cardiac surgery as a result of inadequate care (Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary, 2001). The recommendations of the Inquiry were grouped under seven headings (see Table 2). Two of these recommendations overlap significantly with the World Bank's general strategies. The World Bank refers to reforming public sector management, and the Bristol Inquiry calls for a health service which is well led. The other area of overlap is strengthening civil society participation or public involvement through empowerment.

Many would argue these changes are already under way, citing the initiatives for greater consumer involvement as an area where progress is being made and suggesting this is a significant change from the past. A consumer focus is an important imperative to redressing the balance of power in the current health system. A common strategy for consumer involvement is through consultation that is a process of deliberation, seeking information or advice from, or to take into consideration (feelings, interests) (Sykes 1982).

How genuine is the process? Do we have a truly open consultation or merely the appearance of one where health professionals still control the options? Law 31 of Greene's 48 Laws of Power (Greene 2000) states "Control the options: get others to play with the cards you deal. Give people options that come out in your favour whichever one they choose. Force them to make choices between the lesser of two evils, both of which serve your purpose."

Conclusion

As we re-define the standards of care and community expectations for quality health care are strengthened, perceptions about the reasons and motives for the sub-optimal performance of the health system will change. At present there is little evidence to suggest corruption based on the World Bank typology of state capture and administrative corruption. However, there is a strong case based on the circumstantial evidence that the current health system is rotten. The evidence includes the level of under-use, over-use and mis-use of health care services, the new standards asking for respect, dignity, honesty and transparency from health services, the corporatisation of health and the existing inequalities in power and health outcomes.

We must re-examine the health system with this in mind. Our current understanding of the reasons for the sub-optimal performance may be wrong, and therefore the proposed solutions may not succeed. Collaboration and consultation are meaningless if the system is rotten.

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Table 1: World Bank typology for system wide corruption (The World Bank 2000)

Typology
"State capture refers to the actions of individuals, groups or firms in both the public and private sectors to influence the formation of laws, regulations, decrees, and other government policies to their own advantage by means of illicit and non-transparent provision private benefits to public officials"
"Administrative corruption refers to the intentional imposition of distortions in the prescribed implementation of existing laws, rules, and regulations to provide advantages to either state or non-state actors as a result of the illicit and non-transparent provision of private gains to public officials"

Table 2: concepts and strategies to combat corruption

The World Bank (2000) Infirmary (2001)	Public Inquiry into Children's Heart Surgery at the Bristol Royal
(a) Increasing political accountability	(a) Respect and honesty
(b) Strengthening institutional restraints within the state	(b) A health service which is well-led
(c) Strengthening civil society participation	(c) Competent healthcare professionals
(d) Fostering an independent media	(d) The safety of care
(e) Creating a competitive private sector	(e) Care of an appropriate standard
(f) Reforming public sector management	(f) Public involvement through empowerment
	(g) The care of children