A Course on Sowing Seeds of Social Beauty

Presentation 3

The Children's Hospital Public Economy Model (CHPEM)

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This presentation, which explains the Children's Hospital Public Economy Model (CHPEM)" is the third presentation of "A Course on Sowing Seeds of Social Beauty."

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The course is based on a book entitled "Sowing Seeds of Social Beauty," which is posted on my website (www.notesfromthesocialclinic.org) where all 54 of its chapters may be downloaded and read for free. Here are the front and back covers of the book.

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In this presentation, I will explain how and why public children's hospitals came into being; how they were initially organized, operated, and funded; what the culture was like in those hospitals; what the guiding social understandings and behavioral principles were; and how the CHPEM generated great Social Beauty within those hospitals.

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Since at least the 1950s, Academic Pediatricians throughout the world have practiced an altruistic Public Economy Model---the Children's Hospital Public Economy Model CHPEM) or the Children's Hospital Model (CHM), for short---and have developed a loose, informal Collaborative International Network of Pediatricians and Public Children's Hospitals that practice the CHPEM.

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This model resulted in great Social Beauty within children's hospitals.

The model was developed in exemplary fashion in Canada. Accordingly, I will be describing the development of the model throughout the provinces of Canada.

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The CHPEM is a <u>needs-based</u> model that starts with the question, **"What do children need?"** For example, children need primary care clinics, pediatric sub-specialists, various levels of hospital care, clinical and basic science research, and an educational system to train pediatricians (and other health care workers) and share new knowledge.

The next question is **"What is the best way to organize the above needs-meeting effort?"**

In Canada, it was recognized that each large metropolitan area needed a medical school-affiliated children's hospital, and it was decided to publicly fund these medical schools and hospitals. The province of Alberta, for example, has two major metropolitan areas, Edmonton and Calgary. Accordingly, there is a publicly-funded medical school and a publicly-funded children's hospital in each of those two cities. Each children's hospital is staffed with sufficient types and numbers of academic pediatricians to meet the needs of the population of children in that particular geographic area, including surrounding rural areas.

Canada chose to develop a large collaborative national network of independent-but-closely-linked, geographic/population-based academic pediatric medical centers—consisting of public children's hospitals affiliated with public medical schools in provinces throughout Canada.

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Each Children's Hospital within the Canadian Collaborative Network of Provincial Public Children's Hospitals operates according to a cost-based, budget-based, altruistic economic model. There is no interest in "making money." That is not the purpose of these hospitals. Their purpose is to responsibly meet the needs in their geographic/population area, not to make a profit. The hospitals are guided by moral incentive, not monetary incentive.

A key to the success of the CHPEM and the national network of children's hospitals that practices this model is the CHPEM's emphasis on populating positions of leadership with exemplary "altruistic natural leaders." Altruistic natural leaders have an innate and practiced ability to lead with exemplary kindness, altruism, empathy, trustworthiness, fairness, competence, wisdom, charisma, incorruptibility, humility, and effectiveness. These greatly admired "natural leaders" are asked by their colleagues to please serve as leaders. Accordingly, the provincial governments can trust the budget requests made by these leaders.

Each Children's Hospital is funded according to an appropriate budget presented by the Children's Hospital to the Provincial government. The natural leaders of the Children's Hospital base the budget on actual appropriate costs, including appropriate salaries for physicians, nurses and other employees who are asked to perform appropriate workloads with appropriate efficiency. All physicians are on salaries; there is no fee-for-service billing. Because the Provincial government knows that the children's hospital is led by exemplary altruistic natural leaders, the Provincial government trusts (within reason) that the hospital leadership is presenting an appropriate budget, and trusts that the hospital leadership is committed to running the Hospital in an appropriately efficient way—neither skimping too much, nor being too extravagant. The definition of "appropriate" is democratically determined, with input from all concerned, including patients/parents. The entire network of children's hospitals is guided by an altruistic spirit and work ethic and an emphasis on accountability, fairness, and trust. A guiding principle is that "The highest Duty is to think of others." Another term for this economic model would be an "Appropriate Budget Economic Model."

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Philosophically, the foundational understandings upon which the Children's Hospital Public Economy Model (CHPEM) is based are:

- A positive, nuanced, comprehensive understanding of Human Nature that emphasizes the spectrum of human behavioral capacities that we all have, and emphasizes that the social and economic milieu can either upregulate the expression of our non-altruistic capacities and down-regulate expression of our capacities for altruistic behaviors (as is the case with corporate capitalism) or do the opposite, up-regulate expression of our altruistic capacities and down-regulate expression of our capacities for non-altruistic behaviors (as is the case with the CHPEM).
- An understanding that "moral incentive" is a sufficient motivating factor and that "monetary incentive" is neither essential nor desirable.
- An understanding that it is best to fill positions of leadership with "altruistic natural leaders" who have demonstrated exemplary altruism, honesty, kindness, and incorruptibility---as opposed to filling positions of leadership with those who are inclined to upregulate expression of their non-altruistic capacities.
- A positive, accurate understanding of the true nature and role of "competition," particularly the understanding that the word "competition" comes from the Latin "com petere," which means "to seek (new heights) together.
- An understanding that "monetary incentive" and capitalism's perverted version of competition are not necessary for motivation, innovation or creativity.
- An understanding that private free enterprise and free market activity are not essential for a successful social and economic model. Instead, a different kind of freedom might be the most precious of all---the freedom to enjoy widespread upregulation of the expression of human altruistic behavioral capacities---upregulation in oneself and in society as a whole. This "precious freedom" is provided by a public economy, but not by a corporate capitalist economy.

When practiced well, the CHPEM creates an abundance of Social Beauty and A Most Precious Freedom within the hospital.

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In contrast, the corporate capitalist economic model is based upon a set of highly flawed versions of these social understandings. For example,

- A negative, incomplete, simplistic, and inaccurate understanding of Human Nature.
- An insistence that monetary incentive is an essential and desirable motivating factor and that moral incentive is an inadequate motivating factor.
- A leadership model that deliberately populates leadership positions with individuals who are willing, able, and prefer to upregulate expression of those non-altruistic behavioral capacities that will best serve the financial bottom line of the corporation.

- An inaccurate and simplistic understanding of the role and nature of competition.
- A belief that monetary incentive and capitalism's version of competition are necessary for motivation, innovation, and creativity.
- A belief that individual liberty and the opportunity to maximally pursue one's self-interest (with the least amount of governmental interference possible) are the most important freedoms.

The profound differences between corporate capitalism's foundational social understandings and the foundational social understandings of the CHPEM will be discussed more fully in a later presentation.

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A key to the success of the CHPEM and the informal Canadian national network of children's hospitals is that the public Children's Hospitals within this national network collaborate and coordinate with one another to improve care for children. There is no cut-throat competition or empire-building. To the contrary, an important goal of the children's hospitals is to help each other become better. Each children's hospital freely shares its expertise and new knowledge with all other children's hospitals. Regular local, provincial, and national educational conferences are scheduled to share information. There is no such thing as "intellectual property rights." The academic pediatricians write articles and gladly share their new research insights freely, via medical journals and conferences. They do not sell their knowledge, nor do the recipients buy it. Health care, medical knowledge, and medical expertise are not considered "commodities" for sale; they are considered public property to which the public has a right to free access. Health care and health information are viewed as a Human Rights. A physician's opportunity and ability to serve is considered to be his/her privilege and honor.

In addition to participating in the Canadian Collaborative National Network of Public Children's Hospitals, each children's hospital similarly participates in a Collaborative International Network of pediatricians and children's hospitals, whose values and goals are the same.

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Importantly, all children's hospitals in the network are committed to practicing the fundamental principles of science, medicine, ethics, and democracy. For example, data must be collected in an honest, scientifically-sound fashion and must be honestly presented and honestly explained. All plausible hypotheses need to be honored. Thorough patient education must be offered. Demystification is a key to good clinical practice. A proper process of informed consent must be strictly followed.

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This same needs-based, cost-based, budget-based, science-based, altruistic, collaborative economic model has been practiced by academic pediatricians throughout the world for decades, to the great benefit of the world's children.

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A good example of the creativity, innovation, and efficiency of this collaborative public economy model is the progress made in treating childhood leukemia. In the 1970s pediatric hematologists/oncologists at public children's hospitals in the USA and Canada pioneered the development of The Childhood Cancer Study Group---a multi-center collaborative clinical research effort---to advance progress in treating leukemia. Thanks to this altruistic collaborative Public Effort, the mortality rate for Acute Lymphocytic Leukemia (ALL) went from 90% in the early 1970s to less than 10% by the 1990s. The knowledge gained has been freely shared with pediatric hematologists throughout the world. Not only has this collaborative Public Activity been extraordinarily successful, but it has also been a necessary approach to the problem—i.e., such success probably would not have occurred without this collaborative Public Effort, at least not as quickly and efficiently. For decades, pediatricians in all specialties have, similarly, freely and selflessly collaborated and shared their research and knowledge with other pediatricians, nationally and internationally.

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At this point it is important to emphasize that with the CHPEM **each individual children's hospital is independent and is encouraged to develop in its own creative way, according to its unique local conditions**. Although the CHPEM strongly encourages collaboration, there is no central authority that dictates how all members of the network are to think, operate, or behave. **The CHPEM is a decentralized model that encourages local decision-making and local innovation**. Although there is no central authority, there is, however, a strong central unifying spirit---the altruistic spirit and the specific underlying philosophical principles of the CHPEM, including its commitment to honoring the fundamental principles of Science, Medicine, Ethics, and Democracy.

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So, for decades, Academic Pediatricians, particularly in Canada, have already demonstrated the success and value of the CHPEM, including the feasibility and value of developing a Collaborative National Network of Public Children's Hospitals, and an informal Collaborative International Network of National Public Children's Hospitals. For decades, Children's Hospitals throughout the world have been practicing a needs-based, cost-based, appropriate budget-based, altruistic economic model. **This model (the CHPEM) has not simply been developed in theory, it has actually been practiced, for decades, and has already proved to be of great benefit to the world's children, at an affordable price for societies.**

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Furthermore, the vast majority of Academic Pediatricians have found this Academic Pediatrics Economic Model (the CHPEM) to be very meaningful, gratifying, and emancipating. The vast majority would not wish to have approached their work in any other way. They like the Public Economy Model, including the opportunity and freedom it provides to enjoy expressing altruistic capacities—individually and collectively. They have enjoyed the freedom to plan and act altruistically. They have treasured this "most precious freedom.

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Unfortunately, over the past 30 years, or so, children's hospitals, including those in Canada, have become increasingly corporatized, at the administrative level, particularly in the USA. This corporatization has brought a new leadership model to many children's hospitals. Altruistic natural leaders have been considered a "poor fit" and have been replaced by corporate-minded leaders. Monetary incentive, revenue generation, maximization of fee-for-service billing, cut-throat competition, empire-building, and other corporate behaviors and priorities have been emphasized and have replaced altruistic goals and behaviors. This has threatened opportunities for altruistic pediatricians and pediatric nurses to practice the CHPEM and has threatened the very survival of the CHPEM.

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Children's hospitals, therefore, have existed in two different eras--- the "Social Beauty Era" of children's hospitals (which could also be called the "Altruistic Era" or the "CHPEM Era"), which was from approximately 1955-1995, during which time the CHPEM flourished within children's hospitals. Then, the "Corporate Era" of children's hospitals, which started in approximately 1995 (at least in the US) when the corporate capitalist model was undemocratically imposed on children's hospitals.

The CHPEM flourished during the altruistic era but is now struggling for its survival during the corporate era.

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For decades academic pediatricians, especially in Canada, experienced the proven value and success of the CHPEM, during the Altruistic Era. More recently, they have also experienced the adverse effects of the corporatization of children's hospitals, during the Corporate Era.

In fact, they have been greatly disturbed by the increasing encroachment of a private corporate business mentality into the administrative workings of pediatric institutions (particularly in the USA). That corporate mentality has been increasingly down-sizing (even punishing) altruism, over-extending physicians, and adversely transforming behaviors within our children's hospitals, particularly at leadership levels. The altruism and "most precious freedom" that

pediatricians once enjoyed have been under assault (at least in the USA), and children are suffering because of it.

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During the "Altruistic Era" the CHPEM thrived and created Kind Social arrangements and Social Beauty. During the "Corporate Era" corporate capitalist principles are thriving and compromising those Kind Social Arrangements and Social Beauty.

It is time, now, for caring physicians to reverse the corporate trend, restore Social Beauty in our Children's Hospitals, and create Kind Social Arrangements and Social Beauty throughout Healthcare, including the pharmaceutical industry.

FURTHER READING:

For further information about the CHPEM please see:

- Chapter 12: The Social Beauty of Children's Hospitals
- Chapter 13: The Children's Hospital Public Economy Model (CHPEM)
- Chapter 14: The Foundational Pillars of the CHPEM
- The Social Beauty of Beijing Children's Hospital: https://notesfromthesocialclinic.org/the-social-beauty-of-beijing-childrens-hospital-a-power-point-presentation/
- The Social Beauty of Beijing Children's Hospital (Slide-by-Slide Narrative of the PPT Presentation): https://notesfromthesocialclinic.org/the-social-beauty-of-beijing-childrens-hospital-slide-by-slide-narrative-of-the-pptpresentation/