Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

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Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated. For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE TWENTY-THIRD ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Visions of a Health Care System: What Do We Have, What Do We Want, and How Do We Get It?

The health care system in the United States is in flux and in chaos. Many details are questioned and defended, and many interest groups vie for adjustments to their own advantages. Some comprehensive, coherent, overall perspective is needed to provide a framework for care, the disposition of resources, and the support of recipients, providers, and administrators. But there are as many perspectives as there are constituencies of the health care system. This Lindemann Lecture will offer visions from the points of view of several crucial participant groups of a) the current state of health care, b) a desirable comprehensive health care system, and c) the actions needed to move from a) to b). How can we get good health care or give good health care without a functional health care system? This lecture honors Erich Lindemann, PhD, MD, pioneer and seminal figure in social and community psychiatry, and is a forum for social psychiatry, public health, and social welfare.

Participants

Anne G. Hargreaves, RN, MS, FAAN, President, Massachusetts Association of Older Americans

Alan Sager, PhD, Professor, Boston University School of Public Health.

Steffie Woolhandler, MD, MPH, Associate Professor of Medicine, Harvard Medical School; Member, Ad Hoc Committee to Defend Health Care; Member, Physicians for a National Health Program.

Bernard S. Arons, MD, Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Moderator

David G. Satin, MD, LFAPA, Assistant Clinical Professor of Psychiatry, Harvard Medical School; Chairman, Erich Lindemann Memorial Lecture Committee

Friday, May 19, 2000, 2:30–5:00 pm

Massachusetts School of Professional Psychology
221 Rivermoor Street, Boston, MA 02132

Introduction by David G. Satin, MD

Organized consumers are indulging in short-term, enlightened self-interest as their main concern seems to be—"Keep the premiums down!" and they seem to have lost the concept of "It is our [health care facility] and as a vital institution in our community we should understand it and help to improve it." Medical Staffs still view the hospital as their host and their work-shop and have generally resisted collective action to help reduce [health care] costs by closer attention to admitting and discharge policies and willingness to accommodate themselves to the needs of the institutions (e.g. [evenly distributed work hours], planned vacations to maintain an even [patient flow], exerting a staying hand on overzealous…ordering multiple tests and so on). Medical school deans and their faculties have preoccupied themselves with a curriculum which has not undergone significant change since the Flexner report in 1910 and leaves the student to his own devices as regards the social 'science' of medicine. Hospital Directors criticize their staffs for lack of interest in the hospital and its overall problems and yet make no efforts to communicate the problem clearly and succinctly to the staff and to enlist their help, based on understanding of the problems. Politicians make hay with the present apathetic confusion and the lack of any clear, persistent voice from the medical profession except, 'Make no change—the problems will solve themselves!' The voice from the voters is clear, even if unrealistic: 'Keep the standards up and the costs down!'

On this battlefield of disarray, every vested interest is fighting but only a few understand or want to understand the vital interrelationship amongst all these interests on a long-term basis. The world is full of specialists and cries out for generalists. The summit is crowded with politicians and bereft of statesmen. The orbit of patient, doctor, hospital, medical school, [health insurer], State and Federal Welfare Department, union leader, 'healthy' public and political representative must be closed and strengthened if the best medical care is to be available to the citizens of this country. Indifference or lack of responsiveness and understanding on the part of any of these vital elements will weaken the whole purpose of medicine and jeopardize the highest attainment of its goals (pp. 47-8).

Some of those who graze in the upland academic pastures in the foothills of Mt. Olympus believe that socialized medicine will solve our financial problems. A glance at some of the results should bring this attitude up short—specifically what has happened to the Boston City Hospital, the Jackson Memorial Hospital [in Miami], and Houston's Jefferson Davis under the heel of politically determined priorities on the tax dollar. If we don't fight now for the money to provide the highest standards and the best facilities, will we be any more effective when the money is being doled out from Washington and local City, County and State Departments (p.46)?

How accurately does this analysis and prescription fit our health care system? With relatively few exceptions, I think, though it was presented in December 1964 by

John H. Knowles, M.D. (General Director, Massachusetts General Hospital and Professor of Medicine, Harvard Medical School), under the title "Medical School, Teaching Hospital and Social Responsibility: Medicine's Clarion Call" to the Second Institute on Medical Center Problems, of the Association of American Medical Colleges [Miami, FL, 12/9/64] and at a panel meeting of the Task Force on Economic Growth and Opportunity, U.S. Chamber of Commerce [Washington, D.C. 12/10/64].

What has happened in the 36 years since this insightful clinician, administrator, and planner tried to galvanize us into action? It seems to me that, like the proverbial Sir Ronald, we "rode off madly in all directions." There has been a certain amount of government responsibility, for instance, in the development of Medicare and Medicaid and regulation on the federal and state level. There has been a lot of turning to free private enterprise with the, to me, naïve belief that business would bring efficiency and economy, while ignoring the fact that it brings a focus on profit and growth. And to some extent private groups, large and small, clinicians and patients and community advocates and health care institutions, have organized to counterbalance or replace government and business approaches to health care.

An up-to-date view of the health care system appeared in the "Downtown" column by Steve Bailey in the Business section of the Boston Globe on January 26, 2000:

> Deborah Colon was eight months pregnant when she got caught in the hot crossfire of today's health-care wars. Expecting her first child, Colon had been going to Brockton's Caritas Good Samaritan Medical Center since it was Cardinal Cushing Hospital and she was a 5-year old. Days before her delivery, she fully expected to have her baby at Good Sam.
>
> That's when she got caught in the crossfire. Suddenly her doctor was telling her that her doctors' group was moving its patients from Good Sam to Brockton Hospital. Colon wanted to stay at Good Sam; but could she? ‘Call us when your labor starts and we'll tell you where to go,’ the nurse at the doctors' group told her. ‘I don't think so,’ Colon replied. She dumped her doctor. Her baby was born the next day at Good Sam.
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> It is every man for himself in medicine today. With not enough money to go around, everyone is fighting for survival. It's the hospital vs. the HMOs, Partners vs. CareGroup, Harvard Pilgrim vs. Blue Cross, and too often the patient against the system. Cutthroat competition is one thing when it's the tire business, another when it's about newborns.

When the pie shrinks, the table manners disappear the problems with health care today—in Brockton and elsewhere-are less about bad guys and more about a system that is broken. What should be a cooperative venture between doctor and patient, doctors and hospitals, hospitals and insurers, has been turned into a life and death struggle for survival. When survival is the issue, cooperation is the first casualty.

We are on a course for more Harvard Pilgrims, more Brocktons. What we need, in fact, is not more finger pointing, but just the cooperation that is being lost. If this is not the moment for a health-care summit in this state, when is?

We are glad to provide a forum for views of a health care system that works.

Anne G. Hargreaves, RN, MS, FAAN

President, Massachusetts Association of Older Americans

Introduction by David Satin, MD

Our first speaker is Anne B. Hargreaves, president of the Massachusetts Association of Older Americans, and of the Massachusetts Women's Overseas Service League. She speaks to us as a recipient of health care, and representative of those receiving care, though with the insights of a nurse, former president of the Massachusetts Nurse's Association, and emerita professor and chairperson of the Department of Psychiatric Nursing at Boston College. I am pleased to see that she was a fellow at the Harvard Medical School's Laboratory of Community Psychiatry, which is an outgrowth of Dr. Lindemann's work. Ms. Hargreaves.

Anne G. Hargreaves, RN, MS, FAAN—Visions of a Health Care System

It is my pleasure to speak to you today at this Eric Lindemann Memorial Lecture. I'm old enough to have known Dr. Lindemann. I was especially appreciative of his work on grief, which I tried to pass on to students at Boston University School of Nursing. My emphases in teaching at BU School of Nursing and Management at Boston City Hospital were on the inter-relatedness of mind and body in care, what the patient and family were experiencing, and the necessity of conveying willingness to help. I'd like to share with you, as a consumer of current health care, my experience at a prestigious Boston Medical Center. To be sure it is through the eyes of a nurse who belongs to the elderly generation.

I was sent to the emergency service by my primary care physician who was on the medical team on the recent TV Frontline Program, "Dr. Solomon's Dilemma." A walk-in, I felt rotten and was vomiting. I asked the clerk for an emesis basin, of which she had a ready supply at her desk, indicating I was not the first person to arrive in such a condition. I was interviewed by a nurse and had what seemed like an endless investigation of my medical insurance. Finally, I saw the doctor, was given medication for my vomiting, and spent the day going through a series of tests. At 5 p.m., I was discharged home. My husband, a stroke victim, had sat in the lobby for eight hours. No one spoke to him during that time. So much for family care.

At 8 a.m. the next day, the nurse telephoned me and said I would have to return to the emergency service because of an elevated blood count. Reluctantly, still feeling lousy, I returned. In spite of my objections, I was again subjected to an extensive interview about my health insurance. For almost two hours I sat in the lobby, lying on a hard

bench most of the time. I finally asked my husband to ask the clerk when I would be seen. Without looking up the clerk said, "she is the next one." Until 6 p.m., I went from x-ray to x-ray, test to test, much of the time lying on a gurney alone in the corridors. My husband again sat in the lobby, no one speaking to him. I asked if he could wait with me while an ambulance was called from outside the hospital to drive me from one part of the hospital to another, as I was to be admitted.

I stayed for three days for testing and evaluation. My diagnosis was acute pancreatitis, ulcers and a large tissue growth on each side of my esophagus. I was to have a biopsy of the tissue, which took a week to schedule, as the doctor was not available. It took a good part of another week for an answer. I requested a second opinion at Dana Farber. When I went there, I waited three hours to see the doctor who advised me to have the surgery. Surgery was scheduled for September 22nd. My sister had arrived from Buffalo, New York, to see me through the surgery and to be with my husband, who had ended up in the hospital with a bladder infection the day I arrived home from my first hospitalization.

I called the day before to confirm my admission, only to be told that because of a communication breakdown, the surgery date was changed to October 5th.

My sister, with other responsibilities, left for home and I waited, distressed about the change of date. You need to know I was anxious. I have never been hospitalized, except for the birth of my two children. I'm allergic to most medications, I'm 76 years old, and I was scared.

October 5th, accompanied by my daughter-in-law, the risk management and quality assurance nurse at the Shriner's Hospital, I was admitted for surgery scheduled at 8 a.m. I awoke from anesthesia at 12 midnight, to see my son, who had replaced his wife on the watch. I was attached to 5 bottles- one a narcotic line, and an oxygen. I eventually learned I had a collapsed lung, a perforated esophagus and reaction to anesthesia.

Even in my confused state I remembered you should get up and sit in a chair to avoid pneumonia. I did so by myself the day after surgery, with all five bottles, only to be chewed out by the doctors who said I might have fallen. At the same time, they did not hear my expressed concern about being disoriented, not knowing what day or time it was, and the hallucinations I was having: bloody spider webs on the walls and yellow bubbles filing the room threatening to drown me. They told me when the narcotic was removed, I would be okay. In a week it was removed and the struggle with the pain and out of control blood pressure went on until discharge 16 days later.

I had three medical services: surgical, medical and pain, and my primary care physician. I couldn't tell them apart and I'm not sure they talked to each other. Nurses are so busy admitting and discharging patients, and documenting, that they have no time to relate to patients. Second shifts are common. Everyone is in a hurry and frustrated.

Modern technology, as wonderful as it is, has dehumanized care. Missing is sympathy, empathy and compassion. I was truly concerned about my sanity and soundness of mind. No one listened to my thoughts and feelings; there was little warmth and respect. As an elderly person, I felt discriminated against.

I'm used to a constructive relationship between patient and staff. I found a lack of sensitivity to suffering, to stress and anxiety, to how vulnerable a person feels when sick. There was no working together. I recall a study done years ago on hospitalized doctors and nurses, which found they were not treated as other patients. We are not expected to get sick and then we do, we are not provided information—it's like we should know.

What do we want and how do we get it?

To me managed care is managed cost, and it is not working. We need to have managed care of the patient with decisions made on the needs of the patient. I felt no sense of rapport. I was dismissed as an "old lady," I was referred to by one doctor as the "King of Nurses," only to have a nurse correct him and say "Queen of Nurses." Hospital staff needs to understand the natural results of the aging process. Physical complaints may be exacerbated by the role accorded to the elderly. Feelings of loneliness and abandonment are common and depression sets in which deserves serious attention. Many my age are afraid to assert themselves.

As important as drugs are in the treatment of the elderly, because of possible complications, they must be used judiciously. We are more prone to side effects, especially with narcotics and hypnotics. I had a series of drug reactions, one after another, and earned the reputation of being non-compliant when I objected and asked a doctor be called when my blood pressure went sky high in the middle of the night. The "cook book" approach to prescription defies medical science and common sense. People respond differently to medications depending on age and inborn ability to process drugs. Medication reactions are now a leading cause of death in the U.S. We can't expect everyone to tolerate the same drug and doses.

With the focus on cost in health care there have been consistent cut backs in numbers of nurses and their qualifications. Unfortunately there has been little research on the affect on patient outcomes. The Worcester Nurses strike has demonstrated how hospitals accommodate to reduced staffing by double shifting, causing resentment and leading to errors and accidents.

Peter Buerhaus at the Harvard Institute of Nursing and Jack Needlemen at Harvard School of Public Health are attempting to correlate the relationship between staffing levels and patient outcomes funded by the JCAH Organizations. They have announced a new standard for the effective management of pain for hospitals, home care agencies,

nursing homes, outpatient clinics and behavioral health facilities to go into effect in 2001. They will require plans of care to assess and manage pain, believing unrelieved pain has enormous physiological and psychological effects on patients. Research has indicated unrelieved pain can slow recovery, create burdens for the patients and families, and increase the cost of care.

In Summary

My usual psychic state was disrupted for over a week—I was confused, anxious, and hallucinating. When the narcotic medication line was removed, the pain created an out of control blood pressure, generating further anxiety, which I was discharged with. The side effects of medications administered to control the pain created more anxiety, which no one seemed to recognize, except me when I was in crisis, until the Waltham Visiting nurses helped get things under control by talking to my primary care doctor and getting me into a pain clinic. Pain I understand can go on for a year—I got myself off medication after 6 months. Out of my experience I've had reinforced the need to focus on relating services to needs and developing ways of meetings people's needs in the most relevant and comprehensive manner possible.

The human aspects of care seem to have low priority today. Doctors and nurses seem to have an underlying anger about the system they are operating in, and I can tell you the elderly are not happy with that is happening to them. What I'm asking for will not cost more money, but it means addressing values in the system- thinking differently, putting the focus on people issues rather than on money. It is important to help the patient feel accepted, that one belongs and shares, and above everything else that one is with those who have an appreciation of one's problems and a genuine interest in one's welfare.

As health care providers, it is our role to reduce suffering, not so much because suffering is bad, but because it is human beings who are suffering. It is important that we retain respect for our own and each other's humanity. I'm afraid doctors and nurses are giving up the most gratifying aspect of their practice. I'm telling the elderly to insist on being partners in their care and to learn to take charge of their own care.

Thank you for you kind attention.

Steffie Woolhandler, MD, MPH

Associate Professor of Medicine, Harvard Medical School; Member, Ad Hoc Committee to Defend Health Care; Member, Physicians for a National Health Program

Introduction by David Satin, MD

It's really impressive to hear somebody go through something like that. It's also interesting to hear what the medical practitioners/the clinicians' point of view is, because Mrs. Hargreaves remark, I think, that the doctors and the nurses are suffering under this system also. And somehow it hasn't forged an alliance with patients to speak up. I have a feeling we will hear something about this from our next speaker. Steffie Woolhandler speaks as a clinician with concern for the larger health care system. She is a founder and treasurer of Physicians for a National Health Program and editor for their newsletter, as well as a leading member of the Ad Hoc Committee to Defend Health Care. She is also a fellow of the National Academy of Social Insurance. Medically, she is Director of Inpatient Services at the Cambridge Hospital. Academically, she is Associate Professor of Medicine and preceptor in the course, Introduction to Clinical Medicine at the Harvard Medical School.

Dr. Woolhandler has been writing about medical economics and public policy since 1983. Some of her most recent publications are, "Quality of Care in Investor-Owned versus Not-for-profit HMOs," "When Money is the Mission: The High Cost of Investor-Owned Care," "The National Health Care Program Reader," and "The Rising Costs of Health Care." Dr. Woolhandler might tell us how she got interested in that aspect of medicine and the public policy aspect of medicine even from the very beginning.

Steffie Woolhandler, MD, MPH

Well, I appreciated Dr. Satin's very flowery introduction, but it did remind me a little bit about the old story about Eleanor Roosevelt who hated elaborate introductions and used to tell people to keep taking the shortest possible. So one time this lady introduced her said, "This is Eleanor Roosevelt, and the less said about her, the better." It's a little hard to stand up here after Ann's story about the quality of care that she received and say that my major focus is on making sure everybody gets access to that care, but certainly a part of assuring access to everyone is assuring really quality access. Unfortunately, it's not going to solve all the problems that Ann brings up, but I think that the work that she's doing will take us a long way toward that.

The biggest problem I do want to talk about is the fact that there are 44 million medically uninsured Americans. That's 16% of the under-65 population, and it's really this single fact that was the major inspiration for the group that I work with called

Physicians for a National Health Program, and Physicians for a National Health Program is a single-issue organization. We have over 8,000 physician members that advocate national health insurance for the United States, and a lot of people were kind of surprised when they heard about physicians advocating for a bigger government role in health care, and in fact the editorial writer at the Berkshire Eagle made this joke, "Physicians for a national health program: That's a little like furriers for animal rights." Nonetheless, we are finding that increasing numbers of Americans simply can't get access to care; some of them uninsured, and unfortunately, many people with good insurance are still having problems. Now who are the uninsured? This is just an example- Hispanics. Hispanics, even when they have full-time jobs often don't have health insurance, but that's true more generally. The majority of people would have health insurance who live in a family headed by a full-time worker. So, there's really a problem of a failure of employer-provided insurance to solve the problem.

Consequently, illness and medical costs are a leading cause of bankruptcy in this country. I found this in Norton's Bankruptcy Advisor, that may not be the top of your reading list. But this Harvard law professor did find that in nearly half of all bankruptcies, the main reason given was a medical reason or that bankruptcy involved substantial medical bills. And the numbers on this are huge. If we filled this room with a thousand single women, that would be very crowded but we could probably do it. A thousand single women, in any given year, seven of those women would declare bankruptcy for a medical reason, so paying for care is a major problem in America. Now, this is just part of a more general social problem in that the United States, despite the economic boom, has one of the world's highest poverty rates. So in addition to having 44 million uninsured people, we have a very high proportion of our population living in poverty. I think it's fair to think of these times as an economic boom time, but we're still in effect in social recession in this country.

An economic boom, but a social recession. This is a little hint for you- would anyone in the room think that they can name the largest institution caring for mentally ill people in the United States? Right, the LA County Jail. Instead of providing people the human services that they need in the health care system, we have relied increasingly on incarceration for a huge proportion of the population, and it's a relatively new phenomenon. Up into the mid-1970s the proportion of the population in jail was pretty much stable, maybe even going down, but with this sort of a "get tough on drug addictions, get tough on drugs" policy in the mid-70s. We've been incarcerating an increasing proportion of all Americans as a way of dealing with problems like substance abuse and impulse control problems.

Just to give you some sense of what it means to have a health care system that provides so inadequately for its people, some data that came out actually last month

about problems people have at the end of life. The majority of people needing end of life care, the majority of people dying in this country, are elderly people on Medicare, so most of the patients in this study were in fact insured--they had Medicare. Nonetheless, among people dying, more than a third reported they had a moderate to severe problem, financial problem associated with dying. 21% said they were spending more than 10% of their total family income on care, and 12% someone in the family had to take a second mortgage, take on a second job, or sell an important asset in order to pay for the care of the dying person. In fact these financial burdens of the dying were very highly correlated with the person saying, 'I'm a burden and I want to end it all right now.'

So we have a system where a lot of the humanity and caring that are important that Ann Hargreaves was talking about are simply blocked by the payment structure. That makes it very difficult for people to focus on the real care needs. Now, consequently the United States really does lag behind most of the rest of the developed world on important health indices. We lag behind other developed countries, all of which have some form of national health insurance. We lag behind all of them on indices like infant mortality, on life expectancy for women, life expectancy for men, where we live several years shorter than people in Canada or Western Europe.

The other side of the story is the way in which health care has been transformed into a business in this country and the tremendous growth in for-profit ownership of health care as investors have increasingly seen the health care system, which was previously organized as a public service, as a new field for profit-making. And again, we are somewhat unique in the developed world in allowing so much profit making within our health care system. Other than general hospitals and psychiatric hospitals, for-profit care is actually the predominant mode in most health institutions, though most of our hospitals are still non-profit.

What's the data about the quality of care? I mean, how is this new market in health care working from a patient's point of view? I just want to give you summary slides. This is a paper that came out last fall about for-profit dialysis, kidney dialysis. Lo and behold, for a for-profit kidney dialysis facility you have a 21% higher chance of dying than if you're at a non-profit. You're also much less likely to be referred to a transplant list so you can get a transplant, get off of dialysis, because of course that would lose money for the dialysis firm. So 21% higher death rate for-profit dialysis, very good study.

This is some work that we did on the quality of nursing homes. We used the Oscar database that includes data on 15,000 U.S. nursing homes. Virtually all U.S. nursing homes and the for-profit nursing homes provided worse quality, indicated by their much higher rates of quality deficiencies. What we are describing here is state inspectors going into the nursing homes and giving you a deficiency citation if there's a quality problem,

and those deficiency citations are much more common in for-profit nursing homes than in the non-profit sector.

Data on hospital death rates, one of two studies that has looked at this question, there's three times as for-profit, non-teaching hospitals who have a death rate standardized to 100. This is statistically standardized. And non-profit, non-teaching hospitals had a 7% lower death rate, and of course the major teaching hospitals had a 25% lower death rate. You may have heard the publicity about the major teaching hospitals that was in the headlines in the news, but equally interesting from our point of view is what happens in the comparison between the for-profit, non-teaching hospital and the non-profit, non-teaching hospitals. And you do see a 7% lower death rate as you go to the non-profit hospitals.

Finally, the HMO sectors, about two-thirds of all HMOs are for-profit. Here in Massachusetts we've been lucky to have predominantly non-profit HMOs. There's some data we published in the JAMA, the Journal of the American Medical Association, last summer where we found that on all 14 quality indicators that are collected nationally, the non-profit HMOs had higher quality scores than their investor-owned counterparts. Now, of course, some of you saw this data as the discussion was going on about whether Harvard Pilgrim should be sold to Cigna or to some other for-profit insurer. We did publicize this data that the non-profits do have higher quality scores, not that they're perfect, not that they're good enough, but they are consistently better than their investor-owned counterparts. Now, why do we think the non-profit HMOs function better? I think the simple explanation is the for-profits take a much larger share of the total premium and use it for overhead and paperwork and CEO salaries, etc. And last year, Cigna, who as you will recall was number one in line to buy Harvard Pilgrim, took 1/3 of every premium dollar and used it for paperwork, overhead and profit. So only 67 cents of every premium dollar was available for the actual care of patients. So my simplistic kind of mathematical mind, I think once you spend less money on care, of course, it' s going to be lower quality and I don't really think we have to go much further than that.

This is some recent data that appeared in JAMA about two months ago looking at which hospitals HMOs were directing heart surgery patients to in the state of New York. There's data about mortality, heart surgery mortality at the different hospitals, and the state is publishing this data, this quality data. And, of course, the HMOs are referring the patients selectively to the lower-quality hospitals, presumably because of lower cost. Ok, we'll just skip the cost data because it's getting a little. We don't have this mortality rate at the hospital, not by HMO. Some people, of course, are doing very well in this situation. The CEOs at these HMOs and hospitals are pocketing a small fortune. The other way in which the market has not been successful- this is actually some data about the level of spending, and there's been a lot of talk about the use of the market actually controlling

spending in the United States. But, in fact, spending in the U.S. is well above that of other nations.

When we look at spending in the United States compared to other countries and look at how much its gone up in the 90's, health care spending in the United States is still is going up more rapidly than in other countries. The use of market mechanisms has not been that effective in the United States in terms of controlling cost. What I've done here is put the spending data up in a different way. On the bottom I have total health care spending in the rest of the developed world, and on the top I've divided U.S. spending into two pieces: total publicly-funded spending and total private spending. The publicly funded spending includes the tax-subsidy for private insurance. It turns out the United States is already spending more in tax-funded spending than total health care spending in the rest of the world. Not only are we spending more, we're spending more out of public dollars already than any other nation on earth. The market has not been very successful in terms of cost control.

This is actually an interesting tidbit I picked up. Cigna had the health insurance contract for Phillip Morris and put out a newsletter for the employers at Phillip Morris and Miller Beer. Phillip Morris called them up and said, "Can you take out any anti-tobacco messages from the health newsletters that you send out to the Miller Beer and tobacco employees?" And Cigna said, "Sure, you're paying the bill," raising really serious ethical questions about whether for-profits have any business being involved in health care.

Now I want to talk briefly about psychiatric care, because I think many people here work in the mental health sector, that's correct, right? We've seen a really strong drop in the share of total health care benefits that are devoted to psychiatric care. I'm a general internist, I don't deliver psychiatric care generally, but I do want to say that I think psychiatry and mental health has been the area that has been the most damaged by managed care. It's the one area that we have the most problems getting people the care that they need, and that somewhat correlated, no doubt, to the fall in standing in psychiatric benefits. This is data from the federal employee health benefits program, and I just show it to you because there's been lots of talk of parity, and in fact within the federal employee health benefits program there has been no change in benefit design over the years portrayed in this slide. Despite a constant benefit, design management companies have been able to push down psych utilization basically by harassing and putting pressure on providers, even though the employee may get a booklet that says you're entitled to 20 visits.

Nonetheless, the utilization review has meant less utilization of psychiatric care, and similarly when people actually get in to see a provider, the length of time that they get to spend has been suppressed. Meanwhile, we have seen this tremendous explosion in gross

spending, which is increasing the total health care budget with huge, huge prices paid in the United States- 30% more, 50% more. Other countries pay for the same medication, but of course that's because most other nations have some form of drug coverage that is a part of their national health coverage, and the control of drug prices has been a major instrument of cost control in other countries.

It's also a major reason why the pharmaceutical industry is so staunchly opposed to national health insurance in this country. The other figure is savings through a national health insurance system that would come from administrative cost, and I've just grabbed here administrative cost per capita per year in Canada and in the United States. And simply by eliminating the administrative waste that you have when you have hundreds of different insurance companies, utilization, review, managed care, etc.- by eliminating that insurance and overhead waste, you'd have a lot of money to improve care, not just for the uninsured, but for many with inadequate private insurance.

Finally, there's a lot of data on quality. I did already show you data about life expectancy in other countries, infant mortality in other countries, probably the best measure of quality, but there are also a slew of studies looking at specific diseases, as in this case, Depression. In the United States and countries with national insurance showing that the quality of care is at least as good as in Canada as the quality of care we deliver in the United States.

I know we've got someone else to talk about politics, but I want to speak very briefly about politics and health reform. Recent study in the New England Journal of Medicine shows that over 57% of all academic physicians- including medical students, interns, residents, medical school faculty, medical school deans- 57% of them now support the idea of single-payer national health insurance. In fact, polls continue to show massive public support among the general public for the idea of tax-supported universal access to health care. Many people say, why don't we have that? Of course, the problem is our campaign finance system. We have a one billion dollar Congress. A minister in Cleveland was quoted in the Cleveland newspapers as saying, "Our rotten health care system is the bitter fruit of our campaign finance system." And as long as we have a campaign finance system like this it's going to be very difficult for the American people to get the health care system that they want and deserve. I'd like to talk a little bit about the Massachusetts Health Care Initiative that will be on the ballot next November, but I think I'll wait until we've heard some of the other presentations, but let's make sure and get back to that if we don't get to it.

Thank you.

Alan Sager, PhD

Professor, Boston University School of Public Health

Introduction by David Satin, MD

Thank you to Dr. Woolhandler. I hope that you will talk later on about how this startling, erudite information informs your practice as an internist and as somebody who is in charge of the inpatient service. What's the inpatient service like at the Cambridge Hospital, and how does this kind of insight into the system help to determine that? The other thought that I had was the opinions of medical students and of young practitioners in the system- I worry that people brought up in this kind of a system don't see it as a problem, they accept it as normal. It's nice to know that some of them see an alternative to what they've been brought up in.

Alan Sager brings a public health perspective. He is professor of the Boston University School of Public Health, teaching health care finance, planning and administration. He is a principal in the Access and Affordability Monitoring Project, which analyzes the causes of health care access and cost problems in Massachusetts and designs better ways to finance and deliver care, and is studying the closing of urban hospitals. His doctoral degree is from MIT in city and regional planning, specializing in health care. It's an interesting way to get into the public health business. We look forward to your insights.

Alan Sager, PhD—Affordable Health Care for All that We Can Trust with Our Lives: What We Have, What We Want, and How to Get It

Introduction

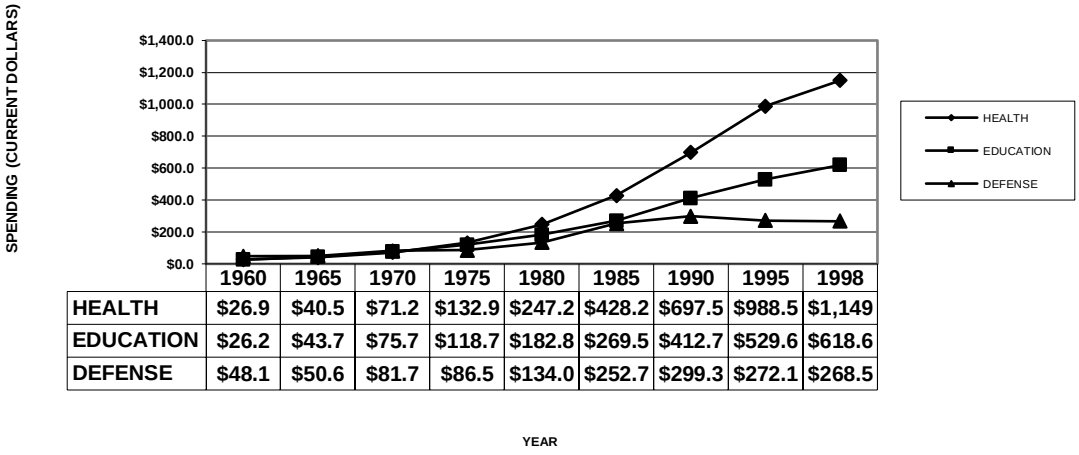
Massachusetts's health care is beset by grave problems of high cost, large numbers of uninsured people, financial instability of many caregivers, and declining quality of care. Yet we have remarkable resources—resources of people and institutions and money that are already adequate to finance and deliver the care that works to the six million people who need it. These resources make the job of winning affordable health care for all that we can trust with our lives the easiest problem to solve in the state or nation—perhaps in the world.

Now, I did not say it was an easy problem- only the easiest. Addressing the others- housing homeless people, repairing the environment, job training, education, criminal justice, and all the other things you care about- all require more money. That is not true in health care.

Here are two ways of understanding this. First, consider that health care spending in 1998 was fully two and one-quarter times defense spending, and health care spending was slightly more than half defense spending in 1960 (See Exhibit 1).

Second, consider that U.S. health spending per person is much greater than spending in other nations, and that Massachusetts spending is about thirty percent above the U.S. average. Some parties complain about waiting lists in the U.K. or in Canada. But imagine their health care delivery methods fueled by our money. As it is, the British live about as long as we do and the Canadians live longer. Yet Canadian health spending per person is only about two-fifths of the Massachusetts level, and British health spending per person is only about one-quarter the Massachusetts level (See Exhibits 2 and 3).

EXHIBIT 1
HEALTH, EDUCATION, AND DEFENSE SPENDING,
U.S., 1960 - 1998 ($ BILLION)

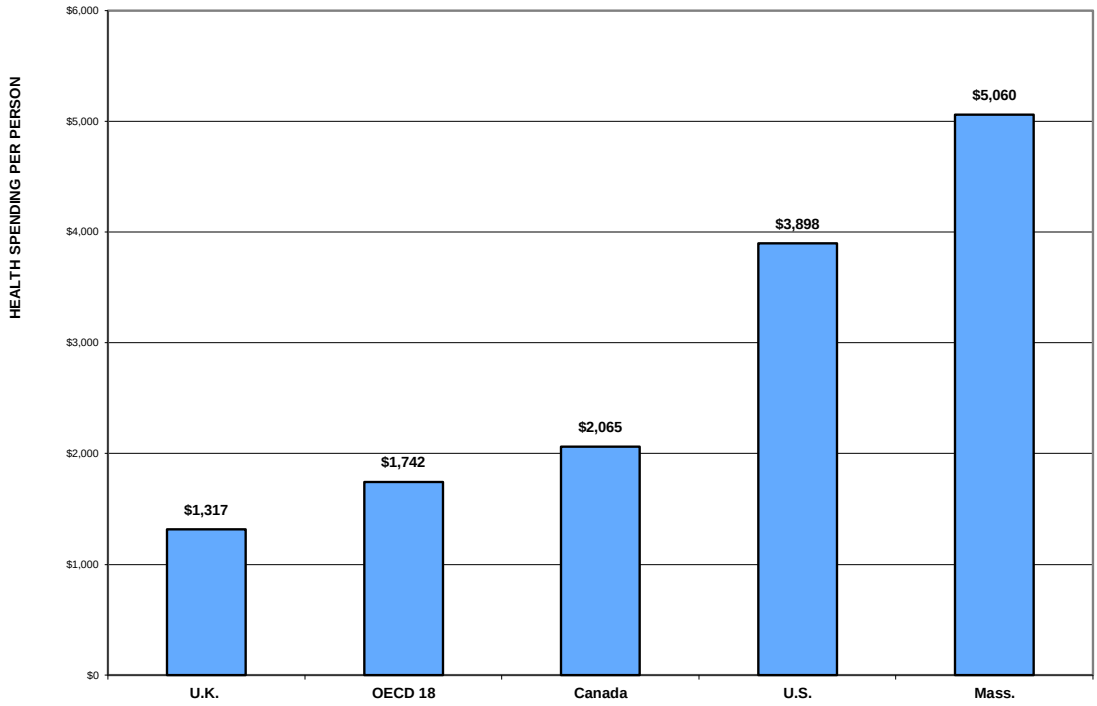


	1960	1965	1970	1975	1980	1985	1990	1995	1998
HEALTH	$26.9	$40.5	$71.2	$132.9	$247.2	$428.2	$697.5	$988.5	$1,149
EDUCATION	$26.2	$43.7	$75.7	$118.7	$182.8	$269.5	$412.7	$529.6	$618.6
DEFENSE	$48.1	$50.6	$81.7	$86.5	$134.0	$252.7	$299.3	$272.1	$268.5

EXHIBIT 2
INTERNATIONAL HEALTH SPENDING PER PERSON, 1996

	Spending/person	% of U.K.	% of Mass.
U.K.	**$1,317**	100%	26%
OECD 18	**$1,742**	132%	34%
Canada	**$2,065**	157%	41%
U.S.	**$3,898**	296%	77%
Mass.	**$5,060**	384%	100%

EXHIBIT 3
HEALTH SPENDING PER PERSON, 1996
U.K. - 18 OECD NATIONS - Canada - U.S. - Mass.



This afternoon, I will begin by sketching several of the problems besetting Massachusetts's health care, and by identifying the main resources that we can use to address those problems. Then, I will briefly describe five things we should want and expect from our health care. Finally, I will conclude by identifying two broad strategies and by applying them to address four serious problems.

I. Problems

Massachusetts's health care faces at least seven serious problems today. These include high overall health costs and hospital costs, very substantial clinical and administrative waste, loss of many needed caregivers, financial distress of many surviving caregivers, quality that is declining in some important respects, large numbers of uninsured people, and soaring drug costs. You may care about some of these, but not others, and you might add still others of your own. But let's start by exploring some of these seven.

Massachusetts's health costs are highest in the world. They will reach about $38 billion this year, my colleagues and I have estimated. That is about $6,100 per

person. If we spent at the national average, we would save $9 billion this year. That $9 billion saving alone would be:

- Enough to build a Big Dig every 18 months (at $13.6 billion per Big Dig),1
- Enough to build a new Fenway Park every 24 days (at $600 million per Fenway, though that's just a ballpark figure),i and
- Maybe even enough to build the long-postponed tunnels to Martha's Vineyard and Nantucket.
- It would also be 72 times the fantasy savings in the McKinley report on special education in the Commonwealth (at $125 million per fantasy)[ii].

I am not suggesting that we cut Massachusetts's health spending by $9 billion, only that we can take care of everyone who lives here very well with the $38 billion we already spend.

Massachusetts's hospital costs are also the highest in the world, at 42 percent above the U.S. average in 1998.[iii] If we spent on hospital care at the U.S. average, we would save $3 billion this year. The hospitals claim that this excess cost is justified by research, training doctors, serving patients from outside the state, higher wages, and similar factors. My colleagues and I disagree; having found that only one-third of the Massachusetts excess was justified by these and other durably legitimate factors.[iv]

In reality, it is easy to explain away the $3 billion excess if you wanted to, and the hospital association and others do try to explain it away. After all, the money is being spent on something. It is not being burnt in a secret old fireplace over at the General. The real questions are: First, is this money being spent well? And second, can our state continue to afford spending so much more than the national average? I suggest that much of this money is not being spent well, and that we probably cannot continue to afford spending so much.

This position rests on a few notions. First, our state is probably first in the nation in the share of its people cared for in teaching hospitals. Teaching hospitals provide more expensive care, partly because teaching itself is inefficient and partly because more things are done to patients in teaching hospital. Is this a "flight to quality?" If so, is that driven by reputation or reality? But then, we probably need to improve the quality of care at smaller community hospitals that can provide most services and do so more efficiently.

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We are second in the nation (behind New York) in the number of medical residents we train, per thousand citizens. Many of the doctors we are training are not needed by the nation, and will contribute to the growing surplus of physicians in general and of specialists in particular. More such doctors will mean still higher health care costs.

Second, our state relies much more heavily on hospitals to provide outpatient care visits to physicians (this excludes emergency room use). We are fully 47.5 percent above the national average. This wastes substantial sums, and we use hospitals more heavily for doctor care even though we lead the nation in doctors per thousand citizens, with 64.1 percent more physicians per capita than the nation as a whole.

Third, the Medicare program, a traditional source of generous financing for medical education, and a program on which most Massachusetts hospitals long earned substantial surpluses for inpatient care, has begun to cut back its payments under the Balanced Budget Act of 1997. As a result, Massachusetts's hospitals are demanding higher payments from in-state sources. They have requested special aid from state government itself, higher payments from the Medicaid program, and higher payments from private health maintenance organizations and insurance companies. All of these requests would require substantial increases in the costs borne by people who live, work, or do business in the Commonwealth.

Yet insurance premiums have already risen substantially in the past year or so. Premiums for family coverage seem to have risen about 15 percent in greater Boston, and that translates into a rise of about $1,000 per year for family coverage. Yet hospitals complain that their own payments from insurers and HMOs have not yet risen. How many large compounded annual increases can employers and families afford before both begin to drop coverage in substantial numbers?

Fourth, some try to justify high health care costs in our state by suggesting that high health care spending is really a good thing, an economic engine for the Commonwealth. These claims are greatly exaggerated. The hospital association recently sponsored a study that claimed a small drop in health care jobs here in the past few years. The study included in a table—but certainly did not highlight the core issue—which is that health care's share of total employment is 31.6 percent above the national average, third-highest in the nation.[v] In other words, if you spend a lot of money on health care, you will employ a lot of people.

Clinical and administrative waste in health care are substantial. Much of the care that is provided does not work, is not needed by the patient who receives it, or is incompetently provided. Much of the effort and money used to move money within the world of health care is wasted as well. Steffie Woolhandler and David Himmelstein have done invaluable work in focusing our attention on this issue.[vi] Lehman Brothers has

recently estimated that fully 51 cents on the health care dollar is waste through unnecessary administration, adverse drug costs, and other inappropriate care.[vii]

Loss of many needed caregivers. Our state had about 127 acute care hospitals in 1970 but only about 75 today. Since 1980, we have closed about 40 percent of our acute care hospital beds. Today, we have about one-seventh fewer beds per 1,000 people than the national average. It is altogether reasonable to expect a shortage of many thousands of hospitals in the years not too far ahead, as the baby boomers inexorably age and sometimes damage or wear out vital body parts. The problem is particularly acute in large expanses of the state that have lost or face substantial risk of losing hospitals that are probably needed to protect the health of the public. Imagine driving down Route 2—not always the safest road in the Commonwealth, even in dry weather—with no ERs or hospitals between, say, Cambridge and the New York State line. We can't think about hospital survival in the abstract- we have got to look at a map.

Further, state policy has embraced price competition among hospitals to try to drive down prices. And the hospital association has embraced that policy—even though it harms vulnerable hospitals. And even though efficient hospitals are likelier to close, and even though hospitals with more money in the bank are more likely to remain open. We call this survival of the fattest. Not the smartest policy ever, but policy nonetheless. As many hospitals close, and as survivors merge, regional monopolies and oligopolies emerge. Within five years, I expect, there will be no price competition among hospitals in our state worth talking about.

By some estimates, about one-tenth of the state's nursing homes are in bankruptcy. Many of these may close. If those beds are not needed today, they will be needed before too many more years pass.

Financial distress of many surviving caregivers. Hospital financial margins in this state were the lowest in the nation in 1998.[viii] But is this because of inadequate revenues or high cost? The debate about the causes goes on, and this is an important debate, because it will shape whether- and how- we respond to the hospital and nursing home crises.

Quality that is declining in some important respects. Some people assert that Massachusetts's health care is the best in the world. The best of our health care may be at or near the best, but what is the average? What is the bottom 20 percent like? How good is that care? We don't know, often because most of us who think about policy or make policy or deliver care don't think we'll get the average, let alone the bottom 20 percent. Too much attention has been focused on the best we do, or claim we do, and too little attention has been focused on the worst.[ix] Yet we know that quality problems are emerging despite our high spending. Nursing homes are having trouble recruiting good workers. Hospital workers advise patients to bring a family member to sleep in the room

because too few nurses are available to answer call buttons. A few months ago, two hospital administrators told me that they were forced to fire nurses and other clinical staff to release dollars they needed to hire more billing experts to re-process and re-submit legitimate claims that HMOs had turned down. And a large threat to quality is posed by the various financial incentives, such as capitation payments to hospitals and doctors, that financially reward the caregivers who give less care or who enroll healthier patients.

Large numbers of uninsured people. In 1998, our state had about 625,000 uninsured people, or about ten percent of the population. That's more than one-third below the national rate, which is great. But most of our state's recent improvement in covering more people has been won by Medicaid expansions. It is far from clear if these can continue, and it is even less clear that these can be sustained when the economy is not doing so well. Rising private health insurance premiums will mean a substantial rise in the number of uninsured people.

Soaring drug costs. Many citizens of the Commonwealth cannot afford the medications they need to avoid pain, disability, and premature death. It is as simple as that. Drug spending has been rising by about 15 percent annually for the past few years. As the CHART shows, this is a national problem. It is more serious in this state, because we spend more on drugs—and because overall background health care spending was so high even before drug spending took off. With the drug makers claiming to have over 1,000 promising new drugs in the pipeline, we can fear higher spending in the future. And there is no reason to be reassured by the drug makers' promises that higher spending on drugs will cut spending on hospitals and doctors. We have to prepare. We have to find ways to buy all the drugs that all people need—without throwing more money at the drug makers, but without impairing their abilities to attract capital or to finance the research they actually conduct.

II. Resources

As serious as our state's health care problems may be, we should be comforted by our ample resources including;

1. World's highest spending
2. Ample professionals and capital
3. Competence and compassion
4. Recent lessons that more government involvement is vital to fixing health care problems (e.g. Harvard Pilgrim, Medicaid expansions)

The challenge before us today is to begin to marshal our vast health care resources- of money and hospitals and doctors and long-term care and prescription drugs- to make Massachusetts health care durably affordable for all people under all economic conditions.

III. Goals

What do we want? Only a few things, I suggest;

A. Universal coverage
B. Cost containment
C. Enough good caregivers, of the right types, located in the right places
D. Incentives to improve quality
E. Reasons to trust our caregivers and our health care

IV. How to Get There?

1. The first step is to reverse the roles of competition and of government planning and regulation in health care.

Recently, we have tried to use competition to contain cost, and government to step in to bandage the wounds that competition inevitably inflicts on quality of care. So we have allowed and even encourage HMOs and insurers to compete by price (though seldom on quality). Then, HMOs cut their prices to enroll more employers and employees so HMOs have to cut their costs of care to levels below their revenue. How to do so? By getting hospitals and doctors to bid for HMO contracts, by dropping costly hospitals and doctors, and by paying caregivers by capitation, which aligns the caregivers' financial incentives- spending less money- with those of the HMO or insurer. Then, we ask government to step in to ban drive-through deliveries, to allow rights of appeal against HMO denial of needed care, to allow patients to sue HMOs, and the like.

The problem with this approach is that none of it works. Competition does not contain cost very well or in a trustworthy way, partly because nothing close to a free market is possible, and government can't regulate quality very well, partly because quality is assured by thousands of doctors, nurses, and other clinicians, patient-by-patient. Government is better at making bigger and cruder decisions than these that determine quality of care. We have to reverse the two roles. Government can cap costs by capping spending, and then by paying hospitals, doctors, drug companies, and other caregivers in ways that force everyone to live within the capped budget. That means asking doctors- who control almost all of the money- to spend more carefully, and they

can do that. We have to pay them a fair amount of money. Then, they must spend the remaining money in ways that cover everyone, and that make the money last all 12 months of the year. But they don't benefit financially if they spend less than what is available. Rather, they must expend the budgeted money carefully, to do as much clinical good as possible, by making trade-offs.

Pathology is remorseless and resources are finite. The challenge is to put the money into the hands of the doctors who inevitably control it, under circumstances that allow us to trust them to spend it carefully. So, government caps spending and covers everyone with the available dollars. It makes the strategic decisions and then gets out of the way. Then HMOs might be allowed to compete- but only by quality, not by price. Each HMO would be paid the same risk-adjusted price- higher for sicker patients and lower for healthier patients. We're learning how to do that.

2. The second step is to plan now for predictable crises (crisis makes change politically possible but practically difficult, especially if ideas haven't been thought through and plans haven't been tested).

Here are four predictable crises we should anticipate:

1. Unaffordable medications
2. Less real money but lots more older people
3. Hospital ER and bed shortages
4. Lots more uninsured people

Anticipating these crises means more than sitting around worrying. It means developing concrete plans that document problems, identify the range of causes, set feasible objectives, devise policies and programs to reach those objectives, and analyze the politics and the implementation problems that need to be overcome.

Only state government can do these things. State government needs to do more than sit by the phone and await the latest disaster. It needs to do more than send a postcard or appoint a commission. It has to put its arms around health care and spend a few million dollars to plan responses to possible crises. Yes, the crises may never materialize, but we have to act as if they might. That's called contingency planning, and people who don't do it get clobbered if the economy turns sour, if HMO premiums keep going up 15 percent a year, and so on.

3. The third step is to implement the plans when the politics and the money permit. Implementation will be much easier if smart people scrutinize the plans, tear them apart, and rebuild them to work better.

The states really are the laboratories of democracy, but in health care they have been effectively locked up by the failure of the Clintons, by ERISA, and by idolatrous worship of market competition, managed care, and hospital closings over the past decade or so.

4. The fourth step is to consider a wider range of solutions to the four problems mentioned.

Throughout, the watchwords are durable affordability, iconoclasm, overthrowing blind worship of failed market competition, evaluating hospitals' and drug makers' demands for more money for business as usual, and finding better ways to spend the vast resources already available.

Prescription drug reform. U.S. spending on drugs this year will be right about $500 per person, highest in the world. Yet 70 million (one-quarter of us) have no insurance for drugs, more of us are losing insurance each year, and dozens of millions of other people have seriously inadequate coverage. The drug makers and their trade association- called PhRMA- insist that government should remain on the sidelines, unless it wants to spend more money to subsidize private purchase of more drugs. But they claim that any government interference with drug makers' prices or profits will destroy research and we will all die. I call that PhRMA's "Fog of Fear."

The drug makers claim they need high profits to pay for research, but profit is what's left over after they pay for research. And their profits are in the generous 30-40 percent return on equity range and have been two and one-quarter higher than the all-industry average for the whole decade of the 1990s. No effective free market functions here. Generics are 40 percent of prescriptions but less than 10 percent of spending. Drug makers hold monopolies and set prices to maximize profits. They suppress generics, they merge with other manufacturers, and there's surprisingly little price competition. So government has to move in to protect us against high prices, and to protect the drug makers from over-reaching. Their extravagant demands are the real threat to research. An angry future Congress will cut prices and profits harshly. We need moderate action now. Here's how:

- Cut factory prices 40 percent by state or federal law
- This cuts revenue by 40 percent
- But drug makers make up much of this through higher volume (price elasticity of demand)

- And public subsidies to Medicare and other patients become much more affordable

All the higher revenue will be sufficient, by law, to replace what was lost from higher prices. We get all the drugs we need. We don't pay more. The manufacturers' profits are intact. They are making more pills, so we could pay them a little extra to cover the marginal cost of manufacturing. But that's tiny, only about 5 percent on the retail dollar.

Iconoclastic long-term care reforms. We spend enough in Massachusetts now to finance all the health care that works for all the people who need it, but not all the long-term care, I fear. So many of us will need so much help down the road, and that help is so costly to provide through traditional nursing homes, home care, and the like, that we need to experiment with new ideas or we will run into serious trouble. I've looked at long-term care for some 25 years now, since Bob Morris hired me to do that at Brandeis in 1975, and the number of new ideas is not impressive. We need to spur innovation. Here's one possibility:

Time is the real medium of exchange in long-term care, not money. Many of us have a little time to give, from time to time, but that's not necessarily when our parents or grandparents actually need the help, or they may live too far away to allow us to help them easily. So let's develop local arrangements that allow us to help neighbors, friends, members of our religious congregation or fraternal organization or union local- when they need the help. Every hour we give is recruited on a PC somewhere nearby. Then, when we need help, we can take our time out of the bank and use it to pay another volunteer who's willing to help us and has the time to do so.

We'd then create or energize a parallel economy in which time and good deeds are the medium of exchange. We'd have to back the time and track it. We could even allow people to pay premiums for time-insurance with their own time, so they could get more help than they put in, if they needed it, on traditional insurance principles. Volunteers might be confused about their motives- altruism or self-interest- but do we really care if we succeed in mobilizing more time to help dependent people? Even if this idea works, it will not be the answer. It isn't for everyone. We need to design and test dozens of ideas, and let them percolate through our cities and towns.

A top-down space program is not the right model for long-term care. Rather, we need real social entrepreneurialism, much like the way the automobile was developed, with lots of people tinkering in their machine shops. Identify and stabilize needed hospitals. Since we can't trust any free market to keep open the hospitals and emergency rooms we require to save our lives, government has to get involved.

Government has to think across time and across space. State government should draw up a list of the hospitals that are needed. It should look at today's bed

supply (which no one knows with any accuracy) and estimate the beds needed 5, 10, and 20 years down the road. The future is always harder to predict than the past, so we should again plan on various contingencies. These could include mothballing some hospital capacity against the chance of future need, and government should look at a map. Where are the hospitals? Where are the people? What are the travel times, in good weather and bad? Then, government should identify the hospitals that are in bad financial condition.

Needed hospitals in bad financial condition should qualify for special state aid from a revolving trust fund financed by a small assessment (1/4 of one percent) on each hospital's revenue. That would generate about $30 million each year, enough for cash grants and technical assistance to lots of smaller and mid-size hospitals, though not enough to stabilize larger hospitals like the Beth Israel/Deaconess if they got into trouble. And government should return to simple rate setting. It should set hospital revenues at levels sufficient to allow efficiently operated hospitals to remain in business and provide high-quality care.

When all this is done, government should turn to the job of financing and assuring universal coverage by squeezing out waste from existing spending. At $6,100 per person and $38 billion annually, we have the money to do it. And we have even prepared a chart, with supporting documentation, to show how this is practical. Covering everyone is what allows cost control by cutting administrative and clinical waste, and by negotiating lower drug prices. A few moderate tax increases are needed to replace all of today's out-of-pocket payments. That's a problem that will have to be addressed in an era when most people think government can't do much or can't do it well.

Thank you for the chance to speak with you today.

Bernard S. Arons, MD

Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Introduction by David Satin, MD

Planning ahead is not something we are very used to doing. Waiting for crisis is the way things usually get done, and to plan ahead would be something new for us. Our final speaker is Dr. Bernard Arons. Dr. Bernard Arons represents the government's perspective and role in the health care system. In a sense I feel bad for Dr. Arons because everybody is giving him the problem, is mentioning the problems, and mentioning government as the way out. And he has to speak to the way government works, the way government operates, and how we can deal with all of these problems and all of these demands from different constituencies and do the impossible thing: plan ahead, do something before it is past time to do it. Dr. Arons is Director for the Center of Mental Health Services in the Substance Abuse and Mental Health Services Administration in the US Department of Health and Human Services.

His past experience in health care planning and funding includes as Director of the Office Overseeing Care and Deinstitutionalization at St. Elizabeth's Hospital in Washington, D.C., Associate Director for Mental Health Financing at the National Institute of Mental Health, Legislative Assistant to the Chair of The Health Subcommittee of the U.S. House of Representatives Ways and Means Committee, Advisor on Mental Health to Mrs. Tipper Gore, and Chair of the Mental Health and Substance Abuse Working Group Cluster of the President's Task Force on National Health Care Reform. You remember what happened when trying to plan ahead there.

Academically, he is Clinical Professor of Psychiatry at Georgetown University School of Medicine and teaches psychiatry at the Center for Mental Health, Incorporated. His recent publications include "Improving and Expanding the Federal System of Care: Role of the Public Sector," and the book, "Managing Care, Not Dollars: The Continuum of Mental Health Services." His talks include "Mental Illness and Managed Care: Solution or Chaos," and "The Shift to Managed Care in the Public Sector." Dr. Arons.

Bernard S. Arons, MD

Thank you, Dr. Satin. I am pleased to have the opportunity to join you for the twenty-third annual Erich Lindemann Memorial Lecture. And, I am encouraged by the theme of this year's event: *Visions of a Health Care System: What Do We Have, What Do We Want, and How Do We Get There*.

As health care professionals, we have the power to examine our practices, to envision the future, and to choose. We can remain faithful to professional and personal ethics, or we can sustain courses of action that threaten our values. We can choose to act wisely, and to usher in a vision that is based on our reason and humanity.

But, there's a flip side—and that's the fact that our vision isn't quite as clear as we need it to be.

Today our vision is challenged by the current decline in coverage for mental health disorders. Studies reveal the gap in insurance coverage between mental health and other health services getting wider, often because of multiple limits on benefits.

For instance, a recent report (by the HayGroup) on changes in health plans of medium and large employers finds that between 1988 and 1997 the proportion of plans with day limits on inpatient psychiatric care increased from 38 to 57 percent. The proportion with outpatient limits rose from 26 to 48 percent.

From 1986-1996, the share of out-of-pocket funds for treating mental illness and substance abuse decreased from 23 percent to 16 percent—yet, this decrease was not accompanied by comparable increases in private insurance coverage. Their share of the funding remained relatively constant.

If we choose to remain faithful to our values, then ultimately our job is to show the value of what we do: in terms of costs and outcomes, in terms of returning people to work and school, helping families stay together, and reducing the toll mental illness takes on society.

In the past year, we have heard a lot about the future: the next 100 years, the 21st century, the new millennium. But, I believe we also need to look back 100 years for real insight about where we are, and what we can achieve.

The turn of the 20th century was a time when influenza was a death sentence, when heart disease had free rein-routinely taking young men in their prime, when the iron lung was soon to become dreaded reality (invented 1927). It was before development of the polio vaccine, before the wizardry of pharmaceuticals like antibiotics and antivirals, before the discovery of insulin, certainly before neuroleptics and antidepressants.

And, as much a role as scientific and technical brilliance played in each of these advances, there was something else that allowed our health system to progress, at each step of the way.

That was shared outrage by the American community of health professionals and consumers, men and women, young and old, at the illnesses. People suffering from diabetes could have more control over their illness. Young men should not drop dead of heart disease. Children should not be paralyzed by polio.

At each step of the way, outrage at illness led to a contract between leaders in the health system and society. According to the contract, health authorities made the

commitment to put their weight behind a solution to the illness. And, as for their part, consumers had the obligation to use services to protect their health.

And that is the significance of the precedents we are seeing today. For the first time, a President has called together a White House Conference on Mental Health. For the first time the Surgeon General has issued a report on Mental Health. And, for the first time, the public is ready for a discussion about our mental health.

As you have pointed out, Dr. Satin, that discussion calls for tremendous responsibility on our part—We must consider health status along a continuum that is responsive to social as well as individual forces, that spans entire lifetimes, and that presents treatment as a hierarchy of preventive practices. These are issues Erich Lindemann addressed when he developed one of the first community health centers in the United States.

And these are issues that provide depth and context to the Surgeon General's recent Report on Mental Health—they are the issues that engage our society today. But, at the same time that the Surgeon General's report was met with national enthusiasm, our vision of making mental health an integral part of our public health approach can be as cloudy as an overcast day on the New England coast. Fear of discrimination threatens that vision by keeping many who could benefit from mental health services from seeking help; they fear for their jobs, housing, insurance coverage, and individual and family reputations.

In 1998, 63 million Americans experienced some form of mental disorder. Yet, only about ½ of individuals with serious mental illness currently receive any treatment at all. And, the stigma that pervades our entire health system clouds our vision in other ways—from stigma that puts up financial barriers to stigma that thwarts access—especially by underserved population.

As we know so well, significant gaps persist in the provision of treatment for mental disorders—gaps that affect those from various ethnic and racial groups, that affect the working poor and people living in poverty, that affect specific groups like children and the elderly.

Yet, who would doubt the tremendous impact that stress and trauma have on mental health? Who would doubt the physical toll of racial or gender discrimination, or the intense emotional response to cancer or a stroke?

The Surgeon General's Report led with an important finding—mental health is a critical part of overall good health. We must start with our own health reform, by making good mental health a public issue—not a secret to be hidden.

Just like breast cancer prevention advocated have done in our lifetimes, we must give the public a model for addressing mental illness as a health problem, with health solutions. And we must work on all levels, by coordinating our efforts with local, state,

and federal officials. We must proceed out of our own certainty, because the sad truth is that stigma has justified a system in which:

- Employer expenditures for mental health needs have declined, and the public sector finances a majority (54.2 percent) of all mental health and substance abuse treatment—more than for treating any other illness.
- Managed care companies tend to separate behavioral health from physical health in an inadequately funded system.
- Medicare provides for a discriminatory co-payment for outpatient mental health coverage.
- Private insurance companies have yet to follow the Federal government's lead in requiring parity in health insurance coverage for behavioral health claims.

Stigma is at the bottom of these bottom-line tactics. But the real bottom line is that appropriate mental health coverage won't break the bank. When SAMHSA conducted a study on costs and effects of parity for mental health and substance abuse insurance benefits, we learned that full parity would increase family premiums less than one percent in private insurance plans that tightly manage care. The increase for all types of plans would average just 3.6 percent.

And we learned that when a state requires parity, costs do not shift from government to the private sector. Employers don't avoid parity laws by becoming self-insured, and they do not tend to pass on low costs of parity to employees.

There's another important financial consideration in our discussion about better mental health coverage—and that is the cost-offset effect. The added cost of the mental health services is offset in part or in full by reductions in the use of general medical services. The American Journal of Psychiatry has published report after report documenting that when patients are treated for behavioral problems, use of medical services declines.

And that leads me to another challenge to our vision of mental health, which is that from insurance to interventions, our current health system promotes a model of patched together care. It is time for our health system to revitalize itself and replace our piecemeal approach with a multidisciplinary philosophy.

In an era when the co-occurrence of depression with heart disease, or a host of other ills, including diabetes, cancer, physical disability, and substance abuse, are undeniable, and in a time when mental illness and/or addiction is the most common diagnosis in community mental health centers nationwide, we are ready for a new plan—one that is based on integration. The community-based system of care, which grew out of a sense of social responsibility, is an important model for the change we've begun to see.

In the 1990s, state spending for community-based care exceeded spending for state psychiatric hospital care. In 1997, 56 percent of state expenditures were for community care, compared to 41 percent for inpatient psychiatric hospitals.

As leaders in the health care profession, we have an important part to play in reform—and I believe we must start by insisting on cross training within the medical profession, so that we can better understand the overlap of illnesses we treat.

Primary care physicians simply don't have the training they need to address the behavioral health needs of patients—despite the fact that, for reasons from personal fears to insurance coverage—primary care physicians often are consumers' first stop when they suffer from behavioral ills. In fact, more that 70 percent of antidepressant prescriptions are written by primary care physicians—but less than half of these prescriptions are written at therapeutic levels.

In fact, over half, come studies indicate up to 75 percent, of older people who have committed suicide saw a physician in the month before killing themselves; the studies also found that many of them saw their physician within a week before committing suicide.

In fact, even when consumers don't acknowledge their behavioral disturbances, primary care physicians should be aware of the risks. For instance, primary care physicians can expect that one in five of their patients will be experiencing a mental disorder—and about half of these patients will be experiencing functional impairment, even though they may have contacted a physician because of other, physical complaints.

Many of these patients also may be at-risk drinkers, problem drinkers, or alcohol dependent. And, in turn, physical problems of those diagnoses with chronic mental illness and/or addictions routinely also often are overlooked.

As we pursue our discussion about our multidisciplinary philosophy, we must explore two approaches. One is to prepare primary physicians to address behavioral health within their own practices. The other is to coordinate a system of referrals among providers.

At CMHS, we're exploring models through interagency collaborations. Through a partnership with HRSA, HCFA, the VA, as well as CSAT and CSAP, we are evaluating alternative models for delivering and financing mental health and/or substance abuse services for older adults through primary health care.

Our goal is to identify differences in outcomes between models referring to specialty mental health/substance abuse services outside the primary care setting and those providing such services within the primary care setting itself.

In the process we hope to gain insights about the relative effectiveness of different models in terms of access, adherence, clinical outcomes, consumer satisfaction, and system outcomes. And, SAMHSA, our umbrella agency, has entered into an agreement

with HRSA's Bureau of Primary Health Care to increase access to behavioral health services in Comprehensive Health Centers.

We've started by developing a Depression Breakthrough Series that uses standardized, evidenced-based outcome measures to track the progress of health system redesign at the health center level—for everything from patient screening to clinical management of depression00 and from clinical information systems that track patient care and outcomes to strong partnerships with community organizations.

Fulfilling our vision will mean a fundamental shift in the way our health system approaches mental health. We have to puncture myths, protect financial fairness, and promote collaborative strategies that work.

I'd like to tell you about one area where we will need all our vision—and that is in addressing the tragic problem of suicide in America today. As you know, in the United States, suicide is the third leading cause of death among 15-24 year-olds and the fourth in 10-14 year-olds. And, for every completed suicide, there are an estimated 8 to 25 attempted suicides.

Again, we have the attention of the country. Last year, the Surgeon General issued a "Call to Action to Prevent Suicide". In that plan, he outlined the work ahead of us, to:

- Prevent premature deaths due to suicide across the lifespan
- Reduce the incidence and prevalence of other suicidal behaviors
- Reduce the mortality associated with suicidal behaviors and the traumatic impact of suicide on significant others
- Provide opportunities and settings to enhance resiliency, resourcefulness, respect, nonviolent conflict resolution, and interconnectedness for individuals, families and communities.

Two months ago, CMHS called together a working group of researchers, suicide survivors, public health leaders, community volunteers, clinicians, educators, mental health consumers, and corporate/nonprofit advocates.

They got to work outlining the framework for a National Suicide Prevention Strategy that would support communities in prevention efforts-from sharing best practices to gathering data, and from providing consultative services to measuring outcomes.

But, the National Strategy is not an exclusively federal project. We need an infrastructure that will foster public-private partnerships and help promote community prevention efforts. But, our ultimate goal is to develop comprehensive solution- so that support at the national policy level sustains collaboration at the community level, and so that we can build an underlying base of personal wellness and safety.

I'd like to leave you today with several thoughts- my personal five best ways to fulfill that vision.

1. We must look beyond our professional backyards. When we talk about access, we must ask ourselves, will our most vulnerable citizens have access to quality care that's effective, efficient, and delivered by consumer-focused providers-or will their care be cut short by out-of-control market-driven forces. We'll lose money on our investment and we'll lose whole communities if we base our decisions on cost alone.
2. It's time to eradicate the ugly habit of stigma. Every day, mental patients lie about their illnesses-saying they were out of work because of a cold or a broken leg. What an unnecessary blow- when we rate illnesses as acceptable and unacceptable. It's not enough to talk among ourselves about our work. We also must speak at our children's schools, our neighbors' workplaces, youth groups, and religious organizations- no audience is too small, and no voice is too soft to break down the walls of silence.
3. It's also time to focus on prevention. Although we may not be able to alter some risk factors, for instance gender or family history, with strategic intervention we can change others-such as lack of social support, inability to read, and exposure to bullying. And in addition to addressing risk factors, we must focus on resilience and building protective factors.
4. Along with the rest of the country, we at CMHS have been very concerned about the incidents of school violence. Last year we launched out interdepartmental "Safe Schools, Healthy Students" grant program, with the Departments of Education and Justice, to help children in schools develop skills that promote mental health.
5. We must train tomorrow's health professionals today- by offering medical school training that conforms to today's knowledge. That means emphasizing the interaction between mind and body. It means teaching physicians to recognize early signs of mental illness, to engage the consumer and family, to focus on prevention.
6. Literacy must mean health literacy. It's not enough to train the best health professionals. Every parent must recognize early signs of mental illness. Every consumer must know the right questions to ask about their own care. And every citizen in America must understand how changes in health policy affect their lives.

If we are to fulfill our vision, everyone must play a role. Our vision will evolve from a partnership. It will take all of us working together- consumers, providers, and policy makers. And it will take our sustained commitment to change. Ultimately, this dialogue is not about what we say today, but what we do tomorrow.

Discussion

Dr. David Satin

Thank you, Dr. Arons. I'm trying to think about how all of this all goes together. We have heard, I think, about the need for practicing clinicians to do things differently and take care of patients better. We have heard a couple of times about the need for government to intervene to organize, fund, and plan health services. We have heard something about community, about people getting together to provide services for themselves to exchange. And I think that one of the things that Dr. Arons spoke about was the need for education: to change attitudes, to change training, skills, to change motivation, to do things differently.

I must say that I may have missed something, but I don't know exactly how we get there, because we got here by reason of people fighting, I guess, for their own interests. Corporations want to make money, government wants to get reelected and to stay out of trouble by espousing unpopular causes, professionals want to control their own practice and to practice well in their own eyes, academics want to study and point out and teach, but that got us into a very fragmented system.

How do we get into a better system? We have people here representing the people, the patients, the community, the Mass. Association of Older Americans, we have somebody here representing clinicians, you are also internist and the director of an inpatient service, we have somebody here representing academia and presumably giving us a clearer view, and we have somebody here representing government, which is to implement policies and to respond to democratic pressures. How do your constituencies make any of this happen and end up with a better system, a single better system that does something for all of us? Is that an unfair question to ask?

Dr. Steffie Woolhandler:

There are a lot of models that people have written about physicians for national health program. There are published papers about how you would have a national health insurance in the United States. The other ad hoc committees, which do have a binding referendum on the November ballot in that this election just calls for the state legislature to enact universal act of health care. I think that a lot of people have leveled that criticism, well, how do you do that? What kind of universal access? But I just want to remind you that every other developed nation has some form of national health insurance. They differ in detail, they differ in cost, they differ to some degree in quality, but all of them cover all of their citizens. They spend less than we do, and most of them have people who live longer. So there are models out there, and it's just not easy, but it's clearly doable because all the other developed nations have done it.

Unknown Speaker:

The merger between the Brigham and the General was probably illegal, because it violated state laws that call for a public hearing before anything like that can happen. If you believe in competition, you don't allow the merger. If you want competition among hospitals, cost control, and better quality, then you have to take apart all the mergers. The only trouble is that the powerful hospitals don't want to compete. So I think you can go the other way and say, "How do we pay every needed hospital enough money to remain open as long as it's operating efficiently?" But let's take it one step at a time. I think we are basically confused on what we want, whether we need it at all, and what kind of services.

Unknown Speaker:

Just a couple of thoughts. I think from a certain perspective we're in a phase at the moment of very slight incremental change for improvement. So we try to fix little things as they occur, we have the patients' bill of, you know, things are a disaster for patients. It's very hard for consumers. The patients, as you pointed out, have very little say in what happens to them, so the patient bill of rights is supposed to help bolster that a little bit. We have, you're kicked out of the hospital too quickly, so a law is passed about the minimum length of stay. There's the mental health as we've gotten more and more squeezed down, 31 states have passed parity bills to try to improve. All these things are really small, incremental tweaking around the system.

Part of it is that at the same time, I think we need to be educating ourselves, as it sounds like the League of Women Voters is attempting to do, to educate the public, and to begin to do some thinking. I think at the level of, why is it that other countries have a different philosophy- a different attitude that they somehow see health care not in the same ballpark as selling a McDonald's hamburger, but they see it as the same ballpark as providing fire protection for fires, your firefighters, and your police department and your garbage collection. Now how is it that we would never think in this country of saying that a community would have several competing different fire departments, that we would decide who to call based on how we felt or who was covering us that month or that year, and they would respond differently.

We organize ourselves as part of a social compact to feel and believe that fire protection is something we ought to do collectively, and yet we somehow evolved our notion about health care in a very different way, and yet other countries do it differently, so I think part of this is a also massive self-education and awareness activity that will also play a part in this in the long run.

Dr. Steffie Woolhandler:

I just want to address a little bit different issue- the idea that everyone's going to cooperate, and we have to decide who we meet at the table and who we don't. I think people, who are actually providing services belong at the table, but the people who are just pushing paper around and extracting 10, 15, 20, 30% of premiums? I don't think we want them at the table, because I don't actually think they have a role in the health care system. The nation's leader in terms of HMOs right now, they had an overhead of 33% last year, so they took 33% premiums just pushing papers around. It doesn't own hospitals, it doesn't employ practitioners, just pushing paper around.

My other example is really the managemental health companies, and for managemental health care companies, an overhead of 33% would look great. Because the average management of health companies has an overhead of 50%, and the worst in this companies have an overhead of more like 73% with only 30-plus percent actually going to care. So, these are actually self-audit findings that were reported to the U.S. Congress, okay. So you have to decide- they're in the health care system, they're making money, do they get a place at the table? I think not.

Anne Hargreaves:

But I think you have to look at who's at the table right now. I cannot believe in the state of Massachusetts we have put all the foxes in the chicken coop. They have absolutely, and you've got Finneran out there playing to everybody- everything's wonderful in the health care in Massachusetts. You have the hospitals fighting with the HMOs, the HMOs fighting, they're all together. I think there's one consumer group that they have that they put into...

Unknown Speaker:

Sounds like you're referring to the Governor's?

Anne Hargreaves:

That's right, isn't it great?

Unknown Speaker:

It has 40 members, 15 hospital people, five HMO people, 30 state legislators, and one health care advocate.

Anne Hargreaves:

That's right.

Unknown Speaker:

Someone once called us the people who cause the problem appointed by someone who doesn't know there's a problem, and led by someone who says that publicly is the solution.

Anne Hargreaves:

And this is the group that's going to recommend what's going to happen. I feel so hopeless. I go out talking to the elderly. First they're confused- they know they hate what they're being subjected to, and anybody you talk to that's my age will say, “Oh, my God, stay out of hospital.” And they've got terrible stories to tell you that turn you right off. Also, the elderly have a hard time because they don't challenge authority- they sort of look to someone to take care of things, like we've got Medicare, which they're very happy about. But what have we got? Bush coming along proposing that social security be invested in the stock market, and the elderly are all saying, “What's this all about? I had a little bit of security, and I'm not sure what the future's going to be about.” There's a horrendous job to be done, to educate people about they don't know what's going on. They're confused, they're not happy.

Unknown Speaker:

I think this is coming back to the question you raised, an earlier question, if the hospitals are looking out for themselves, they want to be first in line for more money for business as usual. But on the other hand- when you're sick and you're worried and it's hard to be a good self-advocate and a good consumer- I think so much of this depends on orienting physicians and nurses, and empowering them to think about us first so that they are being paid in ways that don't give them a stake in your getting less care. They've got a pot of money and then they don't get less money when you get less care, and when there are...

Anne Hargreaves:

But they do.

Unknown Speaker:

They do now, but that could be outlawed.

Anne Hargreaves:

I think it should be outlawed.

Unknown Speaker:

That was one of the first provisions to go from the patient's bill of rights statute, which is one of the reasons it's such a weak law. But there's a dilemma: if it's hard for us

to advocate for ourselves, and if caregivers are thinking about either themselves or other considerations first, how do we put the patient back in the focus? I don't think we have good answers to this.

Unknown Speaker:

I wanted to make, just to share with the people some of things we're doing with your money to try to empower mental health consumers, at least, in some of these areas, because I think it is an important issue, and we're a long way off from doing this. But among the things that we do- we help support three mental health consumer self-help technical assistance centers across the country that try to be a source of newsletters and information to try to help if there's a group of mental health consumers in the area that want to try to form an advocacy organization to try to express their voice. These self-help technical assistance centers try to assist them as well as two supporter technical assistance centers- the National Mental Health Association and the National Alliance for the Mentally Ill- that we help provide federal funds to, your tax money. This is in order to help increase and enhance their advocacy work, and we are seeing some signs of some increased activity.

They are pushing, even when not asked to be a voice at the table, they'll often push themselves to be a voice at the table, especially in state discussions. We've also started a series of provider-professional-consumer dialogues. We've brought together ten psychiatrists, consumers, and psychiatric nurses and tried to stimulate a conversation. What we've found in the course of a day's discussion, kind of a focus group, is that when you're not there as a doctor-patient relationship, you discover you have a tremendous amount in common as far as what you're trying to achieve in the health system, the mental health system. And we are writing these conversations up and making them available. So these are among the ways, we also try to support local consumer activities in a number of states, make sure that people come to both international and national activities so that we can begin to educate and make the consumer movement, at least in the mental health area a lot more a lot more effective. I hope maybe something like that will snowball into other areas as well.

Dr. Steffie Woolhandler:

I would answer the question a little differently in that I think we need do the education and the political policy changing. In the groups that I've worked with, Physicians for National Health Program, we feel that our work is in helping develop physicians and other health professionals.

Dr. David Satin:

If I may step in, I think we are all victims of the situation. I think the doctors- let me speak personally- are as much unhappy about the situation. I worry about the young doctors, because I'm afraid that their experience is to expect this kind of situation. I think we are prevented from doing what we want to, that's why I wanted to hear from Dr. Woolhandler about what her inpatient service does different than any of us when we are pressured one way or another. But I think the patients are certainly victims of the system. I think the politicians are, that's their job, to be responsive to pressures and the situations that they're facing, but I think what people are beginning to tell me about what you do about this is that you educate one another and get together in some setting where you can be effective in changing the situation. In a way, I suppose that's what your groups are trying to do.

Unknown Speaker:

Salary-based insurance doesn't work. Who's salaried? Does anybody here work on salary? A show of hands, please. Do you work hard? Well, once doctors are willing to accept salaried arrangements and are well supervised and encouraged and empowered to give good care, they won't be thinking about the state of Massachusetts. Now, someone said that managing doctors is like herding cats. That's totally understandable, that people come into medicine with high autonomy much of the time. Once we pay them in a way that gives them adequate control they're satisfied with, that liberates them to control the rest of the money, as long as they cover all of us and make the money last long, that's cool.

Alan Sager:

I'm going to have to apologize to exit a little bit earlier. I have a little bit farther to go and there's a taxi waiting. I'm going to leave, Dr. Satin, with some cards for people who have other thoughts or things they want to make sure I'm aware of, and this was a very invigorating discussion. We certainly have a long way to go.

I think the practice, because of the number of people who practice mental health care, I've become impressed as I've gone around the country about how remarkable the practitioners are in mental health care in spite of the tremendous lack of security and the changes that are going on in the mental health field. People have really, for the most part, tried to keep that outside of the treatment room and with their clients, with their patients. People are really trying to keep the focus on what are the issues and how to get better, and I think that's been awfully difficult in the environment that we're in, and I think it's also something that might worry the next generation of practitioners. But in interviewing people going into medical school, there's still that dedication that I think will help solve that problem as well. So thank you very much.

Dr. David Satin:

Did you have something to say? Okay, maybe this is the time to thank all of our speakers for coming and for presenting honestly a lot of different points of view. I think I know a little bit more about how to do it, but I could use some more details about how you get the government to take this responsibility, and how you get physicians and other health care practitioners to be responsible in helping to organize their own work, and how you get patients and community residents to have a voice and have a clear head about what they want, rather than, as people have said, better care for less money. What the details and the mechanics are that we can then commit ourselves to participating with. Thank you all for coming. I hope it was a worthwhile afternoon for you, and let me invite you back to the 24th Annual Erich Lindemann Memorial Lecture next May or late April. Please let us know how to reach you to let you know about it on your way out, make sure we have your name and address and email address and things like that, and let us know if you have some ideas about a topic that you would like addressed.

Thank you again.