

# TECScript 3

## *The Need for Fundamental Change in Healthcare*

*Messages from 24 April 2001 – 26 April 2001*



*An Unedited Compilation of Email Messages from the  
Outcomes Evaluation Topical Evaluation Network  
(OUTCMTEN) at [outcmten@world.std.com](mailto:outcmten@world.std.com)*



**Human Services Research Institute**  
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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services  
[www.samhsa.gov](http://www.samhsa.gov)

This **TECScript** was compiled by *the Evaluation Center@HSRI*. The Center is funded through a cooperative agreement with the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. The mission of the Evaluation Center is to provide technical assistance to the evaluation of adult mental health system change.

**TECScripts** are one component of the **Topical Evaluations Networks (TENs) Program**. The purpose of this program is to provide mental health system stakeholders (consumers, providers, researchers and families) with the opportunity to communicate directly with each other, and with Evaluation Center associates about topics of specific interest in adult mental health system change evaluation. The Networks Program makes use of electronic mailing lists to allow subscribers who have access to the Internet to participate in ongoing discourse about the specific topics listed below.

The **TECScripts** are designed to provide interested persons with unedited compilations of email messages from the various mental health electronic mailing lists that the Evaluation Center operates. The only changes that have been made to the original messages are to correct for misspelled words. Messages are in chronological order. Time stamps are Eastern Standard Time. If the message being replied to is not the original message but is still in the same topic thread, this message is in italics and precedes the response, which is in plain text.

The Center operates four electronic mailing lists that deal with different aspects of mental health evaluation. Following are descriptions and subscribing instructions for the four lists:

- **Legal and Forensic Issues in Mental Health Topical Evaluation Network (LEGALTEN)**  
The purpose of the LEGALTEN list is to facilitate the implementation and use of rigorous evaluations at the interface of the mental health system, the criminal justice system, and the courts.
- **Managed Behavioral Health Care Evaluation (MBHEVAL)** The purpose of the MBHEVAL list is to discuss the evaluation of managed care as it affects the delivery, outcomes and costs of mental health care and substance abuse treatment services at the state, local, program, or consumer level.
- **Multicultural Mental Health Evaluation (MCMHEVAL)** The purpose of the MCMHEVAL list is to foster discussion of issues related to the evaluation of mental health services for diverse cultural, racial and ethnic populations. Potential issues for discussion include measuring ethnocultural identity, cultural competence, and access to mental health services for diverse groups.
- **Outcomes Evaluation Topical Evaluation Network (OUTCMTEN)** The purpose of the OUTCMTEN list is to develop a broad collective expertise with respect to problems of assessing and analyzing outcomes of interventions aimed at improving mental health systems. The list also serves to provide assistance, information, and contacts regarding (1) issues in evaluation, (2) experimental and quasi-experimental design, (3) instrument and survey development, and (4) statistical analysis for mental health.

If you would like to subscribe to LEGALTEN, MBHEVAL, MCMHEVAL or OUTCMTEN visit the list subscription page of our web site at <http://tecathsri.org/lists-form.asp> or send an email message to:

[imailsrv@tecathsri2.org](mailto:imailsrv@tecathsri2.org)

containing only the following words (leaving the subject line blank):

subscribe list name email address

For example:

subscribe legalten jones@yahoo.com

Transcripts of on-line discussions, as well as printed copies of archived documents are made available in TECScripts by email or mail to interested stakeholders; especially those who do not have Internet access. Visit the publications section of our web site at <http://www.tecathsri.org/pubs.asp> to view available TECScripts. For more information contact Clifton Chow at the Evaluation Center@HSRI by phone (617) 876-0426 x 2510 or by email [chow@hsri.org](mailto:chow@hsri.org).

H. Stephen Leff, Ph.D.  
Director & Principal Investigator

Clifton Chow  
Program Manager

**TECScript 3: The Need for Fundamental Change in Healthcare**  
**24 April 2001 – 26 April 2001**

Date: Tue, 24 Apr 2001 11:55AM

From: "Stephen E. Beller" <nhdspres@bestweb.net>

I've just come across a great book titled: "Crossing the Quality Chasm: A New Health System for the 21st Century." It was written by the Committee on Quality of Health Care in America, Institute of Medicine. An excellent executive summary can be printed for free from [http://books.nap.edu/html/quality\\_chasm/exec\\_summ.pdf](http://books.nap.edu/html/quality_chasm/exec_summ.pdf)

Here's a brief overview of what the book is about ...

Quality of Health Care in America - Project Description

Addressing the quality of health care in this nation was the focus of Institute of Medicine's Quality of Health Care in America Project, which began in June 1998. The goal of the QHCA project was to provide leadership, strategic direction and analytic tools that will contribute to a significant improvement in quality in the health care industry during the next decade.

On March 1, 2001, the Committee completed their project and released their final report. Below is a brief description of this report: The health care enterprise is in need of fundamental change. Research on the quality of care reveals a picture of a system that frequently falls short in its ability to translate clinical knowledge and technology into practice. The health care system as it is currently structured cannot consistently deliver effective care in a safe, timely and efficient manner. In *Crossing the Quality Chasm: A New Health System for the 21st Century*, the committee proposes a bold overhaul of the U.S. health care system---and a strategy to address serious shortcomings in the quality of health care available to Americans.

\*\*\*\*\*

I'm no longer so naïve as to believe the behavioral healthcare field will adopt a strategy in which clinicians embrace evidenced-based treatment and work with researchers to develop a useful diagnostic system, but I'm pleased to see that the vision is not yet dead!

Steve Beller

**TECScript 3: The Need for Fundamental Change in Healthcare**  
**24 April 2001 – 26 April 2001**

Date: Tue, 24 Apr 2001 12:39PM  
From: saumitra\_sengupta@dph.sf.ca.us

Interestingly, a lot of US research findings and recommendations (for which we spend top \$\$\$) are adopted and utilized in other countries before the US systems start paying attention to them. In the early '80s when I was studying the habilitation system for the developmental disabled in Japan, the Japanese proudly proclaimed such adoption and always added that the US was much slower to move. Sure enough, many of the systems changes for the DD in Japan that I had witnessed then took another decade to start appearing here in the States.

We will be naive not to take into account the big money political realities in this country both in terms of what is presented for public edification and what gets the policy and fiscal wonks' nod.

Saumitra SenGupta  
San Francisco

**TECScript 3: The Need for Fundamental Change in Healthcare**  
**24 April 2001 – 26 April 2001**

Date: Tue, 24 Apr 2001 2:59PM  
From: "Rex Green" <rsgreen4@HOME.COM>

Stephen,

Thanks for sharing the web site. I downloaded and read the Executive Summary. There certainly are many good ideas contained in just the summary.

Health care is highly regulated in the U.S., making changing the entire system a huge challenge. I am thinking of how to motivate JCAHO to relax its emphasis on good process to allow/foster more innovation. One way would be to conduct very brief, consultative accreditation visits to health care companies that register for ISO 9000 (coming soon) and/or are applying the Baldrige Quality Award criteria to improve their quality management systems. The attraction of the latter approach is that 50% of the points are devoted to showing good results, including client outcomes.

Anybody think this idea is worth pursuing?

Rex S. Green, Ph.D., CQE, RHIT, CSP  
Healthcare Quality Advisor

**TECScript 3: The Need for Fundamental Change in Healthcare**  
**24 April 2001 – 26 April 2001**

Date: Tue, 24 Apr 2001 6:23PM  
From: Art Dyer <Art.Dyer@aadac.gov.ab.ca>

*On Tue, 24 Apr 2001 2:59PM rsgreen4@HOME.COM wrote:*  
*>Stephen,*

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*Healthcare Quality Advisor>*

Some of this seems to be running counter to the Evidence-Based Health Care movement (deconstructing JCAHO) and other parts seem to be running in the same direction (calling for fundamental change in health care).

A couple of web-sites <http://www.cochrane.org/> and <http://cebm.jr2.ox.ac.uk/> talk about the issues of getting scientific evidence used in health care. Similar directions can be found in a variety of "best practises" reviews and sites. In the addictions, SAMHSA's CSAT and CSAP initiatives make attempts to do a similar thing (see <http://www.samhsa.gov/centers/clearinghouse/clearinghouses.html>.)

There are lots of reasons to be dissatisfied with the status quo. I suspect that the solutions we see depend in large part on the expertise we have or the positions we hold (yes, even some of us administration and policy wonks see problems and promote solutions).

Like Steve, I don't think we'll see behavioural health care adopt a strategy for improving the system. I am, however, hopeful that we'll adopt quite a variety of strategies and that some good will come of that mishmash of efforts to improve.

Art Dyer, Manager  
Service Monitoring and Research  
Alberta Alcohol and Drug Abuse Commission

**TECScript 3: The Need for Fundamental Change in Healthcare**  
**24 April 2001 – 26 April 2001**

Date: Tue, 24 Apr 2001 7:16PM  
From: JJbuild96@AOL.COM

VHA recently published a report based on focus groups of health care service consumers. From the VHA website the follow abstract is posted. To access the full report go to [www.vha.com](http://www.vha.com) and click on news releases

"The study, titled Consumer Demand for Clinical Quality: The Giant Awakens, examines the experiences of more than 500 individuals who have experienced the health care system, either directly or indirectly with close relatives. The study participants were asked a battery of questions related to the quality of the clinical care and how they choose providers. Based on the study, VHA has come to the following conclusions:

- Consumers are seeking credible and meaningful clinical health care information and feel it is important to be actively involved in their care or the care of their family members.
- Clinical quality issues are central to consumers' definitions of health care quality and are more important selection drivers than service issues.
- Clearly presented concepts of evidence-based medicine and system-based measures for patient safety are readily understood and embraced by consumers, especially baby boomers, as information that would influence their choice of provider.
- Consumers see hospitals simply as bricks and mortar, performing a minor role in assuring clinical quality within the organization, but they believe hospitals, as functional organizations, should be playing a more active role. Consumers believe physicians are the key drivers of clinical quality in a health care organization.

"This study says consumers want clinical information. The study also indicates that hospitals that want to be successful need to demonstrate leadership in advancing clinical quality within their organizations. Then they need to communicate their efforts to the public," said Ken Smithson, M.D., vice president of clinical affairs at VHA. "

Can behavioral ignore quality issues if it is to achieve full parity with physical health? It would appear to me that groups like PacifiCare Behavioral Health are beginning to push the envelop in documenting outcomes and establishing a "trajectory of change" that is transtheoretical. This system is likely to set the standard for the industry.

Dave Johnson  
Missoula, Montana  
E-Mail: JJBuild96@aol.com



**TEC*Script* 3: The Need for Fundamental Change in Healthcare**  
**24 April 2001 – 26 April 2001**

Date: Tue, 24 Apr 2001 9:52PM  
From: DOCTORUTH@AOL.COM

What about just having everybody covered by the same health/dental/mental health/medication care - called by some single payer/universal coverage? Wouldn't that be a wonderful and fundamental change? We are the wealthiest country in the world, basically, and it is a travesty that so many people have no health or medical care - never mind evidence based medicine.

Ruth Ross

**TECScript 3: The Need for Fundamental Change in Healthcare**  
**24 April 2001 – 26 April 2001**

Date: Wed, 25 Apr 2001 7:27AM

From: "Scott T. Meier" <stmeier@ACSU.BUFFALO.EDU>

*On Tue, 24 Apr 2001 9:52PM DOCTORUTH@AOL.COM wrote:*

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*Ruth Ross>*

Wow, Ruth, you may really get some interesting reactions by opening this can of worms.

Some people would argue that evidence based medicine will increase efficiency in most health care systems and thus make it more feasible to provide care to more people. Of course, that was one of the arguments for managed care, and the last time I checked, there are more uninsured people in our country over the last 10 years, not less.

I agree with your wish and your rationale, but I suspect there will be some elaborate disagreements forthcoming...

**TECScript 3: The Need for Fundamental Change in Healthcare**  
**24 April 2001 – 26 April 2001**

Date: Wed, 25 Apr 2001 9:06AM  
From: "Tom Trabin" <tom@TRABIN.COM>

*On Tue, 24 Apr 2001 9:52PM DOCTORUTH@AOL.COM wrote:*

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The Clintons' unpopular and aborted Health Security Act proposed a standard health care coverage that all private purchasers and payers would adopt. So standard benefit design and single payer need not necessarily be linked. And universal coverage is yet a third, separate issue not necessarily linked to the other two.

There are still many groups advocating for single payer and for universal coverage. Since the demise of the Clinton Act I haven't heard of anyone advocating for single benefit design independent of single payer. For those of you who have been involved on the insurance side of our field, you know there are billions of dollars devoted annually to servicing the variety of benefit designs. Irrespective of whether we ever move to a single payer system, which I doubt, some movement towards greater standardization of benefit design could save millions of dollars that could then be devoted to enhanced services.

Another intriguing aspect of the Clinton proposal was regional quality boards that would require health plan evaluations. I had hoped that would have galvanized all of health care to step up its outcome evaluation efforts, using some of the funds saved by benefit standardization. Oh well.

**TECScript 3: The Need for Fundamental Change in Healthcare**  
**24 April 2001 – 26 April 2001**

Date: Wed, 25 Apr 2001 2:29PM  
From: "Rex Green" <rsgreen4@HOME.COM>

*On Wed, 25 Apr 2001 9:06AM tom@TRABIN.COM wrote:*

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*Another intriguing aspect of the Clinton proposal was regional quality boards that would require health plan evaluations. I had hoped that would have galvanized all of health care to step up its outcome evaluation efforts, using some of the funds saved by benefit standardization. Oh well.>*

I suppose that the forces moving us towards universal coverage, single payer, and standard benefits are gathering steam, converts, and political clout. I attended a Nader2000 meeting last night. The topic was universal health care. The organizations providing the two speakers were the newly formed Labor Party and Healthcare for all in California. The main problems they said we are having with our healthcare system include:

1. Higher quality clinicians are burning out and being replaced by less skilled staff.
2. In the US there are now over 45 million uninsured, about 60% of whom have a worker in the family.
3. The US spends 14% of GDP on health services while other leading industrialized nations spend 7-10%; we spend \$4000 per person served, others spend about one-fourth of that; the cost of a hospital day is twice what it is in these other countries.
4. We spend 20-25% of a healthcare dollar on non-clinical costs, while Canada spends 11% and Medicare spends 2.5%.
5. WHO rated health care systems based primarily on service quality, accessibility, and cost-effectiveness of care and the US placed 37th; France and Italy were the best.
6. Many public health status indicators show the US to be well below these other nations on infant mortality, life expectancy, etc.

Even if all these numbers are off, the consistency of this picture should be alarming to us. So, what should we do.

**TECScript 3: The Need for Fundamental Change in Healthcare**  
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The speakers were recommending universal coverage, comprehensive benefits, single payer, and private provider agencies. The question becomes how well will these changes address our problems?

Looking at the recommendations in a very simplistic way, I doubt that their recommendations will lead to a reduction of the problems. If healthcare systems are to be graded on quality, access and cost, then what will happen to these three factors if we make the changes the speakers are recommending? Here is my take.

A. Universal coverage - if everyone is covered, then more services will be used. Thus, the total cost will go up and until more service providers become available, access will drop, along with quality.

B. Comprehensive benefits - I translate this to mean that only certain services will be paid for. This limits our access to services and reduces quality when higher quality could be achieved by using uncovered services. However, having coverage for selected services ought to lower costs.

C. Single payer - Initially, eliminating middlemen ought to reduce costs, however, the management of who receives which services when would continue, and could lead to lower access. Providers have to enroll to receive payments from the single payer. If reimbursements are too low, they cannot afford to provide services. Providers who are most skilled are more likely to opt out and serve people outside the system.

Since using private provider agencies is not a change, there would not likely be any change except in interaction with the other changes, which might take time to unfold.

Overall, these changes appear to be potentially neutral on costs, with two lowering them and one raising them, while quality and access are likely to be reduced. So, why are we so excited about making these changes???

Rex S. Green, Ph.D., CQE, RHIT, CSP  
Healthcare Quality Advisor

**TEC*Script* 3: The Need for Fundamental Change in Healthcare**  
**24 April 2001 – 26 April 2001**

Date: Wed, 25 Apr 2001 4:18PM  
From: PhDiane@AOL.COM

How do we get the state governments out of the asylum business and allow the integration of mental health services into primary care to occur?

Diane

**TECScript 3: The Need for Fundamental Change in Healthcare**  
**24 April 2001 – 26 April 2001**

Date: Wed, 25 Apr 2001 5:03PM

From: Sylvia Caras <sylvia@PEOPLEWHO.ORG>

*On Wed, 25 Apr 2001 4:18PM PhDiane@AOL.COM wrote:*

*>How do we get the state governments out of the asylum business and allow the integration of mental health services into primary care to occur? >*

Work with the public health model. Context. Community. Work politically to focus the scope of the state block grants. Put health forward as seamless; stop carving out mental health.

Sylvia

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**24 April 2001 – 26 April 2001**

Date: Wed, 25 Apr 2001 6:24PM

From: "Stephen E. Beller" <nhdspres@bestweb.net>

What has to happen before behavioral healthcare adopts a strategy for improving the system? IMO, providers and payers alike have to: (a) realize and admit to themselves that the current system is broken; (b) stop fearing that the open dissemination of evidenced-based knowledge will adversely impact their pocket books; (c) spend time and money to obtain and analyze the clinical data needed to establish best practices; (d) understand that existing information system are sorely inadequate when it comes to decision support; (e) admit that they are less knowledge in diagnosis and treatment prescription than they might believe they are; and (f) feel more pain with the status quo than with the prospect of systemic change. Unfortunately, fear, ignorance, self-deception, and ego are great restrictors in human endeavors ... and the behavioral health field is not immune. So, I'm convinced that until the current system is absolutely unbearable to those whose livelihoods depend on it, or until the public outcry is so load as to not be dismissed, the status quo will dominate.

Steve Beller



**TECScript 3: The Need for Fundamental Change in Healthcare**  
**24 April 2001 – 26 April 2001**

Date: Wed, 25 Apr 2001 8:01PM

From: Lee B Sechrest <sechrest@U.ARIZONA.EDU>

*On Wed, 25 Apr 2001 2:29PM rsgreen4@HOME.COM wrote:*

*> I suppose that the forces moving us towards universal coverage, single payer, and standard benefits are gathering steam, converts, and political clout. I attended a Nader2000 meeting last night. The topic was universal health care. The organizations providing the two speakers were the newly formed Labor Party and Healthcare for all in California. The main problems they said we are having with our healthcare system include:*

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*Even if all these numbers are off, the consistency of this picture should be alarming to us. So, what should we do.*

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Rex S. Green, Ph.D., CQE, RHIT, CSP  
*Healthcare Quality Advisor*>

Rex, I recently read something about Germany's health care system (in the Economist), and it is in trouble. Germany is now spending about 11% on health care, and costs are increasing. They have single payer (federal) coverage with private physicians.

I believed you are quite right in your thinking about the effects of universal coverage and single payer financing of health care. Costs are going up (an up) in part because we are providing more and more "care." Why do we do that? Because people want an MRI just to be sure, because they want medication just to be sure or because they do not want to change anything else, because they cannot stand the thought of Mama or tiny baby dying without "doing everything possible." Hospital costs are going up because, in fact, more care is being provided than is being directly paid for. Here in Arizona "undocumented" persons who are injured are (must be) cared for in hospitals where they will have been airlifted by helicopters (\$3000 a pop). They must be cared for "free." But someone else must pay. So, all the insured customers pay more. Or, rather, all the payers pay more. Or, ultimately, we all pay more because the costs of such things are built into every nook and cranny of our economy. No one wants to pay. How do we get health coverage for fast food industry workers? We all agree to pay a little more for fast food. Simple. But no one wants to do that. Everyone wants the \$1.99 special.

We really need a fundamental rethinking of health, the part it plays in our lives, how to promote it, what we want to do about people who harm themselves and then want everyone else to pay, how we think people ought to end their lives (I'm not thinking euthanasia here), what sorts of amenities we think people are entitled to when they are sick, and so on.

Maybe we ought to have a moratorium on all medical, pharmaceutical, and similar "advances" for about 500 years. Then we would have a "traditional" medical system revered for its longevity. You never hear acupuncture patients demanding new and improved needle placements or ginkgo biloba users wanting genetically modified varieties.

Lee

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From: DOCTORUTH@AOL.COM

*On Wed, 25 Apr 2001 7:27AM stmeier@ACSU.BUFFALO.EDU wrote:*  
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*I agree with your wish and your rationale, but I suspect there will be some elaborate disagreements forthcoming...>*

Thanks for your thoughtful answer, Scott. Let me add this: 20 years ago I undertook a traditional analysis - 4 days a week on the couch - because I felt that I had to see if this would allow me to - well, let's just say, live my life in a more satisfying and rewarding fashion (although that's putting it pretty mildly for the struggles and conflicts I was having). Anyway, one of the first confrontations I had with my analyst - a man, traditionally trained but pretty open and flexible and caring, was that: EVERYTHING WAS EVENTUALLY POLITICAL. And that means: so many of the issues we deal with in scientific arenas (medicine, health and mental health, mental health services, space, science, technology, etc.) have a political and economic reference that cannot be ignored and must initially or eventually dealt with or we just hit a big, big brick wall. And, I believe we are in the process of hitting it regarding medicine, health and mental health.

Ruth Ross

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Rex S. Green, Ph.D., CQE, RHIT, CSP  
*Healthcare Quality Advisor*>

Rex - your comments (1 - 6) are accurate data gathered from today's situation. But after that, with all due respect to your knowledge and experience, I don't know that one person can necessarily define or illustrate the kinds of problems that may or might result from implementing a system designed to give universal coverage with a single payer. While we do have several examples to guide us (or not, as the case may be) we can certainly forge our own way and develop a unique system designed to address the problems and issues faced by the US in providing health, mental health and dental care to its people - all its people. Can anyone say we can't do this - if we have a mind to? We are the (I repeat) the wealthiest country in the world, we have the utmost in resources at our disposal - can you say that we cannot work on and work through the problem of providing good medical care to our citizens?

Ruth Ross

### TECScript 3: The Need for Fundamental Change in Healthcare

24 April 2001 – 26 April 2001

Date: Wed, 25 Apr 2001 11:53PM

From: Lee B Sechrest <sechrest@U.ARIZONA.EDU>

>On Tue, 24 Apr 2001 9:52PM DOCTORUTH@AOL.COM wrote:

*What about just having everybody covered by the same health/ dental/ mental health/ medication care - called by some single payer/ universal coverage? Wouldn't that be a wonderful and fundamental change? We are the wealthiest country in the world, basically, and it is a travesty that so many people have no health or medical care - never mind evidence based medicine.*

Ruth Ross>

Ruth Ross, I will intervene here with an invitation: do the arithmetic. Yes, it is almost certainly true that we, i.e., the US could provide health, dental, mental care for everyone. But, then, we could not do a lot of other things that we do now.

I am not saying that we should not provide all that health, etc., care, but I have noted that assertions about the morality, need, desirability, and so on of doing so are never accompanied by any estimates of what it actually would cost. Nor, for that matter, does anyone ever spell out exactly what would be included under the rubric of "good health care" for everyone.

Everyone? Does that mean "visitors" to this country, everyone who is within our borders? Everyone who might manage to get within our borders? Does that mean free eye glasses for everyone who needs them? Orthodontia? Everything that anyone might regard as constituting "good health care?" For many people, good health care includes doing anything whatsoever that might imaginably do any good for cancer victims, evidence or not. Do we have the will to resist such claims on the system? Do we want to?

We could possibly put together a basic benefits package that would be affordable, at least by shifting everyone out of SUVs (hear me out there?) and into sensible vehicles \$10K cheaper. Maybe by getting a lot of people to give up California wines costing more than \$10 per bottle. By impoverishing our professional athletics system by prohibiting admission charges greater than \$25. By not permitting computer upgrades more often than, say, every two years.

But who will get to decide what is a basic benefit? How will we enforce the limits when we are faced with a pitiful 7-year-old with cancer whose parents hope against hope that a \$100K bone marrow transplant might do some good?

I have to admit that I do not know the answers to our health care problems. I have been very much involved in health policy for many years, and all I can conclude is that the problems are very, very difficult, and they do not lend themselves to \*any\* solutions as simple as "universal coverage and a single payer." (The payer, understand, can only be us. There is no one else to pay.)

Some of my colleagues and I have been discussing these matters seriously for a good long while. We do not see any drastic change in site. If our health system is to improve, it is

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**24 April 2001 – 26 April 2001**

almost certainly going to have to be by incremental change. You know the environmentalist slogan, "Think globally, act locally." Well, the counterpart for health care change may not be better than, "Think big, act small." The trick is to act at all.

Lee Sechrest

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**24 April 2001 – 26 April 2001**

Date: Wed, 25 Apr 2001 11:55PM

From: "Rex Green" <rsgreen4@home.com>

*On Wed, 25 Apr 2001 10:08PM DOCTORUTH@AOL.COM wrote:*

*>Rex - your comments (1 - 6) are accurate data gathered from today's situation. But after that, with all due respect to your knowledge and experience, I don't know that one person can necessarily define or illustrate the kinds of problems that may or might result from implementing a system designed to give universal coverage with a single payer. While we do have several examples to guide us (or not, as the case may be) we can certainly forge our own way and develop a unique system designed to address the problems and issues faced by the US in providing health, mental health and dental care to its people - all its people. Can anyone say we can't do this - if we have a mind to? We are the (I repeat) the wealthiest country in the world, we have the utmost in resources at our disposal - can you say that we cannot work on and work through the problem of providing good medical care to our citizens?*

*Ruth Ross>*

Ruth,

No, I am not a pessimist. However, I am wondering just how the proposed remedies are supposed to cause improvements. I have other suggested remedies, but they are still musings untested on brighter minds than mine. My reluctance to discuss them is that so few people in behavioral health have a background in micro-economics. Thus, I need to search out some of the econ folks first.

Rex



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Date: Thu, 26 Apr 2001 9:11AM

From: "Silzer, Kent RHD" <KSilzer@REGINAHEALTH.SK.CA>

*On Wed, 25 Apr 2001 11:53PM sechrest@U.ARIZONA.EDU wrote:*

*>Ruth Ross, I will intervene here with an invitation: do the arithmetic. Yes, it is almost certainly true that we, i.e., the US could provide health, dental, mental care for everyone. But, then, we could not do a lot of other things that we do now.*

*I am not saying that we should not provide all that health, etc., care, but I have noted that assertions about the morality, need, desirability, and so on of doing so are never accompanied by any estimates of what it actually would cost. Nor, for that matter, does anyone ever spell out exactly what would be included under the rubric of "good health care" for everyone.*

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*Some of my colleagues and I have been discussing these matters seriously for a good long while. We do not see any drastic change in site. If our health system is to improve, it is almost certainly going to have to be by incremental change. You know the environmentalist slogan, "Think globally, act locally." Well, the counterpart for health care change may not be better than, "Think big, act small." The trick is to act at all.*

*Lee Sechrest>*

I'm not sure that I agree with Drs. Ross and Sechrest when they assert that the US could provide a comprehensive basket of health benefits for all of its residents. This assumes that providers are an unlimited resource that can be purchased off the shelf -- something that is assuredly not the case. At the present time many jurisdictions are competing with each other and values are being bid up. Recruiting and motivating (potential) providers is a concern that needs to be given more attention.

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Date: Thu, 26 Apr 2001 1:29PM  
From: "Deliberty, Rich N" <RDeliberty@FSSA.STATE.IN.US>

*At 04:18 PM 4/25/01 -0400 PhDiane@AOL.COM wrote:*

*>How do we get the state governments out of the asylum business and allow the integration of mental health services into primary care to occur? >*

As a good bureaucrat, I do have a thought on this. Primary care isn't the issue, is it? Isn't the issue secondary or tertiary care?

The federal government, Medicaid, discriminates against people with a psychiatric disability. Medicaid pays for residential treatment for children, for people with developmental disabilities. Adults with mental illness, however, have a lot of their care paid for by state governments.

There are too many state legislators that would love to get out of the asylum business, and out of the way of the health care professionals. They'd take their ball and bat and budget and go home.