American Health Care: They Say There's a Crisis, But a Crisis of What?

Everybody knows there is a health care crisis, right? Here are some of the numbers—37 million Americans uninsured (Eckholm, 1993). Cost estimates for 1994: 982 billion (Clymer, 1993a), soaking up 14% of the GNP with medical costs rising at more than three times the inflation rate (Eckholm, 1993), worse than any other industrialized country. People being unable to switch jobs because of the threat of losing coverage. Restrictive clauses. I understand the complaints. After all, the health insurance premiums for my own company increased by 38% last year. It's just that I am a health care provider, in both an outpatient and a hospital setting, and I can assure you that neither my income—nor the income of anyone else I know in the industry—increased by anything even close to that number. Most medical professionals and psychotherapists have, in fact, experienced drops, not only in the rate of increase but also in their actual practice incomes.

I've given a great deal of thought to why I am uncomfortable with this whole semi-public discussion—very uncomfortable. Partly it's self-interest. Who likes to change? Who likes to be threatened? Who likes to be told that they are probably going to make 40% less income? Who likes to be told that although their degree of responsibility and accountability are not going to be altered, their authority is going to be assumed by third parties?

This is a formula bound to dishearten any physician or mental health practitioner. But there are some potential off-setting factors. Anyone intimately connected with the health care industry knows that there have been abuses of the system that could stand clean-
ing up. And we know better than anyone except, perhaps, the consumer, the rage, sense of helplessness, and frustration that attends trying to adequately treat the uninsured or underinsured patient. Most of us emerged from medical school or psychotherapy training program with very few skills available to confront decision-making that rests on economic considerations about who we can and cannot treat and we loathe having to make those decisions. It is just not part of our professional ethos and, in fact, is often in direct conflict with it.

Not only that, but virtually everything about health-care practice has become more difficult, unwieldy, and discouraging. Endless and meaningless paperwork, constant harassment from managed care companies, adversarial relationships with patients who have become increasingly suspicious and mistrustful, the constantly looming threat of malpractice suits and now antitrust and conflict-of-interest suits necessitating for physicians the practice of “defensive medicine” that force us to behave in a way that unnecessarily drives up costs and exposes us to even more criticism. Doctors have become progressively dissatisfied over the past three decades to the extent that a huge 40% would not enter medicine if they had it to do over (Belkin, 1993).

So, when the talk began about the need for “health care reform,” I was somewhat optimistic and voted for President Clinton in the hope that he would be able to lead us toward a viable solution. I haven’t entirely given up on that hope, but I have grown increasingly uncomfortable with the level, form, and content of the public “debate.” In fact, the more I read in the press, the more the skin on the back of my neck starts to crawl. In part, it’s about what is being said, but in larger part my distress is about what is not being said, the undercurrents, the assumptions, and the implications. It is these that I plan to focus on in this paper. I am not at all convinced that we are asking the right questions and therefore any answers that we derive must by necessity be suspect.

THE CRISIS
The first thing that strikes me as very odd is epitomized by a column headline in the Wall Street Journal of September 16, 1993: “People Think Health-Care System Needs Fixing But Aren’t Sure of What’s Broken, Survey Finds.” Does anything about this statement strike you as weird? Have you ever been in crisis when you didn’t know,
or at least thought you knew, what you were in crisis about? The article goes on to tell us that although 78% agree that the system does not meet the needs of most people, only 23% think reform will cut the federal deficit, 55% think it will force small businesses to close, 82% believe it will require new taxes, and 82% think mental health treatment should be adequately covered. They also apparently believe (84%) that costs will be reduced by reducing waste without affecting quality. As the author says, “In short, people at this stage seem to be demanding of Mr. Clinton the impossible fix: They want at least all the benefits they get now and more security that they will be getting more, want everyone else covered and want it all without a big increase in the cost to them.” They also do not want restrictions on their freedom to choose their doctors, or the services available to them (Seib, 1993). And they think the plan is going to have no positive impact on the federal deficit, is going to actually result in raised taxes, and is going to force small businesses to close. Somebody might want to ask, based on these findings, why then do people feel there is a need for radical, rapid, and unproven “reform” if it stands to do so little apparent good and may do even more harm? What is the distress about?

This apparent distress is particularly interesting in light of another survey done by the Robert Wood Johnson Foundation in March, 1993 in which 89% of 2,000 Americans said they think that the quality of their own healthcare is very or somewhat satisfactory, 84% thought that their ability to get routine medical services is satisfactory, 80% thought that the quality of their hospital care is satisfactory, and 77% thought that their own health insurance is very or somewhat satisfactory! Despite this astonishingly high level of apparent satisfaction, 56% thought that the healthcare system needs to be radically changed (Postgraduate Medicine, 1993). Doesn’t this all strike anyone else but me as being a little odd? If that many people are so satisfied, then why do we need radical reform of the healthcare system—and the health care system alone?

And what about escalating costs? As an insider in the industry, I know that cost-containment measures have been in effect for years already. DRG’s began to impact on medical and surgical hospital stays in the 1980’s and psychiatric care is presently being squeezed down to what many of us consider dangerous levels. It is apparently working because the rate of increase in health-care costs is going down. According to the Wall Street Journal, “The health-care cost spi-
ral may be unwinding even before President Clinton delivers the fine print on his health initiative to Congress” (Wessel, 1993). Another interesting point about the cost estimates is that they are based on what the hospitals and doctors charge, not what they actually get paid. The difference amounts to huge write-offs that the providers take, write-offs that are not tax-deductible.

If costs are able to be further controlled will managed care deliver? Not necessarily. “Not all policy experts agree that managed care can deliver [cost control]. A June 1992 Congressional Budget Office report found that ‘the growth of managed care does not appear to have affected system-wide costs. At present, based on existing-knowledge, it cannot be assumed that further growth of managed care would reduce either the level or the rate of increase of system-wide health-care spending” (Kassler, 1993). This is not at all surprising for those of us actually working in health care because we have seen how the “managed care” system works. Managed care is not managed care it is managed cost. There is an important difference. Managed care companies get paid based on how much money they save the insurance companies. They save money by telling doctors and hospitals that they will not be paid for services the doctors are saying their patients require. The more they deprive people of their benefits, the more they profit. And the estimates for saving that can be accomplished depend a great deal on the amount of “waste” in the system as it exists. Estimates have been done by the consulting firm of Lewin-VHI reviewing categories of waste like administrative bloat, excess hospital days, defensive medicine, etc. “Taking high estimate of waste for each category, they figure that increases in health costs might be cut only 20-25%” (Samuelson, 1993).

There has been no meaningful regulation of this new and growing segment of the industry so the ethical and professional basis of the managed care decisions vary enormously. It is possible for the health care provider to establish ongoing and satisfactory relationships with some employees of managed care companies, and some seem to apply responsible standards to their decision-making. Others are patently crooked, making frighteningly arbitrary, capricious, and professionally irresponsible decisions that endanger lives. The people making those decision have a vested interest in performing their jobs to the satisfaction of their superiors and for them it is irrelevant how much time it takes—that is what they get paid for. Physicians do not get reimbursed for any time spend arguing,
pleading, cajoling, debating, and threatening managed care companies. For many physicians in practice, the actual time spent in trying to contact these people, talk with them, and provide documentation takes as much time as actual patient care. And if they refuse coverage, there is a long and drawn-out appeal process that simply consumes more time that does not get paid for. Physicians and hospitals will provide necessary care whether it gets paid for or not. This is another fact that does not get mentioned. So who pays for it? Nowhere have I seen any figures that convey the magnitude of the amount physicians and hospitals give in free care.

The managed care companies make their position clear: “Doctor, we are not saying that you have to discharge this patient. If you feel that medical treatment is necessary you must use your best medical judgment. We are just saying we will not pay for it.” This then becomes more cost-shifting and there is nowhere else to shift it except to doctors and hospitals. This is a “Catch-22” situation and the increasing physician dissatisfaction with medicine has much more to do with these conditions of forced helplessness than it does with dollars.

The strange thing about the “crisis” is the urgency with which we are being hurried towards a “solution.” Health care costs have been steadily rising for decades. The exploitation of the system has been going on for decades, escalated enormously when corporate America took over health care about twenty years ago, and at least from my bird’s eye view, has been substantially curbed in the last five years by all the restraining measures that have already been put into place. So what suddenly made everything so urgent and—even classified,” judging from the secrecy of the meetings held to discuss reform—that we have to revamp our entire health care system all at once and now? Federal District Judge Lamberth has had to order the White House to provide documents that show that the people who worked on the task force had no conflict of interest issues. This comes after three health care and policy organizations had to sue in February about the secrecy of the task force—eventually the names were leaked and then released. The government had made the position that the meetings could be held in secret because everyone was a government employee—but why are only government employees deciding on our health care plan which gives control to the government? And why are there apparently few minutes or agendas for these meeting? If the task force didn’t produce 1,342 pages of the Health Security Act then who did? And if documents do exist, then
why all the secrecy? (Griffin, 1993b)

And isn't it usually better to make changes one step at a time and make sure they work before attempting to disassemble and restructure a fundamental part of the social system, let alone the economy? As the Wall Street Journal wonders, "Assuming for a moment that stagnating the growth of an enormous industry in a fragile, volatile economy is a good thing, what would the reformers need to do to turn this fantasy into reality?" (Kleinke, 1993) The journalist suggests that the answer to the question is to reduce treatment of the elderly, reduce efforts to conquer disease, reduce new technology, leave new diseases untreated, and halt medical progress. Anybody out there up for that kind of a plan? Another journalist notes that "Health care reform [is] installed in the political pantheon along with motherhood and love of country ... what has driven the health care issue thus far is the sense of public urgency" (Toner, 1993). "Mr. Clinton's health care plan represents the most sweeping new venture in social policy in a half-century" (Pear, 1993). Could we please have a historical review about the relative risk/benefit ratio of sweeping social change? Cautions P.C. Roberts in Business Week, "Once a plan is enacted, there will be no going back. Medical institutions will be permanently altered and we will be saddled with a new health entitlement three times as large as Social Security and five times as large as Medicare" (Roberts, 1993). And Samuelson adds, "...the entire health care system could get caught in a huge contradiction, because it would be required by law both to provide more health services and to cut costs" (Samuelson, 1993).

LET THE GAMES BEGIN: FINDING SOMEBODY TO BLAME

OK, let's accept for a minute the premise that there is something seriously wrong with the health care system that requires radical reform. Let's look at whose fault it is, since finding someone to blame usually takes up much more time, energy, thought, newspaper space, television time, and is just more gratifying than actual problem-solving. After all, problem-solving is complicated, tedious, gives us headaches, and usually leaves us feeling more confused than when we started.

In a survey reported in USA Today in June, 1993, "Who gets blamed for medical costs," doctors received almost twice as many votes over insurance companies, or politicians/ government or hospitals as the reason for high medical costs. This sentiment was
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...echoed by the First Lady in her May speech to the International Union of Service Employees when she said, “Talk to your friends and neighbors about what you see every day in terms of price-gouging, cost-shifting, unconscionable profiteering. Explain how you see the system that is being gamed and ripped off because it has no real discipline, no budget, no controls” (Griffin, 1993a). Willard Gaylin points out that efficiency experts advocate a few principles that would solve the crisis. “The first is the need to reduce the venality of health-care providers, particularly physicians. (If only they had the same generosity of spirit and humanity as other professionals in our society—say, lawyers, accountants, and bankers.)” (Gaylin, 1993).

Doctor-bashing is not a particularly new phenomenon. As reflected in one of the mirrors of our group mind—the movies—both doctors and psychotherapists have been in desperate need of some good PR for quite some time. According to Natalie Angier in her analysis of doctors and the movies, “the desanctifying of the medical profession has followed Americans’ gradual disillusionment with technology and paternalism in general... With the Vietnam War, idols in many professions toppled from their pedestals, and the medical establishment began to be seen not as the source of progress but of deception, greed and power-mongering”. In the 1971 movie, “The Hospital,” the chief of medicine presciently remarks that the hospital has become a symbol of “the whole wounded madhouse of our times.” (Angier, 1993)

But it’s not just health care providers, it’s also insurance companies who are to blame. Says Mrs. Clinton, “They have the gall to run TV ads that there is a better way, the very industry that has brought us to the brink of bankruptcy because of the way that they have financed health care” (Clymer, 1993b). The public, however, blames insurance companies only half as frequently as they blame health care providers. This, in spite of corporate profits. “While physician earnings have drawn criticism, they’re paltry compared with corporate wages in the for-profit HMO sector. The chairman and CEO of Oxford Health Plans, Stephen Wiggins, a 36-year-old Harvard MBA, drew $500,000 in annual compensation and held more than $11 million in stock options.... Last May, according to the Wall Street Journal, U.S. Healthcare’s CEO, Leonard Abramson, sold more than $13-million worth of stock—which was only 15% of his earnings.” (Kassler, 1993)

The government doesn’t seem to take much heat for the health
care crisis, at least in the material I surveyed. Only 14% of the people surveyed attribute the increase in medical costs to the politicians and the government. There has been some growing speculation about the issues that Medicare has raised: "Washington knows how to deal with such problems: slap price controls on doctors, hospitals, and medical laboratories—just as it has done with Medicare. So the Clinton health system would be Medicare writ large: constantly over budget, with tighter and tighter controls and with more paperwork and bureaucracy, not less" (Butler, 1993). Of course, it is the policy of cost-shifting originating with Medicare and Medicaid that is such a big part of why we are in this mess. Will the plan change this is or make it worse? I'm not sure anyone really knows.

But it is recently more usual for the Government to be blaming the health care industry for almost all of our major problems. From the President:

The present system we have, I would remind you, my fellow Democrats and Republicans, is largely responsible for the impasse we had over the last budget. We could have had a bipartisan solution lickety-split, given the American people a plan that would have reduced the deficit, and increased investment and putting the American people back to work—if we were not choking on a health care system that is not working (Wines, 1993).

WHAT ISN'T SAID
In the midst of all this finger-pointing and urgent calls to do something, I am not even convinced that we have adequately defined the problem. Ostensibly, the problem is skyrocketing costs, but actually, the increasing costs are the result of the problems, not the cause. Trying to find a purely economic solution to a multidimensional problem is doomed to failure and would most likely make things worse. It's the same kind of thinking that says prisons are an adequate solution to the crime problem—we just get more prisons and more expense while the crime problem continues to escalate.

So, what are the underlying problems enumerated thus far?

1. Doctors' and psychotherapists' greed
2. Lawyers' greed
3. Insurance companies' greed
4. Managed care companies' greed

5. Government greed: Medicare and Medicaid cost overruns

6. Patients' greed: expectations for the best, most accessible healthcare that costs nothing out of pocket.

7. An increase in treatment for various diseases and therefore an increase in expenditures—i.e. treating heart disease or diabetes makes sick people live longer and need more treatment (Gaylin, 1993)

8. A steady increase in the aged population and their expectations for treatment.

9. An increasing demand on the part of the public and the marketplace for new and better and extremely expensive technology and all the research that accompanies it.

10. An increasingly violent society producing an escalating demand for health care and related services.

11. A public refusal to confront extremely uncomfortable issues of rights vs. responsibilities for the costs of allowing people the right to indulge in self-abusive behavior like smoking, drinking, drugging, overeating, abusing their children, abusing each other, and all forms of risk-taking behaviors.

12. A public unwillingness to confront issues of cost vs. benefits of continued care, particularly in the extreme and most expensive cases.

Now, that list should certainly complicate the issue. But is there anything missing from this list? I find several notable absences: Corporate America and its relationship as the employer of health care providers and hospitals, the real reasons behind the public's resentment of doctors, and The Brain.

**CORPORATE AMERICA**

Washington, April 25, a byline from Steven Greenhouse, special to the New York Times, "Changes in military and health spending would slow job growth":

President Clinton's plans to cut Pentagon spending and revamp the health-care system would slow two of the engines of job
growth that powered the boom of the 1980's: the military and health care. Because there has been little job growth in other areas of the economy, Administration officials admit they have little idea where the new jobs will come from over the next decade. (Greenhouse, 1993)

Health care as the power engine of the 1980's for the entire economy. Has anyone heard much about this apparently insignificant fact when looking for who caused "the problem"? I remember because I was there. Corporate America saw a plum ripe for the picking and came into health care and plucked it. Reagconomics. Does anybody remember those days? Long ago, in the '70's even, doctors had relatively little exposure to business practices. The physician-as-business-ignoramus has been a standing joke for as long as I can remember. Doctors are known to be easy to scam, disinterested if not repelled by the necessity of running a practice like a business, and are released from training totally unprepared for the economic exigencies of the real world. There are notable exceptions, of course, like those "millionaire entrepreneur-physicians" (Pear, 1993) endowed with innate business savvy, but for the most part, physicians are business bozos and in the 1970's, when I was a resident in training, most were content to stay that way. Until the MBA's rode into town.

Remember back then, how graduate schools were pumping out MBA and MHA degrees faster than McDonald's does hamburgers? Well, those healthy, bright, young, and enterprising students had to go somewhere and guess where a bevy of them settled—that's right—in the health care "industry". I'm not sure I ever heard it even called an "industry" until that all began. Those were the days when everyone was getting rich, getting rich very quickly, getting rich for free, and getting rich quickly and free was considered good for the country and good for the economy.

Doctors are nothing if not intelligent and quick learners. We also tend to be frighteningly naive about anything other than medicine. Throughout the 1980's virtually every hospital and their offspring were taken over by corporate types. Huge health care chains rapidly emerged. All the executives drove better cars than the doctors, bought airplanes, had luxury vacation homes, special club memberships and all were ever so eager to share a bit of these goodies with the doctors who were responsible for bringing those patients
into the hospitals—as long as they retained corporate control. Prices were hiked, doctors were warmly and coercively encouraged to keep patients in hospitals until their insurance ran out. Doctors were told that applying these tried and true business practices to health care was going to make us competitive, bring jobs, provide a higher level of care to our patients, pump the economy, and in every way, provide only all-round benefit for everybody.

But it wasn't just economics. I can't speak for the quality of care in other specialties, but the quality of care in psychiatry and psychotherapy, at least in the private sector, did improve as a result of the competition in the market place. When corporations had to start competing with each other for patients, they had to become concerned about consumer satisfaction and, synchronous with the patients' rights movement, business America had to begin seeing psychiatric patients not as "fruitcakes" but as consumers. This had an enormous impact on the psychiatric market, at least, in spurring creativity and a drive towards excellence, including better outcomes. Unfortunately, for the most part they did not take a long enough view of the situation and failed to build in actual outcome studies. Additionally, no ethical system of checks and balances had been established to prevent gross exploitation of the system. No one seemed to give much thought to the prospect that there could arise basic clashes between the value system upon which business practices are based and the value system upon which medicine is based. When those value systems clashed, medicine and mental health sometimes took a back seat and by entrenching money as the determining factor for clinical decisions that can only get worse.

The big problem, according to my sources, is government, since Medicare and Medicaid have never paid what it actually costs to provide care, but significantly less than cost, with the expectation that the rest of the industry would pick it up, which is exactly what has happened. So, when a hospital bed costs $500 per day to just have somebody in it, Medicare and Medicaid will only pay $400 per day, Blue Cross pays $550, other insurers pay $1000 and hospitals have to make this whole thing work through a complex juggling system that gives everybody heartaches. If you can attract enough people whose insurance pays $1000 per day and relatively few patients who have Medicare or Medicaid, you can balance your budget or even make a profit. If you cannot, you go broke. Can you imagine trying to run your household like this?
THE PROBLEMS WITH DOCTORS AND THERAPISTS
Another glaring omission from the public "dialogue" on health care are the things I have heard patients bitterly complaining about for as long as I have been in psychiatry. Patients naturally want to have relationships—long term and meaningful relationships—with their health care providers. They want people who are going to be kind, available, listen to them, care about them, give them good advice, and treat them with dignity and respect, a person they can trust. They want "Marcus Welby". I don't blame them—so do I. I have seen no data that convinces me that people would limit Marcus Welby to a health care budget. I also have seen no data that convinces me that anybody's plan is going to provide this kind of personal attention, either from physicians or therapists. There is, however, plenty of data that supports the opposite.

Lawyers have already gone a long way towards making health care providers and patients adversaries. I've only seen one article which indicates the costs of tort compared to other countries along with the costs of healthcare (Postgraduate Medicine, 1993). In that comparison although the U.S. health care percentage of the GDP was 11.2 for 1992, tort (1991) was 2.3%, two and a half times more than Canada or France, three times more than Japan, almost four times more than the United Kingdom. And don't let anyone tell you that practicing "defensive health care" isn't a significant part of the problem. Learning how to defend oneself against suit, or even the possibility of preventable suits has become a major task for health care providers, who become severely emotionally traumatized by suits, whether they are won or lost. Defensive medicine permeates the entire industry and we have all been carefully taught by hospital administrators, medical directors, our professional organizations, the quality assurance directors of hospitals, our personal and hospital attorneys, and each other that protecting ourselves and our hospitals from patients and their lawyers is an extremely important practice if we want to maintain our reputations, our jobs, and the roofs over our heads.

THE BRAIN: STRANGLING MENTAL HEALTH CARE
Finally, what is missing from the entire dialogue is what is probably the most important factor of all—the brain, which includes the importance of mind, consciousness, the unconscious. Hasn't anybody out there watched the Bill Moyer's series, "Healing and the Mind,"
or read that Americans spend almost as much for alternative health care as they do for traditional health care? The division between the mind and the body, the traditional Cartesian duality is passé, old news, out-of-date, old-fashioned, irrelevant, stupid. Besides space, the only other frontier is the human mind, the key to whether we survive as a species or become Nature’s biggest boo-boo.

"An estimated 60 to 70% of the mentally ill have inadequate insurance. Almost 24 million American adults and 12 million American children have a serious mental disorder," reports Shari Roan in the Los Angeles Times. The National Institute of Mental Health states that the full spectrum of mental disorders affects 22 per cent of the adult population in a given year and in a given year, 10.9 percent of the population seek some mental health treatment. The direct cost of treating all mental disorders was only 10% of the Nation’s health care bill (APA, 1993). But the social costs of severe mental disorders skyrocket the figure to an annual financial toll of $74 billion which includes the costs of shortened lives, lost productivity, costs incurred in the criminal justice system and social service system. Given these numbers—and the obvious social problems that we all encounter daily on our streets—any reasonable observer would conclude that a major effort should go into developing and funding ways to adequately treat this huge proportion of the population through finding new and better techniques that build on established knowledge.

Certainly, early in the dialogue, this was the position of Mrs. Gore, an advocate for generous mental health coverage. "We’re fighting to end discrimination against diseases of the mind, to treat mental illness on a par with physical illness (Pear, 1993a). If the initial plan proposal had stood fast, services would have been dramatically cut to anyone who had more generous reimbursement policies under their existing plans, but would have extended some coverage to a broader segment of the population. But already there are predictions that at the Congressional level, mental health care benefits will be one of the pieces of the plan that will be completely eliminated (Murray, 1993). As the Clinton plan originally stood, only thirty outpatient sessions were to be reimbursed at 50% and now it appears that even this has been reduced by half before it even reaches Congress, so the result will be to cap reimbursement for psychotherapy at a few hundred dollars a year, if anything. This in itself will be crushing to most psychotherapy patients and will discour-
age more intensive forms of treatment. There are two other important aspects of the plan: 1) no insurance plan will be able to offer more than 20 percent higher payments or the employer will lose tax deductibility for the plan, and 2) if individuals cannot get tax deductibility for what they pay directly for more expensive care then mental health care will have to be paid for in after-tax dollars. All these provisions add up to a potentially crushing blow for the psychotherapy profession. Ominous as well are the implications of the direction in which mental health treatment is pushed—towards symptom relief and crisis management and away from longer-term intrapsychic and interpersonal change.

This is particularly interesting given that the most profound and far-reaching changes in the mental health field, changes that may be strangled just as they are bearing fruit, are in the area of post-traumatic stress research which is bringing together a knowledge base which synthesizes and connects data about the physiology, psychology, sociology, and spirituality of human beings into a meaningful whole. Progress in the mental health field has been held back by the lack of a cohesive cognitive framework which is presently under construction, but without mental health coverage, and with the proposed limitations of free access to other services, clinical research in this field could well by stymied. This is particularly critical as we discover that a large proportion of psychiatric patients are victims of criminal assaults, usually in childhood and the implications then, for treatment, lead to the need for wide social change. The key to the solution of the problem of human violence, both on an individual and a social scale, resides within a full understanding of what trauma does to people, particularly trauma and neglect in childhood. If we do not understand the source of the problem, we will be unable to solve it. Neglecting the study of the brain, dooms us to repeating the past, and with weapons of mass destruction available, we will annihilate ourselves one way or another.

THE DYSFUNCTIONAL HEALTH CARE FAMILY
The answers to the questions I have posed in this paper, do not lie within the normal confines of rational discourse. When behavior is irrational, when arguments do not make sense in individual or group process, we are looking at the footprints of the unconscious. Unconscious group process is leaving its tell-tale marks all over the health care discussion. I am a psychiatrist. I have difficulty wrestling
with metaphors too far flung from the lens through which I view the world. The health care problem, the alleged "crisis" is such a strange phenomenon that I can only begin to manage any kind of understanding if I look at it through the camera focus of the family, the basic building block of my world—and yours. This country is behaving as my patients behave and since the problem is so huge, I assert that any process that leads to a wider understanding of the problems with which we have to contend is useful, even if it is an oversimplification. The unconscious factors at play here certainly do not negate the conscious realities of the situation. But, as in an individual, if the unconscious factors are not surfaced into consciousness, they will increasingly come to dominant the entire functioning of the being.

As a nation, we are a dysfunctional family. We are not the sickest possible family—there are plenty of reasons for pride and self-congratulation. After all, we've accomplished more in two hundred years than has ever happened before. We have prospered, we have grown, we have enlarged to embrace representatives of all the world's people. But we have reached a developmental impasse as a family. Nobody has gone where we must go. The entire world is faced with problems that require a total shift in perspective, a major shift in consciousness for which there are few guides. And we do not know how to do it. Yet.

A fundamental problem with attempting to reconstruct such a huge part of the nation as the health care industry is that we have no real concensual vision for what the future must look like if we are to survive. So we continue to labor along with ways of thinking and behaving that no longer meet our needs and are, in fact, becoming increasingly self-destructive. Our continued abuse of our children, escalating violence, the decay of the inner cities, continued racism and sexism, substance abuse, excessive spending, the destruction of the environment all attest to our self-destructive, even suicidal proclivities. I believe that this is the real reason for our present predicament. Our culture is behaving like my patients who have been traumatized in childhood behave—as they begin to surface all the unconscious conflict, but before they know how to change, they become increasingly self-destructive, self-mutilative, suicidal. When we are able to recognize the message in the medium, notice the pain, and intervene, the possibility of significant change appears. When we are successful patients are helped to see, under-
stand, develop compassion for and redirect themselves.

I intend to use the metaphor of the family, since after all, it is within the context of our family that we develop ways of behaving, thinking, and feeling that we repeat throughout a lifetime. The behavior, thought, and feelings of the group then reflect a massively summated effect of all of our family experiences. As individuals and families evolve and change, so to do nations, probably along similar lines. First, let's look at the "members" of the health care family and the roles that they play in this vast national psychodrama.

*Patients* are the infants in the present family. As infants, they have many needs, they are helpless, they have relatively little power to satisfy their needs themselves and therefore must depend on older and wiser parenting figures. Even doctors, executives, and Presidents assume this infant position when they become sick. In this state, patients are unable to set their own limits—they are in pain, hungry, despairing, sick and so dominated by their own distress that relief of the distress is the only satisfactory outcome. In Western culture, under the present paradigm, sick people are treated as infants. They have no responsibility to maintain their own health or heal their own suffering. They also have no power to make treatment or financial decisions. And as a consequence, they are never satisfied, they never get enough "food". Having traded off personal power and control over their bodies for the wonders, the technology, of modern medicine, they feel entitled to loving, consistent, predictable, reliable, even miraculous cures that physicians—their responsible older siblings—are bound to provide. Somebody else is supposed to pay for it—Mom, Dad, siblings—anybody who has bottomless pockets—no matter what role they have to play in making themselves sick. If they want to, they should be able to smoke, drink, use drugs, get into unnecessary accidents, shoot each other, maim each other, beat their kids and someone else should have to pay the bill. After all, they are sick and bear no responsibility.

At the same time, the system tells them that the mind is not really important, that mental illness is a second-class citizen, and treatment is really not worth paying for. Entirely neglected is the reality that our entire physical, psychological, social, and moral lives are completely controlled by our mental apparatus. Without a brain and the mind that accompanies it—we are not human. We continue to deny the vibrant and controlling reality of the unconscious mind—both as individuals, as families, and as groups, and in doing
so, continue to be able to project problems—and their potential solutions—into the outside world rather than focusing on the only place they can be solved—within ourselves. Projection is a characteristic defensive style of very early childhood—find somebody else to blame—the problem is always out there, somebody else’s problem. Their bodies for the wonders, the technology, of modern medicine, they feel entitled to loving, consistent, predictable, reliable, even miraculous cures that physicians—their responsible older siblings—are bound to provide. Somebody else is supposed to pay for it—Mom, Dad, siblings—anybody who has bottomless pockets—no matter what role they have to play in making themselves sick. If they want to, they should be able to smoke, drink, use drugs, get into unnecessary accidents, shoot each other, maim each other, beat their kids and someone else should have to pay the bill. After all, they are sick and bear no responsibility.

Physicians are the parentalized older siblings. They are inextricably linked to patients, who have been placed in their care and for whom they are entirely responsible, since the patients are infants. They have a very difficult time understanding why their infant siblings get so angry and fight them, when they consider themselves to be the best caretakers. Lost on physicians is the possibility that much of their behavior may be interpreted as neglectful or abusive, basically because they do not treat their patients with any less compassion and concern than they treat themselves—a sad but typical commentary. At some level, largely unadmitted, these overgrown siblings recognize that an unfair burden has been placed on them, that they should not have to assume as much responsibility for their patients as their patients expect. At least subliminally aware of their own limitations in terms of “curing” the human body, they continue to support the existing paradigm despite its inherent fallacies, a paradigm that treats a person as a machine that can be “fixed” externally until it finally just dies—an outcome that perhaps can be postponed indefinitely, defying all the rules of nature.

Aware at some level, of their own hubris, their arrogance in thinking that they can or should play God, physicians often defend against this awareness and its implications by defending themselves against relating totally humanly with their patients, and in return accept the money and honors that playing the role of God conveys along with it. Physicians have made a Faustian bargain with Science, with Business, and with Law, and increasing satisfaction of materi-
al needs is leading only to increasing fear and loathing. If it were simply government regulation and loss of autonomy that doctors object to, one would expect a different, more organized response from physicians to this erosion of their autonomy. Instead, physicians have behaved like battered spouses, accepting the condemnation and abuse that has been heaped on them without mounting any substantial defense, or banding together in order to protect the interest of the "infants" who depend on them. Why?

In their heart of hearts, the knowledge that binds all health care providers inextricably together into one fraternity is that we know we perpetuate a Big Lie. For the sake of our patients, for the sake of maintaining the system, we allow our patients to believe that we have some special power to cure, that the god, Science, will relieve their physical and mental pain and keep them alive and healthy, probably, certainly someday, forever. Unadmitted, and for most, consciously unknown, there is a secret yearning to be discovered, unmasked, and let off the hook. Health care providers enter their professions to become healers, not managers. If we were so convinced that our paradigm is correct then why are we behaving as if we are guilty? Guilty for making money? Why should people who allegedly save other people's lives feel guilty about taking money that is, for the most part, a fraction of lawyers fees, bankers' salaries, insurance company executives' bonuses, baseball players' incentives?

It's not the money we are guilty about, it is the lying that we have been supporting, the unfairness, the basic inequities in the system, the exploitation that is the fundamental assumption of our economic system and from which we all benefit. The lack of organized response on our part indicates that we are apparently willing now to make sacrifices if it frees us from the Big Lie. We are siblings, not parents. We do not cure these people—they cure themselves. We are simply the transmitters, the teachers, the comforters, the transformers, the vehicles by which healing is conveyed in its myriad forms.

Employers are the paternal parent. Ambivalent about providing for the kids under the best of circumstances, the quality of parenting has varied greatly depending on how badly the Dad needed the children to do his bidding. On the whole, however, he did his bit for many years, since World War II, in fact, at least for his more gifted and more skilled kids. As Mom's demands for increased premiums kept escalating he just kept passing along the price increases to his product or decreased the amount he gave to his kids. After all, he
could understand what the insurance companies were doing—he was doing the same thing. It is our business tradition to make it somebody else's problem and get what you can now and let your successors worry about tomorrow. But times are changing, resources are becoming scarcer, money is in short supply for reasons no one completely understands, and the increasing demands for more health care just got more than he could stand. Although total business spending on health care is less than 4% and employers pass back the largest share of the costs to the employee, the President is saying that it is health care costs that have made American business less competitive (Chandler, 1993), an explanation certainly designed to appeal to businesses since the source of their problems under this scheme, is outside of themselves. Initially, at least, the Administration's plan would certainly benefit the old-line manufacturers like the automotive industry, but much of the costs reflect changing worker demographics that will not be altered by any change in the health care plan (Chandler, 1993).

Insurance companies have traditionally been the maternal parent. For many patients, doctors, and hospitals they were benevolent, all-giving, and generous, and were often taken advantage of through exploitative practices. Making money—through safely sharing risk—was what they had been taught was good for the family, good for business, good for the country. More money flowing through, more profit, more money trickling down. The kids needed more and so Mom passed on the costs to the employers, the Dads, and minimized the risks by refusing to have more kids as part of the family and tossing out those who had become a nuisance. Mom controlled her own purse strings all along with nobody really looking on, and Mom carefully kept what was going on a secret. That was fine as long as there was plenty of money but recently, under the stress of increased costs from various sources including her other investments and businesses (what did Mom do with all that money—it didn't all go to feeding the children—what about that great wardrobe, her fancy cars, her big houses, her great vacations?), Mom has stopped being indulgent and has become overtly abusive. She went out and hired...

Managed care companies, also known as The Nannies—and we are not talking about Mary Poppins. In fact, the nastier they are to the infants and older siblings, the more they yell at them, control them, tell them what to do, use arbitrary threats and physical punishment, the more the nannies' salaries increase. Imagine actually paying
someone to abuse your children and teaching your older children how to deprive and neglect your younger children and call it "man-
aging care" and make it sound like it is really good for them, really in their best interest. This is the system only desperate insanity could create. Thus far, managed care companies have had no real re-
ponsibility to anyone except themselves and their own sharehold-
ers. Anarchy has prevailed and in such situations, whoever has the most power and the biggest weaponry wins. Even those who would play fair can only do so if everyone agrees to play fair and all it takes is for one company to benefit from arbitrary and capricious deci-
sion-making and then everyone has to play that way (Schmookler, 1983). Some companies are better than others—it is the system that is wrong. There is something intrinsically and inherently corrupt in making a company's income depend on depriving someone else of benefits they feel they need and have paid for, without having an overarching, agreed upon, established, fair, and open set of values and practice that curbs essential human greed.

Lawyers are the family's priest. The lawyers fill the position in the family that the clergy used to fill, only the lawyers serve Mammon, not God. Prestigious, wealthy, powerful, they make the rules, set the standards, enforce the laws. Granddad and the priest understand the same language—they both represent patriarchal values undiluted by the caregiving functions that the physicians have to provide. Among the professions, the medical profession represents the feminine and the legal profession represents the masculine which goes a long way to explaining why physicians are always victimized by lawyers but the only way physicians ever get to get theirs is indirectly and quite covertly, if at all.

The members of the family turn to the legal priests whenever there is a conflict to be resolved, whenever one has hurt the other. Lawyers deal in the arena of sin, not sickness. They arbitrate right and wrong, whether as legal advisors, judges, or politicians. Members of the family make confession and then wait for the priest to tell them what their penance must be. The lawyers are smart too, because they have maneuvered themselves into a situation where they have a great deal of authority—albeit hidden—and relatively little responsibility for things like other people's lives. They bene-
fit, no matter what goes wrong with the family, and lose nothing unless they are blantly and willfully stupid—the family will always tithe the lawyer because if you don't he will sue you without hav-
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ing to pay legal costs.

_The administrators_, meaning all the business types who manage the health care industry from the inside, have been called in as the family babysitters. They were supposed to mind the kids, make them clean up their rooms, and stay out of trouble. Mom and Dad were comfortable having them around because they spoke the same language. But with any babysitters, there were frequently major disputes with the kids, often because they simply didn’t agree on basic issues. And in some cases, the babysitters were spending more time and energy going through the family’s drawers and stealing the valuables than they were caring for the kids.

_Executive government_ as a whole represents the Patriarch, the Grandfather. Granddad has decided that Mom and the kids have gotten out of control and that Dad has become ineffectual, even irresponsible, often providing no child support at all. While Granddad—who is also Dad to millions—was busy making bombs and playing with all his war toys, and running up lots of debts, Mom and the kids were making all kinds of mischief. Instead of killing people and clearing out some unnecessary parts of the population, they were developing technologies to save and extend lives, expanding the definition of health to improve the quality of life, and holding off the aging process as long as possible (Gaylin, 1993). Mom and the kids, of course, were no less infatuated with toys than anyone else, and medical technology grew and grew. No one in the entire family paid much attention to who was ultimately going to have to pay the bills for all this stuff.

Not only has Granddad become worried about the family’s expenditures—particularly since he can’t play with his toys anymore—but he also has noticed something else. Granddad just noticed that there are about 40 million children that haven’t been properly cared for and has decided that this is not fair—and good for Granddad. But how is he going to convince Mom and the kids—after ignoring the problem for so very long—that they have to make room in the house for all those others overnight?

_Congress_ is Grandmom. Grandmom is going to have to represent the voice of everybody else in the family and work a solution out with Granddad that ideally provides a workable answer for the whole family. But there are very real problems. Grandmother is not at all secure in her position and could lose a great deal if she takes too strong a stand on anything. And grandmother has lots of secrets
to hide. After all, grandmother colluded with grandfather to create the whole situation and it hasn't been working very well, probably since the last big war. She has rarely been willing to take a meaningful stand on anything, tends to look out after her own best and special interests and puts those interests above those of her constituents in far too many cases. She is always fearful about taking the moral high ground and backing up her beliefs with actions because she tends to get beaten up by her children when she does so. They are just too immature to understand and she hasn't set a very good example, after all.

THE RITUAL SACRIFICE OF HEALTH CARE PROVIDERS

As psychohistorians have repeatedly asserted, leaders are the delegates of the group mind. There are few actual true leaders who follow their own internal guidance system and provide a vision that others follow. There's good reason for that—they tend to get knocked off—Jesus of Nazareth, Gandhi, Martin Luther King. Bill and/or Hillary Clinton may yet have the capacity for true leadership, but it needs time and proper environment to grow. As a people, we are emotionally brutal to our leaders. We behave like babies when we expect them to assume office and then immediately fix everything, know all the right answers, and only tell us what we want to hear. And when they don't perform, there is no compassion. How are they supposed to have time to carefully think things through, dare to be innovative and creative—the only solutions that will work in the present climate—when their environment is so hostile and unsafe?

Under such circumstances, even promising young leaders are susceptible to the influence of the group unconscious and I strongly believe that these leaders are no exception. The group is distressed, as reflected in 56% of the people surveyed saying we need radical reform of the health care policy, even when they weren't sure what the crisis was and the same people—75% of them—were satisfied with their health care plans. In situations of free-floating anxiety such as this, people are open to influence by leadership as represented by politicians and the media (Barnes, 1993), and will fasten on anything that will relieve the anxiety. Back in September the New York Times quoted a Presidential advisor as saying "First and foremost will be the theme of 'security. That is the emotional core of this plan, it speaks to people's deepest fears" (Friedman, 1993). If we are dealing ratio-
nally with a straightforward issue, why do we have to speak to people's deepest fears? Still want to deny there is an unconscious at work here? In similar individual situations people change jobs, wives, houses, or children hoping it will make them feel better. Addicts use drugs or other addictive behaviors in the same way and one could certainly make a case for us being an addicted nation. Right now, we are joining together to buy ourselves a new health care system and avoiding holding still long enough to surface what the problems really are and how we are going to fix them.

Instead, we are dangerously close to doing the traditional human thing—making a ritual sacrifice. In the system that is being presently designed, health care providers first become the scapegoats for all the fundamental value questions that the society—as represented by its politicians—does not want to address. And health care providers appear to be frighteningly willing to be these sacrificial goats. It reminds me of the situation, so common in abusive families, in which the older sibling tries to protect the younger children by making a "deal" with the perpetrator that he or she be the only one who is sexually or physically abused, only to discover later that the perpetrator, in fact, was secretly abusing the little ones all along.

The scapegoating situation—along with the imminent loss of status, money, authority, and power—also raises the question of the role that women play in all this. After all, medical and clinical psychology classes are now over 50% female. Does anyone find it at all interesting that just as women begin to dominate the health care profession, but before they have had time to assume positions of real leadership in any meaningful number, that health care professionals stand on the verge of being relegated to the political and economic cellar along with all the other caretakers—like mothers, daycare workers, teachers, and anyone else that gives service and care to other human beings? Let's just get them back to the kitchen where they belong.

Ultimately, the sacrifice, of course, will fall on all of us, since we stand to lose equally when health care rationing is in place, an inevitable outcome of the direction we are heading. Would such broad sacrifice be necessary if we made some reasonable and consensus decisions about the amount of money spent on terminal care, about reducing the number of injuries second to violence and other preventable causes, about substance abuse? Probably not, but it takes longer and its harder to do. We are always looking for a quick fix.
"Many medical ethicists say American society must decide when to withhold expensive care or technologies" (Eckholm, 1993a) but under the proposed reforms, it is not America who will make these decisions. It is doctors who will have that burden and frankly, we don’t want to carry that alone—“To some degree, the medical structure offered by the White House may take care of these issues implicitly,” Dr. Reinhardt said, “That’s the beauty of a system of medical groups working within fixed budgets. It hides the rationing, makes it ad hoc, keeps it in the obscurity of the H.M.O.” (Eckholm, 1993a). This is slick but this is dirty. It takes what must be a social decision and places it on the shoulders of individuals and then they will be blamed and they will sicken from the guilt and responsibility.

SOME RECOMMENDATIONS FOR "TREATMENT"
This is not the picture of a healthy family. There are some “treatment” recommendations that I will make. Let’s first look at leadership. I am surprised by the attitude that the Clintons have taken towards this issue. And I am saying “the Clintons” because Hillary Clinton is a fundamental part of the executive leadership as demonstrated by her role in the development of the health care plan, and because I think it is an extremely good sign that leadership, even at the top, is entering a partnership model stage. I’ve run several organizations and I can tell you that singular leadership is most prone to mistake. But I expected more openness, less blaming, more efforts to accommodate all parties, more vision.

I don’t think it is because the leadership is bad. I suspect that when the Clintons actually got into Washington and learned what the problems really are, the reality terrified them. We’ve got a crisis alright, but it’s not just about health care. And I think they are trying to protect the rest of us from being terrified as well. I suspect that they discovered what they probably had only suspected—that unless we make radical social and political reform rapidly, our economic system, and very possible our way of life, is going to collapse in the not-too-distant future. It only makes sense. In an increasingly interconnected and threatened world, it is clear that the continuing exploitation of all our natural and human resources cannot continue. A world based on maintaining a rapidly progressive system of have and have-nots is inherently and dangerously unstable. We must find ways to share, to redistribute the goodies, to work together to solve national and global problems or we are all going to
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live—and die—in a nightmare world. But politicians do not dare to say such a thing directly, to let us know just how bad things are, because that kind of truthfulness may not win votes. We have been far to immature as a people to tolerate the idea of limits.

The response of the Administration to this terror is typical of all frightened creatures, rats, dogs or humans. It has been experimentally demonstrated that under conditions of fear, animals will do what they have always done, even if repeating the past is more punishing than doing something new. Animals only seek out novelty when they are feeling calm and safe—so do people. Not only is the world not safe, or the future safe, but certainly the Administration has not felt safe. President and Mrs. Clinton have been under heavy attack since entering the White House. Throughout the first months of the Presidency, I cringed every morning when I would read the newspapers, and say scoldingly to the reporters, “Would you please give the guy a break! Give him a chance. How can someone take over this complex and dysfunctional a system and figure out what to do that fast?” Interestingly, since the President has presented a health care system that would put in place a harsh, patriarchal, disciplinary system, much of the tone of the media—at least temporarily—has been far more respectful.

This is not a coincidence. The press is the voice, not just of the individual reporter, but of the group unconscious mind as well, and we are much more comfortable with people telling us that we are bad and should be punished than anything else. Sadly, for our only-too-human leaders, the tendency to suggest courses of action that make us feel temporarily comfortable, i.e. those things with which we are already familiar, is reinforced and the leader is likely to do the same thing over and over. This produces, throughout the entire network, a systematic error because we keep repeating strategies which have already been proven not to work, just putting them in different outfits to disguise our repetitions. This is exactly what individuals do when they convince themselves that this man or woman is different from the one they divorced, only to find themselves marrying the same—or worse—partner over and over.

The response of the Administration under circumstances of increased fear and hurt, is expectable. They are reverting to the old belief system that encourages us to believe that if we just have a big enough and powerful enough Big Daddy, who is able to apply harsh discipline, we will all behave and do good work. Despite the fact
that patriarchal, repressive, and centralized systems are being found to be totally ineffective in dealing with the magnitude of the problems we have today, they are reflective of our collective pasts and we are having a difficult time giving up the delusion that they work. This helps to explain why so many people, including health care professionals, are jumping on the notion of a centralized system—maybe this time it will work. Unfortunately, however, it never worked all that well and it certainly won't work now. It is time for us to grow up.

Which leads to the concept of expectations. I have been repeatedly struck in my clinical work by the importance of setting expectations for people. Human beings tend to live up to expectations. Unfortunately, throughout much of human history, certainly born out by much of modern history, our expectations for people are relatively low and they tend to live up to those expectations. If you run a psychiatric unit and expect that it will be a violent place, that psychiatric patients can not get well, and that the job of the staff is to enforce as much control from above as is necessary to protect the status quo, then that is exactly the kind of unit that will evolve—harsh, violent, lacking in compassion, repressive, controlling, and crazy-making. If you expect that people can get well, that they desire to get well, that they can act in socially appropriate ways, and that they can assume responsibility for their own behavior, it becomes astonishing to see how well people can live up to those expectations, get well, and become contributing members of the community. This is not rocket science—this is what parents do too, when parenting goes well.

Unfortunately, the expectations that are implicit in the system that is being designed do not expect that much of most people, and expect the wrong things from others. For example, if the entire health care system needs centralized control, with infractions punishable by fines and prison terms, then the expectation is that health care professionals are basically and inherently exploitative and cannot be trusted to demonstrate common sense or good financial judgement. If health care must be rationed through hidden financial incentives or disincentives, with the responsibility falling on doctors' shoulders, than we do not expect that the public is capable of making value decisions about the cost, including the emotional and moral costs, of who gets what treatment and when. If government has to take over control of a major part of our econo-
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my, then the expectation is that government actually has the capacity to fix things and make them better, and do a better job than anyone else could do. Expecting people to behave like spoiled children is a very good way of guaranteeing that they do. Such a policy is understandable, since there is very little that we have expected of people since, at least, World War II except that, but we must remember that maybe we don’t need to repeat the past forever.

To accomplish any of this, leadership—including Congress—is going to have to risk giving us the bad news, breaking the secrecy, and letting us have a much-needed dose of reality. What does the future hold if we don’t grow up? And how soon? And what will it look like? And what could it look like if we changed? And how quickly do we have to change? What we need from our leadership is vision—the big picture. This is the first stage in treating any problem—identifying it accurately and honestly. This is where my patients start. They expect me to “give it to them straight” and by the time they get to me their lives are about as messed up as a life can get. They don’t need it sugar-coated, not if they are going to figure out what to do. Doing anything less is overprotecting, infantilizing, and condescending. It implies an expectation that people cannot respond to crises freely and need to be told what to do. I have not found this to be the case. I have discovered that the most important things a leader can do is be honest, provide support, provide limits, educate, and then place as few obstacles in the person’s path as possible. Human beings do have the capacity for self-healing as long as they are expected to do so and get the safety and support they require.

I suspect that the health care reform plan is a lot about politics, about getting something out to the voters that they like, buying some time, enough time so that they can feel like they actually accomplished something and have the opportunity to accomplish more. Families in crisis often behave in the same way—we just need a vacation, or a new house, or a new car—like a typical dysfunctional family, the Clintons are telling us that we need a new health care system and that will make us feel better. And just like in my patients’ lives, it will—but only temporarily—and only until we have found out that instead of solving problems we have multiplied them.

THE NEED FOR MAJOR REFORM

There is no question that this country needs major reform, but total system reform, not just reform of the health care system. Without
reform and recommitment to an underlying system of values upon which change can be organized and strategically implemented gradually over time, efforts at major change are doomed to failure and will ultimately make the problem worse. This reform can not be forced, it does not lie in creating systems which may permanently destroy personal freedom and initiative in any sector—if we have learned nothing else from the Communist experiment we should certainly have learned that. And it does not lie in finding a scapegoat and then sacrificing them, humanity’s traditional route for expiating its sins and refusing to accept responsibility. A change in any system, in this case the health care system, can only work if all parties are satisfied and such a solution can only come about through a truly democratic process that is based on a vision of the kind of nation we want our children and grandchildren to inherit.

It is time for us to grow up before we, quite literally, commit suicide. It is time for major change. And there is no therapist to turn to who will tell us how to do it. This is going to have to come out of a self-help group, a group that includes all of us, if we truly want democracy to work. Patients are not, in fact, infants, they are adults and should be treated as such. Health care reform can only work if the burden for health care is put back where it belongs so that each person bears responsibility for the health and maintenance of their own body and mind.

The mind-body dichotomy is an archaic notion and the traces of it in our thinking and attitudes towards health should be eliminated in our profession and throughout the community. In the world of physics, the working model of the world is no longer a machine, it is an alive, possibly conscious, self-organizing system. It is time for health care to catch up. Health is defined by the health of all the systems within which we are a part and is ultimately determined by consciousness. Our bodies cannot be healthy when guided by an unhealthy mind. Our minds cannot be healthy when controlled by an unhealthy community. Our community cannot be healthy if we live in an ethically and environmentally polluted environment. Mental health benefits should be supplemented at least to parity, not drastically reduced. The burden of proof for the benefits of treatment should lie with the mental health profession, but such studies should be generously funded so we can actually find out what works and what does not. Discovering ways to help our
community become more emotionally sound is more important than any other endeavor, simply because unless we become less self-destructive—quickly—the rest of it will become totally irrelevant—we'll all be dead.

The government should not be paying for our health care—we should be. It was a mistake to divorce the price of health care from the personal relationship that exists between health care provider and patient. The best plan I have heard of calls for major reform in suggesting a course very different than the Clinton's have suggested. This would involve people buying inexpensive high deductible healthcare insurance and then using tax-free medical savings accounts—all with pre-tax dollars (Griffin, 1993b). People would have the power to control their own dollars, and the responsibility as well. Instead of being able to use insurance companies or government as the indulgent parent and assuming the position of helpless child, patients would be empowered to talk directly about price with their providers, just like we do about everything else—and providers would have to compete with each other for price and quality of care in the open marketplace. In order to do this, providers would be compelled to provide massive public education, because their competitor will be attempting to prove that their service is better—and consumers will want to know facts. For those people who cannot afford to pay, at least a third of whom are under 18 (Eckholm, 1993b) the rest of us are going to have to pitch in because it is in the best interest of the nation.

It may be possible to take this whole issue of the health care crisis and do something really innovative that points us in the direction of a potentially more liveable future. If what we need to do is reinvigorate the notions of community, social responsibility, and participation without stifling initiative and creativity, then why not devise a plan which necessitates that groups of people must learn to develop the skills that go into creating community in order to have a health care solution. The government should not take over providing health care. The government should present us with a plan that expects us to do that on as local a level as possible. It should be a plan that forces people to talk to each other again, so that hospitals are compelled to understand the needs of employers, insurance companies are compelled to bear witness to the sufferings of the insured, physicians have to come to understand the point of view of insurers, and consumers, physicians, hospitals, employers,
and insurance companies all have to negotiate how to do it best and most fairly. Let each region compete with each other for the best experimental design—the cheapest, most efficient, most caring, and most effective. And let those regions be as small as is humanly possible so that the maximum number of people are forced by necessity to become involved if they want good health care.

Under such a system government should serve as the limit-setter and the watch-dog. Clear and fair expectations can be set with enough built-in flexibility to allow for new information and then government should get out of the way. However, if a community balks, will not cooperate, breaks the rules, or acts irresponsibly, there must be consequences. But give up trying to find someone to blame, hold the whole system accountable—tax everybody. If the government has to step in because a community refuses to take care of its own, then everybody in that community has to share in the responsibility. When people recognize that they have a personal stake in social involvement we will see personal involvement skyrocketing. It is entirely too easy under the existing system to always say “It’s somebody else’s problem not mine” and in today’s world, we simply cannot any longer afford that kind of behavior.

But we will never be able to stop the insanity without learning how to be sane. We are at a critical turning point, a time of decision, a time of great danger. And it still could go either way. When my patients experience the awful sense of inner distress so apparent all around us in the cultural milieu, they are presented with two choices—repeat the past or change. Repeating the past is easier. We have a compulsion to repeat the past and it is always what feels most comfortable and brings the most short-term relief. The alternative is to carefully prepare and deliberately, slowly, gradually organize change. This is much more difficult because it demands that we tolerate discomfort, pain, grief, anger, despair, shame, guilt, become more truthful with ourselves, make difficult decisions, and based on the insight that derives from such cognitive and emotional processing, change behavior so that we move towards becoming creatures of integrity.

Can America do it? On my psychiatric unit, we treat people who have been beaten, raped, tortured, chained to dog houses, starved, mutilated, humiliated. I’ve seen and heard stories every day too horrible for network TV. They come into the hospital having practiced every individual and social perversion known to man and only enter
treatment, finally, because they have confronted the fact that the pain is overwhelming and they must either change or die. Sometimes they decide to die. But more commonly, when given the opportunity they decide to try something new. With great courage that is humbling to the on-looker, they hold still, feel the pain, remember its source, confront the past, and finally move on to change. The only real necessity for change is that they discover they are not alone, that there are other human beings who care. There lies the key for the crisis we are in that so desperately needs addressing. We don’t have a health care crisis, we have a crisis of community. Until we understand—all of us, not just doctors, or insurance companies, or the President, or the Congress—that we are all part of one, inseparable community and that we are responsible for ourselves and for each other, we cannot heal (Etzioni, 1993).

We need our leaders to give us a vision of a new and different future, not a vision of a totalitarian, controlled, restricted and rationed health care system within which everyone is deprived. In envisioning that we are only envisioning a medieval past. Together we are bright enough, innovative enough, and creative enough to picture a different world and in imagining it, begin to make it real. But are we brave enough, are we generous enough, are we compassionate enough, to save ourselves and our children? There is still time to make a choice.

"I am captivated more by dreams of the future than by the history of the past"  

Thomas Jefferson

Sandra L. Bloom, M.D., is Medical Director of the Sanctuary at Northwestern Institute, 450 Bethlehem Pike, Ft. Washington, PA 19034.

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